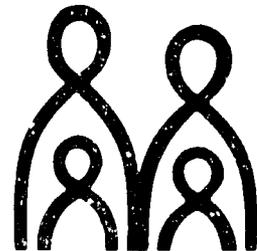


1981

FERTILITY SERVICES DIVISION WORKING DOCUMENT 2



The Pathfinder Fund

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CHAPTER 1. INTRODUCTION.

The Fertility Services Division submits this instrument as the working document to guide the activities of the Division and of the Regional Staffs in working together to reach the broader organizational goals of The Pathfinder Fund. These goals were redefined in 1976 and circulated in the report of the New Paths Committee. Restated, they are:

- A. To improve the conditions of life for people in disadvantaged areas.
- B. To reduce rates of population growth so that they are not excessive for orderly development.
- C. To establish a balance between the numbers of people and their resources at the earliest possible time.

1.1. Foundation. This document is built upon analysis by Pathfinder's staff and consultants of the issues, the possibilities, and the constraints. It draws upon Pathfinder's accumulated experience and is influenced by what Pathfinder has found to be most successful. It includes viewpoints from staff members of the Fertility Services Division, International Staff members, Regional Staff members, and members of a special committee of consultants which met to deliberate the issues. This Advisory Committee included:

- Dr. Alcides-Estrada, Asociacion Sociedad Medico Farmaceutica, Bogota, Colombia.
- Dr. Pouru Bhiwandiwalla, International Fertility Research Project, Chapel Hill, North Carolina.
- Professor Leslie Corsa, Congress of the United States, Office of Technology, Washington, D.C.
- Dr. Philip Darney, University of Oregon Health Sciences Center, Portland, Oregon.

Dr. Donald Minkler, School of Public Health, University of California at Berkeley, and School of Medicine of the University of California at San Francisco.

Dr. O. Ransome-Kuti, College of Medicine, University of Lagos, Nigeria.

Dr. Pramilla Senanayake, International Planned Parenthood Federation, London, England.

Ms. Judith Senderowitz, Center for Population Options, Washington, D.C.

Ms. Maria Luisa Zardini, Associazione Italiana Educazione Contraccettiva Sessuale, Rome, Italy.

1.2. General Orientation of Divisional Programs.

1.2.1. To introduce fertility services into places lacking them, such as countries where little socioeconomic development has yet occurred, or where family planning has been essentially unknown in the past.

1.2.2. To improve existing delivery systems by developing new approaches or by remedying old approaches, and by finding ways to eliminate local obstacles or problems. Improvements can be related to quality of services, or to efficiency, or to effectiveness of the systems involved.

1.2.3. To extend the availability and increase the use of fertility services regionally and nationally. Extensions may involve replication of successful projects, the exchange of current information on approaches and results, or the geographic enlargement of pilot activities.

1.2.4. To explore new and unproven systems for making fertility services available. Explorations will be small in scale, but of such quality of design as to produce results which contribute significantly to the general knowledge about family planning and to the evolution of future Pathfinder programs.



CHAPTER 2. PRINCIPLES OF CONDUCT

The Pathfinder Fund, through the Fertility Services Division, encourages adherence to certain principles of conduct in its programming. These principles reflect respect for the rights and dignity of every individual and a commitment to the highest levels of quality attainable in the communities in which we work.

2.1. Informed Choice. For both the user and provider of contraceptive services, good counseling is the key to family planning success. Every person seeking contraception should understand as completely as possible the reproductive functioning of her or his body, the means for preventing conception, and the reasons for doing so. Good counseling assures that the user is freely and confidently accepting contraception, and counseling is also important to the staff of a project because it aids in preventing the occurrence of various side effects which often lead to method discontinuation.

Each individual should be offered the widest possible choice among methods of contraception so that he or she may choose a method acceptable to the individual within the local cultural context. Both permanent and reversible methods should be offered as well as methods that can be used by either the man or the woman.

2.2. Informed Consent for Sterilization. It is important that a counselor have a thorough discussion with the prospective patient prior to sterilization. If possible the spouse should be included. The patient must understand the nature of the operation and its permanence, as well as the availability of alternative reversible methods. The patient should understand the discomforts and risks involved, as well as the benefits to be expected. The procedure to be used should be explained.

The patient's voluntary consent must be given and documented prior to performing the procedure. Written consent in the patient's language should be secured if the patient is literate. Otherwise, some culturally appropriate method of documenting the patient's consent should be devised and used.

2.3. Interdivisional Synergy. Cooperation with the Women's Programs Division and the Population Policy Division can often maximize a project's opportunity for success. The Women's Programs Division encourages sensitivity on the part of program personnel to the individual user and her or his personal needs, and promotes women's broader role as productive, not simply reproductive, members of society. The Fertility Services Division seeks to incorporate these user perspectives into family planning projects wherever feasible.

The Population Policy Division works toward legal and policy change in the field of population/family planning. The Fertility Services Division is concerned with policy implications of many of its activities, and involves the Population Policy Division in planning and implementing projects.

2.4. Health and Family Planning. When families, or individuals, decide to limit fertility by practicing a form of contraception, both the contraceptive client and the provider of services should consider the interactions between family planning and health. There are health risks and health benefits which accrue to the family planning acceptor. The health status of mothers, of children, and of whole communities are intimately related to the contraceptive choices that are made.

Pregnancy represents a challenge to the health of a woman. She has risks of dying or of becoming seriously ill, either with the pregnancy itself, or a condition arising directly out of it.

Of those illnesses which occur during pregnancy as complications, some are obvious after-effects of too many pregnancies occurring too soon. Iron deficiency anemia and other diseases of malnutrition are common in women with many children born at short intervals. Problems

such as dystocia arising from malpresentation, postpartum hemorrhage from uterine atony, or uterine rupture during labor are typical of grand multigravidae--women with five or more children. Unfortunately, the list of complicating illnesses associated with excessive childbearing is considerably longer. Certain other very serious illnesses make their appearances more often in those women who have had many children. Carcinoma of the cervix, uterine prolapse, chronic urinary tract infections and diabetes mellitus are examples. Clearly, the health and well-being of mothers are positively served by limitations of births and by birth spacing.

Of course, there is also a risk involved in contraception. While one undertakes to prevent pregnancy and the associated risk of death, one necessarily introduces another set of risks from contraception itself. In almost all situations contraception carries a mortality risk which is enormously lower than that of the pregnancies it is preventing. The net difference between the two risks--that of pregnancy and that of the contraceptive method--is the net benefit to maternal health offered by family planning. It must be emphasized that mortality figures are usually used for the comparisons since they are available and comparable from area to area and from method to method, but these mortality figures can be viewed as representative also of morbidity.

Family planning and contraceptive use also have a very special effect and close relationship with child health. Thus, evidence of inter-relationships can be seen in the statistics of infant and child mortality and morbidity, especially as they are looked at with special groups.

Children born to groups with special risk, such as older women or teenage mothers, have greater incidence of early mortality and morbidity.

Mortality in infants born in either higher birth order (i.e., those born after several older siblings) or those born into a short birth interval (i.e., those born shortly after their next oldest sibling) are more likely to die from any cause than those born into lower birth order, or longer birth interval. These causes of mortality

cover a very broad spectrum including stillbirth, prematurity, infectious disease, and nutritional disorders. Even if such children survive the challenges to their lives, they, as groups, display more illnesses. As a result such children tend to have poorer adaptation to their environment. They are more likely to have stunted physical growth, slower intellectual achievement with lower final achievement.

Breastfeeding is important to good infant health in all the world and in all societies, but it is especially important in the lesser developed countries. Maternal milk supplies the infant with the most balanced and the cleanest possible source of nourishment. Where diarrheal diseases of infants represent a major cause of infant mortality, the direct benefit of breastfeeding is obvious.

Lactation tends to lengthen birth intervals partly because a lactating woman whose baby is completely dependent on maternal milk for food ovulates infrequently if at all. She has a relative and temporary infertility. Occasionally, however, such a woman does ovulate and becomes pregnant. This is more likely to happen under circumstances where the breastfeeding infant is offered supplements. Such an infant is placed at risk, especially in a developing country. The quality and quantity of the mother's milk are likely to be dramatically reduced by the increased nutritional demands of the new pregnancy. The nursing infant, unless an alternative source of calories and high quality protein is found, is in danger of developing kwashiorkor, a severe nutritional disease. If the infant is weaned and fed artificially there is an increased danger of infectious diarrheal disease.

Effective family planning, using a method compatible with breastfeeding, is thus an important support mechanism for the infant, contributing to the child's well-being. Continuing the child on the breast helps to lengthen the interval between pregnancies and thus contributes to the well-being of a possible future sibling.

While child/infant mortality and morbidity may be adversely affected by unwanted fertility, undesirable fertility can also be made worse by infant or child mortality. The health of children

generally, and more specifically the good health of the child of one individual, is an essential in the motivation for fertility control. A person who is a prospective user of a contraceptive regimen frequently needs reassurance about the health prospect of his or her children. In the event of a child loss, parents may wish to undertake another pregnancy very quickly, hoping to replace the lost child for emotional, social, or economic reasons. In some societies healthy children are the most reliable kind of social insurance for the old age security of parents. Children can also be seen as an important source of labor and have economic importance to the family.

People tend to resist and reject family planning advice until they can have reasonable assurance of having their desired number of children survive. Parents tend to reject the idea of a longer birth interval without this assurance, and pregnancies may occur in rapid succession. A close link must exist therefore between family planning and child health services. They are clearly mutually supportive, and both work for the benefit of the individual and of the environment.

These points have an important health significance in family planning because, not only is thoughtful consideration important to the initiation of a method of contraception, but also to the likelihood of a family planner continuing with the contraceptive regimen. Family planning dropouts, for whatever reason, do not contribute to a bettering of maternal or child health conditions.

More direct elements of health linkages to family planning are discussed in section 6.5.

2.5. Appropriate Levels of Technology. The Fertility Services Division encourages the improvement of and the building upon whatever effective systems of management and technology already exist in an area in which we are to work. Adaptation of what is indigenous is far preferable to supplanting with imported ideas or methods. This principle applies not only to devices and technological material, but also to social systems, business or management customs, and to health care systems.

The application of family planning methods in a community is carried out most effectively by those people who are already acceptable to the community: the natural leaders, the traditional healers, or the trusted advisors. Overly sophisticated providers, or providers equipped with more training than is relevant to the task, will be less productive than those appropriately prepared.

The apparatus involved with a family planning or primary health care delivery system also should comply with principles of appropriate technology. Simplicity appropriate to the setting is the rule; over-complication may result in disuse. Maintenance problems with laparoscopes and accidents in their use in developing countries are examples of overextension of a technological system. Minilaparotomy, as an alternative method of sterilization, can be shown in more than one way to be an adaptation of appropriate technology.



CHAPTER 3. PROGRAMMATIC PLANNING

Pathfinder initiates or updates its long term and short term programmatic strategies for each geographic zone on an annual basis. The respective International Staff member, Pathfinder management, the three divisions and the Regional Director together develop a set of three to five year goals, which define the direction of Pathfinder's programming. One year strategies are formulated to identify the projects and activities to be developed in support of the goals of each division. Accomplishments are reviewed annually and new programmatic thrusts are identified.

The Fertility Services Division develops its annual plan with the International Staff member and the Regional Director. Priorities are set among the components of the annual strategy, and the strategies of the three divisions are synthesized to produce an annual country/region work plan.

The planning described above is the formalized process. The results are considered fluid. Because the International Staff particularly are in frequent and intimate contact with the individual countries, they may identify new needs and opportunities in the course of the year that require changes--sometime in short term tactics, other times in long term strategy. The Division intends to maintain the flexibility to respond to new initiatives and to be able to move quickly in new directions in the interest of reaching long term goals. Examples of long term and short term country plans are included under Chapter 8.



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CHAPTER 4. DIVISIONAL GOALS

The Division's goals express ideals that we believe would contribute significantly to the quality of our programming. We may find that these ideals are unrealistically high, but we believe that Pathfinder can only benefit from our attempts to meet them. The Divisional goals fall into the categories of development of human resources and innovative projects, maturation of ongoing projects, and the integration of cross-divisional strategies into new and old projects. They define qualitative challenges for the years ahead.

4.1. Human Resources. The Fertility Services Division is committed to the identification of people or groups in priority countries who share our concerns about family planning, population, and maternal and child health. We will assist these people in developing capacities for significant roles in the advancement of family planning in their own countries. Assistance may take several forms, such as training, education, travel grants, consultative visits, or serving as a liaison with others having requisite skills or common interests. Assistance should result in an upgrading of the skills or the positions of the individuals involved. Institutions can benefit from the enrichment of human resources as well as individuals. The Fertility Services Division encourages the identification and development of one such key person (or institution) in each priority country annually.

4.2. Innovation. Projects can be programmatically innovative, that is, they can test new ideas. Projects can also be geographically innovative, that is, they can bring proven programs to a new country

or region. The Fertility Services Division is committed to identifying innovative projects of both types and developing them with sufficient quality so that they contribute to the advancement of the state of the art. The Division promotes the development of four publications annually about projects or programs that contribute to the body of family planning knowledge, and proposes to increase the proportion of new projects that are either programmatically or geographically innovative.

4.3. Maturation. The Fertility Services Division expects that as successful projects reach maturity they will become institutionalized or taken over by a government or another institution. The Fertility Services Division encourages projects that reach their third year of Pathfinder funding to become institutionalized or to have their funding taken over by the end of the fifth year.

4.4. Cross-Divisional Synergy. The Fertility Services Division believes that development of family planning linkages with policy change and the advancement of women enhances the attainment of Divisional goals and objectives. The Division would like to increase by 25% per annum the number of Fertility Services Division projects that have a defined objective that intersects with the Women's Programs Division or the Population Policy Division or both.



CHAPTER 5. CONTRACEPTIVE METHODS

5.1. Sterilization. Numerous studies have shown surgical sterilization to be a safe and effective method of family planning. Its acceptability and geographic scope appear to be increasing year by year. Sterilization should be viewed exclusively as a method of family planning. It must, as of now, be considered irreversible and therefore appropriate only to the couples who plan--in a positive sense--no future children. Because sterilization is employed only by those couples who want no more children, it probably can never become the primary method of family planning, or an effective single method of controlling excessive rates of population growth. While in the total population equation sterilization may help to decrease birth rates, it is frequently selected by those couples who have the highest motivation, and who would, were sterilization unavailable, use an alternative method of contraception. The main advantages and beneficial effects of sterilization are evident in features other than the number of births averted. These positive benefits are of sufficient magnitude to justify the expense and careful attention to detail necessary to sterilization programs.

While the risks of a sterilization operation are real enough, the demonstrated safety of well organized services is also impressive. Under acceptable conditions the risk of the sterilization procedure, male or female, measured in terms of morbidity or mortality, is far less than the risks from alternative contraceptive measures. The major advantage of sterilization as a family planning method lies in this overwhelming positive balance in favor of maternal health. Our projected calculations indicate that a maximum risk of mortality

of 25 deaths per 100,000 procedures should not be unacceptable under conditions prevailing in most developing countries. Our actual experience, to date, has resulted in mortality rates considerably below this limit.

The risk of failure of the sterilization method is also very low. This risk varies by method of approach and by method of occlusion. In general terms, the failure rate should be below 0.5% for any method or approach. This risk compares very favorably with other methods of contraception.

The freedom from further care about side effects, resupply, or sporadic use are also features of sterilization that result in a high degree of user satisfaction and acceptability. The permanence of the method, advantageous as it is for some, may be a burden to others who may have failed to understand the nature of the procedure prior to its performance, or may have had a change of mind or circumstance subsequently. As a practical matter, the procedures must still be considered permanent. Recanalization attempts are not sufficiently successful and are too expensive for wide application.

The technology of sterilization procedures has been progressing over the past few years. Certain patterns of results have emerged which allow us to draw guidelines as to which methods are most appropriate for Pathfinder's program.

Vasectomy techniques have remained relatively static. Basic surgical approaches remain the same with identification of the vas, excision of a segment and separation of the remnants being the essential features. Single incision versus double incision techniques or the uses of a variety of ligature materials are at the discretion of qualified local surgeons. Such variations do not seem to significantly alter effectiveness or acceptability.

Female sterilization has changed more remarkably, and genuine controversy exists in the field about both methods of tubal occlusion and the approaches to the tubes.

Methods of tubal occlusion in general use today include: standard Pomeroy technique, modified Pomeroy technique, electrofulguration with

or without transection, application of "falope" rings, application of spring loaded clips, and fimbriectomy. Of these methods The Pathfinder Fund advocates the use, wherever practical, of standard Pomeroy technique or the application of falope rings. These two methods enjoy the greatest degree of simplicity and the best results. The other methods have relative disadvantages in slightly greater difficulty in accomplishment, failure rates, or complication rates. (The application of tantalum clips by any approach or electrocautery by hysteroscopic approach are modalities which have been discredited and are no longer to be used in any Pathfinder program.)

Various approaches to the fallopian tube are also in use. Pathfinder was a pioneer in the introduction of culdoscopic approaches to the developing countries. The approach proved very useful in some countries. In some settings, for special reasons, it is still appropriately used. Experience has shown that the rates of operative complications, postoperative infections and failed procedures are slightly higher for culdoscopy than for other approaches, and Pathfinder is de-emphasizing its application. However, in situations where culdoscopy is the only approach acceptable (for example, because of the lack of visible scar) we can still support training and equipping for the approach.

Minilaparotomy has emerged in the past several years as a superior approach. Falope rings or Pomeroy techniques of tubal occlusion are easily adapted to this approach. The minilaparotomy technique is easily learned and is also associated with very low rates of morbidity and mortality, and requires a minimum of equipment and program expense. Currently a minilaparotomy kit costs approximately \$150 to supply.

Laparoscopy as the approach to the fallopian tubes is the dominant method in the U.S.A., and in other developed countries. Operative conditions for laparoscopy are somewhat more sophisticated and the number of sterilization failures somewhat higher than with the minilaparotomy approach. The laparoscope requires very high degrees of training and surgical skill. It also requires very sophisticated and fragile equipment which is expensive. Depending on the configuration of the equipment, it currently costs about \$4,000 to equip for laparoscopy, and the maintenance costs relative to wear and tear of equipment are excessively high. Pathfinder is not actively promoting this approach.

Hysteroscopic approaches are currently being developed by others. With these approaches tubal occlusion is accomplished by use of tissue adhesives or sclerosing drugs. Preliminary reports are promising, but the approach is not yet ready for application to Pathfinder's program. It is extremely important that all Pathfinder projects involving sterilization incorporate appropriate safeguards. The risks inherent in the procedure must be kept as low as possible. This will involve careful scrutiny of the theater conditions, sterile technique, and patient care routines on a project by project basis. Any, or every, mortality must be thoroughly investigated, as must any excessive morbidity. Vigilance is essential.

All surgical sterilization must be entirely voluntary. This implies that it is not only submitted to, but desired by the client. This desire must be proven by adequate counseling which looks not only at motivation, but also explains the procedure and its consequences to the client in simple and honest terms.

Sterilization services should also be easily available to persons of either sex. In all areas of the world experience has shown that women tend to use sterilization services more than men. Nevertheless, the procedure is equally effective and as valid for men as for women. Pathfinder programs in sterilization will continue to press for the increased acceptance of male sterilization.

5.2. Oral Contraceptives. Oral contraceptives--widely known as "The Pill"--have revolutionized family planning since their introduction in 1960. Oral contraceptives have become the most popular fertility control method in many countries, and are now being utilized by an estimated 50 million women around the world.

The contraceptive pill has merited its extensive acceptance by women in many countries and cultures. The pill is the most effective reversible form of contraception, and has achieved this distinction with safety and convenience.

When the risks of oral contraceptive use are weighed against the much greater health hazards of pregnancy--especially in those areas where the maternal mortality rates are high--the pill is actually much safer than the pregnancies that would result from using less effective contraceptive methods, or no contraception at all. The most serious hazard associated with oral contraceptives is an increased risk of circulatory system diseases. It is important to understand that the risk of death from these conditions is far less than the risk of mortality from pregnancy itself. When oral contraceptive use is viewed in the perspective of everyday human experience, the safety of the pill is confirmed.

This safety is sufficient to allow Pathfinder to advocate the distribution of oral contraceptives by paramedical personnel without the necessity of prescription or physical examination. Informative counseling, health history, and recognition of conditions which would mitigate against pill use are still advisable, however, and should be included in projects providing oral contraceptives whenever and wherever possible.

Pathfinder distributes oral contraceptives in two dosage configurations--a "standard" dose (50 micrograms ethinyl estradiol and 1 milligram norethindrone) and a "low" dose (35 micrograms ethinyl estradiol and 0.5 milligrams norethindrone).

More complete information on oral contraceptive applications by Pathfinder can be found in a Pathfinder publication: "Oral Contraceptives: A Guide for Programs and Clinics," the third edition of which was published in October 1979.

5.3. Barrier Methods. Barrier methods include the diaphragm, cervical cap and condoms. Foam, creams, foaming tablets and melting suppositories are often grouped with barrier methods generically because of their intravaginal method of application. Only diaphragms, foam, and condoms are available as contraceptive commodities through Pathfinder.

Pathfinder supplies barrier methods of contraception because of our commitment to offer choice in family planning methods and because the most effective modern methods (oral contraceptives, IUDs, and injectables) occasionally have serious side effects or effects that may be culturally or personally unacceptable.

Barrier methods are generally discussed in terms of their effectiveness, safety and acceptability. Effectiveness is largely dependent on such non-method related factors as individual motivation, contraceptive use for spacing or termination, etc. Effectiveness can be increased by using a combination of barrier methods. Barrier methods have failure rates between 1 and 17 failures per 100 woman years of use.

While safety is generally one of the greatest advantages of barrier methods, in the developing world this is less true. To the extent that barrier methods have higher failure rates and thereby expose more women to the elevated risks of mortality that pregnancy entails in the third world, barrier methods must be seen as running a greater risk for women in the developing world than for women in developed countries. One important health advantage is the protection against sexually transmitted diseases provided by barrier methods. The condom provides the greatest level of protection but even foam has a substantial protective effect.

Acceptability of barrier methods differs enormously from country to country. Because their use is related to coitus, it is difficult to maintain privacy in most village settings. We are largely ignorant of the effectiveness of traditional barrier methods, but many enjoy high levels of acceptability in their own setting.

Sporadic use is a major cause of failure with barrier methods. Failure rates can be decreased with careful and sensitive user education. It is vital to assess the prospective user's attitudes and ability to use the method consistently.

A. Diaphragm. The diaphragm is largely a clinical method since it must be fitted by trained personnel. The Pathfinder Pelvic Exam Film (1981) teaches proper fitting of the diaphragm.

Pathfinder supplies the Koromex coil spring diaphragm through General Services Administration. Each diaphragm comes in a storage case with one trial size tube of jelly, one trial size tube of cream, and instructions in English on its use. The Koromex diaphragm comes in sizes ranging from 50 to 95 mm in diameter with 5 mm gradations. The diaphragms are shipped in boxes of a dozen. If properly cared for each diaphragm should last a minimum of two years of use.

B. Condoms. The condom has a unique advantage in that it involves men in contraceptive decision making. Its acceptability varies widely from country to country. For example, it is the most widely used method in Japan, but in many places of the world it is associated with prostitution and is thus not used as a contraceptive method. Where cultural barriers to the condom exist, grantees are encouraged to develop experimental activities to gain wider acceptance of this family planning method.

Pathfinder supplies lubricated latex condoms. The Tahiti condoms come in five colors: yellow, red, green, blue, and clear. The condoms come in boxes of 100 pieces and the manufacturing date is stamped on the box. The International Organization for Standardization recommends that vulcanized rubber (the material from which condoms are made) be stored below 25 degrees Centigrade (77 degrees Fahrenheit) and preferably below 15 degrees Centigrade (59 degrees Fahrenheit). In tropical countries, where the temperature and humidity are very high, these standards are generally impossible to meet. Storage facilities with the lowest temperature and humidity possible should be utilized. The condoms are supposed to last for at

least five years under proper storage conditions. Where storage conditions are inferior, condoms should have a shorter shelf life and should be carefully inspected before distribution.

C. Foam. Foam has been found to be more effective than vaginal tablets, jellies or suppositories (Masters and Johnson, 1963). It basically consists of an inert base material that blocks passage of the sperm and carries a spermicide. There is little data on allergic reaction.

Pathfinder supplies Emko foam kits. One kit contains an applicator, a can of foam which contains 60 applications, and instructions in English and Spanish. Foam is shipped in boxes of 36 kits.

D. New Developments. Two intravaginal methods that may become available for general use in the near future are vaginal rings made of Silastic impregnated with contraceptive hormones, and the intravaginal sponge. Both have the advantage that the user may remove and insert them. The vaginal ring acts to suppress ovulation and create a barrier to the sperm by altering the mucus of the cervix and endometrium. The intravaginal sponge may have a spermicide added. Pathfinder will determine whether to supply these methods when they become available and research results are better known. We do not intend to engage in research about their safety, effectiveness and acceptability.

5.4. IUDs. For centuries, people have sought a method of preventing pregnancy that is not directly tied to the act of sexual intercourse, provides complete protection for as long as it is used without interfering with health, and whose effect is readily reversible. The intrauterine device (IUD) comes closest to that ideal among currently available methods of contraception. An IUD is inserted into a woman's uterus and remains highly effective as long as it is in place. It rarely causes serious side-effects and fertility returns when the device is removed.

The Pathfinder Fund has had long experience with IUDs, and for many years was in the forefront of IUD development through its International IUD Programme. Pathfinder continues to see a useful role for IUDs within family planning programs, especially for women who have had several pregnancies (multiparas). They can obtain very satisfactory long-term contraception from an intrauterine device.

Despite the widespread popularity of IUDs, there has been a good deal of confusion about their safety and proper role in family planning programs. This confusion can in part be traced to the numerous types of IUDs--coils, spirals, loops, shields, springs, and rings--which have been developed over the years. Some devices have been failures, while others have been very successful. The Lippes Loop, one of the first flexible plastic IUDs, still has the best-established record of performance.

Theoretically IUDs are potentially an ideal contraceptive.

- They are relatively safe and effective.
- They require only one insertion for prolonged protection.
- Their contraceptive effect is not directly related to each act of intercourse.
- Their contraceptive effect is readily reversible.

Some observers have expressed concern about the morbidity associated with intrauterine devices, and have cautioned against reliance on IUDs as a contraceptive method. These reports have tended to overemphasize the hazards and ignore the benefits of IUDs, thus creating confusion and uncertainty among family planning personnel.

There is a small but clear increase in the risk of developing pelvic inflammatory disease among those women who use the IUD. This risk appears greater when IUD users are compared to users of other contraceptive methods such as barriers, which in fact offer a small degree of protection against pelvic infection. The risk of infection, because it is small, may be acceptable for most women. Certain groups are exceptions: women who have multiple sexual partners, or women who have never been pregnant, have risks sufficiently high to warrant special caution.

Pathfinder supplies Lippes Loops in the C and D sizes, the Copper T device, and instrument kits for insertion.

5.5. Periodic Abstinence. Recently population/family planning agencies have been subjected to pressure from several sources to increase support for periodic abstinence, sometimes referred to as "natural family planning" by its promoters. In essence, periodic abstinence requires the identification of the fertile stage in a woman's menstrual cycle and coincident sexual abstinence. The major techniques for establishing the time of ovulation are the calendar method, the basal body temperature or thermal method, the cervical mucus method, and combinations of these three.

Use-effectiveness of periodic abstinence has been studied since the late 1930s. When measurement criteria are comparable to those used in research on other contraceptive methods, failure rates are generally high. The newest method which utilizes cervical mucus to identify the fertile period has particular drawbacks that limit its effectiveness. Post-coital seminal fluid often causes confusion and an inability to test the character of the cervical mucus, and vaginal infections, which are very common in the tropical developing world, make charting the cervical mucus very difficult.

Periodic abstinence cannot be regarded as completely safe at this time. Studies have suggested that the aging sperm or ova may produce abnormalities in embryos, and such gametes are likely to be involved in the accidental pregnancies which occur with this method.

The acceptability of periodic abstinence has been low in both developed and developing countries. Data are available from the U.S.A., Australia, the Philippines, India and Colombia which suggest decreasing acceptability of periodic abstinence when modern methods are available.

Pathfinder does not endorse family planning methods that have high failure rates and low degrees of consumer acceptability. Therefore, we cannot strongly support the dissemination of periodic abstinence as a family planning method. However, we can support its presentation as one method among many, with honest client education on the advantages and disadvantages as we do with any other method. We do not plan to supply thermometers or other commodities for periodic abstinence.

5.6 Injectables. A few contraceptive steroid drugs have been tested with injection or implantation as the method of drug administration. The results, to date, have been encouraging that one of these drugs, medroxyprogesterone acetate (MPA), could be very useful when given in this way. The usual regimen involves an intramuscular dose of 150 mg given every twelve weeks.

Controversy of a particularly heated nature has arisen over the use of this method in international family planning circles. Originally this dispute involved genuine questions over safety and acceptability of the method. However, as these questions have been addressed, and in some instances satisfactorily resolved, the controversy has persisted. New questions have arisen over the ethical and legal issues, and the political implications of the resultant highly polarized positions are very significant.

Certain advantages in the use of injectable medroxyprogesterone acetate are definable.

1. It is highly effective. It has the lowest failure rate of any known reversible contraceptive.
2. It is not coitus related.
3. It can be used during lactation.
4. It is highly acceptable by certain groups. In some places people tend to place more confidence in injected medications. The long duration of action adds a factor of convenience as well.
5. It is free of estrogens. It thus avoids many of the side effects of oral contraceptives--both those that are serious and those that are only annoying--most of which are related to the estrogen component.

Disadvantages may also be recognized and must be considered.

1. There may be a delay in return of fertility after the drug is stopped. The ultimate net return to fertility is approximately the same as that for oral contraceptives, but it clearly takes longer after injectables.
2. In those very few cases where the drug has failed as a contraceptive there can be a concern about teratogenicity of the drug in the resultant pregnancy.
3. Positive proof of safety of the drug is still lacking. The lack of reported sequelae is not positive proof of safety. Sufficiently well designed and well documented field studies have not yet been done to document such proof, despite the enormous field experience to date.

The Fertility Services Division believes that medroxy-progesterone acetate, as an injectable contraceptive, should be made available to Pathfinder projects where it is locally desired and legally permissible. Certain groups of women are in situations which makes this drug particularly beneficial for them.

- Women who want no more children but do not want to consider sterilization;
- Women who are high obstetrical risks;
- Women living in rural areas where medical facilities and personnel are sparse;
- Women who suffer from iron-deficiency anemia;
- Women who prefer injections instead of pills;
- Women at particular risk of developing cardio-vascular complications from oral contraceptives containing estrogen;
- Women who want a long-acting yet reversible, contraceptive;
- Women who are over 30, particularly those who smoke tobacco but who will not terminate their smoking habit;
- Women for whom the side effects of oral contraceptives and IUDs are intolerable and/or unacceptable;
- Women who want injectables for post-partum use;

- Women to whom the risks of injectables have been fully explained and who judge any of the disadvantages to be acceptable when compared to those of other contraceptive options;
- Women who are diabetics;
- Women who find a non-hormonal approach to birth control messy, irritating, inconvenient, and/or not sufficiently effective;
- Women who receive rubella vaccine and who must be protected against pregnancy for 3 months;
- Women with sickle-cell disease;
- Women awaiting sterilization or whose husbands are awaiting the disappearance of sperm from their ejaculate following a vasectomy.

A legal constraint prevents Pathfinder from any widespread supplying of MPA. Under current law a drug not approved by the Federal Drug Administration for use in the USA cannot be exported for distribution elsewhere. Approval continues to be sought. Other agencies, such as the UNFPA and IPPF, frequently do supply the drug, however, and we can support its distribution where supplies are available.

5.7. Investigation. Certain kinds of investigations will be both supported by and implemented by Pathfinder (see 7.1, 7.2, 7.3.). Pathfinder should not undertake the responsibility for basic biological research, or the initial medical testing of new contraceptive methods. We should nevertheless be alert to the opportunity to support small scale research projects which could give local investigators the experience needed to convince those at the policy level to remove restrictions against promising new developments.



CHAPTER 6. INDIVIDUAL CATEGORIES OF PROGRAMS

6.1. Clinic-based Services. Clinic-based services (referred to as comprehensive fertility services in the first working document) are family planning services provided directly to clients by medical and paramedical personnel from a facility which has a fixed location in a community. In the past, clinics have been used as demonstration projects and as centers for training medical personnel and auxiliaries. Their utility is not in question; certain services can only be provided in a clinic setting at the present. The medical and paramedical staff and equipment available in a clinic are necessary for sterilization, treatment of incomplete abortion, and the insertion of IUDs. However, they have proven to be an expensive means of providing the simpler types of family planning assistance. The formal atmosphere, rather complex routine, and structured manner of providing services may not be in conformity with the clients' needs for simplicity, reassurance, and ample time for instruction and education.

The functions of clinics in the next three to five years are seen to be mainly in refinement of delivery systems, training of personnel, and as supports to family planning education of clients and potential clients. Refinements in delivery of services includes introduction of clinic-based methods where they have not previously been used, improving the quality of service delivery systems, and improving the quality of the services offered.

Clinics are appropriate where they serve the purpose of meeting local standards of patient care and where they are the most suitable way of providing family planning services in conformity with local customs and governmental regulations. All such clinics should operate under the highest locally attainable standards of family planning and they and their entire staffs should demonstrate the most humane and sensitive attitudes toward the people receiving their

services and toward the larger community which they serve. One component of services which is easily overlooked in a busy facility but to which attention should be directed is the use of a clinic for outreach. The range of services should be the broadest possible under local constraints, and a clinic's personnel should be adequately and appropriately trained. The services which each staff member performs should allow maximum use of his/her training and capabilities.

Where a clinic has been established but is prevented from providing the most suitable methods of family planning by governmental restraints, it may be necessary for the project director to attempt to alter such regulations by introducing applications intermediate between those existing in the community and those most appropriate for the local situation. Such activities would best be undertaken in cooperation with the Population Policy Division. The PPD could be called upon for assistance in the development of effective ways to demonstrate the feasibility and advisability of modifying regulations so that the most appropriate type and broadest range of services could be offered.

Lastly, and equally important, clinics serve the function of developing people-to-people relationships in the community. In coordination with the Women's Programs Division, a clinic could become a center for community activities for women as well as a means of involving local women both as patient advocates and as providers of services. The aim of such activities would be to lead to greater community acceptance both of the clinic and of its functions.

To summarize, the future basis for action regarding clinic-based services will be to continue to support those which demonstrate a clear refinement of delivery techniques, or which are necessary to conform with local customs and regulations, or which serve as training centers. It is expected that Pathfinder's clinic-based services will use resources in the most cost-effective and innovative manner possible. Where a clinic no longer offers opportunity for frontier-expanding activities, or obstacles to cost-effective function cannot be overcome, the project director will be encouraged to seek other sources of funding.

6.2. Extra-clinical Services. One successful innovation in family planning has been the distribution of contraceptive materials away from a clinic setting. Some of the simpler barrier methods (condoms, foams, and jellies) have been available for many years by direct consumer purchase from pharmacies and other retail stores; the materials are sold for profit, and little or no instruction on their use may be offered. This is usually referred to as commercial retail sales. There is a modification of this form of distribution in which one merchant is given instruction in the methods for using the products which are sold and is trained to offer instruction in their use at the time of sale. This and social marketing with widespread advertising, again, are profit-making enterprises, although materials may be supplied to a vendor at cost by a family planning organization.

Comprehensive social marketing has been highly successful in raising the level of contraceptive knowledge and practice in several countries, perhaps most notably in Jamaica and Sri Lanka. This comprehensive approach, however, is probably beyond Pathfinder's financial capability. For this reason and because other agencies have greater experience, the Division discourages involvement in such programs. Smaller scale, more narrowly focused approaches have not clearly demonstrated their effectiveness. The Fertility Services Division encourages any projects developed in this area to take an operations research approach. That is, each project should clearly state what is the expected effect of the training and should plan for a careful evaluation.

The Fertility Services Division is particularly interested in continuing and expanding its extra-clinical work in community-based distribution (CBD). Pathfinder has developed a great deal of experience with extra-clinical services in Latin America and Asia and expects to develop more in Africa. Extra-clinical services are to be given high priority for their potential for community involvement and the improvement of women's lives and health. Within the limits of its resources, Pathfinder would like to introduce such programs where they do not now exist, concentrating on those models which are cost-effective and offer potential for innovation.

There are three basic distribution schemes utilized by CBD projects. Contraceptives may be distributed in an institution. That is, the family planning depot may be established in a church, a school, or other community

organization. A project may use the village distribution system in which a trusted and respected member of the community is trained to provide family planning education, motivation, and supplies. Other projects provide house-to-house distribution in which project staff visit the households in the project area to motivate new acceptors and provide contraceptives. Regardless of the structure chosen for distribution, all projects have five essential components: personnel, training, contraceptive supplies, information and education, and evaluation. Each of these components must be developed with an eye to the cultural setting and the strengths and weaknesses of the sponsoring organization.

In CBD projects contraceptive materials are delivered directly to the users by trained family planning workers. The place of delivery may be the home or a community institution; the person delivering the material may be a traditional birth attendant, a volunteer from a women's program, or another community worker. Many variations are possible in devising a system which will conform with local customs and regulations and which will also preserve the client's needs for dignity and privacy.

Questions of safety and effectiveness of such methods of distribution arise in addition to those of cost-effectiveness and acceptability to clients. The last two issues have been proven: clients accept such services readily and continue their use. In a number of Latin American countries where Pathfinder has supported CBD projects, they have been well-accepted. The annual cost per active user has varied from \$1.40 to \$7.70 (U.S.). The cost of supplying contraceptives to a client through a clinic is rarely less than \$20.00 annually.

The effectiveness of various contraceptive methods has been well documented. Overall, oral contraceptives have the highest theoretical effectiveness (less than 1 pregnancy per 100 woman years of use). Barrier methods can also be effective if they are used with each exposure, but the theoretical effectiveness is less than that of oral contraceptives (5-15 pregnancies per 100 woman years of use). Both kinds of methods are employed in CBD projects.

Evaluation of safety is more complex. One can compare the risk to a woman unprotected from exposure to pregnancy and the resultant number of deaths from pregnancy and birth-related causes with the mortality associated with contraceptive use. As the barrier methods are virtually free of

method-related risk, the mortality associated with their use is from the elevated level of pregnancy. The annual mortality rate for women of all ages using oral contraceptives varies from just over one per 100,000 users to 13.8 per 100,000 users. At all ages, use of a contraceptive is safer for a woman in a developing country than pregnancy and birth, as Table 6.2. demonstrates (see Page 30). The only situation in which the mortality rises above the 40 per 100,000 level (the level of maternal deaths which is considered excessive) is in women over forty who have a physical condition which predisposes them to complications. Distributors are trained to screen for predisposing conditions in CBD projects. These women often have had multiple pregnancies and are suitable candidates for sterilization. The mortality rate from oral contraceptives at any age does not approach the developing world's mortality rate from childbirth, especially in countries which are predominantly rural with limited access to medical care. In these countries the death rate may vary from 400 to 800 per 100,000 live births. Even in developing countries with better access to medical care, the maternal death rate may reach 100 to 150 per 100,000 live births. These maternal death rates make a powerful argument for the prevention of conception. The risk associated with the use of oral contraceptives is seen to be slight in relation to the risk of pregnancy to the mother, especially where skilled help is not readily available to aid in complicated births. Thus, development of an uncomplicated and inexpensive way of introducing and expanding the use of family planning methods has great advantages over the establishment of clinics or hospital-based services.

With the above background information in mind, it can be seen that there are many possibilities for simple and effective CBD projects, and it is anticipated that new developments will be forthcoming from these projects.

Insofar as possible, projects should incorporate the following general principles into their design and operation:

1. Wherever possible, the International Staff should coordinate and cooperate with the Women's Programs Division and the Population Policy Division so that local conditions may be realistically addressed and obstacles overcome synergistically. Collaborative efforts with the WPD will enhance effectiveness and sensitivity to clients' needs and help

TABLE 6.2. ANNUAL NUMBER OF BIRTH-ASSOCIATED DEATHS, AND DEATHS ASSOCIATED WITH FERTILITY CONTROL PER 100,000 NONSTERILE WOMEN, BY METHOD OF FERTILITY CONTROL, AGE, AND DEVELOPMENT LEVEL OF COUNTRY. #

AGE GROUP	15-19	20-24	25-29	30-34	35-39	40-44
<u>MORE ADVANCED DEVELOPING COUNTRIES*</u>						
<u>No Birth Control</u>						
- Live births	41,440	45,940	43,170	39,930	34,210	23,940
- Birth-associated deaths	8.3	9.2	10.8	20.0	34.2	35.9
<u>Oral Contraceptives</u>						
- Live Births	1,590	2,650	2,600	2,410	1,840	890
- Birth-associated deaths	0.3	0.5	0.7	1.2	1.8	1.3
<u>Without Predisposing Conditions:</u>						
- Method-associated deaths	0.8	0.8	0.8	1.3	3.0	5.5
- Total deaths	1.1	1.3	1.5	2.5	4.8	6.8
<u>With Predisposing Conditions:</u>						
- method-associated deaths	1.0	1.0	1.0	6.0	13.0	63.0
- Total deaths	1.3	1.6	1.7	7.2	14.8	64.3
<u>LESS ADVANCED DEVELOPING COUNTRIES**</u>						
<u>No birth control</u>						
- Live births	41,440	45,940	43,170	47,700	34,210	23,940
- Birth-associated deaths	290.0	183.8	215.9	199.7	171.0	191.5
<u>Oral Contraceptives</u>						
- Live births	1,590	2,650	2,600	2,410	1,840	890
- Birth-associated deaths	11.1	10.6	13.0	12.0	9.2	7.1
<u>Without Predisposing Conditions:</u>						
- Method-associated deaths	0.8	0.8	0.8	1.3	3.0	5.5
- Total deaths	11.9	11.4	13.8	13.3	12.2	12.6
<u>With Predisposing Conditions</u>						
- Method-associated deaths	1.0	1.0	1.0	6.0	13.0	63.0
- Total deaths	12.1	11.6	14.0	18.0	22.2	70.1

#Potts, M., Speidel, J.J., Kessel, E. "Relative risks of various means of fertility control when used in less-developed countries." In Sciarra, J.J., Zatzchni, G.I., Speidel, J.J. Risks, benefits, and controversies in fertility control. (New York: Harper and Row, 1978). P. 35.

*Examples: South Korea, Taiwan.

**Examples: Bangladesh, India.

to assure the community acceptance which is so vital. The PPD should be involved in working to develop policy changes which would allow introduction of new programs using methods whose feasibility and safety have been proven elsewhere.

2. Projects are to encourage freedom of choice of family planning methods over as wide a range of options as possible. Methods now available through Pathfinder funding which are appropriate to CBD are barrier methods and oral contraceptives. Injectables, while not available for extra-clinical services at the time of this writing, may be in the near future.

3. Formal clinic ties and/or networks with clinic ties should be established since these ties will be necessary for expanded ranges of services. An example of the need for clinic ties is that of the older women with many previous pregnancies. Her health and family needs might better be served by sterilization than by reversible contraceptive methods.

Past programs have suggested that the recipient may place more value on the contraceptive when there is a charge for it. A user fee should be considered as part of a project where local conditions may warrant it.

A set of exemplary definitions and recordkeeping systems are included in the "Evaluation of Projects" section of this Working Document. We recommend their use because of their proven simplicity and adequacy in providing management indices. They will allow Pathfinder to collect data that is comparable from area to area and that can provide a greater store of information about extra-clinical services.

The prospects for the future of such projects are exciting, and it is anticipated that Pathfinder will repeat its past successes in establishing new groundbreaking programs in all the regions it serves.

6.3. Education and Training. Education and training are both vitally necessary for the provision and dissemination of family planning information, principles, philosophy, and techniques. Education is primarily concerned with teaching people, both professional and nonprofessional, about the aims and desirability of family planning, as well as providing specialized information of a technical nature to professionals. This latter aspect overlaps with training, which is primarily the teaching of skills and methods of family planning to providers to enable them to deal effectively and sensitively with clients in the particular setting in which the providers work. Having established these distinctions, the scope of Pathfinder's activities in the two fields can be elaborated.

6.3.1. Education. Education is, and will always be, a fundamental tool in family planning, for it is the only way of demonstrating the need for and desirability of family planning to those who are unaware of it. It is a continuing process, for workers in family planning must keep themselves informed of current information and its application to their own projects; they must additionally be prepared to educate new clients and reeducate active users so that they may select methods which are appropriate to their own best interest.

Pathfinder has been a leader in originating both client-oriented and provider-oriented educational material in the past and it intends to continue to be so. In preparing this material the Communications Programs Department at Pathfinder has developed certain standards of quality and specificity for the target audiences. These qualities are unique; others have not met such high standards in the preparation of material, and Pathfinder will continue to endeavor not to compromise its own high standards.

Educational materials are available in several languages and are kept up-to-date. Collaboration with other divisions in the production of other material is coordinated through the Communications Programs Department.

There will be one important exception to the general policy of continuing support for all educational areas. International conferences

will be de-emphasized. Past experience with these activities has been disappointing; it has shown the educational value of such conferences to be limited in relation to the effort and expense of organizing and coordinating the conferences. Noneducational benefits from international conferences must be considered, however, and some support for selected international conferences will continue.

6.3.2. Training. In the past, training has been less emphasized than education at Pathfinder. Furthermore, other agencies have started and expanded professional and paraprofessional training programs since the Fertility Services Division's last working document was published. It now seems superfluous for Pathfinder to provide training except where it is inadequate or otherwise lacking. An example would be the efforts to train in techniques of minilaparotomy for sterilization where it is not available through other sources.

In the future there will be decreasing emphasis on training for clinical activities, as less need for this type of training is projected. Instead, efforts will be directed at developing training for distributors, managers, promoters, and supervisors who will be involved in CBD projects. The development of this kind of activity will enable Pathfinder to effectively train workers for specific functions in CBD projects.

Pathfinder also has an interest in meeting the needs of adolescents who constitute its target high-risk group. It may be necessary to provide special training for those who will work with these young people, and the organization is prepared to develop training programs to teach essential skills.

6.3.3. Human Resources. The Fertility Services Division has a programmatic interest in the development of human resources in priority countries; it seeks to identify uniquely talented individuals who might be or become leaders in their own country in promoting family planning. If such individuals are identified, Pathfinder is willing to support them financially while they undertake training or

education. Such support might take the form of tuition, per diem expenses, or similar financial aid. The Pathfinder Staff can help identify limited numbers of such individuals of very special potential.

In summary, Pathfinder will continue its existing educational activities at all levels and expand them as appropriate. It will offer selected training activities, especially if there is no other source, and it will seek out and support talented and capable individuals to become leaders in family planning in their own countries.

EDUCATION AND TRAINING

Activities to be supported

Education

1. Family planning in medical and nursing schools and schools of midwifery.
2. Education concerning adolescent fertility.

Training

1. Techniques of minilaparotomy and vasectomy.
2. CBD
 - Managers
 - Supervisors
 - Promoters
 - Distributors
3. Training for counseling in adolescent fertility.

Future De-emphasis or Non-Support

Education

1. Social work or other allied health fields.
2. International conferences for continuing education.

Training

1. Laparoscopy.
2. Clinical training for nonphysicians.

6.4. Focus on High-Risk Groups. All women between the ages of fifteen and forty-five are generally considered to be capable of bearing children, but the likelihood of maternal death or complications of pregnancy and childbirth, with the resultant deleterious effects upon the infant, are not equally distributed among all women. When a factor which may indicate adverse outcomes of pregnancy and childbirth for the individuals or for society is identified, the group characterized by this factor is called a high-risk group. Two factors which can be most easily identified with increased maternal and infant risks are age and number of previous pregnancies.

Women under twenty and over thirty have a higher incidence of complications of pregnancy and maternal mortality than those in the twenty to thirty year age group. Those who have had five or more births are called grand multiparas. They need not be chronologically old; a woman married at fifteen could become a grand multipara by the age of thirty. Pathfinder has supported sterilization programs aimed at this group of women because of the well-documented risks to the mother and infant when such women conceive. In countries which are largely rural and in which access to medical care is limited, the maternal death rate may be as high as 800 per 100,000 live births, while the mortality rate from sterilization is at maximum about 25 per 100,000 operations and usually much less. With these clear differences in safety, and the benefits to a family of a healthy and productive mother, the advantages of sterilization to prevent conception become clear.

At the other end of the scale are persons under twenty years old. People in this age group are often referred to as adolescents, and that term will be used here to mean males and females who are under twenty years of age and who are sufficiently mature physically to be capable of reproducing. They can be divided into two large groups, those who are sexually active and those who are not. The people in the sexually active group may be married or unmarried. In countries where early age at marriage is the custom, married people are presumed to be sexually active. Whether married or unmarried, sexual activity entails the possibility of pregnancy for the female.

Attitudes toward out-of-wedlock pregnancies vary among different groups, ranging from acceptance to indifference to social ostracism. There are many consequences of adolescent pregnancy to the mother, to the infant, and to society. Consequences to the mother and infant may be social or health related or both. There are also the economic costs of rearing the infant and leaving the less educated mother without the skills necessary to support herself and the infant if she is single or self-dependent.

Many people would assume that adolescents who are not sexually active would not be important as contributors to population pressures as they are not producing children. This group is not static; the adolescents who are to become sexually active obviously must come from the members of the inactive group. There are two subgroups: those who are contemplating initiating sexual activity, who will be referred to as the incipient group, and those who are not, who will be referred to as the reserve group.

The incipient group is often older and more aggressive. They may be nonconforming if premarital sexual activity is regarded as culturally unacceptable. Conversely, they may also be conforming to a cultural norm, especially in the case of males in societies where this activity is given at least tacit approbation. Their behavior is often impulsive; the health and social consequences of sexual activity may not be taken into account. Some young women who know intellectually that intercourse leads to pregnancy do not emotionally accept the fact that they can become pregnant.

The reserve group is the one comprised of adolescents who are not immediately contemplating initiation of sexual activity. They are often younger and may include prepubertal children as young as ten. This group is thought to be flexible in its approach to situations and can be educated about the value of delaying first birth and limiting family size so that they do not follow the same pattern as their older siblings or the adults in their society.

6.4.1. Social Implications. Pathfinder is concerned with the growth rates in a country because of the impact on social and developmental issues. Population growth in a country occurs when the birth rate is higher than the death rate, and the increase in the population will be greatest in the younger age groups. This fact justifies our special interest in projects targeted at this population segment.

The distribution of population in a country is frequently shown by means of a population pyramid, as in Figure 6.4.1. The diagram represents a typical population picture in a developing country.

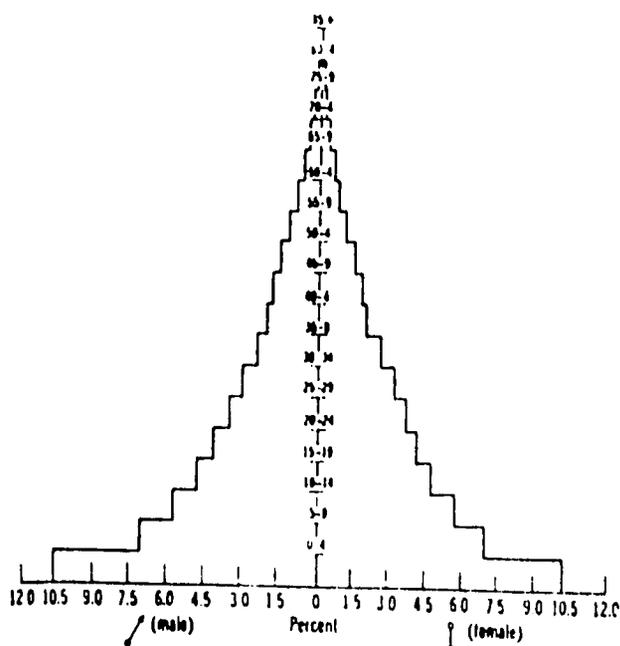


Figure 6.4.1. Population Pyramid of a Typical Developing Country.

It is a series of bar graphs in which the population of a country is separated into age groups. The age groups are usually at five year intervals and the total length of each bar represents the number of people of the age in the country. Such a country will have large numbers of young people and almost half of the total population will be under fifteen years old. Large numbers of young people who have not yet begun or are

just beginning to reproduce have the potential for causing a very rapid increase in a country's population and a short doubling time. This poses grave problems for any country, rich or poor, because of the amount of its food and resources that must be devoted to sustaining a rapidly growing population.

6.4.2. Health Problems in Adolescent Pregnancy. Although the reproductive health of the male may be of some concern, the focus of this discussion will be the female. An adolescent female will be considered to be any woman nineteen years of age or less who has reached puberty and is capable of becoming pregnant. In the last century, menarche (first menstruation) occurred at an average age of between fourteen and fifteen. The age of menarche has been declining, however, in both developed and developing countries so that it is now nearer twelve years of age. It may be less; pregnancy in girls of eleven has been reported from many geographic areas.

Pregnancy is not without hazard for any woman, but the risks are lowest for women between twenty and thirty years old. Maternal morbidity is higher in girls and women under twenty, and certain complications of pregnancy and childbirth occur more frequently in this younger age group also. Difficulties with pregnancy and childbirth may have an adverse effect upon the infant, and there is a demonstrably higher infant mortality rate and a greater number of low birth weight infants, both premature and of term gestation, born to these younger mothers. The total health implications of adolescent pregnancy are highly significant. Taken together, these problems of teenage pregnancy would seem to indicate the advisability of delaying pregnancy and childbirth to as near the age of twenty as possible to benefit both the mother and the infant.

6.4.3. Interventions. In devising effective interventions among adolescents, an attempt must be made to formulate projects that will be specific for whichever of the previously described

four groups they are intended to reach. Where intervention is aimed at altering cultural values, or law, or policy, the Population Policy Division must be involved in the development of the project plans. It is also desirable for a project targeted at adolescent groups to attempt to satisfy the three specific goals or the fourth general goal which the Fertility Services Division has formulated for this age group. These goals were developed because they serve the positive purpose of decreasing the risks discussed in the sections on social implications and health (6.4.1., 6.4.2) and can be stated as:

- I. Delaying the age of first pregnancy.
- II. Increasing the interval time between successive births.
- III. Teaching the value of a small family.
- IV. Changing the environment by means which may reach all groups simultaneously (e.g., radio or newsletter communications, public policy changes).

Interventions must be handled most tactfully among unmarried adolescents for there is often considerable parental and cultural pressure against "sex education". If sex education is to be programmed, it is frequently better introduced as family life education. In cultures where early marriage and early childbearing are the norm and are encouraged, attempts to introduce contraceptive information and materials to these young people require a very delicate approach.

The limitations described above might make intervention seem difficult in this high-risk group. In successful programs, the key has seemed to be the presence of personnel who can gain the confidence of the young people and offer them information which they can accept as valid and which they are willing to discuss with the person who presents it. Training may be an important factor in developing personnel who can gain the confidence of adolescents. Other adolescents, acting as peer counselors or natural leaders, may be the most relevant personnel in some instances.

A. Married Adolescents. Interventions for married adolescents are almost the same as for those married adults. All of the previously tested and accepted contraceptive methods are available for use in accordance with local customs and preferences. In addition, counseling

about the desirability of delaying the first birth and the spacing of subsequent births may be feasible and is to be encouraged. These services would be aimed at achieving one, two, or even three of the specific goals. Projects involving this group would have the advantage of being able to build upon the successful experiences of past Pathfinder efforts which were not specifically aimed at adolescents.

B. Unmarried, Sexually Active. The sexually active, unmarried adolescent also needs family planning services. This group is more difficult to reach as the people in it are not set apart in any way from others of the same age. They may be reluctant to discuss their sexual activity except within the peer group. Some form of encouragement may be necessary for them to identify themselves and seek family planning services. One popular intervention, but certainly not the only design possible, is to offer family planning services in conjunction with other services attractive to them in a center designed to deal only with adolescents. Adaptation to make existing services responsive to the adolescent's needs for privacy and specificity might also be a method of programming.

C. Incipient. The focus of interventions with this subgroup is education and counseling. Peer counseling is a tool which has been used with some effectiveness. It is aimed at helping adolescents establish a sexual value system that is culturally appropriate and in laying a foundation that will prepare them for responsible behavior. Attempts to reach adolescents may be channelled through schools, community centers, youth groups, or other agencies which attract their interest and attendance. Adjunctive recreational programs may also be useful in involving the target individuals in some form of sport or similar activity which utilizes a portion of their great physical energy and time so that they are less apt to seek sexual activity as a form of recreation or peer group status. This often appeals to males, and it must be emphasized that male involvement in family planning activities is equal in importance to that of the female.

D. Reserve. Attempts to reach the adolescent who is not sexually active (and who is usually younger) have been primarily educational. Educational projects may be undertaken alone or in conjunction with a school or community organization. Adjunctive recreational programs may also be useful with the reserve group in gaining their confidence and active participation.

The list of interventions described on the preceding pages is not exclusive. Other creative, innovative ideas will be considered receptively. All projects in this area are to be considered operational research and should be designed with a strong evaluation component. (See Section 7.3.) It is extremely important that successes (and failures) with approaches to adolescent fertility be well documented so that they can be shared with the growing number of people and agencies who will be concerned with this emerging problem in the future.

Interventions must be appropriate to the individual culture and the needs of the target adolescent group. It may be desirable to work with youth-oriented agencies, such as the YWCA, instead of, or in addition to family planning organizations. The Fertility Services Division has identified six broad programmatic categories:

- I. Family planning education and services for adolescents in a multi-service teen center.
- II. Family planning services specifically developed for adolescents as an additional component of a larger family planning activity.
- III. Education--sex education or a larger educational focus, such as family planning within vocational education.
- IV. Peer counseling.
- V. Social marketing, such as a media blitz using well known sports and entertainment personalities.
- VI. A variety of other models capitalizing on a unique social or cultural context.

6.5. Problem-Oriented Health Linkages. Pathfinder recognizes that health services and family planning services are inextricably interwoven. High rates of infant and child mortality and of maternal mortality must be addressed as well as high rates of fertility. In places not previously reached by any kinds of services, the confidence of people in fertility services may only be obtained if primary health care is also provided simultaneously. There are other important aspects that must be considered; for example, high birth rates have strong negative effects on maternal health, child health and human nutrition; high birth rates may even contribute to high death rates. Health planners and family planners cannot afford to ignore these interactions as health care systems evolve in developing

countries. We are well aware that the development of health schemes without adequate thought concerning family planning is both irresponsible and potentially disastrous. (See Section 2.4. for discussion of the indirect linkages between health and family planning.)

6.5.1. The Historical Paradox. Observers of family planning programs, whether experts or novices, are frequently fascinated by the idea of integrating services. There is a tempting appearance of neatness and logic to a diagram on paper showing merged staffs, uniform procedures, simplified descriptions of objectives and accountability. The trouble is that the attempt to integrate services does not work in most of the places that have very limited resources with which to cope with high rates of sickness and death on the one hand and rising population pressures on the other. The person who operates a clinic for the treatment of the sick may either be overwhelmed by lines of people waiting to be treated, or ignored by the populace because services are inconvenient or otherwise unsatisfactory. The realities are such that the overwhelmed provider of curative health services cannot divert adequate time or energy to delivery of family planning services. Likewise, the operator of an exclusively family planning facility which is not offering services perceived as necessary by the client may find his clinic shunned and empty.

There is a further difficulty. If budgets for fertility services are integrated with those for general health services, the funds tend to be swallowed up by the acute needs. The administrator of such a budget finds great difficulty in continuing to emphasize the equal importance of fertility services and to ensure their delivery despite pressures to divert financial resources to the treatment of acute illnesses.

Because attempts to accomplish integration are unlikely to succeed in most places, a better approach is essential if fertility services are to be provided on a scale commensurate with the need in deprived communities. Pathfinder should explore the feasibility of coordinating systems for delivery of fertility services and the health services. In truth, fertility services are a basic part of health services.

6.5.2. Practical Reasons for Exploring Health Linkages. Certain geographical regions are more appropriate than others for exploration, introduction, and extension of health linkages to family planning. In a general sense, Africa may be considered an example of such a region. The introduction of family planning services may often require a demonstrable link to maternal and child health care.

Several factors may contribute to the requirement for a visible link between family planning and maternal and child health. First of all, the family planning clients themselves may require such a link in order to make family planning acceptable to them. Secondly, a linkage may be necessary in order to make the family planning program acceptable to the policymakers and project implementers. These people may have genuine concerns about the appropriateness and the safety of family planning programs which do not have a strong health component. Thirdly, because of local conditions, efficiency may be increased with certain kinds of linkages. These efficiencies may accrue in the areas of management, supervision, materials and logistics, or personnel deployment. Where such improvements in utilization of people and materials are possible, the advantages of health linkages should be fully exploited.

6.5.3. Requirements for Programming. There are three basic requirements for programming in health linkages with family planning.

A. Health interventions should have a logical and rational linkage with family planning programming. The approach must ordinarily be to the women and/or her children, and will normally be preventative in nature. Occasionally an intervention may be of a curative nature, but it should be technically simple and brief in duration. (An oral rehydration program for the treatment of infectious diarrhea of infants would qualify as a linkage, although therapeutic in nature.)

B. Interventions should target on specific health problems rather than on comprehensive care. These specific problems need to be carefully defined. Insofar as possible, they should also be realistically designed for both success and cost-effectiveness. Involvement of the community in the definition of the problem and in the design of the solutions can be an important factor in the ultimate success of the linkage.

Specific low-technology interventions such as nutritional education and counseling, or systematic immunization could be examples of efforts directed to problems in a community.

C. Almost all health linkages with family planning should be considered exploratory programs. This implies that the projects will probably be small in scale, and experimental in nature. Results must be amenable to careful examination, analysis, and possible replication. Insofar as possible, hypotheses as to the effectiveness of family planning/health linkages or other innovations should be designed so that their validity can be tested as the project is carried out.



The Pathfinder Fund

APTER 7. EVALUATION

Over the course of the past several years Pathfinder has established new evaluation procedures and standards. Continuing improvements are expected as the system for evaluation is tested and modified.

Two general types of evaluation activity need to be considered: program evaluation (7.1.) and project evaluation (7.2.). These topics relate very closely with other areas of discussion in this document (1.2.4), (5.7.), (6.4.3.), (6.5.4.).

7.1. Program Evaluation. It is important for the Fertility Services Division to document how well its programs (6.1. - 6.5.) are succeeding and why, or how badly they are failing and why, in the country, region, or cluster--at the broad tasks of introducing, improving, extending, and exploring. Insofar as possible, the documentation should be both quantitative and qualitative, and should be both descriptive and analytical in nature.

Requests for and design of program evaluations will generally be the responsibility of the International Staff in collegial association with expert consultants. Program evaluation will be of three types.

7.1.1. Divisional Goals and Objectives. These are assessed as they are achieved by a series of projects related categorically, or regionally, or in other ways. The results of this type of evaluation are primarily used by the regional, international and divisional staff to modify programs and projects in ways which will allow us to work more effectively. Other uses of the evaluation output, e.g., for publication, are of secondary priority but not to be inhibited if such uses would contribute to Pathfinder's broader organizational goals and objectives.

7.1.2. Evaluation of Systems for Delivery of Fertility Services.

In this context we will be concerned not so much with programs, projects, and total mission, as with a more technical study of the relative advantages of a particular system or approach (e.g., extra-clinical distribution, clinic-based activities, paraprofessional education, problem-oriented health linkages) in a given setting. Such evaluations will be planned for suitability to be given over to public scrutiny in the form of Pathfinder or scientific publication. Additional uses of results may be found in program planning and regional strategy development for Pathfinder. Section 7.3. discusses the designs of research projects.

7.1.3. Evaluations of Impact. Evaluation of the impact of Pathfinder's work will require a wide perspective and a long-range time scale. It will require an assessment of the combined effects of several factors acting concurrently on population pressures in a given place--some of which may have been influenced by Pathfinder's work, others not. The impacts may be on local perceptions, or on constituencies, or on national plans and policies, or on the scope and nature of fertility services provided by other private voluntary organizations or by the local government. At regular intervals, perhaps annually, the Fertility Services Division should attempt an assessment of impacts with special reference to Pathfinder's current contribution and its further opportunities. These evaluations, by implication, are interdivisional efforts. They may take a variety of forms and be conducted with differing degrees of qualitative rigor, depending on the nature of the study. The results are intended for the attention of the Pathfinder Board of Directors, national family planning programs, funders, and others with concerns about Pathfinder's broader effectiveness.

7.2. Project Evaluation.

7.2.1. Design of Evaluation System. The design of the project reporting and evaluation system is an integral part of project development. The grantee who designs the project must develop a data collection system appropriate for management of the project and its evaluation. Pathfinder regional/country staff are responsible for providing assistance to the Project Director.

Project reporting and evaluation are based on the goals, objectives, and work plan of the project. These are outlined in the proposal that is submitted for funding. The goals state the nonquantified purpose for doing the project. The objectives are the quantified statements of the expected outputs needed to accomplish the goals. The work plan describes the inputs and activities needed to accomplish each of the objectives. The Project Director determines an appropriate data collection system to develop management indices and indices of project progress.

7.2.2. Project Reporting and Monitoring. Pathfinder monitors its projects through periodic site visits by the regional/country office staff. A Pathfinder staff member makes a site visit usually in the first two months of the project and again in the third quarter. At the first visit the Pathfinder staff member assists the Project Director with problems in implementation. For example, a new Project Director may have difficulties in clearing commodities or equipment through customs, and the Representative from the International office may assist the Project Director in obtaining clearance. During the third quarter site visit the International Staff member can assess the qualitative aspects of the project, identify unexpected results of the project, assist the Project Director in taking corrective action if any is needed because of delayed progress, and assist the Project Director in developing a proposal for renewal. A member of the Boston Pathfinder staff will usually make one visit annually to provide technical assistance and/or project supervision.

The Project Director submits quarterly reports to both the regional/country office and to the Boston office of Pathfinder. These quarterly reports describe and quantify the project's progress in achieving its objectives and accomplishing the steps in the work plan. The reports are reviewed in the regional/country office where staff are conveniently situated to provide rapid assistance to the grantee if needed. It has been found that data reporting is more complete if a pre-designed reporting form is used. This enables the Project Director to state the quantifiable results for each three month period of the project in such a way that they are easily accessible and understandable. Such a form may be designed by the Project Director and the International Staff. (See Appendix I for sample.)

Responsibility for Project Evaluation on the part of the Boston office is described in the attached Appendix II. The Project Administrator reviews each quarterly report. Progress is analyzed in a systematic manner by the Evaluation Review Committee (ERC) after the second and fourth quarterly reports are received. A one-page summary of the project and the findings from site visits is prepared for the ERC meeting along with a Performance Evaluation Worksheet (see Appendix III) that summarizes the quarterly reports and progress toward meeting project objectives.

At the second quarter the review has the following purposes:

- 1) Determination of project performance relative to its goals and objectives;
- 2) Determination of need for remedial action and assignment of responsibility; and
- 3) Determination of implications for project renewal.

The second quarter Review Committee consists of the Regional Director (and Assistant where applicable) and the appropriate Divisional staff involved with the project, along with the ERC Chairperson and ERC Coordinator.

At the end of the project year a broader assessment of project performance and the degree to which the project accomplished its goals and objectives is made. At times it may be necessary to identify a need to assess the accomplishment of the goal at a later date. The fourth quarter meeting has a wider representation from Pathfinder and

includes the Chairman of the Board and the Executive Director or Associate Executive Director, as well as the Regional Director and Divisional staff.

The findings of the Evaluation Review Committee are communicated to the International Staff member who has responsibility for any action that might be required. The findings are recorded on the Assessment of Project Performance (see Appendix IV for second quarter and Appendix V for fourth quarter). When the renewal proposal is processed in Boston both the Performance Evaluation Worksheet and the Assessment of Project Performance Quarter II are reviewed as part of the renewal consideration.

7.2.3. Evaluation of Community-Based Distribution Projects.

Every project needs a management system which provides data that is vital for project management but this need is especially great for community-based distribution projects. The system should provide information that is needed for the long-term and the short-term. The information required for reporting to the donor agency should be a subset of the information needed for project management (see Appendix I).

Project management has two primary data sources: service statistics and family planning surveys. The service statistics system is the planned collection of data through the program's agency to better manage, control and evaluate it. These data provide the Project Director with the information needed for the efficient management of operations and assessment of progress toward annual objectives. In a CBD project each distributor keeps track of the individual clients, choice of method, and whether or not the user continues to be active in the program. The "Field Worker's Record", shown in Appendix VI, is a suitable tool for recording this information.

From time to time management needs to assess the impact of the program and gather information on the non-user population. Family planning (KAP/CPS) surveys provide this information and can be conducted on either a large or small scale. Large scale surveys by external organizations have been conducted in dozens of countries and the

reader is directed to the World Fertility Survey for more information. The technique of the "mini-survey," which is an internal survey technique, has been developed by the Asian Training Center, Bangkok. The reader is directed to the Center's training materials for more information on small-scale Family Planning surveys.

The Division would like to recommend that future Pathfinder CBD projects incorporate all or part of the above evaluation system.

7.3. Research into Delivery of Services. Certain kinds of innovative programs do not have documented successful results. They are very good ideas in theory, and perhaps in practice, but the effects need evaluation and documentation. Three such Fertility Services Division programs are adolescent fertility programs, drug-store training programs, and family planning with health linkages.

Projects should be developed in each of these categories with a clear and precise goal statement. That is, the expected result of the intervention should be defined. If a project has an experimental design, the hypothesis gives the statement of the expected result. Ideally, a hypothesis should specify the population, the cause of the problem under consideration, and the expected effects to be evaluated after a given period of time. The experimental design may take any of several forms. A test-comparison study design may be selected. This is appropriate when it is possible to compare the variable being studied between two groups, one group which undergoes the project intervention and a second group with no intervention.

In a project with a nonexperimental design the goal statement replaces the hypothesis. The case study technique and surveys are useful tools to evaluate the outcome of these projects.

It is often difficult to collect clean data. It should be kept in mind however, that somewhat faulty data do not necessarily fail to reflect the outcome of a project. When the evaluation of an individual project produces imperfect data, it may be useful to analyze the results along with other, perhaps imperfect data from similar projects. These may be Pathfinder projects designed as a cohesive programmatic unit or they may be projects of a similar nature undertaken by other organizations.

Pathfinder has historically focused on action oriented projects. In programs where an operational research component is appropriate, it may be necessary to commit additional resources to the project for design, evaluative and statistical assistance in order to meet sufficient standards for documentation of results.



CHAPTER 8. GEOGRAPHIC APPLICATIONS

Fertility Services Division programs are not uniformly applicable in every country. The choice of programs depends on need and potential within the country. The political climate for family planning, contraceptive availability, the supply of trainer manpower, and other health needs are some of the issues that impact strategy development.

Pathfinder's program planning is focused on the following geographic subdivisions:

- Brazil
- Latin America North (Central America & Colombia)
- Latin America South (South America)
- Sub-Sahara Africa
- Turkey
- Egypt and other Near East countries (Jordan and Yemen)
- Bangladesh
- Indonesia
- Other Asian Countries, notably Thailand & Nepal

Examples of Pathfinder's long term country goals and the 1981 Fertility Services Division programmatic plans for accomplishing the goals are presented here. The synthesis of the Fertility Services Division plan with annual plans of the Women's Programs Division and the Population Policy Division constitute an annual work plan for the country or region. Planning has not been accomplished for all the regions as this document goes to press.

8.1. Brazil.

8.1.1. Pathfinder Long Term Goals for Brazil, January 1981.

I. To promote a positive policy on IUDs and to develop the necessary skills and supplies of commodities for an adequate level of practice. This involves: policy, training, and service delivery and distribution of IUDs. This involves both the Population Policy Division and the Fertility Services Division.

II. To promote the adoption by the government of a formal sterilization policy, one which mandates governmental reimbursement for sterilization procedures performed; to have an adequate number of providers trained in the technologically appropriate skills; and to have service delivery coordinated with BEMFAM. This goal involves the Population Policy Division and the Fertility Services Division in training and coordination of site centers with BEMFAM. The Women's Programs Division has a role in assuring that user concerns are paid attention to. Special emphasis needs to be paid to assuring adequate counseling and consent standards.

III. To lay the groundwork for long term change in abortion, adolescent fertility, health linkages with family planning, and training paramedics for family planning. This can be accomplished through studies and publication of results, as well as professional education and action projects with a research component.

IV. To encourage family planning to be an official part of medical school curricula.

V. To help bring into operation the government's new program to include family planning in the Social Security/Ministry of Health (PREV-SAUDE).

VI. To develop a constituency among women's groups for promoting and discussing family planning.

VII. To promote service delivery and family planning with an orientation to the consumer through women's groups.

VIII. To contribute to the status of Brazilian women through pilot WID projects.

8.1.2. Fertility Services Division's Annual Programmatic Plans for Brazil, January 1981.

HIGH PRIORITY

- I. Physician Training.
 - a) Seminar with the Brazilian OB/GYN Society to promote an official policy on the part of the Federal Council of Education re: family planning in medical school curricula.
 - b) Introduction of family planning into the Pernambuco Medical School.

The government Social Security/Ministry of Health system, PREV-SAÚDE, recently announced that they are about to begin putting family planning services into their entire system. Our second highest priority, therefore, is to assist this arm of the government in implementing their plans. We see our role particularly to be in the areas of sterilization training and IUD insertion training. We might be able to assist with kits, books, films, and to train trainers in the medical schools that are currently training both students and practicing physicians in their continuing education programs. We are particularly interested in seeing a link between the clinical services and the BEMFAM program.

MEDIUM PRIORITY

The Fertility Services Division is interested in developing one "seed project" in each of the following categories: adolescent fertility, desensitization of abortion, training of nurse trainers, and health linkages with family planning (particularly a project to test the link between family planning and cytology).

LOW PRIORITY

- I. Bahia School of Nursing.
- II. Hospital de Base.
- III. Belen School of Medicine.

8.2. Latin America North.

8.2.1. Pathfinder Long Term Goals for Latin America North,
January 1981.

GUATEMALA.

I. To develop pilot projects to demonstrate how to deliver family planning education and services to Indian populations (with a policy implication).

II. To improve existing programs and services--quality of service, communication, etc.--particularly through training of providers.

III. To identify and use traditional personnel and systems for introducing family planning.

IV. To explore ways to address urban adolescent needs.

HONDURAS

I. To develop pilot projects with new groups using new approaches for delivering community-based family planning services in isolated rural areas.

II. To sensitize top level government policymakers to the population problem and family planning needs of the country (after August 1981 elections).

III. To improve management skills in private family planning organizations.

IV. To assist the government in implementation of its progressive policy on women.

MEXICO

I. To promote abortion services and training and a positive abortion policy.

II. To use the Mexican experience in helping other countries formulate population policies.

III. To explore an appropriate role in the field of adolescent fertility.

COLOMBIA

I. To explore intervention to affect adolescent fertility behavior: policy, training, services.

II. To develop pilot projects to demonstrate how to deliver services to isolated underserved populations--the far east of the country, the west coast, places where fertility rates are very high, the population poor and dispersed, and no services are available.

III. To promote abortion services including training of physician and nonphysician providers and to work towards a favorable abortion policy.

IV. To develop demonstration "beyond family planning" projects where a plateau in family planning acceptance has been reached. These should be projects that can be absorbed into the community.

V. To explore Pathfinder's role in sterilization in individual meetings.

NICARAGUA

I. To develop manpower for family planning services in the government system--physicians, nurses, community agents, etc.

II. To equip and supply the government program.

III. To get family planning services to the community level--through women and family planning programs, through distribution by government community agents, or through an exploration of family planning and health linkages.

IV. To expose policymakers to the population policies and services of other countries.

V. To support implementation of the government's favorable policy towards development of women.

DOMINICAN REPUBLIC

I. To explore interventions in adolescent fertility behavior--service and training.

II. To convince the government to integrate family planning into the SBS effectively.

III. To get contraceptives distributed on a fee for service basis.

IV. To promote abortion training and provide abortion equipment.

JAMAICA

I. To explore interventions into adolescent fertility behavior--service and manpower training.

II. To provide management training for women's programs, adolescent programs and family planning programs.

PANAMA

I. To test methods of approaching adolescents.

II. To convince the government to allow others to deliver family planning services--CBD or CRS.

III. To provide training and equipment for abortion.

IV. To explore the interest of groups other than the government (trade unions, cooperatives, campesino organizations) in promoting and providing family planning with government approval.

HAITI

I. To explore ways to deliver family planning services through CHREPROF.

II. To promote sterilization in private hospitals.

III. To get family planning into the curriculum of medical schools and nursing schools.

IV. To encourage coordination between private and government MCH/FP services.

REGIONAL CARIBBEAN

I. To use the Jamaica Adolescent Project or the Jamaica Women's Bureau (or perhaps the Jamaica YWCA Project) as a model for other countries in the region. We would support the policy aspect while we would broker funding of the implementation to another donor agency.

8.2.2. Fertility Services Division's Annual Programmatic Plans for Latin America North, January 1981.

GUATEMALA

High Priority.

I. New efforts to assist the government to effectively provide family planning through traditional birth attendants.

HONDURAS

High Priority.

I. To develop pilot projects with new groups to deliver CBD services.

II. To improve management skills in ASHONPLAFA (coordinate with Development Associates).

Medium Priority.

I. To explore putting family planning into medical schools' curricula (dependent on August '81 elections).

MEXICO

High Priority.

I. Abortion - National Ob/GYN organization wants to hold a conference on abortion training and equipment.

II. To evaluate the Family Planning in Seven Nongovernmental Institutions Project (perhaps in 1982).

Medium Priority.

I. To develop linkages with adolescent fertility programs so that we can use Mexico as a training source.

COLOMBIA

High Priority.

I. To reach isolated populations (National Territories, rural CBD); this would involve training providers and CBD.

II. Abortion services.

III. CCRP Adolescent Fertility Project with private funds.

NICARAGUA

High Priority.

I. To develop manpower in government health system.

Medium Priority.

I. To equip and supply the government program.

II. To explore with the government a test of contraceptive distribution through community agents.

III. To explore with the universities community level family planning with health linkages.

DOMINICAN REPUBLIC

High Priority.

I. To develop an adolescent fertility project proposal with PROFAMILIA.

Medium Priority.

I. Abortion equipment and training.

JAMAICA

Medium Priority.

I. Adolescent fertility interventions.

II. Management training.

III. Training for abortion services if government policy changes.

PANAMA

High Priority.

I. To develop family planning services outside the government health service aimed at rural underserved populations.

II. To test ways to approach adolescents.

Medium Priority.

I. To provide abortion training and equipment in the private sector.

HAITI

High Priority.

I. To explore ways to get family planning into CHREPROF.

Medium Priority.

I. To get family planning into the curricula of medical and nursing schools.

II. To promote family planning in private organizations under the Ministry of Health.

III. To promote sterilization.



CHAPTER 9. VOLUNTARY TERMINATION OF PREGNANCY

Over the past quarter of a century world opinion has come to the conviction that education and health care are universal human rights. Furthermore, the majority of people who have been polled on the subject believe that each woman has the right to choose for herself whether and when she will bear a child. Each year, however, hundreds of thousands of women resort to unsafe abortions because they have no access to contraceptive services or because the methods they tried did not work.

Clandestine abortions are hazardous--complications are common and many women die as a consequence. In addition to the loss of maternal life, another serious consequence is the higher rate of infant and child mortality that is associated with the prohibition of abortion. The high incidence of clandestine abortion means that far too many communities are failing to provide adequate information, contraceptive services, and basic health services to their members, particularly to those who are poor and illiterate. In this context Pathfinder seeks the following goals:

1. New public attitudes supporting the right of each woman to decide for herself whether and when she will bear a child.
2. Widely available access to comprehensive fertility services including voluntary termination of pregnancy by procedures that are safe, simple and respectful of individual dignity.
3. A sharp decrease in the serious complications caused by clandestine abortions.
4. Improved maternal and child health.

9.1. Achievements. Pathfinder's achievements in voluntary termination of pregnancy include:

1. The introduction of supplies for uterine aspiration.

2. The provision of intensive training for selected providers.
3. The provision of services in integrated legal and extralegal clinical facilities.
4. Publication of a training film and manual on uterine aspiration.
5. The education of policymakers and providers through the mechanism of regional meetings and seminars.

9.2. Obstacles. Pathfinder involvement in voluntary termination of pregnancy is inhibited by United States laws (the Helms Amendment to the Foreign Assistance Act), by foreign laws in various places, by local cultural forces, and by the interpretations of each of the foregoing by granting agencies and self-appointed analysts of public opinion at various levels in a particular society. The restrictions imposed by the Helms Amendment and the administrative interpretations by the Agency for International Development constitute very serious obstacles to the provision of voluntary termination of pregnancy where its benefits are both needed and wanted.

Voluntary termination of pregnancy is an important component in most systems for delivery of comprehensive fertility services. But this ideal in all probability will be inaccessible in the future. Where services of voluntary termination of pregnancy are to be rendered which are supported by grants from Pathfinder, it may be impossible to provide other fertility services there unless the facility is supported predominantly by private funds. Ultimately this will call for very difficult choices to be made. Actions resulting from these choices are likely to compromise efficiency and effectiveness. Pathfinder must be very careful not to allow them to compromise clinical safety.

9.3. Pathfinder's Plan of Action.

Technical and Policy Considerations.

A. First trimester abortion must be considered in two phases since different conditions and needs apply.

Phase 1. Menstrual induction will continue to be a Pathfinder promoted technique, appropriate for early (up to 55 days amenorrhea) terminations. It is important because of its demonstrated applicability, acceptability, safety, effectiveness, and economy.

Pathfinder will continue to supply uterine aspiration kits containing syringes and flexible cannulae, particularly with a view to increase the number of physicians who understand the procedure, who in turn will be able to educate and motivate other providers.

Phase II. Later first trimester abortion (up to 13 weeks of amenorrhea) will also be promoted using dilation and rigid cannula aspiration, and other techniques of proven safety as they become available.

B. Second trimester abortion is recognized as being clinically important to certain individuals for special reasons. We do not oppose its implementation in indicated situations by trained providers. We do, however, recognize it as being less widely acceptable than earlier abortion, technically more difficult, more hazardous, more expensive to provide, and from the public health point of view, not highly effective. We do not intend to pursue its promotion.

C. Pathfinder will continue to emphasize the important linkage between voluntary termination of pregnancy and other components of comprehensive fertility services by:

I. Carefully planned and skillfully managed programs, first to help whole communities to understand that illegal abortion imposes severe penalties on the health of their poorest members, and second, to show them that in the long run clandestine abortions will be greatly decreased when women have acquired adequate alternatives (information and effective contraceptive services).

II. Providing easy access to safe procedures for voluntary termination within the first trimester of pregnancy, as a backup to contraceptive failure or in the event of unwanted pregnancy, using each occasion to introduce the woman to effective contraceptive practices as the preferable alternative to abortion.

III. Demonstrating to the public (through leaders of various segments of the community) that to provide voluntary termination of pregnancy is a humane step in the direction of women's rights, of improved health and well-being, and of eventual prevention altogether of the circumstances that force women to resort to abortion in the first place.

Types of Supportable Programs Include:

A. Abortion Training and Education. Pathfinder can make available intensive clinical training for limited numbers of selected providers at centers of excellence. Pathfinder can design and administer broad training programs in the use of appropriate technology for coordinated regional or national programs of service delivery. Pathfinder can support and sponsor regional or national conferences on abortion and can use these conferences to educate providers, policymakers, and other leaders by means of its own films and audiovisual and printed material on abortion epidemiology and techniques. Pathfinder can play a significant role in providing a variety of educational material including texts and audiovisual aids suitable for both faculty and students of medical schools.

B. Abortion Policy. The Fertility Services Division, project directors, and evaluation consultants will continue to collect and present data, identifying patterns of abortion utilization which would convince leaders of the cultural acceptability and public health advantages of voluntary termination of pregnancy. The Fertility Services Division will closely coordinate its efforts in these kinds of activities with the Population Policy Division to ensure maximum effectiveness for all presentations.

C. Abortion Services:

-Clinical services for women who have undergone a clandestine, septic, or incomplete abortion. Such clinical facilities are not an ideal solution, but may be an acceptable alternative to the proscribed integrated approaches; they can help in family planning recruitment and can provide positive health benefits.

-Clinical services providing voluntary termination of pregnancy in a legal or quasi-legal status.

-Support for clinics that will offer voluntary termination of pregnancy in close proximity to multiservice clinics supported by others, and vice-versa, to support family planning activities in a community where voluntary termination of pregnancy services are being provided by others.

- Support for complete, exemplary clinical services totally with private funds where necessary; (this implies voluntary termination of pregnancy plus other family planning and maternal and child health services).

- Introduction of new technology by supplying necessary commodities and coordinating the distribution and marketing of these commodities with training efforts.

Sites

It became very evident during the Advisory Committee discussion that even broad geographic conclusions were difficult to apply to the topic of voluntary termination of pregnancy. The consideration of abortion delivery is very complex, dealing with technology, law, policy, religion, and the extent of development in the areas. The opportunities for working with this technique must be carefully assessed locally.

Conclusion

Voluntary termination of pregnancy constitutes a very important component of comprehensive fertility services and Pathfinder must include it in its activities.

Voluntary termination of pregnancy relates very closely to the concerns of Pathfinder's Women's Programs Division and Population Policy Division. Coordination of their activities with the Fertility Services Division will be essential.

Major external constraints to extension of voluntary termination of pregnancy exist in training needs, logistics, and policy areas. It makes sense for Pathfinder to work on these constraints in an unrelenting manner, but caution must also be exercised. Great sensitivities can be generated by too vigorous approaches to voluntary termination of pregnancy--sensitivities that can be counterproductive to the total family planning effort.

Funding for voluntary termination of pregnancy continues to be a major internal constraint. Attractive projects will continue to be identified, developed, and promoted.

Pathfinder's policy with respect to inquiries about its position and involvement in abortion is to state that:

"If a specific request comes for support of voluntary termination of pregnancy, and if Pathfinder finds that the project can and should be supported, then Pathfinder will respond with private funds in ways acceptable to the people on whose behalf the request was made."

APPENDICES

RESPONSIBILITY FOR PROJECT EVALUATION

R = Responsibility for decision
S = Responsibility for staff work

	Evaluation Review Committee	Project Administrator (REG or DIV)	Division
Quarter I		S	
Quarter II	R,S		
Quarter III		S	
Quarter IV	R,S		
Update for Renewal		S	
Designation of criteria for evaluation of results		S	R

Explanations:

1. The project administrator will review quarterly reports for Quarters I and III. The project administrator is responsible for determining the need for remedial action and may request that the project appear at Evaluation Review Committee.
2. Project performance will be reviewed in Evaluation Review Committee after Quarters II and IV. The ERC Coordinator will review, compile, and summarize relevant information for the Committee on the Performance Evaluation Worksheets.
3. When projects are up for renewal, the project administrator prepares a summary of the performance for PHM. The project administrator may choose either to use the Performance Evaluation Worksheet from the Quarter II ERC meeting (usually there is no later quarterly report available) or to update the Project Evaluation Worksheet.
4. The procedure for designating criteria for evaluation of results remains unchanged from the assignment of responsibilities in the Flow Chart of the FSD Working Document.

DATE _____

PERFORMANCE EVALUATION WORKSHEET

PIN _____

PROJECT TITLE _____

_____ Quarter

Beginning _____

Ending _____

ACHIEVEMENT INDICES

Objective/Activity to be evaluated	2) No. Programmed for Project Year	3) <u>Quarters</u>				4) Cumulative No. carried out to date ____	Achievement
		1st	2nd	3rd	4th		

EVALUATION REVIEW COMMITTEE
ASSESSMENT OF PROJECT PERFORMANCE

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Date: _____

Reference: PIN _____ TITLE: _____

QUARTER II, beginning _____ and ending _____

PRESENT:

Project Progress:

A. Goals.

B. Objectives.

Action Required:

Renewal Implications:

CLEARANCES:

Fertility Services Division _____

Women's Programs Division _____

Population Policy Division _____

Regional Director _____

cc: International Staff Member

EVALUATION REVIEW COMMITTEE
ASSESSMENT OF PROJECT PERFORMANCE

APPENDIX V

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Date: _____

Reference: PIN _____ TITLE: _____
 QUARTER IV, beginning _____ and ending _____

PRESENT:

Project Progress:

A. Goals.

B. Objectives.

Action Required:

Wrap-up:

CLEARANCES:

Fertility Services Division _____

Population Policy Division _____

Women's Programs Division _____

Regional Director _____

cc: International Staff Member

