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**MIDTERM EVALUATION OF THE
ASSOCIATION FOR VOLUNTARY
SURGICAL CONTRACEPTION (AVSC)
COOPERATIVE AGREEMENT**

by

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**Fieldwork
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Glossary

AFRO	Africa Regional Office
A.I.D	United States Agency for International Development
ARO	Asia Regional Office of AVSC
AVSC	Association for Voluntary Surgical Contraception
AVS	Association for Voluntary Sterilization
CA	Cooperating Agency
COPE	client-oriented and provider-efficient (services survey)
CTO	cognizant technical officer
DHS	Demographic and Health Survey
EPA	end-of-project assessment
FHI	Family Health International
FHS	Family Health Services Project, Nigeria
FPSD	Family Planning Services Division, Office of Population, A.I.D./Washington
FY	fiscal year
IEC	information, education, and communication
INTRAH	Program for International Training in Health
IPPF	International Planned Parenthood Federation
IPPF/WHR	International Planned Parenthood Federation/Western Hemisphere Region
IPPI	immediate postpartum insertion of an IUD
IUD	intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JSI	John Snow, Inc.
LACRO	Latin America and Caribbean Regional Office of AVSC
LAN	local area network
MIS	management information system
MOH	Ministry of Health
MSH	Management Sciences for Health
NAMERO	North Africa/Mid-East Regional Office of AVSC
NGO	non-governmental organization
Norplant	five-year contraceptive implant
NSV	no-scalpel vasectomy
ob/gyn	obstetrics/gynecology
OR	operations research
PATH	Program for Appropriate Technology in Health
PCS	Population Communication Services (project)
PROFAMILIA	family planning organization in Colombia
PVO	private voluntary organization
RFP	request for proposal
RPMT	regional program management team
R&D/POP	Bureau for Research and Development, Office of Population (A.I.D.)
TAC	technical advisory committee
TOT	training of trainers
UNFPA	United Nations Population Fund
URC	University Research Corporation
USAID	United States Agency for International Development (mission)
VSC	voluntary surgical contraception
WHO	World Health Organization

Project Identification Data

1. **Scope:** Worldwide
2. **Project Title:** Association for Voluntary Surgical Contraception Program (AVSC)
3. **Project Number:** 936-3049
4. **Contract/Grant Number:** DPE-3049-A-00-8041
5. **Critical Project Dates:**
 - Cooperative Agreement: August 1988
 - Project Assistance Completion Date: August 1993
6. **Project Funding:**

A.I.D. Central Funding: \$80,000,000
7. **Mode of Implementation:**

A.I.D. Central: Cooperative agreement between the Office of Population, Family Planning Services Division and the Association for Voluntary Surgical Contraception
8. **Contractor/Grantee:**

AVSC
79 Madison Avenue
New York, NY 10016
9. **Subcontractors:**

None
10. **A.I.D./Washington Project Manager:**

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A.I.D.
Washington, D.C. 20523
11. **Previous Evaluations/Reviews:**

A.I.D./AVSC management review was carried out in November 1990.

Executive Summary

Introduction

The current cooperative agreement between the United States Agency for International Development (A.I.D.) and the Association for Voluntary Surgical Contraception (AVSC), the most recent of a series that has continued uninterrupted since 1971, allocates \$80,000,000 for the five-year period August 1988-August 1993. The purpose of the agreement is to provide support to developing countries to enable the institutionalization of high-quality voluntary surgical contraception (VSC) services that are routinely accessible in family planning service programs. Three broad areas are to be emphasized: expanding access to services, rigorous and systematic attention to voluntarism, and maintaining and enhancing the safety and quality of services. To accomplish these goals, the program stresses institutionalization and sustainability, priority to activities that offer the greatest leverage, continued support of the World Federation of Health Agencies for Voluntary Surgical Sterilization, increased decentralization of authority and responsibility to the field offices, and evaluation and research activities to strengthen program performance.

Fifteen amendments have been made to the cooperative agreement as of May 1991, bringing total obligations to \$43,017,000. Of this amount, 81 percent consisted of central A.I.D. funds and 19 percent of buy-in funds, a division consistent with initial expectations. AVSC is not able to determine the exact proportion of this budget allocated to each program area, since most expenditures cover more than one topic. Based on fiscal year 1990 projects, however, it is estimated that activities related to service delivery consumed over half the budget, with training activities the next largest programmatic category.

This report presents the findings of the midterm evaluation of this cooperative agreement, and supplements the A.I.D./AVSC Management Review carried out in November 1990. The purposes of the evaluation are to review AVSC strategy and performance under the cooperative agreement, and to guide plans for future cooperation between A.I.D. and AVSC.

Current Project Accomplishments and Concerns

In general, AVSC has executed its complex responsibilities for this cooperative agreement quite satisfactorily. The accomplishments have occurred through a mix of funded projects (146 subagreements in 40 countries and 76 small grants in 24 countries) technical assistance, training courses and workshops, and publications and program materials.

The quantitative outputs specified in the agreement, with few exceptions, have been achieved on or ahead of schedule; these outputs relate to the expansion of access to services, free and informed choice, medical safety, and program improvement. For example, 10 regional training centers were to be developed during the five-year project; 14 have already been established. Eighty training courses or workshops on counselling or voluntarism were to have occurred; 134 such training events have been undertaken.

AVSC has demonstrated its ability to identify and disseminate appropriate technology worldwide, with projects now in 49 countries and a strong field presence at the regional level. It has handled controversial contraceptive methods — male and female sterilization — with sensitivity and courage.

Although AVSC has definite preferences for methods and approaches (e.g., minilaparotomy under local anesthesia), it recognizes the need for programmatic flexibility to reach long-term goals. The agency is expanding its scope beyond interval sterilization to include other surgical methods (i.e., Norplant, postpartum sterilization, and intrauterine device [IUD] insertion) that build on the agency's strengths and resources. AVSC has shown leadership in quality assurance and counselling, and provides an international model with its focus on the issue of free choice.

Communications between AVSC and A.I.D./Washington, and between AVSC field offices and most USAID country missions, are good. Recommendations that emerged from the 1990 A.I.D./AVSC Management Review have nearly all been addressed, and recently adopted changes should improve communications and lead to quicker resolutions of potential disagreements.

AVSC maintains extensive links with other Cooperating Agencies (CA) and multilateral agencies, and with few exceptions (e.g., in the Family Health Services Project in Nigeria) enjoys effective cooperation and mutually productive relationships with them.

There are, however, several ways AVSC's performance during this cooperative agreement could be improved. Greater attention could be given to information and education efforts and outreach activities, for example. In many countries AVSC has influenced national VSC policy issues by working through local technical staff and program administrators, but its impact might be increased with more direct attention to political policymakers. Lack of systematic follow-up of participants in training courses makes it impossible to assess the true effect of training activities, and training of trainers courses devote too little attention to teaching how to train.

AVSC's evaluation activities need to be strengthened. The management information system (MIS), not yet entirely operational, provides little of value, quarterly reports collect data that are unused, and, overall, there is little systematic effort to utilize evaluation to improve projects or management. Relatively little attention has been devoted to cost studies, making it more difficult to work toward sustainable programs. AVSC is unable to provide quantitative evidence of its impact, and A.I.D. finds accounts of the qualitative effects of AVSC's activities unpersuasive.

Strategic planning is now being taken seriously by AVSC. Its use of country-level workplans in 10 countries is to be commended, but these occur in only a few of the places where AVSC is active. Though small projects are often useful, AVSC supports a disproportionate share of these administratively time-consuming grants, and procedures for review and approval for subagreements are unnecessarily complex.

AVSC's focus on three new contraceptive methods — Norplant, no-scalpel vasectomy (NSV), and postpartum IUDs — now falls within the International Programs Division rather than within the Medical Division. Although the introduction of these family planning methods demands programmatic attention, their relative newness within AVSC also requires special medical expertise.

Overall staff competence and motivation is high, but the lack of field experience and hands-on technical expertise in the Program Management Division, which is composed of four regional program management teams (RPMT), hampers links between headquarters and the field. The 18-month absence of the medical director weakened the Medical Division, whose role in the organization needs clarification. There is an uneven capacity to provide medical technical assistance in the field at short notice, a problem particularly acute in the Asia Regional Office.

The World Federation of Health Agencies for Voluntary Surgical Contraception, supported by AVSC since its inception in 1975, today offers little to augment AVSC's work. The most valuable functions of the World Federation might best be achieved if it were a truly independent international organization, administratively and physically distanced from AVSC.

The current AVSC program is largely consonant with the "principles for family planning delivery in the nineties" recently articulated by A.I.D. To move even closer to these principles, AVSC could devote greater attention to the private for-profit sector, focus more on sustainability by examining cost-effectiveness of services, and increase managerial efficiency by continuing the present trend toward decentralization. Building on A.I.D.'s logic behind the typology of grouping recipient countries into five levels depending on modern contraceptive prevalence, AVSC has proposed an alternative typology using sterilization prevalence.

AVSC's Future Program

A number of changes can be anticipated in the environment for family planning in the coming decade. Without question, the most important trend will be the dramatic growth of family planning programs in general, and of surgical contraception in particular. Sterilization will become a central component of government and private programs, moving from the sidelines to the mainstream. As sterilization gains ground, AVSC's role, now largely focused on nurturing small pilot programs and cutting-edge institutions, will need to adapt if it is to exert maximum leverage.

A key change, if AVSC is to influence thousands rather than dozens of VSC procedures in a country, will be the shift in orientation from a project to a program focus. This evolutionary step will require a global vision of what AVSC is capable of doing, a better grasp of overall needs and opportunities in a country or region, more ambitious strategic planning, and management improvements. As AVSC moves from working on an array of small and often unrelated projects to influencing large national programs, it will increase its leverage, cost-effectiveness, and ultimate impact.

As AVSC moves from local projects to national programs in the coming decade, however, control of VSC services will shift from AVSC project directors and technical specialists to national program administrators. In the future, AVSC will usually operate at a greater distance from the actual clinic procedures, and simply will not be able to ensure strict adherence to the same optimal standards of quality. The diminished control over AVSC-supported activities may lead to an increase in side effects and regret-linked complaints. AVSC, A.I.D., and other donors must adjust their demands for accountability, recognizing that AVSC cannot both maximize its leverage by focusing on national-level programs and simultaneously maintain the degree of control possible through a focus on small projects.

AVSC staff argue that the agency constantly strives for perfection. Through attention to detail and insistence on highest quality performance, together with elaborate and ultimately centralized mechanisms for review and approval of new activities, AVSC has achieved world recognition for its excellent work. The agency's high expectations for itself have been well suited for a very sensitive field. With the probable expansion of its operations and scope of work in the coming decade, however, AVSC may need to relax some of the standards of perfection in non-critical areas. Unless standards of quality are prioritized and adjusted, AVSC will increasingly be constrained by too rigid and unrealistically high expectations, limiting the ultimate impact of its work.

The coming decade will see governments and clients themselves assuming a greater proportion of the costs of family planning programs. A consequence of the shift toward client financing is that financial management will play a critical role in the sustainability of contraceptive programs, and AVSC will need to expand its assistance in this area.

AVSC has adapted to changing needs by broadening its original organizational mission to include other types of surgical contraception in addition to sterilization, and has moved beyond the surgical event itself to include counselling and other non-medical service elements. As VSC becomes increasingly accepted as an integral component of comprehensive national family planning programs in the 1990s, the need will grow for technical assistance for all aspects of VSC service delivery.

First among the new priorities will be the need for AVSC to address policies which inhibit effective sterilization programs; the agency's current stance of studied impartiality toward policy issues will need to be replaced by one of scholarly advocacy. AVSC will also need to significantly expand its efforts in the area of information, education, and communication (IEC) and in strengthening of management skills for VSC program administrators.

As VSC programs grow bigger and become integrated into national family planning programs, monitoring and evaluation mechanisms will increasingly be needed as essential management tools. To assist large VSC programs effectively, AVSC must not only improve its collection and processing of programmatic data, but learn to use the information quickly to anticipate areas of concern, identify and solve problems, increase cost-effectiveness, etc.

Through the 1990s countries will represent a wide range of contraceptive prevalence and program sophistication, from "emergent" through "mature," and will offer an array of mechanisms through which family planning services, including VSC, might be provided. Within the limits of its overall mandate, AVSC must continue demonstrating flexibility to seize opportunities and eliminate constraints in providing VSC services. In each country, for example, AVSC's balance among collaborating non-governmental, government, and private sector organizations will need to be adjusted so attention is given to those sectors most likely to have cost-effective and sustainable impacts. Since this balance varies among countries and changes over time, AVSC must be prepared to adjust quickly to new situations.

Adaptability must also characterize AVSC's response in the coming decade to opportunities for strengthening its programmatic activities. As it did with NSV, AVSC will need to help disseminate improved VSC procedures (including sedation and anesthesia) as well as new ideas for training, counselling, quality assurance, monitoring and supervision, etc. Some future innovations, such as COPE (client-oriented and provider-efficient services) may be developed by AVSC itself; most, however, will be borrowed, with AVSC playing a role in their global introduction.

Flexibility will also be needed in management. AVSC headquarters units and field offices that are strong will need to be given more authority to use their knowledge and experience imaginatively; weaker elements of the organization will need greater attention and support. Creative country program management approaches have already been tried with success in Turkey, Tanzania, and Nigeria, where in-country institutions and professionals handle AVSC project monitoring and technical assistance responsibilities. More extensive use of this decentralizing strategy should strengthen local institutions and free AVSC staff for other activities.

Flexibility will also be needed to deal with A.I.D./Washington and USAID missions in the next decade. Staff turnover at A.I.D./ Washington and USAID missions will continue to disrupt communication links and sometimes lead to revisions of priorities and procedures. As the demand for VSC grows, AVSC can expect to receive even more calls, some on short notice, to handle particular tasks or to explore new initiatives. AVSC will need to respond promptly and thoughtfully to all such requests, seeking immediate advice from its A.I.D. cognizant technical officer in the event a request must be declined.

AVSC has grown and adapted over the past two decades to meet the changing needs for VSC in the developing world. There is every reason to believe AVSC will continue to evolve to meet the new challenges of the coming decade.

Key Recommendations

Overall Policy and Balance of Activities

1. AVSC should continue to focus only on the provision of surgical methods of family planning, exploring new variations and methods of such contraceptives as they become available for programmatic field trials. Though AVSC should continue and expand its role in assisting with the introduction of Norplant, its involvement with postpartum IUD insertion should be carefully examined before widely integrating this method into its programs. Sterilization, both male and female, should remain the agency's central focus.
2. AVSC should give more attention to sedation, analgesia, and anesthesia in the context of VSC procedures, and should involve more anesthesiologists and/or anesthesia technicians in AVSC training and service delivery programs.
3. Greater attention should be paid to ensuring that participants in AVSC training courses can learn the specific technical skills they will need in their home institutions; all trainees should be followed up after completing a course to determine the long-term effects of the program.
4. AVSC should continue to focus on issues of counselling for VSC, and work with other service delivery CAs to improve counselling for all family planning methods.
5. Where existing VSC services are underutilized, AVSC training programs should focus not only on more acceptable surgical techniques, but also on ways to increase demand for the services and to lower programmatic barriers (e.g., through improved clinic management, outreach programs, information and communication).
6. Based on its comparative advantage, AVSC should more systematically address VSC policy constraints at all levels, from local hospital and clinic administrators to national and government family planning programs.
7. AVSC should devote more effort and imagination toward the sustainability of VSC programs. This should begin with developing reliable measures of the true costs and impacts of VSC services and the assessment of the cost-effectiveness of various delivery system models. AVSC should more actively collaborate with the private for-profit sector.

8. The recently introduced process of developing and approving country workplans rather than individual projects should be expanded, by the end of 1992, to include all countries in which AVSC has a major role. In its strategic planning at all levels, AVSC should work closely with A.I.D. and expect clear guidance about A.I.D.'s expectations.

Organizational Structure and Management

9. To streamline the grant approval process, AVSC staff should be given authority to approve subprojects consistent with an approved country program strategy. AVSC should accelerate its move toward approval of multi-year subagreements.

10. The AVSC Board of Directors' International Committee should discontinue its quarterly review and approval of projects and instead review country strategies at an annual meeting hosted by a different AVSC regional office each year.

11. AVSC should reconsider its decision to place the primary responsibility for Norplant, NSV, and postpartum IUDs in the Special Programs section of the International Division. Moreover, AVSC should make special efforts to ensure that the Medical Division (and other units) play major roles in planning and implementing the service provision of these methods. AVSC should fully involve the newly recruited medical director in senior management decisions, and give her clearly articulated authority to direct the medical affairs of AVSC. The role of the Medical Division vis-a-vis the regional offices needs to be redefined, with unambiguous lines of communication and authority.

Research and Evaluation

12. The Research and Evaluation Department needs to be strengthened and refocused to concentrate not primarily on projects, but on programs. Efforts to measure the quantitative impact of AVSC activities on programs, VSC procedures, and demographic events should be accelerated.

13. Service delivery statistics required on subprojects' quarterly report forms should be simplified to the minimum actually used for project monitoring and evaluation. The MIS should be made fully operational and end-of-project assessments either utilized or reduced to a simple exercise to verify the cumulative service statistics provided by the quarterly reports.

14. AVSC should only foster a research capacity insofar as it strengthens its monitoring and evaluation capacity. The present policy — undertaking research in collaboration with other organizations which have the requisite skills and resources — should be continued.

Regional Program Management Teams

15. AVSC should review the job descriptions, staffing requirements, and personnel policies regarding the RPMTs. Regional staff should play a formal role in all personnel actions regarding RPMT staff. Program managers on the RPMTs should be rotated to regional offices for extended periods to gain an appreciation of the field situation.

Decentralization and Field Offices

16. AVSC should be commended for the decentralization it has achieved and should continue in this direction. Headquarters should take a more flexible approach in dealing with regional offices,

continuing to provide direction and support for the weaker offices but allowing more autonomy for the stronger ones; special attention should be devoted to bringing the Asia Regional Office up to the level of the others. AVSC should establish a country representative in Turkey, and begin planning for representatives in other countries with active programs in the coming years.

17. All regional offices should strengthen their capability to provide medical technical assistance, evaluation, and certification, by expanding the pool of medical consultants and, where feasible, adding medical specialists to the field staff. Regional offices should also anticipate that in the coming years they will increasingly be expected to provide technical assistance in non-medical aspects of VSC programs (e.g., training of trainers, IEC, outreach, management, evaluation). Every effort should be made to identify qualified nationals from the region for these tasks.

18. AVSC field offices should express to appropriate USAID missions their availability and willingness to participate in strategy development and the planning of mission-initiated projects, and should improve their ability to accept relatively short notices of meetings with USAID mission staff.

World Federation

19. Over the next few years AVSC should gradually phase out financial support for the World Federation, allowing it time to plan for alternative arrangements for funding and management.

1. Introduction

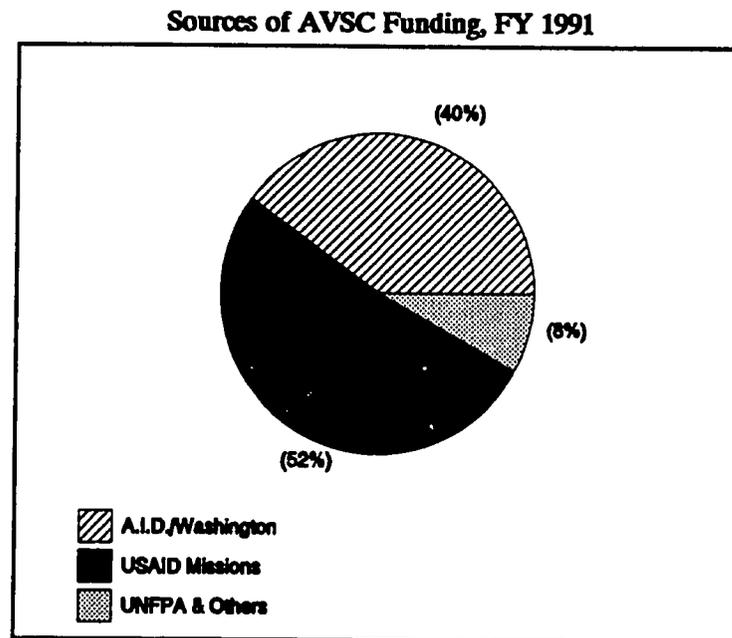
1. Introduction

1.1 Background

The Association for Voluntary Surgical Contraception (AVSC) was founded in 1943 (as the Association for Voluntary Sterilization, AVS) to make voluntary sterilization more widely accessible in the United States. Originally involved primarily in outpatient male sterilization, the organization contributed substantially to changes in the legal, professional, and public climate that led to sterilization becoming the most widely used family planning method in the United States, currently being performed on equal numbers of men and women.

In 1971 AVS(C) began working in the developing world, and received its first funding from the United States Agency for International Development (A.I.D.) in 1972. Since then, A.I.D. has been the principal source of funding for AVSC international activities; today A.I.D. grants constitute 92 percent of all AVSC income (see Figure 1).

Figure 1



When AVS(C) began utilizing its United States expertise in the international family planning arena in the early 1970s, sterilization was an underutilized method with major political and social sensitivities. In order to garner support and demonstrate acceptability, AVSC adopted a slow, steady, nurturing approach to introduce sterilization services. Although the agency has significantly expanded its programmatic activities in the past 20 years, now promoting voluntary surgical contraception (VSC) more boldly, AVSC still avoids direct involvement in shaping national sterilization policies.

Over the years, AVSC's programs have evolved from an emphasis on the transfer of resources — funds, supplies, and equipment — to the transfer of technology and skills. Today's focus is on helping to institutionalize the provision of quality surgical contraceptive services in private and government

health and family planning services. Other themes in the development of AVSC's international program are summarized in Appendix B. Today the agency enjoys a well-deserved reputation as a leader in quality assurance, counselling, and training.

The global attitude toward sterilization has radically changed in the last 20 years, in large part a result of AVSC's assistance in establishing small-scale incremental projects working from the ground up. Such projects are still useful in expanding service delivery to small pockets of people, but the demands for contraception in the 1990s will require larger sterilization programs operating at national levels.

1.2 Cooperative Agreement with A.I.D.

The estimated amount of AVSC's second cooperative agreement with A.I.D. for the period August 24, 1988, to August 23, 1993, is \$80,000,000. As of May 1991, the cooperative agreement has been amended 15 times, bringing total obligation to \$43,017,130. Of this amount, 81 percent consisted of central A.I.D. funds and 19 percent buy-in funds.

The purpose of this project is to provide support for developing countries in order to have high-quality VSC services institutionalized and routinely accessible in their family planning service programs. To achieve this goal, the project has three main areas of emphasis:

- expanding access to services, with emphasis upon institutionalization and sustainability;
- rigorous and systematic attention to voluntarism; and
- maintaining and enhancing the safety and quality of services.

The cooperative agreement summarizes the general activities that are to be implemented in each of these three areas of emphasis (see Appendix C). The document also specifies approaches to lay the foundation for implementing the diverse activities required to carry out a project of this magnitude:

- Continued and intensified activity leading to institutionalization and sustainability of VSC services;
- Assignment of priority to projects that can exert influence beyond the particular activity being supported, i.e., those offering leverage;
- Continued, carefully considered support for the World Federation of Health Agencies for Voluntary Surgical Contraception;
- Decentralization, with continued transfer of authority and responsibility to the regional and country offices and simultaneous strengthening of capacity for medical and programmatic oversight; and
- Diverse evaluation and research activities designed to strengthen program performance.

The cooperative agreement also included a list of the specific project outputs, operationally defined, which A.I.D. expects (see Chapter 2.2).

1.3 1991 Midterm Evaluation

The AVSC cooperative agreement calls for a midterm evaluation to take place in early fiscal year (FY) 1991 by an external evaluation team with A.I.D. staff participation. The purpose of the evaluation was to review AVSC strategy and performance to assess how well AVSC has carried out its program under the cooperative agreement and to guide plans for future cooperation between A.I.D. and AVSC.

Roughly one-third of the evaluation effort was to focus on documenting the extent to which the project is on track in achieving scheduled objectives. Among the issues to be examined were the appropriateness of AVSC's response to the November 1990 Management Review, and the degree to which AVSC's activities have been consistent with the November 1990 A.I.D. Office of Population's Family Planning Services Division (FPSD) principles for family planning service delivery in the nineties. (See Appendix H for a list of these principles.)

Two-thirds of the evaluation effort was to look to the future by suggesting what adjustments in emphasis or process should be made and what unanticipated initiatives should be considered for the remainder of the cooperative agreement period. (See Appendix A for the evaluation scope of work.)

1.4 Future Trends in Family Planning Relevant to AVSC

In the evaluation team's "look to the future," the first step was to envision trends in family planning in the coming decade which AVSC will need to take into account as the agency evolves its strategy and activities. In discussions with leaders in international family planning programs¹ three primary areas of change were identified: demographics, financing of family planning activities, and family planning program management.

Demographic Changes

To achieve the middle-level United Nations projections, the size of family planning programs will have to increase dramatically. The method mix will shift toward more effective long-term contraceptives. This is consistent with the current trend toward a lowering of fertility in Latin America and Asia, and with the beginnings of successful programs in selected countries in Africa, such as Kenya and Zimbabwe.

Moreover, as couples seek to have smaller families, the trend will continue toward younger, lower-parity women seeking permanent contraceptive methods. This, of course, will have enormous impact on the role of sterilization in many national family planning programs in which sterilization will become a mainstream component rather than a separate and relatively unimportant component of the contraceptive mix.

¹Including George Brown, Duff Gillespie, Malcolm Potts, John Ross, and others from A.I.D. and AVSC.

Rapid urbanization, already under way, will increase, with important implications for delivery of services. In most areas today, one of health planners' most difficult problems is providing services to a widely dispersed population in rural areas. With a population balance shifting to cities, the problem will increasingly be to provide services for the urban and periurban poor. The target population will have much better physical access to health and family planning facilities, but for cultural or economic reasons may be unwilling to use them.

One implication of this shift is that services which are hospital-based, such as surgical contraception, are more accessible to large numbers of people who live in physical proximity to such facilities. Another is that, with physical barriers less important, programs can focus more on barriers related to knowledge and attitudes.

Changes in Financing Family Planning Services

In the early stages of many family planning programs, a significant portion of the financial burden has been assumed by international donors, especially A.I.D., United Nations Population Fund (UNFPA), and International Planned Parenthood Federation (IPPF). Increasingly, however, because of limited donor resources and increased prioritization of family planning by both clients and governments, more of this financial responsibility is being assumed by host governments and by clients themselves. This important trend is likely to continue, with many clients assuming the major financial responsibility for their own contraception.

In Latin America and Asia, government support will be needed for people who are too poor to pay; international donor support is likely to be focused on those parts of the world (e.g., Sub-Saharan Africa and South Asia) where neither government nor private resources are sufficient to cover the costs of these programs.

With this shift in financial responsibility will be a commensurate shift toward a focus on the client and her or his needs. Those who pay for services have a greater say in what services are offered and how they are provided, so providers will be forced to give greater attention to factors which make those services more attractive. Hours of clinic operation, privacy, and courteous service are all factors that will likely improve in response to client demand. Coercion should not be a major concern in client-funded programs, since consumers will not pay for services they do not want.

Changes in Program Types and Management

The rapid growth of family planning demand, coupled with the shift toward client payment, will promote a significant diversification in family planning service delivery systems. Commercial programs will provide services for a larger share of the market, building on private sector health practitioners and the sale of contraceptive products through commercial outlets. Large non-governmental organizations (NGO) or health-maintenance-type organizations will gain ground in an environment in which greater numbers of clients pay for services. The public sector will also continue to have a major role, of course, in the regulation of the private sector, in the provision of services which need significant infrastructural back-up, or in the provision of services to a population too poor to pay.

This diversity of providers will mean that the overall environment for family planning services will be much more complex. Control of issues such as quality will be both more difficult and in some sense more important, since the diversity of providers will also mean greater variation in competency.

Technical competence in the management of family planning programs will increase in the coming decade. The more mature programs currently emphasize management issues such as management information systems (MIS), inventory control, and patient flow; as other programs grow and mature, we can expect this trend to continue. Better management will also be promoted by the need for improved efficiency; as provider organizations rely on client funding, costs must be kept down to remain competitive.

1.5 Structure of this Report

Chapter 2 reviews programmatic issues, examining how AVSC is meeting the expectations detailed in the cooperative agreement, and how well it is planning to deal with future needs. Chapter 3, focusing on management issues, discusses organizational structure, the management of projects, and AVSC's success at decentralization. Chapter 4 examines AVSC's relationships with A.I.D., other Cooperating Agencies (CA), and multilateral agencies. The final chapter draws conclusions about AVSC's ability to respond to needs in the coming decade, and summarizes the main recommendations.

Chapters 2, 3, and 4 also examine the degree to which AVSC activities are dealing with the recommendations of the 1990 Management Review, and are consonant with the principles of the 1990s articulated in the Office of Population FPSD document.

2. Programmatic Issues

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2. Programmatic Issues

2.1 Areas of Program Concentration

AVSC's primary distinction is its focus on one category of family planning methods: surgical contraception. Most other CAs are distinctive because of their programmatic concentration on one of the functional divisions identified by the Office of Population (e.g., service delivery; research; information, education, and communication [IEC]; training; policy). To advance surgical contraception within the context of family planning service delivery, AVSC's activities cross-cut the usual functional divisions. AVSC's overlap with other cooperating agencies is necessary and appropriate because sterilization requires — in each of the functional areas — specialized medical and programmatic expertise.

AVSC is not able to determine the exact proportion of staff effort or budget allocation devoted to each programmatic area, since most expenditures of time and money cover more than one topic. The following figures, however, provide a rough sense of the relative balance of program activities. The table shows estimated expenditures for all AVSC divisions and departments except the National Division (which is wholly supported by non-A.I.D. funds) during FY 1990 (April 1, 1990 through March 31, 1991).

Table 1

Estimated AVSC Expenditures*
FY 1990

Service delivery	\$ 5,577,000	61 %
Training	1,170,000	13 %
Information and education	800,000	9 %
Non-medical quality assurance (including counselling)	637,000	7 %
Medical quality assurance	571,000	6 %
Research and evaluation	174,000	2 %
Policy	<u>230,000</u>	<u>2 %</u>
TOTAL	\$9,159,000	100 %

* Except for National Division

These figures are based on an analysis of all FY 1990 subagreements and small grants; technical and administrative support costs have been allocated in proportion to the grant allocations. Since the AVSC financial reporting system slots activities only under the program area where most of the money goes, service delivery is over-reported and other categories under-reported.

2.2 Scheduled Outputs: AVSC Performance to Date

The cooperative agreement stipulated indicators to measure project accomplishments for each category of the logical framework: expanding access to services; rigorous and systematic attention to voluntarism; maintaining and enhancing the safety and quality of services; improving project activities; and increasing knowledge of VSC issues through professional publications and presentations.

Appendix D summarizes the outputs scheduled for completion during the 60-month project, together with the actual outputs achieved for the first 28 months (through December 1990). Nearly all the planned outputs are on or ahead of schedule. Even though the project is not yet at the half-way point, several outputs have already exceeded the five-year objectives (e.g., development of regional training centers; involvement in postpartum projects; support of training courses/workshops on counselling or voluntarism; funding of medical training programs; technical assistance visits).

Two project outputs regarding publications, however, are significantly behind schedule. Thirty issues per year of periodic AVSC-supported publications were projected; only four issues have been produced. The reason is that one of the AVSC in-house publications, *Biomedical Bulletin*, was discontinued because technical information on sterilization began to appear regularly in referenced journals, and the second, *Communique* (the newsletter of the World Federation), suffered from a reduced budget. The planned outputs also included 15 AVSC Working Papers, though none had emerged by December 1990 (the first appeared in April 1991). Although three manuscripts planned for this series were instead accepted in refereed journals, there is cause for concern about the limited output.

Several outputs regarding research and evaluation (topics discussed in greater length below in Sections 2.10 and 2.11) are slightly behind or marginally on schedule (though the "schedule" for research should reflect the fact that studies begun earlier in the project may not be completed until the last year or two of the five-year agreement period). Seventeen final reports of research on client voluntarism, knowledge, and satisfaction were specified; AVSC states that seven have been produced. AVSC further explains that six of the scheduled 10 cost studies are currently operational, as are 18 of the scheduled 34 operations research (OR) projects in which AVSC has participated. The evaluation team did not assess these research and evaluation projects individually.

2.3 Service Delivery Support for Family Planning Methods

AVSC directly supports service delivery through provision of equipment, technical, and financial assistance in operating theater and family planning site construction and renovation; subsidies on a per case basis, once common, are being phased out. The initial provision and replacement of equipment by AVSC has allowed family planning service centers and clinics that would otherwise be unable to purchase adequate equipment to provide quality sterilization services.

AVSC's traditional method-specific focus on male and female sterilization has been enlarged to include reversible long-acting methods of contraception which also involve surgery (e.g., Norplant and the immediate postpartum intrauterine device [IUD]).

2.3.1 Sterilization

Female Sterilization

Female sterilization has always dominated AVSC's international work. During FY 1990, grant obligations for this contraceptive method totaled almost \$5,500,000², nearly eight times the amount spent on vasectomy.

In its effort to promote appropriate technology for tubal ligation, AVSC now gives special attention to minilaparotomy (minilap) under local anesthesia. AVSC's attention to minilap occurs because this approach can be performed by a greater number of trained doctors in a larger number of clinical facilities, is generally less costly than laparoscopy, uses simpler and more readily available instruments, requires a less sophisticated infrastructure than laparoscopy, and avoids some of the most serious complications. In addition, the use of local anesthesia helps to minimize anesthetic complications, reduce recovery time, and lower costs. In the last few years, minilap has been associated with a higher death rate than laparoscopic sterilizations, but this has been due to the settings and surgeons rather than the procedure (see Section 2.8).

Despite AVSC's worldwide success in the promotion of minilap under local anesthesia, the agency recognizes the need for programmatic flexibility to reach long-term goals. Approximately 30 per cent of female VSC procedures done under the auspices of AVSC are laparoscopic. Many obstetrics/gynecology (ob/gyn) specialist clinicians prefer laparoscopic sterilization. It is the primary method employed for tubal ligation in some regions and countries (e.g., the North Africa/Middle East Region, Indonesia), and AVSC recognizes that it will not be replaced overnight. Also, where sterilization is still controversial among service providers, introduction of the laparoscope as a diagnostic tool can open the door for training in sterilization.

In countries where laparoscopy had earlier been introduced as an appropriate technique (e.g., by the Johns Hopkins Program for International Education in Reproductive Health [JHPIEGO]), AVSC supports these services but attempts to provide physicians trained in laparoscopy with cross-training in minilap. The new skills allow clinicians greater flexibility and choice of method, especially if the laparoscope breaks.

AVSC is phasing out its per case subsidy of sterilization, and replacing it with support for non-recurrent costs of sterilization. Progress is uneven. Within the North Africa/Middle East Region, for example, institutions in AVSC-supported programs in Turkey and Yemen receive no payment per operation, but institutions in Morocco, Egypt, and Tunisia are still subsidized according to the number of sterilizations performed. In the Africa Region, per case subsidies are no longer provided. The shift away from per case subsidies allows AVSC to better earmark its support for specific program needs, and reduces the possibility that local clinic staff will focus on numbers of procedures over quality of procedures.

²Although most of this amount represents projects primarily concerned with service delivery, it also includes training, information and education, quality assurance, and research and evaluation focusing on female sterilization.

Recommendations

1. AVSC should continue to focus on female sterilization via minilap under local anesthesia with sedation, but with flexibility where laparoscopic procedures are still dominant.
2. AVSC should continue to disengage from per case subsidies of sterilization procedures.

Vasectomy and Male Involvement

In response to generally low levels of acceptance of male sterilization in most developing countries, AVSC has recently expanded its provision of training and support for vasectomy services. AVSC's special program initiative on males also includes an emphasis on men's roles in all family planning decisions. AVSC-funded research has begun to identify information that men need to improve their contraceptive decision making for themselves and their wives; the results of the studies will help to develop IEC materials both for service providers and potential clients. AVSC's concern with male involvement in contraception decision making could theoretically cover a huge range of issues; though many would fall outside the agency's current focus, some are consonant with stated goals and activities.

No-scalpel vasectomy (NSV), a technique developed in China, is currently a major element in AVSC's male initiative. NSV is promoted as a better method: easier, quicker, less frightening to clients, and more attractive to service providers. The billing as an "easier" method receives mixed responses, though, since it is a little harder to learn and requires more dexterity; some medical personnel are reluctant to change to the more sophisticated technique.

AVSC has done an outstanding job in helping to refine and promote the NSV method and to initiate its programmatic introduction in over 20 countries.

Recommendation

3. AVSC is incorporating into its program a concern for the male role in family planning decision making, but needs to define more specifically what the agency will do — and will not do — on this large and complex topic.

In many countries conventional wisdom holds that men will resist vasectomy even if they agree to accept family planning. In Turkey, for example, many providers believe that men would not be interested in vasectomy — although 89 percent of husbands approve of family planning. Two male methods (withdrawal and condoms) are used relatively effectively, and account for about half of all current contraceptive use.

Where males are thought — rightly or wrongly — to be hostile to vasectomy, it may be difficult to introduce VSC programs. In Turkey, however, AVSC has displayed imaginative ways to help set the stage for a future increased demand for male sterilization, by initiating a study of male knowledge and attitudes, training two surgeons in NSV techniques, and examining the topic at a national workshop. Recognizing that the limited availability of service sites reduces the number of acceptors, AVSC's North Africa/Mid-East Regional Office (NAMERO) is now seeking to develop a training site for

vasectomy in collaboration with Pathfinder (which has its own successful urology-department-based vasectomy program).

Recommendation

4. Even in countries where vasectomy is currently thought to be unpopular, AVSC should continue to provide vasectomy training to clinicians who can then add the technique to their range of services. Greater availability of services could cause an increase in demand.

As AVSC continues and extends its program to fill the demand for vasectomy, it will need — just as with female sterilization — to work to increase the demand for vasectomy.

Recommendation

5. AVSC should play an increasingly more active role in encouraging the adoption of male sterilization.

Future Growth in Demand

To achieve the United Nations middle-variant population projections in the coming decade, an estimated 151 million surgical procedures for female and male sterilizations will be required by the decade's end. This implies a yearly average of 15 million procedures worldwide, a dramatic increase over the estimate of about 10 million procedures in 1990. Meeting this target requires not only strengthening and expanding the supply side (e.g., sterilization equipment and facilities, trained staff), but also increasing potential clients' awareness and information about sterilization.

AVSC is the organization best equipped to lead efforts to achieve the herculean task of augmenting the supply side, though to do so the agency will have to scale-up its efforts appreciably and make adjustments in its operational strategy to maximize leverage (see recommendations in the following sections).

At the same time, without concomitant changes in the knowledge and awareness of sterilization, improved referral and client flow between facilities, and greater felt need for the procedure in large populations, expansions in the provision of sterilization services may be largely wasted in some locations (e.g., many African countries).

Although AVSC, in the past few decades, has boldly supported strengthening sterilization services, it has deliberately adopted a cautious stance regarding public campaigns to increase the visibility and acceptability of sterilization.

Recommendation

6. Simultaneously with its efforts to provide sterilization services, AVSC should significantly expand its efforts to ensure that clients are aware of and appreciate the relative advantages of sterilization, and encourage enlightened national policies regarding sterilization. (Recommendations in the following pages will suggest more specifically how this might be accomplished.)

2.3.2 Norplant

Until the end of 1990, AVSC's Norplant-related work was funded with non-A.I.D. monies. Because of AVSC's experience with surgical contraception and with issues related to quality service provision, in 1991 the Office of Population funded the agency to help introduce Norplant. AVSC is now actively working to develop and evaluate model service delivery components for wider replication.

Norplant fills the gap between the permanence of voluntary sterilization and the short-term efficacy of other contraceptive methods. By providing access to long-lasting temporary alternatives to sterilization such as Norplant, AVSC can serve clients who are younger or have fewer children, and can increase the range of contraceptive options available to clients.

AVSC has been designated by A.I.D. to be lead agency for introduction activities of Norplant in six high-priority countries³ and a participating agency in five other high-priority countries.⁴ In addition, governments of several other countries have asked AVSC to help introduce Norplant.

Where AVSC has begun to assist in incorporating Norplant into ongoing family planning programs, it has been successful. In Tunisia, for example, the National Office of Family Planning is pleased with the progress made by AVSC and the Norplant introduction working group in developing its national Norplant strategy.

Though Norplant was not factored into the contraceptive commodity requirements in UNFPA's projections for the 1990s,⁵ it is probable that this method will play an increasingly important role in national programs in the coming decade. Though it demands a high initial capital outlay, Norplant is a reasonably cost-effective method for the five years it is in place.

Norplant requires clinic facilities, health professionals trained in simple insertion and removal skills, and — particularly in the early years of introduction — skilled counselling and dependable medical quality control. AVSC is uniquely positioned to ensure that these exist. Moreover, through its decades of work in sterilization, AVSC has access in developing countries to the networks of health professionals and policymakers who will determine how Norplant is introduced.

Recommendation

7. AVSC should continue and (if additional funding is obtained) expand its role in assisting with the promotion of Norplant.

2.3.3 Postpartum Family Planning: Sterilization and IUD Insertion

Postpartum family planning is a key component of AVSC's new program initiatives. AVSC's extension into postpartum services occurred because the postpartum period is an obvious — and

³Nepal, Tunisia, Dominican Republic, Kenya, Nigeria, and Rwanda.

⁴Bangladesh, Pakistan, El Salvador, Mexico, and Zimbabwe.

⁵United Nations Population Fund (February 1991) *Contraceptive Requirements and Demand for Contraceptive Commodities in Developing Countries in the 1990s*. New York.

underutilized — time for clients to receive family planning. Moreover, postpartum methods can be provided in hospitals where most AVSC-supported interval sterilization programs are based. Existing maternity services can be used and a separate infrastructure is not required, so postpartum family planning service delivery can be cost-effective and sustainable.

As AVSC recognizes, however, the provision of sterilization to women during the postpartum period can be problematic: special attention is required to ensure free and informed choice and to minimize potential regret.

Because of its strengths in counselling and ensuring informed consent — as well as its technical competence in surgical contraception — AVSC has been an ideal agency to help spearhead the development of postpartum sterilization programs. It has begun with an operations research project for the introduction and delivery of postpartum family planning, meetings for regional personnel, and pilot projects in all of the regions. AVSC has also demonstrated leadership in establishing and chairing an interagency task force on perinatal counselling. Initial experience indicates that more needs to be learned about providing effective education and counselling to pregnant and postpartum women, so that improvements can be made in client education materials and training for service providers.

Recommendation

8. Building on its traditional strengths, AVSC should continue and expand its research and program development regarding postpartum sterilization.

AVSC is also exploring postpartum IUD insertion, a topic somewhat further from its traditional strengths. AVSC is developing a standard protocol for immediate postpartum IUD insertion, and continues to study service delivery of postpartum IUDs worldwide. One rationale for involvement with this method is that postpartum sterilization should always be offered within the context of a choice of methods. This context requires the availability of another long-lasting, highly effective method of contraception that can be initiated in the postpartum period.

Postpartum IUD insertion is different in important ways from postpartum sterilization. Based on the timing of insertion, postpartum IUDs can be classified as (a) immediate (within 10 minutes) postpartum insertion (IPPI) or (b) regular postpartum insertion (after the IPPI window but before the patient's discharge from the delivery site). Unlike the sterilization procedures, usually performed within 24-48 hours after childbirth, research suggests that postpartum IUD insertion should be conducted within 10 minutes after delivery of the placenta to minimize expulsions. Thus, although postpartum sterilization and immediate postpartum IUD insertion are both hospital based, the former can be done in any operating theater when the physician schedules it, and the latter requires the delivery room and takes place whenever the birth occurs. The number of staff who must be trained also differs: since immediate postpartum IUD insertion could occur at any time, trained personnel must be on hand at night and weekends — not merely weekday mornings, or whenever postpartum sterilizations can be scheduled. Regular postpartum IUD insertions, of course, do not require a 24-hour on-call staff person, need not be performed in the delivery room, and in many places could be done by a nonphysician.

Recommendation

9. AVSC should continue to carefully research the clinical and programmatic aspects of postpartum IUD insertion before integrating this method into its programs.

The AVSC postpartum initiative operates, as do most AVSC service delivery activities, primarily through ob/gyn and family practice specialists; the current approach focuses on the delivery site itself. This is an innovative and important approach, and might show even more promise if other opportunities were used to inform women about both permanent and temporary long-term postpartum methods.

2.3.4 Overview of AVSC's Method Mix

Though much interest has surrounded AVSC's recent involvement in long-term temporary contraceptives, the large majority of the agency's work still focuses on sterilization. AVSC has responded creatively and flexibly to advance new techniques for male and female sterilization, and to evolve its program into the provision of carefully selected methods in addition to sterilization.

AVSC's expansion into long-lasting temporary methods builds on its networks and technical strengths, allowing A.I.D.'s funding to be leveraged for maximum impact. No other agency is as strategically positioned to develop worldwide voluntary surgical contraceptive programs — though more systematic research is needed to determine the degree to which AVSC efforts are indeed establishing cost-effective delivery systems (see Sections 2.10 and 2.12).

AVSC's broadening of method focus is consonant with at least half of the six FPSD principles for the nineties⁶:

- (3) **Service delivery systems must evolve to meet the needs of . . . changes in method mix.** As new or improved long-acting surgical family planning methods become available (e.g., Norplant and no-scalpel vasectomy), AVSC has integrated them into programs and has adjusted its training, counselling, etc., to deal with them.
- (5) **Attention must be directed to developing the institutional base and resources to sustain services.** If the same clinic facilities can, with little additional resource input, offer a broader range of methods, the cost-effectiveness and sustainability of the institutional base is likely to improve.
- (6) **Greater attention must be paid to comparative advantage [and] strategic position.** AVSC's institutional strengths and experience with sterilization put the organization in a strong position to provide sound and credible input about other long-acting surgical methods of contraception.

⁶From *Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties*. Destler, Harriett, Dawn Liberi, Janet Smith, and John Stover. Family Planning Services Division, Office of Population, U.S. Agency for International Development, Washington, D.C., November 1990.

AVSC's extension beyond sterilization has not been without objection, however. One member of the evaluation team points out that client follow-up needs for non-permanent methods are greater and different than those for sterilization. Contraceptives requiring regular follow-up examinations or removal demand programs unlike those for sterilization; there are new and different demands for keeping track of clients, maintaining records, collaborating with primary care levels for local follow-up and reference, etc. If AVSC expands the range of family planning methods it helps provide, it is argued, it should do so only for contraceptives that are operating-theater-based and within AVSC's primary area of expertise.

AVSC's involvement with Norplant is a judicious expansion of the mix of methods it provides, augmenting its program only with methods which require the unique expertise which the agency has accumulated over the years. Its exploration of postpartum IUD insertion, however, suggests that AVSC may be tempted to stray rather farther afield.

Recommendation

10. AVSC should continue to focus only on the provision of surgical methods of family planning, exploring new variations and methods of such contraceptives as they become available for programmatic field trials. Though AVSC should continue and expand its role in assisting with the introduction of Norplant, its involvement with immediate postpartum IUD insertion should be carefully examined before widely integrating this method into its programs. Sterilization, both male and female, should remain the agency's central focus.

With the exception of immediate postpartum IUDs, all family planning methods supported by AVSC require some sort of sedation, analgesia, and/or anesthesia. From the client's perspective, in some cases this aspect of the surgical procedure may be nearly as immediately noteworthy as the surgery itself. Though one member of AVSC's Science Committee is an expert in obstetric anesthesia, this area has been relatively neglected by AVSC. For example, of those individuals trained by AVSC-supported programs in 1990 (see Section 2.4 for number trained), only 23 received training specifically focused on administering anesthesia; ordinarily the sedation/anesthesia component of surgical procedures is taught to surgeons, who are then expected to train the anesthetists.

Recommendation

11. AVSC should give more attention to sedation, analgesia, and anesthesia for female sterilization procedures, and should involve more anesthesiologists and/or anesthesia technicians in AVSC training and service delivery programs.

Though AVSC has moved appropriately to broaden the range of family planning methods it supports, concern has been voiced about the adequacy with which the agency handles some of the other program functions linked to each method. This issue is discussed in the following sections.

2.4 Training

Since the 1970s, when AVSC's primary objective was to assist grantees with material resources, the agency has increasingly moved toward a focus on the transfer of skills. AVSC's Strategic Plan for

1988-1992 explains that "training and technical assistance are AVSC's fundamental tools for helping counterparts start and expand high-quality and sustainable VSC services."

In FY 1990, AVSC devoted approximately \$1,170,000 (13 percent of its estimated expenditures) to support the training of individual trainees. About 225 physicians were trained during the year in surgical techniques, and 1,180 individuals received non-surgical training. Non-surgical training included administering anesthesia (23 trainees), counselling (568), clinic administration (79), information and education (258), operating room assistance (110), training of trainers (TOT) in counselling (2), and surgery (1), and other topics (139); most trainees received training in more than one subject. These activities are planned and coordinated by a headquarters-based training unit, and ordinarily supported with AVSC-prepared model training curricula and audiovisual materials.

In the area of surgical training, AVSC generally uses practicing physicians (who are constantly using their surgical skills) rather than trying to rely on physicians on AVSC's staff. AVSC maintains a roster of trainers, training consultants, and training agencies, and collaborates with other specialized CAs (e.g., JHPIEGO, Program for International Training in Health [INTRAH], Development Associates) on training matters.

Training occurs primarily through subagreements that vary in size, intent, target group, etc. For example, the Family Planning Association of Kenya coordinated a training and management seminar for key health personnel from 10 anglophone African countries; and a project in the Philippines supported the Comprehensive Family Planning Center to serve as a national center for training of trainers in minilaparotomy under local anesthesia.

There is no set model; each training project is developed to address the specific needs of a given institution or area. In FY 1990 AVSC funded 69 subagreements whose objectives included training in clinical or surgical skills (the target was 25 such subagreements); supported 58 training events whose purpose was to upgrade knowledge and skills regarding counselling, voluntarism, and related matters (the target was 20); and funded 16 regional training centers that can accept trainees from other countries (the target was 6).

Though the quantity and quality of AVSC training efforts are generally satisfactory, the following areas of concern — which the agency recognizes — need to be addressed.

Identifying Training Needs and Course Participants

Training courses or workshops are set up to meet needs identified by AVSC staff, USAID missions, and local family planning providers, and are designed to complement training provided by other agencies. AVSC has emphasized training in surgical procedures and counselling skills; one of the regional offices has organized an innovative course to strengthen clinic management and accounting skills.

In some countries (e.g., Nigeria), AVSC-trained medical professionals in VSC clinics are underutilized, whether because of poor referral procedures, weak demand for VSC, or lack of awareness of the available services. AVSC recognizes that this problem deserves its attention, and has begun to train outreach workers in communication and education skills.

Recommendation

12. Where existing VSC services are underutilized, AVSC training programs should focus not only on more acceptable surgical techniques, but also on ways to increase demand for the services and lower programmatic barriers (e.g., through improved clinic management, outreach programs, information and communication).

In selecting candidates for training, one criterion is the assurance that the trainee will use the new knowledge and skills in his/her home setting. AVSC seems to have had no more than ordinary problems with this, though incomplete data on trainees' post-course performance make an assessment difficult (see discussion of post-course assessment on page 20-21).

Sometimes the training is not intended merely to infuse a new technical skill into a clinic, but to change the clinic's program approach (e.g., from using laparotomy to using minilap). In those cases in which the system is likely to be resistant to change, a critical mass of clinic staff (i.e., at least two) may have to be trained to promote alterations in procedures and attitudes. In selecting candidates for training programs, flexibility is needed in determining the number of staff chosen from each facility.

Several regional AVSC staff were not well versed in the details of the training programs sponsored or facilitated by AVSC. As training becomes a more central activity of AVSC, field staff need to be able to describe training opportunities, and to recommend priority candidates for training — even, where necessary, in courses outside the country or region. For example, the director of the vasectomy project in Lahore has not yet been trained in the no-scalpel technique, and is thus unable to transmit NSV skills to medical students receiving training through the vasectomy project.

Recommendation

13. AVSC field staff should be thoroughly informed about all the agency's planned local and regional training programs, and should more actively seek to identify key subgrantees and medical personnel for appropriate training.

Matching Training Sites with Trainees

Institutions selected as VSC training sites are certified by AVSC medical staff. The site must meet acceptable medical standards, be fully equipped, be staffed to handle immediate surgical- and anesthesia-related complications, and (in theory) have a sufficient caseload to allow trainees to perform an adequate number of procedures in a relatively short time.

AVSC has established 14 regional "model" training centers, able to accept trainees from other countries. More are still needed, however, and AVSC plans to develop one or more additional sites in each region.

AVSC ordinarily selects one physician — or a physician/nurse team — to attend a training course, and recognizes that trainees should be taught at sites where the situation closely matches their home institutions. Guidelines prepared by the World Federation state that "the training experience provided by the training institution should be as similar as possible to the conditions under which

trainees will ultimately practice. . . . Physicians planning to work in remote rural areas require different training from those working in high-technology urban medical facilities."

Although this ideal is often achieved, there have been numerous exceptions. For example, two Turkish ob/gyn physicians, sent to the Philippines to receive training in minilap under local anesthesia, found conditions quite different from those in their home clinics. Most minilaps in the Philippine training context are conducted postpartum on an outpatient basis, while in Turkey the minilap is generally on an inpatient basis with the more technically challenging interval procedure. Moreover, Turkish women tend to carry much more abdominal adipose tissue than Filipino women, suggesting different variations of instruments to perform the minilap. As another example, some training courses did not transfer skills regarding VSC anesthesia that would be appropriate at trainees' home clinics.

In other cases, training institutions have not had a large enough caseload to allow all trainees sufficient opportunity to practice the clinical technique under supervision during the training course. For example, trainees in vasectomy at the Mayo Hospital in Lahore did not have enough patients during the course, and follow-up revealed poor performance by those who had been sent there. (It should be noted that at some training sites, routine scheduling of VSC clients is disrupted by training courses. In the effort to provide enough patients for trainees' practice, an institution may postpone patients' operations until the dates of a training course.)

TOT courses have special demands: not only must VSC surgical skills be learned and refined, but trainees must master how to teach these skills to others. AVSC TOT courses do not place sufficient emphasis on teaching the participants about the methods of training. As a result, new trainers may become certified solely on their technical skills, not on their ability to transmit information effectively to the next batch of trainees.

Recommendations

14. Greater attention should be paid to ensuring that participants in AVSC training courses will be given opportunities to learn the specific technical skills they will need in their home institutions.
15. In TOT courses, the curriculum should include more emphasis on training methodologies and teaching techniques.
16. More effort should be made to ensure that all institutions selected as VSC training sites can provide enough clients for trainees' practice.

Measuring Trainees' Learning

Two ways of measuring the degree of success of courses were considered. One is the immediate post-learning assessment of each trainee's mastery of the knowledge and skills covered in the course; the second is longer-term follow-up to determine if the knowledge and skills are being appropriately utilized.

AVSC has done well in short-term assessment of trainees in courses focusing on VSC technical skills. Each trainee must receive "certification," granted only if he/she demonstrates the ability to perform the VSC procedure competently.

Certification of TOT trainees is more problematic. At the end of the TOT course, the AVSC Training Report is completed by the master trainer to certify that the course participant is qualified to provide training to service providers. The actual certification itself, however, occurs in the trainees's home clinic, based more on an assessment of clinical technique than on training capability.

Certification of medical trainers is performed, depending on the topic, by two Medical Division staff at AVSC Headquarters, regional medical advisors, other designated medical staff, or AVSC-approved consultants. This array of potential certifiers does not always allow AVSC to respond to regional needs in a timely manner, however. Regional office staff in Asia have waited six months for the certifying physician to have time to travel to the region to certify various specialists as trainers.

Because AVSC has not yet established standardized criteria with measurable objectives for determining competency, it is impossible to ensure equivalence of graduates from different courses. For example, service provider trainees completing the minilap course at the SSK Maternity Hospital in Ankara receive a certificate bearing both the SSK and AVSC logo. However, it is uncertain if the level of competency is the same for a person trained by either of two similar institutions in the same country (e.g., the Ankara Ministry of Health [MOH] or the SSK Maternity Hospital, Istanbul) or by similar institutions in different countries.

Recommendation

17. Criteria (regarding knowledge, skills, and judgement) for certifying graduates of TOT courses should be standardized, allowing some flexibility for variations in local needs and circumstances. Mastery of training skills should be given equal weight with mastery of technical surgical procedures.

AVSC's ability to assess the long-term utilization of course content — and thus measure the real long-term impact of its training programs — is weak. Despite some follow-up of some training subagreements, little systematic and reliable data exists regarding the proportion of trainees who use their new skills in their home institutes after completing the course, the effectiveness with which they use the lessons learned, or the increased number of VSC procedures performed that were made possible by the course. The absence of systematic follow-up "feedback" data limits the ability to improve the training programs and to measure the overall impact of AVSC activities.

Recommendation

18. Trainees in all AVSC training courses should be followed up systematically to determine the longer-term effects of the program (roughly a year after completion). A staff person should be assigned responsibility for conducting these follow-up exercises, and the results should be used to strengthen future training courses.

Future Training

The demands in the next decade for VSC procedures, if both individual needs and United Nations population projections are to be met, will require significant increases in the number of qualified physicians, medical assistants, counselors, and IEC and outreach workers. AVSC recognizes that it cannot hope to train these specialists directly, and has increasingly supported TOT courses.

Recommendation

19. Within three or four years, AVSC should devote its training efforts almost exclusively to TOT courses, implementing direct training of specialists only (a) as model programs for TOT courses, or (b) to gain experience for designing new TOT courses. To reach this stage, AVSC will have to devote more attention to the transfer of training methods and techniques, not merely the transfer of surgical methods and techniques.

TOT courses — and, inevitably, courses to prepare master trainers for TOT courses — distance AVSC from the clinic and field workers who are the ultimate users of VSC skills and knowledge. This distance will result in some loss of control over training courses, and will make it difficult for AVSC to reliably assess, for certification purposes, the ultimate user's mastery of course material.

Recommendation

20. Where AVSC participates in TOT (or master training of trainers) courses, it will need to refine the means of certifying the competence of the clinic and field workers who are ultimately trained; the agency must acknowledge and adjust to the fact that it has less control and less responsibility for the final product.

2.5 Counselling

AVSC has been a pioneer in developing counselling methodology and emphasizing counselling as an integral component of family planning programs. The agency is one of the counselling authorities among CAs, and many national family planning organizations also look to AVSC for technical assistance in the provision of counselling.

As AVSC moves into the provision of longer-term clinical contraceptive methods during both the interval and postpartum periods, counselling continues to be an important component of its activities. The provision of postpartum and postabortion contraceptives pose special counselling problems regarding both ethics and decision making.

The counselling expertise enjoyed by AVSC is shared with other agencies, but could be done on a more systematic basis. In the coming years, as family planning programs increasingly help appropriate clients shift from temporary to permanent methods, AVSC could play an important role in developing model counselling programs.

Recommendation

21. AVSC should continue to focus on issues of counselling for VSC, and work with other service delivery CAs to improve counselling for all family planning methods distributed. AVSC should sponsor a major training exercise to develop and promote counselling for the other service delivery CAs, working with them in institutionalizing counselling as an essential component of their family planning programs.

2.6 Information and Education

For VSC training and for counselling of people identified as clients or earmarked as potential clients, AVSC has produced some experimental material (e.g., video tapes explaining sterilization procedures in Latin America). Much less, however, has been done to develop mass communications material for campaigns intended to raise awareness and to inform general audiences about VSC.

In some places (e.g., Nigeria), AVSC has made VSC available through training and the provision of equipment and supplies, but the facilities sometimes operate at only a fraction of potential capacity. Such underutilization results in part from low demand, which may be largely a function of the client population's inadequate knowledge about what VSC entails and where it is available. Poorly utilized VSC facilities decrease the overall cost-effectiveness of the AVSC effort.

With the planned addition of an IEC specialist in 1991, AVSC will likely broaden its involvement in IEC activities.

Recommendations

22. AVSC should ensure that potential clients are aware of VSC methods and where they are available. Wherever possible, this should be accomplished through collaboration with a CA that specializes in IEC and is willing to handle the task; in the absence of such a specialized agency, AVSC should do the work itself.
23. Research is needed to identify areas of ignorance and misinformation about VSC in potential client populations, and to suggest the most cost-effective IEC campaigns. Such research should be undertaken by CAs or local organizations specifically equipped to undertake applied research, in close collaboration with AVSC.

2.7 Policy

AVSC has influenced VSC policy in many countries, in some instances affecting national decisions about the acceptability of VSC itself (e.g., in Ethiopia, Nigeria, Paraguay, Zimbabwe), and in other cases having an impact on policies regarding how and where VSC is provided (e.g., in Kenya, Mexico, Turkey, Uganda).

Some senior AVSC staff expressed the opinion that direct policy-influencing activities are outside AVSC's mandate as an organization supporting service delivery. In this view, AVSC should influence VSC policies only indirectly through national technical staff and program administrators. (Perhaps it is felt that the World Federation, rather than AVSC itself, should assume responsibility for direct policy-related activities.)

Yet occasionally A.I.D./Washington and USAID missions look to AVSC to provide a leadership role in affecting policy, and the differences in perception have sometimes created tensions. In Egypt, the USAID mission repeatedly asked AVSC to address policy constraints that impede provision of voluntary sterilization services. Because AVSC did not actively engage the Government of Egypt on sterilization policy issues, the mission restricted other AVSC activities that it viewed as less important

to the current family planning environment in Egypt. AVSC interprets this limitation as inappropriate, and the divergence of goals created strains that for a while hindered the ability of AVSC to work in Egypt. The situation is now apparently resolved.

The problem in Egypt may have reflected nothing more than a difference of opinion about the probability of successfully implementing a proposed activity, with AVSC less optimistic than the USAID mission. Or the problem could have reflected some ambiguity in AVSC's interpretation of its mandate and its subsequent definition of appropriate activities. AVSC embraces involvement in areas such as training, counselling, medical quality, and contraceptive technology, because the agency has defined these as being "essential for improving the access and quality of sterilization service delivery." It has devoted less attention to activities aimed at directly influencing the policy arena in order to provide this same improvement of "the access and quality of sterilization service delivery."

AVSC's method-specific specialization, experience, and excellent reputation make it an ideal link to various policymaking levels from hospital administrators, the national medical leadership, and associations to government decision makers. Indeed, there is no other CA as qualified to address the medical/technical policy issues surrounding sterilization service provision.

Recommendation

24. Based on its comparative advantage, AVSC should more systematically address VSC policy constraints at all levels, from local hospital and clinic administrators to national and government family planning programs.

2.8 Medical Quality Assurance

Historically, AVSC has emphasized quality assurance in an exemplary fashion. Its international program has a mortality rate for female sterilization which is as low as that achieved in the United States (four deaths per 100,000 procedures). This has occurred through its emphasis on training non-specialists in minilaparotomy and the use of local anesthesia, which avoids the increased risk of more complex anesthetic regimens in the hands of non-specialist medical anesthetists or basically trained anesthesia technicians.

There were more deaths (12) and a higher rate of deaths (5.6/100,000) for the 219,416 minilaparotomies in 1988-1990 than deaths (2) and rate (1.2/100,000) for the 164,397 laparoscopies performed during that period (see Table 2). However, most of the minilaps were done in a relatively large number of small primary care hospitals and dispensaries with limited personnel, basic surgery facilities, and little back-up for the acute management of complications as they occurred. On the other hand, laparoscopies were done primarily in tertiary care facilities by ob/gyn specialists who were often the trainers of trainers for the primary providers of minilap and thus had much more experience.

Table 2

Female Deaths from VSC by Procedure and Cause (1988-1990)

Procedure Type	Total No.	Causes of Death				Total Deaths	Death Rate (per 100,000 cases)
		Anesthesia Local	Anesthesia General	Surgical Trauma	Infection		
Minilap	219,416	3	1	5	3	12	5.6/100,000
Laparoscopy	164,397	—	2	—	—	2	1.2/100,000
Total	383,813	3	3	5	3	14	4/100,000

AVSC has developed standardized forms for the reporting of deaths related to sterilization procedures. Standardized forms are also available for reporting complications, but this data is generally under-reported and is thus unreliable.

On-site visits to service providers by medical staff from AVSC's New York headquarters and the regional offices have supplemented the visits initially made to verify the quality of services provided by trainees shortly after their training had occurred. In 1989, there were 43 medical quality visits made to various countries, 11 (25 percent) of which were conducted by New York staff. In 1990, there were 29 such visits, 14 (50 percent) of which were by New York staff, despite the absence of a medical director for seven months of that year. The most notable decreases in visitation occurred in Africa (24 in 1989; 14 in 1990) and Latin America (17 in 1989; 7 in 1990).

The inclusion of programmatic duties in the jobs of two of the current regional medical advisors (Africa and Latin America) and in the job descriptions of two who are about to be hired (Asia and North Africa-Mideast) reflects the needs of the regional offices to monitor their current programs to assure that program administration does not over-balance technical/medical supervision.

To date, AVSC's medical quality assurance has been excellent overall. Its currently planned expansion of activities, however, will tax its ability to continue the number and quality of quality assurance visits by the medical division in New York and the regional program/medical advisors.

Recommendations

25. New York Medical Division staff should continue to survey activities in the field on an annual or biannual basis.
26. New York Medical Division staff should be responsible for the quality of the regional program/medical advisors' activities on their more frequent field evaluations in their respective regions. Implementation could be assured in the regions by the requirement that the medical director approve of the hiring of the specific program/medical advisors to ensure that they have appropriate medical skills as well as the administrative capacities necessary, and that they

have sufficient time in their visits to do the medical/technical as well as the programmatic evaluation.

2.9 Non-Medical Quality Assurance

AVSC has developed an impressive strategy to ensure that clients' decisions regarding VSC are free and informed, thus minimizing post-procedure regret. Its success in this area has been achieved by the provision to clients of accurate and complete information, high-quality counselling (see section 2.5), effective access to methods of contraception other than sterilization, and the requirement that each VSC client sign an informed consent form.

The agency has developed norms and guidelines for non-medical aspects of its programs, implemented and verified through training of clinic and non-clinic staff, field supervision and monitoring, and technical assistance. Somewhat less effectively, AVSC also tries to confirm the quality of its non-medical activities through evaluation procedures (see section 2.10).

The projected growth of VSC procedures in the coming decade has implications for maintaining the level of non-medical quality assurance. Clearly AVSC will have to strengthen and expand its procedures for training, direct monitoring, supervision, and technical assistance. However, the increased scale of the future task will make it impossible for the agency by itself to directly undertake all these necessary tasks.

Recommendation

27. AVSC should devote even greater attention to the need for a shift away from direct quality assurance procedures to greater reliance on local VSC providers to implement their own mechanisms for non-medical quality control.

In regard to this recommendation, the development of AVSC's COPE (client-oriented and provider-efficient services) initiative is particularly commendable. Though COPE is primarily an internal evaluation tool (described in Section 2.10), if used appropriately it serves as a valuable means to improve non-medical quality of care. At sites where COPE was tested in Africa, its "follow-up plan of action" led to increased ability to serve clients.

It should be noted that because one of the strengths of AVSC's service delivery program support is the quality of both medical and non-medical care, AVSC activities are consistent with the first FPSD principle of the nineties: "Service delivery systems must emphasize quality of care."

2.10 Monitoring and Evaluation

One of AVSC's stated goals is to improve and expand services by carrying out initiatives, projects, and program activities in a framework of research and evaluation. AVSC removed its research and evaluation activities from the Medical Division in 1990, and established a Research and Evaluation Department that reports directly to the executive director. The new department has two full-time professional members (of the total headquarters professional staff of 56), with recruitment for a third under way.

AVSC monitoring and evaluation activities can be grouped into four categories: systematic review of subprojects; self-evaluation of VSC service delivery systems (COPE); periodic assessment of country programs and special topics; and measurement of program impact.

Systematic Review of Subprojects

One mechanism for subproject monitoring and evaluation is a **management information system (MIS)**, set up with assistance from John Snow, Inc. A file on each subproject is opened with an MIS Input Form when a new proposal is submitted to headquarters for funding, and kept up to date (in theory) with the input of financial and service statistics summarized in each quarterly report from the project. Though the mechanisms are largely in place, the MIS is not yet effectively operational and has contributed little to AVSC's efforts to monitor and evaluate projects. Regional offices observe that the data input by New York are frequently incorrect or late, a situation that can be frustrating and embarrassing. For example, in May 1991 the Nigeria country representative, at a major meeting on the Family Health Services Project (FHS), did not have data at hand to confirm or refute a statement by another participant that the number of sterilizations supported by AVSC in Nigeria had declined in 1990. Both headquarters and the regions acknowledge that the MIS has not helped AVSC provide timely feedback to subproject directors.

One problem is that the MIS comprises two separate and incompatible systems (a minicomputer and a personal computer). A request for proposal (RFP) has recently been issued to locate someone to design a local area network (LAN) system with the capacity to go to the subproject and small grant level. Although this is an overdue step, it is an important one and will provide a better opportunity for AVSC to improve its evaluation capability.

A more fundamental issue is whether the MIS should be based at headquarters or decentralized for direct use by regional offices. Only the Latin America and Caribbean Regional Office (LACRO) now has its own MIS, and it has become an integral part of that regional office's project management, monitoring, and evaluation procedures. Other offices rely entirely on headquarters for MIS outputs, but find them of little value in helping to analyze subproject performance and to plan strategically.

Recommendations

28. AVSC should take immediate steps to make its MIS fully operational, both by standardizing the hardware and software, and by arranging for data to be processed in a timely fashion.
29. AVSC should decentralize the MIS, possibly using the system in operation at LACRO as a model. Regional offices should participate in decisions about how the MIS is to be used, and should be equipped to use it.

A second tool for monitoring is the **quarterly report**, required of directors of each of the 100-150 active subprojects to provide financial data, service statistics, and a narrative summary of training and other activities. These reports, prepared by the subgrantee, are sent by the regional office to the program management team in New York, who in turn pass them on to the Data Processing Department. The Research and Evaluation Department receives the information from these reports only after the end of a given subproject funding period.

In theory, these reports must be submitted by the grantee before the next quarterly installment of project funds is provided, but approximately 20-25 percent of the quarterly reports are not received on schedule. Funding is rarely withheld to hasten compliance, and regional office staff say they have little power to force subgrantees to supply timely reports.

Feedback on the narrative part of quarterly reports is rarely, if ever, sent from headquarters to regional offices or the grantee. Cumulative computer printouts of subprojects' quantitative service figures are received by regional offices, but because of sloppy input and late arrival, are largely useless. LACRO, for example, received sheets from headquarters indicating that ongoing projects had achieved 69,000 minilaps in Costa Rica and none in Colombia; in fact, the data from the two countries are the reverse. Nor is the detailed quarterly report information used to identify poorly performing projects for special attention or possible termination. In LACRO countries, such decisions were made by the regional office on the basis of site visits and other personal contact; quarterly reports played little role.

Staff at regional offices observed that the preparation of quarterly reports, as now structured, imposes an unnecessary burden on subgrantees. Currently the reports require each subproject to report number of female sterilizations by age of client, number of living children, type of anesthesia, "approach and timing" (e.g., minilaparotomy 8-27 days postpartum), and service site. Vasectomy clients must be reported by age, number of living children, age of spouse, type of occlusion method, and service site. If this detailed data were used for evaluation, it might be worth requiring on quarterly reports. However, unless the information is utilized in a timely and relevant way — e.g., for special research projects or trouble-shooting — it seems to be an unnecessary demand on every level from subproject director through headquarters data processing staff.

Recommendation

30. Service delivery statistics required on the quarterly report form should be simplified to the minimum actually used for project monitoring and evaluation. Examination of the issue may reveal that little is needed beyond the number of tubal ligations, vasectomy procedures, Norplant insertions, etc., during the reporting period. Required information on other topics (e.g., finances, training, special occurrences) and the narrative report should also be reviewed for possible streamlining.

A third mechanism for systematic subproject review is **site visits** by staff from headquarters and regional offices, or by consultants trained for this task. AVSC distinguishes several categories of site visits: technical assistance visits, medical site visits, voluntarism assessments, medical assessments, and routine program management visits. Often a single visit fulfills several functions simultaneously. The number of site visits per project varies. In LACRO, a project which runs smoothly receives one or two visits during its life; more visits are made if there are problems.

Site visits as a method for monitoring and evaluation, though infrequent for many projects, seem to be quite successful. They work because of the qualifications of the personnel making the visits, the adherence to site visit guidelines prepared by AVSC, and the subsequent wide circulation of the trip report (to A.I.D./Washington, the relevant USAID mission, and all divisions of AVSC headquarters). Issues identified as needing correction or further assistance are followed up by regional medical and program staff.

One potential problem is that the number of active projects requiring site visits (LACRO, for example, handles some 40 subprojects) places a large demand on the time of AVSC staff and consultants. A larger pool of trained expert consultants might permit more frequent site visits and help AVSC decentralize its operations.

A fourth evaluation tool, initiated in 1989, is the **End-of-Project Assessment (EPA)**, consisting of the cumulative total of the data provided in quarterly reports (i.e., outputs, technical input) supplemented with a narrative overall assessment. The data, linked to the MIS, help AVSC prepare progress reports to A.I.D. Regional office staff must file an EPA within six months of the end of each subproject's funding period (subprojects generally are designed to cover a three-year period, but funding is on a 12- or 18-month basis). Compliance is uneven: LACRO returns 100 per cent of its EPAs on time, but for the approximately 60 subprojects that end each year worldwide the overall return rate is less than half.

Because of the timing of project renewal, EPAs have little impact on changing the direction of a project. By the time a project is completed, the new subproject proposal must already have been written and approved by AVSC and A.I.D., to insure no lapse in funding to the subgrantee. Thus, if issues are identified in an EPA, it is too late to act on them for the next funding period. In principle, the results could be used in structuring the next three-year subproject, but the time lag makes some of the issues raised in an EPA no longer relevant.

Regional office staff tend to view EPA reports as redundant and time-wasting, since (a) the quantitative data have already been provided in quarterly reports, and (b) their narrative reports seem — based on the absence of feedback — to be unread at headquarters (a compilation of answers to at least one question, "What lessons were learned. . .?") might make a useful document to feed back to regional offices.

Recommendation

31. EPAs should either be utilized or reduced to a simple exercise to verify the cumulative service statistics provided in quarterly reports.

Self-Evaluation of VSC Service Delivery Systems (COPE)

COPE is a simple, low-cost technique of self-assessment to help family planning clinic personnel serve more clients in ways that better satisfy clients' needs. It consists of a client-flow analysis, a self-assessment checklist focusing on clinic activities, and a follow-up plan of action. The aim is to get service staff themselves involved in identifying and solving problems hindering the provision of services.

Developed by AVSC's Africa Regional Office and tested in pilot studies in Kenya and Nigeria in 1989 and 1990, the COPE technique is now being extended to AVSC clinics in other countries (e.g., Jamaica) and regions. An operations research project is accompanying the use of COPE at some sites, and is intended to assess the degree to which COPE succeeds in helping to make services both more responsive to clients and more efficient.

Recommendation

32. If indicated by the present OR project, AVSC should continue and expand its efforts to extend the use of COPE, encouraging its use even outside the clinics linked with AVSC. Other service provision CAs should be invited to share COPE through their own networks.

Periodic Assessment of Country Programs and Special Topics

AVSC also conducts periodic assessments of country programs and special issues in response to requests from the field, and reviews regional activities. Some of these assessments focus on special local topics (e.g., counselling in Kenya; medical quality assurance in four district hospitals in Nepal), others on overall VSC needs at a country level (e.g., in Pakistan), still others on special global issues (e.g., voluntarism).

Because these special assessments tend to focus on clearly defined operational questions, the results are likely to be useful. A study in LACRO about training counselors for sterilization, for example, led to the recognition that follow-up retraining was necessary. A special assessment of AVSC programs in the Philippines, carried out in 1990 by a four-member team composed of consultants and AVSC staff, resulted in a new strategy for an expanded country program.

On at least one occasion a special study was undertaken and utilized in the field, but received little if any attention at headquarters. In June 1989, LACRO undertook an "Evaluation of Overall LACRO Program and Workplan," and sent a report to AVSC headquarters. This exercise was valuable for LACRO, even though no feedback has yet been received from headquarters. In other cases, regional offices observe that extensive and relatively non-productive editing by headquarters have resulted in delays which reduced usefulness.

Recommendation

33. AVSC should continue to undertake special assessments where the results can assist planning or help solve operational problems. Care should be taken to ensure that the results of such assessments are disseminated and, if possible, utilized, at the headquarters, regional, and country levels, and that feedback is provided.

Measurement of Program Impact

AVSC's evaluation efforts aim primarily at determining the degree to which subprojects attain short-term objectives (e.g., did a course on minilaparotomy succeed in reaching the targeted number of trainees?). AVSC recognizes that such a microcosmic and short-term view should be supplemented with more macroscopic analyses, but argues that it rarely is able to provide reliable data on changes in VSC adoption and prevalence that can directly be attributed to AVSC input.

When asked to furnish evidence of program impact (as it was for this evaluation), AVSC provides whatever service data are available — but adds that the data under-represent the real impact. In Kenya in 1990, for example, AVSC-supported sterilizations numbered 10,299. This number — in a country with a relatively high rate of sterilization — clearly under-represents the real impact of the AVSC activity, much of which may not be reflected in service statistics or fertility changes for years.

A.I.D. has begun requiring its CAs to provide evidence demonstrating that programs it supports are having measurable impact; it feels that AVSC is not responding quickly enough to document the linkage between what it does and what impact it achieves. AVSC points out that it, like other CAs, does not directly manage services, but achieves results by using its leverage. By providing technical assistance, training, etc., AVSC helps other organizations to deliver and improve services. This strategy, if successful, can influence the large majority of VSC procedures in a country, and indeed can increase the number performed — but its impact cannot be quantified with precision.

For example, a national (non-AVSC) project in India, which is taking the lead to help introduce counselling in India's sterilization program, has adopted the approach and much of the language contained in AVSC's 1990 manual *Family Planning Counselling and Voluntary Sterilization*. AVSC's indirect influence in this instance may, in the long run, result in fewer cases of post-procedure regret and improved client satisfaction, and thus lead to a better image of the services and greater use of them. However, it would be impossible to measure this indirect contribution in terms of a quantitative impact on the number of sterilization procedures. Is this particular qualitative impact worth 2,000 "sterilization equivalents"?

Though it may be impossible to measure precisely the impact of such activities, rough estimates (with some certainty that they are reasonably reliable) may be preferable to the total absence of data. For example, AVSC's impact might be approximated by simple comparisons of VSC adoption rates (or local prevalence rates, or any other output variable) before and after the AVSC input, accompanied with estimates of the proportion of the marginal increase, if any, which can be attributed to AVSC inputs (taking into account simultaneous non-AVSC influences). More specifically, AVSC might follow up its trainees to determine, in the clinics where they work, the marginal changes in rates or patterns of contraception adoption during the year or two after the trainees return (AVSC currently makes no effort to do this); if changes do occur, some proportion might be attributed to AVSC. Although such estimation techniques obviously do not meet the need for scientific data (e.g., there is no control group), they may help deal with the immediate need to demonstrate program impact.

AVSC's problems with demonstrating its programmatic influence are compounded because of the widespread assumption that qualitative accounts of impact are somehow not legitimate. This perspective, rooted in a linear model of inputs and outputs, neglects the complexity of achieving sustainable change through piece-by-piece modifications of the interrelated components of an entire system. In a systems approach to the provision of VSC services in a developing country, it becomes evident that the introduction or alteration of any single element (e.g., improved counselling) may not alone be sufficient to lead to measurable change in an output measure (e.g., the adoption of Norplant), but it may be necessary.

AVSC's activities and planning are clearly based on an understanding of such a systems approach, a glimpse of which is provided in the logical framework set out in the cooperative agreement. The AVSC framework identifies some of the broad elements of a system (e.g., "ensuring safety and quality of VSC services") and, for each, stipulates a number of specific elements (e.g., "medical supervision systems in place"). The specific elements are employed as quantitative project outputs. A refinement and elaboration of this framework might help identify other indices or outputs — both quantitative and qualitative — that could be used to better reflect the real impact of AVSC's activities.

AVSC is exploring more rigorous methods to measure impact, but with little yet to report. It is also developing global, regional, and country evaluation frameworks to measure the impact of its efforts in several areas: access to services; training; Norplant; vasectomy; quality of care; and information and

education. During 1991, AVSC plans to develop an evaluation plan for its international programs.

The current difficulty in measuring program impact is not AVSC's alone; all agencies working to strengthen family planning services — except those which directly provide contraceptive methods — lack effective means to measure impact. This situation is likely to change in the coming years, particularly if innovative methodologies are developed through A.I.D.'s proposed program to examine impact assessment. It will be important for AVSC to collaborate closely with this new program.

Recommendations

34. AVSC should accelerate efforts to measure the quantitative impact of its efforts on programs, VSC procedures, and demographic events. In the short term, "quick-and-dirty" methods which provide rough approximations of impact should not be rejected.
35. AVSC should consider developing qualitative assessments of impact.
36. AVSC should try to collaborate with the CAs involved in the new A.I.D. program on impact assessment, and should consider encouraging the CAs to use AVSC programs (in one or more countries) for the development and/or testing of new methods of impact assessment.

Overview of Evaluation Efforts

In addition to improving project implementation, evaluation can be a valuable means of assessing and providing timely feedback for strategic planning. Although AVSC has many of the necessary components in place to support an effective evaluation system, its overall evaluation efforts are weak. Data entered into the system do not yield timely and useful analyses of project performance, and no established mechanism exists to systematically provide feedback to improve project implementation and future strategic planning.

Six years ago a major evaluation of AVSC⁷ observed that though the organization carried out a number of monitoring and evaluation exercises, it had not yet developed a coherent evaluation system. The report continued

. . . Given that the goal of evaluation is good program management, and given that AVS's management is already laudable, the absence of a well-laid-out evaluation system is not as serious as it would be in a less well-managed organization. Nevertheless, AVS can improve its management and increase its achievements through improved evaluation and monitoring. (pp. 76-77).

The 1990 Management Review noted that AVSC needs to devote more attention to developing reliable methods that evaluate its success:

⁷*The Performance of the Association for Voluntary Sterilization in Developing Countries, 1982-1985*. Prepared for A.I.D. S&T/POP by Edmonds, Scott, Donald Minkler, Barbara Pillsbury, and Michael Bernhart. Population Technical Assistance Project Report No. 85-49-019, January 5, 1986.

... A high priority for AVSC's work under the cooperative agreement should be to develop and test new ways of measuring performance. This should be done in collaboration with A.I.D. (especially the new evaluation section in the Policy Division) and research-oriented cooperating agencies such as The Population Council and FHI [Family Health International].

To date, AVSC has made little progress in developing a comprehensive evaluation action plan and system.

Recommendations

37. AVSC should refocus its evaluation system so that it concentrates not primarily on projects, but on programs. This should be accompanied by more imaginative use of evaluation as a management and planning tool.
38. AVSC should hire an experienced evaluation specialist on a short-term contract to help develop its evaluation program in order to maximize analysis of AVSC program performance.

2.11 Research

AVSC cannot provide exact figures on the proportion of its total budget (including staff time and consultants) that is devoted to research, but the head of the Research and Evaluation Department estimates that about 4 percent of the obligated funds from the current cooperative agreement have been earmarked for research projects. To date AVSC has developed 21 research activities, nearly all carried out by consultants or other agencies (research-focused CAs or local organizations) with AVSC oversight. The topics chosen for research all deal with practical ways to improve the provision of VSC services.

AVSC recognizes that research is not its strong suit, and acknowledges that it should not be. Where research is necessary to answer questions, AVSC collaborates with other CAs which have the experience and resources to design and implement high-quality studies.

An example of such cooperation is research on postpartum IUD insertion, undertaken in collaboration with FHI. Pilot studies are under way in Kenya and Mali to develop, implement, and evaluate an IUD IPPI program. An additional site in Latin America will be included later this year. The studies are designed to gather information on both the medical/clinical issues concerning postpartum IUDs and programmatic aspects of developing effective postpartum contraceptive programs.

In this project FHI is responsible for the research activities of the program, including developing the research protocol and data collection instruments, conducting focus group discussions to assess user needs, and training health professionals in research methodology, data collection, and analysis. AVSC's role includes training the service providers in counselling IUD clients and the appropriate techniques for IPPI insertion, designing information and education materials, providing the necessary equipment and supplies, and monitoring medical quality and voluntarism.

In some cases, a new research need identified by AVSC may not get translated into a research project because neither AVSC nor the proposed partner has the funds to support it. In Nigeria, for example, useful topics for research (e.g., OR to identify optimal IEC strategies for VSC) are not developed because the research-oriented CAs in the collaborative FHS project explain that their budgets do not allow it. In such instances A.I.D., if it wishes to see the research undertaken, may have to step in and help arrange a source of support (e.g., by supplementing central funding or by encouraging a buy-in by the USAID mission).

The 1990 Management Review, in addition to urging AVSC to develop new ways to measure program performance, noted that

. . . Secondary analysis of data from the DHS [Demographic and Health Surveys] to better define the market for VSC would also be an important element for AVSC program planning.

AVSC, as well as helping to develop questions for a future DHS module on sterilization, has begun working more closely on the secondary analysis of DHS data. A paper now being prepared for the DHS World Conference in August 1991 discusses ways the DHS might be used to help plan sterilization services. The authors (the head of AVSC Research and Evaluation and a DHS staff member) point out that DHS data not only help estimate the numbers of potential clients, but provide information about them (e.g., age, current fertility level, level of education, access to family planning services) that can be used to target IEC messages to appropriate audiences, determine fee scales, select service sites, etc. This paper is a useful preliminary step, but there is no indication that AVSC has yet begun to use the data in the ways the authors propose.

Recommendation

39. AVSC should only foster a research capacity insofar as it strengthens its monitoring and evaluation capability. The present policy — undertaking research in collaboration with other organizations which have the requisite skills and resources — should be continued. This approach should be followed for AVSC-involved research at local, regional, and global levels. Where collaborative research is needed but funds are unavailable, AVSC should alert A.I.D. to the dilemma and seek advice.

2.12 Sustainability

One of FPSD's six key principles for the nineties is that "attention must be directed to developing the institutional base and resources to sustain services." In 1983, eight years before this principle was enunciated, AVSC's Board of Directors issued a policy statement affirming that a primary purpose of AVSC financial and technical assistance was

. . . to enable programs and institutions to become self-sustaining, either through the generation of local resources or by having the government, another local agency, or the recipient itself assume full financial responsibility for the voluntary surgical contraception activity.

Until recently this policy does not seem to have been a priority in AVSC's routine program activities. Working primarily in countries where there were neither sufficient VSC technical skills and clinic facilities nor the financial resources to independently fund VSC programs, AVSC chose to concentrate on strengthening technical capabilities so that local institutions could provide high-quality VSC services.

Though true sustainability is not achieved until the full costs of VSC services are borne locally, the institutionalization of these services is a necessary step in reaching sustainability. AVSC has clearly contributed to decisions to institutionalize sterilization in national and NGO family planning services. As an instance, AVSC's work in Nigeria led to the decision in 1990 to incorporate VSC as an integral part of the national family planning effort.

In all its projects, AVSC seeks to achieve reasonable assurance that services will continue to be available after AVSC support ends. For example, financial plans for every service delivery and training subagreement must explain how the project will continue when AVSC support for recurrent costs is phased out. AVSC-produced guidelines help field staff and project personnel to handle budgets and financial management issues.

However, AVSC can point to few cases in which it has been able to reduce its program support because the costs of VSC services have been picked up by local government, local private sector businesses or NGOs, or by the clients themselves.⁸ The situation is much the same for projects and programs developed by other foreign donors and technical assistance organizations working in countries and neighborhoods too poor to provide more than token payments for such services.

The problem was demonstrated in a 1990 study commissioned by AVSC to examine the impact of funding decreases on sterilization at 22 NGO family planning clinics in four Latin American countries. The study showed that of the 15 sites that increased client fees, all but one experienced a decline in caseload, and nine saw fewer lower-income clients requesting sterilizations. However, four sites increased their caseloads by successfully seeking contracts with governments or private sector companies, or by offering other services at the family planning clinic that could subsidize female sterilization.⁹

Building on the lessons of the four successes, AVSC has begun to display more than theoretical interest in sustainability. In a project beginning this year in Paraguay, a local consulting firm is being supported to help identify opportunities for adding to local clinics' income and resource base. New revenue might be generated through proposed gynecological, laboratory, or medical services at the clinics. In another new project in Venezuela (using private funds in conjunction with IPPF/Western Hemisphere Region's [WHR] Matching Grant program), AVSC hopes to help build an at least partially self-sustaining Norplant program. It is donating the first 100 implants to start a revolving fund; fees from clients who receive Norplant will go toward replenishing the funds for additional implants.

⁸AVSC reports that it has been successful in reducing program support to grantees, including per case subsidies, in a number of countries, including Thailand, South Korea, Sri Lanka, Colombia, Mexico, Brazil, Tunisia, and some in Africa.

⁹One site that saw an increase in its caseload when the subsidy was decreased was the Centro de Pesquisas e Assistencia em Reproducao Humana (CePARH) in Brazil. Realizing that a decrease in assistance was imminent, CePARH sought and obtained contracts with private enterprises and city governments for family planning services; it also planned to institute client fees. CePARH now supports its VSC program exclusively from these three sources.

AVSC is also beginning to move toward sustainability in other ways. Where private physicians can assume more of the responsibility for VSC services (e.g., in Indonesia), AVSC has developed projects to encourage them to do so. Where government programs seem most likely to receive continued national funding, AVSC has begun to provide greater technical assistance to the more sustainable public sector. In Colombia, for example, the 1986 Contraceptive Prevalence Survey indicated that the public sector was providing only 16.6 percent of all sterilizations. Recognizing that the private organization, PROFAMILIA, would not continue to receive constant levels of support from A.I.D., AVSC began to encourage the government to support VSC in public sector family planning programs. With funding from UNFPA, AVSC now provides VSC training through municipal as well as the Ministry of Health systems.

Most of the successful examples of AVSC's involvement with sustainability have occurred in Latin America. This region has the highest proportion of countries with family planning programs in the most advanced stages, i.e., with modern method contraceptive prevalence rates greater than 35 percent. Financial factors assume greater importance in such countries, as the FPSD principles for the nineties document notes, and there is a greater likelihood that cost-recovery mechanisms will to some degree be effective.

Even in Latin America, one obstacle in creating sustainable services is AVSC's current inability to define real costs and impacts of VSC programs. Without reliable information on the input and output of VSC services, it is impossible to measure the unit costs, to compare the cost-effectiveness of different approaches, or to provide persuasive data to government or private sector sources which might be able to pay some of the expenses.

Recommendations

40. AVSC should devote much more effort and imagination toward the evolution of sustainable VSC programs. This should begin with developing reliable measures of the true costs and impacts of VSC services, and the assessment of the cost-effectiveness of various delivery system models.
41. AVSC, in collaboration with research-oriented CAs, should continue and accelerate its recent efforts to determine the fees that clinics can charge for VSC procedures without losing lower-income clients. Flexible payment schedules and alternative forms of payment should also be considered.
42. AVSC should, where appropriate, make a greater effort to involve private sector health personnel in the provision of VSC services, and to persuade governments to make more significant contributions toward VSC services provided by NGOs.

2.13 Strategic Planning

Strategic Planning at AVSC

Although AVSC's planning processes until fairly recently tended to be characterized by a short-term opportunistic approach, the agency is moving toward using long-term strategic planning to direct most of its major activities.

AVSC went through an in-depth strategic planning process for its program for the period 1988-1992, the result of which was a strategic plan identifying new technical areas to be pursued, priority countries, and implementation strategies. This plan was developed with significant input from all staff, including field staff who were brought to New York, and was timed to coincide with the planning of the present cooperative agreement. AVSC plans a similar exercise in preparation for the next cooperative agreement, and will again include field staff who will be brought to New York for this purpose. This document will include a description and rationale for new technical interventions, a discussion of how AVSC will carry out its work, and a strategy for selection of priority countries.

AVSC also produces a workplan on an annual basis, which is reviewed by A.I.D. This workplan contains an overall strategy for technical interventions and a strategy for selection of priority countries, in addition to a detailed description of the 100-150 projects with which AVSC is involved in the field. Within this workplan there is a regional strategy for each region and an operational plan for each country.

The AVSC regional office in Africa has prepared a comprehensive five-year plan for both the region and individual countries, laying out the long-term strategies for the major countries in Africa where AVSC is active, and linking these strategies to their operational plans. A similar document has been prepared by LACRO.

Although AVSC has made a considerable investment in the development of worldwide and regional strategies, its country-level planning still tends to focus on the projects it will fund for the coming funding period (usually one year) rather than on the development of long-term country strategies within which each project will fit. This is not to say that the regional staff do not have a long-term vision for each country; rather that the documentation tends to focus on the specific projects instead of the long-term view of the development of the country program. In part, this may be a result of the funding and approval process which focuses on a project-by-project approval rather than a strategic plan.

AVSC is, however, moving toward country programming through the establishment of country workplans. This shift to country-level workplans would accomplish several aims. It would require strategic planning on a country-by-country basis and ensure documentation of these plans. It would increase the efficiency of the review process both at the field level and at headquarters by deleting the requirement for each project to be separately approved. It would help to clarify the respective roles of the regional and New York offices since the development of country strategies would require headquarters to define its expectations for each country. Finally, it would help improve the evaluation system since it would provide an opportunity to specify expected outputs at a higher level than each individual project, and establish a framework for an impact evaluation system.

AVSC is currently revising its "Standard Document Format" for planning projects, and the result may encourage staff at all levels to ensure that individual project needs are seen in the context of a larger strategic plan.

Recommendation

43. The recently introduced process of developing and approving country workplans rather than individual projects should be expanded by the end of 1992 to include all countries in which AVSC has a major role. In its strategic

planning at all levels, AVSC should work closely with A.I.D. and expect clear guidance about A.I.D.'s expectations.

Consonance of AVSC's Plans with A.I.D.'s Plans

A.I.D. undertakes strategic planning at global, regional, and country levels. Each of these plans is developed by a different group of staff, and in different locations. Worldwide planning is primarily the responsibility of the Office of Population in which global strategies are developed and priority countries are set. In 1991, the FPSD division of the Office of Population, developed its own strategy document, the aforementioned *Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties*, to guide both the office at A.I.D. and the CAs in the FPSD division in their decision making and resource allocation. Regional strategies are primarily the responsibility of the regional bureaus, while the country strategies are the responsibility of the USAID missions in each country.

Because A.I.D. strategies originate in different locations and with different staff, they do not always focus on the same issues or have the same priorities. For this reason, CAs such as AVSC are sometimes in the position of trying to respond to multiple directives which may not emphasize the same issues. Thus, it is particularly important that country strategies (in addition to worldwide and regional strategies) are developed to ensure that the AVSC program in each country fits into the overall population program of each USAID mission.

The USAID missions, however, also bear some responsibility for the difficulty that AVSC has had in coordinating its programs with an overall country strategy. In a number of instances (e.g., in Haiti and Nicaragua), USAID missions programmed AVSC funds and staff without notifying AVSC of their plan or including them in the process.

Recommendation

44. AVSC should inform USAID missions that it is available to assist at an early stage in the planning and development of mission-initiated projects.

Strategic planning also requires the identification of regions and countries with the greatest needs. To assist in such planning, the Office of Population has developed a typology, grouping countries into five categories based on their levels of modern method contraceptive prevalence.¹⁰ The typology is intended to help donor governments and assistance agencies analyze global needs, determine country priorities, and design appropriate program assistance.

AVSC, to further its own strategic planning, has also begun to develop a typology based on levels of VSC prevalence (see Appendix E). There is only limited correspondence between the A.I.D. categorization and the AVSC typology, largely because many countries that are in somewhat advanced stages in terms of overall use of modern methods are still characterized by low rates of VSC use. Indonesia, for example, is in the "consolidation" stage according to A.I.D. (modern method prevalence of 35-49 percent), but only "emergent" (VSC prevalence of 0-5 percent) according to AVSC.

¹⁰The five categories are "emergent," with 0-7 percent prevalence; "launch," with prevalence between 8 and 15 percent; "growth," with prevalence between 16 and 34 percent; "consolidation," with prevalence between 35 and 49 percent; and "mature," with prevalence of 50 percent or higher.

It is not essential — indeed, it may not be appropriate — for AVSC to conform precisely to the A.I.D. typology and prioritization of countries. Although it is reasonable for A.I.D. to expect the overall cumulative pattern for all CAs together to be consistent with its priorities, this need not translate down to each individual CA.

The country classifications have important implications for strategic planning and program development. AVSC is in the process of devising a model to show how its typology relates to VSC program planning, but the model has not yet been accepted by A.I.D.

Focusing in particular on those countries without bilateral population assistance, the Office of Population has set regional investment goals for its central funds of 35 percent in Africa, 25 percent in Asia and the Near East and 43 percent in Latin America and the Caribbean. The planned regional obligation of A.I.D. central funds by AVSC for 1991 is 38 percent in Sub-Saharan Africa, 23 percent in North Africa and the Middle East, 26 percent in Latin America and the Caribbean and 11 percent in Asia. However, total AVSC planned fiscal 1991 project obligations (including bilateral, Norplant and other funding) are 41 percent in Sub-Saharan Africa, 15 percent in North Africa and the Middle East, 12 percent in Latin America and the Caribbean and 31 percent in Asia.

Recommendation

45. AVSC and A.I.D. should discuss the usefulness of the AVSC typology, and either accept it or modify it so that AVSC can proceed to use it in strategic planning.

One issue that deserves closer attention is the degree to which AVSC balances its support among the various sectors (i.e., government, private voluntary organizations and for-profit). One of the FPSD principles of the nineties states "All sectors . . . must cooperate in family planning service delivery."

AVSC has actively sought to work with government agencies and private voluntary organizations (PVO) to provide quality VSC services. In countries where the government sector is weak, more attention has been given to working with PVOs. In countries with a well-defined policy toward family planning that is supportive of VSC, AVSC works with the public sector to expand service delivery and enhance quality of care. For many countries, such as those in Latin America, AVSC feels that working with the public sector provides the best possibility of developing sustainable services and services which reach the greatest number of poor clients. With a few exceptions (e.g., Pakistan), AVSC has done less with the private for-profit sector to date (AVSC reports that in 1990, of its approximately 150 projects, it supported 13 that involved working with the private sector). In some countries, however, assistance to this sector may offer excellent opportunities for expanding access to family planning service delivery.

Recommendation

46. AVSC should more actively work with the private for-profit sector.

Despite this issue, AVSC, both at the headquarters level and in the field, has developed a program quite consistent with the overall FPSD strategy guidelines.

3. Management Issues

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3. Management Issues

3.1 Organizational Structure

AVSC's executive director reports to the AVSC Board of Directors and its several committees; the executive director, in turn, supervises four divisions (Finance and Administration, Medical, National [i.e., United States], and International Programs) and two special offices (Research and Evaluation, and Development). The International Programs Division is responsible for the four regional offices in the field. See Figure 2 on the following page for the AVSC organization chart.

3.1.1 Board of Directors and Board-Appointed Committees

Although AVSC is incorporated as a "membership organization," its approximately 5,000 members are not active in its governance. The agency is led by a 30-member, self-perpetuating board of directors and eight board-appointed committees. Two of these committees play active roles in AVSC's international work: the International Committee and the Science Committee.

The International Committee is composed of 14 United States residents (two are non-United States citizens), including family planning specialists and business and community leaders. It meets quarterly to review and approve all subprojects of the International Programs Division over \$25,000 (unless the division has approved a country workplan, in which case the division authorizes staff to develop and implement projects for that plan without the International Committee's review and approval).

The Science Committee consists of representatives of relevant medical specialties (i.e., obstetrics and gynecology, urology, and anesthesiology), as well as epidemiologists and social scientists. It meets annually to review medical issues, recommend medical policies, and discuss AVSC's social science research agenda.

In comparison to boards of other organizations, the AVSC board plays an unusually active role in the agency's activities. In addition to hiring, evaluating, and supervising the executive director, the AVSC board and its committees are active in operational issues, including subgrant and country program strategy approvals and the review of scientific publications.

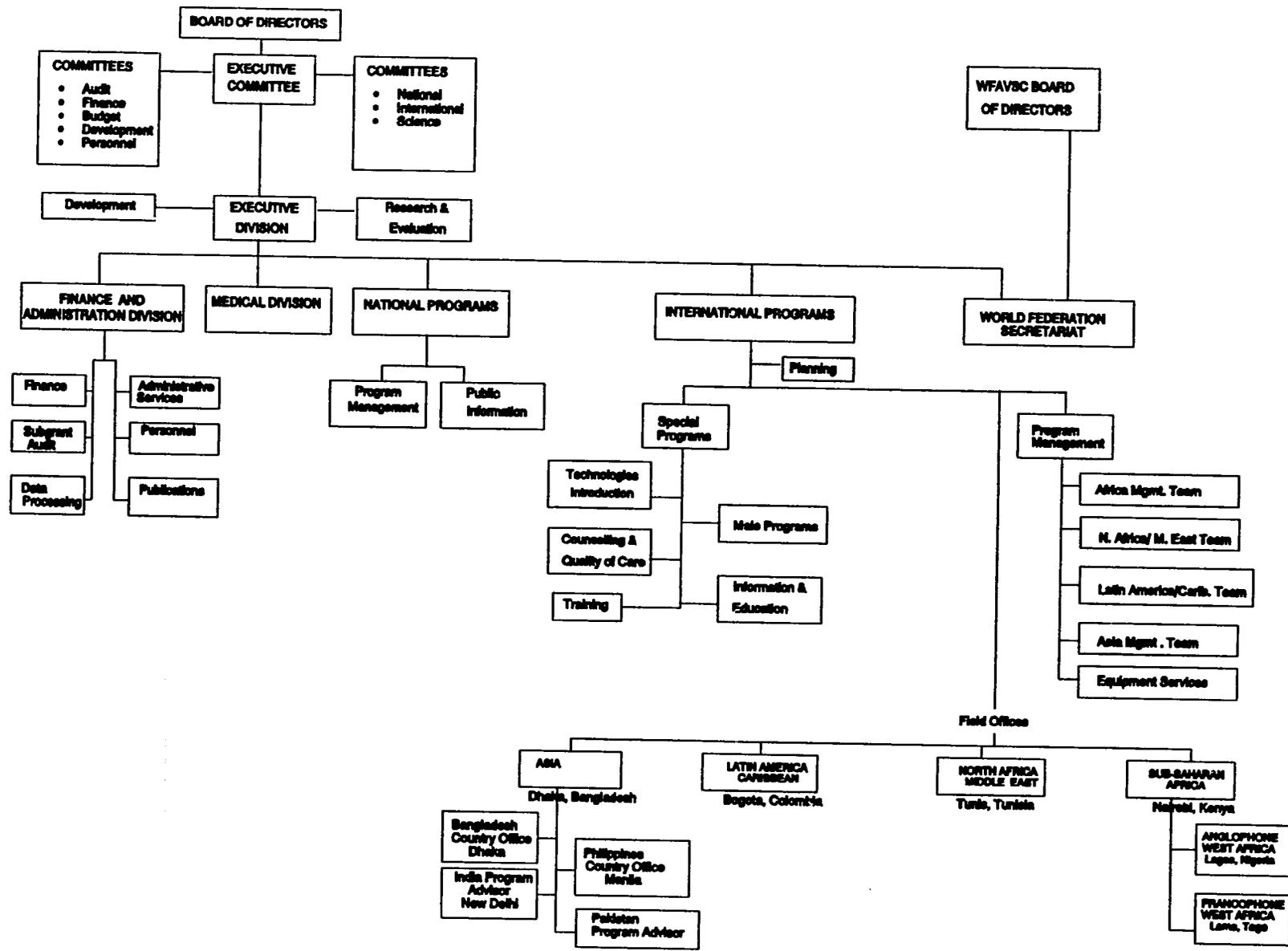
The board's involvement in the approval process is being somewhat reduced as a result of its recent decision to review overall country strategies rather than each separate subgrant proposal. Some board members are reluctant to further surrender the power of decision making to AVSC staff; their argument is that they serve an essential checks-and-balance role, especially important in light of the recent gap in leadership in the Medical Division (see Section 3.1.3).

The board takes its approval tasks seriously. It is questionable, however, whether the board needs to remain so intimately involved in lower-level decisions if the agency is well staffed and functioning smoothly.

Recommendations

47. The International Committee should discontinue its quarterly review and approval of projects, and instead review country strategies at an annual

Figure 2
AVSC Organization Chart



meeting hosted by a different AVSC regional office each year. Once a country program strategy has been approved, AVSC staff should be given authority to approve subprojects consistent with the strategy.

48. AVSC should consider reconstituting the International Committee as a technical advisory committee (TAC), with members who have extensive experience with technical and programmatic aspects of international family planning and VSC. The TAC should include some Americans, but should also include leaders of large, successful VSC programs in developing countries (e.g., Korea and Thailand) which are not necessarily AVSC subgrantees.

3.1.2 International Programs Division

AVSC's structure is heavily weighted toward the International Programs Division, reflecting the agency's emphasis on work in developing countries. Of the approximately 56 professional staff at headquarters, 20 (36 percent) are in International Programs. Within this division are two main departments: Special Programs and Program Management.

Special Programs

The Special Programs Department was established in January 1990 to focus additional organizational energy on several "new initiatives." Currently, there are five special programs: 1) Introduction of New Technologies (Norplant and Postpartum IUDs), 2) Counselling and Quality of Care, 3) Training, 4) Male Involvement and No-Scalpel Vasectomy, and 5) Information and Education.

Special Programs serves a useful function in supporting the work that AVSC is doing in these important areas. Its director explained that the unit is intended to provide "special staff muscle" for issues which need extra attention until they are strong enough to be melded into the overall functioning of AVSC.

New staff are being hired (three are in place) to focus on each of the five special areas. One of the recently added staff is a training expert, who is expected to manage the training component of AVSC's program and collaborate with training organizations such as JHPIEGO and INTRAH. The addition of this expertise to the AVSC staff was greatly needed.

The five focal issues of Special Programs are united only by their importance to AVSC's current activities, and comprise a broad assortment of topics: new technologies (which will not always be new and can eventually be folded into the ongoing routine) and issues which are not new and will need continuing emphasis within the program (training, counselling, quality of care, and information and education). The Special Programs Department appears to represent AVSC's solution to two ambitions of the agency: to extend its expertise to the provision of new methods, and to furnish more comprehensive ancillary services to the methods it now supports. Although this represents an adaptation to growing demands and changing circumstances, the awkward composition of topics may make the work of the unit difficult.

There is concern that the main institutional responsibility for AVSC's focus on three new contraceptive methods (Norplant, NSV, and postpartum IUDs) now falls within the International Programs Division rather than within the Medical Division. Placing postpartum IUDs — particularly immediate postpartum IUDs, an experimental method still under investigation — in a program-

oriented unit primarily concerned with the introduction of new technologies may be putting the cart before the horse. NSV, a surgical refinement of the normal vasectomy procedure, still needs continuing medical input from the experts in the Medical Division who initially recognized its advantages. Even Norplant should not be handled in service programs without oversight by the Medical Division to complement programmatic input from the International Division. Although the introduction of these family planning methods demands programmatic attention, their relative newness within AVSC also requires special medical expertise. Moreover, placing the focus of attention for three contraceptive methods outside the Medical Division takes away the more interesting component of its work.

AVSC is at least partially aware of the potential problems: one of the main tasks of the new staff responsible for each special program is to ensure that the activities are given attention within the other appropriate organizational units within the agency. This may not be enough, however. AVSC's introduction of high-quality tubectomy programs worked well because there was a logical distribution of responsibility between the Medical Division and the International Programs Division. The structural placement of the Special Programs Department, however, may distance the Medical Division from having an equally direct and authoritative role in the introduction and evolution of the three new methods; the task of introducing them may be more difficult.

Recommendation

49. AVSC should reconsider its decision to place the primary responsibility for Norplant, NSV, and postpartum IUDs in the International Division. If the focus of activities for these initiatives remains in the Special Programs Department of this division, AVSC should make special efforts to ensure that the Medical Division is a major partner in planning and implementing the service provision of these methods.

Program Management

The Program Management Department is composed of four regional program management teams (RPMT) which serve as the primary routine links between the four field offices and AVSC headquarters. The department also includes a subunit responsible for supplying special equipment and supplies. The department is led by the assistant director of the International Programs Division.

The RPMTs, except for the Asia desk, consist of a program manager and a grants officer. Because of the prolonged absence of a regional director in Asia, the Asia Regional Office has been managed in large part by staff located in New York and is a special situation.

Some of the functions of the RPMTs are largely administrative and secretarial: they serve as the communication link between the regional offices and all other headquarters units (e.g., the Medical Division and Finance Office), A.I.D./Washington, and other United States-based organizations. RPMTs also arrange for technical assistance, consultants, etc., as requested by field staff.

Other functions are more managerial and technical: RPMTs are expected to manage the process by which projects developed in the regional offices are reviewed and approved at headquarters. Though RPMTs do not have line authority in the approval process, they can play an important role in refining proposals and facilitating their movement through the approval process. RPMTs also perform special assignments in the region. For example, a program manager (depending on background and

expertise) could serve on a needs assessment team, fill in for a regional office staff member as needed, or provide special technical assistance. In addition, some program managers assume responsibility for managing AVSC's program in specific countries within their region.

Because much of the decision making about field activities and funding is centered at headquarters, the RPMTs play a critical role at AVSC. For many of the RPMT staff this role is difficult because — though they may be well versed in headquarters' procedures — they tend to be more junior level professionals with relatively little or no overseas experience. Although this is a less serious problem for grants officers, whose job is basically secretarial, program managers need experience in their regions to understand the difficulties faced by regional office staff, and how to respond appropriately to the sometimes incompatible demands of headquarters and the field.

An exception is the regional program manager for NAMERO, who had been the assistant director in the regional office for several years. NAMERO field staff see their New York-based RPMT as an extension of the regional office, and there is excellent communication and rapport between the two offices.

The lack of experience, with the exception of the NAMERO program manager, is largely due to the recruitment strategy for RPMT staff. Some were hired directly out of graduate school with little or no overseas experience. Others entered AVSC as secretaries and were promoted to RPMT professional positions. AVSC does provide some in-house training workshops so that RPMT staff will develop expertise in needed areas (e.g., IEC or training). However, one headquarters-based program manager stated that opportunities for professional development were not readily accessible, in part due to her superiors' perception of priority needs. The agency has not yet proposed an effective solution to the lack of field experience.

AVSC headquarters sees the RPMTs as "the New York representatives of the regional staff." Regional office staff, however, tend to view their RPMT as the voice of headquarters, and occasionally blame them for what they perceive as annoying, nonproductive, and even counterproductive interventions and delays attributed to New York. One frequently cited problem was the need for headquarters to sign-off on important regional documents, occasionally resulting in postponing actions while not adding substantive value to the document. For example, the current AVSC country assessment for the Philippines was sent to New York on December 1, 1990. As of May 1, 1991 (five months later), it still had not been officially approved in New York, though no substantive changes had been made. In Nepal, a medical assessment was conducted in 1987-88, and a draft circulated within the country. When the A.I.D. mission found it valuable and acted on it, AVSC/New York complained because the document was being used before they had signed-off on it. Both Africa Regional Office (AFRO) and LACRO staff also described cases involving delays in projects because headquarters insisted on time-consuming review of non-essential issues (e.g., amounts of money under \$100; trivial changes in wording of IEC materials).

In every large organization there is an inevitable tension between headquarters and field offices, based on the necessarily unequal division of authority, accountability, responsibility, and knowledge. AVSC seems to underestimate the importance of the RPMTs in reducing or exacerbating these tensions.

One problem is the ambiguous role of the RPMTs. Though ostensibly serving the interests of the regional offices, field staff are inclined to believe that the loyalty and perspective of the RPMTs is oriented toward headquarters. Indeed, few RPMTs' staff have spent more than a couple of months

at the regional offices and receive their supervision and evaluation from New York. While regional directors informally play a role in the appointment and review of RPMT staff, they are not part of the evaluation process.

A second problem relates to the job descriptions and qualifications of RPMT staff. Most people holding these positions are entry-level professionals; few have had extensive field experience. The title "program manager" appears to be a somewhat inflated title for a job whose most important functions are essentially to provide administrative assistance. Current AVSC efforts to provide special technical training to people in these positions may help — or may further confuse the issue.

Recommendations

50. AVSC should review the job descriptions, staffing requirements, and personnel policies regarding the RPMTs. Rather than trying to upgrade the technical competence of staff holding these positions, it might be better to downgrade the expectations of the job and reduce the role of headquarters in approving regional office activities (see Section 3.4). Efforts to upgrade the technical competence of the RPMTs might be more productively directed at staff located in the regional offices.
51. Program managers on the RPMTs should be rotated to regional offices for extended periods (i.e., 3-12 months) to gain an appreciation of the field situation. Willingness to spend this time in the field should be a prerequisite for hiring or maintaining program managers.
52. Regional office staff should play a formal role in all personnel actions involving RPMT staff.

3.1.3 Medical Division

The Medical Division is responsible for keeping abreast of the medical advances in surgical contraceptive procedures, for setting medical policies, and for overseeing and monitoring the overall quality of medical training and service programs which are supported in part by AVSC. At the program level, this requires the development and implementation of service delivery standards, training programs, and supervision and monitoring systems. The division's responsibilities for medical quality oversight include detailed follow-up and investigation in the rare event of client deaths.

The importance of these responsibilities within AVSC are not reflected in the division's size: in comparison with the International Division, with some 20 professionals (not including administrative assistants, program associates, or secretaries), the Medical Division currently has only two professionals (three when the new medical director joins). Much of the work in the field is handled by AVSC staff physicians at regional- and country-level offices, or by consultants — though the pool of medical consultants equipped to undertake technical assistance for AVSC needs to be enlarged (see Section 3.1.5).

The strength of AVSC in the past has been based in part on the very high standards of medical practice which it taught and maintained throughout the world. There is no evidence that these standards have declined, though the number of medical quality visits dropped from 43 in 1989 to 29 in 1990. Moreover, over the past two years there appears to have been a relative downgrading of

the role of the Medical Division within the organization. This is suggested not merely by the allocation of staff, but by the low profile of the Medical Division in AVSC decision making and the choice to locate the special initiatives for new contraceptives (Norplant, NSV, and IPP) within the International Programs Division rather than the Medical Division.

The absence of a medical director for 18 months — a major concern of the 1990 Management Review — doubtless contributed to this situation. The new medical director will arrive in June 1991 and is eagerly awaited by the organization. Her qualifications and experience as an ob/gyn specialist, unlike her predecessor, will be an asset, though her mainly United States-based practical experience will need to be quickly supplemented with a command of the developing country situation.

One of the medical director's immediate objectives will be to clarify the role of the Medical Division in regard to regional offices, and to improve relationships. She inherits a perception from the field that headquarters is insensitive to the unique medical needs, constraints, and variations at the country level, and that the Medical Division thus imposes unduly rigid and occasionally inappropriate directives on local AVSC activities. Such perceptions in the field are based on instances, for example, such as headquarters's insistence that a particular type of suture material be used, disregarding the fact that it simply was not available in the country. In another case, the Medical Division refused to allow an anesthesiologist to be involved in a minilap procedure, though it is legally mandated in some countries. In a third instance, the previous medical director insisted that the peritoneum not be sutured after minilap procedures, a practice which while acceptable, is not the generally accepted standard. As a result of this type of fairly minor, but often irritating disagreement with headquarters, the credibility of the Medical Division in other, more vital areas may have been eroded.

One technical issue relevant to the Medical Division deserves mention: several sources expressed concern that AVSC technical assistance and training programs underemphasize skills in anesthesia. There may be a need to develop consultative relationships with anesthesiologists and anesthesia technicians (or nurse anesthetists) to help with AVSC training and service programs. As it is, the sedation/analgesia/anesthesia component of the procedures is being taught to surgeons, who are then expected to train the anesthetists.

In the coming years, AVSC must evolve new strategies to deal with the greatly increased numbers of VSC procedures needed. The Medical Division must contribute by, among other things, expanding the pool of qualified consultants — particularly those from developing countries — to assist with medical quality visits, medical needs assessments, certification of medical training courses, etc. Current delays are reported even now in certification of trainers and medical needs assessments (it took 18 months to identify a suitable consultant for a medical needs assessment in Nepal), and they will be magnified greatly in the future unless different arrangements are made.

Recommendations

53. AVSC should fully involve the newly recruited medical director in senior management decisions, and give her clearly articulated authority to direct the medical affairs of AVSC.
54. The role of the Medical Division vis-a-vis the regional offices needs to be clarified and reinforced, with unambiguous lines of authority and communication established. This should include the position of the medical director in regard to medical personnel decisions made in the regional offices.

55. AVSC should give more attention to sedation, analgesia, and anesthesia by involving anesthesiologists or anesthesia technicians in AVSC training and service delivery programs.

3.1.4 Research and Evaluation Unit

Research and evaluation activities were moved from the Medical Division in 1990 and this separate unit established, directly responsible to the executive director. It has two professional staff members (a third is being recruited) responsible for developing and overseeing the evaluation component of all AVSC projects, monitoring in-coming progress reports, analyzing collected data, and developing, supervising, or implementing research activities.

Sections 2.10 and 2.11 of this report review the activities undertaken by this unit and offer recommendations. In summary, most of the mechanisms for routine evaluation are in place, but are not used effectively; the MIS has yet to become truly operational. AVSC's most impressive contribution to evaluation — the COPE initiative — was developed not by the Research and Evaluation Unit but by the Africa Regional Office. Site visits, currently the most valuable method of monitoring and evaluating projects, are undertaken by consultants and staff not linked with the Research and Evaluation Unit.

Nearly all AVSC research is carried out by consultants or local institutions, by other A.I.D.-funded CAs, or by AVSC in collaboration with consultants or in-country institutions. Though important topics have been identified for research, other fundamental questions have been neglected; data is not available, for example, to reliably measure AVSC's program or demographic impact.

The Research and Evaluation Unit is the weakest link in AVSC's program. It is unable to fulfill its basic mandate to provide timely evaluation and useful feedback for ongoing AVSC projects.

Recommendations

56. One of AVSC's highest priorities should be to strengthen the Research and Evaluation Unit. This needs greater institutional commitment to systematic evaluation and feedback as a routine management tool, and a recognition that the agency can no longer be assured of continued A.I.D. support without convincing evidence of AVSC's program impact.
57. The position currently under recruitment should be filled by an experienced senior program evaluation specialist, and highly qualified short-term consultants should be hired to deal immediately with specific weaknesses in the evaluation system (e.g., getting the MIS into operation and utilizing data collected for evaluation purposes).
58. It may be unrealistic to expect the Research and Evaluation Unit to meet the evaluation needs of the organization with a staff of three. AVSC should realistically reassess its evaluation objectives and the means to accomplish them, and add staff as needed (especially at the regional office level).

3.1.5 Field Offices

AVSC decided to decentralize its field operations in 1977, opening its first regional office in Dhaka — the Asia Regional Office (ARO) — two years later. This was followed by the North Africa/Middle East office (NAMERO) in Tunis in 1980, the Latin America/Caribbean office (LACRO) in Bogota in 1983, and the Africa office (AFRO) in Nairobi in 1985. A country office for Nigeria was established in Lagos in 1985, later becoming the West Africa Subregional Office (WASRO); there are plans for a francophone Africa subregional office in Lome. Country representatives are now in place in Manila, Dhaka, and New Delhi. Full-time professional staff in the field number 24, about one-third of the total AVSC professional staff involved directly or indirectly in international affairs (this does not include the National Programs Division).

The field offices and representatives have primary responsibility for country and regional strategic planning; project development, monitoring, and evaluation; provision and arrangement of technical assistance; and initiating headquarters support of field-based activities. The ideal composition for each regional office includes a director, a full-time assistant director, one or more program officers, and a full-time medical director. This ideal is achieved only in the Africa office.

Each region, and each regional office, is very different, a result of the variations among countries' needs and opportunities, the unique histories of the offices, and the particular personalities and capabilities of regional office staff. As Table 3 reveals, the number of projects handled by the offices and the type and amount of funding also varies.

Table 3

Regional Offices, Showing Number of Projects with Obligated Funding since the Beginning of the Subagreement

	Sub-Agreements (over \$10,000)	Small Grants (under \$10,000)	Total	Cooperative Agreement Funds (total)	Buy-in and Bilateral Funds (total)
AFRO	51	38	89	\$1,552,000	\$1,837,000
ARO	27	8	35	706,000	2,844,000
LACRO	41	17	58	1,609,000	357,000
NAMERO	22	13	35	1,111,000	300,000

A glimpse at two of the field offices illustrates some of the differences.

Asia Regional Office

Asia, where AVSC has worked intensively for over 15 years, is a region with a tradition of relative success in establishing family planning programs: of the eight AVSC countries only two (Pakistan and Nepal) are classified by A.I.D. in the "emergent" or "launch" categories (i.e., modern contraceptive

prevalence rate less than 15 percent). With governmental policies strongly supporting family planning and long-standing programs in place, the AVSC task is largely to ensure that high-quality VSC services (including IEC, counselling, and training) are integrated into existing programs, and to explore innovative non-governmental avenues to provide VSC services.

In part because of the relative maturity of Asian family planning programs and AVSC's deliberate strategy of reducing central-A.I.D. commitments in the region (and in part because of management problems within the regional office; see below) ARO has been involved in only 35 projects since 1988 — the fewest (tied with NAMERO) of all the regional offices. It also receives the least funding from the cooperative agreement. On the other hand, ARO is responsible for the largest amount of buy-in and bilateral funding, a situation seen as a mixed blessing. Such funds are said to distort ARO's priorities, which in turn creates tension with some of the local USAID missions. Virtually all the program support for Bangladesh, for example, comes from bilateral aid, thus making it difficult for AVSC to assert its own strategic plans and priorities (e.g., phasing out support for the long-supported but now anachronistic Bangladesh Association for Voluntary Sterilization, and instead giving greater support to MOH programs). Bilateral and buy-in funds also require labor-intensive inputs without increasing office infrastructure support, thus reducing the time the small staff has to deal with other projects.

The new ARO director arrived this year to a difficult situation: the high turnover in the regional director post has left the office in an unsettled state. There is still no medical advisor, only one other professional staff member, and an inadequate pool of consultant specialists (particularly puzzling in a region with many local experts in both biomedical and programmatic aspects of family planning), and unresolved conflicts with local USAID missions. The advisors/directors responsible for the country offices in Bangladesh, the Philippines, and India have all been recruited only in the past year or two. Perhaps as a result of these conditions, ARO has displayed little imagination in seizing new opportunities to encourage VSC.

Tentative earlier plans to move ARO headquarters from Dhaka to Bangkok have been abandoned, though the evaluation team was informed AVSC is still discussing the possibility of opening a subregional office in Bangkok. Some headquarters staff were hired with the intention of being assigned to Bangkok, and the issue is still unresolved.

The cause of ARO's problems are partly a result of the turnover of regional directors, and partly AVSC/New York's inability to recognize emerging problems in a timely fashion and provide appropriate technical and program leadership. In the 18-month absence of a resident director, ARO's decision making and leadership was provided by the New York-based regional program management team for Asia. This strategy further exacerbated the problems of an already weakened office. The RPMT's acting regional director and acting assistant director probably would have been better able to coordinate regional activities had they been temporarily assigned to the Dhaka office instead of remaining at headquarters. With the new regional director in place, AVSC must make a conscious effort to relinquish headquarters control of ARO while still providing advice and support.

The 1990 Management Review identified specific problems regarding ARO:

It was agreed that completing the staffing for AVSC's Asia Regional Office is a high priority, and that as soon as a regional director is appointed, recruitment will begin for a regional medical director.

A.I.D. expressed some concern about whether there would be an adequate level of technical skill in this office.

The appointment of the new ARO regional director meets one of the Management Review's concerns, but ARO still needs to recruit a full-time medical advisor and other technical specialists. The regional office is severely hampered in its attempts to secure a physician (and others) willing to make a medium- to long-term commitment: qualified Bangladesh nationals are unavailable and the office is not permitted to hire additional expatriates. The Government of Bangladesh has allotted the ARO only two expatriate slots, both now filled. When AVSC hired an expatriate to serve as the Bangladesh country advisor, it used one of these slots rather than applying for an additional slot for the new country-level office; for Government of Bangladesh approval, the country advisor was titled the assistant regional director.

Africa Regional Office

The Africa Regional Office — and the West Africa Subregional Office under its supervision — work in a very different environment. With a handful of exceptions, government policies regarding VSC are uneven and unsupportive, people's knowledge of and interest in modern contraception is low, and service delivery is rudimentary. The infrastructure for providing family planning services is weak or nonexistent, and extreme economic difficulties limit local efforts to strengthen health care facilities. Of 23 countries in the area, 19 are categorized by A.I.D. as "emergent" or "launch"; using AVSC's classification for sterilization prevalence, all the countries fall into these categories. In this situation, AVSC's task is to establish new VSC services, to create local capacity to keep services voluntary, safe, and effective, and to help increase knowledge and awareness of VSC.

Reflecting AVSC's regional priorities, AFRO has since 1988 been responsible for the largest number of projects and receives only slightly less funding than ARO. It has a well-staffed office with six professionals including a medical coordinator with five year's experience, and the director has been in his position for six years. The subregional office in Lagos has been headed for five years by a physician, assisted by two program officers. In large part because of dynamic leadership able to identify new opportunities and take risks (e.g., developing COPE), AFRO is regarded as one of the most successful regional offices.

Overview of Field Offices' Performance

The performance of the AFRO and LACRO regional offices is excellent, NAMERO adequate, and ARO still weak. Existing staff tend to be experienced and qualified, with sensitive understanding of the cultures in their areas and extensive networks of relationships and contacts. Competitive salaries contribute to a low rate of turnover, allowing experience to be cumulative; the four professionals in LACRO, for example, have been on the job as a team for at least five years and the NAMERO regional director has been an AVSC employee since 1980.

One common weakness lies in the ability of the regional offices to provide timely technical assistance and monitoring regarding medical service and training. In-house clinical experience is thin, and there has been too much reliance on the two specialists in the headquarters medical division and on an inadequate pool of part-time consultants.

To deal with increased needs and growing demands in the coming years, the regional offices also need to accelerate their use of strategic planning methods, raising their sights from individual projects to

larger programs that increase AVSC's impact. Headquarters encourages this shift in vision, but simultaneously requires that regions focus their attention on the meticulous development of new project proposals and the transmission of data for routine project evaluations that remain largely unused (see Section 2.10).

As regions' use of strategic planning becomes more sophisticated (it is already evident in the development of country workplans), more imaginative and influential activities are likely to be proposed. The systematic review of "the big picture" that strategic planning requires should help to identify new needs and opportunities for VSC, more effective ways to build into ongoing programs, and more efficient resource allocation. This, in turn, will likely dispel criticism that the regional offices are unwilling or unable to seize opportunities, and that they succeed by designing modest projects that entail few risks. (It might, of course, be argued that such a risk-averse and conservative approach, in the politically sensitive area of sterilization, is reasonable and adaptive because it reduces the probability of programmatic blunders that could sabotage the entire program.)

Though staff in the regional offices recognize and value support they receive from headquarters, some reservations were voiced — particularly in the more smoothly operating offices (i.e., AFRO and LACRO) — that their colleagues in New York do not always appreciate the constraints and problems of the field situation, and should give the field staff more decision-making authority. It must be added that, on the other hand, field staff often do not appreciate the constraints and demands at headquarters (e.g., A.I.D./Washington's desire for quick action and demonstrations of impact). More frequent and extended face-to-face communication, perhaps through a program of systematic rotation of staff between headquarters and the field offices, might help ameliorate this problem.

AVSC country representatives (or program advisors), directly accountable to the regional offices, are supported in India, the Philippines, and Bangladesh. Though the responsibility for country activities rests with the regional office, the country representatives serve a valuable function in monitoring projects, identifying new needs, assisting with country strategies, and — depending on qualifications — providing technical assistance. Once established, country representatives are delegated the primary responsibility for developing and managing country programs. Several other countries need or will need country representatives. In Turkey, for example, more than 76 percent of women in the reproductive age group say they want no more children, and there are many excellent physicians and hospitals but little access to sterilization services.

AVSC relies heavily on the judgement and effectiveness of its field staff for the organization's superior reputation. Overall, the expertise and motivation of the regional and subregional staff is excellent.

Recommendations

59. Headquarters should take a more flexible approach in dealing with regional offices, continuing to provide direction and support for the weaker offices but allowing more autonomy for the stronger ones, all in the context of the move toward greater decentralization.
60. The regional offices should move more quickly toward strategic planning, developing country-level strategies in collaboration with government and non-government authorities as well as USAID missions.

61. All regional offices should strengthen their capability to provide medical technical assistance, evaluation, and certification by expanding the pool of medical consultants and, where feasible, adding medical specialists to the field staff. Every effort should be made to identify qualified nationals from the regions for these tasks.
62. Regional offices should anticipate an increasing need for technical assistance in non-medical aspects of VSC programs (e.g., training of trainers, IEC, outreach, management, evaluation). In addition to relying on specialized national and international organizations for such assistance, each regional office, with support from headquarters, should establish a pool of consultants with the appropriate qualifications, just as is done for medical consultants.
63. AVSC should establish a country representative in Turkey and should begin planning for representatives in other countries with large, expanding programs in the coming years.
64. Special attention should be devoted to bringing ARO up to the level of other regional offices:
 - With the assistance of headquarters, immediate steps should be taken to fill the medical advisor position. AVSC should negotiate with the Government of Bangladesh to obtain approval for at least one additional expatriate so ARO does not have to continue relying on a series of short-term mechanisms which does not provide the needed continuity in staffing.
 - AVSC should resolve the problem of staff hired for the proposed office in Bangkok but now based at headquarters, so that the Dhaka office receives the commitment, quality, and quantity of support it needs.

3.1.6 The World Federation of Health Agencies for Voluntary Surgical Contraception

In 1975, AVSC established the World Federation as a way to provide an organizational structure and voice for medical leaders from developing countries who were interested in promoting VSC as part of national family planning programs and policy.

The World Federation holds an unusual position within the AVSC structure. In principle it is a separate entity, but in fact has little autonomy; AVSC directly provides both its funding and staff. The half-time director (who actually spends appreciably less time on the World Federation) also fills the position of deputy director of the International Programs Division. Initially conceived as an independent global organization somewhat analogous to IPPF, the federation has always been controlled by AVSC.

At its height, the World Federation provided a unique forum for discussion for representatives from member countries, and codified and legitimated international standards of acceptable medical practice with regard to surgical contraception. Its safety guidelines became the standard against which all practice was measured, and it has also issued reports on training, reversal, and voluntarism.

As funding has been reduced, and as the international activities of AVSC have strengthened, the role and output of the World Federation has decreased. Its standing committees on major VSC issues are now dormant, and it has ceased publishing *Communique*; members today are rarely asked to play an active role and receive few actual benefits. At present, it is little more than a mechanism for holding a one-day international General Assembly every two years on a variety of topics of interest to AVSC or its 44 organizational members. Its close links with AVSC, once an asset, may now be a liability to those who identify it as little more than a tool of AVSC. The World Federation's agenda for the next few years focuses, not surprisingly, on issues of paramount interest to AVSC: counselling, male involvement in family planning, and postpartum family planning.

Today the World Federation, funded by this A.I.D. cooperative agreement with a line item budget of \$350,000, offers little that AVSC is not doing or could not do. The most valuable potential functions of the World Federation in the coming decade might, in fact, be best achieved if it were a truly independent international organization, administratively and physically distanced from AVSC. These functions would include raising international awareness of the vastly increased future needs for VSC services to meet the needs of couples who want no more children, extending the network of national medical leaders interested in VSC (i.e., people outside the existing AVSC network), and fund-raising from non-United States sources (primarily European and Japanese) to support international VSC programs.

Recommendation

65. Over the next few years, AVSC should gradually phase out financial support for the World Foundation, allowing it time to plan for alternative arrangements for funding and management.

3.2 Staffing and Personnel Management

AVSC has a total of about 124 employees, 82 of whom are based at headquarters and 42 at field offices. Approximately two-thirds are professional staff.

Personnel planning and recruitment practices, both for headquarters and the field offices, are generally adequate, and the low turnover rate seems to indicate that salary levels and working conditions are satisfactory. However, the dearth of headquarters staff with extensive field experience may, in part, reflect salaries too low to attract candidates with such qualifications. The 18-month vacancy for the medical director position was unacceptably long, but the mechanism for filling the job (using a professional search firm) was appropriate.

Too few headquarters staff — particularly in the Program Management Department of the International Programs Division — have had field experience in developing countries, a significant handicap for those responsible for managing a large program focused on developing countries (see Section 3.1.2). This problem could be ameliorated by requiring current staff to spend time at AVSC field offices, and by hiring, in the future, only candidates who have appropriate experience in developing countries.

AVSC has a policy to encourage staff development through a tuition-reimbursement program, both at headquarters and through regional offices. However, few of the field staff, at either the regional or subregional level, were aware of this policy.

3.3 Management of Grants and Subagreements

Most of AVSC's activities in developing countries are undertaken by local organizations — both governmental and non-governmental — which receive funding for approved projects. The largest amount of AVSC staff time is devoted to identifying needed projects and the organizations and individuals to implement them, formulating and improving project proposals, reviewing the proposals, and, once the projects are under way, monitoring and evaluating them.

Projects with budgets under \$10,000 (with some exceptions) are referred to as "small grants"; from the inception of this cooperative agreement through the end of 1990, 76 of these small grants have been initiated. Projects with budgets of \$10,000 or greater are usually called "subagreements"; 141 have been funded. A look at all 217 AVSC projects, distributed by size (see Table 4), indicates that nearly three quarters of AVSC projects were for under \$40,000, and 58 percent were under \$25,000. Only 21 projects obligated more than \$80,000. It should be noted, however, that in many cases subagreements cover only a single 12- or 18-month phase of a multi-year project activity, and that the total funds obligated over the life of such an activity are not reflected in the table.

Table 4
Distribution of Small Grants and Subagreements,
by Size and Region

Size	AFRO	ARO	LACRO	NAMERO	Total
Small Grants:					
less than \$2,500	13	5	4	4	26
\$2,500 - \$4,999	10	2	6	1	19
\$5,000 - \$7,499	8	0	2	2	12
\$7,500 - \$10,000	7	1	5	6	19
Subagreements and Amendments:					
less than \$10,000	3	2	6	2	13
\$10,000 - \$24,999	13	7	12	4	36
\$25,000 - \$39,999	12	6	10	7	35
\$40,000 - \$79,999	17	7	7	5	36
over \$80,000	<u>6</u>	<u>5</u>	<u>6</u>	<u>4</u>	<u>21</u>
Totals	89	35	58	35	217

Relatively small grants and subagreements are necessary and appropriate in many cases, particularly in countries identified for "exploratory seeding" and "initial expansion" by AVSC's country program

strategy. At the same time, the administrative and management requirements for the high proportion of small projects consume a substantial amount of AVSC time and effort. This situation is expected to improve when country programming and multi-year approvals become more widely adopted.

Potential grantees are identified in a variety of ways. Regional staff members maintain their own network of contacts; sister agencies offer suggestions; USAID missions make requests; and some institutions themselves propose collaboration. Once contact has been made, an initial site visit is carried out by AVSC regional staff to discuss program ideas and review the institution's capabilities and the overall prospects for a successful project.

If there is potential for collaboration, a proposal (following established AVSC guidelines and document formats) is developed by the organization or written in collaboration with AVSC field staff (or occasionally by RPMT staff). Each proposal is first reviewed at the regional office to ensure that it includes all the necessary information and attachments. It is then forwarded to headquarters, where small grant proposals and subagreement proposals take different tracks. (See Appendix G for a flowchart of the project proposal review process.)

For small grants, approval and processing is quick and requires minimum paper work — about two pages of narrative and responses to a checklist; some 100 are processed each year. Each must be approved by the head of the Program Management Department and by the director of the International Program Division. The time between receipt at headquarters of a small grant proposal and its approval averages four working days; some are approved on the same day they are received. Small grants do not have to be approved by A.I.D. or by AVSC's International Committee.

For the approximately 100 subagreement proposals received each year, the approval process is more complex; it also varies depending on whether it is for a new proposal or for the continuation of an ongoing project. A completed proposal is formally sent by the regional office to the appropriate regional program manager, who reviews it for completeness but does not play a formal approval role. The RPMT manages the review, if necessary convening a meeting of the concerned professional staff to discuss the proposal. Issues raised during this meeting are then worked out between the field and the team office. Subagreement proposals are then reviewed by the head of the Program Management Department and forwarded for approval to the International Programs Division, the Medical Division, the Finance and Administrative Division, and finally to the executive director.

A proposal to continue an ongoing project can move through this process within two weeks. However, the 40 or so proposals for new projects (and requests for extensions of time or budget for previously approved projects) must additionally be reviewed by the International Committee of the AVSC Board of Directors. This committee meets quarterly, so some proposals are delayed for months at this stage of the approval process. Starting in the early 1980s, AVSC has been moving toward multi-year subagreements (up to three years) so that project proposals do not need to be resubmitted each year; at this point, however, most subagreements are still for only one year.

When a subagreement proposal has cleared the International Committee, it is submitted to A.I.D./Washington and the USAID mission. Final approval from A.I.D./Washington can occur only after the mission has signed off on the document. If cleared by both the mission and A.I.D./Washington, a subagreement between AVSC and the subgrantee is prepared.

AVSC field staff have mixed opinions regarding the value of the headquarters review process. Staff of some regional offices believe that it is unnecessarily detailed, takes too much time, and adds little

of substantive value. In one instance, headquarters questioned a \$10 per month budget item to reimburse the expenses of a nurse. Some field staff also note that headquarters staff occasionally comment on issues which seem arbitrary or inappropriate, such as complaints about the colors in brochures and criticism of Spanish translations done by the Latin American field staff (who are native Spanish speakers). Regional staff are particularly sensitive to comments on particular regional issues by headquarters staff who have never lived in the region.

Some regional staff feel that the review process is becoming a major stumbling block to completion of their work. At the same time, other regional staff say that some proposals are improved during their passage through the New York review and approval process.

AVSC, after its years of experience, has developed procedures that provide effective review and approval of project proposals. The efficiency of the process, however, is sometimes questionable, due primarily to the large proportion of relatively small projects, the long chain of authorization, the sometimes minor details which are questioned by headquarters staff, and the inclusion of the AVSC Board of Directors in the final approval process.

Recommendations

66. The grant approval process should be streamlined, starting by eliminating the need for the AVSC Board of Directors to review proposals. The role of headquarters staff in decision making about minor details should be reviewed with the regional staff.
67. AVSC should accelerate its move toward approval of multi-year subagreements with incremental funding.
68. AVSC should continue to fund small projects where appropriate, but move quickly to increase the efficiency of review and management of such projects through country programming, multi-year approvals, and other mechanisms.

The possibility exists that A.I.D. will issue new rules requiring CAs, including AVSC, to instruct their grant recipients to follow much more stringent accounting and auditing standards for all projects. AVSC staff, both at headquarters and in the field, are concerned that such a requirement would place an unacceptable burden on many developing country organizations. Many local organizations that carry out project activities proficiently may not possess the skills or infrastructure necessary to follow United States-based accounting practices. If new auditing standards are unrealistically high, AVSC fears that it will simply have to discontinue collaboration with many otherwise excellent local organizations.

3.4 Decentralization

As AVSC has grown, it has moved toward a more decentralized structure. A.I.D. questions the extent to which this decentralization has been realized, and suggests that further devolution of responsibility and authority is required for efficient and effective operations in the field. AVSC headquarters, on the other hand, argues that decentralization of all appropriate responsibilities has been achieved.

For AVSC, as with any large international organization, decentralization presents a dilemma: redistributing the central concentration of power has both benefits and perils. By empowering those closer to the field to make judgements about suitable courses of action in the field, decentralization can increase the probability of timely decisions founded on an intimate knowledge of the local situation. It reduces some of the burden on central management, allowing more time for essential backstopping and attention to larger strategic issues. Decentralization also manifests senior managements' faith in the staff, increasing their sense of involvement in the organization and strengthening their commitment.

At the same time, decentralization, by definition, moves some of the power to control away from central management who are ultimately held accountable for success and failure; it increases risk at the top. The reallocation of power puts decision-making authority into the hands of people with differing experience and cultural backgrounds, who may not fully take into account the organization's global interests and larger strategic vision. With such a highly sensitive topic as surgical contraception, the potential medical and political repercussions of a blunder in the field might be felt throughout the organization, and could shake the future of country-wide VSC efforts. Rather than to devolve power indiscriminately to a broader category of structural positions, it is safer to promote selected staff members up the organizational ladder of authority as they demonstrate their ability.

The dilemma of decentralization is exacerbated when, as in AVSC's case, there are substantial disparities in the strengths of headquarters units and of field offices, and in the needs of regions and countries. In a more homogeneous situation a single decentralization policy could be applied across the board. As it is, such a policy might well fit a mature office such as LACRO but be temporarily inappropriate for an office in transition such as ARO.

In many ways, AVSC has made important steps toward the decentralization of power to the regional office level (with the exception of ARO). Most field staff acknowledge that critical decisions about initiating grants, budgeting, choosing client organizations, and identifying consultants are largely left to the discretion of the field staff. No similar shift of authority to the country level has yet occurred, however, and there is no plan to delegate real responsibility for country programs to country representatives.

Yet decision making continues to be centralized in several respects. A common view from the field is that headquarters still exerts a heavy hand in decisions about what new initiatives are stressed, how they will be implemented, and how information about this technical work will be disseminated. Examples include tight controls over what may be published by field staff, decisions about surgical technique and anesthesia, and minor decisions about procurement of supplies. The power of headquarters to make slight modifications in field-initiated project proposals, and to occasionally delay the review and approval process, is a source of some dismay in the field.

There is also some confusion about the locus of decision-making authority regarding medical issues. The roles of the regional office medical director/advisors (where they exist) and of the director of the headquarters Medical Division need clarification.

In addition, communication with A.I.D. has been affected by AVSC's centralized approach. Most contact between AVSC and A.I.D./Washington is expected to pass through senior headquarters management, an arrangement that ensures that A.I.D. receives only messages that are corporately correct. Because lower-level AVSC personnel at headquarters and in the field feel obliged to avoid direct links with A.I.D./Washington, a situation is created that works against early, informal

communication that might allow A.I.D. a useful opportunity to contribute ideas before it receives a finished product to review.

AVSC has made progress in strengthening its field offices and decentralizing responsibility. The greatly increased demands for VSC in the coming decade, however, will require even more sweeping changes in the relationships and divisions of labor between headquarters and the field. Regional and country-level staff will be expected to handle larger work loads with greater needs for on-the-spot assistance and the authority to make timely and flexible decisions. Although headquarters will need technical expertise, the greater need will be closest to the projects themselves — that is, in the field. Headquarters's tasks will focus increasingly on global planning, coordination, administrative and financial backstopping, and evaluation (including impact assessment).

Recommendations

69. AVSC should continue its efforts toward decentralization. Greater attention should be devoted to strengthening the technical expertise of field offices and their ability to undertake strategic planning.
70. AVSC field staff should be informed that they may, when appropriate, communicate directly not only with USAID missions but also with A.I.D./Washington.

4. Relations with Other Organizations

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4. Relations with Other Organizations

4.1 Relations with A.I.D.

4.1.1 Links with A.I.D./Washington

A.I.D. maintains a curiously paradoxical image of AVSC. AVSC receives consistently positive evaluations from A.I.D., obtains continued refunding at requested levels, and is generally considered one of the most effective CAs; the relationship with the current A.I.D. cognizant technical officer (CTO) is excellent. On the other hand, some at A.I.D. suggest that AVSC is insular, aloof, and has recently become complacent.

Based on a candid and thoughtful discussion paper prepared by AVSC, the 1990 Management Review directed attention to the problem of communication between the two organizations. It acknowledged problems in communication, and concluded that

Senior AVSC staff should meet with Office of Population staff three or four times a year, for a better exchange of views, and similarly FPSD staff should visit AVSC headquarters three or four times a year.

AVSC should inform the FPSD and the Office of Population about major developments and possible policy shifts earlier than it has.

AVSC should work more closely with USAID missions to become involved earlier with them in strategic planning and in dealing with emerging policy issues, and should work with FPSD to maintain contacts with the regional bureaus and the regional population staff, bringing AVSC regional directors to Washington for this purpose once a year or so. . . . It was agreed also that AVSC would make special efforts to respond promptly to mission requests for technical assistance.

The Management Review pointed out that, given inadequate funds in the A.I.D. budget for travel and other time demands on the CTO, AVSC would have to take the initiative to improve communications with A.I.D. It was also noted that effective communication had been made more difficult by several changes in the CTO in the recent past, and that the location of the AVSC headquarters in New York makes frequent face-to-face communication with A.I.D./ Washington more difficult than for CAs based in Washington.

Formal and informal communications between AVSC headquarters and A.I.D./Washington have improved appreciably since these recommendations were proposed at the end of 1990. AVSC has consulted extensively with its CTO about issues of importance (e.g., plans for moving in new directions, such as the proposal to establish a new subregional office in Lome). Both the AVSC executive director and the director of the International Programs Division regularly phone the CTO to discuss AVSC activities and obtain A.I.D. input. The executive director has met with Office of Population staff in Washington three times since November 1990, and other AVSC senior staff members, when in Washington for other meetings, visit the CTO to update him on current activities.

AVSC regional staff will meet Office of Population staff in Washington for the first time in June 1991 to discuss A.I.D. programming and strategic trends. In spite of funding restrictions on A.I.D. staff travel, the CTO visited New York three times in 1991 year to meet with AVSC.

Although communication between AVSC headquarters and A.I.D./Washington is effective, the efficiency of procedures regarding the cooperative agreement could be improved. The 1990 Management Review observed

. . . In order to make the management of the cooperative agreement more effective and efficient, it would be useful to eliminate some of the routine and redundant paperwork and to otherwise streamline administrative procedures and reporting. A.I.D. and AVSC have already agreed to move increasingly to country-level programming, review and approval.

. . . AVSC will review the administrative and reporting provisions in the cooperative agreement and suggest possible eliminations or modifications aimed at streamlining operations to A.I.D. in early 1991.

The reporting issue has been addressed. AVSC wrote to the CTO indicating which administrative and reporting provisions could be streamlined or eliminated under the current cooperative agreement. After review and critique, the CTO asked AVSC for further refinements. In a March 12, 1991 letter, AVSC formally requested agreed-upon amendments to the cooperative agreement, and a memo outlining the desired modifications has been sent to the A.I.D. contracts office for processing.

AVSC is moving toward country-level programming, review, and approval. To date, country strategies/workplans have been prepared for Nigeria and Kenya, and will soon be submitted for Bangladesh, Philippines, Madagascar, and several other countries.

Communication between AVSC and the A.I.D./Washington Office of Population have improved substantially in the past several months. The relationship between AVSC headquarters and the A.I.D. Office of Population is sound, and there is presently no cause for concern that the situation will deteriorate.

Relations between AVSC and A.I.D. regional bureaus in Washington are more complex. Communication is hindered largely because the A.I.D. bureaus (with the exception of the Latin America/Caribbean desk) have been understaffed and in a constant state of reorganization and flux for much of the past year. Country and individual staff responsibilities within the regional bureaus have changed several times; the Africa technical resource division covering health, population, and nutrition has been disbanded, and the Asia and Asia/Near East bureaus were reorganized once and are about to be split again.

Until the reorganization of regional bureaus is completed, communication will necessarily be less than optimal. In the meantime, AVSC program staff maintain contact with them on an ad hoc basis, and AVSC regional directors plan to visit the bureaus in June 1991.

Recommendation

71. AVSC should continue efforts to keep in touch with the A.I.D. regional bureaus during the reorganization, and remain poised to develop more systematic dialogue with them when requested.

4.1.2 Links with USAID Missions

Relations between AVSC field offices and USAID missions are, with few exceptions, without significant problems; in interviews with a small sample of mission staff, nearly all commended AVSC on its work. For an organization devoted to a highly sensitive issue in over 50 countries, the infrequency of complaints by USAID missions attests to the quality and discretion of AVSC's programmatic activities in the field.

When concerns (other than requests for more frequent visits and input by AVSC staff) were voiced, they tended to focus on two issues: mission participation in AVSC's country-level planning, and the timeliness of AVSC's response to mission requests.

AVSC is aware that it must integrate its country-level affairs into the overall program of activities of country missions, and that to do so it must become involved earlier in country-level strategic planning in collaboration with USAID missions. The agency has recently increased its effort to achieve this end; in the past few months AVSC has cooperated with mission staff in the Philippines and Madagascar, and expects soon to do so in Pakistan and other countries. Regional staff have been alerted to the need to work more closely in strategy development with all USAID missions where AVSC is active.

The occasional inadequacy of AVSC's response to USAID mission requests has stemmed from AVSC's perception that certain requests are inappropriate or that there is too little lead time to act responsibly on them. In a frequently cited example, USAID/Cairo asked NAMERO to help with a workshop on maternal medical indications for sterilization planned for May 1990. NAMERO noted that sterilization was illegal in Egypt, and pointed out that similar workshops over the years had been unproductive; for the proposed workshop to succeed it would take time for planning and preparing a position paper. Short of staff and with inadequate advance notice, NAMERO stated that it could not participate and would not provide funds — though the regional office did put the mission in touch with a qualified consultant and sent written material. Though AVSC subsequently apologized, the incident soured relationships between the Egypt mission and AVSC, and is even today used to illustrate AVSC's "lack of cooperation."

AVSC feels that missions sometimes extend requests with too little lead time for AVSC to participate in key activities (e.g., strategic planning meetings, technical workshops). If regional office staff have already scheduled other commitments, AVSC does not send representatives. Though this is considered evidence of AVSC's non-cooperative attitude, it more accurately reflects the regional offices' small technical staff and AVSC's lack of appreciation for the realities of USAID missions' scheduling procedure. With a larger pool of technical specialists at hand (including qualified consultants) and a greater understanding of the reasons USAID missions occasionally give short notice for meetings, AVSC could respond in a manner that would quickly help it regain its reputation for cooperation.

Recommendations

72. Each AVSC regional office should express to appropriate USAID missions its availability and willingness to participate in strategy development.
73. Regional offices should seek as early as possible to resolve problems that occur with USAID missions, if necessary using third-party mediation. NAMERO staff and USAID/Cairo staff should work with a mediator immediately to resolve long-standing tensions, improve communications, and develop ways to avert problems in the future.
74. AVSC regional offices should improve their ability to accept relatively short notices of meetings, particularly for mission strategic planning exercises. Greater flexibility could occur by recruiting additional technical staff either for regular staff positions or as consultants.

4.2 Relations with Other CAs and Multilateral Agencies

In its 1988-1992 Strategic Plan, AVSC identified interagency collaboration as a fundamental guiding principle for extending the reach and impact of its work. AVSC states that it seeks both to promote VSC provision by other CAs and donors, and to draw on the complementary skills and resources offered by the other agencies. AVSC's specific plans for interagency cooperation are developed at the country, regional, and global level, and incorporated into its annual workplans.

AVSC's operational ties with other CAs and donors have increased in the past few years through joint planning and a growing recognition among all agencies that technical assistance and research are improved if complementary strengths are pooled. During the period of the current cooperative agreement, AVSC has collaborated, or is negotiating collaboration, with the following agencies:

Donors and multilateral agencies: UNFPA, World Bank, World Health Organization (WHO), IPPF

CAs: JHPIEGO, The Population Council, FHI, PCS, Program for Appropriate Technology in Health, (PATH), University Research Corporation, (URC), Management Sciences for Health (MSH), John Snow, Inc., (JSI), The Pathfinder Fund, INTRAH, DHS, and IPPF/WHR.

A senior Population Council staff member estimated that AVSC has been involved in more collaborative activities with them than any other similar agency.

In some cases, the link is with a single agency for a country-specific activity. For example, AVSC has collaborated successfully with JSI's Enterprise program in Kenya. AVSC provided technical assistance to a private sector program to integrate voluntary sterilization into the routine family planning service offered at sites around the country. In FY 1991 this program will expand from an existing 16 to 19 sites. AVSC works closely with The Pathfinder Fund in Pakistan and Turkey. Pathfinder focuses on outreach community-based programs, while AVSC focuses on providing hospital- or clinic-based services.

In other cases, the collaborative activity involves several agencies and/or a number of countries or regions. In one of the most ambitious efforts, largely orchestrated by A.I.D./Washington, AVSC is collaborating and coordinating with The Population Council, FHI, and JHPIEGO in the development of Norplant activities and projects. In Colombia, AVSC is supporting the initiation of Norplant services in three medical schools in collaboration with UNFPA. AVSC also collaborated with The Population Council and PATH to develop the prototype Norplant training curriculum, and provided input to The Population Council in the preparation of the WHO Norplant guidelines.

AVSC staff also participate in a number of interagency task forces and working groups (e.g., the perinatal family planning education and counselling working group; the task force on program performance indicators and its subcommittees on cost-effectiveness, MIS/special surveys, and quality of care), and talk with representatives of other agencies at national and international meetings, conferences, workshops, etc.

Not surprisingly for an organization as widespread and active as AVSC, there have been occasional difficulties: unsatisfactory responses to requests from another agency (e.g., to Pathfinder's appeal for AVSC help to find a site for a VSC referral office in Tunis), delays in getting collaborative projects off the ground and completed (e.g., the slow development of flip charts in Morocco with the PCS project), and inadequate coordination and confused divisions of responsibility on collaborative projects (e.g., the Nigerian FHS project, in which AVSC — though not a formal partner — cooperates with Columbia University, FHI, JHPIEGO, Pathfinder, PATH, and others).

At the country level, representatives of other CAs and, more often, relevant multilateral agencies (e.g., UNFPA in Colombia) are at times not fully acquainted with current AVSC goals and activities. Without accurate up-to-date knowledge of AVSC's program, other agencies are unable to realistically identify opportunities for possible collaboration.

Recommendation

75. AVSC should increase its effort to inform country-level and regional offices and all relevant organizations about AVSC's current interests, resources, program of activities, and policy on interagency collaboration.

In a few instances, potentially useful new projects have been identified but cannot be developed by AVSC alone without the complementary strengths of another collaborating agency. Both AVSC and the other agency may wish to collaborate on the new project, but each expects the other to come up with the funds to support it. This situation has occurred in the Nigerian FHS Project, where some spin-off ideas for new activities (e.g., the inclusion of in-depth material on sterilization in general family planning training and counselling courses) have not yet been developed because each agency claims its existing budget does not provide for such activities. Incidents such as this may encourage the impression that AVSC does not display flexibility and seize new opportunities.

Recommendation

76. When opportunities arise for new and useful collaborative projects which cannot be funded from the budgets of either AVSC or the other interested CA(s), AVSC should discuss the need with A.I.D./Washington and/or the USAID mission and, if appropriate, seek advice about how funding can be obtained.

AVSC's record in interagency collaboration is very good. As a result of its extensive contact with other organizations — and headquarters's insistence that country-level planning include interagency cooperation — AVSC is ordinarily familiar with the relevant plans and activities of other agencies, and they of AVSC's. Other agencies enjoy collegial and productive relations with AVSC, and regard AVSC as a technically competent, dependable, and effective organization with which to collaborate. With a very few exceptions, AVSC has done an excellent job of responding to opportunities to work with other agencies, and in following through on collaborative projects.

5. Conclusions and Key Recommendations

5. Conclusions and Key Recommendations

5.1 Overview: AVSC in the Present and the Future

In general, AVSC has executed its responsibilities for this cooperative agreement quite satisfactorily. The accomplishments have occurred through a mix of funded projects (146 subagreements in 40 countries, and 76 small grants in 24 countries), technical assistance, training courses and workshops, and publications and program materials. The quantitative outputs specified in the agreement have, with few exceptions, been achieved on or ahead of schedule.

AVSC has demonstrated its ability to identify and disseminate appropriate technology worldwide, with projects now in 49 countries and a strong field presence at the regional level. It has handled controversial contraceptive methods — male and female sterilization — with sensitivity and courage. The agency is expanding its scope beyond interval sterilization to include other surgical methods that build on its strengths and resources. AVSC has shown leadership in quality assurance and counselling, and provides an international model with its focus on the issue of free choice.

Communications between AVSC and A.I.D./Washington, and between AVSC field offices and most USAID country missions, are good, as are AVSC relationships with other CAs and multilateral agencies. The balance of budget obligations through central funding (81 percent) and through buy-ins (19 percent) is on target.

There are, of course, several ways AVSC's performance during the first half of this cooperative agreement could have been improved; these have been detailed in the previous chapters. Greater attention could have been given to VSC information and education efforts and outreach activities, for example, and AVSC's deliberate avoidance of involvement in VSC policy issues doubtless reduced the agency's potential impact. Lack of follow-up of participants in training courses makes it impossible to assess the true effect of training activities, and training of trainers courses devote too little attention to teaching how to train.

AVSC's evaluation activities have been less than satisfactory. The MIS provides little of value, quarterly reports collect data that are unused, and, overall, there is little effort to utilize evaluation to improve projects or management. Relatively little attention has been devoted to cost studies, making it more difficult to work toward sustainable programs. Strategic planning is now being taken seriously, but too few country workplans have yet been developed in collaboration with USAID missions and local authorities. Though small projects are often useful, AVSC spends a disproportionate share of its time approving and administering these smaller grants. Procedures for review and approval for larger subagreements are unnecessarily complex.

Overall staff competence and motivation is high, but the lack of field experience and hands-on technical expertise in the Program Management Department hampers links between headquarters and the field. The 18-month absence of a medical director weakened the Medical Division, whose role in the organization needs clarification — especially in light of AVSC's reputation as a medical technical assistance organization. There is an uneven capacity to provide medical technical assistance in the field at short notice, a problem particularly acute in the Asia Regional Office.

Most of the concerns expressed in the previous pages relate not to the past and current satisfactory performance of AVSC, but to its ability to deal with a changing environment for family planning in the coming decade. Without question, the most important anticipated future trend will be the dramatic growth of family planning programs in general, and of surgical contraception in particular. Sterilization will become a central component of government and private programs, moving from the sidelines to the mainstream. As sterilization gains ground, AVSC will have to move with it. AVSC's role, now largely focused on nurturing small pilot programs and cutting-edge institutions, must change with demands for expansion, training of trainers, and large scale management. For maximum leverage in the future, AVSC will have to make several important adjustments.

Shift from Projects to Programs

A key change for AVSC will be the shift in orientation from a project to a program focus, an inevitable change if AVSC is to influence thousands, rather than dozens, of VSC procedures in a country. This evolutionary step will require a grander vision of what AVSC is capable of doing, a better grasp of overall needs and opportunities in a country or region, more ambitious strategic planning, and management improvements.

As AVSC moves from working on an array of small and often unrelated projects to influencing large national programs, it will increase its leverage, cost-effectiveness, and ultimate impact. However, these advantages will come at the expense of control: as a provider of technical advice and relatively minor funding to a national program, AVSC cannot expect to have the degree of control it now exercises over single-clinic or single-hospital local projects which it funds almost entirely.

Loss of Control over Program Outputs

AVSC has done a remarkable job to ensure that standards of quality for VSC in developing country projects approximate, and in some cases match, those of developed countries; quality assurance has been a top priority. Indeed, it may well be that the worldwide success of sterilization could not have been achieved without AVSC's high demands for quality. Sloppy procedures and poor counselling would have left many dissatisfied clients, whose complaints during the formative years of VSC programs would have undermined the willingness of other men and women to follow suit.

As AVSC moves from local projects to national programs in the coming decade, control of VSC services will shift from AVSC project directors and technical specialists to national program administrators. Although these national authorities will obviously try to maintain the highest possible standards for surgical contraception, "the highest possible" may not reach the level that AVSC now demands. National decision makers, intent on dealing with the volume of VSC procedures necessary to meet health and demographic needs, may not have sufficient resources to maintain current criteria for medical and non-medical quality assurance.

In the past, AVSC correctly assumed it was accountable for surgical or counselling problems in projects it funded and monitored; adherence to the highest standards helped reduce the probability of problems. In the future, AVSC will usually operate at a greater distance from the actual clinic procedures, and simply will not be able to ensure strict adherence to the same optimal standards of quality. The diminished control over AVSC-supported activities may lead to an increase in side effects and regret-linked complaints. AVSC, A.I.D., and other donors must adjust their demands for accountability, recognizing that AVSC cannot both maximize its leverage by focusing on national-level

programs and simultaneously maintain the degree of control possible through a focus on small projects.

Aim for Quality, Not Perfection

One theme often voiced by AVSC staff is that the agency constantly strives for perfection. Through attention to detail and insistence on highest-quality performance, together with elaborate and ultimately centralized mechanisms for review and approval of new activities, AVSC has achieved world recognition for its work. The agency's high expectations for itself have been well suited in a very sensitive field, for AVSC has been able to demonstrate that surgical contraception procedures done in developing countries are a safe and sensitive approach to client needs.

With the probable expansion of its operations and scope of work in the coming decade, however, AVSC may need to relax some of the standards of perfection in non-critical areas. Unless standards of quality are prioritized and adjusted, AVSC will increasingly be constrained by too rigid and unrealistically high expectations, limiting the ultimate impact of its work.

As an example, AVSC — to maximize its leverage — will move increasingly to the training of trainers for surgical techniques; it will rarely be directly responsible for training the surgeons who perform the VSC procedures. AVSC cannot, therefore, be held accountable for all the sterilizations undertaken by the trainees of their trainees. A time must come when AVSC — and A.I.D. — recognizes that although some mistakes will be made (and perhaps some lives lost) due to non-adherence to the highest medical standards, there is no alternative. If surgical contraception is not made available to the widest possible client population as quickly as is feasible, many more lives will be lost through maternal deaths, including many from septic abortions.

Attention to Financing Issues

The coming decade will see governments and clients themselves assuming a greater proportion of the costs of family planning programs. A consequence of the shift toward client financing is that financial management will play a critical role in the sustainability of contraceptive programs. This is particularly true of long-term methods, due to the relatively high up-front cost coupled with a favorable long-term cost-benefit ratio.

AVSC will need to develop a capacity to assist VSC programs with financial management issues, since AVSC has been involved in all other aspects of surgical contraception. In addition, AVSC still has many sites where new approaches can be developed and tested. The issue of financing has become even more important with the introduction of Norplant; AVSC is in position to help establish efficiency guidelines and develop expertise in clinic management.

Broadened Scope within VSC

AVSC has adapted to changing needs by broadening its original organizational mission to include certain other methods of contraception in addition to sterilization, and has moved beyond the surgical event itself to include counselling and other non-medical service elements. As VSC becomes increasingly accepted as an integral component of comprehensive national family planning programs in the 1990s, the need will grow for technical assistance for all aspects of VSC service delivery. With its unique experience in the field, AVSC will need to continue to expand its scope to include a wider

array of issues related to the provision of surgical contraception services; no other agency is as well positioned to do so.

First among the new targets for AVSC should be policies which inhibit effective sterilization programs; the agency's current stance of studied impartiality toward policy issues will need to be replaced by one of scholarly advocacy. Using its network of contacts and its documented evidence on the value of sterilization, AVSC will need to aggressively but diplomatically lobby for progressive VSC laws and regulations. With AVSC's support and guidance, considerable support can be mustered to eliminate policy obstacles (both formal and informal) to permanent contraception (e.g., unrealistic limits on an acceptor's age or number of living children).

AVSC will also need to significantly expand its efforts in the area of IEC, beyond the impressive but modest work it is doing in Latin America and Africa. On this topic AVSC might wish, at least initially, to serve as a broker and facilitator by bringing the skills of IEC specialist agencies to bear on VSC programs in which AVSC is active. At a later date, AVSC may wish to develop its in-house expertise in IEC. The same approach might be taken to help strengthen management skills for VSC program administrators, an issue on which AVSC has recently begun to devote attention.

Incorporating Monitoring and Evaluation

As VSC programs grow bigger and become integrated into national family planning programs, monitoring and evaluation mechanisms will increasingly serve as essential management tools. AVSC will need to radically revise its approach to monitoring and evaluation. To assist large VSC programs effectively, AVSC must not only improve its collection and processing of programmatic data, but learn to use the information quickly to anticipate areas of concern, identify and solve problems, increase cost-effectiveness, etc. The mechanisms for these tasks will need to be developed with the help of specialized agencies in collaboration with local program workers and administrators, and eventually handed over to them to implement — as AVSC is now doing in a few sites with COPE.

Demonstrating Flexibility

When AVSC began to help provide tubal ligation and vasectomy services in the developing world 20 years ago, virtually all countries (India was a notable exception) were reluctant, at best, to offer sterilization — and had no facilities to do so; they were in what is today labeled the "emergent" stage. Because few governments were prepared to consider sterilization as part of the national family planning program (if such a program existed), AVSC concentrated on progressive private sector surgeons and on NGOs — some of which AVSC helped create.

Today the situation is much more heterogeneous — and it will become more so in the coming decade. Through the 1990s, countries will exhibit a wide range of contraceptive prevalence and program sophistication, from emergent through mature, and will develop an array of mechanisms through which family planning services, including VSC, might be provided.

Within the limits of its overall mandate, AVSC must seize opportunities and eliminate constraints in providing VSC services. In each country, for example, AVSC's balance among collaborating NGO, government, and private sector organizations will need to be adjusted so attention is given to those sectors most likely to have cost-effective impacts. Since this balance varies among countries and changes over time, AVSC must be prepared to adjust quickly to new situations. In the past, it has done this successfully in some instances (in Colombia support is shifting focus from an NGO to

municipal governments) and with less success in others (in Bangladesh it has been difficult to disengage from a long-funded NGO to provide greater attention to government programs).

Adaptability must also characterize AVSC's response in the coming decade to opportunities for strengthening its programmatic activities. As it did with no-scalpel vasectomy, AVSC will need to help disseminate improved VSC procedures (including sedation and anesthesia) as well as new ideas for training, counselling, quality assurance, monitoring, and supervision, etc. Some future innovations (such as COPE) may be developed by AVSC itself; most, however, will be borrowed, with AVSC playing a role in their global introduction.

Flexibility will also be needed in management. AVSC headquarters units and field offices that are strong will need to be given more authority to use their knowledge and experience imaginatively; weaker elements of the organization will need greater attention and support. Creative country program management approaches have already been tried with success in Turkey, Tanzania, and Nigeria, where in-country institutions and professionals handle AVSC project monitoring and technical assistance responsibilities; more extensive use of this strategy will both strengthen local institutions and free AVSC staff for other activities. This approach also represents a commendable commitment to decentralization.

AVSC will also need flexibility in dealing with A.I.D./Washington and USAID missions in the next decade. Staff turnover at A.I.D./Washington and USAID missions will continue to disrupt communication links and sometimes lead to revisions of priorities and procedures; AVSC must simply adapt to it. As the demand for VSC grows, AVSC can expect to receive even more calls, some on short notice, to handle particular tasks or to explore new initiatives. AVSC must respond promptly and thoughtfully to all such requests, seeking immediate advice from the CTO in the event a request must be declined. AVSC will also need to take the initiative to communicate with A.I.D. staff for early exploratory discussions about proposed new AVSC initiatives, modifications in strategy, major management changes, etc.

AVSC has grown and adapted over the past two decades to meet the changing needs for voluntary surgical contraception in the developing world. There is every reason to believe AVSC will continue to evolve to meet the new challenges of the coming decade.

5.2 Key Recommendations

5.2.1 Overall Policy and Balance of Activities

1. AVSC should continue to focus only on the provision of surgical methods of family planning, exploring new variations and methods of such contraceptives as they become available for programmatic field trials. Though AVSC should continue and expand its role in assisting with the introduction of Norplant, its involvement with immediate postpartum IUD insertion should be carefully examined before widely integrating this method into its programs. Sterilization, both male and female, should remain the agency's central focus.

2. AVSC should give more attention to sedation, analgesia, and anesthesia in the context of VSC procedures, and should involve more anesthesiologists and/or anesthesia technicians in AVSC training and service delivery programs.

3. Greater attention should be paid to ensuring that participants in AVSC training courses can learn the specific technical skills they will need in their home institutions; all trainees should be followed up after completing a course to determine the long-term effects of the program.
4. AVSC should continue to focus on issues of counselling for VSC, and work with other service delivery CAs to improve counselling for all family planning methods.
5. Where existing VSC services are underutilized, AVSC training programs should focus not only on more acceptable surgical techniques, but also on ways to increase demand on the services and lower programmatic barriers (e.g., through improved clinic management, outreach programs, information and communication).
6. Based on its comparative advantage, AVSC should begin systematically addressing VSC policy constraints at all levels, from local hospital and clinic rules and regulations to national and government family planning laws and policies.
7. AVSC should devote more effort and imagination toward the sustainability of VSC programs. This should begin with developing reliable measures of the true costs and impacts of VSC services and the assessment of the cost-effectiveness of various delivery system models. AVSC should more actively collaborate with the private for-profit sector.
8. The recently introduced process of developing and approving country workplans rather than individual projects should be expanded, by the end of 1992, to include all countries in which AVSC has a major role. In its strategic planning at all levels, AVSC should work closely with A.I.D. and expect clear guidance about A.I.D.'s expectations.

5.2.2 Organizational Structure and Management

9. To streamline the grant approval process, AVSC staff should be given authority to approve subprojects consistent with an approved country program strategy. AVSC should accelerate its move toward approval of multi-year subagreements.
10. The AVSC Board of Directors' International Committee should discontinue its quarterly review and approval of projects and instead review country strategies at an annual meeting hosted by a different AVSC regional office each year.
11. AVSC should reconsider its decision to place the primary responsibility for Norplant, NSV, and postpartum IUDs in the Special Programs section of the International Division. Moreover, AVSC should make special efforts to ensure that the Medical Division (and other units) play major roles in planning and implementing the service provision of these methods. AVSC should fully involve the newly recruited medical director in senior management decisions, and give her clearly articulated authority to direct the medical affairs of AVSC. The role of the Medical Division vis-a-vis the regional offices needs to be redefined, with unambiguous lines of communication and authority.

5.2.3 Research and Evaluation

12. The Research and Evaluation Department needs to be strengthened and refocused to concentrate not primarily on projects, but on programs. Efforts to measure the quantitative impact of AVSC activities on programs, VSC procedures, and demographic events should be accelerated.

13. Service delivery statistics required on subprojects' quarterly report forms should be simplified to the minimum actually used for project monitoring and evaluation. The MIS should be made fully operational and end-of-project assessments either utilized or reduced to a simple exercise to verify the cumulative service statistics provided by the quarterly reports.

14. AVSC should only foster a research capacity insofar as it strengthens its monitoring and evaluation capacity. The present policy — undertaking research in collaboration with other organizations which have the requisite skills and resources — should be continued.

5.2.4 Regional Program Management Teams

15. AVSC should review the job descriptions, staffing requirements, and personnel policies regarding the RPMTs. Regional staff should play a major role in all personnel actions regarding RPMT staff. Program managers on the RPMTs should be rotated to regional offices for extended periods to gain an appreciation of the field situation.

5.2.5 Decentralization and Field Offices

16. AVSC should be commended for the decentralization it has achieved and should continue in this direction. Headquarters should take a more flexible approach in dealing with regional offices, continuing to provide direction and support for the weaker offices but allowing more autonomy for the stronger ones; special attention should be devoted to bringing the Asia Regional Office up to the level of the others. AVSC should establish a country representative in Turkey, and begin planning for representatives in other countries with active programs in the coming years.

17. All regional offices should strengthen their capability to provide medical technical assistance, evaluation, and certification, by expanding the pool of medical consultants and, where feasible, adding medical specialists to the field staff. Regional offices should also anticipate that in the coming years they will increasingly be expected to provide technical assistance in non-medical aspects of VSC programs (e.g., training of trainers, IEC, outreach, management, evaluation). Every effort should be made to identify qualified nationals from the region for these tasks.

18. AVSC field offices should express to appropriate USAID missions their availability and willingness to participate in strategy development and the planning of mission-initiated projects, and should improve their ability to accept relatively short notices of meetings with USAID mission staff.

5.2.6 World Federation

19. Over the next few years AVSC should gradually phase out financial support for the World Federation, allowing it time to plan for alternative arrangements for funding and management.

Appendix A

**Scope of Work
List of Persons Interviewed
Bibliography**

Appendix A

Scope of Work

Association for Voluntary Surgical Contraception

Mid-Term Evaluation

I. Overview of the Cooperative Agreement

The estimated amount of the Association for Voluntary Surgical Contraception's (AVSC) second Cooperative Agreement, #DPE-3049-A-00-8041, for the period August 24, 1988 to August 23, 1993 is \$80,000,000. To date, the Cooperative Agreement has been amended twelve times. Amendment 13 brings total obligation to \$30,710,396.

The purpose of this project is to provide support for developing countries in order to have high-quality voluntary surgical contraception (VSC) services institutionalized and routinely accessible in their family planning service programs. It is to do this by expanding access to services, with emphasis upon institutionalization and sustainability; by rigorous and systematic attention to voluntarism; and by maintaining and enhancing the safety and quality of services.

II. The Purpose of the Evaluation

The AVSC Cooperative Agreement calls for a mid-term project evaluation to take place in early FY 1991 by an external evaluation team with A.I.D. staff participation. The purpose of this evaluation is to review AVSC strategy and performance to assess how well AVSC has carried out its program under the cooperative agreement and to guide plans for future cooperation between A.I.D. and AVSC.

Roughly one-third of the evaluation effort will focus on documenting the extent to which the project is on track in achieving scheduled objectives. Two-thirds of the evaluation effort will look to the future by suggesting what adjustments in emphasis or process should be made and/or what unanticipated initiatives should be considered for the remainder of the Cooperative Agreement period. The report will also indicate who should be responsible for acting on the recommendations made and present a timetable for addressing the recommendations.

III. Background

AVSC was founded in 1943 to make voluntary sterilization more widely accessible in the United States by helping create the legal, professional and public climate necessary to allow sterilization to become the most widely used contraceptive in the United States today. In 1971, AVSC began working in the developing world and received its first funding from the Agency for International Development (A.I.D.) in 1972. Since then, A.I.D. has been the principal funder of AVSC international activities.

AVSC's programs have trained approximately 25,000 health personnel for sterilization services and AVSC-supported services have performed nearly 2.0 million sterilizations. AVSC programs have gradually shifted from an emphasis on resource transfer focused on helping institutionalize the provision of quality voluntary surgical contraception services in private and government health and family planning services. Worldwide, more women are protected from pregnancy by voluntary sterilization (their own or their partners') than by any other contraceptive method.

The former cooperative agreement (1982-1988) witnessed a gradual shift in focus, partially in response to the 1985 external evaluation of AVSC. Key evolutionary changes continue under the follow-on project (1988-93) and include shifting from:

- **Introduction of services to maintenance of quality services.**
- **Working for policy permitting VSC to devising guidelines and standards for the delivery of safe, effective, voluntary services.**
- **Full subsidy of services to greater emphasis on sustainability and institutionalization of services.**
- **Working in countries and regions where the sociodevelopmental milieu is relatively receptive to VSC to working in countries where policies and health service capabilities are less conducive to making VSC available and affordable to those who desire it.**

Additionally, AVSC will work increasingly in the private sector, will increase its focus on Africa, will expand its regional apparatus to provide greater technical assistance and medical oversight, and will add long-lasting contraceptives such as NORPLANT and the Copper T-380A IUD to AVSC-supported programs, where appropriate.

Management Review

The management review of the Cooperative Agreement between A.I.D. and AVSC was conducted on November 14, 1990. The review was the culmination of a longer process that included preparatory discussions between A.I.D. and AVSC staff during an Family Planning Services Division (FPSD) staff visit to AVSC in New York in August, 1990, exchanges of letters on the proposed scope of work, and the preparation of 14 discussion papers on topics to be covered by the management review. The process was further helped along by an independent review covering administrative and management issues that AVSC conducted during the spring of 1990.

The participants in the review generally agreed that the process leading up to it and the review itself were useful for identifying important issues and for producing recommendations for action. These issues are reflected in the scope of work that follows. The AVSC participants expressed their satisfaction with the review process and noted that it was carried out in a constructive fashion. A.I.D. participants noted that the discussion papers that AVSC had prepared for the review were candidly written and helpful background information for the issues that needed to be discussed.

Generally, it was felt by all that the work under the cooperative agreement was going well and that the relationship between A.I.D. and AVSC was good. Naturally, there were areas requiring attention and correction, but there was general agreement on action to be taken.

The main findings and recommendations are listed below:

1. Communications:

AVSC should inform the FPSD and the Office of Population about major developments and possible policy shifts earlier than it has. Similarly, AVSC should work more closely with A.I.D. missions, to become involved earlier with them in strategic planning and in dealing with emerging policy issues, and should work with the FPSD to maintain contacts with the regional bureaus and the regional population staff, bringing AVSC regional directors to Washington for this purpose once a year or so. Senior AVSC staff should meet with Office of Population staff three or four times a year, for a better exchange of views, and similarly FPSD staff should visit AVSC headquarters three or four times a year. It was acknowledged that AVSC would have to take the initiative to improve communications with A.I.D., given the diversity of demands on A.I.D. staff both in Washington and in the field. It was noted that in the recent past, effective communication had been made more difficult by several changes in the cognizant technical officer.

2. Medical:

AVSC is interviewing a short list of qualified candidates for the position of Medical Director (MD). AVSC expects to be able to make a decision early in 1991, and hopes to have a Medical Director on board around March of 1991. Everyone agreed that this was a high priority. In the meantime, medical coverage is being provided by the Deputy Medical Director and other medical staff in the medical division and in the field (there is a regional medical advisor in all the regions except Asia). In addition, the medical members of the science committee of AVSC's board of directors, who are leaders in their respective specialties, have agreed to be on call for dealing with urgent medical issues.

3. Field Offices:

It was agreed that completing the staffing for AVSC's Asia Regional Office is a high priority, and that as soon as a regional director is appointed, recruitment will begin for a regional medical advisor. A.I.D. expressed some concern about whether there would be an adequate level of technical skill in this office. AVSC noted that the office would function on the same model as the offices in Nairobi and in Bogota, which are generally acknowledged to have dealt competently with technical issues facing them. It was agreed also that AVSC would make special efforts to respond promptly to mission requests for technical assistance, and that AVSC would seek to become involved as early as possible in mission strategic and tactical planning, so that differences could be identified and resolved as early as possible (see "communications" above).

4. Research and Evaluation:

The importance of evaluation was underscored by recent Congressional request for indicators of performance for the population program. It was agreed that: many of the elements of AVSC's strategy and program (quality of care, leverage, Norplant^R, the male initiative, etc.) cannot be adequately measured by such conventional approaches as simple counts of sterilization acceptors; and a high priority for AVSC's work under the cooperative agreement should be to develop and test new ways of measuring performance. This should be done in collaboration with A.I.D. (especially the new evaluation section in its policy division) and research-oriented cooperating agencies such as the Population Council and Family Health International (FHI).

It was also agreed that secondary analysis of data from the Demographic and Health Surveys (DHS) to better define the market for voluntary surgical contraception would also be an important element for AVSC program planning. It was noted that in fact AVSC was already working with the DHS contractors on this type of secondary analysis.

Finally, it was noted that AVSC has moved its evaluation unit from the medical division and established it as an independent department under the Executive Director. AVSC is adding an additional professional position to this unit.

5. Cooperative Agreement Procedures:

AVSC and A.I.D. agreed that in order to make the management of the cooperative agreement more effective and efficient, it would be useful to eliminate some of the routine and redundant paperwork and to otherwise streamline administrative procedures and reporting. A.I.D. and AVSC had already agreed to move increasingly to country-level programming, review, and approval. This approach will be applied to countries where AVSC involvement is substantial. Country-level programming will involve A.I.D. approval of a packaged plan including multiple subprojects. Once A.I.D. and Mission approval of the country program package is obtained, subsequent A.I.D. approval of the subagreements included is not required. However, Missions are required, as a "fail safe" mechanism, to reconfirm approval of each subagreement prior to incremental commitment by AVSC to each

subgrantee. This country-level programming will eliminate the need for redundant subproject review by A.I.D./Washington and will allow for more substantive A.I.D. and Mission dialogue on country strategy and workplans.

We also agreed that AVSC will review the administrative and reporting provisions in the cooperative agreement and suggest possible eliminations or modifications aimed at streamlining operations to A.I.D. in early 1991.

6. Funding and program initiatives:

Funding needs for AVSC's fiscal year 1991 were also discussed. It was agreed that AVSC's funding needs totaled \$13.5 million, broken out as follows:

<u>Activity</u>	<u>Amount</u>
Maintenance of current level of activity	\$10,700,000
Norplant ^R introduction	1,000,000
Male initiative start-up	250,000
Information materials production start-up	250,000
Additional regional activities	1,300,000
TOTAL	\$13,500,000

It was also agreed that Norplant^R introduction needs to be funded in addition to current voluntary surgical contraception activities. While many organizations could be involved in Norplant^R introduction, AVSC still remains the primary agency involved in sterilization; so it does not make strategic sense to reduce sterilization funding to create funding for Norplant^R. AVSC noted that: the male initiative is an extremely high AVSC priority; the male initiative includes work on the male role in other contraceptive decision-making (especially female sterilization) in addition to vasectomy programs; and AVSC envisions collaborating on this initiative with other cooperating agencies such as Population Communication Services (PCS) for information, education and communication, and the Population Council for Operations Research.

IV. Scope of Work/Issues to be Addressed

The contractor, Dual and Associates, under the A.I.D./Washington Population Technical Assistance (POPTECH) project will field a six person evaluation team for a 4 week period, April 29 - May 24, 1991, to evaluate achievement of project objectives and to assist A.I.D. and AVSC to refine the strategy for optimizing the remainder of the Cooperative Agreement.

The first part of the evaluation will focus on documenting the extent to which the project is on track both in terms of overall strategy and in achieving scheduled objectives. The following are examples of the types of questions the team should address:

- Is the AVSC Strategy and Workplan consistent with the overall thrusts of the FPSD Strategy for the 1990's?
- Are the subproject criteria outlined in the FPSD Strategy being applied?
- How well is AVSC meeting its scheduled outputs?
- How does AVSC propose to respond to Management Review recommendations?

The second part of the evaluation will look to the future by suggesting what adjustments in emphasis or process should be made and/or what unanticipated initiatives should be considered for the remainder of the Cooperative Agreement period. The central question for the second part of the evaluation is whether AVSC has the appropriate organizational configuration and mix of human resources (including functional and geographic distribution of those resources) to meet the needs of the future. In addition, there are four specific issues which impinge on this central question that should be addressed:

1. The AVSC/New York and field office relationship
2. Initiatives
3. Research and evaluation
4. Interagency collaboration

Within each of the four issues, the following are questions the evaluation team should address:

1. AVSC/New York and field office relationship

- Is the functional and geographic distribution of skills among the New York, regional offices and country representatives appropriate? If not, what changes are recommended and why?
- Is the current distribution of responsibilities and authorities between the New York, regional offices and country representatives appropriate? Are any changes recommended?
- What changes should be made to improve the quality and decrease recruitment times of AVSC regional and country-level personnel?
- As AVSC moves away from direct service delivery to training and technical assistance, what system should be employed to monitor sterilization activities?

2. Initiatives

- Is AVSC appropriately structured and adequately staffed to implement the initiatives?
- What should be the objectives for the initiatives?
- Within AVSC's overall portfolio, what is the relative level of effort recommended for female sterilization and the initiatives (Norplant, postpartum family planning, male initiative)? What changes should be made?
- What is the public/private sector mix for future activities? What changes should be made? How can AVSC better exploit the potential for sustainability of the private for profit delivery systems?
- Is the role of the World Federation appropriate? If so, how can the influence of the World Federation be expanded and how can it become more self-sustaining?
- Are there any suggestions for additional initiatives not mentioned above?

3. Research and evaluation

- How is the AVSC evaluation system performing at the following levels: subagreement; country program; regional; global? Are any improvements recommended?
- How can the measurement of impact and quality of care be improved?

- How effectively is AVSC utilizing operations research and data analyses to improve program performance? Are there any recommendations for improvement?

4. Interagency collaboration

- How well is AVSC collaborating and cooperating with
 - a) other service, training and research cooperating agencies;
 - b) international organizations such as UNFPA and WHO; and
 - c) multilateral donors?
 Any recommendations for improving cooperation?
- What can be done to improve strategic collaboration with A.I.D. at the regional and country levels?

V. Methods and Procedures

1. Team members will conduct a review of relevant project documents including, but not limited to:

Cooperative Agreement: A.I.D./DPE-3049-A-00-8041
 Project Paper
 AVSC Annual Reports
 AVSC Workplan 1990, 1991
 AVSC Strategic Plan 1988-1993
 A.I.D./W Management Review November 14, 1990
 Quarterly Reports (Latest Semi-Annual Report)
 AVSC Annual Evaluation
 A.I.D./POP/FPSD Family Planning Strategy for the 1990s
 AVSC Background Paper

2. The team will meet with AVSC Board members, AVSC Headquarters staff and A.I.D./W staff (S&T/POP and Regional Bureaus).
3. The team will divide into 2 subteams of three persons. Each subteam will make a two week field visit to two regions (Latin America, Asia, North Africa or Africa) where they will meet with A.I.D. mission staff, AVSC Regional and/or country staff members, Ministry of Health officials, service providers and administrators. While in country, the subteam will make field trips to project sites. The precise number and location of sites shall be decided in conjunction with A.I.D. and AVSC headquarters and regional staff. Subteam A will travel to Columbia, Tunisia and Nigeria. Subteam B will travel to Turkey, Pakistan and Bangladesh.

VI. Team Composition

1. Team Leader - John Marshall
2. Physician - Alan Margolis
3. Management Specialist - Marc Mitchell
4. Nurse/Midwife - Judith Rooks
5. Social Scientist/A.I.D./W Liaison - Susan Hyatt-Hearn
6. Evaluation Specialist - Thomas Murray

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VII. Reporting Requirements

The format of the draft and final written report shall contain the following sections:

- Evaluation summary (three pages single spaced) including statement of conclusions and recommendations keyed to the questions in the Scope of Work.
- Body of the report which should provide the findings and analysis on which the conclusions and recommendations are based.
- Appendices

The evaluation team will present their major findings and recommendations to staff at A.I.D./W and AVSC in separate debriefing meetings. (It may be appropriate to schedule the AVSC debriefing during their annual meeting with field staff held in New York in late June 1991.) The evaluation team shall prepare and distribute two days prior to the debriefings a matrix summarizing findings, conclusions, recommendations and options for improving programming and management.

A draft report will be prepared and submitted to the CTO for approval before printing and distribution of the final report.

List of Persons Interviewed

USAID/Washington S&T/POP

Duff Gillespie	Director, S&T/POP
Elizabeth Maguire	Associate Director, S&T/POP
William Johnson	Project Manager, Family Planning Services Division
Dawn Liberi	Chief, Family Planning Services Division
Roy Jacobstein	Chief, Information and Training
James Shelton	Chief, Research
Richard Cornelius	Deputy Chief, Policy and Evaluation
Bonnie Pederson	Project Manager, Information and Training

LAC Bureau

Art Danart	HPN Officer
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AVSC/New York

Hugo Hoogenboom	Executive Director
Terry Jezowski	Director of International Program Division
George Woodring	Director of Finance and Administrative Division
Lynn Bakamjian	Director of the World Federation Secretariat and Deputy Director of Special Programs, IP
Evelyn Landry	Director of Research and Evaluation Unit
Leslie McNeil	Research Associate, Research and Evaluation Unit
Betty Gonzales Sansoucie	Acting Director/Deputy Director, Medical Division
Jeanne Haws	Planning and Budget Coordinator, IP
Alison Ellis	Assistant Director of Program Management, IP
Gilberte Vansintejan	Technologies Introduction Coordinator, IP
Tamara Smith	Program Manager (Africa)
Patricia Foxen	Grants Officer (LAC)
Geetanjali Misra	Senior Program Officer, World Federation
Joseph E. Davis	Chair of the Board of Directors
Andrew Davidson	Member of the Board of Directors

Others in New York

Alan G. Rosenfield	Dean, Columbia University School of Public Health and Member, AVSC Science Committee
Malcolm Potts	Family Health International, President Emeritus
George Brown	Executive Director, The Population Council
John Ross	The Population Council
Karen Beatie	The Population Council
Douglas H. Huber	Previous Director of the AVSC Medical Division

Colombia

AVSC/LAC Office

Fernando Gomez	Director
Alcides Estrada	Assistant Director
Luz Helena Martinez de Duque	Program Manager
Gloria Daza de Perdomo	Grants Officer

USAID	
James Smith	USAID Representative
Profamilia (AVSC Grantee)	
Maria Isabel Plata	Assistant to Executive Director
Myriam Gutierrez	Grants Coordinator
Cecilia Cadavid	Director of the Men's Clinic and Coordinator of the National Surgical Program
Gabriel Ojeda	Director of Research and Evaluation
PAHO (Collaborating Agency)	
Manuel Moreno Castro	Technical Coordinator for UNFPA MCH/FP Project (executed by PAHO)
Fundacion Sante Fe de Bogota (Norplant training center)	
Dr. Jaime Urdinola	
Dr. Monica Lopez	
Escuela Colombiana de Medicina (Grantee, Norplant Project)	
Luis Fernando Duque	
Instituto Materno-Infantil (Grantee)	
Maria Helena Lopez	Family Planning Head Nurse
Ana Lucia de Lopez	Administrative Director
Myriam Fernandez	Nurse
Servicio Seccional de Salud de Antioquia (Grantee)	
Fabiola Cuervo Tafur	MCH Program Nurse
Metrosalud - Medellin (Grantee)	
Martha Helena Betancourt	Director of Castilla Unit and Training Center
Ministry of Health, MCH Division	
Cesar A. Jauregui	Family Planning Staff
Norma Patron	Professional Division (Statistics)
Josefina de Sotomonte	Education Specialist
Mary Luz Mejia Gomez	Head of Population Dynamics Section
MOH Hospital San Rafael, Chiquinquirá, Dept of Boyaca	
Oscar Rusinque	Medical Director
Guillermo Medina	Head of the MCH Division
Luis Fernando Rincon	Head of Outpatient Services and Surgeon for VSC Program
Carlos Gustavo Rincon	Surgeon for VSC Program
Others in Colombia	
Sara Bright	AVSC Grantee (Video films)
Mercedes Borrero	Program Officer, UNFPA

Dr. Sumaila A. Shuaibu **Head of JUTH Mini-Lap Team**
Nwanyife C. Okwudili **VSC Counsellor, JUTH**

POPTech Evaluation Team for Family Health Services Project
John McWilliam
Pamela Wolf
Nancy Williamson

Pakistan

AVSC/Asia Regional Office
Nancy J. Piet-Pelon **Director**
Ahmed Al-Kabir **Regional Program Advisor**

Government of Pakistan, Ministry of Population Welfare
Khalil A Siddiqi **General Programme Director**
A. Rashid Khan Ghauri **Joint Secretary**

Pakistan Voluntary Health and Nutrition Association
Mrs. Zeba Zubair **Chairman Executive Board Secretariat**
Dr. Yasmeen Sabeeh Qazi **Physician in Charge of Medical Center**

Non-Governmental Organizations Coordinating Council for Population Welfare
Begum Akhtar Akhlaq Hussain **Chairperson**
Barkat Rizvi **Chief Executive**

Pathfinder Fund
Mrs. Imtiaz Taj Kamal **Country Representative for Pakistan**

Family Planning Association of Pakistan
Begum Tajwar Shaukat **Honorary General Secretary**
Begum Surayya Jabeen **Director General Field Operations,**
International and Government Liaison

Karachi Zone
Dr. Rehana Ahmed **Zonal Director**
In-Charge of Model Clinic

Lahore Zone
Dr. Naumi Shamim **Senior Medical Director**
Mian Abdul Hameed **Zonal Director**

Vasectomy Training Center, Department of Urology, Mayo Hospital, Lahore
Professor Khan Akhtar **Project Director**
Dr. Saeede Ahmed Shamsi **Project Manager**

Behbud Association, Rawalpindi, Pakistan
Nighat Saeed Khan **Executive Director**

Turkey

Hacettepe University Department of Public Health
Professor Sevinc N. Oral **Chairman**

Professor Mulnever Bertan Epidemiologist, Health Education and Maternal and Child Care
Professor Ayse Akin Dervisoglu Maternal and Child Care
Professor Dogan Benli Director of Etimesgut Health Trainer and Research Area
Asst. Professor Cagatay Guler Director, Etimesgut Hospital
Dr. Sevket Bahar Research Assistant
Dr. Nilgun Kircalioglu Research Assistant
Dr. Hilal Ozcebe Research Assistant
Dr. Levent Akin Assistant Professor

Turkish Family Health and Planning Foundation

Professor Sunday Uner, PhD Deputy Executive Director

Social Security Maternity Hospital, Ankara

Dr. Mualla Yildiran Director
Dr, Ismail Dolen Obstetrician Gynecologist
Dr, Kamber Oguzer Obstetrician Gynecologist
Dr. Berna Ozbey Obstetrician Gynecologist
Dr. Gugu
Professor Mu and Pediatrician

Health Family Planning Development

Embassy of the United States of America, Ankara

Carolee Heileman Economic Officer
Dr. Pinar Senlet Consultant who coordinates population/family planning activities

Government of Turkey Ministry of Health

General Directorate for Maternal and Child Health and Family Planning, Ankara

Ugur Aytac Deputy General Director
Nuran Ustunoglu Chief, Public Health Training Division

Z. T. Burak Maternity Hospital, Ankara

Dr. Oya Gokmen Director
Dr. Havva Oral Trainer
Dr. Kasim Aral Chief of Family Planning Unit

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Social Security Maternity Hospital, Ankara

Dr. Mualla Yildiran Director
Dr. Ismail Dolen Obstetrician Gynecologist
Dr. Kamber Oguzer Obstetrician Gynecologist
Dr. Berna Ozbey Obstetrician Gynecologist

SSK General Hospital, Ankara

Dr. Nurettin Sertcelik Urologist

United Nations Fund for Population Activities, Ankara

Dr. Turgut Denizel National Program Officer, Istanbul

Human Resources and Development Foundation, Istanbul

Ms. Nuray Fincancioglu Executive Director

Sevim Zaim
Ms. Nil Fincancioglu
Professor Sunday Uner, PhD

Psychologist
IE&C Expert Turkish Family Health and Planning Foundation
Deputy Executive Director

Tunisia

AVSC/North Africa Middle East Regional Office

Fathi Dimassi	Regional Director
John Pile	Assistant Regional Director
Margaret Duggan	Program Officer
Dr. Dorgham Ghazi Bibi	Medical Consultant

Office Nationale de la Famille et de la Population (ONFP)
Ahmed Beltaief, Director of International Cooperation

USAID/Tunis Mission

Charles Uphaus	Acting Assistant Director
Peter Delp	Computer Technology
Hafid Lakhdhar	Assistant Family Planning Program

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Appendix B

Development of AVSC's International Program

Appendix B

Development of AVSC's International Program

	INITIAL ORGANIZATION AND SEEDING PROJECTS	GEOGRAPHIC EXPANSION	PROGRAM DIVERSIFICATION AND QUALITY IMPROVEMENT	CONSOLIDATION AND TRANSFER OF TECHNICAL CAPACITIES
	1972 to 1975	1976 to 1981	1982 to 1987	1988 to 1993
Dominant Concerns	<ul style="list-style-type: none"> • Introduce services • Demonstrate acceptability • Achieve early successes • Organize management team/systems 	<ul style="list-style-type: none"> • Expand to more countries • Assist first nationwide program • Develop World Federation 	<ul style="list-style-type: none"> • Emphasize quality (medical safety and free, informed choice) • Improve technical capacities: medical, counseling, evaluation, fiscal management • Continue expansion 	<ul style="list-style-type: none"> • Expand to underserved areas • Improve existing services • Program for sustainability • Develop technical capacities of AVSC and counterparts
Programming Themes	<ul style="list-style-type: none"> • Demonstration service projects • Develop new leadership NGOs • Subsidize services/provide equipment 	<ul style="list-style-type: none"> • Continue demonstration projects, service subsidies and equipment • First national training projects • Capital investment: programming (equipment, dedicated space, RAM centers) 	<ul style="list-style-type: none"> • Develop counseling services • Develop medical safety systems and guidelines • Promote vasectomy • Plan for sustainability • Conduct studies, evaluation and operations research • Publish/share experience • Consolidate/streamline projects 	<ul style="list-style-type: none"> • Continue 1982 to 1987 themes • Expand vasectomy services • Re-focus on postpartum and public sector services • Co-opt the for-profit sector • Improve training capabilities • Improve local management • Introduce new technologies: Norplant, no-scalpel vasectomy, CuT380 IUD
Geographic emphasis	<ul style="list-style-type: none"> • Mainly Asia; a few Latin American countries 	<ul style="list-style-type: none"> • Expand to Mexico, Central America and No. Africa 	<ul style="list-style-type: none"> • First Sub-Saharan African countries; expand all other regions 	<ul style="list-style-type: none"> • Global presence with priority on Sub-Saharan Africa, No. Africa/Mid East and other underserved countries
Management	<ul style="list-style-type: none"> • A separate AVSC "International Project" • Centralized program development and management • Small professional staff 	<ul style="list-style-type: none"> • Continued centralized direction • Expand professional staff: first medical and evaluation staff hired • First field offices opened: Dhaka (1979); Tunis (1981) 	<ul style="list-style-type: none"> • Integrate "International Project" in reorganized AVSC: 4 functional divisions • Programming authority delegated to field staff • Field offices opened: Bogota (1984), Nairobi (1986), Lagos (1986), Mexico (1986) 	<ul style="list-style-type: none"> • Stable headquarters staffing/structure • Develop technical capacities of field offices • Use partner agencies and consultants • Establish field representative in India, Philippines and possibly other countries

Appendix C

Cooperative Agreement Areas of Emphasis and Approaches

Appendix C

Cooperative Agreement Areas of Emphasis and Approaches

Areas of Emphasis

As part of the cooperative agreement, the document provided a summary listing, derived from AVSC's proposal, of general activities that were to be implemented under each of the above areas of emphasis. Below is a summary of proposed activities by category.

Expansion of Access to Services

- Continuing efforts to increase the availability and acceptability of vasectomy services, since men generally constitute the largest single under-served population group;
- Providing technical assistance to governments, institutions, or funding agencies that want to establish, expand, or improve VSC services;
- Undertaking more projects involving postpartum sterilization;
- Testing and introducing new techniques/technologies which result in sterilization being even safer and more effective, such as the Filshie clip and the Li no-scalpel vasectomy technique;
- Expanding work with the private sector, especially the for-profit side, in providing VSC services;
- Assisting in the establishment of reversal services, where appropriate;
- Adding long-acting contraceptives such as NORPLANT and the Copper T-380A IUD to AVSC-supported programs, where appropriate;
- Working to ensure that country programs have institutionalized the training for medical and non-medical staff requisite for delivery of high quality VSC services;
- Working with national and international leaders to influence legal, medical, and other policies to increase access to VSC, eliminate barriers to access, and improve the quality of services; and
- Increasing collaborative involvement in operations research and other types of research to make VSC services more accessible, efficient, and cost-effective.

Ensuring Voluntarism and Informed Choice in Service Delivery

- Developing the necessary tools -- guidelines, survey instruments, counseling manuals, program auditing techniques -- for assessing voluntarism;
- Helping to develop the information and educational materials necessary to ensure that clients are fully informed about VSC;
- Expanding efforts in training and counseling;
- Regularly conducting assessments of voluntarism in AVSC-supported programs; and

- Ensuring that temporary contraception methods are effectively available in all service programs that AVSC supports. In particular, AVSC will require that more than one temporary method be available either on the premises or at the VSC clinic, or by referral to an easily accessible program or clinic.

Attention to the Safety and Quality of Services

- Updating safety guidelines and continuing to introduce them via regional and local workshops, including surgical techniques, asepsis, and anesthesia;
- Expanding AVSC's medical supervision programs, including decentralization of much activity via enhanced medical capability in each regional office;
- Establishing special training programs for trainers and trainees;
- Working with other appropriate organizations to identify or develop regional VSC training centers; and
- Participating in international, regional, and national medical conferences.

Approaches for Working in Each Area of Emphasis

To achieve the overall goals of the program, A.I.D. and AVSC agreed upon a number of concepts that would be used to lay the foundation for implementing the diverse activities required to carry out a project of this magnitude:

- Continued and intensified activity leading to institutionalization and sustainability of VSC services;
- Assigning priority to projects that can exert influence beyond the particular activity being supported, i.e., those offering leverage;
- Continued, carefully considered, and refined support for the activities of the World Federation of Health Agencies for Voluntary Surgical Contraception;
- Decentralization, with continued transfer of authority and responsibility to the regional and country offices and simultaneous strengthening of capacity for medical and programmatic oversight; and
- Diverse evaluation and research activities designed to strengthen program performance.

Below is a description of each of these areas in more detail.

Sustainability/Institutionalization

AVSC's subproject support generally focuses on non-recurrent costs such as equipment, facility renovation, and training, with the collaborating institution covering recurrent costs. In addition, AVSC routinely incorporates steps leading to institutionalization into the subproject at its outset, so that costs are increasingly borne by the collaborating institution, with a concomitant diminution of AVSC support. AVSC also provides technical assistance in project management to enable the organization to become capable of operating project activities independently.

As part of the cooperative agreement, future initiatives to support institutionalization and sustainability were to include the following:

- Increased technical assistance to grantees in effective financial management with a view toward project self-sufficiency within a given time frame;
- Inclusion of mandatory financial plans in all AVSC subagreement documentation, including the following where possible and appropriate: expected duration of funding; total project costs estimated and itemized by year; contributions to total cost from local sources, project-generated income, and other donors; and discussion of special conditions and/or activities which bear upon sustainability;
- Continued study of VSC service delivery costs and of the costs and benefits of alternative approaches to service delivery; and
- Diverse cost recovery opportunities, such as the possibility of production of video training materials for sale to physicians and institutions, as AVSC increasingly acts as a center of information dissemination.

According to the cooperative agreement, A.I.D. recognizes that an emphasis on sustainability is not appropriate for all subprojects, and that there are situations in which it is not feasible owing to economic or political circumstances. Furthermore, the agreement describes an inherent tension between a mandate to work with the poorest and neediest segments of a population and a mandate to emphasize cost-recovery and sustainability in service delivery programs. Among the studies which AVSC was to conduct were those looking at just this issue. In particular, AVSC was to examine whether, at the operational level, policies and practices that are meant to strengthen institutionalization and foster sustainability inadvertently introduce disincentives for low-income groups to choose VSC. AVSC completed this four-site study and issued a preliminary report to A.I.D. in January 1991.

Leverage

Priority was to be given to funding subprojects with the potential to exert influence beyond the particular activity being supported. These were to include demonstration/pilot projects; training projects to provide both the personnel and the stimulus for expansion of services; or research projects to look at ways of making VSC more accessible, cost-effective, or easier to deliver. AVSC also was to achieve leverage by serving as an important resource on issues related to VSC (as it has in the past by publishing Voluntary Sterilization: An International Fact Book) by developing follow-up surveys, and by assuming a leadership role in counseling and in assuring informed choice.

The World Federation for Voluntary Surgical Contraception

The World Federation is an important partner in AVSC's international program. Formed in 1975, the World Federation is an international voluntary health and family planning organization with a membership of 51 health and family planning organizations from 43 countries and four regions. It has an executive board and program committees of volunteer international experts, and a small secretariat in AVSC headquarters in New York. Although a separate corporate entity, the World Federation is largely dependent on AVSC for financial support and often uses AVSC programmatic and technical expertise in carrying out its activities. This arrangement has worked well, serving AVSC's broad needs while retaining the independence and international character which make the World Federation's work acceptable and useful. The World Federation's mandate and projected activities have changed since the cooperative agreement was designed. Annex 2 describes more fully the Federation's history and structure, as well as its more current mandate and evolution into a forum for deliberation on important emerging issues in VSC. As originally expressed in the cooperative agreement, the Federation's mandate was to

let

- Address global and regional issues related to the quality and delivery of VSC services in less developed countries (LDC);
- Develop and disseminate policies, guidelines, and standards for the delivery of VSC services;
- Help introduce VSC in new areas; and
- Serve as the link between AVSC and various international agencies working in health and family planning in developing countries.

The work of the World Federation supports that of AVSC by providing a neutral international forum in which important technical or policy issues concerning VSC can be discussed and resolved. Its leadership is largely from developing countries, and the expert groups it uses to address problems have substantial developing country representation. This helps to make the recommendations, guidelines, and policies of the Federation germane to developing country circumstances and more likely to reach beyond the immediate circle of programs supported by AVSC and to have an impact on national family planning programs and policies.

As part of the cooperative agreement, it was anticipated that the World Federation would continue to address the kind of issues that are suited to its mandate and its international approach. Anticipated activities were to include the following:

- Publication in English, French, and Spanish of revised safety guidelines which were to be broadened in their regional coverage and were to include nonmedical quality issues;
- Assessment of the issue of sterilization reversal and its likely impact on VSC services, leading to a publication making recommendations for programs;
- Development and publication of guidelines for counseling, and for training non-physician health workers in VSC services;
- Continuing work in North Africa and the Middle East to get family planning and VSC included in the region's medical curricula; and
- Development and publication of a short, practical guide to assuring voluntarism in VSC entitled The Managers Guide to Voluntarism.

Decentralization

AVSC's regional presence in Dhaka, Bogota, Nairobi, and Tunis, subregional presence in Lagos, and country representation in the Philippines, India, and Bangladesh, have been vital for program development and expansion. As AVSC's program expanded and diversified, the process of decentralization and delegation of authority and responsibility to regional and country offices was to continue. All regional offices were to have medical oversight capability. It was anticipated that some country offices would be added (e.g., a regional office for francophone Africa) and current regional offices would be expanded.

AVSC Research and Evaluation Activities

Evaluation activities have proved useful in the past in documenting the quality and acceptability of VSC services and the impact of AVSC programs. Overall responsibility for coordinating and managing AVSC's evaluation program was to rest with an evaluation unit having two professional positions: an assistant director for research/evaluation and a research associate.

Evaluation activities were to fall into three categories:

- **Program evaluation** - monitoring of performance, modifications as needed, etc. Tools for this effort were to include having built-in evaluation plans in each subagreement prior to commencement of work; end-of-project evaluation assessments; standardized subagreement reports; programmatic or medical site visits; voluntarism assessments; financial audits; and larger-scale comprehensive assessments of institutions or country programs.
- **Special Studies** - examination of issues of broad programmatic significance. These studies were to include global VSC monitoring; client follow-up studies; literature reviews; analytic review of AVSC's morbidity/mortality experiences; assessment of various medical supervision and surveillance systems; and new technology, e.g., improved VSC techniques and NORPLANT.
- **Self-Evaluation Studies** - systematic assessment of output indicators against which progress can be measured. These indicators were to provide the statistical base for the annual report of AVSC program activity to A.I.D.

Appendix D
Summary of Project Outputs

I. Expansion of Access to Services Outputs

Output	Definition	Project Objective*	Accomplished to Date**
No. 1 "New Countries"	The number of countries where AVSC has awarded new subagreements or small grants. New countries include a) successful reentries into countries where previously unsuccessful, b) new countries using private funds, and c) countries where AVSC's A.I.D. funds are used for the first time.	18 countries	13 countries
No. 2 Support for national service programs	The number of countries where AVSC is supporting the national government, or an institution with wide coverage, for a national service delivery program.	30 countries	27 countries
No. 3 Regional training centers	The number of surgical and/or counseling training centers that were developed as models with AVSC assistance and that are able to accept trainees from other countries.	10 centers	14 centers
No. 4 Private sector projects	The number of subagreements that include working with the non-governmental, for-profit sector.	5 projects	7 projects
No. 5 New vasectomy projects	The number of new subagreements awarded in which the introduction, expansion, or improvement of vasectomy services is a stated activity or objective.	25 projects	10 projects
No. 6 Postpartum projects	The number of currently operational subagreements in which the introduction, expansion, or improvement of female postpartum family planning services is a stated activity or objective.	10 projects	21 projects

Project objective is that defined in the cooperative agreement as the objective through August 1993.
December 1990.

II. Free and Informed Choice Outputs

Output	Definition	Project Objective	Accomplished to Date
No. 1 Acceptable informed-consent protocols established in service projects	Prior to distribution of funds for service projects, the grantee must have an informed-consent form that is in compliance with AVSC informed-consent guidelines and A.I.D.'s PD-3.	100% of service projects	100%
No. 2 Counseling components established in services projects	Number of currently operational service projects that include routine client counseling systems.	90% of service projects with routine client counseling	88% of service projects
No. 3 Training courses or workshops in counseling or voluntarism	Includes events supported by AVSC where the purpose is to upgrade the knowledge and/or skills of personnel with respect to counseling, voluntarism, and related matters.	80 training events	134 training events
No. 4 Comprehensive voluntarism reviews	Special in-country assessments of client referral, information and education, service delivery, program policies, and management practices to determine their influence on client decision making, satisfaction, and voluntarism.	22 reviews	13 reviews
No. 5 Research studies of client voluntarism, knowledge, and satisfaction	The issuance of final reports (or published articles) from surveys, special studies, operations research projects, or other research on client voluntarism, knowledge, decision making, satisfaction, and related matters.	17 reports	7 reports
No. 6 Publications, guidelines, or program materials for project and program staff	The production and issuance of any material that is intended to guide or assist program personnel, AVSC staff, or other professionals to set up a system for ensuring voluntarism and client satisfaction.	21 products	14 products
No. 7 Annual internal review of AVSC's overall voluntarism quality assurance program	A concise internal report that a) addresses the adequacy of AVSC's systems for developing and monitoring informed consent, counseling, and related service program components; b) reviews the results of voluntarism assessments, training activities, materials production, etc.; c) identifies and reviews the major voluntarism issues of the preceding years; and d) identifies needed future actions.	4 reviews years 2-5	1 review

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III. Medical Safety Outputs

Output	Definition	Project Objective	Accomplished to Date
No. 1 Medical training programs funded	The number of current subagreements that include training in clinical or surgical skills as part of their objectives. Includes training courses for initial or refresher sterilization surgical skills; workshops and courses in anesthesia, asepsis, and other medical safety topics; and clinical training in IUD or Norplant insertion.	20 subagreements	74 subagreements
No. 2 New technology projects	The number of currently operational subagreements that include introduction or testing of a new technology as their main purpose or as part of their objectives. New technologies include refinements or innovations in existing techniques (e.g., no-scalpel vasectomy, tubal clips) as well as new surgical contraception methods (e.g., Norplant).	20 projects	21 projects
No. 3 Comprehensive medical assessments of quality	Special in-country trips by staff or consultants, conducted in order to review medical quality of one or more AVSC subagreements in a country. These visits involve making observations, providing technical guidance, and recommending improvements at individual service sites and institutions.	21 assessments	10 assessments
No. 4 Medical site visits	The number of country trips by staff or consultants, conducted in order to review medical quality of one or more AVSC subagreements in a country. These visits involve making observations, providing technical guidance, and recommending improvements at individual service sites and institutions.	220 country trips	117 country trips
No. 5 Medical supervision systems	The cumulative number of systems that AVSC assisted in the development of routine monitoring of medical quality for multi-site service programs.	35 systems	36 systems
No. 6 Medical oversight capacity in regional offices	Ability of each regional office to conduct medical site visits through its regional medical staff and consultants.	100% of regional offices	75% of regional offices
No. 7 Publications, guidelines, or program materials for projects and program staff	The production and issuance of any material by AVSC or the World Federation that is intended to guide or assist program personnel, AVSC staff, or other professionals to set up or improve medical safety.	20 products	11 products
No. 8 World Federation meetings on medical issues	Any World Federation-sponsored meeting (workshop, conference, symposium) devoted to examining medical issues that results in a report, guidelines, or some other product of use to program managers.	5 meetings	5 meetings
No. 9 Annual review and analysis of reported morbidity and mortality	A report analyzing the numbers and types of complications and deaths reported by AVSC-supported service programs.	4 reports	2 reports

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IV. Program Improvement Outputs

Output	Definition	Project Objective	Accomplished to Date
No. 1 Subagreement evaluation plans	The existence of a separate section in each subagreement document that describes how the project will be evaluated	100% of subagreements	100% of subagreements
No. 2 Subagreement evaluation reports	The issuance of a concise report by AVSC program staff within 6 months after the end of a subagreement that assesses the performance of the project.	90% of completed subagreements	48% of subagreements terminated in June 1990.
No. 3 Cost studies	Studies supported by AVSC to analyze the cost and cost-effectiveness of VSC or alternative service delivery approaches.	10 studies	6 studies
No. 4 Subagreement audits	Audits within 6 months after the termination of a subagreement of \$35,000 or greater.	100% of eligible subagreements	95%
No. 5 Technical assistance visits	The number of country trips made by AVSC staff or consultants, in order to give specific guidance to a counterpart in the development and conduct of its program.	145 country trips	250 country trips
No. 6 Operations research projects	The number of currently operational projects with an OR orientation or objective, including: a) projects whose OR components are funded in part or entirely by another agency and b) projects to which AVSC staff have made substantial or administrative contributions to the conceptualization, development, implementation, or analysis.	34 projects	9 projects

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V. Publications and Information Dissemination Outputs

Output	Definition	Project Objective	Accomplished to Date
No. 1 Periodic publications	Number of issues per year of periodic AVSC-supported publications	30 issues	4 issues AVSC currently relies on reference materials and professional journals
No. 2 AVSC working papers	The number of working papers finalized by AVSC staff, grantees, and associates that report on research case studies, or other analyses.	15 reports	No reports (3 draft working papers were accepted for publication in professional journals)
No. 3 Scientific or professional sessions sponsored by the World Federation	The number of sessions at professional meetings, sponsored by the World Federation, with the purpose of disseminating information about current research or programs or of updating professional knowledge.	5 public sessions	3 public sessions
No. 4 Journal publications and presentations at professional meetings	The number of published professional journal articles by AVSC staff and the number of presentations made by AVSC staff at non-AVSC professional meetings. Published articles Public presentations	15 published articles 42 public presentations	14 published articles 27 public presentations

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Appendix E

Categorization of Countries by Overall Family Planning Prevalence and Sterilization Prevalence

Appendix E

Categorization of Countries by Overall Family Planning Prevalence and Sterilization Prevalence

<u>Region/Country</u>	<u>FP Prevalence(a)</u>	<u>VSC Prevalence(b)</u>
Sub-Saharan Africa		
Ghana (H)	Emergent	Emergent
Kenya (H)	Growth	Launch
Nigeria (H)	Emergent	Emergent
Tanzania (H)	Emergent	Emergent
Uganda (H)	Emergent	Emergent
Zimbabwe (H)	Consolidation	Emergent
Ethiopia (M)	Launch (?)	Emergent
Guinea (M)	Emergent	Emergent
Liberia (M)	Emergent	Emergent
Madagascar (M)	Emergent	Emergent
Malawi (M)	Emergent	Emergent
Mali (M)	Emergent	Emergent
Zambia (M)	Emergent	Emergent
Botswana (L)	Growth	Emergent/Launch
Burundi (L)	Emergent	Emergent
Cote d'Ivoire (L)	Emergent	Emergent
Gambia (L)	Emergent	Emergent
Lesotho (L)	Emergent	Emergent
Mauritius (L)	Growth	Launch (?)
Sierra Leone (L)	Emergent	Emergent
Swaziland (L)	Launch	Emergent
Togo (L)	Emergent	Emergent
Zaire (L)	Emergent	Emergent
North Africa/Middle East		
Egypt (H)	Consolidation	Emergent
Morocco (H)	Growth	Launch (?)
Turkey (H)	Growth	Launch (?)
Jordan (M)	Growth	Emergent
Tunisia (M)	Consolidation	Growth
Yemen (M)	Emergent	Emergent
Algeria (L)	Growth	Emergent
Iran (L)	Launch/Growth (?)	Emergent (?)
Mauritania (L)	Emergent	Emergent
Sudan (L)	Emergent	Emergent
Latin America/Caribbean		
Bolivia (H)	Growth (?)	Launch (?)
Colombia (H)	Mature	Growth/Consolidation
Ecuador (H)	Consolidation	Growth
Mexico (H)	Mature	Consolidation
Peru (H)	Growth	Launch
Brazil (M)	Mature	Mature

Dominican Republic(M)	Mature	Consolidation
Guatemala (M)	Growth	Launch
Haiti (M)	Emergent	Emergent
Jamaica (M)	Mature	Growth
Nicaragua (M)	Growth (?)	Launch (?)
Paraguay (M)	Emergent (?)	Consolidation
Costa Rica (L)	Consolidation	Growth
El Salvador (L)	Consolidation	Mature
Uruguay (L)	Mature	Launch/Growth (?)

Asia

Bangladesh (H)	Growth	Launch
India (H)	Growth	Growth
Pakistan (H)	Launch	Emergent
Philippines (H)	Growth	Launch
Indonesia (M)	Consolidation	Emergent
Nepal (M)	Launch	Growth
Sri Lanka (L)	Consolidation	Mature
Thailand (L)	Mature	Mature

(a) Categorization of family planning prevalence based on Table 3 from FPSD strategy paper. Emergent = 0-7%; Launch = 8-15%; Growth = 16-34%; Consolidation = 35-49%; Mature = 50+%

(b) Categorization of sterilization prevalence was done as follows: Emergent = 0-5%; Launch = 6-10%; Growth = 11-15%; Consolidation = 16-25%; Mature = 26+%;. Prevalence rates derived from the most recent contraceptive prevalence survey completed as of 1989.

Letters in parentheses indicate AVSC's country prioritization for fiscal 1991. H = High; M = Medium; L = Low

Appendix F

Distribution of AVSC Countries, Projects and Funds, Categorized by Modern Method Prevalence

Appendix F

**Distribution of AVSC Countries, Projects and Funds,
Categorized by Modern Method Prevalence**

	1990*			1991 (planned)**		
	# Countries	# Projects	Total Funds	# Countries	# Projects	Total Funds
AFRICA						
Emergent	14	53	1,220,065	15	56	1,710,500
Launch	1	1	3,800	1	1	10,000
Growth	2	14	623,316	4	18	1,687,000
Consolidation	1	1	110,789	1	4	90,000
Mature	0	0	0	0	0	0
N. AFRICA/M. EAST						
Emergent	1	2	69,385	3	5	106,000
Launch	0	0	0	0	0	0
Growth	3	12	581,078	3	18	770,000
Consolidation	2	9	298,482	2	7	420,000
Mature	0	0	0	0	0	0
L. AMERICA/CARIBBEAN						
Emergent	0	0	0	1	1	40,000
Launch	1	3	70,525	1	3	52,000
Growth	3	9	271,525	2	5	160,000
Consolidation	4	10	615,276	4	6	200,000
Mature	5	22	564,527	3	8	363,000
ASIA						
Emergent	0	0	0	0	0	0
Launch	2	10	500,550	3	16	820,000
Growth	2	10	1,608,174	3	22	1,740,000
Consolidation	2	3	361,188	2	3	235,000
Mature	1	1	173,575	1	2	100,000
TOTAL						
Emergent	15	55	1,289,450	19	62	1,856,500
Launch	4	14	574,875	5	20	882,000
Growth	10	45	3,084,093	12	63	4,357,000
Consolidation	9	23	1,385,735	9	20	945,000
Mature	6	23	733,102	4	10	463,000

NOTE:

*1990 is 15 months: 1 Jan 1990 - 31 March 1991

**1991 is 12 months: 1 Apr 1991 - 31 March 1992

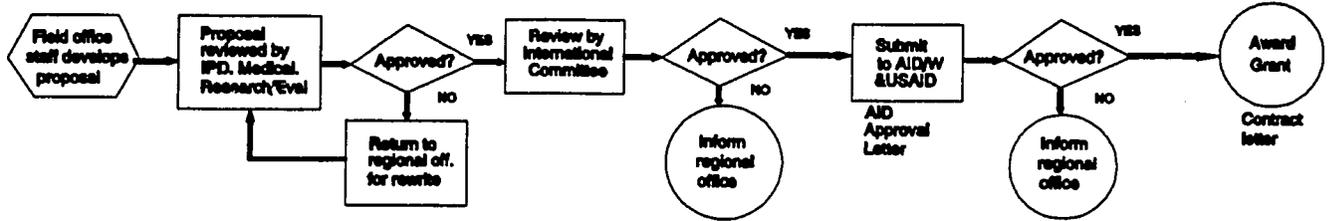
Appendix G

AVSC Project Proposal Review Process

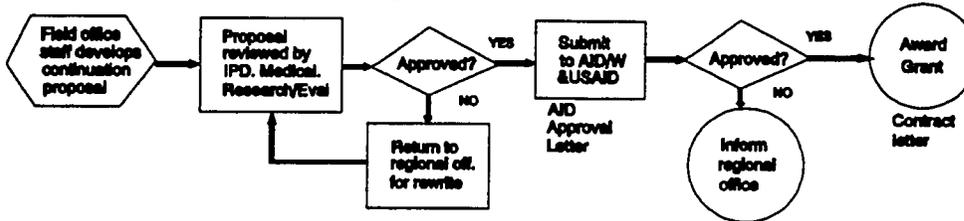
Appendix G

AVSC Project Proposal Review Process

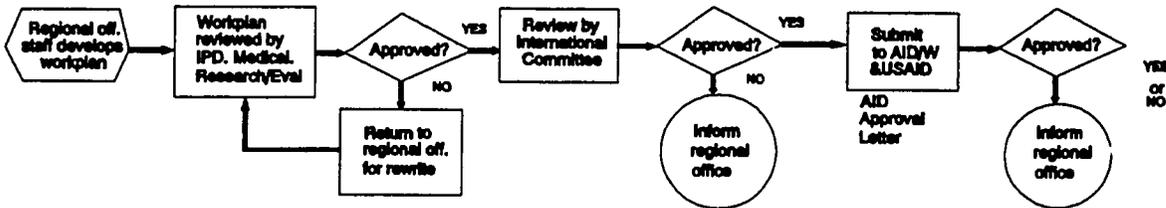
1) First time proposals for AID funding



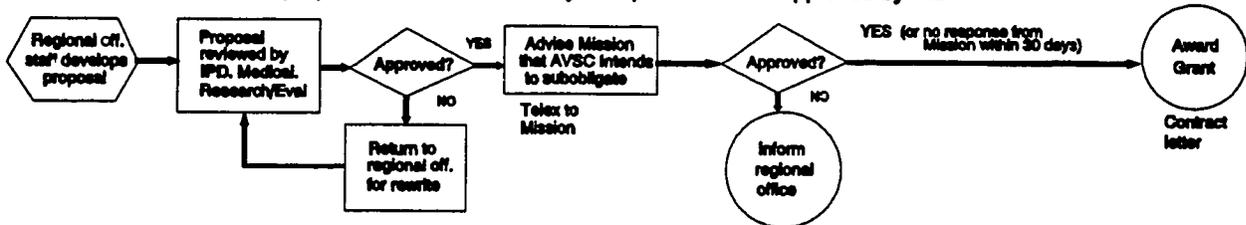
2) Continuation proposals for AID funding



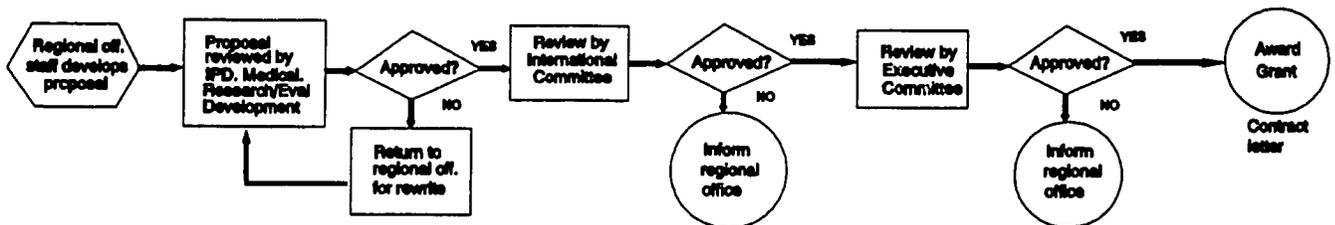
3) Country workplans for AID funding



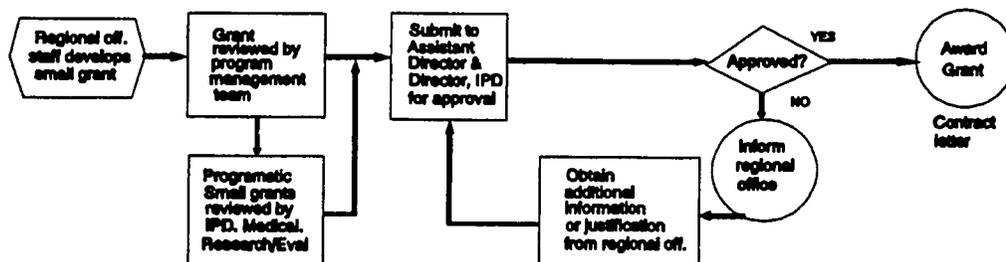
4) First time or continuation proposals for which a country workplan has been approved by AID



5) All proposals for private grants



6) Small grants (< \$10,000)



Note: "In-house" projects are managed in the same manner as first time proposals

Appendix H
FPSD Principles for the Nineties

Appendix H

FPSD Principles for the Nineties*

1. **Service delivery systems must emphasize quality of care.**
2. **Service delivery must expand to serve larger populations in more cost-effective ways.**
3. **Service delivery systems must evolve to meet the needs of a more diverse and younger population and changes in method mix.**
4. **All sectors - government, private voluntary and the for-profit private sector - must cooperate to support family planning service delivery.**
5. **Attention must be directed to developing the institutional base and resources to sustain services.**
6. **Greater attention must be paid to comparative advantage, strategic position and managerial efficiency.**

*From *Preparing for the Twenty-First Century: Principles for Family Planning Service Delivery in the Nineties*. Destler, Harriett, Dawn Liberi, Janet Smith, and John Stover. Family Planning Services Division, Office of Population, U.S. Agency for International Development, Washington, D.C., November 1990.

Appendix I
Recommendations

Appendix I

Recommendations

Programmatic Issues

1. AVSC should continue to focus on female sterilization via minilap under local anesthesia with sedation, but with flexibility where laparoscopic procedures are still dominant.
2. AVSC should continue to disengage from subsidizing sterilization procedures.
3. AVSC is incorporating into its program a concern for the male role in family planning decision making, but needs to define more specifically what the agency will do — and will not do — on this large and complex topic.
4. Even in countries where vasectomy is currently thought to be unpopular, AVSC should continue to provide vasectomy training to clinicians who can then add the technique to their range of services. Greater availability of services could cause an increase in demand.
5. AVSC should play an increasingly more active role in encouraging the adoption of male sterilization.
6. Simultaneously with its efforts to provide sterilization services, AVSC should significantly expand its efforts to ensure that clients are aware of and appreciate the relative advantages of sterilization, and encourage enlightened national policies regarding sterilization.
7. AVSC should continue and (if additional funding is obtained) expand its role in assisting with the promotion of Norplant.
8. Building on its traditional strengths, AVSC should continue and expand its research and program development regarding postpartum sterilization.
9. AVSC should continue to carefully research the clinical and programmatic aspects of postpartum IUD insertion before integrating this method into its programs.
10. AVSC should continue to focus only on the provision of surgical methods of family planning, exploring new variations and methods of such contraceptives as they become available for programmatic field trials. Though AVSC should continue and expand its role in assisting with the introduction of Norplant, its involvement with immediate postpartum IUD insertion should be carefully examined before widely integrating this method into its programs. Sterilization, both male and female, should remain the agency's central focus.
11. AVSC should give more attention to sedation, analgesia, and anesthesia for female sterilization procedures, and should involve more anesthesiologists and/or anesthesia technicians in AVSC training and service delivery programs.
12. Where existing VSC services are underutilized, AVSC training programs should focus not only on more acceptable surgical techniques, but also on ways to increase demand for the services and lower programmatic barriers (e.g., through improved clinic management, outreach programs, information and communication).
13. AVSC field staff should be thoroughly informed about all the agency's planned local and regional training programs, and should more actively seek to identify key subgrantees and medical personnel for appropriate training.

14. Greater attention should be paid to ensuring that participants in AVSC training courses will be given opportunities to learn the specific technical skills they will need in their home institutions.
15. In TOT courses, the curriculum should include more emphasis on training methodologies and teaching techniques.
16. More effort should be made to ensure that all institutions selected as VSC training sites can provide enough clients for trainees' practice.
17. Criteria (regarding knowledge, skills, and judgement) for certifying graduates of TOT courses should be standardized, allowing some flexibility for variations in local needs and circumstances. Mastery of training skills should be given equal weight with mastery of technical surgical procedures.
18. Trainees in all AVSC training courses should be followed up systematically to determine the longer-term effects of the program (roughly a year after completion). A staff person should be assigned responsibility for conducting these follow-up exercises, and the results should be used to strengthen future training courses.
19. Within three or four years, AVSC should devote its training efforts almost exclusively to TOT courses, implementing direct training of specialists only (a) as model programs for TOT courses, or (b) to gain experience for designing new TOT courses. To reach this stage, AVSC will have to devote more attention to the transfer of training methods and techniques, not merely the transfer of surgical methods and techniques.
20. Where AVSC participates in TOT (or master training of trainers) courses, it will need to refine the means of certifying the competence of the clinic and field workers who are ultimately trained; the agency must acknowledge and adjust to the fact that it has less control and less responsibility for the final product.
21. AVSC should continue to focus on issues of counseling for VSC, and work with other service CAs to improve counseling for all family planning methods distributed. AVSC should sponsor a major training exercise to develop and promote counseling for the other service delivery CAs, working with them in institutionalizing counseling as an essential component of their family planning programs.
22. AVSC should ensure that potential clients are aware of VSC methods and where they are available. Wherever possible, this should be accomplished through collaboration with a CA that specializes in IEC and is willing to handle the task; in the absence of such a specialized agency, AVSC should do the work itself.
23. Research is needed to identify areas of ignorance and misinformation about VSC in potential client populations, and to suggest the most cost-effective IEC campaigns. Such research should be undertaken by CAs or local organizations specifically equipped to undertake applied research, in close collaboration with AVSC.
24. Based on its comparative advantage, AVSC should more systematically address VSC policy constraints at all levels, from local hospital and clinic administrators to national and government family planning programs.
25. New York Medical Division staff should continue to survey activities in the field on an annual or biannual basis.
26. New York Medical Division staff should be responsible for the quality of the regional program/medical advisors' activities on their more frequent field evaluations in their respective regions. Implementation could be assured in the regions by the requirement that the medical director approve of the hiring of the specific program/medical advisors to ensure that they have appropriate medical skills as well as

the administrative capacities necessary, and that they have sufficient time in their visits to do the medical/technical as well as the programmatic evaluation.

27. AVSC should devote even greater attention to the need for a shift away from direct quality assurance procedures to greater reliance on local VSC providers to implement their own mechanisms for non-medical quality control.

28. AVSC should take immediate steps to make its MIS fully operational, both by standardizing the hardware and software, and by arranging for data to be processed in a timely fashion.

29. AVSC should decentralize the MIS, possibly using the system in operation at LACRO as a model. Regional offices should participate in decisions about how the MIS is to be used, and should be equipped to use it.

30. Service delivery statistics required on the quarterly report form should be simplified to the minimum actually used for project monitoring and evaluation. Examination of the issue may reveal that little is needed beyond the number of tubal ligations, vasectomy procedures, Norplant insertions, etc., during the reporting period. Required information on other topics (e.g., finances, training, special occurrences) and the narrative report should also be reviewed for possible streamlining.

31. EPAs should either be utilized or reduced to a simple exercise to verify the cumulative service statistics provided in quarterly reports.

32. If indicated by the present OR project, AVSC should continue and expand its efforts to extend the use of COPE, encouraging its use even outside the clinics linked with AVSC. Other service provision CAs should be invited to share COPE through their own networks.

33. AVSC should continue to undertake special assessments where the results can assist planning or help solve operational problems. Care should be taken to ensure that the results of such assessments are disseminated and, if possible, utilized, at the headquarters, regional, and country levels, and that feedback is provided.

34. AVSC should accelerate efforts to measure the quantitative impact of its efforts on programs, VSC procedures, and demographic events. In the short term, "quick-and-dirty" methods which provide rough approximations of impact should not be rejected.

35. AVSC should consider developing qualitative assessments of impact.

36. AVSC should try to collaborate with the CAs involved in the new A.I.D. program on impact assessment, and should consider encouraging the CAs to use AVSC programs (in one or more countries) for the development and/or testing of new methods of impact assessment.

37. AVSC should refocus its evaluation system so that it concentrates not primarily on projects, but on programs. This should be accompanied by more imaginative use of evaluation as a management and planning tool.

38. AVSC should hire an experienced evaluation specialist on a short-term contract to help develop its evaluation program in order to maximize analysis of AVSC program performance.

39. AVSC should only foster a research capacity insofar as it strengthens its monitoring and evaluation capability. The present policy — undertaking research in collaboration with other organizations which have the requisite skills and resources — should be continued. This approach should be followed for

AVSC-involved research at local, regional, and global levels. Where collaborative research is needed but funds are unavailable, AVSC should alert A.I.D. to the dilemma and seek advice.

40. AVSC should devote much more effort and imagination toward the evolution of sustainable VSC programs. This should begin with developing reliable measures of the true costs and impacts of VSC services, and the assessment of the cost-effectiveness of various delivery system models.

41. AVSC, in collaboration with research-oriented CAs, should continue and accelerate its recent efforts to determine the fees that clinics can charge for VSC procedures without losing lower-income clients. Flexible payment schedules and alternative forms of payment should also be considered.

42. AVSC should, where appropriate, make a greater effort to involve private sector health personnel in the provision of VSC services, and to persuade governments to make more significant contributions toward VSC services provided by NGOs.

43. The recently introduced process of developing and approving country workplans rather than individual projects should be expanded by the end of 1992 to include all countries in which AVSC has a major role. In its strategic planning at all levels, AVSC should work closely with A.I.D. and expect clear guidance about A.I.D.'s expectations.

44. AVSC should inform USAID missions that it is available to assist at an early stage in the planning and development of mission-initiated projects.

45. AVSC and A.I.D. should discuss the usefulness of the AVSC typology, and either accept it or modify it so that AVSC can proceed to use it in strategic planning.

46. AVSC should more actively work with the private for-profit sector.

Management Issues

47. The International Committee should discontinue its quarterly review and approval of projects, and instead review country strategies at an annual meeting hosted by a different AVSC regional office each year. Once a country program strategy has been approved, AVSC staff should be given authority to approve subprojects consistent with the strategy.

48. AVSC should consider reconstituting the International Committee as a technical advisory committee (TAC), with members who have extensive experience with technical and programmatic aspects of international family planning and VSC. The TAC should include some Americans, but should also include leaders of large, successful VSC programs in developing countries (e.g., Korea and Thailand) which are not necessarily AVSC subgrantees.

49. AVSC should reconsider its decision to place the primary responsibility for Norplant, NSV, and postpartum IUDs in the International Division. If the focus of activities for these initiatives remains in the Special Programs Department of this division, AVSC should make special efforts to ensure that the Medical Division is a major partner in planning and implementing the service provision of these methods.

50. AVSC should review the job descriptions, staffing requirements, and personnel policies regarding the RPMTs. Rather than trying to upgrade the technical competence of staff holding these positions, it might be better to downgrade the expectations of the job and reduce the role of headquarters in approving regional office activities. Efforts to upgrade the technical competence of the RPMTs might be more productively directed at staff located in the regional offices.

51. Program managers on the RPMTs should be rotated to regional offices for extended periods (i.e., 3-12 months) to gain an appreciation of the field situation. Willingness to spend this time in the field should be a prerequisite for hiring or maintaining program managers.

52. Regional office staff should play a formal role in all personnel actions involving RPMT staff.

53. AVSC should fully involve the newly recruited medical director in senior management decisions, and give her clearly articulated authority to direct the medical affairs of AVSC.

54. The role of the Medical Division vis-a-vis the regional offices needs to be clarified and reinforced, with unambiguous lines of authority and communication established. This should include the position of the medical director in regard to medical personnel decisions made in the regional offices.

55. AVSC should give more attention to sedation, analgesia, and anesthesia by involving anesthesiologists or anesthesia technicians in AVSC training and service delivery programs.

56. One of AVSC's highest priorities should be to strengthen the Research and Evaluation Department. This needs greater institutional commitment to systematic evaluation and feedback as a routine management tool, and a recognition that the agency can no longer be assured of continued A.I.D. support without convincing evidence of AVSC's program impact.

57. The position currently under recruitment should be filled by an experienced senior program evaluation specialist, and highly qualified short-term consultants should be hired to immediately deal with specific weaknesses in the evaluation system (e.g., getting the MIS into operation and utilizing data collected for evaluation purposes).

58. It may be unrealistic to expect the Research and Evaluation Department to meet the evaluation needs of the organization with a staff of three. AVSC should realistically reassess its evaluation objectives and the means to accomplish them, and add staff as needed (especially at the regional office level).

59. Headquarters should take a more flexible approach in dealing with regional offices, continuing to provide direction and support for the weaker offices but allowing more autonomy for the stronger ones, all in the context of the move toward greater decentralization.

60. The regional offices should move more quickly toward strategic planning, developing country-level strategies in collaboration with government and non-government authorities as well as USAID missions.

61. All regional offices should strengthen their capability to provide medical technical assistance, evaluation, and certification by expanding the pool of medical consultants and, where feasible, adding medical specialists to the field staff. Every effort should be made to identify qualified nationals from the regions for these tasks.

62. Regional offices should anticipate an increasing need for technical assistance in non-medical aspects of VSC programs (e.g., training of trainers, IEC, outreach, management, evaluation). In addition to relying on specialized national and international organizations for such assistance, each regional office, with support from headquarters, should establish a pool of consultants with the appropriate qualifications, just as is done for medical consultants.

63. AVSC should establish a country representative in Turkey and should begin planning for representatives in other countries with large, expanding programs in the coming years.

64. Special attention should be devoted to bringing ARO up to the level of other regional offices:

- With the assistance of headquarters, immediate steps should be taken to fill the medical advisor position. AVSC should negotiate with the Government of Bangladesh to obtain approval for at least one additional expatriate so ARO does not have to continue relying on a series of short-term mechanisms which does not provide the needed continuity in staffing.
- AVSC should resolve the problem of staff hired for the proposed office in Bangkok but now based at headquarters, so that the Dhaka office receives the commitment, quality, and quantity of support it needs.

65. Over the next few years, AVSC should gradually phase out financial support for the World Foundation, allowing it time to plan for alternative arrangements for funding and management.

66. The grant approval process should be streamlined, starting by eliminating the need for the AVSC Board of Directors to review proposals. The role of headquarters staff in decision making about minor details should be reviewed with the regional staff.

67. AVSC should accelerate its move toward approval of multi-year subagreements with incremental funding.

68. AVSC should continue to fund small projects where appropriate, but move quickly to increase the efficiency of review and management of such projects through country programming, multi-year approvals, and other mechanisms.

69. AVSC should continue its efforts toward decentralization. Greater attention should be devoted to strengthening the technical expertise of field offices and their ability to undertake strategic planning.

70. AVSC field staff should be informed that they may, when appropriate, communicate directly not only with USAID missions but also with A.I.D./Washington.

Relations with Other Organizations

71. AVSC should continue efforts to keep in touch with the A.I.D. regional bureaus during the reorganization, and remain poised to develop more systematic dialogue with them when requested.

72. Each AVSC regional office should express to appropriate USAID missions its availability and willingness to participate in strategy development.

73. Regional offices should seek as early as possible to resolve problems that occur with USAID missions, if necessary using third-party mediation. NAMERO staff and USAID/Cairo staff should work with a mediator immediately to resolve long-standing tensions, improve communications, and develop ways to avert problems in the future.

74. AVSC regional offices should improve their ability to accept relatively short notices of meetings, particularly for mission strategic planning exercises. Greater flexibility could occur by recruiting additional technical staff either for regular staff positions or as consultants.

75. AVSC should increase its effort to inform country-level and regional offices and all relevant organizations about AVSC's current interests, resources, program of activities, and policy on interagency collaboration.

76. When opportunities arise for new and useful collaborative projects which cannot be funded from the budgets of either AVSC or the other interested CA(s), AVSC should discuss the need with A.I.D./Washington and/or the USAID mission and, if appropriate, seek advice about how funding can be obtained.