

PD-ABZ-374

Improving Access to and Quality of Clinic-Based Family Planning and Reproductive Health Services Worldwide: Five Years of Achievement

End-of-Project Report for EngenderHealth's
Program for Voluntary Surgical Contraception
and Related Reproductive Health Services

USAID Cooperative Agreement
No. HRN-A-00-98-00042-00



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EngenderHealth 2003



ENGENDERHEALTH
Improving Women's Health Worldwide

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440 Ninth Avenue
New York, NY 10001 U.S.A.
Telephone: 212-561-8000
Fax: 212-561-8067
e-mail: info@engenderhealth.org
www.engenderhealth.org

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The Evaluation Team
Marcia V. Mayfield
Hannah Searing
Aparna Jain

ACRONYMS

AIDS	acquired immunodeficiency syndrome
BAVS	Bangladesh Association for Voluntary Sterilization
BCC	behavioral change communication
CA	cooperative agreement
CHAM	Christian Health Association of Malawi
CISTAC	Centro de Investigación Social Tecnología Apropriadada y Capacitación
COPE	client-oriented, provider-efficient
DHS	Demographic and Health Survey
DOH	Department of Health
FP	family planning
FY	fiscal year
GHS	Ghana Health Services
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IFPS	Innovations in Family Planning Services
IMIS	Integrated Management Information System
IMSS	Instituto Mexicano del Seguro Social
IP	infection prevention
ISSSTE	Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado
IUD	intrauterine device
LPP	Local Government Unit Performance Program
LTP	long-term and permanent [methods]
MAP	Men As Partners [®]
MCH-FP	maternal and child health and family planning
MCWC	maternal and child welfare center
M&E	monitoring and evaluation
MGP	Matching Grant Program
ML/LA	minilaparotomy under local anesthesia
MOH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare

MOHP	Ministry of Health and Population
MSH	Management Sciences for Health
MVA	manual vacuum aspiration
NGO	nongovernmental organization
NSV	no-scalpel vasectomy
PAC	postabortion care
PMAC	prevention and management of abortion and its complications
PMTCT	prevention of mother-to-child transmission
POPCOM	Commission on Population
PPAG	Planned Parenthood Association of Ghana
PTS	Performing to Standard
QI	quality improvement
QOCMC	Quality of Care Management Center
RACHA	Reproductive and Child Health Alliance
RCHS	Reproductive and Child Health Section
SOTA	state of the art
SRH	Safe Reproductive Health
SSA	Secretary of Health
STI	sexually transmitted infection
TOT	training of trainers
UMATI	Family Planning Association of Tanzania
UMF	Unidades de Medicina Familiar
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U. S. Agency for International Development
VCT	voluntary counseling and testing
VSC	voluntary surgical contraception

INTRODUCTION

The purpose of EngenderHealth's five-year cooperative agreement (CA) with the U.S. Agency for International Development (USAID) (1998–2003), entitled *Program for VSC and Related Reproductive Health Services*, was to provide global leadership in sterilization, other long-term contraceptive methods, and postabortion care, and to increase the availability and use of hospital-based and clinic-based family planning services. This project represents the final agreement between USAID and EngenderHealth (formerly AVSC International) among several such agreements, dating back to the early 1970s. Over this time, USAID has generously supported EngenderHealth's mission to work worldwide to improve the lives of individuals by making reproductive health services safe, available, and sustainable.

This report presents and highlights key accomplishments and programmatic results achieved by EngenderHealth through both global leadership and field-based activities supported by this CA during the period 1998–2003. (Some activities were begun during prior agreements, but the report is based on data collected under this CA.)

This report consists of four sections. The first begins with an overview of the CA, its results framework, and a review of funding and cost-sharing, to set the context and the resources available for our work. The second section presents country case studies for selected country programs supported under the CA. Each case study presents a brief review of family planning and reproductive health policy and trend data from Demographic and Health Survey (DHS), followed by a review of EngenderHealth's inputs and results based on monitoring and evaluation data and studies. The countries represented include those in which EngenderHealth had a consistent presence throughout the CA. The third section highlights selected global leadership initiatives and their results in postabortion care (PAC), quality improvement (QI), informed choice, Men As Partners (MAP), and vasectomy, and discusses issues related to sustainability, as examined in Mexico and Egypt, where EngenderHealth had programs that ended.

The final section of this report presents data for fiscal year 2002–2003 for several key indicators in EngenderHealth's results framework and five-year trends for service and site statistics. This report, therefore, is intended to satisfy the requirement for the end-of-project report, as well as serving as the annual report for the fifth and final reporting period under the CA.

SECTION ONE OVERVIEW

OVERVIEW OF THE COOPERATIVE AGREEMENT

The CA had two basic objectives: to add to the state of the art (SOTA) in technical knowledge concerning issues important to the delivery of clinic-based family planning and reproductive health services through global leadership activities and to expand the availability of those services in selected countries. For the most part, the global leadership agenda was supported by annual allocations of core funding from the Service Delivery Improvement Division (formerly the Family Planning Services Division) of USAID's Office of Population/Reproductive Health. Field-based activities were supported by USAID missions through annual allocations of field-support funds. Field-based activities were driven by the strategies and needs of the USAID missions and host-country counterparts. At the country level, two important areas of service delivery were identified for EngenderHealth's primary focus: sterilization and PAC.

The global leadership agenda was designed to be relevant and to support the needs of field programs. Conversely, the field-based presence was essential for serving as the testing ground for the global leadership objectives. Through this interplay of global and field activities, EngenderHealth was able to mobilize our expertise and field-based presence to provide technical leadership in the field of clinic-based family planning and reproductive health services, while building the capacity of partner institutions to expand and provide quality services. As a result, thousands more service-delivery facilities are offering women and men choices that they otherwise would not have had, and these sites have contributed to meeting unmet demand for family planning services.

GLOBAL LEADERSHIP

The global leadership agenda for this agreement consisted of the following topics, each of which was led by a headquarters-based team that coordinated work with EngenderHealth country offices and other collaborating agencies. These topics are briefly described below:

FAMILY PLANNING

As the central focus of EngenderHealth's mandate and niche through the years, this global program provided leadership and special attention to emerging issues in clinical service delivery and ensured that EngenderHealth staff and country programs had a solid ground in the fundamentals of clinical care. Under this CA, EngenderHealth continued to conduct research and develop SOTA materials for family planning service delivery. Examples were the publication of *Contraceptive Sterilization: Global Issues and Trends*, *No-Scalpel Vasectomy: An Illustrated Guide for Surgeons, Third Edition*, and *Minilaparotomy for Female Sterilization: An Illustrated Guide for Service Providers*, as well as research on the effectiveness of vasectomy clinical methods and the development and implementation of approaches for revitalizing vasectomy programs.

INFORMED CHOICE

A cornerstone of our work under the CA was to promote and ensure informed choice in service delivery. We convened a Global Informed Choice Working Group in Bellagio, Italy, in 1998 to explore the challenges to informed choice and to formulate strategies for change. We published a report of the deliberations and resulting recommendations, which set out a bold framework for conceptualizing informed choice more broadly, taking the social and rights context into consideration. We pilot-tested a country leadership initiative to foster a social and policy environment for informed choice and a client-centered service culture. This work served as the foundation for the provision of technical assistance to USAID missions and country programs to ensure their compliance with the Tiahrt Amendment after it was enacted in the 1999 Foreign Operations Appropriations Act.

These activities identify broader informed choice problems and vulnerabilities and help program planners develop strategies for improvement. After field-testing and revision, the tools tested under this initiative were packaged and published as *Choices in Family Planning: Informed and Voluntary Decision Making* (called the informed choice tool-kit). Another major activity was the development, field-testing, and publication of *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*, which puts the concept of integrated reproductive health services into practice.

QUALITY IMPROVEMENT

Under this CA, EngenderHealth continued to develop and refine a package of approaches and tools for use by programs in efforts to continuously improve and sustain the quality of services. The package included the following:

- *Facilitative Supervision Handbook*
- *Using the Whole-Site Training Approach to Improve Quality*
- *COPE® Self-Assessment Guides for Reproductive Health Services*
- *COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services*
- *Community COPE®: Building Partnership with the Community to Improve Health Services*
- *Cost Analysis Tool: Simplifying Cost Analysis for Managers and Staff of Health Care Services*

Many of these tools were pilot-tested under the previous CA. A major part of the QI agenda for this agreement was not only to disseminate and scale-up use of these approaches and tools in programs, but also to evaluate their impact on service quality (and if possible, utilization). Therefore, QI was a high priority in EngenderHealth's evaluation and research agenda. EngenderHealth also assisted other global and bilateral projects to use or adapt these tools in their programs. For example, PRIME adapted facilitative supervision for supportive supervision as a key nontraining intervention identified through performance improvement approaches, and PRISM/Guinea¹ expanded COPE throughout sites supported by the Ministry of Health (MOH).

MEN AS PARTNERS®

During the CA, EngenderHealth continued to advocate for male involvement and gender-sensitive programming in reproductive health. Growing from our efforts to improve access to vasectomy, our Men As Partners® (MAP) program developed a framework for

¹ A bilateral project managed by MSH.

taking a comprehensive and holistic approach to addressing gender issues and involving men appropriately in reproductive health care. EngenderHealth's work addressed attitudinal barriers that hinder men's constructive involvement in reproductive health and provided men with access to information and services that prevent pregnancy, including vasectomy. EngenderHealth developed a comprehensive Men's Reproductive Health Curriculum, the first of its kind, and developed several MAP programming guidelines.

POSTABORTION CARE

EngenderHealth built on the PAC expertise we have developed since 1993 to expand and refine approaches to introducing and scaling up comprehensive services. To accomplish this, we conducted an array of applied research studies, including operations research on integrated PAC services in rural areas of Senegal, research on the needs of adolescent PAC clients in the Dominican Republic and Malawi, and exploration of pain management for MVA treatment. In 2000, in collaboration with Ipas, we conducted an international workshop in Mombasa, Kenya, about taking PAC services to scale. This workshop brought together 140 professionals representing MOHs, nongovernmental organizations (NGOs), technical assistance and donor agencies, and research institutions from 21 countries, and resulted in country action plans. The workshop format was subsequently replicated in Latin America and Francophone Africa. EngenderHealth also developed *Counseling the Postabortion Client: A Training Curriculum*. This curriculum presents a training approach that helps providers interact with postabortion clients immediately before, during, and immediately following the procedure, recognizing that while doctors and nurses are not expected to provide full-fledged "counseling," they have a number of opportunities to offer clients essential information and support. The combination of didactic and clinical practicum sessions builds communication skills and addresses how to meet clients' needs for information, confidentiality, privacy, and dignity. EngenderHealth was a founding member of the PAC Consortium, was its chair from 1999 to 2001, and was an active participant throughout the CA.

HIV AND SEXUALLY TRANSMITTED INFECTIONS

Although HIV and sexually transmitted infections (STIs) were not included in the global leadership agenda when this CA was first awarded, given their importance, we created a program to support efforts at integrating HIV and STI prevention into family planning programs. The first step in this process was to conduct a series of workshops with EngenderHealth staff to introduce HIV/STI integration issues and develop integration work plans for country programs. EngenderHealth then trained family planning trainers and providers in Bangladesh, Cambodia, Ghana, India, Kenya, Nigeria, and Senegal in integrating HIV and STI prevention into family planning counseling.

In addition, during the course of the CA to support work at the field level, we produced publications addressing integration and other issues, including:

- *Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual*
- *Integration of Family Planning and VCT Services: Program Planning and Training Manual (field test draft)*
- *The Rights of Clients and Providers to Safety and Dignity: Preventing HIV Transmission and Reducing AIDS Stigma in Health Care Settings*

We also developed COPE® for Voluntary Counseling and Testing Services and COPE® for Sexually Transmitted Infection Management, as well as counseling reference cards for management and prevention of STIs and reproductive tract infections (RTIs). In partnership

with the Population Council, the International Partnership for Microbicides, and the University of Cape Town's Women's Health Research Unit. EngenderHealth conducted research in South Africa to identify sociocultural and structural issues likely to be potential barriers or facilitating factors for the introduction of microbicides, focusing on populations in low-resource settings. Preliminary data analysis was completed at this writing, a dissemination meeting was held in Washington with USAID and CAs in September 2003, and a full report will be completed by the end of September 2003.

In addition, the following support functions were funded through core funds:

Monitoring and Evaluation. EngenderHealth continued to refine monitoring and evaluation processes in support of the use of data for decision making within the agency and with partners, as well as for documenting and disseminating programmatic initiatives. Activities included development of an integrated database for work-planning and reporting, special evaluation studies, and technical assistance and capacity building at the country level.

Research. EngenderHealth supported applied research studies exploring knowledge, attitudes, and practices of providers and clients and improved service-delivery modalities and approaches. Technical assistance and capacity building of partners were integral to our research activities. (See the list of all such studies in Appendix A.)

Publishing. Publishing supported all global leadership activities, ensuring the production and dissemination of cost-effective, high-quality publications. (See Appendix B for a list of the publications produced.)

FIELD PROGRAMS

Over the course of the CA, EngenderHealth supported activities in 26 countries (see Table 1). Of the 26, 10 countries received some support continuously during the five years. Activities were discontinued in countries where major activities had been underway (Guatemala, Paraguay, Uganda, Indonesia, and Egypt), as a result of the consolidation of assistance under a bilateral program, and two additional country programs were graduated from USAID support overall (Mexico and Turkey). An additional nine countries (Colombia, Egypt, Kazakhstan, Kyrgyzstan, Moldova, Russia, Ukraine, Uzbekistan, and Moldova) received small amounts of core funds for small-scale activities or for phasing down prior funding. (These countries are not listed in Table 1.)

USAID's field-support mechanism for funding support of country activities came into effect in full during this CA, and in part explains funding variations from year to year. Because field-support funding was provided at the directive of USAID missions, the field-support mechanism promoted a stronger link between global CA activities and USAID mission strategies and programs. However, the field-support system also resulted in year-to-year fluctuations in funding levels and scopes of work regarding EngenderHealth's role in particular countries, and at times hampered the implementation of long-term strategies and the ability to evaluate impact and results. For the most part, as this report demonstrates, when program resources remained steady or grew, there was an attendant increase in access and utilization of services (as evidenced through program statistics).

The main purpose of field support funding in most countries was to expand sites offering clinical family planning service delivery, including sterilization services. Twenty-two countries had PAC initiatives (including non-USAID-funded activities). Given the focus on service delivery overall, EngenderHealth applied a few key approaches to field-based

Table 1. Country Programs Supported¹ through USAID Global CA # HRN-A-00-98-00042-00

Program	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	FY 2002-2003
The Americas					
Bolivia	√	√	√	√	√
Dominican Republic ²	√	√	√	√	√
Guatemala	√	√	√		
Honduras	√	√	√	√	√
Jamaica		√			
Mexico	√	√			√
Paraguay	√	√	√		
Peru		√			
Western Africa					
Ghana	√	√	√	√	√
Guinea	√	√	√		√
Nigeria	√	√	√	√	√
Senegal ³	√	√	√	√	√
Eastern & Southern Africa					
Ethiopia ⁴				√	√
Kenya/Field Support ⁵	√	√	√	√	√
Malawi		√	√	√	√
South Africa ⁶		√	√	√	√
Tanzania	√	√	√	√	√
Uganda	√	√			
Asia					
Bangladesh ⁷				√	√
Cambodia	√	√	√	√	√
India	√	√	√	√	√
Indonesia	√	√			
Jordan	√	√	√	√	√
Nepal ⁸	√	√	√	√	√
Philippines ⁸	√	√	√	√	√
Turkey	√	√	√	√	
Number of countries	20	24	19	18	19

¹ "Supported" is defined as a country's having expensed to USAID Global CA funds during the indicated fiscal year (core, field support, or special initiative funds).

² PAC activities were partially supported by private funds (the Brush Foundation and the Packard Foundation).

³ PAC activities were partially supported by private and other funds (the Packard Foundation and the Frontiers Project).

⁴ Ethiopia is mostly supported via private funds but uses some USAID funds provided through a collaboration with the PVO Networks Project.

⁵ This program was closed out; a small amount of USAID Global CA funds were used in FY 2002-2003 for administrative purposes related to program close-out. Kenya/AMKENI reports data directly to USAID/Kenya through the bilateral project.

⁶ FY 2001-2002 USAID Global CA funds (field support) were limited to support for MAP activities; there is no service-delivery program.

⁷ This program reported sites and services in FY 2000-2001, but data are not included, as the program was supported through bilateral and private funds; PAC activities were partially supported by private sources and by other funds. Field support began in FY 2001-2002.

⁸ PAC activities were partially supported by private funds.

service programs. These were applied whether a program was in the early stages of development (e.g., Cambodia and Nigeria), in an expansion mode (e.g., Bolivia, Ghana, and Honduras), or at the consolidation or mature stages (e.g., India, Jordan, and Nepal). Applying these approaches or strategies was intended to build a foundation for sustainable programming.

ADDRESSING CLIENTS' RIGHTS AND PROVIDERS' NEEDS THROUGH QUALITY IMPROVEMENT

The clients' rights-provider needs framework shaped our work throughout all regions. EngenderHealth introduced QI approaches built upon the clients' rights-provider needs framework as an integral part of service expansion strategies. The approaches are based on the principles of developing a customer mindset, creating staff involvement and ownership, emphasizing improved processes and systems, being cost-conscious, and promoting continuous learning and sustainable capacity. EngenderHealth developed and transferred the capacity of in-country partners to assess quality issues, solve problems, and monitor and evaluate the reproductive health services they provided. Clients' rights were further addressed through informed choice initiatives, counseling training, development of client information and counseling guidelines, improvement of the quality of client-provider interaction, and attention to the specific needs of underserved populations (e.g., men, pregnant and postpartum women, and postabortion clients). Providers' needs were further addressed through competency-based training, development of technical and training materials, and service-based operations research to find ways of improving clinical services.

LOCAL PARTNERSHIPS AND CAPACITY BUILDING

Country offices and programs were mainly or entirely comprised of local staff with significant experience and reputations in reproductive health, counseling, and clinical services. EngenderHealth joined with in-country institutions such as MOHs, social security institutions, and NGOs to build capacity to deliver sustainable quality services. Capacity-building efforts included involvement in assessments, development of QI and quality assurance systems, training of trainers and service providers, and overall development of a "systems approach" that ensured coordination of the functions and tasks of service delivery (including training, management, supervision, referrals, infrastructure), so providers could respond to customers' needs. EngenderHealth focused efforts with our local partners on developing sustainable services and systems. We also stressed linking increased availability with QI capacity building to ensure that access did not outstrip the system's capacity to address quality-of-care concerns.

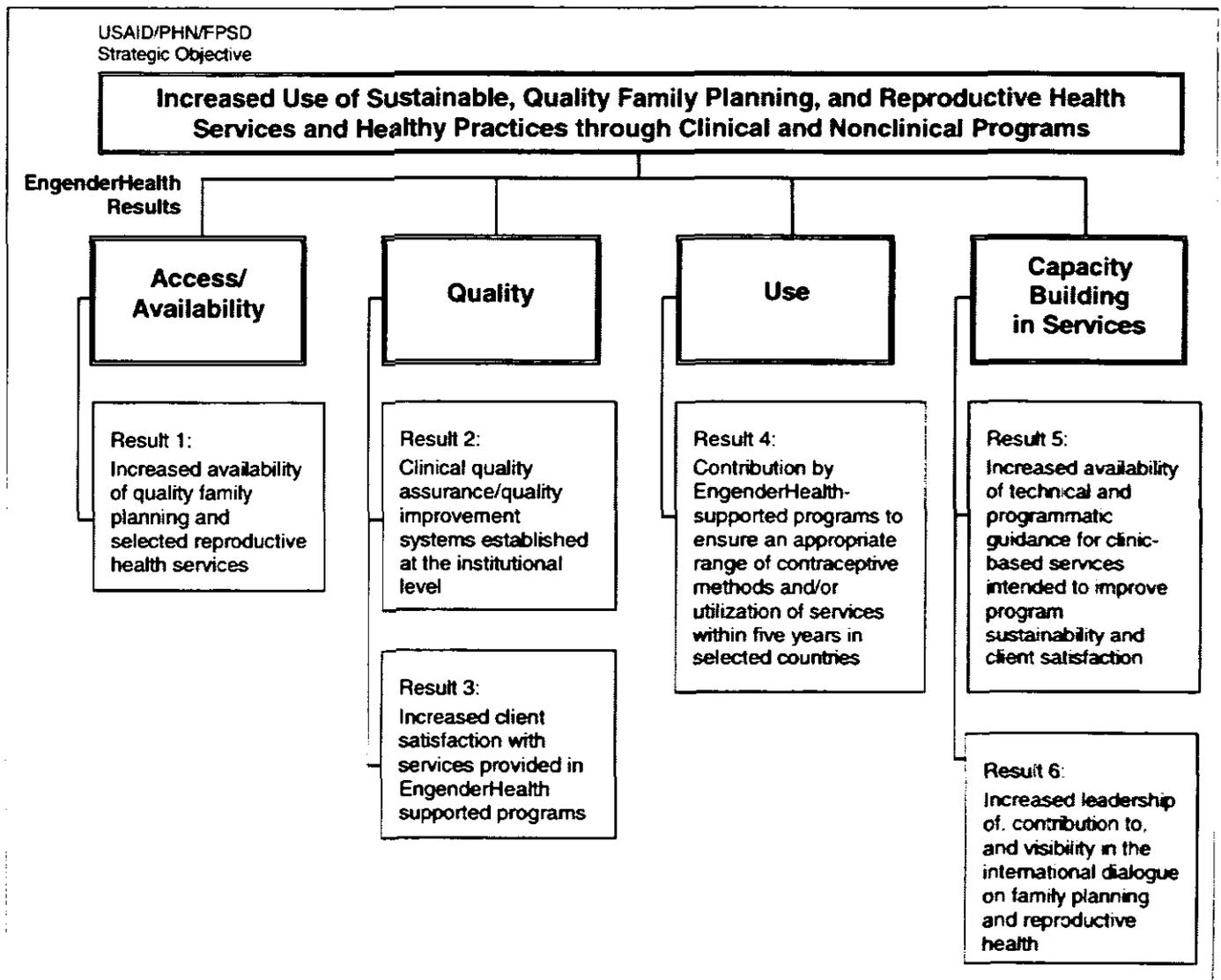
SITE READINESS

Attending to the fundamentals of facility-based care is the ultimate keystone of success and sustainability. Without them, no amount of innovation or best practices can be integrated into programs. Care, concern, and specialized knowledge and skills ensure that the fundamentals are in place, including informed choice, safety for clinical techniques and procedures (including anesthesia regimens and infection prevention [IP]), and quality assurance and management. Throughout the CA, EngenderHealth focused its expertise on these fundamentals. We did so by providing a basic package of technical and financial support, to ensure that facilities were ready and equipped to provide quality services. The support included training in counseling, IP, and clinical skills; upgrading of facilities including minor renovations, provision of supplies and equipment, and improvement of client flow; establishment of site-level protocols for client record keeping, referrals, follow-up, and cost recovery; and site-based QI approaches such as COPE and facilitative supervision.

RESULTS FRAMEWORK

At the beginning of the CA, EngenderHealth developed a results framework that has been grouped into the four concepts consistent with other USAID results frameworks: availability, quality, and use of family planning and reproductive health services, and capacity building for those services. Figure 1 maps EngenderHealth's results to the USAID/PHN/FPSD Strategic Objective and displays six EngenderHealth results by the four concepts listed above. Section Four of this end-of-project report presents data for FY 2002–2003 and five-year trends for service and site statistics.

Figure 1. EngenderHealth Results Framework

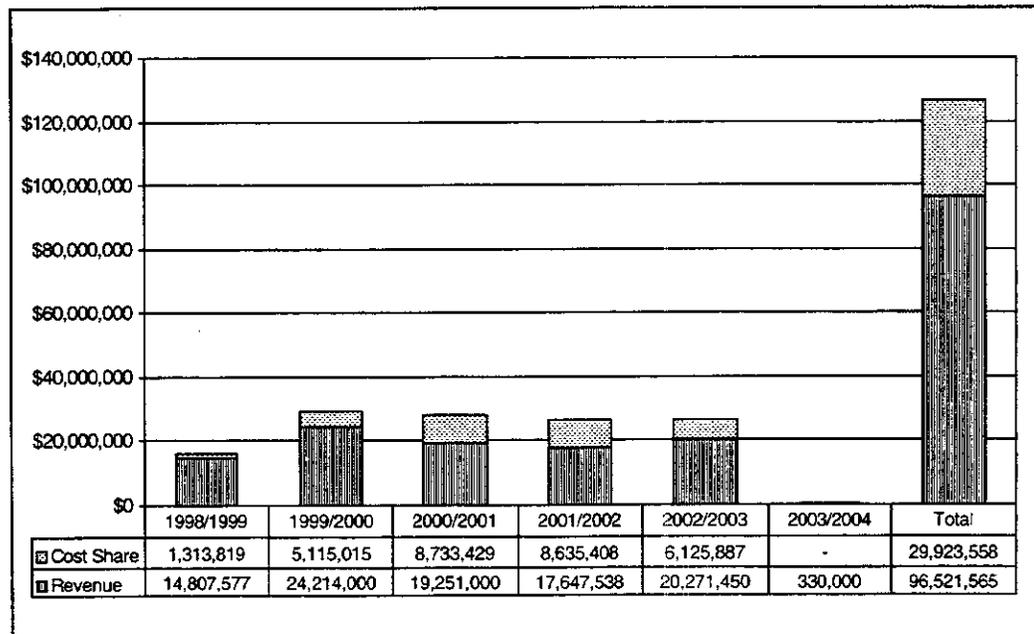


**BUDGET/FUNDS
LEVERAGED AND COST SHARE**

EngenderHealth’s CA was supported by funding from the Office of Population and Reproductive Health. Funding included central funding from USAID Washington to support our global program initiatives, as well as field-support funding from country missions to support in-country activities. Throughout the term of this agreement, EngenderHealth leveraged the USAID funds to provide additional resources to the project, ultimately meeting our 25% cost-share commitment.

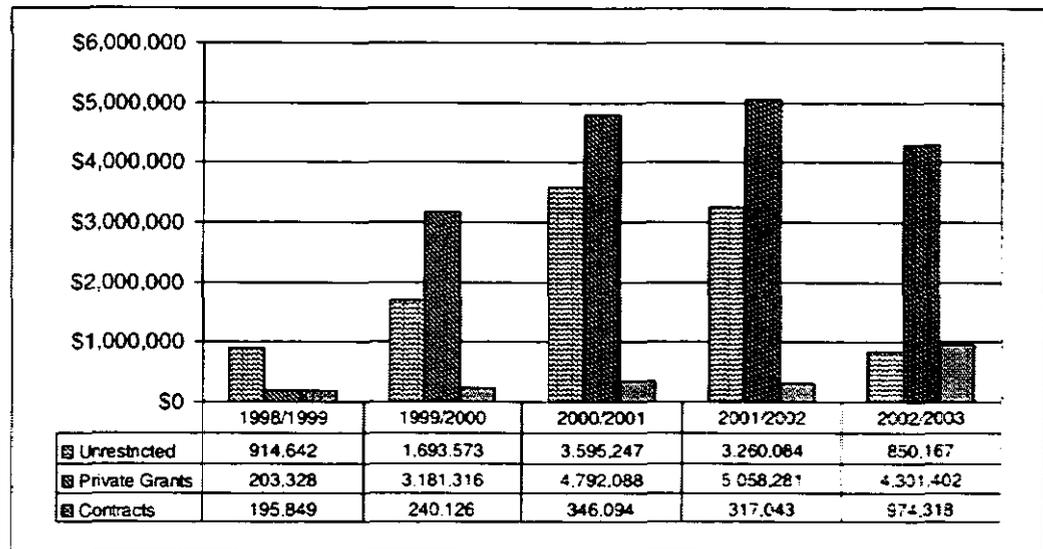
When the agreement was issued, the five-year total project costs were estimated to be \$137,673,774. In April 2003, the award was extended until March 31, 2004, and the estimated project costs were decreased to \$100,000,000. As of June 30, 2003, funds obligated totaled \$96,191,565. EngenderHealth anticipates an additional \$330,000 to be obligated and spent by March 31, 2004, for a total of \$96,521,565. Figure 2 shows that between USAID funding (\$96.5 million) and the EngenderHealth-contributed cost-share total (\$29.9 million), the funds authorized and expended for the CA totaled \$126.4 million. The 31% cost share depicted below (6% more than required) leveraged federal resources to provide 69% of total funding estimated for the project. (Note that these numbers were estimated as of June 30, 2003. The final expenditures and cost-share information will be reported 90 days after the expiration of the agreement.)

Figure 2. EngenderHealth total funding related to the CA, FY 1998–1999 to FY 2003–2004



EngenderHealth has used three nonfederal funding sources to secure cost-share funds and support the CA’s objectives: unrestricted funds, private grants, and contracts. Unrestricted funds include contributions from EngenderHealth’s members, from major donors, and from foundations. Private restricted grants include contributions from major private donors and from foundations; these funds are donor-restricted for specific work aligned with CA activities. Contracts represent funds received from United Nations agencies and from private organizations that contract with EngenderHealth for services. As is illustrated in Figure 3, during the CA, EngenderHealth raised \$10.3 million in

Figure 3. Nonfederal cost-share funds received during the CA, FY 1998–1999 to FY 2003–2004

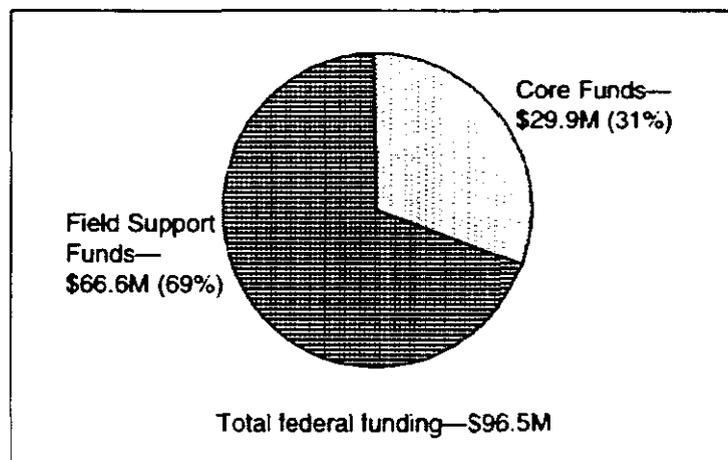


unrestricted funds, \$17.5 million in private grants, and \$2.1 million in contracts, for a total of \$29.9 million.

The cost-share requirement has enabled EngenderHealth to expand the reach of our PAC activities to additional countries not supported under the CA (such as Colombia and Myanmar), bridge country programs between years of field support (such as in Guinea), undertake research on reproductive health issues (such as cervical cancer), explore new clinic-based reproductive health issues (such as obstetric fistula), and address HIV more broadly (such as with prevention of mother-to-child transmission). It also helped reduce EngenderHealth's dependence on USAID funding from 84% to 69% over the course of the five years.

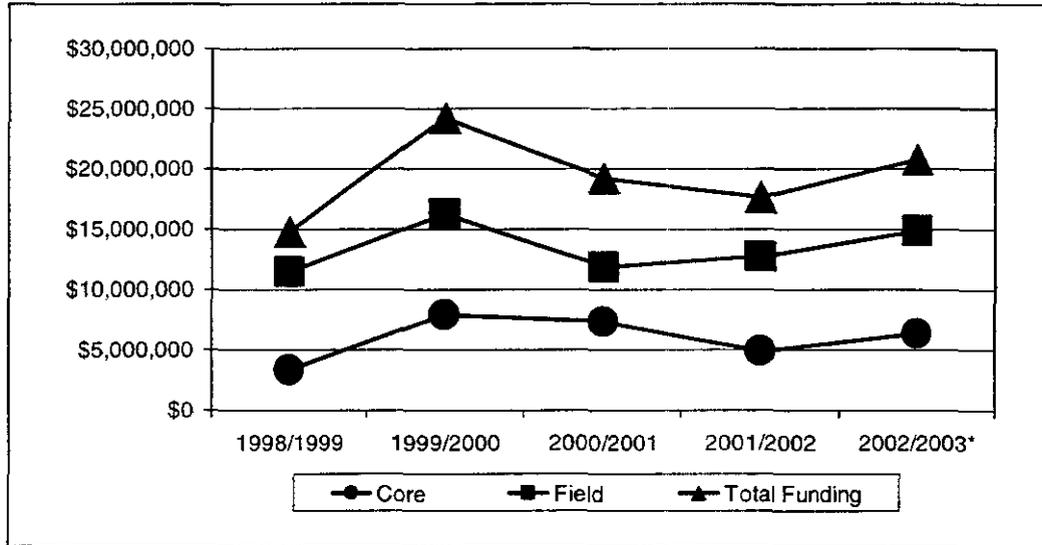
As depicted in Figure 4, 31% of the federal funds authorized were core funds for global leadership activities and 69% were field-support funds for technical and programmatic assistance to country programs.

Figure 4. Sources of federal funds received during the CA



As shown in Figure 5, funding to EngenderHealth for the CA has been consistent each year. (Note: FY 1999–2000 represents funding for 15 months, compared with 12 months in each other period.) The 70%–30% breakdown of field support versus core funding has also remained consistent from year to year.

Figure 5. Trends in funding sources during the CA



* Includes an additional \$330,000 each for core funds expected during FY 2003/2004.

SECTION TWO

CASE STUDIES

ENGENDERHEALTH'S COUNTRY RESULTS: CASE STUDIES

This section of the end-of-project report highlights our work and achievements in selected countries around the world. Countries were selected on the basis of the following criteria: EngenderHealth's long-term and continuous presence in the country, and sustained field support in the country throughout the CA.

Each case study begins with a brief description of the history of family planning in the country, followed by an analysis of contraceptive trends. We then discuss the various inputs and achievements during the CA. For the most part, these are inputs provided with support from USAID through the global CA. In some cases, where USAID funding helped to leverage other funds or where it was used in conjunction with other funds, we discuss those projects as well, noting the funding source. Finally, we present results related to increasing availability, quality, and utilization of services.

Result 4 of EngenderHealth's results framework was "Contribution by EngenderHealth-supported programs to ensure an appropriate range of contra-ceptive methods and/or utilization of services within five years in selected countries." The original intent was to use DHS studies to identify changes in method mix and trends in sterilization prevalence.² However, we encountered several issues:

- In no case did the time frame for the DHS match the time frame for our CA. In fact, in most cases (Bolivia, Ghana, Kenya, the Philippines, Tanzania, and Turkey), the most recent and available DHS was conducted in the first years of our CA.
- Demonstrating a clear link between EngenderHealth inputs and changes in DHS indicators is difficult at best, due to the multiple outside factors that influence contraceptive prevalence.
- EngenderHealth was not always working on direct service delivery at a national level. Many of our national inputs were related to policy efforts, development of guidelines and standards, and institutionalization of QI approaches, among others, all of which ultimately affect the availability and use of services but for which direct relationships with trends are difficult to establish.

Nevertheless, we present the DHS analysis to provide additional background and context for EngenderHealth's work. We also attempt to link these trends with EngenderHealth's inputs (where possible) by clearly documenting what our inputs have been, by presenting results related to availability and utilization, and by then drawing reasonable conclusions regarding our contributions to the national or regional trends.

EngenderHealth analyzed DHS data for all nine countries for which we developed case studies. DHS datasets were downloaded from the MEASURE DHS+ website (<http://www.measuredhs.com/>) into SPSS. For all countries, we used the DHS III standardized questionnaire and individual recode data files for analysis.

² We received technical assistance from John Ross in the analysis of DHS data.

The case study countries reflect the broad range and reach of EngenderHealth's work in reproductive health services. Each country has its own unique challenges, systems, and solutions. Together, they show what can be accomplished with sustained support over time, high-quality technical assistance, and committed local partners.

**INCREASING CHOICE AND METHOD USE
BY REVITALIZING STERILIZATION AND OTHER
LONG-TERM FAMILY PLANNING SERVICES****FAMILY PLANNING
IN BANGLADESH**

The Government of Bangladesh has been committed to family planning since the country became independent in 1971. In the mid-1970s, Bangladesh adopted a broad-based, multisectoral family planning program. Sterilization was the cornerstone of the public sector program for more than a decade. In the 1980s and 1990s, the government focused on making a wider range of modern contraceptive methods available, including Norplant implants and injectables.

Over its 30-year history, Bangladesh has succeeded in providing greater contraceptive choice to its citizens to meet their changing reproductive health needs. The dramatic increase in contraceptive prevalence from 8% in 1975 to 54% in 1999 and the drop in the total fertility rate by almost half from the early 1970s to 20 years later (from 6.3 to 3.3 lifetime births per woman) constitute a remarkable demographic transition and a programmatic success.³ Contributing factors include strong, sustained political commitment to family planning, promotion of a small-family norm, establishment of a widespread service-delivery infrastructure that reaches the village level, strong technical and financial support from development partners, and increased involvement of the NGO sector in complementing the government's efforts and resources.

TRENDS

Since its peak in the 1970s and 1980s, sterilization service performance fluctuated and fell off dramatically in the 1990s. Injectable contraceptives were first offered through NGOs in 1974–1975 and were added to the national program in 1980–1981; the Norplant implant was added in 1993–1994. As a result, overall contraceptive prevalence rose. However, use of sterilization declined, with incidence averaging 60,000 cases per year from 1995 to 2000.⁴ Health-sector reform was initiated in 1998 to integrate the health and family planning directorates of the Ministry of Health and Family Welfare (MOHFW) and to design and introduce an essential-services package. This marked a change for family planning and sterilization, which had hitherto been vertical services with dedicated behavioral change communications (BCC) efforts and service-delivery resources.

DHS studies show a steady decline in the number of users of sterilization and other long-term methods through the 1990s and a marked increase in use of the pill and injectable. In 1999, the pill ranked as the most popular method, followed by the injectable, female sterilization, the condom, and the IUD. Norplant implants and vasectomy each accounted for only 0.5% of prevalence.

The 1999 DHS showed the public sector to be the primary provider of LTP methods (90% of female sterilizations, 86% of vasectomies, and 90% of IUD insertions) and of injectables (85%); government fieldworkers were the largest supplier of the pill (45%).

³ National Institute of Population Research and Training, Mitra and Associates, ORC Macro, 2001. *Bangladesh Demographic and Health Survey 1999-2000*.

⁴ Begum, F., et al. 2000. *Review of sterilization services in Bangladesh*. New York: AVSC International.

Table 2. Contraceptive prevalence in Bangladesh, by method and by year among women in union

	1993	1996	1999
Contraceptive methods			
Any method	44.6	49.2	53.8
Any modern method	36.2	41.6	43.4
Long-term methods			
Female sterilization	8.1	7.6	6.7
Vasectomy	1.1	1.1	0.5
IUD	2.2	1.8	1.2
Norplant implant	0.0	0.1	0.5
Short-term methods			
Injectable	4.5	6.2	7.2
Pill	17.4	20.8	23.0
Condom	3.0	3.9	4.3
% of modern method use attributed to female sterilization	22.4	18.3	15.4

The private commercial sector is a very important source of the pill (30%) and of condoms (52%). The NGO sector and private doctors and clinics still provide a small proportion of services and supplies.

Although the public sector provides the lion's share of clinical methods, its service capacity has diminished with loss of providers to the system, lack of newly trained personnel, inadequate training capacity, and lack of leadership and management at the district and local levels. EngenderHealth (jointly with the MOHFW and with USAID) identified these challenges during the 2000 assessment, which led to the development of the sterilization and other long-term methods revitalization project described below.

The 1999 Bangladesh DHS found that 52% of currently married women wanted no more children. Among those surveyed, 15% reported that they were not currently using contraception and either wanted no more children or wanted to wait at least two years before having another child. Seventy-one percent of women who were not using a family planning method at the time of the survey stated an intention to do so in the future. One-third of births in the last five years either were not wanted when they occurred or were not wanted at all. These findings suggest a substantial unmet need both for both temporary and permanent family planning services.

ENGENDERHEALTH INPUTS AND ACHIEVEMENTS

For nearly 30 years, EngenderHealth has provided support to the Bangladeshi government and to the NGO sector to improve access to and quality of male and female sterilization. EngenderHealth has played a vital role over the years in helping the government to set service-delivery standards, develop training capabilities, and introduce new technologies such as ML/LA and NSV. EngenderHealth has also pioneered and promoted counseling and informed choice as essential elements of quality services, as well as the use of QI tools and approaches.

In the 1970s, we helped establish the Bangladesh Association for Voluntary Sterilization (BAVS, a local NGO) and gradually developed the national training capacity for sterilization by providing technical assistance to BAVS, to the National Institute of Population Training and Research, to Mohammadpur Fertility Services and Training Center, to 13 medical colleges of Bangladesh (with UNFPA support), and to the Associate in Training and Management (AITAM) Welfare Organization (the only NGO sterilization training center in Bangladesh). These EngenderHealth-supported institutions trained hundreds of governmental and nongovernmental surgical teams to perform sterilization and to counsel clients about their contraceptive choices. EngenderHealth inputs contributed significantly to increased service capacity, which delivered rising numbers of sterilization services from the early 1970s to the mid 1980s (when incidence peaked at more than 500,000 procedures per year).⁵

From September 1997 to June 2002, EngenderHealth managed the bilateral Quality Improvement Partnership (funded by USAID), which provided support to the National Integrated Population and Health Program in the NGO sector. This was a project funded outside of EngenderHealth's global CA, but is one that offered lessons learned and capacities to subsequent USAID field-support-funded work. The major results were the establishment of a sustainable quality monitoring and supervision system for NGOs providing an essential package of services (RTI and STI care, child health care, maternal health care, rational drug use, HIV/AIDS care, PAC services, and emergency obstetric care) and the development, production, and dissemination of an array of technical standards, guidelines, protocols, manuals, and job aids for these essential services. The policy guidelines and materials helped raise levels of service quality and established a standard for training, services, and quality assurance. Evaluation of the project demonstrated increased service quality and efficiency.⁶

To better understand DHS evidence that sterilization performance was continuing to decline despite continuing levels of unmet need, the Bangladeshi government and USAID commissioned EngenderHealth to conduct an assessment with the Ministry of Health and Family Welfare in October 2000 of the availability, quality, and use of sterilization services. The assessment attributed the declines in part to changes that began in the 1980s (including increased availability of other family planning methods, greater community-based and household distribution, abandonment of a special focus on sterilization and of intense special campaigns and initiatives to boost sterilization use, and greater knowledge and awareness of contraceptive choices beyond sterilization),⁷ in part to a deterioration in the quality of services delivered, and in part to organizational issues (including leadership and cooperation problems between technical and nontechnical personnel).

Following the assessment, EngenderHealth worked with the government to develop a strategy and project to revitalize sterilization services. EngenderHealth was then provided with field support to work with the public, NGO, and private sectors to increase demand for and supply of quality sterilization services.

The project (*Sterilization and Other Clinical Family Planning Methods Service Delivery Project*) began in June 2001 at 12 subdistrict sites in two districts. Inputs included planning and mapping workshops at the district and subdistrict levels; training on postpartum minilaparotomy, management of complications, IUD insertion, and infection

⁵ Begum, F. et al. 2000. *Review of sterilization services in Bangladesh*. New York: AVSC International.

⁶ EngenderHealth. *End of project report, Quality Improvement Partnership, September 1997–June 2002*. Dhaka, Bangladesh: National Integrated Population and Health Program.

⁷ Begum, F., et al. 2000. *Review of sterilization services in Bangladesh*. New York: AVSC International.

prevention; workshops on counseling; community-level advocacy and BCC activities; the production and dissemination of public information materials; the mobilization of equipment and supplies; supportive supervisory visits; and monitoring the quality of services.

EngenderHealth supported mobile teams to provide services at government sites that lacked trained staff and also supported coaching of local doctors. We also provided inputs to five NGOs to increase their service capacity, and piloted fee-based NSV service provision in one urban site (with plans for expansion), with the aim of providing NSV services as one component of the male reproductive health care services. In this regard, one urologist was oriented to NSV, a BCC planning meeting was held, other service providers at the site where the urologist worked received counseling orientation, and BCC materials were developed for the center.

Inputs also included:

- Support for 136 planning and mapping workshops at the district and subdistrict levels for more than 27,967 health and family planning staff and other stakeholders—including community leaders, journalists, and NGO leaders covering 1,229 unions (Participants generated local plans to improve the quality of information and services, and to reach hard-to-reach eligible populations.)
- Support for 76 counseling, IUD, and IP workshops at the district and subdistrict levels, which were attended by 1,356 service providers
- Support for 55 supervisory visits to provide advice to service providers on improving the quality of the clinical family planning services to identify gaps between standards and actual practice and to reduce the gaps through on-site orientation and coaching
- Technical assistance to increase service capacity:
 - Provided mobile teams to 195 service sites to offer sterilization services and on-site training at sites that lack trained personnel by demonstrating 1,044 minilaparotomy procedures, 584 NSV procedures, and 69 Norplant implant insertions
 - Trained 120 physicians and 308 nurses and family welfare volunteers in tubectomy and vasectomy and offered refresher training in IUD insertion, counseling, and IP
 - Provided job aids on long-term clinical methods (NSV, female sterilization, the IUD, and the Norplant implant) for all health and family planning workers and on informed consent and decision making for all clinical service providers, as well as BCC materials to help providers inform clients during counseling
 - Worked with the department of logistics and supply of the Directorate of Family Planning and with central, regional, and district warehouses and supply officers on supplies and logistics at the district and subdistrict levels
 - Renovated service sites and provided equipment to five NGO sites and provided 2–5 sets of NSV instruments to 15 government sites
 - Established referral linkages with eight secondary-level referral centers
 - Assisted in reorganizing services by streamlining logistic supplies, by physically reorganizing service delivery to ensure privacy, by supporting proper counseling and performance of IP according to standards, by implementing policies, and by strengthening supportive supervision, follow-up of clients, and local-level BCC activities

EngenderHealth provided the following programmatic inputs to stimulate *demand* for sterilization and other clinical family planning methods:

- Disseminated information about the availability of services, plus locations, dates, and times of services, at the community level by field workers

- Developed and distributed 2,039,400 leaflets, 1070 Tiaht posters, and 283 sign-boards to inform the public about available services
- Supported 212 training and orientation sessions and updated 29,323 health care workers and other stakeholders, including community leaders, journalists, and NGO leaders on their knowledge and interpersonal communication skills, to strengthen client-provider interactions and counteract myths and misconceptions about different methods
- Organized and supported 138 community-level advocacy meetings that involved nearly 14,000 community leaders, such as women leaders at the lowest levels of local government, journalists, and local leaders (including NGO leaders), to promote activities to increase access to information, to involve men, and to dispel misconceptions about clinical and permanent methods

With support from the Asia/Near East Bureau of AID/Washington in 2002, EngenderHealth pilot-tested its Informed Choice Toolkit. The introduction involved a workshop with managers, trainers, and service providers at which job aids to strengthen informed choice in service delivery were introduced and action plans developed. A follow-up workshop in 2003 assessed the impact of the toolkit's introduction on participants' understanding of informed choice, their attitude and practices, and progress and problems encountered in implementing their action plans. The follow-up workshop revealed the following achievements:

- Job aids to help clinical providers and field workers better inform clients about their family planning options were developed.
- Community meetings were held on sexual and reproductive health topics to increase public awareness.
- Staff orientations were conducted on informed choice and client decision making.
- Health education classes were held for men who were accompanying their wives for family planning or reproductive health services.
- Family planning counseling was integrated into antenatal service delivery.

(See also Section 3—Global Leadership)

Finally, EngenderHealth was able to leverage other funding for work in reproductive health in Bangladesh. Funding from the Packard foundation supported PAC services in local NGOs and government maternal and child welfare centers. From July 1998 through December 2002, we managed a UNFPA-funded project that established training programs on clinical contraception and RTI and STI case management. From June 2002 through September 2003, we managed a UNICEF-funded project aimed at improving IP practices at 13 public-sector sites that provide emergency obstetric services.

RESULTS

INCREASING ACCESS TO AND QUALITY OF SERVICES

Given the success of the initial pilot of the Strengthening Sterilization and Other Clinical Family Planning Methods Services Project, the MOHFW expanded the scope of the project to 19 additional districts, covering 30% of the districts in Bangladesh. Sterilization services are now being offered at 153 sites in 21 districts. From FY 2001–2002 to FY 2002–2003 alone, the number of sites providing sterilization services increased from 22 to 153. At this writing, of the 21 districts in which we had worked, 16 were directly covered by EngenderHealth, while the remaining five were covered by InHealth (a local NGO supported through an EngenderHealth subagreement).

EngenderHealth is represented on the National Technical Committee for Family Planning, and in 2000 we facilitated policy changes regarding minilaparotomy—namely, a change in the analgesia and anesthesia regimen that enabled clients to return home on the same day as the operation, that no longer mandated an overnight stay during the postoperative period, and that ended the routine use of prophylactic antibiotics.

INCREASING UTILIZATION OF SERVICES

Preliminary results of the 12-site pilot test showed the number of sterilizations during the first quarter of 2002 was double the total performance for the entire preceding year. In Nilphamari district, the number of female sterilizations performed during the first quarter increased from 81 in 2001 to 687 in 2002, and the number of vasectomies rose from 21 to 1,017. In Jhenaidah district, female sterilizations increased from 51 to 746, and vasectomies from none to 72. Since the project's inception, in all of the intervention districts, the numbers of sterilizations performed were 5–15 times greater than preintervention levels.⁸

From November 2001 through June 2003, 11,751 female sterilizations (2,881 in FY 2001–2002 and 8,870 in FY 2002–2003) and 21,208 NSVs (5,164 in FY 2001–2002 and 16,044 in FY 2002–2003) were provided. In addition, 4,819 implants and 20,656 IUDs were provided in FY 2002–2003.

CONCLUSION

EngenderHealth has made substantial contributions to both the public-sector and the NGO-sector family planning programs in Bangladesh in three clear areas: improving service quality, increasing training and service capacity, and increasing the use of clinical methods, particularly sterilization. It has also had great impact in heightening awareness and changing practices to improve IP and client-provider interactions and counseling. By establishing an ongoing quality assurance and monitoring system, it has created the sustainable capacity for continuous QI.

⁸ Data are from the EngenderHealth/Bangladesh management information system and are derived from the government's monthly performance reporting.

**WORKING WITH THE GOVERNMENT
AND WITH NGOS TO INCREASE ACCESS
TO QUALITY FAMILY PLANNING SERVICES****FAMILY PLANNING
IN BOLIVIA**

In Bolivia, one of the poorest countries in Latin America, family planning programs have enjoyed a long history. In the 1970s, however, a national health program that overemphasized surgical sterilization resulted in many forced sterilizations—particularly among indigenous women from rural areas. As a result, the government reacted by restricting sterilization throughout the 1970s and 1980s in all cases except to save the woman's life.

In the 1980s and 1990s, new national health programs that were designed to increase the method mix in Bolivia and that subsidized all methods of contraception except sterilization began to make family planning more widely available. In 1987 and 1988, a government program called "Fight Against Abortion" was instated, identifying family planning as one of the best options for decreasing abortion rates. In 1989, USAID and other public health institutions designed the first Reproductive Health Project, with family planning as one of its components; it was formally established in 1990 by means of a bilateral agreement between USAID and the Bolivian government. A National Strategy for Reproductive Health was established in Bolivia in 1993, and in 1995 this strategy was renamed the "National Strategy for Sexual and Reproductive Health."

Despite these accomplishments, throughout the late 1980s and 1990s, only a few service sites in Bolivia offered a variety of family planning methods. A number of factors have been working to change this, however, including the Bolivian government's clear presence at the ICPD in Cairo. Since then, with the help of CAs and local NGOs, Bolivia is on its way to ensuring that a varied mix of family planning services are available to all who need them at all health facilities.

TRENDS

Though the latest DHS survey conducted in Bolivia is five years old, the three most recent surveys document an impressive trend (Table 3). From 1989 to 1998, modern contraceptive prevalence rose by an average of 1.5 percentage points per year, and total prevalence rose by two percentage points per year—consistent with rates for most countries. This nine-year period saw a general increase in the use of all methods offered in Bolivia, with modern method prevalence rising in each of the country's nine political regions (called "departments"), and with IUD prevalence rising fastest over the full nine years. (By 1998, it was twice as prevalent as sterilization.) Traditional method use rose sharply in the first five years but then fell, while modern method prevalence remained strong, suggesting a successful substitution of modern for traditional methods between 1994 and 1998.

Among the modern contraceptive methods utilized in Bolivia from 1989 to 1998, long-term methods predominated in each survey year (1989, 1994, and 1998); by 1998, the prevalence of long-term methods use (18%) was greater than the prevalence of resupply methods (7.5%).

Table 3. Contraceptive prevalence in Bolivia, by method and by year

	1989	1994	1998
Contraceptive method			
All methods	30.3	45.3	48.3
Any modern method	12.2	17.8	25.2
Long-term methods			
Female sterilization	4.4	4.6	6.5
IUD	4.8	8.1	11.1
Norplant implant	0	0.0	0
Short-term methods			
Injection	0.7	0.8	1.1
Pill	1.9	2.8	3.8
Condom	0.3	1.3	2.6
Total no. of women in union	4,941	5,334	6,649
% of modern method use attributed to female sterilization	36.1	25.8	25.8

Not surprisingly, throughout this nine-year period, method mix shifted with increasing age and parity toward permanent methods. Among women age aged 40 and older who had at least four living children, sterilization prevalence exceeded that of the IUD. However, sterilization also saw a more general increase over time; among women aged 45-49, sterilization use more than doubled over the nine years, from 5% in 1989 to 12% in 1998. Over time, IUD use increased the most among women aged 25-29, from 6% in 1989 to more than 14% in 1998.

The sources of sterilization and the IUD (the two most commonly used contraceptive methods) were encouragingly split between public and private. For all other modern methods (each relatively little used by Bolivian women), pharmacies were active suppliers.

As of 1998, unmet need for contraceptive services in Bolivia was high by international standards, at 28% (Table 4). Given the significant inputs of cooperating agencies and local NGOs to increase access to and use of a method mix over the past five years, however, this number may have since dropped.

Table 4. Demand for contraceptives among Bolivian women in union

	1994	1998
	%	%
Unmet need		
Space	5.9	7.0
Limit	18.3	20.6
Total	24.2	27.6
Met need		
Space	10.9	13.3
Limit	34.5	35.0
Total	45.4	48.3
Total demand for family planning		
Space	16.8	20.3
Limit	52.8	55.6
Total	69.6	75.9
% of demand satisfied by all methods	65.2	63.6
Total no. of women in union	5,334	6,649

ENGENDERHEALTH INPUTS AND ACHIEVEMENTS

EngenderHealth has a long history of working with government agencies, local NGOs, and community organizations in Bolivia to improve the quality and accessibility of voluntary family planning services. EngenderHealth began working with public- and private-sector institutions in 1995, focusing on providing technical support for voluntary sterilization programs. In 1997, we provided technical assistance to the Bolivian government in the development of the first norms for tubal ligation. (At that time, access was limited to women who were aged 35 and older, had five children, and were of "high reproductive risk.") In 1999, EngenderHealth advocated for and was successful in helping to change the norms for female sterilization so that services were no longer limited to women based on their age, parity, or medical requirements. In 2000, we were successful in supporting the MOH in the issuance of standards for male and female surgical contraception that included a focus on gender equity and rights.

Throughout the period of the CA, EngenderHealth provided technical assistance and guidance in family planning program implementation to all levels of the Bolivian health system, in all nine of the country's regional departments. At EngenderHealth-supported sites in all nine departments, we provided QI assistance, conducted medical monitoring, disseminated national norms, and offered trainings and updates in contraceptive technology, counseling and informed choice, and IP. In partnership with PROCOSI (an umbrella organization of 24 family planning groups), we developed a Self-Learning Module in Contraception and Counseling, which was aimed at health service staff who do not have direct access to training.

Beginning in 1998, in collaboration with a local NGO, the Centro de Investigación Social Tecnología Apropiada y Capacitación (CISTAC), EngenderHealth provided technical and financial assistance for a Working Group on Masculinities. We also worked with CISTAC on qualitative research about male perceptions about health services in Santa Cruz. In addition, through the implementation of our MAP curricula (called "masculinities" in Latin America), we were successful in introducing comprehensive reproductive health services for men, including vasectomy, at nine CIES (a local NGO) service sites. EngenderHealth also helped to established integrated reproductive health services for men, including vasectomy, in three MOH hospitals.

In 2000, with the financial support of USAID, EngenderHealth broadened our work in Bolivia to serve as the lead agency for all aspects of contraceptive services, working with the Bolivian MOH to implement a comprehensive package of quality family planning services in both the public and private sectors and supervising all cooperating agencies at work in Bolivia. Given the issues regarding informed choice in other Latin American countries (most notably Peru), we also provided assistance on ensuring informed choice and implementation of the provisions of the Tiaht amendment as part of our strategy in Bolivia.

Throughout the CA, EngenderHealth worked to improve the quality of family planning and reproductive health services at both the national and service-site level. We provided technical and financial support to the MOH for the development of National Norms for Female Sterilization, which included a counseling component and a document for informed consent. We assisted the MOH in developing Technical Procedures for Infection Prevention in the Delivery of Reproductive Health Services, and were instrumental in developing National Norms, Protocols, and Technical Procedures for Family Planning. As a result of advocacy efforts from EngenderHealth, this document included a component on user rights, a focus on gender, equity and informed choice, and forms for informed consent.

In conjunction with our efforts at the national level, EngenderHealth provided technical assistance to improve the quality of services at sites in all nine of the Departments in which we work. We introduced COPE at sites in both the public and private sectors, including tertiary-level and secondary-level MOH hospitals and nine clinics operated by CIES (a local NGO). COPE and facilitative supervision were introduced into the service network of PROSALUD (a local NGO with a network of clinics providing a wide array of health services, including reproductive health).

From 1998 to 2003, EngenderHealth provided training in general family planning information to a total of 5,907 health workers, trained 3,316 service providers in QI techniques such as COPE and facilitative supervision, involved 3,594 providers in IP activities (including training workshops, events for norm dissemination, and IP multimedia presentations), and trained 4,331 providers in family planning counseling.

Finally, EngenderHealth participated in a number of initiatives to strengthen the demand for a variety of family planning methods in Bolivia, including creating a contraceptive method poster for the MOH (to be displayed in all national-level facilities) and a flipchart describing different methods (for use during counseling or clinical services). Additionally, we participated in a successful social marketing project for the SoloShot syringe (an instrument used in administering Depo-Provera). Besides conducting trainings for providers in the use of this syringe, EngenderHealth (with support from USAID/Bolivia and the Bolivian MOH) created a training curriculum and a video for handling the instrument, as well as a support brochure for providers, with the aim of increasing the prevalence of this instrument at pharmacies, where a significant number of clients use Depo-Provera.

RESULTS

INCREASING ACCESS TO SERVICES

EngenderHealth's inputs in Bolivia helped to improve women's and men's access to a variety of contraceptive services throughout the period of the CA. Over these five years, we successfully incorporated female and male sterilization services into national norms, encouraged the MOH to include tubal ligation as a service covered by government health insurance for women during the six-month postpartum period, strengthened counseling for informed choice, incorporated informed consent forms for permanent method use, and collaborated with the MOH to develop a national family planning strategy.

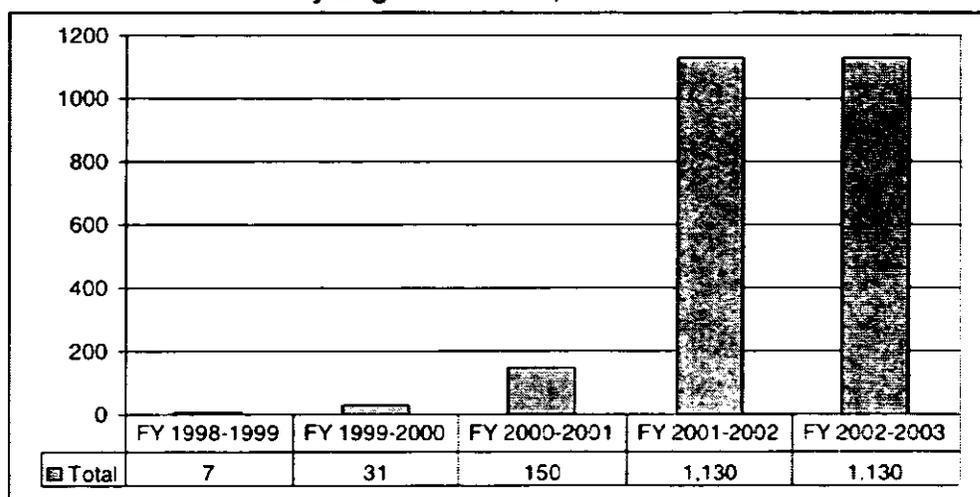
The number of sites supported by EngenderHealth increased from seven in FY 1998–1999 to 1,130 in FY 2002–2003, reflecting the expansion of our role in strengthening contraceptive services at a national level (Figure 6).

IMPROVING QUALITY OF SERVICES

From 2002–2003, EngenderHealth conducted an evaluation of COPE and Facilitative Supervision introduction and use in PROSALUD clinics. PROSALUD is an NGO with a network of clinics providing a wide array of health services, including reproductive health. The evaluation gathered baseline data from 10 health centers and compared them with data collected one year following the introduction of COPE and Facilitative Supervision. The study included interviews with PROSALUD administrators, site supervisors, service providers, and clients, and observation of counseling sessions and infection prevention practices.

Preliminary results revealed changes in the sites' commitment to improving quality, supervisory systems and elements of the quality of the services. Sixty percent of providers reported that supervision had improved over the past 12 months. At baseline,

Figure 6. Total number of sites in Bolivia supported by EngenderHealth, 1998–2003



86% of providers stated that they felt a part of an active quality improvement team; this increased to 93% at follow-up. Over half of family planning clients stated that the quality of care had improved over the past year. Of 19 indicators assessed during family planning counseling, improvements were seen in 15.⁹ (See Section Three, Global Leadership, p. 65 for more detail on evaluation results.)

INCREASING UTILIZATION OF SERVICES

From 1999 to 2003, the following mix of family planning methods was provided to clients at EngenderHealth-supported sites in Bolivia: A total of 45,276 clients were provided with IUDs, 5,462 clients received female sterilization services, and 107 male clients received vasectomy services.

CONCLUSION

Today, a full range of contraceptive methods—including voluntary sterilization for women and men—is available in Bolivia, and most of these methods are fully covered by government health insurance.¹⁰ Moreover, the ministry's national standards for reproductive health care now mandate that providers follow the principles of informed choice and informed consent, require that health workers offer counseling to their clients, and demand that providers respect their clients' basic human rights. EngenderHealth and our local partners have had major successes in establishing a supportive policy and program environment for family planning in Bolivia, and a strong service-delivery network that can serve as a foundation going forward. Given the upward trends in contraceptive prevalence rates and the diversity of sources for the most common methods throughout the 1990s, the inputs and accomplishments of EngenderHealth/Bolivia's varied programmatic activities since 1998, and the longstanding relationship between EngenderHealth and the Bolivian MOH, the successes over the five-year period of the CA indicate that family planning programs have a promising future in Bolivia.

⁹ C&G Consultoras. 2003. *Evaluación de COPE y Supervisión Facilitadora de EngenderHealth en Servicios de la Red PROSALUD*. Borrador 08-08-03.

¹⁰ Through December 2002, all methods were covered for women of reproductive age except for female and male sterilization. Now, all methods, including female sterilization, are covered for pregnant women up to six months postpartum, after which fees are charged for contraceptives.

NATIONAL SCALE-UP OF LONG-TERM AND PERMANENT CONTRACEPTIVE SERVICES

FAMILY PLANNING IN GHANA

Ghana, the first Sub-Saharan African nation to gain independence from Great Britain, adopted a population policy in 1969 to address rising population growth. The policy aimed to decrease fertility rates by increasing access to and use of contraceptive methods. In 1994, the population policy was revised to include (along with its previous mandate) strategies for new emerging health issues, including improving reproductive, maternal, and child health services and decreasing incidence of HIV/AIDS and transmission of STIs.

In 1996, to better address these issues, Parliament enacted the Ghana Health Services Act and formed a health service-delivery structure known as the Ghana Health Services (GHS). In this directive, the Ministry of Health (MOH) maintained its role as a policy body, approving overall country health strategies, while the GHS became responsible for implementing national policies for health delivery. Within the GHS, 10 regional health directorates were created to coordinate health activities and programs for each region. This decentralized approach to health service delivery is intended to enable the Ghanaian government to focus its resources on the changing and diverse needs of each region.

TRENDS¹¹

According to the Ghana DHS, modern contraceptive prevalence among women currently in union increased threefold over 10 years, from 4.2% in 1988 to 13.3% in 1998. During this same period, female sterilization use increased slightly from 1.0% to 1.3%. Overall, use of short-term methods increased at a faster rate than use of long-term methods; the greatest rise in use occurred with the injectable, the prevalence of which increased from 0.3% in 1988 to 3.1% in 1998.

Contraceptive prevalence trends can be attributed to a decrease in unmet need and an increase in the satisfaction of total demand.¹² In 1998, unmet need for family planning methods was high, at 23%. However, the proportion of demand satisfied by the use of all methods increased from 35.7% in 1993 to 48.9% in 1998.

Table 5. Contraceptive prevalence in Ghana, by method and by year, among women currently in union and of reproductive age

	1988	1993	1998
Contraceptive use			
Any method	12.9	20.3	22.0
Any modern method	4.2	10.1	13.3
Long-term methods			
Female sterilization	1.0	0.9	1.3
IUD	0.5	0.9	0.7
Norplant implant	0.0	0.0	0.1
Short-term methods			
Injection	0.3	1.6	3.1
Pill	1.8	3.2	3.9
Condom	0.3	2.2	2.7
Diaphragm/foam/jelly	0.3	1.2	0.9
Total no. of women in union	3,156	3,204	3,131
% of modern method use attributed to female sterilization	11.9	8.9	9.8

¹¹ The latest Ghana DHS survey is 1998. In 2003, data collection was underway for a new Ghana DHS+.

¹² Total demand is equal to contraceptive prevalence plus unmet need for all methods.

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

Since as early as 1986, EngenderHealth provided technical and financial assistance to the MOH/GHS to strengthen family planning services throughout the country, with two main objectives—increasing access to quality long-term and permanent (LTP) methods and improving the quality of services in the public and private sectors.

In 1994, USAID awarded to EngenderHealth a CA to increase access to LTP methods and to improve the quality of services offered in all 10 regions of the country. USAID/Washington also provided field-support funds through the global CA to expand the availability of family planning services. This funding complemented the bilateral CA by supporting special technical assistance requests and oversight from EngenderHealth headquarters. Field-supported activities ranged from clinical trainings in sterilization procedures to financial support for clinic renovations to introductions of QI tools such as COPE and facilitative supervision. Having a long-term program plan with continued financing was an important factor in this program's ability to scale-up service delivery, as it enabled the program to achieve and maintain momentum once the initial foundation was established.

EngenderHealth's strategy to increase access was to build capacity in training and supervision at the regional level, to support expansion of services within the public sector. We assisted the MOH to establish five regional training centers¹³ serving all 10 regions, to provide clinical instruction on minilaparotomy under local anesthesia (ML/LA) and on Norplant implant insertion and removal. One of the challenges of maintaining training capacity is the loss of doctors and nurses to a "brain drain." In 1999, close to 80% of all doctors from Ghana were practicing abroad in the United States and the United Kingdom.¹⁴ As a result, numerous doctors trained in ML/LA and in insertion and removal of the Norplant implant left Ghana, and the LTP method program continuously had to train new staff to keep up with the high staff turnover.

During the period of the global CA, the five training centers produced a cadre of skilled staff, including 203 doctor-nurse teams trained to perform minilaparotomy and to insert and remove the Norplant implant and 41 private practitioners and 399 nurses trained to insert and remove Norplant. EngenderHealth supported the introduction of high-quality no-scalpel vasectomy (NSV) services, to increase availability and to address low utilization of vasectomy. Seven providers traveled to India for NSV training, and two providers traveled to Bangladesh for refresher NSV training.

Another essential component of EngenderHealth's support was in strengthening the physical infrastructure of clinics, including operating theaters, by funding minor renovations. In 2002–2003 alone, EngenderHealth supported the renovation of 27 clinics¹⁵ in nine regions. The types of renovations undertaken included repainting clinic walls and constructing partition walls to improve clients' privacy during counseling sessions and Norplant implant insertions.

¹³ In the Greater Accra, Ashanti, Brong-Ahafo, Central, and Eastern Regions.

¹⁴ Boakye, F. 1999. Ghana loses 80% of doctors in brain-drain. News Vision, Africa: Ghana, December 14, 1999. <http://wvioaptus.wvi.org/wvinews.nsf/0/dde753183f7933ec4a2568470c18456b?OpenDocument>, accessed July 31, 2002.

¹⁵ The number of sites, by region, that received funds for renovations include nine clinics in Ashanti Region, three in Northern Region, two in Brong-Ahafo Region, three in Western Region, one in Eastern Region, one in Central Region, three in Upper East Region, one in Upper West Region, and four in Greater Accra Region.

EngenderHealth also provided technical assistance and support to Planned Parenthood Association of Ghana (PPAG). We supported 14 PPAG sites throughout the country from 1999–2002 to provide a full range of family planning services, including minilaparotomy, Norplant implants, and family planning counseling. Due to the reinstatement of the “Mexico City Clause,” PPAG no longer accepted USAID funding, and support to sites was discontinued during FY 2002–2003.

As an integral component of our effort to build regional capacity in service delivery, EngenderHealth conducted Training of Trainer (TOT) courses for regional trainers from the 10 regions in a variety of quality-related topics, including family planning counseling, IP, COPE, medical monitoring, and integrated sexual and reproductive health counseling. The regional trainers conducted step-down trainings and refresher trainings for district management teams and site-level providers.

Table 6. Number of regional trainers trained, by topic

Topic	Number
COPE	24
Medical monitoring	9 teams
Facilitative supervision	24
Family planning counseling	32
Infection prevention	26

EngenderHealth also assisted with the introduction into and scale-up of family planning counseling in Ghana’s health system at regional and district hospitals. We worked to integrate counseling into all aspects of health service delivery and provided continuous support to the regional trainers. In 2000, refresher trainings in family planning counseling were conducted for the 32 regional trainers. Overall, during the period of the global CA, EngenderHealth supported trainings in family planning counseling to more than 1,088 community health nurses and midwives.

To link the supply of services with demand, EngenderHealth worked and collaborated on several demand creation activities in Ghana. We participated in a series of meetings held by Johns Hopkins University/Population Communication Services in preparation for the “Life Choices” campaign for family planning, with special attention to the parts of the campaign related to long-term methods. EngenderHealth participated in the campaign by posting signs and distributing brochures and T-shirts at clinics.

To address the challenges associated with low utilization of vasectomy, EngenderHealth collaborated with an advertising agency Lintas to increase awareness of and knowledge about vasectomy services. Meridian Development Foundation provided technical assistance in designing a promotional campaign and identified in-country marketing partners for EngenderHealth to work with. A radio and a television segment were each developed to discuss and clarify myths associated with vasectomy. The spots will air in the latter part of 2003. (See Global Leadership, page 85.)

RESULTS

INCREASING ACCESS TO AND QUALITY OF FAMILY PLANNING SERVICES

In July 2003, a review of our Ghana program¹⁶ revealed that improvements in access to and availability of LTP family planning services and the quality of these services had increased during the years of the global CA. In FY 1998–1999, EngenderHealth supported 97 sites, and by FY 2002–2003, we supported 250 sites. At these sites, a full range of

¹⁶ Jain, A, et al. 2003. A review of EngenderHealth-supported activities in Ghana. New York.

family planning methods was available, including at least one LTP method coupled with a range of temporary methods.

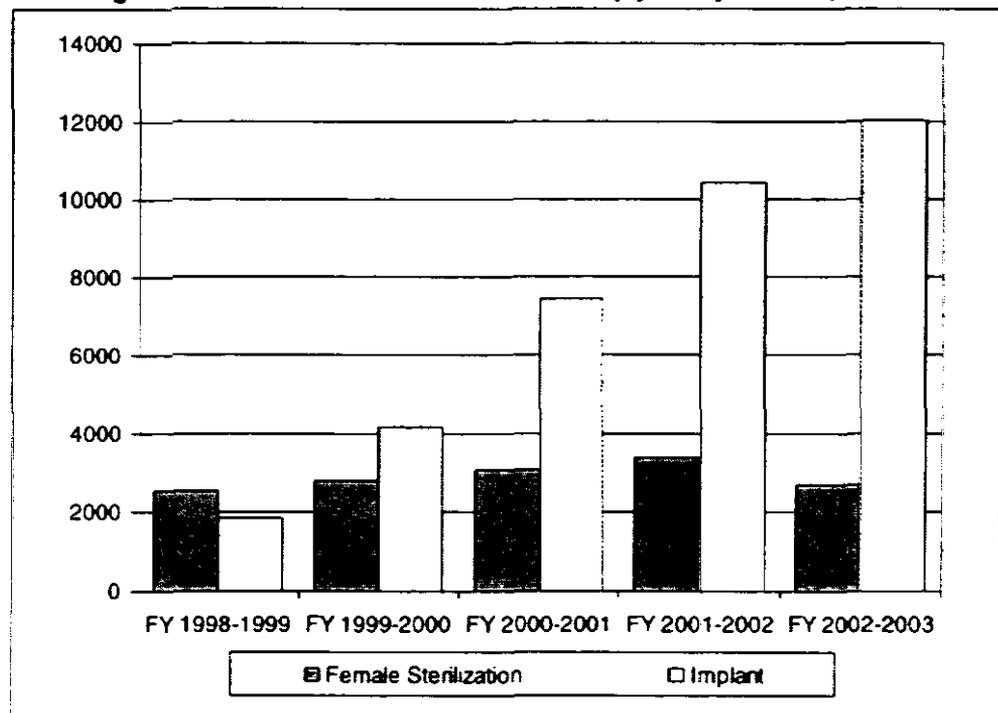
In addition, high-quality services were offered after introduction of IP practices, family planning counseling, and COPE. Furthermore, we built the MOH's capacity to perform facilitative supervision and medical monitoring. Twenty-four nurses in supervisory positions, including deputy directors of nursing services and principal nursing officers, were trained. During the July 2003 review, management throughout the country embraced facilitative supervision as an approach that does not blame individuals. They said that facilitative supervision is having a significant positive impact on the quality of services they are providing:

“Facilitative supervision has helped me a lot. Supervisors are challenged to be up to date. People are now happy to see me, and no longer try to hide away. We always have something to share. We sit down and discuss issues. I make suggestions on how staff can solve their problems” [facility manager].¹⁷

INCREASING UTILIZATION OF SERVICES

EngenderHealth's contributions to Ghana's family planning program have produced impressive results. During the CA, the number of EngenderHealth-supported sites that offered at least one LTP family planning method increased from 97 in FY 1998–1999 to 179 in FY 2000–2001 and to 250 in FY 2002–2003. This increase in the availability of LTP methods impacted family planning service utilization. At EngenderHealth-supported sites, the number of clients choosing Norplant implants or minilaparotomy was 4,400 in FY 1998–1999 but increased to 14,731 in FY 2002–2003 (Figure 7).¹⁸ (See “Section 4: West Africa, Country Analysis—Ghana” for an in-depth discussion of service statistics.)

Figure 7. Total number of clients served, by year by method, Ghana



¹⁷ Jain, A. et al. 2003. A review of EngenderHealth-supported activities in Ghana. New York.

¹⁸ Figure does not include vasectomy utilization.

In 2002, Ghana experienced a shortage of Norplant implants at a period when demand for this method was high. Despite the shortage, all other family planning methods were in full supply, and some clients seeking Norplant implants opted for Depo-Provera as a temporary method. Even with this shortage, Norplant implant usage continued to increase: Overall, the number of users increased from 10,437 in FY 2001-2002 to 12,026 in FY 2002-2003. Having identified this shortage during routine monitoring visits, EngenderHealth brought the need for greater implant supply to the attention of the MOH and USAID/Ghana. As a result, USAID/Ghana, which supplied implants to the mission, airlifted these commodities into Ghana.

It is uncertain whether the observed uptake in Norplant implant services has replaced requests for tubal ligation, the annual number of which decreased from 3,379 in FY 2001-2002 to 2,705 in FY 2002-2003. Several health managers offered two reasons for the rise in use of Norplant implants: First, the cost differential between Norplant implants and tubal ligation is large; second, women prefer a relatively "permanent" method that can be reversed if their life circumstances should change. EngenderHealth will conduct research in the latter part of 2003 to better understand clients' perspectives on Norplant implants.¹⁹

CONCLUSION

Ghana provides a good example of how a long-term, continuous commitment of effort and funding, coupled with a stable political environment, can lead to significant impact at scale. EngenderHealth had tremendous success in increasing access to and availability of quality LTP methods and improving the quality of services offered to all men and women across the country. A critical aspect of our success was the strong relationship we built with the MOH and the 10 regional health directorates of the GHS. Through this working relationship, we contributed to creating a well-established, sustainable infrastructure. With this foundation and new emerging reproductive health issues, EngenderHealth looks to the future in addressing both men's and women's family planning needs, including issues related to STI and HIV/AIDS, prevention and management of abortion complications, and men's reproductive health.

¹⁹ Ghana received an extension of field-support funding under the global CA through December 2003.

LAYING THE FOUNDATION FOR QUALITY IMPROVEMENT AND SERVICE EXPANSION

FAMILY PLANNING IN KENYA

As early as 1967, the Government of Kenya adopted a population policy, at that time focusing on child spacing. In 1982, it established the National Council for Population and Development, which was mandated to coordinate the population program (including government, NGOs, and donors) and to act as the policy arm of the government. In 1984 the Kenyan government reviewed and revised its policies, focusing on balancing population size with available resources while at the same time leaving decisions about family size to individuals. Following the International Conference on Population and Development (ICPD) in Cairo, the Kenyan government developed a program of action. This process led to the creation in 1997 of the National Population Policy for Sustainable Development, which focuses on reducing infant mortality, maternal mortality, and the total fertility rate, and on increasing contraceptive prevalence. The paper includes strategies to address reproductive health and reproductive rights, gender perspectives, and HIV/AIDS.

TRENDS

According to the 1993 and 1998 Kenya DHS reports, contraceptive prevalence reached 39% in 1998 (Table 7). Most prevalence was attributed to modern contraceptive use, which increased from 27% in 1993 to 32% in 1998. The method mix illustrated in the 1998 DHS demonstrates an encouraging pattern, with substantial use of sterilization, the pill, and the injectable.

Reliance on female sterilization rose from 2.6% in 1984 to nearly 5% in 1989, to 5.5% in 1993, and to 6% in 1998.²⁰ The service records of EngenderHealth-supported programs show that while only 68 women utilized female sterilization in 1982, this number rose to more than 6,000 new users in 1986 at EngenderHealth-supported sites alone.²¹

Table 7. Contraceptive prevalence in Kenya, by method and by year

	1993	1998
Contraceptive method		
Any method	32.7	39.0
Any modern method	27.3	31.5
Long-term methods		
Female sterilization	5.5	6.2
IUD	4.2	2.7
Norplant implant	0	0.8
Short-term methods		
Injectable	7.2	11.8
Pill	9.5	8.5
Condom	0.8	1.3
Total no. of women in union	4,629	4,834
% of modern method use attributed to female sterilization	20.1	19.7

²⁰ Ruminjo, J., and Lynam, P. 1997. Fifteen-year review of female sterilization by minilaparotomy under local anesthesia in Kenya. *Contraception* 55(4):249-260.

²¹ Ruminjo, J., and Lynam, P. 1997. Fifteen-year review of female sterilization by minilaparotomy under local anesthesia in Kenya. *Contraception* 55(4):249-260.

DHS data show that the prevalence of long-term methods remained at 9.7% from 1993 to 1998, reflecting an increase in use of female sterilization and Norplant implants but a decrease in IUD use (Table 7). As a percentage of overall modern method use, use of female sterilization did not change significantly over the five-year period between surveys, because modern method use increased overall.

In 1993 and 1998, sterilization usage was much higher among women above age 35 than among those below it, and sterilization prevalence rose most among 40–44-year-olds. (This combines movement into that age-group from 35–39-year-olds over the five-year period, plus new sterilizations obtained.) Sterilization use was much higher among women with four or more births than among those below that level, and its use was highest at parity five.

Unmet need to limit future births decreased from 15% in 1993 to 10% in 1998, while met need to limit increased from 23% to almost 26%. Total demand for methods to space and to limit future births decreased from 1993 to 1998 (Table 8).

By source, use was spread across both the government (public) sector and the private medical sector. The former accounts for about two-thirds of use of sterilization, the IUD, and the injectable, but only half of pill and implant use. In 1998, the private medical sector covered the rest, except for 5% of pill use and 46% of condom use (both from “other private”). Within the private medical sector, Kenya shows the interesting participation of multiple agencies: the family planning association, churches, and private hospitals and clinics.

Table 8. Demand for contraceptive methods among Kenyan women in union

	1993	1998
	%	%
Unmet need		
Space	21.6	14.0
Limit	14.8	9.9
Total	36.4	23.9
Met need		
Space	9.9	13.4
Limit	22.9	25.6
Total	32.8	39.0
Total demand for family planning		
Space	31.5	27.4
Limit	37.7	35.5
Total	69.2	62.9
% of demand satisfied by all methods	47.4	63.2
Total no. of women in union	4,629	4,834

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

Since 1982, EngenderHealth has worked with the Kenyan government and with NGOs to provide quality reproductive health care services. Early priority areas were to establish voluntary and safe sterilization services and to provide training in counseling to ensure sterilization clients' informed consent. Kenya was the first country in Sub-Saharan Africa to expand sterilization services to the point where sterilization prevalence appeared in the DHS survey, and our partners (notably the Family Planning Association of Kenya) were important regional leaders in issues related to delivery of clinical family planning services.

By the late 1980s, we expanded our focus to include a broader range of long-term contraceptive methods, including the Norplant implant and the postpartum IUD. In the late 1980s and early 1990s, we focused our contributions on improving the quality of reproductive health services, including improving supervision and infection prevention practices. Furthermore, in partnership with the Family Planning Association of Kenya, we

pioneered the development of EngenderHealth's QI approaches and tools, including COPE. Early work to pilot-test these QI tools in resource-poor settings provided many lessons that were critical in fueling the expansion of these tools and approaches to other African countries and elsewhere.

Over the duration of EngenderHealth's global CA with USAID, our main focus in Kenya was to build institutional capacity for effective and sustainable systems for QI, supervision, and service-related training. Our work during the global CA, funded with USAID field-support funds, was completed in 2000. This work laid the foundation for the bilateral USAID project AMKENI, which is being led by EngenderHealth.²² The project will span the period 2001–2006 and is focused on increasing the utilization of facility-based, integrated family planning, reproductive health, and child survival services, mainly in Coast and Western provinces.

From 1995 through 2000, EngenderHealth worked nationally and regionally to continue expansion of services and to ensure quality service delivery. On a national level, EngenderHealth collaborated with MSH and helped the MOH develop a system for enhancing institutional capacity for coordinated national clinical family planning and reproductive health services. This resulted in the National Implementation Plan—Kenya Family Planning Program of 1995–2000. We also facilitated the development of a national action plan for scaling up of PAC services in Kenya, which in August 2000 was adopted by the Kenya PAC working group as the national PAC strategy.

EngenderHealth also introduced the practice of ML/LA. (Minilaparotomy was previously provided under general anesthesia, a more costly, more time-consuming, and less safe approach.) EngenderHealth supported the University of Nairobi in training and follow-up of medical undergraduates in ML/LA and advocated for moving ML/LA services from operating theaters to procedure rooms; this innovation was adopted at 36 sites.

To further expand access to family planning services, EngenderHealth advocated for nurses to be able to provide Norplant implants, the IUD, and PAC services. The MOH subsequently approved a policy allowing nurses and clinical officers to be trained as Norplant implant and PAC providers. EngenderHealth supported central training on implant insertion and removal in Nairobi.

EngenderHealth/Kenya also played an important regional and international role. The development and widespread dissemination of our QI tools fostered their uptake and adaptation in many countries around the world. In addition, EngenderHealth organized an international workshop in Kenya on facilitative supervision and QI in 1999. We also cosponsored an international PAC conference in Mombasa in 2000. Finally, we supported training in Kenya for providers from neighboring countries in the provision of LTP methods (e.g., Norplant implant provision for Ugandan providers, and NSV provision for Ethiopian doctors).

At the site level, EngenderHealth supported sites through training in clinical skills, QI, and counseling, through equipping and upgrading procedure rooms, and through providing financial subsidies to cover expendable supplies. This support was critical in increasing access to quality contraceptive services and in building site capacity and readiness to deliver services. Between 1995 and 1999, access to PLT methods increased, with EngenderHealth supporting service-delivery sites in all of Kenya's provinces except the Northeast. EngenderHealth also trained 2,173 providers in clinical skills, including ML/LA,

²² Partners are FHI, PATH, and IntrahHealth.

the Norplant implant, the IUD, and vasectomy procedures. IP practices were an integral component of all trainings. An additional 786 providers were trained specifically in IP. Between 1995 and 2000, EngenderHealth also trained more than 1,400 providers in family planning counseling (focusing on the principles of informed choice) and updated an additional 1,971 providers on general family planning technology.²³

From 1995 to 2000, EngenderHealth introduced an array of QI approaches at 110 sites in Kenya. These included COPE, facilitative supervision, medical monitoring, whole-site training (including on-the-job training and inreach), and cost analysis. We trained more than 780 providers on facilitating these QI approaches. With its local partners, EngenderHealth also developed and tested Community COPE in Kenya. This approach aims at helping site-level staff to connect with the community and gather feedback from current clients, former clients, nonclients, and other community members.²⁴

PAC IN KENYA

With USAID funding, EngenderHealth sponsored an assessment in early 2000: *Postabortion Care in Kenya: Gaps Analysis and Recommendations*. Recommendations from that report informed the development of a 10-month subagreement with the MOH to expand PAC services, funded by USAID. EngenderHealth trained 42 providers from four districts in comprehensive PAC services. PAC services were established at 19 facilities, including health centers and dispensaries. EngenderHealth trained four district supervisors (district public health nurses) in PAC. Findings and recommendations from an evaluation of that program included:^{*}

- Future training should be planned with the potential for immediate use of new clinical skills on the job. (Forty percent of interviewed trainees were unable to begin services for six months or more.)
- Clinical experience and supervision are important for new trainees.
- Seventeen new trainees reported providing on-the-job training in PAC to a total of 78 other service providers; follow-up is required to determine the scope of on-the-job training and to ensure that only fully experienced providers impart clinical training.
- The majority of facilities provided comprehensive PAC services, including postabortion family planning. Continued emphasis on *comprehensive* PAC services is required to ensure that all elements of PAC, in addition to MVA services, receive ample attention.

* EngenderHealth. August 2002. Evaluation of the National PAC Expansion in Kenya. October 1999-June 2002. Draft report.

RESULTS

INCREASING ACCESS TO AND QUALITY OF SERVICES

The number of sites supported increased from 60 in 1997 to 100 in FY 1998–1999 and then dropped slightly to 94 in FY 1999–2000, when some sites “graduated.”²⁵ The number of sites further decreased to 86 in FY 2000–2001 when the field-supported program was being phased out.

EngenderHealth’s sterilization work had a lasting impact. For example, the adoption of ML/LA at service sites throughout the country meant that women could be treated on an outpatient basis, resulting in greater safety for clients and lowering the hospitalization cost to the clients and sites by as much as 80%.²⁶

²³ EngenderHealth. 2001. *EngenderHealth/Kenya: End of project summary report, 1995–2000*.

²⁴ EngenderHealth. 2001. *EngenderHealth/Kenya: End of project summary report, 1995–2000*.

²⁵ Graduated sites had sufficient skills and resources to provide services without external assistance.

²⁶ EngenderHealth. 2001. *EngenderHealth/Kenya: End of project summary report, 1995–2000*.

Evaluation results from 1999 showed that at EngenderHealth-supported sites, shortages of family planning supplies and commodities were rare, a full range of methods was available (with the exception of vasectomy), clinical skills in family planning method provision were good, and IP practices were satisfactory in the case of family planning care (although not so in maternity, gynecology, and postabortion care).²⁷

With regard to QI, the Family Planning Association of Kenya institutionalized the use of QI approaches. The Christian Health Association of Kenya introduced these approaches, but a major reorganization in 1998 contributed to inconsistent use. Within the MOH, despite positive beginnings, the use of QI approaches was hampered by infrequent supervision and monitoring. MOH regional supervisors were overcommitted and were unable to visit sites more than once a year or less. However, where there was evidence of the use of the QI approaches and tools, service delivery improved, particularly in the areas of family planning counseling, client flow, and IP.²⁸

Table 9. Service utilization data, Kenya, FY 1998–1999 to FY 2000–2001

	FY 1998–1999	FY 1999–2000	FY 2000–2001	Total
Female sterilization	5,418	4,138	1,493	11,049
Vasectomy	141	66	10	217
Norplant implant	7,207	6,579	2,845	16,631
Postpartum IUD	250	37	18	305
MVA for PAC	3,035	2,000	578	5,613

Note: These data come from EngenderHealth's Integrated Management Information System.

INCREASING UTILIZATION OF SERVICES

Table 9 shows service utilization data over the years of the CA. Decreases in FY 2000–2001 were likely due to the closing down of the field-supported program. Data gathered from 1995 to 2000 showed a 60% decline in the number of clients receiving female sterilization, Norplant implant, and NSV services from 1995 to 1999, despite a growth in the number of sites.²⁹ The decline in ML/LA procedures (which make up the bulk of long-term method service provision) reported to EngenderHealth may partly be explained by the *accumulated* demand from an older group of women having been met by 1995–1996. Other possible factors include a lack of data from Marie Stopes Kenya,³⁰ a lack of reports from eight MOH sites, and staff disruptions (such as a doctors' strike 1994 and a nurses' strike in 1997) affecting the staff's willingness to provide services.

CONCLUSION

EngenderHealth has played a critical role in expanding access to LTP methods throughout Kenya, by means of its financial and technical assistance to in-country partners such as the Ministry of Health, the Family Planning Association of Kenya, the Christian Health Association of Kenya, and other private service providers. Sterilization will continue to be an important method in the country: Projections show that by 2005, female sterilization prevalence will be 8.5% and will grow to 10% in 2010 and to nearly 12% in 2015.³¹

²⁷ Beattie, K., et al. 1999. *Kenya Program Evaluation, 1995–1999*. New York: AVSC International.

²⁸ EngenderHealth. 2001. *EngenderHealth/Kenya: End of Project Summary Report 1995–2000*.

²⁹ EngenderHealth. 2001. *EngenderHealth/Kenya: End of Project Summary Report 1995–2000*.

³⁰ EngenderHealth's service-delivery program with Marie Stopes Kenya ended in September 1995. Thereafter, EngenderHealth provided only training and capacity building.

³¹ EngenderHealth. 2002. *Contraceptive sterilization: Global issues and trends*. New York.

ESTABLISHING A NETWORK OF QUALITY LONG-TERM AND PERMANENT FAMILY PLANNING DELIVERY SITES

FAMILY PLANNING IN MALAWI

Malawi, one of the most densely populated countries in Africa, has suffered from natural disasters, famine, and decades of authoritarian rule. With the fall of the Malawi Congress Party in 1994, the Malawi government adopted its first National Population Policy focusing on stabilizing population growth through social and economic development. In 1996, aligned with the ICPD Programme of Action, the Family Planning Policy and Contraceptive Guidelines were developed and implemented. The focus of the Family Planning Policy and Contraceptive Guidelines is to increase access to and availability of family planning services to all individuals while removing any selection criteria that impede access to family planning services.

The Malawi government, with EngenderHealth's inputs, further revised these guidelines in 2001 to include up-to-date information on various reproductive health topics including LTP methods, PAC, and emergency contraception. Despite its short history in family planning programs, the government of Malawi has improved access to reproductive health and family planning services.

TRENDS

According to the 1992 and 2000 Malawi DHS reports, the "explosion" of contraceptive use in the eight years ending in 2000 is remarkable. Modern contraceptive use has risen at an annual average of 2.3 percentage points, and total contraceptive use (both modern and traditional methods) has risen by 2.2 percentage points annually. These are fast paces, by international standards. They also indicate that traditional method use has fallen off only a little, so there have been clear gains and little substitution. By far, most of the gains have been for the injectable. Its use rose from 1.5% of couples in 1992 to 16% of couples in 2000 (Table 10). The only other observed gain was for sterilization, the prevalence of which rose from 2% to 5% of couples, largely in the older age-groups and among women with larger numbers of living children.

Unmet need has diminished somewhat, from 36% to 30% over the eight years. Meanwhile, modern contraceptive use has risen by 18 percentage points. This increased use has somewhat addressed unmet need,

Table 10. Contraceptive prevalence in Malawi, by method and by year

	1992	2000
Contraceptive method		
Any Method	13.0	30.6
Any Modern Method	7.4	25.6
Long-term methods		
Female sterilization	1.7	4.7
IUD	0.3	0.1
Norplant implant	0.0	0.1
Short-term methods		
Injectable	1.5	16.4
Pill	2.2	2.7
Condom	1.6	1.6
% of modern method use attributed to female sterilization	23.0	18.4
Total no. of women in union	3,492	9,452

but public demand has clearly risen so quickly that much of the rise in use has created new demand. The “moving target” of unmet need, which declines with use but increases with demand, is very much evident in Malawi.

In summary, the Malawi population seems “ready” and the reservoir of unmet need is still very substantial. The sudden uptake of the injectable, through government supply, is the dominant feature; however, sterilization, alone among the other methods, has risen modestly, partly through its availability in the private sector (private hospitals and clinics, mission hospitals, and Banja la Mtsogolo). From a policy standpoint, attention to a fuller method mix is very important, since a two-method program cannot bring unmet need to a low level or prevalence to a high level. Rural services appear to have lagged, and many couples probably lack access to a method that works for them (or to any method at all).

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

EngenderHealth's main programmatic input in Malawi has been to increase access to and availability of quality LTP contraceptive methods at selected sites of the Ministry of Health and Population (MOHP) and the Christian Health Association of Malawi (CHAM). According to the MOHP's five-year strategy document for LTP methods, inadequate buy-in from key policymakers and decision makers hindered the success of these family planning programs. (This was later confirmed by EngenderHealth's facility assessment, conducted in 1999.) With our assistance, the MOHP and CHAM facilitated several general orientations in reproductive health and family planning for key stakeholders in 2000, including the district health management teams, the Medical Council, and the Nurses and Midwives Council. A two-day workshop about LTP methods and reproductive health programs in Malawi was held for 66 individuals.³² An important outcome of this meeting was the MOHP's increased commitment to support the program and to incorporate equipment for LTP methods into their budget.

To further increase access to family planning services, EngenderHealth assisted the MOHP and CHAM to train seven master doctor-nurse teams in ML/LA and Norplant implant insertion and removal. The trainings consisted of both didactic and practical sessions, with participants attaining exceptional surgical and clinical skills.³³ During the five years of the CA, these seven strong teams trained 50 doctor-nurse teams in sterilization and implant insertion, and they are currently providing clinical services throughout the country. Moreover, seven clinicians from MOHP, CHAM, and Banja La Mtsogolo hospitals were trained in NSV in 2000.

In our efforts to improve the quality of services, we helped the MOHP and CHAM monitor family planning services available at their sites, as an integral component of service-delivery expansion. By training local trainers and supervisors in basic financial management, facilitative supervision, COPE, and Community COPE, service delivery was continuously monitored. During the lifespan of the CA, EngenderHealth trained more than 270 individuals in one or more QI approaches, and COPE was introduced in two MOHP and nine CHAM sites.

³² EngenderHealth. 2000. Increasing access to and quality of long-term and permanent contraceptive methods in Malawi. Annual report, January–December 2000.

³³ EngenderHealth. 2000. Increasing access to and quality of long-term and permanent contraceptive methods in Malawi. Annual report, January–December 2000.

In collaboration with JHPIEGO, EngenderHealth introduced comprehensive PAC services at district-level MOHP and CHAM hospitals. Together, EngenderHealth and JHPIEGO developed a PAC country strategy, training manuals, service guidelines, and monitoring and supervisory tools. We provided technical assistance in MVA to treat incomplete abortions, in family planning counseling of clients, and in contraceptive services to avert unplanned future pregnancy. JHPIEGO assisted the MOHP to establish PAC services at the four central hospitals, while EngenderHealth assisted in setting up PAC services at eight district-level hospitals (six MOHP and two CHAM). Both central and district hospitals served as training institutions (preservice and in-service, respectively). EngenderHealth also trained 27 surgeon-nurse training teams from 10 districts and two supervisors in comprehensive PAC services.

EngenderHealth is also conducting an exploratory study in four districts to investigate the needs of adolescent PAC clients, supported through private funds. The goal of this study was to understand how hospitals can meet the needs of adolescents and prevent additional unwanted pregnancy. (See the Global Leadership in PAC section—Needs of Adolescent PAC Clients in the Dominican Republic and Malawi, p. 66.)

EngenderHealth traditionally works on the supply-side issues in service delivery. However, to address demand, in 2001 we partnered with PATH to assist the MOHP in building a clientele for sites offering LTP methods. In 2002, we worked with the Health Education Unit and with district officers of four districts to complete a formative assessment of the population's interest, attitudes, and behavior towards LTP methods. Furthermore, EngenderHealth explored the use of radio programs and community dramas as methods to catalyze awareness of such methods. The radio programs generated a huge amount of listener interest and response: In four months, 5,400 letters were received. Analysis of the letters will serve as the primary evaluation tool, while service-delivery statistics will ultimately determine whether any shifts in clients served were observed.

During the five-year period of the CA, events beyond EngenderHealth's control inhibited the implementation of service delivery. Shortages in Norplant implant supplies and the unavailability of trained staff due to high turnover stalled the delivery of implant services. This is evident in data from the 1992 and 2000 Malawi DHS surveys: Among currently married women of reproductive age, implant use rose only slightly, from 0% in 1992 to 0.1% in 2000.

In addition, during 2003, Malawi faced a famine that placed 70% of its population at risk of starvation. Despite these external events, EngenderHealth's ability to implement programs and increase service utilization was affected only slightly. This may be the result of the stability of the Malawian government from 1998 to 2003, which has provided ongoing support to family planning and reproductive health programs.

RESULTS

INCREASING ACCESS TO AND QUALITY OF SERVICES

EngenderHealth's contributions to improving access and availability of quality family planning services included the support of 24 MOHP district hospitals and nine CHAM district hospitals located in all regions and most districts of Malawi. We supplied training equipment and materials, essential surgical instruments for surgical contraception, and IP equipment to all 33 supported sites. In addition, we upgraded five operating theaters (at facilities located in Rumphi, Lilongwe Central, Kaungu, Embangweni, and Malingunde) that will be utilized for sterilization procedures.

INCREASING UTILIZATION OF SERVICES

Service statistics collected from EngenderHealth-supported sites indicate that as a result of the interventions outlined above, the numbers of family planning users increased significantly. From January 2000 through March 2003, EngenderHealth-supported sites provided a total of 17,068 clients with family planning services, including 13,327 female sterilization users, 3,710 implant users, and 31 vasectomy users. However, these service statistics are an underestimate, as obtaining data from the supported sites often proves challenging. Despite these difficulties, improvements to the data collection system have been adapted, and the system will continue to be revised.

CONCLUSION

EngenderHealth's main contribution in Malawi was to introduce and establish a network of MOPH and CHAM service-delivery sites capable of providing LTP methods and to establish a foundation for QI as an integral part of service management. Historically, EngenderHealth was the first NGO to introduce minilaparotomy and to train staff in clinical procedures. Given this support, EngenderHealth's work has contributed extensively to the increase in female sterilization use observed in the DHS. Sterilization utilization increased to almost 5% in 2000, from less than 2% in 1992. Furthermore, the prevalence of sterilization is projected to grow to 16% in the next 15 years.³⁴ However, with increasing HIV infections, which have ravaged the country and impacted the availability of health care staff (UNAIDS projects a prevalence rate for 2001 of 15%³⁵), continuous technical support will be critical for further increasing access to and availability of quality LTP methods.

³⁴ EngenderHealth. 2002. *Contraceptive sterilization: Global issues and trends*. New York, 2002.

³⁵ UNAIDS. http://www.unaids.org/hivaidsinfo/statistics/fact_sheets/pdfs/Malawi_en.pdf, accessed 8/25/03.

NEPAL:

EXPANDING METHOD MIX IN THE PUBLIC AND PRIVATE SECTORS

FAMILY PLANNING IN NEPAL

Nepal has a long history of family planning services: Its first national family planning program, the Family Planning and Maternal and Child Health Project, was launched in 1968. Under this project, 24 district offices were established to provide a range of family planning services at the district level and to organize mobile camps that offered male and female sterilization services to rural areas. The project's success led to further expansion, with services now integrated into public health programs in all 75 districts of Nepal.

Under a restructuring of the MOH in 1994, the Family Health Division was given primary responsibility for planning, supervising, and implementing all family planning activities in Nepal. Family planning services have since become an integral part of the government's health program and are widely available through government facilities, community health workers, and volunteers. Currently, a range of modern contraceptive methods is available to all, including the pill, the condom, Depo Provera injectables, the IUD, the Norplant implant, tubal ligation, and vasectomy.

TRENDS

Nepal has experienced more than a 10-fold increase in modern contraceptive prevalence over the past three decades. Prevalence increased from 3% in 1976 to 26% in 1996 and to 35% in 2001 (Table 11).³⁶ Nepal's long history in family planning programs had traditionally focused on providing sterilization, which accounted for 60% of modern prevalence in 2001, down from 67% in 1996. Total modern contraceptive prevalence is relatively high, at 35%, having increased by nine percentage points in five years. The prevalence of all methods has risen, but only use of sterilization and the injectable increased significantly from 1996 to 2001.

Table 11. Contraceptive prevalence in Nepal, by method and by year

	1996	2001
Contraceptive method		
All methods	28.5	39.3
Any modern method	26.0	35.4
Long-term methods		
Female sterilization	12.1	15.0
Male sterilization	5.4	6.3
IUD	0.3	0.4
Norplant implant	0.4	0.6
Short-term methods		
Injection	4.5	8.4
Pill	1.4	1.6
Condom	1.9	2.9
Total no. of women in union	7,982	8,342
% of modern method use attributed to female sterilization	67.3	60.2

³⁶ Contraceptive prevalence data for 1976 were cited from Women, Health and Development Committee, Department of Health Services, Ministry of Health. Women, health and development country profile: Nepal, Katmandu: Department of Health Services; 1998. Comparisons in this summary are based on two DHS surveys conducted in Nepal in 1996 and 2001.

Patterns of contraceptive prevalence by age and by number of living children illustrates expected increases in acceptance rates of female sterilization with increasing age and number of living children. Similarly, injectable prevalence reflects greater utilization among older age-groups, rising from 8% among 20–24-year-olds to about 12% at ages 30–34 and 35–39, and then falling off above age 40. Contraceptive prevalence continues to be significantly lower in rural areas for all modern methods but the ratio of rural to urban use increased from about one half to approximately three-fifths from 1996 to 2001.

Increases in modern contraceptive prevalence can be attributed to many factors, including increased demand for family planning services and increased satisfaction of unmet need. Met need for all methods rose by 11 percentage points, while unmet need fell by only about four percentage points (Table 12), clearly suggesting an overall increase in contraceptive demand. The total demand for family planning services increased from 60% in 1996 to 67% in 2001. As services became more widely available, the percentage of demand satisfied by contraceptive use increased to 59% in 2001.

Table 12. Demand for contraceptive methods among women in union in Nepal

	1996	2001
	%	%
Unmet need		
Space	14.3	11.4
Limit	17.1	16.4
Total	31.4	27.8
Met need		
Space	2.6	3.8
Limit	25.9	35.5
Total	28.5	39.3
Total demand for family planning		
Space	16.9	15.2
Limit	43.0	51.9
Total	59.9	67.1
% of demand satisfied by all methods	47.6	58.6
Total number of women in union	7,982	8,342

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

EngenderHealth has been working in Nepal since 1973³⁷ to support the MOH's efforts to provide quality family planning and reproductive health services in both the public and private sectors. Nepal's family planning program historically relied on sterilization as a program method, and our strategy was to help improve the quality of these services as well as to improve method mix. The scope of our technical and financial support ranged from direct financial support for the procurement of essential equipment and for upgrading facilities to supervision and technical assistance in developing, strengthening, and improving service delivery across sites.

PUBLIC-SECTOR INPUTS

In the early stages of family planning services in Nepal, voluntary sterilization services were provided through mobile clinics. In FY 1987–1988, the Ministry of Health decided to introduce a strategy to provide a full range of family planning services at static clinics throughout the year. The purpose of the approach, called "institutionalization," was to decrease reliance on mobile sterilization services, increase method mix, improve the quality of services, and integrate family planning with other health services.

³⁷ Kumar, J., et al. 1999. Nepal baseline assessment report for AVSC International's Results Framework. New York: AVSC International.

EngenderHealth supported the MOH in this strategy by supporting comprehensive family planning services including permanent methods, at 24 Institutionalized Family Planning Service Centers in 21 districts. In the initial phase of the strategy, EngenderHealth provided essential equipment and supplies, as well as funds for new construction and for renovation of facilities.

In the mid 1990s, the MOH's Family Health Division realized the need to monitor and supervise staff to ensure quality services that complied with the *National Medical Standard*. In 1996, we assisted the Family Health Division to launch the Quality of Care Management Center (QOCMC), which aimed to improve the quality of family planning services. The innovative strategy featured a partnership between an NGO (the Nepal Fertility Care Center) and the government (the Family Health Division). The program initially focused on improving IP practices before tackling other quality variables. This approach—starting small with one key indicator that yielded results and fueled the commitment and interest of site staff and managers to improve quality overall—proved successful.

In 1998, we introduced COPE to numerous service-delivery sites. While IP continued to be a key component of QI, the QOCMC took a comprehensive approach to quality of care and worked to address management issues, maintenance of facilities, and equipment. The QOCMC also paid special attention to addressing the needs of the client, and in 1999 institutionalized client exit interviews and suggestion boxes. A 1999 evaluation of the Nepal program found the QOCMC to be highly effective in filling a gap in government monitoring and supervision of sites, but falling somewhat short in terms of its ability to monitor clinical skills, because of the makeup of the field team.³⁸ To address this shortfall, project staff conducted two workshops for staff from the QOCMC, one on facilitative supervision and the other one on QI and monitoring approaches. In addition, EngenderHealth provided whole-site training and supervision assistance, identified training needs and referred people needing training to the National Health Training Center, and coordinated with central-level organizations to solve problems.

The Chetrapati Family Welfare Clinic, established in 1994 by EngenderHealth, began as a model government center to provide high-quality integrated family planning and maternal and child health services, including immunizations and antenatal examinations. The clinic also served as a comprehensive training center for clinical family planning methods, including NSV and minilaparotomy. The Chetrapati center is currently helping the National Health Training Center to develop a family planning training curriculum and guidelines. We provided this clinic with ongoing technical, financial, and management support and assistance. The facility is another example of a joint public-private venture where the clinic is managed by staff from the Nepal Fertility Care Center while being an integral component of the Family Health Division clinical system.

PRIVATE-SECTOR INPUTS

EngenderHealth has had a long partnership with the Family Planning Association of Nepal, the largest reproductive health NGO in Nepal. EngenderHealth support to three association clinics located in Lalitpur central, Chitwan, and Sunsari included essential equipment, a facility upgrade, training for staff, technical assistance on counseling, IP training, and improved overall service quality. In addition EngenderHealth staff conducted regular monitoring and supervision of the service sites and provided on-site coaching.³⁹

³⁸ Stanley, H., et. al. 2001. *The Quality of Care Management Center in Nepal: Improving services with limited resources*. AVSC Working Paper No. 13, New York: AVSC International.

³⁹ In 2002, we ceased support of FPAN due to the reinstatement of the Mexico City clause.

In 1992, EngenderHealth helped the Nepal Fertility Care Center initiate two private-sector programs: Pariwar Swastha Sewa Network and the Sangini program. The Sangini Program⁴⁰ introduced Depo Provera through a network of nurse-paramedic providers at private pharmacies. Under this program, EngenderHealth supported the training of nurses and paramedics to provide injectables and method counseling and was responsible for monitoring the quality of services provided. Pariwar Swastha Sewa Network is a network of 156 private medical providers in 13 urban areas focused on expanding and improving family planning services. EngenderHealth provided technical support to create this network, design and implement a monitoring and supervision system, and conduct training for network members on clinical family planning methods. In addition EngenderHealth provided essential equipment and assistance to link the network with social marketing system.

EngenderHealth provided financial and technical support to the United Missions of Nepal to improve the quality of family planning services through three hospitals located in Amp Pipal, Okhaldhunga, and Tansen. These hospitals offer temporary and permanent family planning methods and other reproductive health services year round. Training non-family planning providers has allowed family planning services to be integrated into other clinical and outreach programs, including comprehensive PAC services and community health programs. A supervisory and monitoring system was also created to ensure continuous QI.

RESULTS

INCREASING ACCESS TO AND QUALITY OF SERVICES

In support of our efforts to ensure greater access to and availability of family planning services, EngenderHealth trained and supported a cadre of health care professionals in family planning methods and counseling services. During the life of the CA, we supported the training of 70 providers in minilaparotomy and 49 providers in NSV. Furthermore, to expand the contraceptive method mix, we trained 110 health professionals in Norplant implant insertion and removal and 132 health professionals in the provision of injectables. In addition to clinical trainings, EngenderHealth trained 99 providers in family planning counseling and 694 providers in general family planning counseling to increase client access to quality counseling services. These providers were available to provide services in 259 sites in FY 2001–2002.

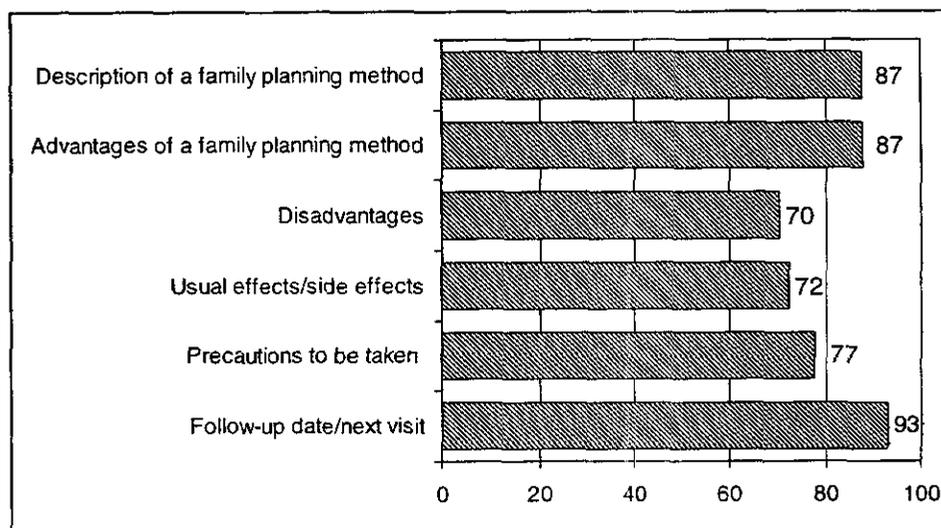
EngenderHealth has made significant contributions to improving the quality of family planning services in Nepal. We trained 331 individuals in QI methods, including COPE for Family Planning and whole-site training, and we trained 277 individuals in IP approaches during the CA. In addition, at the national level, we supported the Family Health Division in its efforts to develop the National Medical Standards for Family Planning, VSC Mobile Outreach Guidelines, and the Family Planning Service Delivery Policy.

In 2001, EngenderHealth conducted a client satisfaction study on services provided through institutionalized family planning service sites.⁴¹ Figure 8 shows the percentage of clients who received specific information regarding a family planning method. Overall, the study found that 73% of clients were satisfied with providers' attitudes and service-

⁴⁰ The Sangini Program was a collaborative alliance with the Nepal Contraceptive Retail Sales Company and the SOMARC project. Sangini is the Nepali brand name for a three-month injectable and translates to "female friend" in Nepali.

⁴¹ EngenderHealth. Quality of Care Management Center/Family Health Division. Nepal. 2001. *Clients' views towards family planning services at institutionalized family planning service sites in Nepal.*

Figure 8. Percentage of clients who received the following types of information during counseling



delivery procedures. The majority of clients reported satisfaction with counseling and availability of methods. EngenderHealth also conducted a study to gain a better understanding of clients' experiences of sterilization within the larger context of their reproductive lives.⁴² Findings of the study included that 95% of female respondents understood that the operation they received was permanent. Clients' suggestions for improving services included improvement of physical facilities (32%), maintaining privacy (31%), good management of waste disposal (17%), the need for good counselors and counseling practices (13%), and the need for service providers to be nice and welcoming (10%). Findings were utilized for program improvement efforts.

From 2002 to 2003, EngenderHealth supported four in-depth follow-up research studies on the use dynamics of four female contraceptive methods—Norplant, IUCD, pill and injectables. Clients who were provided these methods in government and non-government facilities between July 2000 and June 2002 were surveyed. The studies gathered information on demographic characteristics, current and past contraceptive use, information received at service delivery site, level of satisfaction with health care personnel and with contraceptive method, accessibility of service delivery site, cost to the client, the influence of family members, changes in health status experienced, and cumulative discontinuation rates. The findings and recommendations, which are found in the study reports, provide information that will assist family planning program managers in understanding the strengths and weaknesses of service delivery and to increase its quality and effectiveness.⁴³

INCREASING UTILIZATION OF SERVICES

EngenderHealth's contributions to improving quality and increasing access to services have yielded significant results in utilization. At EngenderHealth-supported sites, close to

⁴² Kaufman, A., et al. 2001. *Enhanced monitoring of mobile outreach sterilization services: client perspectives*. (Nepal)

⁴³ New Era, *Norplant Acceptance & Use Patterns in Nepal*, June 2003; *IUCD Acceptance & Use Patterns in Nepal*, June 2003; *Depo-Provera Acceptance & Use Patterns in Nepal*, June 2003; *Pill Acceptance & Use Patterns in Nepal*, June 2003.

108,000 clients were served various permanent, long-term, and short-term family planning methods.⁴⁴ Specifically, from FY 1998–1999 to FY 2002–2003, a total of 21,253 clients selected sterilization, including vasectomy. (See Section 4: Asia and Near East, page 101, for an in-depth discussion of Nepal’s service statistics.)

According to the 2001 Nepal DHS, 86% of current contraceptive users in union reported the source of female sterilization as the government—42% a government hospital or clinic and 41% mobile clinics. Use of female sterilization was highest in the Terai region, where the majority of EngenderHealth’s supported district hospitals are located. Out of the 21 districts supported by EngenderHealth, 15 (71%) were in the Terai (Table 13). Anecdotal evidence suggests that these facilities have seen tremendous improvement in the quality of family planning services in the past five years, in terms of provider competence, regularity of services, quality of counseling, and IP practices.

Table 13. Percentage of district hospitals in Nepal supported by EngenderHealth, by subregion

Subregion	Number of district hospitals	% supported by EngenderHealth
Mountain		
Eastern Mountain	3	0
Central Mountain	3	0
Western Mountain	2	0
Hill		
Eastern Hill	7	0
Central Hill	17	35
Western Hill	10	20
Mid Western Hill	6	0
Far Western Hill	4	0
Terai		
Eastern Terai	7	57
Central Terai	8	63
Western Terai	5	60
Mid Western Terai	3	67
Far Western Terai	4	50

CONCLUSION

During the span of the CA, EngenderHealth had an ongoing and substantial presence in Nepal.⁴⁵ We increased access to and availability of family planning services, improved the quality of available services, generated demand for contraceptive methods, and increased the utilization of contraceptives. The rise in sterilization use illustrated by the DHS survey is consistent with EngenderHealth’s contributions over many years, especially during the period 1996–2001. Our success in Nepal is also attributed to the good working relationships and close partnerships with the Ministry of Health, local NGOs, and the private sector. As Nepal enters the 21st century, the solid foundation for expanding quality reproductive health services will bridge the existing gaps in family planning need.

⁴⁴ This number excludes the number of clients served at the 24 IFPS sites, as these numbers are reflected in the national HMIS. USAID requested that EngenderHealth not include these numbers in our reporting, as USAID used a different mechanism to report family planning achievements in the public sector using HMIS. USAID’s target was to achieve an annual 10 % increase in couple-years of protection in Nepal, which was achieved.

⁴⁵ In 2002, EngenderHealth became a subcontractor to JSI under USAID/Nepal’s bilateral project, the Nepal Family Health Program.

PHILIPPINES:

**AFFECTING POLICY, AVAILABILITY, QUALITY,
AND UTILIZATION OF FAMILY PLANNING SERVICES
AND SERVICES RELATED TO PREVENTING
AND MANAGING ABORTION COMPLICATIONS**

**FAMILY PLANNING
IN THE PHILIPPINES**

Family planning has been an important government policy and service in the Philippines since the 1970s. In 1970, the Philippines Government officially launched its population program and mandated that the Commission on Population (POPCOM) serve as the central coordinating and policy-making body. In 1971, a Population Act established a national family planning program “which respects the religious beliefs of the individual involved.”⁴⁶ In 1972, sterilization for both men and women was recognized as an official method of contraception by the government of the Philippines. In 1976, POPCOM (with USAID support) launched a 10-year National Population and Family Planning Outreach Project.⁴⁷ In 1980, the program expanded its mandate to address “quality of life” issues, including family welfare, maternal and infant care, and livelihood generation; in 1987, government policy recognized the “interrelationships among population, resources, and environmental factors.”⁴⁸ In 1989, the Department of Health (DOH) was designated as the lead agency for family planning, including service delivery, training, and program implementation, with POPCOM maintaining the lead role for population and development. In 1993, a shift took place from a centralized DOH network of nationally funded public providers to a decentralized system with local government units (LGUs) managing hospitals, resources, and services.

TRENDS

As of 2002, the population in the Philippines was 80 million, and that number grows by almost 1.7 million per year.⁴⁹ The overall contraceptive rate as of 2001 was 49.5%.⁵⁰ Modern method use remains relatively low, due to widespread use of natural family planning and traditional methods.⁵¹ Female sterilization, however, continues to be the method of choice for a large number of women. Table 14 shows that the prevalence of female sterilization use rose from 9% in 1995 to 10.5% in 2001, while vasectomy use remained relatively low and unchanged during that time. IUD prevalence remained low, but some growth was seen in the use of the pill and injectables.

The most recent DHS data, which were collected in 1998, show that from 1993 to 1998, *unmet need to limit future births* decreased from 14% to 11%, and *unmet need overall* decreased from 26% to 20%. *Met need to limit* increased from 31% to 34%, and *met need overall* increased from 40% to 47%. Overall demand for family planning remained relatively unchanged.

⁴⁶ <http://www.globalink.net.ph/~popcom5/history.htm>

⁴⁷ <http://www.globalink.net.ph/~popcom5/history.htm>

⁴⁸ http://www.popcom.gov.ph/Agency_Mandate.htm

⁴⁹ http://www.usaid-ph.gov/health_usaid.htm

⁵⁰ Family Planning Survey, Final Report 2001, National Statistics Office, the Philippines.

⁵¹ Senlet, P., et al. 2002. Evaluation of the EngenderHealth Cooperative Agreement, 1998–2003. Appendix D.

Table 14. Contraceptive prevalence in the Philippines, by method and by year

Method	1995	1996	1997	1998	1999	2000	2001
	(FPS)	(FPS)	(FPS)	(NDHS)	(FPS)	(FPS)	(FPS)
Any method	50.7	48.1	47.0	46.5	49.3	47.0	49.5
Any modern method	25.5	30.2	30.9	28.2	32.4	32.3	33.1
Pill	11.2	11.6	12.5	9.9	13.1	13.7	14.1
IUD	3.5	3.7	3.0	3.7	3.4	3.3	3.3
Injection	0.6	1.6	2.0	2.4	2.7	2.5	2.8
Diaphragm/foam/jelly/cream	-	-	0.1	-	0.1	-	-
Condom	1.1	1.6	1.7	1.6	1.7	1.3	1.7
Female sterilization	8.9	10.6	10.6	10.3	10.7	10.6	10.5
Male sterilization	0.1	0.2	0.2	0.1	0.1	0.2	0.1
Mucus/Billings/ovulation		0.1	0.1	0.2	-	-	0.1
Temperature	-	-	-	-	-	-	-
Lactational amenorrhea method	-	0.9	0.8	-	0.5	0.5	0.4
Any traditional method	25.2	17.9	16.1	18.3	16.9	14.7	16.4
Calendar/Rhythm	18.4	10.3	9.7	8.7	9.6	9.5	10.4
Withdrawal	5.6	6.9	5.9	8.9	6.7	4.8	5.6
Other	0.4	0.7	0.5	0.8	0.6	0.4	0.4
No method	49.3	51.9	53.0	53.5	50.7	53.0	50.5
No. of women (in 000s)	10,110	11,088	10,595	8,336	11,087	11,031	11,300

Source: Family Planning Survey, Final Report 2001, National Statistics Office

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

Since the 1970s, EngenderHealth has maintained a steady presence in the Philippines and at the close of this CA remained the primary international reproductive health agency providing technical assistance in family planning to the DOH at the national, regional, provincial, and municipal government levels. EngenderHealth helped to establish sterilization and other family planning services in several large hospitals in the early 1970s. Throughout the subsequent decades, EngenderHealth worked with the DOH and with LGUs to build their technical capacity in sustainable ways, including through establishing regional ML/LA and VSC training centers, establishing clinical guidelines and protocols, introducing supportive systems and approaches for continuous QI (including COPE, facilitative supervision, counseling, and informed choice measures), and developing training materials and curricula. EngenderHealth opened its country office in Manila in 1991, and began work with the private sector in 1997.

INPUTS TO THE PUBLIC SECTOR

From 1995 to 1999, EngenderHealth provided technical and financial assistance on voluntary sterilization and family planning counseling to the DOH at the national and regional levels, to selected LGUs under the Local Government Unit Performance Program (LPP), and to selected NGOs under the Technical Assistance to NGOs II (TANGO II) project. The assistance was part of the USAID-supported Integrated Family Planning and Maternal Health Program (IFPMHP), whose goal was to improve the health

of women and children by reducing the unmet demand for family planning services and improving the health and nutrition of Filipino mothers and children.⁵²

EngenderHealth provided critical technical assistance to the LGU project on sterilization service provision and on the establishment of quality assurance systems for sterilization services. EngenderHealth provided technical assistance to 72 LGUs in the LPP, including 156 LGU hospitals (tertiary and secondary) for the training of service providers (voluntary sterilization teams) on ML/LA and family planning counseling, to ensure informed choice and informed consent. The *informed consent form* was subsequently adapted as a program document by the DOH. EngenderHealth's assistance also strengthened the quality assurance system through:

- COPE introduction and COPE follow-up
- Whole-site training in IP
- Establishment of a Quality Assurance Team at the provincial level
- Establishment of a Quality Assurance Committee at the hospital level
- EngenderHealth also supported strengthening the referral system between the hospitals and the community through the rural health units. Finally, EngenderHealth provided technical assistance in developing policies and guidelines on ML/LA.

From 2001 to the close of the CA, EngenderHealth provided technical assistance to the Matching Grant Program (MGP), a follow-up project of Management Sciences for Health (MSH) to the LPP. Under the MGP, EngenderHealth provided assistance to 24 MGP sites in strengthening referrals for voluntary sterilization and in building capacity in referral hospitals. EngenderHealth also provided technical assistance and training on NSV to other MGP sites where the MGP project generated demand for NSV. EngenderHealth trained service providers in LGUs included in the MGP, provided the necessary NSV instruments to trainees during NSV outreach activities of MSH, and provided technical assistance on the ideal set-up for an NSV service-provision site. We also provided technical assistance to MSH for the development of a counseling training curriculum for barangay health workers.

In 2002, the DOH mandated that all DOH hospitals implement a new administrative order about using itinerant teams to expand access to sterilization services. With support from USAID and the DOH and in partnership with MSH and Johns Hopkins University, EngenderHealth has worked on a pilot project to implement the itinerant teams in selected, densely populated, urban poor areas of Metro Manila. Between June 2002 and March 2003, 12 LGUs were developed as outreach sites for itinerant voluntary sterilization teams coming from 11 assisted hospitals. In addition, EngenderHealth worked with the DOH to establish a vasectomy training center. We also developed, in consultation with the DOH, an NSV training curriculum based on EngenderHealth's global materials; at this writing, the curriculum is awaiting final approval by the Office of the Health Secretary.

In May 2003, EngenderHealth began a pilot media campaign for vasectomy, using USAID core funding. This campaign focused on three public-sector sites: Tuguegarao City in Cagayan Province, Malabon City in Metro Manila, and Cebu City. Radio and newspaper advertisements and posters were developed, and radio spots ran from June through September 2003. The voice-alike of a popular action star was used to promote the benefits of NSV and advertise the services available at the three project hospitals.

⁵² Scherzer, M. 2003. A review of EngenderHealth's USAID supported work in the Philippines, 1998-2003.

Also, beginning in late May 2003, full-page advertisements on NSV featuring two satisfied vasectomy users, or "champions" (the incumbent governor of Cagayan Province and a doctor who is also son of a popular incumbent senator) were also printed in one national and two local dailies once a month. Posters, streamers, bumper stickers, and billboards of the two vasectomy champions were likewise produced and distributed throughout the country. A video of the governor's testimony was produced as an introduction for open forum on NSV. In Manila, a hotline on NSV was also begun in June. (See "Global Leadership, Vasectomy Promotion Initiative in Ghana and the Philippines," page 85.)

In addition, EngenderHealth provided technical assistance to the DOH to establish PAC services. This work began in 2000 with funding from the David and Lucile Packard Foundation. In 2001, EngenderHealth/Philippines received funding for PAC services from USAID/Philippines and in 2002 received USAID/Washington special initiative core funds to further expand the program. Our technical assistance has included training providers in the clinical management of abortion complications (including the use of manual vacuum aspiration, or MVA), in IP, in counseling, and in the use of QI tools. With USAID and private funding, EngenderHealth has helped the DOH implement services at a total of 15 hospitals.

INPUTS TO THE PRIVATE SECTOR

From 1997 to 1999, EngenderHealth helped private hospitals provide sterilization (bilateral tubal ligation and vasectomy) for paying clients through the TANGO II project.⁵³ The assistance included training service providers in ML/LA and counseling, upgrading the surgical spaces of service sites, providing technical assistance to strengthen linkages within the hospital and with the outside community to improve referral of voluntary sterilization clients, and implementing a quality assurance system designed to ensure continuous QI in the family planning program.

From 1999 to 2001, private-sector activities focused on eight family planning-reproductive health clinics that were established as units within hospitals providing integrated reproductive health services (including family planning, prevention and management of abortion complications, RTIs, maternal care, adolescent health care, and MAP services). The units involved the entire hospital and staff, with the counseling staff at the core of the reproductive health centers and the department of obstetrics and gynecology acting as the lead unit. From January through September 2002, five of the original eight private hospitals continued to receive assistance to strengthen the marketing and promotional activities for improving utilization of the centers' services. Tools were developed or revised for client outreach, identification, and referral for use within the hospitals and in the surrounding communities, industries, and commercial establishments. The hospital staff and selected community workers were trained in and followed-up in the appropriate use of these tools, which included a community-based management information system (used in the community), a company-based information system (used in local companies and other institutions), and a family planning-reproductive health assessment form (used for inpatients and clients seeking other health services within a hospital).

MATERIALS

Over the course of our work in the Philippines, EngenderHealth developed 20 materials with the DOH and other agencies. These included a trainer's manual in ML/LA, guidelines

⁵³ TANGO II is the Technical Assistance for NGOs program, managed by John Snow, Inc. (JSI).

for ML/LA, NSV brochures and promotional materials, an instructor's guide for counseling the postabortion client, a trainer's guide for postabortion clinical care, information, education, and communication (IEC) materials on preventing and managing abortion complications, a voluntary sterilization monitoring manual, and a facilitative supervision trainer's guide.

RESULTS

INCREASING ACCESS TO AND QUALITY OF SERVICES

From 1998 to 2003, EngenderHealth helped 185 public-sector hospitals provide female and male sterilization services (Table 15). These hospitals continued to provide services through 2003.⁵⁴

Table 15. Total number of public-sector hospitals assisted by EngenderHealth that offered sterilization services in 2003

	No. of hospitals	No. offering female sterilization services	No. offering male sterilization services
DOH-retained hospitals	28	28	2
LGU hospitals	143	143	5
Municipal health offices	14	4	12

Overall, the number of public- and private-sector sites supported by EngenderHealth fluctuated annually, from 194 in FY 1998–1999 to 78 in FY 2002–2003. This decrease was due to the cessation of the LPP project in 1999.

EngenderHealth contributed significantly to ensuring that trained and competent providers were available to provide services at public- and private-sector sites. Training between 1998 and 2003 focused on ML/LA training for providers and trainers, NSV, family planning counseling, COPE skills, orientation of barangay health workers, and marketing for private-sector services, among other topics. A total of 44 trainers and 407 service providers were trained in ML/LA, and 106 providers were trained in NSV techniques. Family planning counseling training was given to 28 trainers and 3,091 providers; 33 trainers and 83 providers were trained in facilitative supervision skills, and 81 COPE facilitators were trained. Voluntary sterilization orientations were provided for 18,000 barangay health workers.

In addition to family planning–related training, EngenderHealth's introduction of PAC services included the training of 92 doctors and providers between 2000 and 2003 in the clinical management of abortion complications, 185 service providers in counseling, and 175 in infection prevention, as well as orienting more than 315 managers to PAC services. In addition, to build capacity at the teaching hospitals, EngenderHealth conducted TOT courses with a total of 25 trainers for counseling and clinical management.

INCREASING UTILIZATION OF SERVICES

From FY 1998–1999 through FY 2002–2003, EngenderHealth-supported sites in both the public and the private sectors provided 934 vasectomies and 81,008 female sterilizations.

⁵⁴ Scherzer, M. 2003. A review of EngenderHealth's USAID supported work in the Philippines, 1998–2003. Not all 185 sites continued to receive support through 2003.

Female sterilization peaked in FY 1999–2000, at 28,763 cases.⁵⁵ Between June 2002 and March 2003, the 12 LGUs that were developed as outreach sites for itinerant voluntary sterilization teams provided nearly 12,000 clients with sterilization services.

With funding from both USAID and non-USAID sources, between 2000 and 2003, nearly 27,000 women were seen for PAC services; 22% were treated using MVA equipment, 82% were counseled about family planning, and 43% left the hospital with a contraceptive method. The number of clients who were treated with MVA, who were counseled, and who received a family planning method steadily increased each year.⁵⁶

Table 16. Number of services provided, by type of service, according to fiscal year

	FY 1998–1999	FY 1999–2000	FY 2000–2001	FY 2001–2002	FY 2002–2003	Total
Female sterilization	27,200	28,763	11,554	10,039	3,452	81,008
Vasectomy	130	160	0	196	448	934
IUD	0	3,701	0	0	0	3,701
PAC	0	0	6,400	9,321	11,091	26,812
Total						112,455

POLICY

EngenderHealth was also influential in addressing an array of policy issues related to reproductive health services. EngenderHealth provided technical assistance to the DOH in the development and issuance of five important administrative orders focused on sterilization and PAC services. In addition, EngenderHealth participated in the development of a national family planning policy, leading to the development of a national sterilization strategy in 2001. The five administrative orders are:

- **DOH Administrative Order No. 2 s.2000 Jan. 4, 2000: Implementing Guidelines for Strengthening the Training in ML/LA for Resident Physicians in Obstetrics and Gynecology in all DOH-Retained Regional Hospitals and Medical Centers.** Under this administrative order, a minimum number of 40 interval ML/LA cases was added as one of the completion requirements for all physicians undergoing the ob-gyn residency training in all 32 DOH-retained hospitals. Implementation of the order is helping to ensure that a greater number of specialists will be competent in the DOH-approved standard local anesthesia technique. Since August 2000, EngenderHealth provided technical assistance to 23 DOH-retained medical centers and regional hospitals, training 47 trainers in sterilization procedures. The order was formulated following consultations between the DOH, EngenderHealth, and the involved hospitals.
- **DOH Administrative Order No. 45-B s.2000 July 21, 2000: Strengthening the Prevention and Management of Abortion and Its Complications (PMAC) Services in the Philippines.** This administrative order legitimized PMAC as a needed and viable service. It paved the way for the implementation of PMAC services at four pilot sites, including two DOH-retained hospitals, one LGU hospital, and one private hospital. The administrative order states that by the end of 2004, services should be available in 50 DOH-retained hospitals; EngenderHealth helped the DOH establish PMAC services in 15 hospitals.

⁵⁵ Between 1995 and 1999, EngenderHealth directly supported hospitals through 72 subagreements. These subagreements required quarterly reporting of financial and programmatic (i.e., service) statistics. When the subagreements were phased out, we no longer had the same leverage with those facilities to obtain service statistics. At the close of this global CA, 78 hospitals still provided EngenderHealth with data.

⁵⁶ EngenderHealth/Philippines MIS.

- **DOH Department Order No. 34-D s.2001 February 14, 2001: Provision of Free Voluntary Sterilization (VS) Services—Bilateral Tubal Ligation and Vasectomy—to All Qualified VS “Indigent” Clients.** This order calls for the provision of free female sterilization and vasectomy services, including needed drugs and supplies, to all indigent clients in DOH hospitals.
- **DOH Administrative Order No. 153s. 2002. September 25, 2002: Implementing Guidelines for the Creation and Operationalization of Outreach/Itinerant Teams for Voluntary Sterilization Services.** One result of the decentralization that took place in 1993 was a decline in access to sterilization in many parts of the country. This administrative order aimed to address limitations in geographic access and transportation barriers to services. It mandated that all DOH hospitals create itinerant family planning teams to reach clients living in urban and rural poor communities. The administrative order further states that family planning services need to be part of the standard package of services delivered by all hospitals. EngenderHealth was instrumental in assisting the DOH in the organizational design of the itinerant teams, including identifying *minimum standards* for facilities and equipment required for ML/LA and NSV services.
- **DOH A.O. No. X, 2003: Implementing Guidelines for Provision of Family Planning Voluntary Sterilization Services.** This administrative order is designed to further support earlier efforts to expand access to sterilization services by prescribing the guidelines for service provision, rationalizing the requirements imposed on potential sterilization acceptors, and eliminating barriers to clients interested in these services. This order was pending approval from the DOH as of July 2003.

Finally, though the administrative order is not yet signed, EngenderHealth has been assisting the DOH in the development of an order to address procurement and guidelines for use of PAC-related medical equipment.⁵⁷ The objectives of the administrative order (“Policies and Guidelines on the Use of the Manual Vacuum Aspiration [MVA] as the Recommended Treatment for Incomplete Abortion under the Program on the Prevention and Management of Abortion and Its Complications [PMAC] in the Philippines”) are to promote the use of MVA as the recommended method for treating incomplete abortion, and to provide policies and guidelines for the use of necessary equipment, including its registration, procurement, distribution, and use. Ipas is providing technical assistance to the DOH and the Bureau of Food and Drugs to facilitate registration.

CONCLUSION

EngenderHealth has played a critical role in expanding access to voluntary sterilization and PAC services in the Philippines through developing the human resources and systems capacity to meet the need for services and by working to improve the policy environment affecting those services. The percentage of women using sterilization is projected to grow over the next 15 years, to nearly 15% in 2005 and 21.5% in 2015.⁵⁸

The demographic situation in the Philippines has reach a critical point: Population growth is estimated to be 2.4% annually, the total fertility rate of 3.7 lifetime births per woman exceeds the desired family size by one child,⁵⁹ contraceptive prevalence is stagnant, and the potential for an HIV/AIDS epidemic is a hidden threat. Thus, the need for attention to an infrastructure and systems that provide safe and accessible services will continue to exist.

⁵⁷ At the time of writing of this report (July 2003), the administrative order was still under review by the DOH.

⁵⁸ EngenderHealth. 2002. *Contraceptive sterilization: Global issues and trends*. New York.

⁵⁹ http://www.usaid-ph.gov/health_statistics.htm

**FORGING NEW APPROACHES TO QUALITY IMPROVEMENT
AND TO EXPANSION AND DIVERSIFICATION OF SERVICES
WITHIN THE GOVERNMENT AND NONGOVERNMENTAL SECTORS**

HISTORY OF FAMILY PLANNING IN TANZANIA

The Family Planning Association of Tanzania (UMATI) was established in 1959 with the purpose of introducing and expanding services through many regions of the country. The government of Tanzania actively began providing services in 1974 with the launch of the integrated Maternal and Child Health program. At that time, modern contraceptives were not readily available, and long-term and permanent methods were only offered for medical reasons. In 1989, the MOH established a dedicated Family Planning Unit (now the Reproductive and Child Health Section, or RCHS). Since then, both the government and NGOs provide family planning services under the RCHS.

For many years, family planning—and LTP contraception in particular—was accorded a low priority at all health service delivery points, despite explicit government policies and high demand. This was attributed in part to the vertical structure of the program from its inception, and to the fact that provision of LTP methods in health facilities was perceived as competing with treatment of life-threatening conditions.⁶⁰ Until recently, the MOH delegated overall management of the program to UMATI under the supervision of the Directorate of Preventive Services, RCHS. Since many of the facilities providing services were MOH regional and district hospitals, UMATI supervisors had to act as external supervisors to site staff and managers specifically for the LTP methods and PAC services. This supervision structure was parallel to that of MOH supervisors of the same service sites. In recent years, the supervisory responsibility for LTP methods and PAC services has been shifted back to MOH supervisors.

TRENDS

According to DHS data, use of any modern family planning method among women in union of reproductive age more than doubled, from almost 7% in 1992 to 17% in 1999 (Table 17). In the same period, however, use of LTP methods increased only slightly: Female sterilization usage rose from 1.6% to 2.0%. Norplant implant use rose from 0.0% to 0.1%, and IUD use remained stable, at 0.4%. This can be attributed to the low priority given to family planning and LTP methods over the years by the government, and possibly also is due to the rise in and availability and popularity of hormonal methods, particularly injectables. Use of temporary methods increased rapidly: Use of injectables went from less than 1% to 6%, pill use rose from 3% to 5%, and condom use climbed from 1% to 3%. These data suggest both a demand for and an unmet need for family planning services, which would require concerted efforts to improve access to and quality of the family planning services provided in the country. The ratio between modern prevalence and total prevalence has changed little (2/3 modern) across the three surveys since 1992. The diversity of method use is encouraging: Sterilization, the injectable, the pill, and the condom each has a significant role in the mix.

⁶⁰ Riwa et al. 2000. A report on the review of long-term and permanent contraceptive methods and quality improvement program in Tanzania. Tanzania: Reproductive and Child Health Section.

Table 17. Contraceptive prevalence in Tanzania, by method and by year

	1992 %	1996 %	1999* %
Contraceptive method			
All methods	10.4	18.4	25.4
Any modern method	6.6	13.3	16.9
Long-term method			
Female sterilization	1.6	1.9	2.0
IUD	0.4	0.6	0.4
Norplant implant	0.0	0.0	0.1
Temporary methods			
Injectable	0.4	4.5	6.3
Pill	3.4	5.5	5.3
Condom	0.7	0.8	2.7
Total no. of women in union	6,038	5,411	2,653
% of modern method use attributed to female sterilization	24.2	14.3	11.8
% of modern method use attributed to injectable	6.1	33.8	37.3

*Interim survey.

The use of modern contraception increased across all age-groups, most noticeably among women aged 20–24, whose method use rose by more than 14 percentage points. In 1999, use of modern methods was highest among women aged 20–24, at 20%. Modern method use steadily increased among women with one or more living children from 1992 to 1999. A look at modern method use by residence indicates that reproductive health and family planning programs are focused on urban areas. In 1999, 33% of women living in urban areas used a modern method, an increase of 19 percentage points from 1992. Modern contraceptive use is still highest among women with a secondary or higher education, but differences by education have decreased over time, and the reproductive health and family planning program clearly is reaching less-educated groups.

From 1992 to 1999, the unmet need for spacing future births decreased from 18% to 14%, while the unmet need for limiting future births decreased from 12% to 8%. At the same time, met need for spacing increased from 6% to 15%, and the met need for limiting increased from almost 5% to 10%. By 1999, the total percentage of demand that was satisfied by all methods had doubled from 26% to 54%. Although the total met need increased from 10% in 1992 to 25% in 1999, the total unmet need for family planning remained high, at 22% in 1999.

As of 1999, 70% of female sterilizations were performed by public-sector providers and 27% by the private sector. Within the public sector, the vast majority of these procedures were performed in regional and district hospitals (41% and 25%). Within the private sector, nearly all were done at mission hospitals (25%). In contrast, temporary modern methods were more widely available in the private sector (e.g., condoms and pills being available at pharmacies); within the public sector, these methods were supplied primarily at lower-level facilities (e.g., injectables, pills, and condoms being offered at dispensaries).

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

In close partnership with the MOH, with NGOs, and with faith-based organizations, EngenderHealth helped to improve the availability of quality LTP methods and comprehensive PAC services in many public- and private-sector sites. Beginning on a national level in 1982, EngenderHealth worked with the MOH's Family Planning Unit (now the RCHS) to advocate among key government officials, politicians, and religious leaders for the development of a country policy and strategy on family planning. In addition, EngenderHealth collaborated with Intrah and with local NGOs (including UMATI) to help the MOH develop a family planning training strategy, family planning standards and guidelines, family planning training curricula, and PAC curricula.

EngenderHealth's work in Tanzania took place in four phases: initial program introduction and expansion (1984–1992); continued expansion, with a focus on improving management and supervision of services (1993–1997); further expansion and diversification of services (PAC, working with Marie Stopes) (1998–2000); and a shift to working directly with the Directorate of Hospital Services (2001–2003).

From 1984 through 1992, EngenderHealth supported training in ML/LA, introduced COPE, and introduced NSV. By 1992, EngenderHealth was supporting 16 service-delivery sites. From 1993 through 1997, EngenderHealth conducted an assessment that identified problems in management and supervision, training, services, and supplies. The assessment recommended strengthening supervision through teams to act as catalysts to strengthen service provision at the site level. In response, EngenderHealth held five national facilitative supervision workshops and helped to establish seven "area teams" to provide decentralized supervision around the country. During this time, we also began to shift to on-the-job training rather than centralized training, introduced inreach to improve access to family planning services within sites, introduced the annual QI Checklist (now called the *Quality Measuring Tool*), and expanded our work to Marie Stopes sites and to the private sector. We also trained MOH MCH-FP coordinators from all regions in facilitative supervision and COPE, began area management workshops, and the area teams began to orient district health management teams to supervisory and QI tools and to approaches for handing over these functions. To address demand for vasectomy, we launched a vasectomy promotion campaign, in partnership with the Population Council, Marie Stopes, and UMATI. We conducted a PAC needs assessment and baseline study in three MOH hospitals and began a PAC pilot project in three sites. In 1997, Tanzanian representatives participated in the EngenderHealth-sponsored MAP workshop and a regional economic development services conference on QI, both in Kenya. By 1997, EngenderHealth was supporting 101 service-delivery sites.

From 1998 through 2000, EngenderHealth supported the Tanzania program to expand LTP contraceptive services through private not-for-profit organizations such as UMATI, Marie Stopes Tanzania, (and later, in 2002, the Seventh-Day Adventist Church, and the Evangelical Lutheran Church of Tanzania), and through work with the Directorate of Hospital Services. We also worked to transfer supervisory responsibilities to district health management teams within the MOH. EngenderHealth continued to introduce and refine QI approaches and tools, including COPE, facilitative supervision and medical monitoring, whole-site training, inreach, the *Quality Measuring Tool*, and the *Cost Analysis Tool* to improve the management and continuous improvement of service quality in all of the health facilities participating in the program (see below).

EngenderHealth conducted five facilitative supervision workshops at the area level⁶¹ for MOH regional health management teams.

**ENGENDERHEALTH HELPS TANZANIAN PARTNERS
DEVELOP THE QUALITY MEASURING TOOL**

Following a number of years of solid experience with COPE and other QI approaches, the LTP methods program in Tanzania expressed an interest in quantifying the results of their QI efforts. Tanzanian supervisors, having been introduced to COPE by EngenderHealth and having gained and valued their experience with self assessment, sought a participatory tool to be used with site staff that would foster ownership of the measurement process. The resulting Quality Measuring Tool (originally called the Quality Improvement Quotient), developed jointly with EngenderHealth, was based on the COPE self-assessment guides. The Quality Measuring Tool is used annually during a supervisory visit. Questions about service provision are answered by consensus among the supervisor and staff, and scores are easily calculated for each of the seven clients' rights and three staff needs. Any new problems identified are then incorporated into the site's ongoing Action Plan and reviewed on a regular basis.

For example, at one site in which low safety scores reflected inadequate supplies of emergency drugs, a lack of oxygen in the operating theater, and improper disposal of sharps, the site Action Plan included:

- Hospital management and supply staff's use of client fees to purchase emergency drugs
- Assignment of responsibility to an area supervisor to transport empty cylinders for refilling with oxygen
- Area and site supervisors' provision of orientations to staff on all wards about appropriate infection prevention practices.*

The development of the Quality Measuring Tool has allowed Tanzanian supervisors and sites to track progress and changes in quality over time. Changes can be tracked for individual sites and for health systems as a whole (see the Results section of the Tanzania case study). The tool has proved useful for maintaining motivation and enthusiasm for the QI process and for targeting specific areas requiring attention.

* Dohiie, M.-B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574-587.

In June 2001, EngenderHealth provided financial and technical assistance to the RCHS to review the LTP methods program to design a revised national strategy for decentralizing and scaling up the provision of LTP methods within health-sector reform in Tanzania. The review noted that due to the program's vertical approach, LTP methods were not planned for as part of the routine surgical services provided in hospitals. Many clients seeking LTP methods were being placed on long waiting lists or denied services altogether. Further, as central responsibility for monitoring provision of LTP methods rested with UMATI, MOH service providers did not take "ownership" of the program. For the program to meet its goal of "increased access to quality services," the review noted, management needed to be decentralized, and LTP methods and PAC services needed to be integrated into routine clinic services, in line with the ongoing health-sector reforms. To ensure efficient and effective coordination and to create ownership, the review team recommended that the LTP methods program be moved from RCHS to the Directorate of Hospital Services. It is anticipated that this move will enhance ownership of the program at national, regional, council, and facility levels.

⁶¹ UMATI divided the country into areas, which are larger than the country's regions.

In response to these recommendations, in June 2002 the MOH moved the LTP methods program from the RCHS in the Directorate of Preventive Services to the Directorate of Hospital Services. EngenderHealth signed a five-year memorandum of understanding with the MOH to facilitate smooth planning and implementation of the program, including PAC services. Management of sites in six regions—Arusha, Kilimanjaro, Tanga, Morogor, Dodoma, and Singida—was transferred to the Directorate of Hospital Services. As a next step, the Directorate will take ownership in six additional regions—Dar es Salaam, Iringa, Mbeya, Kigoma, Shinyanga, and Lindi. The MOH (as the main custodian of the program) manages, coordinates, and supervises the program in both the public and the private sectors, while EngenderHealth provided technical assistance to ensure that quality services are provided.

EngenderHealth also supported a PAC pilot study from 1996 through 1999 in three Tanzanian regions (Morogoro, Dodoma, and Kibaha) as part of an overall effort to improve reproductive health services in these three regional hospitals. The study revealed the importance of a comprehensive and integrated approach to PAC services, to prevent the sustainability challenges faced in 11 sites that had tried introducing PAC services (primarily MVA) in 1992.⁶² The study results led to recommendations for scaling up PAC and family planning services in other health facilities: in 1999, 24 master trainers were trained and a baseline assessment was conducted at 29 new sites for comprehensive PAC services. In 2001, the PRIME II Tanzania work plan was drafted with RCHS, and EngenderHealth was assigned a lead role in implementing comprehensive PAC services.

Under the current CA, in 1999 EngenderHealth conducted focus groups with men in Maswa and Tukuyu districts, to understand men's attitudes towards reproductive health, sexuality, and communication. Later, in 2001, EngenderHealth funded Heri Adventist Hospital to renovate some of its facilities for use in training NSV providers. In FY 2001–2002, a total of 50 providers were trained in NSV, and in that same year the number of vasectomy clients was double that of the two previous years.

Throughout the CA, EngenderHealth supported a wide array of training for service providers and supervisors. Training interventions were pivotal in expanding the availability of family planning services. Table 18 summarizes the number of individuals trained, by topic.

RESULTS

INCREASING ACCESS TO SERVICES

EngenderHealth worked in 21 regions of the country and supported, on average, 51% of eligible sites (both public and private) in each region,⁶³ thus greatly increasing access to LTP methods of contraception.

The number of sites providing surgical contraception services (both male and female) on an outpatient basis increased from 18 in 1993 to 127 (109, sites plus 18 outreach sites) in 2002. From 1988 through 2002, a total of 5,340 health professionals were trained in various family planning and other reproductive health skills (3,528 since 1998). Of those trained in the past five years, 2,278 providers were trained in various reproductive health clinical skills and 1,250 were trained in QI, MAP, and IEC topics.

⁶² Rukonge, A. et al. 1999. *Improving postabortion care services in three Tanzania hospitals, final evaluation.*

⁶³ Predominantly Catholic regions were less interested in the program, given its focus on LTP methods.

Table 18. Number of providers trained per year, 1998–2002

Training topic	FY 1998–1999	FY 1999–2000	FY 2000–2001	FY 2001–2002	FY 2002–2003*	Total
Female sterilization	61	32	46	62	28	229
Vasectomy	6	5	29	50	17	107
Implant insertion/removal	52	39	62	38	21	212
IUD insertion/removal	0	9	19	0	0	28
Injectable	0	0	14	0	0	14
PAC	0	125	10	0	18	153
Family planning counseling	98	178	62	19	20	377
General family planning information	0	0	113	71	0	184
Maternity/postpartum	0	0	0	33	0	33
STI/RTI	0	37	2	0	0	39
Infection prevention	38	99	573	175	17	902
QI	54	170	729	247	41	1241
MAP	0	0	5	0	0	5
IEC	0	0	4	0	0	4
Total	308	694	1,668	695	162	3,528

*FY 2002–2003 includes data only from July–December 2002.

INCREASING QUALITY OF SERVICES

A study of the quality of family planning services from 1995 to 1999⁶⁴ measured the results of efforts to strengthen the provision and supervision of family planning and other reproductive health services in Tanzanian health facilities, utilizing the Quality Measuring Tool. This study found improved support for staff (in terms of supervision, training, and supplies), increased access to all reproductive health services, improved safety, and increased attention to clients. The introduction of QI tools and approaches was found to have led to significant improvements in quality for family planning and reproductive health services at the sites. Staff felt better motivated through training and facilitative supervision, while systems for tracking and reordering materials, supplies, and commodities also improved.

INCREASING UTILIZATION OF SERVICES

Overall, EngenderHealth-supported providers and sites have made a major contribution to national contraceptive prevalence in Tanzania. As a result of the expanded availability of services, from FY 1998–1999 to FY 2002–2003, a total of 389,376 clients received LTP methods and other reproductive health services in public- and private-sector facilities (see Table 19). The decrease in services from FY 2000–2001 to FY 2001–2002 is due to the cessation of support to Marie Stopes Tanzania in June 2001 (as a result of the reinstatement of the “Mexico City clause”) and to a shortage of Norplant implants. However, in the year following the shift of program monitoring and management from

⁶⁴ Bradley, J., et al. 1998. *Quality of care in family planning services: An assessment of change in Tanzania 1995/6 to 1996/7*. New York: AVSC International; and Bradley, J., et al. 2000. *Family planning services in Tanzania: Results from a project to improve quality, 1996–1999*. New York: EngenderHealth.

Table 19. Number of clients served, by year and by method, Tanzania

	FY 1998-1999	FY 1999-2000	FY 2000-2001	FY 2001-2002	FY 2002-2003	Total
Female sterilization	12,933	11,961	10,189	9,283	12,456	56,822
Vasectomy	176	38	39	92	74	419
Norplant implant	5,977	7,943	6,934	2,271	2,931	26,056
IUD	1,933	1,039	1,001	498	956	5,427
PAC	0	0	1,721	1,323	4,810	7,854
Injectable	60,639	53,999	40,710	23,188	114,262	292,798
Total	81,658	74,980	60,594	36,655	135,489	389,376

UMATI to the Directorate of Hospital Services, the number of LTP method clients who were served increased by nearly one-third and the number of PAC clients increased more than twofold.

CONCLUSION

EngenderHealth has made tremendous contributions to the family planning program in Tanzania. EngenderHealth has contributed significantly to the rising number of women and men using LTP methods and other reproductive health services in Tanzania through long-term technical assistance to the MOH and to NGO and private-sector health facilities. Delivery of LTP methods is entering a new phase in Tanzania, with the MOH (particularly the Directorate of Hospital Services) taking on full ownership of the program and with increased decentralization of management and financing of LTP methods to the district levels as a result of health-sector reforms. Taking into consideration the shift in overall responsibility for managing the services, projections of sterilization usage (expected to increase to 8% by 2015⁶⁵), and a level of unmet need of 22%, there will continue to be a need for strong support to the frontline service providers to meet the demands for reproductive health services.

⁶⁵ EngenderHealth. 2002. *Contraceptive sterilization: Global issues and trends*. New York.

**INCREASING ACCESS TO QUALITY SERVICES
THROUGH INNOVATIVE PROGRAMMING**

**FAMILY PLANNING
IN TURKEY**

For the first half of the 20th century, Turkey followed a pronatalist policy, to counteract the heavy loss of life following World War I and the Turkish War for Independence (1920–1922). In the late 1950s, the government began to reverse such policies and to address soaring fertility rates. In 1965, a law officially mandated the availability of modern temporary family planning methods and established a directorate within the MOH for overseeing the national family planning program. Sterilization remained illegal except in the case of medical necessity. In 1983, the government legalized sterilization, although the MOH and its partners did not promote it until later in the decade. Under the same legislation, the government also legalized abortion on demand by obstetrician-gynecologists (ob-gyns) and allowed general practitioners, nurses, and midwives to insert IUDs. Later that same year, the Turkish Assembly passed legislation allowing trained general practitioners to provide abortions in hospitals under the supervision of an ob-gyn.

TRENDS⁶⁶

Family planning services are provided through both the private and the public sectors. The public sector includes two major institutions: the MOH and the Social Insurance Organization of Turkey (SSK). In 1998, the public sector supplied just over half of all modern methods to clients (56%) and was the source for three-fourths of sterilizations, for 72% of IUD insertions, and for 28% and 26% of condoms and pills, respectively.

In 1998, the total demand for family planning was 76%; unmet need (10%) was low, and contraceptive use (64%) was high. Nevertheless, traditional methods made up almost half of the total contraceptive prevalence rate, with withdrawal being the most commonly used method. Table 20 shows that IUD users accounted for the largest proportion of modern method use throughout the 1990s. From 1993 to 1998, the prevalence of modern methods increased by three percentage points, largely attributable to an increase in female sterilization and condom use. A significant proportion of prevalence increases occurred among 35–39- and 40–44-year-

**Table 20. Contraceptive prevalence in Turkey,
by method and by year,
and change in prevalence between years**

	1993	1998	Actual change*
All methods			
All methods	62.6	63.9	+1.3
Any modern method	34.5	37.7	+3.2
Long-term methods†			
Female sterilization	2.9	4.2	+1.3
IUD	18.8	19.8	+1.0
Injections	0.1	0.5	+0.4
Short-term methods			
Pills	4.9	4.4	-0.5
Condom	6.6	8.2	+1.6
Vaginal methods	1.2	0.6	-0.6

*Absolute percentage difference.

†Although male sterilization is provided in Turkey, its use is too small to show up in these totals.

⁶⁶ Unless otherwise noted, the data for this section come from the DHS.

olds, among whom one in 14 women reported sterilization use. The abortion rate declined from 24 per 100 pregnancies in 1988 to 14.5 per 100 in 1998,⁶⁷ and maternal mortality declined from 207 deaths per 100,000 live births in 1980⁶⁸ to 55 per 100,000 in 1995.⁶⁹

ENGENDERHEALTH'S INPUTS AND ACHIEVEMENTS

EngenderHealth worked in Turkey from 1974 to 2002 to increase access to quality LTP methods (male and female sterilization, long-acting hormonal methods, and the IUD). Throughout these three decades, the EngenderHealth program progressed through four phases. During the **first phase** (1974–1986), EngenderHealth advocated for medical professionals to accept and promote sterilization as a family planning option for their clients. In the **second phase** (1986–1993), as acceptance of sterilization grew, we signed agreements with the public sector to introduce clinical and counseling training programs and to provide health professionals with accompanying client communications materials. During this seminal period, EngenderHealth opened its country office (1993) and laid out a formal strategy to increase access to quality LTP family planning options and to link family planning services to the postabortion and postpartum periods.

During the **third phase** (1993–1998), EngenderHealth worked to convince policymakers and health practitioners to create a supportive policy environment for quality and informed choice through the use of research results and pilot projects. As they gained support, EngenderHealth worked to institutionalize in-service training programs and to develop innovative Turkey-specific service delivery models, including the “freestanding clinic” and postabortion and postpartum family planning programs. Finally, EngenderHealth worked with the MOH to lead stakeholders in developing a hormonal method strategy that resulted in the inclusion of injectables in Turkey’s current family planning method mix. In the **final phase** of the program (1998–2002), EngenderHealth worked to institutionalize the postabortion and postpartum family planning components and to ensure the sustainability of male and female sterilization training in residency and in-service training programs.⁷⁰

During the period of the CA (1998–2003), EngenderHealth was funded through field support from the U.S. embassy⁷¹ at approximately \$600,000 to \$900,000 per year. During this time, EngenderHealth worked with the public and private sectors under USAID’s phase-out plan to institutionalize the in-service and preservice training programs and to expand to new provinces the postabortion and postpartum initiatives that they had pilot-tested with their partners. In March 2002, after 28 years in Turkey, EngenderHealth closed its offices in tandem with the end of U.S. support to the Turkish family planning program.

EngenderHealth’s approach to programming during the late 1990s focused on increasing people’s access to services by building the capacity of providers to deliver LTP methods

⁶⁷ USAID. 2002. Reproductive health and family planning assistance to Turkey: 1990–2002, page 11. Washington, DC.

⁶⁸ Bryan, P. J., and Senlet, P. 1990. Turkey: Population assessment, strategy and action plan recommendations for USAID assistance: USAID assessment visit report. USAID Asia Near East Bureau (ANE/TR/HPN).

⁶⁹ WHO Revised 1995 Estimates of Maternal Mortality (<http://www3.who.int/whosis>)

⁷⁰ For a more in-depth discussion of the EngenderHealth program, see: Searing, H., et al. 2003. *EngenderHealth/Turkey: Three decades of innovative family planning and reproductive health programming, 1974 to 2002*. New York: EngenderHealth. For a detailed discussion of the full USAID program, of which EngenderHealth was one cooperating agency, see: USAID. 2002. Reproductive health and family planning assistance to Turkey: 1990–2002, successful strategies. Washington, DC.

⁷¹ U.S. government assistance to Turkey used an innovative management structure with no mission in-country; instead, a locally hired population, health, and nutrition officer managed the USAID program from within the U.S. Embassy and was backstopped by a joint country programming team based in USAID/Washington

and services, through the development of in-service and preservice programs and through support for study tours and site renovation and by providing equipment and supplies. Although we worked with the public and private sectors to introduce long-acting hormonal methods (particularly injectables), the majority of this work was completed prior to 1998. Therefore, the following focuses primarily on EngenderHealth's sterilization work.

- **In-service training**—Throughout the late 1990s, EngenderHealth worked in partnership with the public sector to train doctor-nurse teams and master trainers in sterilization procedures and counseling, to certify master trainers, and to establish sterilization training centers in Turkey that currently train both Turkish nationals and their foreign colleagues in state-of-the-art sterilization procedures and counseling. We also organized and supported study tours for head doctors to observe sterilization procedures in teaching hospitals. During the study tours, the doctors were provided training curricula and kits that enabled them to return to their respective hospitals and provide services to clients and pass on their skills and knowledge to their colleagues.
- **Equipment and supplies**—EngenderHealth equipped and renovated facilities to support family planning service delivery. In some cases, this included building an operating theater where sterilization procedures could be conducted. In others, it meant building a private room for counseling or providing surgical equipment and supplies. One innovative model that EngenderHealth supported was the renovation and equipping of *free-standing maternal and child health and family planning (MCH-FP) clinics* that provided male and female clients with maternal and infant care and family planning services together in one facility during the antenatal, delivery, and postpartum periods. EngenderHealth documented the success of pilot clinics that we supported, finding increased client loads and use of a wider range of methods—for example, decreased reliance on the IUD and temporary methods and increased use of Depo-Provera and sterilization.⁷² These successes helped influence a major change in ministerial regulation to allow outpatient tubal ligation and vasectomy services to be performed at all ministry-approved sites, including the free-standing clinics.
- **Preservice training**—With the successful introduction of minilaparotomy as an outpatient procedure and NSV into the public-sector service-delivery systems, universities and medical schools became more receptive to integrating training into their family planning curricula. During 2000 to 2001, EngenderHealth convened two meetings with major teaching hospitals throughout the country to discuss the success of the in-service training program and ways in which these hospitals could integrate outpatient training into routine residency training programs. Meeting participants accepted the idea and committed to send at least one person from their department—in charge of residency training—on study tours to existing training centers. That person was then responsible for initiating training at their respective teaching hospital. After these initial study tours, many hospitals started training their residents in sterilization and counseling, and we provided each with curricula and sterilization kits prior to the closing of the EngenderHealth office.

EngenderHealth's postabortion and postpartum family planning programs helped increase access to services and contributed to QI, since EngenderHealth's programs were rooted in the whole-site training quality assurance approach. This involves a range of stakeholders from the beginning to the end of program planning, design and implementation to encourage capacity building, and ultimately, sustainability of the program structure and gains in health status.

⁷² EngenderHealth/TURCO. 1998. The experience of free standing facilities in Adana and Ankara.

The postabortion and postpartum family planning model in Turkey was designed to address “missed opportunities” in family planning and worked as follows. First, the team used data and evidence from pilot programs to convince policymakers and facility administrators about the need to scale up a program. Typically, before going to potential facilities for an introductory visit, EngenderHealth worked with the provincial health directorate to send an official letter to the site asking them about their postabortion or postpartum family planning rates. Since these data were not routinely collected, this encouraged the head doctor and his staff to gather the data prior to a preliminary team visit from EngenderHealth and the MOH to discuss the interest among staff and hospital administration for the program. The team then returned to sites that expressed an interest to plan an on-site training workshop with staff that included action planning and follow-up visits. The team then used EngenderHealth’s training curricula and communications materials, developed directly with the MOH, in the on-site workshop and left materials for programs for the implementation period. As the program progressed, the team provided technical assistance to the hospital staff to institute a simple management information system that collected monthly service statistics on postabortion and postpartum clients and the family planning methods that they received immediately following or within two weeks after the abortion or delivery. The team scheduled follow-up visits two to six months following initiation to review action plans, observe counseling sessions, tour the facility, and discuss the program with hospital administration.

- **Postabortion family planning**—EngenderHealth worked in partnership with the public and private sectors throughout the 1990s to pilot, scale up, and institutionalize a postabortion family planning program in four provinces. In 1998, expansion work began, particularly into the private sector in urban areas (where approximately two-thirds of the country’s abortion services were performed).⁷³ Konak Maternity Hospital implemented an innovative postabortion family planning model that continues to offer couples direct access to LTP methods, including NSV on-site in the same hospital as the abortion procedure.⁷⁴ The program worked well, in large part because of a law that required written consent from the husbands of abortion clients. Managers used this law as an opportunity to counsel men on general family planning options, including vasectomy, resulting in increases in vasectomy procedures among the partners and husbands of women undergoing abortion procedures.⁷⁵
- **Postpartum family planning**—EngenderHealth assisted the MOH to expand the postpartum program (developed in partnership with the MOH in the 1990s) into seven hospitals in two regions. The team launched the program in Istanbul in 2000 through on-site workshops. The workshops covered counseling, communication skills, characteristics of antenatal and postpartum women, postpartum timing of contraceptives, postpartum IUD insertion, IP, and record keeping.

RESULTS

By 1998, EngenderHealth/Turkey was working solely through technical assistance agreements with the public and private sectors, rather than through subagreements. Thus, EngenderHealth did not have the authority to collect service statistics, although a collegial relationship with the public sector enabled us to do so informally at the national

⁷³ Senlet, P., et al. 2001. Bridging the gap: Integrating family planning with abortion services in Turkey. *International Family Planning Perspectives* 27(2):90–95.

⁷⁴ For more information on this intervention and others similar to it, see: Pile, J., et al. 1999. Involving men as partners in reproductive health: Lessons from Turkey. *AVSC Working Paper* No. 12. New York: AVSC International.

⁷⁵ For more information, see: Pile, J., et al. 1999. Involving men as partners in reproductive health: Lessons from Turkey. *AVSC Working Paper* No. 12. New York: AVSC International.

level. However, these service statistics are much less representative of the program than the results provided below, which focus on the structure and sustainability of the health program to which EngenderHealth contributed during the latter half of the decade.

STERILIZATION

By March 2002, EngenderHealth had supported the training of staff in female sterilization service provision in approximately 70%, and vasectomy in approximately 20%, of the country's total provinces. In total, EngenderHealth trained 310 providers (ob-gyns, scrub nurses, and residents) in outpatient minilaparotomy and 110 providers (general practitioners, urologists, and residents) in NSV. The MOH currently offers sterilization as a method choice in its free-standing MCH-FP Centers, and the SSK and MOH offer outpatient sterilization services in many of their hospitals. General practitioners regularly perform vasectomies. Four training centers have been established for minilaparotomy training and four centers have been set up for NSV training.

Fifteen teaching hospitals have integrated NSV training into their urology residency training, and by March 2002 a total of 58 residents had been trained in NSV. Twenty-four teaching hospitals agreed to integrate minilaparotomy into residency training, and by March 2002 the first three hospitals to start this had trained 46 residents. In 2001, the MOH began to purchase sterilization kits for residency training with their own resources.

POSTABORTION FAMILY PLANNING AND POSTPARTUM FAMILY PLANNING

Today, at least 37 public and private hospitals provide postabortion family planning services.⁷⁶ Panel data from quality surveys conducted from 1998 to 2001 showed that in Istanbul, at least 60% of clients in the public and private sectors received a method or an appointment for a method each year.⁷⁷ Private-sector data showed an increase from 26% to 70% in family planning acceptance from 1998 to 2001, and in both sectors, the percentage of women informed about the risk of pregnancy following an abortion increased from 40% to 65%.⁷⁸

Quality surveys showed that in Istanbul, among women delivering, the proportion who received counseling on family planning before discharge increased from 37% to 44%. Additionally, according to service statistics, the proportion of women delivering who received a family planning method prior to discharge increased from 2% to 12%. Today, 18 hospitals in Turkey routinely offer postpartum family planning services. Moreover, in 2001, two family planning centers became international postpartum family planning training centers.⁷⁹

⁷⁶ USAID. 2002. Reproductive health and family planning assistance to Turkey: 1990–2002, successful strategies. Washington, DC. This number probably undercounts the number of sites providing postabortion family planning services, as the MOH routinely provides postabortion training and has included a post-abortion family planning component in the projects funded by UNFPA and others.

⁷⁷ Management Sciences for Health. 2002. Family planning quality surveys in Turkey, Istanbul-Adana-Icel, 1998–2001.

⁷⁸ USAID. 2002. Reproductive health and family planning assistance to Turkey: 1990–2002, successful strategies. Washington, DC.

⁷⁹ USAID. 2002. Reproductive health and family planning assistance to Turkey: 1990–2002, successful strategies. Washington, DC.

SECTION THREE

GLOBAL LEADERSHIP: SELECTED EVALUATION AND RESEARCH RESULTS

INTRODUCTION

As an advocate for QI, we have embraced “practicing what we are preaching.” constantly seeking information that can inform program improvement and management. Throughout the CA, EngenderHealth has conducted numerous applied studies and reviews aimed at documenting our achievements and lessons learned in a given program or content area. This section discusses selected global leadership initiatives and their results in PAC, QI, informed choice, MAP, and vasectomy.³⁰ It also discusses issues related to sustainability as examined in Egypt and Mexico, where EngenderHealth had programs that ended.

POSTABORTION CARE

Under the CA, a major objective was to increase women’s access to safe, high-quality PAC services. Critical funding from USAID helped to leverage additional support from private donors, including the David and Lucile Packard Foundation, which together allowed EngenderHealth to maintain and expand a comprehensive global PAC program that is making a demonstrable difference in the lives of women in more than 22 countries worldwide.

EngenderHealth’s PAC program worked to address gaps in PAC programming by focusing special attention on service delivery, the needs of special populations, and state-of-the-art technologies or approaches. Recognizing that interventions are useful only as long as they are sustainable, EngenderHealth simultaneously worked to support strategies that maintain and sustain service delivery, including supportive policy and financial support, training, monitoring and supervision. Incorporating each of these facets into our work helped EngenderHealth maintain a PAC program that consistently sought innovative ways to increase access to, improve the quality of, and create a more receptive political environment for PAC worldwide. EngenderHealth also was an active participant in the interagency PAC Consortium.

SELECTED WORK

Over the past five years, EngenderHealth carried out a number of research and evaluation studies aimed at addressing gaps in PAC, as identified through its own work as well as through that of other agencies. The result of that effort is a body of work that has explored the three focus areas of PAC: service delivery, special populations, and state-of-the-art technologies or approaches. A selected sample of these studies follows.

³⁰ EngenderHealth’s annual fiscal year reports to USAID present annual activities, products, and results

LESSONS LEARNED: DOMINICAN REPUBLIC⁸¹

EngenderHealth's PAC program in the Dominican Republic began in 1997 at two major maternity hospitals in the capital, Santo Domingo. Since then, the program expanded to include a total of eight sites in six different regions of the country. Inputs included training and follow-up of PAC activities at participating hospitals; research in the area of pain management and adolescent needs (both discussed below); policy work to include PAC in national guidelines on safe motherhood; orientation and training of the private sector in PAC; and negotiations with Ipas and local distributors to address issues of equipment sustainability. Over time, a number of donors contributed to this work: USAID/Washington, the local USAID mission, the Packard Foundation, and other private donors.

Since the program began, EngenderHealth conducted a needs assessment and two follow-up assessments to identify strengths and gaps. Findings from the initial needs assessment, carried out at two pilot sites, revealed poor-quality PAC services, including negative provider attitudes towards PAC clients, inadequate IP, and poor linkages to family planning.

Three years later, as the program was beginning to embark on a period of expansion to sites outside the capital, a subsequent follow-up assessment of the two pilot sites revealed improvements in provider attitudes but persistent weaknesses in establishing linkages to family planning and in developing continuous provision of MVA treatment for incomplete abortions. The introduction of MVA proved to be problematic, with providers either refusing to use the new technique or instead focusing exclusively on MVA, such that linkages to family planning and other reproductive health services were ignored. In response to this gap, the program revised its training workshops so that the content included counseling and discussions on family planning at the beginning of the sessions.

By 2002, the third assessment (conducted as part of an overall evaluation of EngenderHealth's Packard-funded project—see *Expansion of PAC Services*, below) indicated that the program had made considerable advancements. Improvements at sites included the availability of treatment on an outpatient basis, better IP practices, and greater availability of postabortion family planning methods at treatment wards in selected sites. However, of all, the most widely noted change was an improvement in providers' attitudes.

NEEDS OF ADOLESCENT PAC CLIENTS IN THE DOMINICAN REPUBLIC AND MALAWI⁸²

Despite the recognition that adolescents, in particular, face challenges in obtaining good-quality PAC services, the body of research on the needs of adolescent PAC clients has been limited. In FY 2001–2002, with support from USAID core funds, EngenderHealth undertook qualitative research to learn more about the special needs of this group.

⁸¹ Sources include: Bolton, P., and Nuñez, M. 1997. PAC assessment report: Centro Materno Infantil San Lorenzo de Los Mina, November 19 and 26, 1997. Unpublished; Bolton, P., and Nuñez, M. 1997. PAC assessment report: Hospital Luis E. Aybar, November 18, 20, and 25, 1997. Unpublished; Escandon, I., et al. 2001. Lecciones aprendidas en la atención postabortion: las experiencias de AVSC en la República Dominicana. Unpublished; and Solo, J., et al. 2003. Struggling to make services flow more naturally: challenges and successes in expanding PAC in the Dominican Republic, in *Addressing the Global Crisis of Unsafe Abortion by Expanding PAC Services*.

⁸² Sources include: Garcia, B., Escandón, I., and Figueroa, J. 2003. *Los servicios post-aborto para las adolescentes de la República Dominicana*. EngenderHealth: Santo Domingo; and EngenderHealth. 2003. *An investigation of the needs of adolescent postabortion care clients in Malawi*. Draft.

Secondary analysis of DHS data, hospital statistics, and anecdotal evidence all suggested high levels of unwanted pregnancy and induced abortion among adolescents in the Dominican Republic, thus prompting EngenderHealth to choose this country for its study.

Study findings revealed that although most adolescent PAC clients interviewed reported that they had no intention of having a child, none was using a family planning method. In some cases, adolescent PAC clients reported learning about the pregnancy only when the abortion was diagnosed. Among those who knew about the pregnancy, most reported informing family members (particularly mothers) and their partners about their pregnancy and their decision to seek PAC services. Adolescent PAC clients reported a number of gaps in the quality of services, such as punitive treatment from providers, a lack of counseling (including information about the procedure), and a lack of adequate pain control. Providers reported the lack of physical resources (MVA equipment, supplies, and space), medications and analgesics, and counseling as areas for improvement. PAC clients also reported having positive attitudes toward family planning; however, they did not perceive all methods equally positively.

Dissemination of the Dominican Republic study results took place in May 2003, with many representatives from in-country partner agencies and members of the press attending. In addition, planning meetings were held at the study sites to provide a more individualized discussion of findings and plot out future steps for improving gaps.

The study also yielded valuable lessons about how to conduct research with adolescent clients, including the best way of communicating with clients about participation in a study (we tested language and presentation), the importance of thoroughly testing data collection instruments, how to probe appropriately, and the need for detailed orientation of interviewers to ensure appropriate sensitivity and approach. Many of these lessons have been applied to a similar study (in progress at this writing) in Malawi being conducted with private funding. Preliminary findings from the Malawi study indicate that providers and adolescent PAC clients identified many of the same gaps in services as their counterparts in the Dominican Republic. Among clients, this included a lack of counseling (including information about the procedure), a lack of adequate pain control, long waiting times, and negative provider attitudes. For providers, the gaps included negative provider attitudes and the lack of trained staff and supplies. A final report on this study is expected by Fall 2003.

INITIATING POSTABORTION CARE IN THE PHILIPPINES⁸³

Before EngenderHealth began working on PAC in the Philippines (where abortion is illegal and where more than 400,000 induced abortions are performed clandestinely each year), no services were designed to explicitly address the issue. In 1999, a needs assessment conducted with Packard Foundation support found that hospital management of abortion complications often focused on medical treatment alone and women rarely received family planning counseling or were referred for other reproductive health services. To help legitimize the introduction of comprehensive PAC services in the Philippines, EngenderHealth collaborated with a local technical working group to draft an

⁸³ Sources include: Costello, M. P., et al. 2002. *Integrating postabortion management: A cost analysis*. Report to USAID. Manila: Perez, A., et al. 1997. *Clandestine abortion: A Philippine reality*. New York: Alan Guttmacher Institute, and Manila: University of the Philippines Population Institute; and Shire, A. 2002. "We have been made more human": *The Philippines experience with the Prevention and Management of Abortion Complications (PMAC Program)*. End-of-project report to The David and Lucile Packard Foundation. New York: EngenderHealth.

administrative order that mandated PAC as a government health program. With the subsequent support of the government, EngenderHealth introduced PAC services in the Philippines through pilot interventions at eight sites in 2000. While initially a privately funded project, the success of these interventions helped leverage USAID funding to support similar PAC interventions in 2001, initiated by the Pangasinan government. By the end of 2002, EngenderHealth's PAC program—supported by a combination of USAID and private funds—was expanded to a total of 15 sites in the Philippines.

From 2000 to 2002, EngenderHealth trained 1,078 providers in clinical PAC and counseling skills, including the use of MVA equipment. A series of evaluations conducted during and after EngenderHealth's interventions found that overall, 82% of the 15,349 PAC clients served received family planning counseling. Of 83 service providers interviewed, 94% believed that EngenderHealth's PAC trainings facilitated improvements in the quality of postabortion services they provide. Additionally, MVA is now being actively utilized in four of the six intervention sites visited.

EngenderHealth staff in the Philippines also leveraged USAID funds to promote information about the benefits of and to gain political acceptance for the use of MVA among local policymakers. In 2002, a comparative cost analysis of dilation and curettage versus MVA revealed that a shift from dilation and curettage to MVA led to a 62% decrease in per-client cost. In January and March 2003, staff facilitated two workshops for local stakeholders to develop policies and guidelines on the registration, procurement, distribution, use and disposal of MVA equipment. A draft DOH administrative order was developed from the results of these workshops, and at this writing it is awaiting the signature of the Secretary of Health.

INITIATING POSTABORTION CARE IN SENEGAL⁸⁴

During the CA with USAID, EngenderHealth conducted operations research to examine the feasibility of providing integrated PAC services in rural areas of Senegal, where the need is great. (This work was conducted primarily with support from the Frontiers in Reproductive Health program⁸⁵ and from the Packard Foundation, along with other support from private donors and from USAID core funds.) EngenderHealth collaborated with the MOH starting in December 2000 to expand PAC services in secondary- and primary-level sites in six districts in the Kaolack and Fatick regions.

An initial assessment of PAC services in these areas revealed that they usually were poor in quality, lacked integration, and generally were inaccessible to clients. Based on these findings, EngenderHealth worked with the MOH to develop an intervention strategy to improve services in the six targeted districts. The objectives of the strategy included increasing knowledge and improving provider skill in the provision of PAC services, strengthening links between emergency treatment, family planning and referrals, and improving the quality of PAC at all levels. The Senegal initiative built QI, IP, and action planning into its design to ensure appropriate support and systems. It also systematically integrated family planning counseling and services into the PAC program.

A postintervention assessment found that the quality of treatment of PAC services vastly improved. The majority (57%) of first-trimester incomplete abortions were treated with MVA under local anesthesia (a safer and less painful alternative to dilation and curettage

⁸⁴ Dabash, R., et al. 2003. Taking postabortion care services where they are needed: An operations research project testing PAC expansion in rural Senegal. New York: EngenderHealth.

⁸⁵ Funded by USAID CA #00-98-00012-00 and managed by the Population Council.

without anesthesia), and IP practices were improved. In addition, postintervention clients were nearly twice as likely to report receiving information on family planning and were more likely to have received information on other reproductive health services. Finally, as a result of strengthened client-provider interactions, client satisfaction with services was greater.

EngenderHealth's interventions have helped to improve knowledge about, access to, and quality of PAC services in Senegal, where at this writing there are 18 EngenderHealth-supported sites providing comprehensive PAC services. The success of these interventions also points to the feasibility of expanding PAC services to rural areas and suggests that similar efforts could contribute to a reduction in maternal morbidity and mortality at lower-level sites and in rural areas in other settings.

POSTABORTION FAMILY PLANNING IN TURKEY⁸⁶

After the legalization of abortion in Turkey in 1983, rates of abortion increased, the majority being repeat abortions. Among the factors affecting the high incidence of repeat abortions included the lack of linkages between family planning and abortion services and strong provider bias against postabortion family planning, out of fear of infection and other complications. Throughout the 1990s and early 2000s, EngenderHealth (in collaboration with the MOH, the Social Insurance Organization of Turkey, and USAID) worked to pilot, scale up, and institutionalize PAC services in the provinces of Ankara, Istanbul, Adana, and Icel. In 1998, the postabortion family planning program began to include private-sector providers.

As part of the intervention, EngenderHealth provided technical, financial, and material support to provide minor structural changes to facilities, train providers in the importance and safety of contraceptive use immediately postabortion, monitor program sites, and, in some cases, facilitate a regular contraceptive supply. Importantly, the program stressed the role of men in the decision-making process and took advantage of an existing spousal requirement for abortion as an opportunity to counsel and refer the husbands of abortion clients for vasectomy services.

The results of these initiatives proved quite successful. Today, at least 37 public and private hospitals provide postabortion family planning services. In the private sector, in selected hospitals, studies showed that the percentage of postabortion clients leaving the hospital with a method rose from 26% to 70% between 1998 and 2001.⁸⁷ The program also proved to be sustainable: Of the 11 large public hospitals initiating postabortion family planning services, 10 continued to provide the service several years afterward, without external assistance, and all 12 of the original private-sector hospitals continued to provide services.⁸⁸ In both sectors, the proportion of women informed about the risk of pregnancy following an abortion increased from 40% to 65% between 1998 and 2001. In addition to these results, EngenderHealth's experience in this postabortion family planning initiative yielded important lessons learned, including the need to garner commitment from hospital leadership, overcome provider misconceptions, and make interventions unique to a facility.

⁸⁶ Searing, H., et al. 2003. *EngenderHealth/Turkey: Three decades of innovative family planning and reproductive health programming, 1974 to 2002*. New York: EngenderHealth.

⁸⁷ USAID. 2002. *Reproductive health and family planning assistance to Turkey: 1990–2002, successful strategies*. Washington, DC.

⁸⁸ Senlet, P., et al. 2001. Bridging the gap: Integrating family planning with abortion services in Turkey. *International Family Planning Perspectives* 27(2):90–95.

PAIN MANAGEMENT

An independent evaluation of USAID's PAC programs called for the need to standardize protocols and guidelines for pain control, to improve the quality of clinical services provided to PAC clients.⁸⁹ The evaluation report (corroborated by our experiences working in PAC) noted wide variability in terms of existing practices for pain management and a lack of existing literature to provide guidance.

Because of this gap, as well as the variability of pain management across EngenderHealth-supported sites, EngenderHealth embarked on a randomized, controlled clinical study to examine how, in treating complications with MVA, the use of paracervical block compares to the use of no anesthesia (a standard practice in many countries, including the study sites). This study was funded by the Packard Foundation.

The study, which involved 215 clients, took place in a large maternity hospital in the Dominican Republic. It took time to surmount the challenges of measuring pain, which is a subjective experience, and to establish informed consent processes for study participants that clearly explained, in simple terms, randomization and what clients could expect. Results from the study showed a slight reduction of pain among the group receiving paracervical block; however, the differences were not significant, with women in both study groups reporting severe pain. The study concluded that the paracervical block technique used in the study and psychological support were not enough for controlling pain in the study population. Researchers recommended that future studies be conducted to explore the effectiveness of other anesthesia regimens, as well as the use of analgesics in managing pain with MVA. In addition, EngenderHealth plans to document and disseminate lessons learned regarding the implementation of pain research.

EXPANSION OF PAC SERVICES: RESULTS OF A MAJOR EVALUATION⁹⁰

EngenderHealth conducted an evaluation of its three-year, Packard-funded PAC project (1999–2002) between June and October 2002. The project's aim was the expansion of PAC services and the facilitation and support of international and national leadership efforts to reduce barriers to PAC. The purpose of the evaluation was to assess lessons learned. Data collection methods included case studies in three countries (the Dominican Republic, the Philippines, and Uganda), interviews with key program staff, and a review of project documentation.

Findings from the evaluation revealed expansion efforts in eight countries: Bangladesh, Colombia, the Dominican Republic, Indonesia, Myanmar, the Philippines, Senegal and Uganda. In addition, through the work of regional coordinators, the program also helped in establishing or furthering PAC efforts in at least eight other countries. USAID funding supplemented Packard funding in Bangladesh, the Dominican Republic, Indonesia, the Philippines, and Senegal. During the life of the project, more than 150 sites were involved in PAC work and nearly 1,700 providers were trained.

EngenderHealth's experiences in the eight project countries also yielded important lessons learned, valuable both to the agency and to others involved in PAC work. Selected lessons learned included the following:

⁸⁹ Cobb, L., et al. 2001. *Global evaluation of USAID's postabortion care program*. Washington, DC: Population Technical Assistance Project.

⁹⁰ Solo, J., et al. 2003. *Addressing the global crisis of unsafe abortion by expanding PAC services*. New York: EngenderHealth.

- *The approach to initiating programs should be strategic and appropriate to local context.* It is essential to understand the system in which you are working and to know whom to involve.
- *Flexibility is key in training.* No set curriculum or training approach will be appropriate across all sites. Training has to be adapted to local circumstances.
- *A whole-site approach to training should be utilized.* This facilitates the integration of PAC into regular care at facilities.
- *Programs should continue to emphasize that PAC does not equal MVA alone.* Programs need to ensure that all clients, not just those treated with MVA, receive comprehensive care. Starting training with counseling before introducing the new technology can help.
- *However, MVA is crucial for increasing access by being able to offer PAC at lower-level facilities.* Overemphasis of MVA can produce programmatic setbacks, but MVA is also critical to ensuring that facilities that do not ordinarily provide dilation and curettage can provide lifesaving treatment.
- *More humane care is offered after changing provider attitudes, and many view this as one of the major accomplishments of PAC programs.*
- *There is a need to look for more ways to motivate hospital and project staff effectively to improve record keeping.* Programs should explore ways to demonstrate how it is in the interest of health workers to collect data regularly, not just meet an external need.
- *PAC services must expand beyond tertiary-care facilities to reach women in need.* This highlights the importance of involving communities in PAC efforts.

LESSONS LEARNED IN TAKING PAC TO SCALE

Through our experience with PAC work over the years, EngenderHealth has identified three major phases in the process of going to scale with PAC: introduction, expansion, and institutionalization. Each phase has specific characteristics and required inputs to effectively move PAC services along the continuum toward institutionalization. (These phases can be applied generically to other content areas and services as well).

- At the *introduction* phase, activities often involve work with key policy makers, training small groups of well-qualified clinicians, and supporting a few handpicked, high-quality sites.
- At the *expansion* phase, different activities need to take place, such as training trainers, getting buy-in from a larger number of stakeholders, registering equipment, developing performance-monitoring guidelines, and developing national standards for PAC—all activities best conducted in partnerships.
- At the *institutionalization* (“going to scale”) phase, activities include integrating PAC into national monitoring, management information, and supervisory systems, getting MVA equipment into national supply streams, and integrating PAC into preservice training—activities that must be conducted in partnership and with leadership from local institutions. (See Table 24.) These phases are equally applicable to other areas of service delivery.

Table 24. Characteristics of and inputs needed for the three phases for taking PAC to scale

Phase	Characteristics	Inputs
Introduction	<ul style="list-style-type: none"> ■ Actors resist change ■ There is a lack of: <ul style="list-style-type: none"> □ PAC skills or knowledge □ Resources □ Client entitlement ■ There are different political agendas ■ Individualized programs are at handpicked, ideal sites ■ Follow-up and monitoring need to be intensive 	<ul style="list-style-type: none"> ■ Educate policy makers and opinion leaders ■ Train key providers ■ Conduct operations/pilot research ■ Establish intensive support and monitoring
Expansion	<ul style="list-style-type: none"> ■ Sites are more numerous and varied ■ An expansion strategy is needed ■ More approvals, funding, and equipment are required ■ Program is more institutionalized ■ Program has higher visibility ■ Economies of scale develop ■ Shared ownership leads to loss of control on the part of international agencies/donors 	<ul style="list-style-type: none"> ■ Identify different sites ■ Build linkages ■ Develop partnerships ■ Work with multiple sectors ■ Review and disseminate pilot results ■ Gain political will/buy-in ■ Develop and disseminate service-delivery guidelines ■ Train master trainers ■ Analyze costs/sustainability ■ Engage the community ■ Establish equipment supply
Institutionalization	<ul style="list-style-type: none"> ■ Training is institutionalized ■ Quality assurance system is functioning ■ Services meet international standards ■ PAC services, referrals, data collection, and reporting are routine and integrated ■ Cost-recovery system is in place ■ Equipment supply is secure ■ Services are client-centered ■ Local/community partnerships have been developed 	<ul style="list-style-type: none"> ■ Institutionalize preservice training ■ Make service delivery routine ■ Make monitoring routine ■ Make management information systems routine

QUALITY IMPROVEMENT

EngenderHealth has consistently worked to improve the quality of reproductive health services in all field programs. Our approach has been to view QI processes as integral to expanding access and availability to services. To help health care systems, providers, and other international agencies ensure that clients' rights and staff needs (or performance factors) are met, we have developed a package of approaches and tools (see below).

ENGENDERHEALTH'S QUALITY IMPROVEMENT APPROACHES AND TOOLS

APPROACHES

- **Facilitative supervision.** This approach to supervision emphasizes the supervisor's role in facilitating QI among a team of staff. It emphasizes mentoring, joint problem-solving and two-way communication between a supervisor and those being supervised. To facilitate change and improvement and to encourage staff to solve problems, supervisors must have the solid technical knowledge and skills needed to perform tasks, must know how to access additional support as needed, and must have time to meet with the staff they supervise. (See: AVSC International, 1999. *Facilitative supervision handbook*. New York.)
- **Medical quality improvement.** This ongoing approach focuses on the quality of medical services and includes several processes: medical monitoring; developing and/or updating and implementing written medical guidelines, standards, and job aids; analyzing and rectifying detrimental written and "unwritten" medical policies and practices; analyzing relevant medical data and reports for service improvement; monitoring and assuring informed decision making and informed consent; and building the capacity of institutions and sites to continue to improve medical quality.
- **Whole-site training.** Aimed at meeting the learning needs of a site, whole-site training links supervision and training, emphasizes teamwork and sustainability, and includes a range of training strategies. Whole-site training actively engages supervisors in identifying learning needs at a site, planning and implementing the required training (either on-the-job, on-site, or off-site), and facilitating the implementation of newly acquired skills through coaching, mentoring, and teamwork. Types of training include orientations to new services or concepts, knowledge updates, and skills training. Whole-site training includes *inreach* (staff orientations, referrals, linkages between departments, and adequate signs) to ensure that clients do not miss opportunities to access information and services for all of their reproductive health needs when they come to the site.

TOOLS

For implementing these approaches, EngenderHealth has developed the following simple and practical tools designed to help supervisors and staff improve service quality. (For more information about how the tools function together as a package, see: Dohlie, M.B., et al. 1999. Using practical quality improvement approaches and tools in reproductive health services in East Africa. *Joint Commission Journal on Quality Improvement* 25(11):574-587.)

- **COPE.**[®] This is a process and set of tools for health care staff to continuously assess and improve the quality of their services. (See: AVSC International, 1995. *COPE: Client-oriented, provider-efficient services*. New York.) COPE, which stands for "client-oriented, provider-efficient" services, is built on a framework of clients' rights and staff needs. COPE consists of four tools: self-assessment guides

(one for each of the clients' rights and staff needs), a client interview guide, client-flow analysis, and an action plan. The self-assessment guides encourage staff to review the way they perform their daily tasks and serves as a catalyst for analyzing the problems they identify. The guides contain key questions based on international clinical and service standards, and the safety guide includes a medical record review. The tools also highlight client-provider interactions and other areas of concern to clients. Toolbooks for specific health services include *COPE for Reproductive Health Services*, *COPE for Family Planning and Other Reproductive Health Services*, *COPE for Maternal Health Services*, *COPE for Child Health*, and *COPE for Adolescent Reproductive Health Services*.

- **Quality Measuring Tool.** The Quality Measuring Tool is used to measure QI annually. Based on the self-assessment tool used in COPE, site staff and supervisors use the Quality Measuring Tool together to determine whether clients' rights are being upheld and providers' needs are being met. Any new problems identified are then incorporated into the site's ongoing action plan. (See: EngenderHealth. 2001. *The Quality Measuring Tool for reproductive health services: A manual for using the Quality Measuring Tool for health care managers, supervisors, and providers.* New York.)
 - **Cost-Analysis Tool.** Health care staff use the Cost-Analysis Tool to measure the direct costs of providing specific health services. The tool measures the cost of staff time spent directly providing a service or clinical procedure and the costs of the commodities, expendable supplies and medications used to provide that particular service or procedure. The information can be used to improve the efficiency of staffing and use of staff time and supplies at a site, as well as set user fees for different services that reflect actual direct costs. (See: EngenderHealth. 2000. *Cost Analysis Tool: Simplifying cost analysis for managers and staff of health care services.* New York.)
 - **Community COPE®.** This participatory process and tools, an extension of COPE, is for health care staff to build partnerships with community members, to improve local health services by making them more responsive to local needs. It can also have the result of increasing both community "ownership" of health facilities and services and community advocacy for resources for health. It is particularly useful to site administrators in areas undergoing health reform, as it provides a means of engaging the community in defining and supporting the quality of services they want. The range of activities for learning about local needs and suggestions for improvement include individual interviews, group discussions, community meetings, site walkthroughs, and participatory mapping. Like COPE, the process includes identifying and analyzing problems, developing an action plan, and prioritizing solutions. Community members select representatives to join the health facility's QI committee and facilitate ongoing communication between the community and facility staff. (See: EngenderHealth. 2001. *Community COPE: Building partnership with the community to improve health services.* New York.)
 - **Medical Monitoring.** This medical QI intervention entails the objective and ongoing assessment of the *readiness* and the *processes* of service delivery. It is conducted to identify gaps between best and actual practices, and leads to recommendations for improvement. To accomplish medical monitoring, a variety of observation, record review, case review and facility audits are available and need to be adapted to the local situation, as well as for use by either internal or external supervisors.
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While most of these QI approaches had been pilot-tested under previous agreements, USAID encouraged us to document the impact of these approaches and tools as they were more systematically rolled out to field programs under this CA. These approaches and tools included the *Facilitative Supervision Handbook*, a whole-site training working paper, *COPE for Reproductive Health Services*, *Community COPE*, the simplified Cost-Analysis Tool, and the Quality Measuring Tool. Under separate funding (from USAID's Africa Bureau and REDSO/ESA), we produced *COPE for Child Health Services*, with support from UNICEF and others; additionally, with funding from the Gates Foundation, we produced *COPE for Maternal Health Services*, with support from Family Care International.

At the field level, our country strategies emphasized establishing and improving quality of care in reproductive health services, in large part through the introduction and scale-up of our QI approaches and tools, as an integral component of service delivery.

Over the course of the CA, EngenderHealth conducted a number of studies to document the effectiveness of QI approaches and other strategies aimed at improving provider performance. Selected studies are described below.

TANZANIA QUALITY MEASURING TOOL

In 1995, the Tanzanian MOH, EngenderHealth, and UMATI (the Tanzanian nongovernmental family planning organization and IPPF affiliate) redesigned an existing project to address concerns revealed in a 1992 situation analysis study and a 1993 assessment. These identified needed improvements in contraceptive supply and logistics management, management and supervision, IEC materials, and training. Interventions included introduction and use of QI approaches and tools. Doctor-nurse teams were identified and trained to supervise activities at 120 sites.

To assess the success of the QI strategy, UMATI staff, area supervisory teams, staff from selected sites, Marie Stopes Tanzania staff, and representatives from EngenderHealth and the MOH developed a Quality Measuring Tool to measure changes in the quality of services at the sites. The tool has 10 sections, each of which corresponds to one of the clients' rights or staff needs. Each section consists of a list of questions about specific aspects of services. Supervisors and staff collectively answer each question, yes or no (where no indicates a problem with quality), and then calculate scores for each section and the entire tool. When they have completed data collection, the supervisor and staff develop an action plan to address the issues raised by the assessment. By using the Quality Measuring Tool annually, the staff can compare scores from year to year to measure changes in quality. Furthermore, the Quality Measuring Tool is a simple tool that facilitates easy use by site staff and does not rely exclusively on external supervision to complete. (See the Tanzania case study, page 53.)

Between 1996 and 1999, supervisors collected data at up to 93 sites. Of the 93 sites that performed the Quality Measuring Tool exercise in 1999, 66 sites had data from earlier exercises. Some of the sites collected data more than once prior to 1999. Each site compared its score from the first year for which staff collected data (T_1) with its 1999 (T_2) score. Then, central-level supervisors aggregated the data for all 66 sites to obtain measures of quality change across all sites.

For all sites combined, the mean percentage scores on all 10 sections of the tool showed improvement from T_1 to T_2 . The total mean score for all sites increased by

Table 25. Mean percentage scores from Quality Measuring Tool for all sites (n=66)

	T ₁	T ₂	Increase
Clients have a right to:			
Information	55.9	76.3	20.4
Access to care	59.9	74.6	14.7
Informed choice	52.5	71.4	18.9
Safe services	64.7	83.1	18.4
Privacy and confidentiality	74.9	92.3	17.4
Dignity, comfort, and opinion	69.8	82.5	12.7
Continuity of care	62.7	74.6	11.9
Staff have a right to:			
Facilitative supervision and management	61.7	78.5	16.8
Information and training	54.9	81.4	26.5
Supplies and infrastructure	74.4	88.0	13.6
Total	62.7	79.4	16.7

nearly 17 percentage points (from 63% to 79%, Table 25). Separately, all but four of the sites increased their overall scores.

The largest percentage increase was seen in staff need for information and training. Staff experienced an increase in supervision and a linking of supervision and training, much of which was provided using the whole-site training approach.⁹¹ Other changes contributing to overall improvements in quality included more frequent supervisory visits, more frequent COPE exercises, greater availability of reference materials and guidelines, and more orientations for nonclinical staff (through inreach).

The across-the-board improvement from T₁ to T₂ suggests that supervisors and their staffs used the information obtained from QI exercises—including the Quality Measuring Tool—to identify QI opportunities and changes that resulted in higher-quality family planning and reproductive health services.

BOLIVIA EVALUATION OF QUALITY IMPROVEMENT APPROACHES IN PROSALUD

ProSalud is a national NGO in Bolivia with 33 clinics located throughout the country, although its major focus is in the cities of La Paz, El Alto, and Santa Cruz. Its health clinics offer general medical and gynecological services, such as childbirth and pediatric care, immunizations, family planning and other reproductive health services, and dental, pharmacy, and laboratory services. With technical assistance from EngenderHealth, ProSalud aimed to improve the quality of service delivery through the use of facilitative supervision and COPE for Reproductive Health Services in its clinics. The QI approaches were introduced within an evaluation framework, so that data from an evaluation could inform the strengthening of future QI activities.

Evaluation data were collected in 10 clinics. Preintervention baseline data were gathered in February 2002, including a facility audit, supervisor interviews, staff interviews, client

⁹¹ Bradley, J., et al. 2000. *Family planning services in Tanzania: Results from a project to improve quality, 1996–1999*. New York: AVSC International.

exit interviews, observation of client-provider interaction, observation of IP practices, and record reviews. Between March and May 2002, COPE exercises were introduced at the site level, and supervisors were trained in the facilitative supervision approach. COPE exercises were repeated every four months at the sites, and supervisors provided ongoing support to sites. Follow-up facilitative supervision workshops were held in Santa Cruz and La Paz in March 2003.

Preliminary analysis of the final evaluation data (May 2003) revealed changes in the sites' commitment to improving quality, supervisory systems and elements of the quality of the services: Supervisors perceived a wide array of benefits of COPE and FS: 95% reported that COPE is beneficial to service providers and 90% reported that clients have benefited. Eighty-four percent of supervisors interviewed clients as part of a quality improvement process over the past year. Based on the client interviews they conducted, supervisors reported making changes such as reducing waiting times, expanding hours of service for laboratories and x-rays, offering integrated services during prenatal care, and improving hours of vaccination services. Ninety percent of supervisors stated that their clinics have a committee to discuss quality of services, and 17 of 18 actively participate. Sixty percent of providers reported that supervision had improved over the past 12 months. Those 60% stated that improvements included plans of action, constructive supervision, and a greater interest on the part of supervisors in productivity and quality of care. Qualitative data revealed that site supervisors and service providers perceived PROSALUD administrators as being less of a "police force." At baseline, 86% of providers stated that they felt a part of an active quality improvement team; this increased to 93% at follow-up.

Fifty-two percent of family planning clients, 31% of prenatal clients, and 47% of postnatal clients stated that the quality of care had improved over the past year (41%, 53% and 41% respectively stated that the quality had remained the same). In general, clients felt that providers spent sufficient time with them during consultation, that they were able to clarify questions clients had, and when necessary they offered information about additional services. Of 19 indicators assessed during family planning counseling observation, improvements were seen in 15. Large improvements were seen in: asked about her background/medical history (from 69% at baseline to 93%); let her know that the consultation was confidential (from 35% to 53%); verified if client understood the messages imparted (from 41% to 73%); encouraged the client to ask questions (from 73% to 93%); used client records (from 26% to 62%); supported the client's exercise of her rights (46% to 67%); and reinforced the client's self-esteem (from 44 to 75%).⁹²

COPE FOR CHILD HEALTH IN GUINEA AND KENYA

In 1999, EngenderHealth, with financial assistance from the USAID Africa Bureau, with the collaboration of UNICEF, and with technical input from World Health Organization, BASICS, the SARA Project and others, adapted COPE to address child health services. COPE for Child Health was developed to be compatible with the Integrated Management of Childhood Illness approach and to ensure that providers caring for children, whether trained in this approach or not, are supported by enabling colleagues and by a facilitative work environment in which they can delivery high-quality care.⁹³ EngenderHealth took advantage of this special funding and interest by the Africa Bureau to conduct an evaluation, which has applicability beyond child health, as the COPE process remains the

⁹² C&G Consultoras. 2003. *Evaluación de COPE y supervisión facilitadora de EngenderHealth en servicios de la red PROSALUD*, Borrador 08-08-03.

⁹³ Bradley, J., et al. 2002. *COPE for Child Health in Kenya and Guinea: An analysis of service quality*. New York: EngenderHealth.

same and can be applied to a wide range of services. The evaluation was designed to determine the acceptability to service providers of a participatory self-assessment method of QI, its usefulness in problem identification and resolution, and its effectiveness in improving health service quality (i.e., provider performance and client satisfaction).

EngenderHealth designed a quasi-experimental study involving eight intervention and eight matched control sites (all health centers) in Kenya and Guinea. COPE, a participatory method of QI that uses self-assessment and team problem solving and that emphasizes use of local resources in problem resolution, was introduced at the eight intervention sites. All 16 sites were assessed for improvements in service quality after 15 months, using direct observation of client-provider interaction, interviews with providers and caregivers, and facility audits. Focus groups were conducted with providers at intervention sites at the project's end. Staff and clients at health care facilities were interviewed (156 staff and 320 clients [caregivers of children visiting the facility]). In addition, 320 client-provider interactions were observed.

On almost every indicator of quality, the intervention sites performed significantly better than the control sites. Staff solved most problems they identified without outside assistance, including issues related to infrastructure and equipment, human resources, and service delivery. In representative areas of provider performance—client-provider discussions of child health and family planning, privacy and confidentiality, and diagnosis of sick children—sample data showed that 26% of intervention providers and 9% of control providers discussed general health with caregivers. Moreover, 81% of clients of intervention providers had uninterrupted sessions, compared with 58% of clients of control providers. Likewise, 43% of intervention providers asked about the child's fever, compared with 25% of control providers; 64% and 38%, respectively, took the child's temperature. (All of these differences were statistically significant at $p < .01$.) The only indicators not showing improved quality related to prescribing practices; inaccuracies were documented at both intervention and control sites.

Clients at the intervention sites were much more likely than those at the control sites to report understanding everything they were told (98% vs. 88%) and to report being "very satisfied" overall with the visit (70% vs. 48%). At intervention sites, 80% of repeat clients reported that services were better than they had been before, compared with 27% of those at control sites. Providers underwent profound changes in how they viewed both clients and colleagues, treating clients with increased respect and empathy and markedly strengthening their sense of unity at work. The COPE process affected staff's sense of empowerment and accountability: "Before, most problems were someone else's responsibility. But now we see that we ourselves can solve most problems" (health care provider in Kenya). Organizational changes included reduction of hierarchy and bureaucracy and more supportive supervision.

COPE was associated with dramatically improved provider performance, higher client satisfaction, and higher client/caregiver knowledge. Clear improvements in quality of care were evident with a minimal intervention that involved only the provision of some trigger questions about quality and a structure for discussing problems and potential solutions. COPE is not a "magic bullet," however. Training in discrete clinical areas could complement this process for optimal improvements in service quality.

Participatory QI processes, where staff feel a sense of ownership over their work quality, can inculcate a strong sense of unity and teamwork as well as organizational changes, resulting in improved, cost-effective quality of care.

THE “PERFORMING TO STANDARD” TRAINING FOLLOW-UP TOOL: EXPERIENCE IN INDIA

USAID’s Innovations in Family Planning Services (IFPS) Project aimed to reduce fertility and increase contraceptive prevalence through improved quality, access, and demand for family planning and other related reproductive health services at government health facilities in Uttar Pradesh, India. Since 1996, EngenderHealth has provided technical assistance to the IFPS Project to assess and strengthen health facilities, as well as to upgrade and expand provider clinical skills in several sterilization methods, in IP, in updating their contraceptive knowledge, in IUD insertion and removal, in management of RTIs and STIs, and in counseling skills. All trainings were imparted to medical officers; nurses were trained as assistants for provision of surgical contraception. Trainings in IP, RTI and STI management, and family planning counseling also included paramedical staff.

To assess the outcome of these training interventions, EngenderHealth developed a tool for assessing provider performance called the Performing to Standard (PTS) checklist. The checklist was specially designed for assessing trainees’ clinical performance and the quality of service delivery. The first step in the design process was the standardization of job descriptions and procedures that providers would be trained to perform. Next, EngenderHealth detailed learning guides for training. From these, the PTS follow-up checklist was developed, which included critical and noncritical performance steps. The PTS checklist was used for follow-up assessments, which occurred within three months of training.

Posttraining follow-up, in fact, is an integral part of all EngenderHealth’s skills-based training. EngenderHealth gave newly trained trainers support to ensure that they followed the correct methodology for training. Trainers then followed up trainees at their sites to assess their clinical competency in their own work environment. Follow-up was also an opportunity to discuss problems and constraints, to reinforce aspects of clinical training that may not have been well remembered, to identify existing gaps in performance, and to provide additional mentoring to close those gaps. The PTS checklist aided this process by looking consistently at critical tasks that needed to be performed.

From 1998 to 2002, EngenderHealth trained a total of 1,657 providers in clinical topics. Of these, 1,354 still remained posted in IFPS/EngenderHealth districts as of August 2002. As of August 2002, 1,293 received follow-up, and 85.3% were found to be performing to standard. (To be declared PTS, all steps deemed critical to successful performance needed to be performed correctly.) Those providers that were found not performing to standard were given the appropriate coaching and feedback and received a second follow-up visit to reassess competence.

Results from follow-up visits and PTS status were also used to redesign and refine training programs. For example, during early follow-up of IUD trainees, it was observed that providers were not practicing high fundal placement, which ensures that the IUD stays in place and is not expelled. Further emphasis of this aspect of the procedure was incorporated into later trainings.

Routine use of the PTS checklist, coupled with feedback to service providers, resulted in modifications in training methodology, overall improvement in facilities, and ultimately improved provider skills. The checklist has the potential to be adapted and replicated in similar settings.

Lessons learned during development and implementation of the PTS checklist include the following:

- Linking the design of the training intervention and development of follow-up mechanisms such as the PTS checklist allows for consistent and reliable feedback and improvement.
- Gather as much baseline data as possible before the training begins, to have a clear understanding of the reach of the training interventions in the target areas.
- The use of critical steps during trainee follow-up facilitated and simplified the task of determining whether trainees were performing to standard.
- The checklist is comprised of well-defined performance steps and hence assures objectivity and allows for interobserver reliability.
- Observation on both critical and noncritical steps helped in identifying individual trainees' weakness and gaps in the support system.

INFORMED CHOICE

The ability to make informed and voluntary decisions about one's reproductive health, and access to the information and services needed to do so, are widely recognized by the international development community as human rights. Ensuring informed choice is a fundamental element of all service programs that EngenderHealth supports. Over the period of the CA, we dedicated targeted resources to gather and assess evidence of the challenges to informed choice in family planning service programs and to identify the particular informational needs and decisions associated with other reproductive health services. This field-based evidence has framed the design and testing of new approaches and tools to strengthen informed choice in service delivery.

INFORMED CHOICE STUDIES IN LATIN AMERICA

Research is a critical source of evidence. In 1998, EngenderHealth collaborated with UNFPA to review the literature and survey data on sterilization decision making in Latin American and the Caribbean, to better understand the increasing prevalence of female sterilization in many countries in the region. The review revealed that little was known about how and why women choose sterilization and about whether they are indeed making informed and voluntary decisions. To address this gap in knowledge, we selected three Latin American countries in which to conduct in-depth qualitative studies. Over the next couple of years, our program and research teams collaborated with MOHs, other government agencies, and NGOs in the Dominican Republic, Guatemala, and Mexico to determine whether women who undergo sterilization in these countries receive adequate counseling and information for making an informed and voluntary choice to end fertility. We also explored clients', providers', and administrators' perspectives on informed choice and the informed consent process.

The studies provided strong evidence that most women choose sterilization voluntarily, and that the majority of women make their decision before going to the facility for services, based on information acquired from a variety of sources. However, findings also indicated that many decisions were not fully informed. In two of the three countries, many women reported that during counseling they received little or no information about their contraceptive options and that they were not told about the risks of surgery. Most reported that they did not receive information about the risk of STIs and HIV. Many said that they wanted to know, but were not told about, what to expect during and after the procedure. Many said that the provider did not adequately address their personal circumstances, contraceptive history, doubts, and fears. The studies indicated that providers tend to tell

clients what they feel they need to know, rather than ask clients about their needs and interests and tailor information to an individual's knowledge gaps and circumstances.

Important exceptions to women's making their own autonomous decisions included a few cases in which husbands decided for their wives and still others in which doctors decided that sterilization was indicated on medical grounds for women considered to be at high risk of future pregnancy-related complications. In addition to a lack of information, some women were given limited options to choose from, and others who wanted a postpartum procedure could not get it (either because the procedure was not performed on weekends or, in two sites, because water was not always available).

Postpartum sterilization clients in the studies experienced the least-effective informed choice and consent safeguards. Some clients reported that they were not informed about their contraceptive options during their antenatal visits, and that they felt rushed to make a decision about postpartum sterilization while under the physical and emotional strain of labor and delivery. Of particular concern was the finding that the right and ability of high-risk women to make an informed choice was sometimes overridden by the physician on medical grounds.

Another telling finding was that all groups (clients, providers, and administrators) in all three countries perceived the signed informed consent requirement for sterilization clients as primarily benefiting the institution rather than the client. In one country, the form was not on file for a significant proportion of clients, and a number of clients who signed the form reported that they neither had read it nor had had it read to them.

Observations of counseling sessions in two of the study countries revealed that women tend to be passive in their interactions with providers and do not request information, ask many questions, or raise concerns. There were no known complaints about the services received. We believe these facts reflect the status of the women in the studies, most of whom were of low educational and socioeconomic levels, had low expectations, and knew little if anything about their rights.

The results of these three studies confirmed the need to redouble our efforts to ensure informed choice for family planning, particularly for permanent methods. This requires returning to the basics of training and supervision to strengthen counseling and ensure the correct implementation of informed consent protocols, as well as new strategies and tools. There is a clear need to establish safeguards for postpartum sterilization clients where these do not already exist and to identify and address barriers to informed choice at both the policy level (e.g., operating hours and eligibility criteria) and at the community level (e.g., public education on family planning, STI/HIV, and clients' rights).

PILOT TEST OF THE INFORMED CHOICE TOOLKIT

In response to the needs identified through research, consultation with experts, and observation of field programs, EngenderHealth developed a package of simple, practical tools, published in the document *Choices in Family Planning: Informed and Voluntary Decision Making*. (We refer to this as the Informed Choice Toolkit.) These awareness-building, diagnostic, and planning tools explain the essential principles and program elements that underpin informed and voluntary decision making in reproductive health and the factors (both within and beyond the clinic) that affect clients' access to information and service options. It includes, but goes beyond, the requirements of the Tiahrt Amendment. The tools are based on EngenderHealth's expanded conceptual framework for informed choice, designed to address the root causes of the persistent gap between the rhetoric and reality of informed choice in family planning services.

The framework is based on the assumption that individuals have both the right and the ability to make their own reproductive health and family planning decisions. It recognizes both the service program's responsibility for creating conditions that enable clients to exercise this right and the provider's specific role in helping clients make and act on their own well-considered decisions. This framework identifies five essential elements or conditions for informed and voluntary decision making: Service options are available; the decision-making process is voluntary; individuals have appropriate information; there is good client-provider interaction, including counseling; and the social and rights context supports autonomous decision making. For each element, the framework provides illustrative indicators of what one would hope to see to ensure that this element or condition is in place. The tools guide users to identify and consider factors at the community, service, and policy levels that affect these elements, to determine whether they support or challenge informed and voluntary decision making, and to develop strategies and action plans to address identified challenges. The toolkit can be used by donors and technical assistance agencies, by policymakers, by reproductive health and family planning program managers, by community groups, or by coalitions representing all of these groups.

In 2002, with support from the Asia/Near East Bureau of USAID Washington, we conducted an in-depth field test of the work-in-progress version of the Informed Choice Toolkit in Bangladesh and Cambodia. At their orientation workshops, participants identified such barriers to informed choice as a lack of awareness in the community and among clients and providers of gender equity and clients' sexual and reproductive rights; low literacy, leading to low community awareness and lack of knowledge of issues related to reproductive health and rights; low status of women, who have limited decision-making power; limited access to services (in Bangladesh, due to poor service location and inconvenient hours; in Cambodia, due to poor roads, limited method mix and service hours, and not enough trained providers); and inadequate provider skills in promoting client-provider interaction, in assessing clients' needs, and in supporting clients' decision making (specifically linked to insufficient staff training and supervision).

It was interesting to note the strikingly common results of these two very different programs. Bangladesh, a Muslim society, has a long-standing family planning program with an extensive service-delivery infrastructure and a long history of reliance on sterilization (the prevalence of which had undergone dramatic decline in recent years). Cambodia represents a new program in a Buddhist country with limited resources and service capacity, particularly for LTP methods.

Additional challenges identified by participants in Bangladesh included conservative social norms that discourage discussing issues related to sexuality; lack of male involvement in reproductive health; inadequate community involvement in planning and evaluating services; policy barriers; a failure to follow national guidelines for ensuring informed choice in counseling; inadequate use of referral links; a lack of skilled staff due to turnover and low job satisfaction; and provider bias. The Cambodians identified the power imbalance between providers and clients.

To respond to these challenges, groups in both countries designed action plans with interventions that went beyond the point of client-provider interaction. In Bangladesh, participants from different organizations developed eight action plans that included such interventions as organizing community meetings, orienting Health Watch committees, training peer educators, translating and posting the list of clients' rights, arranging health education classes for husbands who accompany their pregnant wives to service sites; and training and orienting providers. In Cambodia, the four action plans (three provincial and one central) included community education efforts; formation of an alliance with the

Ministry of Women's Affairs; training on issues of reproductive health, communication, gender, and rights of health care staff, community-based volunteers, and village drug sellers; stronger supervision of counseling and informed choice; an increased number of service-delivery points to increase access; and introduction and expansion of COPE.

A follow-up to the toolkit introductory workshops after six months in Cambodia and after eight months in Bangladesh provided evidence of the tools' usefulness and effectiveness. In both countries, providers oriented to the conceptual framework and the toolkit demonstrated sustained, increased understanding of clients' rights, of the basic elements of informed choice, and of the range of issues that affect clients' ability to make free and informed reproductive health decisions. They reported a high degree of success in addressing challenges to informed choice both within and beyond the service site, to achieve increased community awareness of reproductive health and family planning services, increased provider awareness of clients' rights and gender issues, improved information for mothers on family planning options and referral for services, increased male involvement, improved client-provider interaction, and strengthened supervision and training to ensure compliance with national guidelines. (See also Section 2, Bangladesh case study, page 15.)

Based on these positive results, the toolkit has been widely disseminated to all EngenderHealth country teams for use in programs they support, as well as to our broader CA and donor community.

MEN AS PARTNERS AND VASECTOMY

CLINICAL VASECTOMY RESEARCH

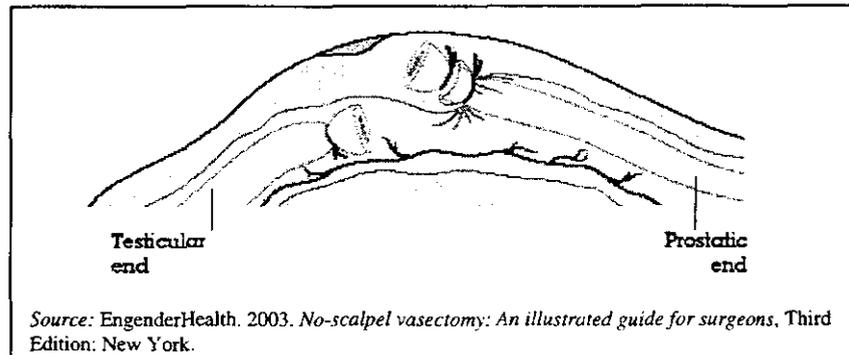
Vasectomy is one of the safest and most reliable methods of contraception and is one of the few contraceptive options for men. Vasectomy failure rates are often quoted as being less than 0.5%. Although vasectomy is a common and popular form of contraception in many countries and a surgical procedure that has been in use worldwide for decades, surprisingly little is known about some aspects of the technique itself. While there are good data to support the use of NSV over conventional scalpel vasectomy, data have been lacking on what occlusion method is better than another or what the most appropriate follow-up protocol is. Over the past decade, EngenderHealth, in collaboration with Family Health International, has conducted a series of clinical studies on vasectomy, the results of which have built upon each other and have begun to change the practice of vasectomy in resource-poor settings.

Results of our collaborative study on time to azoospermia following vasectomy provide detailed information on sperm clearance after vasectomy performed using ligation and excision without fascial interposition. In addition, two key findings emerged from the study. First, there was a prolonged risk of continued fertility. Semen analysis found a surprisingly high percentage of men (25 of 217, or 11.5%) who showed potential fertility (defined as 3 million or more sperm/ml) six months after having had their vasectomy; they were considered vasectomy failures, suggesting that among the methods of vas occlusion, ligation and excision alone may not provide the best success rates. Second, there was great variability in the onset of azoospermia, in terms both of time and of number of ejaculations following vasectomy. This suggests that it may not be possible to develop guidelines for when men can rely on their vasectomy for contraception based solely on time or number of ejaculations since vasectomy, at least when ligation and excision is used.⁹⁴

⁹⁴ Barone, M.A., et al. 2003. A prospective study of time and number of ejaculations to azoospermia after vasectomy by ligation and excision. *Journal of Urology* 170(3):892-896.

The higher-than-expected failure rate seen in the study described above led us to carry out a randomized trial of fascial interposition, again in collaboration with FHI. Fascial interposition places a tissue barrier between the two cut ends of the vas. This is done by suturing (or securing with a clip) the thin layer of tissue that surrounds the vas (the fascial sheath) over one end of the vas (see Figure 9). It has been promoted as a way to reduce vasectomy's already low failure rates by decreasing the likelihood of recanalization. Reported success rates have varied, and until now there had been no randomized controlled trials to evaluate its effectiveness.

Figure 9. A view of fascial interposition



The study enrolled 841 men who had chosen vasectomy at eight centers worldwide. Men were randomized to have a vasectomy with or without fascial interposition. All vasectomies were performed by excising 1 cm of vas and making a suture ligation at each cut end. Semen analysis was done every four weeks for a maximum of 34 weeks or until azoospermia was confirmed. Fascial interposition significantly reduced the time to azoospermia and time to severe oligospermia and reduced the number of failures based on semen analyses by about half, from 12.5% to nearly 6%. Recanalization was the most common cause of failure. By 14 weeks, 91% of men in the fascial interposition group were severely oligospermic (meaning they had fewer than 100,000 sperm per milliliter), compared with 82% of men in the ligation and excision alone group. There was no significant difference in adverse events between the two techniques. On average, the vasectomy procedure took about two minutes longer when fascial interposition was used. Study surgeons were unable to interpose fascia on one or both sides in about 2.4% of men.

There is some evidence that cautery may be a more effective occlusion technique than some of the other methods in use. In collaboration with FHI, we recently completed an observational study of vasectomy using cautery, to describe early trends in sperm counts so as to estimate the probability of early failure following vasectomy with cautery. Four hundred men who chose vasectomy were recruited at four sites and followed with frequent semen analysis for 24 weeks after vasectomy. The failure rate (as defined by semen analysis) was 0.8%. By 12 weeks, 96% of men were severely oligospermic (<100,000 sperm/mL). The two sites that used fascial interposition and thermal cautery had less recanalization than those using electrocautery without fascial interposition. Further study is needed to determine if there are differences in failure rate between thermal cautery and electrocautery, as well as whether fascial interposition used in conjunction with cautery improves vasectomy success.

A comparative analysis between the fascial interposition arm of the randomized trial and the cautery study revealed a significantly more rapid progression to severe oligospermia after vasectomy using cautery techniques and significantly fewer early failures (less than

1% versus nearly 6%). Taken together, the results of these three clinical studies show that ligation and excision without fascial interposition is an inferior vasectomy occlusion method that no longer should be recommended. Cautery appears to be a better occlusion method than ligation and excision with fascial interposition. Data from all three studies call into question the counseling guidelines often used in low-resource settings that advise men to have semen analysis or use a back-up contraceptive method until 15–20 ejaculations have occurred or until a period of 10–12 weeks has elapsed since the vasectomy. Our study results indicate that after vasectomy with any of the occlusion methods, use of 12 weeks should be more reliable than 20 ejaculations.

Based on these study results, we integrated fascial interposition into our resource and training materials. The third edition of *No-Scalpel Vasectomy: An Illustrated Guide for Surgeons*, published in March 2003, contains an expanded description of the steps for fascial interposition. Also, in March 2003, we held a training exercise in New Delhi, during which 10 key trainers from Bangladesh, Cambodia, India, Kenya, Nepal, and the Philippines were oriented to the revised vasectomy training curriculum and standardized their fascial interposition techniques. The illustrated guide and the new curriculum also recommend that another contraceptive method be used for 12 weeks after vasectomy to avoid an unplanned pregnancy; the recommendation for 20 ejaculations has been dropped. The guide and curriculum also highlight the importance of providers' counseling their clients about the small possibility of vasectomy failure.

It is important to note that despite these recent findings, vasectomy remains a highly effective method of contraception. In addition, it is difficult to make general statements about vasectomy failure because of the wide variety of occlusion methods used. It is becoming clearer that some occlusion methods or combinations of occlusion methods are more effective than others. We will continue our joint, coordinated effort with FHI to determine what the most effective vasectomy techniques are for use in resource poor settings. We are planning a jointly sponsored vasectomy experts meeting for December 2003 to review recent research, develop a consensus on the strength of the evidence in favor of various occlusion methods, develop guidelines for optimal vas occlusion techniques in different health care settings, identify additional research priorities, and discuss programmatic implications.

“Vasectomy is as much an IEC operation as a surgical operation.”
—Indian urologist

VASECTOMY PROMOTION INITIATIVE IN GHANA AND THE PHILIPPINES

A major area of global leadership under the CA was to develop a strategy to revitalize vasectomy services. Attention to vasectomy is needed because sterilization will remain the most widely used contraceptive method over the next decade, and yet the number of female sterilization users exceeds that of vasectomy users by five to one. Vasectomy is a safer, simpler, and less expensive method than female sterilization, and it is just as effective. Vasectomy remains an underutilized method of contraception for a variety of reasons:

- Men and women are less aware of vasectomy than of other family planning methods
- When men and women are aware of vasectomy, the information they have is frequently incomplete or incorrect
- Vasectomy services are less available and accessible than other family planning methods
- Program and provider biases exist
- Family planning is still perceived as a woman's responsibility

During this CA, EngenderHealth undertook an evidence-based review of the state of the art in vasectomy, including lessons learned from some of the successful program efforts

conducted in the late 1980s and early 1990s in Latin America. Compelling evidence indicates that programs that do not address both the demand and the supply side of the equation are unlikely to have a sustainable impact. The review of literature and the state-of-the-art analysis, as well as EngenderHealth's own programmatic experience, led to pilot projects in Ghana and the Philippines that coupled effective and strategic demand awareness interventions with site interventions that focused on issues of quality and access. The program design had four key components:

- Training of physicians in NSV
- Creation of "male-friendly" service-delivery points
- Community outreach
- Media campaigns oriented to potential clients

On the supply side, while a common strategy among programs initiating vasectomy services is to conduct short-term centralized surgical training (usually for doctors only), Ghana and the Philippines treated the local service-delivery site as a system and the personnel as members of a team who make the system function. In both countries, training was conducted on-site under conditions that the trainees would face later. The goals of on-site training were not only to transfer knowledge and develop critical skills, but also to forge an effective, smoothly functioning service-delivery system and effective local teamwork. Staff with supervisory and technical support responsibility, as well as managers, doctors, nurses, social workers, receptionists, and gatekeepers or guards (who may provide information to clients), also were oriented to the services.

Because facility staff frequently held prejudices against men and even discouraged them from seeking family planning information and services, training focused on changing attitudes, not just on imparting information. Orientation to "male-friendly services" included clinical aspects of NSV, counseling and referral skills, increased engagement and motivation of all levels of clinic staff, a focus on client satisfaction, implementation and maintenance of high quality of care, and assurance of informed choice on the part of clients.

On the demand side, several approaches allowed for interpersonal communication. A hotline established in Manila provided a means for men and women to obtain information or ask questions in a private and confidential manner. To increase awareness and acceptance of vasectomy at the community level, satisfied vasectomy users and their wives were recruited in Ghana and the Philippines, to provide testimonials and do community outreach.

Three-to-four-month "pulse campaigns" were planned to serve both as a catalyst for men considering vasectomy to take that final step and access services and as a mechanism to raise awareness of vasectomy as a contraceptive option and dispel rumors. Campaigns in both countries adapted the slogan "Get a permanent smile—Have a vasectomy" and planned to provide the names and addresses of sites where quality NSV services were available.

The campaign in Ghana was scheduled to begin in fall 2003. In the Philippines, advertisements for NSV began in May 2003, and radio spots began to be aired in the summer of 2003. Other promotional materials were developed and disseminated throughout the country (see the Philippines case study for more detail). Meridian Development Foundation provided technical assistance in designing the promotional campaign and identified in-country marketing partners for EngenderHealth to work with. Evaluation data are being gathered at this writing.

MEN'S REPRODUCTIVE HEALTH CURRICULUM

During the CA, EngenderHealth tested the effectiveness of a comprehensive men's reproductive health curriculum designed to advance the delivery of such services to men. This curriculum addresses men's reproductive health needs in a holistic way, while helping providers become more comfortable with and competent in working with men. It emphasizes the need to work effectively with men on issues related to reproductive health and sexuality, as well as on women's reproductive health issues and gender concerns. The curriculum has been used with public- and private-sector institutions in seven countries in Africa, Asia, and Latin America. We present here evaluation results from Bolivia and Guinea.

Bolivia

From December 1–5, 2002, EngenderHealth staff conducted an evaluation of MAP activities with CIES staff and clients in La Paz and El Alto. EngenderHealth had provided technical assistance to CIES on QI approaches. Moreover, CIES became familiar with EngenderHealth's MAP work through the research document produced on men in the Bolivian city of Santa Cruz.⁹⁵ and later through information about MAP activities undertaken in other parts of the region (i.e., Colombia, Guatemala, and Honduras). In 2002, CIES approached EngenderHealth to request technical assistance in the introduction of men's services at two of their sites, with the expectation that this work would be scaled up for implementation at all of its sites throughout Bolivia.

The purpose of the evaluation was to determine the impact of the Men's Reproductive Health Curriculum training conducted at those sites in May 2002. The evaluation involved 31 open-ended interviews with male and female providers, managers, and clients designed to assess the knowledge, perceptions, and opinions of the interviewees regarding the introduction of men's reproductive health services at each site.

Overall, staff found the training to have been very useful. Various staff, both male and female, stated that they now felt greater comfort and confidence in dealing with men's reproductive health issues:

"It has been useful— it has changed the panorama of our work and we have seen how useful it is to include these issues. We have also seen a change in attitudes: now the services are not only directed at women...it's a much better way to work."

—Service provider, El Alto

"I have more knowledge of the different services that can be offered to men. In La Paz, this has been a special opportunity, since integrated services do not exist anywhere else. I feel more tranquil and sure that I am giving them correct information—yes, I now feel more confident in my technical capacity."

—Service provider, CIES La Paz

Various staff members noted an increase in the numbers of male clients.

"As a site, we have also seen results—we are seeing increased numbers of clients and have also established an internal reference mechanism between the general practitioners, ob-gyns, and dentists."

—Provider, CIES El Alto

A review of service statistics at both sites suggests that the training and resulting action plans may have contributed to an increase in the number of male clients coming in for services. For example, at El Alto, the number of male clients increased from 11 in June

⁹⁵ CISTAC. 2001. *El momento de involucrar a los hombres en salud sexual y reproductiva, estudio exploratorio en Santa Cruz de la Sierra, Bolivia.*

2002 to 98 in October 2002. In La Paz, the site had been seeing an average of 40 male clients a month prior to the training. This increased to an average of 80 male clients after the training was provided and after action plans related to improved services and social marketing were implemented.

Another outcome of the workshop was increased interest on the part of staff for additional training related to men's reproductive health services, including clinical training in NSV.

"I am an ob-gyn and my focus has always been women. Before the training, I always referred male patients to general medicine. Now I can see men and provide them with care. I am even interested in learning Dr. Li's technique so we can provide vasectomy services."

—Service provider, CIES La Paz

As a result of the training, the participants demonstrated a change in attitudes towards men's reproductive health services, being more positive and less negative. This is important, because it facilitates the introduction of men's reproductive health services and affects the quality and ability of the clinic to offer such services. In addition, personnel will be able to communicate appropriately with male clients and respond to their needs more competently and effectively.

The results of the evaluation were shared with the CIES headquarters staff at a one-day managers' orientation, held in La Paz on June 23, 2003. It is expected that the results will be used by CIES as guidance for the expansion of men's reproductive health services throughout its nine service sites nationwide.

Guinea

In October 2002, EngenderHealth staff conducted a two-week evaluation of men's reproductive health program activities at two clinic sites in Guinea. Twenty-seven in-depth interviews were conducted with clients, providers, and managers at the two sites, as well as with health communication professionals from the MOH's IEC Division. The purpose of these interviews was to evaluate the perceived impact of the training and IEC activities, as well as the introduction of men's reproductive health services at each site. Further, focus-group discussions were conducted with 37 peer educators and 16 religious leaders to evaluate the perceived impact of the peer-education activities on community members' awareness of and knowledge about male involvement in reproductive health issues.

Clinic staff were very responsive to the training they received and enthusiastically implemented a number of changes. Today, a man walking into either of the two sites at Boulbinet or Coronthie would have access to the Men's Section, an area in which services specifically for men are provided by specially designated staff (doctors and counselors). These services include family planning, STI management, and treatment for sexual dysfunction and infertility. In addition, clinic staff made a concerted effort to provide education and information about men's reproductive health. For example, they placed around each site posters conveying specific messages geared to men and provided special educational sessions for men. Finally, site staff took part in outreach efforts with men in the community.

As a result of all of these efforts, staff expressed a greater sense of comfort with, interest in, and commitment to meeting men's reproductive health needs.

"Through the training, we were able to identify specific problems for men in the center. This helped a lot and increased the influx of patients, because awareness is greater about coming to the center. Personally, I was timid, but the training has increased my ability to communicate with others."

—Service provider, Boulbinet

"It has been very practical. Before I only worked with women.... [Now] I am more knowledgeable about men's illnesses and how to deal with men. It is also very surprising—I did not think it would be easy for them to talk to me or for me to talk to them."

—Service provider, Coronthie

Information from client registers supports the perception that service usage by men and their partners increased following MAP efforts. At one site, staff reported that before the program began, they saw an average of five or six male clients each month, but client registers indicated that following the project the clinic had about 30 to 35 male clients per month. In addition, over the period from January to September 2002, 342 male clients visited the men's sections at the two clinics, almost half the number of female clients at the MCH wings of clinics (846). This is an impressive number of male clients, considering that men do not usually access clinical services and that in 2001 the clinics only served a handful of men each month. Further, the registers show that of those 342 visits by male clients, 258 (75%) were for consultations related to STIs.

Another outcome of these efforts was an increased number of couples who come in together for consultations and treatment. As one nurse-midwife said, "We now have more information and knowledge about reproductive health for men. We have shared this information with the women and this has allowed them to speak with their husbands.... After the orientation campaign, the women did not feel bad about coming with the men. They realized that they should come together as a couple." Staff also observed a decrease in the number of repeat STI infections among women, and attributed this change to the number of men who were now receiving treatment at the same time as their female partners.

SUSTAINABILITY: EXAMINATION OF WORK IN MEXICO AND EGYPT

Creating sustainable systems and ensuring sustainable service delivery require a long-term commitment and an approach that fosters the needed commitment, leadership, systems, and resources to ensure that services can and will continue following withdrawal of external technical and financial support. A key question for technical assistance agencies is what happens once external support is withdrawn and what we can learn about how to better extend the potential for sustainability. EngenderHealth explored the status of service delivery in two countries for which our support ended during the period of this CA: Mexico (vasectomy services) and Egypt (a safe reproductive health program focusing on the needs of high-risk women).

VASECTOMY IN MEXICO

EngenderHealth worked in Mexico from 1975 until USAID withdrew its support for population and family planning there in 1999. In 1989, Mexico took the first step to integrate services for men into its national family planning program—a step designed to dramatically increase the availability and accessibility of vasectomy services. At that time, Mexico's largest provider of family planning services, the Instituto Mexicano del Seguro Social (IMSS), initiated a long-term strategy for the introduction of NSV services. EngenderHealth played a critical role in the introduction of NSV into the array of services available in Mexico, both in IMSS and other public-sector institutions. We assisted in the development of the introduction strategy, clinical training, counseling training, supervision and monitoring of services, and provision of the surgical instruments necessary to perform NSV.

The introduction strategy in IMSS involved a *comprehensive* approach for training service-delivery personnel, training auxiliary personnel, and assisting centers in the introduction, organization, and management of services.

- **Phase I.** In 1989, EngenderHealth assisted IMSS in establishing a core group of trained doctors.
- **Phase II.** From 1990 to 1991, IMSS established four NSV demonstration sites in Mexico City staffed by the physicians trained in Phase I. These sites were developed to help demonstrate the effectiveness of NSV in Mexico and to help providers gain practical experience before expanding to other sites.
- **Phase III.** From late 1991 to mid-1993, IMSS trained service providers from selected Unidades de Medicina Familiar (UMFs) in each of the delegations. This clinical training was conducted on-site at each UMF facility, and trainees were certified as trainers to train other providers within their delegation. Physicians at the primary level were also certified as NSV providers.
- **Phase IV.** From mid-1993 to 1997, the focus was on expanding the number of NSV service delivery sites. By 1995, each delegation had at least one certified training team responsible for conducting training for other sites within the delegation, and by 1997, each delegation had two or three certified training teams. In total, 167 IMSS units had been trained to provide vasectomy services and 317 total IMSS providers had been trained.

By 2002, NSV services had been extended to 230 UMFs—representing 21% of the entire primary care service-delivery infrastructure. Although expansion has slowed, the number of vasectomies performed each year has continued to be above 20,000 since 1995, when the volume peaked at 23,056. In 2001, the ratio of female procedures to male procedures was 7.5—the same as in 1995.⁹⁶

The phase-out of USAID support in 1999 and the withdrawal of EngenderHealth support appears not to have seriously hindered the operation of the vasectomy program. Although the program experienced a period of reduced monitoring and supervision, the IMSS headquarters is recovering from this and is now looking at new strategies for providing technical support to their delegates, given limited resources. The major unaddressed issue is funding and logistics for replacement of vasectomy kits. The innovative on-site training program, the emphasis on all medical and nonmedical personnel for counseling and information services, and the rapid decentralization of training were critical factors in the successful institutionalization of the program. The early success of the IMSS vasectomy program helped to generate interest in vasectomy services among other public-sector institutions, including the Secretary of Health (SSA), the Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado (ISSSTE), and IMSS-Solidaridad.

Ultimately, the four largest Mexican public-sector health care organizations succeeded in institutionalizing vasectomy services within their reproductive health programs, with support from EngenderHealth. Two years following the withdrawal of USAID and EngenderHealth support, all of these major public-sector service-delivery organizations continued to offer NSV. In 2001, 29,900 vasectomies were provided by the public sector. IMSS is the major provider of vasectomy services within Mexico, having provided 72% of all vasectomies in 2001. The SSA is the next largest provider, having performed 17% of all vasectomies in 2001, and IMSS-Solidaridad and ISSSTE provided the remaining vasectomies.⁹⁷

⁹⁶ Cisek, C., and Juarez, C. 2003. *The Mexican vasectomy Program: Lessons learned from the introduction of vasectomy services in Mexico's public-sector healthcare institutions*. Mexico City.

⁹⁷ Cisek, C., and Juarez, C. 2003. *The Mexican vasectomy program: Lessons learned from the introduction of vasectomy services in Mexico's public-sector healthcare institutions*. Mexico City.

While the experience of each institution was unique, there are some common observations about the factors leading to the success of their programs, as well as lessons learned.⁹⁸

- The strong central political support for the vasectomy program during the introductory phase in Mexico contributed greatly to its overall success.
- The introduction of the NSV technique and the training of general and family physicians in the procedure contributed greatly to achieving broad access and availability of the service.
- The innovative, on-site training approach developed and introduced by IMSS—and later refined by other organizations—during the introduction of vasectomy services was critical in their institutionalization.
- In general, the vasectomy program was well institutionalized by the time USAID and EngenderHealth concluded their support to the family planning program. However, current resource constraints are very real and create additional challenges for program managers. Three areas have been most affected: the pace of expansion to new facilities; monitoring and evaluation systems at the central level; and operations and clinical research.
- The process for budgeting and procuring the surgical instruments required for the NSV technique was overlooked during phase-out of external support. There was no effort to place NSV instruments on the list of basic medical equipment required for government procurements, to budget for procurement of new instruments, or to identify possible local or international sources for the instruments.
- Personnel changes among key decision makers and management staff can create temporary pitfalls. A systematic process of sensitization of managers and service-delivery personnel at various levels helped to overcome these obstacles, contributing to the program's long-term success.
- It is important to recognize providers for their participation in the program, and simple strategies can help maintain their interest and participation over the long-term, including recognition and praise from local communities for introducing and integrating a new service, certification and points toward accreditations and professional development, and, in some cases, international recognition as demonstration sites that train providers from other countries.
- Vasectomy acceptance among the general population is good when clients receive accurate information and quality services.
- Mass media campaigns are effective at generating interest in vasectomy services, but having access to interpersonal counseling and being able to talk with someone who has had a vasectomy are more critical in the decision-making process.
- Programs are now looking for ways to transition from vasectomy-only programs to broader reproductive health programs for men.

EGYPT: FOCUSING ON THE NEEDS OF HIGH-RISK WOMEN

In 1993, EngenderHealth began a project aiming to pilot-test a broader approach for improving maternal and child health in Egypt, one focusing on the particular needs of high-risk women. The strategy was to offer these women increased contraceptive access and options by seizing missed service-delivery opportunities in the postpartum period. The program's goals were to increase access to and use of long-acting contraception and tubal ligation and to increase acceptance of tubal ligation among providers and clients, especially for women at high risk of poor obstetrical outcome.

⁹⁸ For more detail on lessons learned, see Cisek, C., and Juarez, C. 2003. *The Mexican vasectomy program: Lessons learned from the introduction of vasectomy services in Mexico's public-sector healthcare institutions*. Mexico City.

The project was initiated in 1994 and concluded at the end of 1998. Midpoint and final evaluations documented numerous, substantial achievements of the Safe Reproductive Health (SRH) program and concluded that they had made an important initial impact on reproductive health services in Egypt, particularly at the national policy level and at the sites where services were introduced. The final evaluation concluded that the project had created the potential for national impact by establishing a solid foundation for future program expansion.

A key achievement of this project was the breakthrough it brought about with the MOH. Throughout EngenderHealth's 20-year history of working in Egypt, it had supported various partners to try to increase the acceptability and accessibility of tubal ligation. Yet the method remained culturally sensitive, and the MOH would not agree to participate directly in EngenderHealth's supported service program. In the early phases of the SRH project, EngenderHealth led a successful process of catalyzing local experts to define high risk and to establish acceptable eligibility criteria for tubal ligation that the MOH would endorse. Midway into the project, based on the demonstrated acceptability of the new program approach, the MOH requested EngenderHealth assistance in introducing the SRH program into its hospital network, a dramatic advance toward the goals of expanding access to clinical family planning services.

The program was introduced into four medical school hospitals and eight MOHP hospitals by the end of 1998. Program elements and technical inputs are described below. One year following the end of technical and financial support from EngenderHealth, a consultant conducted a follow-up assessment. The assessment involved qualitative inter-views with program coordinators and providers at five SRH program sites—three university hospitals and training centers and two MOHP hospitals—and the collection of service statistics. The findings confirmed success in achieving a sustained impact for several key program components. They also provided insights into why some elements took root and some did not, yielding important lessons about programming for sustainability.

To summarize the findings, EngenderHealth achieved its goals for the SRH Program and established several critical capacities within its Egyptian implementing partners. The major program achievements included the following:

- By demonstrating a culturally acceptable way to provide tubal ligation services, the pilot project resulted in a plan to take the SRH program (including minitaparotomy and postpartum and postabortion IUD services) to scale nationally throughout the public-sector program under the comprehensive family planning and reproductive health program.
- The number of service points providing an increased number of service options increased, thus increasing access to services for high-risk women.
- National service standards for tubal ligation and for postpartum IUD insertion were established and endorsed by the MOHP.
- PPIUD services were maintained, and in some cases continued to increase, after cessation of external support. (At sites where data were available for both years, 852 were provided in 1998 and 1,018 were provided in 1999.)
- Consensus was achieved on a broad definition of high obstetrical risk and on indications for preventing pregnancy, which made women eligible for elective tubal ligation despite cultural sensitivities.
- Training capacity for postpartum IUD insertion, tubal ligation, counseling, and IP was established at university sites in different regions of the country.
- An operating service model with all program elements and support systems necessary for comprehensive, client-oriented reproductive health services was established.

Capacity in all elements was in place, though not necessarily in use, one year after external support ended.

- Postpartum and postabortion IUD services were integrated into the routine set of services offered by select university hospitals and the public-sector program.
- The essential service quality components of counseling and IP were institutionalized at all SRH program sites, with increased staff knowledge and support of the importance of these program elements.
- Effective linkages among participating universities, between these universities and the MOHP, and between the curative and preventative departments of the MOHP were established.
- An ongoing, multisectoral Technical Advisory Committee was established for the SRH Program.
- The program demonstrated that program innovations can be introduced and institutionalized without salary supplements.

SRH PROGRAM ELEMENTS AND TECHNICAL INPUTS

- (1) Introduction of new service standards for tubal ligation and postpartum IUD insertion developed by local experts in the start-up phase of the strategy
- (2) Establishment of a client screening and interdepartmental referral system (inreach) for high-risk women
- (3) Development of comprehensive training curricula for postpartum IUD, IP, and counseling
- (4) Client counseling
- (5) Development and distribution of client education brochures, flipcharts, and posters
- (6) Improved IP protocols and practices
- (7) Introduction of new clinical services:
 - (a) Postpartum IUD and ML/LA
 - (b) Postabortion IUD
 - (c) Interval tubal ligation
 - (d) Screening and treatment for STIs and RTIs
- (8) Provision of equipment and upgrading of facilities
- (9) Establishment of routine postpartum follow-up and family planning services
- (10) Development and introduction of a comprehensive client record and information system
- (11) Introduction of the COPE QI methodology
- (12) Development of business plans to help achieve financially sustainable services
- (13) Orientations to increase staff awareness of the problems and prevalence of obstetrical high risk and of the SRH Program, and to decrease staff resistance to tubal ligation for medical indications and to postpartum IUD insertion
- (14) Creation of a program identity within the community by giving the program a name and logo, fostering institutional ownership
- (15) Encouragement of interdepartmental cooperation and management by creating management committees and referral linkages
- (16) Fostering of collegial working relationships and coordination among university medical schools and between the universities and the MOHP

However, data from the one-year follow-up interviews indicated that several components of the program model have not been sustained since external financial and technical support expired. These are evidenced by:

- A decline in minilaparotomy and tubal ligation service performance (from 122 total in 1998 to 21 in 1999)
- A failure to transfer some information and capacities to new staff—e.g., counseling; IP; and awareness of the problems and prevalence of high-risk women in Egypt, of the SRH program, and of the medical indications for preventing pregnancy (which constitute eligibility criteria for tubal ligation)
- A failure to sustain some practices that could improve service utilization (e.g., inreach referral, management information systems, COPE, and interdepartmental coordination)
- A failure to incorporate several elements of the SRH Program into routine performance expectations at some sites, and apparently minimal monitoring and reporting.

The follow-up assessment identified the following lessons learned:

- Champions for change, and sustained leadership by a committed individual or group within the institution who believes in the value of the innovations being introduced, are crucial for affecting a lasting impact.
- When service providers perceive the importance or benefit of the innovation or change, they are more motivated to adopt it.
- Changes in attitudes and practice take time, carefully planned and coordinated inputs, intensive technical assistance, and sustained support to break old habits, to develop new skills, and to foster comfort with advances.
- Creating capacities does not assure that they will be used. Mobilizing and applying capacities requires leadership, clear performance expectations, resources, and coordination systems.
- Without clear performance expectations, as well as monitoring and supervision that incorporate innovations, there is no accountability to reinforce and institutionalize change.
- Changes must be incorporated into all ongoing systems (e.g., scope of routine services, protocols and practices, training programs, budgets, new staff orientations, and performance expectations) for them to be sustained after external support ends and internal staff change. It is not enough to transfer new capacities to individuals.
- The use of combined doctor-nurse training teams is effective.
- Whole-site training to orient staff of different departments and to gain their support for a new program (and to apply learning to the providers' work situation) is highly effective
- Cultivating midlevel managers as program coordinators is an effective strategy for fostering program support

SECTION FOUR

IMIS RESULTS AND TRENDS

INTRODUCTION

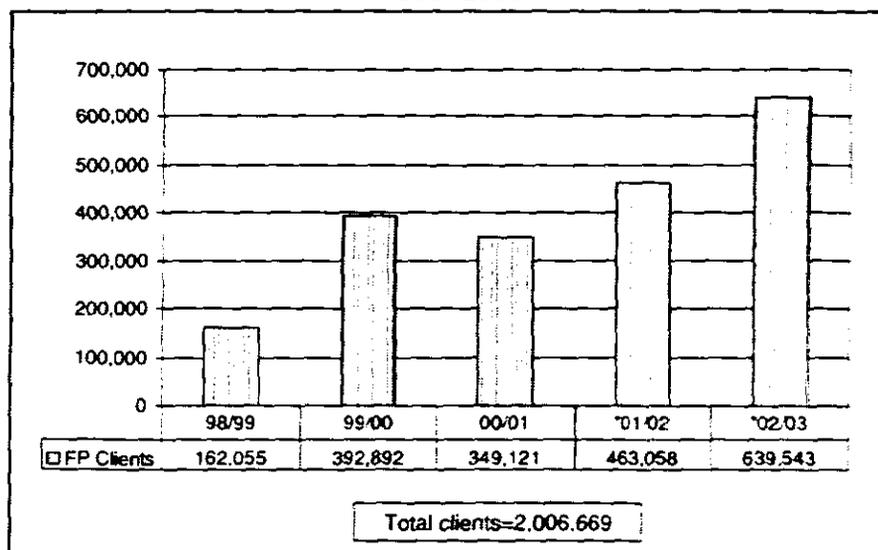
This section summarizes selected EngenderHealth service statistics (sites, services, and training) for the five-year period of the CA (1998–2003). All studies and journal articles that EngenderHealth completed during that same time period are listed in tables in appendixes at the end of the report. The data analysis here should be read in conjunction with the case studies included in Section Two of this report, as together they show country-level results of EngenderHealth's work during the CA. Data are provided according to fiscal year, as shown in the adjacent box.⁹⁹

FY 1998–1999	April 1, 1998, to March 30, 1999
FY 1999–2000	April 1, 1999, to June 30, 2000
FY 2000–2001	July 1, 2000, to June 30, 2001
FY 2001–2002	July 1, 2001, to June 30, 2002
FY 2002–2003	July 1, 2002, to June 30, 2003

During the period of the global CA, 22 EngenderHealth programs supported services to over 2 million family planning and 62,233 PAC clients. Figures 10 and 11 show that the numbers of family planning clients and sterilizations increased each year of the global CA, although the aggregates do show a slight drop in FY 2000–2001, due to a change in the make-up of EngenderHealth's country portfolio and individual country strategies (discussed in detail later in this section).

Figure 12A shows the proportion of clients reported by region, and Figure 12B shows the proportion of funds expended, by region. These last two charts closely resemble each other in proportion, although the West Africa region reports fewer clients served than funds expended compared with the other regions.

Figure 10. Number of family planning clients reported, 1998–2003



⁹⁹ Family planning services data were reduced by 20% during FY 99/00 to account for the 15-month period.

Figure 11. Number of sterilization clients reported (male and female), 1998–2003

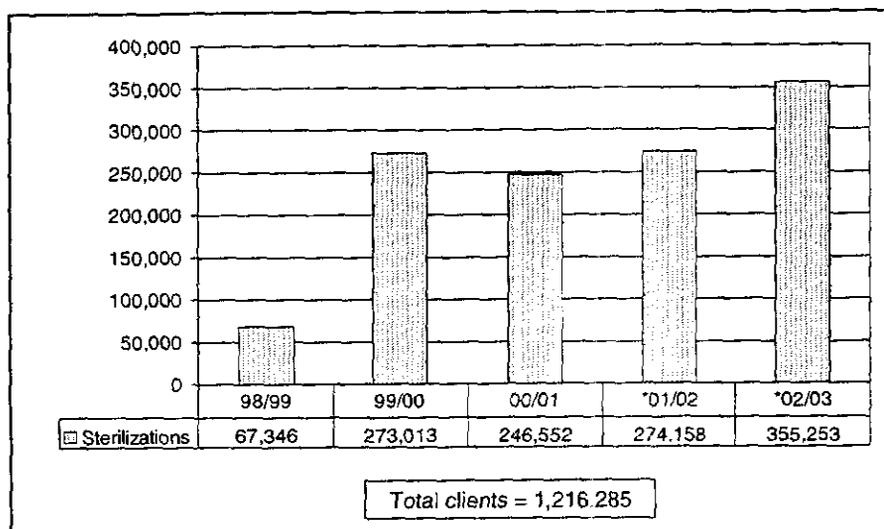


Figure 12A. Proportion of all clients reported served during 1998–2003, by region

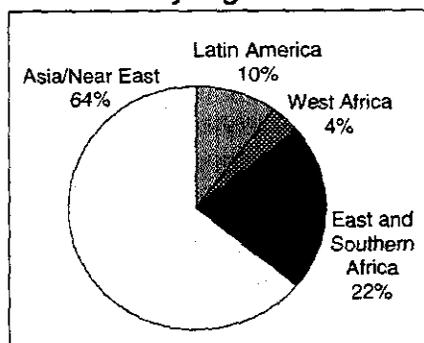
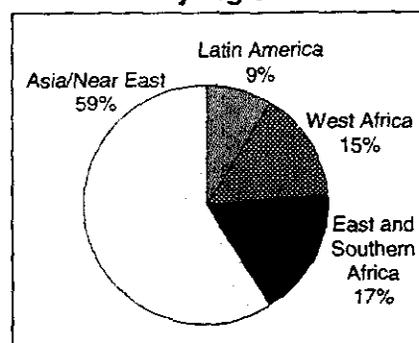


Figure 12B. Proportion of all funds expended during 1998–2003, by region



EngenderHealth reported our service statistics annually to USAID through the use of the Integrated Management Information System (IMIS), which we designed in FY 1998–1999 as a Microsoft Access database, with all staff having access via the agency’s intranet using Active Server Pages as a platform. All country, global, and support programs used IMIS to develop and submit their annual work plans and budgets, as well as programmatic data on a quarterly basis. When local institutions entered into subagreements with EngenderHealth, they became subgrantees of the program. Under subagreements, subgrantees reported their activities, results, and financials using standard formats and protocols that EngenderHealth offices in the field used to enter the data into IMIS. In the absence of subagreements, our programs were still required to report data, which they collected, where possible, through site visits and telephone calls. As a result, our aggregate data had varied sources.

The design and implementation of IMIS taught us valuable lessons that will inform future revisions to our management information systems. One of these lessons was that our service statistics have limitations that must be accounted for in data analysis and reporting.

- Without subagreements, EngenderHealth had no leverage to collect data. While some of our program managers were successful in collecting data informally in the absence

- of subagreements, others had more difficulty and were dependent on the willingness of the MOH or other institutions to provide data to us. Therefore, in some cases, our data may not be fully representative of the programs that we support.
- *The country portfolio changed annually.* This was particularly relevant when our portfolio lost countries with large populations that were farther along in the demographic transition (e.g., Indonesia), while adding countries with smaller populations that were at an earlier phase of the transition (e.g., Cambodia). The result was:
 - Large fluctuations in data reported from year to year, depending on the make-up of the portfolio
 - Skewed aggregates that gave a false picture of the actual norm
 - *PAC data collection was affected by constraining factors beyond EngenderHealth's influence.* Indeed, a 2001 USAID-funded evaluation of the overall USAID PAC program found that in general, PAC data across countries are difficult to collect, creating a "critical need" for data to assess impact.¹⁰⁰ Although we did collect PAC data, which are included in the regional analyses below, EngenderHealth's experience mirrored many of the challenges highlighted in the USAID evaluation. Through site visits and evaluations, we found that systemic challenges limited our ability to fully report indicators of our PAC work, which included the number of postabortion clients treated with MVA and dilation and curettage procedures and the proportion of clients receiving postabortion family planning services. Major limitations were as follows:
 - Recordkeeping systems at sites (many times, logs) were often inconsistent or illegible, making data collection and analysis difficult.
 - Providers and hospital administrators may not have felt ownership of the data, seeing the data as a requirement rather than as useful for programming purposes.
 - Women did not always receive family planning methods in the treatment ward, but were referred elsewhere (e.g., an outside clinic or family planning ward). As a result, a woman's choice of method may not be documented in the treatment ward immediately after the procedure.
 - Providers or administrators may have seen family planning counseling as unnecessary to report, as it is a routine part of the total PAC service.

SERVICES AND SITES

This subsection presents an analysis of country program outputs, including the use of family planning and PAC services,¹⁰¹ total EngenderHealth-supported sites, and total funds expensed over the period of the CA. We define an "EngenderHealth-supported site" as one that provides family planning or reproductive health services and that received any technical or financial assistance from our country or global program staff.

Our programs collected numbers of clients served by method, including male and female sterilization, IUDs, implants, and injectables. What is most apparent in annual service statistic aggregates is the effect that a single country's data can have on overall totals. Moreover, data fluctuations consistently result from changes in the external environments in which we operate, changes over which we have little control.

For these reasons, we first provide an overview of the data for each region, examining trends by service type, and we attribute any fluctuations in the trends to particular country

¹⁰⁰ Cobb, L., et al. 2001. *Global evaluation of USAID's postabortion care program*. Washington, DC: The Population Technical Assistance Project.

¹⁰¹ Not all PAC data are attributed to USAID support, as EngenderHealth does not differentiate between USAID-funded and non-USAID funds for PAC services.

programs, where appropriate. Following, we provide a synopsis of the data for each country and identify specific reasons for the fluctuations identified in the preceding trends section. Our objective is to use our service statistics to present a clear, data-driven picture of how our programs increased access to a range of family planning and PAC services over the five-year period of EngenderHealth's global CA. This information, and the data in the case studies in Section Two of this report, show the results of EngenderHealth's work over the life of the global CA.

ASIA AND THE NEAR EAST

Regional Analysis

From 1998 to 2003, eight Asian and Near East countries—Bangladesh, Cambodia, India, Indonesia, Jordan, Nepal, the Philippines, and Turkey—reported serving 1,282,052 family planning clients (Table 28). The greatest proportion of clients served was for sterilization, which accounts for 81% of the total. Table 26 shows the range of family planning methods reported by these country programs from EngenderHealth-supported sites.

- *Female Sterilization.* Over the life of the global CA, EngenderHealth reported more than 1 million female sterilization clients in the Asia and Near East region. These figures increased in each year except FY 2000–2001. That decrease can be accounted for by the loss of Indonesia from the portfolio and because of a shift in strategy in the Philippines. Each year, India¹⁰² accounted for the largest proportion of the total.
- *Vasectomy.* A total of 39,433 vasectomy clients were reported from all Asian and Near East countries except Jordan. These numbers increased each year except FY 1999–2000, due to a slight decrease in vasectomies reported by Nepal. During the final year of the CA, we saw a more than two-fold increase, attributable to the Bangladesh program, which began working with the government on revitalizing the sterilization program during the final years of the CA.
- *IUD.* In the Asia and Near East region, the total number of IUD services reported for the five years was 48,781. These data fluctuated throughout the five-year period, mainly due to reporting issues in Nepal and the Philippines. From FY 2000–2001 to FY 2001–2002, total IUD data increased by more than 4,000. This is primarily attributable to a change in the **Jordan** program strategy.
- *Implants.* Overall, Norplant implant utilization increased from FY 1998–1999 to FY 2002–2003, with a total of 12,581 implant clients served. **Nepal** was the only country to consistently report these data, and **Bangladesh** began to report data during the last year of the CA.
- *Injectables.* Injectable data fluctuated throughout the five-year period, with the majority of clients reported from the **Cambodia** and **Nepal** programs.
- *Postabortion care.* The majority of the PAC services reported were from the **Philippines** Prevention and Management of Abortion and its Complications (PMAC) program. In FY 2001–2002, **Bangladesh** and **Nepal** reported PAC services for the first time. The Nepal program initiated PAC services at three private hospitals, and reported services from them. However, as this was a one-year grant of limited private funds, services were not reported the following years. The Bangladesh program reported trainings and began supporting services in FY 2001–2002 under the USAID-funded service-delivery project for sterilization and other clinical family planning methods. This effort continued the following year but the PAC services decreased due to a change in the type of service sites and funding.

¹⁰² India reported state-wide (Uttar Pradesh) totals.

Table 26. Range of family planning methods and PAC procedures reported, by country, Asia and the Near East (1998–2003)

Country	Vasectomy	Female sterilization			IUD		Implant	Injectables	PAC	
		Interval	Post-partum	Cesarean section	Interval	Post-partum			MVA	D&C
Bangladesh	✓	✓	✓		✓		✓		✓	
Cambodia	✓	✓		✓	✓			✓		
India	✓	✓								
Indonesia		✓	✓						✓	
Jordan		✓		✓	✓	✓	✓	✓		
Nepal		✓			✓	✓	✓	✓	✓	✓
Philippines	✓	✓	✓		✓				✓	✓
Turkey ¹	✓	✓	✓							

¹ Although no service statistics are available for EngenderHealth supported sites only, Turkey sites also supported IUD, implant and injectables during the life of the CA, and reported national level data, which are not presented.

Country Analysis

Throughout the period of the global CA, the **Bangladesh** program reached 58,434 family planning clients. For the first three years of the global CA, the Bangladesh program provided technical assistance to service sites under the Quality Improvement Project, a separate bilateral agreement. Although the sites are reported in Table 28, the service statistics generated from these sites were reported to the government of Bangladesh and to the project donors, and thus are not reported here.

Prior to the global CA, sterilization acceptance was declining in Bangladesh, despite significant unmet need for family planning. In 2000, the government of Bangladesh and USAID/Bangladesh commissioned EngenderHealth to conduct an assessment of sterilization services. Following the assessment, EngenderHealth worked with the government of Bangladesh to implement a sterilization revitalization strategy for the remaining period of the global CA. (For more information, see the Bangladesh case study, p. 15.) As a result of this work, EngenderHealth increased the number of sites receiving support, and reported increased sterilization use and access to IUDs and implants.

EngenderHealth's **Cambodia** program, the Reproductive and Child Health Alliance (RACHA), reported 72,735 family planning clients served over the life of the CA. These figures exclude temporary methods delivered through RACHA's community-based distribution work, which has also delivered significant services (Table 27). This program also provides maternal and child health services, such as distribution of oral rehydration solution and iron tablets.

Table 27. Service and site statistics for community-based distribution (CBD) work in Cambodia

Year	CBD sites	Services	
		Condom	PIH ¹
FY 2000–2001	800	8,347	57,781
FY 2001–2002	1,450	16,665	78,424
FY 2002–2003	1,580	33,310	102,500

¹ Includes a 10% credit for CBD commodities distributed through the MOH logistics system. Injectable data delivered through this program is included in Table 28.

Cambodia reported substantial increases in female sterilization use during the final two years of the global CA. A major reason for this was that the program implemented a large-scale communications campaign through community and health facility providers. In addition, the program trained 69 providers in ML/LA in FY 2002–2003, making sterilization services more widely available. Cambodia also showed an increase in IUD services in the last two years, mainly influenced by a communications program and by increased technical assistance in training and service delivery at MOH sites. Vasectomy was the one service that declined, decreasing by about half from FY 2001–2002 to FY 2002–2003. The earlier level was attributable primarily to a 2001 pilot campaign that offered free vasectomy services; while the pilot project demonstrated that a considerable demand for vasectomy services existed, offering services for free could not be sustained, so utilization decreased.

Since 1995, EngenderHealth has provided technical assistance to USAID's IFPS Project in **India**, which aims to reduce fertility and increase contraceptive prevalence through improved quality, access, and demand for family planning and other related reproductive health services in IFPS districts in Uttar Pradesh. EngenderHealth worked to assess and strengthen health facilities, as well as to upgrade and expand provider clinical skills in several sterilization methods, in IP, in IUD insertion and removal, in management of RTIs and STIs, and in counseling skills. Since 1998, the India program supported services to 912,116 family planning clients.¹⁰³ Since EngenderHealth served in a technical assistance role, it did not have the leverage to collect data and had to rely on IFPS to supply service statistics for IMIS. The final year of the global CA was the only year in which we were able to obtain breakdowns of male and female sterilizations. The sterilization data show an upward trend each year under the CA.

In **Indonesia** during the first two years of the global CA, EngenderHealth served 6,643 family planning clients. Although sites were reported for the first three years of the CA, services were only reported during the second year of the project. This was because EngenderHealth became a subcontractor to Pathfinder on a bilateral project in mid-2000, and thus was unable to access services data. EngenderHealth did do some PAC work during this time period with Packard funds.

EngenderHealth has been working in **Jordan** for more than two decades to establish, strengthen, and expand sustainable provision of LTP methods. Much of the work in Jordan has been conducted in partnership with the MOH, the Royal Medical Services, and the Jordanian Association for Family Planning and Protection. During the period of the global CA, supported services for 22,616 clients. Although the number of sites reported remained fairly stable throughout the CA, the total number of clients served rose almost each year, with the IUD as the most commonly reported method, followed by injectables and female sterilization. The large proportion of IUD users can be attributed to Jordan's technical assistance in family planning counseling and IP practices to the public sector's Comprehensive Postpartum Project.

The number of clients reported declined slightly during the final year of the CA. A large proportion of this decline was attributable to a decline in IUD services. The reason for this was that the MOH decided to conduct an HIV/STI study in FY 2001–2002 at Al-Bashir Hospital, one of the largest family planning sites in Jordan. The MOH conducted the study in the hospital's postpartum clinic, inside the room where IUD insertions usually take place. As a result, access to IUDs declined, resulting in lower numbers reported.

¹⁰³ All data are state-wide (Uttar Pradesh).

The **Nepal** program delivered services to 107,756 family planning clients during the period of the global CA. Almost all service statistics for the Nepal program began to fall consistently in FY 2001–2002. One reason for this was underreporting by physicians at sites included in the *Pariwar Swathya Sewa Network* (a network of private-practice physicians), who were reluctant to send complete reports to EngenderHealth due to potential tax implications of the financial information. Another was that in 2002, EngenderHealth ceased to support the *Family Planning Association of Nepal* because of the reinstatement of the *Mexico City Clause*. Finally, in 2002, EngenderHealth became a subcontractor to JSI under USAID/Nepal's new bilateral, the *Nepal Family Health Program*. As a result, Nepal Family Health Program sites and service statistics were reported by JSI, and EngenderHealth only supported one site (*Kalimati Clinic*) with USAID field-support funds.

Throughout the period of the global CA, the **Philippines** reached 85,643 family planning and 26,812 PAC clients. From 1995 to 1999, EngenderHealth worked in the Philippines with the DOH under the *Local Government Unit Performance Program (LPP)*, and consistently reported high numbers of clients served as a direct result of a reporting system—one that EngenderHealth helped institutionalize. However, with the end of the LPP project in 1999, our ability to leverage service statistics without the subagreement mechanism proved difficult. The number of local government units that reported sterilization data diminished such that from FY 1999–2000 to FY 2000–2001, the number of sterilization clients had declined by half. (For a full discussion of this program, see the *Philippines case study*, p. 46.)

Throughout the final three years of the global CA, EngenderHealth continued to provide technical and financial support to the DOH hospitals. Despite the change in program strategy, over the past year, the number of vasectomy clients reported doubled. This increase was the result of an increase in on-site NSV training, an increase in new sites providing NSV services (rural and municipal health centers), training and equipping of itinerant teams, and the implementation of demand-generation activities (e.g., community assemblies, men's forums, and advocacy).

PAC services reported in the **Philippines** increased each year since the program began in FY 2000–2001. This steady rise in services was primarily the result of an intensive effort in 2001 to train providers, implement services, and launch an awareness campaign directed at promoting PAC services. In addition, we provided technical support to these sites in record keeping and data collection, which was reflected in our ability to report number of procedures performed for PAC, and percent of clients counseled and leaving the facility with a family planning method.

EngenderHealth worked in **Turkey** from 1974 to 2002 to increase access to quality LTP methods. (For a full discussion of this program, see the *Turkey case study*, p. 60.) During the period of the global CA, the EngenderHealth program served 16,109 clients. These data are an estimate of services and exclude IUD, implant and injectable data. This is because Turkey relied on reports from the MOH rather than on subagreements. As a result, the only data available for EngenderHealth reporting were sterilization data from public-sector sites that EngenderHealth supported. The majority of the data showed declines over time, mainly because the number of EngenderHealth-supported sites also declined over time, during a period when USAID was phasing out its family planning and reproductive health program in Turkey. EngenderHealth closed its office in Turkey in March 2002.

Table 28. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expended to the global CA, by country and by year, Asia and the Near East

	Bangladesh ¹	Cambodia ²	India ³	Indonesia	Jordan	Nepal	Philippines	Turkey ⁴	Totals
Female Sterilization									
FY 98/99	0	0	0	0	66	3,086	27,200	3,603	33,955
FY 99/00	0	99	194,776	6,489	543	2,986	28,763	4,104	237,760
FY 00/01	0	375	197,332	0	1,050	2,329	11,554	4,387	217,027
FY 01/02	2,881	216	224,057	0	881	970	10,039	1,288	240,332
FY 02/03	8,870	1,050	294,555	0	787	0	3,452	0	308,714
Total	11,751	1,740	910,720	6,489	3,327	9,371	81,008	13,382	1,037,788
Vasectomy									
FY 98/99	0	0	0	0	0	3,484	130	756	4,370
FY 99/00	0	7	0	154	0	3,175	160	700	4,196
FY 00/01	0	81	0	0	0	4,047	0	1038	5,166
FY 01/02	5,164	714	0	0	0	1,176	196	233	7,483
FY 02/03	16,044	330	1396	0	0	0	448	0	18,218
Total	21,208	1,132	1,396	154	0	11,882	934	2,727	39,433
IUD									
FY 98/99	0	0	0	0	0	4,472	0	0	4,472
FY 99/00	0	0	0	0	0	3,335	3,701	0	7,036
FY 00/01	0	554	0	0	346	2,600	0	0	3,500
FY 01/02	0	697	0	0	4,415	2,787	0	0	7,899
FY 02/03	20,656	1,166	0	0	4,039	13	0	0	25,874
Total	20,656	2,417	0	0	8,800	13,207	3,701	0	48,781
Implant									
FY 98/99	0	0	0	0	32	2,393	0	0	2,425
FY 99/00	0	0	0	0	39	2,413	0	0	2,452
FY 00/01	0	0	0	0	26	1,366	0	0	1,392
FY 01/02	0	0	0	0	116	1,286	0	0	1,402
FY 02/03	4,819	0	0	0	65	26	0	0	4,910
Total	4,819	0	0	0	278	7,484	0	0	12,581
Injectables									
FY 98/99	0	0	0	0	0	0	0	0	0
FY 99/00	0	9,193	0	0	1,779	20,900	0	0	31,872
FY 00/01	0	8,893	0	0	1,708	20,900	0	0	31,501
FY 01/02	0	20,000	0	0	3,413	18,722	0	0	42,135
FY 02/03	0	29,360	0	0	3,311	5,290	0	0	37,961
Total	0	67,446	0	0	10,211	65,812	0	0	143,469
Total FP Clients									
FY 98/99	0	0	0	0	98	13,435	27,330	4,359	45,222
FY 99/00	0	9,299	194,776	6,643	2,361	32,809	32,624	4,804	283,316
FY 00/01	0	9,903	197,332	0	3,130	31,242	11,554	5,425	258,586
FY 01/02	8,045	21,627	224,057	0	8,825	24,941	10,235	1,521	299,251
FY 02/03	50,389	31,906	295,951	0	8,202	5,329	3,900	0	395,677
Total	58,434	72,735	912,116	6,643	22,616	107,756	85,643	16,109	1,282,052

(continued)

Table 28. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expended to the global CA, by country and by year, Asia and the Near East (continued)

	Bangladesh ¹	Cambodia ²	India ³	Indonesia	Jordan	Nepal	Philippines	Turkey ⁴	Totals
PAC									
FY 98/99	0	0	0	0	0	0	0	0	0
FY 99/00	0	0	0	0	0	0	0	0	0
FY 00/01	0	0	0	0	0	0	6,400	0	6,400
FY 01/02	173	0	0	0	0	206	9,321	0	9,700
FY 02/03	66	0	0	0	0	0	11,091	0	11,157
Total	239	0	0	0	0	206	26,812	0	27,257
Sites									
FY 98/99	74	0	169	14	26	168	194	239	884
FY 99/00	299	108	449	81	45	190	197	605	1974
FY 00/01	303	200	449	84	43	198	32	54	1363
FY 01/02	22	199	487	0	48	259	43	57	1115
FY 02/03	153	195	531	0	48	1	78	0	1006
Total Funds Expended to the Global CA (Not final audited figures)									
FY 98/99	0	1,731,016	583,903	36,014	477,378	802,943	966,481	63,162	4,660,897
FY 99/00	0	3,597,407	1,493,447	18,292	843,931	1,499,929	1,082,902	902,886	9,438,794
FY 00/01	0	3,244,695	1,081,125	0	803,465	768,244	514,912	645,642	7,058,083
FY 01/02	494,843	2,962,677	893,138	0	558,931	522,242	686,435	584,890	6,703,156
FY 02/03	1,278,280	3,596,205	941,763	0	553,707	234,763	1,051,096	0	7,655,814
Total	1,773,123	15,132,000	4,993,376	54,306	3,237,412	3,828,121	4,301,826	2,196,580	35,516,744

¹ Bangladesh provided technical assistance to service sites under the Quality Improvement Project, a separate bilateral agreement, for the first three years of the global CA.

² Site data for Cambodia do not include privately supported CBD sites; injectable data were delivered through these sites.

³ Female sterilization figures represent a combined total of the number of clients served for female sterilization and vasectomy in Uttar Pradesh, India, for years 2-4; Year 5 was the first year in which these data were disaggregated by male and female sterilization.

⁴ Turkey data differ from past USAID Annual Report figures, which represented national-level data. The data in this report are for EngenderHealth-supported sites only. Year 4 data only contain figures up to March 2002, when the Turkey program was closed as USAID phased out activities in Turkey.

EAST AND SOUTHERN AFRICA

Regional Trends

From 1998 to 2003, five East and Southern Africa countries—Kenya, Malawi, South Africa, Tanzania, and Uganda—reported serving 447,377 family planning and 14,673 PAC clients during the five-year period (Table 30). Tanzania accounted for the majority of family planning clients and Tanzania and Kenya accounted for the majority of PAC clients. Although Ethiopia did not expense funds to the global CA, we included them in the analysis because of the USAID-funded work supported through the PVO Networks project.¹⁰⁴ South Africa only reported site data, as most of their work was MAP-related. Table 29 shows the range of family planning methods that these country programs reported from EngenderHealth-supported sites.

- **Female sterilization.** The regional aggregates for female sterilization peaked in the first year of the project, mainly because of strong programs in Kenya and Tanzania. With time, these two programs changed in nature and scope. The Kenya program changed its family planning work to the bilateral portfolio in the final two years of the project, and Tanzania underwent governmental restructuring that resulted in fluctuating amounts of data reported.

¹⁰⁴ This consortium project is implemented by ADRA, CARE, Path, Plan International, and Save the Children.

Table 29. Range of family planning methods and PAC procedures reported, by country, East and Southern Africa (1998–2003)

Country	Vasectomy	Female sterilization			IUD		Implant	Injectable	Postabortion care	
		Interval	Post-partum	Cesarean section	Interval	Post-partum			MVA	D&C
Ethiopia	√	√	√	√	√		√	√		
Kenya		√			√	√			√	
Malawi	√	√	√	√			√			
South Africa										
Tanzania	√	√	√	√	√	√	√	√	√	√
Uganda		√	√						√	√

- *Vasectomy.* The vasectomy aggregate is very small. Tanzania is the main contributor to the total, and their data, although low in numbers, are consistently reported throughout the entire five-year period.
- *IUD.* Tanzania and Ethiopia are the major contributors to the IUD aggregates, with Ethiopia reporting impressively high figures in the final year of the global CA, compared with the other countries in the region.
- *Implant.* Norplant implants were a large proportion of the total clients in the first several years of the CA, but provision of this method dropped off considerably, particularly in Tanzania, in the last years of the CA.
- *Injectable.* Almost all injectable data were reported by **Tanzania**.
- *Postabortion care.* Before ending, the **Kenya** field-support program reported a substantial number of PAC clients served. The **Tanzania** program continued to provide increasing services to PAC clients.

Country Analysis

In FY 2001–2002, EngenderHealth provided technical assistance in PAC and QI in Ethiopia through the PVO Networks Project during the final two years of the global CA. In this short time period, the program reported serving 14,033 clients.

Our work in **Kenya** during the global CA was funded with USAID field-support funds until 2000. This work laid the foundation for the bilateral USAID project, AMKENI, which is being led by EngenderHealth.¹⁰⁵ The project spans the period 2001–2006 and is focused on increasing utilization of facility-based, integrated family planning, reproductive health, and child survival services. (For a full discussion of the Kenya work funded through field-support, see the Kenya case study, p. 31.)

The **Malawi** program reported 17,068 family planning clients served for female sterilization, vasectomy, and implants throughout the CA. As the Malawi case study points out, the clinical family planning program was traditionally focused on female sterilization. Over time, hormonal methods began to replace sterilization as the range of family planning methods increased (see Malawi Case Study, p. 36). In EngenderHealth's case, we were able to provide increasing amounts of implants, due in large part to an increase in supplies through the public sector.

¹⁰⁵ Partners are FHI, PATH, and Intrah.

There are no family planning or PAC services data to report for **South Africa**. In this program, USAID field support was used to implement a MAP program that emphasized men's constructive involvement in family planning and reproductive health.

EngenderHealth worked in **Tanzania** during the period of the global CA to expand LTP method services through private not-for-profit organizations and the MOH. (For a full discussion of this program, see the Tanzania case study, p. 53.) The program reported serving 381,522 family planning and 7,854 PAC clients.

Tanzania supported an increased number of sites throughout the five years, except for a decrease in FY 2001–2002, during which time we stopped support to Marie Stopes International due to the reinstatement of the Mexico City policy. During the last year of the CA, the number of sites increased greatly as the program expanded to include new grantees, including the MOH and two faith-based organizations, the Seventh-Day Adventist Church and the Evangelical Lutheran Church in Tanzania. This new programmatic structure has proven successful, and we have seen a rebound in every type of service reported except vasectomy.

In **Uganda**, EngenderHealth supported services for 6,552 family planning clients during the first two years of the global CA. Some PAC work did occur during the latter part of the CA, although this work was not funded through field support.

Table 30. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expended to the global CA, by country and by year, East and Southern Africa

	Ethiopia ¹	Kenya ²	Malawi	South Africa	Tanzania	Uganda	Totals
Female Sterilization							
FY 98/99	0	5,418	0	0	12,933	3,135	21,487
FY 99/00	0	4,138	1,442	0	11,961	1,037	18,578
FY 00/01	0	1,493	3,526	0	10,189	0	15,208
FY 01/02	222	0	4,214	0	9,283	0	13,719
FY 02/03	535	0	4,145	0	12,456	0	17,136
Total	757	11,049	13,327	0	56,822	4,173	86,128
Vasectomy							
FY 98/99	0	141	0	0	176	96	413
FY 99/00	0	66	0	0	38	37	140
FY 00/01	0	10	8	0	39	0	57
FY 01/02	22	0	10	0	92	0	124
FY 02/03	4	0	13	0	74	0	91
Total	26	217	31	0	419	133	625
IUD							
FY 98/99	0	250	0	0	1,933	0	2,183
FY 99/00	0	37	0	0	1,039	0	1,076
FY 00/01	0	18	0	0	1,001	0	1,019
FY 01/02	1,194	0	0	0	498	0	1,692
FY 02/03	1,575	0	0	0	956	0	2,531
Total	2,769	305	0	0	5,427	0	8,501

(continued)

Table 30. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expensed to the global CA, by country and by year, East and Southern Africa (continued)

	Ethiopia ¹	Kenya ²	Malawi	South Africa	Tanzania	Uganda	Totals
Implant							
FY 98/99	0	7,207	0	0	5,977	1,149	14,333
FY 99/00	0	6,579	89	0	7,943	1,098	15,709
FY 00/01	0	2,845	680	0	6,934	0	10,459
FY 01/02	519	0	922	0	2,271	0	3,712
FY 02/03	1,046	0	2,019	0	2,931	0	5,996
Total	1,565	16,631	3,710	0	26,056	2,247	50,209
Injectables							
FY 98/99	0	0	0	0	60,639	0	60,639
FY 99/00	0	0	0	0	53,999	0	53,999
FY 00/01	0	0	0	0	40,710	0	40,710
FY 01/02	8,916	0	0	0	23,188	0	32,104
FY 02/03	0	0	0	0	114,262	0	114,262
Total	8,916	0	0	0	292,798	0	301,714
Total FP Clients							
FY 98/99	0	13,016	0	0	81,658	4,381	99,055
FY 99/00	0	10,820	1,531	0	74,980	2,171	89,502
FY 00/01	0	4,366	4,214	0	58,873	0	67,453
FY 01/02	10,873	0	5,146	0	35,332	0	51,351
FY 02/03	3,160	0	6,177	0	130,679	0	140,016
Total	14,033	28,202	17,068	0	381,522	6,552	447,377
Total PAC Clients							
FY 98/99	0	3,035	0	0	0	0	3,035
FY 99/00	0	2,000	0	0	0	0	2,000
FY 00/01	0	578	0	0	1,721	792	3,091
FY 01/02	0	0	0	0	1,323	414	1,737
FY 02/03	0	0	0	0	4,810	0	4,810
Total	0	5,613	0	0	7,854	1,206	14,673
Sites							
FY 98/99	0	100	0	0	110	25	235
FY 99/00	0	94	31	34	116	25	300
FY 00/01	0	86	33	0	116	11	246
FY 01/02	13	0	33	0	89	11	146
FY 02/03	71	0	33	0	127	0	231
Total Funds Expensed to the Global CA (in U.S. dollars) (Not final audited figures)							
FY 98/99	0	502,130	0	0	882,862	225,421	1,610,413
FY 99/00	0	1,565,027	1,049,453	154,160	668,109	161,081	3,597,830
FY 00/01	0	222,262	183,016	146,087	751,553	0	1,302,918
FY 01/02	41,067	285,736	406,502	169,758	807,606	0	1,710,669
FY 02/03	15,167	130,964	506,683	175,787	1,386,760	0	2,215,361
Total	56,234	2,706,119	2,145,654	645,792	4,496,890	386,502	10,437,191

¹ Ethiopia funds in PVO Networks project for FY 01/02 and 02/03

² Kenya services data differ from what was reported in previous Annual Reports. The data source for these is the final report, EngenderHealth/Kenya: *End of Project Summary Report (1995 - 2000)*; In last 2 years of program, 4 funds account for these totals: 408-PAC Kenya Core, 628-MAP AFR Bureau, 622-Kenya CS, and 623-REDSO/ESA.

Table 31. Range of family planning methods and PAC procedures reported, by country, West Africa

Country	Vasectomy	Female sterilization			IUD		Implant	Injectable	Postabortion care	
		Interval	Post-partum	Cesarean section	Interval	Post-partum			MVA	D&C
Ghana	√	√	√	√			√			
Guinea		√	√	√						
Nigeria	√	√	√	√	√	√	√	√	√	
Senegal									√	√

WEST AFRICA

Regional Trends

From 1998 to 2003, four West African countries—Ghana, Guinea, Nigeria, and Senegal—reported serving 76,366 family planning clients during the five-year period (Table 32). Table 31 shows the family planning methods that these country programs reported from EngenderHealth-supported sites.

- *Female sterilization.* West Africa reported 15,940 female sterilization clients. Female sterilization levels rose in **Ghana** and **Nigeria** every year except the final year of the CA, while other long-term methods rose continuously during the same period, suggesting a client preference for less permanent alternatives to sterilization.
- *Vasectomy.* Vasectomy is not a popular method in any of the West African countries. However, our Ghana program did report increasing levels of vasectomy during the CA, and their figures account for almost the entire amount of clients reported. (For a full discussion of this program, including vasectomy work, see the Ghana case study, p. 26.)
- *IUD.* Nigeria accounts for all IUDs reported in the West African region.
- *Implants.* Ghana and Nigeria reported all Norplant implants in the West African region. Both programs reported increased numbers of clients receiving Norplant implants throughout the entire CA period.
- *Injectable.* Nigeria was the only program to report serving injectable clients.
- *Postabortion care.* Small PAC programs were implemented in **Nigeria** and **Senegal**, and both countries reported small numbers of clients served. Senegal services increased each year, while the Nigeria PAC program just began in the final year of the CA.

Country Analysis

The **Ghana** program was supported through field-support over the life of the CA. In addition, EngenderHealth had a CA in Ghana since 1994, the funding of which complemented field-support activities. The program reported 50,510 family planning clients during the five-year period. The total number of sites supported increased over time, although it decreased slightly in the final year of the CA, during which trained health staff at four sites left and have not been replaced (See Ghana Case Study for discussion of high attrition rates to the UK and US, p. 26.)

The number of total clients reported also continuously increased over the five-year period. Note that proportions within the method mix changed. In FY 1998–1999, there were 1.5 sterilizations for every implant, but by year 5 there were four implants for each sterilization. This mix is interesting, since EngenderHealth's initial strategy was to develop an integrated Norplant-minilaparotomy training program, which enabled ser-

vices to be expanded to a large number of sites in a short time frame. In addition, EngenderHealth advocated for the MOH to allow nurses to perform Norplant implant insertions.

A new policy enacted in 1997 resulted in this change, and EngenderHealth began training nurses on a pilot basis in Norplant implant insertion in 1998. The program resulted in a decrease in clients' waiting time, which had been a key service-delivery barrier. Our Ghana staff postulates that other possible reasons for the popularity of the Norplant implant are the cost and reversibility in comparison to sterilization. The number of vasectomies in Ghana is small, but did rise in FY 2001–2002 following a Planned Parenthood vasectomy awareness campaign. In FY 2002–2003, the numbers dropped again after the campaign ended, due to a lack of funding. (A new campaign is being launched in 2003—see *Global Leadership: Men As Partners and Vasectomy*, p. 83.)

The **Guinea** program was small, with variable expenses from year to year. Despite low levels of funding, the program continued on a small scale and reported work in increased numbers of sites over time. However, our program was unable to consistently report services. The main reason for this was a lack of resources to enable staff to follow up with sites to collect data. During the final years of the program, the focus was on PAC work, and MVA services for PAC were reported in FY 2002–2003.

The field-support program in **Nigeria** operated in tandem with a bilateral project called VISION, managed by EngenderHealth. Although VISION reports data, they are excluded from this analysis, as VISION is not funded under the global CA. Nigeria's field-support program reported 25,672 family planning clients served. Overall, the number of clients reported increased each year, with the largest increase in FY 2001–2002. This increase was a function of strategy. In FY 2000–2001, the program focused on increasing demand for family planning services and on training service providers in clinical methods. By FY 2001–2002, an increase in client access to and demand for services resulted in the increased number of family planning clients reported. During the last year of the CA, Nigeria reported PAC data following EngenderHealth PAC training and their work in training subgrantees to collect PAC data through existing management information systems.

The largest share of expenditures in **Senegal** was in FY 1999–2000 when USAID/Senegal asked EngenderHealth to manage a matching-grant scheme to fund district-level health activities as part of a transition strategy between two bilaterals. This transition strategy came to an end in FY 2000–2001 upon the award of the bilateral, and the EngenderHealth program was downsized greatly, as can be seen by the drop in the number of sites. Although the program reported the sites it supported throughout the CA, they did not report any family planning services, as medical personnel were on strike for the first three years of the CA and did not collect any data. During the final years of the program, EngenderHealth conducted an operations research project with the MOH to pilot-test the feasibility of delivering PAC services to rural areas. The results are available in an EngenderHealth final report: *Taking Postabortion Care Services Where They Are Needed: An Operations Research Project Testing PAC Expansion in Rural Senegal* (February 2003).

Table 32. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expended to the global CA, by country and by year, West Africa

	Ghana ¹	Guinea	Nigeria	Senegal ²	Totals
Female Sterilization					
FY 98/99	2,550	167	20	0	2,737
FY 99/00	2,804	0	116	0	2,920
FY 00/01	3,069	0	324	0	3,393
FY 01/02	3,379	0	443	0	3,822
FY 02/03	2,705	17	346	0	3,068
Total	14,507	184	1,249	0	15,940
Vasectomy					
FY 98/99	9	0	7	0	16
FY 99/00	12	0	0	0	12
FY 00/01	14	0	0	0	14
FY 01/02	32	0	0	0	32
FY 02/03	10	0	2	0	12
Total	77	0	9	0	86
IUD					
FY 98/99	0	0	1,343	0	1,343
FY 99/00	0	0	24	0	24
FY 00/01	0	0	985	0	985
FY 01/02	0	0	4,454	0	4,454
FY 02/03	0	0	3,172	0	3,172
Total	0	0	9,978	0	9,978
Implant					
FY 98/99	1,850	0	0	0	1,850
FY 99/00	4,168	0	96	0	4,264
FY 00/01	7,445	0	110	0	7,555
FY 01/02	10,437	0	229	0	10,666
FY 02/03	12,026	0	386	0	12,412
Total	35,926	0	821	0	36,747
Injectables					
FY 98/99	0	0	0	0	0
FY 99/00	0	0	400	0	400
FY 00/01	0	0	1,221	0	1,221
FY 01/02	0	0	5,131	0	5,131
FY 02/03	0	0	6,863	0	6,863
Total	0	0	13,615	0	13,615
Total FP Clients					
FY 98/99	4,409	167	1,370	0	5,946
FY 99/00	6,984	0	636	0	7,620
FY 00/01	10,528	0	2,640	0	13,168
FY 01/02	13,848	0	10,257	0	24,105
FY 02/03	14,741	17	10,769	0	25,527
Total	50,510	184	25,672	0	76,366

(continued)

Table 32. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expensed to the global CA, by country and by year, West Africa (continued)

	Ghana ¹	Guinea	Nigeria	Senegal ²	Totals
Total PAC Clients					
FY 98/99	0	0	0	0	0
FY 99/00	0	0	0	0	0
FY 00/01	0	0	0	0	0
FY 01/02	0	0	0	121	121
FY 02/03	0	21	107	392	520
Total	0	21	107	513	641
Sites					
FY 98/99	97	4	36	46	183
FY 99/00	148	9	61	80	298
FY 00/01	179	26	48	92	345
FY 01/02	254	26	47	25	352
FY 02/03	250	49	42	23	364
Total Funds Expensed to the Global CA (in U.S. dollars) (Not final audited figures)					
FY 98/99	197,847	63,609	131,924	707,550	1,100,930
FY 99/00	229,752	149,679	633,520	2,104,242	3,117,193
FY 00/01	281,146	109,521	516,538	410,463	1,317,668
FY 01/02	417,347	0	925,960	-27,153	1,316,154
FY 02/03	818,546	228,530	1,088,961	125,111	2,261,148
Total	1,944,638	551,339	3,296,903	3,320,213	9,113,093

¹ Ghana funds in FY 2000–2001 were transferred to Ghana bilateral fund 761 (\$281,846). Data was incomplete as of report writing with several subgrantee reports still outstanding.

² Senegal FY 2001–2002 includes \$245,369 de-obligation of subagreement.

Note: Ghana data (1998–1999 to 2001–2002) have been revised since they were first reported in the USAID Annual Reports, based on data validation exercises and discussions between New York and the Ghana office.

THE AMERICAS

Regional Trends

From 1998 to 2003, four Latin American countries—Bolivia, Dominican Republic, Guatemala, and Honduras—reported serving 200,874 family planning and 19,662 PAC clients during the five-year period (Table 34). Note that a peak occurred in FY 2001–2002, mostly attributable to the **Bolivia** program, which accounted for about 70% of the all family planning clients and 90% of total sites. The reasons for this are described below, and the full program is discussed in detail as a case study in Section Two of this report. Table 33 shows the range of family planning methods that these country programs reported from EngenderHealth-supported sites.

- *Female sterilization.* The Latin American countries reported approximately 35,869 female sterilization clients during the five-year period, with a peak in FY 1999–2000. This peak was mainly due to **Guatemala**, which became folded into a consortium the following year, causing reported services to fall. Levels rose again in FY 2001–2002 because of changes in the structure of the **Bolivia** program.
- *Vasectomy.* Our Latin American programs reported only 253 vasectomies during the five-year period. The largest contributor to the total was **Guatemala**.
- *IUD.* The programs reported approximately 59,410 IUD clients. Each year, the services remained fairly constant until FY 2001–2002, when **Bolivia** reported increased volume due to changes to their program and a shift in data source.

Table 33. Range of family planning methods and PAC procedures reported, by country, Latin America

Country	Vasectomy	Female sterilization			IUD		Implant	Injectable	Postabortion care	
		Interval	Post-partum	Cesarean section	Interval	Post-partum			MVA	D&C
Bolivia	√	√	√		√	√		√		
Dominican Republic	√	√	√	√	√	√	√	√	√	√
Guatemala	√	√	√		√	√			√	√
Honduras		√	√	√	√	√			√	√

- *Implants.* The **Dominican Republic** reported providing approximately 1,944 Norplant implants and was the only program to report this type of service. Their reporting began at the midpoint of the five-year period and decreased sharply over time.
- *Injectable.* Approximately 103,398 injectables were reported by the Latin American programs. **Bolivia** reported the lion's share of these data beginning in FY 2000–2001.
- *Postabortion care.* Our Latin American countries reported supporting approximately 19,662 PAC clients with life-saving treatments (MVA and D&C) in cases where women presented at facilities after having illegal abortions or miscarriages. In addition to saving their lives, sites also provided crucial family planning services to these clients.

Country Data

In **Bolivia**, the total number of sites supported increased over time with a large jump in FY 2001–2002 as we expanded our work to serve as the lead agency addressing all aspects of contraceptive services nationwide. (For a full description of this program, see the Bolivia case study, p. 21.) The number of total clients reported decreased slightly in FY 2002–2003. A major reason for this was that the MOH had difficulties in maintaining adequate contraceptive supplies in facilities, including sterilization kits and IUDs. There was an increase in postpartum sterilization clients reported (disaggregates not shown in the table) due to a change in governmental insurance policy, which now covers female sterilization procedures up to six months postpartum.

EngenderHealth closed its office in the **Dominican Republic** in June 2003. The program provided support to a core set of facilities and to maintain the level of services. The total number of services reported peaked in FY 2000–2001. This was mainly the result of governmental policy that mandated hospitals and maternities to designate staff to validate data and compile service statistic reports for national reporting. However, in FY 2001–2002, the government stopped enforcing this policy, staff turned over, and EngenderHealth was unable to request data from the government-designated staff.

Throughout the final two years of the program, EngenderHealth made it a priority to advocate for the importance of validating data among new hospital supervisors, and repeatedly retrieved data reports to ensure consistent IMIS reporting. We saw a drop in reported services during the final year of the program because of continued data collection difficulties and incomplete fourth-quarter data. However, method proportions remained relatively constant during the two periods, indicating that services continued to be reported at approximately the same rate during the last several years of the program.

The EngenderHealth office in **Guatemala** expensed the majority of its funds in the second year of the CA. In the third and fourth years, the program shifted its family planning work under a consortium managed by University Research Corporation. As a result, the family planning data for this program was unavailable to EngenderHealth and was not reported in IMIS for FY 2000–2001 to FY 2002–2003.

Guatemala reported PAC data for the final two years of the project. Our PAC program began in October 2001 (work that was not funded through the global CA), and they collect PAC data, including MVA and D&C for PAC. However, the EngenderHealth-supported hospitals did not provide postabortion family planning methods to clients, arguing a lack of supplies from the MOH. They did provide postabortion family planning counseling to their clients, although they did not record these data, since they did not consider counseling as an activity requiring documentation.

The Honduras program reported sites in IMIS until FY 2001–2002, but not services. The primary reason for this was that there was no official MOH data collection system from which to obtain data. Over the past two years, EngenderHealth reported selected family planning and PAC data in IMIS by communicating with sites via telephone and site visits. However, some sites refused to provide EngenderHealth with data in the absence of direct financial support. During the final year of the project, the MOH worked with USAID and other CAs, including EngenderHealth, to develop standard data collection tools and processes for the country.

The largest site supporting MVA for PAC services was Escuela Hospital. At this hospital the PAC program was very successful. All of the ob-gyn residents are now trained to perform MVA for PAC, and this treatment has surpassed D&C for postabortion treatment during the last year. Although the EngenderHealth-supported sites did provide postabortion family planning counseling, they did not record this information and thus EngenderHealth cannot report it in IMIS.

Table 34. Number of family planning methods and PAC procedures reported, number of sites supported, and total funds expended to the global CA, by country and by year, Latin America

	Bolivia	Dominican Republic	Guatemala	Honduras	Totals
Female Sterilization					
FY 98/99	200	3,151	881	0	4,232
FY 99/00	311	3,709	5,387	0	9,407
FY 00/01	996	4,691	0	0	5,687
FY 01/02	2,369	4,527	0	1,648	8,544
FY 02/03	1,586	2,405	0	4,008	7,999
Total	5,462	18,483	6,268	5,656	35,869
Vasectomy					
FY 98/99	0	5	131	0	136
FY 99/00	0	0	0	0	0
FY 00/01	0	0	0	0	0
FY 01/02	95	7	0	0	102
FY 02/03	12	3	0	0	15
Total	107	15	131	0	253
IUD					
FY 98/99	1,512	1,511	977	0	4,000
FY 99/00	0	417	2,630	0	3,047
FY 00/01	0	2,297	0	0	2,297
FY 01/02	24,872	1,267	0	1,094	27,233
FY 02/03	18,892	807	0	3,134	22,833
Total	45,276	6,299	3,607	4,228	59,410

(continued)

**Table 34. Number of family planning methods and
PAC procedures reported, number of sites supported,
and total funds expended to the global CA, by country and by year,
Latin America (continued)**

	Bolivia	Dominican Republic	Guatemala	Honduras	Totals
Implant					
FY 98/99	0	0	0	0	0
FY 99/00	0	0	0	0	0
FY 00/01	0	1,100	0	0	1,100
FY 01/02	0	685	0	0	685
FY 02/03	0	159	0	0	159
Total	0	1,944	0	0	1,944
Injectables					
FY 98/99	0	0	3,464	0	3,464
FY 99/00	NA	0	NA	NA	NA
FY 00/01	0	830	0	0	830
FY 01/02	47,011	4,776	0	0	51,787
FY 02/03	42,833	4,484	0	0	47,317
Total	89,844	10,090	3,464	0	103,398
Total FP Clients					
FY 98/99	1,712	4,667	5,453	0	11,832
FY 99/00	311	4,126	8,017	0	12,454
FY 00/01	996	8,918	0	0	9,914
FY 01/02	74,347	11,262	0	2,742	88,351
FY 02/03	63,323	7,858	0	7,142	78,323
Total	140,689	36,831	13,470	9,884	200,874
Total PAC Clients					
FY 98/99	0	0	0	0	0
FY 99/00	0	0	0	0	0
FY 00/01	0	8,434	0	0	8,434
FY 01/02	0	4,487	241	1,477	6,205
FY 02/03	0	3,200	363	1,460	5,023
Total	0	16,121	604	2,937	19,662
Sites					
FY 98/99	7	10	20	0	37
FY 99/00	31	15	24	14	84
FY 00/01	150	15	0	12	177
FY 01/02	1,130	12	0	12	1,154
FY 02/03	1,130	10	4	16	1,160
Total Funds Expended to the Global CA (in U.S. dollars) (Not final audited figures)					
FY 98/99	12,236	180,035	130,430	19,491	342,192
FY 99/00	155,620	596,989	593,365	204,284	1,550,258
FY 00/01	300,846	33,370	155,173	256,766	746,155
FY 01/02	566,441	150,090	0	460,577	1,177,108
FY 02/03	775,884	252,567	0	541,152	1,569,603
Total	1,811,027	1,213,051	878,968	1,482,270	5,385,316

TRAINING

EngenderHealth's training approach was designed as a dynamic process that builds sustainable training capacity and strengthens and improves existing training systems, particularly trainers' ability to supervise and to provide ongoing technical assistance and follow-up to trainees. We organized training according to our whole-site training approach,¹⁰⁶ which is designed to meet the learning needs of all staff at a health care facility, and build local capacity by:

- Involving staff and supervisors in assessing site needs and planning to meet them
- Focusing on teams, not individuals
- Tailoring the level of training to the needs of different employees
- Conducting on-site training workshops to minimize disruptions in services
- Engaging local supervisors in the entire training process—from assessing site readiness and choosing trainees to selecting and adapting training materials and facilitating the workshops, or training trainers and site coaches to train other staff

In recognition of the limitations of direct training in terms of reach, cost, and sustainability, and to ensure that trainings are appropriate to each country and facility setting, the whole-site training approach was designed to be flexible in training type (e.g., orientations to new services or concepts, knowledge updates, and skills training) and location (e.g., on-the-job, on-site, and regional or central trainings). All of our trainings emphasized the importance of conducting the activity at or as close to the site level as possible to maximize the opportunities for trainees to sustain the application of knowledge and skills.

To increase cost-effectiveness, EngenderHealth worked to encourage our trainers and partners to address multiple content areas during trainings. As a result, our data collection system counts events and individuals trained, by the types of training. This means that numbers of events and individuals may be double-counted to ensure that we have captured all training types. Table 35 shows that over the course of the global CA, EngenderHealth trained approximately 153,000 individuals at approximately 17,800 events.

LESSONS LEARNED

Evidence of EngenderHealth performance should be measured against sustained funding. Table 36 shows the USAID budget by country for the period FY 1998–1999 through FY 2002–2003, and whether the number of sites has gone up or down for the time periods indicated. Over the period of the global CA, the USAID budget was stable or increased in 13 of 21 countries in the time periods indicated. In eight of these 13 countries, the number of sites also increased or remained constant. The USAID budget decreased in eight out of 21 countries in the time periods indicated; in five of these eight countries, the number of sites was stable or increased.

EngenderHealth reporting for the global CA can conflict with USAID Mission protocols, timelines, and requirements, causing heavy reporting burdens on our field staff. Our results framework and indicators may be very different from USAID Mission results frameworks and reporting requirements, against which the field offices also must report.

¹⁰⁶ Bradley, J., et al. 1998. Whole-site training: A new approach to the organization of training. *AVSC Working Paper No. 11*. New York: AVSC International.

IMIS must be adopted as a “monitoring” tool by our field staff to ensure that the data are as accurate as possible. We focused much of our effort on developing a database to report data into, with less effort put into helping our country programs understand IMIS requirements and into working with Partners to use data from national level data collection systems or other mechanisms in the absence of subagreements for management decision-making.

IMIS required too many indicators and disaggregations. Some programs began to use national reporting systems as their data source as they moved away from working through subagreements. These national management information systems do not always disaggregate data as we request. The different types of sterilizations, postpartum data, and postabortion family planning data are sometimes impossible to obtain from our data sources.

Table 35. Individuals trained and training sessions conducted during the CA, by category and by year

	Individuals Trained						Events Conducted					
	1998/1999	1999/2000	2000/2001	2001/2002 (global CA only)	2002/2003 (global CA only)	Totals	1998/1999	1999/2000	2000/2001	2001/2002 (global CA only)	2002/2003 (global CA only)	Totals
Training in clinical family planning methods												
ML/LA ¹	1,174	972	474	455	574	3,649	400	276	163	133	119	1,091
NSV	330	216	161	109	1,792	2,608	232	75	71	20	57	455
IUD/postpartum IUD insertion and removal	1504	1188	635	564	2,366	6,257	632	351	234	153	176	1,546
Norplant implant insertion and removal	232	421	311	261	1,290	2,515	94	85	80	61	60	380
Injectable	232	581	81	280	908	2,082	10	19	3	11	33	76
Trainings to support family planning												
General												
Family planning counseling	7,261	7,121	3,793	7,189	27,295	52,659	543	472	196	347	7,174	8,732
Informed choice	NA	176	1,417	829	4,437	6,859	NA	10	39	40	145	234
IP	4,718	5,869	3,202	3,255	10,839	27,883	364	305	190	135	497	1,491
IEC	1,085	1,209	329	NA	812	3,435	13	57	39	NA	193	302
Health management/ management information systems	NA	2,648	920	NA	427	3,995	NA	61	231	NA	70	362
Postabortion Care	550	5,167	2,058	497	1,467	9,739	32	270	148	39	83	572
QI												
Facilitative supervision	324	1,383	1,391	1019	1001	5,118	116	385	70	76	115	762
Cost Analysis Tool	NA	NA	NA	15	17	32	NA	NA	NA	1	2	3
COPE facilitation	1,007	4,159	2,291	2,195	2,820	12,472	130	273	192	158	179	932
HIV/STIs	2,727	2,265	1,066	1,148	886	8,092	144	141	72	110	176	643
MAP	NA	525	585	124	4,003	5,237	NA	42	19	6	104	171
Totals	21,144	33,900	18,714	17,940	60,934	152,632	2,710	2,822	1,747	1,290	9,183	17,752

¹ Includes minilaparotomy, assisting minilaparotomy, laparoscopy, and assisting laparoscopy.² Includes NSV and assisting in NSV.³ Includes medical monitoring and whole-site training.⁴ Includes STI/RTI diagnosis and treatment, STI/RTI information and/or counseling, HIV/STI prevention, and sexuality training.

Table 36. Association between changes in USAID funding and changes in the number of EngenderHealth-supported sites

Country	Year 1 USAID expenses, FY 98/99	Year 2 USAID expenses, FY 99/00	Year 3 USAID expenses, FY 00/01	Year 4 USAID expenses, FY 01/02*	Year 5 USAID expenses, FY 02/03*	Time period (T ₁ to T ₂)	% change in USAID budget	% change in no. of EngenderHealth- supported sites	USAID \$ is up and no. of supported sites is up or constant	USAID \$ is up and no. of supported sites is down	USAID \$ is down and no. of supported sites is up or constant	USAID \$ is down and no. of supported sites is down
Asia/Near East												
Bangladesh	0	0	0	494,843	1,278,280	Yr 4 to Yr 5	158%	595%	X			
Cambodia	1,731,016	3,597,407	3,244,695	2,962,677	3,596,205	Yr 4 to Yr 5	21%	-2%		X		
India	583,903	1,493,447	1,081,125	893,138	941,763	Yr 4 to Yr 5	5%	9%	X			
Indonesia	36,014	18,296	0	0	0	Yr 1 to Yr 2	-49%	479%			X	
Jordan	477,378	843,931	803,465	558,931	553,707	Yr 4 to Yr 5	-1%	Same			X	
Nepal	802,943	1,499,929	768,244	522,242	234,763	Yr 4 to Yr 5	-55%	-100%				X
Philippines	966,481	1,082,902	514,912	686,435	1,051,096	Yr 4 to Yr 5	53%	81%	X			
Turkey	63,162	902,886	645,642	584,890	0	Yr 3 to Yr 4	-9%	6%			X	
East/Southern Africa												
Ethiopia	0	0	0	41,067	15,167	Yr 4 to Yr 5	-63%	446%			X	
Kenya	502,130	1,565,027	222,262	285,736	130,964	Yr 2 to Yr 3	-86%	-9%				X
Malawi	0	1,049,453	183,016	406,502	506,683	Yr 4 to Yr 5	25%	Same	X			
Tanzania	882,862	668,109	751,553	807,606	1,386,760	Yr 4 to Yr 5	72%	43%	X			
Uganda	225,421	181,081	0	0	0	Yr 1 to Yr 2	-29%	Same			X	
West Africa												
Ghana	197,847	229,752	281,146	417,347	818,546	Yr 4 to Yr 5	96%	-2%		X		
Guinea	63,609	149,679	109,521	0	228,530	Yr 3 to Yr 5	109%	88%	X			
Nigeria	131,924	633,520	516,538	925,960	1,088,961	Yr 4 to Yr 5	18%	-11%		X		
Sonogal	707,550	2,104,242	410,463	-121,942	125,111	Yr 4 to Yr 5	Positive change*	-8%		X		
Latin America												
Bolivia	12,238	155,620	300,846	566,441	775,884	Yr 4 to Yr 5	37%	Same	X			
Dominican Republic	180,035	596,989	33,370	150,090	252,567	Yr 4 to Yr 5	68%	-17%		X		
Guatemala	130,430	593,365	155,173	0	0	Yr 2 to Yr 3	-74%	-100%				X
Honduras	19,491	204,284	256,766	460,577	541,152	Yr 4 to Yr 5	17%	33%	X			

Notes:

T₂ represents the most recent fiscal year in which we received field support; T₁ represents the year prior in which we also received field support.

Same=same number of sites were reported from T₁ to T₂.

South Africa does not report sites and so is not contained in this analysis.

* Negative amount for Senogal FY 2001-2002 reflects a de-obligation of subagreement. Unable to calculate percent change due to negative number in T₁.

APPENDIXES

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EngenderHealth evaluation and research studies, 1998–2003*

Program	Date completed	Title	Author(s)
Country Programs			
Bangladesh	November 2000	Review of sterilization services	T. Jezowski, H. Stanley
Bolivia	March 2003	Strategic assessment of cervical cancer prevention and treatment services in Bolivia	EngenderHealth, PAHO, Bolivian MOH
Bolivia	August 2002	Linea de base para la implementación de herramientas de calidad de EngenderHealth en servicios de la red PROSALUD (Baseline for the implementation of EngenderHealth qualitative improvement tools in services of the PROSALUD network)	C&G Consultoras, PROSALUD, EngenderHealth
Bolivia	2001	El momento de involucrar a los hombres en salud sexual y reproductiva: Estudio exploratorio en Santa Cruz de la Sierra, Bolivia (Involving men in sexual and reproductive health: Exploratory study in Santa Cruz de la Sierra, Bolivia)	EngenderHealth, CISTAC
Cambodia	February 2003	Needs assessment: On operationalizing HIV/AIDS prevention for pregnant women in Cambodia	Dr. P. Choun
Cambodia	March 2002	The drug logistics wall chart for health centers—An evaluation	The Reproductive and Child Health Alliance (RACHA), MOH, UNFPA
Cambodia	February 2002	Follow-up report on the quality of vasectomy services in Seam Reap Province	RACHA, MOH
Cambodia	February 2002	HIV/AIDS knowledge assessment	RACHA, MOH
Cambodia	November 2001	Improving access to VSC services	RACHA, MOH
Cambodia	July–December 2001	Improving access to voluntary surgical contraception services in Pursat, Siem Reap, and Kampot: A pilot study	RACHA, MOH
Cambodia	July 2001	IUDs: Increasing women's options: A study to provide the basis for IUD promotion	RACHA, MOH
Cambodia	July 2001	RACHA's TBA project	RACHA, MOH of Kampot
Cambodia	June 2001	RACHA# 14: IUDs: Increasing women's options—A study to provide the basis for IUD promotion	RACHA
Cambodia	May 2001	RACHA: "Whole health" achieving results and developing sustainability in low resource environments: A Cambodia story	RACHA
Cambodia	April 2001	Documentation and assessment of the RACHA program	J. Stoeckel, MOH, USAID/Cambodia
Cambodia	November 2000	COPE: A qualitative evaluation	C. Sainsbury, D. Samphors, T. Moly, RACHA

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Cambodia	August 2000	Ratings of maternal and neonatal health programs across developing countries: Cambodia's ranking	J. Ross, R. Bulatao, C. Ketsana, Futures Group Worldwide, RACHA
Cambodia	August 2000	RACHA Study # 9: The people speak: Rural mothers and provincial leaders—Their priorities in child health. A response to the Pathway to Child Health Study	The National Center for Maternal and Child Health, the National Pediatric Hospital, RACHA
Cambodia	August 2000	A study of birth spacing in Siem Reap Province: Dropout and late clients	MOH, RACHA
Cambodia	July 2000	RACHA Studies #10: Death among women of reproductive age	L. Paal, C. Ketsana
Cambodia	2000	RACHA Studies #13: Health centers: Are they improving? An analysis of change between 1998–2000	J. Stoeckel
Cambodia	July 2000	Client exit interviews in Bakan District	C. Hermann
Cambodia	July 2000	Rapid focused surveys for reproductive and child health activities	RACHA
Cambodia	May 2000	RACHA Studies #8: The pathway to child health	RACHA
Cambodia	March 2000	The COPE process: Improving the quality of services in Cambodia's public health facilities	RACHA
Cambodia	February 2000	RACHA: The logistics management information system of the Ministry of Health's essential drugs bureau	RACHA
Cambodia	August 1999	A trailer study of the Cambodian Midwives Association continuing education program	RACHA
Cambodia	August 1999	RACHA Photo Essay #1: Midwife life-saving skills program	RACHA
Cambodia	August 1999	RACHA Studies #7: Cambodian Midwives' Association continuing education program	RACHA
Cambodia	August 1999	RACHA working paper: A review of RACHA's results framework	R. Sturgis
Cambodia	July 1999	RACHA Studies #4: Rural women and health center use, staff employment, and health seeking behavior	RACHA
Cambodia	July 1999	RACHA Studies #5: Training, employment and activities level of Cambodia Midwife Association (CMA) members	RACHA
Cambodia	July 1999	RACHA Studies #6: Stock level survey 1999	RACHA
Cambodia	July 1999	RACHA: Some recommendations for IEC at RACHA 1999–2000 and beyond	J. Sherman
Cambodia	June 1999	RACHA Studies #3: Health facilities survey: Service availability, utilization, and resources in Kampot, Pursat and Siem Reap	RACHA
Cambodia	May 1998	RACHA Studies #1: Private sector assessment report	C. Fort, B. Ravenholt, H. Stanley

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Colombia	September 2002	Postabortion care program in Colombia	P. Gomez
Colombia	November 2000	Masculinidades en Colombia: Reflexiones y perspectivas	AVSC International, FNUAP, GMD. HAZ PAZ
Colombia	2000	Impact of health-sector reform in Colombia	Centro de Gestión Hospitalaria. Fundación Corona. EngenderHealth
Colombia	March 2000	The sexual and reproductive health of men: What do Colombian men want and think?	AVSC International, CIMDER Foundation
Colombia	1999	Profamilia's clinic for men: Mombasa workshop case study from Bogota, Colombia (MAP)	AVSC International
Colombia	1999	Perspectives and needs in men's reproductive health Report only in Spanish: <i>Perspectivas y necesidades de servicios de salud reproductiva para hombres (aspectos metodológicos)</i>	AVSC International, CIMDER Foundation
Colombia	1998	Sexual and reproductive services for men: Knowledge, attitudes, and needs in five large cities Report only in Spanish: <i>Servicios de salud sexual y reproductiva para hombres: Conocimientos, actitudes y necesidades en cinco grandes ciudades Colombianas</i>	AVSC International, CIMDER Foundation
Dominican Republic	May 2003	Los servicios postaborto para las adolescentes de la República Dominicana (Services for adolescent PAC clients in the Dominican Republic)	B. Garcia, I. Escandón, J. Figueroa, P. Gomez
Dominican Republic	April 2003	The postabortion services to adolescents of the Dominican Republic.	B. Garcia, I. Escandón, J. Figueroa.
Dominican Republic	February 2003	Effectiveness of paracervical block in managing pain in the treatment of incomplete abortion with manual vacuum aspiration: Randomized clinical study	P. Gomez, H. Gaitan, A. Paradas, C. Nova
Dominican Republic	April 2002	Informed consent for surgical contraception Report in Spanish: <i>Consentimiento informado para la anticoncepción quirúrgica</i>	USAID, EngenderHealth, CONAPOFA
Egypt	November 1998	Evaluation of Egypt's safe reproductive health program: End-of-year evaluation	T. W. Jezowski, K. O'Hanley, F. El-Zanaty
Ethiopia	February 2003	Needs assessment for HIV prevention in pregnancy in Ethiopia	EngenderHealth, UNFPA
Ethiopia	November 2002	Assessment of sites for provision of postabortion care in Ethiopia: Detailed report	NGO Networks Ethiopia, EngenderHealth
Ethiopia	May 2001	Evaluation of supervision training	EngenderHealth, CARE Ethiopia
Ethiopia	January 2000	Assessment of provision of long-term and permanent family planning methods in Addis Ababa, Amhar, and Oromia, Ethiopia	AVSC International, East and Southern Africa Regional Office

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Ghana	July 2002	Factors affecting the safe provision of IUDs: A service-delivery perspective from Ghana	EngenderHealth
Ghana	February 1999	Evaluation of AVSC-supported activities in Ghana	M. Jacob, D. Mandel, M. Mayfield, M. Mehta
Ghana	July 1998	Men as Partners in reproductive health: An assessment of reproductive health knowledge, attitudes, and practice in Ghana	C. Fayersey (Sociology Department, University of Ghana)
Guatemala	February 2001	Informed choice for female sterilization as a contraceptive option in Guatemala Published as: Elección informada de la esterilización femenina como opción anticonceptiva en Guatemala	S. Alvarez, R. Valladares, E. Barillas, P. Robayo, C. Cabarrús, L. González, E. Gaviola, GSD Consultores Asociados; Ministerio de Salud Pública y Asistencia Social, Instituto Guatemalteco de Seguridad Social; Asociación ProBienestar de la Familia Guatemalteca
Guatemala	May 2000	The economic impact of Instituto Guatemalteco de Seguro Social's (IGSS) family planning program Report only in Spanish: Impacto económico institucional del programa de planificación familiar del IGSS	C. Bonatto, GSD Consultores Asociados
Guatemala	July 1999	AVSC's evaluation of the IGSS reproductive health program in Guatemala, 1994–1998	L. DeMaria, P. I. Gómez, E. Bunde, M. Tilili, K. Adachi, C. Pilcavage, D. K. Repass
Guinea and Kenya	June 2002	COPE® for Child Health in Kenya and Guinea: An analysis of service quality	J. Bradley, S. Igras, A. Shire, M. Diallo, E. Matwale, F. Fofana, A. Camara, F. Sawe, J. Becker, MOH Kenya and Guinea, USAID/Africa Bureau, USAID/REDSO/ESA, UNICEF, WHO, BASICS, SARA Project/AED
Guinea and Kenya	May 2000	Child health services in Guinea and Kenya: Report of the baseline survey for the COPE for Child Health project	J. Bradley, S. Igras, E. Matwale, A. Camara, F. Sawe
Guinea	February 1999	Men As Partners in Guinea Report only in French: Hommes Comme Partenaires en Guinée	E. McDavid, M. Diallo
Honduras	2003	The final report of the evaluation of the process of IUD for auxiliary nurses in health regions #1, 2, and 5	L. Martinez
Honduras	June 2003	Evaluation of the family planning services, provided by auxiliary nurses working in health centers in #1, 2, and 5.	L. Martinez

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Honduras	1998	Evaluating job aid use to improve quality of care at clinic and community levels	EngenderHealth
India	November 2001	Introducing DMPA injectable contraceptives to private medical practitioners in urban Gujarat	DKT India, EngenderHealth, Centre for Operations Research Training (CORT)
India	2000	Assessing continuity of DMPA use and provider motivation in urban Gujarat	EngenderHealth
India	April 2000	Attitudes towards male and female sterilization in Uttar Pradesh	CORT
Jordan	June 2003	Jordan: Attitudes toward tubal ligation among users, potential users, and husbands in Jordan	EngenderHealth, Family Health Group, MOH, Royal Medical Services, private-sector hospitals and clinics, Jordan University Hospital
Jordan	May 2002	Trends in female sterilization in Jordan 1991–2000	Team International Engineering, Management Consultants E. Landry, N. Bitar, A. Shah
Jordan	May 2002	Female sterilization trends during 1998–2000	TEAM, EngenderHealth, MOH, Royal Medical Services, private-sector hospitals
Jordan	May 2002	Jordanian providers' knowledge, attitudes, and practices regarding long acting hormonal and permanent family planning methods	E. Landry, N. Bitar, C. Bumin, J. Pile, Market Research Organization
Jordan	May 2002	Client perceptions of Norplant and Depo Provera at JAFPP clinics	Family Health Group, EngenderHealth, Jordan Association for Family Planning and Protection
Jordan	September 1998	Needs assessment of female sterilization services in 20 sites	M. Gallagher, N. B. Hadaddin, T. Jezowski, Z. Khairullah
Kenya	November 2002	Integrated training to improve the quality of maternal care services including postabortion care: Lessons from Kenya, end-of-project evaluation	I. Achwal, L. Goodyear
Kenya	September 2002	AMKENI/Kenya: Barriers to promotion of condoms by family planning service providers	FHI, AMKENI, L. Bloomhall, N. Maggwa, J. Liku, J. Rakwar
Kenya	July 2002	AMKENI/Kenya: The integration of family planning into VCT services	J. Liku, H. Reynolds, N. Maggwa, J. Rakwar, FHI, AMKENI, NASCOP
Kenya	June 2001	End-of-project summary—EngenderHealth/Kenya report 1995–2000	EngenderHealth
Kenya	May 2000	Postabortion care gaps analysis and recommendations	W. Kogi-Makau, J. Solo
Kenya	June 1999	Community involvement and COPE	AVSC/Kenya, MOH, mission hospitals

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Kenya	April 1999	Statistical survey of urban male attitudes to vasectomy: Nairobi, Kenya	D. J. Wilkinson
Kenya	April 1999	Kenya program evaluation, 1995–1999	K. Beattie, C. Camlin, I. Ndong, D. Teutonico, D. Adriance, J. Asila, T. Bwire, G. Kamau, J. Karuthiru, L. Mogeni, F. Mumba, J. Obwaka, R. Simwa
Kenya	October 1998	Man myth: Perceptions from Kenya: Reproductive health attitudes and behavior	D. J. Wilkinson
Kenya	1998	Factors affecting the safe provision of IUDs: A service delivery perspective from Kenya	AVSC International, Kenya MOH, Family Planning Association of Kenya
Kyrgyzstan	1998	Report on the assessment of reproductive health services in Osh and Jalalabad Oblasts of the Kyrgyz Republic	AVSC International
Kyrgyzstan	1998	Evaluation of IEC project	AVSC International
Malawi	November 2002	Detailed assessment of Malawi postabortion care sites	J. Ruminjo, D. Malema, J. Malewezi, L. Linyenga
Malawi	November 2001	Baseline assessment of postabortion care services: Malawi	J. Ruminjo, D. Malema, J. Malewezi, L. Linyenga, MOH/Reproductive Health Unit
Mexico	December 1999	Factors affecting the safe provision of IUDs: A service delivery perspective from Mexico	AVSC International, IMSS Mexico
Mexico	April 1999	Summary of AVSC activities in Mexico: Final desk audit	AVSC International
Mexico	March 1999	Sexual and reproductive health of men in Mexico Report only in Spanish: La salud sexual y reproductiva de los varones en México	C. Juárez, E. Aldaz, G. Medina, A. Estrada
Mexico	March 1999	Counseling training in reproductive health: Its impact Report only in Spanish: Capacitación en consejería acerca de la salud reproductiva: Sus impactos	J. A. Cardona, J. B. E. Otero, M. de la Arceo, C. Juarez, E. Aldaz
Mexico	March 1999	The sexual and reproductive health of men: the perspectives of men, women, health care providers, and experts Report in Spanish as: La salud sexual y reproductiva de los hombres: una perspectiva de hombres, mujeres, proveedores de servicios y expertos	E. Aldaz, C. Juarez, G. Medina, A. Estrada
Mexico	1998	Postabortion study	J. A. R. Padillo, M.A. Olaya, G. Clavelina
Mexico	October 1998	Informed consent for sterilization	M. Mayfield, J. A. C. Perez, E. Landry

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Nepal	August 2003	Men as partners in RH in Nepal	A. Levack
Nepal	June 2003	Pill acceptance and use patterns in Nepal	New ERA
Nepal	June 2003	Norplant acceptance and use patterns in Nepal	New ERA
Nepal	June 2003	IUCD acceptance and use patterns in Nepal	New ERA
Nepal	June 2003	Depo-Provera acceptance and use patterns in Nepal	New ERA
Nepal	May 2001	Assessment of IUD and Norplant contraceptive service pilot program in Kathmandu Valley: A rapid survey	D. P. Shrestha, S. Pokhrel, Nepal Fertility Care Centre (NFCC)
Nepal	April 2001	Clients' views towards family planning services at institutionalized family planning service sites in Nepal	Quality of Care Management Center/Family Health Division, EngenderHealth
Nepal	April 2001	Enhanced monitoring of mobile outreach sterilization services: Client perspectives (phase I and II)	A. Kaufman, EngenderHealth
Nepal	January 2000	An assessment of the family planning and other health services in the industrial-sector project	D. P. Shrestha
Nepal	2000	AVSC International's infection prevention CD-ROM pilot evaluation: Nepal, Ghana, and South Africa	K. Levin
Nepal	June 1999	Consultant report. Review of Chhetrapati Family Welfare Center (CFWC) service delivery and management system	S. Rana
Nepal	April 1999	Nepal baseline assessment report for AVSC's International results framework	J. Kumar, E. Landry, K. Levin, S. Pati, R. Rai, A. Shrestha
Nepal	March 1998	An impact assessment of family planning counseling training	AVSC International
Netherlands	December 1998	Efficacy of percutaneous vas occlusion in comparison to conventional vasectomy	J. V. Zambon, R. Heg, M. A. Barone, A. E. Pollack, M. Mehta
Nigeria	June 2003	Facility needs assessment in nine teaching hospitals in the six geopolitical zones of Nigeria	Dr (Mrs) A.O. Aisien, Dr E.I. Archibong, Dr S. Sule, Dr M. Dankyau
Nigeria	September 2002	Facility assessments in the 3 VISION states	VISION
Nigeria	August 2002	Training needs assessment in 3 VISION states	VISION
Nigeria	July 2002	Commodity logistics assessment of 3 VISION states	DELIVER Project
Nigeria	July 2002	Health-seeking behavior study in 2 LGAs in the 3 VISION states	JHU/PCS
Nigeria	January 2001	Assessing the performance of FP service at the primary care level in Nigerian local government area health centers and NGO clinics	USAID, PRIME/Intrah, TRG, JHU, EngenderHealth, MSH

(continued)

EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Paraguay	June 2001	Perspectives and needs in men's reproductive health Published as: <i>Perspectivas y necesidades de servicios de salud reproductiva para hombres</i>	Centro Paraguayo de Estudios de Población (CEPEP), MOH-Dirección General de Programas de Salud, USAID, CEPEP
Philippines	March 2003	KAP study on abortion for service providers and members of the community as baseline data	EngenderHealth
Philippines	November 2002	Young men's sexuality in the Philippines	Dela Salle University, EngenderHealth
Philippines	November 2002	Integrating postabortion care management: A cost analysis	Dr. M. P. Costello
Philippines	December 1999	Assessing health workers' attitudes and practices on postabortion in selected health facilities in the Province of Neuva Vizcaya	E. B. Tandingan, L. A. Alcantara, E. M. Bautista, M. O. D. Costales
Philippines	July 1998	An intervention study to improve family planning and reproductive health service delivery through enhanced information exchange in Davao Province	M. Lacuesta, A. Atillo, N. Amoyen
Republic of South Africa	June 2003	Cervical cancer mass media interventions in a South African resource-poor setting: Can they increase smear uptake?	L. Risi, J.P. Bindman, O. M. R. Campbell, J. Imrie, K. Everett, J. Bradley, L. Denny, Khayelitsha Cervical Screening Project, London School of Hygiene & Tropical Medicine, Health Services Research Department, Institute of Psychiatry, London
Republic of South Africa	June 2003	Widening the cervical cancer screening net in a South African peri-urban population: Who are the true underserved?	J. Bradley, L. Risi, L. Denny, Khayelitsha Cervical Screening Project
Republic of South Africa	November 2002	Women's perspectives on cervical cancer screening and treatment: Participatory action research in Khayelitsha, South Africa	I. Buskens, L. Denny, J. Bradley, M. Barone
Republic of South Africa	September 2000	Men as Partners: Republic of South Africa evaluation report	V. Kruger, J. Ruthnam
Republic of South Africa	May 2000	Cervical cancer screening study	Columbia University, University of Cape Town, National Cancer Association of South Africa
Republic of South Africa	May 1998	Men as Partners focus group discussions in South Africa: Eastern Cape, Free State, Western Cape, and Gauteng Provinces, South Africa	A. Levack, T. Matladi, P. Kedama, L. Tyoba
Russia	July 2002	Postabortion care operations research study in Perm, Russia.	J. M. Pile, I. Sacci, EngenderHealth, I. Savelieva, consultant, Department of International Research Programs at the Russian Academy of Medical Sciences, Frontiers in Reproductive Health/Population Council

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EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Russia	August 1999	Improving adolescents' access to reproductive health services	AVSC International, UNICEF
Russia	September 1998	Factors affecting the safe provision of IUDs: A service delivery perspective from Ekaterinburg	AVSC International, Ekaterinburg Family Planning Association
Senegal	February 2003	Taking PAC services where they are needed: Testing PAC expansion in rural areas	C. T. Cisse, Frontiers, E.O. Faye, CEFOPRE, MOH, Centre de Formation et de Recherche en Sante de la Reproduction, Population Council
Senegal	September 2000	Senegal transition program evaluation— Programme National de transition USAID/Ministère de la santé du Sénégal pour l'amélioration de la qualité des services de la santé de la reproduction au Sénégal, Octobre 1998 à Septembre 2000	I. Ndong, O. Faye, E. Benga Deh Elizabeth
Senegal	May 2000	Testing COPE for Child Health in Senegal	CESAG/BASICS
Senegal	March 1999	Report in French: Etude experimentale sur l'effet des strategies d'amelioration de la qualite sur le taux de continuite des services de planification familiale au Senegal	Ministere de la Sante Programme National de Planification Familiale, Population Council Project de Recherches Operationnelles et d'Assistance Technique en Afrique II
Senegal	1998	Final report of AVSC International Technical Assistance Program Rapport Final: Du programme d'assistance technique de AVSC International au Senegal	N/A
Tanzania	May 2002	Men as partners in reproductive health: Exploring family planning and reproductive health decision-making and service delivery in two districts	P. Riwa, E. Ngirwamungu, J. Simbawaka, D. Kihwele, R. Becker
Tanzania	March 2002	Evaluation of the Managed Health Care Project (MHCP) of the Evangelical Lutheran Church in Tanzania (ELCT).	J. Mashafi, EngenderHealth consultant, R. Kahando, EngenderHealth consultant, ELCT, EngenderHealth Corat Africa
Tanzania	January 2002	Rapid assessment of Seventh-Day Adventist health facilities	C. Simbakaia, consultant, I. Achwai, G. Wambwa, G. Lusola, EngenderHealth, J. Tayali, Naomba Magubu, Seventh Day Adventist, Z. Ubwe, National Nursing Council Tanzania, R. Bayona, Directorate of Hospital Services, J. Kanama, UMATI

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EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Tanzania	April 2001	Preliminary results on the current situation of permanent and long-term (P<) contraception services in Tanzania	A. D. Rukonge, consultant, A. Isack, EngenderHealth, J. R. Kanama, UMATI, C. Mpemba, RCHS of Tanzania MOH, USAID
Tanzania	July 2000	Family planning services in Tanzania: Results from a project to improve quality: 1996–1999	J. Bradley, E. Mielke, G. Wambwa, J. Mashafi, M. Nasania
Tanzania	March 2000	A report on the review of long-term and permanent contraceptive methods and quality improvement program	P. Riwa, R. Mwaikambo, A. Rukonge, I. Achwaal, C. Camlin
Tanzania	January 2000	Health-sector reform (HSR) and reproductive health in transition	L. Antarsh, D. Adriance
Tanzania	November 1999	Rapid assessment of available Norplant sets in Tanzania	I. Achwal, D. Kihwele
Tanzania	August 1999	Improving postabortion care services in three hospitals in Tanzania	A. Rukonge, M. Wikedzi, D. Mrosso, E. Malekela, E. M'Mbando, A. Kilonzo, I. Achwal, G. Wambwa, M. Mehta
Tanzania	August 1999	Baseline study of 29 proposed PAC expansion sites	G. Wambwa, MOH, UMATI, USAID, Ipas
Tanzania	February 1999	Postabortion care quality assessment	G. Wambwa, E. Westley
Tanzania	1998	PAC evaluation	EngenderHealth
Tanzania	September 1998	Quality of care in family planning services: An assessment of change in Tanzania from 1995/6–1996/7	J. Bradley, G. Wambwa, K. Beattie, J. Dwyer
Tanzania	June 1998	Mid-term evaluation: Improving reproductive health care in three Tanzanian hospitals, May 28–June 4, 1998	A. Eschen, A. Rukonge, B. French, A. Kilonzo, E. Mielke
Turkey	May 2001	Vasectomy decision-making in Turkey—A focus group report	AVSC International
Turkey	March 2000	Private-sector expansion of postabortion family planning initiative in Istanbul, Turkey	MOH, USAID Mission, EngenderHealth
Ukraine	November 1998	Creating youth-friendly adolescent health services in Mikolayev, Ukraine: A model for change	AVSC International
United States	January 2003	Report on FY 2001–2002: The Men's Reproductive Health Capacity Building Project	EngenderHealth
United States	March 1999	Exploring sexual and reproductive health decision-making in South Brooklyn, New York	M. Schehl, J. Haws, R. Becker
Uzbekistan and Kyrgyzstan	December 1999	Assessment of abortion and postabortion care services in republics of Uzbekistan and Kyrgyzstan	AVSC PAC Team, Research Institute of Obstetrics and Gynecology
Uzbekistan	December 1999	Assessment of female sterilization services in Uzbekistan	K. O'Hanley, MOH, Research Institute of Obstetrics and Gynecology

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EngenderHealth evaluation and research studies, 1998–2003* (continued)

Program	Date completed	Title	Author(s)
Country Programs (continued)			
Uzbekistan	1998	Assessment of reproductive health services in Surkhandarya and Kashkadarya oblasts of the Republic of Uzbekistan	AVSC International
Vietnam	July 2002	Factors affecting the safe provision of IUDs: A service delivery perspective from Vietnam	AVSC International
Vietnam	May 1999	Qualitative assessment of sterilization services in six provinces	MOH National Committee for Population and Family Planning, AVSC International
Vietnam	June 1998	Client perspectives on quality of contraceptive and abortion services at three sites in Vietnam	N. M. Thang, B. R. Johnson, E. Landry, R. Columbia
Global Programs			
MaC/PAC	June 2003	Obstetric fistula needs assessment report: Findings from nine African countries	UNFPA, EngenderHealth
MaC/PAC	March 2003	The effectiveness of paracervical block in managing pain in the treatment of incomplete abortion with manual vacuum aspiration (MVA): A randomized clinical control trial	P. Gomez, H. Gaitan, A. Paradas, C. Nova, Center for Clinical Epidemiology, Universidad Nacional de Colombia, International Clinical Epidemiology Network (INCLEN), Maternidad Nuestra Senora de Altagracia, Sto. Domingo, Dominican Republic
MaC/PAC	December 2002	Evaluation of currently available MVA instruments	PATH, J. Ruminjo
MaC/PAC	December 2002	Addressing the global crisis of unsafe abortion by expanding postabortion care services	J. Solo, I. Escandón, L. Leonhardt, A. Shire
Postabortion care	April 2001	A study to assess misoprostol use and associated needs in developing countries	S. Girvin, P. Gómez, E. Westley, EngenderHealth, J. Sherris, A. Bingham, PATH, Reproductive Health Research Unit (RHRU)
LAC	September 1998	Female sterilization decision making in Latin America and the Caribbean Toma de decisiones sobre esterilización femenina en Latinoamérica y el Caribe	AVSC International

*Various funding sources, including USAID, multilateral, and private funds.

EngenderHealth journal publications, 1998–2003

Article title	Authors	Name of journal	Date of publication
A prospective study of time and number of ejaculations to azoospermia after vasectomy by ligation and excision	M.A. Barone, H. Nazerali, M. Cortes, M. Chen-Mok, A.E. Pollack, D. Sokal	Journal of Urology, 170(3):892–896	September 2003
Cervical cancer mass media interventions in a South African resource-poor setting: Can they increase smear uptake?	L. Risi, J. P. Bindman, O.M.R. Campbell, J. Imrie, K. Everett, J. Bradley, L. Denny	Accepted for publication in: Health Education Research	June 2003
Widening the cervical cancer screening net in a South African peri-urban population: Who are the true underserved	J. Bradley, L. Risi, L. Denny	Accepted for publication in: Health Care for Women International	June 2003
Family planning as an integral component in women's reproductive health improvement. WIN Project Integrated Approach	I. Sacci, I. S. Savelieva	Kontraceptziya (Contraception), Russian, May 2003	May 2003
Measuring provider performance: challenges and definitions	A. Fort (E. Mielke contributed)	Summary of a technical meeting sponsored by PRIME II/Intrah and MEASURE	January 2003
HIV infections in sub-Saharan Africa, Letter to the Editor	M. Middleberg, J. Becker, P. Twyman	International Journal of STD & AIDS, 14(8):570–571	January 2003
Provision of modern birth spacing methods	T. Rathavy, M. Reyners	Health Messenger	January 2003
Good communication during antenatal care	M. Smith	Health Messenger	October 2002
Emergency contraception	P.I. Gomez	Proceedings of Latin-American Ob/Gyn Conference, Bolivia 2002	October 2002
Postpartum and postabortion family planning	P.I. Gomez	Proceedings of Latin-American Ob/Gyn Conference, Bolivia 2002	October 2002
Incomplete abortion, medical treatment	P.I. Gomez	Proceedings of Latin-American Ob/Gyn Conference, Bolivia 2002	October 2002
Pain relief for manual vacuum aspiration of uterus	J. Ruminjo, T. Egziabher, C. Sekadde-Kigonde	East African Medical Journal, 79(10): 530–534	October 2002
Participatory evaluation of reproductive health care quality in developing countries	J. Bradley, M. Mayfield, M. Mehta, A. Rukonge	Social Science & Medicine, 55(2): 269–282	July 2002
Empowering frontline staff to improve the quality of family planning services: A case study in Tanzania (chapter 6)	M.B. Dohlie, E. Mielke, G. Wambwa, A. Rukonge	Responding to Cairo: Case studies of changing practice in reproductive health and family planning. N. Haberland & D. Measham, editors	April 2002

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EngenderHealth journal publications, 1998–2003 (continued)

Article title	Authors	Name of journal	Date of publication
Direct visual inspection for cervical cancer screening: An analysis of factors influencing test performance	L. Denny, L. Kuhn, A.E. Pollack, T. C. Wright, Jr.	Cancer, 94(6): 1699–1707	March 2002
EngenderHealth makes creative strategies in low-resource settings	K. Kannitha, T. Savery, M.S. Titus	Global Health Link, Vol. 114. pp. 9, 18	March 2002
Improving maternal and child health services through COPE	E. Mielke, J. Bradley, J. Becker	Quality Assurance Brief, 9(2):23–25	March 2002
EngenderHealth's PAC activities	K. Graff	PAC in Action newsletter, Issue 1	March 2002
Editorial: Saving women's lives: Taking advantage of missed opportunities in health services	S. Mather, A. Malhotra, ICRW; M. Mehta, EngenderHealth	Columbian Journal of Obstetrics and Gynecology, 52(2): 135–140	August 2001
COPE: A process and tools for healthcare	E. Mielke, K. Beattie	Quality Assurance Brief, 9(1):18–20	July 2001
Policy analysis of cervical cancer screening strategies in low-resource settings	S. Goldie, L. Kuhn, L. Denny, A. E. Pollack, T. C. Wright, Jr.	Journal of the American Medical Association (JAMA). 285(24): 3107–3115	June 2001
Bridging the gap: Integrating family planning with abortion services in Turkey	P. Senlet, L. Cagatay, J. Ergin, J. Mathis	International Family Planning Perspectives 27(2):90–95	June 2001
Adolescent girls' life aspirations and reproductive health in Nepal	S. Mathur, A. Malhotra, M. Mehta	Reproductive Health Matters 9(17):91–100	May 2001
Cervical cancer screening in developing countries	L. Denny	IPPF Medical Bulletin 35(2)	April 2001
The Quality of Care Management Center in Nepal: Improving services with limited resources	H. Stanley, D. R. Shrestha, M. A. Barone, M. Lineham	AVSC Working Paper No. 13	January 2001
Cervical cancer screening strategies for developing countries: Symposium	R. M. Richart, S. Robles, R. Sankaranarayanan, T. C. Wright, Jr.	Contemporary Ob/Gyn 46(1):71–79	January 2001
Female sterilization: Evidence	S. Pati, V. Cullins	Obstetric and Gynecology Clinics of North America 27(4): 859–899	December 2000
Population growth and women's health	J. Vajpayee	Women's Health Journal	November 2000
Shifting to a sexual and reproductive health approach: Challenges for family planning providers	S. Pati, J. Becker, B. L. Farrell, M. A. Barone, V. Cullins	HealthLink	November 2000
Efficacy of percutaneous vas occlusion compared with conventional vasectomy	J. V. Zambon, M. A. Barone, A. E. Pollack, M. Mehta	British Journal of Urology (BJU) International 86(6): 699–705	October 2000
COPE, a model for building community partnerships that improve care in East Africa	M. B. Dohlie, E. Mielke, T. Bwire, D. Adriance, and F. Mumba	Journal for Health Care Quality 22(5):34–38	September 2000
Two-stage cervical cancer screening: An alternative for resource-poor settings	L. Denny, L. Kuhn, L. Risi, R. M. Richart, A. E. Pollack, et al.	American Journal of Obstetrics and Gynecology 183(2):383–388	August 2000

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EngenderHealth journal publications, 1998–2003 (continued)

Article title	Authors	Name of journal	Date of publication
Evaluation of alternative methods of cervical cancer screening for resource-poor settings	L. Denny, L. Kuhn, A. E. Pollack, H. Wainwright, and T. C. Wright, Jr.	Cancer 89(4):826–833	August 2000
From consent to choice in family planning: Application of an international framework to the United States	R. Pine, C. Wypijewska	Journal of the American Medical Women's Association (JAMWA) 55(5):265–269	July 2000
Condom counseling in microbicide testing: A right of choice. Letter to the editor.	A. E. Pollack, R. Pine, K. Beattie	American Journal of Public Health 90(7):1154	July 2000
Health-reform impact in reproductive health	P. I. Gómez	Controversias en Ginecología y Obstetricia	July 2000
Husbands as obstacles to contraceptive use in Pakistan	J. Casterline, Z. A. Sathar, M. ul Haque	Studies in Family Planning 32(2):95–110	July 2000
Men As Partners in HIV prevention: A case study from South Africa	P. Kedama, A. Levack, J. Duncan	Social Science: Rights, Politics, Commitment and Action	July 2000
Opening the door to safe abortion: International perspectives on medical abortifacient use: A commentary	A. E. Pollack, R. Pine	Journal of American Medical Women's Association (JAMWA) 55(3 Suppl):186–188	July 2000
Human papillomavirus DNA testing for cervical cancer screening in low resource settings	L. Kuhn, L. Denny, A. E. Pollack, A. Lorincz, R.M. Richart, T. C. Wright	Journal of the National Cancer Institute 92(10):818–825	May 2000
Commentary on tubal sterilization: Focus on the U.S. experience	A. E. Pollack, V. Cullins	Fertility and Sterility 73(5):913–922	May 2000
Putting an ear to the ground: Where now with quinacrine?	R. Pine, A. E. Pollack	International Journal of Gynecology and Obstetrics, 69(1):55–65.	April 2000
Quinacrine for female sterilization: health and ethical concerns, adapted from an insert of the same name produced as part of the AVSC International <i>Voluntary Sterilization</i> folder.	R. Pine	IPPF Medical Bulletin, Vol. 34, No. 2	April 2000
Shifting to a sexual and reproductive health approach: Challenges for family planning providers	V. E. Cullins, J. Becker, B. Farrell, P. Twyman, M. Barone	Healthlink 102:1–4.	March 2000
Partner effects on a woman's intention to conceive: Not with this partner	L. S. Zabin, G. R. Huggins, M. R. Emerson, V. E. Cullins	Family Planning Perspectives 32(1): 39–45	January–February 2000
HPV DNA testing of self-collected vaginal samples compared with cytologic screening to detect cervical cancer	T. Wright, L. Denny, L. Kuhn, A. E. Pollack, A. Lorincz	Journal of the American Medical Association, 283(1):81–86	January 2000
Improving quality of care: AVSC International's experiences in Africa	M.B. Dohlie, E. Mielke, F. Mumba, G. Wambwa, W. Mongo, A.D. Rukonge, J. Mashafi	Journal of Health Management 1(2):249–260	December 1999

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EngenderHealth journal publications, 1998–2003 (continued)

Article title	Authors	Name of journal	Date of publication
Marketing vasectomy: You'd be surprised	R. M. Becker, J. M. Haws, J. N. Welch, R. Belinoff	Social Marketing Quarterly 5(4):114–116	December 1999
Cervical cancer prevention using visual screening methods	V. Cullins, T. Wright, K. Beattie, A. E. Pollack	Reproductive Health Matters 7(14):134–143.	November 1999
Using practical quality improvement approaches and tools in reproductive health services in East Africa	M.B. Dohlie, E. Mielke, F.K. Mumba, G.E. Wambwa, A. Rukonge, W. Mongo	Joint Commission Journal on Quality Improvement 25(11): 574–587	November 1999
Treating vaginitis	V. E. Cullins, L. Dominguez, T. Guberski, M. R. Secor, S. J Wysocki	The Nurse Practitioner	October 1999
Involving Men as Partners in reproductive health: Lessons learned from Turkey	J. M. Pile, C. Bumin, A. Ciloglu, A. Akin	AVSC Working Paper #12	June 1999
Prevalence of visible disruption of cervical epithelium and cervical ectopy in African women using Depo-Provera.	L. Kuhn, L. Denny, A.E. Pollack, T. Wright	Contraception 59(6):363–367	June 1999
Are providers missing opportunities to address reproductive tract infections? Experience from Bangladesh	S N. M. Chowdhury, I Bhuyiya, S. N. Huda, A. J. Faisal	International Family Planning Perspectives 25(2):92–97	June 1999
Clinical aspects of vasectomy	A. E. Pollack, M. A. Barone	Urology, 53(4):862–866	April 1999
What's new in sterilization techniques	S. Pati, C. Carignan, A.E. Pollack	Patient Care	March 1999
No-scalpel vasectomy in the United States	J. Haws, V. Cullins	IPPF Medical Bulletin	February 1999
Men's reproductive health: Defining, designing, and delivering services	I. Ndong, R.M. Becker, J.M. Haws, M.N. Wegner	International Family Planning Perspectives 25(Suppl.)53–55	January 1999
Vasectomy in the United States, 1991 and 1995	R.J. Magnani, J.M. Haws, G.T. Morgan, P.M. Gargiullo, A.E. Pollack, L.M. Koonin	American Journal of Public Health 89(1): 92–94	January 1999
The concept of Men as Partners in Pakistan	A. Levack, T. Rahim	Populi	December 1998–January 1999
Hysterectomy after sterilization	S. Pati	Medical Tribune	November 1998
Clinical practice of vasectomies in the United States in 1995	J.M. Haws, R.J. Magnani, G.T. Morgan, L.M. Koonin, A.E. Pollack, P.M Gargiullo	Urology	October 1998
Emergency contraception: A global overview	E. Westley	Journal of the American Medical Women's Association 53(5 Suppl 2):215–218 & 237	October 1998
Working paper: Whole-site training: A new approach to the organization of training	J. Bradley, P.F. Lynam, J.C. Dwyer, G.E. Wambwa	New	August 1998
What's new with male sterilization: An update	A. E. Pollack, C. Carignan, S. Pati	Contemporary Ob/Gyn	July 1998

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EngenderHealth journal publications, 1998–2003 (continued)

Article title	Authors	Name of journal	Date of publication
Using COPE to improve quality of care: The experience of the Family Planning Association of Kenya	J. Bradley	Quality/Calidad/Qualite	June 1998
What's new with female sterilization: An update	S. Pati, C. Carignan, A. E. Pollack	Contemporary Ob/Gyn	June 1998
Sterilization, still the most popular method of contraception		International Medical News Group	May 1998
Improving women's health around the world	A.E. Pollack	ACOG Today	May 1998
Clinical aspects of vasectomies performed in the United States in 1995	J. Haws, G.T. Morgan, A. E. Pollack, L.M. Koonin, R. Magnani, P.M. Gargiullo	Urology 52(4):685–691	April 1998
Reproductive health and men's responsibilities	I. Ndong, B. Finger	Network 18(3)	Spring 1998
Men as partners in reproductive health: From issues to action	M. N. Wegner, E. Landry, D. Wilkinson, J. Tzanis	International Family Planning Perspectives 24(1):38–42	1998

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Publication Title	Date of Publication
Management of Men's Reproductive Health Problems	In production
COPE® Handbook: A Process for Improving Quality in Health Services. Revised Edition	In production
COPE® for Reproductive Health Services: A Toolbook to Accompany the COPE® Handbook	In production
Minilaparotomy for Female Sterilization: An Illustrated Guide for Service Providers	In production
Reducing HIV and AIDS-Related Stigma and Discrimination in Health Care Settings	2003
Choices in Family Planning: Informed and Voluntary Decision Making	2003
Compass [periodical]: Changing Policies and Attitudes: Postabortion Care in the Philippines	2003
Compass [periodical]: Transforming Men into Clients: Men's Reproductive Health Services in Guinea	2003
Comprehensive Counseling for Reproductive Health: An Integrated Curriculum	2003
Counseling and Communicating with Men	2003
Counseling the Postabortion Client: A Training Curriculum	2003
No-Scalpel Vasectomy: An Illustrated Guide for Surgeons, Third Edition [print and CD-ROM versions]	2003
Trainer's Resource CD-ROM: No-Scalpel Vasectomy: An Illustrated Guide for Surgeons, Third Edition	2003
Compass [periodical]: Improving Provider Performance: Results from Guinea and Kenya	2002
Contraceptive Sterilization: Global Issues and Trends	2002
COPE® for Child Health in Kenya and Guinea: An Analysis of Service Quality	2002
EngenderHealth Annual Report to USAID, July 1, 2001–June 30, 2002	2002
Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling [working draft]	2002
The Rights of Clients and Providers to Safety and Dignity: Preventing HIV Transmission and Reducing AIDS Stigma in Health Care Settings. A Supplement to the EngenderHealth Infection Prevention Curriculum [working draft]	2002
Youth-Friendly Services: A Manual for Service Providers	2002
Community COPE®: Building Partnership with the Community to Improve Health Services	2001
COPE® for Maternal Health Services: A Process and Tools for Improving the Quality of Maternal Health Services	2001
EngenderHealth Annual Report to USAID, July 1, 2000–June 30, 2001	2001
EngenderHealth Publications, Catalogue	2001
Facilitative Supervision Handbook	2001
Men As Partners: A Program for Supplementing the Training of Life Skills Educators, 2nd edition	2001
The Quality of Care Management Center in Nepal: Improving Services with Limited Resources (AVSC Working Paper No. 13)	2001
Taking Postabortion Care Services to Scale: Quality, Access, Sustainability	2001
Cost Analysis Tool: Simplifying Cost Analysis for Managers and Staff of Health Care Services	2000

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EngenderHealth publications, 1998–2003 (continued)

Publication Title	Date of Publication
Emergency Management for the Operating and Recovery Rooms: Reference Manual, Emergency Management [poster], and Steps of Cardiopulmonary Resuscitation (CPR) [poster]	2000
EngenderHealth Annual Report to USAID, April 1, 1999–June 30, 2000	2000
Health-Sector Reform and Reproductive Health in Transition: Meeting the Challenge in Bangladesh	2000
Health-Sector Reform and Reproductive Health in Transition: Meeting the Challenge in Colombia	2000
Health-Sector Reform and Reproductive Health in Transition: Meeting the Challenge in Tanzania	2000
Health-Sector Reform and Reproductive Health in Transition: Meeting the Challenge in Tanzania, Bangladesh, and Colombia	2000
Introduction to Men's Reproductive Health Services	2000
Postabortion Care [folder; English, French, Spanish]	2000
Sexually Transmitted Infections and Other Reproductive Tract Infections (STIs/RTIs): Counseling Reference Cards: Etiologic Management	2000
Sexually Transmitted Infections and Other Reproductive Tract Infections (STIs/RTIs): Counseling Reference Cards: Syndromic Management	2000
What Every Client Should Know: STI/HIV Prevention Quick-Reference Cards for Health Care Providers	2000
COPE® for Child Health: A Process and Tools for Improving the Quality of Child Health Services	1999
COPE® Self-Assessment Guides for Reproductive Health Services	1999
Five Case Studies for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms [English, Spanish]	1999
Infection Prevention Curriculum: A Training Course for Health Care Providers and Other Staff of Hospitals and Clinics	1999
Involving Men As Partners in Reproductive Health: Lessons Learned from Turkey (AVSC Working Paper No. 12)	1999
Literature Review for the Symposium on Male Participation in Sexual and Reproductive Health: New Paradigms [English, Spanish]	1999
Male Contraception: Planning for the Future	1999
Male Participation in Sexual and Reproductive Health: New Paradigms, Symposium Report [English, Spanish]	1999
Medical and Service Delivery Guidelines for Family Planning, 2nd edition [Russian]	1999
Men As Partners: A Program for Supplementing the Training of Life Skills Educators. Guide for MAP Master Trainers and Educators	1999
STD Cue Cards [Russian]	1999
Voluntary Sterilization: Policies and Perspectives [folder; English, French]	1999
Informed Choice [folder; English, Spanish, French]	1998
Men As Partners in Ghana: Cape Coast Workshop Report	1998
Programming for Male Involvement in Reproductive Health: A Practical Guide for Managers [Spanish]	1998
Whole-Site Training: A New Approach to the Organization of Training (AVSC Working Paper No. 11) [French]	1998