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IS STERILIZATION VOLUNTARY
IN BANGLADESH?

A STUDY OF REIMBURSEMENT LEVELS
FOR STERILIZATION IN BANGLADESH

by

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EXECUTIVE SUMMARY

Problem and Overview

Bangladesh is one of the world's poorest yet most densely populated nations with about 100 million largely malnourished and illiterate people crowded into an area only the size of Wisconsin. About 85 percent of the population is rural, 50 percent of rural people are landless, and landlessness is increasing. Overpopulation is a major cause of deteriorating living conditions. It is widely recognized that unless rapid population growth can be brought under control, all other development efforts will be in vain.

Obstacles to providing family planning services are enormous. Bangladesh is a conservative, predominantly Muslim society where young girls enter arranged marriages in their early teens and begin producing children immediately. Infrastructure is barely existent and the annual monsoons leave many villages functionally cut off from the outside for months at a time. The government has yet to develop the administrative capability needed to provide effective services of any kind. Development activities that might contribute to fertility decline are just as difficult to carry out as providing reliable family planning services.

U.S. Assistance

AID is a major supporter of family planning services in Bangladesh. As part of this support, AID reimburses the Bangladesh government for certain costs related to voluntary sterilization services. Among these are payments the government makes: (1) to men and women (clients) who have the operation, to reimburse them for out-of-pocket expenses and to compensate for income forgone; (2) to "helpers" (or "referral agents") who accompany a client to and from the health centers, to reimburse them for incurred costs; and (3) to service providers (physicians and clinical assistants) to compensate for time during which they might otherwise be engaged in more lucrative curative care. The purpose of this reimbursement system is to ensure that there are no financial obstacles or disincentives that would reduce either the availability of sterilization services or access to them. USAID/Dhaka has always closely monitored sterilization in Bangladesh to ensure it is totally voluntary. Due to continuing interest concerning these payments, however, AID decided to call for an independent, external review of this part of the program.

Purpose of This Study

The purpose of this study was therefore to review the current levels of reimbursement for sterilization to determine: (1) whether these levels are appropriate; (2) whether sterilization is being provided in a general context of voluntarism and informed consent; and (3) whether additional studies concerning voluntarism are needed. Primary attention was to be on the reimbursement payments to clients.

Methodology

Findings are based on clinic visits, document review, and intensive interviewing during visits to Bangladesh in June and November of 1985, and on comparison with sterilization services in other countries. Unannounced, spot visits were made to clinics and interviews were conducted with a comprehensive range of people, including critics.

Major Findings and Conclusions

A. Concerning the General Context

1. Sterilization incidence and decline. Only a small percentage of Bangladeshi couples have had a sterilization and fewer sterilizations are being performed now than previously. Although sterilization is the most common method of family planning in Bangladesh, less than 9 percent of all couples of reproductive age (either the husband or wife) have had a sterilization.

2. Is the sterilization program voluntary? The sterilization program in Bangladesh is clearly voluntary. This is formal policy and many safeguards and monitoring systems have been established to ensure that only people who want the operation have it and to bring to a halt any deviation from this policy. The large number of studies and evaluations that have been conducted are evidence of the vigilance of the Bangladesh government and the donors.

3. Coercion. Bangladeshis who become sterilized do so of their own free will; they are not coerced. Over 870,000 men and women underwent sterilization in Bangladesh between January 1, 1984 and September 30, 1985 and there is no evidence that any of them was coerced. Research shows very high satisfaction rates of

96 to 98 percent. The tiny minority who express dissatisfaction do so because the operation failed (a pregnancy occurred anyway) or because of health reasons not related to the operation.

4. Informed consent. The general atmosphere is one of informed consent. Knowledge of family planning is nearly universal among adults in Bangladesh. Nearly all men or women becoming sterilized know that alternative methods of family planning are available and they have a basic understanding of the operation.

5. Cultural and religious appropriateness. Sterilization fits the traditional Bangladeshi cultural preference for early marriage followed immediately by a series of pregnancies until a couple has its desired number of surviving children. The mean number of living children at the time of sterilization is approximately four. There is no organized religious opposition; many religious leaders, or their wives, have had a sterilization.

6. Client reimbursement. The client reimbursement payment does not coerce people to have the operation and does not appear to be an important influence on the decision as to whether to get sterilized. Rather, its importance appears to be in enabling an individual to have the operation relatively soon once the decision has already been made.

7. The sterilization decision-making process. The decision to become sterilized is generally carefully contemplated over a relatively long period of time (7 to 12 months). Consideration of sterilization is usually triggered by the pregnancy or birth of a third or subsequent child--not by reimbursement payments or any other aspect of the government family planning program.

8. Other donors' concerns. Other donors and organizations are not particularly worried about the client reimbursement. Rather their concern has focused on the helper payment and on the need to improve the entire range of family planning and maternal and child health services. None of the critics, however, has been able to identify any alternative strategy that the government could actually implement.

9. Alleged discrimination against women. Sterilization services are not targeted at poor women--or at any other category of people. As of 1985, more vasectomies are being performed than tubectomies.

10. Complexity and alternatives. The voluntary sterilization reimbursement system is extremely complex and alternatives are not apparent. Much progress has been made, but anyone looking for irregularities can easily find isolated examples. To propose feasible alternatives is much more difficult.

B. Concerning The Levels of Reimbursement

1. The role of cost reimbursement. Given the poverty in Bangladesh, sterilization would be prohibitively expensive for many potential clients in the absence of cost reimbursement. Large numbers of people desiring sterilization would either not be able to have it or would need to postpone it for months or even years.

2. Current reimbursement levels. Actual costs are very close to current reimbursement levels for all recipients. Sterilization clients, male and female, currently receive a cash reimbursement of 175 takas, which is judged to be close to average actual expenditures.

3. Average cost reimbursement. It is necessary administratively to reimburse on the basis of average costs rather than attempt to reimburse actual costs on an individual basis. To reimburse on an individual basis would create administrative chaos and greatly increase opportunities for corruption.

4. Adjusting reimbursement levels over time. It is reasonable to adjust reimbursement levels over time to reflect the effects of inflation. Data necessary for this are readily available from the Bangladesh government.

Major Recommendations

1. The reimbursement system. AID should continue reimbursement for sterilization at the present levels. The reimbursement payments should not be eliminated or changed under any circumstance without first: (a) identifying an alternative arrangement that can maintain the successes and momentum that have been achieved and (b) testing the alternative arrangement on a pilot basis.

2. Screening and counseling. AID should increase its efforts to help the government improve pre-sterilization screening and counseling of requestors to be certain that low-parity or otherwise inappropriate requestors do not become sterilized.

3. Monitoring. USAID/Dhaka should continue its systematic monitoring and analysis of results.

4. Research. Where monitoring information is not adequate, USAID/Dhaka should continue to supplement this with special studies aimed at meeting program management needs. AID should join with, or support, the Bangladesh government and World Bank in their comprehensive study of the present payment system, but not conduct a separate parallel study.

Elaboration of these findings and recommendations is presented in sections II and III.

I. INTRODUCTION

A. THE BANGLADESH CONTEXT

The population problem. Bangladesh faces a population problem of greater magnitude than nearly any other country today. It is one of the world's poorest yet most densely populated nations with about 100 million largely malnourished and illiterate people crowded into an area only the size of Wisconsin. Among this population, 85 percent is rural, 50 percent of rural people are landless, and landlessness is increasing. Overpopulation is one of the major causes for the grinding poverty and deteriorating living conditions in Bangladesh. It is also a contributor to deaths brought by natural disasters, as when population pressure pushes people onto previously uninhabited, low-lying land from which they are swept into the sea by tidal floods. The population is still growing and the situation appears to be worsening each year (Mitra and Kamal 1985:7). It is widely recognized that unless rapid population growth can be brought under control, all other development efforts to benefit Bangladesh will be in vain. The health of women and children will also remain poor so long as high parity and short birth intervals continue to prevail.

Obstacles to family planning. Obstacles to providing family planning services are enormous, however. Culturally, Bangladesh is a conservative, predominantly Muslim society where young girls enter arranged marriages in their early teens and are expected to begin producing children immediately and remain in their homes, illiterate and in purdah or semi-purdah. Cultural obstacles are compounded by logistical obstacles. The infrastructure is poor or barely existent; most rural homes are without electricity and clean or running water, and roads wash away annually in the monsoon season when some 10 to 20 percent of the country is flooded and many villages are functionally cut off from the outside for months at a time. The government of this only recently independent country has yet to develop the administrative capability required to overcome the many natural obstacles and provide effective services of any kind. It is not even able to collect basic vital registration (birth and death) statistics. Many lower-level civil service workers treat their jobs as sinecures and are difficult to motivate to work.

AID and other donors are putting large amounts of money and technical assistance into other development activities, including health services. But development activities that might contribute to a fertility decline are just as difficult to carry out on any wide-scale basis as it is to provide reliable, high quality family planning services. Family planning services cannot be deferred until such time when good health care, education and employment opportunities for women and men, and old-age security may have become widely available.

Current use of family planning. Because of the high priority the Bangladesh government accords to family planning, it has become well known throughout the country, even though it is still not very widely or regularly used. Only about 25 percent of Bangladeshi couples of reproductive age currently use any form of contraception, modern or traditional methods (25.1 percent according to the 1985 Bangladesh Contraceptive Prevalence Survey [CPS]). This is in contrast to about 70 percent in the United States or, for example, 65 percent in Thailand and 60 percent in Colombia.

U.S. and other donor assistance. AID began assisting family planning efforts in Bangladesh (and formerly East Pakistan) in 1965. In recent years, AID, with the World Bank, has been one of the major supporters of the government's family planning program and its voluntary sterilization component. Other donors, bilateral and private, also provide support to family planning, including sterilization.

B. STERILIZATION SERVICES

Permanent surgical contraception (sterilization) was introduced in Bangladesh on a voluntary, pilot basis in 1966. As in many other countries, it has gradually become the leading method of contraception. About two-fifths of Bangladeshi couples using some form of contraception have had a sterilization (38.5 percent in 1983). The oral pill is the second most used method (17.2 percent of current users in 1983) (1983 CPS, Mitra and Kamal 1985).

Both male and female sterilization (vasectomy and tubectomy) are available. Female sterilization is virtually all "interval sterilization" (i.e., not immediately postpartum), since nearly all births take place in the home.

Voluntary sterilization services are provided by the Bangladesh government as part of its general family planning program, by the Bangladesh Association for Voluntary Sterilization (BAVS), by several other nongovernmental (private and voluntary) organizations (NGO), and by private physicians. It is government policy that all sterilizations in Bangladesh are to be carried out on the basis of voluntary, informed consent. Sterilization services, except by private physicians, are provided free of charge.

The reimbursement system. As part of AID's support to family planning in Bangladesh, AID reimburses the Bangladesh government for certain costs related to the provision of voluntary sterilization services. Among these costs are reimbursement (compensation) payments the government makes (1) to men and women (clients) who have the operation, to reimburse them for out-of-

pocket expenses and compensate for income forgone; (2) to "helpers" (or "referral agents") who accompany clients to and from the health centers and assist them while there, to reimburse them for their costs and services; and (3) to service providers (physicians and clinical assistants). The purpose of this reimbursement system is to neutralize financial obstacles--that is, to ensure that there are no financial obstacles or disincentives that would reduce either the availability of sterilization services or access to them.

The origins of the "helper" reimbursement are that most rural Bangladeshi women live in a state of purdah (seclusion from non-kin men), or semi-purdah, and so are culturally forbidden from leaving their homes and moving about in public unless they have good reason and are accompanied by the husband or some other situationally acceptable person. Furthermore, many women having a tubectomy take along their youngest child whom they are still breastfeeding and thus must have someone to care for this child during and after the surgery. In the absence of some "helper" to accompany them to and from the clinic, and care for their children during surgery, many women would not be able to overcome the prevailing cultural and logistical obstacles.

Moreover, sterilization is usually the first operation that a client--male or female--has had in his or her life. It may also represent the first time that the client has even stepped inside a clinic or encountered Western medicine. For men as well as women, this is often a frightening experience requiring moral support. In addition, given the lingering false notion that vasectomy is a form of castration, many Bangladeshi men are nervous and apprehensive (just as are many American men) over the possibility that the operation may render them impotent. Thus, just as in the United States, both men and women going to a hospital for surgery need someone to accompany them, so too do Bangladeshi men. For this reason, the "helper" reimbursement has also been made available for persons accompanying a vasectomy client, to ensure that this assistance will be available and to compensate the helper for his or her expenses. (The terms "referral agent" and "referral fee" were used initially for the person who accompanies a client to the clinic, but the terms "helper" and "helper's fees" have now been adopted as they more accurately reflect the reality of the situation. AID does not compensate the Bangladesh government for referrals, only for operations performed.)

Clients and their helpers receive their respective reimbursements just before the client and helper leave the health center to return to the client's home. Providers are similarly reimbursed after the operations have been performed. The Bangladesh government routinely compiles statistics on the number of procedures that have been done and submits these figures to USAID/Dhaka with a request for reimbursement. USAID/Dhaka examines these figures in light of other data deriving from its

monitoring and surveillance systems. During periods when problems have arisen, and where discrepancies exist, USAID/Dhaka decreases proportionately the amount of its reimbursement.

C. THE BACKGROUND AND PURPOSE OF THIS STUDY

The Background. AID has always closely monitored the Bangladesh sterilization program to ensure that AID policy on population assistance is carried out. USAID/Dhaka has monitored the reimbursement system especially closely to ensure that sterilization remains totally voluntary. This has included quarterly surveys by an independent audit firm and technical assistance to upgrade and monitor the quality of services delivered. Due to continuing interest concerning these payments, however, USAID/Dhaka decided to call for an independent, external review of this element of the program.

Purpose of This Study. The purpose of this study therefore was to review the current levels of reimbursement for voluntary sterilization in Bangladesh in order to

- 1) determine whether the current reimbursements levels are appropriate,
- 2) determine whether sterilization is being provided in a general context of voluntarism and informed consent, and
- 3) to the extent that available information is inadequate for answering (1) and (2), identify additional studies that should be undertaken.

Primary attention was to be given to payments made to clients, but all forms of AID-financed reimbursements for sterilization were to be reviewed (see Appendix C).

D. METHODOLOGY

Findings are based on clinic visits, analysis of research findings and program documents, intensive interviewing during visits to Bangladesh in June and November of 1985, and comparison with family planning programs in other countries where sterilization is available. In addition to scheduled visits, unannounced spot visits, unaccompanied by officials, were made to clinics while sterilizations were being performed.

Interviews were conducted with a wide range of persons, including critics of the program. People interviewed included men and women who have been sterilized, men and women who use other methods of family planning, and men and women who use no family planning; clinic personnel and fieldworkers in the govern-

ment-sponsored family planning program; managers, clinic personnel, and fieldworkers of family planning projects sponsored by NGOs (private and voluntary organizations); representatives of United Nations and other bilateral donor agencies, including organizations and representatives that have been critical of the Bangladesh government's program; representatives of women's groups that have expressed concern about women's needs and rights; social scientists and others who have been carrying out in-depth and survey research in rural Bangladesh (on family planning and other topics); and officials in the Bangladesh government and at USAID/Dhaka.

Research reports and program documents analyzed included findings of numerous studies and surveys related to sterilization (see IV.A), selected documents and reports of the Bangladesh government and other donor organizations, and all relevant files at USAID/Dhaka.

The economist team member also had special tabulations prepared from the most recent USAID-sponsored quarterly evaluation survey of sterilization clients and attempted to develop an economic framework to assist in identifying and measuring the costs involved in sterilization and in interpreting program data.

II. MAJOR FINDINGS AND CONCLUSIONS

A. CONCERNING THE GENERAL CONTEXT IN WHICH STERILIZATION IS PROVIDED

1. Sterilization Incidence and Decline

Although sterilization is the most common method of family planning in Bangladesh, only a small percentage of couples have had the operation and fewer operations are being performed in 1985 than were in previous years. Less than 9 percent of all Bangladeshi couples of reproductive age have had (either the husband or wife) a sterilization operation. This is a very small percentage in comparison with 41 percent in the United States or, for example, about 30 percent in such developing countries as Colombia and Panama or 28 percent in neighboring Thailand.

2. Is the Sterilization Program Voluntary?

The sterilization program in Bangladesh is definitely voluntary--as is all family planning in Bangladesh. This is formal policy and is set forth in general statements at all levels as well as in specific directives set forth and sent out by the Ministry of Health and Population Control to implement the national family planning program. The Bangladesh government is clearly aware that the rate of population growth must be slowed if present and future generations of Bangladeshis are to rise above the subsistence level. It also knows its people well enough, however, to know that it must proceed cautiously and that to do otherwise could easily bring its downfall--as happened close at hand in neighboring India.

Many safeguards and systems of systematic monitoring and surveillance have been established to determine and ensure that only people who want the operation have it. Through this surveillance, two or three local violations of the government's voluntarism policy have been uncovered; immediately upon discovery, these deviations have been brought to a halt. The large number of studies and evaluations that have been conducted are evidence of the vigilance of the Bangladesh government and the donors (see IV.A).

3. Coercion

Bangladeshis who become sterilized do so of their own free will; they are not coerced. Over 870,000 men and women underwent sterilization in Bangladesh between January 1, 1984 and September 30, 1985, and there is no evidence that any of them was coerced. People who have had the operation express a high level of satisfaction. Research shows satisfaction rates of 96 to 98 percent. The tiny minority who express dissatisfaction do so because the operation failed (a pregnancy occurred anyway) or because of health reasons not necessarily related to the operation. Most

adults know others who have had a tubectomy or vasectomy but do not know anyone who regrets having had the operation. A rare exception are couples whose children later died (e.g., in an accident); while these are cases of regret, and are regrettable, coercion has not taken place. The government does offer recanalization with expenses paid.

4. Informed Consent

The general atmosphere is one of informed consent. Nearly all men or women becoming sterilized have a basic understanding of the nature of the operation--that it is surgery that will leave them permanently unable to have more children, that there is some risk, and that they will experience pain. They also know that alternative methods of family planning are available. AID-approved informed consent forms, consistent with those used in the United States, are filled out prior to surgery. Exceptions appear to be few and far between. For example, out of the 873,557 men and women sterilized between January 1, 1984 and September 30, 1985, there are five people who apparently had the operation voluntarily but were insufficiently informed about it and, if better informed, perhaps would not have had it (for instance, a person who anticipated that sterilization would also cure some previously existing health problem).

5. Cultural and Religious Appropriateness

Sterilization fits the traditional Bangladeshi cultural preference for early marriage followed immediately by a series of pregnancies until the desired children are born. Traditionally, Bangladeshi girls are married off by their parents in their early teens to an older boy selected by the parents and are expected to begin producing children immediately until they have at least two surviving sons. Typically, only after the desired number of children has been born, or surpassed, do couples begin thinking about preventing more. By this time they have heard about family planning from many sources and know couples who have tried various methods, including sterilization. For couples who are certain they want no more children, sterilization is a logical choice--especially given the difficulty of using other methods when the entire family sleeps in the same tiny space and when there is no running water and no easy way to dispose of condoms or to store pills. Some couples do try another method first but then turn to sterilization after becoming discouraged by the inconvenience, side effects (especially of the pill), or an accidental pregnancy.

Desired family size in Bangladesh is between three and four children, according to recent surveys. Sterilization is used almost exclusively by couples who have a minimum of three children. Moreover, the mean number of living children at the time of sterilization is even higher--approximately four (3.9 according to one recent survey) (Mitra and Associates 1985:36).

There is no organized religious opposition to sterilization. Many religious leaders, or their wives, have now had the operation.

6. Client Reimbursement

The client reimbursement payment does not coerce people to have the operation and does not appear to be an important influence on the decision as to whether to get sterilized. Rather, its importance appears to be in enabling an individual to have the operation relatively soon after making the decision to terminate childbearing and to use sterilization as the method for doing so. Research shows that, in virtually all cases, the reimbursement permits a couple to carry out a decision already made, but is not the reason for the decision itself.

7. The Sterilization Decision-making Process

The decision to become sterilized is generally a carefully contemplated decision made over a long period of time and after discussion with the individual's spouse and others who have had a sterilization. Research shows that, for the vast majority of women, consideration of sterilization is triggered by an event--the occurrence of an additional pregnancy or birth, usually of a third, fourth, or fifth child--that is unrelated to payments, family planning fieldworkers, or any other aspect of the government family planning program. According to research findings, from the time a woman begins considering sterilization until she actually has the operation, the median time lapsed is between 7 and 12 months (a longer sterilization decision-making process than in many other countries where sterilization is common).

8. Other Donors' Concerns

Other donors and organizations involved in family planning are not particularly worried about the client reimbursement payment. UNICEF, some European donors, and some private and voluntary organizations involved in health and family planning in Bangladesh have been critical of the government program. Their chief concern, however, has not been over the client reimbursement nor belief that it is coercive.

Rather their concern has focused on the impact of the helper (or referral agent) payment and potential problems to which it might lead. Specifically, they have been concerned that the Bangladesh government is not providing better maternal and child health care, that the government is not doing a better job of promoting and providing temporary methods of contraception, and that the government clinics are not providing a higher quality of contraceptive care (including counseling and follow-up). This criticism is justified. None of the people who raise the criticism, however, has thus far been able to suggest a strategy that the government could actually implement to achieve

the improvements they are advocating. The World Bank-sponsored study of the payment system, which is to be conducted in 1986, may suggest alternatives that are not now apparent.

9. Alleged Discrimination Against Women

Sterilization services are not targeted at poor women--or any other category of people. There is no policy to target information or services disproportionately to any one group; nor is there any evidence of bias on the basis of sex, age, religion, residence, or economic status. Rural areas are emphasized, for example, simply because over 85 percent of the people live there.

At present, men having a vasectomy outnumber women having a tubectomy. In the early 1980s, many more tubectomies were performed than vasectomies, but vasectomy has gained popularity in recent years. In 1985, the ratio was about 115 vasectomies per 100 tubectomies (158,234 to 137,234). Furthermore, the government has acknowledged the crucial domestic labor contribution that women make by providing the same reimbursement payment to female sterilization clients whether they work for paid wages or perform unpaid domestic and subsistence labor.

It has also been alleged that sterilization is targeted at Bangladesh's Hindu minority.* There is no evidence of this. Tubectomy rates among Hindu women have been somewhat higher than among Muslim women. Among Hindu men, however, vasectomy rates are considerably lower than among Muslim men. Although the precise reasons for these differences are not clear, there is no evidence that any special efforts have been made with respect to Hindu women or Muslim men--or any other religious or ethnic group (Quasem 1985b: 43, 46).

10. Complexity and Alternatives

The Bangladesh family planning program is extremely complex and alternatives are not apparent. Much progress has been made, in large part because of AID and other donors' assistance. AID has had a major impact in improving medical quality (for example, introducing the improved anesthesia regimen that has greatly reduced complications) and helping overcome implementation problems. Still, anyone looking for problems or irregularities can easily find isolated instances. To interpret them accurately and propose feasible alternatives are much more difficult. Most critics in Bangladesh, when asked how to change or eliminate the present reimbursement system, have no concrete answer and end up saying that, despite their concerns, each

* About 80 percent of Bangladeshis are Muslims, about 15 percent are Hindus, and the remaining 5 percent are chiefly Christians or animists.

payment actually has much to recommend it. The only alternative suggested in the course of this study was to "abandon the whole system and start over, but only after careful planning and development of a feasible alternative strategy."

B. CONCERNING THE LEVELS OF REIMBURSEMENT

1. The Role of Cost Reimbursement

Given the poverty in Bangladesh, sterilization would be prohibitively expensive for many potential clients in the absence of cost reimbursement. Evidence from demographic and follow-up surveys indicates that substantial numbers of sterilization clients would either not be able to have, or would need to postpone, their operations in the absence of cost reimbursement.

2. Average Cost Reimbursement

It is necessary, for administrative and monitoring purposes, to reimburse certain costs on the basis of average costs, rather than attempt to reimburse actual costs on an individual basis. (This is the same principle that the U.S. government follows, for example, in establishing the per diem rates that apply to all employees visiting a given city on business, regardless of the precise expenditures of the individual visitor.) Some clinics in Bangladesh (those of BAVS) have in the past attempted to reimburse actual costs on an individual basis. Persons knowledgeable about the national family planning program agree, however, that if the government were to try reimbursing sterilization clients on an individual basis, it would not only create an administrative nightmare but would also greatly increase opportunities for corruption. It is also likely that this would result in reimbursement levels higher than the current levels (as occurred when BAVS attempted to reimburse on an individual basis).

The use of an average cost reimbursement scheme necessarily means that some individuals (in this case, some sterilization clients and some helpers) receive net benefits. It also means that other potential clients still face monetary costs as an obstacle to sterilization. An average cost reimbursement scheme also encourages clients and their helpers to limit their actual expenses, with the result that actual expenses become an imperfect guide in determining what normal expenses are.

The present reimbursement arrangement does not cover all sterilization-related costs. The most significant unreimbursed costs are probably those related to various risk factors, such as the risk of losing additional work time due to surgery-related complications and the risk of children dying who cannot be replaced.

3. Current Reimbursement Levels

Actual costs are estimated to be very close to current reimbursement levels for all recipients.

Client Reimbursement. Sterilization clients, male and female, currently receive cash reimbursement in the amount of 175 takas to cover transport and food costs and wage loss. Average client costs are estimated to be 161 takas for a tubectomy and 192 takas for a vasectomy. (The average of these two estimated average costs is almost exactly equal to the current reimbursement level.) There are several valid reasons for reimbursing men and women equally--as is currently done--even if the average costs differ somewhat. Especially given the significantly greater pain and risk of complications women face, and the longer recovery period, there is a widespread view that a lower level of reimbursement for women would clearly be discriminatory.

Clients also receive a standard issue surgical garment to be worn during surgery to minimize risk of infection. This is a sari (for women) or lungi (for men) and is comparable in purpose and relative quality to the patient gowns provided in U.S. hospitals. This constitutes an in-kind transfer that may yield some small value to some clients beyond the period of surgery. The saris and lungis do not appear to be highly valued, however, and do not appear to be an important influence on the decision as to whether to get sterilized.

Helper Payments. Average helper costs, currently reimbursed in the amount of 45 takas per client, are estimated to be 54 takas for a tubectomy and 42 takas for a vasectomy.

Provider Payments. Reimbursement to service providers is currently 20 takas per case for physicians and 15 takas per case for clinic workers. These are considered to be appropriate levels of reimbursement for income forgone in private practice.

4. Adjusting Reimbursement Levels over Time

It is reasonable to adjust reimbursement levels over time to reflect the effects of inflation. The data necessary for this purpose include a monthly series on unskilled agricultural wages together with government-authorized levels of reimbursement for meals served in hospitals, for travel (per kilometer rates), and for private surgical procedures. These are readily available from the Bangladesh government.

5. Additional Data Needs for Reviewing and Revising Current Reimbursement Levels

No additional data need be collected in order to follow the procedures described in this report for reviewing and revising current reimbursement levels. A special study would be

required, however, to determine the value to clients of the in-kind transfers that they currently receive in the form of surgical apparel.

III. SUMMARY OF RECOMMENDATIONS

1. The reimbursement system. It may be appropriate to make changes in the reimbursement system. It should not be changed in any case, however, without first determining what concurrent changes can be made to maintain the successes and momentum that have been achieved. AID should not suggest eliminating any part of the reimbursement system without being able to propose an alternative arrangement that would accomplish the function now being served by the present system, namely, minimizing or eliminating the out-of-pocket expenditures of field-workers and others who accompany these clients to the clinic. Any new system should be tested on a limited pilot basis before changes are instituted nationwide.

2. Reimbursement to female clients. The present system provides the same amount of work-loss compensation to all female clients, regardless of whether they are employed in wage labor outside the home, work outside the home for pay in kind, or are engaged in unpaid domestic or subsistence labor. This aspect should be retained. Persons knowledgeable about family planning in Bangladesh agree that a policy to reimburse only women, or men, employed for cash wages would be inappropriate, discriminatory, and also encourage corruption.

3. Surgical apparel. It may be appropriate to find an alternative to the present use of special-issue saris and lungis for improving cleanliness. The present system should not be changed, however, until a medically sound alternative is tried on a pilot basis.

4. Screening. The government should improve the pre-sterilization screening of requestors to make certain that low-parity or otherwise inappropriate men and women do not become sterilized. The eligibility requirement instituted in Bangladesh--that a person may not be sterilized until he or she has two children over one year of age--would be judged discriminatory in the United States. But in the Bangladesh context (of universal demand for children and high child mortality) it is an appropriate policy for minimizing the number of sterilized couples who become childless or otherwise regret the procedure.

5. Counseling. AID should assist the Bangladesh government in improving the quality of all family planning counseling, especially for sterilization. AID should support continued efforts by BAVS in this regard and especially its activities to help improve counseling in the government clinics.

6. Monitoring. USAID/Dhaka should continue its systematic monitoring and analysis of results.

- o Questions to measure client satisfaction should be part of the routine evaluation and monitoring process to ensure that current levels of satisfaction continue and to permit ongoing documentation of the absence of coercion. USAID/Dhaka's plan to include this in its regular quarterly evaluation as of January-March 1986 seems very appropriate.
- o USAID/Dhaka should consider including questions in its quarterly evaluation to verify also that aberrations outside the family planning program, like those that occurred in the Vulnerable Group Feeding program (see IV.C.2), do not arise again.
- o AID should consider establishing a surveillance team that would complement the present Voluntary Sterilization Surveillance Team (VSST) (see IV.A.4) but focus specifically on questions of voluntarism, including informed consent. While the VSST consists of medical doctors and has medical quality as its prime focus, the proposed complementary team would consist of social scientists or other non-physicians, at least half of them Bangladeshi, and carry out ongoing open-ended investigations of voluntarism issues (such as verifying that fieldworkers are not misleading the public and that clinic screening is weeding out inappropriate requestors). Discussion with the current head of the VSST suggests this would be a useful and appropriate measure.

7. Research. Where information from monitoring and surveillance is not adequate, it should be supplemented with special studies aimed at meeting program management needs. Studies should utilize a combination of qualitative and survey methodologies and produce results without long waits.

- o AID should join with, or support, the Bangladesh government and World Bank in their comprehensive study of the present reimbursement system. AID should not conduct a separate "definitive" study of this system.
- o AID should encourage the prompt and careful execution of the research on sterilization decision making that was proposed or initiated in late 1985 and should help the Bangladesh government to use the findings for improving sterilization and other family planning services (see IV.A.5 and Appendix E).
- o A village-based study should be carried out, similar to the study sponsored by the Swedish International Development Authority (SIDA) (Akhter, Banu, and Feldman 1983),

to evaluate the program from the perspective of the consumer, focusing on (1) the extent to which services are actually available and (2) the possibility and propensity of people actually to use these services.

8. Response to sterilization decline. If the recent decline in sterilization requests continues, AID should monitor carefully how the government contemplates responding. It should counsel against any increases in sterilization reimbursement unless adjustment to reflect inflation is needed (which it is not as of this time). These reimbursements should, however, be reviewed annually to determine whether adjustments are needed.

IV. DISCUSSION OF THE GENERAL CONTEXT

A. PROGRAM SAFEGUARDS, MONITORING, AND RESEARCH

The Bangladesh government has established clear policies and directives that all sterilization (like all family planning) must be voluntary. Certain procedures and measures have been established to ensure that these policies are carried out throughout the country. These include eligibility criteria, informed consent requirements, client screening and counseling, and monitoring systems. Where monitoring systems, general surveillance, or the press raise questions whose answers are not easily apparent, special research studies are undertaken.

1. Eligibility Criteria

To be eligible for sterilization, a Bangladeshi must be in adequate physical condition to undergo surgery and must have at least two children, the youngest of whom is at least one year old. The purpose of this policy is to reduce the possibilities of post-sterilization complications and/or regret.

2. Informed Consent

All requestors are required to have a basic understanding of sterilization and its effects. Policies are designed to ensure that all requestors document their consent to the operation.

3. Client Counseling and Screening

Each person requesting a sterilization goes through a two-part screening process on arrival at the clinic. The first step is to determine that requestors meet the parity and informed consent requirements. Some clinics, notably those of BAVS and other NGOs, have full-time counselors who have been specifically trained for this purpose. The second step is medical screening. Requestors who do not meet the eligibility requirements are "rejected" and counseled to use some other method of family planning until such time as they may meet the requirements. Many clinics maintain a list of "rejected requestors" with reasons for their rejection.

4. Monitoring Systems

Clearly in any large national program anywhere, deviations and problems can occur. The Bangladesh government and the donors know this and have therefore instituted several systems to monitor the effectiveness of the eligibility, informed consent, and screening requirements.

- o Voluntary Sterilization Surveillance Team. Establishment of a nationwide system for monitoring the quality of sterilization services in particular was made a condition precedent to further financial support from AID to the Bangladesh government in 1982. The VSST is an eight-member international team (headed by its World Health Organization representative) that travels throughout Bangladesh inspecting clinics and identifying areas needing improvement. While the principal focus is on improving medical quality, the team also monitors client counseling, screening, and informed consent practices throughout the country to ensure that the operation takes place on the basis of informed, voluntary consent.
- o Implementation, Monitoring, and Evaluation Division of the Planning Ministry. The Population Section of this division is responsible for monitoring the national family planning program and conducts on-site reviews of compliance with sterilization informed consent and reimbursement policies.
- o Quarterly Evaluation of the National Sterilization Program. This is based on a nationally representative sample of male and female sterilization clients and providers in both the public and private sector. It permits, among other things, monitoring of reimbursement payments, client characteristics, use of informed consent forms, and verification of reported performance. It is conducted by M. A. Quasem & Co., an independent, private-sector Bangladeshi firm.
- o Quarterly surveys of BAVS services. Internal auditors of BAVS, Bangladesh's largest NGO provider of sterilization services, currently monitor use of informed consent forms, and program staff conduct periodic audits of clinic activity. BAVS is in the process of establishing an in-house survey capability with which to conduct routine verifications of clinic performance, service quality, and client satisfaction.
- o Ongoing surveillance. In addition to the formal systems above, government and donor agency staff continuously monitor the sterilization program through field trips and review of key service statistics, such as sterilization incidence, method mix, client characteristics, requestor rejection rates and reasons, and referral patterns.
- o The press. A final tool for monitoring is the press. Bangladesh has an active, fairly free press which, like that of the United States, is eager to expose problems of many kinds, including occasional problems concerning sterilization.

Through this monitoring and surveillance, two or three local violations of the government's voluntarism policy have been uncovered in which officials outside the family planning program have, in their eagerness to promote family planning, engaged in coercive or potentially coercive measures. Immediately upon their discovery by USAID/Dhaka and the Ministry of Health and Population Control, these deviations (discussed in IV.C below) have been brought to a halt.

5. Special Research

In addition to ongoing monitoring, a large amount of qualitative and quantitative research has either been completed, is in progress, or is planned which is related to the sterilization decision-making process, client satisfaction, the role of reimbursement, and improving services. This research includes

- o Female Sterilization Follow-Up Study of 1984. This was a survey of 920 women sterilized in 1984 at one of nine BAVS clinics in different parts of Bangladesh. Findings of this carefully executed study describe the sterilization decision-making process, motivation for having the operation, and sources of sterilization-related information. The women in this sample are representative of the country as a whole. Research was conducted by an independent Bangladeshi research firm, Mitra and Associates (1985).
- o Ministry of Health and Population Control Client Satisfaction Survey. This was a nationally representative sample of 2,377 men and women who were sterilized at government and NGO facilities during 1983 and 1984. Preliminary findings provide data on topics including clients' information sources, characteristics, and levels of satisfaction. The survey was funded by SIDA and carried out for the Ministry of Health and Population Control by P&M (Personnel and Management), an independent Bangladeshi firm (P&M 1985).
- o Population Development and Evaluation Unit [of the Planning Commission of the Bangladesh government] Evaluation of the Sterilization Program. This study, conducted between November 1984 and February 1985, surveyed 807 men and women who had had sterilizations at government and NGO facilities. The Evaluation Unit intends to conduct annual surveys of sterilization client satisfaction.
- o Female Acceptor Focus Group Study. Four focus group sessions were held with 22 women who had undergone tubectomies at a BAVS clinic in 1984. The findings provide detailed insight into women's motives for undergoing sterilization and their subsequent views of it. The research was conducted by Quest, a Bangladeshi social science research group (Alauddin 1984).

- o VSST "Before and After" Survey. At the outset of its work, the VSST conducted a baseline survey of 234 government and NGO clinics performing sterilizations. The team surveyed all aspects of service delivery, including informed consent practices. One year later it conducted a follow-up survey by re-visiting 145 of the clinics to assess the extent of improvements.
- o PIACT Referral Fee Study. The Bangladesh office of the Program for the Introduction and Adaptation of Contraceptive Technology (PIACT) conducted this qualitative study in late 1984 to evaluate the helper (or referral agent) reimbursement system (Choudhury 1985).
- o PIACT Study on Motivational Factors That Determine the Non-use of Contraceptives. The focus group approach used in this study also furnishes information on sources of family planning methods, knowledge about sources of services and supplies, husband-wife communication, relationship to religion, perceptions of village leaders, and desired family size (Choudhury et al. 1985).
- o 1983 Contraceptive Prevalence Study. This is the largest survey ever undertaken in Bangladesh. A carefully executed survey, it involved approximately 20,000 household interviews conducted between October 1983 and January 1984. Findings include detailed data on contraceptive knowledge, use, client characteristics, and access to and availability of services. (Similar contraceptive prevalence surveys are scheduled to be conducted on a biannual basis through 1991.) (Mitra and Kamal 1985)
- o 1984 Mini-Contraceptive Prevalence Surveys. "Mini-CPSs" were conducted in four different areas of Bangladesh in late 1984-early 1985 by Jahangirnagar University. Findings include data on knowledge and use of contraceptives as well as intention to use.
- o ICDDR,B Study of Family Planning Targets and Payments. The International Center for Diarrheal Disease Research, Bangladesh (Matlab) is conducting a two-part study of family planning targets and reimbursement payments and their effects on fieldworker motivation, the amount and quality of services provided, and related issues.
- o SIDA-sponsored In-depth Case Study of Health and Family Planning in Two Villages in Comilla Division. This was a "user-perspective" study in which social science researchers lived in a rural community and employed anthropological techniques to evaluate the government program from the viewpoint of the consumer. Although rather dated in several regards, this study provides an

insightful description of village attitudes toward family planning and the government family planning program, including sterilization services (Akhter, Banu, and Feldman 1983).

The large amount of research activity in this area is itself a positive sign of the seriousness accorded in Bangladesh to developing a more effective yet still totally voluntary family planning program. As research findings become available for use, there should be increasing opportunities for improving both family planning services and the public's satisfaction with them. Other studies now beginning or planned for 1986 include:

- o Motivation and Decision Making for Sterilization. A series of 12 focus group discussions is being conducted with men and women throughout Bangladesh to understand better the factors that motivate rural Bangladeshis to become sterilized. The study is being conducted by Family Development Services and Research, a private, woman-headed Bangladeshi firm (see Appendix E).
- o World Bank-supported Ministry of Health and Population Control Payments Study. A comprehensive study of the current reimbursement system is scheduled to begin in early 1986 as a requirement of the new World Bank-sponsored population project.
- o Male Sterilization Client Follow-up Survey. This proposed survey has essentially the same purpose as the already completed female follow-up survey and is likely to include preliminary focus group research.
- o Study of Factors Influencing Sterilization Incidence in Bangladesh. This BAVS-proposed study intends to examine programmatic and demand-side factors associated with changes in both the overall levels and seasonal patterns of sterilization requests as well as reasons for the shift in popularity from tubectomy to vasectomy.

B. EVIDENCE OF VOLUNTARISM

1. General Satisfaction

The most compelling evidence that sterilization is voluntary is that men and women who have had the operation are virtually unanimous in expressing overall satisfaction with their decision. Survey findings indicate that satisfaction with the sterilization operation is nearly universal among both male and female respondents. Satisfaction rates are in the 96 to 98 percent range. The main reason reported for this high level of satisfaction is the freedom from future pregnancies. Inherent in this satisfaction is knowledge of the operation's effect and

permanence (Mitra and Associates 1985:123; P&M 1985:123, 155, 392).

2. Clients' Recommendations to Others

Large numbers of men and women who have become sterilized recommend sterilization to friends, neighbors, and relatives. Almost half of the tubectomy clients in the Female Follow-Up Survey said they had already recommended the operation within a few weeks after having had the procedure, and 96 percent stated their intention to do so (Mitra and Kamal 1985:122-125). In addition, 76 percent of vasectomy clients and 83 percent of tubectomy clients in the P&M sample said they had recommended sterilization to others while 90 percent expressed intent to do so (P&M 1985:128, 336, 338, 392).

That nearly all sterilization clients interviewed in these two surveys report satisfaction and recommend or intend to recommend the operation to others is strong evidence of a general lack of coercion. It is extremely unlikely that men and women who not only express satisfaction but also counsel others to have the operation were compelled or deceived into undergoing it themselves.

RECOMMENDATION: Questions to measure client satisfaction should be built into the program evaluation and monitoring process to ensure that current levels of satisfaction continue and to permit ongoing documentation of the absence of coercion. Perhaps the quarterly evaluation survey would be the most appropriate vehicle.

3. Reasons for Becoming Sterilized

The main reason Bangladeshis give for having become sterilized is that they did not want any more children. This was the first reason given by most of the 3,297 men and women polled in the BAVS and P&M national surveys as to why they chose sterilization. Other main reasons included "for health reasons" and "because sterilization was the safest method." None said he or she was compelled or deceived into getting sterilized. Few mentioned the reimbursement payment. In the BAVS survey, 96.2 percent of women interviewed did not mention the reimbursement at all. Of the small (3.8) percent who mentioned it at all, none mentioned it as the primary reason (Mitra and Associates 1985: 70-72).

4. Favorable Community Opinion

There is a high level of community support for sterilization. Over 90 percent of sterilized men and women polled in the national P&M survey met with favorable responses from family and friends regarding their decision to have the operation. This finding also reveals the extent to which couples talk about

sterilization with friends and relatives and suggests that the act of getting sterilized, far from being a privately held secret, is one that people discuss quite freely. An exception is some religious leaders who are pleased to have a vasectomy themselves, or to have their wives have a tubectomy, but who are reluctant to have the public discussing this fact. Opposition from religious leaders, and from mothers-in-law, was common in the late 1970s and even early 1980s but is now greatly diminished. The social interaction surrounding sterilization suggests an atmosphere in which coercion would become widely discussed and denounced.

5. Low Level of Dissatisfaction and Regret

Few people express dissatisfaction with the procedure or regret over having had it. Only 1.6 percent of respondents in the BAVS survey, for example, said they were dissatisfied in some way. The tiny minority who expressed dissatisfaction did so because of failure of the operation (a pregnancy occurred anyway) or because of health reasons not necessarily related to the operation (e.g., chronic abdominal pain that a woman hoped would concurrently be cured by the sterilization). No one who was dissatisfied reported this was due to pressure or deception related to having the operation. Some women are also dissatisfied that the doctor operating on them turns out to be a male. Dissatisfaction does not necessarily mean, however, that the person regretted having had the operation.

Regret. Actual regret appears to be rare. Most adults know others who have had a tubectomy or vasectomy but do not personally know anyone who regrets having had the operation. A rare exception are couples who have experienced the death of a child (in an accident or through illness) subsequent to the operation. While such cases are most unfortunate, they do not mean that coercion has taken place. Statistically throughout the world, regret must be expected with any surgical procedure. A common reason everywhere for regret after sterilization is the death of a child (Philliber 1985:14-15).

Requests for reversal. Requests to have a sterilization reversed (recanalization) are a definite indication of regret. The Bangladesh government does offer recanalization with expenses paid, and two or three Bangladeshi surgeons are able to perform the reversal operation. To date there have not been many requests for reversal.

In summary, it can be inferred from the very low levels of dissatisfaction and regret that sterilization decisions are being made in a reasonably well-informed and voluntary manner (Newton 1985:13). It is essential, however, to maintain and even improve procedures for pre-sterilization screening of requestors.

RECOMMENDATION: The government should improve pre-sterilization screening of requestors to be absolutely certain that low-parity or otherwise inappropriate men and women do not become sterilized. In the United States, the requirement that a person may not be sterilized until he or she has two children over one year of age would be ruled out as discriminatory. In the Bangladeshi context (of universal demand for children and high child mortality), however, the government and donors must do all they can to minimize the number of sterilized couples who become childless.

6. Cultural and Religious Appropriateness

Sterilization fits the traditional Bangladeshi cultural preference for early marriage followed immediately by a series of pregnancies until the desired children are born. Traditionally, Bangladeshi girls are married off by their parents in their early teens to an older boy selected by the parents and are expected to begin producing children immediately and to continue until they have at least two surviving sons. There is no desire, as in the West, to postpone childbearing, nor much desire to space births. Typically, only after the desired number and sex of surviving children has been achieved, or surpassed, do couples begin thinking about preventing more. By this time they have heard about family planning from many sources and know couples who have tried various methods, including sterilization. For couples who are certain they want no more children, and especially for those who know a relative or neighbor who has had the operation, sterilization is a logical choice. This is particularly true given the difficulty of using other methods when the entire family customarily sleeps in the same tiny room and has no running water and often no place safe from children, bugs, and humidity to store contraceptive supplies. Some couples do try another method first but then turn to sterilization after becoming discouraged by the inconvenience, side effects (especially of the pill), or an unwanted pregnancy (Huq et al. 1985; M. Islam 1985; S. Islam 1982; Maloney et al. 1980; Akhter, Banu and Feldman 1983).

There is no organized religious opposition to sterilization. Some Bangladeshis perceive family planning in general as "against the religion," and some Muslim religious leaders did oppose sterilization when it was first introduced. Even this scattered opposition, however, has diminished. Many religious leaders, or their wives, have now had the operation and are supportive of family planning, including sterilization.

7. Client Characteristics

Statistics support the apparent fit between sterilization and traditional cultural patterns. The characteristics of men and women who choose sterilization are not at all surprising and indicate that sterilization in Bangladesh, as in many other

countries, is the method-of-choice for older couples who have completed their families. Research reveals also that the main reason Bangladeshis use any method is to limit families, not space children. For example, in Matlab where almost 50 percent of couples use some form of contraceptive, 73 percent say they want no more children while only 27 percent use contraceptives for spacing births (Phillips 1985, in Newton 1985:26). Nationwide, "limiters" also significantly outnumber "spacers" (1983 CPS, Mitra and Kamal 1985).

Desired family size in Bangladesh is between three and four children (1983 CPS, Mitra and Kamal 1985; 1984 Mini CPS; Choudhury et al., 1985). Sterilization is used almost exclusively by couples who have a minimum of three children. Moreover, the mean number of living children at the time of sterilization is even higher, approximately four. (Mitra and Associates 1985:36; Quasem 1985a: A12.) Most women who become sterilized usually have two sons and a daughter--which is considered the "ideal" family.

8. The Decision-making Process

For most Bangladeshis, the decision to have a sterilization is generally made in a reasonably well-informed, considered, and uncoerced manner. By the time a woman actually has the operation, the median time lapsed since she first began considering sterilization is between 7 and 12 months (making this a longer sterilization decision-making process than in many other countries where sterilization is common) (Newton 1985:15). For a woman, elements of the typical decision-making process are as follows:

- o Most women and men have heard about sterilization, and alternative methods of family planning, long before they begin contemplating sterilization for themselves. By this time they have heard about family planning from many sources and know couples who have tried various methods, including sterilization.

- o Knowledge of family planning methods is nearly universal among adult Bangladeshis. Family planning is sanctioned by the Quran, which speaks of withdrawal (azl) and advises people to have no more children than they can provide for. Nearly all (over 95 percent) women of reproductive age report knowledge of female sterilization and the oral pill and the majority also know about condoms, injection, and vasectomy. Pills and condoms are almost universally available through door-to-door delivery or in local pharmacies and shops. IUDs are provided in over 1500 locations. Other methods are also quite widely available (1983 CPS, Mitra and Kamal 1985:89; Choudhury 1985:13; Newton 1985). In many villages, almost every adult knows who has been sterilized and which women have used pills (Akhter, Banu and Feldman 1983:133).

o The catalyst to begin "seriously thinking" about sterilization is usually a pregnancy or birth of a child. For nearly all couples, this is a third or subsequent birth that results in a family of two sons and one daughter (Mitra and Associates 1985:35-38, 68-70).

Couples whose children are still so young as to be at high risk of dying or couples who are apprehensive about going to a strange place (the clinic) and having surgery may prefer initially to resort to pills or condoms. It is common, however, for rural, illiterate women who have never taken any medicine in their lives to use the pill irregularly and thus find themselves with an unwanted pregnancy. It is also an unwanted pregnancy such as this that makes many couples decide to have a sterilization.

o Once a woman enters the "serious consideration phase," she almost always discusses her interest in becoming sterilized with two or more significant others--her husband and women who have already had the operation, as well as with mothers- and sisters-in-law. Of women interviewed in the BAVS survey, 98 discussed the idea with their husbands, 77 percent with already sterilized women, 26 percent with mothers-in-law, and 24 percent with sisters-in-law.

o A woman gets specific sterilization-related information from already sterilized friends, neighbors, or relatives, or from family planning fieldworkers. The vast majority of women who decide to have a sterilization report that other sterilized women were their first source of specific sterilization-related information and, along with family planning fieldworkers and husbands, furnished the most information. This includes information about the nature of the operation, when and where it is available, who can provide help in getting to the clinic, and the availability of money to defray or help defray costs (Choudhury 1985:13). Ready access to satisfied clients appears to allow Bangladeshis to refine and confirm the information on which they are basing a sterilization decision.

o The reimbursement payment does not appear to be an important influence on the decision as to whether to get sterilized. Rather, its importance appears to be in enabling the individual to have the operation relatively soon after making the decision to become sterilized. This finding emerges both from survey research and qualitative research. Researchers who conducted the in-depth village study in Comilla Division concluded, for example:

...findings among our sample population do not confirm the notion that [the reimbursement payments], in and of themselves, are a motivational mechanism, nor did they appear to act significantly differently among different classes of people participating in the Government's programme. Most

clients agreed that the money they received from the Government's programme would ensure that the operation and required stay at the Family Welfare Center would not cost an individual out-of-pocket expenses ... [but] would be used to cover the costs incurred in transportation to the Center and food for the client, her children, and other persons accompanying her. (Akhter, Banu, and Feldman 1983:78)

This study also found that some women were forced to borrow money from others to cover the costs of their stay at the health center. (Clients do not receive the reimbursement until ready to leave the center after surgery.) Borrowing this money sometimes required paying interest or incurring other obligations. In addition, the costs of kerosene, and sometimes tips to workers for bringing water or purchasing food from the local bazaar, exceeded the actual reimbursement. The study concluded that "In short, in almost all cases, there is no actual economic benefit gained" from the reimbursement payment, that it "was not a major attraction for accepting sterilization," and "does not act to independently bring people for sterilizations" (Akhter, Banu, Feldman 1983:78-79).

o After a woman decides to have the operation, there is still a de facto waiting period. Once she conveys her decision to a family planning fieldworker, with whom a surgery date is scheduled, several days or even weeks usually elapse while logistical arrangements (including arrangements for child care and accompaniment to the clinic) are completed. This waiting period appears to present adequate opportunity for reconsideration.

For the vast majority, the decision to have a sterilization appears to have been made prior to arrival at the clinic. When a Bangladeshi woman arrives at a clinic, she has already crossed most of the cultural, psychological, and logistical obstacles to sterilization and the purpose of her visit is to be sterilized, not to collect additional information about sterilization or alternatives.

In conclusion, research to date shows that the decision to limit family size, and the decision to use sterilization as the means, is associated for the vast majority with a specific event--the occurrence of an additional pregnancy or delivery--that is unrelated to payments or family planning fieldworkers. Nevertheless, additional research is still needed to understand better the preconditions, catalysts, information requirements, duration, and main influences in the process, especially among men.

RECOMMENDATION: AID should encourage the prompt and careful execution of the research on sterilization decision making that was proposed or initiated in late 1985 and should help the Bangladesh government to use the findings for improving sterilization and other family planning services.

9. Atmosphere of Informed Consent

Most men and women going into the operation appear to have a basic understanding of the nature of the operation--that it is surgery that will leave them permanently unable to bear more children, that there is some risk, and that they will experience pain. They also know that alternative methods of family planning are available. Despite some unverifiable anecdotes and charges to the contrary (see Robinson 1985), exceptions appear to be few and far between. For example, of the 920 women interviewed in the BAVS Follow-Up Study, virtually all (more than 99 percent) knew that the operation was permanent and that they could have no more children. Of the same women, 92 percent knew of more than two alternatives to tubectomy (Mitra and Associates 1985:35).

AID-approved informed consent forms, consistent with those used in the United States, are filled out prior to surgery by nearly all (98 to 99 percent) requestors (P&M 1985:217; Quasem 1985a:26, Q2'25). Signed consent forms on which are listed the basic facts requestors should understand prior to surgery do not alone constitute proof of voluntarism but, with other evidence, contribute to the likelihood that informed consent is given.

Rejection. A sizable number of persons requesting sterilization are turned down. One reason they are rejected is that they are not sufficiently informed. Some clinics (notably BAVS) reject about 10 to 15 percent of requestors for this and related reasons (i.e., medical reasons or failure to meet eligibility requirements). Government clinics are improving in their rejection of, and documentation of, inappropriate candidates (VSST 1984).

C. PROBLEMS AND ISSUES

While the general conclusion is that sterilization is voluntary in Bangladesh, some problems related to voluntarism have arisen. The public, local press, and program monitoring systems together seem to function as an effective monitoring network. It is therefore likely that the list below is quite complete and that actual problems have been few.

1. Within the Family Planning Program

Inadequate counseling and screening. Of the 873,557 men and women who underwent sterilization between January 1, 1984 and September 30, 1985, there were five people who apparently had the operation voluntarily but were not sufficiently informed about it and, if better informed, might not have had it (for example, a person who anticipated, or hoped, the operation would also cure a previously existing health problem). Examination of "Rejected

Requestor" lists that clinics maintain reveals that a fair number of sterilization requestors have been turned away because they mistakenly believed the operation would cure some pre-existing medical problem (such as chronic abdominal pain or a prolapsed uterus). In these five cases, however, the counseling and screening process, which is designed to weed out such inadequately informed requestors, did not function properly.

The screening and counseling process should also have detected a sixth inappropriate requestor. This was a young man, a gambler, who requested a vasectomy in order to obtain money (the 175 takas) to continue in a card game. Though childless, he deceived clinic staff into believing he had two children and thereby met eligibility requirements.

Six people out of 873,557 is a miniscule percentage. It is of concern nevertheless because five of these cases appear to have resulted from fieldworkers, influenced by the possibility of reaping a small net benefit from the helper reimbursement payment, who misinformed prospective clients about the operation. If these five cases occurred, the potential exists for more. Fortunately the clinic screening process almost always eliminates sterilization requestors who are not properly informed about the operation. (Evidence is provided by the Rejected Requestor records that the clinics maintain.) It would be desirable, however, if counseling were better and information accurately presented in the first place.

RECOMMENDATION: AID should assist the Bangladesh government in improving the quality of all family planning counseling, both for sterilization and for temporary methods. AID should support the continuation, and probably expansion, of recent efforts by the BAVS to help upgrade the counseling in the government clinics.*

RECOMMENDATION: AID should consider establishing a surveillance team that would complement the present VSST, but focus specifically on questions of voluntarism, including informed consent. (The VSST consists of medical doctors and has medical quality as its prime focus.) The proposed complementary team would consist of social scientists or other non-physicians, at least half of them Bangladeshi, and carry out ongoing open-ended investigations of voluntarism issues--such as determining that fieldworkers are not misleading the public and that clinic screening is weeding out

* BAVS places a great deal of emphasis on counseling for sterilization. BAVS has held special training workshops on counseling, employs full-time trained counselors in its clinics, and, recently, has begun assisting the government program in measures to improve counseling in the government clinics.

inappropriate requestors. Discussion with the head of the present VSST suggests this measure would be appropriate.

Reimbursement payments to helpers. This helper reimbursement may be more problematic than the client reimbursement. In fact, it is this reimbursement, not the client reimbursement, that has been the focus of most of the criticism of the reimbursement system that other donors (e.g., European donors and UNICEF) have raised.

The rationale on which this reimbursement was established was extremely sound, and it has a distinct cost-effective impact on the program in financially enabling the government family planning fieldworkers to leave their homes and offices and make the house-to-house visits that are a central part of their job descriptions--but which they are reluctant to make if their travel expenses are not covered. One reason was the inability of the Bangladesh government to reimburse civil servants for travel costs, or to do so promptly; the travel allowance that family planning fieldworkers were technically due thus came irregularly and late.

Now that the helper reimbursement has been in effect for several years, several problems or potential problems having to do with it have emerged. Although statistics do not exist, some fieldworkers, as noted above, have failed to inform potential clients fully about the nature of the operation, and some evidence also suggests that family planning workers may be devoting more effort to promoting sterilization than other methods. Other studies show that fieldworker performance is nevertheless improving in all aspects of contraceptive services (Choudhury 1985:8).

Some donors urge modification or elimination of this reimbursement. The Bangladesh government insists on its importance. Not all people who accompany clients to the clinics, and thus receive the helper reimbursement, are health and family planning fieldworkers. People eligible for the helper reimbursement also include family members, friends, dais (traditional birth attendants), and community leaders. Only about one-third of clients are actually brought to the clinics by family planning fieldworkers. Recent (Dec. 1985 - Feb. 1986) data show that fieldworkers bring to the clinics only an average of one client every three months.

People knowledgeable about family planning in Bangladesh say that an abrupt elimination of this reimbursement would create enormous disruption in the program, and possibly a nationwide strike by the fieldworkers, which could set the program back perhaps two years. There is no clear or easy alternative. The "unwillingness to work" on the part of the government (civil service) fieldworkers has been identified as a major weakness of

the Bangladesh family planning program in virtually every one of the many dozens of previous analyses and evaluations of the program. Thus the idea of establishing this reimbursement to finance costs is a good strategy for trying to enhance fieldworker performance.

RECOMMENDATION: AID should join with, or support, the Bangladesh government, World Bank, and other donors in their comprehensive study of the reimbursement system. AID should not suggest eliminating reimbursements without being able to propose an alternative arrangement that would accomplish the function now being served by the present system, that is, minimizing or eliminating the out-of-pocket expenditures of fieldworkers and others who accompany these clients to the clinic.

2. Outside the Family Planning Program

Feeding program requirements for sterilization. In certain parts of Bangladesh in late 1984 and early 1985, local officials decided to require that women must have had a sterilization in order to receive food supplies. This situation occurred in the "Vulnerable Group Feeding" program, which distributes food to needy Bangladeshis. It is managed centrally by the United Nation's World Food Programme but is administered in the rural areas by elected local officials, called union council chairmen. Food supplies are often not adequate for all requestors, and therefore some means has to be devised to decide who should receive the limited supplies. The problem arose when some union chairmen, eager to assist the government in its family planning effort, and independent of any discussion with superiors, decided to add to the requirements for receiving food that women getting the food must have been sterilized. Standard criteria of the Vulnerable Group Feeding program do not require women to be users of family planning at all. Adding the sterilization requirement was clearly a violation of existing policy.

There is no firm evidence that unwilling or unprepared women actually became sterilized in order to get the food, but the mere existence of such a pre-requisite clearly violated World Food Programme, government, and donor policies prohibiting such inducements. Once the Ministry of Health and Population Control became aware of the situation, swift corrective action was taken, including a formal government directive banning any linking of such welfare benefits to family planning acceptance.

To help verify that the sterilization requirement had been more of a potential than an actual problem, and that corrective actions were effective, USAID/Dhaka added questions to the quarterly evaluation of the national sterilization program to determine if sterilization clients were promised or actually given anything other than the program-approved reimbursement and

surgical garments. None of the sterilization clients interviewed in connection with the 1985 second-quarter evaluation reported receiving food or any other unapproved items, and no new incidents have otherwise been reported. The World Food Programme has now added to the monitoring guidelines used by its field officers questions to verify that sterilization is not being used or perceived as an eligibility requirement for this feeding program.

RECOMMENDATION: USAID/Dhaka should consider including questions to its quarterly evaluation to verify that aberrations such as occurred in the Vulnerable Group Feeding program do not arise again.

Army involvement in 1983. In late summer 1983, the army was assisting in relief and health activities in the aftermath of massive flooding in the Mymensingh area. While helping family planning workers in one subdistrict, military ambulances were used to transport sterilization clients to clinics. Reports were received that these efforts were perceived as coercive and forced sterilizations was reported in at least one case. Immediately upon hearing of this, USAID/Dhaka and Bangladesh government officials visited the site, investigated the situation, and brought it to a halt. The government in Dhaka promptly ordered the military to avoid all further involvement with family planning. There have been no subsequent problems.

3. Decline in Sterilization Requests

The popularity of sterilization climbed from the early 1980s through November 1984, but has since declined. The reasons for the decline are not understood and, in fact, constitute a puzzle for everyone knowledgeable about sterilization in Bangladesh. The decline may be (1) evidence of "saturation"--that most high parity couples who firmly desire to terminate childbearing and who have good access to a family planning clinic have already had a sterilization operation and (2) further evidence that the reimbursement is not enough to induce people to have the operation if they do not want it for terminating childbearing.

Recent data show that many Bangladeshis remain afraid of being operated on. In one study, for example, a substantial number of people indicated "inability to afford treatment for complications" as a reason for not having a sterilization operation, while men in particular mentioned "scared of operation" as a reason (Choudhury et al. 1985: 15-16). In general, there remains a large proportion of Bangladeshi adults (almost 40 percent as of 1983) who are not currently using any form of contraception but say they intend to use contraception in the future (Mitra and Kamal 1985:245).

RECOMMENDATION: AID should monitor carefully how the Bangladesh government contemplates responding to the recent

decline in sterilization requests. AID should counsel against any increases in reimbursement levels unless an adjustment is needed to reflect inflation. As of this review, present levels correspond to actual current costs and such adjustment is not needed. These reimbursements should, however, be reviewed annually to determine whether adjustments are needed.

RECOMMENDATION: Given the recent decline and also the large number of men and women who say they want no more children but do not want to undergo surgery, AID should continue and expand its efforts to improve access to other contraceptive methods, especially the IUD.

V. CONCEPTUAL FRAMEWORK FOR ANALYZING REIMBURSEMENT COSTS

A. BENEFITS, COSTS, AND CONTRACEPTIVE USE

It is assumed that decisions on whether to use contraception and, if so, which contraception method to use, are based on a subjective assessment of the benefits and costs of each method. In the context of this report, benefits and costs include both pecuniary and nonpecuniary (or psychological) elements. The benefits of contraceptive use derive mainly from the increased levels of consumption per family member that become available with a smaller family size. In this regard, one may expect some variation in expected benefits between methods, reflecting the different levels of protection associated with different methods. For example, sterilization provides a significantly higher level of protection--and hence, a higher level of expected benefits--than do condoms.

Costs include out-of-pocket expenses associated with the use of each method--for example, payments for condoms and pills or transportation expenses involved in seeking clinic-based methods. In the case of sterilization (and to a lesser extent IUDs), pecuniary costs also include any income forgone either in the form of lost earnings (wage employees) or in the form of an imputed value for work time lost (self-employed workers, housewives). These pecuniary costs are the costs that are presently reimbursed by AID to the Bangladesh government.

In addition to the above, sterilization involves certain other costs that are not presently reimbursed. Some of these involve various risks, such as the risk that all one's children may die or the risk that complications may arise that prevent the client from working for a longer period of time than the usual recovery period. These risk-related costs are pecuniary in nature because it is possible to place a monetary value on them. For example, when children die and cannot be replaced, parents can expect to lose some financial support in their old age. Similarly, when complications arise, clients lose additional work time (i.e., they forgo additional income) as the result of a sterilization.

Yet a third category of costs to sterilization clients consists of nonpecuniary items that are difficult, if not impossible, to value monetarily but that may nevertheless pose significant obstacles to potential clients. The forgone pleasure that one might otherwise enjoy from having additional children is an example of a "psychological cost" associated with the use of sterilization (although, with the typical sterilization client, this cost is assumed to be more than offset by the perceived benefits of higher levels of consumption per existing family member, as noted above). Other psychological costs might derive from any social stigma or awkwardness associated with the use of

particular methods (e.g., the difficulty in using condoms under crowded living conditions, or the social stigma that may be attached to male sterilization).

Potential clients are assumed to weigh the perceived benefits and costs associated with each method and to select that method for which the benefit-cost ratio is highest. In cases in which all such ratios are below one, the potential client would be unlikely to use any method.

Not only the magnitude but also the timing of benefits and costs is assumed to play an important role in the potential client's decision. Benefits that occur far into the future must be discounted before they can be compared with benefits and costs experienced in the present. The timing factor is particularly important in the case of methods, such as sterilization, that involve a significant pecuniary outlay in the present in order to obtain a stream of benefits lasting for several years. A high subjective discount rate on the part of potential clients, such as is almost certainly the case in Bangladesh, tends to act as an additional deterrent to the use of such methods.

The available data suggest that, in the absence of any program to reimburse clients' costs, the relatively high costs of sterilization would constitute a strong obstacle to its use. For example, in the BAVS follow-up study of 920 female sterilization clients, more than half the respondents said they would either not have been able to afford the operation or would have had to postpone it had they not been reimbursed for their costs (Mitra and Associates 1985).

B. THE ROLE OF REIMBURSEMENT

The objective of the reimbursement system is assumed to be the removal of pecuniary cost (including imputed costs for work time lost) as a determining factor, both in the decision to use contraception and in the choice of contraceptive method. In an ideal family planning program, pecuniary cost would be reduced to zero for all methods, and the decision to use any method, as well as the choice of method to use, would be based on a subjective comparison of the perceived benefits and the perceived nonpecuniary costs.

In practice, this "zero cost" ideal is rarely met. Certain costs, such as those associated with risk factors, are rarely reimbursed. In addition, it is generally not practical, administratively, to reimburse clients on the basis of actual costs. Instead, clients must be reimbursed on the basis of some average cost level. In Bangladesh, past attempts to reimburse on the basis of actual cost--for example, by using schedules for the reimbursement of transport costs that depended on the client's place of residence--led to misreporting of addresses, thereby

complicating follow-up, surveillance, evaluation, and audit work. This was the experience of BAVS, which until about a year ago, reimbursed sterilization clients for their actual travel costs in connection with a return visit to the clinic for suture removal and other follow-up. Individual clients who purported more distant addresses were able to derive a larger travel-cost reimbursement.

C. THE EFFECTS OF AVERAGE COST REIMBURSEMENTS

Average cost reimbursement is thus necessary administratively, but one consequence is that some clients necessarily receive small net benefits as a result (i.e., reimbursements exceed actual costs) while other clients have only part of their actual costs reimbursed. For the latter group, the cost reimbursement scheme fails to remove the obstacles imposed by pecuniary costs. This category of client would include people living at some distance from a clinic (for whom actual transport costs would be relatively high) and people for whom time is relatively valuable (i.e., people receiving relatively high wages or with large landholdings). It is reasonable to expect that actual clients are drawn disproportionately from the group of potential clients who can expect to receive some net benefits from the reimbursement scheme.

The presence of small net benefits for some individuals is a necessary consequence of any average cost reimbursement scheme and persists even if reimbursement levels are set exactly equal to the average of actual costs. The potential for deriving a small net benefit raises the possibility that the reimbursement scheme may attract some individuals to opt for sterilization when they might not do so if faced with the "zero cost" ideal. Even if reimbursement levels are exactly equal to average costs, this possibility remains for a minority of clients.

Another consequence of average cost reimbursement is that it motivates some persons to minimize their actual costs in order to derive a net benefit. Examples are walking to a clinic or bringing food along with them to a clinic, even though the level of reimbursement is premised on their use of paid transport and their purchase of food on the open market. Under these conditions, actual costs provide a biased measure of the true cost of the items for which clients are intended to be reimbursed.

The real litmus test in determining whether the possibility of a net benefit, even though small, inappropriately attracts potential clients is whether a significant number of people are opting for a method, in this case sterilization, that they do not want. In other words, are a significant number of people choosing to be sterilized in order to obtain net benefits? The question can be put simply in economic terms: Is steriliza-

tion an economic "bad" (as opposed to a "good") for a significant number of clients? Would they prefer a package consisting of reimbursement without sterilization to the one offered (i.e., reimbursement with sterilization)?

Under conditions in which the reimbursement of costs is attracting potential clients to accept a method that they do not want, one would expect them to express regrets about that method in a follow-up survey. Thus, responses of satisfaction with a method for which an client has had his or her costs reimbursed constitute strong evidence against the possibility that the potential net benefits are having a coercive effect. In the case of Bangladesh, responses to questions concerning client satisfaction have thus far elicited positive responses from 96 to 98 percent of clients (Mitra and Associates 1985: 123; P&M 1985: 123, 155, 392).

D. INTERPRETING THE DATA

The conceptual framework outlined above can be used to interpret certain phenomena that have been observed--or may be observed in the future--in connection with the Bangladesh sterilization program. Some of these phenomena are discussed below.

1. Seasonal Variation in Clients

The numbers of clients per month varies significantly throughout the year (see Table 1), as does everything in a peasant economy such as that in Bangladesh, where human activity is closely tied to the agricultural seasons. The months of September and October in particular show relatively high numbers of clients. Two explanations for this seasonality of sterilization activity have been suggested.

The reality appears to be that people choose to time their surgery in such a way as to minimize income losses by having the surgery during slack periods in which there is relatively little agricultural work. (Even in the U.S., it should be noted, people do not schedule elective surgery during their peak work periods.) In Bangladesh, September and October are periods of slack labor demand, because they are dry months before the harvest when there is relatively little need for agricultural day labor. This then is a time when people can best afford to spend a week or so undergoing and recovering from surgery.

It has also been hypothesized, however, that the higher numbers of clients during the slack labor periods reflect increased need for income on the part of poor families, since it is then, before the harvest, that the price of rice tends to be highest and opportunity to earn wages in agricultural day labor tends to be lowest. The actual data do not support this hypothesis.

Table 1

MEAN AGE, PARITY AND NUMBER OF CLIENTS BY QUARTER

<u>Quarter</u>	<u>Number</u>	<u>Mean Age</u>	<u>Parity</u>
VASECTOMIES			
April - June '83	12,412	39.1	3.8
July - Sept. '83	19,794	39.7	3.9
Oct. - Dec. '83	65,269	40.0	3.9
Jan. - March '84	67,763	40.3	3.9
April - June '84	61,467	42.3	4.1
July - Sept. '84	92,217	43.1	3.8
Oct. - Dec. '84	84,760	43.7	4.1
Jan. - March '85	43,051	44.1	3.9
TUBECTOMIES			
April - June '83	50,346	29.4	3.9
July - Sept. '83	51,549	29.4	4.2
Oct. - Dec. '83	104,841	29.7	4.0
Jan. - March '84	118,058	29.4	3.8
April - June '84	61,002	30.3	4.0
July - Sept. '84	77,102	30.3	3.9
Oct. - Dec. '84	79,946	29.9	4.0
Jan. - March '85	47,770	29.9	3.7

Source: Age and Parity: USAID Quarterly Evaluation Surveys
Numbers of Clients: BDG MIS Data

If the increases in sterilization clients during such slack labor periods were due to increased need for income, one would expect an increase in younger and lower parity clients at that time (indicating that need for money, rather than desire to limit family size, was motivating people to have the sterilization). Monthly data on the age and parity of clients are available from all the BAVS clinics. Examination of these data reveals no evidence of any correlation between the numbers of clients and their average age and parity: there is no decrease in age or parity during any given year that corresponds to that year's seasonal variation in the numbers of clients; and there is not even any variation in age and parity that is consistent from one year to another.

The monthly age and parity data thus indicate that increased need for income is not an important determinant of the seasonal variation in clients. Age and parity data from the government clinics are available on a quarterly basis only. While less precise, these quarterly data still support the same conclusion as the BAVS monthly data.

2. Increases in Clients Following an Increase in Reimbursement Levels

One would expect an increase in clients following an increase in the reimbursement level. The justification for reimbursing costs is that in the absence of reimbursement many potential clients are unable to afford sterilization. Each time the reimbursement level is increased, a whole new group of potential clients becomes able to cover their expected costs. Under these conditions, one would expect an increase in the reimbursement level to lead to significant increases in the number of clients, particularly in the short run, with the number returning gradually to the lower levels determined by demographic change (i.e., increases in parity among all potential clients).

In Bangladesh, however, even this is not necessarily the case. It is significant, for example, that the dramatic increase in sterilization clients in late 1983 began before increased levels of reimbursement went into effect.

To the extent such increases were due to the possibility of deriving a small net benefit, one would expect declines in parity among clients, as evidence of the impact of higher reimbursement levels on the desire for, as opposed to the affordability of, sterilization. As the data in Table 1 indicate, there is no evidence of any decline in parity among clients following the late October 1983, increase in client reimbursement levels.

3. Decline in Client Quality with an Increase in Reimbursement Levels

It has been suggested that a decline in the "quality" of clients (e.g., older ages and higher parity) following an increase in reimbursement levels constitutes evidence that some people are having a sterilization for the sake of the small net benefit that some sterilization clients can derive from the reimbursement. This is not true. The reason for making reimbursements in the first place is to make sterilization an affordable option for the poor. For this reason, the poor are likely to exhibit a higher degree of sensitivity to changes in reimbursement levels than are the relatively better off. One would also expect older ages and higher parity among clients following an increase in reimbursement levels. The expected benefits from sterilization decline at older ages and at higher parity. As net pecuniary costs decline with higher levels of reimbursement, the benefit-cost ratio associated with sterilization becomes more favorable among older, higher parity couples.

4. Shifts in Method Mix in Favor of Sterilization

It has been suggested that the shifts in the method mix that occur following increases in reimbursement levels may reflect distorted patterns of contraceptive choice due to the potential for receiving a small net benefit. However, some shift in the method mix can be expected as the intended result of increases in reimbursement levels. Such a shift in the method mix in favor of sterilization might signify that the relatively high costs of sterilization acted previously to prevent appropriate potential clients from selecting sterilization as a method. It is at least conceivable that potential clients for whom reimbursement levels can be expected to exceed actual costs (as the result of average cost reimbursement) might be attracted to select sterilization as compared with other methods. On the other hand, it is equally true that potential clients for whom reimbursement levels fall short of actual expected costs would be subject to the opposite influence.

The only way to determine the extent to which such distortions in method mix are present is to ask clients which method they would select if cost and availability were not a constraint (i.e., the "zero cost" situation) and compare their responses with the actual method mix. Although such questions have never been asked in the Bangladeshi context, data from the 1983 Contraceptive Prevalence Survey (Table 11.4) indicate that 11.4 percent of female respondents not then using contraception intended to use sterilization as the preferred contraceptive method. The percentage favoring sterilization corresponds to almost 700,000 women, a figure well below the number of actual post-1983 acceptors, as is clear from the data in Table 1. It is

fair to say, therefore, that the actual levels of female sterilization since the 1983 survey do not suggest any major shift in the preferences of females (Mitra and Kamal 1985:247).

5. Family Planning/Health Worker Time Devoted to Sterilization-related Activities

Increases in the share of family planning/health worker time spent in sterilization-related work could be interpreted as evidence of distortions produced by attempts to reimburse such workers for their sterilization-related costs (i.e., the helper payments). There are at least three alternative explanations, however, for such an observed phenomenon. First, such shifts may be due to shifts in demand from the public, as discussed above. Second, time requirements per case are likely to be higher for sterilization clients, and to a lesser extent IUD clients, than for clients of other methods. In some cases, moreover, sterilization-related work (e.g., discussions with potential clients) can easily be combined with other activities, such as commodity distribution. Third, total time worked may increase significantly, as the result of average cost reimbursement, so that an increase in the share of time spent on sterilization-related work may not signal any decrease in the amount of time spent in other activities. One recent study, for example, found that the gains in sterilization were not being made at the expense of other methods, but that performance was improving in all aspects of family planning (Choudhury 1985: 8). This means that any attempt to look at changes in the proportion of time spent in any single activity should also attempt to measure any changes in the overall level of work effort.

VI. DISCUSSION OF REIMBURSEMENT LEVELS

A. CLIENT REIMBURSEMENT

All sterilization clients are currently reimbursed for wages (or work time) lost, transport costs and food costs. At present, the total amount of this reimbursement for both tubectomies and vasectomies is 175 takas (equal to about \$5.45 at current exchange rates). In addition to cash reimbursement, female clients receive a sari and male clients receive a lungi, both of which are intended to be used as surgical garments.

Clients are not reimbursed for certain other costs, such as those related to various risk factors (e.g., surgery-related complications or children dying who cannot be replaced). Clients are also not reimbursed for various types of "psychological costs" (e.g., forgone pleasure from additional children, shame associated with male sterilization).

1. Wage (and Work Time) Loss

At present, compensation for wages (and work time) lost is 117 takas for male clients and 75 takas for female clients. These levels were established in October 1983. (Original levels had been 50 and 25 takas, respectively.) At that time, USAID/Dhaka concluded that the new levels were reasonable in light of prevailing wages for men and women and on the assumption that six days of work time were lost in the case of both men and women. The premise that the amount of lost work time for which clients are reimbursed should be the same for both men and women has never been questioned. This is chiefly a medical issue.

Tubectomy. Almost all women receiving tubectomies spend one night at the clinic where the operation is performed. Data from USAID/Dhaka's quarterly evaluation surveys confirm that more than 99 percent of tubectomy clients remain at the clinic for only two days (i.e., one night). Two days of work are therefore lost at a minimum. In addition, the women are told to avoid all heavy work for several days after leaving the clinic and, generally, to take it easy for about a week. Originally, it was proposed to reimburse women for six days of work time lost, but this was reduced to four days in the course of the original project review. The number of days for which female clients are reimbursed was restored to six days in October 1983. (This took place during USAID/Dhaka's review of the Bangladesh government's request to raise client reimbursement to the present 175 takas.)

A period of six days for surgery and recovery is clearly justified on the basis of international medical standards. Data from the BAVS follow-up survey indicate that most women return to

light work within three-four days following their operation (Mitra and Associates 1985: Table 10.5). In other developing countries too, physicians advise women to rest about one week after sterilization by minilap (the technique used in Bangladesh), but report that many women do not feel fully recovered until 10 or 11 days later. It should be noted, however, that the use of an average cost reimbursement scheme encourages clients to return to work as soon as possible and that, in the absence of any reimbursement, they might return to their normal activities even earlier, thereby increasing the risk of serious complications. For purposes of this analysis, the period of six days of wage (or work time) lost in connection with a tubectomy has been retained. (If this is considered to be either too short or too long in relation to recommended medical practices, the estimates in Table 2 should be adjusted accordingly.)

Efforts to date to value women's time have estimated that the wage for unskilled female labor is equal to roughly two-thirds of the corresponding male wage. Relatively few women work for cash wages in rural Bangladesh, so it is difficult to obtain comparable wage data for men and women. Poor, rural, and illiterate women are generally employed at low-status jobs, such as rice processing, general housework, or as servants; they are usually paid in kind rather than cash (Hug 1979 in Mitra and Kamal 1985:8). Cash wages are paid, however, by several donor-financed rural employment schemes. The CARE-administered Rural Maintenance Program, for example, pays destitute women a cash wage of 12 takas per day for a five-hour day (the idea is to leave these women enough time to perform their regular household work). Since the typical Bangladeshi housewife can be assumed to work 12 to 15 hours per day, a wage rate of 15 takas per day would appear to be a reasonable basis for valuing women's time. (This amounts to 60 percent of the male wage.) Assuming six days of work loss, the average cost of work time lost in connection with a tubectomy is estimated to be 90 takas.

The question has been raised as to whether any reimbursement should be made to female clients for work time lost, since only about 10 percent of the women undergoing sterilization are employed outside the home. For the other 90 percent, the cost of work time lost must be imputed. Failure to do so (i.e., neglect of this cost component) would result in estimates of average cost for tubectomy clients with a substantial downward bias and would discriminate (as compared with the treatment of male clients) against the approximately 10 percent of women who do work outside the home.

Moreover, it is undeniable that women play an important economic role in Bangladesh and that their labor clearly has economic value, even when confined to domestic or subsistence work. In addition to child care, labor-intensive food preparation and other types of housework, women spend a great deal of

Table 2

CURRENT REIMBURSEMENT LEVELS AND ESTIMATED AVERAGE COSTS

	<u>Estimated Average Costs</u>	<u>Current Reimbursement</u>
TUBECTOMY		
1. Client Compensation		
Work Time	Tk. 90	Tk. 75
Transport	35	40
Food	<u>36</u>	<u>60</u>
Subtotal	Tk. 161	Tk. 175
2. Helper Reimbursement		
Transport	30	30
Food	<u>24</u>	<u>15</u>
Subtotal	Tk. 54	Tk. 45
3. Provider Reimbursement		
Physicians	20	20
Clinic Workers	<u>15</u>	<u>15</u>
Subtotal	Tk. 35	Tk. 35
TOTAL	Tk. 250	Tk. 255
VASECTOMY		
1. Client Compensation		
Work Time	Tk. 150	Tk. 117
Transport	30	40
Food	<u>12</u>	<u>18</u>
Subtotal	Tk. 192	Tk. 175
2. Helper Reimbursement		
Transport	30	30
Food	<u>12</u>	<u>15</u>
Subtotal	Tk. 42	Tk. 45
3. Provider Reimbursement		
Physicians	20	20
Clinic Workers	<u>15</u>	<u>15</u>
Subtotal	Tk. 35	Tk. 35
TOTAL	Tk. 269	Tk. 255

time processing rice and other food products that would be factory processed and readily available for purchase in other countries. The loss of a woman's labor, even for the two days when she is absent and the five-nine days following when she must refrain from abdominal strain, does involve significant costs for the typical low-income family. Either the husband himself must stay home from work, or relatives or neighbors must be imposed upon, which results in a debt that must be reimbursed (for example, with a meal).

Another complicating factor is that many women who work outside the home receive wages in kind (e.g., food supplies) rather than cash. In addition, many men do not receive cash wages for their work either (e.g., men who work on their own small agricultural plot).

Persons knowledgeable about family planning in Bangladesh therefore agree that a policy to reimburse only women, or men, employed for cash wages would be inappropriate, discriminatory, and also encourage corruption. It would be impossible to prevent clinic personnel (many of whom are also very poor) from falsifying records, to show clients not employed for wages as employed for wages, and then pocketing that portion of the client's reimbursement. It would also be extremely difficult to verify earnings, especially when in kind. The answer to this reimbursement question is thus that all female clients (and all male clients likewise) should be reimbursed equally, regardless of whether they work for cash wages, for in-kind pay, or in domestic labor.

Vasectomy. It is not easy to determine exactly how many days males should be reimbursed for wages lost in connection with a vasectomy. Six has been recommended medically, given the heavy labor many vasectomy clients perform, although clients without any complications can return to work earlier. USAID/Dhaka originally recommended six days. This was reduced to four days (as with females) by AID/Washington during its review of the original project. Again (as with females) the number of days reimbursed was restored to six by USAID/Dhaka, and subsequently approved by AID/Washington, in October 1983, when the Bangladesh government proposed increasing client reimbursement to its present level.

A period of three-four days (one day for surgery and two-three days for recovery) appears to be the minimum recommended length of time for which a vasectomy client would be away from work. A longer recovery period would be necessary before resuming the particularly strenuous manual labor that is the mainstay in rural Bangladesh (e.g., pedaling a rickshaw, heavy agricultural labor). The relatively high reported rates of complications among vasectomy clients in Bangladesh also suggest

that the average recovery period is longer than three-four days.* Given that both the chance of complications and the physical demands of heavy manual labor are so much greater in a country such as Bangladesh than in a developed country, it would be medically risky and inappropriate to advise clients to return to work in the same period of time as in a developed country. Therefore, for purposes of this analysis, the period of six days of wage (or work time) loss in connection with vasectomy has been retained. (If this period is considered either too long or too short on medical grounds, the estimates should be revised accordingly.)

Although most men work outside the home, it is certainly not the case that all (or even most) men work for wages. Many men work on their own agricultural land and, accordingly, the cost of work time lost must also be imputed in their case. It has been customary to use the daily wage for unskilled agricultural labor (without food) as a basis for valuing male labor. The most recent data suggest that a value of 25 takas per day is appropriate for this wage (see Table 3). There is evidence of some seasonal variation in this series, but it does not appear large enough to justify the additional effort to develop more refined estimates. Assuming six days of work time lost, the average cost of wage (or work time) loss in connection with a vasectomy is estimated to be 150 takas.

2. Transport Costs

Clients travel to the health center by some combination of bus, boat, rickshaw, train, and foot. Travel time averages about four hours round trip, and considerably more in the rainy season. Both men and women are presently reimbursed 40 takas for transport costs. The original reimbursement, until October 1983, was 35 takas for women and 30 takas for men. The higher rate for women was justified on the grounds that many women must bring along their youngest child (whom they are still breastfeeding).

Some data are available on actual transport costs to BAVS clinics, which until about a year ago reimbursed clients on the basis of actual transport costs of around 30 takas round trip. On the basis of these data, the present levels of reimbursement

* In a follow-up survey of 1,151 tubectomy clients and 334 vasectomy clients, men reported the following relatively high (although not mutually exclusive) rates of postoperative complications: infection (11.7%), fever (21.6%), induration (18.6%), and swelling (28.7%). It is important to note that these were clients' perceptions, not a medical assessment (BAVS, "Prospective Study of Complications and Deaths from Sterilization Procedures," Table 8).

Table 3

**AVERAGE DAILY WAGES (WITHOUT FOOD)
OF UNSKILLED AGRICULTURAL LABOR**

<u>Period</u>	<u>Takas Per Day</u>
1981-82	15.48
1982-83	17.05
1983-84	19.58
1983-84	
April	19.80
May	20.85
June	22.00
1984-85	
July	21.95
August	21.95
September	22.00
October	21.95
November	23.00
December	24.55
January	24.55
February	24.85
March	27.10
April	26.70

Source: Monthly Statistical Bulletin of Bangladesh (May, 1985), Table 3.1.

for transport costs appear a bit high, although a slightly higher transport cost for women may be expected. Accordingly, estimates of 35 takas for the average transport costs of tubectomy clients and 30 takas for vasectomy clients appear reasonable.

3. Food Costs

Women are currently reimbursed 60 takas for food costs, while men are reimbursed 18 takas. In both cases, the reimbursement for food expenses is intended to cover the extra cost of food purchased while the client is actually at the clinic. Originally, the levels of reimbursement for food were set at 48 takas for tubectomy clients and 16 takas for vasectomy clients. According to an International Program of the Association for Voluntary Sterilization (IPAVS) document ("Report on the Proposed Increase of Voluntary Sterilization Acceptor Payment and VSC Medical Cost System in Bangladesh"), the original justification for these reimbursement levels was that women would be accompanied by two persons (a spouse and a child)--and hence provision was made for food for three persons--while it was assumed that a vasectomy client would be accompanied by only one person. This same document indicates that the original levels of reimbursement for food expenses (48 takas for tubectomies and 16 takas for vasectomies) were based on a daily rate of eight takas per person (three persons times two days for tubectomy clients and two persons times one day for vasectomy clients). The quarterly evaluation surveys sponsored by USAID/Dhaka confirm that more than 99 percent of tubectomy clients remain at the clinic for two days (i.e., one night), while almost all vasectomy clients leave the clinic on the same day as their operation.

The Bangladesh government currently authorizes a payment of 12 takas per day to private caterers providing meals to patients at government hospitals. It seems reasonable to reimburse sterilization clients in the same amount for meals prepared and served under similar circumstances. Food costs of 12 takas per day are also close to the Bangladesh government's Daily Allowance (per diem), the food component of which is estimated to be roughly 12 takas per day at a monthly salary level of 500 takas. If it is assumed that women are not generally accompanied by their spouses (as the IPAVS memo indicates) and that the youngest child (who typically does accompany her mother) requires only half of the adult food allowance, average food cost in connection with a tubectomy is estimated to be 36 takas (i.e., two days at 18 takas per day). In the case of a vasectomy, average food cost is estimated to be 12 takas (i.e., one day at 12 takas per day).

4. Surgical Garments

Clients are also given the surgical garment that is provided for each sterilization patient. Female patients receive a sari and male patients a lungi. Their purpose is to reduce the

risk of infection, and there is fairly broad agreement in the local medical community that proper use of these garments does achieve this purpose. Most clinics lack laundry facilities for washing such items and so re-use of these garments from patient to patient would not meet the purpose of minimizing chances of infection. Although intended solely for the purpose of improving the quality of medical care, the provision of surgical garments does constitute an in-kind transfer that presumably yields some minimal value to some clients beyond the period of surgery.

Just what this value, is is questionable. The Bangladesh government currently purchases these saris and lungis for approximately 90 takas and 50 takas respectively. It would be incorrect, however, to consider that these garments represent an in-kind transfer of equivalent value to clients. The saris and lungis are all standard-issue colors, identifiable by the public as sterilization garments, and are not high quality. It appears that people accept them as something that comes to them at no cost, but would not use their own money to buy them. If offered cash instead, it is likely that clients would choose the cash and probably spend most of it on food. Even if an article of clothing were purchased, it is unlikely that sterilization clients would select the same type of garment as that provided by the clinics, in terms of color, style, and quality. Some people do wear the sari or lungi after the period of surgery and recovery, but many do not. Many say they would be embarrassed to wear it, since the standard-issue color and pattern would identify them to everyone as just having had the operation. Others say it is of such poor quality (color washes out and it becomes like mosquito netting) that is only good for putting on the mattress. Hindu men point out that the lungi is a Muslim garment, and Muslim men point out that it is just one unseamed piece of fabric, not seamed like a real Bangladeshi lungi.

For these reasons, and without additional information, it is not possible to place a monetary value on the in-kind transfer received by clients in the form of surgical garments (see further discussion at the end of VI.E).

5. Equal Reimbursement for Men and Women

In the Bangladeshi context, there may be significant political and ethical reasons for continuing to reimburse male and female sterilization clients equally, even if the average wage-loss costs of a vasectomy are somewhat higher than those of a tubectomy. If men were actually reimbursed at higher levels, the government might appear to be promoting sterilization of men over women--not a judicious approach in a traditional, male-dominated society--even if such a policy were the result of donor requirements. This is possibly the reason that the Bangladesh government proposed equal reimbursement levels for men and women in October 1983. (Initially, men received more than women.) Setting reimbursement levels at roughly the average of tubectomy

and vasectomy costs constitutes a reasonable solution. In this regard, it is noteworthy that

- 1) the number of vasectomies has been rising dramatically in recent years in comparison with tubectomies, suggesting that equal levels of client reimbursement do not distort the decision-making process; and
- 2) vasectomies performed during 1985 significantly outnumbered tubectomies and any adjustment in the current reimbursement levels in the direction of the average cost estimates reported in Table 2 would only tend to accentuate this difference.

B. HELPER REIMBURSEMENT

Reimbursement for helpers is currently 45 takas for both tubectomy and vasectomy clients. The levels of reimbursement of helper costs for transport and food should be consistent with those paid to clients. Accordingly, helpers accompanying tubectomy clients should receive 54 takas (30 takas for transport plus 24 takas--2 days @ 12 takas per day--for food), while helpers accompanying vasectomy clients should receive a payment of 42 takas (30 takas for transport plus one day @ 12 takas for food).

It has been possible for a helper to receive more than one 45-taka payment during a single visit to a clinic if she or he accompanied more than one client. Although not the norm, this practice has made it possible for some helpers, chiefly family planning fieldworkers and dais, to receive extra takas by accompanying two or more clients on the same trip while having only a single set of expenses. A concern here is that some fieldworkers, hoping to capitalize on this chance to realize a small financial gain, might inappropriately promote sterilization over other methods.

It has been suggested that one way to eliminate the possibility of net benefits accruing to fieldworkers would be to reimburse them on the basis of their actual costs (i.e., actual transport costs from the locality they serve to the clinic, together with a daily allowance for food). This strategy has already been tried in the BAVS clinics, but found unworkable and abandoned on the grounds that it was not only administratively difficult but also conducive to fraud. (Fieldworker reimbursement was based on stated costs up to a maximum of 90 takas per trip. Transport providers, such as rickshaw pullers, do not provide receipts and many cannot even read and write. This made it tempting and easy for fieldworkers to overstate their costs, and many did so.)

The Bangladesh government is now discussing another stra-

tegy that could eliminate this net benefit possibility. This would be a change in its reimbursement policy to specify that a helper may be reimbursed only 45 takas per visit regardless of the number of clients he or she accompanies to the health center.

If such a change does not usher in yet other problems, it could be significant in helping uphold the principle of informed consent.

C. PROVIDER REIMBURSEMENT

Physicians are currently reimbursed 20 takas per case and clinic staff 15 takas per case. This is done to ensure that providers will be available in the clinics to perform the requested sterilizations. In the absence of this compensation, the evidence is that providers would give sterilization a low priority and not be readily available when requestors arrive at the health center (i.e., it is probable they would be working in their private practices to supplement their income, as is common among government physicians in developing countries). The reimbursement for providers is therefore intended to compensate them for the income forgone in private practice as a result of their being reliably available for sterilization operations.

The level of reimbursement to providers is based on the fee for the least expensive surgical procedure in the authorized fee schedule for private practice in Bangladesh and has been raised over time in accord with increases in this fee. This approach appears reasonable as a basis for setting the level of provider reimbursement. Judging from the number of sterilizations performed, the provider reimbursement has worked effectively to ensure that sterilizations are available on demand.

D. INCREASES IN REIMBURSEMENT LEVELS OVER TIME

In the past, requests of the Bangladesh government to raise levels of reimbursement have been reviewed by USAID/Dhaka with the assumption that

- 1) the original levels were appropriate; and
- 2) any increases should be in line with inflation.

In addition, during USAID/Dhaka's October 1983 review of the Bangladesh government's request to raise client reimbursement levels to their present level of 175 takas, USAID/Dhaka recommended that clients be reimbursed for six days of wage loss (subsequently approved by AID/W), as had been originally proposed.

The adjustment of reimbursement levels on the basis of inflation is a sound practice. Moreover, the data necessary to make such adjustments are readily available from Bangladesh government sources.

1. Client Reimbursement Levels

These may be increased over time, as necessary, to adjust for inflation. The average annual wage for unskilled agricultural labor (without food), a series which is published monthly by the Bangladesh government (Bureau of Statistics), may be used for this purpose. Reimbursement levels for food costs may be adjusted for any changes in the approved level of reimbursement to caterers providing daily meals in government hospitals. Travel costs may be adjusted for inflation in line with any adjustments to the per kilometer travel allowance paid by the Bangladesh government (currently 0.60 takas per kilometer).

2. Helper Reimbursement Levels

These may be adjusted together with any adjustments to client transport and food costs, as explained above.

3. Provider Reimbursement Levels

These may be adjusted, as they have been in the past, with changes in the approved private fee schedule for the least costly surgical procedure. The same proportional adjustment may be made in such cases to the reimbursement levels for both physicians and clinic workers.

E. ADDITIONAL DATA NEEDS

No additional data are needed to implement the above procedures for reviewing and revising current reimbursement levels. The required data are already collected and published by the Bangladesh government.

In addition, it may be useful to interview clients on a regular basis to ensure that levels of satisfaction remain high. USAID's regular quarterly evaluation surveys present an excellent tool for this purpose. It would also be useful to tabulate the data on the parity of clients on a monthly basis, so that these data can serve as an additional indicator of the appropriateness of sterilization clients.

A special study may be carried out to determine the value to clients of the in-kind transfers that they currently receive in the form of surgical garments. Such a study might involve offering selected groups of clients different levels of cash

payments in lieu of their saris and lungis (possibly in connection with a USAID quarterly evaluation survey). The proportion of "takers" at each level of cash payment should provide an indication of the value of these garments to clients. If found to be significant, the value of these in-kind transfers could be taken into account in the reimbursement scheme.

APPENDICES

APPENDIX A

Acronyms Used in this Report

Appendix A

ACRONYMS USED IN THIS REPORT

AID	Agency for International Development
AID/W	Agency for International Development, Washington
AVSC (or AVS)	Association for Voluntary Surgical Contraception
BAVS	Bangladesh Association for Voluntary Sterilization
BDG	Bangladesh Government (Government of the People's Republic of Bangladesh)
CPS	Contraceptive Prevalence Survey
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
IPAVS	International Program of the Association for Voluntary Surgical Contraception (now IPAVSC - International Program for the Association for Voluntary Surgical Contraception)
MCH	Maternal Child Health
NGO	Nongovernmental Organization
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
SIDA	Swedish International Development Authority
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USAID/Dhaka	USAID Mission in Bangladesh
VSST	Voluntary Sterilization Surveillance Team

APPENDIX B
References and Bibliography

Appendix B

REFERENCES AND BIBLIOGRAPHY

- Agency for International Development, "Project Paper, Bangladesh 388-0050." Washington, D.C.: USAID (October 30, 1980).
- Agency for International Development, Bureau for Program and Policy Coordination, "A.I.D. Policy Paper: Population Assistance." Washington, D.C. (September, 1982).
- Akhter, Farida, Fazila Banu, and Shelley Feldman, An Assessment of the Government's Health and Family Planning Programme: A Case Study of Daudkandi Thana and North Mohammadpur and Charcharua Villages in Bangladesh. Dhaka: Swedish International Development Authority (1983).
- Alauddin, Mohammad, and Nihar Ranjan Sorcar, "Focus Group Discussions with Sterilized Women in Bangladesh." Unpublished Report (November 8, 1984).
- Bangladesh Bureau of Statistics, Monthly Statistical Bulletin of Bangladesh. Dhaka: Government of the People's Republic of Bangladesh (May, 1985).
- Choudhury, Abu Yusuf, "Report on a Study of the Referral Fee System in the Population Control Program." Dhaka: Program for the Introduction and Adaptation of Contraceptive Technology (January, 1985).
- Choudhury, Abu Yusuf, Safiqur Rahman Choudhuri, Md. Najmul Huq, and Atiqur Rahman Khan, "Motivational Factors That Determine the Non-use of Contraceptives." Dhaka: Program for the Introduction and Adaptation of Contraceptive Technology (February, 1985).
- Huq, Jahanara, Roushan Jahan, and Hamida Akhtar Begum, eds., Women and Health. Report of the End-Decade National Conference on Women and Health Organized by Women for Women and Concerned Women for Family Planning. Dhaka: Women for Women (1985).
- Islam, Mahmuda, Women, Health, and Culture. Dhaka: Women for Women (1985).
- Islam, Shamina, ed., Exploring the Other Half: Field Research with Rural Women in Bangladesh. Dhaka: Women for Women (1982).
- Maloney, Clarence, K.M. Ashraful Aziz, and Profulla C. Sarkar, Beliefs and Fertility in Bangladesh. Rajshahi: Institute of Bangladesh Studies (1980).

- Minkler, Donald, Julia Henderson, and Ruth Simmons, "Mid-Term Evaluation of USAID Family Planning Services Project Bangladesh." Washington, D.C.: American Public Health Association (August, 1983).
- Mitra, S.N., and G.M. Kamal, Bangladesh Contraceptive Prevalence Survey-1983. Dhaka: Mitra and Associates (July 17, 1985).
- Mitra and Associates, "Female Sterilization Follow-up Study - 1984." Draft Report, Dhaka (November, 1985).
- Newton, Gary, "A Report on the Voluntarism of Sterilization Services in Bangladesh." Draft Report, Dhaka (December 8, 1985).
- P&M [Personnel and Management], "Ministry of Health and Population Control Client Satisfaction Survey." Draft Report, Dhaka (1985).
- Philliber, Susan G., and William W. Philliber, "Social and Psychological Perspectives on Voluntary Sterilization: A Review," Studies in Family Planning, vol. 16, no. 1 (January 1985), pp. 1 - 29.
- Quasem, M.A., and Co., "Report on the Evaluation of the Voluntary Sterilization Program for January-March Quarter 1985" (a). Dhaka.
- Quasem, M.A., and Co., "Report on the Evaluation of the Voluntary Sterilization Program for July-September Quarter 1985" (b). Dhaka.
- Rahman, Azizur, et al., "Prospective Study of Complications and Deaths from Sterilization Procedures." Unpublished Paper, Bangladesh Association for Voluntary Sterilization, Dhaka, Undated.
- Robinson, Warren C., "Some Reflections on Recent Attacks on the Population Program in Bangladesh." Unpublished Report, University Park, Pennsylvania: Institute for Policy Research and Evaluation (December, 1985).
- Ross, John A., Sawon Hong, and Douglas H. Huber, Voluntary Sterilization: An International Fact Book. New York: Association for Voluntary Sterilization (1985).
- Vogel, Russell P., "Report to AVS/New York on the Recently Increased Voluntary Sterilization Acceptor Payment System in Sri Lanka and the Estimated Out-of-Pocket Costs to Volunatry Sterilization Acceptors." Unpublished Report, New York: Association for Voluntary Sterilization (July, 1983).

VSST [Voluntary Sterilization Surveillance Team] Bangladesh Sterilization Surveillance Team Four-Party Review, Dhaka (November 1984), mimeo.

Wright, Nicholas H., "Report on the Sri Lanka Incentive Program for Voluntary Sterilization." Unpublished Report to IPAUS (October 26, 1983).

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APPENDIX C
Scope of Work

Appendix C

SUBJECT: Proposed Workscope for Review of Reimbursement Levels for Voluntary Sterilization (VS) in Bangladesh

Background

As part of AID's assistance to the Bangladesh Government's (BDG) family planning program, AID reimburses the BDG for certain costs related to the delivery of voluntary sterilization services. These payments are made to providers, clients, and those who assist the clients, to compensate for services performed (in the case of providers), out-of-pocket expenses, and income foregone, in the case of clients. The purpose of these payments is to ensure that there are no financial disincentives which would interfere with both the availability and access to VS services.

Since the initiation of this assistance, USAID/Dhaka has monitored this reimbursement system closely to ensure that AID policy on population assistance is carried out. This has included quarterly surveys by an independent audit firm and technical assistance to upgrade and monitor the quality of services delivered. Due to the continuing interest concerning these payments, however, a decision has been made to conduct a review of this element of the program.

Scope of Work

A. The purpose of this study will be to review existing VS reimbursement levels to determine if current levels are appropriate. Although all forms of AID-financed reimbursements for VS will be reviewed, primary attention will be given to payments made to clients.

The specific tasks to be performed include:

economist

(a) Review and evaluate existing empirical data used initially to establish, and later to increase, these payment levels.

(b) To the extent that these data are inadequate, identify the types of data needed to establish these levels. If it is possible to address current inadequacies using secondary data and/or through the collection of primary data during the consultancy, this should be done.

anthropologist

(a) Concurrently, review existing data from various surveys and studies regarding the relationship between VS reimbursements and the level of acceptance of this method. They should include data on characteristics of acceptors, including the factors they cite that lead them to become sterilized, and especially the extent to which acceptors were satisfied with or later regretted their decision.

(b) Interview representatives of both public and private agencies involved in VS service delivery to obtain their views on the need for, and appropriateness, of VS reimbursements.

(c) Within the time constraints, interview both VS acceptors and non-acceptors to obtain their views on the role and importance of these reimbursements in ensuring access to these services. To the extent that such data is inadequate, identify additional studies/surveys which should be undertaken to answer questions.

(d) Through interviews with VSC providers, helpers, and clients, examine the general atmosphere within which VSC services are offered to determine whether or not they perceive the services to be provided in a general context of voluntarism and informed consent.

B. On the basis of the information collected and analyzed, prepare a report which summarizes the findings regarding the appropriateness, including both the nature and level, of VS reimbursements being financed by AID. This report should be submitted to USAID/Dhaka in draft prior to the departure of the consultant team.

C. Proposed timing and duration of the assignment is early October 1985 for a period of 3-4 weeks. Team composition will be one economist and one anthropologist. Both should have developing country experience and in the case of the anthropologist, experience in South Asia with respect to health and family planning. Language skills in Bangla are not required but would be highly desirable.

D. The consultant team will review information on this issue available in AID/W. On the basis of this information, the preceding workscope, and discussions with concerned ANE and S&T/POP staff, the consultant will prepare a description of the proposed methodology and specific questions to be addressed. This will be reviewed and approved by AID/W staff prior to the team going to Bangladesh

APPENDIX D
Principal Persons Contacted

Appendix D

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APPENDIX E

**Scope of Work for Study "Motivation and Decision-Making
in Voluntary Sterilization: A Focus Group Study"**

Appendix E

MOTIVATION AND DECISION-MAKING IN VOLUNTARY STERILIZATION: A FOCUS GROUP STUDY

Scope of Work

General purpose: To understand the factors that motivate rural Bangladeshis, men and women, to become sterilized.

Specific questions to be answered:

Concerning participants in the study:

1. What was the motivation for having the operation?
2. How did the participants decide to have the operation?
3. How well did the participants understand the nature and consequences of the operation?
4. What are their reasons for not using a temporary method?
5. In what way did the compensation payment and the sari/lungi influence their decision to have the operation?
6. In what way did family planning personnel (FWAs and others) influence their decision?
7. Do any of the participants regret having had the operation? If so, why?

Concerning USAID planning needs:

1. What can be concluded about the findings with regard to the national program?
2. In what ways might the findings not apply to the national program?
3. What other studies might be undertaken to understand better the dynamics of family planning in the rural areas?

USAID/Dhaka, 16 November 1985

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