

Assessment of Voluntary Sterilization Services And Training in the Philippines

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VSS Assessment in the Philippines

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Executive Summary

The purpose of this Assessment of Voluntary Sterilization Services in the Philippines was to:

- Assess the implementation of a DOH initiative to integrate the training in voluntary surgical contraception - in particular female and male sterilization which is termed Voluntary Surgical Sterilization (VSS) in the Philippines - into the curriculum of the residency program for obstetricians and gynecologists (Ob-gyn)
- Review curricula and assess the effectiveness of this training and its impact.
- Explore the possibility of expanding the residency training in VSS to other residency programs such as surgery and family medicine.

The methodology for this assessment was to conduct visits to 6 hospitals with residency training programs and 2 district hospitals providing VSS services and to interview Department of Health and Family Planning program officials as appropriate. A total of 25 preceptor questionnaires and 37 resident questionnaires were administered.

For tubal ligation, only few issues of equipment or supplies surfaced during the assessment. One troublesome issue was that of a locally adapted retractor, the Apelo retractor that is difficult for some providers and facilities to obtain.

Surgical technique and practices are generally good during cases the team observed. While counseling was not observed, this is performed by the nursing staff who convincingly describe their practice using the GATHER method.

Infection prevention is the area of service delivery most prone to problems. There are a lot of correct practices, such as the use of sharps boxes, wrapping before autoclaving, etc. Also, some hospitals report the existence of infection control teams or office. While the hospitals are usually and generally clean, the team noted deficiencies for example in surgical hand scrubbing, the use of protective barriers, cleaning and decontamination between cases.

All residency programs in DOH-retained hospitals visited by the team are complying with the DOH mandate to train residents in minilaparotomy. The training focuses on the surgical skills, rather than aspects of service delivery and is primarily clinical rather than didactic. The major gap is in ensuring sufficient caseload and clinical practice in interval minilaparotomy, as opposed to postpartum tubal ligation.

While vasectomy services have not yet acquired the reach of female sterilization, recent efforts to expand services have made significant strides. In particular, the Management Sciences for Health efforts in rural areas have led to increases in caseload. Efforts in urban areas have been less successful and suggest the need to continue exploring the most effective strategies to reach urban men and couples.

Training in NSV has been hampered from a lack of caseload in training facilities, the lack of certification and accreditation systems for NSV training and trainers. There is a

need to expand the number of NSV trainers and ensure that they have training skills and standard training materials, tools and approaches.

The Department of Health has generally been supportive of efforts to expand voluntary sterilization services and issued a number of directives and policies to enhance sustainable provision of female sterilization services. Guidelines and training materials for male sterilization are currently under production, though there is some confusion about allocations of roles and responsibilities in accrediting training.

Suggestions for future USAID investments include:

- Including VSS costs and impact on contraceptive prevalence in analyses conducted as part of the ongoing contraceptive and commodity security efforts.
- Devote additional resource to assure and control the quality of voluntary sterilization services in general and no-scalpel vasectomy services in particular in order to protect the method from the impact of any complications.
- Explore how gender and gender-based approaches could enhance the success of vasectomy service delivery and training efforts.

Background

The Philippines is divided into 16 regions, 79 provinces and some 1,600 municipalities and cities located on three main island groups; and has a population of more than 80 million people. The country has a contraceptive prevalence rate (CPR) of 48.8%. The use of modern methods is 35.5%¹. Method mix is dominated by two methods: pills as the top modern method choice, followed by female sterilization at 11%.

One issue facing the health care system is the exodus of trained physician and nurses to work abroad. There has been no increase in health personnel salary since the early 90's and the inflation rate has been around 6-8% annually. Thus, in real terms, salaries have fallen steadily. During the assessment, there was nostalgic talk of a previous era before the exodus began. Physicians are even taking up nursing, given the need for nurses in developed countries, including the United States. The country is heading into a real manpower crisis in health.

The purpose of this activity was to:

- Assess the implementation of a DOH initiative to integrate the training in voluntary surgical contraception (VSS) - in particular female and male sterilization which is termed Voluntary Surgical Sterilization (VSS) in the Philippines - into the curriculum of the residency program for obstetricians and gynecologists (Ob-gyn)
- Review curricula and assess the effectiveness of this training and its impact.
- Explore the possibility of expanding the residency training in VSS to other residency programs such as surgery and family medicine.

The assessment was carried out over a two-week period from 26 July to 8 August 2003. The team consisted of a senior international ob-gyn consultant, a Philippine ob-gyn consultant and a program planning and evaluation specialist from JHPIEGO.

Methodology

The methodology for this assessment was to conduct visits to hospitals with residency training programs or district hospitals providing VSS services and to interview Department of Health and Family Planning program officials as appropriate. USAID asked EngenderHealth to provide the team with a list of hospitals. From this list, an itinerary for the two-week period was generated to include various types of hospitals providing VSS services.

During hospital visits, the team first contacted the hospital director to inform him or her of the visit and to ask for his assistance. In all cases, the director was forewarned by a letter and quickly delegated the task of assisting the team to the staff in the ob/gyn

¹ 2002 Family Planning Survey

department, except in the cases of district hospitals, where there are no department and the director acted as one of the key respondents.

Subsequent to meeting the director, the team met with consultants and residents from the Ob/gyn department both to discuss the scope of the residency program in broad



terms and to deliver the questionnaires. At the same time, the team asked if there were still any cases of tubal ligation being provided to avail them of the opportunity of observing clinical practices. If cases were available, the international ob-gyn consultant on the team went to observe. However, there were very few cases at the time of our visits, since most hospitals schedule interventions early in the morning.

Finally, the team asked to be shown around the facilities where services are provided, including the family planning unit.

Tools and modifications

The tools used for this assessment were drafted prior to the visit based on examples of similar tools used in other VSS assessments in other countries and reviewed by email. These consisted of 3 tools, copies of which can be found in appendix B:

- Preceptor Questionnaire
- Resident Questionnaire
- ML/LA Observation Checklist

The local consultant also used the opportunity of a workshop to pretest the two questionnaires and proposed modifications. Additional minor modifications were made after the first two visits, to clarify areas that seemed to cause confusion.



A total of 25 preceptor questionnaires and 37 resident questionnaires were administered. Of the preceptors, the majority were ob/gyn consultants and 2 were surgeons. Also, 4 ob/gyn preceptor questionnaires administered as a pretest are included in the analysis.

The team used group discussion and interviews to assess equipment needs, except when obvious gaps could be observed (such as in operating tables or operating room lights) during visits to the OR facilities.

Hospitals visited

The following hospitals were visited:

- Jose Fabella Memorial Hospital (maternity) in Manila

- East Avenue Medical Center (tertiary care hospital) in Metro Manila
- Quirino Medical Center (tertiary care hospital) in Metro Manila
- Region I Medical Center, Dagupan, Pangasinan province, Ilocos Region
- Urdanetta General hospital (district hospital), Urdanetta, Pangasinan
- Davao Regional Hospital, Tagum, Davao Del Norte province, Southern Mindanao
- Carmen District Hospital (meeting also with staff from Kapalong and Samal District Hospitals as well as Carmen Rural Health Unit), Carmen, Davao del Norte
- Davao Medical Center, Davao City, Davao Del Sur



Interviews

In addition, the team met with several public health officials, including:

- Mrs Luz Muego, FP Officer and Dr. Mejia, Provincial Health Officer, in Lingayen, Pangasinan
- Dr. Honorata Cattibog and Dr. Florence Apale from the Center for Family and Environmental Health (CFEH) at the national Department of Health
- Dr. Kenneth Ronquillo from the Health Human Resources Development Bureau (HHRDB) at the national Department of Health
- Dr. Dolores Castillo, Regional Director, and Mrs Niela Gomela, FP Coordinator, Center for Health Development (CHD) in Davao City, Southern Mindanao Region
- Dr. Agapito Homido, Provincial Health Officer, Davao Del Norte, in Carmen

These individuals provided the team with program information, key documents and national guidelines.

Also, the team met with representatives from two USAID collaborating agencies: EngenderHealth (EH) and Management Sciences for Health (MSH) to explore their areas of intervention in VSS.

All interviewees, whether within or outside hospitals, were asked for their input as to recommendations and future directions in voluntary surgical sterilization or VSS.

Compiling and Analyzing the Data

Data from both questionnaires were entered into a spreadsheet for rapid analysis and tabulation.

In organizing the data and presenting the findings, the team sought to answer 3 questions:

1. Do the facilities visited offer high quality VSS services?

2. Do the DOH-retained hospitals offer high quality training in VSS?
3. What are the recommendations to improve the quality of services and training?

These three questions are repeated in three sections of the report covering tubal ligation services and training, vasectomy services and training and FP program aspects supporting services and training.

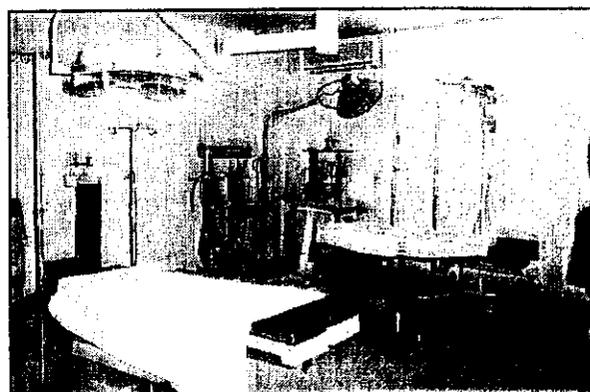
Tubal Ligations: Findings and Recommendations

Facilities

Findings

All hospitals visited except the Davao Medical Center² had a dedicated operating room for what is commonly referred to as bilateral tubal ligation or BTL. This space thus allows scheduling of operations without the risk that the schedule will be disrupted in the case of operative emergencies. East Avenue Medical Center, Urdaneta, Kapalong district hospitals lacked an overhead OR light and, in the two district hospitals, they also need an operating table. Davao Regional Hospital staff report a lack of newer instruments. In other facilities, hospital staff were satisfied with the equipment in the OR.

Most operating rooms were tiled, clean and well maintained. Except in Urdaneta and Davao Regional Hospital, the ORs usually held two operating tables side-by-side, so that a patient can be prepped on the second table, while the surgeon works on the first patient. There is no screen shielding one patient from the view of the other or special attention given to client privacy and medical confidentiality. In one facility where only one table was used, the team observed one client being walked into the OR, while the previous client was still getting off the table.



The surgical scrub sinks do not have elbow or foot handles to allow easy opening and closing of the water flow without assistance. As a result, surgeons risk contamination after hand scrubbing.

The team encountered one recurrent issue with respect to minilap instruments. Physicians are trained in minilap using a so-called Apelo's retractor. This modified

² The team did not have time to visit the facilities at Carmen District Hospital, so that facility is not included in the section on facilities.

retractor has a longer end on one of side and notches to make it narrower at the incision opening. A Philippine physician practicing at Jose Fabella Hospital years ago, Dr. Ruben Apelo, developed this instrument. All physicians have been trained in minilap using this retractor, including the medical staff of EngenderHealth and the physicians trained by this medical staff. However, the instrument is neither part of the standard kit, nor available on the open market for medical products. In both regions visited, hospital staff and the provincial office representatives reported difficulties in obtaining this instrument. A review of the 1999 national DOH guidelines for minilaparotomy refer to this instrument as part of the basic set of instruments required, though it does not list it in the table with the contents of a standard minilap kit. This contradiction is indicative of an unresolved issue in the program.

Most hospitals reported receiving support for expendable supplies and drugs. In Manila, the support most often came from EngenderHealth, while in Pangasinan, the provincial health office provided this through their own local budget. In Region XI or Southern Mindanao, hospitals are expected to include these costs into their budget submissions. The CHD only provides occasional assistance for supplies during outreach services. Staff from hospitals benefiting from outside support report that this support is highly appreciated, especially as their routine budgets have been slashed. Hospital administrators might not be so generous without this external support. In fact, one hospital director told the team that he had cut other activities when he arrived a few months ago, but maintained this one, because "it is a program".

In most cases and from questionnaire responses, it seems that the hospital management is very supportive. In one facility, the director prefers to keep himself removed from VSS activities for religious reasons. In this and other similar cases, the DOH mandate as established in the administrative order for inclusion of VSS in the ob-gyn residency program may provide valuable support for staff in the department.

Recommendations

- Hospital staff should be more conscientious about client privacy. Hospitals should equip ORs with screens between the two operating tables so that patients cannot see each other during the operations. Also, staff should wait until a client has left the OR before bringing in another.
- Equip hospitals according to standards (including OR lights and tables). In particular attention should be paid to the OR sink areas for surgical scrubs.
- Resolve once and for all the issue of the standard instruments for minilaparotomy. There are two options: retrain physicians using standard international retractors (e.g. Army-Navy) or work with medical distributors to add the Apelo retractor to supplies available on the open market. The latter may require proper patenting of the instrument.
- If Engender Health support for expendable supplies and drugs is to end, identify alternative sources of funding for these expenses. Many women served by the hospitals visited are poor and may not be able to absorb the cost of these supplies, unless a cross subsidy system is put in place. However, hospitals would need

support to establish such a system. This is an issue more in Manila facilities than in regional sites.

Clinical Services For Tubal Ligation

Findings

Client Demand Generation (In Reach)

Most clients undergoing tubal ligations in the regional hospitals visited are women who have just delivered in the hospital. The large majority of cases are thus postpartum tubal ligations. This procedure is much simpler than interval minilaparotomies and less prone to complications. In some cases, postabortal clients are also recruited, especially in hospitals participating in the Prevention and Management of Abortion Complications (PMAC) program. A small number of cases are referred from the hospitals' own family planning unit. Typically, family planning services are provided in the hospital's outpatient department, often in the same room where prenatal care is offered.

By contrast, district hospitals serve a majority of interval cases. All hospitals receive additional clients are referred by Volunteer Health Workers (VHWs) and nearby facilities (Rural Health Units).

Counseling

The team did not observe any counseling sessions. Reportedly, midwives or nurses provide counseling. Ob/gyn consultant staff report that they are competent in their counseling skills. The client signs an informed consent form prior to the procedure being performed. A nurse is assigned the responsibility for administering the informed consent form or ensuring that it has been signed. Often, residents also recruit clients on the postpartum and postabortum wards, though in some facilities their schedule is reportedly too hectic for them to have much time for this activity. Some preceptors recommend that this task be formalized in their evaluation. In any case, it is unclear how much real counseling is included in the ward recruitment.

The team notes the practice of recruiting and counseling women for sterilization during labor and in the immediate postpartum. In some cases, the counseling and decision for sterilization takes place during prenatal care when a client can make a sound decision. However, is labor or immediately after delivery the best time for a decision regarding sterilization? The team sees the rationale for this practice as postpartum visits are not standard and rarely occur and this time may be the only chance for the client to get VSS-specific counseling.

Tubal Ligation Procedure (Technique, etc.)

District hospitals have medical officers, commonly referred to as residents although they may have been practicing for decades. In Urdanetta, a retired, non-staff (volunteer) ob/gyn provides tubal ligations on a part-time basis. In regional hospitals and medical centers, residents (ob/gyns in training) perform the great majority of cases. Tubal ligation is a good procedure for learning the skills of opening and closing the abdomen and in cases of postpartum ligations, there are few medical risks for the client, as the

large size of the uterus prevents intestines from interfering with access to the fallopian tubes and thus cannot suffer any injury. Residents are thus highly motivated to perform the procedure. In one facility, competency in tubal ligation is even a prerequisite for performing caesarian sections. In most hospitals, 1st year (second half) and 2nd year residents perform the majority of cases under observation from 3rd or 4th year residents.

The team observed 7 cases of tubal ligation in 3 sites. All residents demonstrated good basic operative technique: good incision, opening of fascia and peritoneum. For ligating the Fallopian tube, the Pomeroy technique seems to be the standard with a few slight variations: at Fabella Hospital, there is just one knot at the base of the loop; in the two other sites, anchoring of the suture in the tube at the base of the loop is practiced. In some cases, the ligation is very close to the suture (less than 1 cm).



Most often, neither the operating resident nor the observer talks to the client before, during or after the procedure. While clients most often are given sedatives (Diazepam and Demerol), talking to the client can maximize the effects of the sedation by reducing the client's anxiety. There are key moments in the procedure where talking is essential – when pain can be expected: opening of the peritoneum, manipulation of Fallopian tubes or intestines. Indeed these "verbal anesthesia" steps appear in the EngenderHealth training materials but are not practiced.

Nurses and OR assistants appeared competent in their care of clients, preparation of the OR, operating area, instruments and supplies.

Infection Prevention

Infection prevention is the area of service delivery most prone to problems. There are a lot of correct practices, such as the use of sharps boxes, wrapping before autoclaving, etc. Also, some hospitals report the existence of infection control teams or office. While the hospitals are usually and generally clean, the team noted deficiencies:

- Surgical hand scrubbing generally does not follow international standards. In all cases, it lasts less than 1 minute (as opposed to 3 to 5 minutes). Soaping, use of a brush and cleaning under the nails is thus abbreviated and substandard. Then hands are dried on the operating gowns.
- Also, operators do not wash their hands or use an alcohol hand rub in between cases; they only change gloves after finishing the procedure with one client and moving on to the next.
- Protective barriers in the ORs: surgeons and nurses are very conscientious about wearing gowns, masks over the mouth and nose, gloves and haimets. However, the team observed a common practice of wearing open sandals, instead of covered

shoes. This can expose them to injuries in case of sharp instruments falling. If a falling instrument is contaminated with blood or body fluids, providers can be exposed to viruses, such as hepatitis or HIV. Similarly, only those providers with regular prescription glasses wear any protective cover over the eyes to shield them against blood spurts³. Simple handmade foam and plastic face shields would be more effective than the current masks used.

- Instrument kits and supplies are opened too early, with long intervals between opening and their use. In one site, the team observed that the table with sterile instruments was placed directly under the air conditioning unit; however, there was space in the OR for the table to be placed elsewhere.
- The operating table is not cleaned or decontaminated between cases.
- Access to the OR is through one door and waste and other dirty items leave from the same door. In Urdanetta, the OR is equipped with two doors (and two sinks), but one door and one of the sink areas are not in use.
- Scrub sinks (used for hand washing prior to the procedure) are also used for decontamination and cleaning of soiled instruments.
- In another facility where this process was observed, the staff cleans instruments with bare hands. Cleaning staff should be made to wear utility gloves and protective gear against splashes to the mouth and eyes.
- Specific to Urdanetta, the hallways in the area outside the OR have rot and water damage on the base of the wall. Note the main surgeon for BTL is a part-time retired physician. On his questionnaire, he himself recommends the need to improve infection prevention. This suggests systemic issues, rather than one of training.

Itinerant Services (Outreach)

All the regional hospitals visited are implementing the DOH program for itinerant services. Hospitals in Manila (East Avenue and Quirino) send teams to one LGU facility, while Region I Medical Center sends teams to various sites based on client demand. In general the outreach program seems to be successful in a number of ways:

- There has been an expansion in the number of clients served through this program
- Services are free during these visits
- The teams reportedly only visit facilities with functioning operating rooms, thus quality is not jeopardized

³ Such blood spurts would be rare in minilaparotomies, but making it a standard part of OR (and delivery room) attire ensures compliance in procedures where the risk of exposure is greater.

- Residents who are part of these teams are exposed to and given a chance to perform interval minilaparotomies, when these are rare in the hospitals in which they are training.

Staff at the participating facility are responsible for counseling and follow up of clients at their facility. This division of roles may mean that cases of infection or other delayed complications are not apparent to the operating surgeon. However, if the visits are frequent enough it is hoped that there is communication about past cases.

There are some concerns in the Manila hospitals about support from EngenderHealth ending, as they may no longer be able to find funds for travel. Instead they report that they have built relationships with the local hospitals or health centers and will ask these to refer their clients directly to the regional hospital. How this will affect client access to services is unclear. In Davao del Norte, the Provincial Health Officer shared his concern that clients in his region are reluctant to access services at the hospitals, as the costs of transportation and opportunity costs of time spent away is too high for agricultural workers.

Davao Regional Hospital (DRH) integrates outreach VSS within a "Surgical Networking Extension Program" for major surgeries, including thyroidectomies, hernia repairs, etc. Tubal ligations are given lower priority (as it does not fit in the "major surgery" category) and clients are often refused services for lack of time.

A DRH consultant also reports that outreach services for interval minilaparotomy are conducted using spinal anesthesia. The rationale for this practice is that it saves time when caseloads are large. However, spinal anesthesia – while more comfortable for the operator as it negates the need for verbal anesthesia – can lead to many more side effects for the client, including hypotension, headaches lasting several days, meningitis, spinal injuries, etc. Also postoperative care must include frequent monitoring over a period of at least 12 hours. Thus, this practice is not recommended. The persistence of this practice does suggest a lack of confidence or skill on the part of the consultants and refresher training might be advisable for clinicians at Davao Regional Hospital.

Recommendations

- Infection prevention must be improved. Providers have been trained; therefore additional training in infection prevention is not needed to change behavior. Instead, IP resource persons should be developed and technical assistance should be provided onsite. Changes can be made at little or no additional cost. Alternatively, in sites where the COPE process is running well, IP concerns might best be integrated into that process to empower staff to make their own analysis and improvements.
- Accreditation of sites providing training should include infection prevention as part of the standards.
- The fact that the majority of clients are recruited from within the walls of the regional hospital suggests that relations between the hospitals and facilities and volunteer health workers (VHWs) who might refer cases could be improved. Staff report that the hospitals' tertiary care status implies that they do not have a proper catchment

area. However, in the case of VSS, they might consider otherwise and at least reach out to communities adjacent to the hospital. This could also ameliorate caseloads for interval minilaparotomy and vasectomy.

- The outreach/itinerant services program should continue if possible. When caseload for vasectomy increases, consultants from the issuing hospitals should be trained in No Scalpel Vasectomy (NSV). All hospital staffs have expressed an interest in this, but at this stage the caseload does not justify conducting training.
- In sites that deviate from standards and where providers are resistant to change (complying with standards), small-scale studies could be conducted. For example, DRH conducts interval services under spinal anesthesia using lidocaine. A study could be organized where VHWs or Municipal Health Officers (MHOs) follow up cases after a week and collect data on anesthesia side effects so as to compare results for each type of anesthesia.

Training Program For Tubal Ligation

Findings

Residency Program Structure

In hospitals visited by the team, there were two models for the organization of VSS services and, by extension, for the inclusion of VSS in the resident training program. In the first, VSS is fully integrated into the department of ob-gyn and the same staff who manage all obstetric procedures also handle VSS (except for IUDs for which insertions are performed in the FP unit). In these facilities, residents learn and practice tubal ligations throughout the four years of residency, assisting in postpartum tubal ligations early in the first year, to performing these themselves under supervision, then to performing interval minilaparotomies under local anesthesia with sedation and finally to working independently without supervision. In East Avenue Medical Center, competency in tubal ligations is a prerequisite for being allowed to perform caesarian sections, creating incentives to seek out BTL cases. In the second model, a separate large family planning unit provides VSS services. In this model, ob-gyn residents only rotate for one month in the unit, during which time they learn to perform tubal ligation. As is further discussed below, the predominantly postpartum caseload in these facilities likely results in residents only being able to acquire skill proficiency for postpartum ligations.

Residents Questionnaires Results

Residents felt well prepared when they began performing the procedure (29 out of 35); only 4 felt either unprepared or somewhat prepared. In contrast, 18 out of 36 felt they had sufficient access to reference materials, while 17 had some access and 1 felt that there was insufficient access. References were most commonly obtained from the hospital library (34), but also from the Internet (11), consultants or professors (9), personal collection (9), friends (5), a university library (5), and other sources (6). Region I consultants were particularly keen to learn of web-based resources to share with residents and the majority of their residents included the Internet as a resource on their

questionnaires. A few of the open-ended recommendations noted the need for additional updated reference materials regarding VSS.

Residents were almost unanimous (36 out of 37) in reporting that they felt well supervised by preceptors. Only one 2nd year commented that this should still improve in the sense that 3rd and 4th year residents rather than consultants supervised her. Similarly, 36 residents thought that VSS skills were included in their performance evaluations. As evaluation can be a strong motivator, this is a positive result.



Only 6 out of 36 (1 missing) reported that their religion posed them some difficulties in performing tubal ligations. All of them still perform the procedure as the training program mandates it. Most residents provided explanations, and in one case reported having decided that some women really benefit from sterilization and that she might continue to offer it when she perceives a great need.

Thirty residents, out of 36 (1 missing), report that they are somewhat or very likely to continue performing the procedure after graduation. On average, they estimate that 80% of their peers will also continue to perform. The predominant reason they cited for not performing was, overwhelmingly, religion. Other reasons included:

- assignment to a facility that does not provide the service (4),
- lack of trained OR nurses or assistants (3),
- lack of demand from clients (2),
- high cost of services (in private facilities) (2),
- lack of confidence (2),
- personal reasons such as lack of time (1) or
- the tediousness of the procedure (1).

Postpartum Vs Interval Caseloads

As noted above, the majority of hospital based cases are postpartum or C-section. This is cause for concern in terms of ensuring resident competency in interval procedures prior to completion of training. Mastery of postpartum cases does in no way indicate or guarantee competency with interval minilaparotomy under local anesthesia (ML/LA). For example, differences include the size of the uterus, the use of a uterine elevator are major differences as well as the potential to cause serious complications by puncturing an intestine in the case of interval procedures. Specific skills and practice are thus needed for interval ML/LA.

The following table presents data on caseload. All interval caseloads include those performed during itinerant services unless otherwise noted.

Table 1. Caseload Characteristics of Hospitals Visited.

Facility	Avg monthly caseload [^]	# cases/resident in past 6 mos by year of residency ^{^^}	% of postpartum cases	% of interval cases
Jose Fabella Memorial Hospital	360-380	2 nd (n=1): 200-300 3 rd (n=4): 0-300	75%	5%
East Avenue Medical Center	40	1 st (n=1): 11 2 nd (n=1): 20 3 rd (n=1): 80 4 th (n=2): 20-30	70%	30%
Quirino Medical Center (2002) ^{1*}	40-80	2 nd (n=1): >40 4 th (n=3): >30	45%	7%
Region I Medical Center (2002) ¹	40-85	2 nd (n=3): 20-50 3 rd (n=1): 40-50	~23%	~10%
Davao Regional Hospital, Tagum ¹	40-50	2 nd (n=4): 10-40+ 3 rd (n=1): 20 4 th (n=2): 0-50 5 th (n=2): 15-20	47%	11%(in house) 44% (outreach)
Davao Medical Center (DMC) [*]	50-95	2 nd (n=2): 5-6 3 rd (n=2): 4-5 4 th (n=1): >20 5 th (n=1): 50	25%	2%
EH annual statistics report 2001 ¹	325 ^{**}	N/A	26%	9%

[^] This is based on preceptor self-report and may include TL during caesarian sections, except for the EH line which is derived from a report.

^{^^} This is based on resident self-report

¹ This line does not add to 100% as the remaining procedures were tubal ligations during C-sections or "other" operative procedures. (Quirino: 48%; Region I: 67%; DMC: 41%; EH stats: 65%)

^{*} Quirino, DMC statistics do not include outreach services.

^{**}PP and interval cases only.

Many residents report having performed additional cases prior to the past 6 months, although all report having learned the procedure at the hospital where they were interviewed (none were trained prior to beginning their residency).

Conversely, district hospitals in the south, have more interval cases. Kapalong gave the team data showing roughly a 2:1 ratio for interval to postpartum while Samal District Hospital data showed that 80% of their caseload is interval. In Carmen, BTL services are offered every second and fourth Tuesday of the month. This system can only accommodate interval cases, as postpartum cases cannot wait two weeks. The only provider performing BTL at Samal is an ob-gyn resident who trained at the DMC. She also had an inservice training course. She reported that her residency had not made her confident in handling interval minilaparotomies.

Approach To Training, Trainer/Preceptor Preparation

None of the hospitals was able to share with us a curriculum for training residents. When pressed, preceptors reported using the EngenderHealth "Minilaparotomy with Local Anesthesia" materials. Through discussions, the team concluded that there is no fixed schedule of didactic sessions to accompany work in the clinical areas, implying that for the most part, residents are not exposed to theoretical information, the GATHER

method of counseling⁴ or principles of infection prevention beyond aspects that can be observed during an operation. Only in Southern Mindanao did preceptors report organizing didactic sessions on counseling, informed consent and in the case of Davao Regional Hospital, infection prevention.

For clinical skills acquisitions, residents are first required to assist operations for a set number of months or cases, before starting on the procedure themselves. Region I medical center and Cagayan Medical Center⁵ are the only programs that utilize anatomical models (Zoe) to demonstrate the minilaparotomy procedure to residents and requires return demonstrations before allowing residents to perform the procedure on clients. When queried about this, a typical response is "we do not need models as we have plenty of cases". Yet the purpose of models is not to replace live clients but to protect them by allowing a trainee to practice the steps in the procedure and become comfortable prior to working with human subjects. In JHPIEGO nomenclature, models allow for humanistic training and protect clients from inexperienced operators.

None of the residency programs actively use learning guides and checklists, whether for residents to follow with during demonstrations or while assisting or for monitoring the performance of residents as they practice the skills. Thus, standard steps, such as counseling, the completion of an informed choice form, abdominal skin preparation, surgical scrubbing or communication with clients during the procedure can easily be skipped. Similarly, these are not used to evaluate the residents and determine whether they are ready to practice the procedure without supervision.

Residents are acquiring the technical skill, particularly for postpartum BTL, but there is no emphasis on other service aspects (counseling, infection prevention, etc.). They may not be exposed to other aspects of the training materials, such as learning guides and checklists for circulating nurses and nursing assistants, which they could use themselves to train staff. Thus, they are ill prepared in establishing services after graduation, whether in hospitals where VSS is not yet practiced or in private practice settings.

Many consultants have attended training of trainers (TOT) courses, but view the approaches learned as applicable to inservice training and not for training of residents. In some cases, 4 to 5 years have elapsed since the TOT and the trainer is unable to recall the skills taught during that course. Even if expectations were made clear that inservice training skills should also be applied with residents, it is uncertain that preceptors would devote the required time⁶ to systematically coach and give individual feedback to residents. Much of that role is now delegated to senior residents. However, they could model the process and thus encourage these practices by senior residents.

⁴ Except in Quirino and Region I where GATHER was mentioned as the method used.

⁵ As indicated from the pretest of the questionnaires with one 4th year resident and a preceptor from that facility.

⁶ Some have private practices in addition to their duties in the DOH hospital.

One preceptor indeed recommended that training skills be imparted to residents as part of the training program.

There is no formal preparation for the preceptor role. Among 25 preceptors who completed the questionnaire, only three respondents (pretest) feel that the expectations for this role are unclear. However, only 15 reported having written guidelines describing their role. The questionnaires did not ask them to describe the document. They may be referring to the DOH Administrative Order No 2 or the POGS handbook. Neither provides a detailed description of the preceptor role.

Competency-Based Evaluation

All the residency training programs visited use a case requirement to certify residents. Residents are required to perform a range of 5-15 interval cases and 5-40 postpartum cases. Only in Davao Medical Center is the number of interval cases required larger than postpartum cases, suggesting that the targets are established with the availability of cases in mind rather than a goal of achieving competency.

An alternative to this system would be to use checklists to determine competency rather than a set case number. Some learners will require more cases than others to reach competency and require additional support and coaching.

Many programs issue residents with separate certificates for VSS as they would for inservice trainees. The authority for this certificate devolves from their status as accredited training centers for VSS. Certificates seem to act as an important motivator in the Philippines. However, other hospitals feel that this is unnecessary given the mandate to include the skill in the program. The team was unable to assess if the programs issuing certificates provide training that is equivalent in breadth and depth to the inservice course. Certainly residents probably experience more procedures, but typically over a longer time period.

Training Facilities

All hospitals had a conference room, equipped with white boards, which could be used for training sessions. The team also noted the presence of computers, printers, photocopiers, television, videos or VCDs, etc. which could support training needs.

In most DOH retained hospitals, consultants reported that they had copies of EngenderHealth materials. However, when asked to show us a copy, they were often unable to locate one, suggesting that these are not used often. Nowhere did the team encounter the DOH/AVSC⁷ "Guidelines on Minilaparotomy" document (1999). EngenderHealth staff commented that part of the problem might be in asking about "the yellow book" when photocopies were sometimes distributed. More often, when a document was produced it was part of the package developed by JHPIEGO and AVSC, printed in 1993.

⁷ AVSC is the former name of EngenderHealth.

The 1999 guidelines are similar in content and structure from the 1993 reference manual, except for a few updates (e.g.; infection prevention content, example of informed consent form) available in the 1999 version.

As noted above, anatomical models are lacking in the majority of sites. Given resident classes of 2-4 (in each year), one to two anatomical models per hospital would be sufficient. Skin repair kits and videos should also be supplied as manipulation of the abdominal slits will rapidly and inevitably lead to tears. In addition, spare "skins" can also be purchased separately from the manufacturer⁸.

Inservice training

A few of the hospitals were originally designated as training centers for VSS and expected to train providers from LGU facilities. Under agreements with AVSC, Region I, Urdanetta and Jose Fabella conducted several courses, but these ended for the most part in 1999. Davao Regional Hospital has recently conducted a course for district hospital providers; however, the duration was shortened to 5 days. Only Fabella continues to provide the standard 2-week courses, including for private provider teams who pay a tuition fee. LGUs rarely devote resources to VSS training, even though they might support the costs of itinerant services. This may be rational, given that additional support is needed to ensure the expansion of service delivery sites, such as supplying equipment and supplies, providing supervision, etc. However, this means that regional hospital trainers are out of practice in performing clinical training outside of the residency program.

Two surgeons trained in ML/LA in an inservice course complained that they never received certificates, despite being told at the end of the course that they "had passed" and were competent. They report feeling the need for certificates to protect them against accusations of malpractice. Reportedly, a bill was recently introduced to enact a malpractice law, however it has not passed. Regardless, certificates should be provided to providers deemed competent at the end of training, based on an assessment of skills.

In addition to 2-week courses for private practitioners, Fabella and other facilities offer a 6-month obstetric surgical skills course for LGU medical officers. At Fabella, postpartum bilateral tubal ligation is included as a skill in that training.

Recommendations

- More efforts are needed to ensure that residents acquire sufficient skills and practice in interval cases and are exposed to potential complications. Resident competency in interval minilap should be assessed prior to issuing certificates.
- Technical assistance should be provided to the DOH and residency program preceptors to design an appropriate generic teaching package for residents, which includes didactic sessions, practice on models and the use of learning guides and

⁸ Gaumard Scientific, the manufacturer, has a website: www.gaumard.com

- checklists for skill acquisition and evaluation. Residency programs can then adapt or apply the generic package as appropriate to their setting.
- In order to ensure that training programs use the same standard, the use of learning guides and checklists must be part of all training programs, whether inservice or residency. While individual obstetrician/gynecologists might deviate from the standard in their own practice, this should not happen in training.
- Zoe pelvic models that can be used for practicing minilap (both interval and postpartum) as well as IUD insertions should be available to all resident training programs.
- The DOH should establish reporting mechanisms, through the Centers for Health Development, which allow for monitoring interval minilaparotomy caseloads at the hospitals and ensure that there are sufficient cases for the numbers of residents trained in these facilities.
- Failing that, residency programs should explore an expansion of outreach services or ensuring that residents continue to practice interval minilaparotomies during their rural dispersals when they rotate to lower level facilities for a period of 6 months. This requires ensuring that the dispersal facilities are suitably equipped for the service. Hospitals or regional health offices might even consider allocating a lot of medications and supplies to residents prior to their dispersal to allow them to perform cases. Such a system should also foster stronger ties between the residency hospital and dispersal facilities and allow resident preceptors to receive reports from and perhaps even visit residents at their dispersal site.
- For inservice training, resolve the issue of certificates and ensure consistent procedures for awarding certificates (see below under Vasectomy).

Vasectomy; Findings and Recommendations

Overview Of Activities And Services

Findings

When devising an itinerary for this assessment, no specific effort was made to allow for visits to active vasectomy sites. As a result, the following findings and recommendation are based on interviews with stakeholders in hospitals, program offices and USAID cooperating agencies. In Carmen, the team was able to meet two physicians recently trained in no scalpel vasectomy (NSV), one by EngenderHealth, the other by a fellow Municipal Health Officer (MHO). In general, use of vasectomy is extremely low at 0.1% of contraceptive method mix according to the latest survey. Program managers report that there was an initiative in the late 70's and early 80's to promote vasectomy, prior to the advent of the no scalpel method. NSV was first introduced when EngenderHealth trained providers in regional courses in Bangkok in the early 90's. Two providers from Jose Fabella Memorial Hospital were included in that course. An NSV clinic was

established (on a separate floor from the FP unit) where an occasional client is served. However, the providers do not include this in residency training, as the services have not been officially accredited.

More recently, with support from EH, male-friendly clinics have been developed in 3 DOH retained hospitals: Cagayan Valley, Tondo and Vicente Sotto, all medical centers. For this process, EH provided technical assistance to train providers and generate client demand and furnished the clinics with equipment, posters and fliers. Client generation is conducted through men's forums and community assemblies organized in conjunction with City Health Offices. Potential couples are invited to the forums for group discussions. Whenever possible appointments are made with clients at that time. EH also schedules training or supervisory visits on the days of the appointments. Tondo MC has so far only served 4 cases, while the other two have seen 29 and 30 cases respectively.

The intent of the itinerant services program is for both male and female sterilization to be provided. At the current time, there is only limited caseload for vasectomy in Manila and none in Region I. By contrast, Region XI has a lot of NSV itinerant services, although these are most often performed by Municipal Health Officers (MHOs). In Manila, the outreach facilities call upon EngenderHealth staff to perform the NSV procedure rather than the issuing facility. In most cases, consultants from the medical centers have not been trained in NSV. In region I, the caseload does not warrant a dedicated staff person for vasectomy. The surgeon who does perform the occasional case uses the conventional vasectomy method with scalpel.

MSH has had more success by using a grassroots approach to generating demand which began late last year. Selected interested LGUs have sent Barangay Health Workers to a refresher course in FP and the use of a Community-Based Management Information System (CBMIS) tool⁹ which allows them to identify couples who are eligible and follow a profile for adopting a permanent method of contraception. The couple is invited to a forum where they are given information regarding male sterilization and other long-term methods. Satisfied users are often present at these meetings to discuss and answer questions about their own experience with vasectomy. Female sterilization services are provided through the EH-supported itinerant services program. When there are a small number of men who have chosen vasectomy, a municipal-level physician is either trained in NSV or, if there is no physician interested in acquiring the skill, an itinerant provider is sent from a neighboring locality. Using this approach, MSH has trained 90 service providers and identified 10 providers or MSH field coordinators as NSV trainers. The providers are distributed in 98 cities and municipalities of 13 out of 16 regions. All 16 regions have LGUs generating NSV clients. To serve LGUs and regions without clients, MSH must rely on itinerant providers. To date, over 3000 men have undergone the procedure, over 800 of which were in Southern Mindanao. This is

⁹ CBMIS as a tool is used for other FP services besides NSV and has been in existence since the late 1990s in MSH-assisted LGUs. Only its use in the NSV program dates back to approximately 6 months ago.

an impressive achievement in a country with reportedly low acceptance of vasectomy and for a period of approximately 6 months.

MSH data show that only 50 NSV sets have been provided, suggesting that some providers do not have sets. The Provincial Health Officer (PHO) from Davao del Norte noted the need for additional sets and would like to learn how to obtain them. In the past, MSH encountered difficulties importing instruments or sets from abroad, both due to low quality of the instruments purchased and problems with customs procedures. They report that a local distributor of NSV instruments has been identified so that sets can be procured from this source.

There are gender issues from both client and provider perspectives. Men prefer male providers. Also, some female MHOs decline offers for training in NSV as they do not wish to perform the procedure.

Recommendations

- Hospitals should explore additional community-based strategies to generate clients, including by collaborating with the City and Municipal Health Offices.
- The hospital-based vasectomy program does not seem to be cost-efficient whereas the community based program has been much more successful and should be continued. Hospitals should demonstrate ongoing capacity to generate cases before receiving training.
- While the CBMIS tool has proven its effectiveness for demand generation, there should be some formative research and experimentation with other types of activities, including using radio programs and articles in the print media. A well-publicized hotline approach could also be tried, especially in urban areas. MSH reports that Satisfied Client groups have spontaneously been organized in a few LGUs. Their experience could be the subject of a case study.
- Information about the approved vendor/distributor for NSV kits in the Philippines should be disseminated to all PHOs and Chiefs of Hospitals.

Training Strategies

Findings

Residency programs

As noted above, most DOH hospitals do not have sufficient caseloads to integrate NSV training in any form of residency training. The only exception is Davao Regional Hospital (DRH), where 2 consultants are trained in NSV and 3 out of the 9 residents who completed questionnaires reported having performed vasectomies. Caseloads varied from 1 for a 2nd year resident, to 4 for a 3rd year and 11 for a 5th year resident. In addition, the Chief of Hospital at DRH noted that, given the female sex of all ob-gyn residents, he would propose that surgery residents learn and practice the skill. However, one of the surgery consultants needs training in NSV. At Quirino medical Center, two surgeons work with the Ob-gyn department to provide vasectomy services,

however they are not trained in NSV, but use the conventional technique (with scalpel), which has been shown to have higher rates of hematomas, bleeding and infections.

In other hospitals and settings, we occasionally asked to speak to surgery residents and enquired about their willingness to learn the NSV technique. In one of the Manila medical centers, surgery residents reported that their department has established procedures that involve the ethics committee before a vasectomy can be performed. While they thought some surgeons might be willing to learn the skill, the two individuals interviewed reported that they personally were not interested. A third surgeon, practicing NSV in a district hospital after inservice training was of the opinion that NSV should be left to ob/gyns during the residency training program. The good news is that despite the predominance of women as ob/gyn residents, a large number of consultants and residents reported the desire to learn and practice NSV. From the client perspective however, a male provider might make them more at ease. There are reports of clients gasping or covering their faces in embarrassment when they see a female physician entering the procedure room.

In most cases, however, it is premature to even consider standardizing training in residency programs, as the caseload is just not there to systematically train all residents from any department. The skill could be taught on models only at least for specialists to have exposure to NSV but would likely not translate into practice in the field. At this stage, training in hospitals can only be on a voluntary basis for residents who express an interest and when there are cases. For surgeons to be trained, the example of Quirino Hospital in good interdepartmental collaboration and coordination will be required.

Inservice Training

In the early days of MSH's NSV efforts, in late 2002, EH clinical staff acted as trainers both for their own program and under a collaboration arrangement with MSH. Now, 8 months later, MSH staff can rely on a group of experienced service providers and MSH field coordinators as trainers. However, these individuals have not attended a clinical training skills course. In addition, EH has conducted standardization workshops for trained providers to ensure that they are aware of the standards and guidelines. For example, EH recommends a post-vasectomy sperm count. However, most MHOs do not have access to a microscope so this is difficult to implement in the field.

Between two hospital visits in Manila, the team made an impromptu visit to a neighboring Friendly Care Clinic¹⁰. By coincidence, the FCC manager - Dr. Raffi Linawag – and two Engender Health trainers appeared. They reported that a course in NSV was about to start for FCC providers. The didactic portion would last 4 half days.

¹⁰ The team also learnt that one of the Manila Friendly Care clinics (although not the one visited) provides tubal ligations. In fact, Dr. Maglaya is one of the providers.

Thirty four cases¹¹ had been scheduled for the following week in a far flung location and two of the 6 participants were to travel with a trainer to undergo practical training. The remaining 4 providers would wait for cases to become available at one or another Friendly Care clinic to complete their training. This model of training provides a good alternative, particularly if the lapse between the didactic and clinical session is not too long.

MSH's training approach is to send the EH NSV course materials to the physicians at least 2 weeks prior to the training with instructions to read the material. One trained physician reported that he received the materials during an orientation organized by MSH when they launched the NSV initiative. Also in the package of materials is a checklist of materials and supplies to be prepared for the services (not including the NSV kits which are provided by the trainers). At a designated time, the vasectomy cases are brought together for services and at the same time one or more local physicians are trained. The trainer meets with the physician(s) to review the materials in the course, review that the necessary supplies are in place and check on infection prevention. There is no formal assessment of trainee knowledge concerning the content of the manual. This gap signifies that there is no emphasis on certain aspects of service delivery, such as the rare but possible occurrence of complications and how to manage them. Two trained physicians interviewed report that they were not given the opportunity to use a model to practice the skill or learn how to manipulate the instruments. The services are provided under supervision from the trainers. MSH has made adaptation to the EH materials and developed guidelines for NSV training which includes the use of checklists for the procedure. Certification is withheld until up to 3 rounds of service delivery sessions supervised by a trainer.

A training video compact disk (VCD) exists which includes a demonstration of the procedure. This video is intended as a demonstration for physicians learning the technique. One Southern Mindanao physician reported that he has shown the video as part of counseling to potential clients. According to him, clients felt reassured after watching it as they could see that the intervention is neither bloody nor very painful, unlike circumcisions. Formative research on the use of such videos might expand available information of their potential in client counseling and recruitment.



¹¹ During a conversation at the end of the two-week assessment, after the clinical portion had been completed, the trainer, Dr. Cynthia Garcia, reported that only 18 clients actually presented themselves for training. Each provider was still able to perform 7-8 cases.

Both MSH and the Center for Family and Environmental Health (CFEH) at the Department of Health report that the NSV training materials are being revised and prepared for official accreditation as the national NSV training package.

Recommendations

- As part of completing the process of finalizing the NSV training materials, there should be additional attention given to ensuring that providers have absorbed the knowledge elements of a high-quality vasectomy service, including how to manage complications. For example, a knowledge test should be applied. In addition, a counseling role play should be performed to assess the providers' ability to communicate effectively with clients and the trainers should demonstrate, coach and observe the use of NSV instruments on a model before proceeding to service delivery. JHPIEGO developed a self-paced NSV training package in Nepal, which is adapted to a training approach similar to that of the MSH program. If MSH and the DOH are interested, JHPIEGO could send a copy of this package as an example for the finalization of the Philippines document.
- An alternative model to the MSH approach to training (remote knowledge acquisition and clinical practice onsite when cases are available) is the one used by Friendly Care clinics where a group-based didactic portion (which includes classroom work on models and counseling role plays) precedes the practical clinical skills component.
- Follow up of trained providers is needed to ensure that trained service providers are effectively applying their NSV skills to eligible and willing clients (transfer of learning). This follow up can also contribute to greater quality improvement as it provides opportunities for additional coaching and support to providers and correction of potential problems.
- MSH has developed a handmade model from a glove or clipboard. While the low cost of this model makes it a great learning tool, there are also alternatives available where providers have to find the vas "blindly" (in the glove model, the membrane is so thin, that the simulated vas can be seen rather than felt). Gaumard Scientific¹² manufactures a vasectomy model for about \$200 (JHPIEGO has access to deep discounts for its own programs and obtains them for about \$57). These models should be made available to trainers who train large volumes of providers.
- Service providers identified as trainers by MSH should attend a clinical training skills course to standardize their training skills, particularly in the use of learning guides and checklists, demonstration, coaching, providing feedback and competency-based evaluation. They should then become certified as NSV trainers so as to facilitate their training activities. As their role as trainers will also include follow up of trained providers, they should be oriented to aspects of supportive follow up/supervision.

¹² Gaumard accepts orders for models online at www.gaumard.com

- The team heard several reports that the process of certifying NSV providers is problematic, in part as there are no officially accredited trainers for this skill. One of the Southern Mindanao providers states unwillingness to provide the service without a certificate for fear of repercussions. MSH is aware of the problem. Ideally, MSH would like both the providers performing the training and the DOH to be part of the certification process. In any case, the process should be formalized. Advocacy to the Health Human Resources Development Bureau at the Department of Health (HHRDB) is needed.
- According to MSH, there is a need to expand both the number of NSV providers and trainers to meet the needs of clients generated under the Matching Grants Program. Indeed, according to data provided by MSH, it seems that there are still significant numbers of LGUs underserved by a trained provider and regions without NSV trainers. Any planning of expansion should include considerations for ongoing quality assurance and supervision.

FP Program Aspects

DOH, National Policies

Findings

During our visit, the Center for Family and Environmental Health (CFEH) staff gave the team copies of the 2001 National Family Planning Policy, the 2000 AO No 2 Implementing Guidelines for Strengthening the Training In ML/LA for Resident Physicians in Ob-Gyne in all DOH Retained hospitals and Medical Centers, and the 2002 AO 153 Implementing Guidelines for the Creation and Operationalization of Outreach/Itinerant Teams for VSS. A review of these documents does not elicit any concerns.

One item of the national policy enjoins CHDs to re-accredit all FP service and FP training institutions every three years; however, the procedures for such accreditations do not exist at the national level. The Southern Mindanao CHD is not aware that they have been delegated this task and needs guidelines on how to implement the policy. The accreditation issue is important in resolving problems linked to certificates noted above. CFEH staff report that a process is underway to develop a standard training center accreditation process for all health areas (which integrates Sentrong Sigla for example). In the meantime, accreditations issued prior to the 1998 DOH reengineering process are still recognized. However, the Chief of the HHRDB reports that this effort has been abandoned after a draft process was rejected at higher levels.

The CFEH also shared copies of the "Guidelines on Minilaparotomy" with the team. As noted above, dissemination of this document to service facilities may not have been effective, as the document was not seen or referred to in any of the site visits or interviews.

When prompted about their role in demand generation, CFEH (and the Region XI/Davao del Norte PHO) only commented that this was an LGU responsibility, yet the

National FP Policy suggests that CFEH should provide technical assistance in the development of IEC programs and materials. They did indicate having set standards for demand generation in the form of launching the Responsible Parenthood Movement, an initiative that promotes fertility awareness. This initiative emphasizes natural family planning methods, which have reportedly been neglected in earlier program efforts.

All VSS services, i.e. male and female sterilizations, are covered under the national health insurance program or PhilHealth. This insurance program covers civil servants and additional self-subscribing members. CFEH staff report that a process is underway to expand coverage to all outpatient procedures. An actuarial analysis is being performed.

CFEH staff report satisfaction with the collaboration with USAID agencies in the implementation of the VSS program. In particular, they report that the itinerant services project has more than doubled the number of new cases for VSS.

They acknowledge that the uptake of vasectomy as a FP method is still below expectation. Reportedly, a 3-day conference in Davao recently examined the issue of vasectomy and issued recommendations for overcoming barriers.

The team also met with the Chief of the HHRD Bureau who explained that specialty societies take the lead in developing and monitoring residency programs. HHRDB's role is one of advocacy to these groups to ensure that the programs meet national goals, needs and objectives. HHRD also participates in performing needs assessments for inservice training, developing nationally accredited training curricula and training centers and evaluating training programs. Current evaluation efforts are focused on the DOH Women's Health program¹³, which recently ended. As mentioned above, the standards for training center accreditation were not accepted, and the efforts to revise them have reportedly been abandoned. Currently, chiefs of hospitals are responsible for all accreditation, whether for services or training programs. However, this does not apply to providers in rural health units – MHOs. Nor does it make sense for hospitals to declare themselves accredited without reference to a common standard.

Recommendations

- The issue of training center accreditation should be resolved. For ML/LA, the issue may not be as pressing, given that the resident training programs already are providing additional trained providers. It is not clear whether the residents will continue to practice and where they will be placed after graduation (many report the goal of entering into private practice). However, the accreditation issue will continue to surface in conjunction with the NSV program. The CFEH in particular wishes to have a system established which delegated the implementation to the regional level (Center for Health Development). However an agreed set of criteria need to be

¹³ Dr. Ronquillo explained that the Women's Health program was a current DOH program of 4-5 years. He described it briefly but the team's interview did not probe further regarding this program when it became clear that family planning was not a major component.

established as well as a process, which includes the appropriate expertise (e.g. a technical advisory board at regional level).

- The DOH should continue to actively monitor the outreach/itinerant services program to make sure it continues, especially since EngenderHealth support is about to end.
- The CFEH remains concerned about the institutionalization of VSS activities in the hospitals, especially in light of budget cuts. They see a need for continued technical assistance in building training capacity and providing logistical support.
- The new training strategy, particularly with respect to NSV, is to identify individual providers as trainers and allow them to come to the facilities of potential trainees to conduct the training. However, there are some concerns that these trainers might not be released from their usual duties as providers to conduct training activities, especially if they do not come for identified training center hospitals. DOH advocacy may be needed to help NSV trainers perform effectively.
- The CFEH recognizes the need to strengthen supervision systems as they report that EngenderHealth has been doing most of the technical supervision. The MSH approach of peer-to-peer training in NSV is particularly difficult to supervise. The issue of supervision is important and resources need to be allocated for it.
- USAID agencies should involve the Health Human Resources Development Bureau in their training efforts so as to gain official recognition of their efforts. This applies particularly to the development of NSV training materials. Doing so will help institutionalize USAID investments.

Provincial Government Offices (Pangasinan and Davao del Norte)

Findings

Pangasinan

During a joint visit to the provincial population and health offices in Pangasinan, the team learned of extensive efforts at the provincial level in Pangasinan to support and extend VSS services. In this province, the Health office is charged with service delivery aspects of FP while the population office handles the overall program and outreach. This was reported as an unusual allocation of responsibilities. The Population Officer described the role and training of VHWs, Barangay Service Point Officers, in using the community based MIS system (CBMIS) to identify eligible users of FP and provide them with information, counseling and referrals, resupplying clients in condoms and pills and serve as advocates for FP at the Barangay level. The BSPOs devote more time to FP than regular VHWs. They are provided a basic course in FP that includes interpersonal communication and counseling using the GATHER approach and an orientation to the referral system.

There are 4 hospitals in the province accredited for VSS services. Other hospitals only provide tubal ligations during C-sections. The provincial CPR is 46%, with approximately 36% modern methods. Female sterilization is the second most used

method after the pill. Injectables come third. The provincial guidelines have established a price of 300 pesos for tubal ligation. This is considered cheap enough that even PhilHealth cardholders often chose to pay it out of pocket, possibly so as to "save up" coverage for the 45 annual inpatient days.

Vasectomy is almost nonexistent. There seems to have been a case of vasectomy several years ago where the man allegedly became impotent. It is unclear if the procedure was linked to his condition. It is now very difficult to convince couples to choose this method. Nevertheless, there is an initiative with women's groups whereby women promote the method with men.

The provincial government funds the FP program with its own budget and receives no external funding. This includes support to hospitals for BTL, although they also report difficulty in procuring minilap kits, in particular the Apelo retractor. The Population Officer reports that mayors are generally supportive of FP.

Davao del Norte

The Provincial health officer described the system of health development clusters existing in his province. Each cluster has a functioning tubal ligation service delivery site.

The PHO, having been trained in performing tubal ligation, advocated for liberalizing standards and allowing spinal anesthesia. The disadvantages of this have been discussed above.

He also suggests that client recruitment for NSV might be enhanced if MHOs provided the services in client's homes. There are no medical reasons for not allowing this practice, as long as cleanliness and appropriate follow up can be ensured. However, this may not be effective in increasing recruitment. Men sometimes come to services in groups of friends and may prefer knowing that other men are going through the same experience. However, there is no harm in testing this approach.

Cost

In Jose Fabella, the hospital asks for a voluntary payment but does not impose it if the client cannot afford to pay. In other facilities, services are either free or payment schedules have been established according to socio-economic status with different fee amount by levels. Hospitals can claim reimbursements for sterilization of all national insurance cardholders. While the team did not interview clients, it appears that cost should not be a barrier to services.

The Chief of Kapalong District Hospital is concerned that the day is approaching when they will be expected to charge clients for services. Already, she reports that they receive some clients that could have been served at Davao Regional Hospital but were dissuaded by the fees charged there. The Provincial Health Officer, however, reports that uniform rates have been established for all LGU hospitals recently and that there is no plan to change these to include fees for tubal ligations. However, he did add that this could change at any time.

PhilHealth insurance covers a proportion of clients (roughly estimated by staff as somewhere between 20-30 percent, thanks to the indigent program). At many hospitals (e.g., Davao Medical Center), PhilHealth enrollment can take place on-site. Staff report that this offers a significant contribution to the hospital's overall financial resources.

The Chief of Davao Regional Hospital mentioned an innovative approach to supplementing his budget and supporting the costs of his facility. He is negotiating agreements with neighboring banana growers whereby employees receive services at the hospital in exchange for a flat fee and an annual invoice. The Chief suggested that family planning educational sessions and services could be made part of the agreement.

Recommendations

- The provincial team in Pangasinan seems very dynamic and committed to the family planning program. The team would benefit from technical assistance in developing quality assurance programs, as they express the desire to have the Urdanetta hospital become an accredited training center for VSS despite its problems in the area of infection prevention.

Philippines Obstetrician/Gynecologist Society (POGS)

Findings

The team unsuccessfully sought to meet a representative from the Philippines Obstetrician and Gynecology Society or POGS. In particular, the team wished to meet with a member of the Board of Examiners, which oversees the residency program. However, POGS representatives reported being too busy with resident examinations to find time for a meeting.

The team did obtain a copy of relevant sections of the POGS Handbook, which describe the skills and competency to be obtained by year of residency. Relevant FP topics included are:

- Advocacy and Counseling in FP (Natural and/or Artificial) (First Year objectives)
- Postpartum Bilateral Tubal Ligation (Second Year objectives)

There are no case requirements for FP or requirements to learn interval minilaparotomy or vasectomy.

The POGS handbook also describes the requirements for accreditation of a hospital as a residency training site. These requirements all refer to hospital facilities (e.g., a library, inpatient and outpatient wards, delivery rooms, operating rooms, etc.). There must be at least 2 board certified ob-gyn consultants. Beyond that, there is no specification about the teaching competencies of these consultants.

Approximately 30% of ob-gyn residency programs are not in DOH retained hospitals. As a result, skills in interval minilaparotomy may not be transferred to their residents. The team did not visit any such facility.

Allegedly, POGS leadership comprises of a few devoutly religious physicians who obstruct family planning initiatives.

Recommendations

- There should be continued advocacy to POGS to seek the integration of the content and spirit of the DOH administrative order pertaining to the residency program and VSS and to ensure consistent and standardized application of the guideline in practice. For example, knowledge and skills in VSS should be included in resident examinations. Catholic hospitals could make arrangements with other high caseload hospitals for the residents to do one- to two-month rotations and acquire VSS skills.
- POGS should participate in the development of a generic training package for transferring skills in VSS. Similar training approaches (use of models, learning guides and checklists) could enhance the teaching of other ob-gyn skills.

CAs (MSH and EH)

Findings

The team met with representatives of both EngenderHealth and Management Sciences for Health (MSH) to discuss VSS activities, lessons learned and future directions.

The EngenderHealth Medical Officer described several EH projects and initiatives, including a regional training center development initiative and the VSS outreach program (itinerant services). For vasectomy, EH sought to establish 3 DOH retained hospitals as NSV training centers. In addition, EH staff have provided technical assistance in the form of training in NSV skills to providers identified by MSH under the Matching Grants Program.

MSH activities have already been described in the Vasectomy section of this report.

Recommendations

- The CBMIS and community forums seem to be effective approaches to generating clients for long-term methods in rural areas. These best practices should be replicated and expanded.
- Alternative strategies, such as a hotline and others mentioned in the above method-specific sections, seem necessary in urban areas. Operations research might uncover successful approaches.
- Given the disparate nature of service providers interested in receiving skills training in NSV, USAID and its cooperating agencies could explore the use of computer assisted learning for the knowledge and clinical decision-making components of training. This training could be delivered using CD-ROMs to MHOs with access to computers.
- MSH or any other agency working in vasectomy must put in place rigorous monitoring and follow up systems to minimize the chances of a complication leading to reversals in method acceptance. Also, a mechanism must be any suspected complications must be q

Future Directions; Suggestions for USAID

USAID investments in voluntary sterilization services have historically been critical in making this method available to, not only Philippine couples, but to many countries worldwide. USAID's comparative advantage, as a humanitarian assistance agency providing state-of-the-art technical assistance adapted to low-resource settings, allows it to make advances in technically more challenging areas in ways that bring long-lasting benefits and are sustainable. As new health challenges occur, USAID needs to build on its past investments while breaking new ground.

A critical issue worldwide and for the Philippines in particular is contraceptive and commodity security. Many interlocutors throughout the assessment visits were aware of this new challenge (and not a little anxious). USAID again has been a champion of efforts to resolve the contraceptive security issue. The challenge in the future is to look at contraceptive security broadly and include voluntary sterilization services in the analyses, projections and forecasting of contraceptive needs. There is a risk of omitting VSS from these analyses, as commodities are not an obvious component of this method. Yet, the danger is that current budgetary support for the VSS infrastructure (in equipment, supplies, training, residency programs, quality assurance, etc.) will be undercut in government planners' efforts to fill gaps for other contraceptive commodities. USAID/Manila can ensure that contraceptive security analyses and scenario include cost information for sustaining female sterilization at current or higher levels.

Two methods, female sterilization and pills, dominate the Philippines method mix. Recent work by John Stover and John Ross¹⁴ suggests that this limits the country's ability to reach replacement fertility. The Mission should continue to support Government of Philippines efforts to expand method choice. This includes continuing to invest in male sterilization.

Another lesson learned from the decades of USAID efforts in family planning is that the period of introducing a new method to a country is a fragile time. In the Philippines, vasectomy is not new, but has never gained general acceptance. Also, the use of the no-scalpel technique is not yet established. Therefore, USAID's efforts in expanding vasectomy must draw upon best practices in introducing new methods of contraception.

This includes a rigorous effort at ensuring quality. As the assessment team observed in Region I, a single case with real or perceived complications can have long-term effect of future acceptance of the method. USAID and its partners in the Philippines must put in place systems and mechanisms to prevent such complications from happening and for managing cases of complications so that they do not become program-defeating rumors. To do this effectively, there must be:

¹⁴ 2002. Ross, J. and J. Stover. Trends and Issues Affecting Service Delivery Over the Next Decade. POLICY project, The Futures Group International. Washington, November, 2002.

- Good client counseling
- Good client follow up
- A protocol and system for handling reported cases of complications
- Good provider post training follow up and supervision to ensure quality of care

Good counseling is essential to delivering any family planning method. New methods require special emphasis on counseling, as knowledge of the method is low. In addition, men have historically been less active in family planning and thus need additional support and time to make informed decisions. Physician training in NSV must include adequate time for counseling. If possible, additional efforts should focus on training male counselors and male community health workers in vasectomy counseling, to complement and back up the counseling of the physician.

Counseling and client follow up are linked as follow up will only be successful if there is a strong emphasis on establishing a rapport with clients and providers. High quality training will ensure that complications are rare. However, established protocols and mechanisms are still needed when those occur.

A good provider-client relationship will contribute to improved success in handling cases of reported complications. Clients will naturally feel very vulnerable in case of any feared or real complication, and may lack the language to discuss their feelings or apprehensions regarding sensitive matters of sexuality. Providers themselves will shy from such discussions unless training has prepared them adequately. USAID may want to invest in a small case-control study to explore whether workshops on gender and sexuality with vasectomy providers, in particular with individuals who are willing to offer the services but not generating many cases helps them improve their performance and reported confidence in providing services. If gender and sexuality training helps providers better communicate with clients and feel more comfortable, it may be worth the investment to make that kind of training a systematic part of the program (or a reward for committed providers?).

In addition, protocols and training materials need to emphasize and teach how to counsel clients appropriately. Some reports will be for problems unrelated to the procedure, yet still require taking the client's complaint seriously, addressing it professionally and compassionately. There should also be a requirement for providers to report all complications. More common complications such as scrotal hematomas will then simply be tracked to flag providers who report many complications for additional supervision; while more serious complications should trigger a special audit. This requires a system at provincial or regional level, which needs to be planned and documented. The response system needs to be fair, seek to protect providers, yet correct any technical or behavioral deviation from protocols. This cannot be a punitive system, otherwise providers will fail to report, but must be seen as a resource for providers during the introduction phase of the method.

In sum, USAID needs to build on past investments and continue to champion both male and female sterilization. USAID service delivery resources in VSS are best directed toward quality improvement and assurance both for vasectomy as a new method and for tubal ligation as the current residency training programs has some weaknesses in training new physicians in interval minilaparotomy.

Summary of Recommendations

- Specific strategies are needed to ensure that residents become competent and confident to perform interval minilaparotomies under local anesthesia. Competency could be enhanced through additional theoretical didactic sessions clarifying clinical decision-making factors in the evidence around minilaparotomy as well as more formal coaching (using checklists and effective performance feedback) during those cases that are available. The existing outreach services should be continued and a system is needed to ensure that all residents participate in a few outings as these offer more interval cases. Other opportunities could exist during rural dispersal to district hospitals. Finally, improved coordination with neighboring facilities to encourage referrals could increase the number of cases in DOH retained hospitals.
- Similarly, there is a need to more generally formalize the training of residents in VSS. Much of the current content of inservice training is not included in the residency program. In addition, the use of evidence and competency-based training (using a curriculum, lesson plans, audio visual aides, learning guides and checklists for skill acquisition, coaching and for competency based evaluation and feedback) would benefit the entire ob-gyn program. However, unlike other operative procedures learned by residents, VSS may not be practiced in all sites where they will be practicing, so they must be made aware of management and organizational issues as well as the technical skill. They must be able to orient nurses and midwives to the relevant information to include in counseling and infection prevention. They should also be aware of what to do if complications occur, even if they are unlikely to have seen them in their own practice in the residency program.
- Infection prevention practices need improvement. This assessment did not include a full review of infection prevention in hospital-based settings, but only noted a few aspects as could be observed during tours of the facilities or during operations. Nevertheless, the team uncovered sufficient numbers of deficiencies that action is required. Additional training is most likely not needed, as the problem is not in the lack of knowledge but in applying the knowledge to practice. Infection prevention trainers should spend a few days in each site to provide onsite assistance to staff in how to assess and address gaps in infection prevention practices. Often, simple measures can be taken to ensure improved practices, yet these are not obvious to providers already used to their environment. An international IP trainer can also coach a small number of Philippine resource persons in how to work with facilities in this area, so that resources become more readily available incountry.

- Accreditation of trainers and training facilities is a recurring issue throughout the assessment. While delegating the tasks to the regional level is appropriate, approved standards and guidelines for the process are needed. To address this gap, the national DOH should convene one or more meetings to draft standards for accreditation. CHD representatives, the specialty associations and a few trainers should participate. The process can be limited to family planning or expanded to cover all the DOH needs, if that is where the DOH decides. USAID may need to offer technical assistance to ensure follow through in the process. The final results, once approved, should be well disseminated to all CHDs.
- Vasectomy requires continued investments from USAID and its partners to ensure high quality services in the initial stages of method re-introduction and expansion. Quality in the context of this male method may include additional operations or formative research on the role of gender for both clients and providers.
- In pursuing contraceptive and commodity security for the Philippines, USAID should ensure that the costs of supplies for VSS are included in the analyses. Female sterilization is already widely accepted and contributes greatly to the country's efforts to reach replacement fertility. Contraceptive security concerns tend to shift program attention away from permanent methods to shorter-term methods, such as the injectable. Caution is needed that this does not translate into changes in method mix away from long-term and permanent methods.

Conclusion

Female sterilization has been the second most popular contraceptive method in the Philippines since the 1980s. All residency programs in DOH-retained hospitals visited by the team are complying with the DOH mandate to train residents in minilaparotomy. This in itself is a remarkable achievement and represents a long-term investment in ensuring the supply of VSS services in the country.

While no scalpel vasectomy training is not at the same stage, there are promising best practice models available and tremendous potential to expand services widely. However, continued efforts and investments will be needed before vasectomy becomes one of the mainstream methods. Special attention is needed concerning the gender issues involved in reaching men and promoting male contraceptive behavior. Establishing vasectomy services should result in a wider array of method choices, greater reliance on long-term methods and a more sustainable family planning program.

Despite the current strong emphasis towards natural family planning, reportedly to correct past neglect of these methods, FP program managers remain committed to the VSS program and to all methods of family planning. The current concern with contraceptive security, linked to USAID's demand for commodity cost sharing, could have two different outcomes with respect to sterilization: it could either lead to greater emphasis, as a non-commodity dependent method, or it could be neglected as managers struggle to address a contraceptive security crisis. USAID and other donors must thus ensure that VSS remains an important part of the national FP program.

Appendices

- **Contact list**
- **Data collection tools**

Contact List

Department of Health

Center for Family and Environmental Health

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- Dr. Florence Apale, Medical Officer

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- Dr. Kenneth Ronquillo, OIC

Pangasinan Population Office,
Lingayen, Pangasinan

- Ms Luzviminda Muego, Provincial Population Officer
- Dr. Mejia, Provincial Health Officer

Center for Health Development, Southern Mindanao, Davao City

- Dr. Dolores Castillo, Director IV
- Ms. Nelia Gumela, FP Coordinator

Carmen Provincial Office, Tagum, Davao del norte

- Dr. Agapito Hornido, Prov. Health officer

DOH and LGU Facilities

Dr. Jose Fabella Memorial Hospital

Manila, Philippines, tel 3146015, 7355561 to 65 loc 130

- Dr. Emily S. Bernardo, Head, Comprehensive Family Planning Center
- Dr. Nilda Catarroja, Medical Specialist III

East Avenue Medical Center, Quezon City, Philippines, tel. 9280611/9269740

- Dr. Gilbert del Castillo, Medical Center Chief II
- Dr. Elenita Veloso, MS, Family Planning Service
- Dr. Salvador, Dr. Espanol, MOIII, Dept. of Surgery
- Dr. Yrastoza, MOIII, Dept. of Urology

Quirino Memorial Medical Center

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- Dr. Rosalinda Arandia, Medical Center Chief II
- Dr. Lily Gomez, MS III, Family Planning Service
- Dr. Albert Capuano, MS III, Dept of Surgery
- Dr. Romeo Albarry, MS III, Dept. of Surgery

Region I Medical Center, tel. 0755220041

Dagupan, Pangasinan

- Dr. Jesus Canto, Med. Center Chief
- Dr. Helen Manzano, Chair, Dept. OB-GYN
- Dr. Rico Reyes, Vice chair, Dept. OB-GYN
- Dr. Casimiro Bacugan, Head, FP Service

Urdaneta District Hospital, Pangasinan, tel. 0755682470/5682420

- Dr. Edwin Murillo, Chief of Hospital
- Dr. Rolando Queliza
- Dr. Bernardo Macaraeg, MOIII

Davao Regional Hospital, Tagum, Davao del norte, tel. 0842182823/4003144

- Dr. Romulo Busuego, Medical Center Chief
- Dr. Agnes Resurreccion, MS
- Dr. Amelia Ang

The list of residents interviewed in the facilities is available from JHPIEGO upon request.

EngenderHealth

Manila

- Dr. Francis Floresca
- Dr. Cynthia Garcia

Management Sciences for Health

tel. 5257145

- Dr. Sonny Magboo
- Dr. Beng Viola

FriendlyCare

Friendly Care Clinic, Cubao, Quezon City

- Dr. Raffy Liwanag

JHPIEGO

Country Representative

- Elizabeth (Elsie) Valles

VSS ASSESSMENT – RESIDENCY TRAINING PROGRAMS – PHILIPPINES

July – August 2003

RESIDENT PRECEPTOR / INSTRUCTOR QUESTIONNAIRE

Preceptor (Name): _____

Position held at center: _____

Today's date: _____

Name of School/Hospital: _____

Location: _____

(City)

(Province / Region)

(District)

Type of Facility: Government Private

Voluntary Surgical Contraception (VSS) Preceptor Profile

1a. Are you a teacher/professor associated with a medical school?

Yes No Don't know

1b. If yes, is your faculty appointment...

Full time Part time

2. Please specify your role in the residency program? (Check all that apply)

Overall Director/planner/manager of the program

Classroom instructor

Clinical instructor

All of the above

8. Even if you do not teach them this, are residents also taught No Scalpel Vasectomy (or performing NSV in this facility)?

Yes No Don't know

9. To your knowledge, does the teaching of residents [in VSS] follow a teaching plan or outline (laying out which activity to conduct when, how, schedule of student assessments etc.)?

Yes No Don't know

Please describe that plan or give us a copy: _____

10. Does your current work with residents include: (check only one)

- Clinical work only
- Classroom work only
- Classroom as well as clinical work

11. Which of the teaching methods listed below do you generally use to teach residents what percentage of the time do you use each of the teaching methods?

METHOD	✓	PERCENT OF TIME USED
Lecture		
Role play		
Case study		
Small group discussion		
Large group discussion		
Videos/slides/PowerPoint		
Demonstration		
Other (specify):		

12. Does the training of residents in VSS include the use of anatomical models in a classroom?

Yes No Don't know

Which models: _____

13. Do you personally use the models in your teaching?

Yes No

Please describe how you used models: _____

14. Do residents practice with anatomic models before actual performance of the procedure during training in VSS?

Yes No Don't know

15. What areas of VSS services are covered in the resident's training and with what level of emphasis

Area of services	Level of Emphasis		
	Low	Medium	High
Counseling			
Informed consent (including documentation)			
Medical screening/preoperative assessment			
Pelvic examination			
Anesthesia			
Clinical procedure			
Verbocaine (verbal anesthesia)			
Postoperative care			
Infection prevention			

16. How much time is allotted for the training of residents in VSS (or how much time is available for residents to practice VSS skills at this facility)? Please describe in context of rotation.
- _____
17. What happens if no cases (or not enough cases) of VSS occur in the time allotted for training/practice?
- _____
- _____
18. How many cases per month on average are performed in this facility?
 _____ BTL cases and _____ vasectomy cases
19. How many VSS cases are typically performed/required for each resident?
 _____ cases
20. How many OB-Gyn residents train here? _____ residents
21. How many residents do you train at a time in VSS? _____ residents
22. Are you aware of the administrative order from the Department of Health regarding inclusion of VSS in the residency program?
 Yes No
 If yes is this being implemented? Yes No
23. How often do clinical instructors/preceptors meet to discuss the performance and progress of residents in training?
 At least once a week
 At least once every 2 weeks
 Once a month
 At the end of a rotation which lasts _____ weeks/ _____ months
 Other (specify): _____

24. How is the resident's performance in VSS documented?
[] Written report
[] Oral report by clinical instructor to residency supervisor
[] Other (specify): _____

25. Does the resident get feedback on his or her performance (e.g. copy of report)?
[] Yes, copy of written report
[] Yes, they get verbal feedback on their performance
[] No, they only get a grade
[] No, they only know how well they performed for the whole year, all rotations combined
Comments: _____

26. What do you feel are the biggest problems in the training of residents in VSS?
Please describe:

27. What improvements would you like to see in the residency program?
Please describe: _____

THANK YOU!

VSS ASSESSMENT – RESIDENCY TRAINING PROGRAMS – PHILIPPINES

July – August 2003

RESIDENT QUESTIONNAIRE

Resident: _____

Year of residency: _____

Today's date: _____

Name of School/Hospital: _____

Location : _____

(City)

(Province / Region)

(District)

1a. Did you receive your Voluntary Surgical Contraception training:

- Prior to starting the ob-gyn residency
- During this ob-gyn residency

1b. The facility where you learned VSS skills is

- this facility
- a different facility (specify) _____

2. Approximately how many procedures have you done since you completed your training in VSS?

_____ Minilaparotomies
_____ Vasectomies

3. Approximately how many procedures have you done in the past 6 months (write "0" if none)?

_____ Minilaparotomies
_____ Vasectomies

4a. Did your training in VSS include:

- Clinical work only
- Classroom work only
- Classroom as well as clinical work

4b. Were you given the opportunity to practice your skills on anatomical models prior to working with clients?

Yes No

5. How well prepared did you feel before actual performance with clients?

Extremely well Well Somewhat Not well

6. Do you feel that you have sufficient access to reference materials to support your specialist training?

Yes Yes somewhat No

7. Where do you access reference information?

- Hospital-based references
- University Library
- My own personal references
- References of friends
- Internet/Web-based resources
- Borrowed references from professors
- Others (*specify*): _____

8. Do you feel you had adequate clinical supervision from a clinical instructor or clinical supervisor?

Yes No Not applicable

If no, please describe: _____

9. Are your skills in VSS included in the overall evaluation of your performance as a resident?

Yes No Not applicable

10. Is your religion a factor in your ability to continue performing VSS after your training?

Yes (if so, please explain below) No

Comments: _____

11. Please rate the likelihood that you will continue to provide VSS services in your professional career (after completion of residency training):

Very likely somewhat likely somewhat unlikely Highly unlikely

12. What percentage of your fellow residents do you think will continue to offer tubal ligation services if left alone in their work as ob-gyn specialist (i.e. if they are not forced to do so by a supervisor)?

_____ %

13. What are some likely reasons why ob-gyns would not offer VSS services, even if they are trained to do so?

14. Do you have any recommendations for improving residency training, particularly as it pertains to VSS (tubal ligation and/or vasectomies)?

THANK YOU!

VSS ASSESSMENT – RESIDENCY TRAINING PROGRAMS – PHILIPPINES

July – August 2003

Date: _____

Observer: _____

Person observed: _____

OBSERVATION CHECKLIST: ML/LA

<u>Counseling</u> (observed or per staff/records)	Yes	No
1. Is there preoperative counseling?	[]	[]
2. Were informed consent forms on file?	[]	[]
3. Was it explained to the client in her own language that:		
- temporary methods of contraception are available?	[]	[]
- ML/LA is a surgical procedure?	[]	[]
- the sterilization procedure is not 100% effective?	[]	[]
- there may be discomfort, risk and side effects?	[]	[]
- the operation is intended to be permanent?	[]	[]
- if the client elects not to be sterilized, other services will be provided?	[]	[]
4. Are verbal and/or written postoperative instructions provided?	[]	[]
5. Is privacy maintained during counseling sessions?	[]	[]

Medical Screening and Preoperative Assessment

6. Are verbal and/or written preoperative instructions provided?	[]	[]
7. Are requested laboratory tests appropriate for the procedure?	[]	[]
8. Are the criteria for selecting VS clients routinely followed?	[]	[]

Pelvic Examination

9. Are pelvic examinations [correctly] performed on clients before procedure?	[]	[]
---	-----	-----

Anesthesia

10. If local anesthesia is used, is other analgesia and/or sedation used? [] []

If "Yes," indicate whether recommended dosage of each drug was used. [] []

11. Are drugs readily available at the institution:
- for general anesthesia? [] []
 - for local anesthesia? [] []
 - for conscious sedation? [] []

12. If general or regional anesthesia is used for the VS procedure, what are the reasons for using it? (*Specify*) _____
- _____

Procedure (or use checklist)

13. Was the bladder emptied before procedure? [] []
14. Was the uterine elevator correctly placed? [] []
15. Was the skin preparation performed correctly? [] []
16. Was the skin incision correctly performed? [] []
17. Was the peritoneal entry properly performed? [] []
18. Was the tubal occlusion technique correct? [] []
19. Was the skin closure correctly performed? [] []
20. Was the estimated operating time reasonable (less than 30 minutes)? [] []
21. Verbocaine [] []

Postoperative Care

22. How long (on the average) do clients stay at the facility postoperatively?
 _____ hours (after minilaparotomy)
23. Are vital signs taken at recommended intervals? [] []

24. Are written postoperative instructions provided? [] []
25. How long after surgery is a follow-up visit scheduled?
 [] <7 days [] 7-14 days [] >14 days

INFECTION PREVENTION

PREOPERATIVE

- [] client washes abdomen and perineum
 [] at home
 [] at facility

Surgical handscrub

- [] antiseptic used (e.g., betadine) (*specify*) _____
 [] bar soap
 [] brush
 [] sponge
 _____ time of scrub in minutes

Post scrub

- [] antiseptic dip after hand scrub (specify antiseptic)
 [] gown
 [] single gloves
 [] double gloves

Pelvic examination

- [] puts on gloves:
 [] new gloves (disposable)
 [] high-level disinfected gloves (reusable)
 [] sterile gloves (reusable)
 [] inserts speculum; looks at cervix and swabs it thoroughly with antiseptic
 [] places uterine elevator without touching walls of vagina (if used)
 [] after removing speculum, places it in chlorine solution for 10 minutes, for decontamination
 [] removes gloves
 [] single use (properly disposes of gloves in leak-proof container)

- reusable gloves
- dips hands into decontaminating solution prior to removing
- other procedure

Skin preparation

- washes abdomen and perineum with soap and water
- lower abdomen (suprapubic and/or umbilical area) is prepared hair/skin preparation
- shaves skin routinely
- shaves skin only if necessary
- clips hair just prior to surgery
- antiseptic used (e.g., betadine) (specify)

POSTOPERATIVE

- places used instruments in chlorine solution for 10 minutes, for decontamination
- properly disposes of waste materials (used gauze, cotton, etc.)
- container is leak-proof
- container is covered
- removes gloves
- single use (properly disposes of gloves)
- reusable gloves:
- dips hands into decontaminating solution prior to removing
- other procedure:
- washes hands with soap and water
- alcohol scrub solution used between cases if handwashing is not possible

Please rate the participant's infection prevention practices by putting a check in the appropriate box.

- Satisfactory Not satisfactory Not observed

SUMMARY ASSESSMENT OF CLINICAL SKILLS

Please rate the participant's performance by putting a check in the appropriate box for each skill/activity. Use the checklist from the course as the basis for making your assessment. If no procedure was observed, please check "Not Observed."

<u>Skill/Activity</u>	Satisfactory	Not Satisfactory	Not Observed
Pre-Procedure Counseling	[]	[]	[]
Client Assessment	[]	[]	[]
Procedure	[]	[]	[]
Post-Procedure Counseling	[]	[]	[]
Overall Performance	[]	[]	[]

If performance is not satisfactory in any area, please identify those tasks needing improvement and list here the action required to correct deficiencies.

Recommended Action: [] Yes
 [] No
