

Have the Supreme Court Guidelines made a Difference?

A Study of Quality of Care of Women's Sterilization in Five States



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INTRODUCTION

Tubectomy is the most common method of contraception in India. Each year nearly 5 million women undergo sterilization, and an overwhelming 75 percent of all contraceptives used in India is female sterilization. There have been reports of poor quality of sterilization services in the 1990s and earlier.¹ In 1998–99, the Government of India issued quality of care standards for conducting tubectomies.² Even after these guidelines were issued, there were media reports³ and a detailed study⁴ emerging out of Uttar Pradesh (UP) highlighting the continuing poor quality of services. The Parliamentary Committee on the Empowerment of Women⁵ in its report noted the violation of quality norms and asked the Department of Family Welfare to monitor quality of care. Healthwatch UP Bihar, a health rights network, filed a writ petition in the Supreme Court (SC) of India against the lack of quality in conducting sterilization operations.

The SC directed all states to report whether these quality parameters were being followed and in March 2005 passed orders for improving the quality of care of sterilization

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Taking the best of what is being followed by some states, we direct that the States shall:

- Introduce a system of having an approved panel of doctors entitled to carry on sterilization procedures in the State
- Each state shall set up a Quality Assurance Committee for the purpose of not only ensuring that the guidelines are followed in respect of pre-operative measures, operational facilities and post-operative follow ups, but also collect and publish reports of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization.
- The state shall also bring into effect an insurance policy to compensate for death of the patient sterilized, in case of incapacity and in the case of post-operative complications.

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operations. The Government of India incorporated elements of the SC order into the Family Planning Insurance Scheme (FPIS) which was launched on 29 November 2005 and issued a new quality assurance mechanism and revised the quality standards manual in 2006. Healthwatch Forum⁶ activists, in partnership with CHSJ, undertook the study in a few districts of five states of India to assess the implementation of quality assurance mechanisms and Family Planning Insurance Scheme.

The Objectives

The objectives of the study were as follows:

1. To examine whether standard operating procedures as prescribed by the Quality Assurance Manual and Standards for Female and Male Sterilizations as revised after

the Supreme Court orders were being followed in reproductive health camps in these sites.

2. To understand women's own experiences of quality of care and informed choice in the process of receiving sterilization services.
3. To understand whether women and providers were informed about the provisions of Family Planning Insurance scheme.

METHODOLOGY

The study was carried out in the states of Bihar, UP, Orissa, Jharkhand and Rajasthan. Data was collected from different locations in each of these states.

Methods, Study Participants and Data Collection

The study used a mix of methods including the following (see Table 1):

- Camp observation.
- Structured interviews with women who had undergone sterilization in the recent past.
- In-depth interview with service providers.
- In-depth interview with district-level official.
- In-depth interview with state-level official.

Checklists based on quality parameters included in the quality standards manual were used for the camp observations. A total of 17 camps were observed. One hundred and sixty women who had been operated in these 17 camps were interviewed between 10 days and no more than 30 days after their surgery. For getting the providers' perspective, surgeons who conducted the operations and were available were interviewed. The study also included interviews

TABLE 1: Overview of Study Sites and Methods

States	Districts	State officials	District FW Officials	Surgeons	Women	Camps
Bihar	Saharsa	1	1	2	20	2
	Madhubani				26	
	Patna				6	2
Jharkhand	Ramgarh	1	1	1	10	1
Orissa	Mayurbhanj	1	1	1	10	1
	Ganjam		2	4	10	4
	Malkangiri		1	1	14	1
	Balasore			1	15	1
Rajasthan	Chittorgarh	1	1		19	3
	Jhunjhunu		1	2	10	2
U.P	Azamgarh	1	1	1	20	
TOTAL		5	9	13	160	17

with district- and state-level officials for understanding the administrative procedures. The data was collected between March and August 2008. All the field investigators were trained and all the protocols were pretested. Ethical issues like confidentiality and informed consent were taken into account during data collection.

Limitations of the Study

The study assessed the current situation by covering a number of states and districts and by triangulating information from a range of different sources. However, the study has the following limitations:

- i) The overall sample size was small.
- ii) All the research tools could not be used in all sites.
- iii) Surgical proceedings inside Operation Theatre (OT) could not be observed as part of camp observations.

FINDINGS

I. Background Information of the Women

Some of the key demographic features of the women interviewed were as follows:

- Sixty percent of the women interviewed were below 30 years of age. The youngest woman was 20 years of age and the oldest 40.
- Sixty percent of the women interviewed were non-literate.
- Fifty-nine percent of the women interviewed had either two or three children.
- Eleven percent of the women who were interviewed were Muslims.
- Sixty-four percent of the women had not used any contraceptives earlier.

2. Background Information about Infrastructure and Other Facilities at the Camps

Physical conditions: In 13 out of 17 camps, the infrastructure like the walls, doors, windows, roof and floor were in good condition. In two camps, a generator was not available. Five camps did not have an oxygen cylinder or running water.

Examination room: Ten out of 17 camps had an examination table in the examination room. In 14 places there was a blood pressure apparatus and weighing scale and 12 had examination rooms.

Operation theatre: In 16 out of 17 camps, there was an OT table but only 12 were capable of being tilted into the recommended Trendelenburg's position. Fifteen OTs had adequate light and clean clothes for the surgical team. Running water was available in only 11 camps.

Recovery room: Ten out of 17 camps had a recovery room for women with patient's cot, mattress, sheet, pillow and blankets in them. In other places, women were adjusted in any room that was free, and they used old and dirty mats (durrie) to lie down.

Infection prevention practices: Disposable syringe and autoclave equipment were seen in 15 camps. Five camps were not using sterilized instruments consistently and one camp did not even have a boiler to sterilize syringes and scissors, etc. Though the providers were aware of the importance of following infection prevention procedures, they were unable to stick to the guidelines because of lack of equipments or overload of patients. "For disinfecting water should be diluted with the yellow solution and boiled for 15 minutes. This procedure should be carried out for every case but due to shortage of time it is not possible to boil water for 15 minutes."

Citizen's charter: Only four camps had the Citizen's Charter displayed at a public place. Timing of the sterilization was displayed at only three camps and four camps displayed information on free sterilization services. Only two camps had complaints or suggestion box.

3. Pre-Operative Care

A. Waiting for Surgery

Camp observations revealed that 10 out of 17 camps had a waiting room for women while seven camps did not have one. From the interviews it emerged that women had to wait between 2–5 hours between registration and surgery time with a majority having to wait for three hours or more.

B. Counselling and Consent

In nine out of 17 camps, women were being counselled before undergoing sterilization. The following observations were made during counselling:

- ANM and ASHA counselled women at the field level and the doctor counselled after the surgery if required.
- The nurse spoke about the benefit of sterilization and gave advice on how to take care and rest after the surgery.
- The women were oriented that this is a permanent method of contraception.
- The women were being counselled and given information about sterilization.

During their interview, only 17 percent said that they were given information on using other contraceptive methods. 89 percent women reported that they had not read the consent form themselves. 4 percent of them had not signed or used thumb impression on the form. Two respondents from Bihar felt that some kind of coercion was used for undergoing surgery, though they have not mentioned the reason for saying so or the form of coercion.

C. Pre-operative Screening

The Standards for Female and Male Sterilization make it mandatory for the operating surgeon to fill up a checklist for each client before initiating surgery. They also stipulate physical and laboratory examination to ensure eligibility of the client for surgery. However, only 28 percent women said they were asked about their medical history, past illnesses or health problems. On asking the surgeons about the practice of filling up pre-surgery checklist, most of the respondents said they do fill it up but only four of 13 elaborated on the procedures. One of them said there is no such provision. One

TABLE 2. Women's Experience of Screening Procedures

Screening Examination	Number of Women	Percentage
Pulse rate	81	50.6%
Blood pressure	98	61.3%
Temperature	40	25%
Urine sample taken	116	72.5%
PV examination	24	15%
Blood sample	13	8.1%
Weight taken	13	8.1%

surgeon responded “Yes, there is a provision of filling the check list before operation. But that check list is not filled before every surgery.”

Camp observations revealed that 12 out of 17 camps had a separate examination room, however only three had a separate laboratory for blood and urine examination available at the facility. During the interviews, 44 percent of women felt that they had no privacy during the examination and 8 percent women said they had no examination. Table 2 gives the information about the women's experience of different screening procedures prior to surgery.

D. Communication between health staff and women

During the camps, the staff was seen to be polite with the women. They listened to women and their family members; however, in one camp in Orissa, the health staff was very busy and they had no time to interact. No screaming at women or family members was observed, and no evidence of physical abuse was found. Most of the respondents said the behaviour of the staff was good, friendly and polite. One respondent from Jharkhand mentioned that the behaviour of the health staff was fine but nobody came to visit later and no proper care was taken during the night.

Fifty one percent women felt nervous in the OT. On asking the women about the staff's response to their nervousness during surgery, there were mixed responses. While most women said that the staff were reassuring and asking them not to fear, there were also responses like "If you are getting scared and the operation goes wrong, then it's not our fault," "if you very scared, then go back home; otherwise think about it, you still have time."

4. Post-Operative Care

A. Post-operative Care and Follow-up Instructions

During interview with the service providers, they were asked about the post-operative advice they give to women. They mentioned that they informed women about precautions such as healthy diet, light work, maintaining cleanliness, abstinence from sexual intercourse at least for two weeks to three months (in some cases), proper care, follow-up health check-up, taking rest, taking proper diet and follow-up, taking care of the stitches properly, taking regular medicine, visiting PHC in case of pain, fever or infection and so on.

The standard operating procedures about discharge mention a minimum time of four hours after surgery and after an evaluation has been done by the surgeon. When surgeons were asked about this, they gave a range of hours after which they discharged women and this was between 2 to 4 hours. One of them said 8 hours. Few of them said that they discharge after 24 hours to 48 hours. It is worthwhile to mention that some of the respondents felt that women usually want to leave after 4 hours. One provider added that "The operated women are discharged after 4 hours. But the women are reluctant to stay for such time as transport is a major concern, besides the lack of infrastructure (ambulance) is another concern."

Women were also asked in detail about the advice given for post operative care. The recommended standards and the summary of what women reported are noted below.

- Resume only light work after 48 hours and gradually return to full activity by two weeks — Over 84 percent of women were given this advice.
- Resume normal diet as soon as possible — Nearly 90 percent of the women were given this advice.
- Keep the incision area clean and dry — Over 84 percent of women were given this advice.
- Bathe after 24 hours following the surgery — Nearly 90 percent of women were told to bathe two days after surgery.
- The client may have intercourse one week after surgery or whenever she feels comfortable — Most of the respondents said they were advised to have sexual intercourse nearly 90 days after the surgery; some of them said they were advised to resume sexual intercourse after 180 days and few of them said they were advised after 60 day. Over a third of the women were not given any advice regarding resumption of intercourse.
- Follow-up contact at home by the female health worker or in a government health institution or reporting of the client to the clinic should be established within 48 hours of surgery — Nearly 65 percent women said the health worker visited them after the sterilization of whom half said that the health worker visited them within two days of the surgery.
- A second follow-up should be done on the seventh post-operative day for the removal of stitches and post operative check-up — 61 percent women said that the stitch was removed at home, 30 percent said at the facility. 46 percent women said that ANM removed their stitch, 16 percent said doctor removed their

stitch, 10 percent women got it removed by nurse, and the rest by others like compounder, hospital staff and Ayurvedic doctor.

B. Discharge slip and certificate of sterilization

On asking if they were given a discharge slip when they left for home, only 17 (10.6%) women reported that they were given written instructions about care to be taken after the surgery. From service providers' interview, it emerged that many women are often not given discharge slip. One provider said, "We are not giving discharge slip to every case. According to the demand or willingness of the patient, we are giving."

On asking whether women are given certificates after sterilization, seven of the 13 service providers said that they do not give such certificates. The remaining six said they do give if asked for. A provider said, "We are not giving any certificate to the sterilized women, only government employees are demanding from their sides and we are giving them only but not to the common patients. Now, in the last meeting, we have planned to give to each individual who undergoes sterilization."

5. Costs and Compensation

Sterilization services, including post-operative medicines, are supposed to be provided free of cost by the Government of India as part of the Family Planning programme. All acceptors are also provided an incentive, which at the time of the study was Rs.600 for women.

Cost of Surgery and Medicines

Eighty percent of the women were not charged for the surgery, though 59 percent had to buy medicines. In Bihar,

women incurred costs ranging from Rs.20 to Rs.2,500 on surgery alone. Seventeen out of 52 women interviewed in the state said they spent more than Rs.1,000 on surgery and five among them had spent Rs.2,000 and more. Forty-nine out of 52 respondents in the state reported expenses incurred for medicine. 18 women had spent Rs.1,000 or more, of whom 11 spent between Rs.2,000 and 5,000 on buying medicines. In Orissa, 25 out of 49 reported having incurred costs related to medicine, with three spending above Rs.1,000 and one woman spending Rs.4,000 on medicines. In comparison to Bihar and Orissa, women from Jharkhand and UP had to spend less on medicines, with fewer women reporting spending money on medicines and the amounts being in the order of Rs.50 to Rs.400.

One hundred and forty out of the one hundred and sixty women said that they received compensation after the sterilization. Of them, 80 percent of respondents faced no difficulty in getting the compensation, whereas 6 percent faced some difficulty and 14 percent women did not respond. In Bihar, one woman said that she did not receive any money despite spending Rs.3,500 on medicine and other things. Most of the women received the allotted Rs.600, though in a few cases they received a lower amount.

6. Quality Assurance Mechanisms

A. Service Providers' Knowledge of SC Guidelines of 2005

Service providers were asked about their knowledge of the SC guidelines on quality of care relating to sterilization procedures. Most of the surgeons knew about these guidelines but many did not know about the specifics of these guidelines. One of them said they received training on this while another respondent said they received guidelines but not training. One said, "Yes, I know that Supreme Court has issued a guideline for the sterilization operation ... and from 2004–05 we are

following it. A Quality Assurance Committee has been formed under the leadership of Directorate of Health at the State-level and Chief District Medical Officers at the district level. ...Insurance for the women and medical officers are given as required. I know that we should do proper counselling to the patients before and after the sterilization operation ... For one case we should give 5 to 10 minutes and in a day we should do no more than 30 operations but we are not able to follow the guideline 100.percent."

Another one said, "Previously the operations were held even in a school, college and sub-centre. Now, it is strictly prohibited to do so in such areas. CDMO circulated a letter which says that only on Tuesday and Friday sterilization can be done either in a PHC or in a CHC with sufficient infrastructural arrangements."

Some were aware about compensation. One said, "If it fails then the compensation is Rs.30,000 and in case of death Rs.100,000."

In discussions with district officials, seven of the nine knew about these guidelines. "Yes, we have prepared a panel of operating surgeons, QAC is there, records are being kept, and insurance is there." Many of them agreed that it is not implemented in total. "Yes, but the order is not implemented fully."

All State-level officials were of the opinion that the SC guideline was a positive step "It is a good thing and it helps in maintaining quality in sterilization operation." They said, "Yes, we are trying to implement the guidelines related to sterilization at every level. The doctors and the nurses are being trained."

B. Ability to follow Standards

Most of the providers said that they try to follow the standards but were not fully successful in doing so. "We are able to

follow only 60 percent of standards set by the government. ...Although we know about the guidelines of Supreme Court in this regard but it is difficult to follow up the guideline minutely in the field level and in an interior place like ZZZ CHC."

In the interview with the district-level Family Welfare Officers, most of them said that they try their best to meet the standards. Few said they "completely" meet the standard, another said that they are successful up to 80 percent. One of them admitted that, "The standards of the sterilization operations are not up to the mark."

When asked about difficulties faced in following standards, most of the service providers complained of different problems. One provider said "...maintaining hygiene is a problem for us. No active follow up due to limited staff with huge workload. Although we are giving the medicines to the sterilized women, we are unable to give all the required medicines." Another said "...Our PHC is technically poor. We do not have sufficient infrastructure to follow the guideline fully. We are still working in the old building, no generator facilities, no running water, shortage of staff etc. During operation, surgical gloves and apron are the requirements. But as there is no supply of these materials, we are conducting the operations without these materials." A third said "...Sterilized women do not follow the advice, in addition to that they can't come again for post-operative follow up. If a minor complication occurs they neglect it, which leads to chronic problem." There were a few providers who denied facing any problem in following standards. "No, what types of problems? What is the difficulty? All standard measures are followed in this camp."

At the district level, officials said they face problems like infrastructural problems, lack of equipments and staff. "It is not possible to observe and examine all the patients in pre- and post-operative period. We are still

unable to provide running water facilities and laparoscopic facilities to all PHCs. We are trying our best or in a process to fulfil all the requirements.” An official from Orissa advised, “It is too difficult to follow the Supreme Court guideline on sterilization operation. It needs lot of restructuring at PHC/CHC level. The community should demand proper care. NGO/GO should jointly try to make aware the common people...we can follow the guideline in the right way.” Two district officials said they did not face any problem.

C. Quality Assurance Committee

Service providers were asked about their knowledge of the Quality Assurance Committee (QAC) in their district. While some knew about such a committee, others did not know. “Quality Assurance Committee has been formed in our district some years back. CDMO and ADMO (Health & Family Welfare) are the two members of quality assurance committee. They are regularly visiting our CHC, monitoring the cases, and giving feedback. Conducting monthly review meeting.” Others who did not know said, “May be, there is a QAC in the district. I am not aware about the committee and their role.” On asking the district officials about QAC, five out of nine said that QACs had been formed in their districts. three of them said it was not formed and one official did not know.

D. Targets for Women’s Sterilization

On asking about targets around women’s sterilization, the service providers gave mixed responses. While five out of 13 respondents said there were no targets given by the district, others said there were targets. “...we have to do 300 operations per annum for internal audit. In our

CHC, the target is 325 per year. We usually conduct operations from end of September to March." Another provider elaborated, "The target is decided by the Family Welfare Department, Deputy CMHO and the Collector....." Others said "The sterilization programme has a significant role to play in the population control programme. The birth rate of our district is 18.92. The state government had kept a target of 18 percent for 2012 but we have succeeded in achieving the target in 2008 itself." An official from Rajasthan advised, "I would like to convey to the Government of India that for population control, instead of a targeted approach based on numbers, a qualitative approach must be adopted."

Complications after surgery

Eighty seven (54%) women said they faced health problem after their surgery. Forty women sought medical attention for these health problems. 11 percent women reported bleeding from the wound, 17 percent had infection, 5 percent had urinary problem and 28 percent had fever after few days of the surgery. In addition, 31 percent had giddiness, 13 percent had nausea, 50 percent had abdominal pain and 25 percent had acidity, immediately after surgery. Forty-five percent said they had consulted the doctor, thirty-one percent consulted the health worker and one respondent said that she had consulted a private doctor.

7. Information about Family Planning Insurance Scheme (FPIS)

A. Knowledge about Family Planning Insurance Scheme

Women were asked about their knowledge of the Family Planning Insurance Scheme, and only 8 percent said that they have heard about it. Their sources of information were the newspaper, television, radio, government advertisements, health worker and social workers. However, 54 percent women reported having faced some problems after

surgery, including 40 who needed to see a doctor. Nobody reported having been told about or having applied for FPIS benefit.

B. Adverse Outcomes and Compensation

Providers, district and state officials, were asked about adverse outcomes and the compensation process. Except one provider from Rajasthan, others did not know of any case where compensation had been paid in case of sterilization-related death. One district level official from Orissa said, "During the year 2006–07, two death cases were there who had received compensation. During the year 2007–08, two death cases were there whose files are under process for compensation. There is no reported case of failure or complication." No information was available from the district officials from Bihar on this issue. From UP, the official from Azamgarh district said, "there was one death case from one CHC and we gave Rs.500. Insurance form was filled up but after that no idea." He added that three failures had taken place in 2007–2008. One of the officials in Rajasthan said, "Though there are no cases of reported death due to sterilization, there are 1–2 cases of failure every year." With regard to FPIS claims by women or their families, he said, "this information could be accessed from 2006 records from Chittorgarh ... they got their insurance from ICICI Lombard Insurance Company."

State-level officials from Bihar reported three deaths in 2007–08 and two deaths in 2008–09 due to sterilization. He also added that though the family of one woman had claimed compensation, they had not been given by the insurance company. The official from Orissa said that in 2006–2007 there were six deaths, 32 failures and 10 complicated cases. In Jharkhand, the official said that there were four cases of deaths and 11 cases of failures in 2007–08.

C. Role of Officials in Providing Compensation

On asking about the role of the District Family Welfare Officials in facilitating compensation to women, the study found that in different states different procedures are followed.

The official from Orissa said, "The Medical Officer of the concerned PHC/CHC conducts the initial inquiry. As in-charge of Family Welfare activities in the district, I then make an inquiry of the case and process the file for compensation. After my inquiry, CDMO conducts final inquiry and sends report to insurance company for compensation." The Orissa state official said, "State directorate is directly monitoring the district authorities whether the beneficiaries are getting their appropriate claim or compensation or not. In fact, district health officer has sufficient power to handle the case. If there is a problem, the state officials can help the district official indirectly."

District officials from Rajasthan said, "We take full responsibility of taking the case and sending it to the Insurance Company. We help them in getting the form filled and sending it across."

The official from UP said, "The forms are filled from our office and sent across." On the role of the Directorate in facilitating payment of compensation of FPIS claimants and in linking with the insurance company, the official from UP said, "Basically, we are involved in monitoring. If any problems come up in getting the compensation we speak on behalf of the woman to the Insurance Company so that the woman gets her complete compensation."

The official from Bihar said, "The claim and other papers are sent to the insurance company from the district level. The directorate has the responsibility of disseminating the guidelines at the right time. Directorate and S.H.S.B can only disseminate the guidelines. Actual implementation agencies are the districts and the insurance company itself." He also added that many times he has to take special efforts so

that the family gets the compensation, “I have to personally make ten phone calls or emails, and even then the insurance company doesn’t reply. Agents and the company are insensitive and non-cooperative.”

CONCLUSIONS AND RECOMMENDATIONS

This study was initiated to assess implementation of SC Guidelines and examine whether standard operating procedures were being followed during service delivery and at administrative level. It tried to triangulate information from three sources, direct observations, women’s experience as well as service providers and officials’ perspectives. There was a reasonable degree of consistency in the information gathered from the different sources. Based on these findings as well as a comparison with the earlier studies that have been conducted on the same issue, the following conclusions can be drawn:

- Periodic camps are not the desirable method for providing sterilization services, and the recommendation is that these services be available on a regular basis at all facilities. However, with a shortage of trained surgeons, camps continue to be the common mechanism in many states. There were no reports of coercion or physical abuse. The overall message from this study is that there has been an improvement in the quality of care of sterilization services being delivered through camps.
- However, there are still gaps in the implementation of quality standards and in the monitoring mechanisms. Not all personnel and district-level managers are equally informed about the procedures. There are continuing gaps in infrastructure and in some cases supplies.
- Some of the crucial areas of quality that continue to be ignored are counselling, pre-operative screening procedures as well post-operative procedures and

discharge-related advice. These can be considered “soft areas” and can be considered to be associated with the provider attitudes about the client’s entitlements to information and choice.

- Cost of care remains a concern in some places. Even though the Family Planning programme is not only supposed to be free, but one where users are provided a form of compensation for time lost, it is worrying that many women have ended up paying large sums of money for surgery as well as medicines. The fact that this is higher in Bihar may reflect the high levels of unmet need for contraceptive services in the state.
- More than a half of all women had some adverse outcome and a quarter of all women had to seek medical help for their complications. This high level of complications indicates that quality of care is inadequate, and high levels of fever indicate inadequate infection prevention. Sterilization is considered a major surgery because it requires entering the peritoneal cavity and such complications should be regularly monitored and addressed.
- Certification continues to be a problem with a large proportion of women not receiving a discharge slip and the certificate. This along with the absence of a citizen’s charter and lack of information being provided about the FPIS together add up to very poor accountability mechanisms being in place.
- Knowledge about the Family Planning Insurance Scheme has not yet reached the client, who needs it the most. This means that large number of potential users will not be able to claim damages for which the government has already paid its premiums. This means that the insurance company concerned may be making undue profits.
- The study did not reveal enough about the mechanisms for seeking compensation and the experiences of women and their families in seeking compensation under the

Family Planning Insurance scheme. However, what it did indicate reveals the lack of adequate procedures enabling women to seek support under this provision provided by the state. This is of course besides a key shortcoming of the FPIS in defining "failure" which requires re-conception to be reported within two weeks of the missed period.

Some of the recommendations that follow from these findings are as follows:

- All managers and service providers must be trained in quality of care issues, especially issues relating to patient's autonomy as well as pre- and post-operative counselling and advice.
- Quality Assurance Committees have begun to function but are not yet fulfilling their role of collecting and publishing information relating to quality and adverse outcomes. This needs to be done forthwith and adverse outcome reporting needs to be made mandatory.
- Reporting of adverse outcomes needs to be tied up with improving accountability mechanisms and information about FPIS and Client rights and Citizen's Charter needs widespread circulation. One practical mechanism would be to print the provisions of the FPIS on the discharge slip, which again needs to be made mandatory.
- There must be studies conducted to set acceptable standards for adverse outcomes. Adverse outcome reports must be compared against these "benchmarks" and time-bound plans made to improve quality of care at the facility and district levels.
- All functionaries of the health department must support clients in claiming their entitlements under the FPIS because the government has already paid the appropriate premium. The provisions for reporting "failures," has

to be reviewed because reporting failures within two weeks is impractical and does not allow for differentiation with delayed periods.

With the improvements that are already visible in the quality of care of sterilization operations it is hoped that these conclusions and recommendations will be welcomed by the ministry and implemented into practice at the earliest.

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NOTES

1. Koenig and Khan (1999), *Improving Quality of Care in India's Family Welfare Programme*, Population Council, New York.
2. MoHFW (1999), *Standards for male and female sterilization*. Division of Research Studies & Standards, Department of Family Welfare, MoHFW, Government of India.
3. See Saxena, R. (2002), "Theatre of the absurd," *The Week*, 22 December.
4. See Das et al (2004), "Medical Negligence and Rights Violation," *Economic and Political Weekly*, 39(35): 3876–79; 28 Aug.-3 Sep.
5. See Committee on Empowerment of Women (2002–2003), *Action Taken on Fourth Report of Committee on Empowerment of Women* (Thirteenth Lok Sabha) March 2003.
6. Healthwatch UP Bihar has subsequently been renamed Healthwatch Forum.