EDITORIALS

Supreme Court judgement on sterilisations

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A recently reported Supreme Court of India order (1) has far-reaching implications for one of India's largest public health programmes. In response to a Public Interest Litigation, the Court noted: "For the time being, no doctor without gynaecological training for at least five years' post degree experience should be permitted to carry out the sterilisation programme." A three-judge Bench also instructed state governments to pay a compensation of Rs one lakh per patient dying due to sterilisation. Further, noting that there were no uniform guidelines for the conduct of these operations, the Court also ordered that the Centre should lay down such guidelines within four weeks.

Given that critics of the family planning programme have frequently drawn attention to the appalling conditions under which target-driven sterilisations are conducted in the country, this judgement can only be welcomed. At the same time, it draws attention to several other issues that equally need consideration.

Sterilisations, whether male or female, are among the safest of surgeries. But they carry, in our country, the burden of the largest mortality toll ever imposed by a welfare programme in the history of the world. During the years of the Emergency official sources admit the death of 1,740 persons, predominantly male (2). These were largely poor people, drawn to undergo sterilisations by the 'compensations' offered, or coerced into undergoing sterilisations. They were disproportionately from among the marginalised and minorities which meant that that the issue did not receive the attention it deserved. But as male sterilisations proved politically costly attention turned to female sterilisations, often in camps, something evocatively described in Deepa Dhanraj's powerful documentary on the family planning programme, *Something Like a War*.

Despite being a signatory to the International Conference on Population and Development, despite the fact that the National Population Policy (NPP) explicitly renounces targets and emphasises issues of quality of care, it is no secret that states were scarcely influenced by the 'paradigm shift' that the NPP is said to have brought about. This shift emphasised the need to meet unmet needs for health services, including reproductive health services (3).

That there continues to be a single-minded focus on numbers is indisputable. Several state population policies link health personnel's performance assessments with family planning target achievements. Family planning performance has also been made a condition for the release of development funds in a range of schemes. A two-child norm has been implemented for contestants to the Panchayat Raj institution elections in several states. This mocks efforts to bring the deprived populations into the political mainstream at the grass roots level, since these population policies take away from dalits, adivasis, women and the poor in general the political space that the 74th Amendment sought to provide. Studies have shown that this has led to women being forced to seek sex-selective abortions followed by sterilisations (4). Ironically, the Supreme Court, in another judgment, upheld this two-child norm (5).

Over the same period, there has been a state-led collapse of the under-funded public health system. The National Health Policy (NHP) admits that India has the dubious distinction – at 0.9 per cent of the Gross Domestic Product – of the fifth lowest public health spending in the world, lower even than countries of Sub Saharan Africa (6). It is no surprise then that we continue to have the largest morbidity and mortality load among countries with similar per capita incomes. The collapse of the public health system has meant that more and more people are driven into the private sector. And thus, again as the NHP admits, medical expenditure has emerged as one of the leading causes of indebtedness. Indeed, the NHP also notes that poor families typically reduce even their basic nutritional requirements to meet their medical expenses.

It is these two factors above all – the collapse of the public health system and the single-minded focus on target achievements in family planning – that lead to sterilisations under unhygienic conditions, with little care to screen prospective patients, or to provide some semblance of quality of operative procedures. Sterilisations are also performed with poor equipment, and the system has no use for follow-up (7). To focus on the training of doctors alone is therefore to miss the woods for the trees. Is there not an urgent need to address the overall conditions and context in which such procedures are performed?

Must matters of quality of care be decided by the Supreme Court? Why is the Indian Medical Association silent? The Department of Health and Family Welfare drafted standard guidelines for quality of care for sterilisations years ago. Of course in their quest for

targets, states are not following these guidelines.

There are other concerns raised by the Supreme Court order that need debate. There is an acute shortage of doctors in the public health system. MBBS trained doctors are perfectly capable of carrying out sterilisations. But if a specialist is now required, does this mean the public health system ceases offering these facilities? Would this then not mean that more patients are pushed into the exploitative arms of the private sector?

It is presumed that quality of care can be guaranteed by specialisation. Specialised obstetricians and gynaecologists in the private sector perform significantly more – and most often unnecessary – Caesaerean sections (8). We only have to remember the silence of the Federation of Obstetricians and Gynaecological Societies of India on sex-selective abortions – to which they contribute disproportionately – to realise that this faith in specialisation may be misplaced.

Reports are legion about poor patients being rendered blind following operations for cataract. Will this too have to be attended to by the Supreme Court? In short, what are the implications for other procedures, from Caesarean sections to coronary by-pass surgery, carried out by the public health system in India? Will norms for training be laid out for all of them? Will these norms apply to the private sector in medical care, the largest and least regulated in the world?

Further, what are the financial implications of the order for the public health system, ailing for lack of funds? In the early 1960s the issue of quality of care hindered the development of the primary health care system in the country. It is also frequently raised to open up Indian markets for multinational companies that equate quality of care with high-tech care.

It is widely accepted that the problems with health care in India are systemic in nature; the solutions too must take a systemic view.

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