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A NEEDS ASSESSMENT OF THE VOLUNTARY SURGICAL CONTRACEPTION PROGRAM IN JAMAICA

Prepared for USAID/Kingston
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ACRONYMS

RAM	Repair and Maintenance Unit
PVO	Private Voluntary Organization
CPS	Jamaica Contraceptive Prevalence Survey, 1983
USAID	United States Agency for International Development Mission
NFPB	National Family Planning Board of Jamaica
GOJ	Government of Jamaica
UWI	University of the West Indies, Mona Campus, Kingston
JFPA	Jamaica Family Planning Association
MOH	Ministry of Health
VJH	Victoria Jubilee Hospital of MOH
VSC	Voluntary Surgical Contraception
AVS	Association for Voluntary Sterilization AID Contractor
JHPIEGO	Johns Hoskins Program for International Education in Gynecology and Obstetrics

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EXECUTIVE SUMMARY

This report is the result of a request from USAID/Kingston for a team to visit the country and conduct a needs assessment of Voluntary Surgical Contraception including a description of the system, client demand, service delivery constraints, and suggestions for improving and expanding the current service delivery system.

The two person team spend three weeks in Jamaica during November 4 - 25, 1985. They visited 8 of the 23 facilities where VSC services are delivered. They also held discussions with key individuals in the National Family Planning Board, the Ministry of Health and the Jamaica Family Planning Association.

The team found that the demand for this method exceeded the current delivery systems ability to meet. The major constraints were identified as shortage of silled nursing staff in counseling and client recovery, shortage of supplies for procedures, non utilization of new techniques aimed at providing safer and more effective service, need to improve medical supervision and monitoring and medical screening. The lack of male education and service was identified as a constraint. Althrough availability of operating theatre time was sufficient in those facilities visited this should be addressed in conducting the assessment of the service network.

Based on these findings the team focused on how the system might be improved. It was suggested that the first step is to conduct an assessment of the system as soon as possible, that 10-12 of the facilities be selected for special support based on their potential for for expanding safe V.S.C services.

The report contains an estimate of costs of VSC procedures and presents several ways of providing financial support including service provider payments, institutional support on a cost sharing basis, and cost sharing between the donor, the institution providing the service and the client.

The report also suggests ways of increasing male VSC procedures through education, counseling and service.

I. Description of Current Status of Voluntary Surgical Contraception (VSC) Activities in Jamaica

according to the 1983 Contraceptive Prevalance Survey. The majority of VSC services are provided in the public sector through Ministry of Health facilities (20) with referrals eminating from the perepheral health clinics (340) where all methods are offered. The Jamaica Family Planning Association operatres two clinics, one in Kingston and the other in St. Ann's where VSC services are offered.

VSC's are provided in government hospitals free of charge . Post-partum procedures are usually provided on a routine basis while interval procedures are scheduled on a twice a week basis. More then two thirds of VSC procedures are post-partum, the balance being interval. There is a variation of techniques used depending primarily on the discretion of the attending doctor. There are no norms or standards currently in use governing counseling, medical screening and anesthesia and sedation practice. VSC has shown a marked increase over the past 4-5 years (See Annex 2) and demand will probably increase over the next ten years.

I.1 Demand for VSC Services in Jamaica

Indications are that the demand for VSC exceeds the current service capability. This is based on several factors. One is the waiting time for scheduling procedures at major facilities where VSC services are available. The fertility unit at the University of the West Indies which has a capacity of approximately 80 - 100 procedures a month has a six week waiting period. The Victoria Jubilee Maternity Hospital which specializes in post partum VSC's is currently performing between 70 - 100 procedures a month and has a request for double that amount which it cannot fulfill. Clients are either told to obtain the services at a facility closest to their home on an interval basis or must face a wait of at least one month if they return to V.J.H. with no assurance that they can receive the service. This could result in many unwanted pregancies of women awaiting service. Other facilities have similarly long waiting periods.

Another indicator of demand is a steady increase of procedures performed each year. In 1980, 2,682 procedures were reported and in 1984, 6,587 procedures were reported: a increase of 146 per cent.*

The other service statistics supporting the unmet demand theory are the records showing the number of referrals and the number of procedures performed during the years

were made and 2,814 procedures done showing that most (75 percent) clients were referred through the health infrastructure. In 1983 the number of referrals were 2,170 while the number of procedures performed were 5,896. The number of clients referred was only 37 percent showing that many clients sought services through non-referral channels. This "off the street" utilization of services is a strong indicator of demand.

Another less precise indicator of demand is to survey women asking if they have reached their desired family size. VSC is a method well designed for this purpose.

The 1983 Jamaica Contraceptive Prevelance Survey contained questions to fecund women in union asking if they wished to have more children. Over 50 percent indicated that they wanted no more children. The study also revealed that 31 percent of current union women 15-24 years said they wanted no more children.

A rough estimate of current demand based on information contained in the 1983 CPS and population estimates can be done using as a base the estimated number of 568,000 women in age group 15-49 of which 70 percent are in union according to the 1983 CPS. Using this base we arrive at a figure of 397,600 women at risk. The age group distributions of these eligible women coupled with the proportion desiring no more children according to the survey are indicated in Table I.

TABLE I

NUMBER OF WOMEN DESIRING NO MORE CHILDREN
AGE 15-44

15-19	31,717
20-24	26,696
25-29	46,211
30-34	23,339
35-39	37,056
40-44	30,016
45-49	NOT INCLUDED
TOTAL	195,053

If these figures were taken as a measure of VSC needs they would include 51 percent of all women at risk.However, using the current proportion of women desiring this method approximately one out of five couples would have the determination and resolve to actually opt for VSC. Even so, this is a figure of 39,011 or an additional 16,290 procedures necessary to meet current demand. Of course thisfigure is illustrative and subject to a complex set of conditions such as counseling and available service points as well as cultural ad socio-economic factors which affect method use. However, it is probably not unreasonable and offers some rationalle for computing demand. It should be noted that some of the women wanting no more children are using temporary methods. Of the women age 35 and over, about 6,000 are using oral contraceptives which in some cases can present a health hazard and have to be considered at high risk.

I.2 Accompishments

The Jamaican Government has made tremendous strides in the Family `Planning Program during the past 21 years.The current goal, according to the NFPB, is to contain the population to within three million by the year 2,000.Presently indications are that, even if the Family Planning Program continues its momemtum the replacement level fertility, 2.1 children per women, will be difficult to reach. The current total fertility rate is 3.3 children per women having declined from 6 per woman in the late 1960's.

The 1983 Contraceptive Prevalance Survey (CPS) indicated that 51 percent of women in current unions were contracepting. The Pill was the most popular method(37.5 percent) while female VSC was the second most popular(21.2 percent).Comparing the 1983 survey with earlier surveys(1975 annd 1970) the proportion of women using these two methods remain about the same.

This report will concentrate on VSC activities. The actual numbers of procedures over the past 4-5 years has shown a significant increase. The following table shows the number performed over the time period 1980-1984 and the annual percentage change.

TABLE II

NUMBER OF STERILIZATIONS PERFORMED IN PUBLIC INSTITUTIONS 1980-1984

YEAR	NO OF PROCEDURES	ANNUAL % CHANGE
1980	2,682	-
1981	3,064	+14.2
1982	4,492	+46.6
1983	5,896	+31.3
1984	6,587	+11.7
TOTAL	22,721	-

Source: NFPB, 1985

As noted in TABLE II, the 1984 percentage increase was less than the previous two years probably indicating that actual service capacity was being reached.

VSC, as well as other family planning methods, is supported by a broad based and intensive public information program using all available media channels. The NFPB also provides supplies to the Ministry of Health Centres (approximately 380) as well as coordinating family planning activities, including VSC, amongst PVO's. In terms of VSC there is not much private sector activity involving private physicians and clinics, in part due to the paucity of these servicess. The number of private physicians currenntly practicing is estimated to be 400. The MOH policy is to allow private practice outside of working hours, a practical policyconsidering the shortage of doctors. This shortage is aggravated by the medical " brain drain" with many trained practitioners emigrating. For example, the medical school graduated 100 last year with only 50 remaining in Jamaica to practice after graduation. The nursing situation is better but discussions with nurses indicated some nurses are leaving the public sector to find employment in other fields due to lack of opportunity for advancement and low salary levels.

In terms of locations where VSC services can be obtained there were 23 institutions providing this service in the country in 1984. They are fairly well distributed with the exception of the western part of the country. Most of the facilities are public institutions with the exception of two

clinics operated by the Jamaica Family Planning Association. The NFPB also directly operates one clinic and plans to establish three more pending available resources.

Included in the facilities are two facilities, called Fertility Units , one at the University of the West Indies, the other located at the Victoria Jubilee Hospital, the countries largest maternity hospital. These two clinics have accounted for 1,649 procedures in 1984, or about 27 percent of the total.

The types of female VSC's include culdoscopy, laparatomy and minilapratomy. Eleven of the 23 institutions provide laproscopic methods, one also culdoscopy and the balance mini laparatomy.

Equipment repair and preventive maintenance is provided by the Repair and Maintenance Unit (RAM), operated by the NFPB which was established in 1979. This unit is staffed by two trained technicians. Preventive maintenance is provided to each of the 19 laparoscopes and laprocators on a routine seven week schedule.

The RAM Unit has one "loaner" laparoscope which is available to institutions while their unit is undergoing repair. According to discussions with RAM staff there is a current need for additional spare parts.

There is no record of the number of VSC's done in private medical facilities but it is known that some are done at these locations.

I.2.1 Female VSC Activities

Women are the recipients of VSC's in Jamaica. As noted previously three techniques are in use, laproscopy, minilaprotomy and culdoscopy. The latter is used principally in the fertility clinic of the U.W.I. hospital. In general terms the laparoscopic method is used in the larger hospitals. Out of the total procedures reported in the public sector by year, in 1983, 31 percent of total procedures were laparoscopic, in 1984, 34 percent were this method, figures were not available for 1985.

Most minilap procedures are post-partum but some interval procedures are done. General anesthesia is used in the majority of cases.

As noted previously there are 23 service sites for female VSC's with 11 offering laparoscopy. High parity and high risk women are encouraged to use this method at the time of their delivery; it should be noted that a great majority of

births in Jamaica are in hospitals. Having the procedure done immediately after birth (12 - hrs) is easier both for the women and the doctorand requires little more recovery time. However, available staff supplies and operating theatre time limits to some extent, the amount of post-partum procedures which are done.

Table I in the previous section shows the increase by year of the number of procedures performed. There is no formal policy declaration on age and parity which bar women from obtaining VSC services in Jamaica. However, the average age of a VSC acceptor is still in the 32-34 age bracket with five children (see Annex 5). According to statistics showing the births attended in the Victoria Jubilee Maternity Hospital, the country's largest maternity hospital, in 1984, 17.61 percent of births occurred in the 30-49 age group while 30 percent occurred in the 15-19 year age group. The average age of the women giving birth was 23.58 years (see Annex 5). These data indicate that more attention should be paid to women in the younger age groups who wish to limit family size if over-all fertility is to be significantly reduced.

In summary the VSC remains the second method of choice by Jamaican women according to the 1983 CPS and great progress has been made in satisfying the demand with a total of 22,721 VSC's having been provided from 1980-1984. The training of service providers, equiping hospitals and establishing a workable referral system are considerable accomplishments.

I.2.2 Male VSC Activities

To all extents and purposes male methods in Jamaica are limited to coitus interruptus, abstenance or condoms, none of which are very popular. In all of Jamaica in 1985, according to service statistics, there were only 20 male VSC's performed.

The reasons given to the team for the lack of male acceptors varied from acceptor indifference, lack of knowledge about the method, to deep seated fears of loss of sexual power and strength. In any event, there is no empirical evidence to substantiate these claims. In the "Male Responsibility" study done by the NFPB eleven percent of the male respondents indicate a willingness to accept the method.

In terms of service availability none of the physicians contacted indicated that they had received training in male VSC and had ever recommended it. It is not included in the normal counseling procedures. Thus it is not suprising or

startling that little has been accomplished in the area of male VSC in Jamaica.

I.2.3 Training in VSC

The training of doctors in surgical techniques for tubal ligations puts major emphasis on laprascopic techniques rather than mini-lapratomy although there has been some training in the use of mini-lap in post-partum and internal procedures. Most of the formal training in VSC has been done under the auspices of the JHPIEGO project. The training in the early stages of VSC was with electro-coagulation and later applying the ring, but both methods of tubal ligation are being used. Most of the JHPIEGO trainees are in the public sector in MOH hospitals and are Senior Medical Officers and consultants in various specialities.

In recent years the Fertility Unit at the UWI has had a major role in training and retraining of health personnel in techniques of VSC as well as special training programs in family planning, and laprascopic and culdoscopic techniques with assistance from JHPIEGO, Republic of Germany, NFPB and the MOH. The UWI has a program to train nurses proposed by NFPB, with major emphasis on management of temporary methods but some training in VSC services has been provided to those doctors wishing to obtain this training. The Fertility Unit from 1982 - 1984 has trained for the NFPB 24 doctors, and under the JHPIEGO project 10 doctors and 40 nurses in family planning (see Annex 9). The OB/GYN residents also rotate through the clinic doing laprascopy.

The other institution which provides the most training opportunities in VSC is the Victoria Jubilee Maternity Hospital where OB/GYN residents receive training in both internal and post-portum tubal ligations using mini-lap. According to the OB/GYN consultant at VJH some of those trained remain in Jamaica and others go into private practice. A small percentage remain to work in the 23 MOH institutions where VSC services are offered.

The doctors responsible for providing VSC services in the institutions visited were trained in VSC techniques, have experience and are well known in the community in which they work. They also appeared to be motivated to provide VSC service.

In some cases the doctors could benefit from retraining in newer VSC techniques including counselling, informed consent, and improved safety practices in VSC.

It was observed that there was a great variation in medical screening, laboratory test requirements, client counseling, informed consent, length of hospitalization and anesthesia regime, tubal ligation techniques, record keeping, service reports, and follow-up. In terms of male VSC there is no program to train doctors in vasectomy and very few of these procedures are performed.

I.3 Constraints

There is sufficient evidence available to indicate that VSC activities, in spite of considerable progress during the past years, are restricted by several factors which are impacting on the increase of the use of this method. As indicated earlier most of these constraints are service oriented rather than demand oriented.

I.3.1 Financial Problems

Jamaica has suffered severe economic setbacks during the past several years. The decline in GOJ revenue has affected governments ability to maintain past levels of expenditures. The budget squeeze has affected the MOH's operational budget of which personnel costs are a substantial part. The result has been that some employees, particularly community level workers are being let out and no new posts can be established.

The currency devaluation which took place over the pastseveral years reduces the buying power of both the organization and its employees who have to struggle on their salaries. The MOH in an attempt to conserve funds is considering closure of some of its 380 facilities.

In 1982 the NFPB faced with a demand for VSC services decided that it would be more cost effective to equip existing facilities in the MOH and train staff to do VSC's rather than building special VSC's facilities. The problem was that operating room staff were not overly receptive to additional work in addition to their regular heavy schedules. It was decided to request USAID/Kingston to provide payments to service providers of J$50.00 per procedure. This amount in 1982 was equivalent to US$28.00 at the exchange rate of US$1.00 = J$1.78. The current equivalent based on todays exchange rate of J$5.61 - US$1.00 is US$8.91. This amount has to be divided between the surgeon, the anesthesiast, the O>R> nurse and the porter. This service provider payment at its current level may not be sufficient to encourage service providers to continue their efforts at the same level as in the past.

Lack of MOH budget also affects the amount and availability of medicines and supplies necessary to do VSC's. At the sites visited staff stated that lack of surgical gloves and other supplies resulted in not carrying out more VSC's.

The inability of the NFPB to increase its staff to include field staff impacts negatively on two critical elements of the VSC program, supervision and counseling. For example, in site visiting the team discovered that facilities doing VSC's did not have sufficient numbers of medical history and other forms provided by the NFPB to permit adequate monitoring of VSC activities. The counseling and referral of VSC potential acceptors at all levels of the health system needs strengthening through training and continuing guidance to ensure that not only are the acceptors well selected and informed, but that initial medical workups can be done at the local level, saving time and money at the facility where the procedure is performed. Currently there are no positions for skilled field staff to assist personnel in improving capability in counseling and referrals.

Retraining of doctors and nurses in new and improved VSC techniques is necessary but funds are not budgeted for this purpose affecting the quality of services.

I.3.2 Personnel and Facility Restrictions

Jamaica has 29 government hospitals with 6,062 beds and 6 private hospitals with 300 beds which represent 3 beds per 1,000 inhabitants. Twenty three government hospitals and two private clinics reported doing 6,587 procedures in 1984, the number ranged from 25 to 1,051 in these institutions during that year (see Annex 3).

Overall review of the medical sector in Jamaica indicates a comparatively low per capita ratio of doctors (1:2900). The number of nurses is slightly larger. There is a total of 800 physicians currently practicing in Jamaica, 50% in the public sector and 50% in the private sector. There are 380 MOH facilities of which 23 of the 29 governmental hospitals provide VSC services. These are fairly well distributed throughout the country.

Most of the hospitals visited had dedicated space for VSC although one facility didn't. In this particular case the regular operating theatre and the post-partum ward forrecovery were used because there was a shortage of nurses. The other facilities have access to the operating theatre so there didn't seem to be a constraint in this regard. But as regards the recovery area the lack of space for this purpose presents some problems. This was very noticible in Spanish Town, where the post-partum ward was

overcrowded with in many cases, two women and their babies occupying one bed.

In relation to equipment and supplies, the major restriction is the availability of surgical gloves, sterile linen, and other consumable surgical supplies. There is no major prlblem with equipment and maintenance, however, it was mentioned that a shortage of spare parts for laproscopes exists.

Of the 800 doctors working in Jamaica 388 worked in MOH institutions in 1984. These doctors are authorized to have private practices because of the shortage of doctors for the population of Jamaica. Fortunately, there are some 60 doctors reporting performing VSC procedures, therefore this number does not present a major problem with respect to VSC service in terms of numbers and motivation. However, the doctors could benefit greatly from seminars or workshops and other retraining programs. The use of simpler and more safe techniques of VSC including use of local anesthesia and sedation, post-partum and interval mini-lap should be encouraged. Also improvements could be made in client selection, counseling, information and follow-up and care of major complications in the VSC procedures.

The major staffing restrictions apply to nursing personnel necessary to assure safety and quality. The restriction is more serious regarding nurses for counseling and in the recovery area. Additional staff is needed to provide adequate client assessment, counseling, informed consent, voluntarism and monitoring the VSC clients during and after the procedure.

There are only nine (9) salaried and trained nurse educators, most of them in the larger hospitals, with 23 facilities providing VSC services it means that client counseling must be done prior to admittance and it is possible that this is not sufficient in all cases due to the lack of qualified personnel for this purpose.

Another important constraint is the current practice to keep the VSC clients in the facilities for 24 hours and sometimes for up to 48 hours. The NFPB, and the MOH should reinforce the idea of outpatient services in all the institutions doing VSC procedures, including the post partum tubal ligation group.

I.3.3 Administration and Management

It is recognized that managing a multifaceted family planning program such as currently exists in Jamaica is not an easy task. The NFPB has the legally constituted task of

coordinating all family planning activities in Jamaica. In addition under its arrangement with the MOH and other service delivery agencies it acts as a supply arm in terms of family planning supplies and equipment. It deals with donors supporting all aspects of family planning activities. It processes VSC service provider fees and accounts for funds directed towards family planning activities. It also collects VSC service statistics and processes them.

VSC procedures because of the fact they are surgical in nature require medical monitoring to a larger extent than other methods. With 23 establishments participating in VSC activities throughout the country insuring that quality control is matained not only in medical terms but incounseling and record keeping requires extensive field visits. It is believed that more attention in this area would improve service.

One of the major constraints identified during the visit concerned the type, amount and level of counseling provided. This, by its nature, does not only apply to VSC but to all methods of family planning. Adequate counseling is crucial in assuring client confidence and satisfaction. It is doubly important for VSC clients because of the methods finality and the unstability of sexual unions in Jamaica. These factors must be taken into consideration to ensure that the potential acceptor thoroughly understands the ramification of his or her action and has the determination and resolve to accept the consequences. The assessment team noted some "no shows" at the scheduled time of the procedure for example, when the team visited the UWI Unit two of the clients did not appear on the scheduled day and a few requests to "untie the tube" after the procedure which indicates improved counseling skills would better prepare the client.

Within the public sector, particularly in the MOH, coordination at the central level appeared to be excellent. The NFPB coordinator, who has an office in the MOH, is active and knowledgeable. In some Parishes the team visited, there seemed to be a pronounced lack of coordination as regards VSC services, and probably other methods also. The hospital and the referral clinics did not appear to have routine discussions and there were infrequent contacts between the OB/GYN department and other institutions in the health service. In some instances there did not appear to be a structured pyramidal system offollow-up and clients in these cases are not provided written post-operative instructions when they are discharged. Some clients must travel long distances if they return to the site of the procedure. The NFPB does not have

a coordinator or field staff at the regional or Parish level to monitor VSC and other family planning methods.

VSC's are not routinely reported in the NFPB's service statistics which isolates it from the attention of health personnel and others involved in family planning activities depriving them of the knowledge of how their particular areas are faring in terms of referrals and follow-up.

Family planning in Jamaica, as in most countries, started asa private initiative. The integration of the NFPB with the MOH in 1974 involved a long period of re-adjustment on the part of both agencies involved. There is still some feeling that in terms of output that a vertical program might have produced better results. This might be true in the short term but over longer periods integration will pay dividends. However, integration does not imply that one agency swallows the other and the NFPB because of its role as a coordinator of all population efforts should have a certain measure of autonomy as regards new initiatives in VSC's activities as well as other family planning methods. The team believes that, over time, this will be worked out. But, in the meantime the monitoring role must be shared, with the leadership role resting with the NFPB.

II. Suggested Future Strategies

Improvement and expansion of VSC's service capability will require an action plan on the part of all agencies involved in this element of the family planning program. This report will focus on this critical need.

II.1 Expansion of Services

There are two approaches to be considered in any service expansion. Basically, these involve; 1) including more service outlets or, 2) increasing production of current facilities. The team believes that at this moment the latter approach is the most effective.

The first suggested step is for the NFPB, the MOH and USAID to conduct an assessment of the 23 current institutions to ascertain service potential. The assessment should include such things as: 1) dedication and availability of staff including trained doctors, nurse-educators and counseling staff; 2) dedicated space and equipment available; 3) watershed area or location in regard to the number of population to be served; 4) client assessability; 5) number of referral facilities and 6) past performance.

On the basis of the assessment the next step would be to select ten or twelve of the facilities to receive special attention. From these facilities two should be selected for

training sites, the UWI for laproscopy and VJH for mini-lap.

The next step is to determine what the selected institutions require in terms of additional support. The discussions with personnel at the sites visited indicated that operating room supplies, medicines and nurses for recovery rooms, and nurse educators for counseling of both interval and post-partum clients were urgently required.

This type of staff support will require that contract staff or nurses paid by session be obtained as the job freeze will not permit permanent posts to be established in most cases. Supplies should also be provided either by local procurement or off-shore whichever is determined to be most cost-effecitve and timely.

It should be noted that this type of support lends itself to institutional reimbursement rather than the current method of payment by procedure. The balance of the institutions should not be eliminated but be placed on a list for future additional assistance when and if they meet the qualifications established by the assessment.

In terms of additional technical and supervisory support mechanisms, if this is to be provided by the NFPB, it should either increase staff or re-configure its staff functionalrequirements to provide, at least one physaician and two senior nurses, one knowledgeable in VSC operational methods and the other in counselling procedures. This staff should have sufficient transportation provided to facilitate both routine monitoring visits and technical assistance upon request. USAID, the MOH and the NFPB may consider also the part-time services of a well respected and senior local consultant as a technical advisor.

VSC service statistics should be incorporated in the over all reporting system both by NFPB and the MOH hospital reports. The six private hospitals while not representing a major resource should be encouraged to participate in providing VSC services. In discussions with private physicians it was noted that bed occupancy rates were usually low. With this in mind consideration should be given to renting space and paying staff on a session basis to handle client overflow from public medical facilities. The JFPA probably would be best agency to coordinate this activity. It is believed that the aforementioned improvements in the delivery system can result in the number of VSC's to be raised to 10,000 per year divided between post-partum procedures and interval in the following proportion - 6,000 post-partum VSC and 4,000 interval procedures.

II.2 Strengthening Male VSC Services

Male VSC procedures are practically non existent as reported in the family planning service statistics. This, according to conversations with service personnel, is because of reluctance to undergo the propcedure. Male procedures are neither covered in public education or counseling procedures at the present time.

The NFPB has made an important step in encouraging male participation through it's male responsibility project which is managed by a full time male educator. Although the educational approach is indirect in nature it constitutes a good first step in encouraging male participation in the family planning process.

The next step should be a more directive educational approach in which VSC is included as a male method. Male VSC as a method should be mentioned in counseling clients and both partners in the union should be encouraged to attend counseling sessions.

A male knowledge and attitude study should be conducted to identify the fears, prejudices, and other barriers to acceptance of vasectomy as a method for family size completion. The study need not be a national probability or household sample but could be done both with men and their spouses in the health facility by skilled research personnel. It will not be a completely valid sample but canprovide, at a reasonable cost, information which can be utilized to develop educational and counseling techniques carefully patterned to fit the local situational forces affecting male acceptance. With an unemployment rate of 28 percent men will be influenced by economic conditions affecting their families.

Male VSC is a procedure which can be done as an outpatient procedure or in a doctors office, it is simple to do, safe to the client, and satisfactory. The three S's certainly apply: Simple, safe and satisfactory.

Male VSC's will not represent a major family planning method in the near future but it is not too early to inform the population about its availability and to train some doctors in the technique.

II.3 Alternate Financial Arrangements

Before analysis of the two alternatives for financing VSC in Jamaica it is necessary to estimate the cost of a VSC in Jamaica. This is done in U.S. dollars at Jamaican prices and can be shadow priced to reflect currency fluctuations. This estimate breaks the cost down into 7 categories; 1) space; 2) equipment; 3) medicine and supplies for each

procedure; 4) personnel costs for each procedure; 5) support personnel costs; 6) office supplies and equipment; and 7) utilities and other costs. Of these categories 3 and 4 do not vary whether you do 1 or 1,000 procedures, the other categories are subject to economy of scale. Included as costs are depreciation of buildings and equipment. All costs with those not associated with each procedure are computed on an annual basis.

ESTIMATED COSTS*

PROCEDURE	COST FOR EACH PROCEDURE
Medicine and supplies	$ 9.00
Personnel Costs	$ 22.50
TOTAL	$ 31.50
Non Procedure Costs Space Requirements (33 yr. straight line depreciation)	$ 3,000.00/year
Equipment (5 yr. life)	$ 3,600.00/year
Support Personnel and services	$17,500.00
TOTAL	$21,100.00

* The breakdown of the various cost elements are detailed in Annex 11.

In addition to cost reduction, there is another advantage to doing more procedures per month in that the doctor becomes more skilled through practice.

For purposes of analysis a range of number of procedures per facility was selected. The range, based on number of procedures possible according to past performance ran from a minimum of procedures 25/month equal to 2,000 procedures/year. At 25 procedures a month it is more cost effective to transport acceptors to the closest sites where a larger number of procedures can be performed. Using these cost estimates the range of costs per procedure are as follows:

	200 procedures/year	2,000 procedure/year
Space & Equipment	$33.00	$ 3.30
Support Coss	$29.00 (17000/3x200)	$ 8.75
Fixed cost/procedure		
Personnel	$22.50	$22.50
Medicine & Supplies	$ 9.00	$ 9.00
TOTAL	$93.50	$43.55

This report will address several ways to provide financial assistance through USAID sources and each has its advantages and disadvantages. Which ones best suits the Missions's portfolio is a matter which ultimately rests with the Mission.

A. Method one - Service Provider Payments by Procedure

This method is to continue at the current level J$50 or increasing it, as requested by the NFPB to J$100, the direct payments divided between doctors, nurses, anesthesists and porters for each VSC performed. The advantage of this method is that you get what you pay for. Payment is made by the NFPB in the names of the persons providing the service. The payment should be made on the receipt of a copy of theinformed consent form which shows that the client was informed about the operation and its consequences, other methods available and agreed to have it done by his/her free will. However, the team found in their visits that many of the facilities were not using this form and payment was made on the basis of the number of procedures reported. Under these conditions payment by procedure carries with it an element of political risk whereby the allegation could be made that clients were either ill-informed or coerced to accept the operation.

It is inevitable that given the unstable sexual unions present in Jamaica and for various other reasons, a person might regret the decision to opt for this method. So extra precautions should be taken to minimize this possibility.

The direct payment to individuals also can create personnel problems in the institutions where the payments are made. Remarks were made to the team that some persons were taking the payments while others equally qualified were denied the opportunity to participate.

Another great disadvantage to this payment by procedure method is sustainability. If, for whatever reasons,

payments are discontinued, the service providers already overburdened with work might not readily provide the service to the extent demand required, causing delays and unwanted pregancies.

The final consideration is how this method of payment by procedure relates to AID policy. In countries such as Bangladeish service provider payments are being paid by government and in Nepal USAID included in its aid to the government funds for this purpose. However, in the latter case USAID/Katmandu is attempting to extracate itself and let the Nepalese government take over this responsibility.

In any event payment by procedure can be a problem, it seems to the assessment team, if paid as an incentive to individuals.

B. Alternative number one - Institutional Reimbursement

This method involves the pro-rating of costs for providing VSC services. This would include all costs related to VSC services and would not be paid on a procedure basis. However, in the request for support the institution providing the service would be required to provide, as an objective, estimates of the number of VSC's it can provide annually or during the life of the agreement. Periodic adjustments could be made according to progress reports. USAID or NFPB could either pay in cash, or in cash and some equipment repair and spare parts and supplies such as surgical gloves and medicines which could be distributed through NFPB's supply channels which are currently operative.

The cash could be used by the institution receiving support for personnel costs to employ necessary skilled staff over and above the normal salaries, such as overtime, also additional personnel through personal service contracts. Extra administrative costs could also be paid. The local institution could absorb some of the costs. The pro-rating could be done with the donor decreasing support as the receiving institution becomes able to absorb additional costs or find funding from the government, the community, or some cases client donations and fees.

The disadvantage is that the costs may be higher than only paying service providers incentives. Another is that it may require periodic auditing to see if the procedures are actually being done. The agreement should contain provisions allowing for supervision and client satisfaction follow up.

One advantage of this type of support mechanism is that you institutionalize the services as part of the institutions responsibility. Secondly, the VSC service is not centered in one person or group of persons but is the responsibility of the institution allowing more flexibility and improved services because more personnel can be involved and the institution feels it is it's own program.

The final advantage is that it prevents the political problem inherent with payment of service provider incentives directly.

C. Alternative Two - Client Institutional Cost Sharing

This would involve a three way sharing of costs between the donor, the recipient local institution and the client. This alternative might be applicable to private institutions as well as government. Clients sometimes contribute funds for other services in government medical institutions. The screening of poor patients for hospital free deliveries is done on the basis of food stamps which could be used to waive charges for VSC services.

The pro-rating can be much the same as alternative number one with the exception of the clients share which can be used as an emergency fund or to support special costs of the institution related to providing VSC services.

The client fee has the advantage of removing any doubt about possible coersion and shows that the person selecting this method voluntarily paid some of the costs. If a person pays for something he/she can demand good service which promotes quality services. A disadvantage might be that those unable to pay might not receive the service although they need it the worst.

There may be other alternatives but these are some of the obvious ones in the opinion of the team. The least favorable from the point of view of sustainability, institutionalization and political risk is the provider incentive.

II.4 Training and Supervision

II.4.1 Training

The re-training of medical and paramedical personnel of the VSC program is an important aspect to insure quality andsafety. In this regard it is urgent that the training of paramedical personnel and retraining of doctors that are providing VSC services be done. The training of paramedical personnel should include information, education, counseling

and voluntarism, and monitoring of clients before, during and after the VSC procedure, the proper filling out of forms and processing service statistics, recognizing complications and the steps required including referrals to the doctor and the norms and service policies of VSC activities. In addition they should know the objectives and the national policy of the program of family planning. The training of para-medics should include not only personnel new to the program but also those currently working.

Another training program should be conducted to provide an educational program for all personnel working in family planning clinics so that they can provide information and education about VSC to the community and make referrals to the institutions where service can be obtained.

For the 60 doctors that are currently working in the program a training program of continuing education should include the BSC program norms and policies, the criteria for client selection and care, making sure that the client is fully informed and consents to the procedure. The continuing education program should also include recent technical advances in safe VSC anesthesia and surgical techniques, what to expect concerning complications and how to deal with them, how to maintain required medical records and service statistics. Two workshops should be held in the next six months to acquaint the doctors working in VSC services with the aforementioned subjects. The NFPB should arrange these workshops and maintain a list of attendees of these training sessions. It is necessary that doctors working in the VSC program be certified as being conpetent to provide safe service and observe standards and norms of the program.

The VSC program should have two training centers for medical and para-medical personnel. The Fertility Unit of UWI is currently providing laprascopic training and should continue to render this service to physicians and give training to nursing personnel in VSC services.

The great majority of VSC procedures are post-partum tubal ligations. Mini-lapratomy is the most appropriate technique for this purpose and also can be performed in interval VSC procedures. The mini-lapratomy technique is currently successfully used at VJH and for this reason this institution should be utilized as the second training center in addition to UWI for teaching post-partum and interval mini-lap techniques under local anesthesia and sedation. The reasons for selecting VJH are: 1) there are sufficient cases for training; 2) the staff is well trained in this procedure; and 3) the hospital has adequate dedicated space and equipment. There is a critical need for additional nursing staff in order to utilize the space and equipment of

VJH. It's suggested that funds be provided to insure that these needs are met.

The training in both centers should have a formal curriculum which includes all aspects of VSC services from counseling to follow-up of clients. These two centers should also be able to provide technical assistance and follow-up to their graduates and training program should include necessary resources for this purpose.

II.4.2 Supervision

Adequate and continuing supervision is necessary to maintainsafety standards and a quality VSC service. This will permit the detection of problems affecting the program and lead to their speedy resolution.

It is recommended that supervision be reinforced within the VSC program allowing systematic visits to each of the VSC service facilities at least every two months. In addition to these routine visits the supervision should include provisions for technical assistance directd towards specific problems. The supervision should include all aspects and activities of VSC services such as client referral, information, education, counseling, informed consent, surgical procedures, anesthesia regime. post-operative care and record keeping including reports on complication. A report of each supervision visit should be required listing any possible problems and recommended solutions so that follow up can be done.

II.5 Dedicated Space, Equipment and Staff for VSC

When an institution has adequate dedicated space with sufficient staff and equipment it can provide VSC services to meet the demand. Because emergency surgery takes precedence over VSC, sometimes the operating theatre cannot be utilized for this purpose. When this is the case provision should be made to meet existing VSC schedules by extending hours and staff availability so that clients do not need to return for service.

The large facilities in Jamaica have, or are going to have, in the near future an area specifically constructed or remodeled to meet VSC surgical requirements including recovery space. They also have the basic and emergency VSC equipment needed to provide adequate and safe service. The problem in utilizing the full capacity of the dedicated space and equipment is the shortage ofnursing personnel and supplies.

In those institutions visited it was noticed that staffing problems were most serious in VJH and Spanish Town Hospital, if this problem was solved many more cases of VSC could be performed in these facilities.

As a training facility the Fertility Unit of UWI has sufficient resources to meet the demand but need to reprogram their case load to permit better utilization of the facility.

III.

ANNEXES

ANNEX 1 Organigram of NFPB

2 Nuber of VSC Performed in Public Institutions 1980-84

3 Number of VSC Performed by Quarter/Institution, 1983-84

4 VSC Referrals made and Number dealt with by Parish, 1980-1983

5 Number of Births by Age Ocurring in VJH, 1976-84

6 Teenage Births by Age at fast birthday occuring in VJH, 1976-1984

7 Total number of Sterilization Performed at Selected Hospitals by Age and number of living children, 1981-1984

8 Doctors Performing VSC by Institution, 1985

9 Health Staff Trained at UWI to present time

10 Forms Supplied by NFPB to Institutions performed VSC procedures

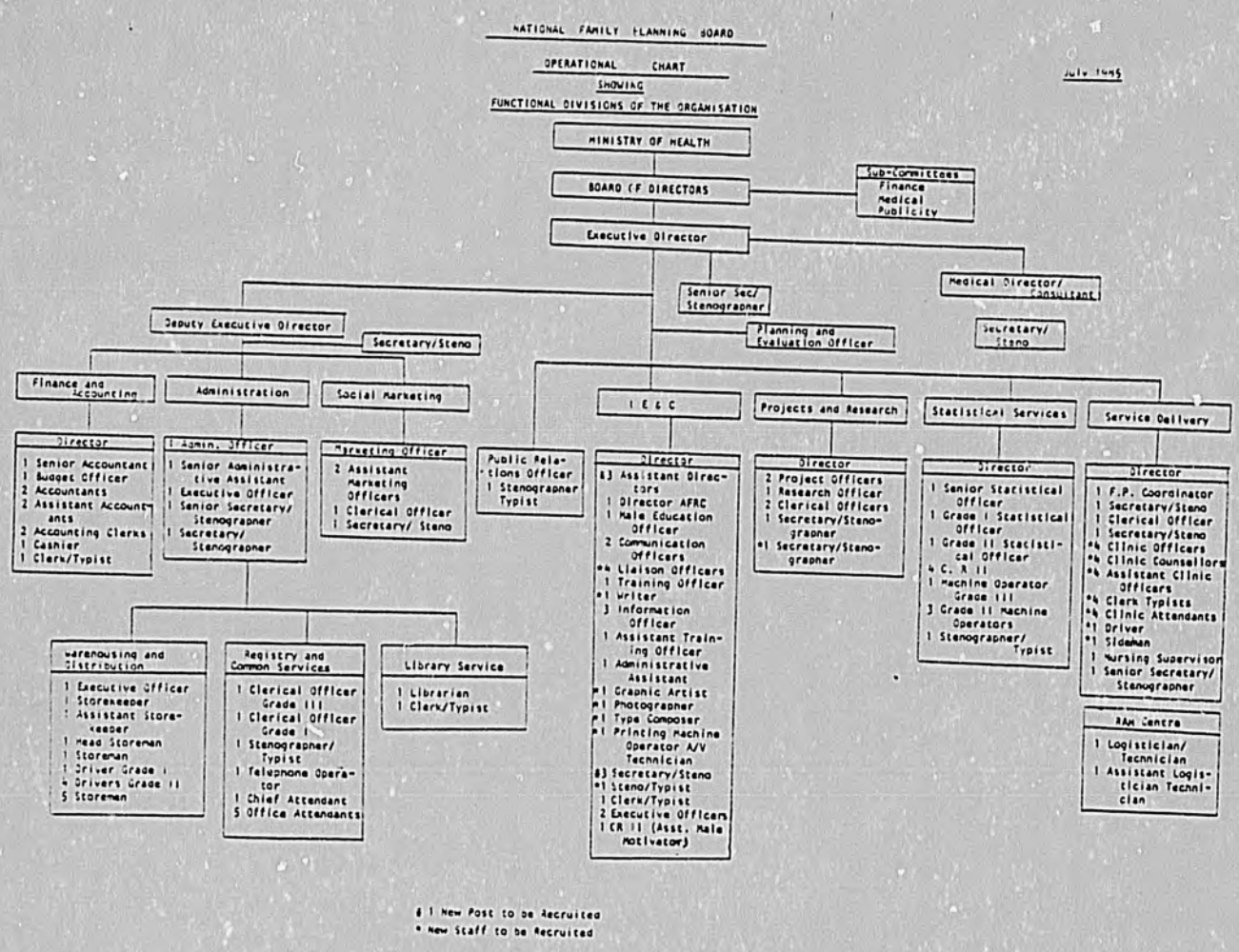
11 Detailed Estimated Costs at VSC in Jamaica

12 Performance of tubal ligation at health centre/Hospital

13 Contacts and institutions visited

14 Bibliography

ANNEX 1


NATIONAL FAMILY PLANNING BOARD
OPERATIONAL CHART
SHOWING
FUNCTIONAL DIVISIONS OF THE ORGANISATION
July 1985
MINISTRY OF HEALTH
BOARD OF DIRECTORS
Sub-Committees
Finance
Medical
Publicity
Executive Director
Senior Sec/ Stenographer
Medical Director/ Consultant
Deputy Executive Director
Secretary/Steno
Planning and Evaluation Officer
Secretary/ Steno
Finance and Accounting
Administration
Social Marketing
I E & C
Projects and Research
Statistical Services
Service Delivery
Director
1 Senior Accountant
1 Budget Officer
2 Accountants
2 Assistant Accountants
2 Accounting Clerks
1 Cashier
1 Clerk/Typist
Director
1 Admin. Officer
1 Senior Administrative Assistant
1 Executive Officer
1 Senior Secretary/ Stenographer
1 Secretary/ Stenographer
Marketing Officer
2 Assistant Marketing Officers
1 Clerical Officer
1 Secretary/ Steno
Public Relations Officer
1 Stenographer Typist
Director
&1 Assistant Directors
1 Director AFRC
1 Male Education Officer
2 Communication Officers
*4 Liaison Officers
1 Training Officer
*1 Writer
3 Information Officer
1 Assistant Training Officer
1 Administrative Assistant
*1 Graphic Artist
*1 Photographer
*1 Type Composer
*1 Printing Machine Operator A/V Technician
&1 Secretary/Steno
*1 Steno/Typist
1 Clerk/Typist
2 Executive Officers
1 CR II (Asst. Male Motivator)
Director
2 Project Officers
1 Research Officer
2 Clerical Officers
1 Secretary/Stenographer
*1 Secretary/Stenographer
Director
1 Senior Statistical Officer
1 Grade I Statistical Officer
1 Grade II Statistical Officer
4 C. R II
1 Machine Operator Grade III
3 Grade II Machine Operators
1 Stenographer/ Typist
Director
1 F.P. Coordinator
1 Secretary/Steno
1 Clerical Officer
1 Secretary/Steno
*4 Clinic Officers
*4 Clinic Counsellors
*4 Assistant Clinic Officers
*4 Clerk Typists
*4 Clinic Attendants
*1 Driver
*1 Sideman
1 Nursing Supervisor
1 Senior Secretary/ Stenographer
RAM Centre
1 Logistician/ Technician
1 Assistant Logistician Technician
Warehousing and Distribution
1 Executive Officer
1 Storekeeper
1 Assistant Storekeeper
1 Head Storeman
1 Storeman
1 Driver Grade I
4 Drivers Grade II
5 Storemen
Registry and Common Services
1 Clerical Officer Grade III
1 Clerical Officer Grade I
1 Stenographer/ Typist
1 Telephone Operator
1 Chief Attendant
5 Office Attendants
Library Service
1 Librarian
1 Clerk/Typist
& 1 New Post to be Recruited
* New Staff to be Recruited

ANNEX 2

NUMBER OF STERILIZATIONS PERFORMED IN PUBLIC INSTITUTIONS

YEAR	NO. OF PROCEDURES	ANNUAL % CHANGE
1980	2682	-
1981	3064	14.2
1982	4492	46.6
1983	5896	31.3
1984	6587	11.7

NUMBER OF STERILIZATIONS PERFORMED IN PUBLIC HOSPITALS BY QUARTER - 1983

HOSPITAL	TOTAL	MARCH	JUNE	SEPT.	DECEMBER
TOTAL	5,896	1,598	1,327	1,522	1,444
Alexandria	139	27	26	41	45
Annotto Bay	108	24	33	22	29
Black River	157	31	33	41	52
Buff Bay	37	16	5	16	n.a.
Chapelton	56	8	14	34	n.a.
Cornwall Regional	354	86	66	112	90
Glen Vincent	736	222	190	113	206
Beth Jacobs	192	46	34	52	60
Lenworth Jacobs	152		9	72	71
Linstead	58	14	16	19	9
Lionel Town	70	28	7	12	23
Mandeville	442	95	98	114	135
May Pen	111	50	24	14	23
Noel Holmes	85	18	17	29	21
Port Antonio	177	51	18	45	63
Port Maria	59	8	13	22	16
Percy Junor	227	56	43	70	58
Princess Margaret	219	65	72	42	40
Sav-la-mar	260	91	58	80	31
Spanish Town	540	158	163	175	44
St. Ann's Bay	100	34	23	24	19
University	630	182	181	116	151
Victoria Jubilee	966	282	176	250	258
Isaac Barrant	n.a.	n.a.	n.a.	n.a.	n.a.
Falmouth	21	6	8	7	n.a.
Ulster Spring	-	-	-	-	-

*JFPA Clinics

TUBAL LIGATIONS BY QUARTER/INSTITUTION
1984

INSTITUTION	MARCH	JUNE	SEPTEMBER	DECEMBER	TOTAL
Alexandria	41	51	38	-	130
Annotto Bay	13	23	23	37	96
Black River	40	25	40	47	152
Buff Bay	3	14	5	3	25
Chapelton	31	66	22	-	119
Cornwall Regional	110	116	72	88	386
Glen Vincent Clinic	94	101	50	72	317
Lenworth Jacobs Clinic	106	109	151	153	519
* Beth Jacobs Clinic	44	52	68	46	210
Linstead	19	15	16	15	65
Lionel Town	23	22	24	26	95
Mandeville	129	111	137	110	487
May Pen	29	46	38	46	159
Noel Holmes	17	7	48	15	87
Port Antonio	65	40	48	54	207
Port Maria	8	33	20	23	84
Percy Junor	57	39	38	64	198
Princess Margaret	37	58	43	44	182
Sav-la-mar	69	42	16	38	165
Spanis Town	143	135	166	177	621
St. Ann's Bay	36	60	40	43	173
U.W.I. Fertility Unit Only	150	168	121	159	598
V.J.H. Fertility Unit Only	304	285	239	223	1,051
TOTAL	1,508	1,6[illegible]	1,465	1,483	6,074

* JFPA Clinics

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STERILIZATION [illegible] THE NUMBER [illegible]
BY [illegible] 1980 - 1983

[illegible]	NO. OF REFER-RALS	NO. OF STERILIZA-TION	NO. OF REFER-RALS	NO. OF STERILIZA-TION	[illegible]	NO. OF STERILIZA-TION	[illegible]	[illegible]
	1 9 [illegible]	[illegible]	1 9	8 1	1 9 8	2	1	8
ALL PARISHES	2,096	[illegible]	1,713	[illegible]	1,991	3,858	2,170	[illegible]
K[illegible] C.	49[illegible]	1,022	[illegible]	1,513	[illegible]	1,891	528	[illegible]
ST. THOMAS	[illegible]	157	90	[illegible]	91	218	68	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	142	116	161	136	[illegible]
ST. [illegible]	245	50	[illegible]	72	[illegible]	73	155	[illegible]
ST. [illegible]	99	108	198	[illegible]	[illegible]	59	139	[illegible]
[illegible]	139	17	52	[illegible]	37	11	[illegible]	[illegible]
ST. [illegible]	85	230	29	[illegible]	[illegible]	[illegible]	49	[illegible]
[illegible]	50	[illegible]	77	[illegible]	61	142	167	[illegible]
[illegible]	77	20	18	[illegible]	[illegible]	266	96	[illegible]
ST. [illegible]	170	81	77	64	45	[illegible]	73	[illegible]
[illegible]	[illegible]	424	147	[illegible]	132	192	177	[illegible]
[illegible]	111	89	25	[illegible]	100	[illegible]	[illegible]	[illegible]
ST. [illegible]	245	444	136	[illegible]	113	[illegible]	[illegible]	[illegible]

Average age of mother:	23 7/12 years	23 7/12 years	23 6/12 years	23 5/12 years	23 7/12 years	23 7/12 years

Age group	1982 Births	1982 Percent of total	1983 Births	1983 Percent of total	1984 Births	1984 Percent of total	SUMMARY: 1976 to 1984 Total births	Average per year	Percent
Under 15	113	0.83%	137	0.97%	126	0.94%	1,253	139	1.04%
15 -- 19	3,759	27.55%	3,958	27.96%	3,681	27.56%	34,769	3,863	29.04%
20 -- 24	4,460	32.69%	4,738	33.47%	4,530	33.91%	39,480	4,387	32.98%
25 -- 29	2,737	20.06%	2,865	20.22%	2,724	20.39%	23,134	2,571	19.33%
30 -- 34	1,544	11.32%	1,466	10.36%	1,430	10.70%	12,559	1,395	10.49%
35 -- 39	764	5.60%	755	5.33%	654	4.90%	6,438	715	5.37%
40 -- 44	242	1.77%	223	1.58%	204	1.53%	1,916	213	1.60%
45 & over	25	0.18%	13	0.09%	9	0.07%	178	20	0.15%
TOTAL	13,644		14,155		13,358		119,727	13,303	
Average age of mother:	23 11/12 years		23 8/12 years		23 8/12 years			23 7/12 years	

see next side for details of births to teenagers.

H. Anglin
Medical Records Officer

ANNEX 6

The following table shows the number of births to teenagers, according to age (at last birthday), which occurred in the Victoria Jubilee Hospital for the period 1976 to 1984.

AGE	1976	1977	1978	1979	1980	1981	1982	1983	1984	SUMMARY: 1976 to 1984 TOTAL	AVERAGE (*) PER YEAR	PERCENT	BIRTHS TO TEENAGERS AS A PERCENT OF ALL BIRTHS
11	-	-	-	-	-	-	1	-	-	1	0	0.00%	0.00%
12	3	2	1	1	2	1	2	1	1	14	2	0.05%	0.02%
13	33	28	28	24	31	15	17	10	18	204	23	0.58%	0.17%
14	123	125	135	125	109	91	93	126	106	1,033	115	2.87%	0.86%
15	365	349	380	348	291	289	275	314	206	2,871	319	7.97%	2.40%
16	634	638	609	614	586	557	576	593	532	5,339	593	14.82%	4.46%
17	841	896	886	857	865	789	825	828	750	7,537	837	20.91%	6.29%
18	1,104	1,067	1,012	1,005	952	1,007	1,007	1,077	980	9,211	1,023	25.56%	7.69%
19	1,191	1,098	1,014	1,106	996	1,025	1,076	1,146	1,160	9,812	1,090	27.24%	8.19%
TOTAL	4,294	4,203	4,065	4,080	3,832	3,774	3,872	4,095	3,807	36,022	4,002	100.00%	30.08%

Average age of teenage mother: 17 5/12 years

(*) To the nearest unit.

H. Anglin
Medical Records Officer

TOTAL NUMBER OF STERILIZATION PERFORMED AT SELECTED HOSPITALS BY AGE OR CLIENT AND BY NUMBER OF LIVING CHILDREN 1981

NUMBER OF LIVING CHILDREN		AGE GROUP						
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+
TOTAL	1567	-	5	87	331	501	454	189
0	6	-	-	2	-	4	-	-
1	18	-	-	3	4	7	-	4
2	96	-	5	7	22	27	26	9
3	215	-	-	29	59	68	40	19
4	291	-	-	16	94	107	58	16
5	296	-	-	23	64	107	82	20
6 & Over	574	-	-	4	77	161	226	98
Unknown	71	-	-	3	11	12	22	23

TOTAL NUMBER OF STERILIZATION PERFORMED AT SELECTED HOSPITALS BY AGE OR CLIENT AND BY NUMBER OF LIVING CHILDREN 1982

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP						
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+
TOTAL	1260	1	7	53	278	426	349	146
0	13	1	6	1	2	1	1	1
1	23	-	1	4	4	5	6	3
2	146	-	-	13	31	57	30	15
3	247	-	-	11	84	83	56	13
4	253	-	-	16	66	93	62	16
5	181	-	-	5	42	64	52	18
6+	383	-	-	2	44	121	141	75
unknown	14	-	-	1	5	2	1	5

TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT[3]

AND BY NUMBER OF LIVING CHILDREN 1983

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	5896	1	44	353	1425	1881	1570	588	34
0	16	-	4	3	3	4	1	1	-
1	89	1	14	12	13	15	27	7	-
2	455	-	16	62	127	129	95	26	-
3	851	-	4	91	286	203	235	32	-
4	1083	-	6	102	350	390	191	44	-
5	986	-	-	44	319	349	218	56	-
6 & Over	2292	-	-	31	310	762	784	405	-
Unknown	124	-	-	8	17	29	19	17	34

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TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	6587	3	35	490	1737	2071	1530	698	23
0	19	3	2	3	3	2	2	4	-
1	100	-	18	20	14	25	18	4	1
2	630	-	6	100	207	183	101	30	3
3	1143	-	7	159	363	364	202	47	1
4	1260	-	-	124	464	381	221	69	1
5	1174	-	2	68	388	383	255	72	6
6 & Over	2216	-	-	13	287	723	720	467	6
Unknown	45	-	-	3	11	10	11	5	5

TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1981 - 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	15310	5	91	983	3771	4879	3903	1621	57
0	54	4	12	9	8	11	4	6	-
1	230	1	33	39	35	52	51	18	1
2	1327	-	27	182	387	396	252	80	3
3	2456	-	11	290	792	718	533	111	1
4	2887	-	6	258	974	971	532	145	1
5	2637	-	2	140	813	903	607	166	6
6 & Over	5465	-	-	50	718	1775	1871	1045	6
Unknown	254	-	-	15	44	53	53	50	39

INSTITUTIONS	DRS. PERFORMING T/Ls
Annotto Bay	R. Thomas G. Sekhon S. Smith
Black River	R. Francis
✓Chapelton	B. Shaw
Cornwall Regional	D. Sumitra P. Vani B. Brown R. Bucknor
Glen Vincent	K. Gajraj
Beth Jacobs	S. McCoy
Lenworth Jacobs	R. Reid
Linstead	A. Wint
Lionel Town	G. V. Rao
Mandeville	P. Bird D. McPherson K. Stanley E. Venket
May Pen	W. Dawes Rajanna Wright
Noel Holmes	R. Brown
Port Antonio	S. Parvataeni
Port Maria	K. Raman R. Watson
Percy Junor	B. Gooden, N. Day
Princess Margaret	S. Kals, R. Lampart
✓Sav-la-mar	H. Ramesh Y. Mohan E. Nepaul
Spanish Town	J. Joseph Y. Pusey M. Beecher M. Douglas G. Alexander F. Hannah L. P. Knight G. Bennett

INSTITUTIONS	DRS. PERFORMING T/Ls
St. Ann's Bay.	Y. Kamara S. McCoy G. Martin W. Wilson N. Black K. McNeil
U.W.I. Fertility Unit	G. Meggs R. Stevens Fletcher A. Mullings Heron Minnis
Victoria Jubilee Hosp.	L. Goldson W. Frazer E. Nepaul J. Lakshemi C. Lai R. Hall V Sumitra F.R. Smith
✓Isaac Barrant	H. Hall
✓Falmouth	K. Ramachandra
✓Buff Bay	
✓Lucea	
✓Alexandra	Dr. Marshall
✓ST Iago Park	

Caribbean Family Planning Conference · Nov. 26-29, 1984

Kingston, Jamaica.

Ministry of Health -

Training of Health staff - at fertility management unit - CRH

1 Sterilization techniques

Dr T. Providence	University Hospital
Dr Kulkarni	" "
Dr S. M'Coy	" "
Dr J Frederick	" "
Dr E Robinson	Private
Dr Hosang	University Hospital
Dr Halasi	Ministry of Health St Ann's Bay
Dr Richard Reid	Ministry of Health Kingston & St Andrew
Dr Earl Wright	Ministry of Health St Thomas
Dr Horace Hall	Ministry of Health Portland

SPONSORS: United Nations Fund for Population Activities (UNFPA), National Family Planning Board (NFPB), Jamaica, West Indies.

Caribbean Family Planning Conference · Nov. 26-29, 1984
Kingston, Jamaica.

Family Planning Techniques for Graduate Nurses

40 Nurses trained

John Hopkins Programme

24 Drs for IUD training

Family Planning Techniques for General Practitioners

Dr Blake MOH Portland (left)
Dr Carpenter " Portland
Dr Hartland UCH
Dr K Dixon UCH
Dr A Kiddoo MOH
Dr A Morgan MOH
Dr W Cockyer Private
Dr H Hall MOH

SPONSORS: United Nations Fund for Population Activities (UNFPA), National Family Planning Board (NFPB), Jamaica, West Indies.

INFORMED CONSENT FORM FOR ACCEPTORS OF TUBAL LIGATION

I, ...the undersigned, wish to be sterilized by the following procedure: ..... and do hereby consent to the administration of any anaesthetic necessary. I understand the following:

1. That there are temporary methods of contraception I can use instead of sterilization for planning my family.
2. That the sterilization procedure is a surgical operation, the details of which and the possible side effects have been explained to me. I clearly understand the risks involved.
3. That if the operation is successful, I will be unable to have any more children.
4. That the sterilization operation is NOT reversible.
5. That I can change my mind at any time prior to the operation and decide against the sterilization procedure.

.....
Signature of patient

.....
Signature of relative (relation)

.....
Signature of witness

Date.....19.....

NATIONAL FAMILY PLANNING BOARD
STERILISATION PATIENT RECORD

NAME.....

PATIENT NUMBER.....

AGE IN YEARS.....

Total No. of Pregnancies.....

Number of Living Children.....

Was Patient Counselled? ( )
Pre-Op.....

Post Op.....

None.....

PREVIOUS MEDICAL HISTORY

Convulsive Disorders.....

Asthma.....

Heart Disease.....

Diabetes.....

Hypertension.....

Other (specify).....

PHYSICAL EXAMINATION

Breast.....

Heart.....

Lungs.....

Pelvic Examn.....

.....

Other (specify).....

LAB TESTS

None.....Haemoglobin .....

Urine Analysis: Sugar.....

Protein.....

Outpatient.....

In Patient (number of days).....

NAMES OF OPERATORS:

Surgeon: .....

Anaesthetist: .....

Nurse: .....

PATIENT ADDRESS.....

.....

.....

NEXT OF KIN-.....

A. Previous Method(s) of contraception ever used Circle number that applies.
   1) None
   2) oral contraceptives
   3) IUD
   4) barrier methods (condoms, diaphragm)
   5) spermicides (foam, cream, jelly, etc.)
   6) Injection
   7) other (specify).....
   8) more than one (specify).....
   9) unknown

B. Timing of the Sterilisation
   1) post partum (within 1 week)
   2) post abortion (within 1 week)
   3) (interval not preg-assoc.)
   4) operation not performed due to medical contra-indication
   5) unknown

C. Approach
   1) laparotomy
   2) minilaparotomy (incision 5 cm. or less, interval or post-pregnancy)
   3) laparoscopy
   4) vaginal (colpotomy or culdoscopy)
   5) other (specify) .....
   6) N/A (vasectomy)
   7) unknown

D. Method of Tubal Sterilisation
   1) electrocoagulation (specify unipolar, bipolar in comments)
   2) falope ring
   3) clip
   4) Pomeroy, fimbriectomy, salpingectomy, or other surgical tubal occlusion
   5) other (specify).....
   6) operation not completed
   7) unknown

E. Anaesthesia
   1) general
   2) regional (spinal, epidural, caudal)
   3) local
   4) unknown

F. Complication (circle No. below).
   0) None
   1) Anaesthetic complication
   2) bladder injury
   3) bowel injury
   4) uterine perforation
   5) accidental burn
   6) Haemorrhage
   7) infection
   8) Other.

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NATIONAL FAMILY PLANNING BOARD

Monthly Report of Sterilization (Male & Female) Procedures Performed

Name and Address of Medical Facility: _____

Type of facility:

1. _____ Hospital
2. _____ Non-hospital clinic
3. _____ Other, specify _____

Does this facility have:

Emergency ventilation equipment _____Yes _____No
Blood transfusion facilities _____Yes _____No
Facilities for surgical management of operative complications _____Yes _____No

Date Day/Mth/Yr	Patient Name	Sterilisation Record No.	Age in Years	Sex M=1 F=2	Total No. of Pregnancies	No. of Living Children	Clinical Information Use codes from record						Names of Operators		
							A	B	C	D	E	F	Surgeon	Anaesthetist	Scrub Nurse

47

SPACE REQUIREMENT
Regardless of No. Procedures*

1. Recovery Room
2. Operating Room
3. Waiting Room
4. Scrub Facility
5. Toilet
6. Dressing Room
7. Sterilization Area
8. Examination Room

Total cost based on AVS addition to Mandeville Hospital $100,000

Cost: US$3,000/year

* Includes depreciation and repair costs at 33 year replacement period.

Equipment*

I. Operating Room

1.	Table	US$ 900.00
2.	Lighting - regular - emergency	US$2,000.00
3.	Instrument Trays (3)	US$ 100.00
4.	Instrument Table	US$ 200.00
5.	Stethescope and sphygomometer	US$ 80.00
6.	Anesthesia Machine	US$3,000.00
7.	Air Conditioner	US$ 400.00
8.	Waste Diaposal Container	US$ 30.00
9.	Cold Sterilization Tray	US$ 50.00
10.	Emergency Equipment	US$1,200.00
11.	Equipment for Tubal Ligation laprocaptor	US$5,000.00
12.	Mini Lap Kit (5)	US$1,000.00

II. Recovery Room

1.	Stretchers or beds	US$2,000.00
2.	Sphygometer and stethescope	US$ 80.00
3.	Emergency Equipment	US$ 800.00
4.	Waste Container	US$ 50.00

III. Examination Room

1.	Table	US$	500.00
2.	Desk	US$	200.00
3.	File Cabinet	US$	100.00
4.	Chair	US$	100.00
5.	Sphynonometer & Stethescope	US$	80.00
6.	Optional - Scale	US$	200.00

---

* Depreciation over a five (5) year period $3,600/year.

Medicine & Supplies Required for each Procedure

Laprascopy

2 Fallope rings	$ 2.00
1 liter CO_2	$ 0.60
1 suture	$ 1.00
1 dressing	$ 0.20
1 adhesive tape	$ 0.50
1 catheter-syringe	$ 1.00
10 mg valium (1 pill) oral	$ 0.10
50 mg mleperidine	$ 0.10
10cc xylocaine	$ 0.50
disinfection solution	$ 0.50
cold solution	$ 0.25
1 pr. sterile gloves	$ 1.00
cotton	$ 0.05
sterile linen	$ 1.20
follow up & complication costs	$ 0.50
TOTAL	$ 9.00

Personnel for each Procedure

1 surgeon - 1 hr.	$12.50
1 O.R. nurse - 1 hr.	$ 5.00
1 recovery nurse - 1 hr.	$ 5.00
TOTAL	$22.50

Support Personnel not necessary for Each Procedure

1 yr. Accountant - 1hr/day	$1,500.00
1 yr. Secretary & file clerk	$6,000.00
1 yr. Porter - Cleaner	$4,000.00
1 yr. Central Supply Personnel	$5,000.00
1 yr. office supplies & service	$1,000.00
TOTAL	$17,500.00

Office Supplies & Equipment

FormsFans
Utilities
Water
Office Equipment
Other

ANNEX 12

STATISTICS UNIT
15A OLD HOPE ROAD
KINGSTON 5

TO: Dr. Estrada
A.V.S. Consultant

FROM: Statistician

Attached please find data on sterilization since 1981.

Review table on performance of tubal ligation at health centre/hospital with caution. This table was extracted from unpublishedsurvey conducted by Ministry of Health on physical and operational featuresof Government health centres and hospitals in 1985.

Kindly note that 1 and 0 in columns 1 and 5 refer to yes and no respectively. P.P.S. refers to post partum services, N.K., not known & N.A., not available.

Hoping you find the data useful.

.....Radlein.....

E. U. Radlein (Mrs)

PERFORMANCE OF TUBAL LIGATION AT

HEALTH CENTRE/HOSPITAL

PARISH HOSPITALS OR H/C	1 T/L PERFORM AT THIS H/C OR HOSPITAL	2 NO:S OF T/L PERFORMED		3 MODE PERFORMED (ANAESTHESIA)		4 NO. REFERRED FROM		5 EXISTANCE OF WAITING LIST	6 APPROX. NO.OF WAITING LIST
		P.P	INTERNAL	GENERAL	LOCAL	H/C	P.P.S.		
K.S.A.C									
GLEN VINCENT	1	0	326	0	ALL	N/A	N/A	1	22
V.J.H.	1	829	222	ALL	0	0	ALL	1	N/A
ST. THOMAS									
P. MARGARET	1	68	124	192	0	124	68	1	5
PORTLAND									
BUFF BAY	1	19	3	22	0	22	0	1	10
PORT ANTONIO	1	80	120	50	150	50	0	0	0
ST. MARY									
ANOTTO BAY	1	112	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PORT MARIA	1	68	0	66	2	68	0	0	0
ST. ANN									
ALEXANDRIA	0	125	32	62	95	56	50	0	0
ST. ANN's BAY	1	111	6	117	0	N/K	N/K	1	0
TRELAWNY									
ULSTER SPRING	0	0	0	0	0	0	0	0	0
FALMOUTH	1	0	13	13	0	0	0	0	0
ST. JAMES									
C.R.H.	1	226	137	226	0	130	226	1	59
HANOVER									
NOEL HOLMES	1	48	3	50	1	0	0	1	0
WESTMORELAND									
SAVANNA-LA-MAR	1	53	93	146	0	100	40	1	36
ST. ELIZABETH									
BLACK RIVER	1	1	0	150	8	50	100	1	0
MANCHESTER									
MANDEVILLE	1	106	321	106	321	0	321	0	0
SPAULDING	1	229	0	0	0	0	0	0	0
CLARENDON									
MAY PEN	1	120	35	155	None	25	None	0	0
ST. CATHERINE									
SPANISH TOWN	1	0	0	418	200	110	500	1	150
LINSTEAD	1	0	0	51	0	24	27	1	10

NUMBER OF STERILIZATION PEROFRMED IN PUBLIC HOSPITALS/HEALTH CENTRES

BY SEX 1981 - 1983

	1981			1982			1983			TOTAL		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
K.S.A.C.	3062	1	3061	3858	2	3856	5896	5	5891	12816	9	12808
GLEN VINCENT	289	-	289	301	2	299	726	5	731	1326	8	1319
UNIVERSITY	707	1	706	708	-	708	630	-	630	2045	1	2044
V.J.H.	317	-	317	882	-	882	966	-	966	2165	-	2165
ST. THOMAS												
ISAAC BARRANT	34	-	34	N.A	N.A	N.A	N.A	N.A	N.A	34	-	34
PRINCESS MARGARET	181	-	181	218	-	218	219	-	219	618	-	618
PORTLAND												
BUFF BAY	N.	O.	P.	N.	O.	P.	37	-	37	37	-	37
PORT ANTONIO	69	-	69	75	-	75	177	-	177	321	-	321
ST. MARY												
ANNOTTO BAY	78	-	78	86	-	86	108	-	108	272	-	272
PORT MARIA	75	-	75	73	-	73	59	-	59	207	-	207
ST. ANN												
ALEXANDRIA	N.	O.	P.	N.	O.	P.	139	-	139	139	-	139
ST. ANN'S BAY	121	-	121	59	-	59	100	-	100	280	-	280
TRELAWNY												
FALMOUTH	28	-	28	11	-	11	21	-	21	60	-	60
ULSTER SPRING	1	-	1	N.	O.	P.	-	-	-	1	-	1
ST. JAMES												
C.R.H.	258	-	258	258	-	258	354	-	354	870	-	870
HANOVER												
NOEL HOLMES	18	-	18	47	-	47	85	-	85	150	-	150
WESTMORELAND												
SAVANNA-LA-MAR	68	-	68	266	-	266	260	-	260	594	-	594
ST. ELIZABETH												
BLACK RIVER	64	-	64	94	-	94	157	-	157	315	-	315
MANCHESTER												
SPAULDINGS	98	-	98	90	-	90	227	-	227	415	-	415
MANDEVILLE	180	-	180	192	-	192	442	-	442	814	-	814
CLARENDON												
CHAPLETON	3	-	3	60	-	60	56	-	56	119	-	119
LIONEL TOWN	35	-	35	64	-	64	70	-	70	169	-	169
MAY PEN	74	-	74	107	-	107	111	-	111	292	-	292
ST. CATHERINE												
LINSTEAD	29	-	29	26	-	26	58	-	58	113	-	113
SPANISH TOWN	335	-	335	241	-	241	540	-	540	1116	-	1116
J.F.P.A.							152	-	152	152	-	152
BETH JACOBS							192	-	192	192	-	192

TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	6587	3	35	490	1737	2071	1530	698	23
0	19	3	2	3	3	2	2	4	-
1	100	-	18	20	14	25	18	4	1
2	630	-	6	100	207	183	101	30	3
3	1143	-	7	159	363	364	202	47	1
4	1260	-	-	124	464	381	221	69	1
5	1174	-	2	68	388	383	255	72	6
6 & Over	2216	-	-	13	287	723	720	467	6
Unknown	45	-	-	3	11	10	11	5	5

TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1981 - 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	15310	5	91	983	3771	4879	3903	1621	57
0	54	4	12	9	8	11	4	6	-
1	230	1	33	39	35	52	51	18	1
2	1327	-	27	182	387	396	252	80	3
3	2456	-	11	290	792	718	533	111	1
4	2887	-	6	258	974	971	532	145	1
5	2637	-	2	140	813	903	607	166	6
6 & Over	5465	-	-	50	718	1775	1871	1045	6
Unknown	254	-	-	15	44	53	53	50	39

ANNEX 13

Contacts and Institutions Visited

Mrs. Brenda Grey	Executive Director, Jamaica Family Planning Association
Dr. J.A. McHardy	Chief Medical Officer, Ministry of Health
Dr. C. Bowen-Wright	Principal Health Officer, Primary Health Care Project Ministry of Health
Ms. B. Chevannes	Family Planning Coordinator, Ministry of Health
Professor H. Wynter	Director of Fertility Unit, University of the West Indies
Mr. Lindo	Technician in Laproscope
Mr. Ruddock	Repair and Maintenance Unit
Dr. Margaret V. Dean	Family Planning Director, Victoria Jubilee Hospital
Dr. L. Knight	Senior Medical Officer, Spanish Town Hospital
Dr. Keith Stanley	Senior Medical Officer, Mandeville Hospital
Dr. R. Lampart	Senior Medical Officer, Princess Margaret Hospital
Dr. Evan Nepail	Director OB/GYN Department, Sav-La-Mar Hospital
Dr. R.E.D. Thwaites	Chairman, National Family Planning Board
Ms. June Rattray	Executive Director, National Family Planning Board
Mr. Newton Forbes	Assistant Executive Director, National Family Planning Board
Ms. Norma Allen	Nurse Supervisor, National Family Planning Board
Dr. K. Gajraj	Director, Glen Vincent Polyclinic
Ms. Patricia Moser	Acting Director, Office of Health/Nutrition/Population, USAID/Kingston

Mr. William Joslin	Director, USAID/Jamaica Mission
Mr. Edward Kadunc	Acting Deputy Director, USAID/Jamaica Mission
Ms. Beth Cypser	Project Development Officer, Office of Project Development and Support, USAID/Jamaica
Ms. Radlein	Director, Statistics Section, Ministry of Health
Ms. Grace-Ann Grey	Assistant Population Officer, USAID/Jamaica
Dr. Peaches McDonald	Medical Director, NFPB

ANNEX 14

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- Bouvier, Leon F. A Review of the Population and Family Planning Services Project, USAID/Jamaica, September, 1985

- Donnelly, Thomas R. Jamaica Family Planning Assessment/Review, October, 1985

- A Statement of National Population Policy, Prepared by the Population Task Force - Ministry of Health, August 1981

- Rattray, June C. Background Paper for Discussion of Proposed Expansion of Sterilization Services by the Chairman and Senior Medical Officers and Consultant Obstetricians/Gynecologists, NFPB, August, 1981

- Rattray, June C. Origins and Development of the National Family Planning Programme, NFPB, October, 1985

- Powell, Dorian L. Report of the Jamaica Contraceptive Prevalence Survey, 1983. NFPB, August 1984

- The Statistical Institute of Jamaica. Demographic Statistics 1984

NATIONAL FAMILY PLANNING BOARD
STERILISATION PATIENT RECORD

NAME.....

PATIENT NUMBER.....

AGE IN YEARS.....

Total No of Pregnancies.....

Number of Living Children.....

Was Patient Counselled? ( )
Pre-Op.....

Post Op.....

None.....

PREVIOUS MEDICAL HISTORY

Convulsive Disorders.....

Asthma.....

Heart Disease.....

Diabetes.....

Hypertension.....

Other (specify).....

PHYSICAL EXAMINATION

Breast.....

Heart.....

Lungs.....

Pelvic Examn.....

.....

Other (specify).....

LAB TESTS

None.....Haemoglobin.....

Urine Analysis: Sugar.....

Protein.....

Outpatient.....

In Patient (number of days).....

NAMES OF OPERATORS:

Surgeon: .....

Anaesthetist: .....

Nurse: .....

PATIENT ADDRESS.....

.....

.....

NEXT OF KIN-.....

A. Previous Method(s) of contraception ever used Circle number that applies.
   1) None
   2) oral contraceptives
   3) IUD
   4) barrier methods (condoms, diaphragm)
   5) spermicides (foam, cream, jelly, etc.)
   6) Injection
   7) other (specify).....
   8) more than one (specify).....
   9) unknown

B. Timing of the Sterilisation
   1) post partum (within 1 week)
   2) post abortion (within 1 week)
   3) (interval not preg-assoc.)
   4) operation not performed due to medical contra-indication
   5) unknown

C. Approach
   1) laparotomy
   2) minilaparotomy (incision 5 cm. or less, interval or post-pregnancy)
   3) laparoscopy
   4) vaginal (colpotomy or culdoscopy)
   5) other (specify) .....
   6) N/A (vasectomy)
   7) unknown

D. Method of Tubal Sterilisation
   1) electrocoagulation (specify unipolar, bipolar in comments)
   2) falope ring
   3) clip
   4) Pomeroy, fimbriectomy, salpingectomy, or other surgical tubal occlusion
   5) other (specify).....
   6) operation not completed
   7) unknown

E. Anaesthesia
   1) general
   2) regional (spinal, epidural, caudal)
   3) local
   4) unknown

F. Complication (circle No. below).
   0) None
   1) Anaesthetic complication
   2) bladder injury
   3) bowel injury
   4) uterine perforation
   5) accidental burn
   6) Haemorrhage
   7) infection
   8) Other.

STERILISATION PATIENT RECORD

NAME.....

PATIENT NUMBER.....

AGE IN YEARS.....

Total No. of Pregnancies.....

Number of Living Children.....

Was Patient Counselled? ( )
Pre-Op.....

Post Op.....

None.....

PREVIOUS MEDICAL HISTORY

Convulsive Disorders.....

Asthma.....

Heart Disease.....

Diabetes.....

Hypertension.....

Other (specify).....

PHYSICAL EXAMINATION

Breast.....

Heart.....

Lungs.....

Pelvic Examn.....

. .....

Other (specify).....

LAB TESTS

None.....Haemoglobin.....

Urine Analysis: Sugar.....

Protein.....

Outpatient.....

In Patient (number of days).....

NAMES OF OPERATORS:

Surgeon: .....

Anaesthetist: .....

Nurse: .....

PATIENT ADDRESS.....

.....

NEXT OF KIN-.....

A. Previous Method(s) of contraception ever used Circle number that applies.
   1) None
   2) oral contraceptives
   3) IUD
   4) barrier methods (condoms, diaphragm)
   5) spermicides (foam, cream, jelly, etc.)
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   7) other (specify).....
   8) more than one (specify).....
   9) unknown

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   4) vaginal (colpotomy or culdoscopy)
   5) other (specify) .....
   6) N/A (vasectomy)
   7) unknown

D. Method of Tubal Sterilisation
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   3) clip
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   7) unknown

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   1) general
   2) regional (spinal, epidural, caudal)
   3) local
   4) unknown

F. Complication (circle No. below).
   0) None
   1) Anaesthetic complication
   2) bladder injury
   3) bowel injury
   4) uterine perforation
   5) accidental burn

NATIONAL FAMILY PLANNING BOARD

Monthly Report of Sterilization (Male & Female) Procedures Performed

Name and Address of Medical Facility: ______________________________

Type of facility:

1. __________ Hospital
2. __________ Non-hospital clinic
3. __________ Other, specify ____________________

Does this facility have:

Emergency ventilation equipment ______ Yes ______ No

Blood transfusion facilities ______ Yes ______ No

Facilities for surgical management of operative complications ______ Yes ______ No

Patient Name	Sterilisation Record No.	Age in Years	Sex M=1 F=2	Total No. of Pregnancies	No. of Living Children	Clinical Information Use codes from record A	B	C	D	E	F	Names of Operators Surgeon	Anaesthetist	Scrub Nurse

SPACE REQUIREMENT
Regardless of No. Procedures*

1. Recovery Room
2. Operating Room
3. Waiting Room
4. Scrub Facility
5. Toilet
6. Dressing Room
7. Sterilization Area
8. Examination Room

Total cost based on AVS addition to Mandeville Hospital $100,000

Cost: US$3,000/year

* Includes depreciation and repair costs at 33 year replacement period.

Equipment*

I. Operating Room

1.	Table	US$ 900.00
2.	Lighting - regular - emergency	US$2,000.00
3.	Instrument Trays (3)	US$ 100.00
4.	Instrument Table	US$ 200.00
5.	Stethescope and sphygomometer	US$ 80.00
6.	Anesthesia Machine	US$3,000.00
7.	Air Conditioner	US$ 400.00
8.	Waste Diaposal Container	US$ 30.00
9.	Cold Sterilization Tray	US$ 50.00
10.	Emergency Equipment	US$1,200.00
11.	Equipment for Tubal Ligation laprocaptor	US$5,000.00
12.	Mini Lap Kit (5)	US$1,000.00

II. Recovery Room

1.	Stretchers or beds	US$2,000.00
2.	Sphygometer and stethescope	US$ 80.00
3.	Emergency Equipment	US$ 800.00
4.	Waste Continer	US$ 50.00

III. Examination Room

1.	Table	US$	500.00
2.	Desk	US$	200.00
3.	File Cabinet	US$	100.00
4.	Chair	US$	100.00
5.	Sphynonometer & Stethescope	US$	80.00
6.	Optional - Scale	US$	200.00

---

* Depreciation over a five (5) year period $3,600/year.

Medicine & Supplies Required for each Procedure

Laprascopy

2 Fallope rings	$ 2.00
1 liter CO_2	$ 0.60
1 suture	$ 1.00
1 dressing	$ 0.20
1 adhesive tape	$ 0.50
1 catheter-syringe	$ 1.00
10 mg valium (1 pill) oral	$ 0.10
50 mg mleperidine	$ 0.10
10cc xylocaine	$ 0.50
disinfection solution	$ 0.50
cold solution	$ 0.25
1 pr. sterile gloves	$ 1.00
cotton	$ 0.05
sterile linen	$ 1.20
follow up & complication costs	$ 0.50
TOTAL	$ 9.00

Personnel for each Procedure

1 surgeon - 1 hr.	$12.50
1 O.R. nurse - 1 hr.	$ 5.00
1 recovery nurse - 1 hr.	$ 5.00
TOTAL	$22.50

Support Personnel not necessary for Each Procedure

1 yr. Accountant - 1hr/day	$1,500.00
1 yr. Secretary & file clerk	$6,000.00
1 yr. Porter - Cleaner	$4,000.00
1 yr. Central Supply Personnel	$5,000.00
1 yr. office supplies & service	$1,000.00
TOTAL	$17,500.00

Office Supplies & Equipment

FormsFans
Utilities
Water
Office Equipment
Other

ANNEX 12

STATISTICS UNIT
15A OLD HOPE ROAD
KINGSTON 5

TO: Dr. Estrada
A.V.S. Consultant

FROM: Statistician

Attached please find data on sterilization since 1981.

Review table on performance of tubal ligation at health centre/hospital with caution. This table was extracted from unpublishedsurvey conducted by Ministry of Health on physical and operational featuresof Government health centres and hospitals in 1985.

Kindly note that 1 and 0 in columns 1 and 5 refer to yes and no respectively. P.P.S. refers to post partum services, N.K., not known & N.A., not available.

Hoping you find the data useful.

.....Radlein.....

E. U. Radlein (Mrs)

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PERFORMANCE OF TUBAL LIGATION AT

HEALTH CENTRE/HOSPITAL

PARISH HOSPITALS OR H/C	1 T/L PERFORM AT THIS H/C OR HOSPITAL	2 NO:S OF T/L PERFORMED		3 MODE PERFORMED (ANAESTHESIA)		4 NO. REFERRED FROM		5 EXISTANCE OF WAITING LIST	6 APPROX. NO.OF WAITING LIST
		P.P	INTERNAL	GENERAL	LOCAL	H/C	P.P.S.		
K.S.A.C									
GLEN VINCENT	1	0	326	0	ALL	N/A	N/A	1	22
V.J.H.	1	829	222	ALL	0	0	ALL	1	N/A
ST. THOMAS									
P. MARGARET	1	68	124	192	0	124	68	1	5
PORTLAND									
BUFF BAY	1	19	3	22	0	22	0	1	10
PORT ANTONIO	1	80	120	50	150	50	0	0	0
ST. MARY									
ANOTTO BAY	1	112	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PORT MARIA	1	68	0	66	2	68	0	0	0
ST. ANN									
ALEXANDRIA	0	125	32	62	95	56	50	0	0
ST. ANN's BAY	1	111	6	117	0	N/K	N/K	1	0
TRELAWNY									
ULSTER SPRING	0	0	0	0	0	0	0	0	0
FALMOUTH	1	0	13	13	0	0	0	0	0
ST. JAMES									
C.R.H.	1	226	137	226	0	130	226	1	59
HANOVER									
NOEL HOLMES	1	48	3	50	1	0	0	1	0
WESTMORELAND									
SAVANNA-LA-MAR	1	53	93	146	0	100	40	1	36
ST. ELIZABETH									
BLACK RIVER	1	1	0	150	8	50	100	1	0
MANCHESTER									
MANDEVILLE	1	106	321	106	321	0	321	0	0
SPAULDING	1	229	0	0	0	0	0	0	0
CLARENDON									
MAY PEN	1	120	35	155	None	25	None	0	0
ST. CATHERINE									
SPANISH TOWN	1	0	0	418	200	110	500	1	150
LINSTEAD	1	0	0	51	0	24	27	1	10

NUMBER OF STERILIZATION PERFORMED IN PUBLIC HOSPITALS/HEALTH CENTRES

BY SEX 1981 - 1983

	1981			1982			1983			TOTAL		
	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE	TOTAL	MALE	FEMALE
K.S.A.C.	3062	1	3061	3858	2	3856	5896	5	5891	12816	9	12808
EN VINCENT	289	-	289	301	2	299	736	5	731	1326	8	1319
UNIVERSITY	707	1	706	708	-	708	630	-	630	2045	1	2044
V.J.H.	317	-	317	882	-	882	966	-	966	2165	-	2165
ST. THOMAS.												
ISAAC BARRANT	34	-	34	N.A	N.A	N.A	N.A	N.A	N.A	34	-	34
PRINCESS MARGARET	181	-	181	218	-	218	219	-	219	618	-	618
PORTLAND												
BUFF BAY	N.	O.	P.	N.	O.	P.	37	-	37	37	-	37
PORT ANTONIO	69	-	69	75	-	75	177	-	177	321	-	321
ST. MARY												
ANNOTTO BAY	78	-	78	86	-	86	108	-	108	272	-	272
PORT MARIA	75	-	75	73	-	73	59	-	59	207	-	207
ST. ANN												
ALEXANDRIA	N.	O.	P.	N.	O.	P.	139	-	139	139	-	139
ST. ANN'S BAY	121	-	121	59	-	59	100	-	100	280	-	280
TRELAWNY												
FALMOUTH	28	-	28	11	-	11	21	-	21	60	-	60
ULSTER SPRING	1	-	1	N.	O.	P.	-	-	-	1	-	1
ST. JAMES												
C.R.H.	258	-	258	258	-	258	354	-	354	870	-	870
HANOVER												
NOEL HOLMES	18	-	18	47	-	47	85	-	85	150	-	150
WESTMORELAND												
SAVANNA-LA-MAR	68	-	68	266	-	266	260	-	260	594	-	594
ST. ELIZABETH												
BLACK RIVER	64	-	64	94	-	94	157	-	157	315	-	315
MANCHESTER												
SPAULDINGS	98	-	98	90	-	90	227	-	227	415	-	415
MANDEVILLE	180	-	180	192	-	192	442	-	442	814	-	814
CLARENDON												
CHAPLETON	3	-	3	60	-	60	56	-	56	119	-	119
LIONEL TOWN	35	-	35	64	-	64	70	-	70	169	-	169
MAY PEN	74	-	74	107	-	107	111	-	111	292	-	292
ST. CATHERINE												
LINSTEAD	29	-	29	26	-	26	58	-	58	113	-	113
SPANISH TOWN	335	-	335	241	-	241	540	-	540	1116	-	1116
J.F.P.A.							152	-	152	152	-	152
BETH JACOBS							192	-	192	192	-	192

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TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	6587	3	35	490	1737	2071	1530	698	23
0	19	3	2	3	3	2	2	4	-
1	100	-	18	20	14	25	18	4	1
2	630	-	6	100	207	183	101	30	3
3	1143	-	7	159	363	364	202	47	1
4	1260	-	-	124	464	381	221	69	1
5	1174	-	2	68	388	383	255	72	6
6 & Over	2216	-	-	13	287	723	720	467	6
Unknown	45	-	-	3	11	10	11	5	5

TOTAL NUMBER OF STERILIZATION PERFORMED BY AGE OF CLIENT AND BY NUMBER OF LIVING CHILDREN 1981 - 1984

NUMBER OF LIVING CHILDREN	TOTAL	AGE GROUP							
		UNDER 15	15-19	20-24	25-29	30-34	35-39	40+	Unknown
TOTAL	15310	5	91	983	3771	4879	3903	1621	57
0	54	4	12	9	8	11	4	6	-
1	230	1	33	39	35	52	51	18	1
2	1327	-	27	182	387	396	252	80	3
3	2456	-	11	290	792	718	533	111	1
4	2887	-	6	258	974	971	532	145	1
5	2637	-	2	140	813	903	607	166	6
6 & Over	5465	-	-	50	718	1775	1871	1045	6
Unknown	254	-	-	15	44	53	53	50	39

ANNEX 13

Contacts and Institutions Visited

Mrs. Brenda Grey	Executive Director, Jamaica Family Planning Association
Dr. J.A. McHardy	Chief Medical Officer, Ministry of Health
Dr. C. Bowen-Wright	Principal Health Officer, Primary Health Care Project Ministry of Health
Ms. B. Chevannes	Family Planning Coordinator, Ministry of Health
Professor H. Wynter	Director of Fertility Unit, University of the West Indies
Mr. Lindo	Technician in Laproscope
Mr. Ruddock	Repair and Maintenance Unit
Dr. Margaret V. Dean	Family Planning Director, Victoria Jubilee Hospital
Dr. L. Knight	Senior Medical Officer, Spanish Town Hospital
Dr. Keith Stanley	Senior Medical Officer, Mandeville Hospital
Dr. R. Lampart	Senior Medical Officer, Princess Margaret Hospital
Dr. Evan Nepail	Director OB/GYN Department, Sav-La-Mar Hospital
Dr. R.E.D. Thwaites	Chairman, National Family Planning Board
Ms. June Rattray	Executive Director, National Family Planning Board
Mr. Newton Forbes	Assistant Executive Director, National Family Planning Board
Ms. Norma Allen	Nurse Supervisor, National Family Planning Board
Dr. K. Gajraj	Director, Glen Vincent Polyclinic
Ms. Patricia Moser	Acting Director, Office of Health/Nutrition/Population, USAID/Kingston

Mr. William Joslin	Director, USAID/Jamaica Mission
Mr. Edward Kadunc	Acting Deputy Director, USAID/Jamaica Mission
Ms. Beth Cypser	Project Development Officer, Office of Project Development and Support, USAID/Jamaica
Ms. Radlein	Director, Statistics Section, Ministry of Health
Ms. Grace-Ann Grey	Assistant Population Officer, USAID/Jamaica
Dr. Peaches McDonald	Medical Director, NFPB

ANNEX 14

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