Tubal ligation candidates who did not get their operation
ABSTRACT

Objectives
To identify bottlenecks in the delivery of comprehensive family planning to women in contact with the health services and to find ways to reduce unmet demand for contraception.

Design
Exploratory descriptive study.

Setting
Large Bulawayo referral hospital and the high-density areas in the same city.

Subjects
Case notes of 284 women who indicated together with their partners that they had completed families and who had their tubal ligation forms duly signed but who never had their operation. Follow-up of a sample of patients.

Interventions
Non intervention study.

Main outcome measures
Are reproductive rights taken seriously? Is there service related unmet demand for family planning?

Results
Even those who had all their paperwork in order for a durante or post partum sterilisation did not have any guarantee that this service would be given. The main reason was found to be lack of well-motivated health staff.

Conclusion
Much can be improved in contraceptive service delivery. Reproductive rights are not respected.
INTRODUCTION
In June 1994 family planning (FP) staff were interviewed in a Bulawayo hospital in order to identify bottlenecks in providing good contraceptive service. During these talks a file was produced with 284 used tubal ligation (TL) forms covering the period September 1989 till June 1994. This involved on average 60 patients per year quite equally divided over those years.

These were forms signed by a woman, her partner (or guardian), two witnesses, a junior doctor, a consultant in obstetrics and gynaecology, the superintendent or sometimes his deputy. But the TLs had never taken place.

On these forms all the above signed, in a rigid sequence and the superintendent also rubber-stamped the papers. All this signing and stamping was done to satisfy the conditions of those in charge so that the 283 women involved could be sterilised. One woman had twice a form filled in, with three years in between. The forms were filled in during or (partly) just after a pregnancy in order to perform a durante or post partum sterilisation. The initiative to approach the patient about a possible wish to be sterilised was often taken by the FP sisters at the Antenatal clinic (ANC) and sometimes in the Ante/Post Natal Ward (ANW/PNW). Some patients would have brought filled in forms from the referring hospital when transferred but these were often not honoured (although completely legal and proper) because the Mpilo consultant and superintendent had not signed and stamped them and there was and is confusion about the regulations.

The rigid sequence mentioned above is of importance because this makes it impossible to go to the superintendent on say a Friday at 1500 hours for a stamp and a signature for a Para six who is not progressing but otherwise stable, whose husband is likely to sign at 1700 hours for a TL, if she happens to need a caesarean section at 1800 hours. The superintendent will only sign after the husband has signed, on Monday morning, long after the caesarean section has been done.

MATERIALS AND METHODS
The forms found in the file were analysed. The particulars of the relevant deliveries were studied in the delivery books. In order to receive some insights into the reasons why these post partum sterilisations had not taken place a convenience sample was taken of 50 women who lived not too far away in the High Density areas of Bulawayo. Elective medical students were given a car to drive an experienced female outpatient translator to interview the women in a semi-structured way, after getting permission. They succeeded with difficulty (because of the illogical house numbering) in finding 34 women often after repeat visits.
RESULTS

Particulars of the women involved

The 284 women were on average 35.5 years with a median of 36 and a range of 22-50. The woman of 50 years had before the index delivery 8 living children. The woman of 22 had had already two caesarean sections and had wanted a TL during her third. Several of the younger women had had repeated problems with (pre) eclampsia. One woman with 2 living children had had 4 caesarean sections and later had her fifth without a TL because the paperwork was not 100% completed. See Table 1 for the relation surviving children and number of women involved.

At the proposed time of sterilisation most women would have one more child, some two. One woman appears twice in this table: once in 1989 with 5 children and once in 1992 with 6 children when she is 33 years. She left the hospital with 7 children without her TL. Of the women (both 23 years old) with one child one had had severe disabling polio the other suffered from rheumatic heart disease.

Three of the 34 interviewed women had become pregnant after being discharged from the hospital. Of these three, one admitted having procured an abortion, one delivered and had afterwards a sterilisation in another hospital, and one was still undelivered from an unwanted pregnancy.

The reasons (non exclusive) given by the 34 interviewed women why they thought they were not sterilised were as follows:

- The husband changed his mind (1).
- The doctors or nurses were on strike (4).
- There was no time because the hospital was too busy and patients’ appointments were postponed all the time including often over a whole weekend (12).
- They were often worried about their children at home when they spent such a long time in hospital (2).
- Patients became fed up (sic) because they were starved for hours, sometimes 2-3 days in a row, before their operations were cancelled (5).
- The baby was not so healthy (1).
- They were postponed and believed that postponement was no accident but a message from the ancestors to show them that they were not amused with the proposed TL (3).
- While waiting one patient was told by her hospital roommate that God did not approve of TLs (lady who later induced an abortion).
- Anaesthetist cancelled the operation because a blood test was not done (2), (probably Hb test) or the blood pressure too high (3).
The patient needed an emergency caesarean section but not all the people, of whom it was erroneously thought that they had to sign, had done so (3).

Patient booked for an elective caesarean section with TL went into labour some time before the operation was planned and all the signatures were not in place yet (1).

Forms got lost (2) (including that of a patient who was delivered with her fifth caesarean section).

Patients became scared or hesitant (5).

Loss of income while waiting in Hospital (2).

On discharge from the hospital without the wanted sterilisation patients were often advised to come to the outpatient department or to the postnatal clinic to arrange for a sterilisation.

Nine patients tried this. They said they were sent from pillar to post. They were advised to come back another time or to another doctor. They were booked, rebooked, cancelled and treated impolitely.

Some could not afford all this travelling to the hospital. Because this was in relation to geography certainly not a representative sample, travelling costs would be even more important for the average woman, than suggested by this sub group.

Table 1   Number of women & number of children alive during index pregnancy.  
N=284

| No. of women | 2 11 22 38 57 59 44 25 12 4 2 8 |
| Children alive | 1 2 3 4 5 6 7 8 9 10 11 unknown |

Average no of living children before intended sterilisation: 5.6 Median no: 6.

**DISCUSSION**

Apart from finding women who were the victim of the policy of insisting on 7 signatures and a stamp, similar study results could be discovered in other central and provincial hospitals. These latter studies would not be so easy because centralised files of unperformed TLs are rare. If the wanted (by women) average completed family size in Bulawayo is like that of Zimbabwe as a whole it includes 4.3 children\(^1\). These 284 women had on average 2.3 children more (see Table 1) when they left the hospital without their TL. The hospital here discussed has together with the relevant clinics about 20,000 deliveries per year. If female sterilisation was the only way to stop having children one would expect one TL per 4.3 deliveries. One has to adjust this figure for child...
mortality, multiple pregnancies and the shape of the population pyramid. It can be estimated that there are thus 2000 candidates for TL annually, ignoring the backlog. The last few years there were less than 300 TLs done in this hospital, about half during caesarean sections and the other half post partum and at interval. An excellent time and place to discuss FP is during visiting hours in the ANW/PNW because there is a concentration of patients with medical and personal indications for a TL and often one can find the partner there. Unfortunately visiting hours coincide with tea time, and in the early morning and evening and weekends, when husbands are most likely to visit, the FP staff is off.

Combining sterilisations of multipara with evacuations after (clandestine) abortions is impossible if seven signatures are needed even if the theatre staff would “allow” it.

The patients discussed here are only those who were pregnant and failed to take the last hurdle to have a TL. There are of course hundreds of pregnant patients admitted after hours and in the weekends or referred from outlying hospitals or un-booked or delivered in the city clinics who are never asked if they want a TL. Then there are all the fertile women with completed families who visit the hospital for hypertension, incisional hernias, eye problems, incomplete abortions or have their children treated for malnutrition. Women who are losing their children or husbands to AIDS are another group. Most of the above are not counselled about their FP options let alone their partners.

Increasing the awareness and motivation of patients for TLs is senseless, if the system cannot provide the service. The FP sisters must lose motivation, because all the work done in coaxing the forms past all the signing authorities was for nought. The women, in the income group provided for in this hospital, have no access, mostly for financial reasons, to the other reliable very long acting method, Norplant. Many women will not succeed in abandoning their reproductive career without a TL. If they try to do it with oral contraceptives they will often fail\(^2,3\). A Saturday morning TL list for patients who just delivered or aborted would be an excellent service but would be impossible without an incentive (100 pounds in the U.K. in 1995).

Because it is so difficult to organise a postpartum or interval TL every effort should be made to sterilise those patients who want a TL and who are going to have a caesarean section, elective or not, during that operation. Insisting on forms with 7 signatures does not help this effort. If the opportunity is missed and the last signature is obtained the day after the caesarean section then these patients at first more likely to have a desired TL because of their operation are now at a disadvantage because most doctors would not like to do a post partum TL in the next few weeks.

The simple forms issued by the Ministry of Health (MOH) and the ZNFPC in 1992 and distributed to (but not used by) all hospitals make it also possible to fill in new forms if it is realised five minutes before the caesarean section that the earlier forms got lost.
Access to a permanent method of family planning is difficult in a busy hospital which looks after non paying patients and where elective operation time is limited because of a “collusion” of anaesthetists, unmotivated doctors, active doctors with private practice on the side and theatre sisters. Sterilisation under local anaesthesia removes one bottleneck but introduces two new ones: training and turnover of surgeons and reluctance of many members of the nursing staff to cooperate with this procedure.

In hospitals with a mixed private/non-private patient population claims on beds and theatre time, by those who after years of investments want to harvest the fruits, are so powerful that an elective sterilisation of a non-paying patient has to be fought for. A paying patient is more likely to get a haemorrhoidectomy than a poor Para 8 a TL.

It is in generally assumed that on average a TL prevents 2 unwanted pregnancies. In this case 566 pregnancies could have been prevented including about 50 vertical HIV infections. Small improvements in hospital organisation and following the MOH directions about the right TL forms, possibly combined with incentives for hospital staff and reimbursement of patient's costs, will improve the FP delivery system. The introduction of an intrauterine Quinacrine sterilisation method on an outpatient basis might remove some of the pressure on elective theatre lists. In those patients who are known to have an HIV infection and who have already children TL is the only reliable option for most and the facilities must become more accessible.

REFERENCES
1 Zimbabwe Demographic and Health Surveys (DHS) III 1994; Central Statistical Office, Gov. of Zimbabwe and Institute for Resources Developments/Macro Systems Inc. Columbia, Md, USA.
Obst Gyn Dep., UBN P.O. Box 958 Bulawayo. Tel 72111. Ext 2222

You had an operation after delivery on 21/1/84.
Can I please ask some questions to improve our services? Please fill in this form and return inside enclosed stamped envelop.
Your answers are of course highly confidential

1. How many children do you have now?...
   How many boys. How many girls...

2. How many children do you want to have in total...

3. Did you lose any child after the operation? No  Yes

4. Would you like to have more children? Yes/ No.

5. Are you satisfied with the operation you had? Yes/ No.

6. Did you get any problems after the operation? No/Yes
   If yes, what problems did you get?

7. Do you have any of the following problems these days?
   - more headache Yes  No
   - loss of appetite Yes  No
   - pain in the abdomen Yes  No
   - getting fatter Yes  No  but I want to be flat
   - feelings of sadness Yes  No
   - less desire in sex Yes  No

8. Did you want to have more children after your operation? No  Yes

9. Your last pregnancy was it: Planned
   - Too early
   - You had hoped before that pregnancy that you would not become pregnant anymore

Please tick right answer
10 Do you have any complaints about your periods? Yes/No?

What complaints? ________________________________

11 If you have period complaints did they start:
   before operation [ ]
   after operation [ ]

12 Would you recommend this operation to your friends Yes/No? Why? Because... it went well... no complications...

13 Do you wish you did not have the operation? No / Yes

14 Do you have any other comments on the treatment and care you received while in hospital? Please feel free to comment on anything.

[Handwritten notes]

15 What church do you belong to...Jehovah's witness

16 Was the operation very painful? Yes/No

Was it more painful than having a baby? Yes/No

Thank you very much for your time. If you still want some advice, please visit the women-walk-in-clinic at UHHS every Tuesday 3 PM or phone my secretary 72111 extension 2222.

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