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FISCAL 1989 INTERNATIONAL PROGRAMS

**WORKPLAN OF
THE ASSOCIATION FOR
VOLUNTARY SURGICAL CONTRACEPTION**

AID Cooperative Agreement
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AVSC'S 1989 WORKPLAN

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1. INTRODUCTION AND OVERVIEW

This document gives the detailed global plan, as well as regional and country strategies and plans, for AVSC's work in fiscal 1989.* The purpose of AVSC's work as set forth in its long-range plan, its five-year strategic plan, and its current cooperative agreement with AID is to assist countries in making high-quality, voluntary, permanent and long-acting, reversible surgical contraception available and accessible to all couples who may need and want it. This 1989 workplan document is submitted in accordance with the requirements of AVSC's current cooperative agreement with AID.

The 1989 workplan is built from the annual budgets developed by regional offices and New York headquarters divisions, and these in turn respond to country and regional needs and the strategies AVSC has evolved over the years to respond to the needs. Furthermore, the workplan is consistent with the broad directions set down in AVSC's five-year strategic plan for its international programs. The strategic plan defines the need and context for AVSC's work, in particular the remarkable demand for VSC services that is projected for the next ten years, and the scarcity of resources, particularly AVSC's, that can be directly applied to this need.

A. General Principles and Global Initiatives

Given large demand and few resources, AVSC's strategy is deliberately calculated to exert a multiplier-effect leverage, or impact, in terms of expanded availability, accessibility and use of VSC services. Consequently, our strategic plan sets forth both general principles and approaches which guide and remind us to work for high impact in all we do, and specific global initiatives which define specific technological and programmatic interventions that are intended to achieve greater availability and access to services.

AVSC's general principles and approaches, excerpted from our strategic plan, are listed below:

1. **Attention to quality**--meticulous and constant attention to quality is the sine qua non of successful delivery and expansion of VSC services.
2. **Appropriate technology**--the development, improvement, and adaptation of appropriate VSC technology is a primary means of expanding access to and use of quality VSC services.

how
measure
monitor

ends

*AVSC's fiscal year is from April 1, 1989 to March 31, 1990.

how done

means

3. **Attention to sustainability**--concern and conscientious attention to the sustainability of VSC services must guide all of AVSC's program development activities.
4. **Training and technical assistance**--training and provision of technical assistance are AVSC's fundamental tools for helping counterparts start and expand high-quality and sustainable VSC services.
5. **Collaboration with other agencies**--a principal means for effectively extending the reach and impact of AVSC's work is to actively involve and collaborate with other agencies.
6. **Working with developing-country professionals**--involvement of the international professional community is critical in developing VSC policies and guidelines and enhancing their acceptability to governments and local health professionals.
7. **Research and evaluation**--in order to constantly improve and expand services, all AVSC initiatives, projects, and program activities should be done, to the extent possible, in a framework of research or evaluation.

The specific global initiatives together form our core overall programmatic response of AVSC to global service needs. Each of the nine initiatives are applied and adapted to specific circumstances and needs in each region. The nine global initiatives are:

1. **Minilaparotomy under local anesthesia**--continue to introduce and expand use of minilaparotomy under local anesthesia.
2. **Vasectomy**--expand the availability of high-quality vasectomy services.
3. **Postpartum family planning**--promote the development of postpartum family planning services.
4. **Norplant**--study the introduction and potential for Norplant in family planning services.
5. **Family planning counseling and client information services**--introduce high-quality family planning counseling and client information services wherever VSC services are offered.
6. **Medical safety oversight**--refine and decentralize medical safety oversight and technical assistance capacities.
7. **Training**--improve AVSC's training capacities.

8. **Client-oriented and provider-efficient services**--conduct a project to define and promote client-oriented and provider-efficient (COPE) VSC services.
9. **Research and evaluation**--implement a comprehensive VSC research and evaluation program.

B. 1989 Highlights from AVSC's Global Initiatives

Chapter 2 gives AVSC's agencywide workplan for each of the nine global initiatives listed above. Although we feel that all of the activities we plan for 1989 are important, the following are perhaps among the most significant:

- o The accelerated introduction of no-scalpel vasectomy through numerous training activities, and an international symposium in December 1989.
- o The formulation of our postpartum family planning services initiative which begins in 1989 with a number of early phase, exploratory activities: a Latin America regional workshop; development of case studies; and examination of the potential for postplacental IUD insertion. These exploratory activities will instruct the directions for future year activities.
- o The distillation and dissemination of AVSC's accumulated experience and knowledge in the important area of family planning counseling in two major pieces: a manual for program managers and service providers entitled Family Planning Counseling and Voluntary Sterilization; and a film for use in counselor training programs in Sub-Saharan Africa.
- o The completion by AVSC staff of peer-reviewed medical safety and program management guidelines for female sterilization which will be published and distributed worldwide by the World Health Organization. When published in 1990 this will be the most exhaustive and comprehensive treatment of the subject to date.
- o The conduct of an international workshop in Indonesia in May 1989 to examine worldwide experience, and identify issues and considerations, in developing medical monitoring and supervision systems for VSC services.
- o The development of a new initiative to improve the efficiency and service delivery capacity of local services. Called COPE --client-oriented and provider-efficient services--this project is being implemented and tested first in Sub-Saharan African countries. We view it as a very promising low-

investment and low-risk endeavor with a potentially high impact.

- o The implementation of a very extensive and ambitious research and evaluation program which reaches into the majority of concerns, programs and activities the agency conducts. In 1989 we are developing a revised global social science and programmatic research agenda.

C. Regional and Country Workplans

Chapter 3 gives the regional and country strategies and workplans for each of AVSC's four regions. Each region is addressed in terms of regional needs and background; country priorities; special program initiatives that are particularly relevant or unique to the region; a brief discussion of AVSC management of the regional program, including any changes proposed for 1989; and discussion with a summary table of projected fiscal 1989 allocations for projects.

Following each regional overview, are the strategies and workplans for individual countries, or for groups of countries sharing similar characteristics, needs, and AVSC involvement. The expected outputs for each major project are listed. The country workplans list not only subagreements, but anticipated small grants, special assessments, consultancies, technical assistance initiatives, and major events. Any collaboration with other cooperating and donor agencies is also described.

D. Fiscal 1989 Resource Allocation Overview

AVSC plans to obligate \$6.98 million (all funding sources) for 119 projects in over 50 countries during Fiscal 1989, as summarized in Table 1.1.

Table 1.1
Number of projects, country involvements and planned obligations,
by region, April 1, 1989 to March 31, 1990

| <u>Region</u> | <u># Projects</u> | <u># Countries</u> | <u>Planned Objectives</u> |
|--------------------------|-------------------|--------------------|---------------------------|
| Sub-Saharan Africa | 39 | 20 | 2,288,000 |
| North Africa/Middle East | 25 | 8 | 1,225,400 |
| Latin America/Caribbean | 34 | 15 | 1,886,600 |
| <u>Asia</u> | 21 | 8 | 1,583,000 |
| Total: | 119 | 51 | \$6,983,000 |

As indicated in Table 1.1, AVSC will maintain in FY 1989 an extensive global presence and will be involved in each of the four regions. Sub-Saharan Africa is earmarked to receive the largest share of resources (33%) for the largest number of countries and project involvements, followed by Latin America (27%), Asia (23%) and North Africa and the Middle East (17%). This is in line with AVSC's strategic plan and AID's resource allocation goals to shift resources to Sub-Saharan Africa.

As discussed more fully in the Strategic Plan (section 5.B), although AVSC expects to be involved in a large number of countries, we will concentrate our work in those few countries where the needs are great or where the potential is best for making a wide regional impact or a significant contribution in the surgical contraception field. Table 1.2 illustrates how planned obligations are spread according to priority ranking -- 61% of FY 1989 project obligations are earmarked for 16 high priority countries (one-fourth of the total countries where AVSC is undertaking program development exploration and/or project commitments). The vast majority of countries fall into medium- or low-priority categories and will receive only 29% and 10% of FY 1989 project resources, respectively.

An analysis of anticipated funding sources for FY 1989 obligations shows that AID/Central funding remains critical to our work in all regions. However, an increasing proportion of funding is coming from USAID/Mission and other sources (e.g., private donors, UNFPA, World Bank). In FY 1989, 53%* of the total project obligations will be supported with AID/Central funds, one of the lowest percentages ever for AVSC. We continue to aggressively pursue USAID mission funding which, in FY 1989, accounts for 40% of all project obligations. We consider these buy-ins crucial for enabling AVSC to maintain its global presence in the face of shrinking AID/Central resources. They also are an important signal of increased commitment by governments in the provision of VSC services.

Table 1.3 shows the allocation of different funding sources by region. The highest percentage of AID/Central funds are earmarked for Latin America, as three of the largest regional programs (Brazil, Colombia and Mexico) are in countries with no bilateral resources. AVSC's efforts in sub-Saharan Africa are beginning to leverage more financial support and collaboration from others than we had anticipated during our planning cycle for this fiscal period. By the end of FY 1989, AVSC expects three new USAID buy-ins from missions in Rwanda, Uganda, and Zambia and financial support for activities from the World Bank in Zimbabwe.

*This percentage would be even lower if there had been a FY 1989 obligation to the Bangladesh Association for Voluntary Sterilization. This \$1.9 million USAID-funded project was obligated in FY 1988 and runs through June 30, 1990.

Table 1.2.
Planned Fiscal 1989 (in Thousands of Dollars) Project Obligations
and Number of Country Involvements* by Priority of AVSC's Country Involvements

| Level of AVSC Effort | Sub-Saharan Africa | North Africa and the Middle East | Latin American and the Caribbean | Asia | Total |
|----------------------------|-----------------------|--|--|------------------|-------------------|
| High | 1,690 (5) | 893 (3) | 963 (5) | 696 (3) | 4,242 (16) |
| Medium | 425 (9) | 212 (2) | 832 (7) | 557 (3) | 2,026 (21) |
| Low | 173 (10) | 119 (4) | 92 (7) | 330 (3) | 714 (24) |
| Total | 2,288 (24) | 1,224 (9) | 1,887 (19) | 1,583 (9) | 6,982 (61) |

* Numbers in parentheses indicates the number of countries. For the low priority category the numbers include countries where there are no obligations planned for fiscal 1989, but where we plan to engage in program development or exploration.

Table 1.3.
Planned FY 1989 Obligations (in Thousands of Dollars)
by Region and Source of Funding

| Region | AID/Central | USAID/Mission | Other | Total |
|--------------------------|-------------|------------------|------------------|-------|
| Sub-Saharan Africa | 944 | 1,135 | 209 ¹ | 2,288 |
| North Africa/Middle East | 730 | 465 | 30 | 1,225 |
| Latin America/Caribbean | 1,079 | 547 | 261 | 1,887 |
| Asia | 944 | 639 ² | ..3 | 1,583 |
| Total: | 3,697 | 2,786 | 500 7 10 % | 6,983 |

¹Includes World Bank funding (\$110,000) for Zimbabwe.

²Amount is artificially low, because no FY 1989 obligation was made for AVSC's largest subrecipient, the Bangladesh Association for Voluntary Sterilization (\$1.9 million was obligated in FY 1988 through June 30, 1990).

³Figure does not reflect on-going UNFPA project in India for \$1.7 million for the period 1988 to 1992.

2. 1989 WORKPLAN FOR SPECIAL GLOBAL INITIATIVES

1989 WORKPLAN FOR SPECIAL GLOBAL INITIATIVES

References

A. MINILAPAROTOMY UNDER LOCAL ANESTHESIA

Continue to introduce and expand use of minilaparotomy under local anesthesia

1. Continue to develop the following sites as model minilaparotomy (both interval and postpartum) service centers so that they will function as regional training centers.

o Kenya - Family Planning Association of Kenya (KEN-02-SV-1-A)

Africa and Kenya
Workplan

o Ecuador - Maternidad Enrique Sotomayer (ECU-05-TR-2-P)

Latin America/
Caribbean and Ecuador
Workplan

o Dominican Republic - Maternidad Nuestra Senora de la Altagracia (DOM-10-SV-1-A)

Latin America/
Caribbean and Dom.
Republic Workplan

2. Explore/conduct initial development of model minilaparotomy service and training centers in the following countries:

o Tunisia - Office National de la Population Familial (TUN-11-SV-5-A)

No. Africa/Mid. East
and Tunisia Workplan

o Philippines - Philippine General Hospital (PHI-17-TR-6-A) or Jose Fabella Memorial Hospital. The development of a strong in-country minilaparotomy training center is essential to future decentralization of training to Department of Health Hospitals (PHI-27-SV-1-A).

Asia and Philippines
Workplan

PROCESSED
DATE

- | | | |
|----|--|-----------------|
| 3. | Complete the <u>minilaparotomy training film</u> in collaboration with the Family Planning Association of Kenya and the Kenyan Ministry of Health. | Africa Workplan |
| 4. | Continue development of a <u>model minilaparotomy surgical team training curriculum</u> . This curriculum was first drafted at an AVSC workshop in Mombasa, Kenya in 1988. It is being tested and adapted in several African countries. We plan to continue to develop and test in other regions and finalize by early 1991. | Africa Workplan |
-

B. VASECTOMY

Expand the availability of high-quality services

- | | | |
|----|--|---|
| 1. | Develop a minimum of five new projects with vasectomy components in calendar 1989. | Cooperative Agreement Logical Framework Various regional and country workplans |
| 2. | Develop no-scalpel vasectomy training <u>centers for international training</u> of trainers and first-generation service providers. <ul style="list-style-type: none"> o Thailand - Population and Community Development Association. Award subagreement in early 1990. o Latin America regional subagreement for NSV training and introduction will be developed for funding in fiscal 1990. Both PROPATER (Brazil) and PROFAMILIA (Colombia) were certified by AVSC in September 1989 to receive international trainees. 1989. | Asia Workplan Latin America/ Caribbean Workplan |
| 3. | Train <u>first generation trainers</u> in fiscal year 1989 from the following countries: Bangladesh, Brazil, Indonesia, Mexico, Pakistan, and the Philippines. Introduce NSV services in these countries. | Latin America/ Caribbean and Asia individual country workplans |

4. Conduct in collaboration with FHI an international symposium on no-scalpel vasectomy in Bangkok, Thailand in December, 1989 to assess worldwide experience of the first generation of providers/trainers outside of China who have been trained to date (GLO-03-PE-1-A). We will use symposium results and other resources/experiences to begin development of model program support materials. The symposium will also be used to begin development of a social science and operations research agenda to guide future clinical and research efforts.
5. Other activities and projects: in each region we will be developing pilot vasectomy service projects; assessing provider and client knowledge and attitudes; and identifying potential future sites for no-scalpel vasectomy introduction.

C. POSTPARTUM FAMILY PLANNING

Promote the development of postpartum family planning services

1. Have established by the end of 1989 a cumulative total of five projects which include postpartum family planning services.
2. Continue to develop model postpartum minilaparotomy services and regional training sites at the following institutions:
 - o Kenya - Family Planning Association of Kenya (KEN-02-SV-7-A)
 - o Ecuador - Maternidad Enrique Sotomayer (ECU-05-TR-2-P)

Cooperative Agreement
Logical Framework
Various regional and
country workplans

Africa and Kenya
Workplan

Latin America/
Caribbean and Ecuador
Workplan

o Dominican Republic - Maternidad Nuestra Senora de la Altagracia (DOM-10-SV-1-A)

Latin America/
Caribbean and Dom.
Republic Workplan

3. Conduct a Latin America regional workshop in September 1989 in conjunction with the Instituto Mexicana de Seguro Social (IMSS), to review issues and considerations in the development of postpartum family planning services (LAC-02-PE-1-A).

Latin America/
Caribbean Workplan

4. Initiate in early 1990 the training of one or two AVSC AVSC medical staff in postplacental IUD insertion at IMSS, Mexico, and begin the process of defining a standard, recommended technique, and its assessment in several international service sites. Assessment of the technique would hopefully be done in collaboration with FHI.

Latin America/
Caribbean Workplan

5. Start the development of case studies of postpartum family planning services in countries where they are well-established in order to review and assess the issue. Case studies for two countries will be completed in fiscal year 1989.

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D. NORPLANT

Study the introduction and potential for Norplant in family planning services

1. Continue our collaboration with other agencies

- o Attend interagency Norplant task forces of AID and other cooperating agencies.
- o Work with FHI, PATH, Population Council to finalize the prototype Norplant training curriculum.

2. Continue to fund and monitor Norplant projects in two countries, listed below, and explore development of new projects in other countries. Our aim is to assess the method's acceptability, cost-effectiveness, and impact on services.

- o Nigeria - Operations research project on clinical contraception methods in 5 sites (NIR-25-OR-1-P).

Africa and Nigeria
Workplan

- o Tunisia - Support for Norplant training and I&E activities (TUN-12-SV-3-A).

No. Africa/Mid East
and Tunisia Workplan

3. Continue to stay informed about clinical and program introduction research findings concerning Norplant's safety and contraceptive effectiveness.

E. FAMILY PLANNING COUNSELING AND CLIENT INFORMATION SERVICES

Introducing high quality family planning counseling and client information services wherever VSC services are offered

1. Have counseling components in 90% of AVSC-funded service projects.
2. Support 20 counselor training courses in AVSC-funded service projects in calendar 1989.
3. Establish model counseling training centers in each region. The following will be operational by the end of fiscal year 1989:

Cooperative Agreement
Logical Framework

Cooperative Agreement
Logical Framework

- o Kenya - Family Planning Association of Kenya (KEN-02-SV-7-A)

Africa and Kenya
Workplan

- o Nigeria - University College Hospital, Ibadan (NIR-12-TR-5-A)

Africa and Nigeria
Workplan

o Philippines - Philippines Association for Voluntary Surgical Contraception (PHI-08-NV-11-A)

Asia and Philippines Workplan

o Brazil, PROPATER (BRA-38-SV-1-A)

4. Conduct an Asian regional workshop in the Philippines in September 1989 in collaboration with PAVSC in order to update national counselor training plans and approaches in the region (ASI-03-TR-1-A).

Asia Workplan

5. Recruit for and select by early 1990 a professional to coordinate agencywide counseling activities.

6. Publish and distribute in early 1990 AVSC's basic guidelines on Family Planning Counseling and Voluntary Sterilization.

7. Complete and distribute the family planning counseling film developed in collaboration with the Family Planning Association of Kenya and the Kenyan Ministry of Health.

Africa Workplan

8. Conduct internal review of AVSC's overall voluntarism quality assurance program.

Cooperative Agreement Logical Framework

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F. MEDICAL SAFETY OVERSIGHT

Refine and decentralize medical safety oversight and technical assistance capacities

1. Publish and distribute Spanish and French translations of Safe and Voluntary Surgical Contraception in early 1990.

2. Complete and submit to WHO in 1989, the technical and program Guidelines for Female Sterilization Services. WHO plans to publish and distribute in 1990.

3. Conduct an international workshop sponsored by the World Federation in collaboration with Pathfinder and WHO in May 1989 in Indonesia regarding the issues and considerations

in setting up and managing medical monitoring and supervision systems for VSC services. Report will be published in fiscal year 1990.

- | | | |
|----|---|--|
| 4. | Complete an analysis of <u>sterilization morbidity and mortality</u> reported in AVSC-supported projects for calendar 1989 by February 1990. | Cooperative Agreement Logical Framework |
| 5. | Conduct 40 <u>medical site visits</u> to AVSC service and training projects in CY 1989. | Cooperative Agreement Logical Framework |
| 6. | Have established a cumulative total of 20 <u>medical supervision systems in multi-site service systems</u> in countries where AVSC is involved. | Cooperative Agreement Logical Framework |

G. TRAINING

Improving AVSC's training capacities

- | | | |
|----|---|--|
| 1. | Training is fundamental to all of our technologies introduction and counseling activities. Training activities are included in the minilaparotomy, vasectomy, postpartum, Norplant, and counseling global initiatives. See training-related activities in the following sections of Global Initiatives Workplan: A.1-4; B.2-3; C.2 and C.4; D.1; and E.2 and 3. | |
| 2. | Support 25 <u>projects</u> with medical training components. | Cooperative Agreement Logical Framework |
| 3. | Recruit for a <u>training program coordinator</u> . Target date: March 1990. | |

H. CLIENT-ORIENTED AND PROVIDER-EFFICIENT SERVICES

Conduct a project to define and promote client-oriented and provider-efficient (COPE) VSC services

1. Conduct pilot studies in Nigeria and Kenya to test and assess different COPE approaches; complete a report on the results by January 1990. Africa Workplan
2. Begin to introduce, adapt and assess a revised COPE approach, synthesized from the pilot studies, in several African countries including Ghana, Guinea, Kenya, Madagascar, Nigeria, and Zimbabwe, and possibly others if time and resources permit. This activity will continue through fiscal year 1990. Africa Workplan
3. Begin in 1989 discussions with the Population Council for organizing one or two operations research projects related to COPE approach. Africa Workplan
4. Develop several prototype self-assessment materials to allow local services to observe and improve management of their services, including a clinical services self-assessment checklist; a simplified client book; simplified client flow analysis procedures, and standard client record forms. Developed in 1989, these will be tested and refined during COPE country projects in 1990 and 1991. Africa Workplan

I. RESEARCH AND EVALUATION

Implementing a comprehensive VSC research and evaluation program

1. Continue to collaborate with FHI and other organizations to identify the safety and contraceptive effectiveness issues that need to be studied regarding vasectomy, including no-scalpel vasectomy, and postplacental IUD insertion.

2. Complete a survey of AVSC program and field staff regarding important social science research issues relating to VSC by October 1989; and with AVSC's Science Committee review and prioritize social science research issues.

3. Conduct operations research projects (a minimum of six ongoing operations research studies, as per cooperative agreement):

| | |
|---|--|
| o Nigeria - Study of the acceptability of clinical family planning methods, including Norplant and female sterilization (NIR-25-OR-1-P), with some assistance from Colombia University. | Cooperative Agreement Logical Framework Africa and Nigeria Workplan |
| o Kenya - Rural information and education for vasectomy, Chogoria Hospital (KEN-22-IE-1). | Africa and Kenya Workplan |
| o Kenya - Urban information and education for vasectomy, Marie Stopes Clinic (KEN-24-IE-1-P). | Africa and Kenya Workplan |
| o Turkey - Alternative information and education approaches (TUR-12-EV-1-A). | No. Africa/Mid. East and Turkey Workplan |
| o Bangladesh - Alternative field worker strategies (BGD-34-EV-1-A). | Asia and Bangladesh Workplan |
| o Mexico - 2 projects for alternative information approaches for male clinics (MEX-47-SV-1-A and MEX-49-SV-1-A), in collaboration with the Population Council. | Latin America/ Caribbean and Mexico Workplan |

4. Continue client satisfaction research:

| | |
|--|--|
| o Publish results from 6 AVSC-funded client follow-up surveys in <u>Studies in Family Planning</u> . | |
| o Complete Morocco client follow-up survey (MOR-04-EV-1-A). | No. Africa/Mid. East and Morocco Workplan |
| o Jordan - VSC KAP Study (JOR-14-EV-1-A-S) | No. Africa/Mid. East and Jordan Workplan |

- o Egypt - IUD client satisfaction study (EGY-31/32/33-SV-2/3-A) No. Africa/Mid. East and Egypt Workplan
 - o Philippines - client follow-up survey (PHI-08-NV-10-A) Asia and Philippines Workplan
5. Conduct VSC cost studies, as follows:
- o Morocco - VSC cost per case study. Cooperative Agreement Logical Framework
 - o Sustainability study in selected Latin American programs (Colombia, Brazil, Dominican Republic and Mexico).
6. Conduct team assessments of AVSC-funded country programs, or large projects, as follows:
- o Nigeria - Assessment of zonal VSC supervision system (November 1989). Africa and Nigeria Workplan
 - o Turkey - Comprehensive review of AVSC projects and country strategy (February 1990). No. Africa/Mid. East and Turkey Workplan
 - o Indonesia - Participate in interagency needs assessment of VSC training (February 1990). Asia and Indonesia Workplan
 - o Bangladesh - Clinic-wise assessment of BAVS service performance (November 1989 to January 1990). Asia and Bangladesh Workplan
7. Complete development and install new program monitoring and evaluation systems, including:
- o End-of-project (subagreement) assessment reports Cooperative Agreement Logical Framework
 - o Subagreements management information system

- o Logical framework monitoring system
-

J. MANAGEMENT WORKPLAN FOR FISCAL 1989

1. Reorganize the International Programs Division into two departments: Technical Assistance and Support Department and Program Management Department. Establish a divisional budget and planning unit.
2. Realign field office structures and staffing as follows:
 - o Relocate Asia regional office from Dhaka to Bangkok by early 1990.
 - o Establish a dedicated country office for Bangladesh by 1990.
 - o Recruit a part-time medical advisor to Latin America regional office.
3. Install a new agencywide budget development system as of September 1989.

3. REGIONAL AND COUNTRY STRATEGIES AND WORKPLANS

SUB-SAHARAN AFRICA
FY 1989 REGIONAL STRATEGY AND WORKPLAN

Need and Background:

Encompassing diverse cultures in 43 countries sub-Saharan Africa has the world's highest maternal mortality rate, highest infant mortality rate, and the highest population growth rate. All but a few countries lack even a mediocre health care infrastructure and all face a significant drain of trained doctors to private practice or foreign countries. Almost all lack data for planning and are severely handicapped in evaluating the impact of all types of health and family planning programs. The lack of maintenance, supplies, equipment, adequate hospital space and trained personnel, and an ever-changing deployment of staff throughout the government sectors often frustrates even the best of plans. Moreover, the region is more broadly characterized by high fertility norms, religious opposition to family planning, official indifference or hostility to family planning and population programs, and medical conservatism. Francophone African countries are farther behind their Anglophone counterparts in policies and support for family planning and population.

This acute situation in a large diverse region has required AVSC to prioritize countries and level of effort. It also has challenged us to re-think and reformulate how we do program development and provide technical assistance. The principles of project development outlined in the Strategic Plan (see Strategic Plan, chapter 3) and several of our new agency-wide initiatives -- our renewed emphasis on minilaparotomy under local anesthesia (Strategic Plan, section 4.A), and the client-oriented and provider efficient (COPE) project (Strategic Plan, Section 4.H) -- grew out of needs expressed in sub-Saharan Africa. In many ways, sub-Saharan Africa is a unique opportunity -- we are better able to try different and more appropriate interventions in the region precisely because family planning services are so new. And, we are able to better apply the lessons from our past mistakes and successes in the other regions.

Despite the difficulties inherent in this setting, AVSC has made substantial headway in introducing voluntary surgical contraception in sub-Saharan Africa. The growing interest in VSC, coupled with the increased AVSC resources devoted to program development in Africa, resulted in a twenty-fold increase in the number of programs in Africa over the past eight years. In 1980, AVSC was supporting 5 VSC projects in 5 African countries, and provided sterilization to 98 women; by 1988, over 13,000 women received voluntary sterilizations in 108 service sites in 20 countries.

Now that VSC services have been introduced in 20 countries, we expect to continue to give high priority to the region in order to build on these gains so as to support the eventual routine inclusion of VSC services into national family planning service delivery systems. Our strategic goal is to have VSC accepted as a routine component of MCH/FP services, in plan or in practice, by 90% of the governments in Sub-Saharan Africa by the year 2000.

Country Priorities:

Although AVSC is involved in supporting services in 20 countries, the level of effort is clearly not the same in each one. Kenya and Nigeria consume the largest amount of financial resources and staff attention, followed by Zimbabwe, Uganda and Ghana. These countries have been earmarked as "high effort," given the potential for AVSC support to result in the creation of a nationwide VSC service delivery system and the potential to serve as regional training and service models. In Kenya and Nigeria, the sheer number of service sites supported by AVSC dictates the intensity of effort. In medium effort countries, AVSC will work in the short term to develop one or a few model programs in the country to impact on the way health providers think about and deliver VSC services and to lay the foundation for training. The few Francophone countries with the greatest potential for developing model service and training programs (Madagascar, Mali, Mauritius and Zaire) are included in this ranking, with the hope that they will follow the same course as the more successful Anglophone countries in time. In the remaining low effort countries, AVSC is at the early stage of services introduction and program development, and we expect it to take a few more years to move these countries along the continuum of service expansion.

Regional Program Initiatives:

Our early successes have been due to a strategy which has emphasized integration of VSC into existing, rather than new, infrastructures; promotion of appropriate technologies that meet the needs of the clients, while being efficient for the provider, e.g., minilaparotomy under local anesthesia; minimum support for recurrent costs; and emphasis on the creation of local training and supervision capacity. This strategy requires a much higher ratio of technical assistance to financial support and is indicative of AVSC's overall operational shift. Moreover, it emphasizes increased collaboration with other donors and family planning agencies, because it is clear that AVSC cannot meet its goals alone.

Special regional activities in FY 1989 follow:

o As one of the major barriers in the Africa region is a lack of adequate management of services, AVSC will undertake its "COPE" (client oriented-provider efficient) initiative; to help programs set up their own systems for making services more responsive to client needs while at the same time making them more efficient for the provider. In FY 1989, pilot COPE assessments were done in Kenya and Nigeria at a total of ten sites. These participatory exercises enabled service providers to look at their own services in areas of administration (equipment, and supplies logistics), client flow analysis and client tracking and follow-up. The favorable response and the improvement garnered by these early efforts has led to plans to expand this to 15 more programs in Kenya, Nigeria, Zimbabwe and Ghana in FY 1990.

o As in the past, expansion of VSC services in Africa will continue as a priority. In FY 1989, AVSC will expand to three new countries -- Malawi, Guinea and Rwanda. In countries where AVSC has already established a VSC program, ~~AVSC's role will shift from direct support of services to providing technical assistance to the established sites to improve their capacity to expand elsewhere,~~ through the development of multisite projects and in-country training and supervision capacity (Kenya, Nigeria, Ghana, Ethiopia, Uganda and Zimbabwe). Finally, in country programs where AVSC's efforts are relatively new and still on a small scale, continued low-level support will focus on strengthening services, with a view toward eventually establishing the capability for in-country training. This will be the strategy in Francophone countries, as well as in Liberia, Sierra Leone, Tanzania and Zambia.

o A key component in our efforts to expand access to VSC is training for doctor/nurse teams in minilap and counsellors in VSC counselling through regional and in-country training centers. Previously, AVSC relied almost exclusively on FPAK to provide training for doctor/nurse teams in minilap. Following a successful training of trainers workshop in Kenya in 1988, AVSC is working in FY 1989 to assist service providers at AVSC-supported VSC sites to prepare to provide training in their respective countries in minilap and VSC counselling. A large part of this is being done through technical assistance by medical staff and consultants, and every effort is being made to develop a cadre of region-based African medical consultants as resources. Through this decentralization of medical training and supervisory capacity, AVSC is working to establish regional training centers over the next five years in Kenya, Zimbabwe, Ghana, Nigeria, Madagascar, Mali and Mauritius. AVSC also hopes that the university teaching hospitals which are providing minilap will begin to integrate this technique into its ob/gyn residency training programs. This is a special initiative for AVSC's work in Nigeria, Zambia, Uganda and Ghana.

o Aware that meeting the demand for sterilization in Africa cannot be accomplished through AVSC efforts alone, AVSC intensified its efforts in FY 1989 to foster collaboration with other family planning agencies in Africa to provide sterilization. A meeting was held in August 1989 in Nigeria for members of FHS-II agencies and Federal Ministry of Health officials to discuss the integration of VSC into other family planning services in the country. In October 1989 AVSC hosted a meeting in Ghana for representatives from AID cooperating agencies and Ghanaian ministry of health officials to discuss integrating long-term and permanent contraception into the family planning activities of international donor agencies in Africa.

o Although past efforts in Africa have focused almost exclusively on female sterilization, we are working to test the potential for vasectomy services. In FY 1989, two studies will be undertaken in Kenya looking at men and women's attitudes towards vasectomy, and a similar study is planned for Nigeria. Two doctors (one from Nigeria and one from Uganda) will be trained in vasectomy in Brazil in an attempt to introduce male sterilization services in sub-Saharan Africa. Over the next five years, AVSC will be

focusing vasectomy service introduction in Kenya, Uganda, Ethiopia, and Nigeria.

o AVSC's target clientele in Africa, as in the rest of the world, is the "limiter." Given the paucity of family planning services in Africa in general, and the need to have more contraceptive options for this group, AVSC is testing the programmatic potential for Norplant in conjunction with sterilization services. In FY 1989, AVSC continued to work on an operations research project in Nigeria, and explored the introduction of NORPLANT in Kenya and Mali in collaboration with the Population Council.

Regional Management:

AVSC's regional office in Nairobi, Kenya oversees this large and logistically-difficult program, with the aid of a sub-regional office in Lagos, Nigeria for West African Anglophone countries. Management of the project portfolio has been facilitated by the consolidation of service sites under umbrella institutions, e.g., in Nigeria, the four zonal leadership institutions in Nigeria; and in Kenya, the MOH, the Christian Health Association of Kenya, JSI-Kenya, and FPAK; and by continued efforts to decentralize medical oversight and training capacity to region-based consultants. There are no plans to expand staff resources in FY 1989, however, this will be given consideration next fiscal year as we expect our involvement to pace with the increased demand for our resources and technical assistance.

Fiscal 1989 Resource Allocation:

Table SSA shows planned FY 1989 project obligations (dollars and number of projects) by country and source(s) of funding. The Africa region is now the leader in terms of number of projects and amount of funds obligated (accounting for 33% of the total planned projects and obligations in FY 1989 in all regions). Clearly, AVSC has achieved in spirit and in fact, the goals of AID's resource allocation plan. It is interesting to note that less than half (41%) of the monies allocated to the Africa region is from Central/AID funding. AVSC's efforts are beginning to leverage more and more financial support and collaboration from USAID missions and others (Kenya, Uganda, Zimbabwe, Zambia, Rwanda).

**Table SSA: Planned Obligations (Dollars and Number of Projects)
in sub-Saharan African
by Country and Source of Funds, FY 1989**

| <u>Country</u> | <u>Amount</u> | <u># of Projects</u> | <u>Fund Source</u> |
|---------------------|--------------------|----------------------|--------------------|
| <u>HIGH EFFORT:</u> | | | |
| Ghana | 60,000 | 1 | AID/Central |
| Kenya | 890,000 | 4 | USAID/Kenya |
| | 40,000 | 1 | AID/Central |
| | 25,000 | 1 | AVSC/Private |
| Nigeria | 339,000 | 13 | AID/Central |
| Uganda | 130,000 | 1 | USAID/Kampala |
| | 36,000 | - | AID/Central |
| Zimbabwe | 60,000 | 1 | AID/Central |
| | 110,000 | 1 | World Bank |
| <u>Sub-total:</u> | <u>\$1,690,000</u> | <u>23</u> | |
| <u>MEDIUM:</u> | | | |
| Ethiopia | 54,000 | 1 | AVSC/private |
| Liberia | 30,000 | 1 | AID/Central |
| Madagascar | 50,000 | 2 | AID/Central |
| Mali | 15,000 | 1 | AID/Central |
| | 20,000 | 1 | AVSC/private |
| Mauritius | 35,000 | 1 | AID/Central |
| Sierra Leone | 49,000 | 1 | AID/Central |
| Tanzania | 47,000 | 1 | AID/Central |
| Zaire | 50,000 | 1 | AID/Central |
| Zambia | 75,000 | 1 | USAID/Zambia |
| <u>Sub-total:</u> | <u>\$425,000</u> | <u>11</u> | |
| <u>LOW:</u> | | | |
| Gambia | 8,000 | 1 | AID/Central |
| Lesotho | 4,000 | 1 | AID/Central |
| Malawi | 36,000 | 1 | AID/Central |
| Rwanda | 40,000 | 1 | USAID/Rwanda |
| Senegal | 45,000 | 1 | AID/Central |
| Other Francophone | 40,000 | -1 | AID/Central |
| <u>Sub-total:</u> | <u>\$173,000</u> | <u>5</u> | |
| <u>TOTAL:</u> | <u>\$2,288,000</u> | <u>39</u> | |

¹ Small grant provisions in FY 1989 for Benin, Cote D'Ivoire, Togo and Guinea.

Kenya
FY 1989 Country Workplan

AVSC's involvement in Kenya has been a model for its approach throughout sub-Saharan Africa. Starting small with demonstration projects in two Family Planning Association of Kenya (FPAK) clinics in 1978, VSC services have expanded to 74 service sites throughout the country. AVSC now provides support for services delivered at 9 non-governmental clinics (through FPAK), 14 mission hospitals (through a subagreement with the Christian Health Association of Kenya), 25 private sector facilities (through a project with JSI Kenya), and 26 public (Kenya Ministry of Health) hospitals. Over 9,500 women received sterilizations in AVSC-supported service sites in Kenya in 1988. Reports from a recently conducted Demographic and Health Survey in Kenya (1989) are encouraging; 68.4 percent of all women know of female sterilization. In practice, sterilization has shown a remarkable increased popularity in Kenya over the past four five years: it is the second most popular "modern" family planning method, and is number one for women over the age of 30.

In view of the increasing demand and government commitment for VSC services, AVSC's strategy is to continue to work with the four major sectors (government, non-government, mission and private for-profit) to strengthen and expand existing services; to extend services to new sites; improve the capacity to train VSC personnel and supervise quality on an on-going basis; and ultimately, to include VSC into the routine funding of these institutions.

As the implementing agency for VSC services delivered under the USAID/Government of Kenya Bilateral Family Planning Project, AVSC is responsible for working in all four sectors with FPAK, CHAK, JSI and the MOH to ensure that the needed services are provided, and that the quality of the services is assured. AVSC will do this by awarding grants to CHAK and the MOH to continue to support training for service providers in minilap and VSC counseling, and provision of necessary equipment, educational materials, and supplies. The bilateral project also supports the model VSC program in Kenya, with the Family Planning Association of Kenya, which provides training in minilap and VSC counseling for service providers throughout Africa. Every year, AVSC sends policy makers from other African countries to witness the successful Kenya program, and to see how well VSC can be integrated into other family planning services. AVSC will also be receiving funds under the bilateral agreement to cover operating costs at the Africa Regional Office for AVSC in Nairobi. These costs will include routine monitoring and provision of technical assistance to the four agencies to assure the quality of VSC services.

Special initiatives in the coming year in Kenya will include attempts to diversify the methods provided. While the program in the past has succeeded in introducing and integrating female sterilization services, future attempts will be made to introduce vasectomy and NORPLANT services in Nigeria. It is felt that this will meet the need for men who wish to limit their family size, as well as women who are not yet ready for a permanent method.

| Name of Project | Description | Funding |
|--|--|----------------------------------|
| Continuation of support for VSC services to Christian Health Association of Kenya (KEN-08-SV-4-A) | <p>This project continues AVSC's assistance to CHAK to provide VSC services in 14 rural mission hospitals in Kenya. Support includes improving I&E activities for personnel from all CHAK hospitals to inform them of VSC; training surgical teams in minilap and counselors in VSC counseling to meet need for trained personnel at several hospitals; assist in improving management of the CHAK VSC program by providing technical assistance and support for various management workshops.</p> <p>Expected outputs:</p> <p>6,085 female procedures 9 doctor/nurse teams trained in minilap 14 counselors trained 20 health care, church and community leaders oriented to VSC</p> | \$380,000 AID/Kenya bilateral |
| Improvement and expansion of VSC services in 25 Ministry of Health (MOH) hospitals (KEN-21-SV-2-A) | <p>Support for improving quality and coordination of information, services and counseling through staff training and support for supervisory visits to 17 MOH hospitals throughout Kenya. Support for expansion to 8 new MOH sites will include training in minilap and counseling, I&E activities for hospital personnel, minor renovations, and necessary equipment and supplies.</p> <p>Expected outputs</p> <p>11,900 female procedures 26 doctor/nurse teams trained in minilap 50 counselors trained 900 MOH hospital workers oriented to VSC program</p> | \$405,500 AID/Kenya bilateral |

| Name of project | Description | Funding |
|--|--|---|
| Introduction of minilap services at Kenyatta National Hospital (KNH): (KEN-26-SV-1-A) | Support will be provided for this first-time assistance to KNH to provide minilap under local services and training at Kenya's premier teaching hospital. This is primarily in response to the need expressed in a 1988 evaluation of VSC in Kenya to provide services to the underserved population of Nairobi. Support is designed to remove the waiting list for VSC by renovating and equipping two new JR theatres, <u>lower the cost by providing a per case subsidy for supplies</u> , and improve I&E about sterilization in the community and among other hospital personnel. Expected outputs: 3000 female procedures 20 field health educators educated about VSC 56 nurses educated about VSC 26 nurses trained in VSC counseling | \$59,000 AID/Kenya bilateral |
| Continued support to the Family Planning Association of Kenya (FPAK) (KEN-02-SV-7-A) | This program represents the seventh period of AVSC support to FPAK, the major provider of family planning and services in Kenya, and AVSC's premier VSC training institution in Africa. The objectives are to continue support of VSC services and counseling at 9 FPAK clinics and expand to 2 additional ones, and support training in minilap for Kenyan and African regional surgical teams, and nurse/counselors and community based distribution agents in VSC information, education and counseling. Additional objectives include improving acceptance of vasectomy and improving management of FPAK clinic services. | \$356,355 AID/Kenya bilateral \$21,045 AID/Central Funds awarded in FY 88; next award in FY 1990. |

| Name of Project | Description | Funding |
|-----------------|-------------|---------|
|-----------------|-------------|---------|

FPAK (continued)

Expected outputs:

- 5,160 female procedures
- 10 male procedures
- 36 surgical teams trained
- 50 counselors trained
- 60 CBD agents trained in VSC IEC

Technical assistance: Africa Regional Office (AFRO)

Support for costs incurred by AVSC Africa Regional Office in conjunction with administering the bilateral project. Includes partial support for salary of Kenya program officer, operating costs of the office, and visits made by AVSC project staff (both in NY and in Nairobi) to the 74 service sites included in the project.

\$46,000
AID/Kenya bilateral

Expected outputs: improved ability of CHAK, FPAK, JSI and MOH to oversee VSC activities; sustainability of VSC program management at these institutions.

Operations research on knowledge and attitudes toward vasectomy (KEN-22-IE-2-A)

This project is continued support to Chogoria hospital to help AVSC determine how to best deliver vasectomy services in Africa. Previous support included a survey of health care providers and community members concerning their attitudes toward vasectomy. Future work will be follow-up surveys of those interviewed after the institution of an I&E campaign designed to address the obstacles to acceptance of vasectomy.

\$40,000
AID/Central

Expected outputs: recommendations on how to increase awareness of how best to deliver vasectomy services in Africa.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|---|--|--------------------------|
| Introduction of NORPLANT in Kenya at Kenyatta National Hospital (KEN-27-OR-1-P) | <p>This pilot project for NORPLANT delivery in Kenya will include support for training doctor/nurse teams from KNH in NORPLANT insertion/removal, and training counselors in counseling for NORPLANT. Additional support will be provided for I&E activities related to NORPLANT in Nairobi.</p> <p>Expected outputs: 5 doctor/nurse teams trained in NORPLANT insertion/removal 5 counselors trained in NORPLANT counseling</p> | \$25,000 AVSC Private |
|---|--|--------------------------|

Nigeria
FY 1989 Country Workplan

AVSC's strategy in Nigeria is directed at introducing and expanding access to sustainable and effective VSC services in each of Nigeria's 21 states. This strategy is influenced by a number of factors, including the experience of working intensively in Nigeria for the past five years, the positive changes in policy and attitudes of policy makers and service providers, and the growing awareness of and demand for voluntary sterilization.

Nigeria will continue to be a priority country for AVSC in the future. It is Africa's most populous country, with a contraceptive prevalence rate of 2%. Problems of inadequate information, shortage of trained counseling and medical personnel, and lack of operating facilities for elective procedures have persisted because of Nigeria's size and large population. AVSC's efforts in this country are designed to address this critical shortage of knowledge, personnel, and materiel so that more couples can exercise their option to limit their fertility.

AVSC first began investigating the introduction of VSC services in Nigerian Hospitals in 1977, and by 1983 was working with two university teaching hospitals and one private medical center. By 1988, this assistance has expanded to 37 institutions in 15 states. And, AVSC played a significant role in shifting service delivery from inpatient procedures performed by laparotomy or laparoscopy under general anesthesia to outpatient minilap using local anesthesia.

AVSC's long-range goal in Nigeria is to assist in the integration of VSC into the overall MCH and family planning program of the country. A major constraint to this strategy is the decentralized, state-based nature of health services in Nigeria. Therefore, in the short term, AVSC is working to develop a VSC leadership network in the four zones of Nigeria, to manage and supervise VSC service delivery in their respective zones. These "zonal centers" are housed in four university teaching hospitals in each of Nigeria's four primary health zones and are responsible for overseeing VSC services at neighboring hospitals. The zonal leadership network is the major building block for promoting sustainable VSC services in Nigeria.

In FY 1989 AVSC will support 13 separate subagreements (in support of 37 service sites). Most have the same programmatic foci: to increase awareness and acceptability of VSC among health providers, policy makers and the general public; to expand services through training of doctor-nurse teams and counselors; and to provide technical assistance to the four zonal leadership groups to transfer project management and supervision to in-country institutions. AVSC will also conduct an assessment of the zonal strategy to date in FY 1989 to determine whether our current strategy is on track.

AVSC will also work to promote the collaboration of FHS-II donor agencies in Nigeria to assist with the integration of VSC into all family planning activities, and this will be crucial to the successful expansion of VSC in Nigeria. A special meeting will be held in FY 1989 to further this goal.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Continuation of activities at Jos University Teaching Hospital (JUTH) (NIR-10-SV-4-A) | At this important and active zonal center, services will continue to be provided at JUTH, and the zonal leader will train doctors, nurses and counselors from neighboring States in VSC, in order to initiate services in other sites in northeastern Nigeria. In addition, the project director will be trained in vasectomy in Brazil in October, 1989. Estimated outputs: 400 female procedures 50 male procedures 4 surgical teams trained in minilap 25 counselors trained | \$40,000 AID/Central |
| Continued support for training and services at University College Hospital (UCH), Ibadan (NIR-12-TR-5-A) | The most active zonal center, UCH will be responsible for overseeing provision of VSC at its own site, as well as six additional sites in southeastern Nigeria, including the University of Ilorin and Benin Teaching Hospitals, Ogbomosho Baptist Hospital, Akure State Specialist Hospital, and Yaba Military Hospital. Estimated outputs: 700 female procedures 4 surgical teams trained in minilap 75 counselors trained | \$58,000 AID/Central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|--|
| Continued support to the Ministry of Health, Ogun State (NIR-22-SV-2-A) | AVSC will continue to support services at Oba Ademola Maternity Hospital and the Family Planning Training School -- both of which are MOH facilities in Ogun State. AVSC will send one doctor/nurse team to Kenya for training in minilap, and will continue to provide necessary expendable supplies and technical assistance to these two sites. Estimated outputs: 250 female procedures | \$12,000 AID/Central |
| Continued support to two hospitals in southeastern Nigeria: University of Calabar Teaching Hospital (UCTH) (NIR-24-SV-2-A) and University of Port Harcourt Teaching Hospital (UPTH) (NIR-26-SV-2-A) | Support will continue to UCTH and UPTH in the form of expendable supplies, information and education seminars, and training for two nurses from each site in VSC counseling. Estimated outputs: 150 female procedures at each site | \$15,000 to UCTH AID/Central \$12,000 to UPTH AID/Central |
| Continuation of services in the underserved northeastern region at the University of Maiduguri Teaching Hospital (UMTH) (NIR-27-SV-2-A) | AVSC will support services at UMTH, Maiduguri General Hospital, and Maiduguri Nursing Home. Support will be provided for expendable supplies, and information and education seminars for community and hospital members. Estimated outputs: 200 female procedures | \$10,000 AID/Central |

13

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|-------------------------|
| Continuation of services in Benue State through an agreement with the Ministry of Health (NIR-28-SV-2-A) | Support will continue to this large multisite project at eight hospitals in Benue State including four government sites, two mission and two private hospitals. I&E seminars will continue throughout the state, and an additional family planning counselor from each site will be trained in VSC counseling. Since equipment has been provided and renovations taken place as required at each site, continued support will consist mainly of technical assistance and expendable supplies. Estimated outputs: 800 female procedures | \$25,000 AID/Central |
| Initiation of VSC services in the private sector in Lagos with the Mt. Sinai Hospital Group in Lagos (NIR-32-SV-1-A) | This first time support is to introduce VSC services to the Mt. Sinai Hospital Group, a consortium of 12 private sector hospitals in Lagos. This support will train one surgical team in minilaparotomy and one counselor in VSC counseling from Borno Way Hospital -- where VSC services will be piloted before expanding to the other sites in the consortium. A one-day I&E seminar will be held for 30 workers from all 12 sites. Expected outputs: 100 female procedures 100 health workers educated | \$20,000 AID/Central |
| Meeting to discuss the integration of long-term and permanent contraception into all family planning methods in Nigeria (NIR-29-SV-1-A) | A meeting to bring together FHS-II agencies, Planned Parenthood Federation of Nigeria representatives, Federal and State Ministry of Health officials, VSC zonal leaders and AVSC staff to discuss the sustainability of VSC services in the country. | \$52,000 AID/Central |

| Name of Project | Description | Funding |
|---|---|----------------------------------|
| | <p>Expected outputs: increased awareness by meeting participants of the need to include VSC information, training and services into all other related family planning activities.</p> | |
| <p>Introduction of vasectomy services at Planned Parenthood of Nigeria (PPFN) (NIR-30-SV-1-A)</p> | <p>Pilot service project with PPFN in Lagos, to provide vasectomy to requesting men; support includes training for a doctor/nurse team in Brazil in vasectomy, information and education activities in Lagos, and establishment of referral networks from other FP service providers to PPFN.</p> | <p>\$40,000 AID/Central</p> |
| | <p>Expected outcomes: 2 male nurses trained in FP and VSC counseling 1 doctor/nurse team trained in vasectomy 25 male procedures</p> | |
| <p>Operations Research for vasectomy, to UCH, Ibadan (NIR-31-OR-1-A)</p> | <p>This research project is designed to learn more about knowledge of and attitudes toward vasectomy on the part of service providers, as well as men and women in Nigeria's four zones, and Lagos.</p> | <p>\$20,000 AID/Central</p> |
| | <p>Expected output: information designed to guide AVSC in initiating and piloting vasectomy services in Nigeria and throughout sub-Saharan Africa.</p> | |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|----------------------------------|
| Introduction of VSC services in the Federal Capitol Territory (FCT) Abuja through a grant to the Federal Capital Development Authority. (NIR-32-SV-1-A) | <p>Pilot project to introduce services in FCT, Abuja through the provision of equipment, and training of service providers in counseling for family planning and VSC. In addition, a doctor/nurse team will be trained in minilap in Kenya.</p> <p>Expected output:</p> <p>1 counselor trained in FP I&E and counseling 1 counselor trained in VSC counseling 1 surgical team trained in minilap 100 female procedures</p> | <p>\$20,000 AID/Central</p> |
| Clinic management consultancy -- COPE initiative | <p>Special study to look at the management of services at four AVSC-supported VSC sites in Nigeria with low caseloads. Purpose of consultancy is to work with grantees to identify barriers to improved efficiency of services, and to identify improvements which can make services both efficient and more oriented to the clients' needs.</p> <p>Expected Output:</p> <p>consultant report with revised prototype for self-assessment tool for use in COPE initiative with local service providers.</p> | <p>\$15,000 AID/Central</p> |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|--|
| Operations Research for clinical methods at five sites in Nigeria; grant given to UCH (NIR-25-OR-1-P) | This research project is designed to learn more about the impact of the provision of NORPLANT on delivery of other clinical family planning services, including sterilization. AVSC is supporting training for NORPLANT insertion and removal for doctors from 5 AVSC-supported VSC service sites in Nigeria. UNFPA is providing the implants. AVSC is supporting technical oversight of project by UCH staff, who are responsible for data collection from all five sites. Original grant was made in collaboration with Columbia University for the data collection. | \$85,000 Private funds (FY 1988 obligation, but major staff involvement in 1989) |

Expected outcomes:

10 doctor/nurse teams trained
in NORPLANT insertion
and removal
10 nurses trained in NORPLANT
counseling
Information to aid in the
delivery of NORPLANT in
other institutions in Nigeria and
Africa.

Ghana
FY 1989 Country Workplan

AVSC support in Ghana has focused on introduction of VSC at two teaching hospitals: Korle Bu Teaching Hospital in Accra, and Komfo Anokye Teaching Hospital in Kumasi. Both have received assistance for equipment and renovation of dedicated space for VSC, training for surgical teams in minilap and counselors in VSC counseling, and support for expendable supplies. Komfo Anokye hospital has fared well; services have expanded to the point where the hospital has established the capability for training other Ghanaian doctors and nurses in minilap. The hospital's success has also resulted in increased funding for the VSC program from the Ghanaian Government. The program at Korle Bu has not experienced the same success; the project director continues his preference for laparoscopy under general anesthesia, and there is a lack of commitment to the VSC program.

The Government of Ghana already supports the inclusion of VSC as a component of MCH/FP and the management of health services is well-coordinated by the Federal Ministry of Health. There is great potential for developing a coordinated VSC service program throughout country, thus, AVSC considers this a high priority country. In the short term, directions in Ghana will be geared toward strengthening the services provided at Komfo Anokye by ensuring continued provision of quality minilap services at the hospital, and continuing to train doctor/nurse teams in minilap and counselors in VSC counseling. This training will, it is hoped, result in the expansion of VSC services to five other Ministry of Health hospitals in Ghana. Komfo Anokye will be responsible for overseeing this expansion by assessing needs, providing training, and assuring medical quality at other VSC service sites in Ghana.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Improvement and expansion of VSC services in central Ghana through a grant to the School of Medical Sciences in Kumasi (GHA-02-SV-3-A) | This support will expand the activities at the School of Medical Sciences of Komfo Anokye Teaching Hospital (KATH) to include its establishment as a regional training center in minilap and counseling, and to improve the staff's ability to oversee the expansion and development of VSC activities in the country. Support will be provided for training and community outreach activities, and staff monitoring and technical assistance visits to other potential VSC sites. | \$60,000 AID/central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|----------------|
| Kumasi Teaching Hospital (continued) | Expected outputs: 300 female procedures 10 surgical teams trained in minilap 40 counselors trained 40 health workers informed about VSC | |

Zimbabwe
FY 1989 Country Workplan

Since independence in 1981, Zimbabwe has had a committed population policy with wide political support in the country. The Government considers high fertility a problem, and has introduced one of the most active family planning programs in sub-Saharan Africa. At the request of the Zimbabwe National Family Planning Council (ZNFPC), AVSC began assisting the Government in providing VSC services at two ZNFPC clinics in 1986. In a five-year development plan written in July 1988, ZNFPC has requested assistance from AVSC to establish VSC services in provincial and district centers around the country.

The short-term objective of the plan include assistance to establish VSC services in six new sites, develop the skills of service providers and establish in-country training in minilap under local and counseling at ZNFPC, and increase the awareness of government officials and health care providers concerning the health benefits of permanent contraception. The Government's interest in expanding VSC services results in part from the realization of the demand in the country for sterilization; the 1988 Zimbabwe Demographic Health Survey found that 33% of currently married women want no more children.

AVSC's strategy is to support the ZNFPC in this expansion with the ultimate outcome being the establishment of ZNFPC as a southern Africa regional training center, and the eventual institutionalization of VSC in all ZNFPC clinics.

AVSC is also collaborating directly with the Ministry of Health and the World Bank to provide VSC services at six health centers in three urban areas of Zimbabwe. This assistance will be funded by the World Bank. AVSC will be responsible with Bank funding for procuring and shipping equipment to the Ministry for distribution to the six sites which will begin to provide VSC services. Funding for training health providers from these sites will be provided for under the grant with the ZNFPC.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|-------------------------|
| Expansion of services at ZNFPC sites in Harare and Bulawayo (ZIM-01-SV-2-A) | Continued support to ZNFPC will consist of expendable supplies and educational materials, support for establishment of in-country training of doctors and counselors at the Harare clinic, and improvement of management of services so as to institutionalize VSC at ZNFPC sites. | \$60,000 AID/Central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|-------------------------|
| ZNFPC (continued) | Expected outputs: 400 female procedures 6 doctor/nurse teams trained in minilap 50 counselors trained | |
| Introduction of VSC services at six MOH sites in 3 urban areas in Zimbabwe | AVSC will procure and ship equipment to the MOH for distribution to 6 sites | \$110,000 World Bank |

**Anglophone Africa
FY 1989 Workplan**

AVSC involvement in Anglophone Africa is designed to introduce quality VSC services at select "model" sites, i.e., sites which serve a large family planning clientele, and have the potential for having the greatest impact on service delivery in the country. These are often Ministry of Health facilities and teaching hospitals, which have the potential for having the most leverage on others in the country. In addition to providing services at these sites, AVSC's assistance is intended to have a multiplier effect in that, within a few years of the introduction of VSC services, all will have developed a caseload and begin to provide training in minilap and VSC counseling to other family planning service providers in the country. In this way, AVSC hopes to contribute to the expansion and sustainability of VSC services throughout Anglophone Africa.

Under this strategy, Ethiopia, Liberia, Sierra Leone, Tanzania and Zambia are classified as medium effort countries as they are farther along the continuum of VSC services development and require more technical support. In these countries, future support is geared toward institutionalizing services by supporting in-country training, reducing per case subsidies, and improving the ability of site visit staff to manage the program and assure quality. This will require much AVSC technical assistance in order to improve the way services are delivered, to make them more efficient for the providers, and more convenient and oriented to clients' needs.

At new countries (Malawi, Gambia and Lesotho), these initial seeding efforts will be geared toward training new service providers in minilap and VSC counseling at the Family Planning Association of Kenya, and providing educational materials and support for educational activities to improve knowledge of VSC in the community.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|--------------------------|
| Expansion of services in MOH facilities through an agreement with the Family Guidance Association of Ethiopia (FGAE) (ETH-01-SV-2-A) | This support will expand services from four to eight Ministry of Health hospitals in Addis Ababa, and establish the ability for the FGAE to provide training in minilap and counseling for service providers in Ethiopia. Support is provided for training courses, information seminars for health workers, equipment and minor surgical supplies, and project oversight and management activities of FGAE staff. | \$54,000 AVSC private |

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| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|--|---|--|
| FGAE (continued) | <p>Expected outputs:</p> <p>2260 female procedures 10 surgical teams trained in minilap 30 nurses trained in counseling 76 health workers educated about VSC</p> | |
| Expansion of VSC services to five Liberian hospitals through a grant to JFK Hospital in Monrovia (LIR-01-SV-2-A) | <p>This support will expand VSC services from the current two sites in Monrovia to three other counties: Bomi, Lofa Nimba. Expansion will be assisted by the establishment of the ability of JFK to train teams from the new sites in minilaparotomy, and the ability of Phebe Hospital to train in VSC counseling. Assistance will also be given to improve the project director's and project coordinator's ability to conduct oversight management of the program in Liberia.</p> <p>Expected outcomes:</p> <p>500 female procedures 4 surgical teams trained in minilap 30 counselors trained</p> | <p>\$30,000 AID/Central</p> |
| Continued support to National Diamond Mining Company (NDMC) (SIL-04-SV-2-A) | <p>This support to NDMC will enable it to continue to provide sterilization to women at two hospitals in eastern Sierra Leone, and to begin to provide training for surgical teams in minilap. By training service providers from other Sierra Leone hospitals, it is hoped that VSC will expand to other institutions in the country.</p> <p>Expected outcomes</p> <p>250 female procedures 4 teams trained in minilap</p> | <p>\$49,000 AID/Central</p> |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|---------------------------------------|
| Expansion of VSC services in Tanzania through an agreement with UMATI (URT-02-SV-2-A) | <p>This program builds on the success of the previous pilot program with UMATI to establish services in Dar es Salaam at Muhimbili Medical Centre (MMC). AVSC will support MMC's ability to train doctor/nurse teams in minilap, and UMATI's ability to train counselors. MMC will continue to provide VSC services, and services will be expanded to three additional sites in Dar es Salaam. AVSC will support these services and training, as well as the activities of project staff to improve management of services and assure quality of care.</p> <p>Expected outputs:</p> <ul style="list-style-type: none"> 1500 female procedures 30 surgical teams trained in minilap 68 counselors trained 90 hospital and community members informed about VSC | \$47,000 AID/Tanzania bilateral |
| Support to the Fertility Management Centre at the University Teaching Hospital (UTH) (ZAM-01-SV-2-A) | <p>Continued support in the form of funds for training surgical teams in minilap, nurses in VSC counseling, information seminars for hospital and community leaders, and meetings to continue to update curricula to include VSC information, counseling, and training.</p> <p>Expected outputs:</p> <ul style="list-style-type: none"> 1500 female procedures 4 surgical teams trained in minilap 50 counselors trained 300 community and hospital leaders informed about VSC | \$75,000 AID/Central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Pilot project to introduce VSC services at three Private Hospital Association of Malawi (PHAM) (MLW-01-IE-1-A) | This project with is designed to introduce minilap under local at 3 mission hospitals in Malawi. Support includes funds for training one surgical team from each site in minilap and one counselor from each site in VSC counseling. Special emphasis in this project will be to improve the I&E on all family planning methods in Malawi through provision of I&E materials and by conducting information seminars for community members. Also, special attention will be given to work with the Howard University program which is currently responsible for training all family planning workers in Malawi. It is hoped that they will work with PHAM to integrate VSC into their family planning training curricula. | \$36,000 AID/Central |
| | Expected outcomes: 1175 female procedures | |
| Introduction of VSC services at Serre Kunde (GAM-01-SV-1-A) | This pilot program is designed to introduce VSC services in the Gambia through an agreement with Serre Kunde Hospital in Banjul. Assistance will be for minor equipment, training one doctor/nurse team in minilap and one counselor in VSC counseling. | \$8,000 AID/Central |
| | Expected outcomes: 200 female procedures | |
| Assistance to selected sites in Lesotho | Small grants will be provided to selected Ministry of Health sites in Lesotho as identified in conjunction with the World Bank. Initial discussions have suggested that AVSC may assist with training for a few service providers in order to begin introducing VSC services at a few government facilities. | \$4,000 AID/Central |

**Francophone Africa
FY 1989 Workplan**

AVSC's strategy in Francophone Africa is tempered with caution. In this difficult region with strong pronatalist predispositions, family planning services in many countries are still in their nascent stages. For these reasons, AVSC support is focusing on small-scale introduction in a few countries, trying to establish demonstration VSC projects in areas with high demand for family planning services. As with Anglophone Africa, all projects are designed with the intention to eventually establish a model site which will be capable of conducting in-country training in minilap and counseling, and will be able to oversee the expansion of future service sites in the country as considered necessary. In this grouping of countries, priority will be given to countries that are demonstrating the potential to serve as model service and training sites, e.g., Mali, Madagascar, Mauritius and Zaire. Countries which are still in the preliminary service introduction stage and which require less involvement include Burundi, Guinea, Rwanda and Senegal. Given the need in these countries, their ranking is expected to rise in future workplans.

In many Francophone countries, VSC is illegal unless performed for medical indications. Policy makers and health care providers are still wary about becoming involved in sterilization. For this reason, AVSC will support the participation of policy makers and hospital personnel from Francophone countries to Kenya to witness the successful VSC program at MOH, FPAK and CHAK hospitals. In countries where VSC is legal but relatively unknown, special efforts will be made to train health workers in information and education for VSC.

The greatest obstacle to establishing services in Francophone Africa has been the shortage of trained personnel. This is due to the lack of a training facility for Francophone doctors in minilap under local. For this reason, AVSC contracted with French-speaking doctors in Kenya to assist with training the first teams of doctors and nurses in minilap and counseling at FPAK in October, 1988. As a result of this training, services at sites in Mali, Madagascar, Mauritius, Guinea, Senegal, Burundi and Zaire have all begun to take off. Moreover, the trained teams from Madagascar, Mauritius and Mali have all been identified as capable of performing in-country training at their home institutions. The focus at these sites will be to improve access to services and increase the numbers of clients so as to establish the ability of these sites to serve as regional Francophone training sites.

In Burundi and Senegal, efforts will be made to continue to work with Ministry of Health institutions in the capital cities to improve their ability to provide VSC services. The pilot projects in Guinea, Rwanda, Cameroon and the Cote d'Ivoire will be designed to introduce VSC services at selected government hospitals through training additional health care providers, and improving VSC information and education activities.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|---|---|---|
| Support for two institutions in Madagascar: FISA and MHJRA (MAG-04-IE-3-A) (MAG-05-SV-2-A) | These two sites are complements to the family planning program in Madagascar. The grant with FISA will support the I&E activities which FISA conducts throughout Madagascar. The grant with MHJRA, the maternity hospital in the capital city, will support the provision of sterilization services in Antananarivo, and at two other hospitals in Madagascar. In addition, support will be given to enable FISA to train Francophone VSC counselors, and to enable MHJRA to conduct minilap training for Francophone doctor/nurse teams. | \$20,000 to FISA: AID/Central \$30,000 to MHJRA: AID/Central |
|---|---|---|

Expected outputs:

- 300 female procedures
- 3 surgical teams trained in minilap
- 12 counselors trained
- 20 health professionals educated about VSC

| | | |
|---|--|-------------------------|
| Continuation of services at Hamdallaye Hospital through a sub-agreement with AMPPF (MLI-01-SV-/-A) | AVSC support in Mali is directed toward working with the IPPF affiliate, AMPPF. AMPPF provides information on all family planning methods. Support to them will continue these efforts, while improving the attention given to VSC in those activities. Support will also be provided through this grant to Hamdallaye Hospital. The doctor is a committed VSC surgeon with excellent technical skills. It is hoped that once caseload at this site increases, it will become a VSC training site. | \$15,000 AID/Central |
|---|--|-------------------------|

Expected outcomes:

- 250 female procedures

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|----------------------------------|
| Pilot operations research project on acceptability of NORPLANT on other clinical services (MLI-02-OR-1-P) | AVSC is investigating the possibility of collaborating with the Population Council and AMPPF to introduce NORPLANT into AMPPF and their family planning program. Support will be providing for training in NORPLANT insertion and removal and NORPLANT counseling. Data collection and analysis of results will be the responsibility of the Population Council. | \$20,000 AVSC Private |
| Continued support to Mauritius Family Planning Association (MFPA) (MAR-02-SV-6-A) | AVSC will continue to work with the MFPA to provide sterilizations to men and women in Mauritius, and to improve the ability of MFPA to serve as a Francophone regional training center in minilap and counseling. Support will include funding consultants to assist with the training activities and other costs associated with training. Minimal support is necessary for the continuation of sterilization services, as VSC is virtually institutionalized in the MFPA program. | \$35,000 AID/Central |
| | Expected outcomes: 400 female procedures 50 male procedures 12 surgical teams trained in minilap 12 counselors trained | |
| Introduction of VSC services in selected Office National de la Population (ONAPO) (RWA-01-SV-1-A) | This first time venture by AVSC into Rwanda will focus on training surgical teams in minilap and counselors in counseling to be able to introduce VSC at three hospitals. Additional support will include minor surgical equipment and supplies, and training for health educators in VSC information and education. | \$40,000 AID/Rwanda bilateral |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|-------------------------|
| | Expected outcomes: | |
| | 600 female procedures | |
| Introduction of VSC services at selected private hospitals in Senegal | In conjunction with ISTI in Dakar, AVSC has identified potential private hospitals in Senegal which will receive small grants for training and minor surgical supplies to aid in the introduction of sterilization in the country. AVSC's only other program in Senegal at the moment is with Centre Sante Dominique-Pikine. This will be an attempt to expand VSC to other sites in the country. | \$45,000 AID/Central |
| Introduction of services at selected mission hospitals through a grant to SANRU (ZAI-08-SV-1-A) | AVSC's sole project in Zaire is with PSND, the provider of family planning services in urban centers. This project has faced numerous problems, and AVSC is looking to work with other organizations in Zaire who may be better able to oversee and manage a multisite VSC program in this large country. SANRU, the provider of family planning services in rural hospitals, received AVSC-donated equipment in 1985 for 10 rural hospitals. This project will follow-up with selected SANRU hospitals to assist in training service providers so as to begin offering VSC services. | \$50,000 AID/Central |
| | Expected outcomes: | |
| | 300 female procedures. | |
| Individual small grants to selected sites in Benin, Cote d'Ivoire, Togo, Guinea | These small grants will be used for seeding efforts such as training service providers, conducting observation tours to Kenya and provision of educational materials or minor equipment. | \$40,000 AID/Central |

**NORTH AFRICA AND THE MIDDLE EAST
FY 1989 REGIONAL STRATEGY AND WORKPLAN**

Background and Need:

AVSC has been working in the North Africa and Middle East during the last fifteen years to make voluntary surgical contraception services more acceptable and available in the region. The need for improving access to VSC is great, given the large numbers of high parity women who say they want no more children and the low sterilization prevalence in the region (with the exception of Tunisia). [See Tables 1.1 and 2.5 of the Strategic Plan.]

AVSC has had mixed success in this region, due mainly to obstacles of working in a context of varying degrees of religious (Islamic) and political opposition to sterilization, and the resulting lack of commitment from family planning leaders in many of the countries. Our early approach was somewhat cautious and conservative in that AVSC worked with medical leaders in semi-autonomous settings to establish laparoscopy programs in the context of "fertility care." While this worked in countries such as Tunisia and Morocco, where the health infrastructure and policy support were good, it failed to gain the expected toehold elsewhere, as in Egypt and Sudan.

As we gained both understanding of the situation in the various countries of the region, our approach has evolved to a diversified approach tailored to the individual countries: minilaparotomy under local anesthesia to enable the expansion of voluntary sterilization services beyond high-level facilities in those countries where it is politically feasible; long-lasting reversible methods (e.g., Norplant and the Copper T 380 A IUD) in countries where serious political obstacles to sterilization continue to exist; and vasectomy, wherever feasible, because we can no longer avoid the difficult task of promoting male responsibility for family planning in this male-dominated region.

Country Priorities:

Per AVSC's Strategic Plan (see Strategic Plan, Table 5.1) AVSC has decided to focus its efforts in two sets of six priority countries during the five-year cooperative agreement. The first set includes Morocco, Tunisia and Turkey (accounting for 32% of the total population in the region), where voluntary sterilization has been successfully introduced and where the focus will be on new, innovative program approaches to improve quality and access. We will be substantially involved in these countries, providing technical assistance and support working with new technologies (minilap, postpartum family planning, vasectomy, Norplant IUD's) and increasing acceptability of services through professional I&E and client education and counseling.

The second set is Egypt, Jordan, and North Yemen (30% of the regional total), which have not yet been successful, but which are important due to their size and/or political stature in the region. Our focus in these countries will be on introducing services, either sterilization or long-

acting reversible methods. We do not expect to commit a high degree of staff or financial resources in these countries, yet they remain important to our regional strategies.

Lower priority countries include Sudan and Algeria (12% of the regional total), where there remain many obstacles for program development. These countries will not figure prominently in AVSC's strategy, although we will respond to opportunities as they arise.

Regional Program Initiatives:

Given the emphasis on pilot service introductions and appropriate technology, AVSC's strategy focuses on two major interventions: training for the purpose of ensuring the quality of pilot, start-up efforts; and information and education -- for both health professionals and clients -- to remove obstacles to services resulting from misinformation about VSC.

Tunisia has been identified as a high priority for introducing minilaparotomy under local anesthesia, postpartum family planning services, Norplant and vasectomy so that we can use Tunisia as a regional springboard for introducing these technologies to other countries in the region. Thus, we will also work to develop Tunisia's capacity in the "new" technologies so it can serve as a regional training center.

In FY 1989, special regional initiatives in support of our strategy follow:

- o Conduct a regional training workshop in April 1989 for information and education personnel from AVSC-supported projects in English-speaking Arabic countries to provide skills in I&E and counseling.
- o Introduce safer, more appropriate technologies (e.g., minilap, outpatient interval and postpartum, local anesthesia) through a series of study tours for program officials (Jordan, Tunisia, Turkey) to programs outside the region (Kenya, Philippines).
- o Undertake first-time vasectomy initiatives (a) in Tunisia via a study tour to Brazil and (b) in Turkey via the conduct of an operations research study to determine effective I&E strategies for men.
- o Expand AVSC's experience with long-acting temporary contraception through the Norplant initiative in Tunisia, and an evaluation of IUD services in AVSC-supported VSC projects in Egypt.

Regional Management:

AVSC's regional office for North Africa and the Middle East based in Tunis, Tunisia oversees this relatively small yet complex portfolio with a small staff of two professionals. Technical medical oversight is provided by a long-term consultant physician based in Tunis. In FY 1989 AVSC will

fill the assistant director position (vacant since 1988) given that our inputs are becoming increasingly technical and additional programmatic depth is required.

Fiscal 1989 Resource Allocation:

Table NAME shows planned FY 1989 project obligations (dollars and numbers of projects) by country and source(s) of funds. The vast majority of funds (73%) is earmarked to the three high priority countries, Tunisia, Morocco and Turkey. This region uses the highest percentage of AID/Central resources relative to other fund sources (although the lowest in terms of actual dollars allocated) (see FY 1989 Workplan, Table 1.3). This is because there is no bilateral program in Turkey, and the bilateral program in Tunisia is phasing down. AVSC has been unable to obtain mission funding in Egypt, despite the large bilateral program there, due the political sensitivities concerning sterilization. Central AID funding will, therefore, remain critical to maintaining our presence in this region.

Table NAME: Planned Obligations (Dollars and Number of Projects)
in North Africa and the Middle East Region
by Country and Source of Funds, FY 1989

| <u>Country</u> | <u>Amount</u> | <u># of Projects</u> | <u>Fund Source</u> |
|-----------------------|--------------------|----------------------|--------------------|
| <u>High Effort:</u> | | | |
| Morocco | 465,000 | 2 | USAID/Morocco |
| Tunisia | 170,000 | 1 | AID/Central |
| | 30,000 | 1 | AVSC/private |
| Turkey | 181,750 | 6 | AID/Central |
| Regional ¹ | 46,500 | 1 | AID/Central |
| <u>Sub-total:</u> | <u>\$893,250</u> | <u>11</u> | |
| <u>Medium:</u> | | | |
| Egypt | 82,650 | 4 | AID/Central |
| Jordan | 85,000 | 3 | AID/Central |
| North Yemen | 45,000 | 1 | AID/Central |
| <u>Sub-total:</u> | <u>\$212,650</u> | <u>8</u> | |
| <u>Low:</u> | | | |
| Algeria | 29,500 | 2 | AID/Central |
| Sudan ² | 90,000 | 4 | AID/Central |
| <u>Sub-total:</u> | <u>\$119,500</u> | <u>6</u> | |
| <u>Total:</u> | <u>\$1,225,400</u> | <u>25</u> | |

¹ This regional project is described in the FY 1989 Tunisia workplan.

² AID funding was cut off to Sudan in 1989, thus a FY 1989 country workplan is not included. Funds will be re-programmed in FY 1990.

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Algeria
FY 1989 Country Workplan

Algeria is a relatively new country for AVSC involvement, with our first small grant of support in 1986. Only recently has the Algerian government indicated that the population is increasing too rapidly and there is the need to expand the practice of contracepting for spacing births. Because of the political sensitivity to VSC, AVSC's goal is to gradually introduce services within the context of family health.

Activities will be geared toward small-scale pilot service projects with select physicians in Ministry of Health hospitals. In FY 1989, this will involve "seeding" small grants for physician training and equipment provision, and an observation tour for MOH officials to promote a favorable policy dialogue regarding VSC.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Service introduction at Blida Teaching Hospital (ALG-05-TR-01-A-S and ALG-06-SV-1-A-S) | Two small grants for the refresher training of a physician in minilap and laparoscopy at the National Training for Reproductive Health Center in Morocco, and for basic minilap and laparoscopy equipment. | \$15,000 AID/Central |
| Observation Tour | An observation tour is planned in late 1989 for senior physicians from MOH facilities in the three main provinces of Algiers, Constantine and Blida. The tour will be of one or two successful programs within the region (Tunisia and Morocco). | \$14,500 AID/Central |
| | Expected output: | |
| | Increased commitment to introducing appropriate VSC services at these institutions. | |

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Egypt
FY 1989 Country Workplan

Following several years of large-scale involvement in the late seventies and early eighties to introduce VSC services in the leading medical universities under the aegis of the Egyptian Fertility Care Society AVSC scaled back its support due to a lack of impact relative to investment. However, Egypt remains a medium priority country due to the large unmet need for services and its political importance in the region. Therefore, AVSC maintains a small project portfolio with a few key institutions with committed leadership. This allows us to continuously reassess VSC program opportunities.

Because VSC remains politically sensitive, AVSC is in the process of exploring with USAID and others what its role could be in the introduction of long-acting reversible contraception in Egypt. In FY 1989, AVSC is supporting a study of IUD service delivery problems and client satisfaction/dissatisfaction in order to strengthen the provision of these services in AVSC-supported sites. And, AVSC will explore with USAID, the Family of the Future, and other organizations our plans to expand Norplant services once USFDA approval and Egyptian regulatory approval is received.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Continuation of VSC service and training activities in three institutions: Alexandria University (EGY-31-SV-3-A), Ain Shams University (EGY-32-SV-2-A) and Misr Company Hospital (EGY-33-SV-2-A) | AVSC will continue to support voluntary sterilization services and training for resident and other interested MOH physicians at these three institutions where past projects have been relatively productive and successful. In addition, AVSC will undertake an operations research component in each of these sites to assess IUD services. The results of the study will be used to improve the quality and access to temporary contraception services. | \$76,000 AID/Central |
| | Expected Outputs: | |
| | 1500 female sterilizations 8 physicians trainees Guidelines for improving the delivery of IUD services | |

| <u>FY 1989 Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|------------------------------------|---|------------------------|
| Assessment of AVSC's role in Egypt | An mini-assessment is planned by end of FY 1989 to assess the outlook for VS services and to identify what role, if any, AVSC should have with regard to Norplant introduction. Expected output: Revised country strategy | \$6,650 AID/Central |
|------------------------------------|---|------------------------|

Jordan
FY 1989 Country Workplan

AVSC has been working in Jordan since 1986 to increase the availability of VSC services in key institutions in Jordan. Prior to 1988, AVSC was involved minimally with small-scale "seeding" activities. However, the government adopted in 1988 a more favorable stance towards family planning, thus, AVSC has been working recently more extensively to develop the groundwork for a national service network in the country. The possibility for a national program exists in Jordan due to the creation in 1988 of the National Medical Institute (NMI), which has effective policy oversight for all public hospitals in the country.

Strategic initiatives for the FY 1989 (and 1990) include the development of in-country training capability in techniques for voluntary sterilization, and the improvement of information and education in support of VSC services. The results of the FP KAP survey conducted in 88-89 will be used to develop appropriate I and E materials for both clients and service providers. In addition, AVSC will inaugurate a policy dialogue with decision-makers through the conduct of observation tours of successful VSC projects, especially those employing simpler techniques, such as postpartum and interval minilaparotomy.

Future plans include the development of medical standards for national use and technical assistance in shifting from general anesthesia to lighter anesthesia regimens and the development of medical data collection and monitoring systems. The end goal will be to give the NMI the capacity to provide services and implement and supervise VSC service delivery.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|-------------------------|
| Continuation program to strengthen VSC service and training capacity at King Hussein Medical Center (JOR-05-SV-2-A) | King Hussein Medical Center is the premier teaching facility of the newly created National Medical Institute. This project supports the development of in-country physician training capacity in minilap, training for nurse-educators, and the development of I&E materials for clients. | \$20,000 AID/Central |
| | Expected Outputs: | |
| | 1 physician trainer trained | |
| | 2 physician trainers refresher trained | |
| | 3 nurses trained in I&E | |
| | 250 female procedures | |

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| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|---|---|-------------------------|
| Service Introduction at Al Basheer Hospital (JOR-06-SV-1-A) | This project supports the provision of services to low-income clients in Amman. The focus is on strengthening in-house training capacity in minilaparotomy, improving I&E skills of the project's educator and developing I&E materials for clients | \$59,000 AID/Central |
|---|---|-------------------------|

Expected Outputs:

1 physician trainer trained
1 nurse trained in
I&E materials (flip chart,
poster and all-methods
pamphlet)
200 female procedures

| | | |
|--|--|------------------------|
| Family Planning Education Workshop (small grant) | An orientation workshop for paramedical personnel on the role and health benefits of family planning and VSC to be held by the General Federation of Jordanian Women | \$6,000 AID/Central |
|--|--|------------------------|

Expected Outputs:

30 participants educated/oriented about VSC

| | | |
|---|--|---------------------------|
| Family Planning KAP Survey at Al Basheer Hospital (JOR-14-EV-1-A-S small grant) | A survey of 400 prenatal and 400 postpartum clients at Al Basheer Hospital to learn more about the knowledge of attitudes towards and practice of Jordarnian women viz-a-viz family planning, including voluntary sterilization. | \$7,500* (AID/Central) |
|---|--|---------------------------|

Expected Outputs:

Survey report on FP KAP among prenatal & postpartum clients at Al Basheer Hospital. The findings on this will be used to develop client-sensitive FP I&E materials in Jordan.

*Funded in 1988, but active staff involvement in FY 1989.

Morocco
FY 1989 Country Workplan

AVSC's program in Morocco is one of the most successful in the region. We have been working extensively since 1983 with the National Training Center for Reproductive Health (in cooperation with USAID/Morocco and JHPIEGO), a national and regional level training resource in family planning and voluntary sterilization. AVSC's strategy for the past several years has consisted of providing technical assistance via the NTCRH to its physician trainees to establish VSC services in their home institutions. This has resulted in the development of a nationwide service network covering 30 provincial health facilities through the country. The focus of AVSC's support since 1983 has been on developing service capacity in these provincial institutions through the provision of equipment to and quality supervision of trainees by NTCRH trainers.

A client follow-up survey was undertaken in 1988 (the results to be available in 1989) to assess client outreach channels and client satisfaction with services. A mid-term evaluation of the program was done by AVSC in 1988, which identified new directions that the program could take to improve quality and access, including adding postpartum minilap to the laparoscopic services now offered through the program and improving client education and outreach at the provincial level. Another major recommendation of the mid-term evaluation was to integrate the NTCRH's activities better with the Ministry of Health, since the NTCRH functions somewhat autonomously, even though it is a public sector institution.

AVSC's program in Morocco is supported by a buy-in from USAID, from a bilateral program that is about to end. A new buy-in is going to be negotiated early in 1990 for the next 3 to 5 years based on the recommendations of the above assessment and survey, and USAID/Rabat and cooperating agency strategy meeting to take place in early 1990. AVSC will participate in that meeting along with JHPIEGO and PCS.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|----------------------------|
| National Program for Reproductive Health (MOR-03-SV-4-A) | This project supports the delivery of VSC female services at 32 provincial hospitals in Morocco. Expected Outputs: 8,200 female procedures Medical supervision visits to 32 sites | \$415,000 USAID/Morocco |
| Information and Education workshop for NTCRH service sites | This proposed project would be a skills workshop on VSC client education and counseling for health education personnel from each of the 32 service | \$50,000 USAID/Morocco |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|----------------|
| NTCRH I and E workshop | sites involved in the NTCRH program. Expected Output: 32 educators trained | |
| Client follow-up survey (MOR-04-EV-1-A) | The goal of this project is to evaluate the quality of VSC services provided and the overall satisfaction with VSC from the client perspective, and to learn more about the formal and informal referral networks which exist for voluntary sterilization. Expected output: Completed survey report | \$22,892* |

* Funded in FY 1988, but active in FY 1989

Tunisia
FY 1989 Country Workplan

Introduction:

The goal of AVSC involvement in Tunisia is to assist the national family planning program, the Office National de al Famille et de la Population (ONFP), in maintaining the quality of voluntary sterilization services and to provide technical assistance in improving both quality and access of services to a broader segment of the population.

AVSC has supported ONFP with its voluntary sterilization service delivery since 1977, but this support has shifted from subsidization of services to identifying and responding to areas in which quality and access to services can be broadened. At the same time, overall level of grant funding diminished as AVSC technical assistance increased. In FY 1989 (and beyond) these will include introducing postpartum services, developing Norplant service and training capacity, and setting the stage for a vasectomy services introduction. The postpartum initiative is noteworthy in that it involves the provision of services in non-ONFP facilities belonging to the Ministry of Health, and thus, results in the expansion of services into another sector.

The ONFP program is very important in that it serves as a regional model and training site for other programs in the region. A priority activity for AVSC will be working on developing regional training capacity for postpartum minilap, vasectomy and Norplant, as there are no regional training sites yet identified to fulfill this need and Tunisia is farthest along.

| Name of Project | Description | Funding |
|---|--|----------------------------------|
| Continuation of ONFP's VSC national service program (TUN-11-SV-5-A) | <p>This project supports VSC service delivery at 20 sites, quality assurance through medical meetings and supervision, training in postpartum and interval minilap, efforts directed at involving men in family planning, including the development of an I&E campaign based on research conducted in the previous subagreement and training of vasectomy trainers</p> <p>Expected outputs:</p> <ul style="list-style-type: none"> 7,500 female procedures 100 male procedures 15 doctor/nurse OR teams trained in minilap 10 male educators trained | <p>\$170,000 AID/Central</p> |

Old document

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|--------------------------|
| Expansion of Norplant Services in Tunisia (TUN-12-SV-3-A) | <p>This will be the third year of an effort to gradually expand Norplant to select ONFP centers via the training of I&E and counseling personnel, the training of physician providers in Norplant insertion and removal and the reproduction of Norplant materials developed in the first program year.</p> <p>Expected outputs:</p> <p>2,000 clients served 10 physicians trained 10 additional educators trained</p> | \$30,000 AVSC private |
| Regional Workshop on I&E (NAF-02-TR-1-A) | <p>This project supports a second skills development workshop for education personnel in AVSC-supported projects from French-speaking countries, the first one having been supported in FY 1988 for English-speaking Arabic countries.</p> <p>Expected output:</p> <p>25 educators trained (some of whom will be trainers)</p> | \$40,000 AID/Central |

Turkey
FY 1989 Country Workplan

Despite its legalization in 1983, voluntary sterilization has yet to be a widely available method of contraception in Turkey. Previous efforts to introduce VSC services via laparoscopy equipment and training have not been successful. AVSC resumed involvement in Turkey in 1986 with private funds because of a conservative stance on the part of the US Embassy concerning sterilization activities. This stance has changed and AID funding can now be used.

Following the successful initiation of a pilot minilaparotomy service program at Ankara Maternity Hospital AVSC expanded to eight additional MOSHA facilities and began work with the Turkish Social Security Institute. A basic element of these programs is improving VSC education for health providers through orientation workshops and by incorporating sterilization into training curricula at medical universities. Another element in AVSC's current strategy is to begin low-key exploration of vasectomy service introduction through research and pilot service activities.

Thus far, AVSC-funded projects and activities support early-stage VSC services introduction by working mainly with public sector initiatives. While the policy framework is very supportive, services have, nevertheless, not expanded as hoped to meet the needs. It is not evident yet what the obstacles are.

Thus, in FY 1989, an assessment is planned to take stock of initial programmatic efforts and to develop a strategy for the further expansion of services through the Ministry of Health and other sectors. Turkey is likely to be a country with substantial AVSC involvement for the next several years with a view towards developing the capacity of the major public sector institutions to deliver and supervise services on their own and to provide medical and I&E/counseling training.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|-------------------------|
| VSC services at 8 provincial MOSHA facilities (TUR-10-SV-3-A) | This is an expanded continuation project which aims to strengthen VSC services, particularly mini-laparotomy, through training and I&E skills and materials development. In addition, a vasectomy service component will be introduced at Numune Hospital. | \$40,000 AID/Central |
| | Expected output: | |
| | 12 doctors trained in minilap | |
| | 1 doctor trained in vasectomy | |
| | 4 I&E workshops, 20 participants ea., one on vasectomy | |
| | 2,000 female and 100 male procedures | |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|-------------------------|
| VSC program at Sosyal Sigortalar Kurumu (Social Security Institute) (TUR-11-IE-1-A) | <p>Activities under this project will enable the SSK to reorganize and upgrade its service delivery capacity, and to provide better information and education regarding VSC and other methods. This will be done through a study tour of outpatient VSC services for senior Ob/Gyn staff, through training of physicians at key provincial SSK facilities, and through an I&E workshop for paramedical staff from 12 provinces.</p> <p>Expected outputs:</p> <p>4 ob/gyn's trained in minilap 24 paramedical staff trained in I&E 2 senior ob/gyns oriented to outpatient service delivery overseas</p> | \$25,000 AID/Central |
| Operations research for an effective I&E initiative, Hacettepe University (TUR-12-EV-2-A) | <p>This supports the completion of a two-year research project begun in 1988 to facilitate the VSC service introduction by identifying an effective I&E approach. This project will establish baseline KAP in Etimesgut, a suburb of Ankara, followed by OR to test and evaluate different I&E and outreach interventions.</p> <p>Expected outputs:</p> <p>Evaluation report for use in design of I&E programs in Turkey</p> | \$5,000 AID/Central |
| VSC Curriculum Development Workshop (TUR-13-IE-1-A) | <p>This project will review the VSC training curricula of Ob/Gyn departments of major medical universities, to be followed by a workshop to identify weaknesses and a common approach to incorporating VSC into routine resident training.</p> <p>Expected output:</p> <p>a model VSC training curricula</p> | \$25,000 AID/Central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|--------------------------------|
| Turkish Family Health and Planning Foundation (TFHPF) | A tentative project to integrate VSC service delivery into the clinical family planning activities of the TFHPF at 2 sites in Istanbul. This would be AVSC's first private sector activity in Turkey. | \$50,000 (est.) AID/Central |
| Needs Assessment | A team evaluation to refine AVSC's strategy for the next 3 to 5 years (Feb 1990) Expected Output: new strategy | \$24,750 AID/Central |
| Translation of World Fed Safety Guidelines | An in-house project to translate and produce a Turkish version of the World Federation's <u>Safe and Voluntary Surgical Contraception</u> (Singapore version) for use in service programs in Turkey | \$12,000 AID/Central |

Yemen Arab Republic (North Yemen)
 FY 1989 Workplan

AVSC's strategy in North Yemen is to reinforce awareness of family planning and VSC as a means to safeguarding maternal and child health. While the government has not promulgated an official family planning policy, it has named the Yemen Family Care Association (YFCA) as the designated agency for education and promotion of family planning in the country. A 1985 survey by the Ministry of Health reported a large unmet demand for permanent contraception.

AVSC is not now nor does it expect to be extensively involved in this country; however, we will continue to work on a small scale with carefully selected activities to improve education and access to services in the country. Through our involvement with the YFCA, we expect to strengthen service and outreach capacity in key facilities in the country by instituting both minilaparotomy and information, education and counseling training capability in the national medical training programs.

| Name of Project | Description | Funding |
|---|---|-------------------------|
| YFCA service delivery program (YEM-03-SV-1-A) | The current project supports the introduction of VSC services and education at 3 sites: Al Thawrah, Al Sabein and Djibla Hospitals, with expansion to the Taizz and Hoddeida governorates in FY 1990. | \$45,000 AID/Central |
| | Expected outputs: | |
| | 400 female procedures 25 health educators trained 2 MD/RN teams trained in minilap/local & vasectomy at Jose Fabella Hospital in Manila. | |

**LATIN AMERICA AND THE CARIBBEAN
FY 1989 REGIONAL STRATEGY AND WORKPLAN**

Background and Need:

At the time AVSC began its work in the Latin America and Caribbean region in the mid-seventies, sterilization was a little known and little used method of family planning. Religious and political opposition to sterilization was high, and in several countries, notably Brazil, Colombia and Mexico, it was necessary to start up programs using non-AID funding. Our early strategy emphasized support for the establishment of service capacity, e.g., equipping and renovating surgical facilities, training physicians, and subsidizing services. Our main partners in most countries, with the exception of Mexico, were the International Planned Parenthood Federation (IPPF) affiliates, as governments were opposed to or wary of involvement with sterilization services. Today, in the sixteen countries where AVSC is working,¹ sterilization is the leading method in eight, and is gaining in several others.

Despite these positive changes, there are still many issues facing VSC programs in Latin America today:

o There are still several countries where family planning programs are nascent and are not yet reaching those who want and need services, e.g., Bolivia, Haiti, Peru and Paraguay. The obstacles to service delivery are similar to those in other underserved regions, such as poor infrastructure and lack of political commitment to family planning, in general, and sterilization, in particular.

o In many countries, the public sector continues its reluctance to providing voluntary sterilization services, and private voluntary organizations, especially the IPPF affiliates, still bear much of the responsibility for providing services. Today, in many countries, (e.g., Colombia, Dominican Republic, Guatemala and Honduras), the IPPF affiliates are the major family planning service providers, although most are highly dependent on outside donors and cannot hope to meeting the growing demand for services on their own. Both of these factors affect the prospects for sustainability of VSC services in the region.

o Except for a few successful pilot programs (PRO-PATER in Brazil and PROFAMILIA's all-male clinics in Colombia), services for men are lacking throughout the region. Much more needs to be done to study how best to promote and deliver services in appropriate and cost-effective ways so as to improve the availability and acceptance of this method.

o There are quality issues that still need to be addressed even in the well-established programs. Despite the fact that minilaparotomy under

¹ This total does not include Argentina, Chile, Uruguay or Venezuela, as AVSC involvement is just beginning in these countries.

local anesthesia is the most appropriate method for services provided immediate postpartum, in public and in basic health facilities, Latin American family planning programs have historically emphasized laparoscopy. There are no model minilap service or training sites, a factor which has been a major constraint to expanding services. Moreover, more needs to be done to develop effective medical oversight and monitoring systems in large, multisite programs.

o Regarding informed choice, although much has been done to develop counseling capacity in AVSC-supported services, much more needs to be done to institutionalize counseling as a routine component of VSC programs. This is especially important in the countries where sterilization prevalence is high (Dominican Republic, El Salvador) and effective access to temporary methods needs strengthening.

Country Priorities:

Not all countries will receive the same level of attention and priority. For example, we expect to expend intensive staff effort (if not funds) in Bolivia and Peru, to nurture the nascent programs there. The Dominican Republic and Ecuador (the latter with private funds) will also be high priority because they are the best prospects for serving as regional training sites for minilaparotomy. Colombia will also be a high priority, for public sector programming and for model vasectomy services.

Brazil and Mexico, two important countries, are classified as medium priority as we attempt to phase down our support of long-standing private sector organizations in order to work on smaller-scale, but potentially high-impact, efforts with the public sector. Mexico, in particular, remains important because of its experience in providing postpartum contraception services in the public sector.

Haiti and Jamaica are also interesting examples of medium-effort countries, as AVSC is providing technical assistance (as opposed to direct program support) for voluntary sterilization services being underwritten by large bilateral projects.

Classified as low effort countries are the Central American countries of El Salvador, Guatemala and Honduras, where AVSC's role has changed as funding responsibility has shifted to the USAID missions. There are, nevertheless, significant quality and access issues to be addressed, as AVSC assessments have suggested; however, the USAID missions in these countries have not been as open to AVSC's technical assistance role as, for example, in Haiti and Jamaica.

Regional Program Initiatives:

To meet the many needs outlined above, AVSC has shifted its strategy towards involvement with the public sector. In recent years, political opposition to sterilization has become less strong, and the door is opening

for AVSC collaboration with government family planning programs in many countries. We see working with the public sector, particularly in the area of postpartum contraception programming, as the strategy with the greatest potential for achieving an impact on the institutionalization of VSC services in the region.

Emphasizing the public sector does not mean that AVSC will ignore the important role of the private sector in Latin America. The private sector still has an important service demonstration role to play, particularly in the promotion of vasectomy and male responsibility for family planning. Encouraging sustainability of these organizations will be an overriding theme of our activities with the private sector.

In FY 1989, regional priorities and activities in support of our strategy follow:

- o To support pilot postpartum service projects in public sector facilities. Because postpartum contraception has not been focused on a specific programmatic intervention since the early seventies, AVSC's global postpartum initiative is important to learning how best to offer services in this milieu.

Additionally, to help identify the needs of these programs, AVSC held in September 1989 a regional workshop on postpartum contraception issues. It was held in Mexico in conjunction with the Instituto Mexicana de Seguro Social, the institution with the most experience in postpartum programming in the region (and one of the only institutions in the world providing postplacental IUD's). The meeting identified areas which require further attention by AVSC, including meeting the special counseling needs of postpartum clients, adding other options to postpartum sterilization services, and developing training and service requirements specific to postpartum programs, particularly with respect to the postpartum IUD insertion.

- o Related to the above activities, provide intensive technical assistance to potential training and demonstration service sites for postpartum minilaparotomy (Dominican Republic, Ecuador). By the end of FY 1989, AVSC will have certified at least one institution as a training site for the region.

- o To promote male responsibility for family planning and vasectomy by introducing the no-scalpel technique through the training of master trainers (Brazil, Colombia, Guatemala, Mexico) and by supporting services in conjunction with operations research on effective I&E and service strategies (Colombia, Mexico).

- o To promote sustainability (a) by providing technical assistance in cost-recovery initiatives (e.g., PRO-PATER and ABEPF in Brazil) and (b) by conducting case studies that examine the trade-offs between donor agency policies promoting sustainability and those promoting access to services for those who cannot afford them (Brazil, Colombia, Dominican Republic and Mexico). This study is being supported through a buy-in from the Office of

Population's Policy and Program Coordination Bureau. Latin American institutions were chosen for study as they are facing the constraints of reduced funding as much as, if not more acutely than, other regions. The case studies will be completed in December 1989, and the results will be used to develop a prospective, controlled study of the effects of cost recovery interventions on maintaining access to quality care.

Regional Management:

AVSC's Latin America/Caribbean regional office is located in Bogota, Colombia and is staffed by four professionals. In FY 1989, given the important medical, technical, and training needs inherent in our public sector and postpartum strategic emphasis, a part-time (50%, based in the Dominican Republic) regional medical advisor has been added to regional staff.

Fiscal FY 1989 Resource Allocation:

Table LAC shows planned FY 1989 project obligations (dollars and numbers of projects) by country and source(s) of funds. AVSC plans to obligate a total of \$1,886,600 for 34 projects in 15 countries. This represents 27% of the total allocation for projects (all fund sources). Just over 50% of the total funds allocated are for projects in high effort countries. This is because in some of the high priority countries (Bolivia and Peru), we are still working with small, pilot service projects that do not have high absorptive capacity for funds. Also, Brazil and Mexico, although medium priority, still require relatively large amounts of central AID/funding. Latin America also accounts for the highest percentage of AID/Central resources (57%), given that three of the largest countries in the region, Brazil, Colombia and Mexico, have no bilateral resources.

2

**Table LAC: Planned Obligations (Dollars and Number of Projects)
in Latin America and the Caribbean
by Country and Source of Funds, FY 1989**

| <u>Country</u> | <u>Amount</u> | <u># of Projects</u> | <u>Fund Source</u> |
|---------------------|--------------------|----------------------|-----------------------|
| <u>HIGH EFFORT:</u> | | | |
| Bolivia | 52,000 | 2 | AID/Central |
| Colombia | 258,000 | 5 | AID/Central |
| Dominican Republic | 395,000 | 2 | USAID/DR ¹ |
| Ecuador | 106,900 | 2 | AVSC/private |
| Peru | 151,200 | 4 | AID/Central |
| <u>Sub-total:</u> | <u>\$963,100</u> | <u>15</u> | |
| <u>MEDIUM:</u> | | | |
| Brazil | 348,000 | 3 | AID/Central |
| Costa Rica | 25,000 | 1 | AVSC/private |
| Haiti | 20,000 | 1 | AID/Central |
| Jamaica | 151,900 | 2 | USAID/Jamaica |
| Mexico | 153,000 | 5 | AID/Central |
| Nicaragua | 81,300 | 1 | AVSC/private |
| Paraguay | 52,700 | 2 | AID/Central |
| <u>Sub-total:</u> | <u>\$831,900</u> | <u>15</u> | |
| <u>LOW:</u> | | | |
| Argentina | 37,500 | 2 | AVSC/Private |
| El Salvador | 44,100 | 1 | AID/Central |
| Venezuela | 10,000 | 1 | AVSC/Private |
| <u>Sub-total:</u> | <u>\$91,600</u> | <u>4</u> | |
| <u>TOTAL:</u> | <u>\$1,886,600</u> | <u>34</u> | |

¹ Approximately \$80,000 of the total allocation for the Dominican Republic is from AID/Central funds.

Peru, Bolivia and Paraguay FY 1989 Workplan

These countries are characterized by restrictive policies governing the availability of sterilization, and in some cases, other contraceptive methods. While sterilization has been available to clients who can afford fees in the private for-profit sector, it has not been included in government family planning programs, where these exist. As a result, access to sterilization services has been very limited.

There is significant unmet demand for contraception; for example, according to the most recent contraceptive prevalence survey findings, in Bolivia and Peru, 74% and 60% respectively, of married women of reproductive age, do not want any more children but are not contracepting.

What these countries have in common is a need to make safe and voluntary surgical contraception available, and the present existence of opportunities in public sector hospitals to introduce sterilization services for high risk women. In all three countries, a reproductive risk approach is being adopted to acquaint health professionals with the health rationale for family planning, and to assist in screening clients for whom an unintended pregnancy poses risks. As there are many high parous and older women giving birth, in Peru, Bolivia and Paraguay, the provision of family planning methods, including sterilization, is an important preventative health measure, and is sanctioned.

Because of the high level of need that exists, Peru and Bolivia are high priority for AVSC involvement. Paraguay is considered medium priority because, although prevalence is low, the climate for family planning is becoming more favorable and less technical assistance is required than the other countries.

AVSC's major emphasis is with the key maternity hospitals to make postpartum surgical contraception services available to high risk women. AVSC is also supporting pilot interval VSC services in key private voluntary family planning organizations in Peru and Paraguay as a parallel effort to promote access to services. (AVSC continues to explore opportunities for private program development in Bolivia.)

Towards this end, FY 1989 activities include the development and dissemination of norms for VSC, professional education on the reproductive risk approach, training in surgical, anesthesia and counseling techniques, and the provision of necessary equipment and supplies to initiate service delivery. Technical assistance by AVSC staff and consultants is a major feature of the project plans, since it is critical in the initial phase of service start-up.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|--------------------------------------|
| Instituto Marcelino (PER-14-SV-1-) | The current subagreement supports the initiation of sterilization services for high-risk low-income women in downtown Lima; and includes counselor training, provision of equipment and partial support for services. Expected outputs: service and counseling capacity established 200 female procedures | \$17,750 ¹ AID/Central |
| PROFAMILIA, Cusco (PER-15-SV-2-A) | Support will continue for minilaparotomy services in a very underserved area. The high quality of the surgical technique make this a potential training site. Support will subsidize services, and renovate the clinic, to meet unmet demand. Expected Outputs: expanded service capacity 600 female procedures | \$21,700 AID/Central |
| Instituto Peruano Paternidad Responsable (INPPARES) (PER-16-SV-2-A) | Support will continue to expand availability of female VSC for women at reproductive risk in three sites in Peru: Lima, Chiclayo, and Iquitos. Technical assistance and other activities, including training in no-scalpel vasectomy, will also be undertaken to expand vasectomy services in Lima. Expected Outputs: VSC services initiated in Chiclayo, Iquitos 1600 female and 100 male procedures establishment of medical supervision system for clinic services | \$57,800 AID/Central |

¹ FY 1988 obligation; FY obligation is estimated to be \$15,000.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|-------------------------|
| Maternidad de Lima PER-17-SV-1-A | Initiation of postpartum VSC services and family planning counseling in Peru's largest maternity facility. Support will be provided for physician, nurse and counselor training; professional education regarding the reproductive risk approach and medical safety; provision of equipment and necessary supplies; and technical assistance inputs. | \$56,700 AID/Central |
| | Expected Outputs: | |
| | 3 MD/RN teams trained in postpartum minilap | |
| | 2 counselors trained | |
| | workshop on medical safety for medical staff | |
| | workshop for educational staff on family planning education | |
| | 3 orientations for hospital personnel | |
| | 1200 female procedures | |
| Maternidad Germain Urquidi, Cochabamba (BOL-08-SV-1-A) | Postpartum VSC services at main maternity hospital will be initiated through support for professional education in reproductive risk; physician, nurse and counselor training; technical assistance; provision of needed equipment; and partial support for services. | \$24,000 AID/Central |
| | Expected Outputs: | |
| | 2 MD's and 1 RN trained in minilap | |
| | 1 counselor trained | |
| | 400 female procedures | |
| | 30 MD's oriented to reproductive risk | |
| Maternidad Percy Boland, Santa Cruz (BOL-09-SV-1-A) | Postpartum VSC services at main maternity hospital will be initiated through support for professional education in reproductive risk; physician, nurse and counselor training; technical assistance; provision of needed equipment; and partial support for services. | \$28,000 AID/Central |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|----------------------------------|
| Maternidad Percy Boland (continued) | <p>Expected Outputs:</p> <p>2 MD's and 1 RN trained in minilap 1 counselor trained service capacity established and hospital staff oriented to VSC</p> | |
| Maternidad de Asuncion (AR-03-SV-2-A) | <p>This subagreement will continue and expand VSC service delivery for high-risk women by increasing and improving the surgical and recovery areas, and continuing medical training.</p> <p>Expected Outputs:</p> <p>10 residents trained 350 female procedures workshop on reproductive risk</p> | <p>\$14,100 AID/Central</p> |
| Centro Paraguayo de Estudios de Poblacion de Poblacion (CEPEP) (PAR-04-SV-2-A) | <p>Support will enable continued provision of interval procedures via laparoscopy at the Clinica de la Mujer in Asuncion, and counseling for all VSC requestors.</p> <p>Expected Outputs:</p> <p>950 female procedures</p> | <p>\$38,600 AID/Central</p> |

Colombia
FY 1989 Workplan

AVSC has provided support to Colombia for work in voluntary surgical contraception since 1972. The main recipient of this support has always been PROFAMILIA, the country's major VSC provider, which has received around 94% of the total amount allocated to Colombia. However, over the last few years, AVSC strategy for Colombia has evolved to focus more on the support of services in the public sector. Though AVSC continues to provide some modest support to PROFAMILIA to pioneer new initiatives and address quality concerns, the shift in emphasis toward the public sector represents an important step toward institutionalizing VSC services throughout the country, especially as financial resources for Latin America become more limited.

AVSC currently has four programs with public sector institutions in Colombia: the Instituto Metropolitano de Salud (METROSALUD), the Servicio Seccional de Salud de Antioquia (SSA), the Hospital General de Medellin, and the Instituto Materno Infantil in Bogota. The AVSC country strategy for Colombia emphasizes the importance of working with the public sector as a key to improving and increasing access to VSC services. Data from the 1986 CPS from Colombia shows that only 16.6% of all sterilizations are provided through the public sector which indicates a very heavy reliance on private sector services for VSC (83.2%).

In 1984, Colombian public sector institutions sharply curtailed their involvement in family planning following sustained attacks against this program by the Church and other opposing groups. PROFAMILIA has been able to fill some of the void in family planning, but not all, because it serves different populations than the public sector (e.g. PROFAMILIA serves only interval clients and does not cover all areas of the country). Moreover, in an era of diminishing international resources for family planning activities in Latin America, there is no assurance that PROFAMILIA will be able to continue to carry the primary responsibility for providing family planning in Colombia in the future. For this reason, and the fact that the more open political/religious environment makes it possible, AVSC is concentrating support in public sector institutions. In each case, programs are being supported in major public sector hospitals where services are being offered to postpartum clients, a sector of the population not served by PROFAMILIA.

PROFAMILIA is the only institution currently providing vasectomy services. AVSC's current subagreement with PROFAMILIA focuses on vasectomy services at the three male-only clinics that have been established in Bogota, Medellin, and Cali. These clinics have been extremely successful and are a strong indication that Colombian men will seek family planning services when they are offered to them.

Four PROFAMILIA surgeons were trained in no-scalpel vasectomy in September 1988 and have subsequently adopted the technique. During this fiscal year two PROFAMILIA physicians were certified as no-scalpel trainers. AVSC plans to use PROFAMILIA as a no-scalpel vasectomy training site as programming for the regional dissemination of this technique moves forward.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|-------------------------|
| PROFAMILIA (COL-22-SV-1-A) | Support is to help improve capability to provide high-quality vasectomy services as well to promote awareness among the men about this contraceptive option and ensure its availability and accessibility. Continued support will be provided to the initial male-only clinics and expansion of male services to additional PROFAMILIA clinics. Vasectomies will be performed using the no-scalpel technique. Funds will also be provided for the development and implementation of a vasectomy awareness campaign. | \$155,000 AID/Centra |
| | Expected Outputs: | |
| | Initiation of vasectomy services in four additional PROFAMILIA clinics | |
| | Establishment of PROFAMILIA as a no-scalpel vasectomy training center | |
| | 4 MD's from expansion clinics trained in no-scalpel vasectomy technique | |
| | Orientation workshop for personnel from expansion clinics | |
| | Implementation of medical quality supervision system | |
| | 5,600 vasectomy procedures | |
| Instituto Materno Infantil (COL-21-SV-1-A) | The objectives of this first time support is to reactivate VSC services at the Instituto through postpartum and interval minilaparotomy and interval laparoscopy under local anesthesia and sedation; to train medical and paramedical personnel in these techniques as well as in counseling; and to provide the surgical and education equipment necessary for the delivery of VSC services. | \$35,400 AID/Centra |
| | Expected Outputs: | |
| | I and E workshop for 70 participants | |
| | 1 counselor trained | |
| | 2 MD's sent to workshop on contraceptive advances | |
| | 3 project personnel oriented to established VSC programs in region | |
| | 1,500 female procedures | |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|-------------------------|
| Hospital General de Medellin (COL-20-SV-1-A) | This project supports pilot postpartum services, including IUD insertion and minilaparotomy under local anesthesia and sedation, and seeks to establish the hospital as a demonstration center for other major hospitals in the area and throughout the country. Expected Outputs: 120 hospital personnel oriented to VSC Medical safety seminar for 50 MD's and nurses Asepsis seminar for 60 MD's and nurses Development of I&E and counseling program 1,600 female sterilization procedures 2,600 postpartum IUD's inserted | \$28,500 AID/Central |
| METROSALUD (COL-18-SV-1-A) | This project supports VSC services at Castilla Hospital, a municipal facility in Medellin and the start-up of minilaparotomy services in three additional METROSALUD hospitals. Project personnel will be trained in I and E and counseling, and educational materials will be developed. Expected Outputs: I and E workshop for 20 participants MD's trained in minilaparotomy and local anesthesia at three new sites Initiation of services at three new sites 1,200 female procedures | \$15,400 AID/Central |
| Secretaria de Salud (SSA), Medellin (COL-17-SV-1-A) | The objectives for this program are to extend VSC services to additional regional hospitals in the Department of Antioquia; to strengthen the program through community level I and E activities and to develop counseling capacity. Expected Outputs: I and E workshop for 20 participants MD's trained in minilaparotomy and local anesthesia at five new sites Initiation of services at five new sites Implementation of medical supervision system 1,500 female procedures | \$23,730 AID/Central |

**Dominican Republic
FY 1989 Workplan**

The Dominican Republic has one of the highest sterilization prevalence rates in the hemisphere (33% of married women of reproductive age are sterilized per the 1986 GPS), and a well developed sterilization service program. Because services are relatively available and accessible to the population, AVSC efforts in recent years have been directed to efforts to improve medical quality and informed choice. Emphasis has been given to strengthening medical supervision, paramedical training, as well as counselor training, physician training in IUD and Norplant insertion, and other activities designed to ensure effective access to other contraceptive methods as well as sterilization.

Despite the prominent status that VSC enjoys in the Dominican Republic, AVSC continues to accord the country high priority attention because of its potential to serve as a regional training site for postpartum minilaparotomy. Moreover, the Dominican Republic serves as a crucible for many of AVSC's initiatives, such as sustainability of private sector services, integrating clinical contraceptives with sterilization, introduction of vasectomy, and integration of postpartum services within maternity settings.

Recent support in the Dominican Republic has focused on the private service delivery network, via PROFAMILIA, the IPPF affiliate, because of a ban on funding the public sector family planning program under the Consejo Nacional de Poblacion y la Familia (CONAPOFA) by USAID/D.R.

AVSC is working with PROFAMILIA to increase the self-sufficiency of the private physician network. However, an opportunity now exists to reinvigorate VSC services and training at the largest maternity hospital in the country, which has great potential as a regional training center. Its strengths in the areas of surgical and anesthesia technique, service delivery via private physicians, and medical supervision and surveillance systems make the Dominican Republic programs important demonstration projects for others in the region.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|-------------------------------|---|------------------------------------|
| PROFAMILIA (DOM-09-SV-2-A) | Support is geared to increasing the self-sufficiency and cost-effectiveness of sterilization service sites in the PROFAMILIA network and to improving quality. To this end, medical norms will be revised and supervision will be | \$180,000 ¹ USAID/DR |

¹ Approximately \$80,000 of the FY 1989 allocation for PROFAMILIA is from AID/Central funds.

| Name of Project | Description | Funding |
|---|---|---|
| | <p>ongoing. Modest service subsidies or expendable supplies will be provided to ensure access to low-income requestors. Training of MD's in Norplant and IUD will help improve access to a range of contraceptives and PROFAMILIA's newly established clinic in Santo Domingo will be developed as a VSC training center.</p> <p>Expected Outputs:</p> <p>2 MD/RN teams trained in IUD/Norplant 16,430 male and female procedures at 27 service sites</p> | |
| <p>Maternidad Nuestra Senora de la Altagracia (DOM-10-SV-1-A)</p> | <p>To develop training capacity at the Maternidad through support for training, professional education, equipment and technical assistance.</p> <p>Expected Outputs:</p> <p>2 workshops on paramedic aspects of VSC delivery and on medical safety 20 counselors trained 2 MD's trained in post-partum IUD 4,800 female sterilizations and 2,000 IUD's</p> | <p>\$215,000 (to be provided by USAID/DR)</p> |

Ecuador
FY 1989 Workplan

One of the pressing needs in the Latin American region is training capacity in minilaparotomy under local anesthesia. AVSC's main public sector counterpart in Ecuador, the Maternidad Enrique Sotomayor, has been identified as a potential regional training site because it has good surgical and anesthesia techniques, sufficient caseload and other prerequisites for effective training. In FY 1989, AVSC will give high priority to Ecuador for technical assistance in the development of regional training capacity.

Ecuador also presents a good regional model, particularly for other Andean countries where government involvement in family planning has been limited. AVSC supports with its private funds the Maternidad Enrique Sotomayor in Guayaquil, which is a pioneer in providing VSC services, and APROFE, the IPPF affiliate which has three VSC service delivery sites in Ecuador. APROFE is considered a regional resource in counseling as well. Because of the high quality of medical care, and of client counseling, these institutions are well suited to training, and serving as demonstration centers for the region.

Although local Mission policy bars the funding of sterilization services with AID funds, the Mission has agreed to allow in-country training, which is critical to meet regional needs for good training.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|--------------------------|
| Asociacion ProFamilia Ecuatoriana (APROFE) (ECU-04-SV-4-P) | The purpose of AVSC support is to continue service delivery in Quito and Guayaquil and to expand services in a third city, Machala. In addition, vasectomy services will be initiated in Quito and Guayaquil and a medical supervision system will be started since 3 clinics now offer services. | \$63,400 AVSC private |
| | Expected Outputs: | |
| | 2,800 female and 200 male procedures medical supervision system established at new site, Machala | |

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Name of Project Description Funding

Maternidad Enrique
Sotomayor
(ECU-05-TR-1-P)

The propose of this support is to \$43,500 develop the hospital as a regional AVSC private training center. Technical assistance will be provided to develop a model training curricula, improve post-operative monitoring practices, and upgrade the recovery area.

Expected Outputs:

Training curricula developed
24 MD's trained in minilap
5,000 female procedures
Recovery room improved



**Brazil
FY 1989 Workplan**

AVSC has been working in Brazil since the mid-seventies to improve the accessibility and quality of voluntary sterilization services. After years of providing support, mainly through the private, non-profit sector, AVSC assistance for subsidizing services is phasing down as we work to shift our emphasis to the public sector, where the majority of sterilizations are carried out. Our strategy in Brazil is to increase access to safe and appropriate VSC technologies -- postpartum and interval minilaparotomy, and vasectomy -- as alternatives to the prevalent practice of providing tubal ligation in conjunction with C-sections.

This strategy has many constraints. Although the public sector accounts for many of the sterilizations performed, VSC policy status is unclear, and the decentralization of health services at the state level results in uneven access to services. It also makes it difficult to achieve a national impact when there is no national normative or implementing family planning body in the country. Thus, at present, it is possible to work only with individual, strategically-selected public sector facilities towards our goal, e.g., the pilot postpartum contraception service program at the Sao Paulo Maternity Hospital. Another major constraint is funding, since there is no bilateral support in Brazil to help make up for the shrinking AID/Central resources.

Given the limited potential for public sector programming, AVSC will remain involved with key nongovernmental family planning groups -- ABEPF and PROPATER. The pioneering efforts of PROPATER in Brazil have shown that Latin men will accept vasectomy if offered in a way geared towards their needs, however, much needs to be done to replicate this model elsewhere in Brazil. In FY 1989, the focus will be on training master trainers in the no-scalpel technique and providing technical assistance in cost recovery activities to promote sustainability. Sustainability is also a key program issue for ABEPF, as we continue to phase-down service support while assisting with medical quality.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|--------------------------|
| Asociacao Brasileira de Entidades de Planejamento Familiar (ABEPF) (BRA-29-SV-3-A) | This subagreement partially supports VSC services at 12 ABEPF affiliates (bringing the total number of clinics "graduated" from AVSC support to 35). In addition, it will strengthen medical quality through support for routine medical supervisory visits and meetings, refresher training in sterilization techniques, and paramedical training in asepsis, pre- and post-operative care. Finally, a workshop on cost-recovery and sustainability | \$234,845 AID/central |

jb

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|----------------------------------|
| ABEPP (continued) | <p>will be held.</p> <p>Expected outputs:</p> <p>4,000 female procedures 15 physicians trained in minilap 15 paramedicals trained 1 cost-recovery workshop (15 participants)</p> | |
| Promocao da Paternidade Responsavel (PRO-PATER) (BRA-34-SV-1-A) | <p>This subagreement supports the delivery of male services at PRO-PATER's model clinics in Sao Paulo. Two programmatic strategies supported include the dissemination of the no-scalpel vasectomy technique through Brazil via physician training and the development of a manual, and the continued provision of technical advice on how to recover costs for service delivery.</p> <p>Expected outputs:</p> <p>1800 vasectomies 10 physicians trained in no-scalpel vasectomy marketing/cost-recovery strategy developed</p> | <p>\$97,800 AID/central</p> |
| Maternidad de Sao Paulo, Centro de Planejamento Familiar (BRA-33-SV-2-A) | <p>This continuation project supports pilot postpartum minilaparotomy and IUD services at a large public sector maternity hospital in Sao Paulo. AVSC hopes to use this program as a model for other public hospitals to promote an alternative to sterilizations performed in conjunction with C-sections. This site also provides vasectomy as a choice for postpartum couples.</p> <p>Expected outputs:</p> <p>600 female and 400 male sterilizations 300 postpartum IUD insertions</p> | <p>\$15,100 AID/central</p> |

**Costa Rica
FY 1989 Workplan**

According to the most recent survey data (1986), 17% of married women of reproductive age are protected by sterilization, making it the second most widely used method. However, restrictive policies govern the availability of sterilization; it is only allowed for medical reasons. Because it has not been sanctioned as a contraceptive method, sterilization is not available on a regular basis in the public health system and consequently, normative guidelines on service delivery, counseling, and effective surgical techniques have been lacking.

Therefore, AVSC's strategy is to improve the quality of existing VSC services as a means of ultimately reducing medical restrictions to access. Towards this end, AVSC is supporting, with private funds, the most important health system in the country, the Caja Costarricense de Seguro Social (CCSS) to improve services delivered within its network of facilities. Because this institution is highly visible and an important center for health services and training, there is significant potential for AVSC support to have a positive impact on VSC service delivery in Costa Rica.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|-----------------------|
| Caja Costarricense de Seguro Social (CCSS) COS-09-SV-1-P | Support, with AVSC private funds will enable the standardization of VSC service delivery for high-risk women at its 24 hospitals through the following means: observation visits to successful public sector programs in other countries; establishment of medical supervision system; development and dissemination of legal and technical norms; development of training and counseling capacity; provision of needed equipment; and support for endoscopic equipment repair and maintenance capacity. Expected Outputs: development of legal and technical norms for VSC development of counseling capacity development of training center workshop on medical safety and reproductive risk study tour for 5 CCSS VSC Commission members | \$50,519 ¹ |

¹ FY 1988 obligation; FY 1989 obligation estimated to be \$25,000 (private funds).

Haiti and Jamaica FY 1989 Workplan

Though AVSC has in the past supported programs in both Haiti and Jamaica, this fiscal year represents a re-entry into both of these countries. In both cases, AVSC support takes the form of a technical assistance package rather than a subagreement to an in-country organization, as is the standard mechanism for AVSC support in most countries. AVSC technical assistance, in both instances, is a component of a larger program funded by another organization.

In Haiti, USAID is providing support for family planning services in the private sector through a cooperative agreement with IPPF/Western Hemisphere Region. VSC's role is to provide technical and advisory services as VSC services are initiated in private sector family planning programs included in the IPPF project. A VSC needs assessment conducted in 1988 by a team of AVSC staff and consultants was used in the design and development of the technical assistance package which focuses on VSC-related medical issues and the training of family planning counselors. These efforts are being coordinated through IPPF/WHR, USAID/Haiti, and local counterparts at L'Association pour la Promotion de la Famille Haitienne (PROFAMIL), Association des Ouvres Privées de Santé (AOPS) and the Haitian Community Institute (INHSAC).

Implementation of the technical assistance plan calls for periodic visits to Haiti by AVSC staff and consultants. Scheduled activities include: a counseling workshop, VSC standards development, and technical assistance in asepsis and surgical techniques.

In Jamaica, AVSC technical assistance was requested by USAID/Jamaica to assist officials of the Ministry of Health (MOH) and the Jamaican National Family Planning Board (NFPB) to develop and implement a plan for expanding and improving VSC services. Beyond AVSC technical assistance, the public sector VSC program in Jamaica will continue to receive support through a larger family planning program funded by the World Bank. As was the case in Haiti, the design of the AVSC technical assistance package was primarily based on an earlier VSC needs assessment conducted by AVSC staff and consultants. In Jamaica this assessment was conducted in 1985.

The technical assistance package for Jamaica has four areas of program emphasis: medical quality, counseling and education, access to services, and vasectomy introduction. Activities to introduce vasectomy will begin with the Jamaican Family Planning Association, an IPPF affiliate, where there is already an established female VSC program. Scheduled activities include: to develop and implement the VSC supervisor position, to revise VSC norms, to define VSC training needs, and to conduct an assessment of individual VSC services sites country-wide.

Both countries are classified as medium involvement countries, as staff attention is relatively high compared to financial inputs.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|--|
| Technical Assistance to PVO's in Haiti | To provide AVSC technical assistance to PVO's in Haiti to help initiate high quality, safe VSC services, and to ensure voluntarism. | \$19,660 ¹ AID/ Central |
| Technical Assistance to the Jamaican MOH and the NFPB | To provide AVSC technical assistance to public sector services in Jamaica to help improve and expand VSC services. | \$140,832 USAID/ Jamaica |
| Small grant to the NFPB (JAM-04-SV-1AS) | To provide short term salary support for two surgical nurses at the Victoria Jubilee so that VSC services can be re-initiated. | \$11,026 USAID/ Jamaica |

Expected Outputs:

Haiti - Counselor workshop
VSC norms manual
improved medical quality and asepsis techniques

Jamaica - Re-initiation VSC services at the Victoria Jubilee Hospital
VSC norms manual
Plan for improving individual VSC service sites (definition of equipment and training needs)
Plan for professional training
Functioning VSC supervisor

¹ Local in-country costs are funded directly by USAID/Haiti.

**Mexico
FY 1989 Workplan**

In Mexico, there is a high level of commitment to family planning and to sterilization, and female services are offered by a variety of government and nongovernment providers. However, access and quality are uneven, regional anesthesia is routinely used, and counseling services are not yet widely integrated in VSC programs. Moreover, vasectomy is not yet a viable alternative and also requires more attention and study.

In recent years, AVSC has been working primarily with private family planning entities, but we are now increasing, as in other countries, our collaboration with the public sector as a way to achieve the greatest leverage on the major providers of sterilization services, the Secretaria de Salud y Asistencia (SSA) and the Instituto Mexicano de Seguro Social (IMSS). Our current strategy is to develop training and medical supervision capacity within the SSA; to assist the IMSS to introduce no-scalpel vasectomy and counseling into its routine sterilization activities; and to collaborate with the IMSS in efforts to learn more about postpartum IUD service delivery. In addition, we will work with other private family planning groups to support pilot vasectomy services. Thus, we will remain substantially involved in Mexico, and will continue to give it "medium" priority and attention.

The increased focus on the public sector and on vasectomy, and the lack of a demonstrated impact of past AVSC assistance, necessitates a phasing out of support for a long-standing recipient of AVSC funding, the Mexican Federation of Private Family Planning Associations (FEMAP).

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|-------------------------|
| Vasectomy services in conjunction with operations research to test I&E and service strategies to reach men (MEX-47-SV-3-A and MEX-48-SV-3-A) | These projects support vasectomy services by two private family planning organizations: MEXFAM and the Mercadotecnica Social Aplicada (MSA, formerly PROFAM), sites of operations research being done by INOPAL to test cost-effective ways to promote and offer male services. This will be the final year of support, as it is expected that increased client caseloads will result in sufficient cost recovery through client fees in both clinics. Expected outputs: 750 vasectomies | \$25,000 AID/central |
| Secretaria de Salud de Nueva Leon, Mexico (MEX-51-SV-1-A) | This project represents the final year of AVSC assistance for sterilization services in Monterrey. Over the years, AVSC had provided support to public sector facilities | \$40,625 AID/Central |

| Name of Project | Description | Funding |
|-----------------|-------------|---------|
|-----------------|-------------|---------|

through the FEMAP affiliate, Pro-Superacion Familiar Neoleonesa. However, this channeling of support failed to achieve the desired institutionalization of services. So that services would not be disrupted through an abrupt withdrawal of funding, this is a reprogrammed effort to achieve full institutionalization at the project's end.

Expected outputs:

3,500 female and male sterilizations
25 SSA personnel trained in I&E and counseling

Introduction of vasectomy in the Instituto Mexicano de Seguro Social (various small grants)

This support provides for the training of trainers in no-scalpel vasectomy and an orientation to the no-scalpel technique for IMSS family planning officials as a first step to the introduction of this refined techniques in the IMSS system.

\$15,000
AID/Central

Expected outputs:

30 doctors oriented to no-scalpel
5 vasectomy trainers trained

Introduction of counseling services in IMSS's postpartum VSC services (new project)

This project supports a workshop to train social workers from key IMSS facilities in counseling skills. At present, although most postpartum sterilization and IUD clients are receive antenatal care through IMSS health posts, there is no counseling provided at the facility where delivery and immediate postpartum contraception service are provided. This is an important pilot effort to improve informed choice in the largest family planning service network in Mexico.

Expected outputs:

30 social workers trained in
voluntarism and counseling

| Name of Project | Description | Funding |
|---|--|------------------------------------|
| Final support to the Federacion Mexicana de Asociaciones Privadas (FEMAP) (MEX-50-SV-2-A) | Presently under negotiation is a proposal for "bridge funding" to enable AVSC to wind down its support of FEMAP services in the least disruptive manner possible. AVSC is presently supporting voluntary sterilization services or referrals at 6 FEMAP affiliates. However past assessments and evaluations of FEMAP's program have shown that it has little leverage beyond the relatively small number of services it provides. And, except for one or two affiliates, services are not cost-effective. Therefore, AVSC support is being terminated. The AID Affairs office in Mexico has recommended that AVSC pull out in a phased manner, and negotiations are underway (outputs are yet to be defined). | \$50,000 (upper limit) AID/Central |

**Central America
FY 1989 Workplan**

Countries included under this workplan are El Salvador, Guatemala, Honduras and Nicaragua. A major similarity in these countries is the lack of government support or involvement with voluntary sterilization activities. As a result the International Planned Parenthood Federation affiliates have a virtual monopoly on family planning and donor support. With the exception of Nicaragua, the IPPF affiliates are all receiving large amounts of bilateral support for their family planning activities, and responsibility for sterilization service support is with the USAID/Missions. (Nicaragua receives no AID funds; AVSC provides private donor support.)

Therefore, in recent years, AVSC has phased down its involvement with voluntary sterilization activities with Asociacion Pro-Bienestar de Familia (APROFAM) in Guatemala, Asociacion Hondurena de Planificacion Familiar (ASHONPLAFA) in Honduras and Asociacion Demografica Salvadorena (ADS) in El Salvador, following over 10 years of assistance to establish VSC service and training capability in their own networks, and through government facilities.

Although AVSC has prioritized these as low involvement countries, there is still work yet to be done. Public sector capacity and involvement need to be encouraged as a means of promoting the long-term sustainability of family planning and sterilization services. The IPPF affiliates, no matter how active, will be unable to fully meet the service needs in their respective countries. This activity relates to AVSC's overall and regional strategy to increase access to postpartum services, and in FY 1989 AVSC is exploring collaborative relationships with the MOH's in El Salvador and Guatemala.

There is also much potential for increasing access to vasectomy, again feeding into AVSC's global vasectomy initiative. In FY 1989 this will be done through introducing no-scalpel vasectomy in Guatemala and following-up the results of research on vasectomy barriers done last year in Honduras. And, in El Salvador, there is a need to improve informed choice by increasing the mix of contraceptive methods, given the reliance on sterilization. This is a high priority country for postpartum IUD programming.

Finally, although USAID has taken over responsibility for funding sterilization activities, AVSC is being called on to provide technical assistance for special needs, e.g., vasectomy in Honduras and medical monitoring and supervision in Guatemala. This has raised a special problem in that AVSC has less of an ability to program its involvement according to its expertise when not directly supporting service delivery. We need AID/Washington's support in assisting with fostering more collaboration on bilateral activities.

In Nicaragua, AVSC will expend a larger amount of effort in FY 1989 and beyond. This is an important country for private donor support since we're working with the sole provider of services in the country, PROFAMILIA

(formerly ADN). Because prospects for financial sustainability are low given the deteriorating economic conditions in the country, AVSC will work with ADN as part of AVSC's overall regional and global sustainability effort, to identify costs and implement cost recovery measures.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|--------------------------------|
| Asociacion Demografica Salvadorena (ADS) (ELS-16-SV-4-A) | <p>This project represents the final year of support for ADS's surgical contraception service program. It will provide partial support for services and will help expand ADS's capacity to train and support the extension of counseling to public sector hospitals. This component is viewed as critical to improving informed choice in El Salvador. Finally, to assist with the phase-out of AVSC funding the project supports a feasibility study for generating income through rental of OR space to private physicians.</p> <p>Expected outputs:</p> <p>4,200 female and 400 male procedures 8 counseling workshops for 200 MOH personnel</p> | \$44,100 AID/Central |
| Completion of AVSC subagreement with APROFAM (GUA-09-SV-1-A) | <p>AVSC's final subagreement with APROFAM will terminate at the end of FY 1989, with support being transferred to the bilateral program. During FY 1989, some additional activities were supported through a budget reallocation of remaining funds: the production of a client education video, training a master trainer in no-scalpel vasectomy.</p> | no FY 1989 obligation |
| Ministry of Health pilot service project (GUA-10-SV-2-A) | <p>Based on the results of a pilot project to initiate services in two MOH facilities in Salama and San Marcos, AVSC will explore potential for USAID mission funds to expand services to other areas. The buy-in discussions are on hold as agreement has not been reached about the pace and the level of expansion, with AVSC arguing for a slower approach (the results of the first two pilot sites</p> | pending receipt of USAID funds |

as

have not yet been evaluated.)

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|------------------------------|
| Phase II of Vasectomy Study, ASHONPLAFA | AVSC plans in FY 1989 to work in collaboration with ASHONPLAFA and Tulane University to follow-up the results of the study on Barriers to Vasectomy. Phase II will conduct operations research to test various strategies to overcome the barriers identified in ASHONPLAFA service facilities. USAID will fund this activity, but as of this writing, AVSC is still awaiting word about plans to design the study. | budget pending |
| PROFAMILIA -- Nicaragua (NIC-07-SV-1-P) | This grant of private funds supports male and female sterilization service delivery at PROFAMILIA's clinic. In addition, AVSC will support the establishment of a laboratory to improve service as well as to increase cost recovery efforts. Expected outputs: 3,600 female and 180 male procedures | \$81,300 AVSC/ Private |

**Argentina, Chile, Venezuela, Uruguay
FY 1989 Workplan**

A relatively low level of activity, using AVSC private funds, is envisaged for these countries for two principal reasons. First, because of relatively high levels of socioeconomic development, health standards are among the best in the region, and fertility rates are low. Second, in the case of the countries in Latin America's Southern Zone (Argentina, Chile, Uruguay), opportunities to support voluntary surgical contraception are limited, due to restrictive government policies and an unfavorable climate for family planning. Several of these countries have strong pro-nationalist traditions as well.

Sterilization in Argentina, Chile, and Uruguay is legal only for women with medical indications. For these reasons, it is virtually inaccessible in these countries, except for wealthy requestors who can afford fees in the private sector. In Venezuela, sterilization is a more widely used method of contraception, but, again, is primarily available in the fee-for-service sector.

AVSC is in the process of initiating project development in these countries. Private funds will be used, and AVSC seeks opportunities to demonstrate the feasibility of VSC activities in-country. In addition, AVSC is interested in initiating a policy dialogue with health officials and policy-makers regarding the health benefits of family planning. In the countries where sterilization is permitted for health reasons only, AVSC efforts will focus on temporary long-acting contraception, and, if possible, the introduction of sterilization services for women at high reproductive risk. Pilot projects will be funded to permit the development of experience and a knowledge base in these countries.

Argentina

Two proposals are slated for private funding in FY 1989: with the Hospital Juan Fernandez (\$18,600) and with the Lugano Health Center (\$18,850) to support professional education, services, and training for temporary contraception, especially IUD's. From this clinical family planning base, it is hoped that VSC services will be introduced in the near future.

Chile and Uruguay

AVSC will investigate opportunities to support professional education, training, and services, if possible, in the private sector (possibly with a university hospital in Chile and a feminist clinic in Uruguay). Support for post-partum IUD training and services will also be explored.

Venezuela

AVSC is currently funding, via a small grant of \$10,000 with private funds, the provision of equipment and partial support for laparoscopy services at PLAFAM, the IPPF affiliate in Venezuela. A more extensive program may be developed with this institution. Contacts will also be explored with the Maternidad Concepción Palacios to assess possibilities of working in postpartum contraception.

ASIA
FY 1989 REGIONAL STRATEGY AND WORKPLAN

Background and Need:

Asia is more of a geographic convenience than an organizing principle. There are substantial differences between the subregions and even between countries in the same subregions. The commonalities, with a few exceptions, are: large populations; high population density; relatively little political or religious opposition to family planning; general official recognition of population concerns and support for family planning services; great disparity in the spread of health services between rural and urban areas; and the longest history with family planning.

VSC services have been under development in Asia for over 15 years and, with the exception of Pakistan, in countries where AVSC is working female sterilization services are widespread and relatively well established. Government policies are favorable to sterilization and many Asian governments support either directly or indirectly much of the sterilization service delivery ongoing today. The nongovernmental organization counterparts AVSC has worked with over the years, particularly the national voluntary sterilization leadership groups, contributed to the favorable climate for sterilization in Asia today. On the other hand, AVSC has been gradually shifting resources from Asia to underserved regions.

The issues that we see facing sterilization services in Asia today, and indicating the need for a continued presence by AVSC in the region, include:

- o uneven access to sterilization services; many areas are not well served, particularly rural areas;
- o the leveling, or even decline, of sterilization incidence in the eighties throughout Asia, despite the growing number of women of reproductive age;
- o the continued relative lack of services geared toward men in many countries;
- o concerns about the voluntary nature of service delivery systems that include client and provider payments and that have emphasized sterilization over other program methods.
- o inefficiencies and poor management of service delivery; and
- o inadequate medical oversight of VSC services.

To address these needs, we expect to remain substantially involved in Asia over the remainder of this cooperative agreement given the work yet to be done and the sheer size of the population. While we will continue to aggressively pursue non-AID/Central sources of funding (USAID mission, UNFPA and other), we plan to allocate 23% of our total AID/Central funds for

project obligations to Asia. However, the use of central resources will be geared to highly leveraged activities and not for maintaining the recurrent costs of institutional support.

Country Priorities:

AVSC will devote a large share of overall staff and financial resources to three countries: Bangladesh, Pakistan and Philippines. In all three countries, we are working extensively using non-AID/central resources in support of service delivery and to develop in-country training capacity. The Bangladesh and Philippines country programs are managed with in-country representation given the extensive nature of involvement.

Indonesia, India (with UNFPA funds) and Nepal also require intensive staff effort; however, AVSC is playing a more technical rather than direct implementation role. Thailand and Sri Lanka will receive a relatively lower level of attention and resources, as services are institutionalized in these countries and AVSC's assistance is required only for program refinement.

Regional Program Initiatives:

To meet the needs outlined above, AVSC has been redefining our role from supporting direct service delivery to supporting activities designed to have an impact on improving the quality and the reach of services. This will involve providing technical assistance to service programs we are not supporting directly. Working with national programs to develop training capacity in VSC services and counseling (for sterilization and other clinic-based, long-acting methods) and quality assurance monitoring and supervision systems is a key element of our evolving regional strategy. To improve access to services, AVSC will promote vasectomy, primarily through the no-scalpel technique, and will look at better ways to improve services for women (e.g. the postpartum initiative). The role of many of our long-standing non-governmental recipients will need to change as well, as we look for ways for them to have increased leverage on the government programs. One major challenge will be to assist these groups to reduce dependency on AVSC and to find other sources of support. Thus, sustainability and cost-recovery programming will receive priority attention in Asia in the coming years.

Special regional priorities in FY 1989 follow:

- o To work towards the institutionalization of counseling through the development of training of trainers and counselor training curricula and the development of country counseling strategies aimed at diffusion counseling concepts within the national family planning programs (Bangladesh, Indonesia, Nepal, Pakistan, Philippines, Thailand and Sri Lanka). This will be done mainly through technical assistance, and via a regional workshop in the Philippines to update the national counseling strategies and to standardize a regional approach to counselor training.

o To improve medical monitoring and supervision through the provision of technical assistance in the development and assessment of systems designed to collect data on quality (Bangladesh, Indonesia, and Thailand). The World Federation co-sponsored with Pathfinder an international symposium on medical monitoring and supervision in May 1989 in Indonesia.

o To improve VSC (and clinic-based contraception) training through the conduct of training needs assessments and the implementation of their recommendations (Bangladesh, Indonesia, Nepal, and the Philippines).

o To promote vasectomy services by introducing the no-scalpel vasectomy technique (Bangladesh, Indonesia, Philippines, Nepal, and Thailand). Asia is taking the global lead in AVSC's strategy. We have worked with Population Development Association (PDA) in Thailand to set up an international no-scalpel vasectomy training center and have used Thai experts regionally and globally to promote and train in the technique.

o To better understand the current trends in service delivery and to improve program effectiveness through operations research or other studies, e.g., a study of factors affecting the decline in sterilization service delivery (Bangladesh), a study of field worker strategies (Bangladesh), and a client follow-up survey (Philippines).

Regional Management:

AVSC's Asia regional office in Dhaka, Bangladesh, established in 1979, oversees this large and decentralized regional program in eight countries, including two country representatives (in India and the Philippines) and encompassing several AID and non-AID fund sources. It has become increasingly difficult to manage this portfolio from a base in Bangladesh, which itself consumes a large amount of programmatic attention. Therefore, in FY 1989 AVSC will relocate its regional office to Bangkok, Thailand, and maintain the office in Dhaka as a country office. This will enable AVSC to provide dedicated attention to Bangladesh, and to manage the regional portfolio more effectively.

Fiscal 1989 Resource Allocation:

Table A shows planned FY 1989 project obligations (dollars and numbers of projects) by country and sources of funding. AVSC plans to obligate a total of \$1,583,000 for 21 projects in 8 countries. This represents 23% of AVSC's total allocation for projects (all fund sources). Sixty-six percent of the projects and 44% of funds are earmarked to the three "high effort" countries of Bangladesh, Pakistan and the Philippines. Forty percent of the funds allocated for Asia are from non-AID/Central sources.

**Table A: Planned Obligations (Dollars and Number of Projects)
in Asia
by Country and Source of Funds, FY 1989**

| <u>Country</u> | <u>Amount</u> | <u># of Projects</u> | <u>Fund Source</u> |
|-------------------------|---------------------------|----------------------|--------------------|
| HIGH EFFORT: | | | |
| Bangladesh ¹ | 147,000 | 4 | USAID/Bangladesh |
| Pakistan | 215,000 | 5 | USAID/Pakistan |
| Philippines | 84,000 | 2 | AID/Central |
| | 250,000 | 3 | USAID/Philippines |
| <u>Sub-total:</u> | <u>\$696,000</u> | <u>14</u> | |
| MEDIUM: | | | |
| India ² | --- | 1 | UNFPA |
| Indonesia | 380,000 | 1 | AID/Central |
| Nepal | 150,000 | 1 | AID/Central |
| | 27,000 | 1 | USAID/Nepal |
| <u>Sub-total:</u> | <u>\$557,000</u> | <u>4</u> | |
| LOW: | | | |
| Sri Lanka ³ | 100,000 | 1 | AID/Central |
| Thailand | 230,000 | 2 | AID/Central |
| <u>Sub-total:</u> | <u>\$330,000</u> | <u>3</u> | |
| <u>TOTAL:</u> | <u>\$1,583,000</u> | <u>21</u> | |

¹ This does not include AVSC's major project in Bangladesh, a \$1.9 million subagreement to the Bangladesh Association for Voluntary Sterilization, as FY 1988 funding is programmed through June 30, 1990.

² FY 1989 is the second year of a five-year project, totalling \$1.7 million for the period, 1988 to 1992. No FY 1989 obligations are foreseen.

³ This obligation is on hold due to political disturbances which have made travel to assess program needs impossible in FY 1989.

**Bangladesh
FY 1989 Workplan**

FY 1989 represents the second year of a plan to reorient and completely overhaul our assistance strategy in Bangladesh from support for model voluntary sterilization services in the non-government sector to the creation of an in-country training resource for clinical contraception for the national family planning program. This shift is seen as the way to have a long-lasting impact on the institutionalization of voluntary sterilization services in the country, as it will result in the government having the ability to deploy fully trained and qualified staff in its service facilities throughout the country. The lack of comprehensive basic and refresher training for government service providers is acknowledged as the single most important obstacle to the provision of safe and voluntary services in Bangladesh.

Towards this end, AVSC has been working since 1987 to improve the organizational management and training capacity of the premier sterilization NGO provider in the country -- the Bangladesh Association for Voluntary Sterilization -- so that it may serve as a national resource for training government physicians, nurses and family welfare visitors (FWVs). In FY 1989, AVSC continued to provide major infusions of technical and financial assistance in order to: a) improve the service capacity of its 25 clinics to serve as practical training sites, b) develop a training plan, and c) improve voluntarism through a complete overhaul of BAVS's outreach structure and an assessment of field worker strategies through operations research, and d) continued management technical assistance via consultants. This assistance will be evaluated in late 1989 in order to determine whether BAVS is ready to assume the role as a clinical contraception training resource.

In addition, AVSC will work directly with the Government of Bangladesh through separate subagreements to support the training of practicing government physicians, training for interns in the government's eight medical colleges and training of all physicians undergoing post graduate specialty Ob/Gyn training.

AVSC's program in Bangladesh is supported by a separate cooperative agreement with USAID/Dhaka. A new three-year agreement was signed in October 1989 in support of the strategy outlined above. A detailed and separate workplan has been developed for this cooperative agreement. In FY 1989, AVSC's Dhaka office will be transformed into a focused and dedicated country office when our regional operation relocates to Bangkok. A country director and training advisor will be recruited to manage the technical operations.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|--|
| Bangladesh Association for Voluntary Sterilization (BGD-03-NV-12-B) | The second period of a two year project to improve BAVS's capacity to serve as a national leader and resource in clinical family planning training and service delivery in Bangladesh. Emphasis is on completing the organizational restructuring initiated during the first year. The training division will be further strengthened through in-service training for all staff, and TOT training for clinical trainers. A national counseling strategy will be developed and existing BAVS counselors will be trained. Basic and refresher training will be provided for GOB doctors and nurses; services and the OR study on field worker strategies will continue at all 25 BAVS clinics. No-scalpel vasectomy will be introduced and plan for introducing Norplant will be developed. Expected outputs: 83,000 clients served: - 40,000 tubectomy - 25,000 vasectomy - 12,000 IUD - 5,000 injectables - 1,000 Norplant 24 clinic managers trained 6 counseling trainers trained 50 counselors refresher trained 25 OR teams trained (1 doc/2 rn) 25 nurses trained in IUD/injectables 624 field workers refresher trained | \$1,981,280 ¹ USAID/Bangladesh |
| Training for GOB physicians (BGD-31-TR-4-B) | This proposal supports another year of refresher and basic training for GOB physicians at certified BAVS training centers. The program, administered by the NIPORT (the National Institute for Population Training), is considered an interim | \$42,000 USAID/ Bangladesh |

¹ FY 1988 obligation. No funding projected for FY 1989.

| Name of Project | Description | Funding |
|-----------------|-------------|---------|
|-----------------|-------------|---------|

one until basic training capability is established in the eight medical colleges.

Expected outputs:

410 GOB doctors trained

Medical Colleges
Training for GOB
Physicians
(BGD-32-TR-1-B)

This programs aims to strengthen VSC training for medical college interns through improving the training component at FP model clinics attached to the eight medical colleges.

\$40,000
USAID/
Bangladesh

Expected outputs:

500 interns trained
16 counselors trained (2/college)

Model Services and
Training at the
Institute of Post-
Graduate Medicine and
Research
(BGD-33-TR-1-B)

This project supports Bangladesh's premier hospital and training institute for post-graduate doctors to establish a model family planning clinic in its ob/gyn department and strengthen practical training in VSC for potential medical college professors and District Hospital specialists.

\$30,000
USAID/
Bangladesh

Expected outputs:

15 ob/gyn specialists trained

Study of Factors
Affecting Demand for
Sterilization in
Bangladesh
BGD-35-EV-1-B)

This study is being undertaken by Research and Evaluation Associates in Development (READ) in order to examine factors which may have influenced the decline of sterilization performance from three perspectives: the national policy level, the program implementation level and the community (user and non-user) level.

\$35,000
USAID/
Bangladesh

Expected output: findings useful to government and NGO providers for improving program strategies

Other important (non-project) initiatives in FY 1989:

1. Recruitment for Bangladesh country director and training advisor to staff country office once regional office moves to Bangkok
2. Clinical Contraception Training Needs Assessment (done)
3. BAVS clinic review and training capacity assessment (by December 1989) to be followed by new BAVS workplan for review by USAID (by March 1990)
4. Operations research study assessment and final conclusions (by December 1989)

? 4

India
FY 1989 Country Workplan

AVSC is receiving separate funding from the United Nations Fund for Population (UNFPA) for a discrete project to assist the Government of India (GOI) to improve the quality of existing voluntary sterilization services and to establish microsurgical training and service capacity to meet the growing need for reversal services. Sterilization is the number one contraceptive choice in India, accounting for 60% of all current users. According to GOI projections, the demand for sterilization is likely to increase from 4.3 million procedures annually in 1985-86 to 7 million by 1989. While facilities are being expanded to meet this demand, the quality of sterilization services is not uniform throughout the country, no uniform training curricula for sterilization exist, and the demand for reversal services is also likely to increase as incidence of sterilization increases.

AVSC's project with UNFPA is intended to address the qualitative issues described above by upgrading four existing training facilities in Bombay, Calcutta, Madras and New Delhi to serve a regional "centers of excellence" for training in sterilization and recanalization. These centers will develop appropriate standards and training curricula for sterilization and recanalization services and training; train key trainers from state level training centers in improved techniques of sterilization; will establish state level microsurgical centers for recanalization; and will develop a quality control and assurance scheme to monitor the safety and quality of sterilization and recanalization services throughout the country.

Although not part of the AID workplan, this activity is important to AVSC's and AID's work for a number of reasons. First, India is a very important provider of sterilization services in the world. Having leverage on quality in India will impact a large number of sterilization clients. Moreover, AVSC's work in India is our first major hands on project on reversal and will give us a practical experience base for dealing appropriately with this issue in other countries. Finally, it may open the door to more extensive collaboration with UNFPA which is in line with AID's policy of increasing commitment and involvement of multilateral donors.

UNFPA is supporting all the staff and program costs for this activity, including in-country representation.

Indonesia
FY 1989 Country Workplan

AVSC has been working in Indonesia since 1974 mainly with the Indonesian Society for Secure Contraception (PKMI), a national level leadership organization whose purpose is to promote VSC availability and to assist with quality assurance. During this time, with AVSC continuing assistance totalling \$6 million, PKMI has contributed significantly to the development and quality of services through a variety of activities, including training for doctors and counselors, professional education for medical personnel, the development of monitoring and surveillance systems, and the provision of sterilization services in government facilities. Because sterilization is not included as an official part of the national family planning program, PKMI has been designated as the coordinating agency for all VSC efforts.

In recent years, and under the aegis of PKMI, USAID has directly supported activities aimed at increasing access to sterilization, specifically, upgrading (by means of equipment provision and training) hospitals and health centers around the country to provide VSC services. Sterilization performance has not yet kept pace with these developments, despite the fact that over 50 percent of women interviewed in the 1987 National Demographic and Health survey stated that they wanted to terminate their fertility.

In early 1988, AVSC conducted a team needs assessment to develop a strategy for our assistance in the coming years. Given the large amount of bilateral USAID resources available in the country, this role will be limited to providing technical assistance to the government program through support to PKMI in areas related to quality assurance (medical supervision, counseling), increasing demand for services (through testing effective ways to conduct outreach and link services to the communities) and by improving the acceptability of vasectomy. AVSC hopes, through this technical assistance and in partnership with USAID and PKMI, to institutionalize the capacity of the national program to implement and monitor quality services and training.

A question remains about the availability of bilateral support for AVSC's contribution to the program, and this may hamper future efforts to accomplish the above.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|--|---------------------------------------|
| Indonesian Society for Secure Contraception (INS-03-NV-12-A) | This project supports the development and testing of programs and strategies aimed at increasing the demand for VSC services: to establish | \$331,940 ¹ AID/Central |

¹ FY 1988 obligation; FY 1989 obligation is estimated at \$380,000 (for award in March 1990).

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

PKMI (continued)

model services in 5 outer island provinces, to test I&E strategies in Bali and Java provinces, to introduce no-scalpel vasectomy, to conduct a policy dialogue on health insurance reimbursement for VSC. In addition, AVSC will provide assistance to PKMI to develop an overhead rate and a business plan for recovering costs from donors.

Expected outcome:

20 supervisors from 5 outer island provinces trained in VSC I&E and referral

430 BKKBN fieldworkers oriented to VSC

Development of I&E materials

18 counselors trained

3500 female VSC procedures

700 male VSC procedures

Test community intervention

strategies in 13 provinces

to increase awareness of VSC

One day orientation to VSC for

30 satisfied male and female

VSC acceptors

4 Senior vasectomy trainers trained

in no scalpel vasectomy

1 workshop to orient insurance

companies to VSC in an effort

to obtain reimbursement for VSC

Other important (non-project) initiatives in FY 1989:

1. Administrative support for a consultant seconded to USAID/Indonesia who provides assistance to the BKKBN and PKMI on VSC activities (supported with bilateral buy-in funds).

2. Technical and equipment procurement support for Phase II of the facilities upgradation project (supported with bilateral buy-in funds).

3. Training needs assessment to be conducted in February 1990 in conjunction with USAID and JHPIEGO.

4. Technical assistance on the evaluation of two pilot medical monitoring and supervision systems supported by AVSC and Pathfinder.

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Nepal
FY 1989 Workplan

AVSC has been working in Nepal since 1975 mainly supporting voluntary sterilization service delivery through the Family Planning Association of Nepal (FPAN). Sterilization prevalence is estimated at 12%, one of the lowest rates in Asia. Total contraceptive prevalence is estimated at 15%, thus sterilization accounts for an unusually large proportion of contracepting couples. The majority of sterilizations are provided by the FPAN and the Family Planning/Maternal Child Health Project (of the Ministry of Health). Although year-round services are available at certain static sites, access to services is limited and generally confined to urban populations. Moreover, the vast majority of procedures are provided by mobile teams, organized jointly by FPAN and FP/MCH, and operating on a seasonal basis. Mobile teams, although an acceptable mode of service delivery, are more difficult in terms of assuring quality and institutionalization.

At present, we are currently expanding our involvement from working exclusively with FPAN to providing technical support directly to the government program. Our current strategy is based on two assessments conducted in 1987 and 1988 on the topics of institutionalization and quality assurance, respectively, as we see these issues as critical if Nepal is ever to provide sustainable services. The 1987 assessment on institutionalization looked at the feasibility and requisites for providing quality family planning and sterilization services on a routine, year round basis at static government facilities. AVSC and Population Council are collaborating on an operations research design to test this in select districts of Nepal.

The 1988 assessment on quality (medical and voluntarism) recommended several program interventions, all of which form the basis of the scope of work for the buy-in recently received by AVSC from USAID/Nepal. These include: counselor training; basic and refresher training for clinical service providers; development of a quality assurance system; and an assessment of facilities, equipment and supplies needs. These interventions will be done in the designated institutionalization districts. The buy-in began in FY 1989 and will be on-going into FY 1990. At the end of this time, AVSC will have assisted the government and USAID to test the feasibility of institutionalizing services in Nepal, and to develop a strategy for same.

AVSC is also exploring a collaborative relationship with UNFPA in Nepal, as they are the MCH/FP's other major funder of sterilization services.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
|------------------------|--------------------|----------------|

| | | |
|---|--|---------------------------------------|
| Family Planning Association of Nepal (NEP-01-SV-11-A) | This project supports several important activities by FPAN which are preparatory to the development of a long-range strategy for institutionalizing family planning services in Nepal. These include the development of uniform medical standards for clinical contraception services; testing the effect of providing static-only services in three provinces; and conducting training. | \$132,750 ¹ AID/Central |
|---|--|---------------------------------------|

Expected outputs:

1,000 female and 400 male procedures
 20 doctor/nurse teams trained
 15 counselor trainers trained
 15 FPAN counselors trained
 45 paramedical trained in asepsis control

| | | |
|---|--|-------------------------|
| Counseling training for Ministry of Health personnel (cost-extension to NEP-01-CO-11-A) | This supports counseling training and orientation for Ministry personnel to be conducted by FPAN | \$26,889 USAID/Nepal |
|---|--|-------------------------|

Expected outputs:

720 health personnel oriented to basic counseling concepts
 36 counselors trained

Other important (non-project) activities in FY 1989:

1. Operations research design team visit (AVSC/Pop Council) to develop project for testing the feasibility of institutionalizing static clinical contraceptive services on a routine, year-round basis in four districts.
2. National training needs assessment team exercise by AVSC, FPAN and FP/MCH (scheduled for February 1990)
3. Facilities, equipment and supplies assessment (scheduled for late 1989)

¹ FY 1988 obligation; FY 1989 obligation estimated to be \$150,000.

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Pakistan
FY 1989 Country Workplan

Pakistan is a high priority country for AVSC given the low level of sterilization prevalence (estimated at 2% overall, female only) relative to other countries in the region. Access is hindered by lack of strong commitment by the Government of Pakistan (GOP), due to political uncertainties and religious (Islamic) opposition to permanent contraception. AVSC's current strategy is to work primarily with non-governmental institutions to develop pilot services in coordination with the government's NGO coordinating council. In FY 1989, AVSC is working with 7 NGO's and one training project at a government hospital.

AVSC expects Pakistan to be a country of substantial involvement for the next several years, we work to encourage services to gain a foothold and to develop training and monitoring oversight capacity by the NGO coordinating council and the GOP. This will require a large amount of staff time and technical assistance, especially until the individual projects can be consolidated under an in-country umbrella organization. An important issue is sustainability, as the NGO sector is heavily dependent on outside support. Institutional reimbursement by the GOP exists but is inadequate for covering the cost of services. Thus, AVSC will be giving priority to cost-recovery programming in Pakistan. [Pakistan is being earmarked for Phase 2 of the sustainability study being planned for FY 1990.]

As FY 1989 marks the fourth year of our current strategy in Pakistan, an assessment is planned for late FY 1989 or early 1990 to evaluate our programs and redirect our strategy if necessary. Also, AVSC receives buy-in funds from Pakistan, and is in the process of negotiating a new tranche. This assessment will help to refine the scope of work for future buy-ins. If the project portfolio enlarges much further, AVSC will consider FY 1990 the possibility of in-country representation (supported with the buy-in).

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|--------------------------------|
| VSC program with Behbud Association (PAK-17-SV-2-A) | This will be the third year of support for VSC services in the underserved areas of Rawalpindi-Islamabad through refresher training for medical teams, training of physicians in vasectomy, provision of OT equipment, counselor training, development of I&E materials and expanded outreach activities. | \$57,907 USAID/ Pakistan |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|---|--------------------------------|
| | Expected Outcome: | |
| Behbud (continued) | Increased male acceptance of VSC Strengthened I&E efforts to increase knowledge about VSC and temporary methods 200 male VSC procedures 1000 female procedures | |
| VSC outreach service program (PAK-18-SV-2-A) | The purpose of this program is to establish male and female VSC as an integral part of the community based family planning activities of the Pakistan Voluntary Health and Nutrition Association in Karachi. This will include expansion of training and orientation activities for physicians, counselors and outreach workers. Expected outcome: 900 female VSC 100 male VSC 2 trained in minilap 1 trained in vasectomy 1 trained in asepsis | \$55,000 USAID/ Pakistan |
| VSC program with All Pakistan Women's Association (PAK-20-SV-2-A) | This will be the second year of an effort to increase the acceptability of VSC and temporary contraceptive methods and improve and strengthen existing VSC services in Peshawar. This will be achieved through expanded outreach and I&E activities, provision of necessary equipment, and orientation workshops for physicians and field workers from sister agencies. Expected outcome: 1000 female VSC procedures 50 male VSC procedures | \$40,000 USAID/ Pakistan |

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|--------------------------------------|
| Family Planning Association of Pakistan program to provide quality VSC services in Faisalabad (PAK-22-SV-2-A) | This program is aimed at improving the quality of existing VSC services through the organization of refresher training for surgical teams in asepsis, training in counseling, ensuring follow-up of clients, providing required equipment and improving client referral systems. Expected outcome: 600 male VSC procedures 6050 female VSC procedures 1 refresher training MDs 2 MDs trained in counseling | \$60,000 USAID/ Pakistan |
| Community Based VSC program in Karachi with Pakistan Medico International (PMI) (PAK-14-SV-3-A) | This program is in its third and final year of activities. This program is aimed at providing VSC and temporary family planning services through two static service sites in Karachi and maintaining the high quality of services at both sites. Quality of services will be improved through additional training in asepsis, autoclaving, use of anesthesia, counselor training and training in in I and E. Expected outcome: 800 female VSC procedures 50 male VSC procedures | \$10,000 USAID/ Pakistan |
| Pakistan Society for Planned Parenthood Leadership Activities in VSC (PAK-25-NV-1-A) | The goal of this program is to establish standards and guidelines for VSC, expand FP component of the medical college curricula to include VSC, supervise and monitor 26 affiliated FP service outlets and continue I&E activities to increase awareness of VSC among | \$66,650 ¹ AID/Central |

¹ This is a FY 1988 obligation; continuation funding will come on line in FY 1990.

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Name of Project Description Funding

health professionals and potential clients.

Expected outcome:

Standards and Guidelines for provision of services
600 female VSC procedures
300 male VSC procedures
3 I&E leaflets developed
6 issues PSPP newsletter
3 meetings for general medical practitioners
4 one-day orientation/coordination meetings for private MDs

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Philippines
FY 1989 Country Workplan

A number of activities supported by AVSC in the Philippines have confirmed that training is the main requirement for improving the quality and expanding the availability and accessibility of services. The Philippines needs VSC training, both initial and refresher, for physicians and nurse-assistants, as well as training in information, education and counseling (IE&C) for nurses and midwives. This is consistent with the goals of the Population Policy of the Government of the Philippines (GOP) to improve access of effective contraception to underserved areas. Therefore, AVSC's thrust during 1989 will be to assist NGOs and the Government of the Philippines to meet the vast need for trained service providers. Another need is to improve access to vasectomy which accounts for less than 1% of contraceptive prevalence.

AVSC received buy-in funds totalling \$900,000 in 1988; however, in March, 1989, AVSC received legal notification from the U.S. Agency for International Development that it could no longer expend funds under the PIO/T as the PACD was February 28, 1989. Replacement bilateral funds therefore, have not yet been made available to AVSC and program activities will be limited until AVSC receives notification of a new PIO/T.

In FY 1989, a first ever collaboration between AVSC and the public sector is programmed. A needs assessment to select Department of Health Regional Hospitals in the Philippines was conducted. The findings from the assessment will serve as the basis for a subagreement with the DOH. AVSC will assist the DOH to upgrade the delivery of services in the Philippines at government regional medical centers and hospitals and high quality family planning services will be fully integrated into health activities routinely. AVSC will also continue to work with NGOs in the areas of quality assurance and vasectomy. AVSC expects to be substantially involved in the Philippines over the course of the Cooperative Agreement (pending receipt of bilateral funds), and thus has established in-country representation in 1989.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|--|---|-------------------------|
| Qualitative Improvement of VSC services at Philippines Association for Voluntary Surgical Contraception (PAVSC) (PHI-08-NV-11-A) | Activities under this project will further support the major need to provide counseling training for public and private sector family planning service providers including VSC and continue to serve as the technical arm to POPCOM in matters relating to VSC. | \$50,000 AID/Central |

Expected Outcome:

Final counseling strategy and workplan
 2 TOT counselor workshops for 30 counselors
 5 Training of Counselor workshops for 200 counselors in 3 regions

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|--------------------------------------|
| National Training Center for Surgical Contraception Philippines General Hospital (PHI-17-TR-6-A) | This project focuses on institutionalizing VSC training at PGH and assisting the GOP in establishing through the integration of training activities under the Reproductive Health Care Center of the Ob/Gyn Department of Philippines General Hospital. Trainers from 6 DOH hospitals will be trained in clinical and counselor training and a model program for comprehensive VSC and FP training of medical residents of the Ob/Gyn Department will be initiated. Expected Outputs: 12 counselors trained 27 MDs trained in minilap/vasectomy | \$24,000 AID/Centra |
| Children's Medical Center expanded male voluntary surgical contraception programs with two pilot demonstration projects with two pilot demonstration projects in Region IV (PHI-25-SV-2-A) | This program is aimed towards increasing the accessibility and acceptability of male VSC by establishment of pilot demonstration projects in two underserved provinces as well as continued assistance to CMCP's vasectomy service and outreach program in Manila. Expected Outcome: 1770 male VSC procedures 14 trained in counseling 5 IEC "outings" at each demonstration clinic weekly IEC outing at CMCP in Manila | \$63,639 ¹ AID/Centra |
| Family Planning Organization of the Philippines expansion of VSC services through static and mobile sites | This project will expand the availability and accessibility of VSC by establishing two itinerant service teams and five static centers in two underserved regions, and provide orientation and refereshers | \$122,760 ² AID/Centra |

¹ This is a FY 1988 obligation; FY 1989 funding is projected to be \$50,000 under the Philippines buy-in.

² This is a FY 1988 obligation; FY 1989 funding is projected to be \$100,000 under the USAID/Philippines buy-in.

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| Name of Project | Description | Funding |
|--|---|---|
| FPOP (continued) (PHI-26-SV-1-A) | <p>training for VSC program personnel and outreach workers. This project will also test a special vasectomy outreach activity.</p> <p>Expected Outcome:</p> <p>785 male procedures 7575 female VSC procedures 9 one-day workshops for 450 outreach workers 1 vasectomy training program for 6 outreach workers in the Bacolod FPOP Minicipality</p> | |
| Support to Department of Health Regional Medical Centers and Regional Hospitals (PHI-27-SV-1-A) | <p>This project represents a first time collaboration with the public sector. Activities are aimed towards improving and expanding VSC training at six regional medical centers and 6 regional hospitals, upgrading national service delivery standards and introduce effective counseling and quality assurance systems.</p> <p>Expected outcomes:</p> <p>12 hospitals upgraded for service delivery 12 Mds trained as trainers Finalized standard curriculum for basic & refresher training in minilap and vasectomy.</p> | \$100,000 USAID/ Philippines (pending receipt of buy-in) |

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Sri Lanka
FY 1989 Workplan -- on hold

AVSC's involvement in recent years has been consistent with the USAID/Sri Lanka Population strategy and implementation plan for 1989 and the April 1987 report by John Dumm and Nicholas Wright. These state that the basic thrust of USAID strategy will be to phase out support for permanent contraception service delivery programs. Given the high prevalence of sterilization in Sri Lanka, it is a low priority country for AVSC.

AVSC's plan for 1989 was to assess the status of VSC in Sri Lanka and develop a mutually acceptable plan for withdrawal of support. The assessment has been on hold since 1988 due to political instability in the country and the difficulties of arranging travel. (AVSC's main counterpart is in Kandy, a focal point of the civil disturbances.)

The last AVSC staff visit was in late 1987, the purpose of which was to develop a strategy for assuring voluntary choice in the Sri Lankan national family planning program. In the meantime, AVSC has been extending its current subagreement activity with the Sri Lankan Association for Voluntary Surgical Contraception (SLAVSC) which was begun in January 1987 to allow time to develop an appropriate program strategy and activity plan. [Note: At the time of this writing, USAID mission approval is still pending for an additional extension through January 30, 1990.] Thus, at the present-time, we have no activity plan for FY 1989 and beyond, except to try to conduct a needs assessment as soon as feasible. AVSC had budgeted in FY 1989 \$110,000 to continue support to SLAVSC for a program based on the results of the assessment findings.

Thailand
FY 1989 Country Workplan

With its mature, well organized and successful family planning program, Thailand ranks third in total fertility decline among the world's 15 largest developing countries, behind only South Korea and China. Between 1969 and 1987, contraceptive prevalence among MWRA increased from under 15% to 67.5%. Sterilization is the leading method of contraception -- in 1987, 22.4% of MWRA were relying on female sterilization and 5.5% on vasectomy. Family planning services exist throughout the country, trained personnel are available at the district level, close to 1,000 government and private facilities provide services and all district hospitals are fully equipped.

Despite this success, AVSC maintains a modest yet important level of involvement because there are still some quality and program improvement issues to be addressed within the Thai program. These include improving the climate for vasectomy, the development of an effective safety surveillance and feedback system, and the institutionalization of counseling and counseling training. These are important issues for AVSC both globally and in the region, and we plan to take advantage of Thailand as an important partner and regional and international resource in surgical contraception programming. As the site of AVSC's to-be-relocated regional office, such collaboration will prove mutually beneficial.

AVSC is presently working with two main counterparts in Thailand, the Thai Association for Voluntary Sterilization (TAVS) and the Population Development Association (PDA). We have been providing core administrative and programmatic support to TAVS since 1975 to assist the Thai government to make services available and acceptable. Since it has achieved this mandate, AVSC is phasing out its core support for TAVS (while assisting it to develop other cost recovery measures), and will fund in the future only discrete project activities in key areas such as those mentioned above. PDA is our closest and most important partner in the global introduction of no-scalpel vasectomy, as they are the key technical resource and internationally-recognized trainers outside of China. PDA is co-hosting the international symposium scheduled for December 1989 to review no-scalpel experience worldwide to date and, next year, will conduct formal no-scalpel training courses for international participants.

| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|---|--|---------------------------------------|
| Thai Association for Voluntary Sterilization (THA-08-NV-11-A) | The current TAVS subagreement supports several quality assurance and vasectomy efforts: the dissemination of revised national VSC medical standards; the initiation of refresher training based on the revised standards for provincial and district service providers; to | \$117,886 ¹ AID/Central |

¹ FY 1988 obligation. FY 1989 obligation estimated to be \$180,000.

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| <u>Name of Project</u> | <u>Description</u> | <u>Funding</u> |
|------------------------|--------------------|----------------|
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establish comprehensive counseling training and services in 40 district hospitals in 2 provinces; to follow-up 12 no-scalpel trainees; to design an operations research study to address problems addressed in a vasectomy attitudes study completed in 1989. In addition, AVSC will provide assistance in establishing an indirect cost rate to encourage cost recovery from donors. AVSC's new and final subagreement will support the vasectomy operations research and additional quality assurance activities.

Expected outputs:

- counseling services established in 40 provincial hospitals
- evaluation of no-scalpel introduction at 12 provincial hospitals
- 1 day seminar for 20 participants on medical standards
- 1 day seminar to disseminate vasectomy research findings

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| Population Development Association (new project) | No-scalpel vasectomy services introduction in two provinces in Thailand | \$50,000 AID/Central |
|--|---|-------------------------|