Reporting on post-Cairo changes : Quality of care in laparoscopic sterilisation camps

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Laparoscopic sterilisation has been made available in India since the 1970s. This procedure requires high skill on the part of the surgeon and can be performed as an outpatient procedure. In the absence of reliable spacing methods, it is believed that women find this method convenient as it takes little time and also leaves a very small physical scar. Since the early 1980s, this method of female sterilisation has become the mainstay of India's family planning programme. It is provided in camps as well as in health centres.

Keeping in view the need to maintain aseptic procedures and safeguard patients from hepatitis and HIV infection, the government issued guidelines relating to the cleaning and use of laparoscopes. According to the guidelines, laparoscopes are to be washed and dried after each operation and immersed in Cidex solution for at least 30 minutes. This implies that a surgeon using two laparoscopes can perform a maximum of 25 operations in one working day of eight hours. (*source: letter from ministry of health and family welfare dated September 23, 1993, quoted in Ramanathan et al in* Reproductive Health Matters, *November 1995*).

In the post-Cairo period, under the new RCH approach, the government issued guidelines with regard to client screening - taking medical history, basic physical examination and laboratory examination for haemoglobin, blood sugar and albumin. Patients are also expected to be given clear pre- and post-operative instructions. The operation is to be followed by strict monitoring for three hours followed by three visits by the ANM at stipulated intervals.

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In the last three years, researchers have observed sterilisation camps in many states. Some common observations made by them:

- General infrastructure facilities are very poor. There is little drinking water or water for medical teams to wash their hands. Toilet facilities are poor.
- Women queue up, and wait upto even four hours.
- Women are huddled together in makeshift tents with poor hygiene and almost no privacy.
- Few pelvic examinations are done. By and large doctors do not take medical histories. (There were cases reported where women were not even asked if they had undergone an abortion in the last 24 hours. Ramanathan et al report that given the pressure of work, women go for an abortion and come directly to a sterilisation camp. Similar cases have also been observed in Rajasthan.)
- Urine samples are tested in most of the camps, primarily to test for pregnancy.
- Women are asked to walk up to the operation table, lie down head downwards on benches with some help from female or even male workers.
- Women are prepared for the operation (swabbed and cleaned, local anaesthesia given, tubes inserted, abdomen inflated) on the table and again there is little privacy.
- Innumerable operations are performed in one day. In most cases, the laparoscope is not immersed in Cidex solution. Doctors do not change their gloves after each operation; the rubber sheet used on the operation table is also not changed.
- Women are helped down from the table and asked to walk or are carried to a post-operative room/tent. Hygiene is poor and again, there is little privacy. They are attended to by ANMs/ staff nurses. Unless there is evidence of a complication women do not see the doctor again.
- The women are not counselled about post-operative care and symptoms of complications. There is hardly any verbal communication between the women and the nurses / ANMs. They are given antibiotic tablets and asked to go home.
- After resting a while, women walk back to take buses/jeeps/ tempos to reach home.
- Follow-up care is entrusted to ANMs. In some states, women have reported that ANMs visit them three times in quick succession - in two or three days.

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The most worrisome aspect is the attitude of service providers. They treat the clients with little regard for human dignity. Unfortunately, even women doctors do not treat their clients differently.

While there may be some variations across states, the above description is quite representative of what happens in sterilisation camps. During discussions with administrators and technical people in the government, most agreed that the situation in the

camps was far from desirable, admitting that it was a dehumanising experience - not only for the clients but even for sensitive service providers. The following reasons were cited by administrators in many states as factors responsible for this situation:

- Camps are normally organised between December and March each year. Funds are transferred in the last quarter of the financial year - putting pressure on the health delivery system to pack a year's work in three months.
- If laparoscopic sterilisation is made available on one day of the week in a routine manner, such poor service delivery can be avoided. Unfortunately, this is not possible (at least in the more backward states) because trained surgeons are not available in every district There are many districts in UP, Rajasthan and MP where there is not even one lady doctor or a trained surgeon. Therefore, the state government has little option but to organise camps.
- The health delivery system has never laid any importance on provider-client interaction. This attitude is not typical of the health care system alone; it is the same in all public sector services.
- Many administrators and service providers believe women are the culprits - that they produce too many children. This is a mindset that will take many years to change.
- Unfortunately, even in the post-Cairo period where quality is given so much importance, no one is looking at quality of care in sterilisation camps.

It is more than apparent that there is a huge gap between policy-level intentions and government of India guidelines and the ground reality. While officers in the government of India acknowledge the need to improve quality of care, operationalising it is bound to be an uphill task.

References :

The observations made in this article have been drawn from:

Papers presented at the National Workshop on Quality of Services in the Indian Family Welfare programme, May 24-26, 2997, Bangalore.

HealthWatch consultation reports, 1995-97 and 1998-99.

Ramanathan et al, 'Quality of care in laparoscopic sterilisation camps: observations from Kerala, India'. *Reproductive health matters*, November 1995.

In-service training manual of PHC medical officers, FP Quality of care, Department of Family Welfare, Government of Himachal Pradesh, 1995.

Personal communication with the director, medicine and health, government of Rajasthan, Jaipur.

Draft project document prepared for the proposed SIDA-assisted RCH initiative in seven districts of Rajasthan, Indian Institute of Health Management Research, Jaipur, March 1998.

Mavlakar Dilip: Quality of family planning in India: a review of public and private sector. Indian Institute of Management, Ahmedabad, January 1996.

http://members.theglobe.com/jester_haven/health.htm

Population control raises hackles

A bill introduced in the Delhi State Assembly seeks to deny ration cards to families exceeding the two-child norm. It also demands that families which exceed the norm be punished by denial of bank loans, enrollment in government housing schemes and cooperative societies and the parents lose the right to contest civic body elections.

"The bill is wholly misconceived, unconstitutional and discriminatory and also objectionably elitist in its assertions," said Suhasini Ali, former member of Parliament and activist with the All India Democratic Women's Association.

The bill flies in the face of commitments by India to agreements at the International Conference on Population and Development at Cairo in 1994 and the Fourth World Conference on Women in Beijing the next year. Since then, on paper, the country's family welfare programmes have increased funding for reproductive health and tried to expand the range of services while trying to limit population size.

But according to the Voluntary Health Association of India (VHAI), the new policy directives have failed to reach the grassroots level. Says VHAI's Mira Shiva, "the government must get out of the sterilisation trap of which the Department of Family Welfare is itself the main victim." According to Shiva doing away with the department would be a good beginning.

According to Shiva, the infant mortality rate in India at 74 per thousand is still too high to expect people to take the two-child norm seriously. "There is no question of a poor woman agreeing to have only two children when she knows that both of them may die of some disease or the other," she said. "Basic survival, potable water, proper sanitation and affordable health care have to be the crux of any population policy."

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