LAPAROSCOPIC FEMALE STERILISATION CAMPS — A RETROSPECTION IN BIHAR

By

BEENA KUMARI SINHA

Introduction

To face this burning problem of population explosion, laparoscopic camp sterilisation has proved its efficacy in last a few years. Decline in popularity has been noted everywhere in the country, affecting badly Bihar.

A trial has been made to highlights the short comings causing its decline on part of surgeon, management and health officials.

The author has studied the various facets of this problem in laparoscopic cases in last four years in Bhagalpur district of Bihar, in camps.

These deficiencies relate to the organisation of camps, publicity and mass health education, proper selection of cases and pre-operative care, good laparoscopic Surgeon, maintenance of equipments, post-operative care and proper follow-up.

Organisation of Camps

As the main explosives in this population explosion are lower class people, camps must be organised at rural places with full equipments, drugs and facility.

In the begining it was relatively easy to draw a large crowd due to its simplicity, safety, and some new thing to people.

From: Deptt. of Obst. and Gynaecology, Bhagalpur Medical College Hospital, Bhagalpur.

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The crowd was not managed properly in sense of accomodation, proper health check up, adequate medicines, good behaviour of staff, electricity facilities etc. Some times they were left under the sky, with no proper privision for water, electricity, food etc. No free transport facilities had been provided.

Often altercations developed between the relatives and the paramedical staff vitiating the whole atmosphere.

These things hurted the self motivated back log which made the task of further motivation more difficult. Therefore to promote this most needed sterilisation camps it should be properly organised by Government and voluntary agencies with a proper attention on the best amenities provided.

Publicity and Mass Health Education

Mass health education is necessary to convince the acceptor. This can be done with the help of our public relation wing, health staff, press, Radio and T.V. etc. As people are more conscious now (They should not be confused by any rumour or slogan). Previously it was being told that this Operative procedure takes as much time as putting a bulb on. It is totally wrong. It is an operative procedure not injection, which is being told. Door to door health education is quite necessary to gain their confidence in programme. Every body should realise its importance. This sense of duty in most of the government staff are lacking.

They are more engaged in strikes now. This will improve after regular just and constant supervision of superior authorities.

Selection of Cases and Pre-Operative Care

As already emphasised (Mehta and Bandookwala 1980) pregnancy, puerperal, post-abortal, previous lower abdominal scars and medically unfit cases are best avoided to ensure a low complication rate. Pelvic examination must be done by a doctor to exclude pregnancy and pelvic tumour etc. Extreme courtsey and privacy must be provided to each woman. Every cese must be treated well.

Number of acceptors must be limited. Not more than 50 cases should be operated in one day, It will reduce failure rate. Every case must be investigated properly for Hb% estimation and routine urine examination.

The quality of potent drugs used for premedication are being supplied inadequately. Often the patients feel pain and shouts during the procedure, which alarm waiting crowd. Adequate sedation and local anaesthesia is necessary for better acceptance of procedure.

Experienced and Effcient Laparoscopic Surgeon

The art of laparoscopy being a highly skilled technique, surgeon must be properly trained and confident about the procedure. In target oriented and time bound programme, chances of inadequately trained laparoscopist conducting camps are high with resultant complications Laparoscopic surgeon must be dedicated, not in a hurry and interested to work as it is monotonus, repititive and exhaustive. Government should select interested person and train them properly. He must be very honest to his work to apply the rings on tubes only. More failure rates is the most discourging point of this programme. Theoretical instructions are inadequate in form of literature and books.

Drugs and Equipments

According to Mehta (1984) Like a pilot before a flight, the laparoscopist should maintain a check list of the important drugs, instruments and equipments before proceeding for laparoscopy at camps.

Instruments supplied should be properly maintained and enough spares should be at hand. Lack of spares lead to cancellation of several camps. There should be quality control for the rings used in banding. Adherence to strict criteria in the selection of the rings, will prevent the failure rates. Defective rings increases failure rate.

Post-Operative Care and Follow Up

As it had been observed that after operation the acceptors are treated as fused bulbs. Post-operative care and proper follow up helps the patient's confidence in the programme. Proper care and good operative procedure makes every case as a motivator to their relatives since it is a quick and easy procedure. Motivators, health visitors and field staff often consider unnecessary to follow up. Thus unattended insecure patients develop distrust in health delivery system. The failure cases must be dealt with full caution and facilities. These failure cases are cited as examples which go against the programme.

Tubal recanalisation should be an inmportant point of programme and should be done in genuine cases of unforeseen infant deaths.

Conclusion

For the desired birth rate as 25 per 1000, camp approach through quick, safe, economical and easy leparoscopic sterilisation technique is a reality to be experienced. This study may be concluded with following facts:

1. There is lack of proper management at all level.

2. Proper check up and selection of acceptor is not being done.

3. There is lack of pre and post operative care and follow up.

4. Surgeon must be very specific, being properly trained and experienced. He should not be in hurry, high headed and quantity minded.

5. Proper surgical ethics in sterilisation and sepsis are not followed.

6. Wrong propaganda, slogans and rumors are causing lack of confidence in procedure.

7. Rural infra structure of these camps are extremely poor-attracting less no of acceptors.

8. Health personnel at P.H.C. do not realise that it is a major surgery as tubectomy operation needs proper theatre and sterilisation.

References

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