

## Chapter 1

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# Delivering Quality Sterilization Services in the Post-Cairo Era

### Highlights:

- Contraceptive sterilization is inherently a medical service, but women's and men's access can be broadened through offering services during the postpartum period, through mobile outreach, or in male-only clinics (for vasectomy).
- While the use of fees and compensation for providers in sterilization programs has led to concern over the potential for coercing clients into accepting sterilization, few programs engage in such activities, and there is little evidence that such approaches have promoted reliance on sterilization.
- With sterilization, even more than for reversible contraceptive methods, critical issues are the client's ability to make a well-informed, voluntary decision (informed choice), his or her authorization to proceed with the surgical procedure (informed consent), and his or her participation in true two-way communication with a health care worker about the risks and benefits of the procedure (counseling).
- In helping clients make an informed decision, providers need to assess the client's needs, offer appropriate method options, fill in gaps in the client's knowledge, help the client make his or her own choice, ensure that the client knows how to use the method, and encourage the client to use other appropriate reproductive health services.
- Once a client has been sterilized, he or she continues to have reproductive health needs, and providers should make strong efforts to promote such services as screening for cancer and sexually transmitted infections and adoption of condom use.

In the early years of family planning programs, especially in the developing world, sterilization services often were introduced and provided in a vertical manner—i.e., they were offered in separate facilities, were promoted to the exclusion of other methods, and were not always integrated into the country's health structure. Such approaches were simplistic, rarely addressed the multiple needs and health concerns of the client, and left providers of sterilization services isolated from other health services. Health care providers in these programs rarely had connections with other reproductive health services; they were trained in surgical sterilization techniques, but lacked other important skills and knowledge. Clients were often treated only in relation to their needs as sterilization patients; other health concerns were marginalized (Bakamjian & Harper, 1997). Over time, as family planning services in general gained acceptance, family planning programs integrated sterilization services with other contraceptive and reproductive health services.

Among the hallmarks of the International Conference on Population and Development (ICPD) in 1994 and the Fourth World Conference on Women in 1995 (UN, 1994; UN, 1996) were resolutions emphasizing the need to integrate family planning with other reproductive health services, growing out of an awareness that an individual's needs are multidimensional. To improve the reproductive health of women and men, a range of services must be available and supported by trained staff and by effective, functioning support systems.

The purpose of this chapter is to describe some of the factors essential to the delivery of quality sterilization services.

## Provision of Quality Sterilization Services

Sterilization services may be available from a legal or policy perspective, yet access to these services may be limited physically (by the client's distance from a provider and the time needed to access services), economically (by prohibitive service fees, transportation costs, or opportunity costs), cognitively (by a lack of knowledge of contraceptive methods), administratively (by rules and regulations that inhibit choice), and psychosocially (because of cultural, familial, or gender-based traditions or practices). (These issues are discussed in more detail in Chapters 2 and 4.) Because sterilization is a surgical and provider-dependent method and is intended to be permanent, the ability to deliver quality sterilization services depends on voluntary decision making, client-centered counseling, good infection prevention, clinical safety, standards and guidelines for care, appropriate pain relief, and appropriate follow-up care—all of which may be more difficult to provide in low-resource settings. These are many of the same factors necessary for providing an array of family planning methods.

Quality health services are achieved by meeting or exceeding the needs and desires of clients with a minimum of effort, repeated effort, and waste (Berwick, Godfrey, & Roessner, 1990).<sup>1</sup> The successful provision of quality family planning services considers the political, social, and economic environment and systems in which those services are provided. In addition, to maximize the potential of individual contraceptive methods (in this case, sterilization), program managers must take into account and address client and service-delivery characteristics that may facilitate or constrain successful use of those methods (Simmons et al., 1997).

Table 1.1 summarizes some key supply and demand factors that affect quality service delivery and need to be addressed in the provision of sterilization services. These issues are critical to ensuring informed choice for any contraceptive method and are especially important in delivering a permanent method of contraception. (Medical technology factors related to female and male sterilization are addressed in Chapters 6 and 7, respectively.)

## Supply Factors

The World Health Organization (WHO) guidelines for female sterilization and vasectomy—*Female Sterilization: A Guide to Provision of Services* (WHO, 1992) and *Technical and Managerial Guidelines for Vasectomy Services* (WHO, 1988)—are excellent resources that describe the essential elements required for establishing quality sterilization services, as outlined in Table 1.1. These guidelines are designed to help managers and service providers organize and maintain quality sterilization services.<sup>2</sup> Highlighted below are just a few key issues that managers and service providers need to consider when designing sterilization programs: service-delivery modalities, fees and compensation programs, and the cost of providing services in the era of health-sector reform.

## Service-delivery modalities

Sterilization is a surgical procedure, so there are limitations as to where, how, and by whom it can be provided. Although female and male sterilization are surgical procedures, both are relatively simple and do not require fully equipped hospitals. Because of the simple nature of female sterilization, it is possible to offer services closer to the com-

<sup>1</sup> This definition implies that services are provided in a manner consistent with technical standards.

<sup>2</sup> The two WHO publications provide more information about how sterilization services can be set up and managed. These books specifically discuss the following supply factors shown in Table 1.1: program management and leadership; financial management; service-delivery modalities; equipment, supplies, and logistics; training systems; and monitoring and evaluation.

**Table 1.1. Supply and demand factors affecting the delivery of quality services**

Supply factors	Demand factors
<ul style="list-style-type: none"> <li>• Laws, policies, standards, and guidelines</li> <li>• Program management and leadership</li> <li>• Financial management (including cost-sharing or user fees)</li> <li>• Service-delivery modalities (static vs. mobile, vertical vs. integrated)</li> <li>• Surgical techniques (male or female, interval or postpartum)</li> <li>• Equipment, supplies, and logistics</li> <li>• Training systems</li> <li>• Supervision systems</li> <li>• Medical quality-assurance procedures</li> <li>• Sector involvement (public, nongovernmental organization, or private)</li> <li>• Payments and incentives to providers</li> <li>• Information, communications (mass media and outreach), and counseling</li> <li>• Monitoring and evaluation</li> </ul>	<ul style="list-style-type: none"> <li>• Client decision making (assuring informed choice, including informed consent; counseling)</li> <li>• Sociocultural and gender influences</li> <li>• Community influences</li> <li>• Policy and program factors (payments and incentives to clients)</li> <li>• Service-delivery factors (addressing the reproductive intentions and needs of different population groups, communication activities, client-provider interactions)</li> </ul>

munity than might be expected. Basic facilities for both female and male sterilization should include a waiting or reception area, an examination area, access to laboratory services, a clean surgical area isolated from the outside and from clinic traffic, and a recovery area (WHO, 1988; WHO, 1992). Most female sterilization services are provided in permanent service-delivery sites (tertiary, regional, or district hospitals, or family planning clinics having simple operating theaters). Vasectomy is even simpler than female sterilization and can therefore be offered in a wider variety of settings, such as treatment rooms in family planning clinics or private physicians' offices (WHO, 1988).

### *Postpartum services*

Providing general postpartum family planning services involves integrating family planning into a site's existing maternity services. Because postpartum programs rely on existing staff and facilities, the costs of establishing such services may be lower than for other means of service provision (Ross & Frankenberg, 1993). Nevertheless, integrating postpartum programs also requires intensive coordination among different departments at a site, which may be difficult to achieve (Church & Geller, 1990; Ross & Frankenberg, 1993). Postpartum minilaparotomy is a safe and effective procedure that does not increase hospitalization time and that allows women access to female sterilization during their delivery hospitalization (Chi, Gates, & Thapa, 1992; WHO, 1982; WHO, 1992).

Postpartum sterilization is usually performed in hospital facilities by obstetrician-gynecologists, though in some instances it has been provided by nurse-midwives and other paramedical staff (Chi & Thapa, 1993). In general, the provision of any sterilization procedure (whether postpartum or interval) requires not only experienced personnel to perform the procedure, but also well-trained staff to offer counseling, preferably during the antenatal period.

### *Mobile services*

Though sterilization services are generally available only at permanent service-delivery sites, in some countries mobile surgical teams are deployed to provide services on a pe-

riodic or seasonal basis. Use of mobile teams allows a program to offer sterilization to clients who live a great distance from static facilities, to maximize the use of trained providers (who may be in short supply), and to respond to demand for sterilization services during selected months of the year, especially during the postharvest winter months. Mobile teams can be expensive to operate, require extraordinary care and special systems to maintain quality, need skillful providers to manage possible complications, require special follow-up, and can be challenging to manage (Jezowski & Hollerbach, 1991). It is best if mobile-team services are provided to communities as a temporary stopgap arrangement and in the context of developing and implementing an action plan for establishing routine services.

Mobile teams can be deployed in two ways. First, a team of trained providers can be sent to existing health facilities that meet national standards but that do not have trained staff. Alternatively, teams can be deployed to perform procedures either at inadequate health facilities or at facilities normally used for other purposes (such as schools or office buildings). The former approach is acceptable, while the latter is extremely difficult to organize and manage and requires special efforts to provide services that comply with standards.

Sometimes mobile services are referred to as “camps.” This type of mobile service can be problematic, and in some countries the term is misleading. In the early days of family planning programs in some countries (e.g., Bangladesh, China, India, and Thailand), camps frequently were massive promotional events, with hundreds and even thousands of sterilizations being performed over a short period, often in schools or tents (Begum et al., 2000; Ross, Hong, & Huber, 1985).

In the 1970s, mobile teams were used in many parts of Asia (such as India, the Republic of Korea, Nepal, and Sri Lanka) and in a few countries in Latin America (e.g., Colombia) (Ross et al., 1985). Thirty years later, both India and Nepal still rely on mobile teams as part of their basic family planning program, because the health care infrastructure is weak or because geographic access for many potential clients is difficult, and because of a high demand for sterilization during the winter months. In northern India and Nepal, where the agricultural cycle dominates life plans and activities, the months of November to February represent a postharvest period with adequate stocks of food, relative leisure time, dry weather in which travel is easier, and cooler weather with less dust and perspiration (and a resulting belief that a wound is less likely to become infected). Beginning in 1999, in the state of Uttar Pradesh in northern India, sterilization camps have been broadened to cover basic reproductive health services (Spaid, 2001).

Mobile outreach for family planning is still needed in Nepal. Such services, which are usually offered in rural and remote areas and at temporary facilities, reach a large number of clients. At present, most sterilization services in Nepal are provided through mobile outreach teams on a seasonal schedule, predominantly between November and February. (While services are available throughout the year at selected static clinics, they are used at a much lower rate than during this period.)

Providing services at temporary facilities may create a range of conditions that can lower the quality of care. Medical monitoring reports from supervision teams indicate that some problems encountered at mobile service sites in Nepal include poor sanitation, poor infection prevention practices, crowding, a lack of privacy and counseling, long travel and waiting times, an inability to conduct follow-up care, and a stressful working environment for providers. To address these quality issues, the Family Health Division of the Ministry of Health, Nepal, in collaboration with EngenderHealth (Stanley et al., 2001), developed guidelines for mobile voluntary sterilization services, supported regional workshops where district health officers and family planning assistants worked together to develop an annual plan for mobile outreach services, and strengthened family planning assistants' ability to manage family planning services by participating in orientation sessions and planning meetings.

As noted above, providing mobile services takes careful planning and follow-up. After Peru legalized sterilization services in 1995, the government family planning program decided to increase access to services by conducting mobile outreach services in

rural areas of the country. However, since the government had little experience in providing services on a large scale, inadequately trained providers were dispatched to rural areas as mobile teams to provide services. Besides having staffing problems, the teams lacked the appropriate equipment for providing quality services. These factors compromised service quality, leaving clients without follow-up care postsurgery. In 1998, after receiving public criticism of the poor quality of services, the government took steps to improve quality by strengthening counseling services and by certifying physicians and facilities for surgery (Coe, 2001).

### *Male-only clinics for vasectomy services*

Some countries have experimented with providing vasectomy services in male-only clinics that also offer broader men's reproductive health services (Liskin, Benoit, & Blackburn, 1992; Wegner et al., 1998). In the late 1980s, in an evaluation of their experience in the design of separate male-only clinics or hours for vasectomy services, PROFAMILIA of Colombia found that while the male-only clinics performed more vasectomies, there was no difference in client satisfaction between services provided at integrated clinics and services offered at separate clinics (Vernon, Ojeda, & Vega, 1991). In countries where cultural norms mandate the segregation of men and women, however, it may be more appropriate to organize male-only clinics, to generate interest among potential male clients (Wegner et al., 1998). Regardless of where vasectomy services are provided, it is essential to ensure that health care providers are trained in counseling so they can address clients' questions, resolve their doubts, and reduce their anxieties about vasectomy. Couples counseling for men seeking vasectomy services should be encouraged (AVSC International, 1997).

### **Fees and compensation programs**

The promotion of family planning through financial payments is one of the most controversial and divisive issues in population and development policy. Critics of payments to clients, referrers, or providers have expressed concern that these incentives may jeopardize the principle of informed consent. Some have argued that provider rewards, in the form of special recognition or financial compensation for achieving or reaching specific contraceptive targets, could lead to persuasion that borders on coercion of clients to accept specific contraceptive methods (Cleland & Mauldin, 1991). Further, when these payments are in place, providers may be biased about the side effects of other methods and may steer clients toward sterilization.

Advocates of client compensation schemes argue that the payments cover lost wages and the direct costs of food and transport that are associated with undergoing the sterilization procedure and do not act as an inducement or incentive to accept sterilization. Research in Bangladesh and India suggests that for the large majority of clients, where financial payments are offered, they are not a motivating factor for the decision to obtain sterilization; rather, the payment can remove barriers to access to services (Cleland & Mauldin, 1991; Landry, 1990; Saavala, 1999). Nevertheless, of the countries that historically have offered financial payments to promote family planning, few still make use of client payments and worker incentives and targets.

In 1999, EngenderHealth surveyed its staff in 25 countries to assess the status of any remaining programs that offer compensation or payments to sterilization clients, providers, or referrers. In four of the countries surveyed—Bangladesh, India, Pakistan, and Vietnam—sterilization clients were offered cash payments as compensation for lost wages. Payments were offered to providers in Bangladesh, Nepal, Pakistan, and Vietnam (AVSC International, 1999), and payments were provided to community-based delivery (CBD) agents or other family planning program referral agents in Bangladesh, Indonesia (although only to some referrers), Pakistan, and Vietnam.

Despite the presence of compensation schemes in these countries, there is little evidence that such approaches have promoted reliance on sterilization. Indeed, steril-

ization use has declined during the last 10 years in Bangladesh, despite the presence of payments to clients, an increase in client payments to offset inflation (in 1996), and reimbursement of travel payments to government field workers (Begum et al., 2000).

### Cost of providing services

Until fairly recently, little attention was paid to how to develop models for providing reproductive health services in the current climate of health-sector reform. Many countries are undergoing a transition from an era in which health care services (including sterilization) were provided free of charge or at minimal cost (Ross & Frankenberg, 1993) to a time of experimenting with cost-sharing and introducing user fees for services. Thus, it is crucial for program managers to understand the costs associated with providing sterilization services.

Estimates of the cost of sterilization commodities may vary greatly by country, in part because these costs depend on where the commodities are purchased, the volume of each purchase, and packaging and shipping. A 1994 United Nations Population Fund study provided global estimates of the costs of sterilization commodities, using information from a variety of sources (UNFPA, 1994). After estimating the average number of uses of minilaparotomy and vasectomy kits and Laprocator<sup>®</sup> systems, as well as the number of gloves, gauze pads, sutures, and cold sterilization solutions needed, the authors calculated the average cost for female and male sterilization commodities in 1994 to be US\$10.38 per procedure. The authors reported that equipment and supplies required for sterilization increased in price by about 5% from 1990 to 1993 (UNFPA, 1994). At the same rate of increase, the cost of sterilization commodities in 2000 would be \$11.63 per procedure.

The cost of sterilization commodities is just one component of an estimate of the overall cost of providing sterilization services. The total cost per client visit includes costs of all supplies, as well as personnel time spent not only on delivering services (including counseling and informed consent) to the client, but also on providing support activities (such as keeping the facility clean and maintaining records). The true cost also includes capital costs such as buildings, equipment, and other infrastructure. Capital costs typically are not included in family planning cost studies, however, because data on these costs are hard to obtain, as capital equipment and buildings are often donated or purchased in bulk for multiple uses. In addition, the marginal capital costs of adding new reproductive health services to existing infrastructure—a key concern for managers interested in expanding service-delivery capacity—are thought to be small (Mitchell, Littlefield, & Gütter, 1999).

Numerous studies have assessed the costs of sterilization (along with other family planning services); however, the results are difficult to compare across countries because of wide variations in economic conditions, family planning programs, and study methodologies. Some include commodity costs in their estimates, and some do not. Authors of studies conducted in countries where commodities are offered free of charge by donor organizations reason that they should not include the costs of these supplies, but only the expenses incurred by the program under observation. Other investigators have examined the true costs, including commodity costs, anticipating the possibility that if donor monies were withdrawn, the full cost would need to be covered by the programs themselves. Aside from these differences, studies take different approaches to the estimation of personnel costs, which constitute the largest percentage of total costs in most programs. As noted by Janowitz, Measham, and West (1999), variations in the amount of time that personnel devote to various types of visits and in unused time can significantly influence the costs of services. Standard methodologies rarely measure these personnel costs.

While various approaches and methodologies (often complicated or requiring technical expertise) have been used to study costs, simple-to-use tools have been developed in recent years to assist managers of family planning or other health services in deter-

mining the actual and potential costs of service provision. Two such approaches that have been used in developing country programs are the Cost Revenue (CORE) Analysis Tool (Management Sciences for Health, 1998) and the Cost Analysis Tool (AVSC International, 2000).

## Demand Factors

As described in Table 1.1, several issues affect clients' access to quality sterilization services: factors affecting clients' decision making (such as informed consent and informed choice), sociocultural and gender influences, community effects, policy and program factors, and service-delivery issues.

### Informed choice

Informed choice is a fundamental principle of quality services, is recognized as a human right by the international community (UN, 1994), and is the basic foundation of all sterilization programs. Despite widespread support for informed choice in international conventions, in professional discourse, and in program policies, clients in many parts of the world lack truly informed choice. Barriers exist within the social and community context in which services are provided, at the level of program policy and design, and in actual service delivery. This section, therefore, describes the process for informed choice in a service-delivery setting and addresses some of the special issues and challenges related to informed choice and informed consent for sterilization from a client perspective.

Clients who make informed decisions about sterilization are more likely to be satisfied with their contraceptive method and to experience less regret than if they are not the actors in the decision-making process (Hardy et al., 1996; Vieira & Ford, 1996). Before moving into the discussion of informed choice and factors within and outside the health care system, we define the basic terms of informed choice, informed consent, and counseling.

*Informed choice* in health care is an individual's well-considered, voluntary decision, based on method or treatment options, information, and understanding. It is something that the individual experiences as an interplay of factors related to:

- His or her own personal circumstances, beliefs, and preferences
- The sociocultural and health and human rights context and community factors
- The availability and attributes of method or service options
- Service-delivery factors that affect access to options and the individual's ability to make free and voluntary decisions

Informed choice in family planning has several key elements. First, it is voluntary, meaning that options are not limited by access barriers or by coercion, stress, or pressure. Additionally, the client should have information about contraceptive options and about the various methods' relative effectiveness in preventing both pregnancy and sexually transmitted infections (STIs), their advantages and disadvantages, their contraindications, and their complications and side effects. Finally, there should be a real choice among a range of accessible alternatives.

*Informed consent* is a client's agreement to receive medical treatment or to take part in a study as a result of having reached an informed choice. Written informed consent is universally required to authorize surgery, including sterilization—although in and of itself, a signed informed consent form does not guarantee informed choice. The key points that a client should know to give truly informed consent for sterilization are that:

- Temporary methods of contraception are available.
- Sterilization involves a surgical procedure (the details of which need to be explained before consent is given).
- The surgical procedure involves risks in addition to benefits (both of which need to be explained as part of the informed choice process).

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- If the procedure is successful, the client will not be able to have any more children.
- The effect of the procedure is permanent, though there is a small risk of failure.
- The client can change his or her mind and decide against the procedure at any time before the operation is performed, with no resulting loss of medical, health, or other benefits or services.
- Sterilization does not provide any protection against STIs or HIV/AIDS.

*Counseling* refers to two-way communication between a health care worker and a client with the specific purposes of helping the client confirm or reach an informed decision, helping the client understand how to use his or her chosen method or treatment, and addressing any questions or concerns the client may have. Counseling serves as a check-point to ensure that the client has correct information on which to base a choice and that he or she is not being pressured or coerced. Counseling thus helps clients exercise their right and ability to make their own decisions, thereby safeguarding informed choice.

While informed choice applies to all health care decisions, it is of particular importance for sterilization, both because the procedure involves elective surgery, with its attendant risks and unique fears, and because it is the only contraceptive method intended to end fertility permanently. The decision to have no more children does not necessarily mean that the client is ready to undergo an operation to end fertility. With the exception of medical obstetric emergencies, even in cases where there are medical indications for preventing pregnancy, a woman still has options and should be assisted to make a reasonable choice that suits her health status, personal circumstances, beliefs, and preferences; if she is unable to make the decision, a family member should be consulted whenever possible.

To ensure that clients who choose sterilization make a truly informed choice, counselors need to explore clients' feelings about ending fertility and their readiness for the procedure. This process helps identify clients who have doubts, hold unrealistic expectations, or have requested sterilization in response to short-term life stresses or external pressure. Each of these factors increases the risk of postoperative regret (Chi & Thapa, 1993; Keller, 1997; WHO, 1988; WHO, 1992). (Chapter 5 includes a detailed discussion of regret in the context of sterilization.)

Written informed consent for sterilization should document, but does not substitute for, a health care worker's active involvement in the client's informed choice process, to ensure that the client has knowingly and freely requested sterilization. Often someone other than the surgeon obtains informed consent for sterilization. Therefore, the ultimate responsibility for ensuring informed choice lies with the surgeon, who must verify that the client reached an informed choice and gave informed consent prior to surgery.

### Sociocultural, gender, and community influences

Sociocultural factors, commonly held beliefs, social norms, and the client's status within the society and the family powerfully determine desired family size, perceptions of what is desirable and undesirable in a family planning method, the ability to access information and services, and the ability to make autonomous decisions. Marginalized groups, including poor, uneducated women and youth, often lack access to choices and have limited decision-making power. In some societies, the social norm is for partners and mothers-in-law to make decisions about the number and timing of a woman's pregnancies and about whether and how she will limit her fertility. Moreover, in some places where men exercise much influence over the choice of family planning methods, the society does not support vasectomy as an option, often because of misunderstandings about the method: Men and women in several countries have voiced fears of physical and sexual impotence and of a reduced ability to do physical labor (Bertrand et al., 1989; Schuler, Hashemi, & Jenkins, 1995; Shrestha, Stoeckel, & Tuladhar, 1988; Vieira & Ford, 1996). (Chapter 5 provides more information on misconceptions about female and male sterilization.)

Clients obtain much of the information on which they base their family planning decisions from sources within the community. These sources are of varying accuracy, completeness, and credibility. Family members and friends often are the primary sources of information, but their knowledge may be based on their own method use and may be biased by their positive or negative experiences (see Chapter 5 for more information). Religious leaders, community volunteers, health care workers, and referral agents also play important roles that contribute to clients' knowledge, perceptions, and choices. In addition, the media are common sources of information, although messages may be specific to particular methods or motivational rather than balanced and objective. Increasingly, programs recognize the importance of the community's influence, not only in the availability and use of services, but also in their quality. Some programs are now using innovative participatory tools to engage communities in a dialogue about how to improve services (CARE, 1999; Chambers, 1997; Dohlie et al., 2000; Gubbels & Koss, 2000).

## Policy and program factors

A number of factors related to program policies and design directly bear on the range of contraceptive methods offered, an individual client's access to available options, and his or her ability to choose freely. Any factor that either limits a client's access to information or services or creates biases or pressures in favor of a preferred method is a challenge to informed choice.

With regard to access, any program that offers a limited range of family planning methods compromises informed choice by limiting a client's options. Eligibility criteria such as age, parity, and spousal or parental consent can override clients' decision making and may deny some clients their preferred method. Waiting periods, spousal consent, and high age and parity requirements are commonly imposed for sterilization and raise potential concerns about clients' access to desired information and services. In Brazil, the excessive documentation required for female sterilization was found to result in barriers to women's access to sterilization services (Lassner, Janowitz, & Rodrigues, 1986); requirements were later simplified. A three-city study of poor women in the United States found that institutional or procedural barriers contributed to unfulfilled sterilization plans, resulting in regret for not having become sterilized (Davidson et al., 1990). (Chapter 5 presents a discussion of other barriers to sterilization.)

The issue of informed consent has raised concerns, particularly in regard to population policies in which sterilization played a major role. For example, at various times in the history of China, India, and the United States, sterilizations have been performed without individuals' informed consent. Physical or psychological pressure have been applied and full, detailed information has not been provided; in China and India, incentives and disincentives have been used and were even written into local laws in both countries (Boland, 1997).

On the other hand, program targets or quotas and performance-based funding and reporting requirements may bias providers toward a particular method, thus leading them to direct clients to a predetermined choice rather than allowing them to decide freely. And some programs still use as a performance indicator the measure couple-years of protection (CYP), which is biased in favor of sterilization because of that method's long-term protection against pregnancy.

Where method-related payments are made to providers, referral agents, and clients, they are most often made for sterilization, a situation that could compromise free and informed choice. Additionally, mobile service settings, also often associated with sterilization, can threaten informed choice by limiting effective access to a range of methods and follow-up care and by compromising counseling as a result of serving a large number of clients in a limited period of time.

## Service-delivery factors

The service-delivery point is the critical locus of contact between the health care delivery system and the individual client. For truly informed choice, it is essential to make a

wide choice of methods available, either at the site or through effective referral mechanisms, by modifying scheduling, ensuring continuous commodity supplies, and reviewing fees to maximize access to the most choices for the most clients.

The rights and needs of clients cannot be fully addressed without identifying and meeting provider needs (Huezo & Diaz, 1993). Many providers strive to achieve quality services but lack the necessary skills, training, and general support from their supervisors or institutions. Providers need clear guidelines and standards that are developed or adapted for the context in which they work. They need reliable, ongoing supervision that facilitates work, helps to resolve problems, and develops their knowledge and skills. They must also have the opportunity for special training when it is indicated. Attending to provider needs requires strong organizations that can deliver effective supervision and training while empowering and supporting problem-solving by clinic staff.

Such variables as clinic schedule (both overall and for specific services and methods), commodity supply, fees, interpretation and application of eligibility criteria, and number of required laboratory tests and visits for particular methods differ from service point to service point, but all affect clients' access to a choice of methods.

### *Addressing provider needs*

To provide informed choice for more sterilization clients, providers must cope with very real constraints on their time and resources. Ways in which to do this include maximizing the use of available opportunities, staff, and volunteers to inform clients; using space creatively to ensure privacy during counseling; identifying and meeting providers' needs to help them do their job well; developing and testing new job aids and service models; reinforcing training with supportive supervision and self-assessment tools; and focusing on the six essential aspects of the provider's role in helping clients make informed choices:

- Assessing client needs
- Offering method options
- Filling gaps in clients' knowledge and answering their questions
- Helping clients exercise their right and ability to make their own choice, to ensure that their decision is voluntary, appropriate, and well-considered
- Helping clients understand how to use their chosen method correctly
- Providing ongoing client support for other reproductive health services

The practices of individual providers, and at times program or institutional guidelines, either support or undermine the client's right and ability to make informed, autonomous decisions. For example, risk data (e.g., age or parity) often guide decision making in clinical practice: Health providers refer to population-based risk data to "tailor advice and treatment to individual [clients]" (Maine et al., 1994). Although risk data are based on epidemiological science, they are not objective measures in decision making; using them to determine need for sterilization raises concerns about informed choice. Physicians who identify a particular health condition may advise women to undergo sterilization without fully exploring other available contraceptive options (AVSC International, 1998). For example, in a study conducted in Brazil (before a ban on nonmedical sterilizations was lifted), physicians considered certain medical conditions (e.g., AIDS, arterial hypertension, or three or more previous cesarean sections) to be indicators of a need for sterilization (Berquo et al., 1996).

Providers' attitudes toward particular client groups or family planning methods can influence their interaction with clients and the options they offer them. Their knowledge and communication skills, as well as their awareness of clients' reproductive rights and the cultural factors that influence their decision making, govern how effectively providers assess clients' needs, help clients understand their options, and confirm or reach their own well-considered decisions.

### *Addressing the intentions and needs of different groups*

Reproductive health services must start with the individual client as a whole person whose needs may change over the course of a lifetime, and must include access to different contraceptive options throughout a person's reproductive years. If services are to be responsive to client needs, they must be client-centered, respectful of rights, and comprehensive. Clients with special needs include postpartum women, postabortion women, people living in distressed situations (e.g., refugees, victims of natural disasters, or oppressed minorities), and men in general.

The popularity of postpartum sterilization (performed within 42 days after delivery) appears to have grown, particularly in developing countries (Chi & Thapa, 1993). Postpartum procedures are more common than interval sterilizations in seven out of 10 Latin American and Caribbean countries examined in Chapter 3, as well as in the Philippines and in some Sub-Saharan African countries (Botswana, Tanzania, Zambia, and Zimbabwe). Chi and Thapa (1993) cite the desire for smaller families, increases in hospital deliveries, and restrictive policies toward interval sterilization procedures in some countries as reasons for the growing demand for postpartum sterilization.

The timing of decision making on sterilization can affect how well-considered the decision is and the likelihood of subsequent satisfaction or regret, regardless of whether a woman or man is having the procedure. Although sterilization can be performed safely and conveniently immediately postpartum or postabortion, the stress of labor or abortion makes the period before, during, and just after a pregnancy-related event a poor time to counsel and obtain informed consent from a client who is considering sterilization. Ideally, informed choice and consent for postpartum or postabortion sterilization should be completed well in advance of labor or pregnancy termination. When this is not possible, it is advisable for the client to use a temporary family planning method during the postpartum period while taking the time to reach a fully informed and well-considered decision about ending fertility.

Further, individuals living in distressed situations should be carefully counseled about the use of sterilization. Providers can help these special populations assess whether sterilization is the right choice for them and how they might feel when or if their circumstances change, and can provide them with effective temporary methods in the meantime (AVSC International, 1995).

The 1994 ICPD Programme of Action recognized the importance of men's own reproductive health needs (UN, 1994). Paying attention to men's reproductive health needs and encouraging them to participate in reproductive health activities is a good strategy for improving women's reproductive health. Some health care professionals argue against this idea, saying that men are already too involved—they hold too much power over decisions affecting women's fertility and health. However, men's participation in reproductive health activities is critical to help stop the spread of STIs and, in general, to help improve women's health, by supporting their use of family planning or by using a method themselves, such as condoms or vasectomy (Drennan, 1998).

### *Communications*

Strategies and safeguards at several levels can support, promote, and protect informed choice. Most broadly, health professionals can embrace an expanded conceptual framework for informed choice that extends beyond the clinic walls to incorporate broader social aspects of decision making and access to services. Agencies should forge alliances and create or join multisectoral coalitions to advocate for social and policy change to support clients' rights, including the right to informed choice. This effort should include increasing client and community participation in public information efforts, as well as designing and evaluating programs to better understand and meet client needs and to make the programs more accountable to the communities they serve (AVSC International, 1999).

Other important strategies are strengthening and expanding public education efforts to increase the public's knowledge about their reproductive health and rights and their contraceptive options, correcting misinformation, and reducing stigma. Maximizing the

*The stress of labor or abortion makes the period before, during, and just after a pregnancy-related event a poor time to counsel and obtain informed consent from a client who is considering sterilization.*

use of all available communication channels to inform the public and to reduce the burden on facility staff will advance the goal of informed decision making for more clients. Involving field workers, community volunteers, peer educators, satisfied users, pharmacists, and CBD workers can help to extend the reach of information and education efforts. Moreover, giving men an opportunity to discuss vasectomy with other men who have had the procedure is a key step in the decision-making process (Landry & Ward, 1997; Vernon, 1996; Wegner et al., 1998).

### *Client-provider interactions*

At the service site, programs can make client-provider interactions more client-centered and counseling more effective by emphasizing that informed choice is the client's right and by clearly defining expectations and rewarding performance that supports that right. Staff training can be expanded by using new approaches to increase providers' awareness of clients' reproductive rights and to sensitize them about power imbalances in service delivery, as well as by increasing their comfort in addressing sensitive topics associated with sexuality and their ability to communicate with clients about them.

Providers also need training in how to foster couple or spousal communication in reproductive health decision making. More than 40 years of research consistently shows that men and women who discuss family planning are more likely to use contraception effectively (Drennan, 1998). Nonetheless, there may be times when couple communication is impossible. For example, providers need to be aware if a woman is being abused by her partner or is practicing contraception covertly, and they must use their judgment about the appropriateness of encouraging communication (Drennan, 1998; Wegner et al., 1998).

Cultural sensitivities around topics related to sexuality inhibit both clients and providers, challenging communication. In addition, power imbalances between providers and clients based on differences in gender, education, and economic status pose significant challenges for effective client-provider interactions.

## **Challenges: Continuity of Care for Sterilization Clients**

Since limiting childbearing is one of the main reasons for choosing sterilization, many women who are sterilized often do not perceive a need for further reproductive health services after the procedure (Cates & Stone, 1992). For many women, family planning and maternal and child health services are their only contact with the health care system, and once they cease childbearing and have no further need of contraceptives, their incentive or perceived need for seeking out other reproductive health services may be low. Yet even in the absence of a need for contraception, some reproductive health issues—for example, cervical cancer screening and STI prevention—need attention.

Most women in developing countries who choose sterilization as their family planning method do so in their late 20s or early 30s. If they no longer consider reproductive health needs a priority, they are unlikely to seek cervical cancer screening services, just when it is most important for them to do so. Women in their 30s and 40s are at the highest risk for precancerous lesions, and screening should initially focus on these women. Progression from lesions to cervical cancer is a long process—perhaps 10 years or more—so opportunities to prevent cancer in later life are critical for this age-group. In settings where services are available, women undergoing sterilization should be educated about the importance of screening for the prevention of cervical cancer. When women who are older than 30 seek sterilization services, this could represent an opportunity for providers to screen them for cervical cancer. Such a strategy may be less of an issue for women living in developing countries that have well-established cervical cancer screening programs, as many may be accustomed to having regular Pap smears.

Two U.S. studies examining the correlation between sterilization use, high-risk behavior, and condom use show that sterilized women may be at greater risk for STI/HIV infection than women who have not been sterilized (Cates & Stone, 1992; Santelli et al., 1992). This highlights the importance of integrating STI/HIV prevention efforts into presterilization and poststerilization counseling and of ensuring that once they are sterilized, women continue to have access to other reproductive health services.

Another U.S. study showed that sterilized women attending a drug treatment program were less likely to use condoms than were nonsterilized women, even when the data were adjusted for a variety of confounding factors (Armstrong et al., 1992). Furthermore, most sterilized women did not perceive a need for reproductive health services, yet when counseling and gynecological services were provided, they used them. The study's authors concluded that when STI services are provided to sterilized women who are at increased risk for STI/HIV infection, women will be encouraged to take preventive measures to guard against transmission of infections.

A 1989–1990 study comparing personal risk behavior<sup>3</sup> and partner risk behavior<sup>4</sup> among sterilized and nonsterilized women showed that more than one-third of both sterilized and nonsterilized women had a personal or partner risk factor for STIs. Among other findings, 78% of women who had been sterilized reported not currently using a condom, compared with 46% of nonsterilized women. The study concluded that STI/HIV risk-reduction counseling should be offered both before and after sterilization, and that STI/HIV risk assessment should be integral to sterilization counseling and to provider training (Santelli et al., 1992).

Data are lacking on the reproductive health needs of sterilization users in developing countries. In one study in Brazil, researchers found that sterilized women were less likely than were nonsterilized women to have used condoms for protection against STI/HIV infection (Barbosa & Villela, 1995).

Moreover, little is known about the ability of sterilized women to negotiate the use of condoms, which may provide some protection from STIs and other culturally specific reproductive health problems. Entrenched gender roles in highly patriarchal societies may prevent or inhibit the negotiation of condom use. Cultural taboos against discussing sex limit practical negotiations. In some societies, the association between condoms and commercial sex makes condoms unacceptable for use in stable partnerships. In others, men consider condom use a major barrier to their sexual satisfaction (Bawah et al., 1999; Cates & Stone, 1992).

Providing reproductive services to men has not been the norm of family planning programs and has only begun to receive increased attention in recent years. This closer focus on men's services grew out of the Cairo and Beijing conferences (UN, 1994; UN, 1996). Further, widespread STI/HIV transmission has brought to public attention the need for both men and women to understand what behaviors may increase the risk for contracting and transmitting such infections. The widespread transmission of these infections has also heightened awareness of how power imbalances between men and women may play a role in increasing women's risk for STIs and other illnesses.

In one study on vasectomy decision making, researchers reported that some men identified as an advantage of using vasectomy that it protected them against pregnancy with more than one sexual partner (Landry & Ward, 1997). None of the men interviewed cited the lack of STI/HIV protection as an issue with or a disadvantage of vasectomy. Thus, all

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<sup>3</sup> Personal risk behavior was defined as having had more than one sex partner during the year preceding the survey, having used injectable drugs during the month preceding the survey, ever having been in a drug treatment program, ever having received money or drugs for sex, having been treated for STIs during the six months preceding the survey, having used drugs during the last sexual episode, or having used alcohol during the last sexual episode (which was associated with nonuse of condoms).

<sup>4</sup> Partner risk behavior was defined as having had sex during the six months preceding the survey with someone who had an STI, had AIDS, was a prostitute, used injectable drugs, or was bisexual or homosexual.

counseling for vasectomy should include the fact that it does not provide protection against STIs/HIV and should stress the importance of dual protection—use of one method for family planning (i.e., vasectomy) and another method for disease prevention (condoms).

The information that we have to date on sterilization users' knowledge about the need to use condoms when engaging in risky sexual behavior is not promising. However, family planning programs have begun to incorporate messages about condom use into counseling for sterilization users. Since sterilization prevalence will continue to grow, programs must further develop interventions for reaching these men and women with reproductive health information and services.

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