

BIBLIOGRAPHIC DATA SHEET

1. CONTROL NUMBER
PN-AAH-6252. SUBJECT CLASSIFICATION (695)
PC00-0000-0000

3. TITLE AND SUBTITLE (240)

Program in voluntary sterilization; annual report, 1979

4. PERSONAL AUTHORS (100)

5. CORPORATE AUTHORS (101)

Assn. for Voluntary Sterilization.

6. DOCUMENT DATE (110)

1980

7. NUMBER OF PAGES (120)

206p.

8. ARC NUMBER (170)

613.942.A849 -1979

9. REFERENCE ORGANIZATION (130)

AVS

10. SUPPLEMENTARY NOTES (500)

11. ABSTRACT (950)

12. DESCRIPTORS (920)

Sterilization
Family planning
Voluntary organizationsBirth control
Project management

13. PROJECT NUMBER (150)

932096800

14. CONTRACT NO.(140)

AID/pha-G-1128

15. CONTRACT
TYPE (140)

16. TYPE OF DOCUMENT (160)

52

613.942
A 849
1979

PN- AAM- 625

INTERNATIONAL PROJECT
OF THE ASSOCIATION FOR
VOLUNTARY STERILIZATION

Annual Report

January - December 1979
Grant # AID 144-01-1128

708 Third Avenue, New York, NY 10017



TABLE OF CONTENTS

INTRODUCTION

SUMMARY - Annual Report 1979

CHAPTER 1. GRANT MANAGEMENT & POLICY DEVELOPMENT	1 - 1
Section 1. Fiscal Report	1 - 1
Staffing and Organization	1 - 3
Section 2. Policy & Procedure Development	1 - 4
Section 3. Field Operations	1 - 7
CHAPTER 2. PROGRAM DEVELOPMENT	2 - 1
Section 1. Proposal Submissions	2 - 2
Volume of Submissions	2 - 2
Proposal Budgets	2 - 3
Geographic Distribution of Proposals	2 - 4
Final Status of Proposals	2 - 6
Section 2. Subgrant Awards	2 - 6
Regional Distribution of Sub-grant Awards	2 - 10
Regional Distribution of Sub-grant Funds	2 - 11
Sources of Sub-grant Funding	2 - 13
Sub-grant Awards by Program Component	2 - 14
Small Grant Awards	2 - 16
Special Equipment Grants	2 - 18
CHAPTER 3. PROGRAM ACCOMPLISHMENTS	3 - 1
Section 1. Service Acceptors	3 - 1
Male & Female Acceptors of Services	3 - 3
Changes in Techniques: Female Sterilizations	3 - 5
Age & Parity of Female Acceptors	3 - 8
Medical Complications	3 - 10
Section 2. Training Activities	3 - 12
Physician Training	3 - 13
Training for Health Support Personnel	3 - 18
Training Evaluation & Follow-up	3 - 20
Section 3. Equipment	3 - 21
Repair and Maintenance Centers	3 - 23
CHAPTER 4. INFORMATION AND EDUCATION	4 - 1
Section 1. Sub-grant Awards for Information and Education	4 - 3
Section 2. Counselling and Informed Consent	4 - 3
Section 3. Conferences	4 - 6
Section 4. Library Activities	4 - 11
IPAVS Publications	4 - 12

Table of Contents (continued)

CHAPTER 5. NATIONAL LEADERSHIP GROUPS FOR VOLUNTARY STERILIZATION	5 - 1
Background	5 - 1
National Association Structure and Activities	5 - 3
IPAVS Funding of National Associations for Voluntary Sterilization	5 - 5
CHAPTER 6. THE WORLD FEDERATION OF ASSOCIATIONS FOR VOLUNTARY STERILIZATION; an International Leadership Network	6 - 1
Statement of Purpose	6 - 2
Membership	6 - 3
Committees	6 - 6
Official and Collaborative Relationships	6 - 10
CHAPTER 7. PROGRAM SUPPORT FUNCTIONS FOR MANAGE- MENT ACTIVITIES	7 - 1
Section 1. Proposal Development Procedures and Sub-grant Monitoring	7 - 1
Proposal Development Procedures	7 - 1
Routine Sub-grant Monitoring	7 - 3
Sub-grant Reporting	7 - 4
Sub-grant Financial Reporting	7 - 6
Audits of Sub-grants	7 - 6
Site Visits	7 - 7
Consultants	7 - 9
Section 2. Information Storage & Retrieval	7 - 10
Reports on Sub-grant Activities	7 - 10
Computer Information System	7 - 11

TITLES, TABLES AND FIGURES

	Page		Page
Table 1.1	1-1	Figure 3.5	3-7
Table 1.2	1-2	Table 3.4	3-8
Figure 1.1	1-3	Figure 3.6	3-9
Figure 1.2	1-5	Table 3.5	3-11
Figure 2.1	2-2	Table 3.6	3-14
Figure 2.2	2-3	Table 3.7	3-15
Table 2.1	2-4	Table 3.8	3-16
Table 2.2	2-5	Table 3.9	3-16
Table 2.3	2-8	Figure 3.7	3-17
Figure 2.3	2-7	Table 3.10	3-18
Figure 2.4	2-9	Figure 3.8	3-18
Table 2.4	2-10	Table 3.11	3-20
Table 2.5	2-10	Table 3.12	3-22
Table 2.6	2-11	Table 3.13	3-22
Table 2.7	2-12	Figure 3.9	3-24
Table 2.8	2-13	Table 4.1	4-2
Table 2.9	2-14	Table 4.2	4-2
Table 2.10	2-16	Table 4.3	4-3
Table 2.11	2-17	Table 4.4	4-7
Table 2.12	2-18	Table 4.5	4-8
Figure 3.1	3-1	Table 4.6	4-9
Table 3.1	3-2	Table 4.7	4-10
Figure 3.2	3-3	Table 4.8	4-11
Figure 3.3	3-4	Table 5.1	5-2
Table 3.2	3-4	Table 5.2	5-3
Table 3.3	3-6	Table 5.3	5-6
Figure 3.4	3-6	Table 6.1	6-4
		Figure 6.1	6-5
		Figure 6.2	6-7
		Figure 7.1	7-2

INTRODUCTION

IPAVS's accomplishments of the past year, 1979, cap a decade which saw voluntary sterilization gain, in developing countries, an acceptability that was virtually nonexistent ten years earlier. While such acceptance does not mean our job is done, it does signify that our job is different.

As in other years, 1979 was a year in which there were new beginnings; for example, entries into geographic areas previously indifferent if not hostile to voluntary sterilization. But it was also a year in which IPAVS was increasingly called upon to respond to needs of a maturing international community concerned with improving and expanding not only the delivery of services but training and educational programs as well.

Through the forums provided by national leadership organizations and the World Federation of Associations for Voluntary Sterilization, new priorities are emerging and new areas of importance to developing countries have been identified.

There is, for example, an expressed need for policies and standards from an international authoritative body on various aspects of voluntary sterilization. Countries also require assistance in developing their own medical guidelines and standards. There is a need for improving management and organizational skills in countries that have comprehensive service programs. Countries have also requested help in organizing educational programs; that is, designing strategies for comprehensive plans for education on voluntary sterilization.

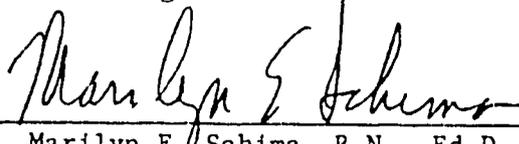
There is increasing interest and concern about the appropriate use of paramedics, the roles they should play in service delivery and the types of training that should be made available for them.

The accessibility and availability of services in rural areas continue to be pressing concerns that require more and innovative direction from IPAVS, which continues in its role as the principal agency for operational initiatives in the field of voluntary sterilization.

Countries—primarily in Africa—have an intense concern about infertility problems to which IPAVS is responding by donating technology which can be shared by both infertility and sterilization facilities.

In surveying the landscape of voluntary sterilization in the developing countries, we are viewing several stages of evolution taking place at once. There are, for example, countries in which the legal status of surgical contraception still remains unclarified. There is, on the other hand, a well-functioning World Federation whose members are beginning to raise the more sophisticated issues alluded to earlier. Thus, IPAVS's role as initiator is changing as the organization responds to problems engendered by the very acceptance of voluntary sterilization that we have succeeded in fostering.

The following annual report for 1979 describes the array of accomplishments by IPAVS in meeting our obligations to AID and to the facilities and organizations supported through the Grant.



Marilyn E. Schima, R.N., Ed.D., M.P.H.
Director of International Programs

ANNUAL REPORT 1979

SUMMARY

In 1979, IPAVS completed the fourth year under Grant AID/pha-G-1128 from the Agency for International Development. The broad purpose of the Grant is to "provide an action program in voluntary sterilization" in the lesser developed countries.

In order to fulfill the requirements of the Grant, IPAVS developed a series of objectives, summarized below:

- Assist lesser developed countries to design, develop and implement voluntary sterilization service programs;
- Promote the development of Information and Education programs;
- Stimulate and support the development of indigenous leadership organizations such as National Associations for Voluntary Sterilization;
- Support, organize and conduct international, regional and national conferences;
- Assist the development and implementation of training programs for physicians and health support personnel.

Using the mechanism of sub-grants to government or private agencies and organizations, IPAVS has implemented strategies through which the above objectives may be fulfilled.

The quantifiable accomplishments of the 1979 program year are summarized below:

- Voluntary sterilization services were provided to 78,873 men and women, an increase of 30 percent over 1978.
- There were 674 physicians trained in surgical contraception procedures, 60 percent more than last year.
- Training was provided for 249 health support personnel, a four fold increase over 1978.
- National Associations for Voluntary Sterilization or National Leadership Organizations were operational in 28 countries of the developing world.
- Information and Education components were incorporated into 53 of the 81 sub-grants awarded in 1979.
- IPAVS participated in 17 conferences on voluntary sterilization or related health topics and sponsored one regional, three national and one international conference during the year.
- The 4th International Conference on Voluntary Sterilization was organized and conducted by IPAVS in Korea. Participants came from 73 countries, 57 of which were developing nations.
- An IPAVS regional office for Asia was opened in Bangladesh.

The following report describes the activities undertaken to support the objectives of the Grant. It should be noted that the computerization of our budget and sub-grant data permitted the updating of previous years' data which had been in a manual system. Thus, there may, in some cases, be disagreement between historical data reported here and those reported in previous Annual Reports.

CHAPTER 1

GRANT MANAGEMENT AND POLICY DEVELOPMENT

Section 1. Fiscal Report

IPAVS currently operates under a grant from the Agency for International Development, number AID/pha-G-1128, which became effective on September 1, 1975. The grant has been extended several times by AID and is now in effect through November 30, 1980. It is anticipated that a new grant action will provide for the continuation of the program after that date.

The current AID grant contains projections for expenditures totalling \$34,647,800 from the original effective date through the current expiration date. Of this total, \$25,650,000 represent obligations, which were allocated incrementally as required during the progress of the grant and out of which commitments and expenditures had been made available as of December 31, 1979. An estimated additional \$8,997,800 are projected to be available for expenditure through November 30, 1980 (See Table 1.1).

Table 1.1 Incremental Funding History of Grant AID/pha-G-1128, 1975 to 1979 and Budget Projection through November 30, 1980.

Period		Funds	
From	To	Obligated	Projected
Sept. 1, 1975	Aug. 31, 1976	1,500,000	
Sept. 1, 1976	Dec. 31, 1976	1,875,261	
Jan. 1, 1977	Apr. 30, 1977	1,574,739	
May 1, 1977	Nov. 30, 1977	8,500,000	
Dec. 1, 1977	Nov. 30, 1978	4,000,000	
Dec. 1, 1978	Nov. 30, 1979	7,100,000	
Dec. 1, 1979	Nov. 30, 1980	1,100,000	
Jan. 1, 1980	Nov. 30, 1980		8,997,800
TOTALS		25,650,000	8,997,800
TOTAL GRANT (Obligations & Projections)		34,647,800	

Table 1.2 is a Budget and Expenditure Statement covering the period of the original grant and its continuations, from September 1, 1975, to November 30, 1979. The free balance includes funds for sub-grants approved by IPAUS and submitted to but not yet approved by AID as of November 30, 1979.

Table 1.2 Grant AID/pha-G-1128, Budget and Expenditure Statement, September 1, 1975 to November 30, 1979

	Reallocated Budget	Actual Expenditures	Committed But Unexpended Funds as of 11-30-79	Free Balance as of 11-30-79
Salaries	\$ 1,951,269	\$ 1,951,269		-
Fringe Benefits	343,775	343,775		-
Consultants	85,492	85,492		-
Rent and Utilities	140,678	140,678		-
Equipment and Furniture	73,666	73,666		-
Supplies and Services	215,836	215,836		-
Communications	144,856	144,856		-
Travel and Subsistence	330,322	330,322		-
I & E	101,787	101,787		-
Conferences	1,137,698	1,137,698		-
Sub-Grants	17,256,950	11,461,106	\$4,350,731	\$1,445,113*
NAVS	2,346,536	1,120,156	275,847	950,533*
Regional Offices	<u>221,135</u>	<u>221,135</u>		-
TOTALS	<u>\$24,550,000**</u>	<u>\$17,527,776</u>	<u>\$4,626,578</u>	<u>\$2,395,646</u>

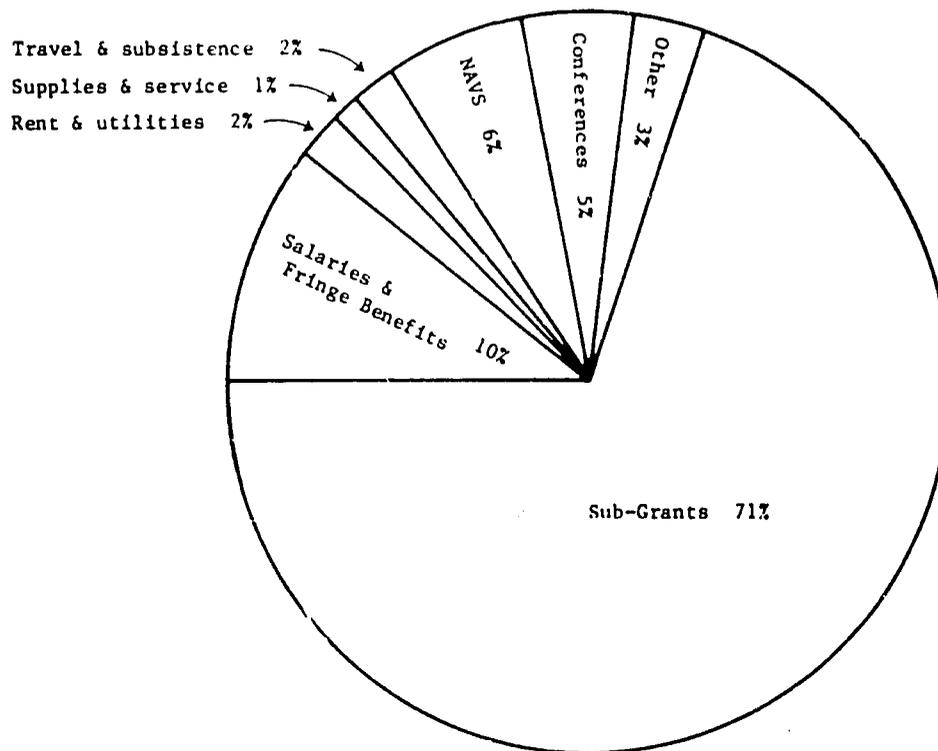
* Sub-Grants and NAVS expenditures do not reflect proposals of \$1,632,000 and \$443,000 submitted to AID for approval and under review as of November 30, 1975.

** Includes funding through November 30, 1979 only.

Figure 1.1 shows the percentage breakdown of total expenditures and commitments by budget category for the period of the grant and its extensions through November 30, 1979. It is significant to note that the total amount expended or committed for program costs -- conferences, sub-grants and National Associations for Voluntary Sterilization -- accounted for 82 percent of the total funds obligated, while administrative

costs accounted for a mere 18 percent.

Figure 1.1 Percentage Distribution of Total Expenditures and Commitments by Budget Category for Grant AID/pha-G-1128, September 1, 1975 to November 30, 1979



STAFFING AND ORGANIZATION

When Grant AID/pha-G-1128 was awarded on September 1, 1975, there were twelve administrative/technical and seven support staff members authorized. As IPAVS activities expanded, the number of approved staff grew to 31 administrative/technical and 19 support personnel at which level they stood on November 30, 1979. A further staff increase of ten percent was provided in the grant which became effective December 1, 1979, making the present personnel ceiling 55 (excluding Regional Office staff). The current approved positions include 35 administrative/technical

and 20 support staff. IPAVS expects further growth in its staff during 1980.

The organizational structure is shown in Figure 1.2. Reporting to the Executive Director is the Director of International Affairs, who is aided by three Administrative Assistants. At the middle management level, there are four Assistant Directors who are responsible for developing and managing the operations and work flow in their departments: Programs, Field Operations, Management and Fiscal Affairs.

Section 2. Policy and Procedure Development

Considerable time and effort has been spent in the past year to define areas of policy needs and to develop corresponding written policies and procedures. The following formal policies and procedures were developed and distributed in 1979:

1. Policies Governing Overseas Assignments:

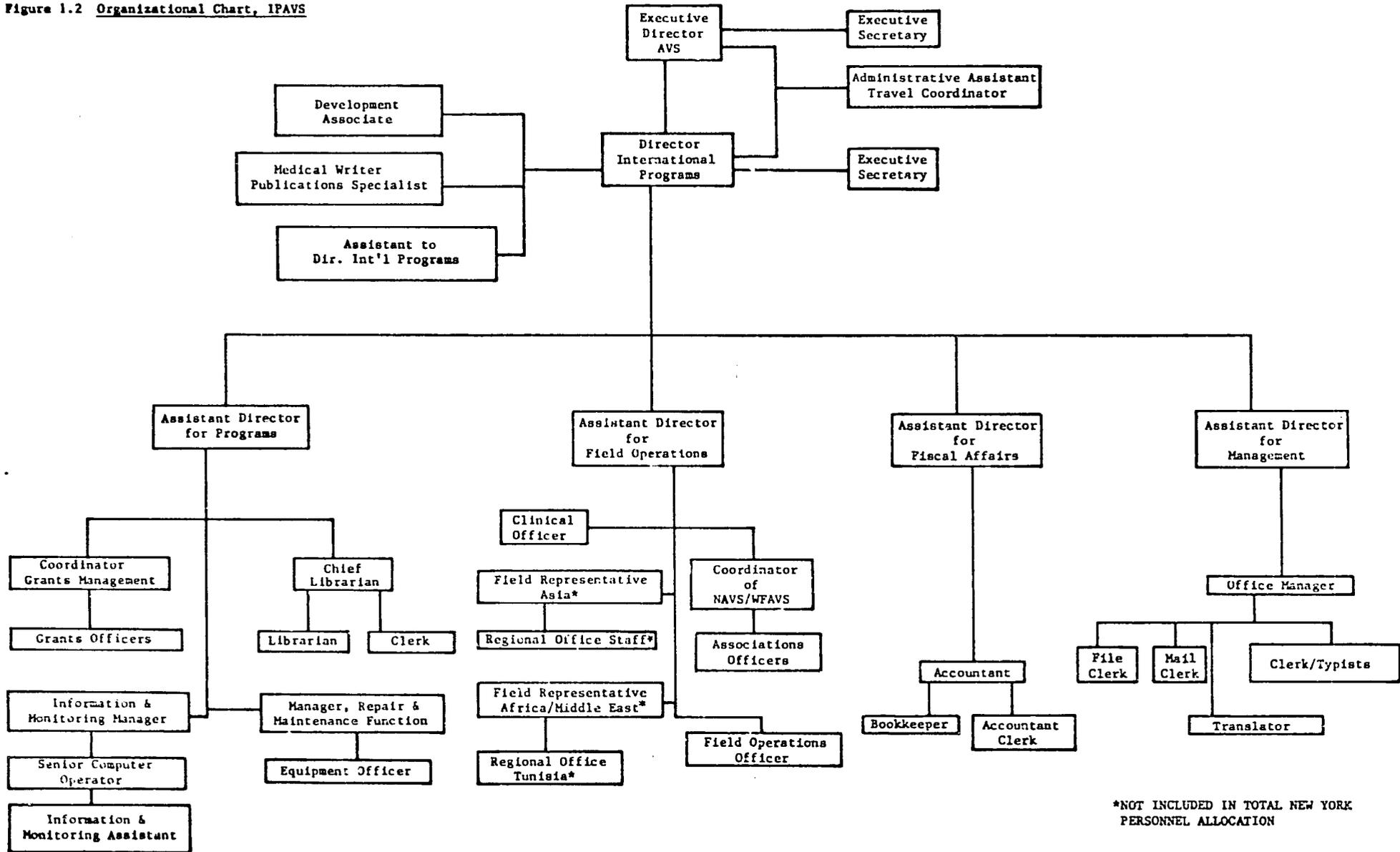
With the impending opening of the Regional Office in Dacca, the Personnel Committee approved, in January 1979, policies governing overseas staff.

Corresponding procedures were subsequently developed defining program responsibilities, communications, financial transactions and logistical support between New York and the Regional Office.

2. Minimum Medical Standards for Female and Male Voluntary Sterilization Programs: (Appendix A)

Over a year ago, IPAVS set forth as one of its priorities the development of minimum medical standards for clinics and hospitals providing female or male services. After fourteen

Figure 1.2 Organizational Chart, IPAVS



drafts and numerous reviews, the minimum standards were approved by AVS's Biomedical Committee in the fall of 1979. The minimum standards specifically define the service, facility, staff and record-keeping requirements that a program must meet for IPAUS funding. The purpose of these medical standards is to ensure high quality medical services in all IPAUS funded programs.

3. Employee Performance Evaluation:

In June, 1979, the Personnel Committee approved policy and procedures for employee performance evaluation. The system was implemented in September with performance evaluations of all employees. Over the next year the system will be tested and modified as necessary.

In addition to the policies and procedures approved by the various AVS committees, several operational procedures were developed, including:

- procedure for reports of medical complications in sterilization procedures;
- procedures for site visits -- planning, preparation, implementation, and follow-up;
- mechanisms for establishment of the escalator clause to be field tested as a possible method for increasing the number of sterilizations performed in projects;
- procedures for monitoring abortion-related activities;
- procedures and forms for medical facilities checks; and
- procedures for audits of sub-grantees.

In recognition of the importance of written procedures, during 1980 each division will be working to develop a Procedures Manual, and it is anticipated that a comprehensive Operational Manual for IPAVS will be developed by the end of the year.

Development of formal policies and procedures reflect the maturing nature of IPAVS and should enhance its management capability and contribute to consistency and thoroughness in all program operations.

Section 3. Field Operations

IPAVS entered a transitional phase with respect to field operations in 1979. While responsibility for program development, awards and monitoring continued to be centralized, efforts towards eventual decentralization of some of these functions were begun.

In April, 1979, the IPAVS Regional Office for Asia was opened in Dacca, Bangladesh. Headed by a Representative who established residence there, the office hired nationals to complete staffing. The office also assumed full program responsibility for Bangladesh. During the year, the Asia Representative visited the eight countries with IPAVS programs in the two regions for which the Asia Office has responsibility. In addition to sub-grantees, the Representative met with local government leaders, USAID mission personnel and representatives of other related agencies in those countries.

In 1979, initial approvals were received from the Tunisian government which paved the way for establishing a Regional Office for Africa

and the Middle East in Tunis. Final government approval is expected in February, 1980, and it is anticipated that the office will be operational by mid-1980.

The IPAUS strategy for a Latin American Regional Office was under development in 1979. Possible structures and locations for such an office serving Central America, South America and the Caribbean were investigated. At the end of the year, it had not been decided whether the interests of these regions can best be served by outstationed personnel or by a New York based regional office.

With the realization that nationally staffed, regional arms of IPAUS will enable the organization to be more responsive to local needs, we will continue to explore regionalization of some centralized functions. In the long term, it is envisioned that there could be up to five IPAUS Regional Offices serving developing nations. Among the functional responsibilities of each office will be to:

- establish relationships with governmental and non-governmental leaders who are responsible for the types of development programs that can be inter-related with voluntary surgical contraception programs;
- develop comprehensive regional strategies based on identified needs;
- identify and evaluate the suitability of prospective applicants for IPAUS funds and inform them of the scope and magnitude of potential IPAUS assistance;
- monitor, on site, the progress of on-going IPAUS programs;

- explain IPAVS policies and procedures for IPAVS applicants and sub-grantees;
- provide technical assistance in proposal development and for renewal of funded programs; assist sub-grantees to develop appropriate reporting mechanisms; advise on equipment, administrative, or programmatic problems that may arise;
- maintain liaisons with appropriate AID and government officials and other donor agencies in order to coordinate IPAVS activities with other family planning efforts in countries of the region; and
- facilitate communications between the field and IPAVS headquarters.

CHAPTER 2

PROGRAM DEVELOPMENT

It is the policy of IPAVS to respond to requests and give assistance to non-profit medical and health institutions, government agencies, professional and voluntary service organizations for programs with one or more of the following objectives:

- development or expansion of voluntary sterilization service programs;
- training of physicians in surgical sterilization techniques;
- training of health support staff to assist physicians, counsel patients and maintain medical equipment;
- development of voluntary sterilization education programs for health professionals, government officials and the lay community;
- development of educational curricula and materials;
- provision of equipment and the establishment of equipment maintenance programs;
- support of organization and/or participation in conferences and seminars at the local, national, regional and international levels.

In 1979, IPAVS worked with 122 such agencies in developing sub-grant proposals. At the end of the year, 100 proposals had been developed to the point of final submission. Of these, final IPAVS action was taken on 59. A total (including proposal carryovers from 1978) of 81 sub-grants, 31 small grants and five special equipment grants was awarded for a total of \$7,478,085.

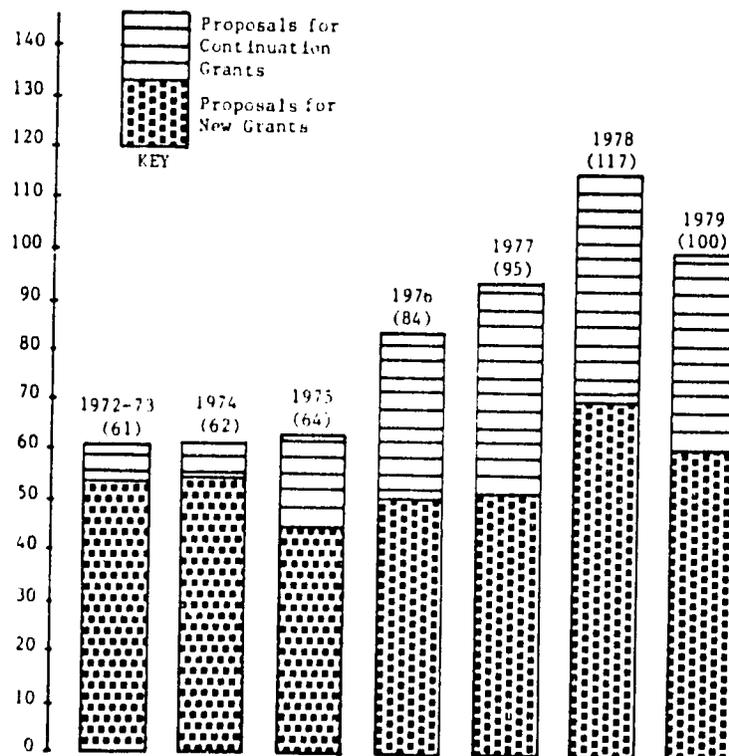
Section 1. Proposal Submissions

Volume of Submissions

Proposals come to IPAVS from multiple sources, among them: staff site visits, referrals from other agencies, AID population officers and National Associations for Voluntary Sterilization or other leadership organizations.

The applicant is assisted by the IPAVS Grants Management staff in developing a well-designed program. Proposals may be for new activities within a country or for the continuation of a program started in a previous year. Figure 2.1 shows the volume of submissions for new and continuation sub-grants throughout IPAVS's history. A measure of the expansion of our program is seen by the number of submissions

Figure 2.1 Number of Proposals Submitted by Year, 1972 to 1979

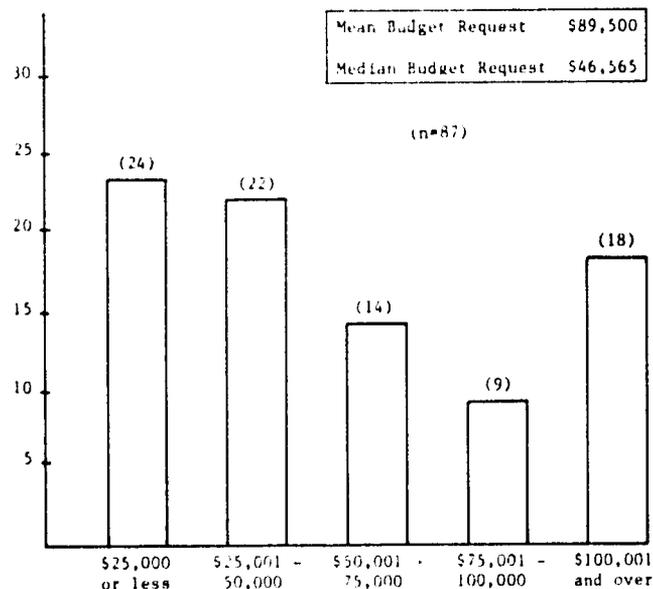


for new programs, which is steadily high, representing half or more of all submissions every year. In addition to the 100 proposals submitted in 1979, 22 other proposals were under development during the year, making the total in process 122.

Proposal Budgets

In 1979, 87 of the 100 proposals included budget figures representing total requests of \$7,782,149. Among the 87, the mean budget request was \$89,500 and the median, \$46,565. Figure 2.2 shows the distribution of budget request levels for 1979. The majority of all requests were for programs with budgets of \$50,000 or less. Among the larger funding requests were those for consolidated programs in Guatemala, Honduras and Tunisia. These programs are national in scope and naturally require higher budgets. It is expected, however, that the consolidation of

Figure 2.2 Frequency Distribution of Budget Request Levels of Proposals Submitted, 1979



funding and administration through one agency will result in better coordination within a country and in more efficient management.

Opportunities for future consolidations are now under study at IPAVS. While, as a result of consolidation, fewer proposals will have to be processed each year, each consolidated program will require more technical staff assistance for development. Nevertheless, with adequate planning and follow-up, it is postulated that various components such as service, information and education, training and equipment maintenance can be more effectively coordinated within a fully integrated program. A review of the progress of presently consolidated sub-grants will determine the application of this concept to other programs in the future.

Geographic Distribution of Proposals

As seen in Table 2.1, the regions of East Asia, South Asia and Central America have submitted the vast majority of all proposals received

Table 2.1 Geographic Distribution of Proposals Submitted by Year, 1972-73 to 1979

REGION	1972-73	1974	1975	1976	1977	1978	1979	TOTALS
East Asia	21	20	26	24	29	24	23	167
South Asia	0	8	11	23	26	25	22	115
Central America	12	9	9	13	16	23	19	101
South America	14	12	9	7	9	5	16	72
Africa	3	8	4	7	4	25	11	62
Middle East	6	2	2	3	6	2	4	25
Caribbean	3	1	2	6	2	7	5	26
Europe	0	1	0	0	2	5	0	8
North America	2	0	1	1	1	1	0	6
Oceania	0	1	0	0	0	0	0	1
TOTALS	61	62	64	84	95	117	100	583

since 1974. The volume has been consistent, with these three regions accountable for almost two-thirds of all submissions in 1979 as well as for all years.

In 1979, as in the past, the fewest requests came from the Middle East and Caribbean regions. The African region showed a marked increase in proposal activity in 1978 when submissions jumped to 25 from the four of the previous year. Although there was a drop in new submissions from Africa in 1979, nine of the region's 1978 proposals were still under development at the end of the year. South America showed an increase in submissions, from five in 1978 to 13 in 1979. Five of the 1979 requests were from Peru and one from Uruguay, countries from which IPAVS had never received proposals. It is gratifying to see a surge in activity in a region characterized by past conservatism with respect to voluntary sterilization.

As seen in Table 2.2, the regions with the highest mean budget

Table 2.2 Total Budget Requests by Region, 1979

Region	Total Aid Requested	# Proposals	Mean Amount Requested	Median Amount Requested
Africa	\$ 926,261	9	\$102,918	\$25,890
Central America	1,961,019	17	115,355	59,000
South America	1,127,603	13	86,739	44,028
East Asia	1,798,274	22	81,739	56,350
South Asia	1,392,358	17	81,903	50,931
Caribbean	335,445	5	67,089	43,805
Middle East	141,167	4	35,292	40,735
North America	--	0	--	--
Oceania	--	0	--	--
TOTALS	\$7,782,149	87	\$ 89,500	\$46,565

requests were Central America and Africa. The relatively high mean requests are due in part to the higher budget requirements for the consolidated programs in these two regions.

Final Status of Proposals

The status of the 100 submissions at the end of 1979 is as follows:

	New	Continuation	Total Number	Percent
Awarded	11	17	28	28
Approved by IPAVS and forwarded to AID	9	11	20	20
In Process at IPAVS	30*	9*	39*	39
Rejected	9	2	11	11
On Hold	<u>1</u>	<u>1</u>	<u>2</u>	<u>2</u>
	60	40	100	100%

*Includes proposals for which no budget was included

Of the eleven proposals rejected, two were rejected as full programs and funded as small grants, one was rejected due to loss of interest by the prospective sub-grantee, five due to political considerations, and three for failure to agree to meet IPAVS programmatic criteria.

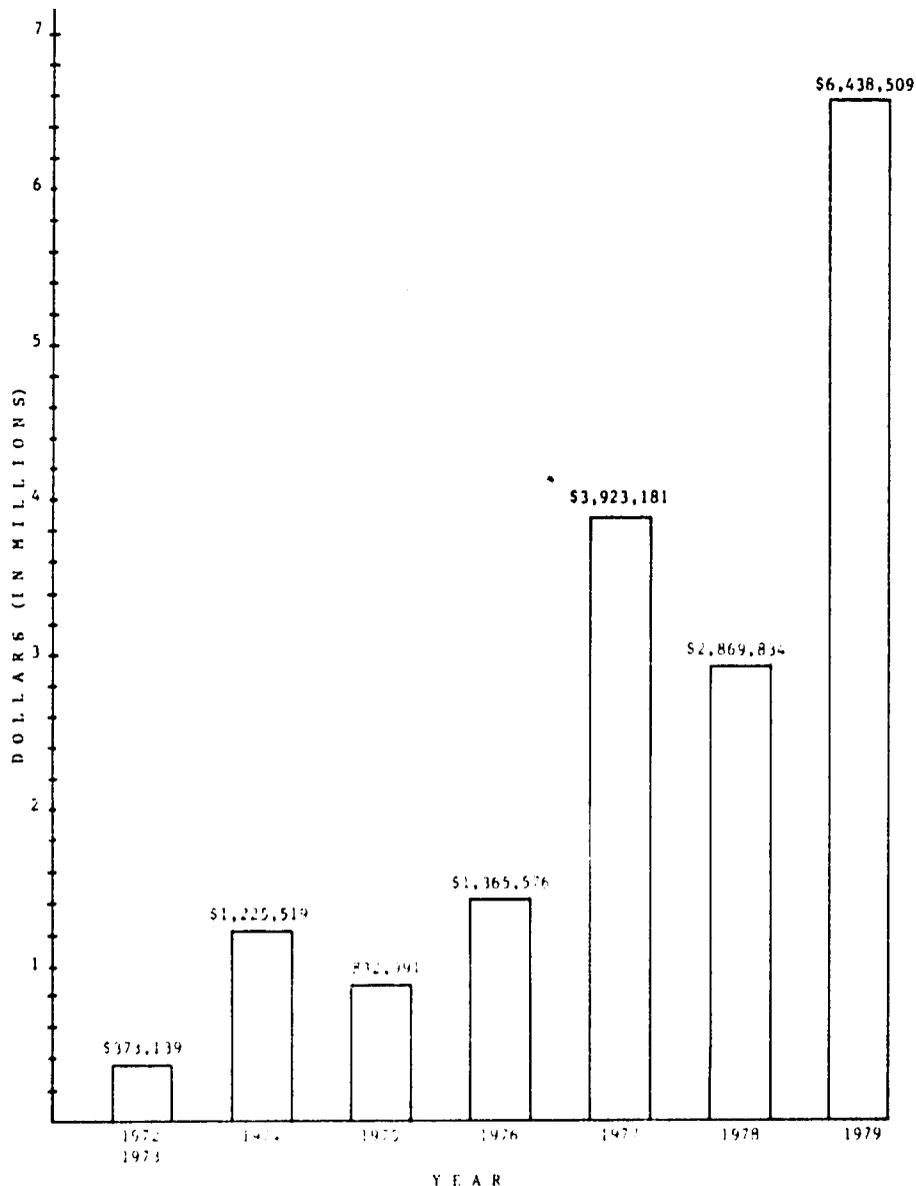
Among the 39 proposals still in process at IPAVS at the end of the year, 30 were new submissions, which take an average of two to three months to develop and six to nine months for all steps to be completed for final approval.

Section 2. Sub-grant Awards

In 1979, IPAVS awarded 81 sub-grants in 34 countries for a total

of \$6,438,509. Figure 2.3 shows yearly allocations since 1972-73. The 1979 total represents a 124 percent increase over that awarded in 1978, a year characterized by a relatively low award rate. The apparent 1978 slowdown was due in part to the number of new applications requiring processing, as well as the fact that many of the previous year's applications were extended through 1978, thus not due for refunding until 1979. The 1979 increase over the previous year's allocations represents,

Figure 2.3 Total IPAVS Budget Awards by Year, 1972-73 to 1979



in part, the re-funding of such extended sub-grants and is not an indication of erratic program growth.

The growth of the IPAVS program is characterized by steady and continuous increments in the number of countries having program activity. Table 2.3 shows that country activity has increased almost three-fold since 1973, from twelve to 34 countries with active programs. During the same time period, awards within countries increased from an average of slightly under two to between two and three. These data give a measure of IPAVS's progress in providing for orderly expansion within countries wherein voluntary sterilization activities may eventually become part of the national network for health care delivery.

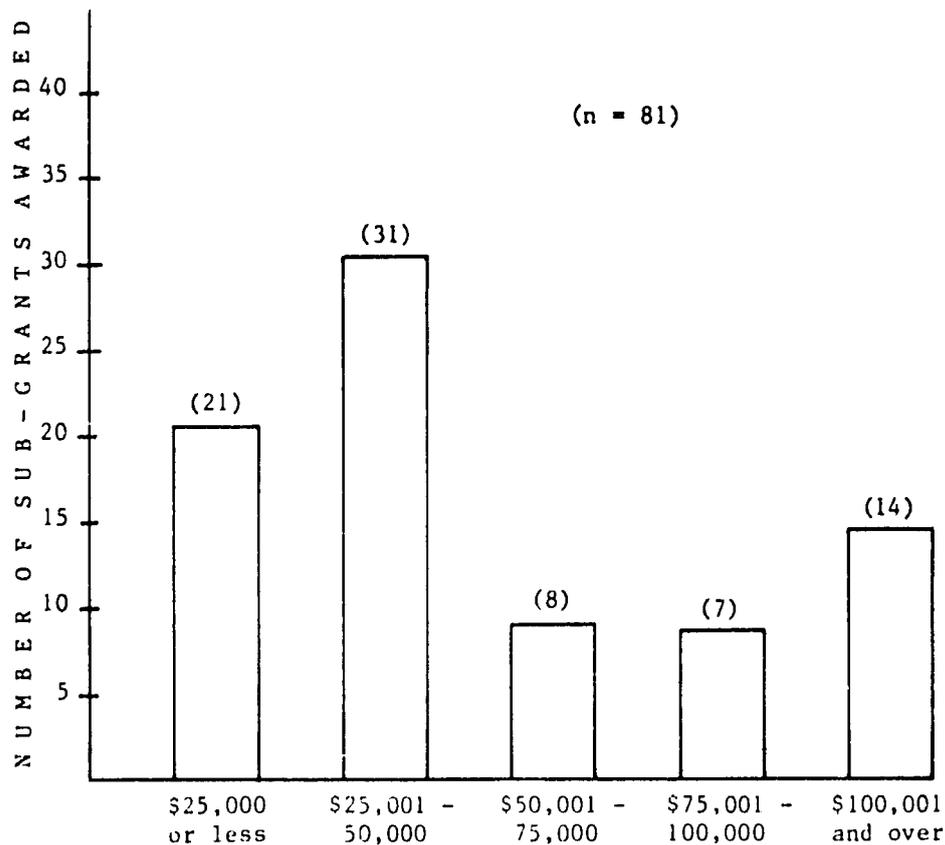
Table 2.3 Number of Countries with Active Sub-grants and Number of Sub-grants Awarded by Year, 1972 to 1979

YEAR	NUMBER OF COUNTRIES WITH ACTIVE SUBGRANTS	NUMBER OF SUBGRANTS AWARDED
1972	1	1
1973	12	22
1974	22	36
1975	21	40
1976	20	43
1977	26	72
1978	23	50
1979	34	81

NB: Distribution excludes Special Equipment and Small Grants

Figure 2.4 illustrates that the majority of sub-grant awards were \$50,000 or less during 1979. Among the awards that were in excess of \$100,000 were those with more programmatic and geographic comprehensiveness.

Figure 2.4 Frequency Distribution of Budget Award Levels, 1979



In 1979, as noted in Table 2.4, more than one third of the 81 awards were made to National Associations for Voluntary Sterilization, followed by 28 percent to other voluntary organizations, many of which are family planning associations. Sixteen percent of the awards went to government agencies; the remaining sub-grantees were hospitals, universities and other non-profit institutions.

Table 2.4 Numbers and Percents of Sub-grants Awarded by Type of Agency, 1979

TYPE OF AGENCY	NUMBER	PERCENT
National Association	29	36
Voluntary/Family Planning	23	28
Government Agency	13	16
Hospital	6	7
University	6	7
Other	4	5
TOTAL	81	(100%)*

*Percentages do not add due to rounding

Regional Distribution of Sub-grant Awards

The number and percentages of sub-grants awarded annually among the ten geographic regions are noted in Table 2.5. There was a sub-

Table 2.5 Numbers and Percents of Sub-grants Awarded by Region, 1972-73 to 1979

REGION	1972-73		1974		1975		1976		1977		1978		1979		TOTALS	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
East Asia	11	47.0	12	33.3	18	45.0	17	39.5	19	26.4	18	36.0	18	22.2	113	32.8
Central America	4	17.4	7	19.4	3	7.5	10	23.3	16	22.2	11	22.0	18	22.2	69	20.0
South Asia	0	-	5	13.9	4	10.0	8	18.6	21	29.1	6	12.0	20	24.7	64	18.6
Africa	1	4.3	0	-	4	10.0	1	2.3	4	5.6	5	10.0	17	14.6	27	7.8
South America	3	11.7	6	16.7	7	17.5	3	7.0	5	6.9	3	6.0	6	7.4	35	10.1
Middle East	1	4.3	2	5.6	1	2.5	2	4.7	2	2.8	4	8.0	2	2.5	14	4.1
Caribbean	2	-	2	5.6	1	2.5	1	2.3	3	4.2	2	4.0	2	2.5	11	3.2
Europe	0	-	1	2.8	0	-	0	-	1	1.4	0	-	2	2.5	4	1.2
North America	1	4.3	1	2.8	1	2.5	1	2.3	1	1.4	1	2.0	1	1.2	7	2.0
Oceania	0	-	0	-	1	2.5	0	-	0	-	0	-	0	-	1	0.3
TOTALS	23	100	36	(100)*	40	(100)*	43	100	71	100	50	100	81	(100)*	345	(100)*

*Percentages do not add due to rounding

stantial increase in awards made to Central America, South Asia and Africa. Yearly shifts in award activity are not necessarily reflections of proportional shifts in program activity. As mentioned above, radical drops in annual award levels are often attributable to the fact that many sub-grantees receive program extensions carrying them over a program year. The 1979 increase in Africa, on the other hand, does reflect increased interest in voluntary sterilization by that region, an interest to which IPAVS is responding by the establishment of a Regional Office for Africa and the Middle East.

Countries receiving the greatest number of IPAVS sub-grants in 1979 were Bangladesh with twelve, Honduras and Indonesia with six each, and Korea and Mexico with five each. Syria and Morocco received IPAVS assistance for the first time in 1979.

Regional Distribution of Sub-grant Funds

Table 2.6 shows that Central America, East Asia and South Asia accounted for the largest regional funding allocations in 1977 and

Table 2.6 Total, Mean and Median Budget Awards by Region, 1979

REGION	1972-73		1974		1975		1976		1977		1978		1979		TOTALS	
	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
Central America	54,100	14.5	107,150	17.1	151,200	21.1	195,400	27.7	1,137,033	39.7	1,224,000	42.7	2,082,281	32.3	5,479,874	32.2
East Asia	213,200	54.9	518,874	82.1	410,874	58.5	475,386	67.6	371,144	18.4	746,471	26.0	1,028,336	16.0	4,152,655	24.4
South Asia	--	--	203,400	32.4	448,550	63.4	407,121	57.9	418,549	23.4	424,110	14.6	1,125,933	17.5	3,192,191	18.7
Africa	15,800	4.1	--	--	18,125	2.6	6,813	1.0	44,781	1.6	1,094	0.0	1,707,119	26.5	2,502,164	14.7
Middle East	8,000	2.1	19,340	3.1	100,000	14.1	19,000	2.7	43,100	1.6	122,535	4.3	59,015	0.9	264,346	1.6
Caribbean	--	--	42,900	6.8	42,900	6.1	42,900	6.1	42,900	1.9	90,324	3.1	14,085	0.2	182,639	1.1
South America	52,500	13.4	299,705	47.4	139,200	19.6	11,404	1.6	19,700	0.7	51,040	1.8	29,845	0.5	899,467	5.3
Europe	--	--	85,000	13.5	1,000,000	141.4	1,000,000	141.4	1,000,000	35.3	--	--	10,000	0.2	10,000	0.1
North America	19,534	5.0	23,170	3.7	14,885	2.1	9,870	1.4	9,400	0.3	9,660	0.3	1,745	0.0	112,309	0.7
Oceania	--	--	--	--	1,000	0.0	--	--	--	--	--	--	--	--	3,000	<0.1
TOTALS	373,134	100	621,119	100	711,441	100	711,441	100	3,921,181	100*	2,869,834	100	8,415,104	100	17,028,749	100

* Percentages do not add due to rounding

1978. In 1979, Africa replaced East Asia as one of the top three recipients, although East Asia still accounted for 16 percent of the total 1979 budget allocations. The bulk of the Africa budget, 70 percent of the total for this region, went to the Office National du Planning Familial et de la Population (ONPFP) in Tunisia for its national voluntary sterilization program. Approximately 50 percent of the funds awarded in Central America went to the Government of Mexico, for its national voluntary sterilization program. The Tunisian and Mexican programs also contribute to the large average 1979 sub-grant budget totals in Africa and Central America (Table 2.7).

Table 2.7 Regional Budget Awards and Percents of Total Annual IPAVS Awards by Year, 1972-73 to 1979

<u>REGION</u>	<u>TOTAL REGIONAL BUDGET AWARDS</u>	<u>% OF TOTAL 1979 BUDGET AWARDS</u>	<u># OF SUBGRANTS</u>	<u>MEAN</u>	<u>MEDIAN</u>
Central America	\$2,082,281	32.3	18	\$115,682	\$41,803
South Asia	1,125,933	17.5	20	56,297	46,547
Caribbean	114,085	1.8	2	57,043	57,043
East Asia	1,028,336	16.0	18	57,130	42,121
Africa	1,707,119	26.5	12	142,260	37,453
Middle East	59,015	0.9	2	29,508	29,508
South America	291,885	4.5	6	48,648	33,343
North America	11,045	0.2	1	11,045	—
Europe	18,810	0.3	2	9,405	9,405
Oceania	—	—	—	—	—
TOTALS	\$6,438,509	100%	81	\$79,486	\$44,042

Sources of Sub-grant Funding

In 1979, over 99 percent of all sub-grant funds allocated by IPAVS were received from AID (Table 2.8). To the Federal portion, \$6,402,664, was added \$35,845 in private contributions raised by the Executive Committee of the Association for Voluntary Sterilization expressly for the purpose of supporting projects in countries which are ineligible for AID funds. There were fewer awards funded out of private contributions in 1979 -- down from \$42,000 in 1978 -- due to the fact that more countries, for example, Brazil, were eligible to receive AID dollars. Ecuador and Italy received private funding for new sub-grants, and France for the continuation of a sub-grant.

Table 2.8 Source of Budget Awards by Year, 1972-73 to 1979

Source of Funds	1972-73		1974		1975		1976	
	#	Amount	#	Amount	#	Amount	#	Amount
AID	23	373,139	31	1,190,644	32	738,231	39	1,291,432
Private Contributions	0	--	5	34,875	8	94,760	4	74,144
TOTALS	23	\$373,139	36	1,225,519	40	832,991	43	1,365,576
Source of Funds	1977		1978		1979		TOTALS	
	#	Amount	#	Amount	#	Amount	#	Amount
AID	66	3,795,404	48	2,827,834	78	6,402,664	317	16,619,348
Private Contributions	6	127,777	2	42,000	3	35,845	28	409,401
TOTALS	72	3,923,181	50	2,869,834	81	6,438,509	345	\$17,028,749

Sub-grant Awards by Program Components

Each sub-grant has a primary program focus, although any one sub-grant may have several program components. Components of IPA VS programs are: service, training, information and education, national associations for voluntary sterilization, equipment and repair and maintenance. Characterizing all sub-grants by primary program emphasis indicates the prevalence of any one program priority, while examining the frequency of various activities among sub-grants shows the pervasiveness of a program component irrespective of priority.

Table 2.9 shows the numerical distribution of 1979 sub-grant awards according to primary program emphasis and the frequency of each component among all awards. As in previous years, service is the most frequent

Table 2.9 Incidence of Program Components Among Sub-grants Awarded, 1979

PROGRAM COMPONENT	INCIDENCE OF COMPONENT					
	Among all Sub-grants				Among 51 Sub-grants with Services	
	As Primary Emphasis		As One Activity		#	Frequency
	#	%	#	Frequency	#	Frequency
Service	42	51.9	51	63.0	51	100.0
Training	12	14.8	29	35.8	24	47.1
NAVS	11	13.6	11	13.6	0	0
Repair & Maintenance	6	7.4	9	11.1	3	5.9
Equipment	2	2.5	57	70.4	32	62.7
Information & Education	6	7.4	53	65.4	38	73.1
Other*	2	2.5	1	1.2	0	0
TOTALS	81	(100.0)**				

* includes one special study and administrative costs for a national leadership group

** percentages do not add due to rounding

primary program emphasis and, this year, is the focus for almost 52 percent of all sub-grant awards. National associations and training continue to be prime program areas as well. In 1979, for the first time, IPAVS awarded six sub-grants whose primary program emphasis is information and education.

Table 2.9 also shows, for 1979, the frequency with which each program component is represented among all sub-grantee awards. There is an emphasis on multi-component programs among sub-grantees. For example, while 42 sub-grantees are primarily service programs, an additional 9 grantees, having different primary purposes, also provide services; while only six programs are primarily information and education, an additional 47 are budgeted for this component; while well over half the sub-grantees have equipment budgets, only 2 are receiving allocations primarily for equipment.

Given the IPAVS philosophy that services cannot be offered in isolation, it is worthwhile to examine the other components of the 51 sub-grants which provided service, as either a primary emphasis or as a component. Table 2.9 shows that almost three-quarters of the service sub-grants were also funded by IPAVS for information and education; 47 percent had training components; almost 63 percent had equipment components. Although not indicated by the table, all but four service programs were funded for other components as well.

Table 2.10 illustrates the distribution of budget allocations among budget categories and shows that the majority of funds are earmarked

Table 2.10 Distribution of Sub-grant Funds Among Sub-grant Budget Categories by Year, 1972-73 to 1979

SUB-GRANT BUDGET CATEGORY	1972-73	1974	1975	1976	1977	1978	1979	TOTAL AWARDS
PERSONNEL	\$ 28,939	\$ 103,010	\$229,811	\$ 516,302	\$ 868,867	\$ 965,813	\$2,169,357	\$4,882,120
SERVICE	133,540	321,167	143,886	222,791	418,428	355,595	794,642	2,390,049
TRAINING	20,025	70,958	55,848	50,237	288,475	69,136	301,193	855,872
INFORMATION & EDUCATION	15,405	106,707	66,652	108,143	170,796	110,709	300,607	879,218
MEDICAL EQUIPMENT	108,410	440,985	244,610	200,242	1,493,847	867,924	970,416	4,326,435
RENOVATION	---	---	980	8,000	202,456	75,860	908,292	1,195,588
OTHER	66,820	182,692	91,204	259,661	480,292	424,797	994,002	2,499,467
TOTALS	\$373,139	\$1,225,519	\$832,991	\$1,365,576	\$3,923,181	\$2,869,834	\$6,438,509	\$17,028,749

for personnel and for equipment. Almost twelve times more funds were allocated for renovation in 1979 than in 1978, an indication of the IPAVS commitment toward providing for adequate facilities for services.

Appendix B lists all sub-grants awarded in 1979.

Small Grant Awards

In 1974, IPAVS established a funding mechanism that would permit a quick response to inexpensive requests and avoid the lengthy process characteristic of sub-grant proposals. The "small grant" mechanism is used for awards of \$5,000 or less in the following categories:

- medical or surgical equipment;
- provision of audio/visual materials and equipment for use in information and education programs;

- training for medical, paramedical and public health professionals in administration and delivery of voluntary sterilization services, including training by specialists in surgical techniques;
- training of selected administrators and specialized technicians in the repair and maintenance of endoscopic equipment; and
- travel and/or per diem expenses for selected conference participants or for key administrators and health professionals for orientation to the work of IPAVS or IPAVS sub-grantees.

Table 2.11 shows that 361 small grants were awarded over the period 1974 to 1979. Of the total for all years, 112, or almost one-third, were awarded in 1979.

Table 2.11 Number of Small Grants by Purpose and Year, 1974 to 1979

PURPOSE	1974		1975		1976		1977		1978		1979		TOTAL	
	No.	%	No.	%										
MEDICAL EQUIPMENT	24	77.4	15	57.7	15	49.0	38	60.3	60	71.7	83	74.1	241	66.8
TRAVEL	1	3.2	4	15.4	10	31.0	3	4.8	8	8.7	9	8.0	35	9.7
TRAINING	6	18.4	7	26.9	11	34.7	6	9.5	10	10.9	3	2.7	43	11.7
A/V MATERIAL	--		--		--		15	23.8	8	8.7	14	12.5	37	10.2
OTHER	--		--		1	3.1	1	1.6	--		3	2.7	5	1.4
TOTAL	31	100.0	26	100.0	37	100.0	63	100.0	92	100.0	112	100.0	361	100.0*

*Percentages do not add due to rounding.

In 1979, small grant allocations totalled \$175,661 (see Table 2.12), most of which were awarded for medical and surgical equipment. Among the equipment for which 1979 funds were provided were 30 sets

Table 2.12 Number and Amount of Small Grant Awards by Purpose and Geographic Region, 1979

REGION	MEDICAL EQUIPMENT		TRAINING		TRAVEL		A/V		OTHER		TOTALS	
	Amount	No.	Amount	No.	Amount	No.	Amount	No.	Amount	No.	Amount	No.
AFRICA	\$ 36,689	25	*	1	\$2,643	2	\$4,525	5		0	\$ 46,857	33
CENTRAL AMERICA	24,036	14	*	1	760	1	1,200	3	*	1	25,996	22
SOUTH AMERICA	21,600	8		0		0		0		0	21,600	8
EAST ASIA	9,918	6		0	1,222	1	975	3	*	1	12,115	11
SOUTH ASIA	42,480	17		0	*	1	400	1		0	42,880	19
CARIBBEAN	13,640	6		0	*	1		0	\$ 120	1	13,760	8
MIDDLE EAST	8,378	6	*	1		0	575	2		0	8,953	9
EUROPE	1,500	1		0	*	1		0		0	1,500	2
TOTALS	\$163,241	83	*	3	\$4,625	9	\$7,675	14	\$ 120	3	\$175,661	112

* Amounts not yet established

of endoscopic equipment. These awards followed the approval for purchase of this equipment from AID/W and the International Committee in 1978.

Also illustrated in Table 2.12 are the numerical and funding distributions of small grants by region by category. Africa is the region which received the most money and the largest number of small grants, showing the efficacy of having a quick and simplified grant mechanism to provide start-up training and equipment for countries in which the program is new.

Appendix C lists individual small grant awards for 1979.

Special Equipment Grants

Special equipment grants were established to provide equipment in bulk when there are no other direct IPAVS program costs involved.

Five grants were awarded in 1979, as follows:

Recipient Agency	Country	Amount	Purpose
Bangladesh Association for Voluntary Sterilization (BAVS)	Bangladesh	\$140,089	To provide medical equipment to 12 BAVS Satellite Clinics which are co-funded by UNFPA and the Government of Bangladesh
Ministry of Health and Social Assistance	El Salvador	\$ 45,413	To provide voluntary sterilization and other items of equipment to 13 health centers in El Salvador to increase voluntary sterilization service capacity in each of these institutions.
Indonesia* Society for Voluntary Sterilization (PUSSI)	Indonesia	309,263	To provide minilaparotomy and vasectomy kits and endoscopic equipment to be distributed to trainees who have been certified under the auspices of PUSI's National Voluntary Sterilization Program.
Mexican Social Security Institute (IMSS)	Mexico	381,570	To provide a bulk supply of equipment to be used in the IMSS's service and training program in the surgical techniques of permanent fertility control as part of the National Family Planning Program.
TOTAL		\$876,335	

*Two grants awarded

CHAPTER 3

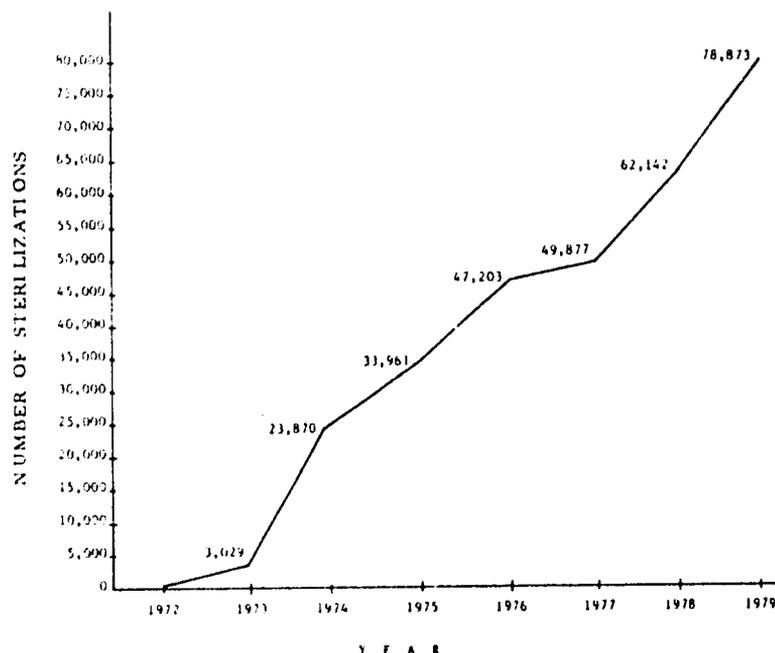
PROGRAM ACCOMPLISHMENTS

One of the principal operational objectives of IPAVS is to provide quality medical treatment to men and women who freely choose voluntary sterilization as a method of permanent contraception. Our accomplishments in meeting this objective are measured in part by program data on the numbers of acceptors and their characteristics, the quality of medical and support services provided and the improvement of such services through the provision of training and modern equipment.

Section 1. Service Acceptors

In 1979, 72 sub-grants with service components were operational and reported a total of 78,873 voluntary sterilization procedures - an increase of approximately 28 percent over 1978. Figure 3.1 shows the total numbers of sterilizations reported annually since 1972 and

Figure 3.1 Number of Voluntary Sterilizations Reported Annually by IPAVS Sub-grantees, 1972 to 1979



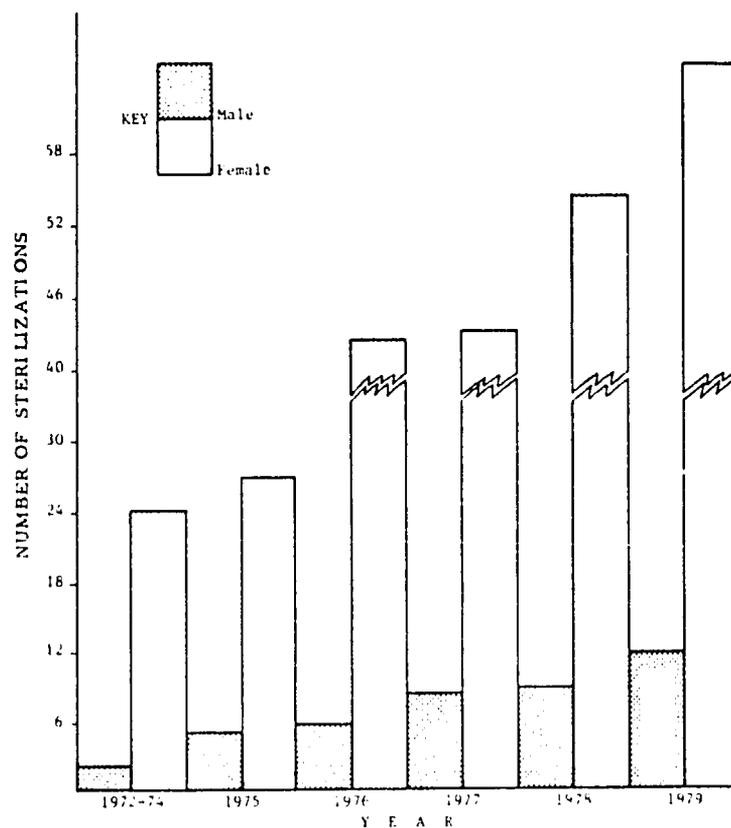
illustrates the rate of IPAVS service program growth. Table 3.1 shows that the number of male procedures gradually increased -- from 2,303 in 1972-74 to 12,324 in 1979 -- over the history of the program, but showed a dramatic increase of 45 percent in the past year (See also Figure 3.2). Central America, East and South Asia, the regions reporting the bulk of all male procedures in 1979, each showed increases of 40 percent or more.

Regions showing marked increases in numbers of female procedures for 1979 are South America, Central America, Africa and South Asia. These three regional totals reflect recent reintroduction of program activities in Colombia, the implementation of a government program

Table 3.1 Number of Male and Female Sterilizations Reported by IPAVS Sub-grantees by Region and Year, 1972-74 to 1979

REGION	Male Sterilizations							Female Sterilizations							TOTAL FEMALE	TOTALS MALE & FEMALE
	1972-74	1975	1976	1977	1978	1979	TOTAL MALE	1972-74	1975	1976	1977	1978	1979			
East Asia	1,251	1,896	2,075	1,903	2,806	3,968	13,599	15,226	18,292	23,811	16,708	15,182	11,148	100,367	113,966	
South Asia	30	3,569	4,287	3,177	4,091	5,655	22,739	510	3,422	6,751	11,231	19,378	24,391	67,683	90,422	
Middle East	-0-	-0-	-0-	-0-	35	93	128	288	218	13	455	775	540	2,269	2,417	
Africa	-0-	-0-	-0-	10	-0-	33	65	-0-	172	269	100	885	1,782	3,208	3,273	
Caribbean	24	24	19	9	8	20	95	583	1,433	554	664	751	437	4,422	4,517	
Central America	2	189	437	1,582	1,614	2,518	6,342	5,298	3,884	3,963	9,873	14,708	22,164	59,840	66,182	
South America	996	-0-	29	23	34	35	1,117	3,448	542	3,004	2,472	1,965	6,087	17,818	18,935	
TOTALS	2,303	5,498	6,838	8,424	8,498	12,324	44,085	25,353	28,263	40,365	41,453	53,644	66,549	255,627	299,717	

Figure 3.2 Number of Male and Female Sterilizations Reported (All Regions)
by Year, 1972-74 to 1979

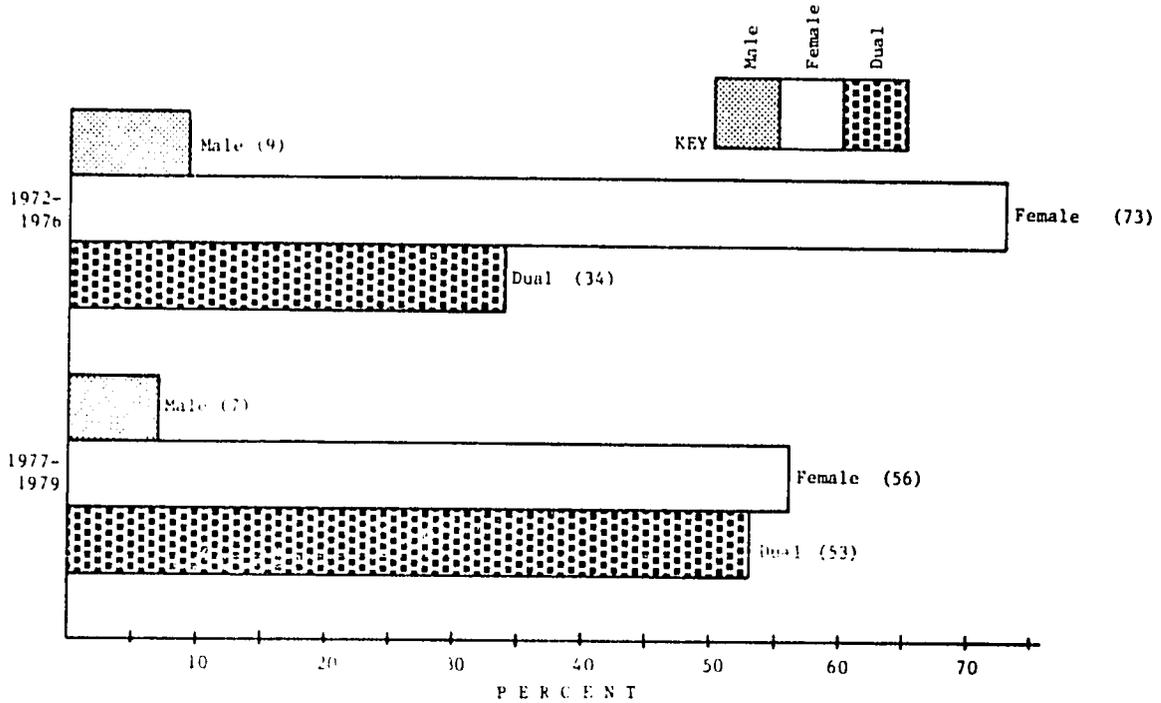


in Mexico, the new IPAVS emphasis in Africa and the funding of a number of new service programs in Bangladesh. The marked decline in reported female sterilizations for 1979 in East Asia is explained by the fact that, in this region, many of the older programs have achieved self-sufficiency and, although they continue to provide services, no longer report to IPAVS. In 1979, four programs became self-sufficient in Korea, two in the Philippines and two in Thailand.

Male and Female Acceptors of Services

As in the past, many more services were provided for women in 1979. However, as illustrated in Figure 3.3, the proportion of dual

Figure 3.3 Percent Distribution of Male, Female and Dual Programs Prior and Subsequent to 1977



program -- in which both male and female procedures are performed -- increased substantially subsequent to 1976, essentially because of the increase in the number of dual programs. Table 3.2 shows that of the 46 service programs awarded in 1979, only three were for males

Table 3.2 Number of Sub-grants with Service Programs Awarded, 1979 by Region and Sex of Target Population

	Male/Female	Female	Male	Totals
East Asia	0	3	2	8
Central America	8	2	1	11
South Asia	13	2	--	15
Africa	1	6	--	7
Caribbean	1	--	--	1
South America	--	4	--	4
TOTALS	26	17	3	46

only. thus, the 1979 increases in male sterilizations indicate that more males are taking advantage of the services provided by dual programs.

While IPAVS encourages provision of services to both sexes within the same facility, local prejudices may interfere with the continued expansion in the numbers of dual programs. In fact, as IPAVS intensifies efforts in Africa and South America, where male acceptance of services is mediated by strong cultural taboos, a shift in favor of female programs is expected to be reflected in future program statistics. Such an expectation is supported by the data in Table 3.2, which shows the geographic distribution of dual programs among sub-grants awarded in 1979. Ten of the 17 female programs and no male programs were awarded in Africa and South America; the only male services in these two regions were made available through a dual program in Mauritius.

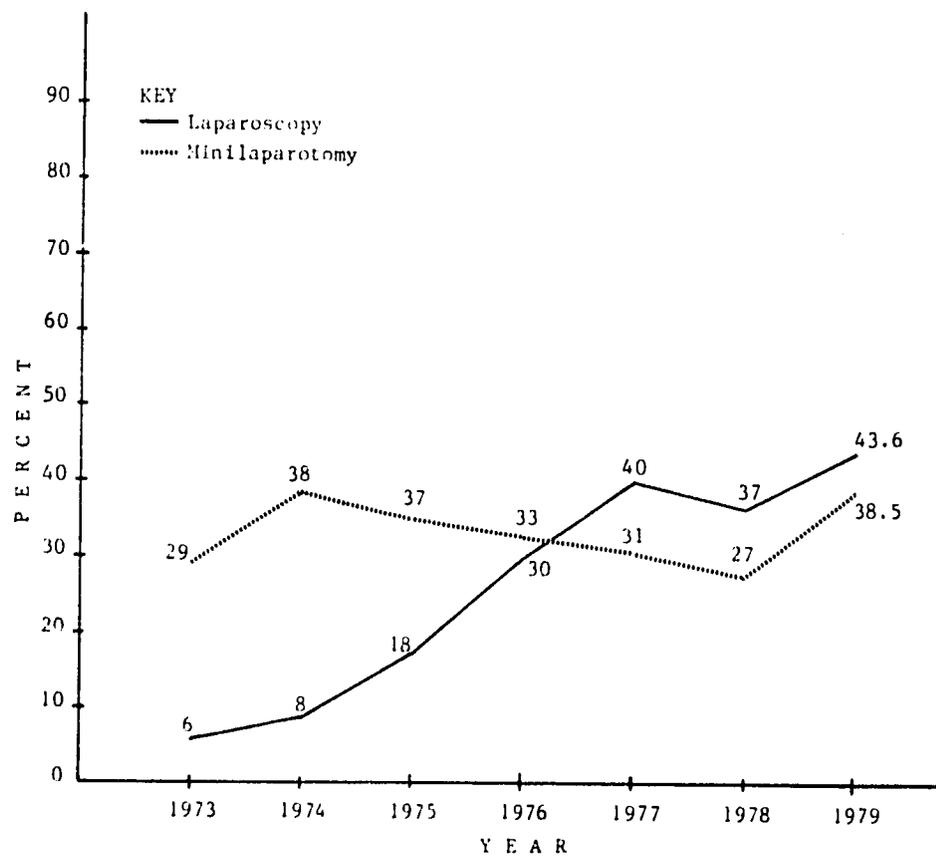
Changes in Techniques: Female Sterilizations

IPAVS's policy with respect to surgical methods used in voluntary sterilization avoids the promotion of any one technique. Service programs are expected to use, under appropriate safeguards, the simplest surgical techniques most suited to the settings in which they are performed with every effort to provide the safest and surest sterilization services. Table 3.3, which shows the distribution of the types of female procedures employed by sub-grantees from 1972 to 1979, illustrates the changes that have occurred in choice of surgical procedure during this period. There has been a dramatic increase in minilaparotomy from 6 percent of all female procedures in 1973 to the prevalent technique in 1979 (Figure 3.4). Laparotomy has markedly declined as have colpotomy and

Table 3.3 Percent Distribution of the Types of Female Sterilization Techniques Reported by IPAVS Sub-grantees, by Year, 1972-73 to 1979

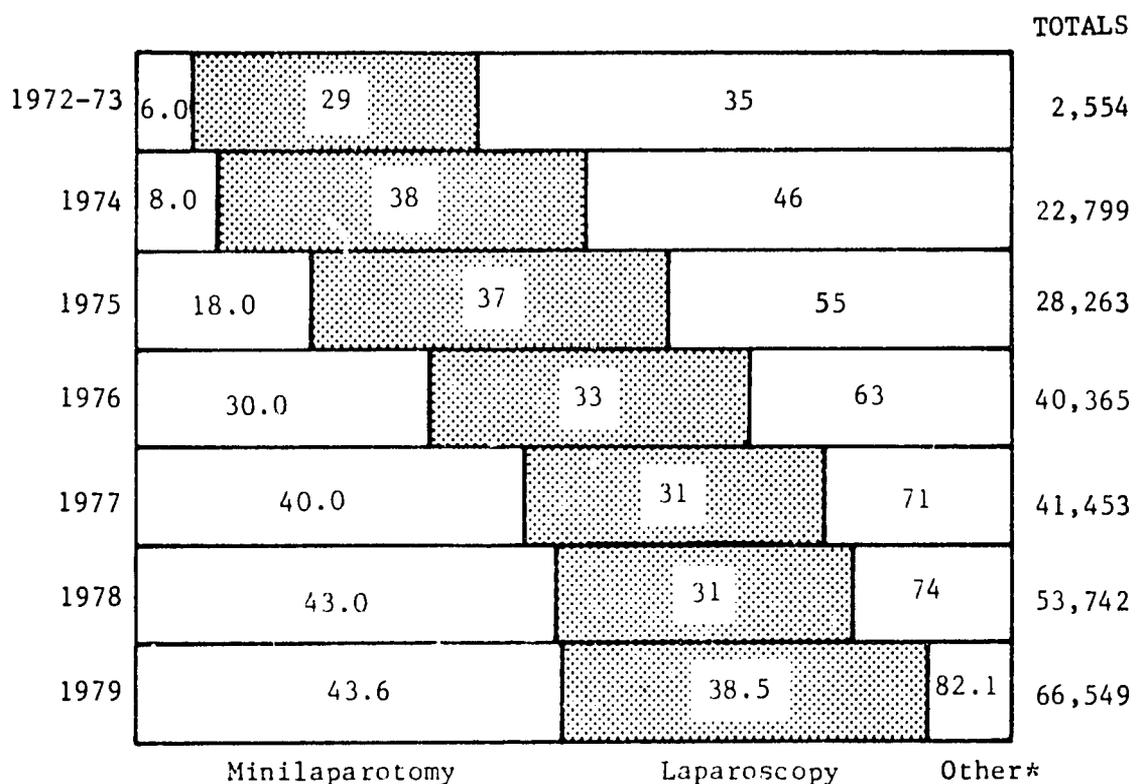
YEAR	TOTALS (All Techniques)		Mini- laparotomy	Lapa- roscopy	OTHER INTERVAL			Post- partum	Other
	#	%			Pome- roy	Colpo- tomy	Culdo- scopy		
1972-73	2,554	100	6	29	45	1	2	16	1
1974	22,799	100	8	38	9	3	5	30	7
1975	28,263	100	18	37	8	5	3	24	4
1976	40,365	100	30	33	5	3	2	24	3
1977	41,453	100	40	31	6	<1	<1	19	3
1978	53,742	100	43	31	7	<1	2	12	4
1979	66,549	100	44	39	5	<1	1	5	7

Figure 3.4 Percentages of Minilaparotomies and Laparoscopies Reported by IPAVS Sub-grantees by Year, 1973 to 1979



culdoscopy, two methods that were never widely popular. Laparoscopy procedures have remained relatively constant through the years, accounting for more or less one third of all procedures annually (See Figure 3.5). Postpartum sterilizations have decreased from 30 percent of all procedures in 1974 to five percent in 1979. The decrease is a reflection of the recent trend to support independent, free-standing clinics rather than funding services in hospital settings.

Figure 3.5 Proportions of Female Sterilization Techniques Reported by Year, 1972-73 to 1979



*Other: laparotomy, culdoscopy and culpotomy

The increasing use of the minilaparotomy and the steady popularity of laparoscopy point to the level of sophistication prevailing in IPAVS's

service programs, as these procedures are also in most widespread use in the developed countries. Both procedures, though one requires advanced technique, are also among the simplest and safest sterilization methods available. It is laudable that these two methods were used for over 80 percent of the 66,549 female procedures reported in 1979. The popularity of the two methods is expected to remain high as the program continues.

Age and Parity of Female Acceptors

Table 3.4 displays the mean age and parity of female acceptors over two year periods since 1975. Over time and in all regions, the average age has been between 30 and 36 with average parity between

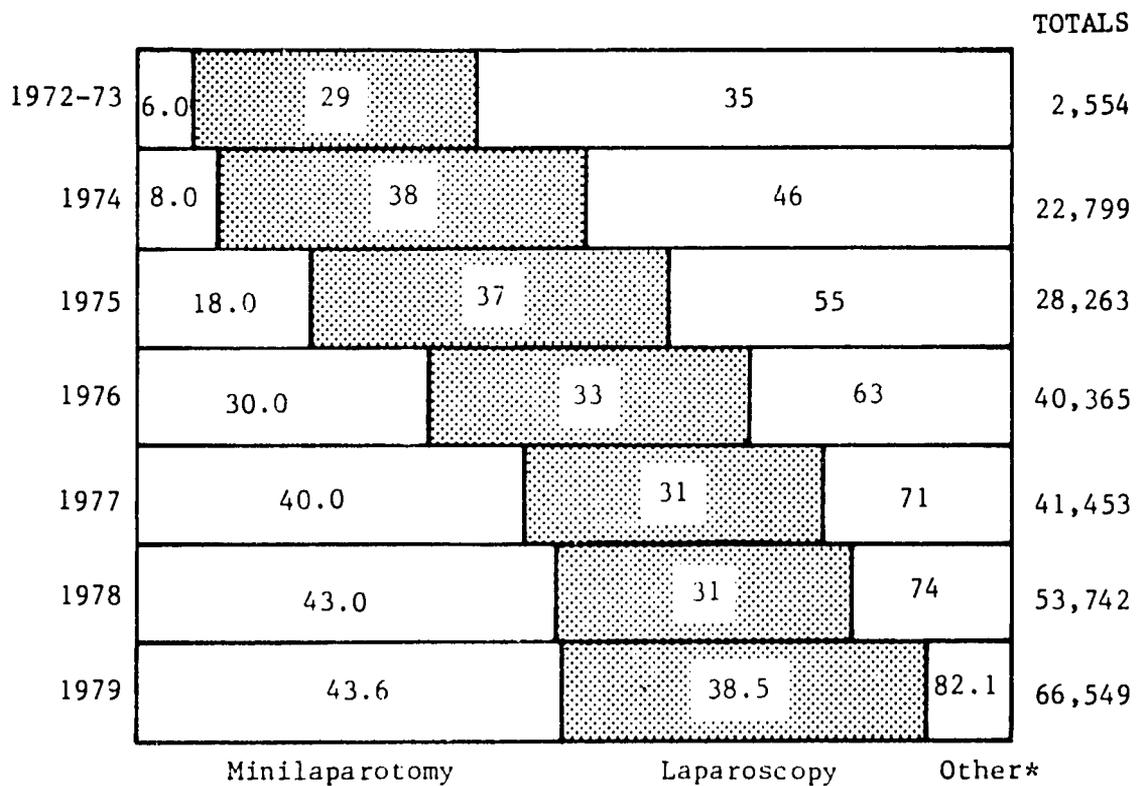
Table 3.4 Mean Age and Parity of Female Acceptors by Region, Biannually, 1974 to 1979

REG	1974-75		1976-77		1978-79	
	Age	Parity	Age	Parity	Age	Parity
AFR	33.6	5.5	34.9	5.4	36.1	5.3
ME	31.7	3.8	34.6	4.7	34.2	4.8
CAR	33.0	5.2	34.1	4.9	33.5	5.2
C.AM.	32.1	4.4	31.2	4.2	30.8	4.3
S.AM.	32.9	4.7	33.1	4.5	33.4	4.1
E.AS.	32.0	3.8	32.4	3.7	32.5	4.8
S.AS.	32.6	4.9	31.4	4.7	30.2	4.4

4 and 6. The reported data permit few inferences, and no real trends are observed over the six year period. The data for 1978-1979, graphically displayed in Figure 3.6, is representative of the data for each of

culdoscopy, two methods that were never widely popular. Laparoscopy procedures have remained relatively constant through the years, accounting for more or less one third of all procedures annually (See Figure 3.5). Postpartum sterilizations have decreased from 30 percent of all procedures in 1974 to five percent in 1979. The decrease is a reflection of the recent trend to support independent, free-standing clinics rather than funding services in hospital settings.

Figure 3.5 Proportions of Female Sterilization Techniques Reported by Year, 1972-73 to 1979



*Other: laparotomy, culdoscopy and culpotomy

The increasing use of the minilaparotomy and the steady popularity of laparoscopy point to the level of sophistication prevailing in IPAVS's

service programs, as these procedures are also in most widespread use in the developed countries. Both procedures, though one requires advanced technique, are also among the simplest and safest sterilization methods available. It is laudable that these two methods were used for over 80 percent of the 66,549 female procedures reported in 1979. The popularity of the two methods is expected to remain high as the program continues.

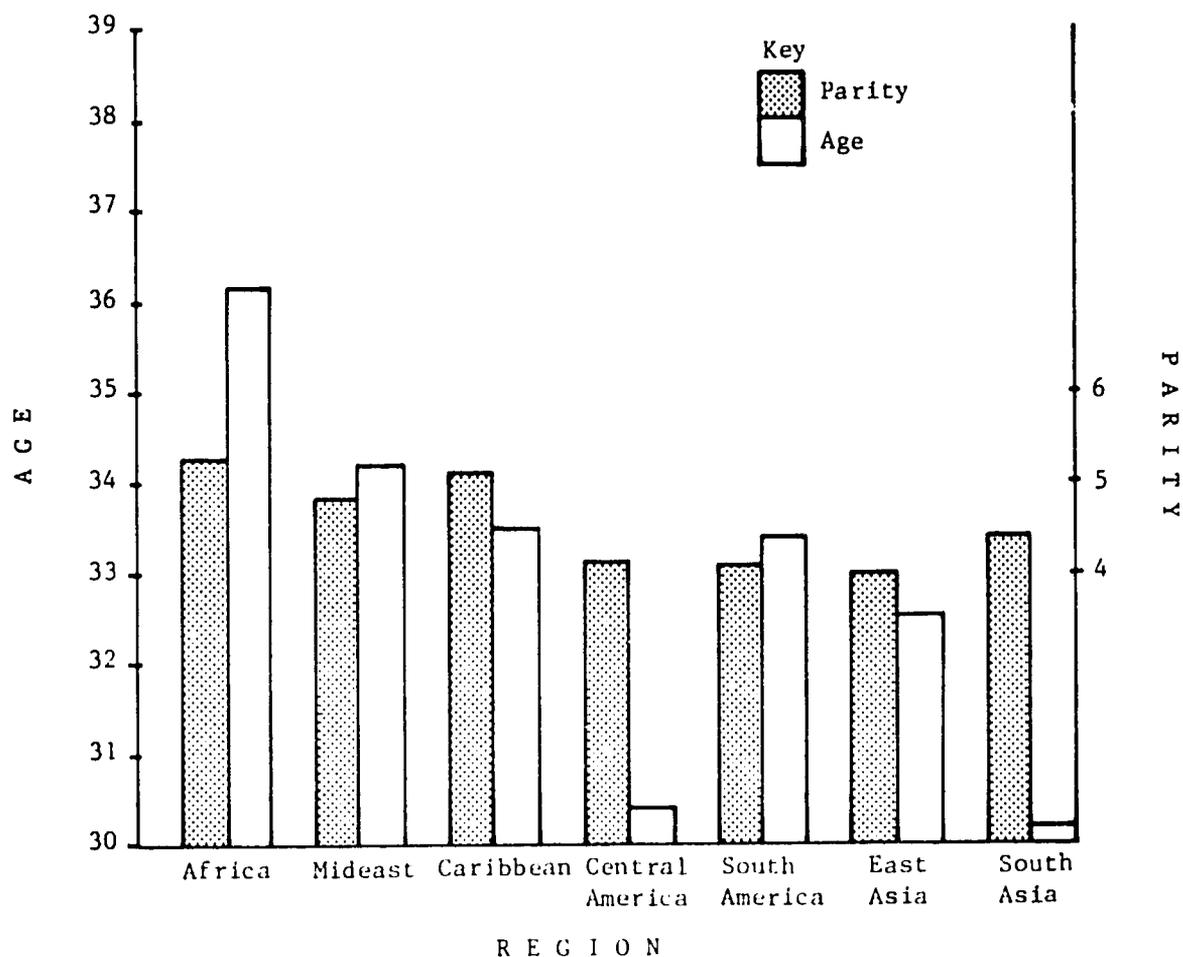
Age and Parity of Female Acceptors

Table 3.4 displays the mean age and parity of female acceptors over two year periods since 1975. Over time and in all regions, the average age has been between 30 and 36 with average parity between

Table 3.4 Mean Age and Parity of Female Acceptors by Region, Biannually, 1974 to 1979

REG	1974-75		1976-77		1978-79	
	Age	Parity	Age	Parity	Age	Parity
AFR	33.6	5.5	34.9	5.4	36.1	5.3
ME	31.7	3.8	34.6	4.7	34.2	4.8
CAR	33.0	5.2	34.1	4.9	33.5	5.2
C.AM.	32.1	4.4	31.2	4.2	30.8	4.3
S.AM.	32.9	4.7	33.1	4.5	33.4	4.1
E.AS.	32.0	3.8	32.4	3.7	32.5	4.8
S.AS.	32.6	4.9	31.4	4.7	30.2	4.4

4 and 6. The reported data permit few inferences, and no real trends are observed over the six year period. The data for 1978-1979, graphically displayed in Figure 3.6, is representative of the data for each of

Figure 3.6 Mean Age and Parity of Female Acceptors by Region, 1979

the other two periods. Africa shows the highest mean age 36.1, and Central America and South Asia the lowest, 30.8 and 30.2 respectively. Average parity is relatively high across all regions and particularly high for age of mother in Central America and South Asia. There is the implication from these data that, on the average, women tend to choose sterilization in all regions after achieving parity 4, and to opt for sterilization before age 34 in all regions but Africa and prior to age 31 in South Asia and Central America.

Medical Complications

All sub-grantees are expected to subscribe to IPAUS medical standards (see Appendix A) as a condition of their sub-grant award. Furthermore, the IPAUS Field Clinician is responsible for medical site visits to sub-grantee facilities. Each facility providing services is also required to report major medical complications, using the Complications Report Form (see Appendix D) supplied by IPAUS. The form was introduced during 1979 as an addition to the sub-grant document in order to emphasize the importance of reporting complications.

In 1979, fifteen instances of complications were reported. The following were indicated in the reports: uterine perforations, bowel injuries, respiratory-related problems, tubal transections, bladder injuries, serious wound infections and post-sterilization sexual dysfunction. Additionally, thirteen pregnancies following female procedures were reported.

In 1979, there were five deaths related to female sterilization procedures. IPAUS responded to each with an immediate and full investigation. Four of the five facilities at which the fatalities occurred were visited by the IPAUS Field Clinician who interviewed personnel and analyzed the circumstances under which the death occurred. Even in cases in which no gross negligence was found, the facilities were evaluated for compliance with IPAUS medical requirements and, in one case, where there was not full compliance, clinic services were suspended. (Procedures for IPAUS response to sterilization-related deaths are found at Appendix E).

The five deaths among the 66,549 female procedures in 1979 represent a mortality rate of 7.51 per 100,000 procedures (see Table 3.5). In developed countries, the death rate for female sterilization is on the order of 10 per 100,000.¹ Even though IPAVS sub-grantees are operating in the lesser developed countries, the low death rate can be regarded as realistic. The following factors contribute to the credibility of such a low death rate: the high medical standards required of all facilities, standards which are often well above those in the rest of the country; the use of minilaparotomy and laparoscopy as the major sterilization methods; the virtual absence of the use of general anesthesia; the skill of the surgeons. That procedures are performed

Table 3.5 Female Mortality Rates (Reported Deaths per 100,000 Sub-grantee) Procedures by Year, 1973 to 1979

Year	Number of Deaths	Total Female Procedures	Mortality Rate
1973	0	2,554	0.00
1974	2	22,799	8.77
1975	0	28,263	0.00
1976	3	40,365	7.43
1977	4	41,453	9.65
1978	1	53,644	1.86
1979	5	66,549	7.51
TOTALS, OVERALL RATE	15	255,627	5.87

¹Green, Cynthia P., Voluntary sterilization: World's Leading Contraceptive Method. Population Reports, Special Topic Monographs, No.2 Washington, D.C., George Washington University Medical Center, Population Information Project, March 1978, page 56.

by such highly skilled physicians is not hyperbole when it is recognized that the physicians serving the IPAVS programs generally do no surgery other than sterilization; they are well trained and experienced.

As sub-grantees come into compliance with IPAVS medical standards and more are subject to scrutiny by trained staff physicians and consultants, the quality of medical services will continue to improve and IPAVS service programs will come closer to achieving the ideal of making voluntary sterilization the safest of all surgical procedures.

Section 2. Training Activities

Since 1972, IPAVS has recognized the need for training health professionals to serve voluntary sterilization programs. At first, the emphasis was solely on physician training, and IPAVS is proud of its record. Since 1972, IPAVS has provided training for physicians, many of whom were trained in more than one technique, in the following categories: endoscopic techniques, 1094 trainees; non-endoscopic techniques, 2016; vasectomy, 667; vasovasostomy, 2.

Since 1977, IPAVS has also been encouraging the training of non-physician support personnel and is presently supporting comprehensive training programs for the entire health care team including physicians, nurses, counselors, social workers and midwives.

In 1979, there were 41 or 44 percent of all active programs with training components, of which ten were new projects in 1979. Furthermore, in order to advance the goal of integration of voluntary sterilization services into national health care systems, IPAVS, wherever practical,

supports governmental training programs. In 1979, the following government programs were funded:

Country and Institution	Objectives
Morocco Ministry of Health	To establish a national training center and train 40 physicians in surgical techniques, and 80 paramedical personnel.
Mexico Ministry of Health	To train 30 physicians in minilaparotomy and vasectomy, 16 physicians in laparoscopy and 16 nurses to assist in the laparoscopic procedure.
Colombia PROFAMILIA	IPAVS will support service costs for the training of 180 Ministry of Health physicians in female techniques.
El Salvador Ministry of Health	To train 16 physicians in laparoscopy, 12 physicians in minilaparotomy and 6 nurses to assist in the operations
Tunisia ONPFP	To train 30 physicians in laparoscopy, 20 nurses in operating room procedures, and 80 midwives in family planning methods.

Physician Training

Table 3.6 indicates the reported number of physicians trained in either male or female or in both types of sterilization techniques since 1972. The totals represent individuals trained. (see p.3-14)

Program accomplishments for 1979 can be measured by the fact that

Table 3.6 Number of Physicians Trained (One or More Procedures) by Year, 1972-73 to 1979

	1972-73	1974	1975	1976	1977	1978	1979	Totals
No. Trained in Male Procedures	20	30	38	18	14	17	67	204
No. Trained in Female Procedures	3	163	247	298	211	311	449	1,702
Ratio Male to Female	7:1	1:5	1:6	1:16	1:15	1:19	1:6	1:8
No. Trained in Both Types	0	2	50	62	108	76	158	456
Total No. of Physicians Trained	23	195	335	378	333	424	674	2,362

almost 30 percent of all physicians trained in the history of the IPAVS program were trained in 1979, a year which also saw substantial increases in training in male as well as both male and female procedures. The expansion of the program is due in part to the increased support of national training programs which tend to have higher training objectives.

The regional distribution of physician trainees by procedure for 1979 is indicated in Table 3.7. The totals do not represent individuals, as many are trained in more than one technique. The procedure most often taught was minilaparotomy, which represents the major type of training in all regions except Africa. Following in popularity was laparoscopy, representing the majority of all procedures in Africa and about 46 percent of those in South America. Together, minilaparotomy and laparoscopy make up over 90 percent of all procedures taught in 1979, a gratifying statistic given the appropriateness of these procedures in developing countries. (see p. 3-15)

Table 3.7 Number of Physicians Trained in Different Procedures by Region, 1979 (Projected) - Includes Small Grants

Type of Procedure	East Asia	South Asia	Africa	Central America	South America	Middle East	TOTALS	
							#	%
Laparoscopy	30	0	47	47	151	0	275	31.6
Culdoscopy	30	0	11	0	0	0	41	4.7
Minilaparotomy	146	139	16	61	174	0	536	61.3
Colpotomy	0	0	9	0	0	0	9	1.0
Other Internal	0	2	0	0	0	0	2	.2
Postpartum	6	5	0	0	0	0	11	1.3
Total Female	212	146	83	108	325	0	875	100
Vasectomy	139	53*	0	34	0	1	227*	100
Total Female & Male	351	193	83	142	325	1	1,102	
Percent Female	60.4	73.7	100	76.1	100	0	79.4	

*includes one vasovasotomy

Male procedures represented one third or more of all training in three regions: Central America, South Asia and East Asia, areas in which male acceptance of sterilization is already high.

The regional distribution of physician trainees since 1972, illustrated in Table 3.8, shows Central America, East Asia and South Asia with relatively high numbers of vasectomy trainees. These areas along with South America also account for 94 percent of the total trainees in all techniques. The remaining six percent is divided among the other regions, which show a preponderance of training in female techniques. (see p. 3-16).

Table 3.9 illustrates the number of trainees by procedure annually since 1972-73. As mentioned, each procedure total represents the number of individuals trained in that particular technique, and the totals can-

Table 3.8 Cumulative Number of Physicians Trained in Different Procedures by Region, 1972 to 1979

Type of Procedure	AFR	CAR	CAM	SAM	EAS	SAS	EUR	MEA	OCE	TOTAL	
										#	%
Laparoscopy	71	8	232	253	348	15	-	21	-	948	30.4
Culdoscopy	15	-	1	-	127	1	-	2	-	146	4.7
Mini-Laparotomy	28	-	107	229	758	420	-	14	9	1,566	50.4
Colpotomy	13	-	1	-	30	12	1	15	-	72	23.2
Other Interval	5	-	4	16	50	7	-	-	-	82	26.4
Post-Partum	3	-	60	33	154	36	-	10	-	296	9.5
TOTAL FEMALE	136	8	405	531	1,467	491	1	62	9	3,110	100
Vasectomy	0	0	70	30	359	208	1	1	0	669	100
TOTAL FEMALE & MALE	136	8	475	561	1,826	699	2	63	9	3,779	
PERCENT FEMALE	100	100	86.5	94.5	80.3	70.2	50	98.4	100	82.3	

Table 3.9 Number of Physicians Trained in Different Procedures (All Regions) by Year, 1972-73 to 1979 - Includes Small Grants

Type of Procedure	1972-73	1974	1975	1976	1977	1978	1979**	Totals	
								#	%
Laparoscopy	1	119	143	126	128	158	275	950	30.6
Culdoscopy		22	32	26	4	21	41	146	4.7
Minilaparotomy		29	189	262	253	293	536	1,562	50.3
Colpotomy		23	4	13	11	12	9	72	2.3
Other Interval	2	5	11	27	18	17	2	80	2.6
Post-Partum	2	27	47	89	49	70	12	296	9.5
TOTAL FEMALE	4	225	426	543	463	571	875	3,108	100
Vasectomy	20	32	90	87	122	91	227	669	100
TOTAL MALE & FEMALE	25	257	516	630	585	662	1,102	3,777	
PERCENT FEMALE	16.0	87.5	82.6	86.2	79.1	86.3	79.4	82.3	

*projected

**includes one vasovasotomy

not be summed to represent the number of individual trainees as some were trained in more than one technique. As the table shows, vasectomy, laparoscopy and minilaparotomy training has expanded considerably since 1972. The particularly steep increment in vasectomy in 1979 is a result of large vasectomy training programs in Nepal and Korea. While training in minilaparotomy increased significantly in 1979, it has not completely displaced laparoscopy, which enjoys a prestige in rural areas, no doubt because of the sophisticated instrumentation used for the procedure.

Figure 3.7 graphically portrays the data in Table 3.9 and shows the marked domination of minilaparotomy, vasectomy and laparoscopy procedures in the more recent years of the IPAVS training program.

Figure 3.7 Number of Physicians Trained in Different Procedures by Year, 1973 to 1979 - Includes Small Grants (All Regions)

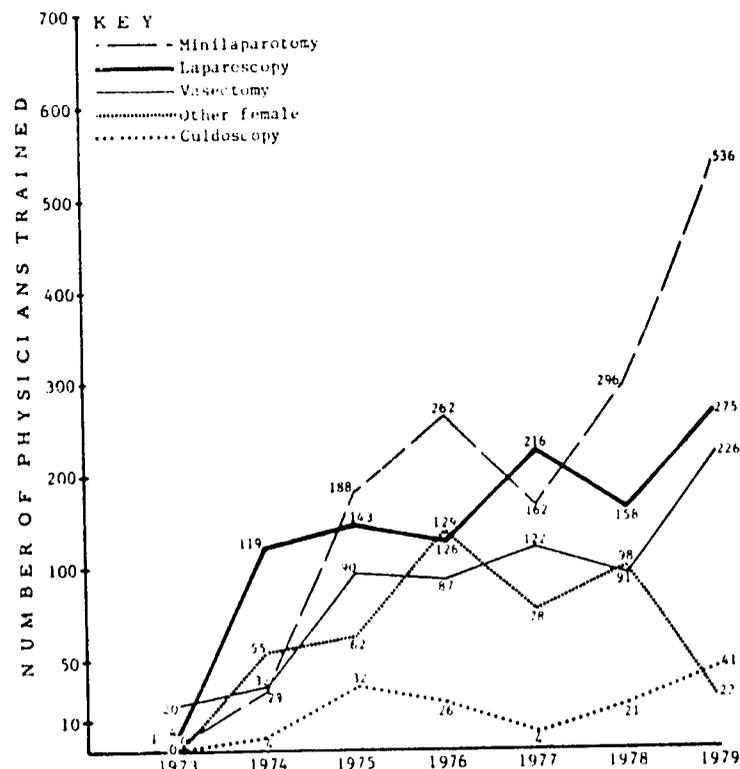


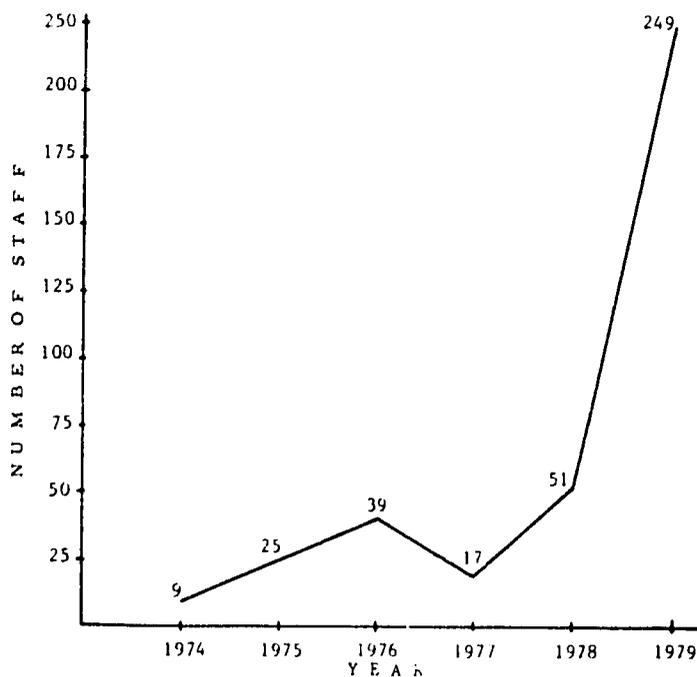
Table 3.10 Number of Health Support Personnel Trained by Region and Year, 1974 to 1979

Region	1974	1975	1976	1977	1978	1979	Totals
Africa					1	98	99
Caribbean	3			1			4
Central America	3	3	14	13	36	33	102
South America	1		10		7		18
East Asia	2	21	13	1	2	55	94
South Asia		1	2	2	5	63	73
Totals	9	25	39	17	51	249	390

Training for Health Support Personnel

Training programs for non-physicians has been expanded by IPAVS in recent years. As Table 3.10 and Figure 3.8 illustrate, IPAVS has been financing the training of health support personnel since 1974, but the program

Figure 3.8 Number of Health Support Staff Trained by Year, 1974 to 1979



has grown markedly since 1977. In fact, more than three times as many health support personnel were trained in 1978 and 1979 than were trained in the first four years of the program. One of the factors contributing to the increase is IPAVS's ability to move into the support of comprehensive national training programs. Such programs include larger para-medical training components.

The 1979 data in Table 3.10 and Figure 3.8 come from Trainee Record Forms (F82) submitted by sub-grantees to IPAVS where they are computerized. The forms were used for the first time in 1979 to tabulate training statistics; therefore, this year's data are more accurate than previous years' when they were estimated. Numbers represent the total number of individuals, as health support personnel are trained in but one area.

There are numbers of persons trained under IPAVS auspices, but not reported. For example, in service programs at teaching hospitals, interns, residents, and para-medical personnel are trained in conjunction with service delivery. Because only trainees involved in formal training programs are reported, it is accurate to state that IPAVS supports the training of many more personnel than are documented.

Table 3.10 displays the regional distribution by year of health support staff trainees from 1974 to 1979. These data reveal that the majority of trainees each year were in Asia and Central America, a logical result of IPAVS's long and continuous involvement in these regions. The 1979 jump in numbers of trainees in Africa follows IPAVS's recent activities in that region, in particular, the new training center in Rabat, Morocco.

The types and numbers of personnel trained are shown in Table 3.11. The largest group of trainees is paraprofessionals, who are primarily nurses' aides. Nurses, representing 34 percent of all trainees, are trained to assist during surgery and are taught the care and handling of surgical equipment. Anesthetists, who are often also nurses, receive training in anesthesia techniques appropriate to the service delivery sites where they are used. Equipment technicians are trained in maintenance and repair of endoscopic equipment. Curricula for counselors and outreach workers include interviewing, patient screening, informed consent and non-surgical and surgical family planning methods.

Table 3.11 Distribution of Health Support Personnel Trained by Type of Trainee, 1974 to 1979

TYPE OF TRAINEE	# OF TRAINEES	PERCENTAGE
Equipment technicians	24	6
Nurses	133	34
Anesthetists	36	9
Counselors	10	3
Outreach workers	20	5
Paraprofessionals	167	43
Totals	390	100%

Training Evaluation and Trainee Follow-up

A mechanism to permit appropriate follow-up of IPAVS trainees is currently under development. Standards for follow-up are currently being refined and will be established in final form in 1980. The standards will be applied to all formal training grants.

In 1979, IPAUS funded an evaluative study of the generational physician training program at Ramathibodi Hospital, Thailand, the results of which were published and distributed by the hospital. The study, based on a sample of first generation (trained at the hospital), second generation (trained at satellite centers by first generation trainees) physician trainees plus a control group of other health service physicians, demonstrated that the majority of sterilizations performed at the hospital by all three groups were postpartum, but that first-generation trainees performed more interval procedures than the second-generation or control groups. The results tend to indicate a greater confidence on the part of the first-generation group, a finding corroborated by the more positive attitude toward the training exhibited by this group. The study also found no appreciable difference with regard to the safety of the procedures between the first and second generation trainees.

Section 3. Equipment

Major pieces of medical and surgical equipment are provided by IPAUS to sub-grantees having an approved equipment component budgeted or to those which are awarded special equipment sub-grants. In 1979, more than one million dollars in equipment was provided to sub-grantees almost doubling the amount expended in 1978. Special equipment grants, listed in Table 3.12, accounted for \$876,335 and the remaining amount secured instruments and other items for sub-grantees with equipment components. (see p. 3-22)

Table 3.13 shows the type and number of equipment items ordered for IPAUS projects in 1978 and 1979. The bulk of the surgical items

Table 3.12 Special Equipment Grants, 1979

SUB-GRANTEE	COUNTRY	BUDGET
Social Security Institute	Mexico	\$381,570
Bangladesh Association for Voluntary Sterilization	Bangladesh	140,089
Ministry of Health	El Salvador	45,413
Indonesian Society for Voluntary Sterilization (PUSSI)	Indonesia	258,750
Indonesian Society for Voluntary Sterilization	Indonesia	50,513
TOTAL		\$876,335

Table 3.13 Distribution of Equipment Items by Region, 1979

EQUIPMENT ITEM	1979	AMOUNT	1978	AMOUNT
Laparoscope, System "A"	59	\$ 277,300	41	\$192,700
Laparoscope, Ophcs only	6	5,400	16	14,400
Laparoscope, System "C"	1	2,000	8	16,000
Teaching Attachment	5	6,000	9	10,800
Vasectomy Kit	1007	76,532	380	28,880
Colpotomy Kit	5	650	2	260
Minilaparotomy Kit	1676	217,750	614	79,820
Culdoscopy Kit	30	63,000	33	69,300
Falope-Ring Applicator	18	5,400	6	1,800
Forcep	22	4,400	59	11,800
Anesthesia Machine	7	14,000	17	34,000
Operating Room Table	44	132,000	5	15,000
Operating Room Light	49	107,800	31	68,200
Gomco Aspirator	39	15,600	22	8,800
Autoclave	65	130,000	7	14,000
Laprocator	25	80,500	-0	-0
TOTALS	3,058	\$1,138,332	1,250	\$565,760

ordered include System "A" laparoscopes, vasectomy kits and minilaparotomy kits. In view of IPAVS's inclination and AID's policy to phase out System "A" laparoscopes in favor of laproscators -- safe, effective, less expensive instruments for sterilization by the Falope-Ring technique -- future decreases in the number of System "A's" distributed are expected as well as decreases in the numbers of component spare parts (scopes, teaching attachments, forceps) for that system. In 1979, 25 laproscators were distributed in 10 countries.

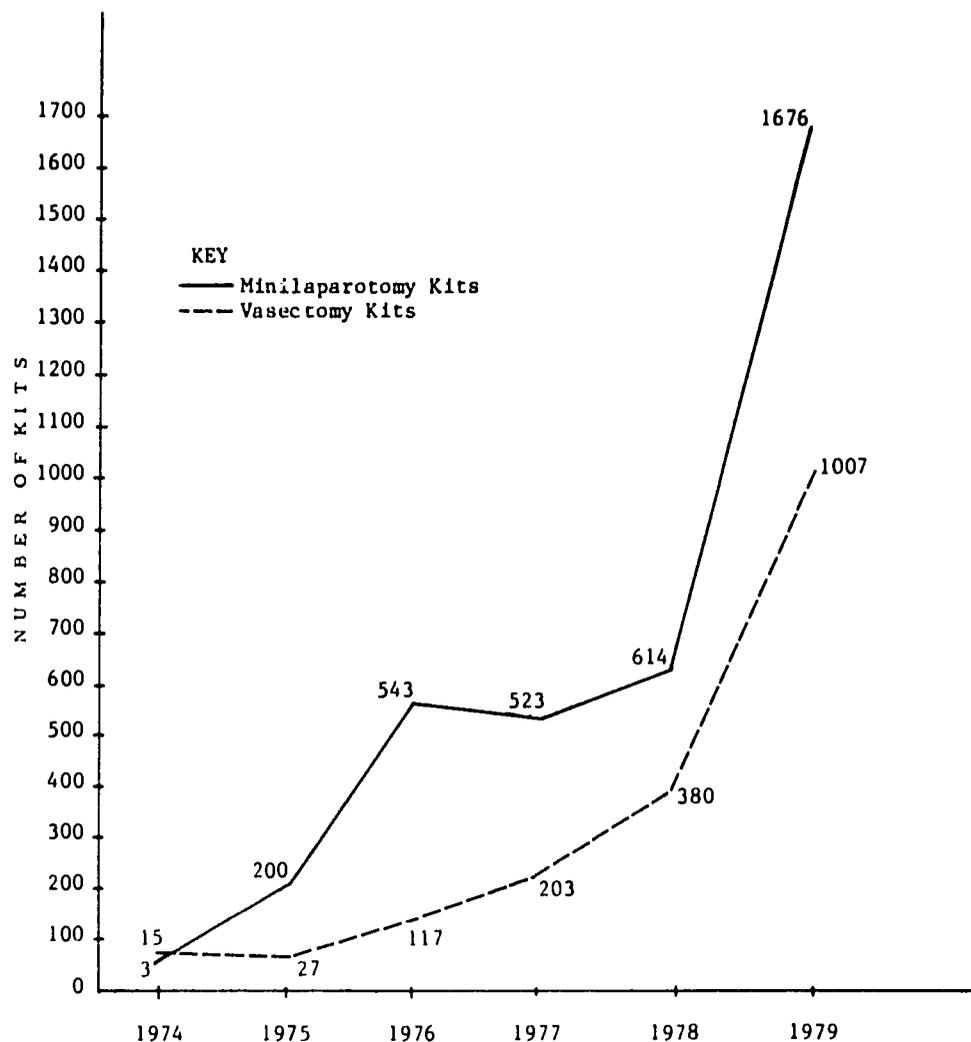
Table 3.13 also demonstrates IPAVS's continuing commitment to adequately stock operating rooms with lights and tables and with required emergency equipment. Thirty five percent of the 1979 equipment budget was expended for such items.

Figure 3.9 traces the provision of minilaparotomy and vasectomy kits from the year they became available until 1979 and illustrates the increasing demands for these inexpensive items. IPAVS will undoubtedly supply the kits in even greater numbers as their adaptability to rural settings becomes more widely recognized.(see p. 3-24)

Repair and Maintenance Centers

Because of the need to keep rather fragile endoscopic equipment in working order, IPAVS established its first Repair and Maintenance Center (RAM) in Korea in 1975 for the purpose of servicing publicly donated units. Additional RAM Centers have since been inaugurated in ten other countries: Mexico, Indonesia, Thailand, Egypt, Panama, Guatemala, Honduras, Jamaica, Tunisia and Morocco. The centers are

Figure 3.9 Number of Minilaparotomy and Vasectomy Kits Distributed by Year, 1974 to 1979



presently maintaining approximately 1,100 endoscopic units. IPAVS has also contributed to the support of a RAM facility in El Salvador by providing funds to cover the salary of the principal technician for one year. Whereas repair and maintenance is but one component of multi-purpose sub-grants in Guatemala and Morocco, the other countries' sub-grants are exclusively for the establishment and operation of RAM Centers.

New RAM Centers sub-grants awarded in 1979 are:

Honduras	\$15,040
Jamaica	28,905
Morocco	44,181

In view of the need expressed by sub-grantees for technical assistance, IPAVS asked the RAM Center in Mexico to develop a manual for the establishment and operation of such a service. The completed manual will be distributed to all IPAVS - funded RAM Centers. IPAVS also funded the Mexican RAM Center's Technical Services Manager to assist the Panamanian RAM Center in developing its systems and procedures. Future constultancies are planned and a RAM Center and Equipment Specialist will be added to the IPAVS staff.

In the future, the scope of activities at the IPAVS RAM Centers is expected to broaden to include the servicing of auxiliary equipment used in service programs. Repair and maintenance of operating room equipment is already being done by the Honduran Center at no cost to the sub-grant, and the repair of generators will likely be included in the Nepal Center under a sub-grant to be awarded to the Family Planning Association in 1980.

CHAPTER 4

INFORMATION AND EDUCATION

Section 1. Sub-Grant Awards for Information and Education Assistance

IPAVS is committed to the freedom of couples to choose the method of contraception which best suits their needs. To provide people with knowledge about voluntary sterilization, IPAVS supports Information and Education (I & E) activities as either a primary sub-grant function or as a component of service programs. Information and Education activities include development and general distribution of brochures, booklets and banners; mass media publicity for educating the lay public about voluntary sterilization; seminars and meetings; use of audio/visual equipment and materials in meetings or at clinics.

In 1979, of the 81 sub-grants awarded by IPAVS 53 included components for developing and disseminating information about voluntary sterilization to the general public or to special groups. Funds budgeted for information and education purposes in these sub-grants averaged five percent of their total 1979 budgets. This percentage has ranged between four and eight percent of total sub-grant budgets since 1974, as seen in Table 4.1, which also shows, significantly, that more than one-half the sub-grants awarded each year contained I & E components.

Table 4.2 illustrates that I & E budgets in sub-grants with this budgeted component averaged between \$4,400 and \$6,700 annually since 1974. The majority of all sub-grants for all years had annual budgets below \$10,000, and none or very few in any one year had components budgeted in excess of \$20,000. Each year, as well, up to seven sub-grantees included

Table 4.1 Number of Sub-Grants with I&E Components Awarded by Year, 1974 to 1979

YEAR	TOTAL NUMBER SUB-GRANTS AWARDED	TOTAL WITH I & E COMPONENTS		TOTAL FUNDS ALLOCATED TO I & E	% OF TOTAL YEAR'S SUB-GRANT FUNDS ALLOCATED TO I & E
		#	%		
1974	36	19	53	\$ 71,827	6
1975	40	26	65	63,465	8
1976	43	24	56	103,343	8
1977	72	42	58	149,223	4
1978	50	32	64	107,354	4
1979	81	53	65	300,607	5
TOTALS	322	196	61	\$795,819	

Table 4.2 Number of Sub-Grants with I&E Components by Size of Budget and Year, 1974 to 1979

I & E BUDGET LEVELS	1974	1975	1976	1977	1978	1979
No IPAVS Funding	3	2	3	7	5	7
Less than \$1,000	4	9	8	11	6	12
\$1,001 - 5,000	9	11	6	16	15	21
5,001 - 10,000	2	3	1	4	4	5
10,001 - 20,000	0	1	6	3	2	4
Over 20,000	1	0	0	1	0	4
TOTALS	19	26	24	42	32	53
AVERAGE BUDGET FUNDED PROJECTS	\$3,489	\$2,644	\$4,921	\$4,624	\$3,976	\$5,568

I & E activities exclusively. Information and Education activities in these other countries were designed to take place in conjunction with other service or physician training programs. The sub-grants devoted entirely to I & E account for 30 percent of all funds allocated for I & E by IPAVS in 1979.

Table 4.3 displays the numbers and average budgets for I & E activities by region. The most active regions in 1979 were South Asia and Central America. The largest budgetary commitment was made in East Asia. East Asia's seeming budgetary exuberance is due to that region's four national associations for voluntary sterilization, each funded almost exclusively for I & E activities.

Table 4.3 Average Sub-Grant Budget for I&E by Region, 1979

	Africa	Middle East	East Asia	South Asia	Central America	South America	Caribbean	Europe	Total
Number of Subgrants with I & E	10	2	8	16	13	2	1	1	53
Number With IPAVS Funds	8	2	7	16	9	2	1	1	46
Total I & E Budgets	\$20,935	\$10,450	\$92,378	\$72,770	\$78,584	\$16,490	\$4,250	\$4,750	\$300,607
Average I & E Budget of Funded Projects	\$ 2,617	\$ 5,225	\$13,197	\$ 4,548	\$ 8,732	\$ 8,245	\$4,250	\$4,750	\$ 6,535

Section 2. Counselling and Informed Consent

One of the prime concerns of IPAVS is to assure that individuals selecting sterilization as a means of limiting family size do so voluntarily, without coercion or pressure of any kind. Informed consent procedures were initially developed in 1973, after which they were refined and amended. In 1976, the present procedures were adopted, and are the first international informed consent procedures developed and implemented for literate as well as illiterate populations.

As part of these procedures, IPAVS requires that each potential acceptor be thoroughly counselled about all the non-surgical contraceptive methods as well as surgical contraception with regard to the advantages, disadvantages and risks. During the time that IPAVS assists prospective

sub-grantees with the development of service programs, careful attention is paid to the counselling procedures to be employed by the prospective service facility.

To promote voluntarism, IPA VS developed informed consent guidelines which must be followed by all service providers funded by IPA VS. The guidelines require that each person who considers being sterilized be advised in his or her native language of the risks and consequences of the surgical procedure. Before the sterilization is performed, the acceptor is asked to signify his or her full understanding by signing a special Informed Consent Form which includes the following points:

1. Nonpermanent contraceptive methods are available to the individual and his/her partner;
2. Sterilization is a surgical procedure;
3. There are discomforts and risks which have been explained to the individual by the physician and must include the fact that sterility is not guaranteed, the possible complications and the side effects of the procedure;
4. If successful, the operation will prevent the patient from bearing or fathering children;
5. The operation is considered to be irreversible;
6. The individual can decide against having the procedure at any time and no services or benefits will be withheld as a result of such a decision.

There is another requirement of the guidelines for individuals who are illiterate. A witness must be present during the counselling and must

sign the Informed Consent document after the acceptor has signed or made his/her mark. The form must subsequently be kept on file for a minimum of three years. IPSVS's informed consent guidelines, recommended procedures for their implementation and model Informed Consent Forms are shown in Appendix F.

IPAVS is currently funding 55 programs with service and/or training components which must have approved consent forms for either patient use or for physician use as part of training. Forty-three (78%) were in full compliance with IPAVS guidelines at the end of 1979. Of the 12 sub-grantees that were judged out of compliance with informed consent policy, seven had not yet submitted forms. These seven were awarded late in the year, and the programs had not become fully operational. The remaining five sub-grantees were in partial compliance, having omitted from their forms only one or two of the six points enumerated above. The point most frequently omitted is the last, which prohibits the withholding of services or benefits if the individual decides against undergoing the procedure. Correspondence with sub-grantees whose consent form does not include this point revealed that it is considered inappropriate in service facilities which provide only voluntary sterilization services and do not offer any other benefits which could be withheld.

IPAVS advised sub-grantees whose consent forms did not comply with IPAVS guidelines that funds would not be provided for voluntary sterilization services until proper consent forms are in use at the site and on file at IPAVS. When making site visits to facilities providing services, IPAVS staff members routinely review consent forms and procedures to assess

whether each sterilization performed is in documented compliance with IPAVS guidelines.

Section 3. Conferences

Conferences generate interest and spread knowledge of surgical contraception. They are forums for communication among professionals and are vehicles for advancing voluntary sterilization through the sharing of research findings. They serve as programmatic exchanges wherein new techniques may be shared and new materials reviewed.

In 1979, IPAVS involvement in such forums -- whether by direct sponsorship, by awarding grants to sponsors or by funding participation of delegates -- increased 50 percent over 1978 and included involvement in 18 meetings held in 14 countries. The meetings were national, regional and international and were attended by health and family planning experts as well as leaders from government and representatives of a variety of disciplines with overlapping population and developmental concerns.

Table 4.4 enumerates the conferences for which IPAVS made a contribution as sponsor, direct participation and/or support of delegate participation.

The 4th International Conference on Voluntary Sterilization.

More than 400 participants from 73 countries, 57 of which were developing nations, attended the IPAVS 4th International Conference in Seoul, Korea. See Table 4.5 for the represented countries. Eighteen countries were represented for the first time at an IPAVS major conference. In addition to sponsoring the meeting, IPAVS supported the attendance of more than 50

Table 4.4 Conferences at Which IPAVS Participated, 1979

CONFERENCE TITLE	PLACE/DATE	PRINCIPAL CONFEREES		IPAVS SUPPORT		COMMENTS
		PHYSI- CIANS	NON PHY- SICIANS	PAPER	ATTEN- DANCE	
*1st Asian Congress of Induced Abortion & Voluntary Sterilization	Bombay March 4-9	X			X	Organized by the Indian Association of Fertility and Sterility to address problems of fertility limitation in India and other parts of Asia
1st Pan-American Congress of Andrology	Caracas March 13-16	X	X	X	X	Addressed current and future trends in male sterilization; IPAVS staff delivered two papers
Egyptian Urological Association Conference	Cairo April 5-8	X		X	X	Addressed problems and technology of male fertility control
Korean Urological Association	Seoul May 11	X		X	X	After conference, there was a demonstration of microsurgical techniques for reversing vasectomy & transurethral resection of the prostate as well as assistance with fertility & prostate surgery at the Seoul National University Hospital by IPAVS sponsored attendees.
Annual Meeting of Indonesian Society for Voluntary Sterilization (PUSSI)	Jogjakarta June 16-17	X	X		X	More than 300 conferees; papers on reversibility of sterilization; Indonesia NAVS provided training for medical personnel
International Symposium on Medicated IUDs and Polymeric Delivery Systems	Amsterdam June 27-80	X		X	X	Papers on the action and side effects of inert, copper and steroid IUDs; seventy conferees
International Conference on Parliamentarians on Population and Development	Colombo, Sri Lanka Aug. 28-Sept. 1	X	X		X	A model law on voluntary surgical contraception was distributed to the delegates in order to stimulate legislative action
*St. Lucia Voluntary Sterilization Conference	Castries, St. Lucia Sept. 11-13	X	X	X	X	Forty medical and paramedical personnel, government officials and public health and family planning administrators attended; lectures and panels on techniques in male and female sterilization; the role of nurses; target populations; informed consent
JHPIEGO Conference on Surgical Equipment for Educational Programs in Reproductive Health	Key Biscayne, Florida Sept. 16-18	X		X	X	A review of the state of the art of laparoscopy and evaluation of the new laproscator; new techniques & methods of sterilization, training, anesthesia
Third Australian Symposium on Voluntary Sterilization	Sydney Sept. 23	X		X	X	More than 90 physicians from Australia and neighboring countries attended; program covered all aspects of male and female sterilization.
1st National Congress on Gynecological Endoscopy	Bombay Oct. 14-16	X		X	X	Conferees addressed population problems in India; IPAVS staff delivered paper
International Conference on Family Health Services	Nairobi Oct. 24-27	X	X		X	Approximately 100 attendees from developing countries; papers devoted to improvement of family health; discussions on maternal and child health care, health manpower and education; general reticence to discuss voluntary sterilization
Pan-Arab Medical Federation Meeting	Tunis Oct. 20-23	X	X		X	More than 1200 attendees; included a symposium on surgical contraception to promote its acceptance in Africa and the Middle East
6th World Congress of Gynecology and Obstetrics	Tokyo Oct. 24-31	X		X	X	Plenary session on social obstetrics
4th International Congress on Gynecological Endoscopy	Las Vegas Nov. 4-9	X	X		X	Attendees were physicians, engineers, scientists and administrators concerned with increasing the efficiency and effectiveness of medical care and research. Some physicians noted that laparoscopy has made voluntary sterilization acceptable abroad; popularity of laparoscopy in some developing countries may be because acceptors do not consider it a surgical procedure.
*Communications, Information & Education Workshop	Jakarta Dec. 3-5	X	X	X	X	Objective was to formulate a comprehensive set of policies and communication, information and education in order to increase acceptance of voluntary sterilization in Indonesia
6th Annual Congress of the Brazilian Society of Human Reproduction	Londrina Dec. 1-5	X		X	X	IPAVS papers at both Brazilian Conferences
*International Fertility Research Programs Seminar	Sao Paulo Dec. 8-9	X		X	X	

*IPAVS Sponsorship

Table 4.5 Countries Represented at Korea Conference, by Region

AFRICA (17)	<u>Central America</u> (7)	<u>Middle East</u> (6)
Benin *Cameroon Egypt Ethiopia Ghana Kenya *Mali Mauritius Morocco Nigeria Senegal *Seychelles *Sierra Leone Sudan *Swaziland Tanzania Tunisia	Costa Rica El Salvador Guatemala Honduras Mexico Nicaragua Panama	Iran Jordan Lebanon *Syria Turkey *Yemen Arab Republic (North)
	<u>South America</u> (9)	EUROPE (9)
	Bolivia Brazil Chile Colombia Ecuador *Paraguay Peru *Uruguay *Venezuela	*Belgium England France Germany *Italy Netherlands *Portugal Switzerland Yugoslavia
AMERICAS (25)	ASIA (20)	OCEANIA (2)
<u>North America</u> (2)	<u>East Asia</u> (9)	Australia New Guinea
Canada U.S.A.	*Hong Kong Indonesia Japan Korea Malaysia Philippines Republic of China Singapore Thailand	
<u>Caribbean</u> (7)	<u>South Asia</u> (5)	
*Barbados *Dominica Dominican Republic *Grenada Haiti Jamaica *St. Lucia	Bangladesh India Nepal Pakistan Sri Lanka	

*Countries represented for the first time at a major IPAVS conference (18).

percent of the delegates. Delegates included Ministers of Health, a Secretary of State and Public Health, Vice-ministers or Undersecretaries of Health as well as family planning officials, program planners, administrators, physicians, lawyers, educators, researchers and national policy makers.

The primary purposes of the Conference were to foster the integration of voluntary surgical contraception services into national health programs and to stimulate new programs that will result in increased availability, accessibility and acceptance of services. The conference afforded delegates both formal and informal opportunities for the exchange of information and ideas. It also permitted other international and regional health organizations an opportunity to dovetail their meetings.

The success of the Conference was borne out by two phases of a three-level evaluation designed to assess conference preparations, planning and implementation. Of the respondents, 98.5% rated the entire conference excellent or satisfactory. (Table 4.6)

Table 4.6 Assessment of Major Sessions from Overall Conference Evaluation Forms

Respondents were requested to indicate their satisfaction with the contents of each conference session. Figures in parentheses indicate number of persons responding. Percentages are proportion of those responding to each question.				
SESSION	RESPONSE:			
	EXCELLENT	SATISFACTORY	FAIR	NO RESPONSE
Special Evening Session	71.3% (127)	25.3% (45)	3.4% (6)	40
The Entire Conference	69.6% (125)	37.9% (78)	1.5% (3)	12
First Plenary Session	66.1% (127)	37.0% (75)	2.9% (6)	15
Seventh Plenary Session	55.2% (101)	41.0% (75)	3.8% (7)	35
Second Plenary Session	53.5% (108)	40.6% (82)	5.9% (12)	16
Luncheon Presentations	50.5% (101)	36.0% (72)	13.5% (27)	18
Fifth Plenary Session	49.3% (98)	47.2% (93)	3.0% (6)	21
Third Plenary Session	49.3% (98)	47.2% (94)	3.5% (7)	19
Fourth Plenary Session	42.7% (84)	48.2% (95)	9.1% (18)	21
Sixth Plenary Session	34.7% (66)	55.8% (106)	9.5% (18)	28

Eighty-three percent of the conference participants also requested IPAVS assistance (Table 4.7) in response to a questionnaire. The largest number of requests was for establishment or expansion of voluntary sterilization information and education programs. This indicates a perceived

Table 4.7 Requests for IPAVS Assistance

TYPE OF REQUESTS	NUMBER
To start or expand a voluntary sterilization Information & Education program	102
To train physicians and health personnel	95
To obtain equipment	88
To conduct seminars and workshops	85
To start or expand a voluntary sterilization service program	81
To obtain personal training in voluntary surgical techniques	69
To obtain specific information and literature	63
To organize a voluntary national association	<u>31</u>
Total requests received	614*

REGIONAL ANALYSIS	
REGION	NUMBER
Africa	30
Caribbean	11
Central America	21
East Asia	39
Europe	7
Middle East	6
North America	9
Oceania	2
So. America	21
So. Asia	35
Unlisted	2
Total	180

*Of the 402 conferees, 218 persons completed evaluation forms with 180 persons requesting one or more types of IPAVS assistance.

need on the part of professionals engaged in sterilization activities to increase public and peer receptivity to voluntary sterilization. Of almost equal concern was the expressed need to train physicians and health personnel in sterilization techniques. IPAVS has been following up on these requests by corresponding with and providing Grant Applications to respondents.

A Conference program and Task Force Assessment results are found at Appendices G and H.

Section 4. Library Activities

The purpose of the IPAVS library is to gather, disseminate and exchange information on voluntary sterilization and related topics for IPAVS staff and the international community. It functions as a resource in the field of voluntary sterilization, making its materials accessible to staff, sub-grantees, independent researchers, libraries and other interested parties. Table 4.8 indicates the expansion of the IPAVS library collection since 1973.

Table 4.8 Growth of IPAVS Library Collection, 1973 to 1979

	1973	1974	1975	1976	1977	1978	1979
Volume of Books	200	393	550	750	950	1,350	1,587
Serials (Titles)	64	143	200	200	144	182	187
Number of Reprints	300	1,381	1,970	2,750	3,450	3,100*	3,441
Volume of Audio-Visuals	15	30	36	43	68	88	99

*Figure adjusted to reflect relocation of catalogued journal articles, annual reports, and IEC materials.

In 1979, the library completed the compilation and publication of the four IPAVS Bibliographies. The newer editions update and expand the original versions, incorporating several new topics. The Audio/Visual Review File was also created for ease of use by staff in selecting audio/visual materials for distribution or showing to IPAVS guests. Wherever possible, it contains assessments of the items by staff members, including their recommendations for appropriate audiences. During the year the entire Audio/Visual Collection, including films, slides, cassettes, and filmstrips was converted to standard subject classification. Non-medical items are under the Library of Congress system, while medical items are classified under the National Library of Medicine system.

The library also conducts an audio-visual program for the IPAVS staff as part of a program to provide in-service training for IPAVS professional staff. Through this activity the library provides staff with an opportunity to become familiar with medical procedures used in sterilization and makes audio/visuals on patient education, family planning, and related topics available through regular lunchtime screening sessions. These sessions have been well-attended, indicating staff enthusiasm for the program.

IPAVS Publications

IPAVS prints and distributes and following publications:

IPAVS Informational Brochure

The brochure, Since the Dawn of Civilization, is due for an update in the near future. It is sent to interested parties on request and gives general information about IPAVS.

IPAVS Fact Sheet

The latest fact sheet was produced in 1978 and is due for an update. It is sent to interested parties on request and gives information on the number of sub-grants funded by IPAVS, types of services provided through these sub-grants, information and education activities, and WFAVS activities. The 1978 edition is available in French and English.

IPAVS Newsletter

The IPAVS Newsletter, which is published bimonthly, provides condensed information on recent events in the field, significant program accomplishments, scientific advances and other matters relating to surgical contraception. The Newsletter is routinely sent to all sub-grantees, many of whom receive multiple copies for distribution in their area, to approximately 2,430 other individuals on the IPAVS mailing list, and on request to others. Copies are always made available at conferences, meetings, and exhibits attended by IPAVS directors or staff.

Bibliographies

There were four bibliographies, prepared by the library and distributed in 1979:

1. A selected International Bibliography on Voluntary Sterilization - 1,000 copies reprinted.
2. A Selected International Bibliography of Audio/Visual Materials on Voluntary Sterilization - 1,000 copies reprinted.
3. Una bibliografía de literatura en español sobre la esterilización anticonceptiva - not reprinted but updated by an appendix of new Spanish language publication.

4. Une bibliographie de la litterature française au sujet de la sterilisation chirurgicale - not reprinted, but updated as the Spanish bibliographia (n. 3)

Conference Monographs

The latest Conference Monograph, Voluntary Sterilization: A Decade of Achievement, will be published and available in 1980.

CHAPTER 5

NATIONAL LEADERSHIP GROUPS FOR VOLUNTARY STERILIZATION

IPAVS uses the term, "national leadership groups," to denote voluntary, democratic, non-governmental organizations -- whether newly formed or established health and family planning associations -- which devote themselves to the promotion of voluntary sterilization as a method of contraception.

National leadership groups are either organizations incorporated for the sole purpose of promoting voluntary sterilization or are organized as voluntary sterilization committees of other public health organizations. They focus the attention of national governments, public health leadership, the medical community and the general public on the need to incorporate voluntary sterilization services into the national health delivery systems of their countries. They identify unmet needs and investigate new approaches to stimulate the acceptance and accessibility of voluntary sterilization services on a national scale.

IPAVS has been committed to the support of leadership organizations since 1973 when the Second International Conference on Voluntary Sterilization recommended their development. Since that time, national leadership groups have played critical roles in promoting the acceptance of voluntary sterilization by professionals and the lay public. It is felt that the success of IPAVS service programs in many countries is due in large part to the hard work, dedication, guidance and support from national leadership groups.

National Associations for Voluntary Sterilization originated primarily because of the reluctance of many established family planning agencies and governments to support voluntary sterilization services on a national scale. During the last six years, they have grown in number from 2 to 19 world-wide. (See Table 5.1)

Table 5.1 Number of Countries with Legally Registered NAVS's, 1973 to 1979

	1973	1974	1975	1976	1977	1978	1979
Developing Countries	1	5	14	14	12	14	14
Developed Countries	1	1	2	4	4	5	5
TOTALS	2	6	16	18	16*	19	19

*Two countries, Iran and Costa Rica, let their registrations lapse after the first year due to organizational difficulties.

IPAVS is concerned in not duplicating an existing organization which is prepared to take leadership for voluntary sterilization within a country. In some cases, an already established organization (medical society, voluntary family planning agency, etc.) is willing to provide a focus for voluntary sterilization through a special committee. IPAVS is working closely with a number of national organizations that have formed such committees. Table 5.2 depicts the growth of these organizations.

In addition to the organizations enumerated in the Tables 5.1 and 5.2, IPAVS is currently working with groups and/or individual leaders in 20 additional countries with an interest in promoting voluntary ster-

Table 5.2 Number of Countries with Organizations That Have Formed Voluntary Sterilization Committees, 1973 to 1979

	1973- 1976	1977	1978	1979
Developing Countries	0	5	7	8
Developed Countries	0	0	0	1
TOTALS	0	5	7	9

ilization through national leadership groups. IPAVS is assisting these groups or leaders to form either new organizations or committees within already established organizations. Please see Appendix I, for details on the overall status of these organizations.

National Association Structure and Activities

National Associations for Voluntary Sterilization have been pioneers in exploring unmet needs and investigating new approaches to the provision of services. They have taken the lead in implementing innovative demonstration projects which are often later transferred to government or other institutional programs. The associations have thereby served as catalysts for adding sterilization services to existing national family planning and health programs. They have proven to be highly effective in stimulating acceptance of voluntary sterilization on a national scale.

Similar to other voluntary organizations, national associations have the following characteristics:

- A legal entity;
- Organized democratically;
- Non-profit;
- Non-governmental;
- National in scope;
- A broad membership base.

Although methods and strategies vary according to concerns and priorities of individual countries, each national association has worked toward the goal of furthering the acceptance and availability of surgical family planning methods. Programs of existing national associations have included such activities as:

- Planning and implementing education/communications programs for a variety of target groups;
- Forming a resource center/library;
- Exchanging information and facilitating the coordination of voluntary sterilization activities in a country;
- Developing systems for maintaining and repairing sophisticated endoscopic equipment used in service programs;
- Assisting with the formation of national legislation and policy favoring voluntary sterilization;
- Collecting and utilizing national data relating to surgical conception activities;
- Providing consultant services and technical assistance to various groups interested in voluntary sterilization;

- Organizing service and training programs; and
- Encouraging appropriate research in clinical, operational and social aspects of voluntary sterilization.

IPAVS Funding of National Associations for Voluntary Sterilization

As part of its ongoing program, IPAVS offers guidance to prospective associations in developing countries and, once an association is established, provides technical and financial assistance for the development and implementation of organizational and program objectives.

In 1979, IPAVS awarded 32 sub-grants to the National Associations of 13 countries: Bangladesh, Egypt, Indonesia, Korea, Philippines, Sri Lanka, Sudan, Syria, and Turkey. France, Italy and Taiwan were given private funds because of their influence respectively in the developing countries of Francophone Africa, Catholic countries and Asia. Ten NAVS administrative sub-grants were developed and awarded, totaling \$558,728. This represents a 60% increase over the comparable figure for 1978. Of these ten sub-grants, two were for first-year funding, one for second-year funding, three for third-year funding, two for fourth-year funding, and two were for fifth-year support. As can be seen in Table 5.3, there has been a steady increase, since 1973, in the amount of financial assistance and the number of sub-grants IPAVS has awarded each year to national associations for administrative activities.

National associations, after establishing effective management capability and gaining the support of the professional community, have been developing comprehensive, sophisticated, action-oriented programs.

To encourage and support this kind of program growth, IPAVS awards special NAVS project sub-grants for service, training, information and education, equipment repair and maintenance, and branch development programs. In 1979, 22 special project sub-grants were awarded to five national associations for a total of \$1,104,841. This compares with 12 special project sub-grants for \$702,523 in 1978, as shown in Table 5.3, and represents a 57% annual increase.

Overall IPAVS administrative and special project support to national associations has grown steadily, as can be seen by the data presented in Table 5.3.

Table 5.3 Awards for Administrative Support and Special Supplemental Projects to NAVS's, 1974 to 1979

YEAR	ADMINISTRATIVE AWARDS			SPECIAL SUPPLEMENTAL PROJECT AWARDS			TOTAL NAVS AWARDS		
	Number	Total	Average	Number	Total	Average	Number	Total Budgets	Average T. Budgets
1974	3	\$ 35,340	\$11,780	1	\$141,390	\$141,390	4	\$176,730	\$44,183
1975	7	90,584	12,971	2	99,430	49,715	9	190,017	21,113
1976	6	173,397	28,900	3	191,586	63,862	9	364,983	40,553
1977	9	310,084	34,454	9	474,339	52,704	18	784,423	43,579
1978	9	349,014	38,779	12	702,523	58,544	21	1,051,531	50,073
1979	10	558,728	55,873	22	1,104,841	50,220	32	1,663,569	51,986

The total amount of IPAVS financial support -- including funds for both the core administrative and special programs -- to national associations totalled \$1,663,569 in 1979, a 58% increase over the 1978 amount and nine and one-half times the 1974 amount. Although a measure of the increase in the average administrative award may be due to inflationary pressures, it is also an indication of the internal expansion within many of the

associations. The average supplemental award has remained relatively constant even as NAVS's have developed more sophisticated and comprehensive programs. The increase in overall funding is a result of IPAUS's conviction that national leadership groups are essential to the success of upgrading the status of voluntary sterilization within countries as well as around the world.

As expected, the formation, development and funding of national associations has proved to be a time-consuming process, requiring much technical assistance from IPAUS. Helping associations to define their plans of action has been a major IPAUS technical assistance activity and has been valuable in accomplishing smooth and effective operations of the associations. IPAUS made site visits in 1979 to twelve of its funded national associations and to nine potential leadership organizations to offer encouragement, direction and technical assistance in their development efforts.

The following examples demonstrate the effectiveness of national associations using various means to promote voluntary surgical contraception on a national scale.

Bangladesh: The Bangladesh Association for Voluntary Sterilization (BAVS), in operation for five years, has developed a network of 40 BAVS branch groups throughout the country. BAVS has emphasized the establishment of model demonstration service facilities and the provision of technical assistance and training to groups desirous of establishing local service clinics. It has been demonstrated that the public will seek surgical contraception at these clinics

if high quality services are available. BAVS is currently working to replicate its service model in 25 locations throughout Bangladesh.

BAVS has also made headway in development of I & E materials and counselling strategies that have had an impact on professional and public knowledge regarding voluntary surgical contraception. The innovative efforts of BAVS have demonstrated to the government the need for and feasibility of including voluntary surgical contraception in the national health program and the government has now accepted primary responsibility for provision of services in Bangladesh. However, the government still relies on BAVS for specialized professional training and the development of medical standards for voluntary sterilization. Because of developmental problems due mainly to rapid growth and heavy demand, IPAUS has recently sponsored an independent evaluation of BAVS. Appropriate guidance and direction should result from this evaluation to assist BAVS to overcome its developmental difficulties and to adequately respond to the needs in Bangladesh.

Egypt: The Egyptian Fertility Care Society (EFCS) has been working behind the scenes to encourage acceptance of voluntary sterilization in Egypt. At the Society's Fifth Annual Meeting, a plan was adopted and endorsed by the Government establishing an EFCS-coordinated national training and service program in twelve medical facilities in Egypt. In addition, the Society, with Government endorsement, adopted a resolution endorsing voluntary surgical contraception as one means to reduce high parity. The EFCS recently moved their

office to Cairo and hired a full-time professional staff.

EFCS has been able to gain support and cooperation from all levels of the medical community, obtaining the assistance of Egyptian professionals to help design the national training program and other EFCS activities.

The primary aim of the training program is to incorporate in all medical schools a special sterilization training component for inclusion in the Obstetrics/Gynecology curriculum. For physicians receiving special certification as a result of the sterilization training component, equipment will be provided to the institution where they are posted and assistance provided by EFCS so that sterilization services can be established.

In addition to developing and coordinating the training project, EFCS is providing a valuable forum for voluntary sterilization among the medical community and is also operating an endoscopic repair and maintenance center that provides essential services throughout Egypt.

Indonesia: Voluntary sterilization is a sensitive subject in Indonesia and is not an official part of the national family planning program. However, the government has designated the Indonesian Society for Voluntary Sterilization as the national coordinator of surgical contraceptive activities in Indonesia. Because of its relationship with the national family planning government organization, the Indonesian Society has received cooperation from various government agencies in its effort to popularize and integrate voluntary sterilization into the Indonesian health system.

The Society has developed and organized a national manpower training program in conjunction with six major Indonesian medical teaching centers. The program includes standardized trainee selection and certification criteria, medical guidelines, informed consent materials and a standard curriculum. The Society is also responsible for the dissemination of voluntary sterilization information to the Indonesian medical profession.

Finally, much effort is being made by the Society to strengthen its eleven branches throughout Indonesia and to recruit additional members throughout the country.

Korea: Since voluntary sterilization is widely available and acceptable in Korea, the Korean Association for Voluntary Sterilization (KAVS) has been a proving ground for innovative voluntary sterilization activities that will further institutionalize voluntary surgical contraception in the country. KAVS established a national endoscopic equipment maintenance and repair center which currently operates throughout Korea. In addition, KAVS developed and implemented two demonstration projects on sterilization complications and vasectomy reversal. It is anticipated that the Korean Government will assume responsibility for all three of these projects in the near future.

KAVS is also instrumental in providing surgical training and is working hand-in-hand with the national health program to train appropriate public and private physicians. Furthermore, the

Association has made progress in designing and implementing an I & E program for professionals, making use of professional print media, seminars and other appropriate forums to educate the medical community concerning voluntary sterilization.

Sudan: The Sudan Fertility Control Association (SFCA) has been working primarily to disseminate information regarding VSC to health professionals throughout Sudan. The organization established an office and library in Khartoum and publishes a Newsletter. Several booklets on voluntary surgical contraception have been written and distributed to the medical community. SFCA also arranged for physician training outside Sudan. SFCA was a founder of the Regional Arab Federation of Voluntary Fertility Control Associations to promote voluntary surgical contraception in the Arab region.

These examples demonstrate that each association has assumed its own identity and each has developed and implemented programs which have responded to individual national concerns and priorities.

Specific activities carried out by each IPAUS-funded association are listed in Appendix I.

CHAPTER 6

THE WORLD FEDERATION OF ASSOCIATIONS FOR VOLUNTARY STERILIZATION: AN INTERNATIONAL LEADERSHIP NETWORK

In recognition of the need for an international forum and a channel of communication for the worldwide voluntary sterilization movement, the World Federation of Associations for Voluntary Sterilization (WFAVS) was established in 1975. The World Federation is seen as one means of strengthening national associations by providing a formal international network and channel of communications. In addition, the World Federation provides the necessary international focus on voluntary surgical contraception which is necessary for successful national programs. Therefore, provision of logistical and staff support for the Federation is an important IPAVS activity.

The growing importance of the World Federation at IPAVS is reflected in the IPAVS Management Plan for 1978-81 in which special focus is given to WFAVS by making it a separate objective with 14 specific activities. To further define the role and explore various issues basic to the support of WFAVS, a special Select Study Group has been established. This Study Group will critically examine the World Federation, its purpose, function and current role, as well as investigate its potential future role within the international family planning community. This Select Study Group will help guide IPAVS in its efforts to support the World Federation.

Although IPAVS has assisted with WFAVS establishment and nurtured its development from the start, the World Federation is a separate, distinct organization, with its own legal registration, bylaws, and separate structure.

Statement of Purpose

The World Federation of Associations for Voluntary Sterilization is a professional, non-governmental, international public health organization. Since its inception, the Federation has endeavored to promote voluntary sterilization as a basic component of health and family planning programs. As an international federation, WFAVS is composed of member associations which represent national, regional, and international organizations interested or involved in advancing voluntary sterilization as a method of fertility management. The Federation provides a way for member associations to act in concert at the international level and also provides a means of communication between members and with other international public health and family planning organizations.

At the international level, the Federation seeks to promote voluntary sterilization by:

- Developing and publicizing policy on issues related to voluntary sterilization;
- Establishing standards for voluntary sterilization services, education, training, data collection, and equipment maintenance;
- Providing information to members of the Federation and other professionals regarding developments in voluntary sterilization;
- Encouraging research and demonstration projects in voluntary sterilization, including medical, psychological, and cultural aspects, and disseminating research findings throughout the international health community;

- Serving as a liaison between its members and other related health organizations and institutions.

At the national level, the Federation works through its member organizations. Federation members are dedicated to promoting voluntary sterilization in their own countries and have already demonstrated their unique influence on national policy. Although methods and strategies vary according to the needs and priorities of each individual country, each member organization works in some way to promote the concept and increase acceptance of voluntary sterilization.

The World Federation has a strong commitment to the principles of voluntarism, and its activities are designed to promote worldwide recognition of voluntary sterilization as a health service. The Federation pursues its activities through professionals -- groups and individuals -- involved with fertility management.

Membership

There are currently 27 member associations in the Federation, 19 of which represent developing countries, and eight, developed countries. The membership comprises more than 16,000 individuals who are interested in promoting voluntary sterilization. World Federation members come from 18 percent of the world's countries which have 41 percent of the world's population. Specific characteristics of the current World Federation members are included in Appendix J.

The growth of the Federation membership since its inception is depicted in Table 6.1. Besides an increase in the number of members,

Table 6.1 Growth of WFAVS by Membership Category and Year, 1975 to 1979

MEMBERSHIP CATEGORIES	1975	1976	1977	1978	1979
National Association	6	11	14	15	17
Affiliate Association	0	0	2	6	7
Regional Association	1	1*	0	0	1
Associate Organization	1**	0	0	1	2
TOTALS	8	12	16	22	27

*Regional association was anticipated, but disbanded in 1977 after it was unable to register.

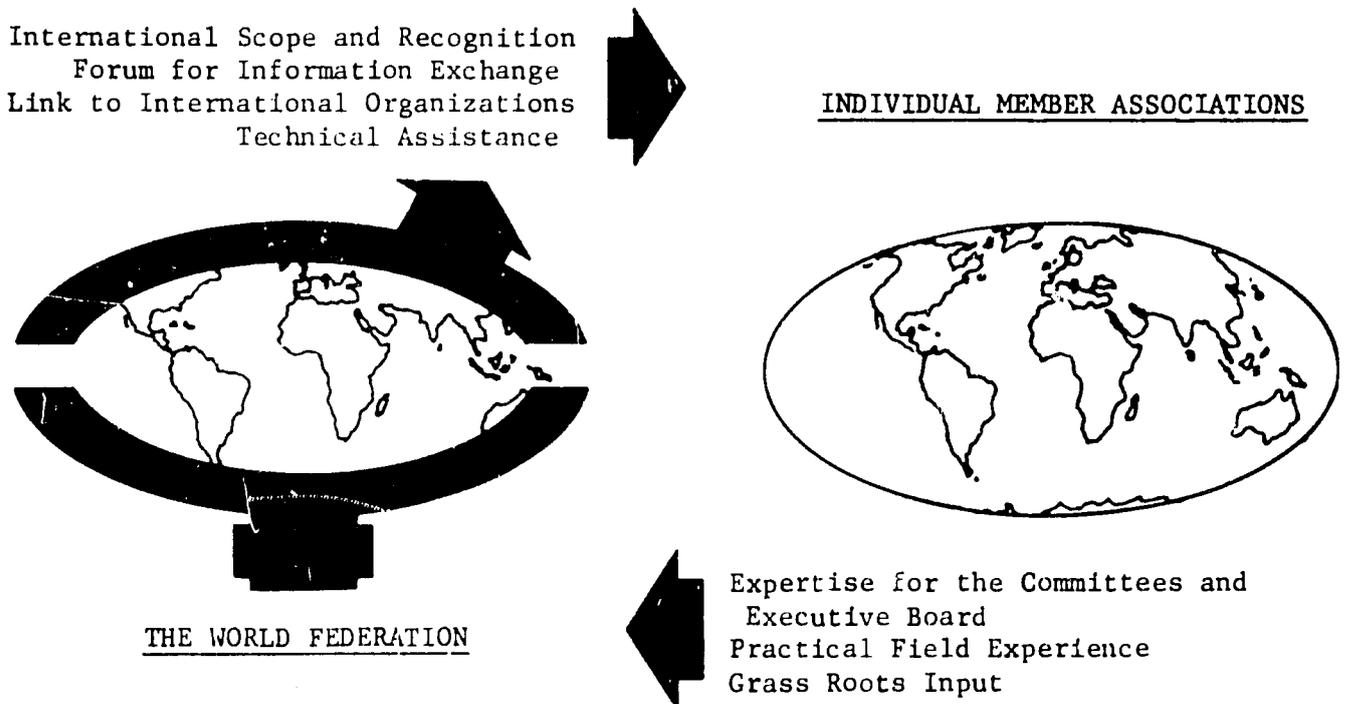
**Associate member withdrew in 1976.

the WFAVS has demonstrated certain trends in its development. In the early years, interest in the World Federation was highest in Asia. In 1976, Asia represented 66 percent of the members, whereas by 1979, Asia represented 37 percent. The Middle East/Africa area has shown steady growth from one member in 1975 to six members in 1979. Nineteen seventy-eight was the year for the Americas, which contributed four new members to the World Federation. There has been a steady increase in the number of members from developed countries from two in 1975 to eight in 1979. The Federation now has a great diversity with representatives from all major geographic regions.

The Federation and its member associations are partners in mutual growth. The member associations benefit from their participation in the Federation, which, in turn, is stronger and more viable because of its strong, effective national membership. Individual member organ-

izations bring to the World Federation expertise for its Committees and Executive Board, practical field experience and input from the grass roots level. Reciprocally, the Federation works to provide its member associations with international scope and recognition, a forum for information exchange, a link to other international organizations, and technical assistance. Figure 6.1 describes the relationship between the Federation and member associations.

Figure 6.1 Interaction Between the World Federation and Its Member Associations



In order to continually strengthen this dynamic partnership, the World Federation holds an annual General Assembly. The General Assembly provides members with an opportunity to meet and exchange ideas and allows time for planning and coordination. In the intervals

between General Assemblies, the Federation maintains contact with its member associations by correspondence, occasional committee meetings and site visits by Federation staff and officers. These procedures greatly contribute to the smooth functioning of the Federation.

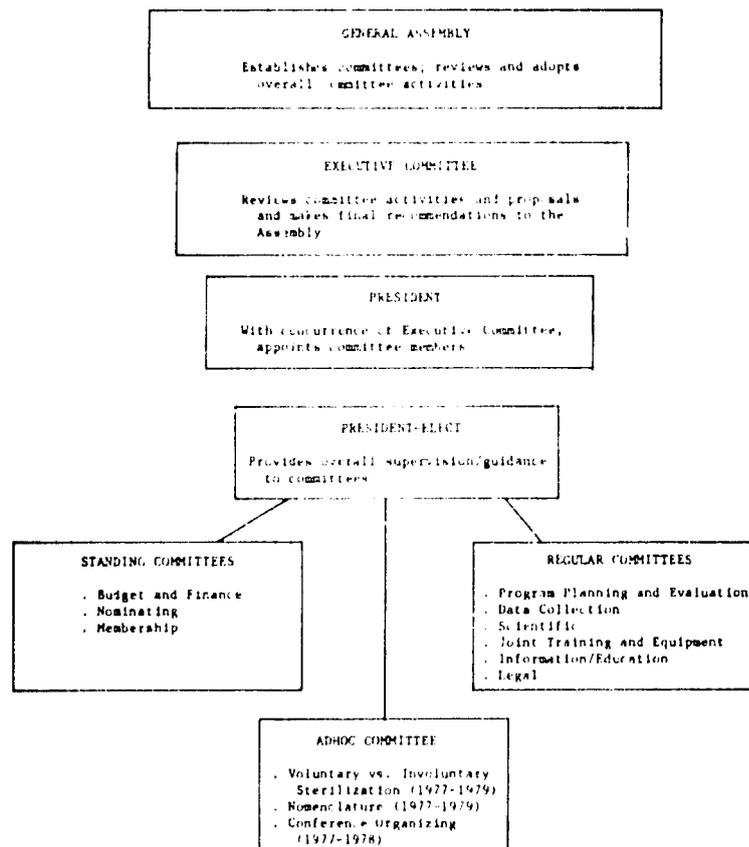
To encourage the expansion of the Federation's membership, certain documents, such as the WFAVS Bylaws and other informational materials, were translated into Arabic, French and Spanish. IPA VS staff has also refined the WFAVS Membership Guidelines Manual which assists the Membership Committee in its review of new applications for membership. The Office of the WFAVS Executive Secretary, located at IPA VS, is the communications liaison with prospective members as well as with the whole network of Federation members. The Office also provides members with information, technical assistance, materials and mailings of current literature or other important information.

Committees

A special effort has been made to establish a strong committee structure to implement the multi-faceted program of the Federation. In 1976, a series of program strategies was adopted, and the Third Assembly provided a mandate for the formation of the necessary committees. In 1977, committees were established, members appointed, and purposes, responsibilities and procedures defined. In 1978, the task was to translate these efforts into program action. The committees critically reviewed their responsibilities in order to develop plans of action for 1978-1979.

The WFAVS committee structure is the backbone for implementation of the Federation's activities. The committees carry out World Federation activities, and are provided with overall guidance and supervision by the President-Elect. The President of the Federation has the responsibility for appointing committee members with the concurrence of the Executive Committee. The President reports to the Executive Committee, and the Executive Committee reviews committee activities and proposals and makes final recommendations to the General Assembly. The General Assembly has ultimate responsibility for establishing committees, reviewing their activities and adopting their recommendations. A Schematic View of the WFAVS Committees' structure is given in Figure 6.2.

Figure 6.2 The WFAVS Committee Structure



WFAVS committee achievements for 1979 include:

- The Budget and Finance Committee investigated and identified potential funding sources for WFAVS.
- The Nominating Committee further defined the criteria for choosing WFAVS officers in order to enhance the leadership selection process and strengthen the democratic process.
- The Information and Education Committee conducted a survey of the I&E activities of all member organizations and collected information regarding I&E policies and guidelines from other international agencies. This information will be used by the committee to formulate WFAVS I&E strategies.
- The Scientific Committee started to compile a list of all publications concerning voluntary sterilization which are available in each member association's country. The Committee has also requested WFAVS members to submit the names and addresses of Medical Colleges in their countries that wish to receive the IPAVS Newsletter. To aid in the dissemination of technical information, PARFR has been requested to supply all member associations with a complimentary copy of all its publications.
- The Joint Committee on Training and Equipment gathered baseline data on existing training programs for voluntary sterilization and on the needs for training and equipment in member countries. The results of this survey were presented at the IPAVS Fourth International Conference on Voluntary Sterilization.

● The Expert Study Group on Nomenclature developed and distributed to Federation members a questionnaire on the understanding and use of the word, "sterilization." Based on the results, the Committee recommended that the organizational title of WFAVS be retained pro tem, because a change in name would result in a temporary loss of identity. However, a search for a better term is to be continued.

● The Expert Study Group on Voluntary vs. Involuntary Sterilization developed and distributed to WFAVS members a questionnaire to gather information on the concept of "voluntarism." Their findings will be the basis for future statements by WFAVS defining and refining the concepts of compulsion and incentives.

● A Legal Committee has been established to promote legislation and to handle other legal issues relating to voluntary sterilization.

● At the recommendation of the Information and Education Committee, WFAVS staff developed "Provisions for a Model Law on Voluntary Sterilization" based on the recommendations generated from the 2nd, 3rd, and 4th International Conferences on Voluntary Sterilization. IPAVS sponsored a WFAVS representative observer to the Parliamentarian Conference in Sri Lanka in order to seek support for the Model Law. A formal WFAVS exhibit is currently under preparation for display at future international conferences.

To help WFAVS maintain a strong committee system, the Committee Procedures Manual, which outlines specific procedures for each committee, and the Committee Responsibilities, which defines each committee's

purpose and responsibilities, are being reviewed and updated by the committees for approval by the Program Planning and Evaluation Committee and the General Assemblies.

The Program Planning and Evaluation Committee was restructured in 1979 to include the chairpersons of all Regular Committees. This was seen as an important step in assisting the committees to better plan and coordinate all committee activities. A Program Planning and Evaluation Committee meeting is planned for January, 1980, to draft a Five Year Program Plan and determine WFAVS activities for the coming year.

Unquestionably, the WFAVS committee structure is the backbone of the Federation, and the chairpersons, committee members, member organizations and WFAVS staff have worked hard to further the interests of the Federation.

Official and Collaborative Relationships

During 1979, the WFAVS officers and Executive Secretary concentrated on forming important communication links with other health and social organizations. The Federation now has official and collaborative relationships with sixteen organizations.

Non-governmental organization (NGO) status within the United Nations membership is an important part of the process of gaining official recognition for WFAVS and for coordination of activities between the Federation and other agencies at the international level. The WFAVS officers and Executive Secretary have been actively involved during the year in establishing these important contacts and have

opened up lines of communication. WFAVS application for NGO status with the Economic and Social Council (ECOSOC) of the United Nations will be considered in June, 1980.

WFAVS has had NGO status with UNFPA and is currently establishing a sequential timetable to attain NGO status with the following international bodies: UN ECOSOC, UNESCO and WHO.

The World Federation has also submitted an application to the International Council of Voluntary Agencies (ICVA) in Geneva for membership in that organization.

Conclusion

The Federation has grown rapidly in its first four years. The WFAVS officers, committees, members and staff have worked hard to lead it through its early stages of development and now have a viable and purposeful organization. The Federation has made innovative changes in its structure and organization. New member needs have stimulated the formation of regional associations within the WFAVS structure. In addition, there is a trend toward increased interest in WFAVS from countries in the Middle East, Africa and Latin America as well as Europe. WFAVS membership has grown and strengthened collaborative working relationships with other organizations. The Federation's past program accomplishments and future priorities will increase its prestige as well as its credibility. Member organizations should have every reason to believe that the Federation will continue to grow and take its place as the recognized leader in the worldwide voluntary sterilization movement.

CHAPTER 7

PROGRAM SUPPORT FUNCTIONS FOR MANAGEMENT OF SUB-GRANT ACTIVITIES

Sub-grantee activities are managed by IPAVS through the analysis of information submitted by sub-grantees as well as by on site evaluations by IPAVS staff and consultants.

Section 1. Proposal Development Procedures and Sub-Grant Monitoring

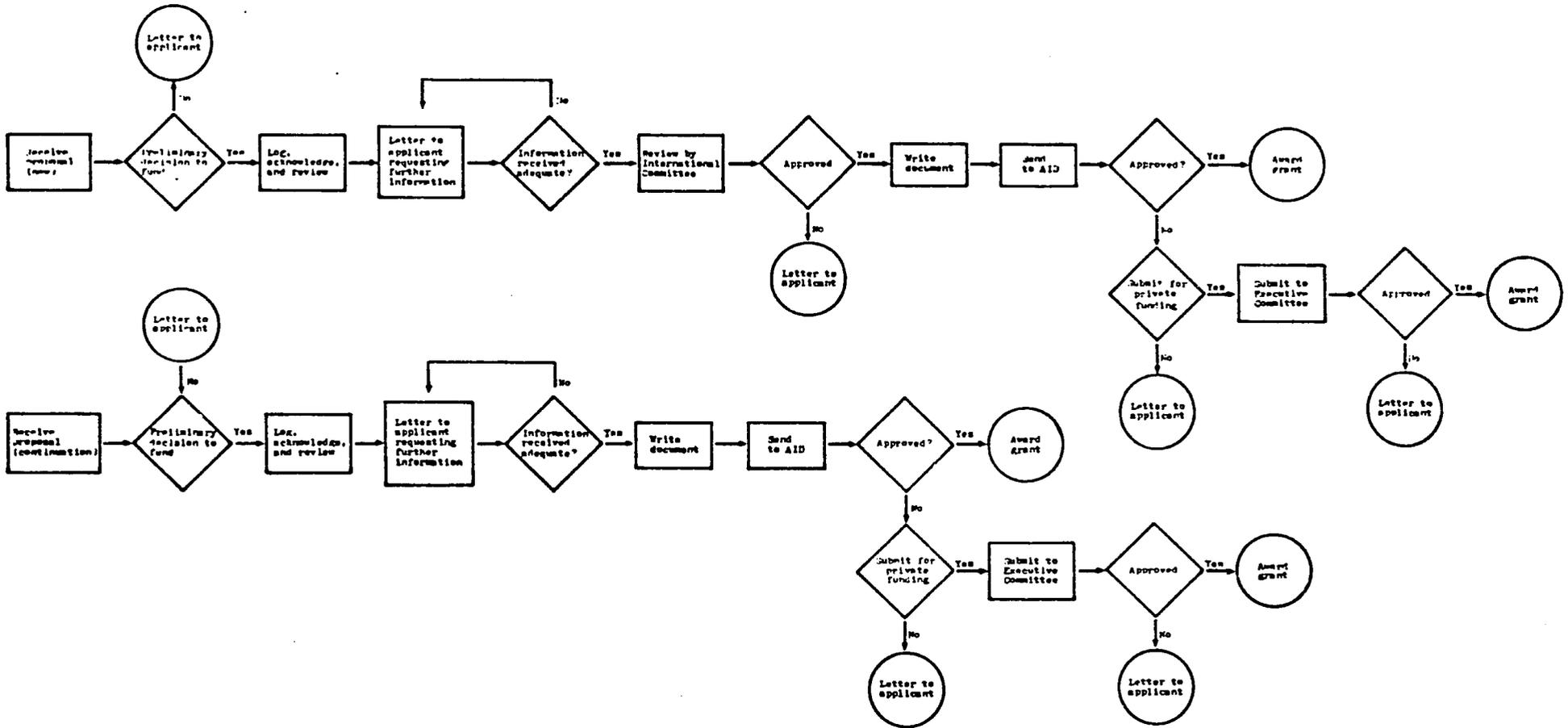
The Grants Management Section, as mentioned in Chapter 2, handles requests for IPAVS's assistance and is responsible for aiding an applicant to develop a sound and workable proposal. After sub-grants are awarded, the Grants Management Section monitors the progress of each project in accomplishing its program objectives. Grants Management staff members have specific country assignments so that each Grants Officer follows the progress of programs in assigned countries from the submission of the initial request to the termination of the sub-grant.

Proposal Development Procedures

In the initial stages of a proposal's development, IPAVS often provides extensive assistance to the applicant so that program objectives are clearly identified and the scope of the proposed program is carefully defined. In order to improve the quality of information submitted by applicants, the IPAVS Grant Application Form was revised. Put into effect March, 1979, the improved form elicits more precise information.

Figure 7.1 illustrates the proposal development process. After a request is received and logged, it is acknowledged by return to the

Figure 7.1 Flow Diagram of Proposal Submission Process



sub-grantee of a checklist. The checklist is updated on a monthly basis with respect to proposal status. Staff meetings are convened as needed to review and determine the changes needed in proposals before presenting them to the International Committee of IPA VS. Once a proposal is approved the the International Committee, it is sent to AID for final approval. Upon AID approval, a sub-grant is awarded by IPA VS. If AID rejects the proposal, it may be submitted to the Executive Committee of AVS for consideration for an award from private funds.

By updates of the checklist, the applicant is kept informed of the significant events in proposal progress such as the dates of review by the International Committee, of submission to AID and of approval.

Routine Sub-Grant Monitoring

When a sub-grant is awarded, a contract package -- containing a copy of the sub-grant document and contract letter, a cover letter including outstanding questions pertaining to the program and copies of required reporting forms and the report schedule -- is forwarded to the applicant. At that time, an IPA VS schedule for followup is prepared.

After the applicant signs the contract letter and returns it to IPA VS, the proposal achieves sub-grant status, funds are transferred and equipment is shipped. After a sub-grant has been in effect for seven weeks, the sub-grantee is queried in order to ascertain whether initial funds were received, accounting procedures established

and program activities begun. Formal staff review meetings are held five and eight months after the effective date of the sub-grant. At the eight month sub-grant review meeting, the questions of need for administrative extension or for submission of a continuation proposal are addressed.

Sub-Grant Reporting

At the time a proposal is approved for funding, a schedule for required routine reporting is established for the new sub-grant.

Routine reports which may be required are:

1. Statistical Report for Acceptors: cumulative totals of acceptors by age, parity and procedure; cumulative number of major complications, if any;
2. Complication Report: description of the nature, treatment and outcome of each major complication, if any;
3. Progress Report: narrative account of progress and problems (includes, as appropriate, Service Progress Report, Information and Education Progress Report, Repair and Maintenance Center Progress Report and NAVS Progress Report);
4. Equipment Problem Report: description of the condition of and problems encountered with equipment provided through IPAVS;
5. Financial Report: information on budget and expenditures to date and cash on hand;
6. Trainee Form: evaluations of the performance and capabilities of physician and health support staff trainees (includes Health

Support Staff Trainee Form and Physician's Report Form).

Some reports are due quarterly, others, semi-annually. Financial Reports may be submitted as often as once a month for reimbursement.

In addition to the routine reports, sub-grantees may be required to submit special reports less frequently, usually on an annual or semi-annual basis. Examples of special reports are:

1. Activity Plan: specifies how, when, and by whom program objectives will be accomplished (usually for NAVS grants);
2. Information and Education Strategy Plan: indicates how, when, by whom, and for whom specific information and education activities will be carried out (usually for NAVS grants);
3. Collaborative Relationship Report: describes the collaborative and functional relationship between the sub-grantee and other private and public agencies involved in the family planning movement (usually for NAVS sub-grants);
4. Training Curriculum: outlines the practical and theoretical content and schedule of training courses;
5. Equipment Distribution Plan: indicates to whom equipment provided by IPAVS will be given (usually for special equipment grants);
6. Equipment Receipt Report: sent to IPAVS by sub-grantee upon receipt of equipment; and
7. Special Study Report: gives results of any special surveys conducted by the sub-grantee.

In 1978, IPAVS's reporting forms were revised to make them easier for sub-grantees to complete and to elicit information in a more concise manner. These forms have been translated into Spanish and French, and are expected to be distributed in early 1980.

Sub-Grant Financial Reporting

IPAVS sub-grantees are required to submit detailed financial reports at least four times a year on a calendar quarter basis. As financial reports are received from sub-grantees, the IPAVS Financial Office updates its financial records for each grant with respect to the performance of appropriate activities and to the progress of financing each grant. The newly installed IPAVS computer provides summarized and individual print-outs which list sub-grants by country, purpose, status of completion and audit requirements.

Audits of Sub-Grants

IPAVS's policy is to audit sub-grants at the completion of each sub-grant. The audit is conducted by an independent accounting firm selected by IPAVS but located in the sub-grantee's country. A total of 56 sub-grants in 17 countries were audited during 1979. Whenever discrepancies or irregularities are detected from the audit reports, the IPAVS Financial Office communicates with the sub-grantee and warns them of possible sanctions if discrepancies or irregularities are not corrected. The Program and Field Operations Divisions are also informed of audit findings as appropriate. In addition, technical assistance is provided by staff when site visits are conducted. On

the whole, audit reports indicate that IPAVS's sub-grantees are in compliance with all sub-grant contractual provisions.

Site Visits

Site visits are made for three basic purposes: development, technical assistance and medical assessment. They also reinforce IPAVS staff understanding of local conditions affecting the development and operation of a sub-grant.

During 1979, 14 IPAVS staff members made 93 visits to 90 sub-grantees and 50 potential sub-grantees for a total of 543 working days in the field (See Appendix L). Initial and technical assistance visits were made to sub-grantees in 27 countries and to potential sub-grantees in 10 countries. IPAVS staff members endeavored to visit every sub-grantee at least once during the year; larger projects were visited semi-annually or quarterly.

The establishment of the IPAVS Regional Office for Asia in Bangladesh permitted an increased number of site visits to be made in this region. In addition, the special needs of the Bangladesh Association for Voluntary Sterilization were addressed by an international consultant team which did an evaluation of BAVS and its program in October, 1979.

Developmental visits establish initial contacts with individuals who might be interested in IPAVS assistance and to meet with other family planning or health organizations to coordinate activities and establish lines of communication. In 1979, 20 countries were

visited to establish such contacts, assess the need for IPAVS assistance, attend conferences, coordinate meetings with other family planning organizations and work on proposal development with potential sub-grantees. Of particular importance were a ten-nation tour of Africa and a comprehensive trip to Brazil. These trips served to provoke interest and encourage acceptance of voluntary sterilization and to pave the way for the establishment of new programs in these areas.

Technical assistance visits serve to comprehensively review sub-grant programs and to provide sub-grantees with advice and expertise in order to resolve problems, develop specific program components or develop organizational and administrative capabilities. Prior to the award of a sub-grant, visits may be conducted to inspect project facilities, to establish rapport between project staff and IPAVS and to review the project's overall design.

Medical visits are made to assess whether sub-grantees are performing sterilizations in accord with the principles of sound medical practice and to evaluate the adequacy of physician and paramedical training activities and facilities.

Seven countries were visited for medical site visits by the IPAVS Field Clinician in 1979. The field clinician has recently developed a Medical Site Visit Form that can be used by any professional staff member in conjunction with a site visit to service projects. The form permits uniform data collection by the sub-grantee and is an aid to

the sub-grantee in preparing for site visits as well as useful to professionals on-site and from IPAVS.

Consultants

Over the past year, IPAVS used consultants to assist with special problems in sub-grant programs and for internal management purposes. To facilitate the ease with which qualified consultants can be matched with agency and sub-grantee needs, IPAVS is working to develop a registry of resource persons. The objective of the registry is to maintain a comprehensive data file on experts involved in voluntary sterilization program development, planning, management, implementation, and evaluation. The registry will serve as a resource for IPAVS, its sub-grantees and other related organizations, and will be used to:

- identify consultants for special assignments for IPAVS, its sub-grantees, or other national/international organizations;
- identify individuals with special expertise;
- identify appropriate individuals for conference speakers and seminar/workshop participants.

It is expected that the registry will be computerized and ready for use during 1980.

During 1979, consultants employed by IPAVS for management purposes included: an expert to finalize the personnel evaluation manual for IPAVS's New York headquarters; an international consultant team to evaluate the Bangladesh Association for Voluntary Sterilization; an equipment technician from the Repair and Maintenance Center in Mexico to assist the Panamanian Ministry of Health in establishing and developing a working system for their RAM Center; a translator to edit and

prepare for publication the proceedings of two Brazilian conferences related to voluntary sterilization.

Section 2. Information Storage and Retrieval

The Information and Monitoring Section of IPAVS was created in May, 1979 as part of the Program Division. Its principal functions are data processing and information retrieval and distribution. The Information and Monitoring Section provides information on sub-grants, small grants and equipment grants -- obtained by routine or special reports -- to appropriate program and financial personnel. It also processes information useful for internal IPAVS operations.

Reports on Sub-Grant Activity

The project monitoring system, first implemented as a manual system in 1977, was designed to assist IPAVS program staff to systematically track sub-grant program activity in order to permit appropriate and timely followup. In 1978, computer files and data collection procedures that facilitated project monitoring were established. In 1979, the files and procedures were modified by computerization of the data and production of routine computer reports.

Among the computer programs developed in 1979, one generates a report indicating the status of reimbursements to sub-grantees and is provided on a weekly basis to the Financial Office, which also receives a monthly report on audit status. In 1980, the Information and Monitoring Section will further develop the project monitoring system to include an Equipment Transaction Report for the purpose of assuring that equipment orders are shipped and received on time.

An additional function of the project monitoring system is to track routine reports submitted by sub-grantees in order to determine whether they are received on time. This reports tracking system is intended to assure a smooth and timely flow of information about each project and to enable appropriate staff to be aware of current activities and problems.

The Computer Information System

After more than a year in operation, IPAVS'S mini-computer proved to be an important adjunct to staff operations. By the end of 1979, more than 20 data files had been created and stored on five disk cartridges. In addition, several other operational files were developed to assist in information retrieval. The files continue to grow in number and expand in size as new applications for the computer are devised.

At present, computer files store information on proposal development, sub-grant characteristics, equipment transactions, national associations for voluntary sterilization, small grants, conference grants, service statistics and trainee statistics (Appendix K explains the variables contained in each data file). A number of data files were expanded and refined in 1979; others will be reviewed and updated to meet future needs. Among the latter are files on equipment transactions, small grants, conference grants and trainee statistics.

Two new files in the process of development during 1979 were: complications and mortality statistics for monitoring data derived from sub-grantee programs, to be used in conjunction with newly developed complications reporting forms; a consultants file for storing professional

data on past and potential consultants.

During 1979, several files were in the early planning phase. One was the site visit information file to include information such as name of visitor, dates and type of visit. Another was a travel monitoring file to keep staff travel plans current and accessible as well as to list dates of past trips.

In 1980, the Information and Monitoring Section will focus on the development of a comprehensive Procedure Manual as well as on the final revision and stabilization of the structures of all data files. The development of more routine computer programs and the implementation of new files should further expand the project monitoring support capabilities of the minicomputer.

MINIMUM STANDARDS
FOR IPAVS-FUNDED
FEMALE VOLUNTARY STERILIZATION PROGRAMS

JANUARY, 1980

TABLE OF CONTENTS

	Page
1. Service components	1
1.1 Information and counseling	
1.2 Informed consent	2
1.3 Medical screening and pre-operative assessment	3
1.4 Surgical procedure	4
1.5 Post-operative care	4
1.6 Post-operative follow-up	5
2. Personnel	5
3. Minimum standard facilities	6
3.1 Examining room	6
3.2 Operating room	7
3.3 Recovery room or ward area	7
4. Minimum standard emergency requirements	7
4.1 Minimum standard emergency equipment	8
4.2 Additional emergency back-up requirements for single-purpose clinics	8
5. Specific requirements for the various female sterilization procedures	9
5.1 Minilaparotomy	9
5.2 Colpotomy	9
5.3 Culdoscopy	9
5.4 Laparoscopy	10
6. Medical record requirements	10

Appendices:

- Appendix A Key terms used by the International Project Association for Voluntary Sterilization (IPAVS)
- Appendix B Flowchart of voluntary sterilization service delivery recommended by the International Project Association for Voluntary Sterilization
- Appendix C Informed consent guidelines for IPAVS projects
- Appendix D Medical site visit report on facilities/service program

References

MINIMUM STANDARDS FOR FEMALE VOLUNTARY STERILIZATION PROGRAMS

1. SERVICE COMPONENTS

A voluntary sterilization service shall have the following components:

- Information and Counseling
- Informed Consent
- Medical Screening and Pre-operative Assessment
- Surgical Procedure
- Post-operative Care
- Post-operative Follow-up

1.1 Information and Counseling

Prospective patients for voluntary sterilization procedures must be provided with the information necessary for making a reasoned, non-coerced decision, in the language and terminology they best understand.

In view of the critical and sensitive nature of this decision, it is essential that this information be provided by doctors, nurses, or other health professionals, such as social workers, especially trained for this task.

The following information must be included:

- a) Description and discussion of both temporary and permanent modes of family planning, including the benefits and risks of the various techniques available, with special attention to their failure rates, possible complications and side effects.
- b) Special attention to the intended permanency of all sterilization procedures.
- c) Discussion of the various sterilization procedures and types of anesthesia available, including possible operative and post-operative complications and side effects, as well as the possibility of failure with subsequent intra- or extra-uterine pregnancy.

- e) Assurance that withholding or withdrawing consent at any time prior to the sterilization will not prejudice future care, nor result in the loss of other project or program benefits to which the patient might otherwise be entitled.

Temporary methods of contraception should be made available both to those individuals who decide not to proceed with the sterilization, and to those who are judged to be ineligible for other reasons, such as age or number of children.

For individuals who are to undergo the sterilization procedure, pre-operative counseling must include any special instructions. These patients must also be alerted to the importance of seeking immediate medical attention if pain or other problems occur post-operatively.

1.2 Informed Consent

To preclude misunderstanding and the potential for coercion, every person contemplating sterilization should, before signing any consent forms, have the opportunity to ask questions freely at any time during the process, and have, in addition, the option of being accompanied by a person of his own choosing who is also free to ask questions.

Utmost care must be used to ensure that sterilization operations are done only after a person gives his voluntary, informed consent.

Voluntary, informed consent is arrived at when:

- a) The individual presents himself at the treatment center after choosing freely to do so, having been offered no undue inducement or incentive, nor having been subjected to any force, fraud, duress, or other form of constraint.
- b) The individual is capable of understanding, and in fact understands, the nature and effects of the sterilization operation he is requesting. Specifically, he understands all of the following elements:
 - (1) Temporary contraceptive methods are available to him and his partner.
 - (2) Sterilization is a surgical procedure.
 - (3) Certain discomforts and risks attend the procedure, including possible complications and side effects, as well as the fact that sterilization cannot be guaranteed.
 - (4) If successful, the operation will prevent the patient from producing any more children.

(5) The operation is permanent. In selected circumstances, if the service is available, reversal may be attempted.

(6) The individual can decide against the procedure at any time and no services or benefits will be withheld from her as a result.

Informed consent in the specific language of each country or area must be documented for each patient.

1.3 Medical Screening and Pre-operative Assessment

It is mandatory that prospective patients for sterilization be assessed to determine their physical and emotional fitness for surgery in general, and for sterilization in particular.

The following minimum information must be obtained and recorded on the patient's record:

a) Medical History

- (1) Age
- (2) Family health history
- (3) Past medical and surgical illnesses
- (4) Allergies
- (5) Obstetrical history
- (6) Menstrual pattern and last menstrual period
- (7) Present state of health
- (8) Previous use of contraceptive methods

b) Physical Examination:

- (1) Weight
- (2) Pulse and blood pressure
- (3) Evaluation of nutritional state
- (4) Auscultation of heart and lungs
- (5) Abdominal palpation
- (6) Breast examination
- (7) Pelvic examination (including estimation of size and mobility of uterus and adnexa to rule out pregnancy or gynecological abnormalities)
- (8) Other areas to be examined based on patient's medical history

c) Laboratory Examination:

- (1) Hemoglobin and/or hematocrit
- (2) Urinalysis for glycosuria and proteinuria determination.

If indicated, a pregnancy test and/or Pap smear should be performed.

No procedures will be done at an ambulatory facility when a patient has any medical condition indicating that surgery may involve above normal risk. These patients should be provided with temporary methods of contraception, if appropriate, and/or referred to a hospital for further medical assessment.

1.4 Surgical Procedure

While female surgical procedures can be performed on an inpatient or outpatient basis, the following operating conditions must be met:

- a) The procedure must be performed by a licensed physician competent in the particular procedure. (See section 5, for an elaboration of the special requirements for each sterilization method.)
- b) The surgery must be performed in an adequately equipped operating room under aseptic conditions with appropriate surgical instruments. (For an elaboration of this equipment, see sections 4.1 and 5, respectively.)
- c) Regardless of the particular surgical procedure performed, the vital signs, such as blood pressure, pulse, and respiration must be monitored and recorded during the operation by trained health personnel.

While IPAVS recommends the use of systematic sedation and local anesthesia for the procedure, the use of other methods (such as general or regional anesthesia) will be left to the discretion of the director of the facility, depending on the availability and experience of health personnel and individual patient characteristics.

1.5 Post-operative Care

Immediately following surgery, the patient should be transferred to the recovery room/ward area where:

- a) She will be observed and monitored intermittently for at least two hours or until she has fully recovered from the anesthetic. The recording of the vital signs will be entered on the record.
- b) She will receive oral and written post-operative counseling on problems that may arise after discharge and will be told whom to contact in case of emergency.
- c) She will not leave the facility until she is fully stable and discharged by the staff.

Appropriate arrangement for the follow-up should be made before discharge.

Accommodations must be available for overnight stay or hospitalization referral if needed.

1.6 Post-operative Follow-up

There must be a minimum of one follow-up examination for each patient who has been sterilized:

- a) It must be scheduled approximately one week after surgery and the results recorded.
- b) The examination can be performed by health personnel other than the physician, but a physician must be available as a back-up.
- c) During this visit the patient must again be informed of the possibility of failure (i.e., subsequent intra-uterine or extra-uterine pregnancy), with stress on the need for immediate follow-up if amenorrhea, pain, or vaginal bleeding occur in the future. It is important that the patient be encouraged to have an annual gynecological examination.

It is preferable for these examinations to be done at the facility where the sterilization procedure was performed. However, patients may be referred to other health centers or to public health personnel provided that previous arrangements for follow-up have been made.

2. PERSONNEL

For the delivery of sterilization services, specific types of personnel are required to perform the following functions:

- a) **Physical Examination and Surgical Procedure:** All physical examinations and sterilization procedures must be performed by licensed physicians who are competent in the techniques used, and who have the necessary expertise to deal with the immediate complications that may arise during the performance of the procedure.
- b) **Surgical Assistance:** A trained nurse or paramedic is required to assist the operating physician during the performance of each procedure.
- c) **Patient Monitoring:** A nurse or trained paramedic must be assigned to care for and monitor the patient throughout the surgical procedure.
- d) **Post-operative Care:** A nurse or trained paramedic must be assigned to provide immediate surveillance during the post-operative period.
- e) **Information and Counseling:** Trained personnel - either doctor, social worker, nurse, educator, trained paramedic or equivalent - must be available for the pre- and post-operative counseling.

- f) Anesthesia: An anesthesiologist or competent technician must be immediately available when laparoscopy is being performed. General anesthesia, when used, must be administered by an anesthesiologist or physician competent in the specialty.
- g) Support: Other personnel such as porters, cleaners, and technicians should be provided. The number will depend on the needs and characteristics of the facility.

Depending on the facility, one person may perform more than one function, provided that all are adequately covered.

3. MINIMUM STANDARD FACILITIES

Depending upon the particular female sterilization procedure to be performed, services may be provided in a:

- a) Hospital
- b) Multi-purpose clinic or
- c) Single-purpose clinic

Regardless of the location and size of the center, it must meet certain basic minimum requirements. Each facility must contain:

- a) Running water, electricity, and adequate toilet facilities
- b) Waiting room/area
- c) Registration/reception area
- d) Space where social workers or counselors can interview patients privately
- e) Examining room(s)
- f) Space for simple laboratory tests
- g) Operating room or isolated surgical area with screened windows
- h) Auxiliary facilities such as a sterilization room, storage area, scrub facility and dressing room
- i) Recovery room or ward area

3.1 Examining Room

The following equipment must be available in the examining room area:

- a) Examining table
- b) Adult weight scale
- c) Chair or stool for examiner
- d) Adequate lighting
- e) Sphygmomanometer
- f) Stethoscope

- g) Small desk, table or writing surface
- h) Thermometer
- i) Instruments for basic pelvic examination: speculum, tenaculum, sponge forceps, straight clamp, uterine sound, etc.

The facility should be equipped to handle simple tests such as:

- a) Urinalysis
- b) Hemoglobin or hematocrit

For these purposes, it must have adequate storage for the supplies and equipment necessary to perform these tests.

3.2 Operating Room

The surgical space allocated to sterilization must be located in a separate area, building, or floor isolated from nonsurgical patient services. It should be easy to enter and leave in case of emergency. It should be accessible to sterile equipment and supplies needed for the sterilization and for management of any immediate complications.

The following items are mandatory:

- a) Operating table adjustable to the Trendelenburg position
- b) Instrument tray
- c) Supplies, surgical kits, or endoscopy equipment
- d) Adequate lighting, approved by the surgeon and designed to minimize the danger of explosion (self-contained lamp)
- e) Emergency light (battery-operated) to be used in case of power failure
- f) Sphygmomanometer and stethoscope
- g) Emergency equipment
- h) Hand-washing facilities in or adjacent to the operating room

3.3 Recovery Room or Ward Area

The post-operative recovery room or ward area must have good lighting and ventilation. The number of beds will be determined by the space available and the number of prospective patients. Thermometers and at least one sphygmomanometer and one stethoscope should be readily available.

4. MINIMUM STANDARD EMERGENCY REQUIREMENTS

All facilities in which female sterilization procedures are performed must be able to provide basic emergency care. This necessitates the availability of basic emergency equipment on site and staff trained in its use.

4.1 Minimum Standard Emergency Equipment

The following emergency equipment must be readily available and in good working order in all facilities where female sterilization procedures are performed:

- a) Airway
- b) Ambubag
- c) Laryngoscope and endotracheal tubes
- d) Suction apparatus
- e) Oxygen unit
- f) Intravenous administration sets with large-caliber needles
- g) Intravenous fluids
- h) Emergency drugs and antidotes for treating narcotic overdose or adverse reaction to anesthesia or other drugs
- i) Standard laparotomy tray
- j) Anesthesia machine (Required only in facilities where laparoscopy is performed)

The tray containing the drugs and this equipment should be kept in an accessible place. The medical director is responsible for maintaining this emergency equipment in good working order and for ensuring that all staff is familiar with its location and proper use.

4.2 Additional Emergency Back-up Requirements for Single-Purpose Clinics

Since single-purpose clinics generally have only limited capability to perform major surgery, and often do not have inpatient facilities, the following emergency back-up must be provided:

- a) All the single-purpose clinics must have an established arrangement with a fully equipped hospital which would permit the transfer, hospitalization and treatment of patients in the event of any major complications.
- b) The location of this hospital must not be farther than a 30-minute drive from the facility.
- c) Adequate means of transportation by car must be available in all single-purpose clinics during surgery, and until all post-operative patients have been discharged.
- d) No endoscopy procedures must be done in facilities that are not adequately staffed and equipped to perform an emergency laparotomy within 5 minutes.

5. SPECIFIC REQUIREMENTS FOR THE VARIOUS FEMALE STERILIZATION PROCEDURES

In addition to the preceding minimum standards required for all female sterilization procedures, specific equipment, facilities, and staff are mandated for each surgical technique:

5.1 Minilaparotomy

- a) Equipment: Standard surgical equipment with the possible addition of a uterine manipulator elevator, small retractors, and a tubal hook for the delivery of the tubes are required.
- b) Facility: The procedure must be performed in an operating room of a hospital, multi-purpose clinic or single-purpose clinic.
- c) Staff: The procedures must be performed by physicians with knowledge and experience in performing simple abdominal surgery who have special training in this technique.

5.2 Colpotomy

- a) Equipment: Standard gynecological equipment, including a heavy weight speculum, tenaculum, vaginal retractors, and some form of forceps to grasp the fallopian tubes are required. The operating table must have a drop end and be fitted with lithotomy leg supports.
- b) Facility: The procedure must be performed in an operating room of a hospital, multi-purpose clinic or single-purpose clinic.
- c) Staff: The procedure must be performed by gynecologists or surgeons experienced in standard gynecological surgery. Nursing support for operating assistance and patient monitoring must also be provided.

5.3 Culdoscopy

- a) Equipment: This is the same as for colpotomy with the addition of: a culdoscope, a trocar or cannula, a light source and the instruments designed for tubal occlusion.
- b) Facility: The procedure must be performed in an operating room of a hospital, multi-purpose clinic or single-purpose clinic.
- c) Staff: The procedure must be performed by gynecologists or surgeons experienced in standard gynecological surgery who have special training in the technique.

5.4 Laparoscopy

- a) Equipment: Special equipment used for this procedure will depend on factors such as the type of laparoscope, method of tubal occlusion used, etc. The basic items include a trocar and needle for insufflation, the insufflation apparatus, a light source, the laparoscope and the instrument for tubal occlusion.
- b) Facility: The procedure must be performed in an operating room with the equipment necessary to perform an emergency laparotomy within 5 minutes should any complications occur that require major surgical intervention. This implies that laparoscopy must be performed only in a fully equipped operating room in a hospital or multiple-purpose clinic. Even when a single-purpose clinic may occasionally meet these standards, IPAVS does not recommend the performance of laparoscopy in single-purpose clinics.
- c) Staff: Laparoscopy requires efficient team work. The procedure must be performed by a gynecologist or surgeon with at least three years of experience in abdomino-pelvic surgery who has received special training in this technique. Nursing support for operating assistance, patient monitoring and equipment maintenance must also be provided. An anesthesiologist or adequately trained technician must also be immediately available when laparoscopy is being performed.

6. MEDICAL RECORD REQUIREMENTS

A medical record must be written for each patient who undergoes a sterilization procedure, and should contain:

- a) Pre-operative assessment (medical history, physical examination and laboratory tests)
- b) Signed consent form
- c) Surgical procedure
- d) Post-operative data
- e) Complications and outcome
- f) Follow-up data

The medical director of the facility is responsible for the completeness and supervision of these records.

The records should be maintained at the facility for five years after the discharge of the patient. For that purpose, filing cabinets, binders, etc. should be available.

References

- American Association of Medical Record Librarians. Glossary of Hospital Terms, Chicago: American Association of Medical Librarians, 1969.
- American College of Obstetricians and Gynecologists. Standards for Ambulatory Obstetric Care, Chicago: American College of Obstetricians and Gynecologists, 1977.
- American College of Obstetricians and Gynecologists. Standards for Obstetric-Gynecologic Services, Chicago: American College of Obstetricians and Gynecologists, 1974.
- Association for Voluntary Sterilization. "Recommended Standards for Voluntary Female Sterilization," New York, November 3, 1976. (Mimeographed.)
- Planned Parenthood Federation of America. 'Sterilization Standards and Guidelines,' in 'Manual of Medical Standards and Guidelines,' New York, September 6, 1977. (Mimeographed.)
- U.S. Congress. House. A Discursive Dictionary of Health Care. 94th Cong., 2^d sess., 1976. Prepared by the staff for the use of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce.

MINIMUM STANDARDS
FOR IPAUS-FUNDED
MALE VOLUNTARY STERILIZATION PROGRAMS

JANUARY, 1980

TABLE OF CONTENTS

	Page
1. Service components	1
1.1 Information and counseling	1
1.2 Informed consent	2
1.3 Medical screening and pre-operative assessment	3
1.4 Surgical procedure	3
1.5 Post-operative care	3
1.6 Post-operative follow-up	4
2. Personnel	4
3. Minimum standard facilities	5
3.1 Examining/operating room	
4. Minimum standard emergency requirements	5
4.1 Minimum standard emergency equipment	6
5. Medical record requirements	6
Appendices:	
Appendix A Key terms used by the International Project Association for Voluntary Sterilization (IPAVS)	
Appendix B Flowchart of voluntary sterilization service delivery recommended by the International Project Association for Voluntary Sterilization	
Appendix C Informed consent guidelines for IPAVS projects	
Appendix D Medical site visit report on facilities/service program	

References

MINIMUM STANDARDS FOR MALE VOLUNTARY STERILIZATION PROGRAMS

1. SERVICE COMPONENTS

A voluntary sterilization service shall have the following components:

- Information and Counseling
- Informed Consent
- Medical Screening and Pre-operative Assessment
- Surgical Procedure
- Post-operative Care
- Post-operative Follow-up

1.1 Information and Counseling

Prospective patients for voluntary sterilization procedures must be provided with the information necessary for making a reasoned, non-coerced decision, in the language and terminology they best understand.

In view of the critical and sensitive nature of this decision, it is essential that this information be provided by doctors, nurses, or other health professionals, such as social workers, especially trained for this task.

The following information must be included:

- a) Description and discussion of both the temporary and permanent modes of family planning, including the benefits and risks of both techniques, with special attention to their failure rates, possible complications and side effects.
- b) Special attention to the intended permanency of all sterilization procedures.
- c) Discussion of the sterilization procedure and anesthesia available, including possible operative and post-operative complications and side effects, as well as the possibility of failure.
- d) Advice that contraceptive measures should be continued after the sterilization until a semen analysis performed after a minimum of 15 ejaculations shows the patient's azoospermia.

- d) Assurance that withholding or withdrawing consent at any time prior to the sterilization will not prejudice future care, nor result in the loss of other project or program benefits to which the patient might otherwise be entitled.

Temporary methods of contraception should be made available both to those individuals who decide not to proceed with the sterilization, and to those who are judged to be ineligible for other reasons, such as age or number of children.

For individuals who are to undergo a sterilization procedure, pre-operative counseling must include any special instructions, such as the necessity of not eating after midnight on the day preceding the surgery. These patients must also be alerted to the importance of seeking immediate medical attention if pain or other problems occur post-operatively.

1.2 Informed Consent

To preclude misunderstanding and the potential for coercion, every person contemplating sterilization should, before signing any consent forms, have the opportunity to ask questions freely at any time during the process, and have, in addition, the option of being accompanied by a person of her own choosing who is also free to ask questions.

Utmost care must be used to ensure that sterilization operations are done only after a person gives her voluntary, informed consent.

Voluntary, informed consent is arrived at when:

- a) The individual presents herself at the treatment center after choosing freely to do so, having been offered no undue inducement or incentive, nor having been subjected to any force, fraud, duress, or other form of constraint.
- b) The individual is capable of understanding, and in fact understands, the nature and effects of the sterilization operation she is requesting. Specifically, she understands all of the following elements:
 - (1) Temporary contraceptive methods are available to her and her partner.
 - (2) Sterilization is a surgical procedure.
 - (3) Certain discomforts and risks attend the procedure, including possible complications and side effects, as well as the fact that sterilization cannot be guaranteed.
 - (4) If successful, the operation will prevent the patient from having any more children.

(5) The operation is permanent. In selected circumstances, if the service is available, reversal may be attempted.

(6) The individual can decide against the procedure at any time and no services or benefits will be withheld from him as a result.

Informed consent in the specific language of each country or area must be documented for each patient.

1.3 Medical Screening and Pre-operative Assessment

It is mandatory that prospective patients for sterilization be assessed to determine their physical and emotional fitness for surgery in general, and for sterilization in particular.

A comprehensive history of past medical and surgical illnesses, allergies, present state of health, and number of children, as well as an appropriate physical examination, must be obtained and recorded for each patient undergoing a sterilization procedure.

No procedures will be done at an ambulatory facility when the patient has any medical condition indicating that surgery may involve above normal risk.

1.4 Surgical Procedure

Male surgical procedures must be done in a properly equipped operating space under appropriate aseptic conditions. The procedure must be performed by a licensed physician trained and competent in the procedure.

1.5 Post-operative Care

Immediately following the surgery, the patient should be transferred to the waiting room, recovery room or ward area where:

- a) He will be observed and monitored intermittently, if needed, until he is fully stable.
- b) He should receive post-operative counseling on problems that may arise after discharge and will be advised orally and in writing whom to contact in case of emergency.
- c) He shall be advised to continue contraceptive measures until a semen analysis performed after a minimum of 15 ejaculations shows azoospermia. For this purpose, condoms should be provided.
- d) He will be instructed in the arrangement for follow-up examination before discharge.

No patient should leave the facility until he is fully stable and discharged by the staff.

1.6 Post-operative Follow-up

There must be a minimum of one follow-up examination for each patient who has been sterilized:

- a) It must be scheduled for approximately three to four weeks after surgery.
- b) A semen analysis after a minimum of 15 ejaculations must be obtained. This specimen must show azoospermia before the patient is permitted to discontinue contraceptive measures. If immobile sperm are present in the ejaculate, the semen analysis must be repeated with a fresh specimen. When mobile sperm are present after 30 ejaculations, the operation has probably not been successful.

It is preferable for these examinations to be done at the facility where the sterilization procedure was performed. However, patients may be referred to other health centers or to public health personnel provided that previous arrangements for follow-up have been made.

2. PERSONNEL

For the delivery of sterilization services, specific types of personnel are required to perform the following functions:

- a) Surgery: Each male sterilization should be performed by a licensed physician competent in such procedures. Other qualified medical individuals may also perform these procedures if locally acceptable.
- b) Surgical Assistance and Patient Monitoring: The operating physician may be assisted by a trained surgical assistant during the performance of the sterilization procedure. Trained personnel must be available to monitor the post-operative patient.
- c) Information and Counseling: Trained personnel - doctor, social worker, nurse, educator, trained paramedic or equivalent - must be available for pre- and post-operative counseling.
- d) Laboratory Analysis: Trained personnel must be available for the semen analysis.
- e) Support: Other personnel such as porters, cleaners, and technicians will depend on the needs and characteristics of the facility.

Depending upon the facility, one person may fulfill more than one function provided that all are adequately covered as required.

3. MINIMUM STANDARD FACILITIES

Male sterilization services may be provided in a:

- a) Hospital
- b) Multi-purpose clinic
- c) Single-purpose clinic
- d) Doctor's office
- e) Mobile unit
- f) Temporary "camp"

Regardless of the location and size of the center, and with the exception of the camps, it must meet certain basic minimum requirements. Each facility must contain:

- a) Running water, electricity, and toilet facilities
- b) Registration/reception area
- c) Space where social workers or counselors can interview candidates
- d) Examining room/operating room
- e) Recovery space or ward area
- f) Sterilization room, storage area, and dressing room

3.1 Examining/Operating Room

The surgical space for performing the procedures must be an area, building or floor isolated from other patient services. There must be access to sterile equipment and supplies necessary for the performance of sterilizations and management of immediate complications.

The following items are mandatory:

- a) Operating table
- b) Instrument tray
- c) Surgical kits and supplies
- d) Adequate lighting
- e) Emergency light (battery operated) to be used in case of power failure
- f) Sphygmomanometer and stethoscope
- g) Emergency equipment
- h) Hand-washing facilities in the space or nearby

4. MINIMUM STANDARD EMERGENCY REQUIREMENTS

All facilities in which male sterilization procedures are performed must be able to provide basic emergency care. This necessitates the availability of basic emergency equipment on site and staff trained in its use.

4.1 Minimum Standard Emergency Equipment

The following emergency equipment in good working order must be available in the operating room:

- a) Ambubag
- b) Airway
- c) Suction apparatus
- d) Emergency drugs, and antidotes to treat narcotic overdose or adverse reactions to anesthetics or other drugs

The tray containing the drugs and this equipment must be in an accessible place. The medical director is responsible for maintaining the emergency equipment in good working order, and for ensuring that all staff is familiar with its location and proper use.

As emergency back-up, all facilities should have an established arrangement with a fully equipped hospital which would permit the treatment of patients in the event of any major complications.

5. MEDICAL RECORD REQUIREMENTS

A medical record must be written for each patient who undergoes sterilization procedure, and should contain:

- a) Pre-operative evaluation
- b) Signed consent form
- c) Surgical procedure
- d) Post-operative period
- e) Complications of any nature and outcome
- f) Follow-up data

The medical director of the facility is responsible for the completeness and supervision of these records.

The records should be maintained at the facility for five years after the discharge of the patient. For that purpose, filing cabinets, binders, etc. should be available.

References

- American Association of Medical Record Librarians. Glossary of Hospital Terms, Chicago: American Association of Medical Librarians, 1969.
- American College of Obstetricians and Gynecologists. Standards for Ambulatory Obstetric Care, Chicago: American College of Obstetricians and Gynecologists, 1977.
- American College of Obstetricians and Gynecologists. Standards for Obstetric-Gynecologic Services, Chicago: American College of Obstetricians and Gynecologists, 1974.
- Association for Voluntary Sterilization. "Recommended Standards for Voluntary Female Sterilization," New York, November 3, 1976. (Mimeographed.)
- Planned Parenthood Federation of America. 'Sterilization Standards and Guidelines,' in 'Manual of Medical Standards and Guidelines,' New York, September 6, 1977. (Mimeographed.)
- U.S. Congress. House. A Discursive Dictionary of Health Care. 94th Cong., 2^d sess., 1976. Prepared by the staff for the use of the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce.

APPENDIX B Sub-Grants Awarded from January, 1979 - December 31, 1979,
by Dollar Amount, Major Programmatic Emphasis, Program Components
and Funding Components

Key: A = Administration N = National Association related
B = NAVS Branch Development O = Operational Expenses
C = NAVS Coordination Costs P = Personnel
E = Equipment (N.Y. purchase) R = Equipment Repair
F = NAVS Special Conference S = Service
H = Health Care other than VSC T = Training
I = Information and Education U = Special Study
L = Equipment (Local purchase) V = Renovation
M = NAVS Annual Meeting

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Bangladesh	000-090-M14	\$140,089	E	E	E,L
Bangladesh	062-049-4I	46,155	I	I	P,E,I,O
Bangladesh	062-049-5N	67,211	N	E,N	P,E,L,O
Bangladesh	062-049-5S	243,253	S	E,H,S	P,T,I,E,L,O,V,S
Bangladesh	193-049-3S-02	55,701	S	S,H,I	P,I,E,L,O,S
Bangladesh	216-049-2S-03	38,668	S	S,I	P,I,E,L,O,V,S
Bangladesh	217-049-2S-04	72,567	S	S,H,I	P,I,E,L,O,S
Bangladesh	249-049-2S-05	32,943	S	S,I	P,I,E,L,O,S
Bangladesh	253-049-1S-06	48,264	S	S,I	P,I,E,L,O,V,S
Bangladesh	260-049-1S-07	47,341	S	S,I,	P,I,E,L,O,S
Bangladesh	261-049-1S-08	44,738	S	S,I	P,I,E,L,O,V,S
Bangladesh	263-049-1S-09	46,528	S	S,I	P,I,E,L,O,V,S
Bangladesh	266-049-1S-10	45,098	S	S,I	P,I,E,L,O,S
Barbados	250-156-1	85,180	S	I,S	P,I,E,L,O,V

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Brazil	094-070-4	\$ 49,650	S	S	P,O,S
Brazil	324-167-1	12,775	S	S,T	P,E,O,S
Chile	206-132-2	12,720	S	S,T,I	P,T,I,O,S
Colombia	307-155-1	150,000	T	T,S	S
Colombia	337-171-1	49,705	I	I	P,I,O
Ecuador	342-170-P1	17,035	T	T	P,T,E,O
Egypt	194-147-1	11,057	S	S	P,I,E,O,S
Egypt	226-148-2	25,890	S	I,S,T	P,I,E,L,O
El Salvador	000-090-M15	45,413	E	E	E
El Salvador	035-034-3	25,490	S	S,I	P,I,O,S
El Salvador	147-091-3	24,008	S	I,S,T	T,I,E,L,O
El Salvador	165-105-3	75,742	S	S,I	P,O,S
El Salvador	292-162-1	22,670	S	I,S	I,L,O,S
France	202-127-P2N	3,810	N	N	P,O
Guatemala	156-109-3	438,242	S	A,I,S,T,R	P,T,I,E,L,O,S
Honduras	106-112-3	113,625	S	S,T,I	P,T,O,S
Honduras	179-113-2	36,844	S	S,T,I	P,L,O,V,S
Honduras	180-114-2	29,777	S	S	P,O,S
Honduras	251-143-2	46,762	A	A	P,O,V
Honduras	273-165-1	91,772	I	I,T	P,I,I,O
Honduras	279-154-1	15,040	R	R	P,E,O
India	000-090-M12	386,400	E	E	E
India	305-164-1	15,200	E	E	T,E

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Indonesia	000-090-M18	\$258,750	E	E	E
Indonesia	000-090-M20	50,315	E	E	E
Indonesia	078-062-3N	123,840	N	I,N	P,I,L,O,M,C,B
Indonesia	078-063-3EM	40,200	R	E,L,R	P,E,L,O
Indonesia	221-134-2	37,872	T	T,S	P,T,I,O,S
Indonesia	222-135-2	60,903	T	S,T,I	P,T,I,L,O,S
Indonesia	223-136-2	88,833	T	S,I,T	P,T,E,L,O,S
Indonesia	304-166-1	33,948	T	T,S	P,T,O,S
Italy	310-157-P1N	15,000	N	I,A	P,I,O
Jamaica	313-163-1	28,905	R	E,R	P,E,O
Korea	082-055-5N	99,644	N	I,N	P,I,L,O,M
Korea	145-055-3EM	92,523	R	R	P,E,L,O
Korea	196-055-2T	59,657	T	S,T	T,E,O,S
Korea	210-055-2S	9,810	S	S	O,S
Korea	211-055-2T	28,780	T	S,T	T,E,L,O,S
Mauritius	091-075-2	26,723	S	I,S	P,I,E,O,S
Mexico	000-090-M13	381,570	E	E	E
Mexico	170-137-2	12,620	S	S,T	P,T,O,S
Mexico	244-139-2	115,303	R	R	P,E,L,O
Mexico	245-140-2	827,305	E	T,I	P,T,I,E,V,O
Mexico	248-142-2	47,704	S	S,I	P,I,O,S
Mexico	322-174-1	22,025	S	S,T,I	P,I,E,S
Morocco	299-176-1	42,896	S	T,S,I,E,L	P,I,E,L,O,V,S
Morocco	344-172-1	334,466	T	E,I,R,S,T	P,E,L,O,V,S

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Nepal	090-060-4	\$ 96,726	S	I,S,R,T	P,T,I,E,L,O,S
Nepal	258-158-1	68,571	I	I	P,T,I,E,O
Nicaragua	121-093-2	17,413	S	S,I	P,O
Nicaragua	181-108-3	119,939	S	I,S,T	P,T,I,E,L,O,V,S
Nigeria	132-100-2	14,345	T	S,T,I	P,I,E,O
Nigeria	272-169-1	20,800	I	I	P,I,E,L,O
Pakistan	052-043-4	65,183	S	I,S,T,H	P,T,I,E,L,O,V,S
Pakistan	053-044-3	46,565	S	S,T,I	P,T,I,E,L,O,V,S
Philippines	101-068-4	44,042	S	S	P,O
Philippines	104-065-4N	29,253	N	I,N	P,I,O
Philippines	178-116-3	37,472	S	S,I	P,I,E,O,S
Sri Lanka	186-125-2	20,920	S	S,T	P,T,E,L,O,V,S
Sri Lanka	256-124-1S	21,806	S	S,I	P,I,E,L,O,V,S
Sri Lanka	297-124-1EV	2,495	U	U	P,O
Sudan	155-123-3N	32,010	N	I,N	P,I,E,O,M,C
Syria	275-168-1N	32,165	N	N,I	P,I,E,L,O,M,C,U
Thailand	149-096-3N	128,945	N	I,N	P,I,L,O,V,M,F,C
Thailand	220-096-2EM	62,426	R	E,L,R	P,E,L,O
Thailand	286-096-1S	39,838	S	E,S	P,E,O,V,S
Thailand	291-096-1T	10,350	T	T	P,T,O
Tunisia	096-122-2	235,940	S	I,S	P,I,L,O,S
Tunisia	294-160-1	650,009	S	S	P,E,L,O,V
Tunisia	295-161-1	205,675	I	I,H	P,E,L,O,S

Continued

Country	Grant Number	Budget Total	Major Programmatic Emphasis	Program Components	Funding Components
Tunisia	312-159-1	\$107,308	T	T	P,E,L,O
Turkey	077-059-4N	26,850	N	I,N	P,I,O
USA	000-014-7N	11,045	N	N	P

KHK/sw
1/15/80

Appendix C Small Grants Awarded, Calendar Year 1979

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-268	Dr. C. T. Kim	KAVS	Korea	3000 Yoon rings
S-269	Dr. Diaz Chazaro	Hospital General de Veracruz	Mexico	3 male plugs/ 2 Verres needles
S-270	Dr. Hugh Wynter	Univ. of West Indies	Jamaica	1 falope ring applicator
S-271	Prof. Mahmoud Badr	Egyptian Urological Association	Egypt	Assorted films and film strips
S-272	Mr. Dosseli Tettekpo President ATBEF	Association Togolaise pour le Bien Etre Familial	Togo	3 stethoscopes/3 sphygmomanometers
S-273	Dr. Suporn Koetsawang	Dept. Ob/Gyn, Faculty of Medicine/Mahidol Univ.	Thailand	Travel/per diem to conduct a lecture tour on voluntary sterilization in Turkey
S-274	Prof. Mahmoud M. Badr	Egyptian Urological Association	Egypt	Travel/training costs/1 week per diem for vasectomy training
S-275	Dr. Azizur Rahman	BAVS/Dacca	Bangladesh	2 mechanical stage attachments for microscopes provided in 062-049-3S Dacca
S-276	ONPFP	ONPFP	Tunisia	5000 Yoon rings
S-277	Dr. Ramiro Abaunza Silinas	Teles Pain Hospital	Nicaragua	Assorted laparoscopic replace- ment parts

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-278	Dr. Zein El-Abidin Khairullah	Syrian Fertility Control Association	Syria	Film "Technique of laparoscopic tubal cauterization"
S-279	Drs. Da Chunha, Petlan, Aguiño	Universidade Estadual Paulista	Brazil	4 minilap kits/4 colpotomy kits
S-280	Dr. Faridon Setna	Lady Dufferin Hospital	Pakistan	Travel to U.S. for reanastomosis training 5/29-6/1/79 (Kentucky)
S-281	Mr. Aray Sriburatham	Thai AVS	Thailand	1-35mm single reflex camera with case and flash attachment
S-282	Dr. Prajitno Prabowo	Dr. Soetomo Hospital	Indonesia	Film-"Question of choice"/slide-"Choosing a contraceptive method"
S-283	Dr. Azizur Rahman	BAVS	Bangladesh	Surgical blades, sizes 10 & 11
S-284	Dr. Aguinaga	CPAIME	Brazil	Laprocator kit
S-285	Dr. Aguinaga	CPAIME	Brazil	Laprocator kit
S-286	Dr. Estellita-Lins	Gaffree Quinlee Hospital	Brazil	Laprocator kit
S-287	Dr. Sayed Etman	Misr Spinning & Weaving Company Hospital	Egypt	1000 rings
S-288	Dr. Helen Michie	Seychelles Hospital	Seychelles	Laprocator kit

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-289	Dr. Hosni Abdelkader	Ministry of Health	Morocco	Hook & elevator set
S-290	Dr. Khairullah	Syrian Fertility Control Society	Syria	4 films
S-291	Dr. Major Paul M. Ngumbi	Armed Forces Medical Services	Kenya	16mm projector/2 films
S-292	Mr. Leary Myers	National Family Planning Board	Jamaica	Travel/perdiem for KLI technician training 5/14 - 29/79
S-293	Dr. Luis Galich	APROFAM	Guatemala	200 Yoon rings
S-294	Prof. Mohamed Tahar Alaoui c/o Mr. W. Trayfors POP Ofcr	Maternite de Rabat	Morocco	1 minilap applicator/500 silastic bands
S-295	Professor Eusebe Alihonou	Cotonou University Hospital	Benin	2 minilap kits/surgical gloves
S-296	Dr. Lavissou Assani	Comite National Du Benin Pour La Promotion de La Famille	Benin	2 minilap kits/surgical gloves
S-297	Dr. N.S. Motashaw	KEM Hospital	India	1 laprocator kit
S-298	Dr. Rolando Lacayo	Nicaraguan Social Security Institute	Nicaragua	750 Yoon rings

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-299	Dr. Maria Manuela Tavares Lanhosa	General Hospital of San Antonio	Portugal	1 laproscator kit
S-300	Professor Alihonou	Contonou University Hospital	Benin	Training in Canada & USA Endoscopy training 8/6-31/79
S-301	Dr. Vovor	Centre Hospitalo-Universitaire	Togo	1 vasectomy kit
S-302	Dr. Argueta	Santa Tecla Clinic	El Salvador	1 laproscator kit
S-303	Dr. Mawupe Vovoy	Ecole Nationale de Sage Femme	Togo	1 examining table/3 dozen gloves
S-304	Dr. Joaquin Nunez	Leonardo Martinez Hospital	Honduras	Airways/laryngoscope/endotracheal tubes/N ₂ O tank
S-305	Dr. Tona Piere Adigo	Polyclinic Hospital	Togo	1 minilap kit
S-306	Professor Rene Darlin Zinsou	Services Cliniques du Centre Universitaire	Gabon	2 minilap kits
S-307	Dr. Miguel Trias	Profamilia	Colombia	2 anesthesia machines
S-308	Ministry of Health	Ministry of Health	Korea	1 lettering set
S-309	Dr. Marshall Raymond	Hopital de L'Universite d'Etat d'Haiti	Haiti	1 laproscator kit / 1 minilap kit / 1 vasectomy kit

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-310	Dr. Bernard A. Surhaindo	Princess Margaret Hospital	Dominica	1 laprocator/1 colpotomy kit 4 minilap kits/2 vasectomy kits
S-311	Dr. Joaquin Nunez	Honduran Family Planning Association	Honduras	Films and slides
S-312	Mrs. Genoveva M. de Hamilton	Asociacion Pro Salud Maternal	Mexico	Film: "Contraception"(Spanish)
S-313	Mrs. Guadalupe de la Vega	Family Planning Association of Ciudad Juarez	Mexico	Film: "Contraception"(Spanish)
S-314	Dr. Zein El-Abidin Khairallah	Khairallah Hospital	Syria	1 laprocator kit
*S-315	Dr. M. Kochar	Kasturba Hospital	India	1 laprocator kit
S-316	Dr. Tshipeta-Ntumba	National University of Zaire	Zaire	To attend symposium 8/7-11/79; To JHPIEGO orientation 8/12-14/79 IPAVS 8/14-17/79
S-317	Dr. Luis Galich	APROFAM	Guatemala	1 adult intubation model/2 films
S-318	Dr. Kyung Hee Lee	Seoul National University Hospital	Korea	Emergency equipment
S-319	Dr. L.A. Robinson Vaz	Hospital General	Panama	Laprocator
S-320	Mrs. Guadalupe de la Vega	Family Planning Association of Ciudad Juarez	Mexico	25 dozen gloves

*Grant cancelled; equipment donated by JHPIEGO.

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-321	Dr. Rodolfo Quinones	Secretaria de Salud y Asistencia	Mexico	100 Tuohy needles
S-322	Dr. Arunee Fongsree	McCormick Hospital	Thailand	Laprocator kit
S-323	D. Alvaro Muniz	Clinica Anglo-Americana	Peru	System C
S-324	Mr. Sutherland	RAM Center	Panama	Trocar & sleeve
*S-325	Dr. Habib Toumi	Family Planning Association of Tunisia	Tunisia	Laprocator kit
*S-326	Prof. Samiha Ben Fadhel	Hospital La Marsa	Tunisia	Laprocator kit
*S-327	Dr. Moncef Slama	Hospital Charles Nicolle	Tunisia	Laprocator kit
S-328	Dr. Hamid Arshat	National Family Planning Board	Malaysia	5 minilap kits
S-329	Dr. Azizur Rahman	BAVS	Bangladesh	Narcan, films
S-330	Dr. Wembodinga Utshudienyema	Hopital Wembo-Byama	Zaire	1 minilap kit
S-331	Dr. Joaquin A. Nunez	Honduran Family Planning Association	Honduras	7 resuscitators/7 laryngoscopes/ 7 airways/7 endotracheal tubes/ 5000 Yoon rings

*Grant cancelled per AID/Tunis

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-332	Dr. Faustin N. Massawe	Muhimbili Medical Centre	Tanzania	Films/slides
S-333	Dr. Saad Gadalla	Ashman Central Hospital	Egypt	System A-1
S-334	Dr. Saad Gadalla	El Shohada Central Hospital	Egypt	System A-1
S-335	Dr. Saad Gadalla	Chebin El-Kem Teaching Hospital	Egypt	System A-1
S-336	Dr. Saad Gadalla	Tala Central Hospital	Egypt	System A-1
S-337	Dr. Tshipeta-Mtumba	National Committee of Birth Control	Zaire	1 vasectomy kit
*S-338	Dr. Joaquin A. Nunez	Honduran Family Planning Association	Honduras	7 resuscitators/7 laryngoscopes/ 7 airways/ 7 endotracheal tubes/ 5000 Yoon rings
S-339	Mr. Mohamed Taher	Yemen Family Planning Association	Yemen	2 sphygmomanometers/2 stethoscopes/1 minilap kit
S-340	Dr. Martha Myers	Djibla Hospital	Yemen	2 minilap kits/2 vasectomy kits/ surgeon's gloves/ 1 ambubag/ 2 sphygmomanometers/ 1 examining table/1 16mm projector
S-341	Dr. Martha Myers	Djibla Hospital	Yemen	1 Sphygmomanometer/1 stethoscope

*S-338 cancelled (duplicate to S-331)

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-342	Dr. Hussain El Eryani	Republican Hospital	Yemen	1 minilap kit/3 uterine elevators/ surgeon's gloves
S-343	Dr. Mohamed Abdel Wadoud	Revolutionary Hospital	Yemen	1 minilap kit/1 vasectomy kit/ 1 stethoscope/ 1 sphygmomanometer/ surgeon's gloves
S-344	Dr. Fritz Lespinasse	University of Haiti	Haiti	1 laprocator kit
S-345	Dr. Adnan Mansour	Aleppo Hospital	Syria	To India for vasectomy training Oct. 1-14, 1979
S-346	Dr. C.T. Kim	Korean Institute for Family Planning	Korea	Films
S-347	Dr. Azizur Rahman	BAVS/Dacca	Bangladesh	Mirror assemblies for microscopes
S-348	Dr. Mohammed Boukhris	El Ariana Clinic	Tunisia	OR lamp
S-349	Dr. Adeline Verly	Immaculate Conception Hospital	Haiti	OR lamp
S-350	Dr. M.F. Fathalla	RAM Center	Egypt	500 Yoon rings
S-351	Mr. Raymond Louisy	Family Planning Association	St. Lucia	2 minilap kits/ 1 vasectomy kit

Small Grant Number	Individual(s)	Institution	Country	Purpose
*S-353	Mrs. Gloria Elena de Garcia	Honduran Family Planning Association	Honduras	Travel/per diem for 2 supervisors' orientation to US promoters' program in Guatemala
S-354	Dr. David Rebelo	University of Coimbra	Portugal	Travel/per diem to attend "Minilap Week" in Amsterdam 9/10-14/79
S-355	Dr. Luis Galich	APROFAM	Guatemala	3 microscopes
S-356	Mr. Binod Khambu Mr. Gahesh Rai	Ministry of Health	Nepal	Travel, per diem, KLI training (Nov. 5-16, 1979) technician's tool kit
	Dr. Hong-Ming Chen	Female Sterilization Training Center	Taiwan	KLI training (Nov. 5-16, 1979) technician's tool kit
S-357	Dr. Dinah Jarrett	Planned Parenthood of Sierra Leone	Sierra Leone	Films
S-358	Prof. M.F. Fathalla	Egyptian Fertility Control Society	Egypt	16mm Projector/overhead projector slide projector
S-359	Dr. M.N. Parikh	Nowrosjee Wadia Maternity Hospital	India	Laprocator kit/light sheath/ Trocar & sleeve
S-360	Dr. Bahl-Dahll	Marie Stopes Society Clinic	India	Laprocator system

*S-352 was cancelled (duplicate of S-356)

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-361	Dr. Dinah Jarrett	Planned Parenthood Association	Sierra Leone	1 air conditioner
S-362	Dr. Azizur Rahman	BAVS	Bangladesh	Training slides
S-363	Luis Francisco Patzan Jose Luis Pos	APROFAM	Guatemala	Travel/per diem for 2 technicians to San Salvador RAM Center 11/11-17/79
S-364	Dr. Hadi Zein Nahas	Sudan Fertility Control Association	Sudan	Slide projector
S-365	Mr. Horacio Vasquez	Honduran Family Planning Association	Honduras	Travel to APROFAM, Guatemala 11/11-17/79 for vasectomy orientation
S-366	Dr. Adeline Verly	Dept. of Public Health and Population	Haiti	Per diem for 3 days orientation in outpatient sterilization
S-367	Mr. Del Valle Mr. Ariel Escobar	PIACT de Mexico	Mexico	Travel/ per diem to Panama RAM Center to assist organization
S-368	Dr. Maria Estella	Centro Materno Infantil	Brazil	Falope-ring/minilap gun
S-369	Dr. Chan Moo Park	KAVS	Korea	Emergency equipment
S-370	Dr. D.K. Myint Dr. D.K. Yin	Rangoon Maternity/ Magwe Maternity	Burma	4 hooks and elevators

Small Grant Number	Individual(s)	Institution	Country	Purpose
S-371	Dr. Roberto Jose Bezerra	Unidade de Saude de Oroco	Brazil	1 vasectomy kit/2 colpotomy kits/ 3 minilap kits
*S-372	Dr. Yacaman	Honduran Family Planning Association	Honduras	Travel to APROFAM, Guatemala for vasectomy training
S-373	Dr. S.L. Agarwal	M.L.B. Medical College	India	3 vasectomy kits
S-374	Prof. B. Palanippan	Kilpauk Medical College	India	Laprocator system
S-375	Dr. Siral Mullich	Calcutta Family Welfare Hospital	India	Laprocator system
S-376	Dr. R.V. Bhatt	Baroda Medical College	India	Laprocator system
S-377	Dr. C.S. Dawn	Eden Hospital	India	Laprocator system
S-378	Dr. A. Padma Rao	Kasturba Medical College	India	Laprocator system
S-379	Dr. M.H. Gangal	Dr. Gangal Nursing Home	India	Laprocator system
S-380	Dr. N. Motashaw	Masina Hospital	India	Laprocator system
S-381	Dr. Husnu Kisnisci	Turkish National Fertility and Infertility Association	Turkey	6 film cartridges
S-382	Mr. Neer Bickram Shah Mr. Jagannath Timilsina Mr. Madhukar Basnyat	Family Planning Association of Nepal	Nepal	Travel/per diem for 3 film technicians to Bombay for production of 2 movies

*S-372 trip not yet realized

Date _____

Sub-Grant No. _____

COMPLICATION REPORT**Major Complications of Voluntary Sterilization Procedures**

A major complication is defined as any problem occurring during or after surgery necessitating surgical intervention, hospitalization, or medical treatment that is above and beyond that normally provided in conjunction with a sterilization procedure. Pregnancies following surgical sterilization are also considered major complications. This form should be completed by the Project Director.

- | | |
|--|--|
| 1. Date of sterilization: _____ | 6. Number of living children: _____ |
| 2. Date when complication occurred: _____ | 7. (For women only) |
| 3. Date of complete recovery: _____ | Total number of pregnancies _____ |
| 4. Age of patient: _____ | Total number of abortions _____ |
| 5. Sex of patient: _____ | Number of children ever born _____ |

Please indicate your answer by checking (✓) the appropriate response

8a. By whom was the sterilization procedure performed? () Staff Physician () Trainee

8b. What was the qualification of the person performing the sterilization procedure?

() General Practitioner () Ob/Gyn () Surgeon () Other: (Specify) _____

9. Please specify with a check mark (✓) the type of procedure performed.

- () Laparoscopy () Colpotomy () Culdoscopy
 () Mini-Laparotomy—interval () Mini-Laparotomy—post-partum () Laparotomy—interval
 () Vasectomy

10. What type of anesthesia did you use? () Local () Regional () General

11. What type of complications did you have? (Please check *all* relevant answers).

A. Complications related to Anesthesia

- () Respiratory arrest/depression
 () Cardiac arrest
 () Convulsions
 () Other: (specify) _____

B. Unintended Trauma

- () Injury to bladder
 () Injury to bowel
 () Uterine perforation
 () Electrocoagulation of any organ other than the fallopian tubes

Other: (specify) _____



COMPLICATION REPORT (Continued)**C.(1) Hemorrhage**

- Epigastric vessels
 Fallopian tubes
 Hematoma (requiring hospitalization)
 Other: (specify)_____

C.(2) Did the patient receive blood transfusion?

Yes () No ()

D. Infection

- Wound abcess
 Wound disruption
 Epididymitis or epididymo-orchitis
requiring hospitalization
 Other: (specify) _____

E. Pregnancy

- Intrauterine () Ectopic

F. Other complications not mentioned above

(specify)_____

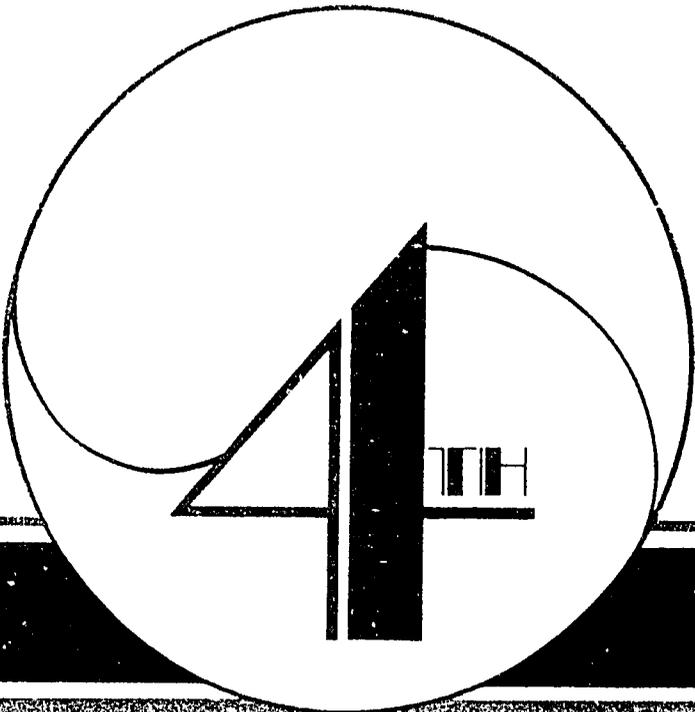
12. Was the patient hospitalized? No () Yes () If yes, for how long? _____

13. Please describe the type of treatment administered. _____

14. What was the final outcome of the complication?

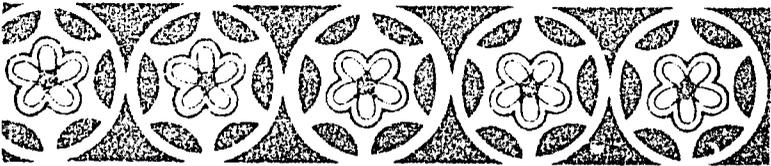
- Patient completely recovered with no permanent physiological damage.
 Patient recovered but with permanent physiological damage.
 Patient died. (Please provide a *detailed* report of exactly what happened, *in addition* to this form).

(Signature of Project Director)



**INTERNATIONAL
CONFERENCE
ON VOLUNTARY
STERILIZATION**

**1964
BANGKOK
MAY 2-6, 1964**



CONFERENCE PROGRAM

FOURTH INTERNATIONAL
CONFERENCE ON
VOLUNTARY STERILIZATION

May 7-10, 1979



Sponsored by the
INTERNATIONAL PROJECT OF THE
ASSOCIATION FOR VOLUNTARY STERILIZATION
708 Third Avenue, New York, N.Y. 10017 U.S.A.



CONFERENCE ORGANIZATION

President

Γ Mahmoud F. Fathalla

Program Chairperson

Dr. Elizabeth Connell

Director

Dr. Marilyn E. Schima

Co-Sponsors

The International Federation of
Gynecology and Obstetrics

The International Federation of
Fertility Societies

The International Federation of
Family Health Research

Hosts

The Ministry of Health of the
Republic of Korea

The Korean Association for
Voluntary Sterilization

In Cooperation With

The World Federation of Associations
for Voluntary Sterilization

Association for Voluntary Sterilization
of the United States

Sunday, May 6

10:00 a.m.—6:30 p.m.

10:00—5:00 p.m. **Registration**

3:00—5:00 p.m. **Audio-Visual Program,
Orchid Room**

6:30 p.m. **Pre-Conference Cocktail Party,
hosted by Mr. Jwah Kyum Kim,
President of Korea National
Tourism Corporation
Hotel Shilla**

ALL PLENARY SESSIONS IN THE DYNASTY HALL

Monday, May 7

7:45 a.m. — 7:00 p.m.

7:45—8:45 a.m. **Audio-Visual Session A:**
Orchid Room
Audio-Visual Session B:
Pine Room

8:00—9:00 a.m. **Registration**

FIRST PLENARY SESSION

- 9:00—9:10 a.m. Introduction of Distinguished
Guests
Dr. Elizabeth Connell, Program
Chairperson, U.S.A.

Dr. Mahmoud F. Fathalla,
Conference President, Egypt
- 9:10—9:40 a.m. Official Welcome and Remarks
Hon. Hyon Hwack Shin,
Deputy Prime Minister of Korea
- 9:40—10:10 a.m. **KEYNOTE ADDRESS**
The Challenge and Response of
Family Planning
Dr. Jorge Martinez Manautou,
Mexico
- 10:10—10:30 a.m. **COFFEE BREAK**
- 10:30—10:50 a.m. Conference Goals and Direction
Dr. Elizabeth Connell
- 10:50—11:10 a.m. The Role of AVS in the Growing
Acceptance of Voluntary
Surgical Contraception in the
U.S.
Dr. John C. Cutler
President, AVS, U.S.A.
- 11:10—11:30 a.m. The International Status of
Voluntary Surgical
Contraception and Its
Implications for National Health
Programs
Dr. Ira Lubell
Executive Director, AVS, U.S.A.

Monday, May 7 (Continued)

11:30—11:50 a.m. An Overview of Family Planning
in Korea
Professor Jae Mo Yang, Korea

12:00—2:30 p.m. **LUNCH**

SECOND PLENARY SESSION

**The Socio-Cultural, Political, Religious and
Economic Factors That Influence Surgical
Contraception Programs**

Chairperson Dr. Susan Scrimshaw, U.S.A.

2:30—3:00 p.m. Factors Affecting the
Acceptance of Voluntary
Sterilization: An Overview
Dr. Abdel Omran, U.S.A.

3:00—3:15 p.m. Political Factors
Dr. Haryono Suyono, Indonesia

3:15—3:30 p.m. Economic Perspectives
Professor Kee Chun Han, Korea

3:30—3:45 p.m. Religious Factors
Dr. Melanio Gabriel, Philippines

3:45—4:00 p.m. Male-Female Roles
Mrs. Mufeweza Khan,
Bangladesh

4:00—4:15 p.m. Professional Attitudes
Dr. Mahmoud F. Fathalla, Egypt

4:15—4:30 p.m. An Acceptor
Mr. Yung Koo Park, Korea

4:30—5:00 p.m. Discussion Period

7:00 p.m. **COCKTAILS/DINNER**

Ministry of Health and
Social Affairs.
Host: His Excellency Hyon Hwak
Shin, Deputy Prime Minister,
Minister of Economic Planning
Board, and Chairman of the
Population Policy Coordinating
Committee. The Sheraton
Walker Hill Hotel, Kaya Kum
Theater Restaurant

Tuesday, May 8

7:45 a.m.—7:00 p.m.

7:45—8:45 a.m. **Audio-Visual Session A:**
Orchid Room
Audio-Visual Session B:
Pine Room

THIRD PLENARY SESSION

**Development and Implementation:
From Policy to Program**

Chairperson Dr. Malcolm Potts, England

- 9:00—9:20 a.m. Panel Address: The Health Implications of Voluntary Sterilization
Dr. Benjamin Viel, England
- 9:20—9:30 a.m. Linking Voluntary Sterilization, Family Planning and Health Services
Dr. Vitoon Osathanondh, Thailand
- 9:30—9:40 a.m. Training and Manpower Development Programs in Surgical Contraception Programs
Dr. Allan Rosenfield, U.S.A.
- 9:40—9:50 a.m. Role of Non-Governmental Sector in Program Development and Implementation
Lt. Col. Dennis Hapugalle, Sri Lanka
- 9:50—10:00 a.m. Before and After Policy—The Development, Acceptance, and Implementation of a National Voluntary Sterilization Policy in El Salvador
Dra. Vilma de Aparicio, El Salvador
- 10:00—10:25 a.m. Discussion Period
- 10:25—10:45 a.m. **COFFEE BREAK**



Tuesday, May 8 (Continued)

FOURTH PLENARY SESSION

Information and Education Programs

Chairperson Dr. Phyllis Piotrow, U.S.A.

10:45—11:05 a.m. Education for Family Planning in Mexico
Dr. Manuel Urbina, Mexico

11:05—11:15 a.m. Planning an Information and Education Program
Dr. Azizur Rahman, Bangladesh

11:15—11:25 a.m. Role of the Physician and Health Team Members
Dr. Emilia Dacalos, Philippines

11:25—11:35 a.m. Designing Innovative Programs for Males and Females
Mrs. Peggy Lam, Hong Kong

11:35—11:45 a.m. Innovative Approaches to Promoting Voluntary Sterilization
Mr. Mechai Viravaidya, Thailand

11:45—12:10 p.m. Discussion Period

12:45—2:30 p.m. **LUNCH**
Luncheon Address: Future Prospects for Voluntary Sterilization
Dr. Reimert T. Ravenholt, U.S.A.

2:30—5:00 p.m. **TASK FORCE SESSIONS**

SPECIAL EVENING SESSION

5:00—7:00 p.m.

Restoration of Fertility Following Sterilization

Chairperson Dr. Robert S. Neuwirth, U.S.A.

Rapporteur Dr. Joseph E. Davis, U.S.A.

5:10—5:20 p.m. Pre-Operative Evaluation—Female
Dr. Patrick C. Steptoe, England

- 5:20—5:30 p.m. Pre-Operative Evaluation—Male
Dr. Fardoon Soonawala, India
- 5:30—5:50 p.m. Microsurgical Restoration of
Fertility Following Tubal Ligation
Dr. Robert Winston, England
- 5:50—6:10 p.m. Microsurgical Restoration of
Fertility Following Vas Ligation
Dr. Sherman Silber, U.S.A.
- 6:10—6:30 p.m. Role of Reversibility in the
Acceptance of Sterilization
Dr. Gerald Zatuchni, U.S.A.
- Summary Remarks
Dr. Robert S. Neuwirth, U.S.A.
- 6:30—7:00 p.m. Questions and Summations
-

Wednesday, May 9

7:45 a.m.—7:00 p.m.

- 7:45—8:45 a.m. Show and Tell A: Orchid Room
Show and Tell B: Pine Room

FIFTH PLENARY SESSION

Surgical Techniques and Their Program Implications

Chairperson Dr. Berislav M. Beric, Yugoslavia

- 9:00—9:15 a.m. The Evolution of Female
Sterilization
Dr. Rustom Soonawala, India
- 9:15—9:30 a.m. The Evolution of Male
Sterilization
Dr. Fardoon Soonawala, India
- 9:30—9:45 a.m. The Role of Female Sterilization
in Family Planning Programs
Dr. Gloria Aragon, Philippines
- 9:45—10:00 a.m. The Role of Male Sterilization in
Family Planning Programs
Dr. Badri Raj Pande, Nepal
- 10:00—10:15 a.m. Male and Female Sterilization:
The PROFAMILIA Experience
Dr. Fernando Tamayo, Colombia

Wednesday, May 9 (Continued)

10:15— 10:40 a.m. Discussion Period

10:40— 11:00 a.m. **COFFEE BREAK**

SIXTH PLENARY SESSION

The Legal and Ethical Aspects of
Voluntary Sterilization Programs

Chairperson Dr. Wickrema Weerasooriya,
Sri Lanka

11:00— 11:20 a.m. Legal and Ethical Perspectives
Mrs. Harriet Pilpel, U.S.A.

11:20— 11:30 a.m. The Americas
Dra. Rosa Cisneros, El Salvador

11:30— 11:40 a.m. Africa
Dr. U.U. Uche, Kenya

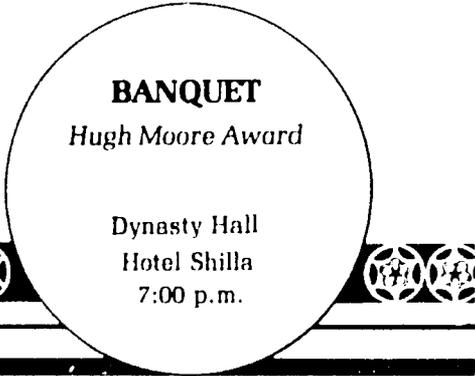
11:40— 11:50 a.m. South and East Asia
Dr. Irene Cortes, Philippines

11:50— 12:00 p.m. Europe and the Mid-East
Mme. Anne-Marie Dourlen Rollier
France

12:00— 12:25 p.m. Discussion Period

1:00— 2:30 p.m. **LUNCH**
Luncheon Address:
Contraception and Sterilization-
A Modern Dilemma
Dr. Patrick C. Steptoe, England

2:30— 5:00 p.m. **TASK FORCE SESSIONS**



BANQUET

Hugh Moore Award

Dynasty Hall
Hotel Shilla
7:00 p.m.

Thursday, May 10
9:00 a.m. — 12:00 noon

SEVENTH PLENARY SESSION

9:00—10:00 a.m. Task Force Reports

Legal Task Force
Technical Task Forces
Restoration of Fertility Special
Session
Socio-Cultural Task Force
Program Development Task
Forces

10:00—10:30 a.m. Discussion Period

**10:30—10:45 a.m. Challenges and Perspectives:
Toward the Future**
Dr. Marilyn E. Schima, U.S.A.

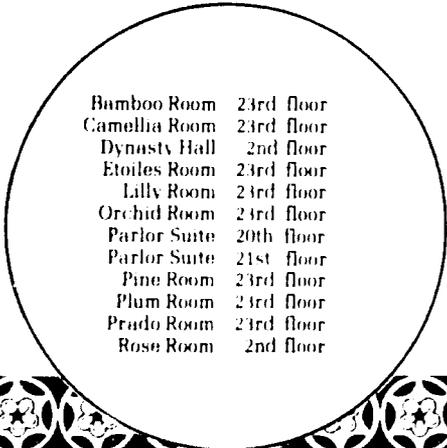
**10:45—11:00 a.m. International Implications of the
Conference for Professionals and
the Non-Governmental Network**
Dr. Mahmoud F. Fathalla, Egypt

11:00—11:10 a.m. Conference Evaluation

11:10—11:30 a.m. Summary and Conclusions
Dr. Elizabeth Connell, U.S.A.

Farewell
Dr. Chan Moo Park,
President of KAVS

ROOM DESIGNATIONS



Bamboo Room	23rd floor
Camellia Room	23rd floor
Dynasty Hall	2nd floor
Etoiles Room	23rd floor
Lilly Room	23rd floor
Orchid Room	23rd floor
Parlor Suite	20th floor
Parlor Suite	21st floor
Pine Room	23rd floor
Plum Room	23rd floor
Prado Room	23rd floor
Rose Room	2nd floor



CONCURRENT TASK FORCE SESSIONS

**Tuesday and Wednesday, May 8-9,
2:30—5:00 P.M.**

- Task Force 1 **Cultural, Social, Political, and
Religious Factors:
Regional Variation**
Pine Room
- Task Force 2 **Health Care and Voluntary
Sterilization**
Bamboo Room
- Task Force 3 **Resources, Strategies and
Programs for Voluntary
Sterilization**
Plum Room
- Task Force 4 **The Non-Governmental Sector in
Developing Voluntary Sterilization
Programs**
Etoiles Room
- Task Force 5 **Utilizing Evaluation in Program
Development**
Lilly Room
- Task Force 6 **Training Programs for Physicians
and Health Support Personnel**
Camellia Room
- Task Force 7 **Organizing for Communication
and Education Programs**
Parlor Suite 21st floor
- Task Force 8 **Current and Future Male
Sterilization Technology**
Parlor Suite 20th floor
- Task Force 9 **Current and Future Female
Sterilization Technology**
Orchid Room
- Task Force 10 **Legal and Ethical Issues in
Voluntary Sterilization Programs**
Prado Room
- Task Force 11 **Decision-Making and Policy-
Making for Voluntary Sterilization**
Rose Room



COMMITTEES

PROGRAM

CHAIRPERSON Dr. Joseph Davis

MEMBERS
Dr. Se Kyong Kim
Dr. John Cutler
Dr. Elizabeth Connell
Dr. Robert Neuwirth
Dr. Luke Lee
Mr. Werner Fornos
Dr. Allan Rosenfield
Dr. Nafis Sadik
Mr. Thomas Keehn
Dr. Benjamin Viel
Dr. Mary Kritz
Dr. Susan Philliber
Dr. Marilyn E. Schima
Dr. Ira Lubell

PUBLICITY AND PRESS

CHAIRPERSON Dr. Lewis Keith

MEMBERS
Mr. Yong Cheol Won
Dr. Benjamin Viel
Dr. Mahmoud F. Fathalla
Dr. O.A. Ojo
Mme. Anne-Marie Dourlen Rollier

REGISTRATION

CHAIRPERSON Dr. Yon Wan Kim

MEMBERS
Mrs. Anne Howat
Dr. Marian Hamburg
Ms. Evelyn Keys MacManus
Dr. Andrew Wiley
Mr. Robert Gillespie
Mr. Werner Fornos
Dr. Morris Hamburg

EVALUATION

CHAIRPERSON Dr. Jack Reynolds
MEMBERS Mr. Robert Gillespie
Dr. Does Sampoerno

HOSPITALITY

CHAIRPERSON Mrs. Anne Howat
MEMBERS Dr. Chan Moo Park
Mrs. Elise Cutler
Dr. Hadi El-Zein Nahas
Dr. Jorge Bustamante,
Dr. Emilia Dacalos
Dr. Azizur Rahman
Dr. D. Jarrett

AUDIO-VISUAL

CHAIRPERSON Dr. Syng Wook Kim
MEMBERS Mrs. Cecilia Cadavid
Dr. Arnee Fongsri
Mrs. Carrie Lorenzana,

EXHIBITS

CHAIRPERSON Dr. Hugh Davis
MEMBERS Dr. Byoung Choo Bai
Dr. Fakhar-un-Nisa
Mrs. Genoveva Mora de
Hamilton

EDITORIAL CONSULTANT

Ms. Polly Bolian



PARTICIPANTS

Prof. Carlos Dunshee de Abranches

President

Inter-American Commission on Human Rights

Rio de Janeiro, Brazil

Dr. Helio Aguinaga

Professor, Obstetrics Gynecology

Centro de Pesquisa Asistencia Integrada a Mulher e a Crianca

(CPAIMC)

Rio de Janeiro, Brazil

Dr. Kye Choon Ahn

Professor, Head Sociology Department

Yonsei University

Seoul, Korea

Dr. Rudi Ansbacher

Chief, Obstetrics Gynecology

Letterman Army Medical Center

California, U.S.A.

Dra. Vilma Hercules de Aparicio

Chief de la Division de Materno Infantil Y Planificacion

Familiar

Ministerio de Salud Publica y Asistencia Social

San Salvador, El Salvador

Dr. Ruben Apelo

President

Philippines Association for the Study of Sterilization

Manila, Philippines

Dr. Gloria Arago.

Professor, Obstetrics Gynecology

University of Philippines Obstetrics Gynecology Department

Manila, Philippines

Dr. Alain Audebert

Department of Obstetrics Gynecology

University Hospital Center, Haut-Loeveque

Bordeaux, France

Dra. Delfina de Badia

Senior Laparoscopist

Hospital de Maternidad

San Salvador, El Salvador

Dr. Jane Baltazar

Associate Professor

University of Philippines

Manila, Philippines

Dr. Peter Bayliss

Director

Fertility Control Clinic

Melbourne, Australia

Dr. Berislav M. Beric

Professor, Obstetrics Gynecology

Medical Faculty

Novi Sad, Yugoslavia

Dr. Roger P. Bernard

Director, Field Epidemiology

International Fertility Research Program

Geneva, Switzerland

Dr. Rohit Bhatt
Professor and Head, Department of Obstetrics/Gynecology
Medical College & S.S.G. Hospital
Baroda, India

Dr. Youssef Boutaleb
Chief, Obstetrics Gynecology
C.H.V. Hospital Averoes
Casablanca, Morocco

Prof. Mohamed Bouzidi
Vice Dean, Faculty of Law
University Mohamed V
Rabat, Morocco

Dr. Ivo A. Brosens
Professor, Obstetrics Gynecology
Academisch Ziekenhuis
Leuven, Belgium

Dr. Jorge Bustamante
President
Asociacion Demografica Salvadorena
San Salvador, El Salvador

Ms. Cecilia Cadavid
Director, I & E
PROFAMILIA
Bogota, Colombia

Dr. Ridha Chadi
Chief of Medical Division
National Office on Population and Family Planning
Tunis, Tunisia

Dr. Mezri Chekir
Executive Director
National Office of Population and Family Planning
Tunis, Tunisia

Dr. Mark C. F. Cheng
Senior Lecturer
University of Singapore
Singapore

Dr. W. H. Chiang
President
Association for Voluntary Sterilization, ROC
Taipei, Republic of China

Prof. Kyung-Kyoon Chung
Professor
Seoul National University
Seoul, Korea

Dra. Rosa Cisneros
Attorney at Law
Asociacion Demografica Salvadorena
San Salvador, El Salvador

Dr. Elizabeth B. Connell
Research Project Development Coordinator
Program for Applied Research on Fertility Regulation,
Northwestern University
Illinois, U.S.A.

Prof. Paul Correa
Chairman, Obstetrics/Gynecology Department
Faculté de Médecine
Dakar, Senegal

Dr. Sergio Correu
Director General
Secretaria de Salud y Asistencia
Mexico, D.F., Mexico

Dr. Irene Cortes
Dean, Faculty of Law
University of the Philippines
Quezon City, Philippines

Dr. John C. Cutler
Director, Population Division
Graduate School of Public Health, University of Pittsburgh
Pennsylvania, U.S.A.

Dr. Emilia Dacalos
Director of Family Planning Services
MIAM College of Medicine, Southwestern University
Cebu, Philippines

Dr. Hugh Davis
Professor, Obstetrics/Gynecology
Johns Hopkins University
Maryland, U.S.A.

Dr. Joseph E. Davis
Clinical Professor of Urology
New York Medical College
New York, U.S.A.

Dr. Richard Derman
Obstetrics/Gynecology
New York, U.S.A.

Dr. Djoko Rabardjo
Department of Obstetrics/Gynecology
Klinik Raden Saleh
Jakarta Pusat, Indonesia

Mme. Anne-Marie Dourlen Rollier
President
French National Association for the Study of Sterilization
Paris, France

Dr. Nikorn Dusitsin
Professor, Obstetrics/Gynecology
Chulalongkorn Hospital Medical School
Bangkok, Thailand

Dr. Mahmoud F. Fathalla
President
World Federation of Associations for Voluntary Sterilization
Assut, Egypt

Dr. Arunee Fongsri
Project Medical Director
McCormick Hospital
Chiang Mai, Thailand

Mr. Werner Fornos
Director
Population Action Council
Washington, D.C., U.S.A.

Dr. Carolina Gabriel
Project Director
INC Family Planning Program
Manila, Philippines

Dr. Melanio Gabriel
Program Administrator
Mobil Family Planning Program/INCC
Manila, Philippines

Dr. Juan Giner
Head, Family Planning Services
Instituto Mexicano del Seguro Social (IMSS)
Mexico, D.F., Mexico

Dr. Kanti Giri
Medical Advisor
World Health Organizations Regional Office of South East
Asia
New Delhi, India

Mrs. Betty Gonzales
Assistant Director for National Affairs
Association for Voluntary Sterilization
New York, U.S.A.

Dr. Joel R. Greenspan
Chief, Sterilization Epidemiology Section
Center for Disease Control
Atlanta, Georgia, U.S.A.

Dr. Young Soo Ha
Professor and Dean
College of Nursing, EWHA Woman's University
Seoul, Korea

Dr. Hadi El-Zein Nahas
Chairman
Sudan Fertility Control Association
Khartoum, Sudan

Mr. Hem Hamal
Chief
Division of the Information, Education and Communication
Division of the Family Planning MCH Project of Nepal,
Ministry of Health
Kathmandu, Nepal

Dr. Marion V. Hamburg
Chairperson, Department of Health Education
New York University
New York, U.S.A.

Mrs. Genoveva Mora de Hamilton
Director General
Asociacion Pro Salud Maternal
Mexico, D.F., Mexico

Prof. Kee Chun Han
Member of Parliament
Republic of Korea
Seoul, Korea

Dr. Yusef Hanafiah
Professor, Obstetrics/Gynecology
University of North Sumatra
Medan, Indonesia

Prof. Hanifa Wiknjosastro
President-Elect
World Federation of Associations for Voluntary Sterilization
Jakarta Pusat, Indonesia

Lt. Col. Dennis Hapugalle
Honorary Executive Director
Community Development Services
Colombo, Sri Lanka

Dr. Polly Fortier-Harrison
Medical Anthropologist Consultant
Department of State/Washington, D.C.
Port-Au-Prince, Haiti

Dr. Haryono Suxono
Deputy Chairman
National Family Planning Coordinating Board
Jakarta, Indonesia

Dr. Abdol H. Hosseinian
Professor, Obstetrics, Gynecology Department
Chicago Medical School, Cook County Hospital
Illinois, U.S.A.

Mrs. Anne Howat
Chairman Executive Committee
Association for Voluntary Sterilization
New York, U.S.A.

Dr. Dina F. Jarrett
Acting Consultant
Planned Parenthood of Sierra Leone
Freetown, Sierra Leone

Dr. C. I. Jhaveri
President
International Federation of Family Health Research
Bombay, India

Dr. Kamhaeng Chaturachinda
Associate Professor, Obstetrics, Gynecology Department
Mahidol University, Ramathibodi Hospital
Bangkok, Thailand

Dr. Joseph Kanvi
Project Director, Nyeri Sterilization Project
Chama Clinic
Nyeri, Kenya

Dr. Louis Keith
Medical Director
Illinois Family Planning Council
Illinois, U.S.A.

Dr. Elton Kessel
President
International Fertility Research Program
North Carolina, U.S.A.

Dr. Zein H-Abidin Khairullah
President
Syrian Fertility Control Society
Aleppo, Syria

Dr. Ahmad M. Khalifa
Chairman
National Center for Social and Criminological Research
Cairo, Egypt

Dr. Atiqur Rahman Khan
Director
Bangladesh Fertility Research Program
Dacca, Bangladesh

Mrs. Mufeweza Khan
Project Coordinator
Concerned Women for Family Planning
Dacca, Bangladesh

Dr. Chiya Kim (Cheong)
Senior Researcher
Korean Institute for Family Planning
Seoul, Korea

Dr. Chung Tai Kim
General Secretary
Korean Association for Voluntary Sterilization
Seoul, Korea

Dr. Theodore M. King
Chairman, Department of Obstetrics, Gynecology
Johns Hopkins University
Maryland, U.S.A.

Dr. F. N. Kisob
Professor of Law
University of Yaounde, Faculty of Law & Economic Sciences
Yaounde, Cameroon

Mr. Kap Suk Koh
Chief, Research Division
Korean Institute for Family Planning
Seoul, Korea

Dr. Hyun-Mo Kwak
Professor and Chairman, Obstetrics, Gynecology Department
Yonsei University Medical School
Seoul, Korea

Dr. George Labanya
Professor, Obstetrics, Gynecology Department
University Teaching Hospital
Lusaka, Zambia

Dr. O. A. Lapido
Obstetrics, Gynecology Department
University College Hospital
Ibadan, Nigeria

Mrs. Peggy Lam
Director, FE&C
Family Planning Association of Hong Kong
Hong Kong

Dr. Leonard E. Laule
Director, Research and Training
International Fertility Research Program
North Carolina, U.S.A.

Dr. Luke T. Lee
Director
Office of Population Affairs, Dept. of State
Washington, D. C., U.S.A.

Dr. Sung JIn Lee
Director
Korean Institute for Research in Behavioral Sciences
Seoul, Korea

Dr. Boonlert Leoprupal
Director
Institute for Population and Social Research
Bangkok, Thailand

Dr. Hans Joachim Lindemann
Chief Assistant, Obstetrics/Gynecology Department
Elisabeth Krankenhaus
Hamburg, West Germany

Dean Nicholas J. Liverpool
Dean, Faculty of Law
University of West Indies
Bridgetown, Barbados

Mrs. Carrie Lorenzana
Regional Director
Family Planning International Assistance
Manila, Philippines

Dr. Ira Lubell
Executive Director
Association for Voluntary Sterilization
New York, U.S.A.

Dr. Nimrod Mandara
Medical Officer
International Planned Parenthood Federation
Mbabane, Swaziland

Dr. Jorge Martinez Manautou
Coordinator Ejecutivo
Coordinacion Del Programa Nacional de Planificacion
Familiar
Mexico, D.F., Mexico

Mrs. Zahiah A. Marzouk
President
Institute for Training and Research in Family Planning
Alexandria, Egypt

Mr. Mechai Viravaidya
Director
Community Based Family Planning Services
Bangkok, Thailand

Dr. Leila Mehra
Medical Officer
World Health Organization
Geneva, Switzerland

Dr. Nargesh D. Motashaw
Professor, Obstetrics-Gynecology Department
Seth G. S. Medical College
Bombay, India

Dr. Milton Nakamura
Professor, Obstetrics/Gynecology Department
Centro de Planejamento Familiar
Sao Paulo, Brazil

Dr. Robert S. Neuwirth
Director, Obstetrics/Gynecology
St. Luke's Hospital Center
New York, U.S.A.

Mr. Mamadou Moustapha Nlang
Charge de Recherche en Sciences Sociales
Institute Fondamentale d'Afrique Noir,
University de Dakar
Dakar, Senegal

Dr. Fakhar-Un-Nisa
Assistant Professor, Obstetrics/Gynecology Department
Lady Willingdon Hospital
Lahore, Pakistan

Mrs. Dorothy Nortman
Associate
Center for Policy Studies, Population Council
New York, U.S.A.

Dr. Virgilio Oblepías
Assistant Professor
Mary Johnston Hospital
Manila, Philippines

Dr. O.A. Ojo
Professor, Obstetrics/Gynecology
University College Hospital, University of Ibadan
Ibadan, Nigeria

Dr. Abdel Omran
Professor Epidemiology
School of Public Health, University of North Carolina
North Carolina, U.S.A.

Dr. Tenrei Ota
President, Ota Ring Institute
Japan Euthanasia Society
Tokyo, Japan

Dr. Dattatraya Pai
Director Family Planning
MCH Family Planning Hospital
Bombay, India

Dr. Badri Raj Pande
Chief
Nepal Family Planning Maternal & Child Health Project
Kathmandu, Nepal

Dr. Chan Moo Park
President
Korean Association for Voluntary Sterilization
Seoul, Korea

Dr. Hyung Jong Park
President
Korean Health Development Institute
Seoul, Korea

Dr. Seung Hamm Park
Deputy Vice Minister of Health
Seoul, Korea

Mr. Yung-Koo Park
Director, Sales Promotion Division
Hotel Shilla
Seoul, Korea

Dr. J.Y. Peng
Director of International Activities-East
International Fertility Research Program
North Carolina, U.S.A.

Dr. Gordon Perkin
President
PIACT International
Mexico, D.F., Mexico

Dr. Phaitun Gojaseni
Head, Department of Urology
Ramathibodi Hospital
Bangkok, Thailand

Dr. Jordan M. Phillips
Chairman of the Board
American Association of Gynecologic Laparoscopists
California, U.S.A.

Mrs. Harriet Pipel
General Counsel
Planned Parenthood/World Population
New York, U.S.A.

Dr. Phyllis Piotrow
Director, Population/Information Program
Johns Hopkins Hospital
Maryland, U.S.A.

Dr. Malcolm Potts
Executive Director
International Fertility Research Program
North Carolina, U.S.A.

Dr. Rodolfo Quinones
Coordinator of Hospital Programs
Direccion Salud-Materno Infantil y Planificacion Familiar
Mexico, D.F., Mexico

Dr. Azizur Rahman
President
Bangladesh Association for Voluntary Sterilization
Dacca, Bangladesh

Dr. Reimert T. Ravenholt
Director, Office of Population
Agency for International Development, Department of State
Washington, D.C., U.S.A.

Mrs. Najwa Robaaoui
Project Director, Family Planning in the Organized Sector
National Office of Family Planning and Population
Tunis, Tunisia

Dr. Jack Reynolds
Vice President
University Research Corporation
California, U.S.A.

Dr. Allen Rosenfield
Director
Center for Population and Family Health, Columbia University
New York, U.S.A.

Dr. Hamid Rushwan
Director
Sudan Fertility Control Association
Khartoum, Sudan

Dr. Nafis Sadik
Assistant Executive Director and Chief, Programme Division
United Nations Fund for Population Activities
New York, U.S.A.

Dr. Does Sampoerno
President
Indonesian Society for Voluntary Sterilization
Jakarta Pusat, Indonesia

Dr. Robert Santiso-Galvez
Executive Director,
APROFAM
Guatemala City, Guatemala

Dr. Marilyn E. Schima
Director of International Programs and Conference Director
International Project, Association for Voluntary Sterilization
New York, U.S.A.

Dr. Susan Scrimshaw
Professor of Public Health
UCLA School of Public Health
California, U.S.A.

Dr. Pramilla Senanayake
Acting Medical Director
International Planned Parenthood Federation
London, England

Dr. Pierre Sende
Professor, Obstetrics, Gynecology
Centre Universitaire des Sciences de la Santé
Yaounde, Cameroon

Hon. Hyun Hwack Shin
Deputy Prime Minister
Republic of Korea
Seoul, Korea

Dr. Sherman Silber
Consulting Urologist
St. Luke's West Hospital
Missouri, U.S.A.

Dr. Morakinyo Soghanmu
Obstetrics, Gynecology Department
University of Ife
Ibadan, Nigeria

Dr. Somboon Vacharotai
President
Thai Association for Voluntary Sterilization
Bangkok, Thailand

Dr. Fardoon Soonawala
Consulting Surgeon and Urologist
Family Planning Association of India
Bombay, India

Dr. Rustom Soonawala
Honorary Medical Director
Family Planning Association of India
Bombay, India

Dr. Patrick C. Steptoe
President
International Federation of Fertility Societies
Oldham, Lancaster, England

Dr. Fernando Lamayo
President
PROFAMILIA
Bogota, Colombia

Mr. Abderrazak Thrava
Director of the Family Planning Training Center
Office National du Planning Familial et de la Population
Tunis, Tunisia

Ms. Olga Lucia Toro
Director
Unidad de Orientacion Y Asistencia Materna
Bogota, Colombia

Mr. Richard B. Turkson
Professor of Law
University of Ghana
Legon, Ghana

Dr. Louise Tyrer
Vice President for Medical Affairs
Planned Parenthood Federation of America
New York, U.S.A.

Dr. U. U. Uche
Attorney
U. U. Uche and Associates
Lagos, Nigeria

Dr. Manuel Urbina Fuentes
Chief, Department of Information and Education
Coordinacion de Planificacion Familiar
Mexico, D.F., Mexico

Mr. Rafael Vara
Technical Services Manager
PIACT de Mexico
Mexico, D.F., Mexico

Mrs. Maria Guadalupe de la Vega
Project Director
Planificacion Familiar de Ciudad Juarez
Ciudad Juarez, Mexico

Dr. Benjamin Viel
Senior Advisor on Medical Education
International Planned Parenthood Federation
London, England

Dr. Vitoon Osathanondh
Chief, Family Planning Unit
Ramathibodi Hospital, Mahidol University
Bangkok, Thailand

Dr. Wickrema Weerasooriya
Secretary
Ministry of Plan Implementation
Colombo, Sri Lanka

Mr. Young Whan Whang
Chief of Repair and Maintenance Center
Korea Association for Voluntary Sterilization
Seoul, Korea

Dr. Robert Winston
Consultant, Obstetrics, Gynecology
Hammersmith Hospital
London, England

Dr. Jae Jo Yang
Dean
Yonsei University College of Medicine, Severance Hospital
Seoul, Korea

Dr. A. Albert Yuzpe
Associate Professor, Department of Obstetrics/Gynecology—
Infertility
University of Western Ontario
Ontario, Canada

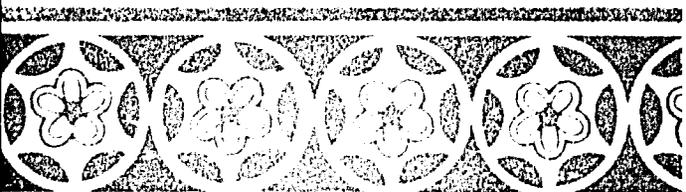
Ms. Maria Louisa Zardini
Member of the Board of Directors
Italian Association for Voluntary Sterilization
Rome, Italy

Dr. Gerald F. Zatzchini
Associate Professor
Program for Applied Research on Fertility Regulation,
Northwestern University Medical School
Illinois, U.S.A.

Dr. Jamie Zipper
Associate Professor of Physiology
School of Medicine, University of Chile
Santiago, Chile

CONTENTS

2	Conference Organization
2	Registration
2	Audio-Visual Program
2	Pre-Conference Cocktail Party
3	Audio-Visual Session
3-4	First Plenary Session
4	Second Plenary Session
4	Ministry of Health Cocktail Party
5	Audio-Visual Session
5	Third Plenary Session
6	Fourth Plenary Session
6-7	Special Evening Session
7	Audio-Visual Session
7-8	Fifth Plenary Session
8	Sixth Plenary Session
8	Banquet
9	Seventh Plenary Session
9	Room Designations
10	Concurrent Task Forces
11-12	Committees
13-24	List of Participants

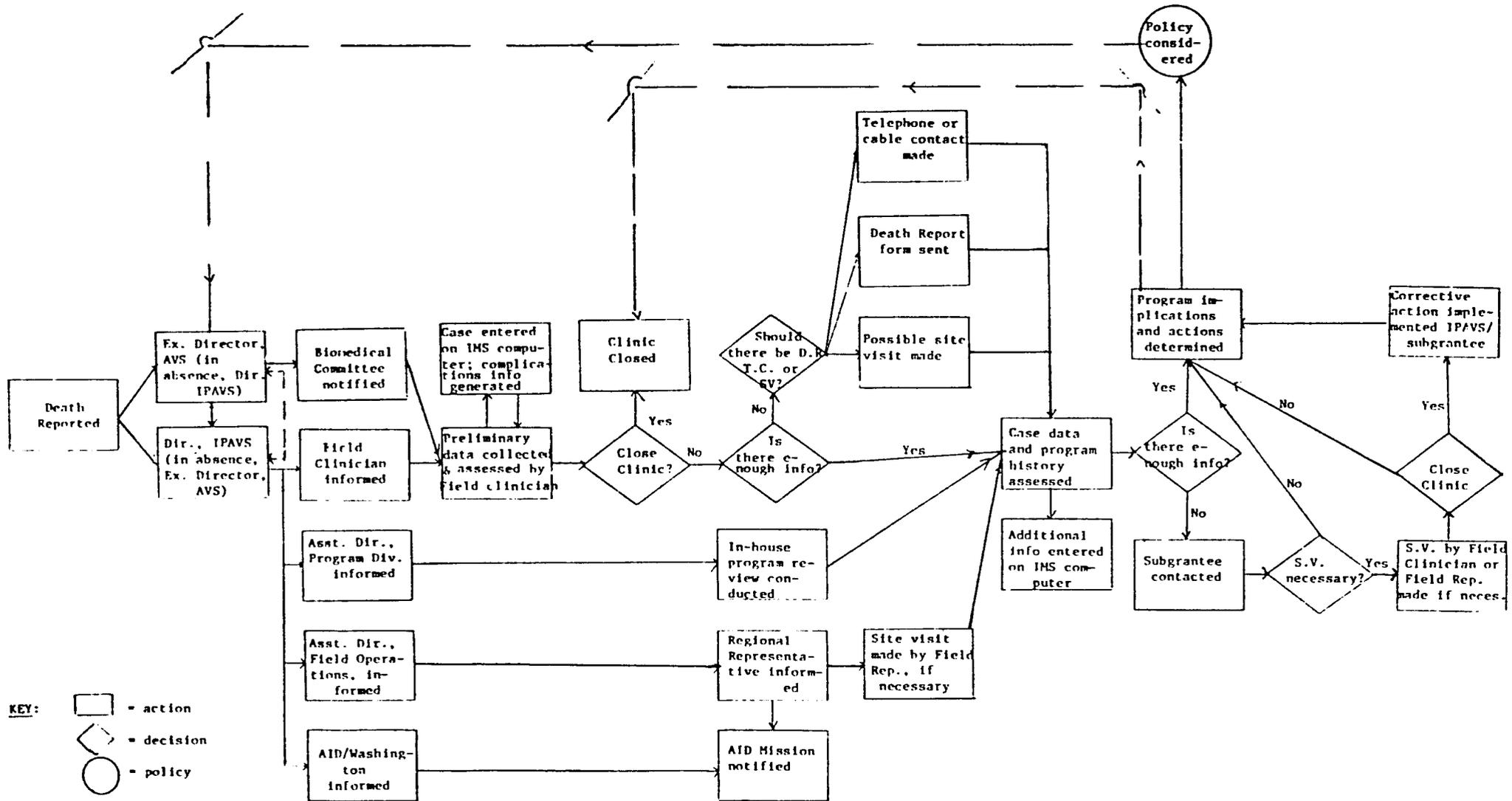


PROCEDURES FOR IPA VS RESPONSE TO A VOLUNTARY STERILIZATION-RELATED DEATH

1. Within 24 hours after a voluntary sterilization-related death, the subgrantee is required to notify IPA VS. Within seven days, the subgrantee is required to submit a comprehensive report, including:
 - Narrative report of the circumstances surrounding the death;
 - Curriculum vitae of physician involved;
 - Copies of pertinent medical records;
 - Postmortem findings, if available; and
 - Actions, if any, taken by the subgrantee to prevent a recurring situation.
2. Upon receipt at IPA VS of the notification of a death, the Executive Director, AVS, and Director of International Programs, IPA VS, are immediately informed.
3. The Executive Director informs one of the Chairmen of the Biomedical Committee, depending on whether the death is male or female voluntary sterilization-related. The Director of International Programs informs the Field Clinician, the Assistant Directors and AID Washington.
4. The Directors, in consultation with the Chairman of the Biomedical Committee and appropriate staff, hold a preliminary discussion. If decided that the death might have been preventable, IPA VS may direct the subgrantee to suspend services until a comprehensive investigation has been completed.
5. Immediately upon notification, IPA VS initiates a comprehensive investigation to review the circumstances surrounding the death in order to determine whether the death was preventable and what corrective action should be taken:
 - a) The Field Clinician conducts a medical review of the data available, including analysis of the circumstances of the case, previous history of complications of the site, patterns of medical supervision, curriculum vitae of physicians involved in the case, etc. If data is insufficient, the Field Clinician contacts the subgrantee by telephone, cable or letter for clarification. If warranted, an immediate medical site visit is conducted.

- b) The Assistant Director of Programs initiates a program review, including review of program design, all previous correspondence, trip and progress reports, as well as the status of emergency equipment, whether purchased by IPA VS or not.
 - c) The Assistant Director of Field Operations contacts the Regional Field Representative, if available, to request input and advice. If necessary, the Regional Field Representative is dispatched to conduct an on-site investigation. The Regional Representative notifies the AID Mission abroad.
4. After all data is collected and analyzed, the Field Clinician, in coordination with the Assistant Directors, submits to the Executive Director, the Director of International Programs, and the Chairmen of the Biomedical Committee a final report with recommendations for IPA VS/subgrantee corrective action.
 5. The Directors and appropriate staff determine a definitive action strategy for rectification.
 6. If indicated, IPA VS informs the subgrantee of expected corrective action. Corrective action may include definitive or temporary suspension of clinic services, provision of further emergency equipment, or further training of physicians involved, etc. If necessary, a special medical site visit is conducted.
 7. IPA VS monitors closely the progress of subgrantee actions until assurance is obtained that all corrective measures have been implemented. A medical and/or program site visit may be scheduled during this period.
 8. After review of all details, IPA VS management considers any implications for IPA VS policy and procedures and, if required, changes in policies and procedures are made accordingly.

FLOWCHART OF IPAVS PROCEDURES FOLLOWING REPORT OF A DEATH IN IPAVS FUNDED FACILITIES



International Project

MEMO TO: Project Director

FROM: Director of International Programs
International Project, Association for
Voluntary Sterilization, Inc. USA (IPAVS)

SUBJECT: INFORMED CONSENT GUIDELINES FOR IPAVS PROJECTS

It is the responsibility of the IPAVS Grantee and staff to:

1. Use the utmost care in ensuring that sterilization operations are performed only after a person gives his/her voluntary, informed consent.

Voluntary, informed consent is defined as occurring when:

- a) The individual presents himself/herself at the treatment center after choosing freely to do so, having experienced no undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion.
 - b) The individual is capable of understanding and in fact understands the nature and effects of the sterilization operation (s)he is requesting. Specifically, the individual understands all of the following elements:
 - i. Temporary contraceptive methods are available to the individual and his/her partner.
 - ii. The sterilization is a surgical procedure.
 - iii. Certain discomforts and risks attend the procedure, which have been explained to the individual by the physician and include the fact that sterility is not guaranteed, what complications may result, and what side effects may occur.
 - iv. If successful, the operation will prevent the patient from having any more children.
 - v. The operation is irreversible.
 - vi. The individual can decide against the procedure at any time and no services or benefits will be withheld from him/her as a result.
2. Require that informed consent be documented with informed consent forms. Suitable forms are attached and can be used as models.
 3. Ensure that copies of the documents are kept for audit and annual review for at least three years at your headquarters.

RECOMMENDED INFORMED CONSENT IMPLEMENTATION PROCEDURES

*RECOMMENDED PROCEDURES FOR IMPLEMENTATION BY PROJECT DIRECTOR

1. Become familiar with IPAVS Informed Consent requirements and contract agreement.
2. Develop an Informed Consent Procedure which:
 - identifies individual project staff who are responsible for patient counselling and education.
 - provides for project staff training in informed consent.
 - prepare appropriate informed consent forms for documenting the informed consent of each patient, in each patient's native language.
 - implement the informed consent procedure.

***Responsibilities of Project Director:**

- The Project Director is ultimately responsible for ensuring that an informed consent procedure is in effect or implemented immediately.
- The Project Director is responsible for planning and identifying which staff members will be providing patient counselling and education.
- The Project Director must provide each individual staff member's role in the informed consent procedure.

***Responsibilities of Project Staff:**

- Project staff must recognize that informed consent is mandatory for all patients.
- Project staff must understand the informed consent guidelines and know the six essential elements of informed consent as outlined in the guidelines.
- Project staff must be aware of the fact that ALL informed consent must be documented by an informed consent form which is in the patient's native language.

MODELINFORMED CONSENT FORM FOR LITERATE ACCEPTOR

(This form is a model, prepared by IPAVS to assist sub-grantees in implementing an informed consent program. The form is designed to be used by patients who can read. A form of this kind should be in the local language(s) and designed to best fit your needs while conforming to the underlying informed consent concept).

I, the undersigned, wish to be sterilized by the following procedure: _____ (specify sterilization procedure to be performed). I understand the following:

1. There are temporary methods of contraception I can use instead of sterilization for planning my family.
2. The sterilization is a surgical procedure, the details of which my physician has explained to me.
3. The sterilization operation involves risks, which my physician has explained to me.
4. If the operation is successful, I will be unable to have any more children.
5. The sterilization operation is irreversible.
6. I can change my mind at any time and decide against the sterilization procedure and no medical, health, or other services or benefits will be withheld from me as a result.

Date

Signature of Patient

Date

Signature of physician or other authorized person attesting to the patient's understanding of the above statement.

INFORMED CONSENT FORM FOR ILLITERATE ACCEPTORS

(This form is a model, prepared by IPAVS to assist sub-grantees in implementing an informed consent program. The form is designed to be used for patients who cannot read. A form of this kind should be in the local language(s) and designed to best fit your needs while conforming to the underlying informed consent concept).

I, _____, certify that _____
 (name of attending physician or authorized assistant) (name of patient)

has presented himself/herself freely to undergo a _____
 (specify sterilization procedure to be performed.) I have explained to the patient and he/she understands the following:

1. Temporary contraception techniques are available which the patient and his/her partner can use to plan their family.
2. The sterilization procedure is a surgical one.
3. The sterilization operation involves some risks, which have been explained.
4. While sterility is not guaranteed, if the operation is successful, the patient will be unable to have more children.
5. The sterilization operation is permanent and irreversible.
6. The patient can change his/her mind and refuse the sterilization procedure and no medical, health, or other services or benefits will be withheld from the patient as a result.

I certify that the patient's mark or signature is made with the understanding that such mark attests to the fact that I have explained the above to the patient and that he/she understands it fully.

 Date

 Signature of attending physician
 or other authorized person

 Date

 Signature or mark of patient

 Date

 Signature of witness of patient's
 choosing

TABLE 2

Comparison of Task Force Responses
by Different Task Force Groups

All Task Force
Assessment Forms

	O P I N I O N Q U E S T I O N S									
	Useful Info		New Info		Attitude Changes		Useful End Product		Active Participation	
	+	-	+	-	+	-	+	-	+	-
All Task Forces (188)	99.5	.5	94.5	5.5	60.3	39.7	96.7	3.3	87.8	12.2
Task Force 1: Socio-Cultural (11)	93.8	6.2	100	0	12.5	81.3	100	0	93.8	6.2
Task Force 2: Health Care (18)	100	0	94.5	5.6	50	50	100	0	88.2	11.8
Task Force 3: Program Development (12)	100	0	91.6	8.3	58.3	41.7	100	0	100	0
Task Force 4: Non-Government (15)	100	0	100	0	53.9	46.1	92.3	7.7	92.3	7.7
Task Force 5: Program Evaluation (11)	100	0	90.1	9.1	54.6	45.4	81.2	18.2	90.0	10.0
Task Force 6: Training (25)	100	0	91.6	8.3	64.0	36.0	96.0	4.0	96.0	4.0
Task Force 7: I&E (1)	100	0	100	0	100	0	100	0	100	0
Task Force 8: Technical - Male (23)	100	0	90.5	9.5	71.4	28.6	95	5	95	5
Task Force 9: Technical - Female (58)	100	0	96.5	3.5	67.8	32.2	98.3	1.7	73.7	26.3
Task Force 10: Legal (11)	100	0	88.9	11.1	88.9	11.1	100	0	100	0

CURRENT NAVS ACTIVITIES	Bangladesh	Egypt	France (private)	Indonesia	Italy (private)	Korea	Philippines	Republic of China (Taiwan)	Sri Lanka	Sudan	Syria	Thailand	Turkey	TOTAL COUNTRIES
Organizational development, strengthening of administration and management	x	x	x	x	x	x	x	x	x	x	x	x	x	13
Provision of technical assistance and expert advice on voluntary sterilization	x	x	x	x		x	x	x	x	x		x	x	11
Establishment of standards for voluntary sterilization service delivery and training	x	x		x		x	x		x	x		x		8
Promotion of legislation and national policies for voluntary sterilization	x	x	x	x	x	x		x	x	x		x	x	11
Coordination of voluntary sterilization activities among public and private agencies	x	x	x	x	x	x	x	x	x	x	x	x	x	13
Maintaining a register or list of physicians/clinics providing services	x	x	x	x		x	x	x	x	x				9
Research/investigation of medical and biomedical aspects of sterilization		x				x				x				3
Collection of socio-economic, legal and psychological data regarding sterilization	x		x	x			x	x			x	x		7
Provision of funding of voluntary sterilization services	x							x				x		3
Training of physicians in sterilization techniques	x	x		x		x		x		x				6
Training of paramedia/auxiliary voluntary sterilization support personnel (e.g. nurses, midwives, counselors, etc.)	x					x		x	x			x		5
Implementation of public information program	x	x			x		x	x	x	x	x	x		9
Development/distribution of professional educational materials	x	x	x	x		x	x	x	x	x	x	x	x	12
Holding of seminars/conferences to educate physicians, allied health personnel, and other professionals	x	x		x	x	x	x	x	x	x	x	x	x	12
Organization of library/resource centers	x	x	x	x	x	x	x	x	x	x	x	x	x	13
Provision of sterilization equipment to other institutions	x	x		x		x			x			x		6
Organization of voluntary sterilization equipment maintenance and repair center		x		x		x						x		4

General Characteristics of Member Associations
to the World Federation of Associations for
Voluntary Sterilization, 1979

Name of Association	Date of WF Membership	Type of WF Membership	No. of Assoc. Members	No. of Assoc. Branches	No. of Assoc. Comm.	Amt. of Assoc. Annual Dues (US)
<u>Australia</u> Australian Association for Voluntary Sterilization	January 1978	National Association - Voting	36	0	1	\$35
<u>Bangladesh</u> Bangladesh Association for Voluntary Sterilization	April 1975	National Association - Voting	408	29	6	\$1
<u>Colombia</u> Asociación Pro-Bienestar de la Familia Colombiana	January 1978	Affiliate Association - Voting	100	0	4	Unk.
<u>Egypt</u> Fertility Control Society of Egypt	April 1975	National Association - Voting	85	0	5	\$3
<u>El Salvador</u> Asociación Demográfica Salvadoreña	January 1978	Affiliate Association - Voting	622	0	11	Unk.
<u>France</u> French National Association for the Study of Voluntary Sterilization	January 1977	National Association - Voting	200	0	1	\$22
<u>Great Britain</u> Vasectomy Advancement Society of Great Britain	January 1977	Affiliate Association - Non-Voting	300	0	2	\$2
<u>Guatemala</u> Asociación Pro-Bienestar de la Familia de Guatemala	January 1978	Affiliate Association - Voting	646	0	7	Unk.

Name of Association	Date of WF Membership	Type of WF Membership	No. of Assoc. Members	No. of Assoc. Branches	No. of Assoc. Comm.	Amt. of Assoc. Dues (US)
<u>Honduras</u> Asociación de Planificación Familia Hondureña	January 1978	Affiliate Association - Voting	206	0	4	Unk.
<u>India</u> National Association for Voluntary Sterilization of India	February 1976	National Association - Voting	260	0	3	Unk.
<u>Indonesia</u> Indonesian Society for Voluntary Sterilization	February 1976	National Association - Voting	400	12	7	\$3
<u>Italy</u> Associazione Italiana per la Sterilizzazione Volontaria	May 1979	National Association - Voting	583	5	7	Unk.
<u>Jordan</u> Jordan Family Planning and Protection Association - Irbid Branch	May 1979	Associate Non-Voting	200	0	1	Unk.
<u>Korea</u> Korean Association for Voluntary Sterilization	April 1975	National Association - Voting	426	0	5	\$4
<u>Nepal</u> Family Planning Association of Nepal	May 1979	Committee Affiliate Voting	1500	0	7	Unk.
<u>Netherlands</u> Population Services Europe	May 1979	Associate Non-Voting	8	0	0	Unk.
<u>Pakistan</u> Fertility Regulation Association of Pakistan	April 1975	National Association - Voting	200	0	2	\$5

Name of Association	Date of WF Membership	Type of WF Membership	No. of Assoc. Members	No. of Assoc. Branches	No. of Assoc. Comm.	Amt. of Assoc. Annual Dues (US)
<u>Philippines</u> Philippine Association for the Study of Sterilization	February 1976	National Association - Voting	240	0	7	\$3
Regional Arab Federation of Associations for Voluntary Sterilization	May 1979	Regional - Voting	7	0	6	Unk.
<u>Republic of China</u> Association for Voluntary Sterilization of the Republic of China	January 1977	National Association - Voting	3297	0	2	\$5
<u>South Africa</u> Cape Association for Voluntary Sterilization	January 1977	Affiliate Association - Voting	32	0	1	Unk.
<u>Sri Lanka</u> Sri Lanka Association for Voluntary Sterilization	Apr'1 1975	National Association - Voting	160	2	5	\$4
<u>Sudan</u> Sudan Fertility Control Association	February 1976	National Association - Voting	83	0	2	\$2
<u>Syria</u> Syrian Fertility Control Society	May 1979	National Association - Voting	14	0	0	Unk.
<u>Thailand</u> Thailand Association for Voluntary Sterilization	February 1976	National Association - Voting	400	0	3	\$2

Name of Association	Date of WF Membership	Type of WF Membership	No. of Assoc. Members	No. of Assoc. Branches	No. of Assoc. Comm.	Amt. of Assoc. Annual Dues (US)
<u>Turkey</u> Turkish Fertility & Infertility Association	January 1977	National Association - Voting	35	0	4	\$7
<u>U.S.A.</u> Association for Voluntary Sterilization	April 1975	National Association - Voting	5800	0	5	\$15
<u>U.S.A.</u> Population Dynamics	January 1978	Associate Non-Voting	100	0	1	Unk.

(1) GRANT MASTER FILE

1. IPAVS project number.
2. The country in which grant is located.
3. The geographic region in which grant is located.
4. Institution (agency name).
5. Address of the project.
6. The name of the agency director.
7. The type of agency.
8. Ownership of the agency.
9. The name of the project director.
10. Effective date of grant.
11. Termination date of grant.
12. Total budget of grant.
13. Category of the final funding (AID, private).
14. Category of grant (standard, NAVS, NAVS branch, NAVS supplemental).
15. Various program components of grant (service, training, etc.).
16. Various funded components of grant (personnel, renovation, equipment, etc.).
17. Primary programmatic emphasis of sub-grant.
18. The type of service procedures offered.
19. The number of male procedures to be carried out under grant.
20. The number of female procedures to be carried out under grant.
21. Sex of the service target population.
22. Does the grant comply with informed consent requirements (yes, no)?
23. List of the informed consent guidelines with which grantee is not in compliance.
24. Are the informed consent forms for literate and illiterate acceptors the same (yes, no)?
25. Where /how are temporary planning methods available (on site, by referral)?
26. Temporary family planning methods available.
27. Is the agency involved in any abortion related activities (yes, no)?
28. If yes, is IPAVS providing direct or indirect cost support, or both?
29. What type of facility offers service under this sub-grant (hospital, hospital clinic, etc.)?
30. Is this a co-funded program (yes, no)?
31. What is the scope of this program (rural, urban, national, urban and surrounding rural areas)?
32. What is the I&E target population (patients, physicians, health support personnel, general public, etc.)?
33. The number of physicians to be trained under the grant.
34. The type of surgical training to be carried out.
35. The number of persons to be trained in non-surgical areas (nurses, midwives, physician assistants, equipment technicians, etc.).
36. The type of non-surgical training to be carried out.
37. The type of equipment items requested in the proposal (medical and non-medical).
38. Date proposal is received.
39. Date proposal reviewed by staff.
40. Date proposal approved by International Committee.
41. Date proposal sent to AID for approval.
42. Date proposal approved by funders (in writing).

(1) GRANT MASTER FILE - continued

43. Date grant document was sent to sub-grantee.
44. Date grant contract was signed.
45. Date signed contract letter was received at IPAVS.
46. Date of the last site visit.
47. Number(s) of any small grant(s) related to this sub-grant.
48. Number(s) of any conference grant(s) related to this sub-grant.
49. What category does this record fall into (proposal, approved grant, expired grant, etc.)?
50. Has this grant been cancelled?

1/7/80
/sw

(2) GRANT MONITOR FILE

1. IPAVS project number
2. Country in which grant is located.
3. Geographic region in which grant is located.
4. Effective date of grant.
5. Termination date of grant.
6. Operational date of grant.
7. The date all equipment items have been ordered.
8. Date all equipment items have been shipped.
9. Date all equipment items have been received by sub-grantee.
10. Number of times grant has been reviewed by staff.
11. Dates staff reviewed the grant.
12. Number of requests made to sub-grantee for a continuation proposal.
13. Dates the continuation proposal was requested.
14. Date the continuation proposal was received by IPAVS.
15. Number of administrative extensions given to the grant.
16. Administrative extension dates.
17. Reason for the administrative extension (use remaining funds, accomplish objectives, delay in starting program, etc.).
18. Date of final letter.
19. Date grant file closed.

/sw
1/9/80

(3) FINANCIAL MASTER FILE

1. Geographic region in which grant is located.
2. Country in which grant is located.
3. IPAVS project number.
4. Has the budget been amended (yes, no)?
5. Number of times the budget has been amended.
6. Has the budget been reallocated (yes, no)?
7. Number of times the budget has been reallocated.
8. Has there been any uncommitted balance (yes, no)?
9. Amount of the uncommitted balance.
10. Budget total.
11. Budget Salary Line
12. Budget Training Line.
13. Budget I&E Equipment Line (NY purchase).
14. Budget I&E Equipment Line (Local purchase).
15. Budget I&E Other.
16. Budget Medical Equipment Line (NY purchase).
17. Budget Medical Equipment Line (Local purchase).
18. Budget Operational Travel Line.
19. Budget Operational Rent Line.
20. Budget Operational Utility Line.
21. Budget Operational Communication Line.
22. Budget Operational Office Equipment Line (NY purchase).
23. Budget Operational Office Equipment Line (Local purchase).
24. Budget Operational, Other.
25. Budget Renovation Line.
26. Budget Service Line.
27. Budget Bookkeeping Line.
28. Budget Bank Charge Line.
29. Budget, Other.
30. Number of financial periods covered to date.
31. Last date the financial report covered.
32. Total of advances made to date.
33. Cash on hand with the sub-grantee.
34. Expenditures Salary Line.
35. Expenditures Training Line.
36. Expenditures I&E Equipment Line (NY purchase).
37. Expenditures I&E Equipment Line (Local purchase).
38. Expenditures I&E, Other.
39. Expenditures Medical Equipment Line (NY purchase).
40. Expenditures Medical Equipment Line (Local purchase).
41. Expenditures Operational Line - Travel.
42. Expenditures Operational Line - Rent.
43. Expenditures Operational Line - Utility.
44. Expenditures Operational Line - Communication.
45. Expenditures Operational Line - Equipment (NY purchase).
46. Expenditures Operational Line - Equipment (Local purchase).
47. Expenditures Operational Line - Other.
48. Expenditures Renovation Line.
49. Expenditures Service Line.
50. Expenditures Bookkeeping Line.

(3) FINANCIAL MASTER FILE - continued

- 51. Expenditures Bank Charge Line.
- 52. Expenditures, Other.
- 53. Total of expenditures to date.
- 54. Is the total expenditure figure the final expenditure figure for this sub-grant?

/sw
1/9/80

(4) FINANCIAL MONITOR FILE

1. IPAVS project number.
2. Country in which grant is located.
3. Geographic region in which grant is located.
4. Effective date of grant.
5. Official termination date of grant.
6. Operational date of grant.
7. Number of administrative extensions given to the grant.
8. Final termination date.
9. Number of financial reports submitted to IPAVS.
10. Last date the financial report covered.
11. Dates financial reports were received at IPAVS Financial Office.
12. Number of reimbursements sent to grantee.
13. Dates reimbursements were sent.
14. Dates sub-grantee received reimbursements.
15. Amount of reimbursements sent to sub-grantee.
16. The status of financial report submission (all received, some overdue).
17. Is the most recent report the final financial report (yes, no)?
18. Date audit was requested.
19. Number of follow-up letters sent to auditor.
20. Dates of the follow-up letters.
21. Date audit was initiated.
22. Date audit report was received at IPAVS.
23. Is the audit report acceptable (yes, no, code for problems)?
24. Date of the letter to sub-grantee to request more information.
25. Date of the letter to auditor to request more information.
26. Date IPAVS received responding letter from sub-grantee.
27. Date IPAVS received responding letter from auditor.
28. Financial file closure date.
29. Audit fee.
30. Date audit fee sent.
31. Date audit fee received.

(5) NAVS FILE

1. Development state of the association (initial dialog.e, formed but not registered, etc.).
2. Type of organization (NAVS, Affiliate, etc.).
3. Organizational structure pertaining to vote (federated, one man/one vote, etc.).
4. Geographic region in which organization is located.
5. Country in which organization is located.
6. Full name of organization.
7. Full address of organization.
8. Telephone number.
9. Cable address.
10. Telex number.
11. Name of individual who is the key IPAVS contact for organization.
12. Name of Administrative Officer.
13. Job title of Administrative Officer.
14. Date constitution adopted.
15. Date organization was registered.
16. Agency with which organization is registered.
17. Date Affiliate Committee was formed.
18. Name and title of President or Chairman of organization.
19. First Vice-President of organization.
20. Second Vice-President of organization.
21. Secretary of organization.
22. Treasurer of organization.
23. Chairman of Sterilization Committee.
24. Number of paid staff.
25. Date of last annual meeting.
26. Date of last election of officers.
27. Date of next election of officers.
28. Annual dues in U.S. Dollars.
29. Number of members in organization.
30. Number of organization branches.
- 31 - 37. Names of seven committees.
38. Member of WFAVS (yes, no)?
39. Type of WFAVS membership (NAVS, Affiliate Committee, etc.).
40. Is this organization a voting member of WFAVS (yes, no)?
41. Date organization joined WFAVS.
42. Funding sources of organization.
43. IPAVS sub-grant number.

/sw
1/9/80

Appendix K Description of Variables Contained in Each Computer Data File

(6) EQUIPMENT FILE

1. IPAVS project number.
2. The country in which grant is located.
3. Code for the country (used for sorting purposes).
4. The geographic region of the country in which the grant is located.
5. Purchase order number of the equipment item.
6. The source from which the item was ordered.
7. Is this item part of a larger order with the same order number (yes, no)?
8. Type of equipment.
9. Equipment item code.
10. Quantity of the item ordered.
11. Unit price of the item.
12. Total price of the item order (UNITPRICxQUANTITY).
13. The date the item was ordered.
14. Date the item was shipped.
15. Date the sub-grantee received the item.

/sw
1/9/80

(7) SERVICE STATISTICS FILE

1. The country in which grant is located.
2. Country Code.
3. IPAVS project number.
4. The geographic region in which grant is located.
5. Name of facility where procedures were performed.
6. Facility Code.
7. Type of facility where services are offered.
8. Name of city in which service facility is located.
9. Year of the reporting period.
10. Calendar quarter of the reporting period.
11. Starting date of the reporting period.
12. Ending date of the reporting period.
13. Report covers procedures for which sex?
14. Number of vasectomies performed in this reporting period.
15. Number of vasovasostomies performed in this reporting period.
16. Number of mini-laparotomy post-partum ring procedures performed in this reporting period.
17. Number of mini-laparotomy post-partum no-ring procedures performed in this reporting period.
18. Number of mini-laparotomy interval ring procedures performed in this reporting period.
19. Number of mini-laparotomy interval no-ring procedures performed in this reporting period.
20. Number of mini-laparotomy no-ring procedures performed in this reporting period.
21. Number of mini-laparotomy ring procedures performed in this reporting period.
22. Number of laparotomy post-partum ring procedures performed in the reporting period.
23. Number of laparotomy post-partum no-ring procedures performed in this reporting period.
24. Number of laparotomy interval ring procedures performed in this reporting period.
25. Number of laparotomy interval no-ring procedures performed in this reporting period.
26. Number of colpotomy ring procedures performed in this reporting period.
27. Number of colpotomy no-ring procedures performed in this reporting period.
28. Number of culdoscopy ring procedures performed in this reporting period.
29. Number of culdoscopy no-ring procedures performed in this reporting period.
30. Number of laparoscopy ring procedures performed in this reporting period.
31. Number of laparoscopy no-ring procedures performed in this reporting period.
32. Number of Pomeroy procedures performed in this reporting period.
33. Number of other procedures performed in this reporting period.
34. Total number of procedures reported in this statistical report.
35. How many major complications were there during this reporting period?
36. How many patients were refused a VS procedure for either health or other reasons?
37. How many procedures were attempted but could not be completed?
- 38-85. Variables (48 in all) giving the number of patients accepting a sterilization procedure who fall into the age categories of age 24 or under, 25-29, 30-34, 35-39, 40 or over, age unknown, and into the parity categories of no children, 1 child, 2 children, 3 children, 4 children, 5 children, more than 5 children or parity unknown.

(8) TRAINEE FILE *

1. Input sequence number.
2. IPAVS project number.
3. Trainee's full name, first name first.
4. Trainee's name, last name first.
5. Trainee's sex
6. Trainee's birthdate.
7. Trainee's age at time of training (by coded category).
8. Years of education of non-physician trainees.
9. Trainee's institutional affiliation.
10. Country of trainee.
11. Country code.
12. Geographic region of trainee.
13. Type of area in which trainee will work (major urban center, small urban area, rural).
14. Is trainee first from area to offer service (yes, no)?
15. Do others in trainee's area provide this service (yes, no)?
16. Trainee's professional status (MD, RN, etc.).
17. Trainee's professional specialization (GP, OB/GYN, etc.).
18. Type of training provided for the non-physician trainee.
19. Institution where training took place.
20. City in which the training institution is located.
21. Country in which the training institution is located.
22. Geographic region in which the training institution is located.
23. Date first training period started.
24. Date first training period ended.
25. Instructor's name for first training period.
26. Was trainee taught laparoscopy no-ring procedure (yes, no)?
27. Was trainee taught laparoscopy ring procedure (yes, no)?
28. Was trainee taught mini-laparotomy no-ring procedure (yes, no)?
29. Was trainee taught mini-laparotomy ring procedure (yes, no)?
30. Was trainee taught laparotomy post-partum procedure (yes, no)?
31. Was trainee taught laparotomy interval procedure (yes, no)?
32. Was trainee taught other abdominal procedure (yes, no)?
33. Was trainee taught culdoscopy no-ring procedure (yes, no)?
34. Was trainee taught culdoscopy ring procedure (yes, no)?
35. Was trainee taught colpotomy no-ring procedure (yes, no)?
36. Was trainee taught colpotomy ring procedure (yes, no)?
37. Was trainee taught other vaginal procedure (yes, no)?
38. Was trainee taught vasectomy procedure (yes, no)?
39. Was trainee taught a reanastomosis (reversal) technique?
40. Procedures for which trainee did not perform the number required by IPAVS policy. (IPAVS requirements listed in coding manual under each procedure.)
41. Did any complications result from this trainee's performance?
42. The type(s) of complications which resulted.
43. Trainer's evaluation of the trainee, first training period.
44. Number of follow-up reports on trainee.
45. Date second training period started.
46. Date second training period ended.
47. Instructor's name for second training period.
48. Trainer's evaluation of the trainee, second training period.
49. Number of follow-up reports on trainee.

*To be revised

/sw 1/8/80

(9) SMALL GRANT FILE*

1. IPAVS small grant number.
2. Country in which grant is located.
3. Geographic region in which grant is located.
4. Name of addressee who receives shipment.
5. Name and address of the agency to which small grant is awarded.
6. The date the grant file is opened.
7. Type of sterilization equipment provided by the grant.
8. Estimated cost of the grant.
9. Actual cost of the grant.
10. The date AID approved the grant, if required.
11. Code for current status of the grant (on hold, closed, etc.).
12. Components of the grant.
13. Primary programmatic emphasis of grant.
14. Explanation of the status of the grant.
15. Is information for this small grant incomplete or not available (yes, no)?

*Being revised

(10) CONFERENCE GRANT FILE*

1. IPAVS conference grant number.
2. Agency to which grant is awarded.
3. Key contact individual.
4. Country of grantee.
5. Geographic region of grantee.
6. City in which conference is held.
7. Country in which the conference is held.
8. Geographic region in which the conference is held.
9. Short title of the conference.
10. Full title of conference.
11. Starting date of the conference.
12. Ending date of the conference.
13. Date the contract became effective.
14. Date the contract terminated.
15. Total budget.
16. Funding source of the grant (AID, private).
17. Components of the grant (contract, travel, per diem, etc.).
18. Main emphasis of the conference (technical aspects of VS, program administration, annual meeting, etc.).
19. The scope of the conference (national, regional, etc.).
20. Number of participants.
21. Categorical breakdown of participants (MDs, government officials, etc.).
22. Is there a list of participants in the office (yes--in conference file; yes--in library; no)?
23. Main sponsor of the conference.
24. Co-sponsors of this conference.
25. IPAVS staff attending conference.
26. Date AID approved the grant.
27. Date document (contract) sent to sub-grantee.
28. Date sub-grantee signed the contract.
29. Date IPAVS received the signed contract.
30. Date of first transfer of funds.
31. Date sub-grantee received first transfer of funds.
32. Date of second transfer of funds.
33. Date sub-grantee received second transfer of funds.
34. Type(s) of materials sent to sub-grantee.
35. Date materials ordered.
36. Date materials shipped.
37. Date sub-grantee received materials.
38. Reporting requirements.
39. Due date(s) of progress report(s).
40. Date(s) IPAVS received progress report(s).
41. Due date of financial report.
42. Date IPAVS received financial report.
43. Date IPAVS received report of proceedings.
44. Are travel arrangements completed (yes, no)?
45. Per diem transactions completed (yes, no)?
46. Total IPAVS expenditures for conference.
47. Is the conference still pending?
48. Has this grant been cancelled?

*Being revised

/sw
1/9/80

(11) REGISTER

1. Country in which grant is located.
2. IPAVS project number.
3. Number used to identify type of grant.
4. Geographic region in which grant is located.
5. The name of the project director.
6. The title of the project director.
7. The last name of the project director.
8. Address of the project director.
9. Institution (agency name).
10. Phone number.
11. Cable address.
12. Effective date of grant.
13. Termination date of grant.
14. Number of administrative extensions given to the grant.
15. Administrative extension dates.
16. Total budget of grant.
17. List of service sites involved in project.

(12) CUMULATIVE TRAINING AND SERVICE STATISTICS FILE (TRANSERV)

1. The country in which grant is located.
2. IPAVS project number.
3. The geographic region in which grant is located.
4. Total number of individuals trained.
5. Total number of physicians trained.
6. Number of equipment technicians trained.
7. Total number of non-physicians other than technicians trained.
8. Number of nurses/midwives trained.
9. Number of midwives trained.
10. Number of paraprofessionals trained.
11. Number of anesthetists trained.
12. Number of social workers/counselors trained.
13. Number of other non-physicians trained.
14. Total number of non-physicians trained.
15. Number of male trainees.
16. Number of female trainees.
17. Number of trainees below 30 years old.
18. Number of trainees ages 30-39.
19. Number of trainees ages 40-49.
20. Number of trainees ages 50 or older.
21. Number of trainees whose base institution is in a major urban center.
22. Number of trainees whose base institution is in a small urban center.
23. Number of trainees whose base institution is in a rural area.
24. Number of trainees trained in male procedure, above and below standard.
25. Number of trainees trained in female procedures, above and below standard.
26. Number of trainees trained in male and female procedures above and below standard.
27. Number of trainees trained in laparoscopy no-ring procedures.
28. Number of trainees trained in laparoscopy ring procedures.
29. Number of trainees trained in mini-laparotomy no-ring procedures.
30. Number of trainees trained in mini-laparotomy ring procedures.
31. Number of trainees trained in other abdominal procedures.
32. Number of trainees trained in culdoscopy no-ring procedures.
33. Number of trainees trained in culdoscopy ring procedures.
34. Number of trainees trained in colpotomy no-ring procedures.
35. Number of trainees trained in colpotomy ring procedures.
36. Number of trainees trained in other vaginal procedures.
37. Number of trainees trained in laparoscopy post-partum procedures.
38. Number of trainees trained in laparoscopy interval ring procedures.
39. Number of trainees trained in vasectomy.
40. Number of trainees trained in vasovasostomy.
41. Number of trainees performing below standard number of laparoscopy no-ring procedures.
42. Number of trainees performing below standard number of laparoscopy ring procedures.
43. Number of trainees performing below standard number of mini-laparotomy no-ring procedures.
44. Number of trainees performing below standard number of mini-laparotomy ring procedures.
45. Number of trainees performing below standard number of other abdominal procedures.

(12) CUMULATIVE TRAINING AND SERVICE STATISTICS FILE (TRANSERV)

Page 2.

46. Number of trainees performing below standard number of culdoscopy ring procedures.
47. Number of trainees performing below standard number of culdsocopy no-ring procedures.
48. Number of trainees performing below standard number of colpotomy no-ring procedures.
49. Number of trainees performing below standard number of colpotomy ring procedures.
50. Number of trainees performing below standard number of other vaginal procedures.
51. Number of trainees performing below standard number of laparoscopy post-partum procedures.
52. Number of trainees performing below standard number of laparoscopy interval procedures.
53. Number of trainees performing below standard number of vasectomy procedures.
54. Number of trainees performing below standard number of vasovasostomy procedures.
55. Number of mini-laparotomy post-partum no-ring procedures performed to date.
56. Number of mini-laparotomy post-partum ring procedures performed to date.
57. Number of mini-laparotomy interval ring procedures performed to date.
58. Number of mini-laparotomy interval no-ring procedures performed to date.
59. Number of laparotomy post-partum ring procedures performed to date.
60. Number of laparotomy post-partum no-ring procedures performed to date.
61. Number of laparotomy interval procedures performed to date.
62. Number of laparotomy interval no-ring procedures performed to date.
63. Number of colpotomy ring procedures performed to date.
64. Number of colpotomy no-ring procedures performed to date.
65. Number of culdoscopy ring procedures performed to date.
66. Number of culdoscopy no-ring procedures performed to date.
67. Number of laparoscopy ring procedures performed to date.
68. Number of laparoscopy no-ring procedures performed to date.
69. Number of other procedures performed to date.
70. Number of post-partum procedures performed to date.
71. Number of pomeroy procedures performed to date.
72. Number of mini-laparotomy no-ring procedures performed to date.
73. Number of female procedures performed to date.
74. Number of vasectomies performed to date.
75. Number of vasovasostomies performed to date.
76. Number of complications to date.
77. Number of pregnancies to date.
78. Number of deaths to date.
79. How many patients were refused VS procedures for either health or other reasons?
80. How many procedures were attempted but could not be completed?

(13) PROPOSAL FILE

1. IPAVS proposal number.
2. Date IPAVS received proposal.
3. The country in which applicant is located.
4. Geographic region.
5. Agency presenting the proposal.
6. Staff review date.
7. Date International Committee reviewed proposal.
8. Date proposal was sent to funder.
9. Date funder approved the proposal.
10. Proposal status.
11. Contract status.
12. Date contract was sent to sub-grantee.
13. Budget total for new sub-grant.
14. Type of proposal.
15. Number used to indicate status of record.
16. Grant number if proposal has been awarded.

(14) BIRTHS AVERTED FILE

1. The country in which grant is located.
2. Number of acceptors whose age is 24 or less and who have no children.
3. Number of acceptors whose age is 25-29 and who have no children.
4. Number of acceptors whose age is 30-34 and who have no children.
5. Number of acceptors whose age is 35-39 and who have no children.
6. Number of acceptors whose age is 40 or above and who have no children.
7. Number of acceptors whose age is 24 or less and who have 1 child.
8. Number of acceptors whose age is 25-29 and who have 1 child.
9. Number of acceptors whose age is 30-34 and who have 1 child.
10. Number of acceptors whose age is 35-39 and who have 1 child.
11. Number of acceptors whose age is 40 or above and who have 1 child.
12. Number of acceptors whose age is 24 or less and who have 2 children.
13. Number of acceptors whose age is 25-29 and who have 2 children.
14. Number of acceptors whose age is 30-34 and who have 2 children.
15. Number of acceptors whose age is 35-39 and who have 2 children.
16. Number of acceptors whose age is 40 or above and who have 2 children.
17. Number of acceptors whose age is 24 or less and who have 3 children.
18. Number of acceptors whose age is 25-29 and who have 3 children.
19. Number of acceptors whose age is 30-34 and who have 3 children.
20. Number of acceptors whose age is 35-39 and who have 3 children.
21. Number of acceptors whose age is 40 or above and who have 3 children.
22. Number of acceptors whose age is 24 or less and who have 4 children.
23. Number of acceptors whose age is 25-29 and who have 4 children.
24. Number of acceptors whose age is 30-34 and who have 4 children.
25. Number of acceptors whose age is 35-39 and who have 4 children.
26. Number of acceptors whose age is 40 or above and who have 4 children.
27. Number of acceptors whose age is 24 or less and who have more than 5 children.
28. Number of acceptors whose age is 25-29 and who have more than 5 children.
29. Number of acceptors whose age is 30-34 and who have more than 5 children.
30. Number of acceptors whose age is 35-39 and who have more than 5 children.
31. Number of acceptors whose age is 40 or above and who have more than 5 children.
32. Total number of acceptors whose age is 24 or less.
33. Total number of acceptors whose age is 25-29.
34. Total number of acceptors whose age is 30-34.
35. Total number of acceptors whose age is 35-39.
36. Total number of acceptors whose age is 40 or above.
37. Mean parity of women of reproductive age whose age is 24 or less.
38. Mean parity of women of reproductive age whose age is 25-29.
39. Mean parity of women of reproductive age whose age is 30-34.
40. Mean parity of women of reproductive age whose age is 35-39.
41. Mean parity of women of reproductive age whose age is 40 or above.
42. Age specific marital fertility rate for women whose age is 24 or less.
43. Age specific marital fertility rate for women whose age is 25-29.
44. Age specific marital fertility rate for women whose age is 30-34.
45. Age specific marital fertility rate for women whose age is 35-39.
46. Age specific marital fertility rate for women whose age is 40 or above.
47. Total number of acceptors of all ages and parities.

(15) COST DATA FILE

1. Geographic region in which the grant is located.
2. Country in which the grant is located.
3. IPAVS proposal number.
4. IPAVS project number.
5. Year of program (first year, second year, etc.).
6. Type of service provided (male, female, both).
7. Calendar year of grant.
8. Budget line for personnel.
9. Budget line for service.
10. Budget line for operational expenses.
11. Budget line, other.
12. Budget line for equipment.
13. Number of equipment depreciations.
14. Value of equipment at each depreciation.
15. Budget line for renovation.
16. Number of renovation depreciations.
17. Value of renovation at each depreciation.
18. Number of male procedures performed (service objective used for year 1 grants).
19. Number of female procedures performed (service objective used for year 1 grants).
20. Weighting factor for male procedures (number of procedures done in grant divided by number of procedures done in country).
21. Weighting factor for female procedures (number of procedures done in grant divided by number of procedures done in country).
22. Cost per male procedure.
23. Cost per female procedure.
24. Total fixed costs.
25. Total recurring costs.

(16) KOREAN CONFERENCE INVITEE FILE

1. Name of invitee, last name first.
2. Name of invitee, first name first.
3. Invitee's title/agency affiliation.
4. Invitee's area of expertise.
5. Type of agency with which invitee is affiliated (university, hospital, family planning association, etc.).
6. Invitee's address.
7. Invitee's city.
8. Invitee's country.
9. IPAVS Country Code.
10. Geographic region of invitee.
11. Invitee's office telephone number.
12. Invitee's home telephone number.
13. Telex number of invitee.
14. Cable address of invitee.
15. General invitee or program participant?
16. Plenary panel number.
17. Plenary panel role(s).
18. Task force number.
19. Task force role.
20. Date invitation sent (most recent).
21. Date invitation sent (most recent, in computer format).
22. Date reply received (most recent).
23. Date reply received (most recent, in computer format).
24. Invitee's reply.
25. Date advanced registration received (most recent).
26. Date advanced registration received (most recent, in computer format).
27. Date confirmation letter sent.
28. Date confirmation letter sent (in computer format).
29. Date of last follow-up letter.
30. Date of last follow-up letter (in computer format).
31. How is invitee funding travel to conference (IPAVS, self, other)?
32. Name, address of other agency funding invitee's travel.
33. Date of invitee's arrival in Seoul (office format).
34. Date of invitee's arrival in Seoul (computer format).
35. Date of invitee's departure from Seoul (office format).
36. Date of invitee's departure from Seoul (computer format).
37. Accommodations requested.
38. Is spouse accompanying invitee (yes, no)?
39. Is individual on an organization committee (yes, no)?
40. Title/Name of committee.
41. Committee role.

/sw
1/9/80

(17) KOREA CONFERENCE REGISTRATION FILE

1. Name of invitee, last name first.
2. Full name of invitee, first name first.
3. Invitee's country.
4. Country code.
5. Geographic region of invitee.
6. Invitee's title/agency affiliation.
7. Degrees held by invitee as listed on conference registration form.
8. Invitee's professional affiliation as listed on conference registration form.
9. Invitee's address.
10. Invitee's city.
11. Invitee's office telephone number.
12. Invitee's home address.
13. Invitee's home telephone number.
14. Is the invitee a physician?
15. Professional involvement of the invitee as listed on conference registration form.
16. Specification of other professional involvement if PROFACTS=16 or if registrant checked more than one category.
17. Physician's medical specialty as listed on conference registration form.
18. Specification of other medical specialty if MEDISPEC=5 or if registrant checked more than one category.
19. Type of institution which employs registrant according to conference registration form.
20. Specification of another type of institution which employs registration is TYPEINST=7 or registrant checked more than one category.
21. How is invitee funding travel to conference?
22. Name, address of other agency funding invitee's travel.
23. Invitee's area of expertise.
24. Telex number of invitee.
25. Cable address of invitee.
26. General invitee or program participant?
27. Plenary Panel number.
28. Plenary panel role(s).
29. Task Force number.
30. Task Force role.
31. Is individual on an organizing committee?
32. Title/name of committee.
33. Committee role.

/sw

6/1/79

(18) KOREA CONFERENCE EVALUATION FILE

1. Is this evaluation form evaluating a task force or the overall conference?
2. Title of task force.
3. The country of the respondent (person completing form).
4. The geographic region of the respondent.
5. Is the respondent a physician?
6. What is the professional involvement of the respondent?
7. Other professional involvement of respondent, used if PROFACTS=16 or if respondent checked more than one category.
8. Medical specialty of physician respondents.
9. Other medical specialty, used if MEDISPEC=5 or if respondent checked more than one category.
10. Type of institution which employs respondent.
11. Other type of institution which employs respondent, used if TYPEINST=7 or if respondent checked more than one category.
12. Did the conference cover "a review of the status and progress of the voluntary sterilization movement"?
13. Did the conference cover "a review of the impact of technological advances on program development"?
14. Did the conference cover "a discussion of the various issues related to surgical contraception services"?
15. Did the conference cover "a discussion of the relationship of surgical contraception to the health of the individual, family and community"?
16. Did the conference cover "the sharing of ideas, experiences, knowledge, and information that will provide a sound basis for decision-making"?
17. Did the conference cover "a discussion of the role of voluntary organizations in promoting the integration and institutionalization of surgical contraception"?
18. Did the conference cover "the identification of policy-making processes and decision points which must occur as programs are initiated, grow, and become part of national health programs"?
19. Rating of respondent's satisfaction with First Plenary Session.
20. Rating of respondent's satisfaction with Second Plenary Session.
21. Rating of respondent's satisfaction with Third Plenary Session.
22. Rating of respondent's satisfaction with Fourth Plenary Session.
23. Rating of respondent's satisfaction with Fifth Plenary Session.
24. Rating of respondent's satisfaction with Sixth Plenary Session.
25. Rating of respondent's satisfaction with Seventh Plenary Session.
26. Rating of respondent's satisfaction with Special Evening Session.
27. Rating of respondent's satisfaction with Luncheon Presentations.
28. Rating of respondent's satisfaction with The Entire Conference.
29. Does the respondent's organization sponsor, support or otherwise engage in voluntary sterilization activities?
30. (If SPONSRVS=Y), does the respondent think his/her VS program should be changed or expanded based on the discussions and information presented at the conference?
(If SPONSRVS=N), does the respondent think his/her organization will start some kind of VS program in the near future (i.e., within the next 12 months)?
31. Does the respondent feel, as a result of attending this conference, that he/she would like some special kind of assistance from IPAVS?
32. Types of assistance requested by respondent.
33. Respondent's comments regarding conference organization, contents, mechanics, logistics (such as site, preconference communications, travel arrangements, facilities, etc.).

(18) KOREA CONFERENCE EVALUATION FILE

Page 2.

34. Identification number of overall conference evaluation form.
35. Did the respondent find the information discussed during the Task Force Sessions useful?
36. Did the respondent obtain new knowledge during involvement with the Task Force being evaluated?
37. Did any of the respondent's attitudes change due to involvement with the Task Force being evaluated?
38. Did the respondent feel that the end product of the Task Force would be personally helpful?
39. Did the respondent participate actively in the Task Force sessions through discussions and interaction with the Task Force members?
40. Recommendations or opinions of the respondent concerning the organization of the Task Force sessions for future conferences.
41. Identification number of the Task force evaluation form (actually used to give a number to all evaluation forms).

(19) CONSULTANTS FILE*

1. Is IPAVS interested in the company or the individual?
2. Last name(s) of consultant or company contact.
3. Other initials of consultant or company contact.
4. Full name of consultant or company contact.
5. Position or title of consultant or company contact.
6. Name of company/institution with which contact/consultant is affiliated.
7. Business address--building, number, street.
8. Business address--city.
9. Business address--state and zip code.
10. Business address--country.
11. Business address--zip code if used after country.
12. Business telephone number(s).
13. Business cable address.
14. Business telex number.
15. Type of company or institution.
16. Is the consultant self-employed?
17. Home address--number, street, apartment, neighborhood.
18. Home address--city.
19. Home address--state and zip code.
20. Home address--country.
21. Home address--zip code if used after country.
22. Home telephone number(s).
23. Which address is the mailing address?
24. Date of birth of consultant.
25. Country of citizenship.
26. Name of person/company from whom IPAVS got consultant's/company name.
27. Has this person/company done consulting work for IPAVS before?
28. Number of IPAVS consultancies.
29. Dates of three most recent IPAVS consultancies.
30. Sites of three most recent IPAVS consultancies.
31. Purposes of three most recent IPAVS consultancies.
32. Honorarium received for each of three most recent IPAVS consultancies.
33. Evaluation by IPAVS of each of these consultancies.
34. Code used to access information on degrees received and academic fields.
35. Degrees held by consultant.
36. Fields in which degrees were obtained.
37. Is the consultant a physician?
38. Physician's medical specialization.
39. Physician's areas of expertise.
40. Company's or non-physician's areas of expertise.
41. Country experience/expertise of consultant.
42. Region experience/expertise of consultant.
43. Native language.
44. Second languages/degree of fluency.
45. Availability constraints.
46. Do we have the consultant's CV on file?

*Structure awaiting final approval/modifications and implementation.

(20) RESOURCE PERSONS FILE

1. Full name of resource person.
2. Position/title of resource person.
3. Name of organization which employs individual.
4. Mailing address of resource person.
5. Telephone number.
6. Cable address.
7. Is this resource person a physician (yes, no)?
8. Geographic region where the resource person is located.
9. Areas of expertise of the resource person.
10. Is the individual's curriculum vitae on file?
11. From what source did IPAVS learn of this person?

(21) COMPLICATIONS FILE*

1. IPAVS project number.
2. The country in which grant is located.
3. Geographic region in which grant is located.
4. Year of report.
5. Calendar quarter.
6. Beginning date of reporting period.
7. Ending date of reporting period.
8. Service site.
9. Type of facility where VS procedure was performed.
10. Complication, death, pregnancy, or incomplete procedure (failure)?
11. Age of patient.
12. Sex of patient.
13. Height of patient.
14. Weight of patient.
15. Total number of pregnancies.
16. Total number of births.
17. Total number of abortions.
18. Total number of living children.
19. Age of youngest child.
20. Types of contraceptive methods used before surgery.
21. Relevant past medical history.
22. Person performing procedure.
23. Qualification of person performing procedure.
24. Specification of other qualification.
25. Type of procedure.
26. Number code for type of procedure.
27. Date VSC procedure was performed.
28. Timing of sterilization procedure (post-partum, etc.)
29. Date of complication.
30. Timing of complication (trans-operative, etc.)
31. Type of complication.
32. Number code for type of complication.
33. Specification of other complication.
34. Is this complication considered by IPAVS to be major or minor?
35. Was the patient given a transfusion?
36. Was the patient hospitalized?
37. If yes, how long?
38. Type of treatment administered.
39. Outcome of complication.
40. Number code for type of outcome.
41. Date of complete recovery.
42. Date of death.
43. Cause of death.
44. Was a post-mortem performed?
45. Code for type of anesthesia.
46. Code for type of pregnancy.
47. How long after procedure did pregnancy occur?
48. Outcome of pregnancy.
49. Reason why procedure could not be completed.
50. Comments.

*Structure awaiting final approval/modifications and implementation.

(22) WFAVS COMMITTEE MEMBERS FILE

1. Last name, first name of committee member.
2. Full name of member.
3. Country of member.
4. Position held on Budget and Finance Committee (chairperson, member, ex-officio).
5. Position held on Membership Committee.
6. Position held on Nominating Committee.
7. Position held on Data Collection Committee.
8. Position held on Legal Committee.
9. Position held on Program Planning Committee.
10. Position held on Female Sterilization Scientific Sub-Committee.
11. Position held on Male Sterilization Scientific Sub-Committee.
12. Position held on Joint Committee on Training and Equipment.
13. Position held on Information and Education Committee.

(23) PRINCIPAL COUNTRY CORRESPONDENTS FILE
(of the IPAVS Associations Office)

1. Country.
2. Full name of principal correspondent.
3. Address of principal correspondent.
4. Name of WFAVS correspondent in country.
5. Type of WFAVS member in country.
6. Cable address of principal correspondent.
7. Telex address of principal correspondent.
8. Type of stationery needed for correspondence.
9. IPAVS staff who should receive copies of correspondence to this individual.
10. Name and address of one person needing a copy of correspondence to this individual.
11. Name and address of a second person needing a copy of correspondence to this individual.
12. Name and address of a third person needing a copy of correspondence to this individual.
13. Initials of anyone needing to receive a blind copy of correspondence to this individual.
14. Comments.

Key to Type of Visit

I = Initial Visit
 TA = Technical Assistance
 WF = World Federation

M = Medical Assessment
 C = Conference Attendance
 D = Assessment of Potential
 Role of IPAVS Involvement

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
--------------------	------------	-----------------	---------------

AUSTRALIA

Australian AVS Seminar	September 22 - September 25	I. Lubell	C
------------------------	--------------------------------	-----------	---

BANGLADESH*

062-049-3I, 062-049-4I BAVS, Dacca	January 29-30	T. Jezowski	TA
062-049-4N, 062-049-4S, 062-049-5N BAVS, Dacca	January 29 - February 3	T. Jezowski	TA
062-049-5S BAVS, Dacca	1. January 29 - February 8	T. Jezowski	TA
	2. September 4 - September 10	R. Hopper	TA
	3. July 1-11	J. Aubert	M
193-049-3S-02 BAVS, Rangpur 249-049-2S-05 BAVS, Faridpur	February 3	T. Jezowski	TA
253-049-1S-06 BAVS, Jessore 266-049-1S-10 BAVS, Kushtia	1. January 29 - February 10	T. Jezowski	TA
	2. September 4-10	R. Hopper	

*In May, 1979 the IPAVS Regional Office was opened in Dacca making possible close monitoring of all Bangladesh V. S. activities.

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>BANGLADESH</u>			
260-049-1S-07 BAVS, Comilla	1. January 29 - February 10	T. Jezowski	TA
	2. July 6	J. Aubert	M
261-049-1S-08 BAVS, Dinajpur	1. January 29 - February 10	T. Jezowski	TA
	2. July 7	J. Aubert	M
263-049-1S-09 BAVS, Sylhet	January 29 - February 10	T. Jezowski	TA
Regional Office Dacca, Bangladesh	May 22-25	W. Tiongson	I
<u>BENIN</u>			
Prop. 359 University Hospital & Prop. 341 CNBFP	March 20-21	C. Aguiillaume	D
<u>BRAZIL</u>			
324-167-1 CPAIM & 6th World Congress Brazilian Society of Human Reproduction IFRP Meeting	December 1-5	I. Lubell	TA, C
	December 6-13	I. Lubell	C
Prop. 349 CLAM & Prop. 347 Centreme	July 10-12	I. Lubell	D
<u>COLOMBIA</u>			
307-155-1 PROFAMILIA	April 29 - May 5	J. Aubert	M
<u>EGYPT</u>			
070-057-3N & Props. EFCS	1. July 6-9 2. August 30 - September 9	C. Aguiillaume R. Vogel	TA TA

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>EGYPT</u>			
073-130-1 & Props. Boulak El Dakrou Hospital 194-147-1 & Props. Inst. for Cardiac Diseases 226-148-2 & Props.	August 30 - September 9	R. Vogel	TA
255-057-1EM & Props. EFCS	1. July 6-9 2. August 30 - September 9	C. Aguiillaume R. Vogel	TA
<u>EL SALVADOR</u>			
197-121-1 Hospital de Maternidad 292-162-1 Ministry of Health	March 21-23	J. Aubert	M
<u>FRANCE</u>			
202-127-P2N FNAVS & Prop. 318 I NAVS	1. March 26 2. November 12-13	C. Aguiillaume C. Aguiillaume/ M. Schima	D. TA WF
<u>GRENADA</u>			
Prop. 309 GPPA	October 5-6	M. Schima/ V. Beyda	D
<u>GUATEMALA</u>			
156-109-2 APROFAM & Prop. 317 APROFAM	1. April 17-22 2. July 19-20	P. Butta P. Butta	TA TA
156-109-3 APROFAM	1. March 18-20 2. April 23-26	J. Aubert J. Aubert	M M
<u>HAITI</u>			
Maternity Ioie Jeanty Hosp. DHF	August 22-24	L. Bakamjian/ I. Lubell	D

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>HONDURAS</u>			
106-112-3, 273-165-1, 279-154-1 & Prop. 350 Honduran Family Planning Assoc. 180-114-2 Hospital Materno Infantil	July 20-27	P. Butta	TA
251-143-2 Honduran Family Planning Assoc.	March 26-29	J. Aubert	M
<u>INDONESIA</u>			
000-090-M18 PUSSI	July 19-30	T. Jezowski	TA
078-063-3EM PUSSI	July 21,25,30	T. Jezowski	TA
221-134-1 University of Indonesia & Props. 000-090-M18 & 075-053-4 Dharma Dutta	July 25	T. Jezowski	TA
225-062-1E PUSSI	July 19-30	T. Jezowski	TA
<u>ITALY</u>			
310-157-P1N AS.STER	1. February 23-24 2. October 18-19	R. Vogel M. Schima/ C. Aguilleaume	TA WF
<u>IVORY COAST</u>			
To meet with Prof. Sangaret UTH, Cocody	March 6	C. Aguilleaume	D
<u>JAMAICA</u>			
175-104-2 Jamaican Family Planning Assoc. 313-163-1 Jamaica Family Planning Board & Props. 326, MOHEC & 327 JFPA, Kingston	July 27 -- August 1	P. Butta	TA
259-149-1 University of the West Indies	February 9-12	I. Lubell	TA, I

Site by Country	Trip Dates	Site Visitor(s)	Type of Visit
Health Soc./ Improvement of Family Health Kenyatia National Hospital	October 24-26	M. Schima/ C. Aguilleaume	C, D
<u>KOREA</u>			
082-055-5N KAVS	1. May 14-18 2. November 11-19	J. Holfeld/R. Hopper R. Vogel/R. Hopper	TA TA
105-055-3EM & 210-055-2S KAVS	November 11-19	R. Vogel/R. Hopper	TA
196-055-2T KAVS	1. May 16 2. November 11-19 3. May 14-18	J. Holfeld/R. Hopper R. Hopper/R. Vogel R. Vogel/J. Aubert	TA TA M
198-055-1S KAVS	1. May 17 2. May 14-18	J. Holfeld/R. Hopper J. Aubert	TA M
210-055-1S KAVS	May 14	J. Holfeld/R. Hopper	TA
211-055-1T KAVS	May 16	J. Holfeld/R. Hopper	TA
211-055-2T KAVS	May 14-18	J. Aubert	M
4th International Conference on VS & 5th General Assembly WFAVS	1. May 7-10 2. May 11	I. Lubell M. Schima P. Butta C. Aguilleaume J. Aubert J. Holfeld R. Hopper W. Tiongson W. Gluck S. Marks R. Vogel	C C C C C C C C C C C
<u>MALAYSIA</u>			
Ram Center University of Malaysia Kuala Lumpur	May 16	R. Vogel	TA
<u>MAURITIUS</u>			
091-075-2 Mauritius Family Planning Assoc.	September 25-27	I. Lubell	TA, C

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>MEXICO</u>			
170-137-P1 & Prop. 000-090-M19 University of Juarez	June 12-13	P. Butta/ L. Bakamjian	TA
244-139-2 & Prop. 000-090-M19 PIACT/Veracruz City	January 7-10	I. Lubell	TA
245-140-1, 245-140-2 & Prop. 000-090-M19 Sec De Salud Y Asistencia	June 21	P. Butta/ L. Bakamjian	TA
248-142-2 FPA of Ciudad Juarez	June 10-11	P. Butta/ L. Bakamjian	TA
<u>MOROCCO</u>			
344-172-1 Ministry of Public Health & Prop. 299 Averroes University Hospital	1. February 16 - March 30 2. November 5-8 3. July 17-25	C. Aguilleaume M. Schima/C. Aguilleaume C. Aguilleaume	TA TA TA
<u>NEPAL</u>			
090-060-3, 090-060-4 Family Planning Assoc. of Nepal & Prop. 331, FPAN Ram Center	February 12-15	T. Jezowski	TA
258-158-1 & Prop. 331 Family Planning Assoc. of Nepal	August 16-22	T. Jezowski	TA, I
090-060-5, 258-158-2 Family Planning Assoc. of Nepal	October 29 - November 5	T. Jezowski	TA, I
<u>NETHERLANDS</u>			
Pop. Serv. Europe Wayne State Univ. Symp. on IUD's & Polymeric Delivery Systems Amsterdam	1. March 3 2. June 25-29	R. Vogel I. Lubell	WF C
<u>PAKISTAN</u>			
052-043-3 Lady Dufferin Hospital	May 25 -	T. Jezowski	
053-044-2 Lady Willingdon Hospital	June 1		
052-043-4 Lady Dufferin Hospital 053-044-3 Lady Willingdon Hospital	February 27 - March 10	I Lubell	D, TA

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>PANAMA</u>			
204-128-1	1. October 21-26	P. Butta	TA
Ministerio De Salud & Prop. 204-128-2	2. June 17-20	J. Holfeld	TA
RAM Center			
<u>PERU</u>			
Prop. 348 - Limoncarro, Prop. 353 - Centro Hospitalario, Prop. 354 - Maternidad de Lima & Prop. 336 - Central Hospital #2	July 12-13	I. Lubell	D
<u>PHILIPPINES</u>			
020-021-4 MHAM College of Medicine 101-068-3, 101-068-4 Family Planning Org. of Phil. 104-065-3N, 104-065-4N Phil. Assoc. for Study of Ster. 178-111-1 Children's Medical Center & Props. 328, PGH & 271, HFMC	July 11-19	T. Jezowski	TA
<u>PORTUGAL</u>			
Prop. 301 Hospital San Joao Lisbon	November 9-11	C. Aguiillaume/ M. Schima	D, TA
<u>SENEGAL</u>			
Hospital H. Lubke	March 5-16	C. Aguiillaume	D
<u>SIERRA LEONE</u>			
Prop. 338, PCMH Freetown	1. March 7-14 2. November 1-3	C. Aguiillaume M. Schima/ C. Aguiillaume	D D
<u>SINGAPORE</u>			
Meeting with Dr. Vengadasalam Alexandria Hospital	May 15-17	T. Jezowski	D
<u>SRI LANKA</u>			
103-124-2N, 297-124-1EV Sri Lanka AVS 186-125-2 Fam. Plan Assoc. of Sri Lanka	August 26 - September 2	T. Jezowski/ R. Hopper	TA

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>ST. LUCIA</u>			
St. Lucia V. S. Conference	September 10-18	J. Aubert	C, M
164-106-2 St. Lucia Fam. Plan Assoc.	October 3-4	M. Schima/V. Beyda	TA
<u>SUDAN</u>			
155-123-2N & Prop. 3N Sudan Fertility Control Assoc. & Props. 278, Soba Univ. Hosp. & 321EV, SFCA	September 9-13	R. Vogel	TA
<u>SYRIA</u>			
275-168-1N Syrian Fertility Control Soc.	February 24-31	R. Vogel	TA
<u>THAILAND</u>			
149-096-2N, 149-096-3N THAI AVS & Props. 290I, THAI AVS & 323, Population & Community Development Assoc.	1. February 15-22 2. August 22-26	T. Jezowski R. Hopper/T. Jezowski	TA, I TA
150-096-1S THAI AVS 169-103-1 Ramathibodi Hospital	February 16	T. Jezowski	TA, I
220-096-1EM THAI AVS	August 22-26	R. Hopper/T. Jezowski	TA
220-096-2EM THAI AVS	February 16-19	T. Jezowski	TA
286-096-1S Ramathibodi Hospital	February 17	T. Jezowski	TA, I
291-096-1T THAI AVS	February 19-21	T. Jezowski	I, TA
<u>TOGO</u>			
Prop. 308 - ATBEF Lome, CNBFP	1. March 15-19 2. May 16-19	C. Aguilleaume C. Aguilleaume	D D
<u>TRINIDAD</u>			
Prop. 265, I & E Fam. Plan Assoc. of T & T	October 5	M. Schima/V. Beyda	D

Purpose by Country	Trip Dates	Site Visitor(s)	Type of Visit
<u>TUNISIA</u>			
096-122-2, 280-153-1, 294-160-1, 295-161-1, 312-159-1, ONPFP & Pan Arab Conference V.S.	1. September 22 - October 2	L. Bakamjian/ J. Holfeld	TA
	2. October 19-23	C. Aguilleaume/ M. Schima	C, TA, D
<u>TURKEY</u>			
024-037-3 Hacettepe University	1. March 4-5	I. Lubell	TA
	2. May 22-26	R. Vegel	TA
077-059-3N, 077-059-4N Turk. Nat. Fert. & Infert. Assoc.	March 4-5	I. Lubell	TA
<u>VENEZUELA</u>			
Pan Am. Conf. on Andrology	March 12-17	R. Frischer	C
<u>YEMEN</u>			
Prop. 343, YFPA	July 9-16	C. Aguilleaume	D
<u>ZAIRE</u>			
Props. 285, CNND Kinshasa, 293, CRND Bukavu & 316, CNND	October 27-30	C. Aguilleaume/ M. Schima	D