

# Mistreatment and Coercion: Unethical Sterilization in India



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## **Human Rights Law Network's Vision**

- To protect fundamental human rights, increase access to basic resources for marginalized communities, and eliminate discrimination.
- To create a justice delivery system that is accessible, accountable, transparent, and efficient and affordable, and works for the underprivileged.
- Raise the level of pro-bono legal experience for the poor to make the work uniformly competent as well as compassionate.
- Professionally train a new generation of public interest lawyers and paralegals who are comfortable in the world of law as well as in social movements and who learn from such movements to refine legal concepts and strategies.

India's Family Planning Programme  
Cruelty in Sterilization Camps

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**Editors:** Madhulika Masih, Sarita Barpanda and Zahra Wynne

**Sub-Editors:** Leon Rauch, Sangeeta Banerjee, Mahima Duggal

**Design & Print:** Shivam Sundram

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Human Rights Law Network (HRLN):

A division of Socio Legal Information Centre

576 Masjid Road, Jangpura New Delhi 110014 India

Ph: +91-1124379855/56

**E-mail:** [publications@hrln.org](mailto:publications@hrln.org)

**Website:** [www.hrln.org](http://www.hrln.org)

### **Disclaimer:**

Since writing the original report, newer information and data have been published and have shed new light on female sterilization programme in India, and phasing out of sterilization camps in the various states of India. We have made an effort and have tried to update the publication, but then there is a need to understand that there will be gaps in the information. We would be grateful if you could share with us relevant information and we will ensure that it is incorporated in the next publication.

### **Note on Footnote and Endnote:**

HRLN has employed a simple and straightforward formatting style to maximize the usability of the sources cited. Any section of this volume may be reproduced without prior permission of the Human Rights Law Network where it is for public interest purposes and contains appropriate acknowledgment.

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# ACRONYMS

ADMO	Assistant District Medical Officer
ANC	Ante Natal Checkup
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
BPL	Below Poverty Line
CDMO	Chief District Medical Officer
CEDAW	The Convention on the Elimination of all Forms of Discrimination
DQAC	District Quality Assurance Committee
FPP	Family Planning Programme
FPIS	Family Planning Indemnity Scheme
HRLN	Human Rights Law Network
HTTS	Health Department Operated, Incentive-based, Target-Oriented, Time-bound and Sterilization-focused
IUCD	Intrauterine Contraceptive Device
ICPD	International Conference on Population and Development
IPHS	Indian Public Health Standard
INC	Indian National Congress
IEC	Information, Education and Communication
JSSK	Janani Shishu Surakshya Karyakram
JSY	Janani Surakshya Yojana
LPS	Low Performing State
LGBT	Lesbian Gay Bisexual Transgender
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate



MOIC	Medical Officer in Charge
MoHFW	Ministry of Health & Family Welfare
NHM	National Health Mission
NRHM	National Rural Health Mission
NFHS	National Family Health Survey
ObGyn	Obstetrician/Gynaecologist
OT	Operational Theatre
PIP	Programme Implementation Plan
PHC	Primary Health Centre
PPH	Post Partum Haemorrhage
RCH	Reproductive and Child Health
SQAC	State Quality Assurance Committee
SOP	Standard Operating Procedure
WHO	World Health Organization

# 1. INTRODUCTION



*“My name is Saraswati Devi. I was sterilized at Kapafora camp, Bihar. I had to be hospitalized for 8 days after that. We had to spend money our own money so that I could get better. I did not know anything about operation.”*

In September 2016, the Supreme Court of India directed the Union Government to ensure the discontinuation of ‘sterilization camps’ within the following three years and to induce the state governments to follow suit. It also charged the government to ensure proper monitoring of the programme, investigate sterilization failures, complications or deaths, and increase the compensation amount in these cases. It further ordered the implementation of established legal, medical and technical standards for sterilization. These directives came as a result of a

2012 petition filed by a health activist through the Human Rights Law Network, the case better known as the *Devika Biswas vs. Union of India*. This was the second public interest litigation filed on the subject of widespread negligence and human rights abuses occurring regularly in sterilization camps across India.

Newspaper reports and research by a multitude of human rights groups paints an appalling picture of the conditions under which the sterilization surgeries take place. Reports assert that the women who were being convinced to go through these sterilization surgeries were below 30 years of age and illiterate with most being completely unaware of other forms of birth contraceptives. Most of them, as stated earlier couldn't read, so the consent form hadn't made sense and many had never even signed or affixed their thumbprint on any form. The camps were set-up in makeshift locations, with no generators, oxygen cylinders or running water. The equipment used for the surgery was hardly sterilized, with many camps even lacking proper boilers for the purpose. Women were made to lay on bare mattresses for the surgeries, with no post-surgery recuperation facilities. Often the women were made to wait up to five hours after registering, and by the time they reached the operating table their anaesthetic would have worn off.

In places like Bhubaneswar, Odisha and Ferozpur, Uttar Pradesh, the doctors conducting surgeries would use bicycle pumps instead of an insufflator, to introduce air into the women's abdomens (as reported by Shreelatha Menon). The doctor in Bhubaneswar stated that he had done over 60,000 tubectomies and many of them with bicycle pumps. In Kaparfora, Bihar, a woman was operated upon, even though she was pregnant, and suffered a miscarriage as a result.

In August 2016, the government shared with the court that 113 women died after tubectomies in 2015-2016. According to figures presented in Parliament, 1,434 tubectomy deaths were reported across the country between 2003 and 2012: about 150 a year or about three per week. However, the official figures are a gross underestimate, and half of the women undergoing this surgery suffer long-term complications like pain, bleeding and infection. One of the largest single incidents of reported deaths took place

in November 2014, when 18 women died at four camps in Bilaspur, Chhattisgarh, where 137 women went through tubectomies. A single surgeon operated on 83 women in two hours- that means less than two minutes per surgery.

While this remains the status quo in relation to the implementation of the Family Planning Programme (FPP), it is crucial to examine the process through which this programme, one of the largest in India, came into being. India is a country of 1.2 billion people, second in population only to China, and likely not for long<sup>1</sup>. The Indian government struggles to meet the needs of countless people when it comes to nutrition, healthcare, education, and more. As of 2011-12, approximately 21.92% of people in India lived below the poverty line<sup>2</sup>. Additionally, India is failing to meet standards set by the United Nations Millennial Goals for issues like maternal mortality:

From a Maternal Mortality Rate (MMR) of 437 per 100,000 live births in 1990-91, India is required to reduce MMR to 109 per 100,000 live births by 2015. Between 1990 and 2006, there has been some improvement in the Maternal Mortality Rate (MMR), which has declined to 167 per 100,000 live births in 2009. However, despite this, India's progress on this goal has been slow and off track<sup>3</sup>.

While conditions seem to be slowly improving, the vast, ever-growing population makes addressing these issues quite the challenge. Attempts to address population concerns have a well-established historical context. "In 1952, India launched the world's first national programme emphasizing family planning to the extent necessary for reducing birth rates 'to stabilize the population at a level consistent with the requirement of national economy.'"<sup>4</sup>

<sup>1</sup> CIA World Factbook: <https://www.cia.gov/library/publications/the-world-factbook/geos/in.html>, Accessed on 13.06.2017

<sup>2</sup> Planning Commission, Government of India. 2013. "Handbook Of Statistics On Indian Economy - Table 162 : Number And Percentage Of Population Below Poverty Line". New Delhi: Reserve Bank of India.

<sup>3</sup> *Millenium Development Goals; Eight goals for 2015; Goal 4- Reduce Child Mortality* <<http://www.in.undp.org/content/india/en/home/post-2015/mdgoverview.html>>, Accessed on 18.07.2017

<sup>4</sup> "National Health Mission - Family Planning: Background". 2018. *Nhm.Gov.In*. <http://nhm.gov.in/nrhm-components/rmnc-h-a/family-planning/background.html>.

India was, and still remains, a nation that lives and thrives in its hundreds of villages, where the population boom remained uninhibited despite the many natural and man-made setbacks that came in its way. Family planning was a policy raised to tackle this handicap, a possible solution to the dilemma of providing acutely short services through overstretched resources to an ever-growing population. In other words, family planning in India was meant to restore a semblance of parity between the population and the capacity of the State to provide for society's economic and social needs.

Family planning options are an essential part of ensuring a higher quality of life for the entire population. The ability to plan and space children allows families to stay within their means and have control over their lives.

One way to measure access to family planning is through unmet need data. "Unmet need for family planning refers to [the percentage of] fecund women who are not using contraception but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting)."<sup>5</sup> Ideally, unmet need for family planning would be at 0% and every woman would have bodily autonomy and control over her reproductive health. Unfortunately, this is not the case in India. While total unmet need for family planning in India varies by state, the national figure is 21% percent.<sup>6</sup> The northeastern region of India, including states from Chhattisgarh to Nagaland, has the highest rates of unmet need. Rates in these areas vary from the astonishing 56.4% in Siwan, Bihar to less extreme but still troubling rates in the 20-30% range in other parts of Bihar as well as other states like Jharkhand and Chhattisgarh<sup>7</sup>. These numbers paint a concerning picture in which immense numbers of women do not have bodily autonomy or choice about if, when, and how they have children.

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<sup>5</sup> Ministry of Health and Family Welfare; *National Family Health Survey-4: State Fact Sheet Bihar*: <[http://rchiips.org/nfhs/pdf/nfhs4/br\\_factsheet.pdf](http://rchiips.org/nfhs/pdf/nfhs4/br_factsheet.pdf)> Accessed on 08.08.2017

<sup>6</sup> Health and Population- Perspectives and Issues 36 (1&2), 26-44, 2013; *Regional Variations of Unmet Need of Family Planning in Rajasthan*; Sherin Raj T, V.K. Tiwari and J.V. Singh <<http://medind.nic.in/hab/t13/i1/habt13i1p26.pdf>> Accessed on 08.08.2017

<sup>7</sup> Sheet, India Fact. "NFHS-4 (National Family Health Survey-4)." *International Institute for Population Studies* (2017).

The reasons for such a high level of unmet need in India are layered and complex. It is evident, however, that the government must redistribute and allocate public resources to address crucial social problems, which may sometimes include controlling population growth. Any universal strategy to encourage family planning must necessarily include public awareness and education in order to increase the use of and decrease the stigma associated with contraceptive measures. Despite government campaigns seeking to limit family size harmful perceptions associated with family planning still remain. It often continues to be seen as socially unacceptable, taboo, and an insult to the Indian family. India is not unique in adopting family planning programmes, however India does stand alone in its worrying reliance on sterilization in general, and unsafe, non-consensual female sterilization in particular.

## WHAT IS STERILIZATION?

Sterilization is a typically permanent procedure used to prevent conception.<sup>8</sup> The sterilization procedure for women is called *tubal ligation* and involves closing shut the fallopian tubes by a variety of methods, from silk thread to electronic coagulation. For male patients, the procedure is called vasectomy and involves severing each vas deferens through a small incision in the scrotum. The procedures are usually permanent, though they can sometimes, more frequently for men, be reversed. Sterilization reversal in India, especially among the poor, is highly unlikely as the reversal procedures have a high rate of failure and are expensive.

Sterilization procedures for women are riskier, more complex, and more expensive than for men. Despite this, family planning programme tend to focus on women. Globally, sterilization procedures performed on women outnumbers those for men. This focus on women for family planning in general and sterilization in particular is a symptom of patriarchal systems. The onus is placed on women to care for families that they tend to have little control over producing. In addition, not only is any form of birth control still

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<sup>8</sup> Sterilization. (2015). *Encyclopedia Britannica*. Retrieved 16 February 2018, from <https://www.britannica.com/topic/sterilization-medicine>

stigmatized in many parts of the world and in India, but also male sterilization is particularly stigmatized. When theorizing over why sterilization efforts are focused on women, Mary Hvistendahl said, "This may be because women are deemed less likely to protest."<sup>9</sup>

While sterilization is a valid way for people to choose not to have more children, it has also been used for dubious purposes, such as its historic use for eugenic purposes. Certain conditions were declared, often arbitrarily, as inheritable and groups of people were sterilized as a form of selective breeding in order to "purify" the human race. In the early twentieth century the United States engaged in eugenics-driven sterilization. In the US, "between 1907 and 1939, more than 30,000 people in twenty-nine states were sterilized, many of them unknowingly or against their will, while they were incarcerated in prisons or institutions for the mentally ill." The most famous historical sterilization programme was the eugenics agenda pursued by Nazi Germany during the Holocaust, in which an estimated 300,000 to 400,000 people were sterilized. "A diagnosis of 'feeblemindedness' provided the grounds in the majority of cases, followed by schizophrenia and epilepsy." "Although the *Sterilization Law* sometimes functioned arbitrarily, the semblance of legality underpinning it was important to the Nazi regime."<sup>10</sup> Public support was generated using propaganda and eugenics-based logic to fuel a legitimate, government initiated aim, which completely violated human rights of countless people.

Today, while laws may not announce eugenic aims, hidden agenda to dispose of "undesirables" in society can still be discovered by looking beyond the face of the law. While many population control policies may appear benign on their face, upon further investigation the stated medical reasons for sterilization and the identification of groups to which the law applies are revealed to be morally and legally suspect. For example, compulsory sterilization law laws often target LGBT+

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<sup>9</sup> *India's dark history of sterilization*; BBC News India; 14.11.2014 <<http://www.bbc.com/news/world-asia-india-30040790>> Accessed on 08.08.2017

<sup>10</sup> *Transgender sterilization: Sweden and Beyond*; 07/01/2013 07:55 pm ET | Updated Feb 02, 2016; The Huffington Post <[http://www.huffingtonpost.com/entry/transgender-sterilization-sweden-and-beyond\\_b\\_3519723.html?section=india](http://www.huffingtonpost.com/entry/transgender-sterilization-sweden-and-beyond_b_3519723.html?section=india)> Accessed on 08.08.2017

people, especially transgender people. In many countries, in order to transition, a transgender person may be faced with a “non-choice” between sterilization and a transition procedure that is not legally or medically recognized.<sup>11</sup> As a result of these laws, transgender people must give up the ability to reproduce to gain access to healthcare and legal rights. Even still, transgender persons are refused access to the same range of rights enjoyed by cisgender people.

“We’ve learned from the emergence of fertility medicine that recognition of gender is not contingent on reproductive capacity, so why is this unrelated ability brought to bear on trans people’s legal gender legitimacy? Ultimately, this is about what sterilization has always been about: purifying a state by punishing “others,” rendering nonconformist lives undesirable, stripping away the agency and dignity of oppressed peoples, and sacrificing reproductive freedoms for basic rights.”<sup>12</sup>

In India, state-imposed quotas result in many coerced and forced sterilizations, leading to countless human rights violations. Indeed, the BBC documented India’s “dark history of state-sponsored population control, often with eugenic aims - targeting the poor and underprivileged.”<sup>13</sup> One of the darkest times in terms of sterilization use by the government was during the Emergency Period of the 1970’s, which will be discussed in the following chapter.

India’s family planning programme, especially its sterilization initiatives, has focused exclusively on target-oriented population control without any consideration for the reproductive rights of women. As a result of a target-based initiative which ignores the material needs of the population, the State machinery, especially in the rural areas, neglects its obligation to maintain women’s

<sup>11</sup> *Transgender sterilization: Sweden and Beyond*; 07/01/2013 07:55 pm ET | **Updated** Feb 02, 2016; The Huffington Post <[http://www.huffingtonpost.com/entry/transgender-sterilization-sweden-and-beyond\\_b\\_3519723.html?section=india](http://www.huffingtonpost.com/entry/transgender-sterilization-sweden-and-beyond_b_3519723.html?section=india)> Accessed on 08.08.2017

<sup>12</sup> *ibid.*

<sup>13</sup> *India’s dark history of sterilization*; BBC News India; 14.11.2014 <<http://www.bbc.com/news/world-asia-india-30040790>> Accessed on 08.08.2017



health and dignity. As Shree Venkatram of the Population Foundation of India notes, "family planning saves lives. When it ends up taking the lives of young mothers, or inflicting them with lifelong sickness, it is a monumental tragedy. And it has the potential of setting back the programme by decades."<sup>14</sup>

The purpose of this book on sterilizations in India is multi-faceted. It traces the history and evolution of family planning and sterilization initiatives in India and addresses the issues that plague this initiative. It attempts to reflect on the fallacies within India's focus on sterilization, by delving into the two of the most important public interest litigations in India involving gross violations of human rights. This book sets out a family planning programme which is humane, consensual, and respects and upholds the rights dignity of all people, especially the people upon whom it is implemented.

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<sup>14</sup>Shree Venkatram, "*India's family planning must give way to proper family planning*," Accessible at: <<http://www.theguardian.com/global-development/poverty-matters/2014/nov/22/india-sterilization-camps-family-planning-tragedy>>, Accessed on 08.08.2017

## 2. HISTORY OF FAMILY PLANNING IN INDIA



*"In this 1950 photo, a group of women sit below posters advocating family planning in a doctor's clinic in the Indian village of Badlapur in Maharashtra."  
Source: Getty Images*

The concept of 'family planning' encompasses a couple's conscious choice regarding family size and reproduction. However, a state controlled programme with structural and policy interventions, aimed specifically at lowering the society's birth-rate among particular sections of the population is a relatively new phenomena. Its roots lie in the period between the end of feudalism and the growth of capitalist societies that we see today.

India's National Family Welfare Programme was launched in 1951, making India one of the first countries in the world to have an official programme for the purpose of family planning. The programme aimed to reduce the birth rate nationwide, thus stabilizing the population at a level consistent with that required for growth of the national economy. Since its launch, the programme has been pursued by the Government of India as a priority of the national agenda and has been a fully centrally sponsored scheme<sup>15</sup>.

### GOPALASWAMI'S REPORT AND MALTHUSIAN CHECKS

The idea of a family planning programme was not new to the policy makers of 1950s. In fact, advocacy for a stringent birth control programme in India can be traced back to P. K. Wattal's monograph '*The Population Problem in India: a Census Study*', published in Bombay in 1916. In the years leading up to India's independence, numerous government commissions commented on the clear need for a comprehensive approach to birth control in the country. Ultimately, the National Planning Committee set up by the Indian National Congress (then chaired by Jawaharlal Nehru) institutionalized the National Family Welfare Programme in 1935<sup>16</sup>.

Gopaldaswami's report, based on the staggering results of the first post independence census, was the spark which set light to India's eagerness to institute a policy to curtail the booming population<sup>17</sup>. R.A Gopaldaswami, a demographer by training, was the Registrar General and ex-officio Census Commissioner<sup>18</sup>.

The results he presented were stupefying in their scale. In 1951, India had a population of over 365 million people and

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<sup>15</sup> National Family Welfare Programme < <http://pbhealth.gov.in/pdf/FW.pdf>> Accessed on 08.08.2017

<sup>16</sup> *The status of family planning in India: An introduction*, Family Health International India, <<http://www.fhi360.org/sites/default/files/media/documents/india1-family-planning-status.pdf>> Accessed on 01.04.2016

<sup>17</sup> Galor, O., & Weil, D. N. (1999). From Malthusian stagnation to modern growth. *The American Economic Review*, 89(2), 150-154

<sup>18</sup> *The status of family planning in India: An introduction*, Family Health International India, <<http://www.fhi360.org/sites/default/files/media/documents/india1-family-planning-status.pdf>> Accessed on 01.04.2016

a life expectancy of just over 35 years. Only 12 percent of the population could safely be considered literate. The average number of children that a woman had in her lifetime was six and one-fifth of all infants born never lived to see their first birthday. Gopaldaswami predicted that India would continue to add over 500,000 persons to the global demographic annually<sup>19</sup>. He anticipated that by 1981, India would boast of a population of 520 million (a number we actually reached a decade earlier in 1971). Gopaldaswami questioned the nation's capacity to support and feed such an immense population which ultimately led to his drastic recommendation of a policy of mass sterilization to control population numbers.

Mass sterilization can be categorised as a preventive check according to Malthusian population theory. In his theory, Malthus<sup>20</sup> sets forth two forms of check (or control measures) through which the rate of population growth is controlled and brought to a sustainable level:

- i. 'Positive Checks' - This referred to anomalies which lead to premature death like wars, epidemics, starvation and so on.
- ii. 'Preventive Checks' - This referred to voluntary actions taken by the population to avoid contributing to population growth, such as moral restraints, abstinence, delayed marriage, restrictions on marriage between people belonging to certain sections of the society and so on.

Sterilization has long existed as a more permanent check on population growth. Mass sterilization, however, was an experiment made inevitable by India's looming population explosion and the concern that such a massive population is more of a liability than a dividend.

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<sup>19</sup> Terrence McCoy, 'The forgotten roots of India's mass sterilization program,' The Washington Post 15.11.2014, <<https://www.washingtonpost.com/news/morning-mix/wp/2014/11/14/the-malthusian-roots-of-indias-mass-sterilization-program/>> Last accessed on 01.04.2016

<sup>20</sup> Thomas Robert Malthus was English sociologist and scholar of the 18<sup>th</sup> century who is widely credited with his theory on population. His theory was based on the relationship between population growth and resources. The basic premise of his theory was that population growth always rises exponentially and will eventually outstrip and outgrow the resources available for them

## INITIAL EXECUTION OF THE FAMILY PLANNING PROGRAMME

Initially, despite the gloomy outlook of Gopaldaswami's report, the National Planning Committee under INC considered the issue of India's booming population as one that would eventually correct itself through a basic welfare plan and India's trajectory from a developing nation to a developed one. The State believed that India would follow in the path of other developed nations and see marked improvement of the standard of living which would cause a fall in the rate of population growth.

Hence, Jawaharlal Nehru instituted a family welfare policy under the first Five Year Plan of 1952 that was largely clinical in nature. He saw the massive population as a hurdle to a growing social economy, family happiness and national planning which could be solved through his constituted policy measures. The first decade of India's Family Planning Programme (FPP) adopted an almost 'clinical' approach where chief emphasis was laid on natural methods. Hence, it focused extensively on creation of facilities required for the implementation and execution of the FPP, like setting up family planning clinics. The process was quite slow-paced and half baked. This is made clear in the fact that a meagre 65 lakhs of a total outlay of 1,960 crores - i.e. a negligible 0.033 percent - was allocated to FPP. Of this, only an approximate of 15 lakhs was spent<sup>21</sup>.

The Second Five Year Plan (1956-61) followed a similar approach. Gopaldaswami's Malthusian suggestions were largely ignored as the nation state refrained from adopting an aggressive approach to family planning in favour of expanding India's healthcare infrastructure. However, of the mere five crores allotted to FPP, only half were spent and only 411 clinics were set up nation-wide. All failed to attract the expected number of clients. With the country in its nascent years, one of the reasons often cited as a cause for such abysmal results was deplorable literacy rates and severely lacking transportation networks.

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<sup>21</sup> Arup Maharatna, 'India's Family Planning Programme: An Unpleasant Essay', *Economic and Political Weekly*, Vol. 37, Issue 10, 9<sup>th</sup> March 2002, p. 971

The Third Five Year Plan (1961-66) attempted to correct the shortcomings of the previous clinical approach and shifted focus to the 'Information-Education-Communication' (IEC) approach. This involved health workers visiting women of childbearing ages to encourage them to limit their family size. As FPP expenditures jumped by 11 times under this plan, it became an integral part of India's public health department. Nevertheless, its expenditure constituted far less than one percent of total government outlays<sup>22</sup>. The IEC approach was not successful and faded out before it could even take root, giving way to a 'target based' approach<sup>23</sup> entered around sterilization.

### Emergence of Sterilization as the Flagship of India's Family Planning Programme



*“Family Planning Programmes have been implemented in ways that have led to numerous human rights violations for women in India.”*

<sup>22</sup> *ibid.*

<sup>23</sup> P. Visaria and V. Chari, 'India's Population Policy and Family Planning Programme: Yesterday, Today and Tomorrow', *Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya, and Mexico*, A. Jain (ed.), Population Council, New York, 1998, p. 63

The Fourth Five Year Plan (1966-74) saw a significant shift with the government adopting an aggressive target based approach to combat the rapidly rising population. This was sparked predominantly by the overwhelming and deeply disturbing results of the 1971 census. India had already crossed the 520 million mark, which was Gopalaswami's predicted number for India's population in 1981. Moreover, statistics showed that India would continue to add over 10 million people to its already staggering population every year.

This marked the beginning of the state-backed family planning policy's evolution into a robust, almost mechanical programme we see today. While the State initially viewed economic and social development as the best contraceptive and the biggest bulwark against rapid population growth, the Indira Gandhi government oversaw a radical shift to the right, and the pursuit of a more permanent method of population control: sterilization.

The health department set demographic goals and targets to be achieved. FPP began to be ingrained in what K. Srinivasan named the 'HITTS' model: health department operated, incentive-based, target-oriented, time-bound, and sterilization focused<sup>24</sup>. Annual targets for number of acceptors of contraception were set by the central government and the responsibility to achieve these targets was passed on to lower administrative units such as states, districts, primary health centres, subcenters and their functionaries<sup>25</sup>.

Different states used different methods to achieve targets during the campaign:

"...to a very wide variety of activities involving interaction of the public with government agencies of almost any kind. Issue of licenses for guns, shops, cane crushers and vehicles, issue of loan of various kinds, registration of land, issue of permits for cement, fertilisers, seeds, etc, issue of ration cards, exemption from payment

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<sup>24</sup> K. Srinivasan, 'Population Policies and Programmes since Independence', K. Srinivasan, *Demography India*, Vol. 27, Issue 1, 1998, p. 6

<sup>25</sup> *supran.* 5

of school fees or land revenue, supply of canal water, submission of application for any job, exercise of food control regulations against shopkeepers, getting transfers, obtaining bail and even facilitation of court cases, were linked up with the procurement of cases for sterilization."

Eventually, sterilization targets were even given to teachers, with immense pressure and threats of consequences if they failed to meet these targets, like the pressure placed on health and government officials. It was a drastic step up from previous government efforts for sterilization, which had offered enticing incentives. It drew into question the validity of consent for the procedure. While not physically forcing men and women to undergo sterilization, these new methods presented even less choice for those subjected to them.

The decade of 1965 to 1975 witnessed the building up and consolidation of an FPP dictated by the 'tyranny of targets'. The outlays on FPP reached 1.8 percent during this time period. In an attempt to reduce the birth rate faster, the central government also stepped up the incentive programme for acceptors and motivators of vasectomies and tubal ligations. This gave rise to organisation of mass sterilization camps and lead to the 'camp based' approach.

The camp-based approach saw its nightmarish form during the Emergency rule (1975-77), under Prime Minister Indira Gandhi's government. Population control featured prominently in the government issued twenty-point programme<sup>26</sup>. The 42nd amendment added family planning to the concurrent list in the Indian Constitution<sup>27</sup>.

Sanjay Gandhi, son of PM Indira Gandhi, was at the forefront of India's horrific sterilization initiative. Millions of people, mostly men, were carted off to be sterilised on back of trucks. There were many reports of physically forced sterilizations through raids in villages

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<sup>26</sup> *Twenty Point Programme - General Knowledge Today*. (2015). *Gktoday.in*. Retrieved 16 February 2018, from [https://www.gktoday.in/twenty-point-programme\\_22/](https://www.gktoday.in/twenty-point-programme_22/)

<sup>27</sup> *The Inevitable Billion plus: exploration, of Interconnectivities and action possibilities; deepening the debate on science, population and development*; Vasant Gowariker; published 1993



by police-accompanied health and government officials. Those who appeared eligible for sterilization were rounded up and sterilized in large groups. This included not only those who already had children, but also those who were childless, unmarried or still in puberty.

It is important to note again that these raids disproportionately targeted the poor. "The weaker sections usually formed the focus of the raids. Persons belonging to the more prosperous sections were let off even though eminently eligible for sterilization. Some, however, had to buy their 'release' by procuring substitute cases from the poorer classes." The deadly danger of these hasty surgeries was exacerbated further by the complete lack of follow-up care provided. In some villages, people fled and hid in fields, sometimes for weeks, in fear of the raids.

Hence, the voluntary aspect of Gopaldaswami's Malthusian plan seemed to have been entirely abandoned. The state went from rewarding men with transistor radios for undergoing a vasectomy procedure to a spree of forced sterilizations.

Millions of people were sterilized in India under these coercive and forceful measures during, before, and after the Emergency Period. To put it into perspective, it is estimated that over 6 million people were sterilized in 1976 alone, more than the number of people sterilized by Nazi Germany before 1939. As result of this political and administrative push, the number of sterilizations rose from 1.3 million in 1974-75 to 2.6 million in 1975-76 and then shot up to 8.1 million in 1976-77, a level which has not been reached since. Sterilization 'quotas' lead to many abuses.<sup>28</sup>

In addition to the sheer number of coerced and forced sterilizations, the way in which the sterilizations were performed was hasty, unprofessional, unsafe, and unsanitary. It had lasting effects on the public perception of family planning practices in India. The unsound methods used to achieve ridiculous sterilization quotas tarnished the public's view of health workers. For example,

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<sup>28</sup> Soutik Biswas, "India's dark history with Sterilization," 14 November 2014 <<http://www.bbc.com/news/world-asia-india-30040790>> Accessed on 02.09.2017

when in 1977, fear and suspicion led to "...mass refusal to accept immunizations from the public health institutions, fearing that these are surreptitious ways of sterilizing children, [which] indicates the depth of the crisis of confidence among the community about its health institutions." The failed campaign during the Emergency Period contributed to strong opposition to family planning in India, which can still be seen today.

## **FURTHER DOWN THE TIMELINE**

Predictably, the excesses during Emergency gave rise to a backlash that resulted in the bitter loss of the Congress Government in the next General Election and the formation of a new government in 1977. The new government tried to reduce targets on sterilization and rely more on IEC, India's FPP returned when Indira Gandhi was voted back into power in 1980: the health-based, time-bound, target-oriented FPP was revived.

During the 1980s, an increased number of family planning programmes were implemented through the state governments with financial assistance from the central government. In rural areas, the programmes were further extended through a network of primary health centers and subcenters. By 1991, India had more than 150,000 public health facilities through which family planning programmes were offered. Four special family planning projects were implemented under the Seventh Five-Year Plan (1985-89). One was the All-India Hospitals Post-partum Programme at district and sub district-level hospitals. Another programme involved the reorganization of primary health care facilities in urban slum areas, while another project reserved a specified number of hospital beds for tubal ligation operations.

Through all of this, sterilization remained a principal method of population control. Even though the phase of forced sterilizations en masse had passed, the state still continued to push and encourage the population to opt for sterilization by influencing them with monetary provisions. However, with the horrors of sterilization camps still a recent memory, men would often refuse to come forward for vasectomy and due to limited availability of spacing methods, the tubal ligation of women began to rise

steadily, eventually becoming the dominant method of family planning.

The Seventh Five-Year Plan (1985-90) continued the tradition of target setting, with incentives being offered to young couples to not have more than two children. Health officials came under severe pressure by the government to reach sterilization quotas, they responded in turn by pressuring women to undergo this drastic procedure with little regard to the personal wishes and safety of the patient. This represents a serious abridgment of the rights and autonomy of the targeted persons.<sup>29</sup>

The International Conference on Population and Development (ICPD) organized by the United Nations in 1994, in which India participated, restored some sanity to official policies and temporarily slowed state aggression against women. The conference concluded that, henceforth, population policies should be guided principally by considerations of reproductive health and gender equity rather than by the macro-demographic considerations and target-driven programmes which unnecessarily burden women and are driven by the sole concern of fertility regulation. As a signatory, India was forced to adopt the so-called Reproductive and Child Health (RCH) approach to family planning and abolish the existing target based approach. The target driven implementation of family policy was officially discarded in 1996 through the National Population Policy and subsequently ratified by the parliament in 2000<sup>30</sup>.

The abolishment of targets caused the prevalence of female sterilization to slow down in the late 1990s, although it remained the dominant form of contraception. Despite this, there was not a noticeable change in the usage of IUDs, however use of condoms increased slightly. On the other hand, the proportion of married women who had reported sterilization rose from 27% in 1992-93 (NFHS-1) to 34% in 1998-99 (NFHS-2) and further to 37% in 2005-06 (NFHS-3). During this period, the proportion of men who reported

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<sup>29</sup> *supran*, p. 973

<sup>30</sup> *ibid.* p.975

sterilization fell from 3.5% to 1%.<sup>31</sup> Not only are women undergoing sterilization in larger proportions but they are also doing so at an earlier age than before. Between 1992-93 (NFHS-1) and 2005-06 (NFHS-3), the median age of women when they or their husbands underwent sterilization dropped from 26.6 years to 25.5 years<sup>32</sup>. Further, women's education is significantly associated with the use of sterilization as contraception – the more the years of schooling, the lower the odds of opting for sterilization<sup>33</sup>.

Nevertheless, despite official abandonment of target based approach, there is ample of evidence to suggest that unsaid and unspoken targets remain to be achieved by doctors on the ground, ASHA workers and others of their kin. Ambiguous terms like 'expected level of achievement' reinforce the idea of targets and incentives at the grassroots level.

India carried out nearly 4 million sterilizations between 2013 and 2014, according to official figures. Less than 100,000 of these surgeries were done on men. More than 700 deaths were reported due to botched surgeries between 2009 and 2012. There were 356 reported cases of complications arising out of the surgeries. Though the government has adopted a raft of measures and standards for conducting safe sterilizations, an unseemly haste to meet high state-mandated quotas has often led to botched operations and deaths.

China adopted institutionalized population control in the 1980s, however the conditions experienced by targets of these programmes did not approach the level of abuse inflicted in India. There have been reports of the appalling quality of tubal ligation for many years now, yet authorities refuse to recognize this as an important reproductive health concern. These disreputable surgeries continue, risking the lives of poor women.

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<sup>31</sup> Bali Ram, 'Fertility Decline and Family Change in India: A Demographic Perspective', *Journal of Comparative Family Studies*, Vol. 43, Issue 1, Jan-Feb 2012, p. 23

<sup>32</sup> *ibid*

<sup>33</sup> L.K. Dwivedi, F. Ram and R.S. Reshmi, 'An approach to understanding change in contraceptive behaviour in India', *Genus*, Vol. 63, Issue 3-4, Jul-Dec 2007, p. 39

The quality of services presented in India's FPP has been far from satisfactory and has not improved over time. This is unsurprising as India's allocation of funds for family planning services continuously falls below 2% of the total developmental budget despite seemingly high-level of official concern over rapid population growth<sup>34</sup>. This is probably why even though the Indian government has on paper aimed to provide a choice of contraceptive methods, the history of India's FPP indicates its focus on permanent methods like sterilization<sup>35</sup>.

Policy makers have remained blind to the possibility that a bold allocation of funds for FPP, especially if utilized towards IEC and motivational efforts to create awareness and demand for temporary contraceptive and spacing methods, could create wider acceptability of family planning and safeguard people's health and reproductive rights through voluntary contraception methods. Health officials' ambivalence and half-hearted recognition of the crucial importance of IEC, especially in the context of mass poverty and illiteracy, has been matched by the typical bureaucratic zeal and predilection towards records, targets, numbers and incentives, thereby losing sight of the key fact that effective motivational and demand creation efforts should precede the promotion of the so-called 'cafeteria approach' to the provision of modern contraception<sup>36</sup>.

A leading cause of India's overpopulation is a high fertility rate. Rather than waiting for economic development to take its slow and gradual course to curb a possible situation of population explosion, a well-planned and executed family planning programme can be the immediate answer. However, it is the apprehension of a population explosion and an irrational urgency to control the same which drives the government to set targets so severe that it results in an unfortunate case of harsh birth control measures. This is mainly, due to the low budgetary allocation

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<sup>34</sup> K. Srinivasan, 'Population policies and family planning programmes in India: A review and recommendations', *Proceedings of the fifth Dr. C. Chandrasekaran Memorial Lecture, IIPS Newsletter*, Vol. 47, Issue 1-2, 2006, pp. 5-41

<sup>35</sup> *supran.* 15

<sup>36</sup> *supran.* 1, p. 976

towards FPP, which indicates weak official willpower towards realizing individual families' needs and reproductive autonomy. As a result, the government chooses to use female sterilization (which is often coercive or manipulative) as the primary modus operandi to curtail population growth instead of encouraging and creating awareness about different spacing and limitation methods and temporary forms of contraception. It is the State which then becomes the decision-making body when it comes to the reproductive choices of a couple.

India's FPP thus, unfortunately, remains characterized by an overriding concern for numbers – as measured by the recruitment of sterilization acceptors – frequently at the expense of higher quality, client-centered service<sup>37</sup>. Having target-driven sterilization as the flagship of Indian family planning often results in a host of human rights violations relating to restricted choice of methods, lack of informed consent, deprivation of reproductive autonomy, poor standards of healthcare services, unhygienic and unsanitary conditions at sterilization camps, etc., which will be covered in more detail in subsequent chapters.

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<sup>37</sup> M.A. Koenig, G.H.C. Foo and K. Joshi, 'Quality of Care Within the Indian Family Welfare Programme: A Review of Recent Evidence'

### 3. VIOLATIONS HAPPENING ACROSS INDIA



*“Coercive policies cannot be justified on any grounds; they violate human rights, gender justice, equity, and human dignity.”* Indian Family Welfare Programme: A Review of Recent Evidence', *Studies in Family Planning*, Vol. 31, Issue 1, 2000, p. 12

As the previous chapters have shown, sterilization in India is beset with many reproductive health rights issues and social problems that are seemingly inherent in India's family planning policies since Independence. The the belief that sterilization is the best-suited family planning method to tackle population growth has far-reaching and detrimental implications. Indeed, the origins of its implementation in India is riddled with faults and fallacies.

India carried out nearly 4 million sterilizations between 2013 and 2014, according to official figures. Less than 100,000 of these surgeries were done on men. More than 700 deaths were reported due to botched surgeries between 2009 and 2012. There were 356 reported cases of complications arising out of the surgeries.<sup>38</sup>

The year 2010-11 ended with 34.9 million total family planning acceptors at national level comprising of 5.0 million Sterilizations, 5.6 million intrauterine device (IUD) insertions, 16.0 million condom users and 8.3 million O.P. users as against 35.6 million total family planning acceptors in 2009-10. A total of 50.09 Lakh sterilizations were performed in the country during 2010-11 as against 49.98 Lakh in 2009-10. States/UTs viz. Assam, Bihar, Gujarat, Jharkhand, Madhya Pradesh, Orissa, Punjab, Arunachal, Manipur, Meghalaya, Nagaland, Tripura, Uttarakhand, Daman & Diu, Lakshadweep and Puducherry have shown improved performance in 2010-11 as compared to 2009-10.<sup>39</sup>

Instead of presenting sterilization as a safe alternative to other family planning methods on a voluntary basis, there is an aggressive culture of sterilizing people in hordes under substandard conditions in which a simple surgery may turn out to be fatal in its consequences.

Some of the major issues plaguing the services of sterilization in India include:

## I. Camp Culture

The horrors of the Emergency- era sterilization camps are a lesson from which policymakers must learn. India has recently developed a system of administering sterilization, which Al-Jazeera has famously termed 'camp culture'.<sup>40</sup> To reach the centrally decided goals, people are often brought in hordes to such camps. Sterilization in these camps happens *en masse*, and

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<sup>38</sup> Biswas, S. (2018). *India's dark history of sterilization*. BBC News. Retrieved 16 February 2018, from <http://www.bbc.com/news/world-asia-india-30040790>.

<sup>39</sup> Family welfare statistics in India 2011-Ministry of Health and Family Welfare, <<http://mospi.nic.in/statistical-year-book-india/2011/199>> accessed 26.07.2017

<sup>40</sup> Lisa Le Bode, "Why Indian Women are victims of sterilization 'Cattle Camps,'" 14 November 2014 <<http://america.aljazeera.com/articles/2014/11/14/women-india-sterilization.html>>, accessed on 18.07.2017



tens and thousands of people are sterilized over the course of a few days. While it is the administration's responsibility to ensure that such services are provided to so many people, their attitude of the administration is largely careless and irresponsible, and they only remained concerned for the 'numbers', which need to be attained.

Most camps only have limited facilities at their disposal, with little or no help from the administration these camps make do with the least possible requirements. Most of these camps are tents, located in makeshift facilities such as schools, which are in no way equipped to administer pre and post-surgical care to patients, men and women alike.

Further, these camps are often conducted without the permission of the state medical authorities, and in those cases where they are sanctioned, the camps are organized without adhering to the necessary requirements involved in operating such a camp. It is also to be noted that these camps do not have quality assurance committees, leading to unacceptable standards of health, hygiene and sanitation. The resources available for such programmes are extremely limited and the administration, by allowing the sterilizations to take place en masse, further stretches the resources out. Thus, due to a lack of any post-surgical care, men and women are often left bleeding after operations, often carried out using old, unsterilized instruments.

Consider the case of Araria, Bihar where 53 women were sterilized in a matter of mere hours in dirty, unhygienic conditions in a makeshift facility created in a school.<sup>41</sup> Also consider the case of West Bengal where, as mentioned in the article, 'women [were] dumped on [the] street after sterilization drive'. Here 103 women were sterilized at a disturbingly rapid rate in a 'Mega Ligation Camp'.<sup>42</sup> The most infamous instance of the camps is in

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<sup>41</sup> Shoumijit Bannerjee, "Barrack-room surgeries in Bihar's backwaters," 32 January 2012 <<http://www.thehindu.com/todays-paper/tp-opinion/barrackroom-surgery-in-bihars-backwaters/article2824008.ece>>, accessed 27.06.2017

<sup>42</sup> Soudhriti Babani, "Women dumped on field after Sterilization drive," 7 February 2013 <<http://indiatoday.intoday.in/story/women-dumped-on-field-after-sterilisation-drive/1/249324.html>>, accessed on 12.07.2017

Chhattisgarh where 140 women were sterilized in similarly dismal conditions leading to the deaths of over a dozen, largely due to septicemia.<sup>43</sup>

The camp approach has attracted intense national and international condemnation for its perpetuation of gender and caste discrimination and flagrant, systemic violations of Government mandated guidelines on the quality of care, as it is strongly associated with the sterilization of women. These practices violate the standards for female sterilization services as covered in the 'Standards for Female and Male Sterilization Services' published by the Division of Research Studies and Standards, Ministry of Health and Family Welfare, Government of India in October 2006.<sup>44</sup> This document specifically states the following with respect to establishing the standard procedures for conducting female sterilizations:

Eligibility of providers for performing female sterilizations

Physical requirements

Case selection methods

Clinical processes that include counselling, informed consent, preoperative instructions, and surgical techniques.

Post-operative care, which also requires a certificate of sterilization to be issued by the Medical Officer.

Despite government initiatives, at least on paper, the practice of sterilization is carried on without much concern for ethical values or human life.

Further, Human Rights Watch<sup>45</sup> has reported that the family planning programme focuses almost entirely on married women,

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<sup>43</sup> *Medical Negligence, Sub-standard drugs cause Sterilization tragedy*, "26 August 2015 <<http://www.firstpost.com/india/medical-negligence-sub-standard-drugs-caused-chhattisgarh-sterilisation-tragedy-panel-2409264.html>>, accessed on 29.08.2017

<sup>44</sup> Ministry of Health and Family Welfare (Research Studies and Standards Division), Government of India. (2018). *Standards for Female and Male Sterilization Services*. New Delhi: National Health Mission, Ministry of Health and Family Welfare.

<sup>45</sup> Human Rights Watch is a nonprofit, nongovernmental human rights organization

while completely neglecting the male responsibility and the need to educate the young people and adolescents, regarding safe sex practices. It has been found that this 'camp approach' is now being expanded for insertion of IUDs as well. Further, field reports have revealed that IUDs are being inserted stealthily after women give birth in hospitals. Therefore, it is evident that the resulting deaths, failures, complications and coercion caused by female sterilization have grave implications for women's right to life, right to health and right to reproductive health.

## **II. Target- Based Approach**

Unfortunately, despite the positive steps taken by the State in the late 90s and the paradigm shift marked by the National Population Policy of 2000 which eliminated numerical targets for sterilization or the number of people that must be sterilized, reality confirms that district and sub-district authorities continue to assign individual annual targets for contraceptives, with a heavy focus on female sterilization.

Therefore, whilst 'top-down' targets have officially been eliminated, this has merely been replaced by the emergence of 'bottom-up' targets and quotas couched in the euphemistic phrase, 'Expected Level of Achievement'. In practice, State-level authorities and district health officials continue to be pressured to achieve targets through a system of financial incentives including monetary payments, or are otherwise threatened with salary cuts, negative performance assessment, suspension and dismissal. Numerous reports and studies confirm that grassroots health workers face immense pressure from their superiors to achieve targets.

According to Human Rights Watch, several health workers have alleged that they were humiliated and verbally abused by their supervisors for not motivating enough women to accept contraception, threatened with salary cuts or dismissals while others were suspended from their jobs. Supervisors are not in regular contact with the local community and have no personal relationship with the women that the health workers are seeking to motivate. They are therefore insensitive to the needs and

opinions of the women. The target-based system represents a state-sanctioned violation of sexual and reproductive rights, and inevitably results in a substantial deterioration in the quality of care.

With high targets set for the ANMs and ASHA workers, which otherwise may result in them losing their jobs, their targets are usually women who have had two children who are both male or at least one that is male as there is a strong son-preference in India. This also affects the sex ratio adversely. One ASHA worker in Khurda region put it this way, “We are required to motivate and bring in couples for sterilization, and we try our best to do this. We do not persuade those clients who have daughters to consider this option but prefer to focus on those who have already given birth to boys. They are much more receptive to the message. Sometimes we even motivate the woman's mother-in-law to send her across for sterilization and she immediately agrees because she too does not want granddaughters.” (Women Feature Service).

The negative impact of targets on basic reproductive healthcare is further highlighted by the practice that local health workers will dedicate most of their time on fulfilling targets and subsequently spend less time and resources on distributing timely supplies of other contraceptive methods and on providing other essential reproductive health services.

### III. Gender- Bias

There is a deep- rooted gender bias against women within India's sterilization programme. Instead of spending resources and energy on more and effective awareness programmes, especially among men, the national and state health budgets focus mostly on the administration of sterilization services to women. In fact, a report had suggested that vasectomies, or sterilizations on men, accounted for a mere 4% of all sterilization procedures in India.<sup>46</sup>

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<sup>46</sup> Mavalankar, Dileep; Sharma, Bharti, “*The Quality of Care in Sterilization Camps: Evidence from Gujarat*. : In *Improving Quality of Care in India's Family Welfare Programme*”. Population Council. 1999. p.293-313. ISBN 0-87834-099-8

Further, another report suggests that less than one percent of men undergo sterilization procedures while four out of ten women undergo tubectomy operations.<sup>47</sup> Given that a vasectomy is much easier and safer to perform than a tubectomy, this reflects a clear bias against women and represents a denigration of their rights.

A lot of the reasoning behind such bias lies in the defective idea of manhood and the persisting social norms of masculinity that find its way not only into society, but also in the public healthcare system. In a traditionally patriarchal society such as in India's, anything that might affect any man's masculinity or virility is considered taboo. For many, a man who undergoes such a procedure is an outcast, incapable of procreating children who may extend his line. Further, many associate sterilization with a loss in sexual potency. This attitude is readily subscribed to by society writ-large and has permeated the general policy strategies of the healthcare system.

This gender bias reflects a widespread belief that women can be coerced, or even forced into a sterilization procedure, of which they have no knowledge. Authorities believe that women are less likely to complain and are therefore easier targets for such operations. Accredited Social Health Activists (ASHA) workers for instance, rarely approach men to undergo such sterilization operations.<sup>48</sup>

Such a bias, unconscious or not, affects women who are poor and underprivileged and who belong to minority groups the hardest as their access to information, education, and legal recourse is particularly limited.

#### **IV. Lack of Informed Consent**

Women make easy targets for sterilizations because authorities believe they are less likely to complain about such procedures.

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<sup>47</sup> Raksha Kumar, "India's Lethal Contraception Culture," 8 February 2015 <<http://america.aljazeera.com/multimedia/2015/2/female-sterilization-in-india.html>>, accessed 5.08.2017

<sup>48</sup> Aditi Malhotra, "Why Indian Men don't get sterilized," 13 November 2014 <<http://blogs.wsj.com/indiarealtime/2014/11/13/delhis-mega-vasectomy-camp-and-why-indian-men-dont-get-sterilized/>>, accessed on 3.07.2017

This is reinforced by a lack of information or the presence of misinformation related to sterilization procedures, leading to further coercion and misleading activity.

There have been cases where patients have been carted off for 'minor' operations, only to come out incapable of bearing a child ever again.<sup>49</sup> As healthcare service providers, it is the duty and responsibility of doctors, nurses and ASHA workers to duly inform such women about the nature, consequences, positive and negative implications or side effects of the said procedure. Yet, as is the case most of the time, these providers fail to do their duty by simply skimming through the details of the procedure in a rush, without adequately explaining them to the women.

The issue is accentuated further by the low rates of literacy among rural women, who constitute the most significant populace participating in the said sterilization drives. This does not resolve the issue even after the State has mandated written forms for consent as most of these women can't read or write. It is therefore left for these women to trust their healthcare providers blindly, in an extension of that faith placed in a doctor by his patient.

## **V. Futility of Family Planning Indemnity Scheme**

With sensitive operations such as a sterilization procedure, it is important to have some form of accountability against those who are responsible for providing these healthcare services. However, where such procedure is unsuccessful, punitive actions against such service providers responsible is sorely lacking.

The Family Planning Indemnity Scheme (FPIS), was a scheme to ensure a form of monetary recourse to such a failure in sterilization operations. Under NHM State Programme Implementation Plans (PIPs) w.e.f. 1st April, 2013, under the Family Planning Indemnity Scheme it has been decided that States/UTs would process and make payment of claims to beneficiaries of sterilization in the event of death/ failure/complication and indemnity cover to

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<sup>49</sup> "Teen tricked Into Sterilization Surgery," 21 March 2015, <<http://timesofindia.indiatimes.com/city/gurgaon/Teen-tricked-into-sterilization-surgery-was-told-it-was-vaccination-camp/articleshow/46641098.cms>>, accessed 3.07.2017

doctors/health facilities. It is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective Programme Implementation Plans (PIPs) in the relevant head under the National Health Mission (NHM). The scheme is uniformly applicable for all States/UTs.

A failure in this case includes death or permanent injury to the patient, as well as a case where a form of monetary remain is able to procreate. For instance, under the scheme there is a compensation of Rs. 50,000 to Rs. 2 lakh for death caused by a sterilization procedure. Further, where a sterilization procedure has failed, there is a compensation of Rs 30,000.

Section	Coverage	Limits
IA	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
IB	Death following sterilization within 8 - 30 days from the date of discharge from the hospital	Rs. 50,000/-
IC	Failure of sterilization	Rs 30,000/-
ID	Cost of treatment in hospital and up to 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/
<b>SECTION II: Empanelled Doctors under Public and accredited Private/Ngo Sector and Health Facilities under Public and accredited Private/Ngo Sector</b>		
II	Indemnity coverage up to 4 cases of litigations per doctor and per health facility in a year	Upto Rs. 2 Lakh per case of litigation

However, the scheme itself is beset with a lot of problems, which include:

Patients are not made aware of and informed about the existence of the scheme. The knowledge of those who have these procedures performed on them and the ASHA workers is restricted to the amount of incentive money they are entitled to after such surgery, another example of the State's failing effort to fully inform the public. As a result, the provisions relating to the compensation that can be claimed in the event of a death, failure or complications following the sterilization remain unknown to a majority of the public.

In the event of any complication due to the surgery, the acceptors lose their faith in the government hospital's facilities and prefer to avail the services at a private hospital where they then must shell out exorbitant amounts of money.

Another issue is the lack of awareness about the scheme among the Government officials. Health officials/service providers and ASHA workers that are entrusted with the responsibility of creating awareness about family planning are themselves unaware of the various family planning policies of the government in place.

Even when FPIS is made known to people, the entire process of claiming compensation under the scheme is long-drawn and fraught with red tape. The claim process, despite being an urgent need, is instead made cumbersome and draining for the party concerned.

India's adoption of sterilization has several serious shortcomings which will be addressed in the following section.

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## 4. FALLACIES WITH INDIA'S FOCUS ON STERILIZATION



*"My name is Bikki Devi. I was operated in 2012 in the sterilization camp in Kaparfora Govt. School. I was not given any incentive by the government. I ended up spending from my own pocket."*

As discussed in the previous chapters, there is nothing wrong in introducing sterilization programmes in the country as a reliable method of family planning. However, while the initiatives may be established with good intentions, their implementation is often dramatically harmful. This may be attributable to the complete lack of political power amongst those most affected by the policies. Further, the problems with the implementation

of sterilization initiatives in India stem from fallacies and wrongful mindsets of the people and the government.

India's sterilization campaign has mostly claimed female victims. That, in part, is explained by the nature of the medical procedure — vasectomies are safer, medical experts say, than the operation women undergo, which involves cutting and tying fallopian tubes through a keyhole-sized opening in the abdomen.

Another explanation for Indian women's victimization in sterilization 'cattle camps' lies in the sheer figures, which began to shift radically in the mid-1990s. Less than one percent of the Indian male population chooses to undergo the sterilization procedure, while nearly four out of ten women choose sterilization — the highest percentage in the world, according to the World Health Organization. Men's reluctance, centered on cultural taboos, comes despite more generous financial compensation for the procedure: In most states, men who choose to be sterilized are paid approximately Rs.2000/- by the Indian government. Women, on the other hand, typically receive Rs. 1400/-.

## **THE REALITY OF STERILIZATION PROGRAMMES IN INDIA**

The truth of what happens in the name of sterilization has quite extensively been explained in the previous chapters of this book. Injustice is woven into the implementation of sterilization practices in India, including compulsory sterilization, the continued issues since the horrific sterilization campaign of 1975, the unhygienic conditions in which the operations take place, the lack of medical care including lack of pre-operative and post-operative assistance for patients, the target-driven methods of botched up operations, the lack of compensation for victims of failed sterilization operations, and the gross violation of human rights through lack of informed consent and the deprivation of choice for individuals regarding their own bodies.

Discussed below are some of the issues pertaining to sterilizations as practiced in India.

## THE FEMALE- CENTRIC NATURE OF STERILIZATION PROGRAMMES

India's population control policies continue to be women-centric, with female sterilization being the largest mode of intervention at 36 per cent, while male sterilization is a mere 0.3 per cent, according to data from the National Family Health Survey, 2015-16.

Despite tubal ligations being riskier, more complex, and more expensive than vasectomies, sterilization efforts in India and around the world have overwhelmingly focused on women.<sup>50</sup> In Chhattisgarh, for example, in 2011-12, "1,27,114 tubectomies were performed against just 6,765 vasectomies — this means almost 19 times as many women were sterilized as men."<sup>51</sup> The trend is the same in every state. According to the Executive Director of Population Foundation of India, Poonam Muttreja:

Tubectomies contribute to 38% of India's family planning efforts while vasectomies are just 1%. There are strong social reasons, there is a myth that men lose their virility or become weak after vasectomy and the government has not done anything to dispel that notion. There are fewer trained people now that we have done away with the male health worker. We do not have targets for vasectomies but we have targets for tubectomies. Women undergo the procedure in subhuman conditions.

This trend shows a government supported system that places the burden of family planning almost entirely on women's shoulders. This system is accompanied by complete disregard for logical and scientific reasons that sterilization efforts should be at least equally, if not more, focused on men due to the decreased risks, costs, and the ease of the procedure for men.

Female sterilization remains the first choice for family planning

<sup>50</sup> Lisa De Bode on "Why Indian women are victims of sterilization 'cattle camps'", <<http://america.aljazeera.com/articles/2014/11/14/women-india-sterilization.html>>

<sup>51</sup> Ghosh, A. (2014). Chhattisgarh: 19 times as many women sterilised as men. *The Indian Express*. Retrieved from <http://indianexpress.com/article/india/india-others/19-times-as-many-women-sterilised-as-men-in-state/>

in India. Results of the NFHS-4 released by the Union Ministry of Health & Family Welfare conducted in 2015 also revealed that the percentage of male sterilization surgery (vasectomy) is minuscule.

The female sterilization percentage in Andhra Pradesh stands at 68.3 per cent while male sterilization is barely 0.6 per cent while the usage of pills and condoms remains extremely low at 0.2 per cent. This is when 62.9 per cent women and 79.4 per cent men are literate in the state. Karnataka recorded a high number of female sterilization surgeries at 57.4 per cent while male sterilization was opted by merely 0.2 per cent of those surveyed. Only 0.8 per cent used pills and 1.7 per cent used condoms for spacing children.

The situation is no different in Tamil Nadu with 55 per cent women undergoing sterilization surgery and merely 0.4 per cent men opting for Vasectomy. Pills and condoms are a choice for barely 0.2 per cent women 2.3 per cent men. Madhya Pradesh fares no well, with usage of pills at 1.7 per cent and condoms at 4.8 per cent. As many as 44.3 per cent women underwent sterilization surgery in 2015.

The findings of NFHS-4, 2015-16 for thirteen states, including Andhra Pradesh, Bihar, Goa, Haryana, Karnataka, Madhya Pradesh, depict that married women are devoid of using modern family-planning methods in eight of the First Phase states/union territories. Tamil Nadu also records an abysmal usage of condoms at 2.3 per cent and pills at 0.2 per cent. Female sterilization is preferred by 55 per cent though. In Telangana too, condoms and pills are least preferred, with only 0.5 per cent preferring condoms and 0.3 per cent birth control pills.

Figures for male sterilization have been low in previous government surveys. NFHS-3 indicated that only 1 per cent of the currently married women reported male sterilization as a method of family planning. The reported use of the male sterilization was even worse than indicated by the NFHS-2 during 1998-1999. NFHS-2 showed that 1.9 percent married women reported male sterilization as a method of family planning when almost all the respondents (97.4 per cent) were aware of the male sterilization as a family planning method.

When women undergo compulsory sterilization, they are moved to sterilization camps where these procedures take place in a dangerously haphazard manner. Their treatment is often compared to how cattle are treated, without much proper care or caution. Venues of sterilization are referred to as “cattle camps” because of the extremely poor treatment of women undergoing the procedure by officials and medical personnel.

## STERILIZATION DRIVES

In January 2012, the Times of India reported that the Madhya Pradesh government pressurised health workers in Indore to conduct 3500 procedures in three months. A 16-year-old boy who had gone to the hospital because he had a fever was injected with something that made him lose consciousness and when he woke up, he had been sterilized. The state had set a target of sterilizing 10% of the population. In Jabalpur, three people who had already been sterilized in 2011 were forced again in 2012.

Sterilization targets are wrapped beneath a bureaucratic veil by calling them “Expected Levels of Achievement”. The women who are the targets of these sterilization drives are either from rural or semi-rural areas or slums in the cities with ASHAs and Multi Purpose Health Workers being their interface with the health centers.

The ASHAs and Multi Purpose Health Workers do not have a fixed salary system and are paid per delivery or per surgery, so they are underpaid and have uncertainty of job as well. In Madhya Pradesh, workers are given the incentive of winning a Nano (car) if they get 500 people sterilized, a fridge for fifty people and a ten gram gold coin for twenty- five people. Under their uncertain circumstances, it is easy that they get lured by such offers and mobilize women to achieve their sterilization targets without giving them information of other available contraceptives. Hence, government health workers are known to lure people for sterilization. Due to the poor state of government health facilities people also prefer to choose these camps.

In the state of Tamil Nadu, which follows sterilization- centric family planning schemes, there is a pattern of using institutional

deliveries to convince women to get sterilized while they are in labour. Southern states such as Kerala and Tamil Nadu are constantly shielded from criticism and pushing for improvement in healthcare practices as they are regarded as forward due to good Maternal Mortality Ratio, sex ratio and Fertility Rate. However, doctors here regularly sterilize women between 18 and 21, which is in violation of the Government of India guidelines. The state has monopoly on maternal reproductive healthcare. In one instance, a woman only discovered that an IUD had been inserted in her after 20 years.

### LACK OF INFORMATION

India is a signatory of ICPD, committed to “voluntary and informed choice and consent”. This necessitates a government effort to educate and seek the informed consent of all persons subject to family planning schemes. Further, it is the constitutional right of all persons to have access to sexual and reproductive health education and family planning information. Doctors and nurses often display an abhorrent level of apathy and may refrain from properly counselling women. India's family planning programme claims to follow a “cafeteria approach” with a “basket of choices”. The method-mix in this programme includes five official methods — female sterilization, male sterilization, intrauterine contraceptive device (IUCD), oral contraceptives, and condoms. However female sterilization and insertion of IUCD are the only two methods pushed across by the states.

Medical health workers frequently use inhumane language such as ‘we can't encourage these women’ and ‘we must decrease the population’. Saroj, a resident of Delhi, explicitly stated, “I don't want to do this” right before the procedure but she was quickly administered an injection that rendered her unconscious. Perhaps this is because page 9 of the Standards for Female and Male Sterilization Services which deals with General Anesthesia states “it may be required...in case of a non-cooperative patient”. Non-cooperative may be used synonymously with non-consensual and robs a patient of the right to say ‘no’.

Additionally, the contraceptive and family planning needs of young widows and separated and divorced women are ignored. Contraceptive and spacing methods are also not available to couples outside marriage. In 2003, India's Youth Policy recognized that 'information in respect of the reproductive health system should form part of the educational curriculum'. However, sex education still remains a topic that is talked about in whispers in India.

## TWO- CHILD NORM

The two-child norm is one of India's target-oriented, family-size control policies, which encourages parents to limit their families to two children and creates disadvantages for couples with more than two children. Disadvantages include disqualification from Panchayat council positions; denial of certain public services and government welfare programmes, including maternal and child health programmes. The two-child policy was modeled on China's one-child policy (1979), under which couples were forbidden from having more than one child. Politicians and leaders are expected to set an example for others by adopting this norm themselves, influencing the villages to follow suit. It was believed that through the two-child policy, the national target of replacement level fertility of 2.1 would be achieved by 2010.

The policy disqualified any candidate with more than two children from running for a local, municipal, or district office. Government employees and local elected representatives who have a third child while in office would be forced to resign. As a result of the policy many women were been coerced into resorting to abortion in order to save their jobs if they are over their two-child limit. In many places where a two-child policy is in effect, male elected representatives have abandoned or divorced their spouses in order to be in compliance with the policy. Others have taken a second wife so as to be able to have more children and still retain their government posts.

The state in India to adopt a two-child limit for government employees are Andhra Pradesh, Odisha, Maharashtra, Rajasthan, Bihar, Gujarat, and Uttarakhand. Since in a country like India

where men in a marriage alone decide the number of children, many women have been forced to hide their pregnancies, registering their children under the names of their relatives or refusing to register them altogether, resorted to abortion to save their government posts.

The two child norm has been viewed as anti-democratic because it seeks to prevent people from participating in local self-governance after they have been elected through people's mandate. This policy interferes with the reproductive rights of individuals because it prevents individuals from exercising their right to decide the number of children they choose to have and discriminates against young citizens in their reproductive prime, because it creates distinction based on number of children.

Just as sterilization should not be seen as a population control measure alone, in a similar fashion, the aim of family planning programmes must be to enable couples and individuals to make informed choices and availability of safe and effective methods. The two-child norm, which is promoted as a family planning policy, robs an individual's freedom to reproductive choices and is discriminatory in that its non-compliance prevents an individual from participating in local self-governance and from holding government jobs. This also leads to complications such as forced abortions, forced sterilization, sex-selective abortions, divorce, desertions and disowning of the third child. This has an adverse effect on the sex ratio as well because in the want of a male child, more sex-selective abortions are carried out.

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## 5. CASE STUDY OF TWO IMPORTANT SUPREME COURT RULINGS AND AN ANALYSIS OF THE FALLOUT OF THE FPP IN RECENT TIMES

Sterilization surgeries leading to serious infections and deaths of young women across the country led to the filing of PIL in the Supreme Court of India. Several reports and surveys were done on the appalling conditions in Government-run sterilization centres where Government health workers had failed to respect basic dignity of their patients, highlighting doctor's failure to provide counselling to women being brought for sterilization surgeries, lack of outlining alternative forms of birth control or warn about dangers associated with operation and health facilities that failed to respect privacy or confidentiality of women.

### **RAMAKANT RAI VS. UNION OF INDIA, W.P (C ) NO. 209 OF 2003**

The petition in this public interest litigation (PIL) case, which is known as the *Ramakant Rai vs. Union of India*, cited practices of female sterilization by the government in the States of Uttar Pradesh, Bihar, and Maharashtra. Each case of sterilization lacked counselling or informed consent, lacked pre and post-operative care, and included unhygienic and unanesthetized operating conditions, sterilization of minors, coercion and cruelty.

The basic code of human rights law protects the reproductive rights of women to have access to voluntary sterilization services free of coercion, discrimination, and violence. In April 2004, a legal memorandum was drafted based on the illegality of coercive sterilization, how it violates human rights law, and the possible

remedial measure to address the abuses done to poor people through the crime of compulsory sterilization.<sup>52</sup>

Human Rights Law Network (HRLN) submitted the memorandum in support of its petition to the Indian Supreme Court, alleging coercion and abusive practices resulting from poor quality of care in government-run sterilization camps and failure to comply with national guidelines on the performance of sterilization, which establish mandatory procedures for obtaining informed consent.

In March 2005, the Supreme Court ordered state governments to take immediate steps to regulate health-care providers who perform sterilization procedures, and to compensate women who suffer complications due to substandard practices and the relatives of victims who died due to botched operations.

Later, a Public Interest Litigation (PIL) was filed requesting the Indian Supreme Court to direct the Union of India (and all its subsidiary bodies) to implement the Ministry of Health and Welfare's Guidelines on Standards of Female Sterilization, enacted in October 1999. This petition further sought compensation for victims of medical negligence in sterilization procedures, as well as accountability for violations of these guidelines.

The objective behind this petition was to make known the injustice being done to poor and vulnerable women who underwent these procedures without a number of essential rights including informed consent, pre-operative and post-operative care, hygienic facilities, anesthesia when appropriate, and freedom from coercion, cruelty, and sterilization of minors.<sup>53</sup> It was further asserted that the current sterilization conditions violated not only the guidelines, but also patients' reproductive rights, women's rights, and health rights as articulated in international instruments ratified by India, including the Alma Alta Declaration, CEDAW, the ICPD Programme of Action, and the Beijing Platform for

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<sup>52</sup> Ramakant Rai v. Union of India / Amici (Supreme Court of India), <<http://www.reproductiverights.org/case/ramakant-rai-v-union-of-india-amici-supreme-court-of-india#>>, accessed on 5.08.2017

<sup>53</sup> Ramakant Rai v. Union of India, W.P ( C) No 209 of 2003, <<https://www.escri-net.org/caselaw/2013/ramakant-rai-v-union-india-wp-c-no-209-2003>>, accessed on 6.07.2017

Action. The PIL further contended that the current conditions violated patient's constitutional right to health, which is a part of the right to life enshrined in Articles 14, 15, 21, and 47 of the Indian Constitution.

An interim order issued by the Court in March 2005 pointed out the lack of uniformity of procedures and norms to ensure that the guidelines were followed. This resulted in the case being left open. The court ordered all states in India to establish implement and follow the following guidelines:

1. Introduce a system of having an approved panel of doctors and limiting the persons entitled to carry on sterilization procedures in the State to those doctors whose names appear on the panel. The panel may be prepared either on a state-wise, District-wise or Region-wise basis. The criteria for including the names of the doctors on such panel must be laid down by the Union of India as indicated subsequently. Until the Union of India lays down uniform qualification criterion for the empanelment of doctors, for the time being no doctor without gynecological training for at least 5 years' post degree experience should be permitted to carry out the sterilization programmes.
2. The State Government shall also prepare and circulate a checklist, which every doctor will be required to fill in before carrying out sterilization procedure in respect of each proposed patient. The checklist must contain items relating to (a) the age of the patient, (b) the health of the patient, (c) the number of children and (d) any further details that the State Government may require based on the guidelines circulated by the Union of India. The doctors should be strictly informed that they should not perform any operation without filling in this checklist.
3. The state Governments shall also circulate uniform copies of the proforma of consent. Until the Union Government certifies such proforma, for the time being, all the States shall follow the pro forma as utilized in the State of U.P.

4. Each State shall set up a Quality Assurance Committee which should, as being followed by the State of Goa, consist of the Director of Health Services, the Health Secretary and the Chief Medical Officer, for the purpose of not only ensuring that the guidelines are followed in respect of pre-operative measures (for example, by way of pathological tests, etc.), but also operational facilities (for example, sufficient number of necessary equipment and aseptic conditions) and postoperative follow ups. It shall be the duty of the Quality Assurance Committee to collect and publish six-monthly reports of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization.
5. Each State shall also maintain overall statistics giving a breakdown of the number of sterilizations carried out, particulars of the procedure followed (considering there are different methods of sterilization), the age of the patients sterilized, the number of children of the persons sterilized, the number of deaths of the persons sterilized either during the operation or thereafter, and the number of persons incapacitated due to the sterilization programmes.
6. The State Government shall not only hold an enquiry into every case of breach of the Union of India guidelines by any doctor or organization but also take punitive action against them. As far as the doctors are concerned, their names shall, pending enquiry, be removed from the list of empanelled doctors.
7. The state shall also bring into effect an insurance policy according to the format followed by the state of Tamil Nadu until such time the Union of India prescribes a standard format. The Union of India shall lay down within a period of four weeks from date uniform standards to be followed by the State Governments regarding the health of the proposed patients, the age, the norms for compensation, the format of the statistics, checklist and consent proforma and insurance.

8. The Union of India shall also lay down the norms of compensation, which should be followed uniformly by all the states. For the time being until the Union Government formulates the norms of compensation, the States shall follow the practice of the State of Andhra Pradesh and shall pay Rs. 1 lakh in case of the death of the patient sterilized, Rs. 30,000/- in case of incapacity and in the case of post-operative complications, the actual cost of treatment being limited to a sum of Rs. 20,000/-.

### **SIGNIFICANCE OF THE CASE:**

First, the court issued directives not only for the States highlighted in the petition but to the entire country. Second, the case is also significant as the Court underscored the need for uniform guidelines in performance of sterilization procedures for women and men, including requirement of informed consent, punitive action for violations, and compensation for victims. Third, it is considered to be the landmark judgment for anything regarding sterilization measures adopted in India and every case on compulsory sterilizations that followed referred to this case as the basis for standards of care during sterilization procedures.

After the decision of the Supreme Court, Union of India published the following documents, manuals and referencing materials to be used as guidelines for all sterilization procedures that followed:

#### **“Standards for Female and Male Sterilization Services” (2006) –**

The Government of India states in the manual that the Development of Standards on Sterilization Services is an important step in ensuring the provision of quality services. This document sets out the criteria for eligibility, physical requirements, counselling, informed consent, preoperative, postoperative, and follow-up procedures, and procedures for management of complications and side effects. It also highlights the salient steps of the surgical procedures and the recommended practices for infection prevention.

This provides, inter alia, for doctors to be put on a panel, the physical infrastructure required, informed consent, and that

the women should be married, be between the ages of 22-49 years, and have at least one child above the age of 1 year. This manual explains the nature of counselling that should take place so an informed decision can be made. Women are also required to be informed of all the available methods of family planning, and that they have the option of refusal. In the procedure for operations, it is inclusive of medical examination and monitoring after the operation. The post-operative care requires that the women be kept overnight at the facility. It is stated that all failures of complications are required to be documented, that cleanliness be maintained, and that equipment and supplies be sterilized.

### **Standard Operating Procedure for Sterilization Services in Camps (2008) –**

The formulation of Standard Operating Procedures (SOPs) for Sterilization Camps was to ensure provision of quality services to the clients in camps. It envisaged that programme managers and service providers would be encouraged to take appropriate remedial measures for ensuring adherence to standards in the camps as laid down in the “Manual on Standards for male and female sterilization” by Government of India. The Standard Operating Procedures would also serve as a guide for planning, implementing and monitoring quality of services in sterilization in a camp setting, for programme managers, camp managers and service providers at all levels. This document may also be found useful by the service delivery organizations engaged in organization of the camps, including NGOs.

This manual extensively highlighted the operating procedures to be followed in camps, which includes the camp timings and the number of laparoscopic tubectomy operations that can be performed in one day, and mandates that sterilization camps can be organized only at established healthcare facilities as laid down in the standards of Government of India.

The major elements included in the SOP are the range of services in a camp, pre-requisites for sterilization camps, roles

and responsibilities of programme managers and service providers, conduction of camps, prevention of infection (asepsis and antisepsis), and the assurance of quality in camp setting and the management of emergency.

### **Standards & Quality Assurance in Sterilization Services (2014) –**

'Standards and Quality Assurance in Sterilization Services coalesce the four manuals ('Standards on Female and Male sterilization, Quality Assurance Manual, Standard Operating Procedures' for sterilization services in camps and 'Fixed Day Static' 2008) into one without diluting any of the contents and at the same time strengthening with new technical knowledge and learning from the field so that the outcome is a comprehensive manual which touches all aspects of sterilization services in India and act as a one stop reference for all issues concerning standards, quality assurance, skilled provision of services, logistics and supplies, indemnity coverage and robust monitoring protocols. The manual has also been made user friendly for all levels of the health system.

This manual ensures the provision of quality services to the clients by programme managers and service providers providing permanent methods of contraception. This document sets out the criteria for eligibility, physical requirements, counselling, informed consent, pre & post-operative care, follow-up protocols and procedures for management of complications. It also highlights the salient pre-operative, operative and post-operative instructions of the surgical procedures and the recommended practices for infection prevention. It also serves as a guide for assessing service quality and enable programme managers and service providers both in the public sector and in accredited private/NGO facilities to provide quality sterilization services and to take remedial measures wherever deficient for ensuring adherence to standards in service delivery. In addition, a framework for the process of payment of compensation for unforeseen situations such as complications, failures, deaths, arising out of sterilization procedure for clients as well as service providers, has been specified in detail.

The standards laid down in this manual applies to both 'static' and 'camp' mode. This document includes the eligibility criteria of the patients and how to carry out counselling and informed consent/choice.

### **“Manual for Family Planning Indemnity Scheme (FPIS) (2013)”–**

The “Family Planning Indemnity Scheme” was developed with an objective of providing a framework for the process of payment of compensation for death/failure/complications cases arising out of sterilization failures for acceptors and indemnity coverage for service providers both in the public and in the accredited private/NGO facilities. The manual highlights certain payments made by the government on sterilization, the compensation paid for loss of wages, transportation, diet, drugs, dressing, death, failure, etc. The manual also carries the procedure for claim settlement.

Under the Family Planning Indemnity Scheme, it is envisaged that States/UTs would make suitable budget provisions for implementation of the scheme through their respective Programme Implementation Plans (PIPs) in the relevant head under the National Health Mission (NHM). The scheme is uniformly applicable for all States/UTs. The scheme provides a compensation of Rs 50,000 – Rs 2 lakh for death caused by a sterilization procedure. Further, where a sterilization procedure has failed, there is a compensation of Rs 30,000.

### **“Reference Manual for Female Sterilization” (2014)**

These manual attempts to lay down uniform standards in the surgical technique to be adopted by all training centers and service delivery facilities. The manual also aims to equip the service providers to screen clients, counsel them on different methods of contraception, and perform minilap tubectomy and laparoscopic tubal occlusion safely. The manual enables providers to recognize and manage potential problems as well as provide appropriate follow-up. It also lays down uniform standards for training across the country incorporating management aspects of conducting training in female



sterilization, laying down curricula and setting up of training centers.

## INFORMED CONSENT

Informed consent in the case of sterilization procedures may be defined as the process where healthcare providers are required to disclose all appropriate information to the patient regarding the medical procedure to be undertaken. In other words, informed consent is where consent is so sought after having provided such patient with all relevant information, including but not limited to facts, details, circumstances, necessity, alternatives and complications that may accompany a medical procedure such as sterilization.

Informed consent implies that the information provided to the client is comprehensive, that the client has fully understood the information, and that the client freely consents to adopting a particular method. For consent to be valid, it is the duty of the provider to ensure that the client understands the given information. As the Declaration of Helsinki notes, "after ensuring that the subject has understood the information, the physician should then obtain the subject's freely given informed consent".<sup>54</sup>

Informed consent originates from the legal and ethical right that, the patient must direct what happens to his/her body and from the ethical duty of the physician, doctor, or surgeon to involve the patient in her health care. The most important goal of informed consent is that the patient has an opportunity to be an informed participant in her health care decisions. Ordinarily, informed consent, regarding a sterilization procedure, would require that the attending doctor or surgeon inform the patient of the following:

1. The nature and purpose of the proposed method of sterilization

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<sup>54</sup> Touitou, Y., Portaluppi, F., Smolensky, M. H., & Rensing#, L. (2004). Ethical principles and standards for the conduct of human and animal biological rhythm research. *Chronobiology international*, 21(1), 161-170.

2. The risks and benefits associated with the said method of sterilization
3. Alternatives to such method of sterilization
4. The risks and benefits associated with the alternatives to the said method of sterilization
5. The risks and benefits associated with not receiving such treatment or sterilization procedure

These pre-conditions to satisfy the criteria of informed consent additionally may or may not include an assessment of the patient's understanding of the said sterilization procedure, including all of its risks and benefits, as well as the risks and benefits associated with secondary sterilization procedures as well.

## **INDIAN STERILIZATION SERVICES' NOD TOWARDS INFORMED CONSENT**

As Ms. Rajalakshmi and the Population Council's Report<sup>55</sup> on informed consent in India's contraceptive services notes, evidence of the extent to which consent in contraceptive services in India is truly informed is limited. The sparse evidence available from the literature on quality of care in reproductive health services in India suggests that information provided to clients is generally incomplete and superficial. Likewise, anecdotal evidence from India suggests that informed consent is often misunderstood and perceived as a mere formality, that is, of obtaining a signature on a consent form rather than an ongoing process that takes place between the provider and the client. Even where a consent form is signed, it is not clear whether providers have made the effort to ensure that the client has understood the information provided.

This is particularly unsettling because the procedures of sterilization, like Vasectomy and Tubectomy are supposed to be permanent measures of contraception and a failure to adequately inform the patient about the said procedure will lead to distressing and unwarranted consequences for the said patient. It is therefore

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<sup>55</sup> Ram Prakash, Rajalakshmi, Indian journal of medical ethics- *Reducing reproductive rights: spousal consent for abortion and sterilization*, Vol. 4, pp.102-3, 2007

of utmost necessity that the client must be informed about the array of alternative options to sterilization, including non-terminal methods, and the comparative benefits and risks of each method, so that she can decide whether she would like to undergo sterilization or not.

Informed consent however, is not a concept or a procedure independent from any other arms of the delicate procedure. In fact, the argument can be made that informed consent is part and parcel of every stage of the sterilization process. That said primarily, the question of what constitutes informed consent, or that querying how informed consent is administered and ensured is one that arises during the process of counselling.

Section 1.4.1 and 2.4.1 of the Standards for Male and Female Sterilization Services defines counselling as, "the process of helping clients make informed and voluntary decisions about fertility." Informed consent, ensures that the volunteer or patients are made aware of all information regarding all procedures involved, before making any choice or decision and is therefore, an integral part of the entire sterilization process.

To continue quoting 1.4.1 of the Standards of Male and Female Sterilization Services in verbatim,

General counselling should be done whenever a client has a doubt or is unable to take a decision regarding the type of contraceptive method to be used. However, in all cases, method-specific counselling must be done.

The following steps must be taken before clients sign the consent form:

1.4.1.1. Clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes this operation is a permanent one.

1.4.1.2. Clients must make an informed decision for sterilization voluntarily.

1.4.1.3. Clients must be counseled whenever required in the language that they understand.

1.4.1.4. Clients should be made to understand what would happen before, during, and after the surgery, its side effects, and potential complications.

1.4.1.5. The following features of the sterilization procedure must be explained to the client:

- It is a permanent procedure for preventing future pregnancies.
- It is a surgical procedure that has a possibility of complications, including failure, requiring further management.
- It does not affect sexual pleasure, ability, or performance.
- It will not affect the client's strength or her ability to perform normal day-to-day functions.
- Sterilization does not protect against RTIs, STIs, or HIV/AIDS.
- Clients must be told that a reversal of this surgery is possible, but that the reversal involves major surgery and that its success cannot be guaranteed.

1.4.1.6. Clients must be encouraged to ask questions to clarify their doubts, if any.

1.4.1.7. Clients must be told that they have the option of deciding against the procedure at any time without being denied their rights to other reproductive health services.

Further, 1.4.4 of the Manual additionally does stipulate, albeit briefly guidelines related to Informed Consent regarding male and female sterilization services. To quote Section 1.4.4,

1.4.4.1. Consent for sterilization operation should not be obtained under coercion or when the client is under sedation.

1.4.4.2. Client must sign the consent form for sterilization before the surgery

It can therefore be inferred that Indian sterilization services are not immune to the idea of informed consent and that the very concept is not alien to India's persistence with sterilization, in theory if not in practice.

## THE REALITY OF INFORMED CONSENT FOR STERILIZATION

It has been proven by the many cases of ill-informed consent, not only among the media but as concluded by several independent fact-finding missions as well. To check the implementation of this guideline and whether the 'informed consent' is genuinely an informed one, whether the beneficiaries have been counseled, informed and made aware of what is the surgery about, what will happen pre, during and post op, about the complications and side effects that may occur, are explained in detail. Further, one must also pay attention to the fact that, the consent given is voluntarily or of their own will and is not a coerced one or is taken when the client is under the influence of drugs etc. and the consent of that same person on whom the surgery is to be done is taken and not of their spouse/guardian etc.

Incidents of poor counselling and sterilization camps were recorded by NGOs and media in different parts of the country. Some are mentioned below to understand the realities at the ground level:

1. On 23.05.2012, Kolayat Hospital in the state of Rajasthan sterilized 72 women. The same hospital had earlier been reported to have sterilized another 42 women on 25.04.2012. These sterilizations, all done en masse were in violation of the guidelines which prescribe that no more than 30 sterilizations may be done by a team with three laparoscopes in a single day. Further, the women were not put under post- operation observation for the required period of three hours. In the absence of recovery rooms, they were forced to lie on the crowded and dirty floors of corridors for recovery. None of these women had ever been counseled on any other forms of contraception. Further, over 80 percent of these women stated to have been unconscious when discharged.<sup>56</sup>
2. In an incident dated 05.02.2013 in the Manikchak Rural Hospital in Malda, West Bengal, 103 women were

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<sup>56</sup> The Horrors of India's Population Control Programmes" issued by the Caravan Magazine, Accessed on 12.11.2014

sterilized in 'Mega Female Minilap Ligation Camp' by the State authorities. As per the written record, three doctors conducted 103 Minilap operations. The hospital was used as a makeshift facility for the sole purpose of sterilization and had a capacity of only 60 beds with dirty and torn mattresses thus the aseptic part was completely overlooked. The patients were made to lie on the open dirty grounds of the hospital in a painful, semi-conscious state, attended to only by concern family members. There was no adequate counselling regarding what will happen before, during, and after the surgery, its side effects, and potential complications, including failure. The consent forms on which women gave their consent for the operations were not translated in the local language and were in English. There were no post-operative examinations conducted or any post-operative instructions given to the women. There were no discharge cards indicating the name of the institution, the date and type of surgery, the method used, and the date and place of follow-up as mandated by MOHFW given to the women after the surgeries. It was in this regard, that local health officials acknowledged the appalling conditions of the programme and notices were sent by the NHRC to the District Magistrate in Malda and the Principal Secretary, West Bengal.<sup>57</sup>

3. In a continuing trend of medical laxity and negligence, in the Mandi district of Himachal Pradesh on 12.12.2014, a drunken doctor performed five sterilizations and fell asleep during the course of his sixth laparoscopic tubectomy in the Primary Health Care Centre in the village of Thunag. It was informed that the doctor had locked himself up in a room to sleep while he left the sixth patient after the administration of anesthesia. The doctor in question was credited to have performed hundreds of surgeries over the past few years. However, the said doctor was later suspended and it was further suspected he had a previous record of intoxication

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<sup>57</sup> Mukherjee, A. (2013). 103 women sterilised in a day at West Bengal hospital; probe ordered. *NDTV India*. Retrieved from <https://www.ndtv.com/india-news/103-women-sterilised-in-a-day-at-west-bengal-hospital-probe-ordered-512610>

at work and had also fallen asleep during the course of a previous sterilization procedure.

### CRITICISM OF INDIA'S PRACTICE OF 'INFORMED CONSENT'

India's much maligned sterilization programme has, in its literal sense and forms each of these duties. Additionally, it would seem, that India's sterilization drive, in spirit at the very least, understands what exactly 'informed consent' means and implicates. However, it is unlikely to amount to anything unless the many drawbacks of it are addressed urgently. Some limitations and handicaps of India's practice of 'informed consent' in its sterilization drive include,

1. As is required by the guidelines issued by the Apex Court in *Ramakant Rai v. Union of India*, volunteers must sign a consent form before going through sterilization. However, there remain many who cannot read or write and therefore, the contents of the same are not understood by such volunteers. Further, there have been cases where health officials have refused to clarify what was written in the same and thus, consent was given without an understanding of the consent form.
2. Another criticism is the fact that a lot of the consent forms given to volunteers before going through the operative procedures of the sterilization were not in the local language of the community resulting which, many of whom who were literate in their local language had to give consent to the procedure without much clarity and understanding. As is often the case, ASHA workers are left to sign the consent forms on the behalf of the volunteers.
3. It has been reported that even where health official and ASHA workers have informed the volunteers of the sterilization process, they aren't informed adequately or enough. In fact, according to a report by the Population Research Institute, 34% (1 in 3) of all women who had been sterilized admit that they were not told that tubectomy was permanent in nature. Further, 68% of all women so sterilized were never informed about the side effects or

possible complications that may arise out of a procedure as delicate as tubal ligation. There is a failure to provide comprehensive information about the procedure and its alternatives by healthcare officials.

4. As has been exhibited by fact-finding missions across India, comprehensive knowledge of the entire process of sterilization is still left wanting among healthcare workers. ASHA workers often do not possess complete information on the procedure. This calls for a review of the training gone through by such workers.
5. Since sterilization often happens in hordes and en masse, there is a lot of pressure on healthcare officials to meet the 'expected level of achievements' for the day. Therefore often, concerned volunteers do not always get the opportunity to properly address and clarify any doubts they may have.
6. Motivating people to undergo sterilization has become very target-oriented, which is why there have been cases where ASHA workers and other healthcare professionals have misinformed volunteers so that they may undergo such procedures, a practice that is also ethically wrong.
7. Due to the often patronizing and subservient relationship between a volunteer and the doctor, volunteers often agree to whatever the doctor may recommend, without seeking to clarify any doubts they may have and 'trusting' their doctors. Here, such consent is not informed but is instead, a confirmation of the volunteer's confidence in his doctor.
8. There have also been cases where family members gave consent on behalf of the volunteer, a practice that does not constitute informed consent. Healthcare officials must ensure that the volunteer gives such consent voluntarily, free of any influence and on their own.



## FAMILY PLANNING INDEMNITY SCHEME (FPIS)

The FPIS was a result of the culmination of events which led to the PIL in *Ramakant Rai & UP & Bihar Health Watch vs. Union of India*, a petition against the rampant abuse and negligent sterilizations of women in camps across India.

The Family Planning Insurance Scheme is one of the initiatives launched under direction from the Hon'ble Supreme Court, with a view to do away with the complicated process of payment of ex-gratia to the acceptors of sterilization for treatment of post-operative complications, failure of sterilization or death attributable to the procedure of sterilization. The Family Planning Insurance Scheme (FPIS) was introduced in November 2005 with Oriental Insurance Company, to take care of such cases.

The scheme was further modified in procedure w.e.f. 01-04-13 to 31-3-2014, and was a part of State Programme Implementation Plans (PIPs) under NRHM and renamed as Family Planning Indemnity Scheme. The available benefits are as under:

### **Eligible beneficiaries/ doctors/ health services providers:**

- a. All persons undergoing sterilization operations and signed the Consent Form are covered under Section IA, IB, IC and ID.
- b. All the Doctors/Health Facilities including Doctors/Health Facilities of Central, State, Local-Self Governments, other Public Sectors and all the Accredited Doctors/Health Facilities of Non-Government and Private Sectors rendering Family Planning Services and conducting such operations shall be indemnified against the claims arising on them out of failure of sterilization, death or medical complication.

Though the Supreme Court ruling in the above mentioned PIL was in place, we discuss the fallouts of the still horribly implemented family planning programmes, especially the sterilizations drives in places like Araria in Bihar and Chhattisgarh, which have resulted in the many unnecessary deaths, these two places are just two examples of such practices which take place across the country.

## **DEVIKA BISWAS VS UNION OF INDIA WPC 95/2012**

“In clear violation of nearly all the guidelines, government Accredited Social Health Activist under National Rural Health Mission workers recruited between 50 and 63 below poverty line, scheduled caste and other backward class women for NGO (Jai Ambe Welfare Society) sterilization camp at Government Middle School, Kaparfora, on January 7. Neither the NGO nor the surgeon conducted pre-operative tests to determine suitability of the enlisted women for sterilization,” alleged Biswas, who hails from Araria and claimed to be an eye-witness.”

### **BACKGROUND- ARARIA STERILIZATION CAMP**

According to official figures, India carried out nearly 4 million sterilizations during 2013-2014. More than 700 deaths were reported due to botched surgeries between 2009 and 2012 with 356 reported cases of complications. Though the Government has adopted standards for conducting safe sterilizations, an unseemly haste to meet high state-mandated quotas has often led to botched operations and deaths. There have been persisting reports of the horrifying quality of tubectomies but authorities continue to disregard it as an important reproductive health concern. One of such similar incidents, which caught much of media attention and subsequently led to the filing of PIL, was *Devika Biswas vs Union Of India & Others (WPC 95/2012)*.

On the night of 7<sup>th</sup> January 2012, a single doctor sterilized fifty-three women in two hours with the help of unqualified staff. The camp was organized at Kaparfora Government Middle School, in Araria District of Bihar, which did not have basic amenities like running water and sterilizing equipment.

The women that were brought to the camp belonged to Below Poverty Line (BPL), Scheduled Caste (SC) and Other Backward Classes (OBC). The camp was organized in complete violation of the guidelines on “Standard Operating Procedures for Sterilization Services in Camps” laid down by the Supreme Court and Government of India. The State of Bihar authorized a local NGO “Jai Ambe Welfare Society” to organize the camp. The camp

was conducted after school hours, when the staff had left for the weekend. The surgeon performed the operations from about 8pm to 10pm in unhygienic and cruel conditions.

Local inhabitants of Kaparfora and nearby villages came to know about the sterilization camp when the women (who were eventually sterilized) were swayed by ASHA workers. They were persuaded and lured for free sterilization operation and free medicine but none of the women had any idea what that actually meant.

Women along with the ASHAs and their guardians started pouring in from 12:00 noon. None of the women received any health checkups or counselling. They were not informed of other methods of family planning or of what would happen before, during, and after the surgery, its side effects, and potential complications. Eyewitnesses report that the NGO had made no arrangements. The patients were kept waiting from noon till 8:00 pm for the doctor. They were given anesthesia once the doctor had arrived and were taken to the makeshift operating theatre in groups of four within ten minutes.

The classroom being used for the procedures had not been cleaned; the school desks being used as operation tables without being disinfected; and the doctor did not change his gloves between procedures. Operations were carried out by an all male staff in the dim bulb and torch light and no post operative care was given. Post surgery, they were made to lie on straw that their guardians had arranged for. As a result, three women were left profusely bleeding. One of these women was admitted to the nearby PHC where she remained for eight days. Another woman, who was operated on despite being three months pregnant, miscarried just days after the procedure. The surgeon left immediately, leaving them in the hands of three staff members of the NGO. All 53 women suffered excruciating pain. They were given expired painkillers for pain management. With no further medical care available, they were forced to seek out private practitioners, incurring heavy out of pocket expenses. Exasperated by the callous attitude of the NGO workers, the public nabbed the three of the NGO staff and phoned to

register their complaints with MOIC and the police. None of the women had received any of the promised compensation. Police investigation revealed that the school authorities had not been asked for the use of the premises as a sterilization camp. Mr. Dilip Verma, school in charge, said that his staff had vacated the building by 11:30am on the day of the camp and were unaware of its use over the weekend. The Superintendent of Police, Mr. Lande, raided the NGO's offices and found forged stamps, videos and photographs. The village Mukhiya said that he inquired the NGO staff of "what were they doing and if they had any order with them". The staff informed him that they had the required permissions for conducting a sterilization camp. The NGO staff also informed that since they did not have cash, they would be giving free medicines to people.

Throughout India, rural women are routinely dehumanized by the unsanitary conditions of sterilization camps. The incident in Araria highlighted the pattern of violations that occur frequently in Kaparfora. The Government of India strictly prohibits the practice of organizing camps in school and states that "under no circumstances should Sterilization Camps be organized in a school building/Panchayat Bhavan or any other such set up".

Most of the women were within the prescribed age group of 22 to 49 years but seemed under age and anemic due to their frail physique and malnourishment. The doctor's absence for post surgical case was in violation of the government guidelines which say that "women will be discharged only after a physical examination by the doctor has been completed, if found to be satisfactory after the women come back to their senses, and when they have an attendant with them".

A series of complaints were filed and they were registered at Kursakanta Police Station on 8<sup>th</sup> January 2012 being S.DE No.135/12, 136/12, 137/12 and 144/12. State investigations into the complaint concluded that the camp was a success although women had admittedly been provided expired medication. In fact, the Principal Secretary of Health for Bihar, Mr. Amarjit Sinha, the District Magistrate and the Civil Surgeon issued statements that the camp was conducted according to the Government of

India guidelines and praised the NGO and doctor for a job well done. However, investigations carried out by Devika Biswas and journalist Francis Elliott concluded that the sterilization camp did not meet any of the requirements laid down by the Court or the Government of India.

Even though the Ministry of Health and Family Welfare clearly states that a client can only be discharged: "after at least four hours of procedure, when the vital signs are stable and the client is fully awake, has passed urine, and can walk, drink or talk. The client has been seen and evaluated by the doctor. Whenever necessary, the client should be kept overnight at the facility"; none of the above mentioned instructions were followed.

In consonance with the Ramakant Rai judgment, the Centre issued guidelines that must be followed in sterilization procedures all over India:

- a. Quality Assurance Manual for Sterilization Services (2006)
- b. Standards for Female and Male Sterilization (2006)
- c. Standard Operating Procedures for Sterilization Services in camps (2008)

These give explicit instructions regarding the place where the camp must be conducted, the timings, the number of procedures a surgeon is allowed to perform in a day, the required pre-operative screening tests, selection criteria of the women, steps to maintain a hygienic and sterile environment and post-operative mandates, checklists to be maintained and forms to be explained to the women.

Ms. Devika Biswas, a Health Rights Activists and native of Araria filed public interest litigation under Article 32 of the Constitution of India, relating to violation of the directions issued by this Hon'ble Supreme Court in *Ramakant Rai vs Union of India and Others (Writ Petition (Civil) No. 209/2003)* wherein the Supreme Court addressed rampant forced, unsafe sterilization and target-driven practice of 'sterilization camps' in India that had resulted into an incident which completely violated the women's right to life.

The petition highlights wrong practices employed by the state to achieve sterilization targets, which is discouraged by the Supreme Court and the National Population Policy, 2000. It also underlines how sterilization is viewed as a 'population control measure by the healthcare personnel rather than a way of safeguarding a woman's reproductive rights.

## TESTIMONIES OF WOMEN

### **1. Saraswati Devi, 28 years old woman, three children- 2 girls and 1 boy.**

Saraswati Devi visited the camp only after being motivated by the ASHA worker who had spread information about the camp in her village. She was aware of what sterilization meant and since she already had three children, she wanted to undergo the procedure. Saraswati said that she was forced to wait at the camp from noon until the doctor finally arrived at 8 p.m. It was then that the four women were given anesthesia and quickly taken inside. Saraswati underwent the procedure at approximately 8:30 p.m.

Saraswati shared that she was more or less drowsy, but not fully conscious so she did not know what happened. She became conscious only after midnight when she started crying out with excruciating pain and noticed that there was bleeding. There was nobody present who could tend to her. The doctor left the camp soon after operations at around 10:30 pm. There were three men left behind who were from the NGO. The medical team left with the doctor. Hence, there was no medical help available when women started waking up bleeding and in pain. Hence, she called her family who contacted the PHC and took her to the hospital.

Saraswati testified that the operations were carried out in dim light from a temporary generator and through the use of a torch. In two hours sixty women were operated upon. Saraswati was placed on hay on the floor following the surgery. She was told that she would be getting cash money and medicines worth Rs. 600/-. But instead of cash money, they were given expired Nimesulide, which was a painkiller. Saraswati had to be admitted in a hospital on 8<sup>th</sup> January and was discharged on the 15<sup>th</sup> (of January).

## **2. Jitni Devi, 25 years old woman, sterilized at Araria Camp.**

Jitni Devi has two children. She came to know about sterilization camp through the ASHA worker who persuaded her of the procedure although she had no knowledge of sterilization or the procedure she was to go through. Although she was informed that the camp would begin by 12 noon, it was 9:00 or 10:00 pm when she underwent the operation. Jitni Devi was given an injection at 8:00 pm. She was very scared and kept her eyes closed. She had no idea of what happened to her or who did what.

Jitni Devi was pregnant at the time of sterilization operation. She was told that she would still give birth but a few days after the operation, she had a miscarriage. Jitni Devi did not know that she was pregnant and was only informed of her pregnancy later by the doctor who performed the surgery. Jitni Devi stated that she was placed on the hay on the floor post surgery and her pain had become unbearable. She has not been given any money.

## **3. A woman sterilized at the Araria Camp (name not provided)**

This woman has two sons and one daughter. Her youngest child was two years and six months old at the time of sterilization operation. She went to the camp because she was persuaded by a health worker who told her about the sterilization operation. Since she had three children already, she wanted to get an operation. She reached the camp by noon and waited until 8 pm when she was given the anesthesia.

She testified that there was no pre-screening and after the operation, they were not given any certificate. She, like other women, was made to put her thumb imprint on a paper, without being informed that it was a consent form.

The doctor did not consult with any of the women. Upon arrival, he immediately proceeded with the surgeries and had already performed three operations within a mere 10 minutes. The said woman was understandably terrified and anxious as she underwent a delicate procedure without the proper required counselling. She woke up in immense pain and realized that there was no doctor present for post-surgical care

She was also informed that she wouldn't get any money and would instead be given medicine. Later, the said woman had to seek treatment from a private doctor.

#### **4. Reika Devi, 32 years old woman, sterilized at the Araria Camp:**

Reika Devi has three children, two girls and one boy. She came to know about camp from an ASHA worker who impelled her to come to the camp. Since Reika already had three children, she wanted to get an operation. Reika reached the camp at around 5:00pm and had an operation at 9:00 in the night. She arrived late because she expected a delay in the commencement of the procedure. She lived a mere eight kilometres away from the school where the camp was being held. The women were placed on desks for the procedure and made to lie on hay after. Reika woke up to profuse bleeding and agonizing pain. Her clothes were soaked in blood. Although the staff was present, they did not consider her condition as serious and did nothing to help her. The locals finally came to her aid and bandaged the wound. She was forced to seek treatment at a private medical facility.

#### **5. Dauchna Devi, 22 years old, woman sterilized at the Araria camp.**

Although she did not wish to undergo the sterilization procedure, Dauchna went the camp due to pressure from her guardian. She became drowsy with anesthesia and was made to lie on the floor. However, she was not completely unconscious and could still hear and see. Dauchna Devi shared that the women were operated in the clothes that they were wearing; the doctor had only an apron and gloves on.

When Dauchna Devi woke up, she had intolerable pain. She did not take the medicine given by the NGO staff but she took the painkiller at home.

### **OBSERVATIONS MADE BY DEVIKA BISWAS**

1. S.P. Lande could assess that the accredited NGO was running a racket to make money by using forged documentary evidences. He wanted the guilty to be punished, but was perhaps unable



to see that the entire health system was faulty and in violation of Supreme Court guideline.

2. All Health Dept. personnel (from present no. of Kursakata, Ex MOIC, Dr R Praset, CS Dr Husana Ara Begum, Mr. Reham PMO, Araria, Mr. Hoda Reg DP MO and ACMD and other officials) tried to defend the accredited NGOs irregularities because they wanted to hide lapses in the system.

3. The villagers and relatives of the Kaparfora stated that no advertisement or information was given to them about the sterilization camp but there is evidence that ASHA workers lured the eligible couples for sterilization camp. The villagers quarreled with the five NGO workers to get medical help and compensation packages, which they did not give. They informed the police and SP Lande to could get justice. They did not however make any written complaints.

4. Most of the women who were sterilized were from poor, Dalit and OBC families with substandard health conditions. There is a dire need for family planning and marginalized people want a free treatment facility. They wait for sterilization camps for free procedures and since they are largely ignorant of their rights, they accept whatever services and compensation they get without questioning. In this instance, upon realisation of the poor quality of services through SP Lande's investigation, they readily testified to all fact-finding teams. Observation of Procedural Violations that took place in Kaparfora Government Middle School in the light of the sanction/accreditation order of the office of DHS, Araria (Memo No 1165/ Araria dated 29.11.2011):

The following directives have to be followed compulsorily	Compliance by the organizing agency
Adherence of Government of India's Quality Assurance Manual for Sterilization Services (2006) – all directives given in Annexure C, Clause 2.	Did not adhere to all guidelines.

The following directives have to be followed compulsorily	Compliance by the organizing agency
Availability of all physical conditions as per Government of India's Standards for Female and Male Sterilization Services.	No, it was not carried out in any government health facility. Rather, it was carried out in a school where all these facilities were not available.
Camp organized at any government health facility, SHC/ Additional PHC, PHC/ CHC/ Referral and district hospitals.	No. It was carried in a school, flouting the Supreme Court's order.
Camp to be organized preferably between 9AM to 4PM.	Candidates with ASHA and guardians started pouring in from 12AM. Besides enlistment and getting their thumb impression on blank consent form, no health check up, and investigation were done with single sterilized women. The actual operative procedure started at about 8PM on the arrival of Operating Doctor, A.K. Chowdhury.  Thus, all operation carried out under dim bulb light, and torch lights from 8.00 to 10.00 PM on 7.01.2012.
Availability of fully equipped ambulance for referral service at the campsite.	No ambulance was available.

The following directives have to be followed compulsorily	Compliance by the organizing agency
<p>Discharging women only after physical examination by the doctor if found to be satisfactory after the women come back to their senses, and when they have an attendant with them.</p>	<p>The doctor himself left the place at night soon after all operations were over, without checking any sterilized women and no government health staff was there at the campsite at night.</p>
<p>Adherence to age limit for sterilization, and carrying advertisement for the same. Age limit for sterilization: Men: 22 years to 60 years Women: 22 years to 49 years</p>	<p>Most of the women were of the prescribed age but due to their frail physical frame and malnourishment, seemed under age and anemic. ASHA workers did mobilize people.</p>
<p>The upper limit for sterilization cases to be handled by single surgeon is 50. If more cases come for sterilization, the number of doctors to be increased accordingly.</p>	<p>This norm was violated; as per the government's own guidelines. The single surgeon operated 53 sterilization cases in the camp, on that day.</p>
<p>Same as condition number 2, regarding OT facility and other physical infrastructures.</p>	<p>Not adhered to, as it was a makeshift temporary arrangement. Violation of all hygienic conditions.</p>

The following directives have to be followed compulsorily	Compliance by the organizing agency
<p>Prior plan approval from CS office with copy to MOIC of that area unit.</p>	<p>Perhaps it was done as it was in the knowledge of the CS. Dr. Rajendra Prasad, the then MOIC, Kursakata, gave a statement to police that all operations were done under his supervision. Even, involvement of ASHA confirms that the health department had prior knowledge and approval.</p>
<p>The supervision of camp to be done at the venue on the fixed date and time by the concerned MOIC/MO/BHM/BCM, and also supervise giving all details of manpower (with name, address, and designation).</p>	<p>Though the health officials only accepted that all operation took place under the direct supervision of Dr. Rajendra Prasad, the then MOIC, Kursakata, but they are silent about other team members and about the team of NGO involved in the work. Their qualification, age, address, designation, not made available.</p>
<p>The MOIC /MO/BHM/BCM of the concerned area would verify and attest the number of sterilization cases done as per the QAC manual (page-13) and only after doing that would put his or signature on the sterilization register at the camp itself.</p>	<p>The health department certifies that 53 sterilizations took place under the direct supervision of the MOIC. It implies that he has verified attestation and put his signature on the sterilization register at the campsite (the public did not see him on the 7<sup>th</sup> at the camp).</p>

The following directives have to be followed compulsorily	Compliance by the organizing agency
<p>The accredited organization has to do the photography/ videograph of the beneficiaries of sterilization camp compulsorily and to submit within three days all activity reports photocopy of the sterilization register, all photographs and video to the office</p>	<p>Perhaps no photography or videograph been conducted this time. It has not been confirmed from any source. To shoot videos at the camp seemed violating privacy of women.</p>
<p>The concerned MOIC have to submit his report on the second day of the camp certifying the number of sterilized person to DHS office</p>	<p>Information could not be obtained regarding submission of report. However since the then MOIC and CS, both certified that 53 cases of sterilization took place, it implies that they have MOIC's report at the DHS office.</p>
<p>As per the letter number 4437 dated 26.6.2007, of SHS; the register has to be maintained at campsite by only the government staff.</p>	<p>The people did not see any government health staff, except ASHA health workers on 7.01.2012. It was only after Police intervention, people saw the MOIC, as well as, CS, and DPM, on 8.01.2012. So it is a mystery whether any government staff maintained such register at all.</p>
<p>The concerned organization would get Rs.1500/- per sterilization case.</p>	<p>This could not be verified.</p>

The following directives have to be followed compulsorily	Compliance by the organizing agency
All conditions are mandatory and obligatory for adherence by the organization.	Under the direct supervision of government officials, all main conditions were overlooked. Hence, the government themselves, are at fault. Rather, they suppressed facts, saying all work was done as per norm. There should an explanation provided regarding why blatant violations are taking place all over India, particularly in Bihar.

### **The Supreme Court Case- Devika Biswas vs Union of India WP(C) 95 of 2012**

Devika Biswas, (MA, Econ. PGDip, PM & IR), is a native of Araria with an extensive professional experience in the development and health sectors. She has worked in Uttar Pradesh, Delhi, Jharkhand and Bihar in her capacity as a health rights activist and has also been associated with the Integrated Child Development Scheme in Bihar. She has published articles and books in her field of specialization and is a public spirited individual. Ms. Biswas felt the need to file a Writ Petition in the public interest against the rampant forced and unsafe sterilizations after the Bihar sterilization camp. The petition raised concerns regarding State government's management of sterilization procedures, lack of pre-operation and post-operative care. Ms. Biswas was compelled that this petition should ensure that sterilizations nation-wide are conducted as per the legal norms, proper medical procedures and the provisions of the manuals set by the Supreme Court of India. She also wanted that the victims in Bihar to should receive compensation for their injuries.

The petition highlighted that despite the extensive guidelines and directions issued by the Hon'ble Supreme Court of India in

the matter of *Ramakant Rai (I) & Anr. v. Union of India & Ors*<sup>58</sup> inhumane sterilizations, particularly in rural areas, continued with reckless disregard for the lives of poor women. Sterilizations in the state of Bihar, the case study in the writ petition, showed that the most horrendous practices persist in contempt of the Ramakant Rai directions and violation of guidelines (the Government of India published a Quality Assurance Manual for Sterilization Services (in 2006); Standards for Female and Male Sterilization (in 2006); and Standard Operating Procedures for Sterilization Services in Camps (in 2008).

Disregarding these standards and quality assurance guarantees, most health facilities do not meet minimum standards in regard to staff, services, infrastructure, equipment, drug supply, and respect for patient's' rights. Sterilization operations can be done in a respectful, ethical, and healthy way under the Standard Operating Procedures and Quality Assurance Controls. However, in complete disregard of the Supreme Court's orders, the Constitution of India, and the Sterilization Guidelines outlined by the Ministry of Health, inhumane sterilizations were observed in Bihar and throughout the country.

The petition further covered similar violations in not only Bihar and but also in all other Respondent States (Union of India, Bihar, Jai Ambe Welfare Society, Andaman Nicobar Island, Arunachal Pradesh, Assam, Punjab, Goa, Delhi, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Kerala, Maharashtra, Manipur, Meghalaya, Mizoram, Madhya Pradesh, Nagaland, Orissa, Puducherry, Rajasthan, Sikkim, Tamil Nadu, Tripura, Uttar Pradesh, Uttarakhand and West Bengal).

The filing of petition was followed by State Health Society issuing a memorandum on 9<sup>th</sup> February to the Civil Surgeon in each district permitting private health facilities to conduct sterilization camps in places other than accredited nursing homes as long as there is "requisite quality assurance."

The State Health Society, Bihar, also issued financial guidelines: for each sterilization operation, the government will pay the facility

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<sup>58</sup> (2009) 16 SCC 565

fee (Rs 1350) and the motivator fee (Rs. 150), but will not cover expenses for equipment, management, or transportation. The empanelled doctor will receive Rs. 75 for each surgery.

On 8 Feb 2012, the Civil Surgeon issued a report praising the camp, with one exception: the expired medicines. On 10 January 2012, the Principal Secretary of Health for the State Government of Bihar, Mr. Amarjit Sinha, called a press meeting to discuss the camp. He used the Civil Surgeon's report to demonstrate that all sterilizations followed government standards and guidelines.

Following a 10 January 2012 letter from the District Magistrate for Araria, M. Sarvaran, states:

- Under the supervision of the Kurshakanta MOIC, M.B.B.S., Dr. Ajay Kumar Chowdhary performed sterilizations on 7 January 2012.
- The sterilizations were conducted at a camp sponsored by an accredited NGO.
- The facility had adequate rooms for the camp.
- No patients complained about the camp.
- FIRs have been lodged with the police, and an investigation has commenced.

The writ petition initially was concerned with responses from Union of India, States of Bihar, Kerala, Madhya Pradesh, Maharashtra and Rajasthan due to incidents of mass sterilizations reported in these states. However, numerous other allegations surfaced during the course of hearing.

The massacre in Bihar was not an isolated incident. Evidences of similar rampant fundamental rights violation and deaths in sterilization camps were submitted from states of West Bengal, Rajasthan, Madhya Pradesh, Kerala, and Uttar Pradesh. The situation in Maharashtra in districts such as Nagpur, Chandrapur and Gardhchiroli highlighted the plight of women who were being sterilized in camps with poor infrastructure, unsafe and unsanitary conditions on routinely basis. The PHCs lacked the provision of Blood Bank, no transport facility, inadequate counselling



for sterilization services; inadequate replacement equipment; inadequate basic supplies- women and their families have been forced to purchase their own supplies including stitches.

In Madhya Pradesh, after Chief Minister Shivraj Singh Chouhan declared 2012 as the year of family planning, some district collectors seemed to have tossed the rule book to the winds to meet their targets. The officials lured and misguided protected tribals with dwindling population into sterilization with monetary gain of Rs 1,100 as an incentive. Two of these tribes, Gonds and Korkus, are designated "primitive", whose numbers have dwindled by 11% were not spared. Rehka Wasnik, a poor labourer's wife, a mother of six, was brought to Balaghat the district hospital on February 9 for sterilization. She was twelve weeks pregnant with twin girls. Rekha died hours after she began bleeding on the operation due to sheer negligence. Her post-mortem report described "external and internal bleeding" in her uterus from injuries caused by a sharp and pointed instrument as the cause of her death.

During the course of hearing of this writ petition, allegations surfaced with regard to sterilization camps conducted in Bilaspur district, Chhattisgarh [between 8<sup>th</sup> and 10<sup>th</sup> November 2014] and there were also concerns with the allegations made in respect of the camps conducted in that State as well. *[The details of the incident explained in subsequent chapters]*

In addition to these grave violations of Article 21, 14, and 15, Devika Biswas documented near universal failure to comply with Union of India Guidelines on informed consent, hygiene, infrastructure, or post-operative care during sterilization camps. Additional affidavits were filed in this petition in July 2012 with evidence of continuing and widespread sterilization surgery related fundamental rights violations. In February 2013, the respondents filed a rejoinder to the respondents who had replied. In May 2013, the Petitioner filed a second rejoinder to additional states that had replied.

Notice in the writ petition was issued on 2<sup>nd</sup> April 2012 and thereafter the petition was taken up for active consideration only on 30<sup>th</sup> January 2015 when the Social Justice Bench of this Court

was seized of this matter and after completion of pleadings and instructions received by the learned Additional Solicitor General from the Union of India.

On 30<sup>th</sup> January 2015, learned Additional Solicitor General from the Union of India completed the pleadings. The petitioner's counsel suggested for a status update of implementation of each direction given in *Ramakant Rai (I) & Anr. v. Union of India & Ors* with details related to the implementation of the Family Planning Indemnity Scheme, 2013 particularly with regards to the release and utilization of funds under the said scheme.

### **STATES RESPONSES REGARDING IMPLEMENTATION OF RAMAKANT RAI GUIDELINES:**

A majority of the 37 respondents made submissions in reply to the original petition. Most of the states have failed to provide concrete evidence and documentation to support generic and sweeping statements that the Centre's guidelines are being implemented. The Petitioner filed additional documents as well as rejoinder affidavits in reply to the Respondents.

The State responses can be broadly summarized as under:

#### **1. Union of India**

UOI did not place on record whether States and districts were implementing the Ramakant Rai guidelines. It claimed to have empanelled doctors, uploaded manual on Standard and Quality Assurance in Sterilization Services, 2014 including Standard Operating Procedure for Camp, Reference Manual for Female Sterilization, 2014, Reference for Male Sterilization, 2013 and manual for Female Planning Indemnity Scheme, 2013 on the website of Ministry of Health and Family Welfare. As per one of the directions given by the Supreme Court of India (*Ramakant Rai v UOI*) the state governments were to circulate uniform copies of the proforma of consent. Even though the State Government agreed to have circulated uniform copies of the proforma of consent, there was no mention of compliance or non-compliance of guideline. Merely issuing forms does not ensure implementation and enforcement of guidelines.

UOI stated that a Quality Assurance Committee was established to ensure that guidelines are followed for pre-operative measures, operational facilities, and post-operative follow ups. There was no information provided if states were maintaining overall statistics giving a break-up of the number of the sterilization carried out and particulars of the procedure that should be followed. There was no data supplied.

Union of India in their affidavit did not make any mention if there were any enquiries held into cases of breach by any doctor or organization or any punitive action taken against them. It merely claimed that the Government has carried out an audit; the accounts are open to the inspection of the CAG and the internal audit of the Ministry of Health and Family Welfare. The government did not have any supporting evidence to their claims.

## **2. Bihar**

The affidavit submitted by State of Bihar confirmed a series of violations of Ramakant Rai guidelines. The state did not provide a detailed list of empanelled doctors for verification or any documentary evidence to show that the checklist (to fill before carrying out sterilization procedure) was being used as per guideline. The State government was required to circulate uniform copies of the pro forma guidelines, which the state till that point had failed to do. The State of Bihar claimed to have established a functional Quality Assurance committee, chaired by Principal Secretary (Health) and Govt. of Bihar. However, it provided vague details regarding the functioning of the committee in its affidavit, with no substantial evidence. It did not provide any evidence if the statistics along with break-up of the number of the sterilizations carried out was being maintained at state/district/block level.

The state did not provide supporting data to prove if District Quality Assurance Committee was reviewing all cases and taking necessary action against errant doctors. The State has an operational insurance policy, in accordance with FPIS and Government of India guidelines. State government of Bihar had not substantiated their claims on following FPIS guidelines.

### **3. Andaman & Nicobar**

Andaman & Nicobar (Union Territory) in its response regarding implementation of guidelines issued by Ministry of Health and Family welfare claimed to have prepared a checklist (contain items relating to (a) the age of the patient, (b) the health of the patient, (c) the number of children and (d) any further details) which every doctor was required to fill in before carrying out sterilization procedure. The UT also claimed that all doctors were asked to strictly adhere to the checklist. However, it has not provided any evidence to back their claim of circulating uniform copies of proforma of consent. The UT claimed to have constituted State Quality Assurance Committee and that the quality reports were being submitted to the Govt. of India. There was no document produced to show that the Administrative Order has been implemented and none of these reports were submitted to the Supreme Court for verification. There was no documentary proof provided to show that statistics giving a breakup of the number of sterilization carried out are being maintained. The Union Territory claimed that it was conducting an enquiry into every case of breach, 4 failure cases have been submitted, three are rejected and 1 is pending before the DQAC. The Union Territory has not provided, to the petitioner, any documents to verify their claim of compliance with this guideline.

With regards to Family Planning Indemnity Scheme (FPIS) which has been implemented since November 2005, the UT had no evidence to show if funds have been released as per the scheme to deserving persons.

### **4. Assam**

The state of Assam filed an affidavit confirming implementation of guidelines by Ministry of Health and Family Welfare. However, they could not provide any proof to show that doctors have been empanelled as per guideline. The state claimed that no operation is conducted without filling in the checklist but no checklist was placed on record and no documentary evidence was submitted to show adherence to guideline. The State was supposed to maintain statistics of number of sterilizations carried out, the

number of death of the persons sterilized and complications but no data was given on the website and no concrete evidence was provided to show that the statistics are maintained.

The Government of Assam did not have any proof to show that doctors who breached guidelines are being “obstructed” and if FPIS scheme was being implemented.

## **5. Goa**

The state government of Goa also failed to provide the list of qualified gynecologists/surgeons to perform the sterilization operations. It claimed that the checklist is maintained for each and every patient. However there was no documentary evidence to show adherence.

The state said that the consent form is duly signed by the patient/ husband of the patient prior to the sterilization. This is a grave violation as only the patient has the authority to sign the consent form; the husband cannot do so on her behalf. The Honorable Supreme Court was informed that Quality Assurance Committee and District Quality Assurance Committee were also in place and that the data is uploaded on [dhsgoa.gov.in](http://dhsgoa.gov.in). But there was no data available to cross-check the information. Since the state was not maintaining any statistics, it could not provide information on percent of death in the state, which clearly indicates proper statistics, is not maintained. Despite so many violations there were no complaint filed against any doctor who performed sterilization. The State of Goa could not provide any evidence to corroborate the implementation of FPIS guideline.

## **6. Delhi**

Delhi could not provide any satisfactory response with regards to list of panel of doctors. There was no documentary evidence to prove that doctors filled out checklists for each patient. Despite state's submissions that informed consent were taken prior to each sterilization procedure, there was a lack of supporting documents for the claim. It was stated that Delhi has a State level Quality Assurance Committee and 11 District Level Quality Assurance committees but there was no documentary proof

provided to corroborate aforementioned claims. There was no statistics maintained and no information provided regarding service facilities and monthly and quarterly reports submitted by districts. The government's assurance that they will comply to hold enquiry in case of breach of guidelines cannot be taken at face value. The Union Territory has not provided any documents to show that the FPIS scheme is being implemented.

## **7. Gujarat**

The state of Gujarat made several claims of having a panel of qualified doctors, checklists being regularly filled in and uniform pro forma of consent forms being available in all districts throughout the state, yet the government failed to provide any evidence to substantiate their claims. The state claimed that there were 26 DQAC and one SQAC setup in State but no data provided to verify this information. The state, in its affidavit, did not mention any numbers of deaths of the person due to sterilization, list of number of incapacitated and those who were sterilized or action against errant doctors has been provided. The Gujarat Government's response only confirmed that the state did not adhere to the Ramakant Rai guidelines. It failed to implement FPIS and did not provide any information regarding compensations under the scheme.

## **8. Haryana**

State of Haryana in its response stated that the Ramakant Rai guidelines were being implemented. Some of the claims included having a panel of qualified doctors, proper filling of checklist before sterilization procedure, circulation uniform copies of the pro forma, setting up of Quality Assurance committees at both State and District level and maintaining of overall statistics. There was no documentary evidence provided by the state to substantiate the claim made by the Government of Haryana. The Government of Haryana did not provide any proof to show if there was any investigation against the doctors who breached guidelines or if the FPIS was implemented.

## **9. Jammu & Kashmir**

The state of Jammu & Kashmir did not provide any documentary evidence of implementation of guidelines of Ministry of Health and Family Welfare. The state stated that it was implementing Ramakant Rai guidelines such circulation of checklist to all the Chief Medical officers, setting up of Quality Assurance Committees at State and District level and maintaining the statistics as per the guidelines of MOHW Govt. of India. None of the claims made by the state of Jammu and Kashmir could be supported with documentary proof. Mere mentioning does not imply that the guidelines are being followed properly. It was highly unlikely that there was no case of breach of guidelines or incident with regard to sterilizations was reported. There was information provided by the state.

## **10. Kerala**

It claimed to have introduced the system panel of doctors and accredited hospitals as per GOI guidelines. However there was no evidence to support the statement. The state govt. also failed to provide any in depth information regarding implementation of Ramakant Rai guidelines, using uniform pro forma of consent or if QAC's were formed. The State of Kerala did not provided any evidence in showing real implementation of claims made. The state claimed to have maintained overall statistics and it is being reviewed at state, district and block level meetings but no evidence was given.

## **11. Maharashtra**

The state of Maharashtra stated in its response that the sterilization procedures were being carried out as per directives of the Hon'ble Supreme Court. There was no evidence provided regarding proper implementation of the Ramakant Rai guidelines. The State government despite its claims did not provide any evidence to prove if it circulated the checklist for sterilization procedures. The QAC was established at both State and District level however there was no evidence regarding meetings being regularly held to review quality of sterilization programme. There

was no data provided to corroborate claims made by the State government in their response. State claimed of maintaining the statistics of sterilizations carried out at respective institutions related to age, number of children etc. Information on number of deaths and failure of procedures was not produced before the Hon'ble Supreme Court. The state failed in providing any verifiable evidence to show that the state government is in reality implementing the directives of the Hon'ble Court.

## **12. Manipur**

The state in its affidavit claimed to have introduced a panel of doctors/gynecologist' with more than 20 years of experience. There has been no mention of the District Panel of doctors, no documentary evidence to show that State has implemented guideline, prepared and circulated the checklist, which every doctor before carrying out the procedure has to fill, there were no details provided regarding circulation of uniform copies of the pro forma. As per the affidavit submitted by state of Manipur, QAC are set up both in State and District. The government of Manipur has not furnished any tangible proof to corroborate their claims, maintaining the overall statistics of the sterilization carried out. Statistics have not been uploaded on the website. The State Government also stated that it would follow the guidelines of the Union of India. This clearly indicates that the directives of the Supreme Court were not being implemented. The State of Manipur did not have any data or supporting documents for their claims.

## **13. Mizoram**

The responses received from state of Mizoram were not very different. The State Government did not provide any proof to show that doctors have been empanelled as per guidelines. Merely mentioning that guidelines are being implemented is not sufficient. There was no data provided to substantiate the claim made by the Government of Mizoram. It was mentioned by the state that QAC cell has been "implemented". The government could not provide any evidence to show if they had complied with the guidelines. It was stated that the state had taken measures



to ensure that all records were being maintained. The affidavit failed to provide any information on number of deaths or failures of sterilization. The State Government of Mizoram has failed to provide any evidence to corroborate their claim of implementing the guidelines.

#### **14. West Bengal**

The state government of West Bengal made several claims like it had empanelled district wise qualified doctors for performing male and female sterilization as per Standards for Female and Male Sterilization Services, issued by Government of India on 2006. There was documentary proof of whether medical officers were filling up checklists before operation or if uniform copies of the proforma of consent were being maintained at the district level. The West Bengal Government stated that QACs had been established at the State and District Levels and that the state was maintaining statistics of the number of sterilization operation carried out, particulars of the procedure followed were recorded and maintained monthly through HMIS. The State Government did not provide any documentary evidence to verify their claim. The Government of West Bengal has failed to produce any evidence to show if cases of breach are being investigated.

#### **15. Nagaland**

As per the affidavit submitted by the state of Nagaland, it was yet to introduce a system of having an approved panel of doctors for carrying out sterilization procedures. Nagaland responses were in a single word "Yes" with no documentary evidence to show compliance with the Hon'ble Courts directions. The state government's response on circulation of uniform copies of the proforma of consent is not verifiable as they have failed to produce any data to show compliance. The government website [nrhmnagaland.in](http://nrhmnagaland.in) had expired and hence no uploaded data or information regarding QAC was available.

#### **16. Punjab**

The state of Punjab consented to implementing orders of the Hon'ble Supreme Court. It claimed to have constituted a panel

of doctors; assuring that checklists were being filled before sterilization and circulation of consent form for Sterilization operations as per Government of India guidelines. It also claimed to have set up QAC both in State and District as quality assurance manual dictates. There was no verifiable data provided to prove the claims of the government. In the absence of any evidence it was doubtful if the State was maintaining statistics of sterilizations. The State government failed to provide any evidence to show that Ramakant Rai guidelines were successfully implemented. The state claimed that the FPIS guidelines were implemented but there was no evidence to prove the same.

### **17. Rajasthan**

Rajasthan also claimed to have implemented the Ramakant Rai guidelines as per GOI norms. The state did not provide any documentary evidence of whether it circulated uniform copies of the pro forma of consent, data to verify their claims of compliance with the terms set out by the Hon'ble court. This state too did not provide any concrete document stating that overall statistics were being maintained giving a break-up of the number of the sterilization carried out, particulars of the procedure. The state also stated that there was no case of breach of guidelines. It is highly unlikely that no untoward incidents occurred in the state. With regards to implementation of Family Planning Indemnity Scheme, the State of Rajasthan provided no evidence to show that the scheme is being implemented or not.

### **18. Sikkim**

This state did not provide any documentary evidence related to implementation of GOI guidelines. It claimed to have constituted a panel of doctors, circulated uniform copies of forms and checklist being filled before sterilization procedure but there was supporting document to show if it was being carried out at ground level. The state of Sikkim also responded in one word "Yes". This does not establish conformity to the guidelines. The Government of Sikkim has failed to produce any evidence to show cases of breach are being investigated.

## 19. Uttar Pradesh

Uttar Pradesh claims that it has empanelled qualified doctors for providing sterilization services as per criteria given by the Union of India in sterilization manual and the empanelled doctors to carry out sterilization surgeries. There was no evidence provided to show that the guidelines were being adhered to. It asserted that the consent forms were being filled before sterilization procedures at the facility level. Though the Hon'ble Supreme court saw it fit to set the State's Consent form as the standard to be followed, there is no evidence to show continued implementation of the guidelines. Even though the state govt. claimed to have constituted QAC at the State and the District levels, the government failed to furnish any documents to corroborate their claims. The state did not submit the statistics for verification. Uttar Pradesh State Government did not provide any verifiable evidence to show if the guidelines were being followed. The statement from the state regarding implementation of FPIS seemed to convey that the process of implementation is still underway.

## 20. Tripura

The state government of Tripura too claimed to have implemented the guidelines of GOI. It however, did not provide any documentary evidence in support of its claims. The state in its responses merely mentioned to have a panel of doctors, prepared checklist, and circulated consent forms also in Bangla language, constituted QAC at state and district level. This does not necessarily mean that the guidelines are being followed. The State of Tripura has no data to show that the guideline is being implemented. A copy of annexure was not available for verification of claims made by the State Government. The state could not provide any proof of maintaining overall statistics on the sterilization operation conducted by the all-public and private health institution. The state also was unable to provide any information on conducting enquiries into cases of breach of union of India guidelines on male and & female sterilization by any doctor or organization. It was not clear from the affidavit provided by the state if FPIS was implemented. Hence the state stood in violation of orders of the Hon'ble Court.

## **21. Tamil Nadu**

The state of Tamil Nadu stated that a panel of doctors was prepared at state and district level and that only the empanelled doctors carry out the sterilization procedure. The state did not provide the names of the doctors for verification. The state also mentioned in the affidavit that it was made mandatory for all the doctors to fill out checklists before performing sterilization procedures. It claimed to have prepared and circulated the checklist and consent form however there was no documentary evidence. The government of Tamil Nadu was prompt in sharing regarding establishment of DQAC and SQAC and the implementation of the guidelines and that reports are being published regularly. The state maintains that all the information and periodical reports were sent to GOI regularly.

There was no periodical report that was annexed with the affidavit for verification. Though it is true the Hon'ble court ordered the FPIS scheme to be based on the model followed by the state, there were no documents provided to show the continued and effective implementation of the scheme.

## **22. Uttarakhand**

The state of Uttarakhand claimed in its affidavit that the state has implemented the guidelines by the Government of India. This included empanelment of qualified doctors to carry out sterilization operation to ensure the safety and standard, circulation to all districts a copy of checklist to be filled by every doctor before carrying out the sterilization, circulation of uniform copies of the pro forma of consent. However there was no evidence to verify any of the information provided. The State also claimed to have constituted the QAC at the State level. District level QAC has not been constituted and though on paper the State Quality Administration Committee existed, there was no proof furnished to verify its performance. It was mentioned in the affidavit that the state maintains overall statistic giving a break up of number of sterilization carried out and deaths of persons sterilized. The state failed to furnish status report mentioning the deaths caused by the method of procedures. The Government of Uttarakhand has

not given any proof to show that doctors who breach guidelines are being “obstructed”. The State Government of Uttarakhand failed to provide any evidence to corroborate their claim of implementing the guidelines.

### **23. Puducherry**

As per the information provided by UT of Puducherry, 150 doctors entitled to carry on sterilization procedures in the U.T. of Puducherry are empanelled in 44 accredited centers. There was no documentary evidence to verify the qualification of the 150 doctors empanelled. The state also claimed to be conducting pre-operative checkups as per the items included and the basic blood investigations for each person but no documentary evidence was presented. It claimed that it gets a written consent form in both English and local language. Though it is noted that the State is issuing the forms in the local language as well, it has still not furnished any substantial proof to verify its claims. QAC exists with a 9-member committee; information from the committee is provided but not verifiable. Puducherry stated that it was maintaining the overall statistics giving the breakup number/ procedures of sterilizations and number of persons incapacitated by sterilization programmes. The state did not provide any number of failures.

As stated in the affidavit, so far there was no case of breach of guidelines. Union Territory of Puducherry is following an insurance scheme as per FPIS guidelines. There was no evidence that was provided to show the scheme is being implemented as per the guidelines.

### **24. Arunachal Pradesh**

Arunachal Pradesh stated that it has a panel of doctors for conducting surgeries. The state also claimed to have implemented the guidelines. No documents were provided to verify names or number of doctors. The affidavit mentioned that the necessary steps such as circulation of checklist, proforma of consent were completed. However simply mentioning circulation does not suffice, no documentary evidence to show actual compliance

was submitted to the Supreme Court. A mere one word reply from the government of Arunachal Pradesh does not suffice to show that they are conforming to the guidelines laid down by this Hon'ble Court. The state in its response used one-word responses like "Compiled" and "Yes". There weren't any details regarding implementation of the guideline. The state government was unable to provide documents to its claim of maintaining overall statistics giving a break-up of the number of the sterilization carried out, particulars of the procedure followed. The State government further failed to provide any evidence to show if it has successfully implemented the guidelines. Though the State government has claimed it is following the norms related to implementation FPIS, no evidence to support their claim has been provided.

## **25. Andhra Pradesh**

The government has through its affidavit claimed to have empanelled the eligible doctors to carry out the sterilization operation to ensure the safety and standard. As per the direction of Government of India, Uniform medical records & case sheet for male/female sterilizations were printed and circulated to all the facilities, which are providing sterilization services. The State however did not provide any documentary evidence to show that the guideline is being implemented to its fullest extent. As per the information Quality Assurance Committees were set up at both State and District levels and audits have been conducted periodically, to assess quality of facilities, and number of deaths. No relevant documents have been furnished by the state to show either that the committees have been set up or any audits have been conducted. Separate register are maintained at the facility level and at the districts level to record in case of any death, failure and complication are followed by the sterilization. The state claimed that the Death Audit has been conducted at the facility level. The mere claim of a death audit being conducted is not enough to show any real implementation. The District Quality Assurance Committee is yet to review the report and make recommendation for corrective action. The state government also could not provide any information regarding implementation of FPIS.

## **26. Dadra & Nagar Haveli**

The Union Territory through its affidavit submitted that services of one doctor were being undertaken for conducting sterilization surgeries. The usage of the services of only one doctor is a clear violation of guideline by the government. It is compulsory for patients to undergo physical examination and blood test however no documentary evidence was submitted to prove this assertion. The pro forma of consent used was annexed in the affidavit. But the Union Territory did not provide any evidence to back their claim. It was merely mentioned that State Quality Assurance committee and Family Planning sub-committee have been formed and that the union territory maintains the overall statistics giving break-up of the number of the sterilization carried out. The reports are also provided to the Family Planning Division MoHFW, Govt. of India every quarter as stated in the affidavit. No report or statistics were submitted for verification of claims. From the statement in the affidavit it seemed to indicate that Dadra & Nagar Haveli has observed no breaches. Since the UT did not provide any evidence to support their statement, it could not be verified. The Union Territory has not provided any documents to show if Family Planning Indemnity Scheme is being implemented.

## **27. Chandigarh**

The government of Chandigarh had not constituted a panel of doctors as per the guidelines, which was a clear violation of the guidelines. It claimed that as per the directions of the Supreme Court checklists were circulated to all the delivery points. Issuing directions does not translate to implementation. It also stated that Quality Assurance Committee was already in place and the report regarding the same is forwarded to Govt. of India. The affidavit stated that procurement process has been initiated for new equipment. There was no report submitted corroborating the setting up of the Qualitative Assurance committee. The Union Territory did not even claim that the guideline is being implemented. There were no clear statements if the work has begun in implementing FPIS guidelines.

## **28. Chhattisgarh**

The state of Chhattisgarh claimed that it was following the guidelines of GOI. There was no evidence provided by the state for verification. Regarding preparing and circulation of compulsory checklists for doctors, the state claimed that directions have been implemented. The state did not feel the need to provide any documentary evidence to confirm the implementation. Regarding the proforma of consent, the State government claimed that a proforma was already in place but the pro forma mentioned in the guidelines shall be complied with further. The state government did not provide any documents to the petitioner for scrutiny. Its responses regarding implementation of guidelines and maintain overall statistics giving a break-up of the number of the sterilization carried out, particulars of the procedure followed were given in one word "Yes", Government of Chhattisgarh made no claim of implementation of the guidelines. The Government of Chhattisgarh did not give any proof to show that if any investigation was conducted against doctors who breached the guidelines. It is unclear from statements if State of Chhattisgarh was implementing guideline on Male and Female sterilization. Post Chhattisgarh sterilization massacre, the Chhattisgarh government filed "incomplete" affidavit over alleged botched up sterilization surgeries at Bilaspur district in which 13 persons lost their lives. The state did not file certain details like the number of FIRs filed, progress made in their investigation etc. are not submitted.

## **29. Himachal Pradesh**

The state of Himachal Pradesh stated that only approved and trained panel of doctors are carrying out the sterilization procedures. The list of panel of doctors was not on record for verification. It was also mentioned that checklist has been circulated to all the Chief Medical officers and these checklists are being maintained before performing sterilization operations at district level. Mere circulation does not amount to implementation of the guidelines. No relevant documents were annexed for verification. The State government failed to produce any evidence to support their claim of SQAC and DQAC meeting regularly, as per Govt. of India guidelines. The data was unavailable to support claim of State



government. Regarding the clause that the state has to maintain the statistics by giving a breakup of the number of sterilization carried out by different methods, the state failed to provide any documentary proof for the same. The Government of Himachal Pradesh also did not provide any evidence to show if cases of breach are being investigated. The State of Himachal Pradesh has provided no evidence to show if FPIS was being implemented.

### **30. Jharkhand**

The state claimed that directions to district and GOI Standard guidelines were disseminated. There was no documentary evidence of implementation. It also implied using one word response "circulated" that checklist has been circulated to all districts. A mere one word reply from the government of Jharkhand does not suffice to show that they are conforming to the guidelines laid down by this Hon'ble Court. It was mentioned that SQAC have been formed but no evidence was provided to verify claims made. As per the guidelines each state is to maintain overall statistics giving a break-up of the number of the sterilization carried out, particulars of the procedure followed. The state in its response did not share any records of failures or deaths by the procedure provided. Even though the state claimed that it "implemented" guideline so that cases of breach can be investigated but mere claim of implementation being conducted is not enough to show adherence to guidelines. There was no evidence provided regarding implementation of FPIS guidelines.

### **31. Karnataka**

The state of Karnataka stated that an approved panel of doctor is prepared at the district level; strict adherence to the criteria as laid down by the GOI regarding empanelment of doctors is followed. Any evidence for verification of implementation of guideline did not support this. The affidavit stated that a checklist for sterilization is maintained; proforma is circulated to all the centers conducting sterilization. There was no documentary evidence provided. The State of Karnataka has no data to show that this guideline is being implemented. SQAC were not formed. The state claimed

to have compiled a report but it was not made available. The facts claimed by the State of Karnataka in their Annexure were not verifiable. Statistics related to different methods of sterilization as well as demographic profile of the client is maintained at the facility level. The state maintains the actual number of different sterilization operations only not the statistics of how many deaths are caused following procedure. The claim of the Karnataka State government regarding implementation cannot be verified as no evidence has been provided to show any implementation. The mere mention of the word "implemented" cannot be accepted as proof of any actual implementation by the State.

### **32. Lakshadweep**

The state claimed that sterilization procedures were being performed by gynecologists in RGS agatti and by specialists (gynecologists) deputed to IGH by Ministry of health & Family Welfare. It also held that a panel could not be implemented in this U.T because shortage of specialists, sterilization procedures is being performed only after filing the checklist. The proforma of the consent is being followed by the Union Territory's administration. The Union Territory has not provided any evidence to back their claim. Quality Assurance Committee constituted, guidelines are strictly followed Information provided by the Union territory of Lakshadweep cannot be corroborated as no evidence has been provided. The affidavit maintained that statistics on sterilization procedures are maintained and monthly report is being sent to the ministry. The Report, which is claimed to have been sent to the Ministry, is not furnished. It was stated that no breach of guidelines came before the Quality Assurance Committee. The Union Territory did not provide, to the petitioner, any documents to verify their claim of compliance with this guideline. The Union Territory does not even claim that the FPIS scheme is in place, which is a clear violation of the order of this Hon'ble Court.

### **33. Madhya Pradesh**

The affidavit submitted by the state of Madhya Pradesh stated that empanelment of doctors approved by DQAC has been done at district level. But the state government did not provide

any detailed information to show empanelment. It was claimed that all the necessary steps such as circulation of checklist and that it was being filled by doctors diligently. Mere circulating a copy of the checklist does not prove that doctors use the same for all sterilization. The thumb impression/signature is taken of the client on the proforma after explaining the surgical procedures and implications. The Madhya Pradesh Government has provided no evidence to substantiate their claim of explaining the surgical procedure before taking the signature of the patients. The state claimed that SQAC and DQAC have been formed, however half yearly reports were not being submitted despite the claims that committees were fully functional. The State of Madhya Pradesh has furnished no documents to support their claims made in the annexure. As per the guidelines the state should maintain the statistics giving a breakup of the number of the sterilization according to the procedure. Madhya Pradesh failed to furnish concrete evidence about the statistics. In cases of breach the enquiries were pending. The State government has failed to provide any evidence to show that they have successfully implemented the guidelines.

### **34. Meghalaya**

This state did not provide documentary evidence related to implementation of GOI guidelines. The affidavit submitted stated that a district wise empanelled doctors lists were available as laid down in QA manual for sterilization. Names of the list of doctors not annexed. There was no documentary proof annexed that would confirm if the state government had taken any steps to prepare checklist, if these checklists were being filled up properly, if proforma of consent as per Quality Assurance Manual for sterilization is utilized. The Government of Meghalaya has not produced any evidence to substantiate their claims of following this guideline. SQAC and DQAC have been formulated, deaths, failures and complications not published. The state failed to provide documents to prove the compliance of the State of Meghalaya with the Ramakant Rai guidelines.

The affidavit did not mention any information or evidence to show that statistics are being maintained. The Government of

Meghalaya has not given any proof to show that doctors who breach guidelines are being “obstructed”. No evidence has been provided to show the Insurance Policy scheme is being implemented as per the guidelines.

### **35. Odisha**

The state government through its affidavit claimed to have constituted a district wise panel of doctors that carries out the sterilization in Odisha. The State government also stated that it has circulated uniform copies of the pro forma guidelines, prepared and circulated checklist for every doctor performing sterilization and directed them to fill them up mandatorily before such procedure. There was no documentary evidence provided with any of the claims made. Mere circulation and an affirmative response do not suffice as proof of the State's action on the guideline. No data has been provided to substantiate the claim made by the Government of Odisha. The state government did not provide any verifiable evidence to show if both District & State assurance Committee were constituted and were the functioning of the committees. No concrete evidence in support of the regular collection of information on number of persons sterilized, number of death cases during sterilization operations was provided. The State government has failed to provide any evidence to show if DQAC have successfully investigated all deaths relating to any breach of Union of India guidelines.

### **36. Telangana**

The state of Telangana in its affidavit stated to have complied by the orders of Supreme Court and implemented the guidelines. Government claimed to have taken steps like printing of uniform medical record and circulating it to all the facilities, which are providing sterilization services. The government has not provided any solid evidence to show effective implementation of this guideline. The QAC was set up at the State and District levels, but no data was provided to verify information provided by the State government. All the death, failure and complication arising out of the sterilization are audited by the districts level QAC. The audit reports are furnished to the state for taking necessary action

on the recommendations of the committee. No proper statistics was furnished in support of the statement. The death audit has been conducted by the DQAC and action is being taken against doctors who breach the guidelines.

The claim of the Telangana State government regarding implementation cannot be verified as no evidence has been provided to show any implementation. State mentioned to have extended the benefit of the scheme to all those affected and deserving under FPIS guidelines. The aforementioned Annexure has not been made available to the petitioner for verification of claim made by the State Government.

### **37. Daman & Diu**

It was stated that qualified gynecologists and general surgeons have been included in the panel and competent authority has approved the same. The government mentioned that the checklist is being filled up and maintained before carrying out sterilization procedure. The government in its response stated that informed consent is being taken prior to each sterilization procedure. The Union Territory has not provided any evidence to back their claims. There was no response from the state government regarding establishing a Quality Assurance Committee to ensure that guidelines are followed for pre-operative measures, operational facilities, and post-operative follow ups. Daman and Diu gave no response regarding maintenance of overall statistics of the number of the sterilization carried out and particulars of the procedure followed. The state government also maintained silence on issue of taking action in case of breach by doctors. The FPIS scheme was clearly not implemented till that time which was in violations of orders of this Hon'ble Court.

### **The Chhattisgarh Massacre**

The incident of sterilization massacre took place in Chhattisgarh on 8th & 10th November 2014. This was brought to the notice of Supreme Court with regard to the sterilization camps conducted in Bilaspur district. The report submitted showed that as many

as 137 women were subjected to a sterilization procedure and 13 of them died. Many others complained of problems such as vomiting, difficulty in breathing, severe pain etc. They were taken to nearby hospitals and discharged after necessary treatment. It appeared that some women who had not undergone a sterilization procedure also had similar complaints and some of them died thereby increasing the number of deaths to over 13. The State of Chhattisgarh was directed to submit sufficient particulars and details with regard to the action taken subsequent to the mishap in the sterilization camp including a copy of a sample FIR, post mortem report and charge sheet filed, if any. [Details of the incident and developments described in subsequent chapters]

### **SUBMISSION BY UNION OF INDIA**

The Ministry of Health and Family Welfare of the Government of India in its affidavit accepted that UOI received a complaint regarding sterilization camp on 7<sup>th</sup> January in Araria district of Bihar. A report received in this regard stated that Dr. Abhay Kumar Chowdhary, a contract physician (who conducted surgeries in sterilization camp) at the Primary Health Centre had been dismissed and it had further been ordered that he may not be employed for any government work in future. First Information Reports (FIRs) were lodged in respect to the events of 7<sup>th</sup> January 2012, investigations were concluded and charge sheets were been filed.

The affidavit filed by Union of India affidavit in relation to the implementation of the Family Planning Indemnity Scheme, 2013, claims that all States fully complied with the Hon'ble Supreme Court's order in Ramakant Rai and that an advisory was issued to all the states to adhere to the standard operating procedures. The Union of India in its affidavit stated that compensation scheme for Acceptors of Sterilization was revised on 31<sup>st</sup> October 2006 and improved with effect from 7<sup>th</sup> September 2007. It also stated that public health is a "State Subject" occurring in Entry 6 of List II of the Seventh Schedule of the Constitution. It highlighted that Government of India only provides support and facilitates in achieving health welfare schemes. Hence it is the State Government that can monitor the quality of services in

accordance with agreed benchmarks.

UOI further stated that large funds were approved and utilized (in lakhs) by the States under the Family Planning Indemnity Scheme 2013. In year 2013-14 a budget of 15.66.69 lakhs were approved with an expenditure of 675.59 lakhs. Similarly the year 2014-15 saw an expenditure of 828.19 lakhs by the end of 3<sup>rd</sup> quarter for an approved fund of 1485.80 lakhs. However, the Union of India's own expenditure data shows gaps in implementation of FPIS. Across the board, the states are not spending their full budget for FPIS.

State / UT	Particulars	Approval		Expenditure	
		2013-2014	2014-2015	2013-2014	2014-2015
Andaman and Nicobar	4 failure cases (3 rejected, one pending) compensation paid as per guidelines	5.00	4.80	0.00	0.00
Andhra Pradesh Arunachal Pradesh Assam and Bihar no information provided					
Chandigarh	In 2013- 14, death (not paid yet), four failures (paid Rs. 120, 000)	5.00	3.80	5.00	0.00
Chhattisgarh, Dadar and Nagar Haveli, Daman and Diu, Delhi no information provided					
Goa Gujarat	No death since 2010. 5 failures in 2013/14, 5 failures in 2014-15	5.00	0.00	5.00	1.20
Haryana	Amount approved under PIP in 2013-14 is 12.00 and expenditure incurred 25.30. In 2014-15 amount approved 16.50, 3.60 extended till December 14	52.50	50.00	25.86	44.30

Jammu and Kashmir Jharkhand Karnataka no information provided					
Karnataka		65	65	63.00	21.82
Kerala Lakshadweep MP Maharashtra Manipur Meghalaya Mizoram no information provided					
Nagaland	State is yet to introduce a system of having and approved panel of doctors for sterilization				
Orissa no information provided					
Puducherry	Q AC latest six monthly report no death or complications	5.00	5.00	4.50	0.00
Punjab no information provided					
Rajasthan Sikkim	For 2013-14, paid for 1367/ 1495 failure. For 2014/15, paid for 1 /3 complications and 1499/ 1626 failure				
Tamil Nadu	For 2013-14, out of 462 claims (failure) received 270 paid, 38 rejected and 154 returned for want of required documents. For 26 deaths claims received, 21 paid 2 lakh, 4 paid 50000 and one rejected. Funds passed to victims is rupees 132 20 000, balance left is 694 000. For 2014-15 claim preceded for 18 deaths and 214 failure	139.14	142.97	27.0	123.25
Telangana, Tripura, Uttar Pradesh, West Bengal information not provided.					



Union of India in its affidavit refrained from providing appropriate explanation regarding the audit of disbursement of the amounts and simply mentioned that the States and the Union Territories are required to follow the financial management system and submit statutory audit reports, utilization certificates, quarterly summary on concurrent audits etc. It failed to provide any evidence to prove if any of it was being adhered to. It was not clear from the affidavits if the organisations involved in sterilization had proper accounts, whether sanctioning authority and audit including the Comptroller and Auditor General of India had ever inspected accounts of any of these organisations.

As an interim measure the Hon'ble Supreme Court directed the Secretary in the Ministry of Health and Family Welfare, Government of India to hold a meeting with his counterparts in the States and Union Territories to arrive at a consensus on the effective implementation of the various schemes relating to sterilization, Family Indemnity Scheme (2013) and the directions given by this Court in Ramakant Rai Vs. Union of India. The Supreme Court directed the State for payments to be made to the victims under Family Planning Indemnity Scheme. Later, the Court ordered for bi-monthly high-level meetings with the states to inform of guidelines of the Government of India and the policy decisions that get modified from time to time. It also ordered for the state to implement the decisions taken in the meeting in the Ministry of Health and Family Welfare on 15<sup>th</sup> May, 2015. The key decisions taken during the meeting were:

- Sterilization services must be provided in a client friendly manner and in a safe environment after taking informed consent. Safety of those who opt for it should be ensured.
- A mechanism should be put in place wherein service providers or managers are not victimized or arrested without instituting a proper enquiry by the district/State quality assurance committees.
- All States to conduct workshops on quality in sterilization services orienting its programme managers and service providers both at the State and district level on the updated

manuals on standards, male and female sterilization and family planning indemnity scheme.

- All Government of India guidelines to be strictly adhered by the states.
- A periodic assessment of all the facilities and fixed day camps by 1-2 members of the sub-committees under the State Quality Assurance Committee/District Quality Assurance Committee on implementation of the infection prevention protocols as well as the efficacy of the services provided, should be carried out (as laid down in the Manuals).
- The issue of shortage of pool of providers for sterilization could be addressed by resorting to compulsory training of MBBS medical officers when they join government services.
- Onsite Training/mentoring be initiated by identifying high caseload facilities (first) to undertake sterilization trainings. This will ensure the service provider is available at the facility to undertake their primary task of providing services to the clients in addition to provide training to prospective trainees.
- Retraining of providers who are either short on confidence or have high failure rates.
- There should be more thrust on Minilap Sterilization as it leads to fewer failures and complications.
- The scope of increasing the basket of contraceptive choices like injectables/implants and weekly pills like 'Saheli' be explored urgently to provide more choice.
- The idea of mobile teams or clinical outreach teams needs to be encouraged to address the issue of shortage of surgeons.
- Every case of sterilization death must be audited as per format lay down and reported to the Government of India.
- Line listing of deaths and failures to be undertaken district/facility wise and surgeon wise. Disbursal of claims for deaths, failures and complications should be computerized.

- To address the issue of sterilization failures, sterilization certificates should be issued after at least one month in case of female sterilization and after three months in case of male sterilization.
- States to take urgent steps to rejuvenate the Family Planning Programme with the ultimate aim of reducing the maternal and infant mortality and morbidity in addition to achieving population stabilization.
- Government of India to conduct high level meeting like the instant one with all States to acquaint them with the latest policies and programmes of the Government of India on a yearly basis.

In compliance with directions of the Hon'ble Court, another meeting was held under the chairmanship of Additional Secretary & Mission Director (HFW) as officer-in-charge during the period of leave of Secretary (HFW), with Principal Secretaries (HFW), Mission Directors (NHM), Directors (Family Welfare) and others of all states/UTs on 17th November 2015 through video conferencing at Nirman Bhawan, New Delhi. Representatives of all states and Union Territories of India participated in the meeting. Uttar Pradesh could not attend due to a state holiday and on account of the state National Informatics Centre (NIC) office being closed. The following key priority areas were shared with the State Governments and Union Territories:

- Uniform consent forms should be available in all facilities, which should be duly filled in, and the consent of the client should be taken prior to the procedure in all cases.
- State Quality Assurance Committee (SQAC)/District Quality Assurance Committee (DQAC) and State Indemnity Sub Committee (SISC)/District Indemnity Sub Committee (DISC) to be constituted as per the GOI guidelines.
- All the Family Planning guidelines should be printed and disseminated at the State/district as well as facility level.
- State/District level orientation of all the programme

managers and providers for the guidelines and protocols to be completed in all States.

- Members of SQAC and DQAC should conduct periodic supportive supervision visits as per quality protocols. The findings of the same are to be documented and corrective actions should be taken.
- Training calendar for training newly recruited doctors is to be prepared and updated in each State.
- Line listing of all the sterilization providers needs to be prepared and periodically updated by all States.
- Every death attributable to sterilization should be audited.
- Sterilization certificates should be issued as per existing guidelines.

Since the State of Uttar Pradesh was not present for the high level meeting, it suggests that responsible officers in the State of Uttar Pradesh seem to give more importance to State holidays rather than issues relating to Family Planning.

A National Summit on Family Planning was held on 5th and 6th April 2016. The Government in addition to the new guidelines proposed to be undertaken proposed the following practical and pragmatic measures:

1. Conducting annual review workshops of the programme in all States of India with the State and district programme managers and service providers.
2. Monthly monitoring of at least 2 public health facilities and 1 accredited private/NGO facility by SQAC/DQAC.
3. Replacement of operational 'Camps' by regular 'Fixed day services' over the next three years.
4. Further Strengthening of the State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) mechanism.

5. Close monitoring, reviewing and collection of reports of deaths attributable to sterilization by the Government of India.
6. Conducting Client exit interviews of 10% cases as per the prepared checklist.
7. Feedback from beneficiaries by Maternal and Child Health Tracking Facilitation Centre (MCTFC).

UOI informed the Supreme Court that states of Tamil Nadu, Maharashtra, Sikkim, Goa and also Chhattisgarh have already phased out the holding of sterilization camps. Hence it proposed to phase out camp approach over a period of next three years. Union of India also claimed to have taken several measures for improvement in the Family Planning programme and sterilization procedures. Such as:

1. Decline in deaths following sterilization from 140 in 2014-15 to 89 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
2. Decline in the number of failures from 5928 in 2014-15 to 2093 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
3. The empanelled list of providers is available in every district;
4. Surgeons are not performing more than 30 cases per day;
5. Camps are being held only in public health facilities or accredited private/NGO facilities.
6. Workshops relating to Family Planning programme have been held in 28 out of 29 States (as on 21<sup>st</sup> July 2016). Unfortunately, no such workshops were held after 24<sup>th</sup> August 2015.
7. The number of deaths attributable to sterilization procedures in 2014-2015 was 140 but it has come down in 2015-2016 to 113.
8. In 2015-2016 clients exit interviews have been conducted in respect of 1,06,055 persons.

9. Monitoring and supervision of facilities by SQAC/DQAC in 2015-2016 in regard to public facilities is as high as 12,044 and with regard to private accredited facilities it is as high as 2,984.
10. The amount allotted for quality improvement which includes training, family planning equipment, other service delivery activities, human resource cost, infrastructure share, planning and monitoring (including quality assurance) and family planning commodities is as follows:

Year	2013-14	2014-15	2015-16
Amount in Crores	1000.7	1648.07	1243.9

11. The Ministry of Health and Family Welfare of the Government of India reiterated that it has constantly been working and taken adequate steps for improvement and success of the Family Planning programme. It stated that over the years considerable amount of work has been done and is still being done particularly in sterilization procedures in public and private health facilities. While deficiencies and faults have been pointed out, there has also been considerable improvement in an ongoing exercise of national importance.

### SUBMISSION BY STATE OF BIHAR

The State of Bihar filed two affidavits- a Status Report and Written Submissions. The state also accepted all the allegations made by Devika Biswas regarding fundamental rights violation at sterilization camps and accepted that Jai Ambey Welfare Society (NGO) conducted a sterilization camp on 7th January 2012. The state agreed that the camp was held late in the evening, which stands in violation of the orders of the concerned Civil Surgeon. An FIR was lodged against the NGO for violating the directives and distributing expired medicine to the women who had been brought to the camp for the purpose of sterilizing. A Charge Sheet has been filed in this regard and cognizance of this offence has also been taken by the Trial Court, but the details are not available on record.

Kumar Nath Choudhary, Secretary of Jai Ambey Welfare Society (respondent No.4) confirmed through an affidavit filed on 14<sup>th</sup>

January 2013, that Jai Ambe Society (NGO) has been blacklisted and that appropriate steps were being taken to compensate women who had developed complications during the surgeries. Two charge sheets were filed in this regard - Kursakanta P.S. Case No.03/2012 and Case No.05/2012. Three FIRs were also lodged against the NGO, namely:

1. Kursakanta P.S. Case No.03/2012: Charge Sheet bearing No. 23 of 2012 dated 09.03.2012 and supplementary Charge Sheet No. 167 of 2012 dated 31.12.2012 have been submitted. Cognizance of the offence has been taken and thereafter Revision Application No. 44/369/12 has apparently been filed by the accused persons and that is pending in the District Court in Araria
2. Kursakanta P.S. Case No.05/2012: Charge Sheet No. 24 of 2012 dated 12.03.2012 and supplementary Charge Sheet No. 87 of 2013 have been submitted. Cognizance of the offence has been taken on 28.06.2012 and a Revision Petition has apparently been filed by the accused bearing No. 31/226/13 which is pending in the District Court in Araria.
3. Kursakanta P.S. Case No.14/2012: No details were provided which is a matter of concern.

The affidavit also stated that after the completion of inquiries by the state of Bihar into the events that took place on 7th January 2012, a show cause notice was issued to the Medical Officer in charge in the Primary Health Centre in Bausa, Purnia, Kursakanta, Araria and also to the Civil Surgeon, Purnia.

### **SUBMISSION BY STATE OF MAHARASHTRA**

The State of Maharashtra, filed only one affidavit 14th August 2012. In its submission, it stated that the family planning programme is being conducted effectively. On the contrary Devika Biswas and other health groups submitted ample evidence to dispute this assertion. Women continue to experience fundamental rights violation at sterilization camps in India every day. This was proved by incidents that took place in sterilization camps that were held in Nagpur, Chandrapur and Gadchiroli districts, the

state had asked for a detailed from the Civil Surgeon, Gadchiroli, Chandrapur and Nagpur District.

The counsel for the petitioner submitted a report on condition of women in sterilization camps in Maharashtra highlighting that sterilization camps are routinely conducted in unsanitary and unsafe facilities where patients do not have complete pre-operative counselling in Nagpur, Chandrapur and Gadchiroli districts. The state of Maharashtra in its affidavit claimed to have take immediate corrective action and instructions were issued to all the District Health Officers and Civil Surgeons to perform the family planning operations as per the standards prescribed by Govt. of India in hygienic conditions.

The state of Maharashtra did not provide any evidence detailed report with the affidavit and also failed to provide details of any action taken against any officer responsible for the mishap or any compensation paid or any further action taken in this regard.

### **SUBMISSION BY STATE OF RAJASTHAN**

In response to the report and violations highlighted in the report by Manjari and Centre for Health and Social Justice, the State of Rajasthan filed an affidavit on 23rd November 2012. It did not contradict the events relating to the sterilization procedures carried out in Bundi district. The state in its affidavit affirmed that the standard operating procedures are being followed and that the failure rate is in conformity with the failure rate prescribed by the Government of India.

Despite the testimonies of several women that were recorded and findings based on interviews conducted with 749 women (who were sterilized) the State of Rajasthan stated that the women were properly instructed before operation and advised with respect to both the sterilization as well as post-sterilization care. The State further mentions that continuous efforts are made by the health employees "to motivate females to take up sterilization surgery". The State also submitted that it was taking sufficient steps to ensure implementation of the directions in Ramakant Rai (I) as well as the guidelines of the Government of India.



## SUBMISSION BY STATE OF CHHATTISGARH

The State of Chhattisgarh confirmed that sterilization camps were organized in Sakri village of Bilaspur district on 8th November 2014 and in Gorela, Pendra and Marwahi in Bilaspur district on 10th November 2014. There were 137 operations that were carried out after which several women ended up with severe health complications. Consequently, all of them were admitted in nearby hospitals for treatment. Unfortunately, 13 women died. Apart 137, five more people had died due to consumption of Ciprocin 500 tablet. Hence bring the total number of death to 18.

Departmental action for medical negligence was taken against the doctors who were involved in sterilization surgeries at the camp. Two of them have been dismissed from service while two others have been suspended pending a departmental enquiry. The Licensing Authority has also been suspended. The state government claimed that Rs. 4 lakhs compensation was given to the families of those who died and Rs. 50,000/- was given to those who were discharged from medical institutions. As claimed by the state government, the children of the deceased have been adopted by the State Government. These children would be provided free education and health care till they are 18 years of age. The State Government has also put in an amount of Rs. three lakh in a fixed deposit for children of the persons who died in the tragedy. The children would be entitled to the amount on attaining the age of 18 years.

The state submitted that a one person Judicial Commission of Inquiry headed by a retired District Judge Ms. Anita Jha was set up. This commission probe into the casualty of 13 women in government-run sterilization camps in Chhattisgarh's Bilaspur district and cited the administration of substandard poisonous drugs and medical negligence as the causes of death. The report given by the Ms. Anita Jha Commission has been accepted by the State Government on 10th August 2015. The report was likely to be considered by the State Cabinet within two weeks of its submission.

A charge sheet No.19/2015 dated 15th February 2015 has been filed in the Court of Judicial Magistrate, First Class at Bilaspur against Dr. R.K. Gupta, Ramesh Mahawar, Sumit Mahawar (manufacturers

of Ciprocin 500 tablets), Rajesh Khare, Rakesh Khare and Manish Khare (suppliers of Ciprocin 500 tablets). Rakesh Khare and Manish Khare have since been declared proclaimed offenders and their property attached and a reward for their arrest and information of their whereabouts has also been announced.

In order to prevent the recurrence of such an incident, Chhattisgarh has phased out sterilization camps and begun placing greater emphasis on spacing measures. The state also encouraged vasectomy for gender equity. An advisory has been issued that Ciprocin 500 should not be consumed and efforts are being made to educate people about the importance, benefits, methods and availability of services in health facilities. A mass awareness campaign has also been launched and several other proactive measures have been taken. The State of Chhattisgarh has reacted positively to the tragedy and has not sought to hide inconvenient facts under the carpet.

### **SUBMISSION BY STATE OF KERALA**

The State of Kerala in its affidavit stated that has filed a 'Statement of Facts' through a letter dated 15th March 2013. As per the letter, camps in Kerala were conducted only in well-equipped centres (usually in first referral units and above hospitals), which comprised of proper operation theatre facility, lab facility, and referral facility. The state further stated that sterilization procedures are carried out in hygienic, well equipped hospitals under the control and supervision of qualified empanelled doctors.

As per the affidavit filed by State of Kerala on 1st July 2013, it reiterated that:

“[The] tribal population of Kerala State is accorded special consideration for its dealing members. There is no compulsion of promotion of sterilization as part of Government policy. At the same time family planning services are not denied to this segment of the population if demanded. Felt need of the community is assessed by the Health Worker and various options are put before them explaining the merits and demerits of each method and encouraging making right choice.”

The Statement of Facts could not be put on record because there was no evidence provided and it was not annexed with the affidavit. The state also did not deny any of the submissions that were made in the PIL filed by Devika Biswas.

### **SUBMISSION BY STATE OF MADHYA PRADESH**

The State of Madhya Pradesh filed only one affidavit on 7th August 2013. The state did not deny any allegations made by Devika Biswas. The state in its affidavit stated that sterilization operations were carried out only after women made an informed choice and gave consent. The State further submitted that the state Government has issued instructions for taking due precautions for sterilization operations. The State Government has formed Quality Assurance Committee in each District of the State, which is headed by the Chief Medical, and Health Officer of the district. The function of the Quality Assurance Committee was to review all types of cases where there is some complication and take necessary steps to rectify the same. Yet, the state did not deny any events in Balaghat district.

### **DEVIKA BISWAS SUBMISSION**

Devika Biswas has pointed out that the entire Family Planning Programme focuses on female sterilization, as was highlighted in affidavits filed. Targets are set by the state for female sterilization and the National Health Mission Project Implementation Plan allocates 85% of the family planning budget exclusively to female sterilization. As per the statistics provided by the Ministry of Health and Family Welfare of the Government of India, 97.4% of all sterilization procedures during 2012-13 were of women. This has gone up to 98.1% for 2014-15. The affidavits filed by States like Madhya Pradesh, Andhra Pradesh and Goa confirmed the allegations made by Devika Biswas. What was equally worrisome in the fact submitted by states was that number of men seeking sterilization is very low.

As per the data released by the Ministry of Health and Family Welfare during the period 2010-13, at least 363 people have died as a result of sterilization procedures. There are equally a

large number of procedures that have failed and surgeries that have led to severe complications with respect to persons who underwent a sterilization procedure. This has resulted in payment of compensation of at least Rs. 50 crores.

Lack of proper implementation of the various processes and guidelines issued by the Government of India has led to deaths of women across the country. Hence mere issuance of guidelines by the Government of India does not guarantee their implementation. It was also pointed out that despite the Hon'ble Supreme Court's order, the list of empanelled doctors still is not readily available; consent forms are not available in the local language except in the Union Territory of Puducherry; unrealistic targets and pressure from the authorities for contraceptive with a heavy focus on female sterilization has resulted in non-consensual and forced sterilizations. Some young persons have been sterilized to meet targets and by and large illiterate persons are sterilized. Devika Biswas is opposed to setting of targets, but unfortunately State Governments and Union Territories are still setting informal targets for sterilization.

The Quality Assurance Committees (QACs) at the State and the District Quality Assurance Committees (DQAC) levels needs to be strengthened to ensure that the standards for female and male sterilization as laid down by the Government of India are being followed in respect of preoperative measures, operational facilities and post-operative follows ups and are monitored by the Quality Assurance Committees formed at the State level under the Chairmanship of the Principal Director and the District Collector at the District level. Devika Biswas pointed out that the vital information is not available on the website of the Ministry of Health and Family Welfare. This included the details of the constitution of QACs and DQACs, the steps and decisions taken or the minutes of their meetings or reports submitted by them. Hence it is of utmost importance that there is transparency regarding existing institutions effectively and efficiently functioning.

Inadequate monitoring mechanism of sterilization camps and facilities was proved through incidents that were brought forth during the hearing. Essential standards as prescribed for the

services were compromised and there was no monitoring done in the sterilization camps and health centres, to ensure quality services. In all the camps accountability measures were not found to be in place and the rights of thousands of women who undergo sterilization procedures were violated. It is not enough for the Government of India to show that it is merely playing a supportive and facilitative role since the campaign is a national campaign and if it is not properly implemented, it merely leads to passing the buck with the State Government blaming the Government of India and vice versa.

With sensitive operations such as a sterilization procedure, it is important for there to be some form of accountability against those who are responsible for providing these health care services. It is unclear even after submissions if disbursements in case of death, failure, complication etc. are made available anywhere. There is no indication of the number of claims filed, the number of claims rejected and the reasons for the rejection and the amount provided to each successful claimant. It is observed that specialists who are conversant with the Scheme are not available at sterilization camps and health centres to explain the Scheme in detail so that there is no difficulty or complication faced in the event of an unfortunate mishap. The death audits are completely missing in every instance even though it is a requirement under the scheme.

In most of the camps it was observed that people seeking sterilization have not been guided or provided with correct information that has led to lack of awareness amongst women about the procedure. In fact, all information that is disseminated with regard to the sterilization procedure should be made available in the local language at all Government health facilities and accredited private facilities.

The petition encouraged the Government of India to look at the quality of care made available to persons post a sterilization procedure. As is clear from various documents on record including the Ms. Anita Jha Commission Report, after-care facilities in terms of counselling, assistance, follow-up etc. are totally absent.



## CHHATTISGARH MASSACRE

“Chaiti Bai, a Baiga — a protected tribe was sick with jaundice and the mitanin told her that she could go to the Community Health Center for treatment. The mitanin never mentioned sterilization or family planning. Chaiti Bai died after operation. She was just

22 years old and a mother of two children.”

The major fallacies of the sterilization programme of India are revealed through the Chhattisgarh sterilization massacre that shook the entire state and incited nationwide protests against the family planning programme of India.

The mass sterilization camp in Chhattisgarh in November 2014 resulted in tragic deaths of the 13 women who were in their 20s and 30s. While 13 died, more than 70 women were left in critical condition following procedures of laparoscopic sterilization. They had to be hospitalized at Apollo Hospital, Bilaspur. This incident was one that raised grave questions once again about the callous treatment given to women, as well as the clear violations of ethical and quality norms in the healthcare system. In several interviews with the women and their family members, they shared never ending tales of unsafe, unhygienic conditions at the camp and the careless way the sterilizations were conducted resulting in deaths and morbidities among the women.

On 08.11.2014, a single doctor performed sterilization surgeries on 83 women in Nemi Chand Trust Private Hospital in Sakri town (Takhatpur District). It was an abandoned private charitable Hospital and Research Centre located 6 kilometers from Bilaspur city. The hospital had been shut hence it was not cleaned for long and was stinking. There were no plans, initially to conduct camp at Sakri however it was deliberately changed because it was easier to bring more women for operation in this area. Similar camps

were organised on 10.11.2014 in PHC/CHC at Gorela, Pendra and Marwah blocks, Chhattisgarh where inhumane sterilizations continued with reckless disregard for the lives of poor women. Nearly 140 women were brought to these camps for sterilization. The largest of these camps for 83 women was conducted within a short span of 3-4 hours.

This unnecessary loss of life took place as the Government of Chhattisgarh, in order to fulfill the 'numbers' in this target-driven initiative of curbing population, provided incentives to the poor families to make their women undergo sterilization procedures. As it has been reported, none of the women had ever been counseled about sterilization. They were not made to understand what would happen before, during, and after the surgery, its side effects, and potential complications. They did not know anything about the consent forms that they were made to sign on. The women after going through surgeries, done using the same laparoscope, were made to lie on dirty mattresses placed on the floor. Some reports have stated that women were paid for the operation. However, they have differed on how much each one was paid with some saying the amount was Rs. 1400/-, while others have said it was Rs. 600/-.

As per the Anita Jha Commission's Report, evidence from the victims and their families, CMHO, BMO, civil society groups have clearly revealed the violations of the guidelines laid down by the Hon'ble Supreme Court in Ramakant Rai vs. Union of India & Ors. and guidelines laid down by Ministry of Health and Family Welfare in Standard Operating Procedure for Sterilization Services (2006, 2008) leading to the death of 13 women, and serious illness of many more.

It should also be noted that the women who were selected were not selected at random. The very basis of the Indian society which is defined by discrimination at all levels can also be seen in the women who were forced to go through this procedure, only to be added to the numbers of this target driven programme. Amongst the women who died many belonged to the Dalit, Adivasi/Tribal and OBC (Other Backward Classes) communities. Most of the families were landless and their main source of income was daily-

wage work. Many women who lost their lives had up to three children. Some of them, with infants as small as three months old, had undergone the sterilization surgeries. A woman from Baiga Protected Tribal Community was brought to the camp on pretext of treatment for weakness but was sterilized instead. She like the other women was operated upon and left on mattress unconscious. The woman died leaving behind small children.

The Chhattisgarh Government attempted to wash off its responsibility for the deaths of the poor women who were killed. It stated that, “the emerging evidence shows that the immediate cause of the deaths could be either polluted drugs or sepsis from rusty or infected instruments used during the surgery. The drugs administered apparently showed traces of toxic substances.” The sterilization camps in the Health Minister, Amar Agarwal's own constituency (one of them a short distance from his own home) had abysmal standards of basic hygiene. It was found that the Operations were done on the floor, with lack of proper amenities women were piled on to beds, rusty and infected instruments were used. The doctor (since arrested) performed 83 operations in 5 hours. The State Government must squarely accept responsibility for the target-driven and incentive-driven approach.

With pressure building up from the media and women's rights group, the then Chief Minister of Chhattisgarh, Raman Singh stated that it was a serious matter of negligence and that it was unfortunate. Further, when the attempts to cover up the gross mismanagement of the sterilization camp, completely failed the surgeon, who had been previously honored by the State Government for the ‘ distinction’ of conducting the ‘ maximum number of sterilizations’, Dr R. K. Gupta was suspended on the charges of negligence. He along with a doctor who had no training or experience had performed the ill- fated procedure, which resulted in the death of thirteen women.

There were also reports of the women having fallen ill after consuming Ciprofloxacin tablets that were provided to them following the surgeries at the Camp. State officials initially said that they believed that the women had contracted infections because of the poor conditions in the camp. It was also suspected



that the Ciprofloxacin tablets given to the women post-surgery were contaminated with zinc phosphide, a rat poison. The Police detained Ramesh Mahawar and Sumit Mahawar – father and son, who run Mahawar Pharmaceuticals Pvt. Ltd.; a Chhattisgarh based Pharmaceuticals Company, which supplied the Ciprofloxacin. While the postmortem reports have been kept under wraps, it is widely believed that the cause of death was due to septicemia.

The camps were in contempt of two of Supreme Court orders in the matters of Ramakant Rai vs Govt. of India, 2005, and “Devika Biswas Vs Govt. of India, 2012” where SC ordered restrictions on sterilization procedures. The cases mandate that “a maximum of 30 operations can be conducted in one day, with two different surgeries only in a government controlled facility.” In addition, “one doctor cannot conduct more than 10 sterilizations in a day. “Despite this, Dr. Gupta performed 83 surgeries in about 5 hours, a clear violation that apparently was not out of the norm.

Reports of doctors performing over the acceptable number of surgeries in a day abound:

Health workers in Gujarat told Human Rights Watch that between 40 and 150 women are sterilized in weekly camps in their district. Dr. Abhijit Das from the Centre for Health and Social Justice, a leading Delhi-based health rights organization, told Human Rights Watch that he found at least one gynecologist in Madhya Pradesh state conducting 250 to 300 sterilizations on some days.

In one state, a study found that the state's approach to female sterilization forced doctors in the public hospital to commit so much staff time to sterilization camps that other basic reproductive health care suffered. A civil society team that investigated maternal deaths in Barwani district of Madhya Pradesh state found that the senior gynecologist from the district hospital was absent four days in a week, performing sterilizations in camps.

Police reported that the location of the procedures was dirty and with the speed of the operations, there was certainly not enough time to change bloody sheets. The cleanliness of the instruments is questionable at best. Dr. Gupta was quoted saying, “they are dipped in spirit after an operation and then reused. If I feel it is not working well I change it. I do about 10 operations with the same knife. Towel clips are also reused after being dipped in spirit.” Dr. Gupta also said the dirty conditions of the abandoned hospital were “normal”, sparking serious concern for conditions around India.

Additionally, post-operative procedures were not followed, as the women received virtually no follow-up care, as is reportedly the routine for sterilization procedures in practice across the country. A doctor caring for the women with complications reported, “They discharged them immediately”. If they had visited these women after the operation, the tragedy could have been averted. The patients came on their own only after their relatives realized that they had become serious.

It should be noted that the incentives which are provided by the state, encourages, and often even forces doctors into committing these gross violations of court orders, regulations, and human rights. The state of Chhattisgarh claimed that the tainted drugs resulted in the women’s deaths. However, many prominent forensic experts, doctors, and activists have articulated the drug story in a red herring, meant to distract from crucial shortcomings in health services delivery, gross neglect for hygiene and infection prevention, and rampant undignified treatment. These abusive camps continue undeterred without meaning accountability measures from the Supreme Court.

The drugs cannot be solely responsible for the women’s deaths. First, as forensic expert stated in the Population Foundation of India report, an adult human would have to take a very large quantity of rat poison to actually die. The report stated:

“Further according to forensic medicine and toxicology expert an adult male need to consume 5 gm of zinc phosphide to die. For average adult women this would be 4.5 gm. This if consumed

in one go or slowly over a period where buy it get deposited in the body. The contaminated medicines were of 500 mg of the antibiotic. Even though it is impossible but for the sake of argument if we assume that the entire 500mg was zinc phosphide a woman would need to consume a minimum of 9 tablet to make the poison fatal, which was not the case with the women who died. So it is completely that zinc phosphide in the medicines could not have been the major cause of these death, even if we accept that they could have been one of the causes."

The Down to Earth article explains that soon after the incident, drug samples from the spot were sent to 4 Laboratories- Government and private- to determine the cause of deaths and illness. The list includes the Central Drug Laboratory, Kolkata; The National Institute of Immunology, Delhi; Sriram Institute of Industrial Research, Delhi; and Qualichem Laboratories, Nagpur. All four laboratory reports stated that the medicines used in operations were substandard.

Down to Earth reports, "The National Institute of Immunology, Delhi shows that after administering very high dose of the cross in 500 (500 mg/ facts, or the same dosage given to adult humans) the animal suffered from acute toxic shock and died. A public health expert on condition of anonymity says such high doses can be fatal for animals. It was pointed out that the women at the camp did not consume such high doses.

The state also tested viscera or organs of 5 of the deceased women and found no rat poison in their bodies. Forensic expert at Lady Hardinge Medical College Delhi, B L Chaudhary told Down To Earth, "viscera report is the final word in forensic science in investigations of death. The state forensic laboratory reports suggest the deaths occurred due to infection caused by unhygienic conditions and medical practices at the camp". Interestingly, the government did not send viscera sample for the women whose postmortem report lists "shock due to septicemia" as the cause of death. Septicemia is a blood infection caused by unhygienic operating conditions.

Moreover if a large batch of basic antibiotic was so contaminated as to cause death, many more women at the camp would have died and many more people in the area would have suffered. Moreover poor quality drugs do not count for the death of Chaiti by who died after undergoing sterilization at a similar mass camp on 10th November 2014 days after the major camp.

In April 2015 the Collision against Coercive the Population Policy and the National Alliance for Maternal Health and Human Rights organised a campaign to document the reality at the Camp post Chhattisgarh. The teams observed 6 camps where a total of 59 women underwent sterilization in Uttar Pradesh from January to March 2015. The report highlights the following major findings:

1. None of the women received discharge slip or sterilization certificate
2. None of the women received counselling about Side Effects associated with sterilization
3. None of the women received information about the family planning indemnity scheme
4. In all camp Healthcare workers failed to read the contents of the consent form
5. None of the women received slips or reports regarding the medical test they underwent
6. In the camps doctors used just 2 Level scopes to operate on more than 30 women (sop requires three laparoscopes)
7. Two camps continued after 4 p.m. in violation of sop
8. Unhygienic conditions at Street dogs at the camp
9. No attention to post surgery care

At Karvi Public Health Centre the operation took place in the delivery room even though the facility does have a separate operation theatre. The medical professional completely disregarded the women's dignity and privacy other people Walked in and out of the room during surgery and deliveries continued side by side

sterilization surgeries. The facility did not have a recovery space; “after the operation women lay down on the verandah on red colour thick clothes.” The stray dogs roamed freely.

At the Pahari Community Health Centre camp 35 women underwent sterilization. None of the women received counselling and Information about the family planning indemnity scheme. The operation theatre was not hygienic and the doctor operated on three women simultaneously. After the surgery no Hospital staff came to check on the women's status.

The violations in Chhattisgarh never would have come to light have so many women not died at once, drawing attention to the incident. It is important to note, however, that this was not a one-time, unusual event. Conditions for sterilization and implementation of sterilization initiatives across India are laced with danger, which is disproportionately targeted at poor women.

### **THE JUDICIAL COMMISSION REPORT- MS. ANITA JHA**

Post Chhattisgarh sterilization massacre, the State Government constituted single-member commission to probe the deaths of 13 women following the sterilization surgeries Bilaspur district that has stated that “serious negligence” and use of “substandard” and “poison-laced” medicines led to the tragic incident.

The enquiry by the state government on the given incident required the constitution of a committee, which would investigate into the following:

1. Were Standard Operating Procedures (SOP's henceforth) followed in conducting the sterilization camps?
2. Identification of gaps, which lead to the occurrence of the incident?
3. Were standard medicines used in the camps?
4. Identification of individuals responsible for the incident?
5. Identification of ways to prevent such incidents from occurring in future?
6. Suggestions for a gender equity approach on family planning practices in the state of Chhattisgarh?

7. Identification of other issues of public importance applicable to the incident as found during the course of the investigation procedure?

As per the Anita Jha Commission's Report, it is an indisputable fact that on 8<sup>th</sup> November 2014 camps were organized in Nemi Chand Trust Private Hospital in Sakri town (Takhatpur District) and similar camps were organised on 10<sup>th</sup> November 2014 in PHC/CHC at Gorela, Pendra and Marwah blocks, Chhattisgarh where inhumane sterilizations continued with reckless disregard for the lives of poor women. Evidence from the victims and their families, CMHO, BMO, civil society groups has clearly revealed the violations of the guidelines laid down by the Hon'ble Supreme Court in Ramakant Rai vs. Union of India & Ors. and guidelines laid down by Ministry of Health and Family Welfare in Standard Operating Procedure for Sterilization Services (2006, 2008). 83 women were sterilized on 8<sup>th</sup> November 2014 out of which 13 women died during the treatment. Other women were later admitted in Bilaspur Apollo Hospital due to serious illness. The sterilization camps maintained a target-based approach to sterilization.

A single doctor performed sterilization surgeries on 83 women. These women who were not provided with any information or counselling were primarily motivated by ASHA workers. A lot of women coming to the camp did not know about sterilization. Hence some women thought they were going to be treated for weakness. The consent form was not read out to women, the floors and bathrooms were dirty and stinking. Soon after the operation, women were asked to go home. They were not issued any certificate or given after care services. Women were given medicines, which further caused problems like vomiting.

Members of the families of these women later stated that the surgery of the women had been completed within 2-4 minutes. After surgery they were laid on floor mattresses. The floor was not cleaned. The women were then discharged in 20-30 minutes after operation. Sterilization certificates were not provided.

Baiga Protected Tribal Community- Husband of Chaita Bai stated under oath that they did not want a sterilization operation. Chaita Bai was weak, hence use to stay unwell. ASHA worker told them that Chaita Bai could get treatment for weakness but did not inform her that she was going to get Chita Bai sterilized. Her husband only came to know about Chaita Bai's sterilization after his wife had been operated upon and was lying unconscious. The couple was not given any certificate, reports of tests conducted or money. They were given two stripes of ciprocin 500mg and I-Brufin 400mg. His wife died the next day after taking 2-3 doses of medicine.

Operations were done with the help of a trainee doctor. There was just one laparoscope machine used to operate on 83 women. As per the Ramakant Rai guidelines, no rules were followed for maintaining a checklist and standard consent form, Pro-forma, was not followed in both the camps. There were series of violations, which led to deaths of innocent and marginalized women.

### The Standard Procedures Were Not Followed in Conducting Camps

1. Dr. Rishi Kumar Bhange, CMHO Bilaspur stated under oath that for conducting such sterilization camps an administrative committee is set up which comprises of the District Collector, MVO, and Nodal officers among other specialist. The committee has to inspect the private hospital before giving their approval for any camp to be conducted on private hospital premises. The committee had not recommended this private hospital, and was not aware that a camp will be conducted hence there was no inspection that was done.
2. A calendar is prepared on the requisition of Family Planning Officer for each block of district for the purpose of conducting monthly camps. As per this calendar a camp was to be organized in Kota block. In Sakri (Takhatpur Block) there was no plan of organizing camp on 6<sup>th</sup> and 8<sup>th</sup> November 2014. If there is any correction required in date and address then Block medical officer either in writing or

through personal meeting can request the DHO for the same. A local meeting was conducted on 3<sup>rd</sup> November 2014, where Dr. Ari (Dist Family Planning Officer) shared that a camp has to be organized on 8<sup>th</sup> November at Pendari. He was not physically present at the meeting. Members of the meeting decided (after talking to Dr. Ari on phone) to conduct camp at Pendari. Dr. Bhangre in his statement stated that there was no such permission granted to conduct a camp at Nemi Chand Hospital.

3. Dr. Tiwari (BMO) has stated under oath that no camp was planned for Sakri (Pendari) on 8<sup>th</sup> or 10<sup>th</sup> November 2014 (page 23, point 36) and that he had not informed CMO about the change in writing or through any other means.
4. The original plan as per the calendar was to conduct health camp at Kota on the 8<sup>th</sup> November 2014. However, the plans were changed without informing CMO. Dr. Khetrapal conducted the health camp in CHC in Ratanpur on 8<sup>th</sup> November 2014 because there were not enough women in Kota. The CMO was informed about this change of plan.
5. Dr. Saxena (CMO) stated that Nemi Chand hospital was non functional before 8<sup>th</sup> November and was not recommended for organizing any camp in 2014. Also other committee members and officials had not given any recommendation for the same. Nemi Chand Trust Hospital was not given any recognition for maternal health camps in 2014.
6. As stated in the report that according to MoHFW "under no circumstances should sterilization camps be organized in a school building/public Panchayat Bhawan or any other such setup. Camps should be always organized either at CHCs or PHCs.
7. As per Dr. Tiwari- He has conducted many similar camps since 2006 where more than 30 women in each camp were sterilized. In 2014, through a letter from CMO office, a target of 2100 women had to be met. As per meeting on 3<sup>rd</sup> November, it was estimated that approximately 40



women would come to the camp. Dr. Tiwari also conveyed this to Dr. Gupta on the day of the camp (over the phone, in morning)

8. Dr. Dhurve (Camp Incharge) shared that Dr. Tiwari had informed him of the camp to be organized on 8<sup>th</sup> on 7<sup>th</sup> itself. Hence, when Dr. Dhurve reached the venue on 8<sup>th</sup> at 10 am, registrations were being carried out at that time. The OT was locked hence he did not inspect.
9. Dr. Gupta (surgeon) was accompanied by a female trainee doctor (for training) who was not from Bilaspur. Ramakant Rai Guidelines violated, the trainee doctor assisted in the operations.
10. As per Saxena, Dr. Gupta was not given any written or verbal instructions for camp on 8<sup>th</sup> November 2014 at Nemichand. Dr. Saxena admitted that the surgeries at Nemi Chand hospital were done without the permission of Chief Medical Officer.
11. He also stated that BMO sent only one doctor to this camp where 83 women were sterilized. They have no info about the number of laparoscopy machines used for surgeries, which is a clear violation of Supreme Court guidelines.
12. On an average time spent on each surgeries is from 10-12 minutes (i.e. only 30 surgeries could have been possible from 2-7 Pm) But a total of 83 surgeries were done in same period. Hence 3-4 minutes were spent on each operation.
13. Dr. Dhurve did not fulfill duties of a camp manager Dr. Dhurve stated that he did not sign the list of medicines required for the camp. Also the surgical gloves ordered for the surgeries were only 35 in numbers.
14. Dr. Dhurve also first stated that the certificate after the inspection of arrangements for camp is not required. Yet, he submitted a certificate for the same (which he has signed himself) after a month of the camp. The certificate is made on 8<sup>th</sup> Dec 2014. His justification is that the CMO

office asked a copy of the certificate and the clerk who later took his signature on it prepared the said certificate. It is evident that the certificate submitted by Dr. Dhurve is on false facts.

15. Before and after the operation, the patients were made to lie down on mattresses on floor. Later on more bed sheets were brought from Sakri tent house once the number of patients increased. It is highly doubtful that the sheets from tent house would be sterilized.
16. As per Ramakant Rai guidelines, no rules were followed for maintaining a checklist. Checklist (with seven points) required complete information of the male/female beneficiary but it was filled as mere formality without name of surgeon and seal of concerned doctor.
17. Standard consent form Proforma was not followed in both the camps. The case card of women who were sterilized was not filled properly and the standard procedures were not followed which resulted in symptoms of infections.
18. Medicine given to the patient after the surgery were ciprocin 500 and I-brufin 400 which resulted in deaths and complications like vomiting, weakness after taking 2-3 doses of medicines.

### **Some concerns of Chhattisgarh groups regarding the Judicial Commission and its report:**

The Judicial Commission Report compiled testimonies of women and family members of those who were affected due sterilization camps. The commission did not comment on the status of the affected women and their families, the status of compensation and other services that the Government had announced for them. The findings of the judicial commission were mostly on the anticipated lines as state government that the deaths were caused due to distribution of substandard and poisonous drugs and medical negligence. This is highly debatable.

Ms. Anita Jha's appointment to the one person Judicial Commission raised some questions. Her recommendations on 'rewarding' government and private sector employees, who adopt family planning methods, reflect her lack of knowledge and understanding on the current debates and discussions around reproductive rights and coercive population policies.

The way the Judicial Commission conducted the investigation was highly debatable and questionable. The commission made no attempt to reach out to the affected women and their families. As shared by a local field worker from Bilaspur district on condition of anonymity, "the commission has published notices in Hindi in the local newspapers to inform the public about the procedure for filing the affidavit, but how do they expect illiterate people in villages to access this information?" The affected families were expected to read the advertisement of the Judicial Commission in the newspaper (published on 19th November 2014) and travel from 20 to 100 kms to Bilaspur to submit their affidavits before the deadline of 8th December 2014.

The families willing to file affidavits were not provided any support or given any legal advice. As per the stock taking report, the deadline for filing affidavits was revised from 8th December to 6th January 2015 at the insistence of civil society groups and because very few affidavits had been submitted. At the end of the second deadline, the Commission sent letters to the affected women, asking all of them to come on the last date, i.e. 6th January 2015. The women and their families travelled from the different blocks but once they reached Bilaspur, they received no help. They had to bear all the expenses of travel and making of the affidavits. Finally a proportion of affected persons could file the affidavits with help from legal groups likes Kanooni Margdarshan Kendra, HRLN and Janhit.

The commission's report stated that negligence in following the standard operating procedure (SOP) for holding tubectomy camps and substandard medicines led to the incident. Dr. Surya Prakash Dhaneria tested by commission of inquiry, Professor and Head of Department, Department of Pharmacology, AllMS Raipur, has oath fully stated that only one chemical Ciprofloxacin

is present in powder form in Ciprocin tablet. There is no adverse effect of these chemicals on human body.

All reports, including the postmortem report, viscera report, the histopathological report, all point out to the fact that the surgeries which were performed in the camp were done in complete violation of the guidelines and instructions of the Hon'ble Supreme Court. The surgeries were performed in a manner and in unhygienic conditions that made the women susceptible to infections and the deaths were not due drugs which were administered, as the same drugs had been used in other camps. Based on the facts and evidences gathered from the camp, the report of the commission clearly shows that standard guidelines were not followed and mandatory requirements were violated as a result of which women were infected. The commission held the following responsible for the tragedy and suggested for actions to be taken against them:

- The Block Medical Officer – Takhatpur,
- On-duty camp manager at Takhatpur
- Surgeon performing the surgery at Takhatpur
- Block Medical Officer – Gaurella
- Medical Officer- CHC Takhatpur
- Mahavar Pharma Pvt Ltd, Khamadih, Raipur, Technical Lab and Pharma Pvt Ltd, Haridwar Uttarakhand
- Kavita Pharma, Tifra, Bilaspur
- Members of District Drug Purchase Committee Bilaspur
- Members of District/ State Drug Purchase Committee (whichever was involved in purchasing the drug.
- The Licensing Authority and Drug Officer.

The Judicial Commission in its recommendations to the Health and Family Welfare Department suggested that surgeries should be done in adherence to the standards in public hospitals. It also suggested that private hospitals could be used for holding camps only under special circumstances in agreement at high-level committee at state level consisting of Director Health, District

Magistrate, CMHO and Civil Surgeon. The hospital chosen by a high level committee should be one, which has been performing such surgeries at least since the last five years. The commission expressed the need for awareness programmes related to family planning. The government should mandatorily involve drug and pharmaceutical companies' operation in CG in sterilization camps through corporate social responsibility.

Two points should be kept in mind when purchasing medicines for distribution in sterilization camps –

1. For transparency in buying emergency medicines by the purchase committee, the decision taken by the committee and the decision-making process should be ratified by the government.
2. It is important that the inspection of medicines is done before distribution and hence it is important to have a government laboratory in the state itself for such purpose. Such a laboratory should be set up in the state immediately

The commission requested an assurance that the Mitanins (ASHA workers) whose support is sought for sterilization have finished their 14th round of training, which focuses on Family Planning Services. Hence the review of the activities of mitanins should be done by BMO.

There should be an introduction of a Mitan Karykram in the lines of Mitanin Karyakram to encourage men to take part in sterilization activities can lead to gender equality in Family Planning programme.

Suggestion to work towards gender equality in Family Planning programmes.

In FPP, targets should be kept regarding gender equality. Extensive campaigning and awareness should be done by men about the options of contraceptives available for men.

Those employed in private sector should be given incentives in terms of salary for contraception. This will bring parity in government and private sector policies.

Involvement of administration and society is expected through proper implementation and follow-up of programmes meant for gender equality, Empowerment of women should be undertaken so that they can make informed choices about the options of contraception available to them.

### **THE CASE AGAINST DR R.K. GUPTA**

Two years after 13 women died and several others impaired in botched sterilization camp, the Chhattisgarh High Court on Technical grounds acquitted Dr. R.K Gupta.

The surgeon accused of using the same gloves, syringes and sutures on all the eighty- three women, and causing life-threatening infections, was acquitted after the prosecution argued that the investigation did not have the State government's sanction, necessary to prosecute a public servant.

Dr. Gupta was arrested and released on bail twenty- seven days after the incident.

As the Anita Jha Judicial Enquiry Commission report has clearly pointed out: "It is evident from the facts that in the camps organized on 8.11.2014 and 10.11.2014 there was a breach in the important necessities hence the standard operating procedure were not followed. As a result of which the symptoms of infections were found in post-operative female beneficiaries". It further states: "On the background of deliberation of investigation point number 1 to 3, investigation committee has found following persons guilty/ responsible, functionary, during 08 and 10 November, 2014: - 4.1 For not following standard procedures and for medical negligence by immediate functionary Block Medical Officer, Takhatpur and surgeon who conducted surgery in tubectomy camp at Sakri and Gaurella. (Surgeries were completed by the same surgeon in the both camps)".

The decision came as a shock to many who felt that justice had been denied to the bereaved families of those 13 young women who died in Bilaspur district, the many more women who suffered serious illness in hospitals and the many small children deprived of

their mothers' care. However, the Hon'ble Court in its judgment has stated that "the Respondent State shall be free to take previous sanction of the State Govt. in this regard if it still desires to prosecute the petitioner and in the event of obtaining sanction, they would be at liberty to further prosecute the petitioner. It is made clear that this Court has not given any opinion on the merits of the case as the prosecution case was not sustainable on the preliminary objection itself and the merits of the case is still left open to be considered and adjudicated upon at a subsequent appropriate stage if the situation so arises"....

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## 6. Critique of the Target- Based Approach in Family Planning

### GENESIS AND ABANDONMENT OF THE TARGET- BASED APPROACH

According to projections made by various institutions, India's total fertility rate is likely to fall somewhere between 1.85 and 2.50 by 2020 and 2025.<sup>59</sup> However, in the early 20th century, the fertility rate in India was approximately 6.0, threatening economic development and raising concerns about the ability of the Government to feed the population.<sup>60,61</sup>

The Central government considered it impractical to passively wait for improvements in development and education to decrease fertility rates, and instead introduced method-specific contraceptive targets for each State in the 1960s. Sterilization was heavily promoted, as it is a provider-dependent option that is relatively cost-efficient when compared to other user-controlled options such as condoms and OCPs. State targets for each contraceptive were set based on certain demographic goals derived from national data such as the census, and pressures to achieve these targets were filtered down to the lowest administrative levels. Failure to achieve targets at grassroots levels resulted in punitive measures such as the suspension of salaries for the community-based health workers involved.

The administrative preoccupation with meeting centrally decided targets eventually became unsustainable. The achievement

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<sup>59</sup> Bali Ram, 'Fertility decline and Family Change in India: A Demographic Perspective' (2012) 43(1) *Journal of Comparative Family Studies* 11, 31.

<sup>60</sup> Ram, above n 1, 12; Peter J. Donaldson, 'The elimination of contraceptive acceptor targets and the evolution of population policy in India' (2002) 56 *Population Studies* 97, 98.

<sup>61</sup> National Health Mission, Ministry of Health and Family Welfare, Family Planning: Background (2 February 2015) <<http://nrhm.gov.in/nrhm-components/rmnch-a/family-planning/background.html>>.



of targets became an end in itself, and health workers were encouraged to engage in unethical practices and outright coercion in order to achieve demographic targets, resulting in a corresponding deterioration in the quality of services and client satisfaction. Furthermore, the use of centralized planning and target setting from the top hindered innovation and flexibility in the Family Planning Programme to adequately respond to the needs of the community, adversely impacting the reproductive health situation. Therefore, in 1996, the Central government initiated a significant paradigm shift, which eliminated numerical targets.

The National Population Policy of 2000 advocated a holistic, multi-sectoral approach towards population stabilization. Numerical targets for specific contraceptive methods were abolished; instead, States were directed to achieve a national average total fertility rate (TFR) of 2.1 by the year 2010.<sup>62</sup>

This target-free approach was known, as the community needs assessment approach. Under this decentralized approach, grassroots workers such as Auxiliary Nurse Midwives (ANM) are given the discretion to assess the real needs and preferences of family planning services within the local community and to use this information to develop their own targets.

### **63 THE CURRENT SITUATION**

In 2003-05, the fertility rate was at or below the replacement level (i.e. the total fertility rates of 2.1 children per woman) in several states, including Punjab, Delhi, Kerala and Karnataka.<sup>64</sup>

However, even in states where the replacement fertility level has been achieved, for example, in Tamil Nadu, State authorities continue to pursue female sterilization as a key contraceptive method."<sup>65</sup>

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<sup>62</sup> Suneela Garg and Ritesh Singh, 'Need for integration of gender equity in family planning services' (2014) 140(1) Indian Journal of Medical Research 147.

<sup>63</sup> Donaldson, above n 2, 99.

<sup>64</sup> Ram, above n 1, 13.

<sup>65</sup> Human Rights Watch, India: Target-Driven Sterilization Harming Women (12 July 2012) <<https://www.hrw.org/news/2012/07/12/india-target-driven-sterilization-harming-women>>.

Despite the optimism and potential for change in government policy to catalyze a major shift in the delivery of family planning services, a report on the use of targets by Human Rights Watch confirms that district and sub-district authorities continue to assign individual yearly targets for contraceptives, with a heavy focus on female sterilization.

Therefore, whilst 'top-down targets have officially been eliminated, this has merely been replaced by the emergence of 'bottom-up' targets<sup>66</sup> and quotas couched in the euphemistic phrase, 'Expected Level of Achievement'. In practice, State-level authorities and district health officials continue to be pressured to achieve targets through a system of financial incentives including monetary payments, or are otherwise threatened with salary cuts, negative performance assessment, suspension and dismissal. Numerous reports and studies confirm that grassroots health workers face immense pressure from their superiors to achieve targets.

In a report published by Human Rights Watch, several health workers alleged that they were humiliated and orally abused by their supervisors for not motivating enough women to accept contraception, while others were suspended from their jobs.<sup>67</sup> Supervisors are not in regular contact with the local community and have no personal relationship with the women that the health workers are seeking to motivate. They are therefore insensitive to the needs and opinions of the women; to them, achieving targets is merely a game of numbers.

The various State Governments are also complicit in the continued coercion, albeit through indirect means by way of various government programmes and policies, which require people to accept various forms of contraception, most notably sterilization, in order to receive benefits. For example, health insurance will only be provided to poor families if they undergo sterilization after two children.<sup>68</sup> Furthermore, 'girl child promotion' programmes have been initiated in five Indian states, which provide monetary benefits to

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<sup>66</sup> Donaldson, above n 2, 107.

<sup>67</sup> Human Rights Watch, above n 8.

<sup>68</sup> Keya Achara, 'Sterilization in India' (2001) 279(1626) Contemporary Review 26.

parents of girls, with a final cash benefit if she reaches the age of 18 unmarried. However, the receipt of benefits and monetary payments is contingent upon couples producing a sterilization certificate.<sup>69</sup>

## ARE TARGETS NECESSARY?

The proponents of the target-based approach assert that targets act as a crucial guiding posting order to effectively plan and orient family planning services, and are useful for estimating supplies and budgets, and for assigning staff.<sup>70</sup> Targets have been considered an essential tool to measure the functioning and efficacy of family planning programmes as progress can be judged by the extent to which the targets are achieved.<sup>71</sup> Furthermore, a fear persists amongst senior health workers and programme administrators that, without targets, lower level workers 'would have no motivation to get anyone to use contraception.'<sup>72</sup>

## ANALYSIS OF THE IMPLICATIONS OF TARGETS

The target-based system represents a state-sanctioned violation of sexual and reproductive rights, including the right to make informed reproductive choices, and inevitably results in a substantial deterioration in the quality of care.

This deterioration can be attributed to healthcare providers ignoring the needs and preferences of individual clients and instead engaging in unethical practices such as the provision of incomplete, inaccurate or otherwise biased information. Most health workers are likely to promote permanent, provider-controlled methods such as sterilization rather than user-controlled options such as the pill,<sup>73</sup> motivated by self-interest and the need

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<sup>69</sup> Human Rights Watch, above n 8.

<sup>70</sup> M Johnson-Samuel, M Lingaraju and P Prabhuswamy, 'Has Abolition of Targets Improved the Quality of Family Planning and Health Services? A Survey in Karnataka' (2000) 2(1) *Journal of Health Management* 99, 100.

<sup>71</sup> Leela Visaria, Shireen Jejeebhoy and Tom Merrick, 'From Family Planning to Reproductive Health: Challenges Facing India' (1999) 25 *International Family Planning Perspectives*.

<sup>72</sup> Donaldson, above n 2, 107.

<sup>73</sup> Ruth Simmons and Laura Ghiron, 'Family Planning Targets and Quality of Services: Workers' Perspectives and Dilemmas' (1999) 1(2) *Journal of Health Management* 277, 279.

to fulfill sterilization and IUD targets. In seeking to achieve targets, health workers routinely provide prejudiced information and in some circumstances, outright lies are told to women regarding the side effects of certain contraceptive methods to present an option as more favorable. For example, health workers have been reported to have told women that injectable contraceptives are 'likely to make the blood impure' in order to make the Copper-T seem like a better option.<sup>74</sup>

Women living in rural areas are particularly susceptible to this distortion of information because of low literacy and educational levels. This practice ought to be viewed as unlawful discrimination, violating the non-discrimination provisions under Articles 14, 15, and 16 of the Indian Constitution. This endemic misinformation is responsible for the negation of the right to make informed reproductive choices and nullifies the exercise of sexual and reproductive autonomy, violating several legal rights flowing from the right to life enshrined in Article 21 of the Constitution.

Even in situations where health workers are cognizant of a client's individual situation and needs, there is often limited possibility to appropriately respond because of the time and resource constraints imposed by the preoccupation with meeting formalized targets.<sup>75</sup> Health workers frequently forego important processes such as screening clients for contraindications, and are likely to recommend inappropriate contraceptive methods without first properly examining the physical condition of the client in their attempts to achieve numerical targets. In fact, the results of a recent study which compared the health outcomes of women in a target-oriented family planning regime with women who were not subject to such targets demonstrated that a significantly higher incidence of side effects was reported when numerical targets were in place.<sup>76</sup> Thus, targets can be seen to jeopardize the health outcomes of individuals by placing them at unnecessary risk of infection and other complications as they are coerced into a particular form of contraception they neither need nor desire.

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<sup>74</sup> Ibid 281

<sup>75</sup> Johnson-Samuel, Lingaraju and Prabhuswamy, above n 14, 103.

<sup>76</sup> Ibid

The target-based approach is therefore in violation of the broad protections provided under Article 21 of the Constitution, guaranteeing the right to life and the right to live with dignity. The Indian Supreme Court in *Bandhua Mukti Morcha v. Union of India and Ors* [AIR 1984 SC 802] held that this encompasses the right to health, and in particular includes the enforcement of the reproductive rights of women.<sup>77</sup>

The right to health is also adversely impacted because of the tendency to utilize the camp approach in order to provide mass family planning services to people living in interior areas, and to conveniently fulfill contraceptive targets. Such camps are organized routinely. For example, a total of 438 female sterilization camps were proposed for the years 2015-2016 in the state of Uttarakhand, which works out to 6 camps per block per year for four high-focus districts, and 2 camps per district per month for the remaining districts.<sup>78</sup> Analysis of the NHM Budget Sheet also reveals a heavy bias towards sterilization as the main form of contraception encouraged by the State. In 2015-16, 81.46% of the total budget allocated for family planning services was to be used in association with the provision of terminal methods such as sterilization, whereas a mere 0.09% was allocated for alternative spacing methods.<sup>79</sup>

The camp approach is heavily associated with the sterilization of women, where it has attracted intense national and international condemnation for its perpetuation of gender and caste discrimination and flagrant, systemic violations of Government mandated guidelines on the quality of care, including the negation of informed free choice and persistence of substandard conditions at camp facilities.

Therefore, this focus on sterilization camps as a means to fulfill sterilization targets is a violation of the right to live with dignity and the right to freedom from torture and cruel, inhuman or degrading treatment, which is implicit in Article 21 of the Indian

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<sup>77</sup> *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, [1996 SCC (4) 37].

<sup>78</sup> Uttarakhand State, NHM Budget Sheet 2015-16.

<sup>79</sup> *Ibid.*

Constitution.<sup>80</sup> Additionally, it was found that certain state approaches to female sterilization 'forced doctors in the public hospital to commit so much staff time to sterilization camps that other basic reproductive health care suffered'. A civil society team that investigated maternal deaths in Barwani district of Madhya Pradesh state found that the senior gynecologist from the district hospital was absent four days in a week, performing sterilizations in camps.<sup>81</sup>

The negative impact of targets on basic reproductive health care is further highlighted by the fact that local health workers will dedicate most of their time on fulfilling targets and subsequently spend less time on distributing timely supplies of other contraceptive methods. Furthermore, when healthcare workers are burdened by fulfilling set targets, the average time and attention given to existing patients is reduced, and less time is available to focus on other important reproductive and maternal health issues.

A study conducted in 2000 highlighted that fewer women received proper antenatal care while health workers were seeking to fulfill targets. For example, 84% of women received tetanus injections during the target-oriented regime, while up to 96% received injections after the targets were lifted.<sup>82</sup> Only 24% of mothers had their babies weighed during the target-oriented regime; this increased to 37% after targets were removed.<sup>83</sup> 47% of mothers were advised about breastfeeding during target-oriented regime; in contrast, 67% were advised about the benefits of breastfeeding after targets lifted.<sup>84</sup> Therefore, targets are clearly seen to have an impact on the provision of other essential healthcare services in further violation of the right to health.

## THE WAY FORWARD

The above cost-benefit analysis of the justifications for the continued use of numerical targets as compared to the harms

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<sup>80</sup> Ibid.

<sup>81</sup> Human Rights Watch, above n 8.

<sup>82</sup> Johnson-Samuel, Lingaraju and Prabhuswamy, above n 14, 108.

<sup>83</sup> Ibid 110.

<sup>84</sup> Ibid.

that are perpetuated through the preoccupation with achieving those targets militates against their continued use. Such flagrant human rights violations cannot be justified in the name of controlling population growth. Instead, government policy should focus on addressing the underlying causes of high fertility rates in India. Evidence shows that the driving forces of high fertility rates in India are attributed to social factors. 'National and international experience' clearly indicates that family size is dependent on non-demographic factors'.<sup>85</sup>

One of these factors is the age at marriage and subsequent childbearing. Traditional Indian norms sanction early and universal marriage. In many parts of the country, early marriage continues to be prevalent. According to the NFHS-3 (2005-06), 47.4% of women in India were married by the age of 18. Severe social stigma is attached to childlessness; this applies to both low-fertility and high-fertility regions in India.<sup>86</sup> In 2003-05, two-fifths of all married women aged 20-24 had already given birth to a child. About 97% of all married women had given birth by their early 30s.<sup>87</sup> These statistics demonstrate that many people marry early, and start childbearing early – usually within two years of marriage,<sup>88</sup> and therefore have a much longer window of childbearing. Whilst legislative measures have been enacted to prevent early marriage such as the Prohibition of Child Marriage Act (2006), which imposes monetary sanctions and jail terms for those involved in facilitating marriages under the legal age, these laws are largely ineffective in modifying customs and tradition and facilitating attitudinal change.

Another reason for high fertility rates in India is the preference for male children, which pervade every section of society; rich and poor, less educated and highly educated, urban and rural. Despite significant modernization and socio-economic development, male preference has not weakened. Sons are continued to be seen the only security for poor parents in old

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<sup>85</sup> Achara, above n 12, 27.

<sup>86</sup> Ram, above n 1, 19.

<sup>87</sup> Ibid 18.

<sup>88</sup> Ibid 32.

age, and women face intense family pressure to bear sons.<sup>89</sup> Many couples give birth to many children in pursuit of male children. Even in cases when a son is born, couples are unsure whether he will survive to adulthood, given the high infant and child mortality rates in India.

The 2011 Census shows that 39 out of every 1000 children born died before reaching their first birthday. Therefore, 'there is ample evidence that the experience with, or fear of infant and child mortality leads parents to have additional children by 'replacing' those who have already died or as an 'insurance' against expected deaths. Many couples produce a larger number of children, expecting that at least one of them will be able to provide economic support in their old age'.<sup>90</sup>

Therefore, the most effective approach that does not compromise fundamental human rights is through the adoption of non-coercive measures such as the promotion of education for girls, which has been linked to delayed age of marriage and improved socioeconomic conditions and employment opportunities. Evidence from low-fertility states such as Kerala supports the notion that 'higher levels of autonomy and a better social position for women... have led to increased female utilization of health services and contraception, higher levels of female education, and later ages of marriage and first birth'.<sup>91</sup>

The government must also do more to address the high infant and child mortality rates. Evidence also exists which supports 'greater investment in women's education [as] a more pragmatic approach in terms of the reduction in infant and child mortality as it is the better-informed mothers who are more likely to save their children from diseases and death'.<sup>92</sup> Finally, there is also a pressing need to address India's lack of social security for the elderly. Whilst India created a National Policy for Older Persons in 1999 and passed the Maintenance and Welfare of Parents and Senior

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<sup>89</sup> Achara, above n 12, 27.

<sup>90</sup> Ram, above n 1, 25.

<sup>91</sup> Trina Vithayathil, 'Pathways to Low Fertility in India' (2013) 9(3) Asian Population Studies 301, 304.

<sup>92</sup> Ram, above n 1, 34.



Citizens Act, 2007, little has been done to implement the policy and law.<sup>93</sup> This failure of the Central Government to implement social security programmes has been a major deterrent to contraceptive use.

Therefore, the above options represent perhaps better alternatives than the current coercive regime of achieving contraceptive targets in family planning.

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<sup>93</sup> Human Rights Watch, above n 8.

## 7. INTERNATIONAL LAW AND CASES ON STERILIZATION

According to the WHO, women in many regions of the world continue to suffer from forced sterilization. The people most often subjected to these abusive practices are women, especially those living in poverty, women living with HIV, women with disabilities, minority and indigenous women, and transgender and intersex persons. “Eliminating forced, coercive and otherwise involuntary sterilization”, a statement released by several UN agencies, describes the history of this practice, including its use as a method of mass birth control in the latter half of the 20th century in contravention of fundamental human rights principles of autonomy and dignity.

The agencies, including the UN Office of the High Commissioner for Human Rights, have produced the research in the form of a statement for general release to add weight to calls for States to act to eliminate involuntary sterilization. While acknowledging that “sterilization is one of the most widely used forms of contraception in the world”, the statement reaffirms that it must only be used with the “full, free and informed” consent of those undergoing the procedure. The UN agencies offer a set of guiding principles for sterilization procedures, principal among which is autonomy—the respect for dignity and the physical and mental integrity of each person expressed through full, free and informed decision-making. People should be able to choose and refuse sterilization, the statement says. In addition to the UN Human Rights Office, UN Women, the Joint UN Programme on HIV and AIDS (UNAIDS), the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO) all contributed to the statement

Following are some of the international convention and conference plan of action which focus on family planning and ensuring adequate health care service without any discrimination:

#### **A. INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS (ICCPR):**

ICCPR was adopted by UN General Assembly in 1966, with the ideal of free human beings enjoying civil and political freedom and freedom from fear and want. This can only be achieved in conditions where everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights. India being signatory to the covenant is obligated to follow the laws of ICCPR. Article 7 of the ICCPR states-

'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.'

Hence, without informed consent women cannot undergo any sterilization procedure. India's system of sterilization camps is deliberate and pervasive. According to the report Sterilization Camps in India (2015): Population Research Institute, 'India's systematic sterilization of women en masse, without informed consent, and in dangerous conditions demands our attention.'

#### **B. CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN (CEDAW):**

CEDAW was adopted by UN General Assembly on December 18, 1979 and it focuses on women's rights and women's issue. The convention focuses for ensuring adequate women health care and services.

1. Article 10 of the convention, the state is required to ensure education for women as well as access to information relating to the health and well being of families, including information and advice on family planning.

2. Under Art 12, the state must ensure appropriate healthcare services for women, including family planning services.
3. Under Article 16, the state shall ensure that women can freely and responsibly decide on number and spacing of their children and have access to information, education and the necessary means to enable them to exercise these rights.

### **C. COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (CESCR):**

CESCR is the body of 18 independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR) by its state parties. The Committee was established under ECOSOC Resolution 1985/17 of 28 May 1985 to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSOC) in Part IV of the Covenant.

Article 102, Article 12.1- “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

### **D. INTERNATIONAL CONFERENCE ON POPULATION DEVELOPMENT (ICPD):**

The United Nations coordinated an International Conference on Population and Development (ICPD) in Cairo, Egypt from 5–13 September 1994. Its resulting Programme of Action is the steering document for the United Nations Population Fund (UNFPA). The programme highlights the importance of universal access to health-care services including family planning and sexual health.

#### **Principle 8 declares-**

“States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion.”

## E. FOURTH WORLD CONFERENCE ON WOMEN (FWCW):

FWCW was organised by UN women with an agenda for women's empowerment and considered the key global policy document on gender equality. It sets strategic objectives and actions for the advancement of women and the achievement of gender equality in 12 critical areas of concern.

Paragraph 89 -"Women have the right to the enjoyment of the highest attainable standard of physical and mental health.... Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity...."), Paragraph 92, Paragraph 267

Paragraph 223 -"The Fourth World Conference on Women reaffirms that reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so."

### **Case Law on Sterilization Decided by International Courts**

**Case Name: A.S. v. Hungary, Communication No. 4/2004**

**Forum: UN Committee on the Elimination of Discrimination  
Against Women**

**Date of Ruling: August 29, 2006**

### **Summary:**

Upon going into labor, Ms. A.S., a member of the Roma community, needed an emergency Cesarean section. Immediately before the surgery, a doctor asked Ms. A.S. to sign consent forms on which the doctor had hand-written a statement that Ms. A.S. consented to a sterilization procedure. Ms. A.S. did not understand the statement or that she had been sterilized until after the operation took place. Her claim of civil rights violations and negligent sterilization was rejected at the local level. In her communication to the CEDAW Committee, it found that the Ms. A.S. exhausted her domestic remedies because under Hungarian law she was unable to appeal this decision to the Constitutional Court given the nature and facts of her case. Hungary was found

to have violated Ms. A.S.'s rights to (1) fully informed consent to medical procedures; (2) right to information on family planning; (3) right to appropriate services in connection with pregnancy and the post-natal period; and (4) right to determine the number and spacing of her children, under Articles 10(h), 12 and 16(1) (e) of the Convention on the Elimination of Discrimination Against Women. The Committee also found that the communication was admissible, even though the operation occurred before the Optional Protocol entered into force for Hungary, because sterilization was a continuous injury, and because sterilization is permanent, irreversible (despite the state's claims) and success of reversal is low.

### **ENFORCEMENT OF THE DECISION AND OUTCOMES:**

The Committee recommended that Hungary compensate Ms. A.S. and take measures to make sure health officials give information to patients and obtain informed consent. In 2008, Hungary amended the Public Health Act to ensure that women received proper information regarding sterilization procedures. Finally, in February 2009 the Ministry of Social Affairs and Labour announced that they will compensate Ms. A.S. according to the Committee's recommendations.

### **SIGNIFICANCE OF THE CASE:**

This is a landmark decision, in which for the first time an international body held a state responsible for failing to provide a woman with necessary information and obtain full consent for reproductive health procedures. This decision establishes that obligations to ensure women's human rights require that they must be provided with acceptable reproductive health services, specifically requiring free and informed consent to a sterilization procedure. This decision was an important step in addressing the systemic discrimination against Romani women in Central and Eastern Europe; however, governments in the region remain highly reluctant to acknowledge marginalization and discrimination of Romani peoples.

## 1. E vs. Eve, [1986] 2 SCR 388

**Forum: Supreme Court of Canada**

**Date of Judgment: 10-23-1986**

**Summary:**

Mrs. E was the mother of Eve, who was intellectually and developmentally disabled (IDD). When Eve turned twenty-one, she was sent to a school for adults who have IDD in another community. At this school, Eve struck up a close friendship with a male student: in fact, they talked of marriage. He too has IDD, though somewhat less so than Eve. The situation naturally troubled Mrs. E., Eve was attracted and attractive to men and Mrs. E. feared she might quite possibly and innocently become pregnant. Mrs. E. was concerned about the emotional effect that a pregnancy and subsequent birth might have on her daughter. Eve, she felt, could not adequately cope with the duties of a mother and the responsibility would fall on Mrs. E. This would understandably cause her great difficulty; she is a widow and was then approaching sixty. That is why she decided Eve should be sterilized.

Mrs. E. applied to the Supreme Court of Prince Edward Island for permission to give consent to the sterilization of Eve. The application sought: (1) a declaration that Eve was mentally incompetent pursuant to the *Mental Health Act*; (2) the appointment of Mrs. E. as committee of Eve; and (3) an authorization for Eve's undergoing a tubal ligation. The application for authorization to sterilize was denied, and an appeal to the Supreme Court of Prince Edward Island, *in banco* (in the bench), was launched. An order was then made appointing the Official Trustee as Guardian *ad litem* for Eve. The appeal was allowed. The Court ordered that Eve be made a ward of the Court pursuant to the *Medical Health Act* solely to permit the exercise of the *parens patriae* jurisdiction to authorize the sterilization, and that the method of sterilization be determined by the Court following further submissions. A hysterectomy was later authorized. But Eve's *ad litem* guardian filed an appeal against the authorization for hysterectomy at the Supreme Court of Canada.

## Judgment:

It was held that the appeal should be allowed. The *Mental Health Act* did not advance respondent's case. This Act provides a procedure for declaring mental incompetence, at least for property owners. Its ambit is unclear and it would take much stronger language to empower a committee to authorize the sterilization of a person for non therapeutic purposes. The *Hospital Management Regulations* were equally inapplicable. They are not aimed at defining the rights of individuals.

The *parens patriae* jurisdiction for the care of the mentally incompetent is vested in the provincial superior courts. Its exercise is founded on necessity the need to act for the protection of those who cannot care for themselves. The jurisdiction is broad. Its scope cannot be defined. It applies to many and varied situations, and a court can act not only if injury has occurred but also if it is apprehended. The jurisdiction is carefully guarded and the courts will not assume that it has been removed by legislation.

While the scope of the *parens patriae* jurisdiction is unlimited, the jurisdiction must nonetheless be exercised in accordance with its underlying principle. The discretion given under this jurisdiction is to be exercised for the benefit of the person in need of protection and not for the benefit of others. It must at all times be exercised with great caution, a caution that must increase with the seriousness of the matter. This is particularly so in cases where a court might be tempted to act because failure to act would risk imposing an obviously heavy burden on another person.

Sterilization should never be authorized for non -therapeutic purposes under the *parens patriae* jurisdiction. In the absence of the affected person's consent, it can never be safely determined that it is for the benefit of that person. The grave intrusion on a person's rights and the ensuing physical damage outweigh the highly questionable advantages that can result from it. The court, therefore, lacks jurisdiction in such a case.

The court's function to protect those unable to take care of themselves must not be transformed so as to create a duty



obliging the Court, at the behest of a third party, to make a choice between two alleged constitutional rights that to procreate and that not to procreate simply because the individual is unable to make that choice. There was no evidence to indicate that failure to perform the operation would have any detrimental effect on Eve's physical or mental health. Further, since the *parens patriae* jurisdiction is confined to doing what is for the benefit and protection of the disabled person, it cannot be used for Mrs. E.'s benefit.

Cases involving applications for sterilization for therapeutic reasons may give rise to the issues of the burden of proof required to warrant an order for sterilization and of the precautions judges should take with these applications in the interests of justice. Since, barring emergency situations, a surgical procedure without consent constitutes battery, the onus of proving the need for the procedure lies on those seeking to have it performed. The burden of proof, though a civil one, must be commensurate with the seriousness of the measure proposed. A court in conducting these procedures must proceed with extreme caution and the mentally incompetent person must have independent representation.

## **2. V.C. Versus Slovakia, 18968/07**

**Forum: European Court of Human Rights**

**Date of Judgment: 08-11-2011**

**Summary & Judgment:**

The applicant is a Roma woman who was sterilized during the delivery of her second child via Caesarean section on 23 August 2000. Under Article three of the European Convention on Human Rights (hereinafter referred to as the Convention) the applicant complained that she had been subjected to inhuman and degrading treatment on account of her sterilization without her full and informed consent, and that the authorities had failed to carry out a thorough, fair and effective investigation into the circumstances surrounding her sterilization. She also claimed that her Roma ethnicity – clearly stated in her medical record – had played a decisive role in her sterilization. The applicant's sterilization has had serious medical and psychological after-

effects. She has been treated by a psychiatrist since 2008 and continues to suffer from the fact that she was sterilized. She has also been sterilized by the Roma community. Under Article 8 of the Convention the applicant complained that her right to respect for her private and family life had been violated as a result of her sterilization without her full and informed consent. Under Article 12 of the Convention the applicant complained that her right to found a family had been breached on account of her sterilization without her full and informed consent. She also complained under Articles 13 and 14.

The Court noted that sterilization amounted to a major interference with a person's reproductive health status and, involving manifold aspects of personal integrity, required informed consent when the patient was an adult of sound mind. However, from the documents submitted, the applicant had apparently not been fully informed about the status of her health, the proposed sterilization and/or its alternatives. The applicant's sterilization, as well as the way in which she had been requested to agree to it, must therefore have made her feel fear, anguish and inferiority. The applicant's sterilization had been in violation of Article 3. There had been no violation of Article three as concerned the applicant's allegation that the investigation into her sterilization had been inadequate. Given its earlier finding of a violation of Article 3, the Court did not consider it necessary to examine separately under Article 8 whether the applicant's sterilization had breached her right to respect for her private and family life. It nevertheless found that Slovakia had failed to fulfill its obligation under Article 8 to respect private and family life in that it did not ensure that particular attention was paid to the reproductive health of the applicant as a Roma. There had therefore been a violation of Article 8 concerning the lack of legal safeguards at the time of the applicant's sterilization giving special consideration to her reproductive health as a Roma. The Court found that there had been no violation of Article 13. It held that there was no need to examine separately the applicant's complaints under Articles 12 and 14.

*Article 3: No one shall be subjected to torture or to inhuman or degrading treatment or punishment.*

Article 8: 1) *Everyone has the right to respect for his private and family life, ...*

2) *There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.*

Article 12: *Men and women of marriageable age have the right to marry and to found a family, according to the national laws governing the exercise of this right.*

Article 13: *Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity.*

Article 14: *The enjoyment of the rights and freedoms set forth in [the] Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.*

### **Held by The Court:**

1. *Holds* unanimously that there has been a substantive violation of Article three of the Convention;
2. *Holds* unanimously that there has been no procedural violation of Article three of the Convention;
3. *Holds* unanimously that there has been a violation of Article 8 of the Convention;
4. *Holds* unanimously that it is not necessary to examine separately the complaint under Article 12 of the Convention;

5. *Holds* unanimously that there has been no violation of Article 13 of the Convention;
6. *Holds* by six votes to one that a separate examination of the complaint under Article 14 of the Convention is not called for;
7. *Holds* unanimously
  - (a) that the respondent State is to pay the applicant, within three months from the date on which the judgment becomes final in accordance with Article 44 § 2 of the Convention, the following amounts:
    - EUR 31,000 (thirty-one thousand Euros), plus any tax that may be chargeable, in respect of non-pecuniary damage;
    - EUR 12,000 (twelve thousand Euros), plus any tax that may be chargeable to the applicant, in respect of costs and expenses;
  - (b) that from the expiry of the above-mentioned three months until settlement simple interest shall be payable on the above amounts at a rate equal to the marginal lending rate of the European Central Bank during the default period plus three percentage points;

**4. Concern raised by the Human Rights Committee through its Concluding Observations on the Fourth Report of Slovakia regarding the implementation of provisions of the UN International Covenant on Civil and Political Rights:**

**Sterilization of Roma Women:**

Para 26: The Committee is concerned that the State party has still not acknowledged responsibility for the past practice of forced sterilization of Roma women or provided compensation for the victims, except in one case.

Para 27: The State party should: (a) establish an independent body to investigate the full extent of the practice of sterilization without informed consent and to provide financial and other

reparation to the victims; (b) provide ongoing training for healthcare personnel on how to ensure that informed consent is obtained; and (c) monitor health-care providers' implementation of legislation on informed consent in situations of sterilization and ensure that appropriate sanctions are applied if breaches occur.

### **5. Joelle Gauer and Others Versus France, 61521/08**

The case was brought before the European Court of Human Rights and concerns five disabled women who were forcefully sterilized, which according to them was a violation of Articles three (freedom from torture or inhuman or degrading treatment or punishment), Article 6 (right to a fair trial), Article 8 (right to respect for private and family life), Article 12 (right to marry and to found a family), and Article 14 (right to non-discrimination in the enjoyment of protected rights and freedoms) of the European Convention on Human Rights. This case was filed after no remedy was provided to the women in the domestic courts of France.

In this case, a document containing Written Comments was submitted to the court jointly by five organizations, viz. Centre For Reproductive Rights, European Disability Forum, International Centre for the Legal Protection of Human Rights (INTERIGHTS), International Disability Alliance and Mental Disability Advocacy Centre. These comments contained insights on how and why are forced sterilizations are a violation of a person's rights setting forth international human rights and medical standards, with focus on the violation of the rights of disabled women.

In the written comments, reference was made to a previous judgment of the Court wherein it had held that a guardian's placement of a person who has a mental disability and has been deprived of his legal capacity in a psychiatric hospital solely based on the guardian's belief that the person requires hospitalization, against the person's will and in the absence of a judicial review, violates Article 5 of the Convention. In its *Shtukaturov* judgment, the Court recognized that the will of a person placed under guardianship had to be taken into consideration when a restriction on a right as fundamental as the right to liberty is concerned.

21 In so doing, the Court recognized that a person whose legal capacity has been formally restricted may retain capacity to make medical and other decisions rather than having such decisions made by third parties.

The provisions of the United Nations Convention on Rights of Persons with Disabilities (hereinafter referred to as CRPD) were frequently referred to. Article 12 of the CRPD mandates States Parties to recognise that persons with disabilities enjoy legal capacity on an equal basis with others. This means that an individual's right to decision-making should not be replaced by decision-making of a third party, but that each individual without exception has the right to make their own choices and to direct their own lives, whether in relation to living arrangements, medical treatment, or family relationships. Article 12 is central to the CRPD because the exercise of legal capacity affects so many other fundamental rights.

International standards explicitly endorse the principle of informed consent as fundamental to the exercise of one's individual human rights. Informed consent, which includes the right to information, is particularly critical to the life-altering procedure of sterilization which seriously impacts upon an individual's human rights. The Committee on Elimination of Discrimination Against Women (hereinafter referred to as CEDAW Committee) has expressed concern about forced sterilizations that result from the lack of full and informed consent. In its General Recommendation 24, the CEDAW Committee explains that "acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives."

The Committee on the Rights of Persons with Disabilities (hereinafter the CRPD Committee<sup>2</sup>) specifically recommended that states "incorporate into the law the abolition of surgery and treatment without the full and informed consent of the patient, and ensure that national law especially respects women's rights under article 23 and 25 of the Convention." World Health Organisation (WHO) clearly states in its Declaration on the Promotion of Patients

Rights in Europe<sup>94</sup> that “the informed consent of the patient is a prerequisite for any medical intervention.” Also, International Federation of Gynaecology and Obstetrics' (FIGO) guidelines on female contraceptive sterilization stress that surgical sterilization must be preceded by “the patient's informed and freely given consent.” The FIGO guidelines note that “medical practitioners must recognise that, under human rights provisions and their own professional codes of conduct, it is unethical and in violation of human rights for them to perform procedures for prevention of future pregnancy on women who have not freely requested such procedures, or who have not previously given their free and informed consent.”

The United Nations Special Rapporteur on the Right to Health emphasised that States have an obligation to respect, protect and fulfill the right to health of all individuals, including those with mental disabilities. He recognised that “forced sterilizations, rape and other forms of sexual violence, which women with mental disabilities are vulnerable to, are inherently inconsistent with their sexual and reproductive health rights and freedoms.” The Special Rapporteur also stressed that “consent to treatment is one of the most important human rights issues relating to mental disability,” and accordingly “it is especially important that the procedural safeguards protecting the right to informed consent are both watertight and strictly applied.”

The Council of Europe's Convention on Human Rights and Biomedicine obligates the medical provider to give each patient objective and comprehensive information about his or her contemplated treatment, including its purpose, nature, consequences and risks, in order to enable the patient to make an informed decision. The FIGO guidelines specify that the physician who performs the sterilization is responsible for ensuring that a woman has been counseled regarding risks, benefits, and alternatives to sterilization. Women must be made aware of and have the opportunity to consider alternatives to sterilization, particularly family planning methods that are reversible. Surgical

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<sup>94</sup> A Declaration on Patient's Rights in Europe; < [http://www.who.int/genomics/public/eu\\_declaration1994.pdf](http://www.who.int/genomics/public/eu_declaration1994.pdf)> Accessed on 23.08.2017

sterilization is recognized as a permanent contraceptive method by international medical bodies, and while surgery to reverse sterilization exists, such procedures are costly, not widely available and have a low success rate. The FIGO also lays out information that must be conveyed during counselling, including that sterilization is intended to be permanent; that life circumstances may change as a result of the procedure; and that a person may later regret her state of sterility. The FIGO also emphasizes that “informed consent is not a signature but a process of communication and interaction.”

In order for an individual to give full and informed consent, the information communicated should be provided in a manner that is understandable to her. The WHO explains that “information must be communicated to the patient in a way appropriate to the latter’s capacity for understanding, minimizing the use of unfamiliar technical terminology. If the patient does not speak the common language, some form of interpreting should be available.” The CRPD recognizes that “communication includes languages, display of text, Braille, tactile communication, large print, accessible multimedia as well as written, audio, plain-language, human-reader and augmentative and alternative modes, means and formats of communication, including accessible information and communication technology.” The FIGO Guidelines Regarding Informed Consent specifically note that the difficulty or time consuming nature of providing such information, for example, to patients who have had “little education,” does not absolve medical providers from striving to fulfill the criteria for informed consent.

The CEDAW Committee which, in a statement on violence against women, stated that “compulsory sterilization ... adversely affects women’s physical and mental health...”

The WHO in a recent report (World Report on Disability) relied on standards set out in the CRPD in relation to non discrimination, and reiterated the right of persons with disabilities to retain their fertility and exercise their legal capacity in making healthcare decisions, including sexual and reproductive decisions. The report specifically states that “the presence of a particular



health condition is not sufficient to determine capacity. The assumption that people with certain conditions lack capacity is unacceptable, according to Article 12 of the CRPD." The report notes "there are many cases of involuntary sterilization being used to restrict the fertility of some people with a disability, particularly those with an intellectual disability, almost always women.... Involuntary sterilization of persons with disabilities is contrary to international human rights standards. Persons with disabilities should have access to voluntary sterilization on an equal basis with others." It also stated that legal frameworks and reporting and enforcement mechanisms, should be put in place "to ensure that, whenever sterilization is requested, the rights of persons with disabilities [should be] always respected above other competing interests."

## **6. F.S. Versus Chile, Report No. 52/14, Petition No. 112/09**

### **Forum: Inter-American Commission on Human Rights**

#### **Summary:**

F.S., a young woman from a rural town in Chile, was forcibly sterilized without her knowledge or consent when she was just 20 years old because she is HIV positive.

During the first trimester of her pregnancy, F.S. learned that she was HIV positive through a routine pre-natal test. Despite her initial dismay and fear on receiving this news, F.S. was relieved to learn that there was a good chance that her child would be born healthy and HIV negative—the risk of mother-to-child transmission is less than 2% when necessary precautions are taken. Throughout her pregnancy, F.S. took all the necessary steps to carry to term a healthy child, seeking regular prenatal care, accessing antiretroviral therapy, and delivering through a caesarean.

In November 2002, F.S. checked into the Hospital of Curicó, the public hospital where her caesarean delivery was going to take place. The night before the operation, though, she went into labor, and shortly after midnight, F.S. was brought into the operating room and administered anaesthesia. F.S. slept through the procedure, awaking only to learn that she had given birth to a boy. The following morning, F.S. awoke to learn that her son was

born healthy and HIV negative. But then she received a shocking blow—the operating surgeon had decided to surgically sterilize her during the delivery without her knowledge and without ever discussing sterilization with her, and she and her husband would not be able to have any more children together. F.S. continues to suffer the physical and psychological harms of this forcible sterilization.

Over time, F.S. learned that the doctor's actions violated Chilean law and her rights. In March 2007, to vindicate her rights and to prevent other women from experiencing the same abuse she had suffered, F.S. filed a complaint against the operating surgeon. The complaint sought criminal sanctions against the surgeon and financial indemnification. A police investigation confirmed that F.S. had not given written consent for the sterilization as required by Chilean law, but the Public Prosecutor carried out a substandard investigation into F.S.'s complaint. The surgical team gave contradictory testimony either that F.S. had requested the sterilization or that the surgeon asked if she would be sterilized and she assented, and the nurse that completed F.S.'s medical chart said that she did not recall any request for sterilization.

Ignoring these glaring discrepancies in the testimonies of the medical team, F.S.'s own testimony that she had never consented—verbally or otherwise—to be sterilized, and Chilean law requiring written consent, the Public Prosecutor recommended that the case be dismissed, saying that F.S. had verbally consented to the sterilization. The trial court followed the Public Prosecutor's recommendation and dismissed the case. F.S. and her lawyers appealed this decision, but the appellate court upheld the dismissal, leaving F.S. without any redress for the irreparable harm that she suffered.

On February 3, 2009, the Centre for Reproductive Rights and VIVO POSITIVO, a Chilean nongovernmental organization, brought F.S.'s case to the Inter-American Commission on Human Rights (Inter-American Commission). The case is the first international human rights case to address the sexual and reproductive rights of women living with HIV and to seek government accountability for these violations.

**Status:** The Inter-American Convention on Human Rights has declared the case as admissible.

**7. María Mamerita Mestanza Chavez Vs. Peru, Report No. 71/03, Petition No. 12.191**

**Forum: Inter-American Commission on Human Rights**

**Summary:**

In a petition lodged with the Inter-American Commission on Human Rights on June 15, 1999, the nongovernmental organizations Office for the Defence of Women's Rights (DEMUS), the Latin American and Caribbean Committee for the Defence of Women's Rights (CLADEM), and the Asociación Pro Derechos Humanos [Association for Human Rights] (APRODEH), which subsequently accredited as co-petitioners the Center for Reproductive Law and Policy (CRLP) and the Centre for Justice and International Law (CEJIL), alleged that the Republic of Peru violated the human rights of Ms. María Mamérita Mestanza Chávez, by forced sterilization that ultimately caused her death.

Ms. María Mamérita Mestanza is just one among a large number of cases of women affected by a massive, compulsory, and systematic government policy to stress sterilization as a means for rapidly altering the reproductive behaviour of the population, especially poor, Indian, and rural women. They noted that the Ombudsman had received several complaints on this matter, and that between November 1996 and November 1998 CLADEM had documented 243 cases of human rights violations through the performance of birth control surgery in Peru.

The petitioners stated that Ms. María Mamérita Mestanza, a rural woman about 33 years old and mother of seven children, was pressured to accept sterilization starting in 1996 by the Health Center of Encañada District. She and her husband Jacinto Salazar Suárez were subjected to various forms of harassment, including several visits in which health personnel threatened to report her and Mr. Salazar Suárez to the police, and told them that the government had approved a law requiring anyone who had more than five children to pay a fine and go to jail.

They state that finally, under coercion, Ms. Mestanza agreed to have tubal ligation surgery. The procedure was performed on March 27, 1998 at the Cajamarca Regional Hospital, without any pre-surgery medical examination. Ms. Mestanza was released the next day, March 28, 1998, although she had serious symptoms including nausea and sharp headaches. In the following days Mr. Jacinto Salazar reported to personnel of La Encañada Health Center on Ms. Mestanza's condition, which worsened daily, and was told by them that this was due to post-operative effects of the anaesthesia.

Ms. Mestanza Chavez died at home on April 5, 1998, and that the death certificate specified a "sepsis" as the direct cause of death and bilateral tubal blockage as a precedent cause. They report that a few days later a doctor from the Health Centre offered a sum of money to Mr. Jacinto Salazar in an effort to put an end to the matter.

On April 15, 1998 Mr. Jacinto Salazar filed charges with the Provisional Combined Prosecutor of Baños del Inca against Martín Ormeño Gutiérrez, Chief of La Encañada Health Center, in connection with the death of Ms. Mestanza, for crimes against life, body, and health, in premeditated homicide (first degree murder). They add that on May 15, 1998 this Provincial Prosecutor indicted Mr. Ormeño Gutiérrez and others before the local Provincial Judge, who on June 4, 1998 ruled that there were insufficient grounds to prosecute. This decision was confirmed on July 1, 1998 by the Circuit Criminal Court, so on December 16, 1998 the Provincial Prosecutor ordered the case dismissed.

**Status:** On March 2, 2001 during the 110<sup>th</sup> regular session of the IACHR a Preliminary Agreement for Friendly Settlement was reached. The final friendly settlement was signed on 26<sup>th</sup> August , 2003. The terms of the friendly settlement are:

1) Recognition: In that agreement the Peruvian State admitted international responsibility for the facts described and pledged to take steps for material and moral reparation of the harm done and to initiate a thorough investigation and trial of the perpetrators and take steps to prevent the recurrence of similar incidents in the future.

2) Investigation and Punishment: The Peruvian State promises to make a thorough investigation of the facts and apply legal punishments to any person determined to have participated in them, as either planner, perpetrator, accessory, or in other capacity, even if they be civilian or military officials or employees of the government.

In this regard, the Peruvian State pledges to carry out administrative and criminal investigations into the attacks on the personal liberty, life, body, and health of the victim, and to punish:

- a. Those responsible for the acts of pressuring the consent of Ms. María Mamérita Mestanza Chávez to submit to tubal ligation.
- b. The health personnel who ignored the need for urgent care for Ms. Mestanza after her surgery.
- c. Those responsible for the death of Ms. María Mamérita Mestanza Chávez.
- d. The doctors who gave money to the spouse of the deceased woman in an attempt to cover up the circumstances of her demise.
- e. The Investigative Commission, named by Cajamarca Sub-Region IV of the Health Ministry, which questionably exonerated the health personnel from responsibility for Ms. Mestanza's death.

Apart from the administrative and criminal penalties, the Peruvian state pledges to report any ethical violations to the appropriate professional association so that it can apply sanctions to the medical personnel involved in these acts, as provided in its statutes.

In addition, the State pledges to conduct administrative and criminal investigations into the conduct of agents of the Office of Public Prosecution and the judicial branch who failed to take action to

clarify the facts alleged by Ms. Mamérita Mestanza's widower.

**Indemnification:**

**Monetary Compensation:**

a) Moral damages: The Peruvian State awards one-time compensation to each of the beneficiaries of ten thousand U.S. dollars (\$10,000.00) for reparation of moral injury, which totals eighty thousand U.S. dollars (\$80,000.00). Beneficiaries are the husband and seven children of María Mamérita Mestanza.

The State will deposit the amount due the minors in a trust account in accordance with the best terms available under sound banking practice. Arrangements will be made jointly with the Salazar Mestanza family's legal representatives.

b) Corollary damages: Injury caused as a direct consequence of the event giving rise to the claim consists of expenses incurred by the family as a direct result of the acts. These expenses were incurred to file and follow-up criminal charges with the Office of Public Prosecutions for aggravated homicide of María Mamérita Mestanza, as well as the costs of Ms. Mestanza's funeral and burial. The amount expended for these purposes is two thousand U.S. dollars (\$2,000.00), which the Peruvian State shall pay to the beneficiaries.

**Indemnification from those criminally responsible for the Acts:**

The Agreement for Peaceful Settlement does not include the beneficiary's' right to damages from all those responsible for violation of Ms. María Mamérita Mestanza's human rights, as determined by a competent court in accordance with Article 92 of the Peruvian Penal Code, a right which is recognized by the Peruvian State. This agreement expressly waives any other claim by the beneficiaries against the Peruvian State as responsible party, a co-defendant, or in any other capacity.

6) Right of Recovery:

The Peruvian State reserves the right of recovery against all persons found to be responsible in this case through the definitive sentence of a competent national tribunal, in accordance with current domestic law.

7) Tax exemption, compliance, and late penalty:

The damages awarded by the Peruvian State shall not be subject to payment of any present or future tax, assessment, or fee, and shall be paid no later than six months after the Inter-American Commission on Human Rights has sent notification of this agreement's ratification, after which the State shall pay the maximum late fee and interest required or permitted by domestic legislation.

**Medical Payments:**

The Peruvian State promises to make a one-time payment to the beneficiaries of seven thousand U.S. dollars (\$7,000.00) for psychological rehabilitation treatment they require as a result of the death of María Mamérita Mestanza Chávez. That sum shall be paid in trust to a public or private institution, designated as the trustee, which will administer the resources spent on providing psychological care needed by the beneficiaries. The institution will be chosen jointly by the State and representatives of the Salazar Mestanza family, with support from the National Human Rights Coordination, DEMUS, APRODEH, and the Archbishop of Cajamarca. Expenses for legal establishment of the trust shall be paid by the Peruvian State.

In addition, the Peruvian State promises to give the husband and children of María Mamérita Mestanza Chávez permanent health insurance with the Ministry of Health or other competent entity. The surviving spouse's health insurance will be permanent, as will that of the children until they have their own public and/or private coverage.

### **Education Payments:**

The Peruvian State promises to give the victim's children free primary and secondary education in public schools. The victim's children will receive tuition-free university education for a single degree at state schools, provided they qualify for admission.

### **Other Payments:**

The Peruvian State agrees to make an additional payment of twenty thousand U.S. dollars (\$20,000.00) to Mr. Jacinto Salazar Suárez to buy land or a house in the name of the children he had with Ms. María Mamérita Mestanza. Within one year of the date of this agreement Mr. Salazar Suárez must register the purchase by delivering the deed to the Executive Secretariat of the National Human Rights Council of the Ministry of Justice. Furthermore, Mr. Salazar Suárez agrees not to sell or lease the property purchased until the youngest of his children is of legal age, unless authorized by the court.

Peru's National Coordinator of Human Rights will be responsible for the necessary follow-up to ensure compliance with the provisions of this clause.

### **Changes in laws and public policies on reproductive health and family planning:**

The Peruvian State pledges to change laws and public policies on reproductive health and family planning, eliminating any discriminatory approach and respecting women's autonomy.

The Peruvian State also promises to adopt and implement recommendations made by the Ombudsman concerning public policies on reproductive health and family planning, among which are the following:

#### **A. Penalties for human rights violations and reparation for victims**

1. Conduct a judicial review of all criminal cases on violations of human rights committed in the execution of the National Programme of Reproductive Health and Family Planning,



to break out and duly punish the perpetrators, requiring them to pay the appropriate civil damages, including the State if it is determined to have some responsibility for the acts that gave rise to the criminal cases.

2. Review the administrative proceedings initiated by the victims and/or their family members, linked to the cases in the previous paragraph, which are pending or have concluded concerning denunciations of human rights violations.

## **B. Methods for monitoring and guaranteeing respect for human rights of health service clients**

1. Adopt drastic measures against those responsible for the deficient pre-surgery evaluation of women who undergo sterilization, including health professionals in some of the country's health centers. Although the rules of the Family Planning Programme require this evaluation, it is not being done.
2. Continuously conduct training courses for health personnel in reproductive rights, violence against women, domestic violence, human rights, and gender equity, in coordination with civil society organizations that specialize in these topics.
3. Adopt the necessary administrative measures so that that rules established for ensuring respect for the right of informed consent are scrupulously followed by health personnel.
4. Guarantee that the centers that offer sterilization surgery have proper conditions required by standards of the Family Planning Programme.
5. Take strict measures to ensure that the compulsory reflection period of 72 hours is faithfully and universally honored.
6. Take drastic action against those responsible for forced sterilization without consent.

7. Implement a mechanism or channels for efficient and expeditious receipt and processing of denunciations of violation of human rights in the health establishments, in order to prevent or redress injury caused.

## Constitution of India and Case Law

The Constitution of India guarantees the Right to Life (Article 21) and the Right to Equality (Article 15). The Supreme Court has determined that the Right to Life includes the Right to Health (See *Pashim Banga Khet Mazdoor Samiti*, 1996 4 SCC 37), the Right to dignity, and the Right to be free from cruel, inhuman, and degrading treatment (*Francis Coralie Mullin v. Administrator, Union Territory of Delhi & Ors.*). Some of the fundamental right which focuses on health of women are discussed below:

### 1. Right to access contraceptive information and services.

Article 21 guarantees Right to Life. In *Suchita Srivastava vs. Chandigarh Administration* AIR 2010 SC 235) holding that: "The woman's right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution of India. It is important to recognize that reproductive choices can be exercised to procreate as well as to abstain from procreating."

### 2. Right to be free from discrimination based on sex

Articles 14, 15, 21 gives people the fundamental rights to free from any form of discrimination based on sex but India's family planning policy targets only women to control the booming population.

### 3. Right to dignity

*Suchita Srivastava vs. Chandigarh Administration* (AIR 2010 SC 235) holding that: the crucial consideration is that the woman's right to privacy, dignity, bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively to insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods."

**4. Ramakant Rai v. Union of India, W.P ( C) No 209 of 2003, Supreme Court of India, 12/06/2007)**

A Public Interest Litigation (PIL) was filed by the petitioner for the implementation of the Ministry of Health and Welfare's Guidelines on Standards of Female Sterilization, enacted in October 1999. The petition further sought compensation for victims of medical negligence in sterilization procedures, as well as accountability for violations of the guidelines.

**5. Devika Biswas vs Union of India (WP (c) 95/2012):**

On September, 2016 the Supreme Court ordered a ban on mass sterilization camps in India within three years. "The public interest litigation was filed after 53 women underwent sterilization in unsanitary conditions in Kaparfora, in Araria district of Bihar. The procedure was conducted in a school, in complete violation of the guidelines for female sterilization laid down by the Supreme Court and the Government of India. The judgment directs the central and state governments to stop all camp-based sterilizations within three years and instead strengthen health facilities so that they are able to provide this facility. The judgment also directs governments to not set even informal targets, compelling health workers to undertake "what would amount to a forced or non-consensual sterilization".

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## 8. FINDINGS FROM THE FIELD

*Human Rights Law Network (HRLN) carried out fact findings along with a team of activists and lawyers in different states of India. In this section, fact findings from the states of Rajasthan, Chhattisgarh, Uttarakhand, Madhya Pradesh and Delhi carried out between January 2012 - July 2017 have been compiled with the objective of investigating and documenting case studies of women who have undergone sterilization. The fact-finding missions revealed numerous parallels across health facilities and similarities in women's experiences in accessing the health system. Lawyers and social activists visited sterilization camps throughout rural areas and interviewed various doctors, nurses, hospital staff, patients and families in order to assess the nature and conditions of the sterilization camps; assess whether the guidelines for sterilization were being followed by surgeons and other health workers; assess the patient's level of understanding of the inherent risks of the surgery; examine why women were choosing to undergo sterilization; and finally assess the camps and facilities where women were undergoing sterilization.*

### **1. FACT-FINDING MISSION TO RAJASTHAN (SIKAR, BHILWADA, MADHOPURA)**

**DATE OF VISIT: 12<sup>th</sup> till the 14<sup>th</sup> of February 2017**

**STATE PROFILE: RAJASTHAN**

The state of Rajasthan has the most comprehensive implementation of family planning policies and sterilization camps in the country. Every year, Rajasthan conducts sterilization of over three lakh men and women, often offering Nano cars and free gas connections as incentive. The state government has been promoting sterilization as the best family planning method for years. Just in the last three years, Rajasthan has ended up paying over Rs 10 crore as

compensation for failed sterilization procedures, according to an RTI (right to information) request filed by a resident of Jaipur, Yadunath Dashanan.

The Government of Rajasthan has also employed a series of policies that are highly coercive, policies that incentivise sterilization through offering women who go through sterilization prizes such as motorcycles, television sets, and even a chance to win a car.<sup>95</sup> Although such programmes are no longer conducted, cash incentives for sterilization remain, with women receiving 1400 rupees for undergoing the procedure. ASHA workers are also incentivised to encourage their patients to undergo sterilization, but receive no incentives for promoting other forms of family planning like spacing methods. The structures and schemes in place are coercive measures that encourage impoverished women to undergo potentially dangerous and harmful surgeries with permanent effects.

## FOCUS AND METHODOLOGY

An RTI was filed in state of Rajasthan to the District Medical Officer requesting the authorities to share the calendar prepared for the purpose of conducting sterilization monthly camps.

A team of lawyers and social activists visited various sterilization camps throughout rural areas of Rajasthan. The team interviewed several doctors, nurses, hospital staff members, patients and families in order to assess the nature and conditions of the sterilization camps.

## THE FACT-FINDING INVESTIGATION

### 5.1 CAMP VISIT 1-SHRI KHATUSHYAMJI COMMUNITY HEALTH CENTRE

The team visited Community Health Centre at Shri Khatushyamji on 12/02/2017 to observe the sterilization camp and the healthcare provider's adherence to Hon'ble Supreme Court's recent judgment passed in the matter of Devika Biswas v UOI regarding the violation of standard operating procedures (SOP) in mass

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<sup>95</sup> British Broadcasting Company News, Delhi, Why do Indian women go to sterilization camps? 11/11/2014 <http://www.bbc.com/news/world-asia-india-29999883>

sterilization camps. The team arrived at the CHC at 10:00 am and observed that women had already started coming in - most with general health issues, and very few for the sterilization operation.

The doctor (general physician) on duty informed the team that the camp usually starts after the doctor has arrived, which is after 12:30 or 1:00 pm. He also stated that there are no gynaecologists in the CHC, Khatushyamji, Rajasthan. 19 women between the ages of 20-30 years were registered for the camps. They had been motivated by their local ASHA workers to undergo the procedure, who accompanied them to the camps along with their family members. A sticker carrying a number was pasted on the back of the women's hands to keep count.



THE CHC AT KHATUSHAMJI

Representatives from Foundation for Research in Health Systems, an NGO, filled up forms for the women with basic information, leaving several sections incomplete. Women were then sent for blood and blood pressure tests. However minimal counselling was observed. Moreover, physical examination of women was merely a formality, as it was completed within seconds.

One of the team members was invited to observe the counselling sessions. The NGO representative spoke positively about sterilization, thus promoting it. It was unclear if the women had been informed about the risks of the procedure, and they did not appear to be giving informed consent as mandated by the guidelines. The hospital staff and NGO team appeared to consider attendance at the camp as an indication of the patient's consent to sterilization. The camp was scheduled



WOMEN LYING ON FLOOR AFTER GIVEN ANESTHESIA

to occur from 12:30 pm-3:00pm, with the NGO operating team arriving shortly before this. The fact finding team was informed that the procedure would take 4 to 5 minutes, with the women remaining for observation after the procedure for 1-2 hours. This is far less than the government mandated 4 hours of post sterilization observation. 17 women, out of the 19 registered, were operated on. One woman was denied the procedure as she tested positive on a pregnancy test, and the other was denied due to problems with her appendix and the associated risk of the surgery.



WOMEN BEING CARRIED BACK TO WARD AFTER OPERATION

The women received anaesthesia via injection from an anaesthetist. Following the anaesthetic, women were left to lie on the floor of a room with their bodies completely covered by a blanket. The women were left unattended, as the doctors took breaks to allow the anaesthetic to take effect for approximately 45 minutes. An activist from the team was invited to observe several of the procedures by the surgeon. The activist was informed by the doctor that he changes gloves frequently, which he demonstrated. To prove that cleanliness was maintained in the operating theatre, NGO workers attempted

to cover walls of the operating theatre with a sheet; displayed equipment neatly and used separate colour coordinated dustbins. However, not much attention was paid when it came to changing blood stained sheets on operation table.

Even though the team was previously informed that there were three laparoscopes available, it was difficult to assess if laparoscopes were changed/disinfected between procedures. Following surgery, the women were taken via wheelchair to a ward for post-operation monitoring. The team observed that the women were provided with beds in the ward. The team was informed that the women would make their own way home. There was no ambulance facility available to take the women home, thus causing them out of pocket expenditures. The patients interviewed stated that they were not aware of their entitlement to transportation from the facility to their homes under sterilization

guidelines. A doctor from FRHS, a local NGO, informed the team that the operation usually took around 4 to 5 minutes and the whole process takes around 2 hours (pre-operation and post-operation).

The Medical Superintendent (MS) of CHC at Khatushyamji shared with the team that the CHC in question is a First Referral unit (FRU) with a provision of 50 beds. In Sikar (within 8 Blocks) there are approximately 33 CHCs, 99 PCHs, and 624 sub-centres. As there is no gynaecologist present in this CHC, the govt. engaged FRHS to organize sterilization camps. Female patients were given INR 1400/- whereas male patients were given INR 2000/- for No Scalpel Vasectomy (NSV) as incentives either through cheque or cash.

Regarding meeting the targets, the team was informed that the Anganwadi workers and ASHA workers monitor women, especially those who are pregnant. They encourage women to get sterilization operations done after two children. Health workers informed the team that mobilizing women and convincing them to undergo a sterilization procedure was a big challenge.

## CAMP VISIT 2 – PALSANA COMMUNITY HEALTH CENTRE

The team visited the community health centre at Palsana on the 12/02/2017. The team spoke to Vinod, a Lower Divisional Clerk, and Sheesh Ramji, who was part of the male nursing staff. These individuals were the only ones present at CHC at the time of visit. They informed the team that the camp had occurred the day before i.e. on the 11/02/2017 (Saturday). The women had arrived for registration and counselling at 9:00 am. Seven women were registered for sterilization surgeries. The team responsible for conducting operations arrived by 11:00 am and consisted of government employees. During registration and counselling, a physical check-up is performed, and before the operation the women's blood pressure is checked again. The women receive sedation via injection and are then left for 30



OPERATION THEATER



minutes to allow the operation to occur. It is unclear what level of supervision the women are given during this period and whether they have access to beds in the hospital. The staff informed the team that the operation takes 10-15 minutes, and the women are left for monitoring for 1-2 hours. This suggests that the women are not receiving the mandated 4 hours of post operation monitoring.

The women were also monitored by a different doctor as the operation team left shortly after the operations was completed. Women were required to find their own transport home, in violation of the guidelines, and were provided with post-operation tablets. The team was informed that the patient receives 1400 rupees for undergoing sterilization. The ASHA workers also received 150 rupees for every patient they counselled and referred for sterilization and an added INR 1000/- bonus if the patient already had two children.

### **CAMP VISIT THREE – GULABPURA COMMUNITY HEALTH CENTRE**

HRLN's team of lawyers and social activists visited Gulabpura Community Health Centre on the 13/02/2017 as the sterilization camp was underway. The CHC had a facility of 50 beds with a provision of one general physician (MBBS Doctor) and no Gynaecologists, Paediatricians, ENT specialists, or Eye specialists. Several women were present for sterilization, some of whom had been present at the CHC since 7 am. The women's first point of contact in the hospital was for registration, which largely consisted of filling in the (selective) relevant documentation. The nurse filling up the forms asked very few and specific questions on menstrual cycle, number of children, caste etc. The registrations were being carried out in an extremely small room meant for conducting ECG tests. It served multiple purposes with male patients receiving ECGs while the nurse kept filling up the form as the women poured in. Hence, there was no privacy for the women to openly discuss their sexual health or to ask any questions that they may have had. Out of ten registered cases, one was rejected because the patient's pregnancy test was positive.

Additionally, the team also observed that no counselling was provided to women. There was no discussion with women about

the associated risks of the surgery or the necessary post operation procedures and care. It was not evident that the threshold of informed consent was being met. The team was informed that sterilization camps were conducted every Monday with an average of 10-12 procedures being conducted. A male nurse mentioned that the maximum number of patients at a sterilization camp was 20, while another doctor at the CHC stated that there may be up to 30 women at a camp. The fact finding team was informed that the medical team (which included a surgeon, a nurse and supporting staff from Bhilwada District Hospital) conducted the sterilization camps. The doctor kept inquiring about the no. of women who had come for operation. The seriousness of filling up the forms can be assessed from the fact the nurse asked social activists to fill up the forms when she had to leave her desk for a few minutes.



ASHA'S AND MEDICAL STAFF GETTING THEIR CLIENTS REGISTERED.

The doctor and his team arrived at 12:22 pm and did quick physical examination, spending merely a few seconds on each patient. Subsequently, women proceeded to the OT where they were injected with anaesthetics. It was unclear if there was a dedicated anaesthetist for this task, or if the anaesthetic was being administered by the surgeon or a member of the support staff. The operations began at 1:15 and by 1:50 seven women had already undergone the procedure. Thus, the doctor spent an average of 5 minutes on each patient. However, when the medical team was interviewed after the surgeries, the doctor stated that he spent 10 minutes on each sterilization procedure. The staff further stated that patients remained at the facility until evening for post-operative observation; however the surgeon and his team left shortly after completing the



surgeries. Other staff at the CHC asserted that on average the women remained for observation for only two hours, rather than the mandated 4 hours of observation. Women were not given hospital gowns for the operations and remained in their personal clothes. After surgery, the women were taken to female wards with the aid of wheelchairs and placed on beds for recovery. The CHC staff stated that women used their own means to travel home as there was no ambulance facility available.

The fact-finding team identified a complete lack of hygienic practices and general hygiene within the hospital. Bed sheets that the women were provided for recovery appeared unclean and unhygienic. The staff used the same needle to administer anaesthetic to all the women, cleaning it via the use of boiling water for 1-2 minutes. A source who wished to remain anonymous informed the fact-finding team that the surgeon used only one laparoscope and that it required 3-4 minutes cleaning with disinfectant solution. However, according to guidelines, proper cleaning of laparoscopes requires 20-30 minutes of cleaning. In order to adhere to these guidelines and perform multiple sterilizations continuously, at least 4 laparoscopes are required with rotational cleaning of the instruments.

The fact-finding team reported that the hospital was dirty, with unclean floors and beds. It had open spaces that were exposed to the elements. The team observed a stray dog walking through the hospital and near the entrance of the operating theatre and women's wards.

The fact finding team was informed that for every sterilization procedure conducted, a surgeon gets paid INR 100, a gynaecologist gets INR 50 and an anaesthetist gets INR 50 as cash incentives. The surgeon also informed HRLN's team that the Quality Assurance Committee Meetings are held in Jaipur regularly where cases of failure have been brought up and studied. The doctor said that rate of failure is approximately 4 cases of every 1000 cases in an ideal condition. In such cases, there exists a provision to provide INR 30,000 to the victim (under FPIS). A district level committee has been set up to follow up the case and record the reason for failure.

## 5.5 CAMP VISIT 4 – SHRIMADHOPUR COMMUNITY HEALTH CENTRE

The team visited a sterilization camp at Shrimadhapur on 14/02/2011, and interviewed the doctors, nurse, health care workers and ASHA workers. The hospital MS and a senior Doctor were relatively willing to talk about the sterilization camp after an initial inquiry regarding the team's motive for the interviews.

A health care provider shared that six women and one man had registered for sterilization and NSV procedures respectively and their counselling had already been by RFHS team member. However, pre-operation counselling, as observed by the team, amounted to little more than registration. The women did not appear to be informed about the inherent risks of the procedure, and many were not aware of the contents of the documents that they were signing. The nurses stated that they performed 10 minute counselling sessions with the women. It was unclear whether this time consisted of merely filling out the forms and booklets or if it also included discussions of sterilization alternatives, risks of the operation and instructions on post-operative care. The health care provider stated that she discussed the risks associated with the operation as well as what food the women should eat after the surgery, however this was not observed by the team.

### INTERVIEW WITH THE LAB TECHNICIAN/ANAESTHETIST

The team was informed that there was no anaesthetist in the area. Instead of a qualified doctor, the lab technician for the CHC had undertaken the duties of an anaesthesiologist after undergoing a short two month course in the subject. During the course of interaction with the Lab technician, the team observed that the technician was very rude and disrespectful





towards women. Women were forced to lie on the floor after anaesthesia was administered and no beds were made available for their use. The Lab technician was harsh towards ASHA workers as well. She got offended and scolded ASHA workers for talking amongst themselves. She also did not allow women to talk and instructed them to lie down quietly. The lab technician informed that the women received minimal pre-operation lab tests and check-ups. The lab technician/ anaesthetist spoke negatively about women from

marginalised communities as they lay on the floor.

The doctor informed the fact-finding team that the average operation time was between 5 and 7 minutes. It was not clear how long the women remained for post-operational care after the procedure.

### **INTERVIEW WITH THE DOCTOR AND ASHA WORKERS**

The ASHA workers and nurses discussed the motivations behind women opting for sterilization procedures. They considered monetary incentive a significant driving force. ASHA workers counselled women and attempted to convince women that a sterilization operation after two children was best for their physical health and financial status. They emphasised that families

would be able to give greater support to their children, in terms of education and job opportunities, if they limited number of children to two. The team noticed several boxes of condoms in the counselling room which read "for home delivery by ASHA (Govt of India Supply)." These boxes appeared full and it remained unclear whether the ASHA workers and nurses were discussing alternative methods of contraception with the women. It should also be noted that there are greater incentives for the ASHA workers to counsel these women to receive



sterilization than any other forms of contraception. Although there are significant cash bonuses for counselling women to be sterilized, ASHAs receive no similar bonus for advising alternative means of contraception. For instance, the ASHA workers receive no financial benefit for handing out of condoms, and this would likely require a higher level of continued work for the ASHA worker as compared the work required in counselling and supporting women for sterilization.

On being asked how targets were set, the health worker informed the team that 1% of the population in an area was considered the target for sterilization. The ASHA workers stated that they had a target of counselling 12 women per month. In cases where an ASHA was unable to meet the target, they were scolded and yelled at in meetings. An ASHA also shared that doctors and MS are also required to bring in cases for sterilization. They frequently ask ASHA workers to convince more women for the procedure, to add them to their numbers and accomplish their set targets. This puts extra pressure on ASHAs. An ASHA worker added that she sometimes had to request her husband to talk to men to convince their wives to undergo the sterilization procedure.



AWWs and ASHA workers undergo special training regarding how to motivate women for sterilization, although they continue to find it challenging. Male members of a family are usually reluctant to discuss the issue as they believe it affects their masculinity. They downright refuse to undergo the procedure as they think it makes them unfit for work.

## OBSERVATIONS

The operation of sterilization camps in Rajasthan presents significant health risks to women who attend them. All of the camps attended by the teams failed to meet several requirements

outlined by the Ministry of Health and Family Welfare as the basic standards in the administration of sterilization services. Failure to meet these standards limits the capacity of women to make informed choices about their sexual health, creates significant health risks and may cause lasting harm or death.

The sterilization standards outline that women must receive counselling before undergoing the procedure through camps. The purpose of this counselling is to allow women to make “well informed, well considered and voluntary decisions about fertility and to choose a contraceptive method.”<sup>96</sup> This requires that women be made aware of alternative means of contraception, the potential risks and complications of the procedure, and the permanency of the procedure. Only through explaining these elements of the procedure can an individual give informed consent to the surgery. While the team observed counselling sessions occurring at all the camps, the standards for counselling were not being met. The counselling sessions amounted to little more than the filling out of the necessary forms and documents. Many of the women were not made aware of the inherent risks of the procedure, as well as the necessary post-operative procedures. When the risk of infection and complication is so significant, due to the substandard hygiene and conditions of the hospital, the failure to inform women of operative risks is more so alarming. Most importantly, women were not counselled about the alternatives to sterilization, such as the use of condoms or copper I's. Rather than providing the necessary information for women to give informed consent to the procedure, many of ASHA workers and other health professionals appeared to employ coercive measures in favour of sterilization. The incentive based system for ASHA workers rewards them for encouraging women to become sterilized, while providing no similar financial incentive for the promotion and use of other forms of contraception. Furthermore, some ASHA workers spoken to indicated that they received significant financial bonuses when they encouraged women who had already had 2 children to receive sterilization.

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<sup>96</sup> Ministry of Health & Family Welfare, *Standards & Quality Assurance in Sterilization Services*, November 2014.

The same financial incentives exist for women to undergo the sterilization procedure and serve a similar coercive purpose.

There was an overwhelming overrepresentation of women at the sterilization camps. In all camps visited by the team, only one contained a single male patient receiving sterilization, and it was unclear whether he went through with the procedure. Existing taboos and cultural practices place the risks of sterilizations camps disproportionately upon women. While the government has introduced higher financial incentives for male sterilization than for female sterilization, this has had limited effect. Health workers themselves perpetuate these taboos, with ASHA workers seemingly counselling in favour of female sterilization over male sterilization. Greater education, government incentives and legislation are required to reduce the disparity between male and female sterilization.



The medical standards of sterilization camps continually failed to meet required guidelines. Following the administration of anaesthetic, women at all the camps were left unattended and unmonitored by the doctor or anaesthesiologist, with some lying on the floor. This is in direct contravention of sterilization standards which state that the “client must be monitored and attended to after the parenteral administration.”<sup>97</sup> The guidelines outline that the anaesthetic should take effect within 4-5 minutes if the prescribed drug is used and is properly administered. However, several of the doctors spoken to stated that the anaesthetic took between 30 to 45 minutes to take effect. This suggests that the anaesthetists were not using the appropriate anaesthetic for the procedure as mandated by government standards. Furthermore, at one of the camps visited, the anaesthetic was not being administered by a medical anaesthetist. Instead a lab technician

<sup>97</sup> Ministry of Health & Family Welfare, *Standards & Quality Assurance in Sterilization Services*, November 2014.



with 2-3 months of anaesthetic training was responsible for administering the medicine.

Sterilization camps and community health centres also demonstrated a disregard for basic hygiene, with patients being subject to unhygienic conditions that place their health at risk. The team observed bedding and linen that was often soiled, unhygienic and not changed between different patients. This significantly raises the post-operation risks that the women face, like the risks of infection and contagious diseases. The use and cleaning of medical instruments at the camp was also below standard. The required standards mandate the cleaning of laparoscopes via initial decontamination with a swab soaked in a spirit and then the use of High Level Disinfection (HLD) or where possible sterilization. This process can vary between 20-30 minutes and this necessitates that surgeons have access to multiple laparoscopes in order to conduct multiple sterilizations in short periods of time as occurs in the camps. While some of the camps visited had access to multiple laparoscopes, many of the camps only had access to 1 or 2 laparoscopes. Thus the speed and volume of the sterilizations at these camps indicates that laparoscopes were not being cleaned appropriately putting patients at a significant risk of infection. The team also witnessed one hospital that had a stray dog roaming throughout the hospital and near the operating room where the sterilizations were taking place. The Community Health Centres visited to by the team did not represent suitable locations for en masse sterilizations to take place, lacking the necessary facilities and equipment to ensure that safe and hygienic operations were conducted.

The post-operative procedures were also found to be lacking at all the camps visited by the teams. The government standards outline that women must remain for post-operative observation in the hospital and must only be discharged "after at least 4 hours of procedure, when the vital signs are stable and the client is fully awake, has passed urine and can talk, drink and walk."<sup>98</sup> The standards also outline that the client must be seen

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<sup>98</sup> Ministry of Health & Family Welfare, *Standards & Quality Assurance in Sterilization Services*, November 2014.

and evaluated by a healthcare provider before discharge and wherever necessary the client should be kept overnight at the facility. None of these post-operative standards were reached in any of the sterilization camps attended to by the team. All the health professionals spoken to mentioned that the women remained for observation for 1-2 hours, with some stating that the women remain till evening without providing a specific timeframe. Several of the camps visited also had surgeons leave almost immediately after surgery, with other doctors at the CHC thus being responsible for the monitoring of the women. All of the camps observed took the women from the operation room to the wards via wheelchairs, and provided women with beds for the recovery process.

All the camps attended failed to provide women with transportation to and from the sterilization camp. All the women interviewed had made their own way to and from the sterilization camp with the assistance of their family. None of the women interviewed were aware of their right to request an ambulance service for transportation. Many of the CHCs did not appear to have active or functional ambulance services. This limits their capacity to offer this mandated service to the patients as well as provide general medical services to the region.

The promotion of sterilization camps in Rajasthan greatly endangers women who may choose to or be coerced into undergoing these procedures. Sterilization camps provide women with access to a form of contraceptive service for free and incentivize them for doing so. However, the practice of conducting these forms of surgery en masse places the health of these women at risk in favour of cost and time efficiency. These camps are also comprised entirely of BPL and ST women which suggests that the most vulnerable sections of Indian society are becoming subject to the grievous health risks associated with sterilization camps and being sterilized at disproportionate rates in comparison to the wider Indian population.

## 2. FACT-FINDING MISSION TO UTTARAKHAND, CHAMPAWAT AND PITHORAGARH, DATE OF VISIT: 23RD JAN-28 JAN, 2016

### Family Planning and Population Control in India



India's public sector family planning programme claims to provide a 'cafeteria approach'<sup>99</sup> with a 'basket of choices'. Five official contraceptive methods are provided at different levels of the public health system, including spacing methods such as oral contraceptive pills (OCPs), intra-uterine devices (IUDs) and condoms; and limiting methods such as male and female sterilization.<sup>100</sup> However, the use of modern spacing methods is minimal. In 2005-2006, it accounted for merely 10.1% of total contraceptive use.<sup>101</sup> Furthermore, negligible male interaction and engagement with family planning is widespread. In 2005-2006, only 9.1% of married couples used male methods or couple-dependent contraceptive methods.<sup>102</sup>

<sup>99</sup> A cafeteria approach is individualized plans allowed by employers to accommodate employees preferences for benefits.

<sup>100</sup> Ibid.

<sup>101</sup> Saroj Pachauri, 'Priority strategies for India's family planning programme' (2014) 140(1) *Indian Journal of Medical Research* 137; India, Mumbai: IIPS; 2007. International Institute for Population Sciences (IIPS) and Macro International. National Family Health Survey (NFHS-3), 2005-06.

<sup>102</sup> India, Mumbai: IIPS; 2007. International Institute for Population Sciences (IIPS) and Macro International. National Family Health Survey (NFHS-3), 2005-06.

Female sterilization is aggressively promoted by the state through centrally-decided numerical targets despite India's commitment at the 1994 International Conference on Population and Development to adopt a 'target-free' approach to family planning.

### Research Methodology

A team of activist and lawyers visited two district of Uttarakhand, Champawat and Pithoragarh, from 23<sup>rd</sup> Jan-28<sup>th</sup> Jan 2016 with the objective of evaluating sterilization services and looking at the gaps in implementation of standards and guidelines for quality care and services. The mapping of the district is based on the data of Annual Health Survey which highlighted the fact that usage of sterilization as spacing method is highest in Champawat and Pithoragarh as compared to other district of Uttarakhand. This research is based on secondary data like census, District Level Household Survey Report, government reports and primary data based on household surveys in 15 villages of Champawat and Pitthoragarh village.

### STATE PROFILE OF UTTARAKHAND:

**Table: 1: State Profile**

S.No.	Background Characteristics	State
		Number
1	Geographic Area (in Sq. kms)	53,484 sq. kms
<b>2</b>	<b>Number of blocks</b>	95
<b>3</b>	<b>Size of Villages (2011 Census)</b>	
	Number of villages	16826
	1-500	13460 (80 %)
	501-2000	2679 (17%)
	2001-5000	426 (2.7 %)
	5000+	NIL
<b>4</b>	<b>Number of towns</b>	31

<b>5</b>	<b>Total Population (2011)</b>	1,01,16,752
	Male	5,154,178
	Female	4,962,574
<b>6</b>	<b>Sex Ratio (F/M*1000)</b>	
	Population Sex Ratio	963
	Child Sex Ratio	886
<b>7</b>	<b>Decadal growth rate</b>	19.17
<b>8</b>	<b>Density- per sq. km.</b>	189
<b>9</b>	<b>Literacy Rate (+6 Pop)</b>	79.63%
	Male	88.33%
	Female	70.70%
<b>10</b>	<b>SC/ST population</b>	
	SC	15.17%
	ST	2.56%

### 3. Champawat district profile

The district of Champawat was established in 1997. It currently ranks 12th in terms of population size, with a total population of 259,648.<sup>103</sup> Decadal population growth in Champawat (15.63%) is lower than the growth rate of the state (18.81%).<sup>104</sup> Champawat is one of the least urbanized districts in Uttarakhand; only 14.77% of the population resides in urban areas. The following table contains key health indicators in the district of Champawat, as compared to state and national averages:

**Table 2: Health indicator 2012-13**

INDICATOR	CHAMPAWAT	UTTARAKHAND	INDIA
Crude Birth Rate	16.9	18.0	21.8
Total Fertility Rate	2.0	2.1	2.4
Crude Death Rate	5.6	6.1	7.1
Infant Mortality Rate	34	32	44

<sup>103</sup> Government of India, Census 2011.

<sup>104</sup> Government of India, Census 2011.

Maternal Mortality Rate	182	292	212
Sex Ratio (per 1000)	980	963	940
Male literacy rate (%)	91.61	88.33	82.14
Female literacy rate (%)	68.05	70.70	65.46

Sources: AHS 2012-13, Census 2011, SRS 2012

#### 4. PITHORAGARH DISTRICT PROFILE:

The district of Pithoragarh was constituted in 1960. It is the eastern-most district in Uttarakhand and currently ranks 8<sup>th</sup> in terms of population size, with a total population of 483 439.<sup>105</sup> Decadal population growth in Pithoragarh (4.58%) is lower than the growth rate of the state (18.81%).<sup>106</sup> Pithoragarh is one of the least urbanized districts in Uttarakhand; only 14.4% of the population resides in urban areas. The following table contains key health indicators in the district of Pithoragarh, as compared to state and national averages:

**Table 3: Health Indicators 2012-13**

INDICATOR	CHAMPAWAT	UTTARAKHAND	INDIA
Crude Birth Rate	15.4	18.0	21.8
Total Fertility Rate	1.7	2.1	2.4
Crude Death Rate	6.2	6.1	7.1
Infant Mortality Rate	23	32	44
Maternal Mortality Rate	182	292	212
Sex Ratio (per 1000)	767	963	940
Male literacy rate (%)	96.8	88.33	82.14
Female literacy rate (%)	78.9	70.70	65.46

Sources: AHS 2012-13, Census 2011, SRS 2012

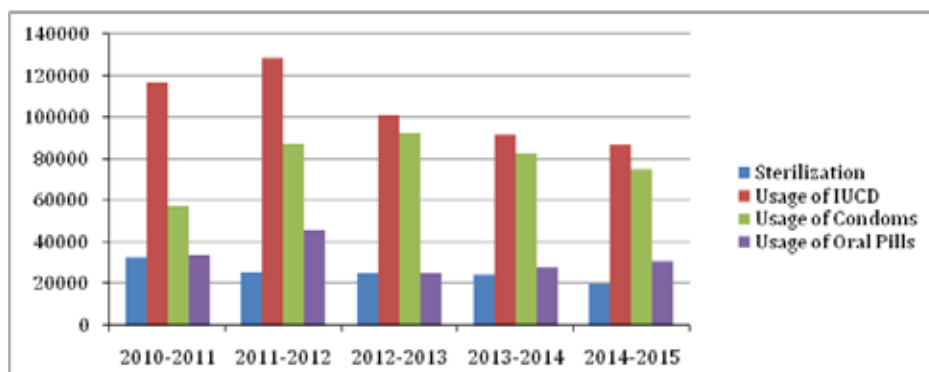
<sup>105</sup> Government of India, Census 2011.

<sup>106</sup> Government of India, Census 2011.

### Status of Family Planning Programme in the State:

All the modern contraceptive methods are available in the state. The following graph analysis highlights the usage of different spacing methods in the state from 2010-2015:

**Graph 1: Status of family planning in the state**



Thus, from the above table it is clear that usage of condoms and IUCD are common mechanisms for family planning mechanism in the state. Women also undergo sterilization process but it is less as compared to usage of other family planning process. Further, the graph shows that number of sterilization usage is constant since 2010.

In the state of Uttarakhand, a total of 438 female sterilization camps were proposed for the years 2015-2016.<sup>107</sup> The Uttarakhand state government openly states that it needs to conduct 48,000 additional sterilizations annually to meet its fertility targets.<sup>108</sup>

- Usage of contraceptive methods in Champawat:

The disproportionate reliance upon female sterilization and the limited access to alternative contraceptive methods is illustrated in the following table on family planning practices in Champawat.

<sup>107</sup> Uttarakhand State PIP 2014-2015.

<sup>108</sup> Ibid.

**Table 5: Family planning practice in Champawat**

INDICATOR	CHAMPAWAT	UTTARAKHAND	INDIA
Any modern method of contraception (%)	67.6	62.7	47.1
Female sterilization (%)	46.8	27.6	34.0
Male sterilization (%)	0.7	1.3	1.0
Copper T/IUD (%)	0.2	0.9	1.9
OCP (%)	4.2	4.9	4.2
Condom (%)	15.6	18.7	5.9
Emergency contraception pill (%)	0.0	0.7	0.6
Total unmet need for family planning (%)	15.8	15.3	21.3

Source: AHS 2012-13, DLHS-3 2007-08

Thus, from the above table it is clear that among the modern contraceptives usages, the usage of female sterilization is high with 46.8%.

- Usage of contraceptive methods in Pithoragarh:

The following table on Family Planning practices in Pithoragarh.

**Table 6: Family Planning practices in Pithoragarh**

INDICATOR	PITHORAGARH	UTTARAKHAND	INDIA
Any modern method of contraception (%)	72.2	62.7	47.1
Female sterilization (%)	52.4	27.6	34.0
Male sterilization (%)	1.3	1.3	1.0
Copper T/IUD (%)	0.4	0.9	1.9
OCP (%)	2.7	4.9	4.2
Condom (%)	15.3	18.7	5.9
Emergency contraception pill (%)	0.1	0.7	0.6
Total unmet need for family planning (%)	13.3	15.3	21.3

Source: AHS 2012-13, DLHS-3 2007-08



## Findings:

The fact-finding mission revealed numerous parallels across the health facilities and similarities across women's experiences in accessing the health system. Each hospital appeared understaffed, and had infrastructure in need of urgent upgrading. Public amenities and washrooms were unhygienic, as were the wards where women stayed. Women commonly reported receiving incomplete information regarding sterilization, and a lack of access and information regarding alternative contraceptive methods available.

The following section details the results of the fact-finding mission, before extracting key issues of concern as identified by the team. The report finally concludes with recommendations to improve the quality of care with regard to sterilization services. These recommendations are not confined to the state of Uttarakhand, but apply to sterilization and the provision of family planning services within India in general.

- Interviews with women:
  1. Sunita Mehra, 25 year, is married for five years and has two children, a boy and a girl. Her husband works with ITBP (Indo-Tibetan Border police) posted outside Uttarakhand. While interviewing her, it came into light that she was planning to undergo sterilization in a few months. When asked why she is opting for this permanent method of sterilization, her answer reflected that all she wants is 'permanent methods'. But she was not aware of the complications of the sterilization. She was well educated but it seemed that the decision of sterilization was influenced by her in-laws. On further questioning, the other thing that came into light was that she 'wants' another daughter, but at the same time, she cannot express her want (for the obvious reason that her economic conditions did not allow it and her family's view that she was already a mother to a boy and a girl and hence had no need of a third child).
  2. Rani Devi, a 34 year old woman has three children: a boy and two girls. Her husband owns a shop in their village. She

underwent sterilization in 2014, although the procedure failed. She was sent back after the operation after being told that the procedure had been successful. However, after three months, she realized that she had conceived and was carrying three month old foetus. She went back to the hospital where she underwent the surgery, tried talking to the doctors and asking for compensation, but the hospital authorities gave no response. She further went to higher authorities and filed a case against the hospital for being careless towards her. The government awarded her a compensation of Rs. 35,000. She is now suffering from back pain.

3. Soni Devi, 25 years old, had 2 children. She went for sterilization on 25 Jan, 2016 but was disappointed. The doctors spent 15 minutes trying to find the right nerve to be operated on, but failed. She was given high doses of antibiotic and injections which kept her drowsy and nauseated for the next two days. The doctors sent her back and asked her to return the following week for the procedure. While at the hospital, Soni Devi was not provided a bed after the attempt at the procedure and was made lie on the floor. Moreover, the failure in conducting a successful procedure not only delayed her operation but also kept her in bed, which affected her household chores and she could not even look after her children. Soni Devi was accompanied only by the ASHA worker of her village. Hence, not only was she was forced to travel 120 kms on her own expense for for the failed surgery, but she also suffered terribly from fever, nausea and severe abdominal pain.
4. Pari Devi, 25 years of age, also underwent the procedure at Lohaghat CHC on 25<sup>th</sup> Jan, 2016. Though she did not face any complications with her operation and received the incentive that she was entitled to, she was completely unaware of complications and risks associated with the sterilization procedure. The local ASHA workers signed her consent form at the hospital. Her interview clearly indicated that the sterilization operation had affected her mental health poorly. She confirmed that her husband

was unaware that she had undergone the procedure as he worked away from home, in a city. She already had three kids -two girls and a boy. Although she did not say much regarding her feelings for sterilization as a method of contraception, it was evident that the procedure had been conducted against her choice.

5. Soni Devi, a 24 year old woman, has two children - a boy and a girl. She never received any formal education and was married as a child, at the early age of 16. She underwent the sterilization procedure a week before her interview with the team and was in the hospital for her follow-up. She confirmed that her operation went well and that she had received the incentive that she was entitled to. However, her interview revealed that Soni Devi was completely unaware of other methods of contraception. She chose sterilization simply because she and her husband could not afford to bring up any more children, considering that her husband is a daily wage labourer. She added that a 'woman is helpless when her husband is at home and cannot take risk every time so it should be better if we get rid of it once and for all'.
6. Parvati Devi, 26 years of age, got married at the age of 20. She delivered her third child which was 'finally' a boy. When she visited the Lohaghat CHC for her delivery, doctors referred her to the Pithoragarh hospital during labour. According to Parvati Devi, the doctors mishandled her by inserting hand in her vagina to check her progress, due to which she had vaginal tract puffiness and swelling. This had actually increased her pain and doctors could not handle her delivery anymore later as they are not equipped for it. She then came to Pithoragarh in the labour pain only, travelling 75 kms. Here in this hospital the doctors treated her well and were given full medications and proper care. Further, she underwent sterilization in 2014 because she delivered baby boy and now she want permanent solution. She was not aware of the process and complication of sterilization.

7. Nanda Devi, aged 22 years, has three children. Her husband is a daily wage earner and works in Delhi. She lives with her mother-in-laws and children. She opted for a sterilization procedure due to the cash assistance programme. She was not aware of the complications involved with the procedure.
  - Visits to hospital facilities and interaction with healthcare providers:

### Champawat District Hospital

The fact-finding team first visited Champawat District Hospital, established in 2010. The hospital does not have its own ambulance service; the only functional ambulance service in the district is the government service of 108. There is also no functional blood bank.

Upon entry, the fact-finding team first noticed that it was extremely busy, with a lot of patients. Although we were told that the staff included 12 nurses, two gynaecologists and one pediatrician, the only healthcare workers that could be seen attending the patients were two nurses, one dispensary worker, the CMO and a single doctor. As a result, many people were forced to wait long times before they were seen. Although the hospital building itself was well-lit and spacious, there were inadequate seating arrangements outside the consultation rooms. Furthermore, there was a lack of privacy as the doors were not closed, and other patients would wait in the same room or just outside.





There were numerous posters on mother and child care, prevention of HIV/AIDS, the importance of institutional delivery and the 'benefits' of sterilization on the walls of the hospital. However, they were placed upstairs and it seemed unlikely that they would be seen by the women and 'couples' for whom they were targeted.

After making enquiries, the team discovered that the two permanent gynaecologists were on leave; in their place a single gynaecologist with only a year's experience was looking after all the gynaecology patients. Furthermore, we were informed that the nurses were responsible for delivering babies; the gynaecologists were either hesitant or absent. The team was able to witness this first-hand as they observed a nurse assisting a pregnant woman in labour. The labour room itself was spacious and contained all the necessary instruments as well as medicines required at the time of delivery. The team observed a functional autoclave and noticed the boiling of instruments. However, basic hygiene standards were otherwise not observed; there were blood stains on the floors, pillowcases and linens; medical waste including blood-stained gauze were left on a tray on the side of the room; and the floors and lower part of the walls were covered in grime and dirt.

Failure to maintain basic sanitary conditions was also evident in the washrooms, which were very dirty and foul smelling. There was a large puddle of dark water on the floor, and the taps and lights were not working. The sink was clogged and filled with rubbish.

### **Interview with ASHA worker at Champawat district hospital**

We interviewed one ASHA worker of the village who belongs to this village only. The following facts came up on talking to her:

- The average age of women who undergo sterilization is between 22-25 years of age.
- She has motivated women to use copper-T also in her village.
- The average number of children with the woman who has decided to undergo sterilization is two.
- There have been instances where women have three children only because of the want/desire of a male child.
- On being asked how they motivate women to undergo sterilization, she indicated that ASHA workers do not need to go to women, they come themselves to the ASHA workers that now they want to go for sterilization as they now have two or three kids. According to the ASHA worker, women are now educated and are aware that sterilization is required because their economic conditions do not allow them to raise more than two or at most three children. Whereas, women say that they have been informed of sterilization camp that have held in the district hospital and 'they have to come'. ASHA workers are also given incentives based on the number of women they bring to hospital for sterilization.
- According to her, women generally don't go for follow-ups because the hospital is nearly 60 kms away and they cannot afford to visit it frequently. Hence, their stitches are also being cut in the village only by the ANM or the ASHA worker herself.
- She said that during her three day training period she only receives 100/- which includes travel.

### INTERVIEW WITH CMO –CHAMPAWAT DISTRICT HOSPITAL

The fact-finding team spoke to the CMO in his office. We were told that the most common health issues faced by women and children in the area are infection, malnutrition and anaemia. The women patients are motivated and brought in by



ASHA workers who have trained at nearby PHCs and CHCs. Each ASHA received Rs. 1000 for each person brought in for sterilization; however, the motivation fee has recently been reduced to Rs. 500. He reported that 90% of sterilization procedures were performed on women; men were unwilling to undergo vasectomy and all prior attempts to motivate men have failed. The CMO further told us that the normal trend now is to target women after the birth of their first child, whereas before women were only approached after giving birth to 2-3 children. The CMO denied that any sterilization surgeries were performed on girls aged less than 18 years. Champawat District Hospital has only one Family Welfare Counsellor serving the district who is responsible for the counselling of women and ensuring they know their rights, the permanency of sterilization and its risks and benefits. The CMO also told us that most patients and families were aware of the services and benefits provided by the hospital as mandated by the Government Schemes, however, they had no means to contact women living in interior areas as they were over 20km away.

### Lohagat CHC



The fact-finding team next visited Lohagat CHC, which was located in the town centre. This CHC is a 30 bedded hospital. As the only CHC for the districts of Champawat and Pithoragarh, it serves as the prime health centre for villages as far as 62km away. The hospital has recently been undertaken into a public-private partnership.

The hospital was empty when we arrived; the team found only one woman mopping the floor with a bucket of grey water. We were informed that the sterilization camp held that day was over – the operating surgeon and medical staff and all the women had returned home. After some enquiries, the team discovered that a total of 30-40 women were operated on that day. The women were from the village of Madlak located 100km away,

on the border of Nepal. All women came to the CHC by their own transport which cost them a total of Rs. 400/-.

The conditions at Lohagat CHC were abysmal. The entire building was in want of repair and general maintenance. A large pack of stray dogs was found behind the main building. There was no waste disposal mechanism. All waste was dumped in an area just behind the hospital.

Moreover, the washrooms were extremely unhygienic. The taps were broken and the sinks were clogged with dirt. It is unclear when the urinals were last cleaned; a thick layer of grime along the lower part of the walls and floor was clearly visible. Urine covered the floor.

Upon further exploration, the fact-finding team found evidence of complete disregard for asepsis and infection control measures, in direct violation of the Indian Public Health Standards (IPHS). Bed sheets were filthy and had noticeable blood stains and rubbish. The floors were filthy and liquid spills not cleaned. The door in one of the operating theatres was broken; the bottom third of the door was covered in a thick layer of black mould.

### Pithoragarh district hospital



The fact-finding team visited Pithoragarh District Hospital. There is an altogether different building for women only and therefore separate male and female wards.

Upon entry, the fact-finding team immediately noticed it was far busier than the previous health facilities that had been visited. There were many women and children standing while waiting to see the gynaecologist. Others were forced to sit outside on the dirt floors. Inside the consultation room, there was an evident lack of privacy. The team observed one



woman being examined by the doctor while a long line of patients stood nearby and watched.

During the visit, the fact-finding team found various posters placed inside and on the outer walls of the building on JSY, AIDS control, breast feeding, post-natal care and antenatal care. Some of these posters were in Hindi, however, some posters, including those on breastfeeding and feminine hygiene, were written in English only and therefore inaccessible to women from less educated backgrounds.

Overall, the hygiene and sanitation levels of the hospital was concerning. The fact-finding team was able to locate the delivery and labour rooms, where it was observed that the infrastructure was deficient. The small room had 2-3 beds squeezed in, the floors were dirty and overall, the room did not smell clean. A woman was moaning in pain for a few minutes in the room next door, before a doctor came to her assistance.

The washrooms were in a grossly unhygienic state. A dirty mop was left on top of the cistern, dripping grey coloured water onto the floor. The bucket filled with murky water was left in the toilet. The tiled walls were covered in dirt, and there was urine on the ground.

### Observations:

- 1. Camp Site and client load:** From the findings it was observed that the timing of sterilization was from 2:00 pm-4:00 pm. But according to SOP, camp timing "should preferably be between 9am and 4pm". Thus, within the span of 2 hours, they have operated 40 women that mean per operation they spend 3-5 minutes. This clearly shows the violation of the guidelines.
- 2. Physical requirements for female sterilization:** There was no provision of drinking water at Lohghat CHC. There is a generator for electricity backups but it's not functional since 6 months.
- 3.** The bathrooms and sterilization rooms were not cleaned at Pithoragarh district hospitals, Lohghat CHC and Champawat

District hospitals. The fact finding team noticed blood stains on the bed sheets.

4. At Lohaghat CHC, due to shortage of beds, women were made to lie down on the floor without any mattresses, before and after the operations. Moreover, in peak winter, hospital authorities did not provide blankets to the women, instead asking them to carry their own blankets.
5. There is no proper waste disposal mechanism at the Lohaghat CHC. All the waste is disposed in an open area just behind the hospital building. Furthermore, women interviewed by the team stated that since health centres do not have hygiene and clean environment they don't feel comfortable to get admitted at the hospitals.
6. **Counselling:**<sup>109</sup> Before the operation women should be counselled for sterilization. From the case studies it is clear that all interviewed women were not aware of the available methods of family planning but they opt for sterilization because it's a permanent method and moreover women gets paid for it. Women are not aware of the potential complication and side effects. This shows that the hospital authority failed to give proper counselling to women and instead they motivate the women in order to fulfill the targets.
7. **Failure in Clinical assessment:** Out of 10 interviewed women, 8 women reported that medical history and physical examination were not recorded prior to their surgeries. Only the laboratory examinations, including blood and urine, were conducted. This shows poor quality of care at the camps. In many cases, women were not given thorough post-operative instructions other than to rest and take medicines provided. This is insufficient and below the minimum level mandated by the Government of India Sterilization Standards. For example, there was no information on what to do to prevent infection, or who to contact for help if needed. Women were also discharged from hospital merely one hour after their operation, despite the requirement that they may be discharged after a minimum of four hours and only after

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<sup>109</sup> ibid

evaluation by a doctor. These factors together contribute to greater levels of unnecessary infection and complications, which could otherwise be easily avoided. This violates a woman's right to health (Constitution of India Article 21; ICESCR Article 12).

- 8. Informed consent:** Women are not provided with the complete information necessary to make an informed decision to undergo sterilization. Although the permanency of sterilization was understood, many women could not name any alternative contraceptive methods, or the risks associated with the procedure in breach of the Standards for Female and Male Sterilization (2006). In fact, for many women the local ASHA worker was their only source of information. This may partially be due to the resource constraints identified above regarding available counsellors. However, in the majority of instances the provision of partial or incorrect information is directly related to the incentive based target driven approach to family planning which forces health workers to withhold information that may be prejudicial to their own self-interests. Additionally, consent forms were not explained to women in their own language, and in one case the nurse signed on behalf of a woman without asking for any further information.
9. This is a violation of the right to access contraceptive information and services, the right to informed consent and the right to bodily integrity (Constitution of India, Article 21; CEDAW Article 16).
- 10. Follow up visits:** After the surgery, women are kept only an hour for observations as reported by the ASHA worker and interviewed women. Women from Madlak village informed the teams that it will be difficult for them to visit the Lohoghat CHC for follow up check ups since transport services are not available and Lohaghat CHC is 70 kms from the village. Also, there are no PHCs in the village and so women must visit local 'quack' doctors in the village for follow up visits. Out of 10 interviewed women, 5 women complained about complications like nausea, abdominal pain, back pain and abdominal swelling.

**11. Under-resourced public sector:** Many of the hospitals visited had problems with staff shortages. For example; there is only one Family Welfare Counselling service for the entirety of Champawat. In many of the facilities, the number of patients exceeded the number of available nurses. This was the case also for those healthcare facilities that had entered into public-private agreements. Lack of skilled staff has serious implications for the level of quality of care that can be provided to each individual patient, and shortcuts are commonly taken to keep up with workflows.

**12. Lack of access to contraceptives:** Research shows that financial barriers exclude poor and uneducated women from accessing modern contraceptive methods. The public health sector is mandated to provide modern contraceptives including sterilization services free of cost.<sup>110</sup> However, government data shows that 10% of women had to pay to access sterilization services in the public sector, while 32% had to pay to access IUD, 24% had to pay for the OCP and 30% had to pay for condoms.<sup>111</sup> Many women interviewed reported that they did not have access to alternative contraceptives either because they were not provided with information about the alternative methods available or because the ASHA worker did not have any stock. These particularly affected women from rural areas, as the ASHA worker from Pithoragarh confirmed that women in the city areas mostly used the Copper-T, and that men from these areas used condoms.

## FACT-FINDING MISSION T SATNA AND KHANDWA DISTRICT, MADHYA PRADESH

**Date of Visit: 5th January 14th of January 2016**

### Background

From 5<sup>th</sup>- 8<sup>th</sup> January and 11<sup>th</sup>- 14<sup>th</sup> January 2016, the team investigated the conditions of sterilization camps in two districts

<sup>110</sup> Tiago de Oliveira, Dias and Padmadas, above n 10, 8.

<sup>111</sup> India, Mumbai: IIPS; 2007. International Institute for Population Sciences (IIPS) and Macro International. National Family Health Survey (NFHS-3), 2005-06.

of Madhya Pradesh. The team interviewed ASHA and ARSH workers, doctors at camps and hospitals, sub centres, assistants, pharmacists and women who underwent sterilization surgeries. The team also visited two camps each in the districts of Satna in Madhya Pradesh.

### Health indicators in Madhya Pradesh

	Total AHS 2103	Urban AHS 2013	Urban Poor (NFHS three reanalysis)
Infant Mortality Rate	62 (2013)	47	78.4
Neo-Natal Mortality Rate	42 (2103)	30	54.8
Under-five Mortality Rate	83 (2013)	57	97.9
Total Fertility Rate	3.1 (2011)	2.4	3.7
Full Immunization (percentage)	54.9 (2011)	64.9	54
Number of SAM children identified (ICDS data)	187599 (2012)	-	-
Annual Blood Examination Rate (ABER) for malaria	13.55	NA	NA
Annual Parasite Index (API)	1.23	NA	NA
Dengue Case Fatality Rate	0 (2011)	NA	NA
Annual New Smear Positive case detection rate	5708	NA	NA
Treatment success rate among new smear positive cases	5459	NA	NA
Leprosy Prevalence Rate	0.66 (2010-11)	NA	NA
No. of outbreaks reported under IDSP in past year	213 (2011)	NA	NA

Source: NATIONAL URBAN HEALTH MISSION PIP 2015 -16 - MADHYA PRADESH

## Coercive Policies in Madhya Pradesh

The aggressive sterilization policies of India are apparent in Madhya Pradesh. The Government of Madhya Pradesh has approved a 38% increase in the number of sterilization camps in Madhya Pradesh according to the 2015-16 budget proposals, as compared to 2014-15. The government has gone to great lengths to promote female sterilization through incentives. As recently as 2011, Madhya Pradesh offered Tata Nano cars for motivating 500 people to undergo sterilization procedures.<sup>112</sup> Furthermore, in 2008, Madhya Pradesh offered a “guns for vasectomy” programme, where gun permits were promised in exchange for a vasectomy,<sup>113</sup> while at the same time making claims that it was not using any coercive measures or targets in its’ sterilization policies.

Furthermore, the government of Madhya Pradesh has approved a budget for organising 6,200 camps in the rural areas of the state, with the aim of conducting a total of 186,000 female sterilizations. This directly defies their publicly stated policy of not using targets, which lead to coercive behavior by state officials. Female sterilization is currently the most popular form of contraception in Madhya Pradesh. 45% of women have been sterilized according to the District Level Household & Facility Survey. All other forms of contraception (IUDs, condoms, male sterilization and pill) combined only equaled 11% of the family planning methods used. Hence, female sterilization is the dominant form of contraception and is done in a targeted and coercive manner by the government of Madhya Pradesh.

### Interviews and visits:

#### 1. Interaction with women who were sterilized:

##### i. Free and informed consent?

<sup>112</sup> Shubham Ghosh, *MP: Win a Nano by sending 500 people to sterilization camp!*, One India, 3/18/2013, <http://www.oneindia.com/2013/03/18/mp-win-nano-by-sending-500-people-to-sterilization-camp-1174182.html>.

<sup>113</sup> HT Bhopal Correspondent, *Go for vasectomy, get a gun licence*, Hindustan Times, 2/4/08, <http://www.hindustantimes.com/bhopal/go-for-vasectomy-get-a-gun-licence/article1-295124.aspx>.

Twenty-eight women were interviewed of which nineteen were housewives and the rest worked as agricultural labourers. The women belonged to poor families with small monthly income and often did not earn themselves. The Rs. 1400/- given to women as an incentive for sterilization is a clear indicator that the consent is "bought" and not obtained freely. There is no counselling provided to the women. None of the women had any personal consultation with a qualified doctor. Most women (apart from three women, two of who were operated on by the same doctor) did not even know the name or qualification of the doctor operating them. Women simply put their trust in the doctors without providing an informed consent for the surgery, particularly in the given conditions. Many women admitted that the consent forms were not in their local language because of which they did not follow them. Many consent forms were left incomplete even though doctors proceeded with the procedure.

#### **ii. Pre-operational care**

Of all the interviewed women, only one had received the full pre-operational check-up in accordance with the guidelines. Nine of them did not even have tetanus immunization.

#### **iii. Post-operational care**

There were only two women who had received the required exit check up. There was only one woman who had received information about follow-up care. Only one woman had received free transport to home. Some women informed the fact-finding team that they only received Rs. 600/- while others said that they had received Rs.1300/-. Some did not even receive proper medications. All women interviewed were asked to go back home within 1.5 hours of the surgery, contrary to guidelines which require patients to be kept under observation post operation for at least 4 hours.

#### **iv. Maximum number of operated women by one single doctor**

Six women, interviewed on 8<sup>th</sup> January 2016, informed the team that 45 to 50 women had undergone sterilization on 12<sup>th</sup> December

2015 at the Mundai CHC by a single doctor. The women did not know anything about the number of laparoscopes used.

A woman added that on 20<sup>th</sup> December 2015, in a camp at PHC Moondi, around 30-35 women were operated. Another informed that 200 women were operated at the same time when she underwent the procedure. However, she did not want to provide us with the information about when and where this happened.

## 2. Interviews of Asha workers

25% of the 13 interviewed Asha workers were not aware of major health issues concerning women and what they should counsel women about. Of the interviewed workers, half included men in their family planning counselling sessions, 61% were not provided with enough ASHA Kits as prescribed by the government and 90 % had no clear or organised form of methodology when it came to counselling women and recommending forms of contraception to their clients. 25% of ASHA workers talked about meeting targets for sterilization and the corresponding incentives of Rs. 200/-.

## 3. Interviews with the Doctors:

- a. District Khandwa, CHC Mundai, Dr. Gagan BMO and Dr. Themerse, surgeon.
- b. District Khandwa, PHC Sulgawn, Dr. Sunil Romde as MMBS and Dr. Rehmann, surgeon

Since doctors did not have much time to spare, the interaction with the doctors was very focused on duration of an operation and the number of operated women by a single doctor.

As per MoHFW guidelines and quality assurance committee recommendations, “doctors are allowed to conduct only 30 operations in a day to maintain quality and avoid any death or complications”.

Dr Sunil shared that he performs 15-70 sterilizations surgeries a day in a camp. He also shared that one surgery lasts for 3-5 minutes. Additionally, Dr. Themere informed that he needed 3-5 minutes for each patient and that he would perform 30 to 100 sterilizations



in a day. The same statement was given by Dr. Rehmann. Dr. Themere and Dr. Rehmann added that they could perform the surgeries without any assistance.

#### 4. Camp Visits:

##### a) Visit at Satna District PHC Camp Kulgadhi- Block Unchehera

Dr. K.L. Nandio, the surgeon who was supposed to perform the sterilization operations, arrived late for the camp. Patients were waiting outside, in an open ground. Most women were accompanied by their kids; some aged less than a year and breastfeeding. An assistant sitting outside was filling the forms for "free informed consent". The consent forms were not being filled in properly and were hence incomplete. The surgeon informed that he spent 1 to 2 minutes on each surgery. Further, he revealed with pride that he had once operated 262 women in a single day and had already operated around 88000 women in his life.

Regarding the operation apparatus, there were only 2 laparoscopes. On the day of the camp 18 women were sterilized with 1.5 hours. So intentionally the doctor ignored the need to disinfect the laparoscope and breached the guidelines with regards to quality of care, women's health and sanitary conditions.

A surgeon gets Rs. 75/- for every procedure performed. Surgeons are more concentrated on maximising their earnings and hence conduct as many procedures as possible in a short amount of time. This practice leaves more room for negligence, causing infections and jeopardising women's lives. On inquiring about the post-operative care, the team was told that all patients were kept for 4 hours after the surgery and were given enough time to recuperate. On further questioning, the surgeon excused himself to start the camp. It was about 3:15 pm. There was no anesthetist available.

The women were given local anesthesia by a medical assistant, who had no qualification to administer it and were made to lie on the floor. Inside the OT, there was just one operation table which seemed unhygienic. The toilets were in poor condition and did not even have the basic facility for washing hands.

**b) Satna District CHC Camp Nagaur- Block Unchehara**

The camp started at 2 pm; the surgeries began at 2:15pm and were finished by 3.40 pm. There were no stretchers to move the patients. Patients were paid compensation but they had to spend out of their pockets for the transport back, and in some cases even to reach the camp. One of the patient's relatives shared that the staff had told them that the incentive of Rs.1400 would include the transportation cost as well. Family members were waiting outside the camp to pick up the patients. Conditions were so poor that there was no arrangement for water. The doctor, after completing surgeries in less than 1.5 hours, had already left by 3:40 pm. Seven women were still in the unhygienic recovery room. There was no monitoring in the recovery room at all. The women were manually being carried like sacks of vegetables post-surgery. There was no provision of beds or mattresses; the patients were left to lie on the floor without any disinfection or proper hygiene.

On exploring the hospital, it was found that the room adjacent to the post op recovery room was a dilapidated room with many decrepit bed frames and threadbare mattresses just lying there. Despite the availability of bed frames, the staff did not bother to maintain them.

Within in ten minutes of the operation, all women began returning home in delirious states; unable to stand or even walk; and in self-hired private transport despite multiple idle ambulances being available. When questioned about this, the administrative woman told the team that there were no drivers available and hence the ambulances will not ply.

The team saw five of seven women, very weak, going home without any post- operational information or care given. These women did not receive any exit check up or transport facility. The bathrooms were found to be highly dirty and unhygienic and were in no condition to be of any use, there was no wash basin, or water pressure. The operation theatre was unhygienic as well. Two patients were still resting in the makeshift recovery room without monitoring. After talking to some of the people accompanying the patients, the team left for the PHC at Kulgadhi.

## 2nd Visit at Satna District PHC Camp Kulgadhi- Block Unchehera

On revisiting the camp at around 5pm, the team discovered that this camp was also coming to an end. Of the initial 18 patients who were present at 3:15, only three were left in the recovery room and one was being transported back home on the backseat of a bicycle.

In less than one and a half hours, all the operations had been completed and the patients dispatched. The operations of eighteen women had been conducted with only two laparoscopes, within a span of an hour. Yet; the doctors reported that the disinfection time of instruments was thirty minutes after every operation. The disinfectant used is called Cidex OPA. Again, it seemed that the camp staff was not even aware of the concept of post-op care. Of the last three patients left at the camp, none was given any sort of attention and any form of post operational check up or follow up- information. The women left in a delirious state, unable to talk and in need of assistance to walk.

### Breaches of the Guidelines Observed:

1. The doctor at the first camp was late and did not abide by the guidelines to start the camp on time.
2. The surgeries were carried out in unhygienic setup and no postoperative care was provided to women.
3. In both camps the surgeons had already left and no person from the staff gave any aftercare and monitoring of women. Nobody monitored them, nobody checked vital signs as required and nobody gave them follow up instructions before the women left.
4. There were only two laparoscopes which were not being disinfected after each operation. None of the women were given any transport facility. There was no anaesthetist available at both the camps.
5. At the hospital in Chintipurt, only one laparoscope was available even though 20-30 women are operated at the

camp monthly. The surgeon often operates in more camps (sometimes 4–5 a day). No register is maintained in case of deaths (he estimated 1 or 2 deaths a year caused by sterilization) nor is pre-operational check up list available there. The women get only Rs. 600, and the Asha worker Rs. 200 as incentive. The hospital did not have a doctor for the past three years. It lacked facilities like phone, internet access and emergency vehicle. There was only one district hospital, at a distance of 30 kms. On Sunday, only one person was available. The staff had no capacity to reach out to people in villages. The pharmacist could not provide us with any further information about post-op care.

6. ANM Shivkali Dhurve at Juna Pani and her colleague shared that there was a governmental target for sterilization which needed to be fulfilled. Both ANMs tried to convince men as well because they considered male sterilization a less complicated procedure. Men did not often participate in these meetings; they feared losing their manhood after sterilization. If a couple did not have a male child, then they were recommended to wait for another child before undergoing the procedure.
7. ARSH worker Arti Dube at District Hospital Chhindwara informed that 1% of women between 16 and 18 years get sterilized when they have more than two children. She also shared that there was a weekly (every Wednesday) camp where 30 to 40 surgeries were performed by single doctor. The same doctor worked in 4-5 camps, sometimes in one day. The team was told that after approximately three hours after the operation the women were sent home. The district hospital was not clean and smelled revolting. The team was shown the OT, where a recently operated uterus with cancer remained on the floor for more than half an hour while the team spoke with the ARSH worker.
8. Young people between 13 and 24 had no clear idea about the reproductive process, HIV, how to protect pregnancy or any forms of existing contraception.

## Conclusion

There has been complete violation of guidelines regarding unhygienic practices, numbers of women being operated- on by one single doctor, lack of pre- and post-operational check-up. All sterilization in camps happens as mass procedures in unhygienic circumstances. The camp ideology concentrates on highest and allegedly cheapest possibility of birth control. There are very few cases of male sterilization. The target and incentive based approach of the government comes at the cost of health and life of women and in violation of their right to lead a life with dignity.

### 3. FACT-FINDING MISSION TO SONIA VIHAR, DELHI,

**Date of Visit: 27th November 2014**

The reproductive rights team of HRLN conducted fact finding in Sonia Vihar, Delhi to get acquainted with the ground realities of sterilization in Delhi. A list of all the women who underwent tubectomy was sought under the Right to Information Act, 2005. The list also included those whose tubectomy operations had resulted in failure/complication/death. The objective was to find out whether these women had received proper treatment, care and whether they were aware of the Family Planning Indemnity Scheme to compensate women and families in the event of complications, failures, and deaths.

The address list provided by the government did not give all the information. In many cases the addresses were not taken down properly, and hence could not be verified.

### CASES OF LACK OF INFORMED CHOICE AND INFORMED CONSENT AND SHEER NEGLIGENCE

#### 1. Story of Kailash Devi, Sonia Vihar, New Delhi

**Age: 28 years**

**Number of Children: 04**

**Date of Sterilization: 10.9.2014**

Reproductive History: Mrs. Kailash Devi lives in Sonia Vihar, New Delhi with her husband and four children; three boys who are ten, five and seven years of age and one girl who is two months old.

**Documents Available:** Kailash Devi had her ultrasound report with her, as well as Jugpravesh and Guru Teg Bahadur hospital treatment documents. She was asked to collect the certificate after one month she could not go.

Discharge slip dated 22/9/2014 mentioned tubal ligation.

### Case Story:

When Kailash Devi was sterilized, she did not have any intention of undergoing tubectomy. As per hospital records, her LMP was on 1/12/2013 and EDD was on 8/9/2014. She visited Jag Prakash hospital because her delivery date had passed without any labour pains. Kailash Devi was told to get a caesarean section since the foetus weighed 4 kg.

After she was taken in for the surgery at GTB hospital, her husband was asked for permission to conduct tubectomy but he was not given sufficient time to consider this decision. Doctors told him that since the couple already had three living children (two daughters and a son) and were now having their fourth child through a caesarean section, there was a risk to Kailash Devi's life. He was given only ten minutes to decide and sign the consent form. Worried that his wife, who had already undergone five pregnancies and had an abortion once, would not survive another pregnancy, he gave consent for the procedure impulsively. He did not know anything about the procedure, its repercussions and most importantly its permanent nature, except for the fact that it was a method of birth control. Nobody explained or read out the consent form to him. While Kailash Devi was in labor she was asked to sign the consent form which she did, mistaking it as the consent for the caesarean procedure. She said that she would not have agreed to undergo tubectomy if she knew about it. She was admitted to GTB hospital on 10 September 2014 for her delivery; immediately after which the tubectomy was performed. They were falsely informed in an ultrasound report that the baby's weight was more than four kgs and that she would have to undergo a C-Section Delivery. They were later informed by hospital staff that the ultrasound report, which leads to a caesarian section and ultimately a tubectomy, was incorrect.

This was a case of sheer negligence and violation of Ms. Kailash Devi's health rights. Neither the hospital nor the local dispensary where she went for check-up during her pregnancy conducted any prior tests on her to see if she was suitable for tubectomy. Kailash Devi did not get a sterilization certificate.

Fortunately, she did not experience any sort of side effects or complications from the procedure. However she had no information about the family planning indemnity scheme which benefits women whose tubectomy fails or becomes subject to complications. No representative of the hospital or the government has informed her about the same. Conducting tubectomy without getting her voluntary consent is a gross violation of her human rights.

## **2. Mrs. Mamta Rajan**

**Age: 28 years**

**Total living children: 3**

### **Case story:**

Mamta has two boys aged eight and seven years respectively and a girl of two years and six months of age. Her husband works in another city. She was aware of and had been using contraceptives like oral pills and condoms before she chose sterilization. In her case, these methods failed and she got pregnant. However, she did not realise this and continued to take the pills as well as other harmful food items, resulting in a miscarriage at 4 months. Perturbed by this, she decided to undergo tubectomy.

She received adequate information regarding the procedure and signed the consent form being fully aware that it is a permanent contraceptive. She was given information regarding its advantages, disadvantages and alternatives available by the doctor. She chose to have the surgery done because she felt that the other methods were not reliable and she did not want such an incident to happen again. However, she was initially interested in getting a Copper-T. Upon visiting the government dispensary in Sonia Vihar for this purpose, she was told that she would have to wait for at least six months as the facility was not available at the moment and she thought it unwise to wait for that long.

Thereafter, she had the surgery done in March 2014 at Aruna Asaf Ali Hospital. She was requited with the facilities in the hospital as it was clean and the staff were courteous. They conducted a pregnancy test and checked her blood pressure before the surgery and she was made to feel comfortable enough to ask questions about the procedure. She did not receive any instructions on post-operative care except a prescription for the medicines. The doctor examined her before discharge and she commuted to and from the hospital in her own vehicle. She was given Rs. 400/- after the surgery as incentive and a certificate showing that she has undergone tubectomy.

Her case was different from the other women in that she gave full consent to the procedure but she developed side effects from the surgery. Her skin peeled off near the area where the surgery was done. She went back to the hospital and they gave her medicines but they had no effect. She was also the only woman who was aware of FPIS. However, her information came from her mother - an Anganwadi worker - and not the hospital she visited. Mamta did not try to avail compensation for her complication because the travel to the hospital was more expensive. Her friend had previously tried to avail compensation for a failed tubectomy but did not receive the amount she was entitled to in spite of trying for a long time. This only served to discourage Mamta from following the same path.

Upon being asked her opinion of men undergoing vasectomy as it is much less complicated, she said that she would not want her husband to undergo it because people in her neighbourhood looked down upon sterilized men. Un-flattering rumours were spread about the family, thus highlighting the stigma that prevails in our society when it comes to male sterilization. Education and information are crucial in changing this mindset, with out which gender disparity in sterilization will persist.

The FPIS, in practice, contains multiple deficiencies. Its existence is not widely known by medical facilities, doctors, other family planning medical workers, or women who undergo the sterilization procedure. Additionally, women are not consulted prior to the procedure and many cannot name alternative methods of birth



control available, indicating lack of informed consent. Although some sign the consent form, they do not know what it contains nor are they aware of the complications that could arise as a result of the procedure. Many do not speak to the doctor prior to the surgery and are not given any post-operative instructions. In many cases, patients are not given a copy of the consent form and are not given proof of sterilization after the procedure is conducted. Many ASHA workers are also unaware of the existence of the FPIS.

### **3. Mrs. Sapna**

**Age: 33 years**

**Total living children: 2 (younger child is 2 months old)**

Sapna, a home maker, is a graduate and mother of two boys who are aged five years and two months respectively. She underwent tubectomy right after the delivery of her second child at GTB Hospital. She chose sterilization as she felt that with copper-T and oral pills there was a higher chance of failure and she would rather not take the risk.

She was told about the procedure by the ASHA worker. Even though she was aware about other methods of contraception, she had never used any of them before the surgery. She was admitted to the hospital without any prior tests to determine the suitability of the method. She signed the consent form which she read and clearly understood. She recovered on a bed after the surgery and was examined by the doctors in a room full of other women which did not offer much privacy to the patients to ask personal questions regarding their health. This coupled with the fact that she was frightened rendered her unable to freely interact with her doctor. She also had to deal with a rudely behaved staff.

The doctors examined the stitches before her discharge from the hospital and gave her a written prescription of the medicines to be taken for post-operative recovery. She was not informed of when she could resume sexual intercourse or given any other instructions to be followed. However, she was asked to return to the hospital for a routine check-up after a month, which she had not done as of the time of the interview. She travelled to the hospital and back in an auto rickshaw and spent Rs. 200 in

the process. She was not given any incentives for undergoing the surgery nor did she receive the money she was entitled to under the JSY because she did not have a bank account. She has not received any documentation evidencing the fact that she has undergone tubectomy. On being asked about the Family Planning Indemnity Scheme, neither she nor the rest of her family was aware of the same.

#### **4. FACT-FINDING MISSION AT BILASPUR DISTRICT, CHHATTISGARH, DATE OF VISIT: 14-18 NOVEMBER 2014**

##### **1. Introduction**

On 8 November 2014, a sterilization camp resulted in 15 deaths in Takhatpur Block of Sakri, Bilaspur District; Chhattisgarh. On 10 November 2014 doctors conducted sterilization camps in Gaurella Block at Gaurella, Marwahi, and Pendra. One woman died as a result of the Gaurella camp. Some women remained hospitalized in critical condition at Apollo Hospital, Bilaspur. The government issued Rs. 4 lakh to the families of the deceased and promised to provide health care and education to their children.

Journalists from India and across the world reported the gruesome details: a single doctor operated on 83 women in just a few hours; the hospital, which is usually closed, was filthy; women recovered from the surgery on the floor; and all parties, the doctor, field level health workers (Mitaniins) and the women received an incentive payment. 16 young women who attended this camp expecting a simple procedure to control their fertility died as a result of their undignified, unsafe, and unethical treatment.

The Government of Chhattisgarh and media outlets released the following list of deaths:

<b>Name</b>	<b>Age</b>	<b>Caste</b>	<b>Village</b>	<b>Children</b>
1. Janaki	24	SC	Chichirda	3
2. Chaiti	22	ST	Dhanauli	2
3. Ranjita	25	SC	Nirtu	3
4. Shivkumari	27	OBC	Ganiyari	3
5. Dularin	24	OBC	Lokhandi	2

Name	Age	Caste	Village	Children
6. Nembai	37	SC	Ghuru	5
7. Chandrakali	22	OBC	Bharari	3
8. Rekha	24	SC	Amsena	2
9. Dipti	28	OBC	Dighora	3
10. Phool	28	OBC	Amsena	3
11. Neera	30		Vindhasar	
12. Pushpa	25	ST	Nachuwa	
13. Sunita	25	OBC	Ghutku	

### Methodology

On 14 November 2014, a reproductive rights activist from the Delhi based Human Rights Network traveled to Bilaspur to conduct a fact-finding with two local lawyers. The fact-finding had two primary goals:

1. To determine whether the sterilization camp held at Sakri in November 2014 violated women's fundamental rights;
2. To determine whether this camp represents a single case of medical negligence or whether the camp is part of a larger state failure to ensure women's reproductive rights.

At hospitals, the team spoke with 14 women from camps throughout Bilaspur, including six women from the Sakri camp that resulted in 13 deaths. At Apollo Hospital, the team spoke with hospital administrators. In villages, the team met with family members of the deceased, the Panch and/or Sarpanch, the mitanins, and women in the community.

This report outlines findings from the field; major fundamental rights violations; state failures to comply with the Supreme Court's *Ramakant Rai* orders; state failures to ensure compliance with the Standard Operating Procedures for Sterilization Services (Ministry of Health and Family Welfare, 2008); women's experiences at sterilization camps in Bilaspur District; interviews with families of the deceased; observations from facilities and interviews with health workers, and recommendations.

Ultimately, this report concludes that Chhattisgarh's ill-equipped public health system coupled with the state's relentless pursuit of family planning targets creates an environment where death becomes inevitable. This report recommends immediate improvements in quality of care; a complete end to the target-based approach to family planning; accountability for flagrant violations of Government of India and Supreme Court guidelines; and justice for grave fundamental rights violations.

## 2. Health Indicators and Family Planning in Chhattisgarh

The 2011 Census records Chhattisgarh's population as 2.55 crore with large populations from diverse tribes. Chhattisgarh is one the poorest states in India with about 49.4% of the population living below the poverty line. The Multidimensional Poverty Index, which measures more than mere income, finds that 69.7% of the state's population falls below the poverty line.

Health indicators, Chhattisgarh (District Level Household Survey 2007-2008, unless otherwise indicated)

Health Indicator	Chhattisgarh	India
Total Fertility Rate	2.7 (Sample Registration System, SRS, 2011)	2.4 (SRS, 2011)
Sex Ratio	964 women /1000 men (2011 census)	940/1000 (2011 census)
Anemia in married women 15-49	56.2%	56% (National Family Health Survey 2005)
Infant Mortality Rate	48 deaths/1000 live births. (SRS 2011). 113/1000 for teenage mothers.	44 (SRS, 2011)
Child Marriage	45.2% of women age 20-24 married before 18.	43% of married women age 20-24 married before 18.

Health Indicator	Chhattisgarh	India
Maternal Mortality Ratio	260 (Sample Registration System (SRS) Bulletin, 2011)	212 (SRS 2011)
Women who had full ANC	13.7%	18.8%
Women who received JSY benefit	9.3%	13.3%
Institutional Delivery	34.9% of married women have had an institutional delivery. (Annual Health Survey, 2011-2012)	47%
Married Women Using Contraception	49.7%	54%
Married Women Using Modern Methods	47.1%	47.1%
Married Women Using Sterilization as Contraception	41.3%	34%
Married Men Using Vasectomy	1.8%	1.0%
Married Women Using IUD as Contraception	0.6%	1.9%
Married Couples Using Condom as Contraception	1.6%	5.9%
Unmet need for contraception	20.9%	21.3%

Chhattisgarh has failed to comply with minimum public health infrastructure, staffing, and services guarantees under the National Health Mission. The state lacks 45 Community Health

Centres (CHC), 302 Primary Health Centre (PHC) doctors, 131 CHC obstetricians and gynecologists, 130 pediatricians at CHCs, 525 total CHC specialists, 293 CHC and PHC pharmacists, 460 PHC and CHC laboratory technicians, and 1246 PHC and CHC nurses. Hence, the state's health care infrastructure falls short of the minimum government prescribed standards.

### 3. Failure to Comply with Supreme Court orders in Ramakant vs. Union of India & Ors.

The fact-finding team recorded a complete failure to implement the Supreme Court's 2005 sterilization camp orders:

ORDER	COMPLIANCE
1. Limited panel of doctors authorized to carry out sterilization procedures.	<ul style="list-style-type: none"> <li>• Only three laparoscopic surgeons in the district. No information on empanelment.</li> <li>• The number of camps planned in Chhattisgarh's health budget for 2014-2015 greatly surpasses the number of qualified physicians.</li> </ul>
2. Checklists to complete for each patient with health information and bio data.	<ul style="list-style-type: none"> <li>• None of the women saw hospital staff completing a checklist.</li> <li>• The amount of time per patient makes it impossible to thoroughly complete the checklist for each patient.</li> <li>• Tribal women who should not be sterilized underwent the procedure.</li> </ul>

<p>3. Consent forms.</p>	<ul style="list-style-type: none"> <li>• The camp staff did not give women time to read the form.</li> <li>• Camp staff did not read or explain the form to women who cannot read/write.</li> <li>• Some patients signed blank sheets of paper.</li> <li>• Women did not have adequate counselling to make an informed decision regarding sterilization.</li> </ul>
<p>4. Establish a Quality Assurance Committee.</p>	<ul style="list-style-type: none"> <li>• District Quality Assurance Committee established months before the camp, but not functional.</li> </ul>
<p>5. Maintain statistics on the age and number of children and on sterilization injuries and deaths.</p>	<ul style="list-style-type: none"> <li>• Information is not available.</li> </ul>
<p>6. Hold inquiries into guideline breaches and take punitive action.</p>	<ul style="list-style-type: none"> <li>• The fact-finding team uncovered a pattern of guideline breaches (e.g., a camp with 100 women in July 2014). No investigation or accountability steps taken.</li> <li>• Even here, the DQAC has not launched the investigation, it is the High Court and the Health Ministry.</li> <li>• Quality Assurance report never completed in this District.</li> </ul>

7. Create an insurance policy.	<ul style="list-style-type: none"> <li>• State has an insurance scheme, but camp staff did not inform a single woman about the policy or how to access it.</li> <li>• Not a single woman received any proof of sterilization – a necessary component for accessing compensation.</li> <li>• Women did not know the doctor's name. Doctor's signature is necessary for accessing the insurance scheme.</li> </ul>
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#### **4. Overwhelming Failure to Follow the Standard Operating Procedures for Sterilization Services in Camps (SOP, Ministry of Health & Family Welfare, March 2008)**

The team interviewed women from the Sakri, Gaurella, Marwahi, and Pendra Camps, families of the deceased and government health workers. These interviews show that the sterilization team acted with complete disregard for the Sterilization Services in Camps SOP. The following table outlines the countless infractions:

#### **5. Major Fundamental Rights Violations**

The fact-finding team uncovered evidence of grave violations of fundamental rights at sterilization camps in Bilaspur District. As per the Government of India schemes including the National Health Mission, guarantees information and access to a “basket” of contraceptive choices. Additionally, the Constitution of India guarantees the Right to Life (Article 21) and the Right to Equality (Article 15). The Supreme Court has determined that the right to life includes the right to health (See *Pashim Banga Khet Mazdoor Samiti*, 1996 4 SCC 37), the right to dignity, and the Right to be free from cruel, inhumane, and degrading treatment (See *Francis Coralie Mullin v. Administrator, Union Territory of Delhi & Ors.*).



Additionally, sterilization camps in Bilaspur District violate the Government of India's international obligations under the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Elimination of Racial Discrimination (CERD), and the Convention on the Elimination of all forms of Discrimination against Women (CEDAW).

Right	Obligation	Brief Description of Violation(s)
<p>Right to access contraceptive information and services.</p>	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21 (See <i>Suchita Srivastava vs. Chandigarh Administration</i> AIR 2010 SC 235) holding that: "The woman's right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution of India. It is important to recognize that reproductive choices can be exercised to procreate as well as to abstain from procreating."</li> <li>• CEDAW, Article 12: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.</li> <li>• CEDAW, Article 16. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women: (e) the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.</li> </ul>	<ul style="list-style-type: none"> <li>• The State has failed to ensure that women have access to contraceptive information and services.</li> <li>• The State's Project Implementation Plans demonstrate a clear commitment to targets for female sterilization. Targets for a specific form of contraception ensure a provider bias and eliminate true free choice.</li> <li>• Chhattisgarh reports an unmet need for contraception at 20% and Bilaspur's unmet need is at 29%.</li> <li>• Interviewees never received counselling on contraceptive options.</li> <li>• Interviewees did not know where to access information or services for non-permanent forms of contraception.</li> <li>• Mitanins do not receive in-depth training on non-permanent forms of contraception. The state trains field level health workers "to convince" women to undergo sterilization.</li> <li>• Camps illustrate the inadequate access to contraceptive information and services; women cannot avail of services when and where they want, they have to wait for a camp, which may only take place once or twice a year.</li> </ul>

Right	Obligation	Brief Description of Violation(s)
<p>2. Right to informed consent and Right to bodily integrity.</p>	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21.</li> <li>• CEDAW, Article 16.</li> </ul>	<ul style="list-style-type: none"> <li>• Without adequate access to contraceptive information and services, women cannot control when they become pregnant.</li> <li>• Women did not receive counselling on the sterilization procedure (what would happen, possible risks, side effects, etc.)</li> <li>• Women did not have time to read the consent form.</li> <li>• No one read or explained the consent form to women who cannot read/write.</li> <li>• Husbands signed some consent forms.</li> <li>• Most families of the deceased did not receive any records – post-mortems, death certificates.</li> </ul>
<p>3. Right to be free from discrimination based on sex.</p>	<ul style="list-style-type: none"> <li>• Constitution, Articles 14, 15, 21.</li> <li>• CEDAW.</li> </ul>	<ul style="list-style-type: none"> <li>• State family planning policy targets women. Sterilized women comprise 41.3% of modern contraceptive users in Chhattisgarh; sterilized men comprise just 1.8%.</li> <li>• Women comprise 97% of all sterilization surgeries in India.</li> <li>• Inadequate primary and maternal health services have resulted in an unacceptable number of maternal deaths in Chhattisgarh.</li> </ul>

Right	Obligation	Brief Description of Violation(s)
4. Right to be free from discrimination based on caste.	<ul style="list-style-type: none"> <li>• Constitution of India, Article 15</li> <li>• Convention on the Elimination of Racial Discrimination (CERD), Article 1, defining racial discrimination as “any distinction, exclusion, restriction or preference based on...descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the...enjoyment or exercise, on an equal footing, of fundamental freedoms in the political, economic, social, cultural or any other field of public life.</li> </ul>	<ul style="list-style-type: none"> <li>• Sterilization camps target marginalized women who have limited options for contraception.</li> <li>• The government provided data for 13 deceased women – 4 women from SC; 6 women from OBC; 2 from ST; 1 unknown.</li> </ul>
5. Right to dignity.	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21.</li> <li>• CEDAW, Article 16.</li> <li>• Constitution of India, Article 21 (See <i>Suchita Srivastava vs. Chandigarh Administration</i> AIR 2010 SC 235) holding that: the crucial consideration is that the woman's right to privacy, dignity, bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively to insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods.”</li> </ul>	<ul style="list-style-type: none"> <li>• No respect for patient confidentiality or privacy.</li> <li>• Operations conducted in assembly line fashion.</li> </ul>

Right	Obligation	Brief Description of Violation(s)
6. Right to be free from cruel, inhuman or degrading treatment.	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21 (<i>Francis Coralie Mullin v. Administrator, Union Territory of Delhi &amp; Ors.</i>).</li> <li>• ICCPR, Article 7 (See General Comment No. 7: Article 7 "clearly protects not only persons arrested or imprisoned, but also pupils and patients in educational and medical institutions.")</li> </ul>	<ul style="list-style-type: none"> <li>• Women recover on the floor.</li> <li>• Two minutes per surgery.</li> <li>• No attention to infection prevention.</li> <li>• Non-consensual medical procedures amount to inhuman and degrading treatment.</li> </ul>
7. Right to health.	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21.</li> <li>• ICESCR Article 12 (Guaranteeing the right to the highest attainable standard of health and available, accessible, acceptable, quality health services).</li> <li>• CEDAW, Article 12.</li> <li>• CEDAW, Article 16.</li> </ul>	<ul style="list-style-type: none"> <li>• Inadequate primary health services – less than 40% of women deliver in institutions.</li> <li>• Health services are not available or accessible: Women cannot avail of sterilization when they want, they have to wait for a camp; Bilaspur District Hospital is three hours from some villages; Facilities and health workers do not have available stocks or information on non-permanent forms of contraception.</li> <li>• Complete disregard for quality and acceptable basic care practices including infection prevention, patient confidentiality, surgical best practices, post-operative instructions.</li> </ul>
8. Right to life.	<ul style="list-style-type: none"> <li>• Constitution of India, Article 21.</li> </ul>	<ul style="list-style-type: none"> <li>• 16 deaths as a result of unsafe and unethical sterilization.</li> </ul>

## 6. Women's Experiences at Sterilization Camps in Bilaspur

Interviews with women create an indisputable pattern of women's rights violations in Bilaspur. Interviews with women about sterilization camps consistently revealed poor access to primary health services, woefully inadequate access to contraceptive services and information, insufficient informed consent procedures, negligent and harmful surgical practices and infection prevention, failure to provide post-operative instructions, and undignified treatment.

**1. Name: Manisa; Age: 25; Number/Age of Children: three (Ages 5 years, three years, and 6 months); Camp: Sakri; Interviewed at District Hospital.**

Manisa's husband works as a daily laborer. Although she had full antenatal care during each pregnancy, she never received family planning counselling. Days before the camp, her mitanin came to her house and told her about the camp. The mitanin only told her that the surgery would "stop children" and that she should avoid eating on the morning of the procedure.

Manisa, her husband, and the mitanin travelled 30 minutes to the camp. She received a consent form, but she did not have time to read it. In violation of the Ministry of Health and Family Welfare Guidelines, no one counseled Manisa about contraceptives or the procedure after she reached the facility. Health workers took blood and urine samples and conducted a physical exam. No one told her what were the tests regarding or what the results were. She received five injections, two in each arm and one in the abdomen. She received these shots while on a bed with four other women. Then she became drowsy. Male health workers lifted her onto a table for the surgery. She never saw the doctor. After, the male health workers put her on another bed for stitches and then moved her to the floor. She stayed in the same clothing throughout the procedure and never saw anyone wash their hands. She was in excruciating pain.

After thirty minutes, she received Rs. 600 and two pills. A nurse told her to take the pills with food. She did not receive any additional post-operative instructions, warnings and proof of sterilization or documentation on the Family Planning Insurance Scheme. Manisa paid Rs. 150/- for an auto home. She vomited after taking the medicines and the mitanin brought her to the District Hospital. After a few days in the hospital, she feels fine and is ready to go home. No one has discussed compensation with her. She does not know when she can go home.

**2. Name: Sobha; Age 20; Number/Age of Children: 3(Ages 2 years, 1 year and 6 months); Camp: Pendra; Interviewed at District Hospital.**

Sobha married at 19 and during her pregnancies, she received antenatal care at her local Anganwadi Centre. She chose to deliver at home with the help of the Mitanin because she was afraid to go to the hospital. She did not receive JSY payments for either delivery. She never received counselling on spacing methods or family planning.

A week before the camp, the mitanin told her about the sterilization surgery. Sobha could not explain the surgery; she only knew that it would permanently prevent pregnancy. At 3pm on the day of the camp, Sobha and her mother-in-law walked to the hospital with five women from the village. She knows how to read and write, but she did not read the consent form before signing it. Next, she had a urine and blood test and injections. Then she only remembers waking up on the floor. She did not receive any post-operative instructions or a certificate showing that she had been sterilized. She received Rs. 500/- and went home in an ambulance. She had a slight fever, but no additional post-operative issues.

**3. Name: Rambati; Age 25; Number/Age of Children: 4 (Ages 7 years, 6 years, two years, 9 months); Camp: Pendra; Interview at District Hospital.**

Rambati married at age 14 and received Antenatal Care at the local Anganwadi Centre during all of her pregnancies. She delivered each child at the PHC and received her entitlement cash under the JSY scheme. She never received counselling on contraceptives during her pregnancies or after delivery. A week before the camp, the mitanin came to her house and told her that if she did not want more children she could go for the upcoming camp. On the day of the camp, Rambati traveled 2 kms in an auto with her mother, the mitanin, and three other women from the village. Rambati does not know how to read or write, so she did not read the consent form. No one read or explained the form to her. Rambati does not know anything about the sterilization procedure, she only understands that she will never have children again. She provided urine and blood for testing. She then received five injections and began to feel drowsy. When she woke up she was on the floor and had a slight pain in her stomach. She received her stitches on the floor. She did not receive post-operative instructions or proof of sterilization.

She received Rs. 600/- and medicines. She paid Rs. 100/- for an auto home. She took the medicines, but she did not experience side effects. She felt very scared during the camp, and the whole experience has made it difficult for her to trust doctors.

**4. Name: Kumal; Age: 23; Number/Age of Children: 2 (Ages three years and three months); Camp: Marwahi; Interview at District Hospital.**

Kumal received antenatal care at the Anganwadi Centre and she delivered both children at home with help from the mitanin. She never received counselling regarding contraception. A week before the camp, she took her children for immunization and the local health workers told her about the upcoming camp. The only thing she knows about the procedure is that it prevents pregnancy. On the day of the camp, she traveled to the camp with two women from her village. She cannot read and write, so she did not understand the consent form. No one read or explained the form to her. She gave urine and blood for testing. When she woke up after the surgery, she was on the floor. She did not receive documentation of her sterilization or post-operative care instructions. The hospital staff gave her Rs. 600/- and prescribed two medicines. She traveled home in a car for Rs. 200/-.

**5. Name: Marti; Age 26; Number/Age of Children: 2 (Ages 4 years and 2 years); Camp: Pendra; Interview at District Hospital.**

Marti delivered both children at Pendra Hospital where she received her Rs. 1400/- incentive JSY payment. The mitanin told her about sterilization – the only thing Marti knew about sterilization is that it stops conception of children. She could not name non-permanent forms of contraception. Marti does not know how to read or write – she put her thumb impression on a form, but no one read it to her or explained the contents. She had blood and urine tests and received five injections. She remembers that the surgery lasted less than five minutes. When she woke up after the surgery, she was on the floor. She did not receive documentation of her sterilization. The hospital staff did tell her not to bathe post the procedure and gave her Rs. 600/- and two medicines.



**6. Name: Gauri; Age 25; Number/Age of Children: 3 (Ages 7 years, 3 years, and 2 months); Camp: Sakri; Interview at District Hospital.**

The mitanin told Gauri about the camp three months in advance. On the day of the camp, Gauri, a family member, and the mitanin travelled to the camp and reached there at noon. She never saw a consent form. She could not explain the procedure and had no counselling about the surgery. The camp staff tested her urine and blood and then gave her five anaesthetic injections. She received the injections along with four other women on a bed. However, it is possible that the anaesthesia was incorrectly administered as she remembers a cut being made and the doctor "pulling something out of her" during the surgery. After the operation, male health workers placed her on another bed where she received her stitches. The health workers moved her to the floor for recovery. She did not receive proof of sterilization or post-operative instructions. She took an auto home for Rs. 100. She took the medicines and did not experience side effects. The mitanin took her to the District Hospital per government orders.

**7. Name: Reena; Age: 22; Number/Age of Children: 2 (Ages 2 years and 3 months); Camp: Sakri; Interviewed at CIMS.**

Reena received Antenatal Care at her local Anganwadi Centre for both pregnancies, but she never received counselling regarding contraception. She delivered at a private hospital in Korba, where she lives. She traveled to Bilaspur for the sterilization surgery and to be with her mother. She did not receive any information or counselling about sterilization prior to the camp. The only thing she knew about sterilization was that it prevents pregnancy. Eight people from her village traveled to the camp in two cars, each person had to pay Rs. 200/- for the day. They reached the camp at 12:30. She did see and sign the consent form, but she did not have time to read it. The hospital staff conducted a physical exam and tested her blood and urine and asked her to sit on the floor. When it was her turn, she lay on a bed with many women and received five injections. After the surgery, she received medicines from the hospital staff. However, she took the medicine once she reached home and vomited. Although

she felt fine, the mitanin brought her to the hospital once other women at the camp began facing gross complications and died. Reena's husband is a traditional doctor who told the fact-finding that the camp conditions constitute unsafe and unethical medical practice.

**8. Name: Shree Kumari; Age: 22 years; Number/Age of Children: 3 (Ages 7 years, 3 years and 2 months); Camp: Sakri; Interviewed at CIMS**

Shree Kumari had antenatal care for all her pregnancies and delivered all three children at home with the help of a 'dai'. Unlike other women the team interviewed, she did have counselling on alternate and non-permanent forms of contraception. She took oral contraceptives for a year, but she discontinued them because people in the village told her that the pills might harm her. Her neighbours and the local mitanin advised her that she should undergo the procedure. She stopped taking the pills and decided to have a third child before undergoing sterilization "in case something happened to the other children." The mitanin told her about the surgery a few days prior to the camp. She had wanted to undergo sterilization after her third delivery, but she had to wait for the camp season.

On the day of the camp, she booked an auto for the day for Rs. 500/-. She traveled to the camp with her mother and two women from her village. When she reached the camp, she filled out the consent form and the health workers asked her to sign it. However, the workers were in such a rush that she did not have time to read it. The staff checked her blood pressure, her blood, and her urine. They did not show her the test results. She told the team that the camp staff should have told the women if they were not healthy enough to undergo surgery. The health workers asked the women to lie down on a bed and they gave each woman five injections. Shree Kumaree woke up during the surgery and screamed in pain. The doctor gave her a light slap to calm her down. After the surgery, male health workers shifted her to another bed for her stitches. After ten minutes on the floor, the staff gave her two medicines, one to "dry the wound" and one for pain. She received Rs. 600/- and took the auto home without

any proof of sterilization. She took the medicine with food and did not experience side effects.

**9. Name: Santoshi; Age 23; Number/Age of Children: 3 (Ages 4 years, 2 years, and 3 months); Camp: Sakri; Interviewed at CIMS.**

Santoshi had antenatal checkups at her local Anganwadi Centre and delivered each child at home with the help of a Dai. The mitanin told her about oral contraceptive pills, but she and her husband never really discussed preventing pregnancy so she did not feel comfortable taking the pills without his knowledge. After her third child, Santoshi wanted to have a sterilization surgery to prevent future pregnancies. She did not understand the specifics of sterilization, only that it prevents pregnancy. On the day of the camp, Santoshi and three women from the village traveled to the camp for Rs. 100/- each. They each quickly signed a form and a health worker recorded the number of children each woman had. Next, she had a blood pressure, urine, and blood tests. The health workers asked her to lie down in a bed with four other women and a nurse gave each woman five injections. Other women became dizzy and fell asleep, but Santoshi was awake throughout the operation. The doctor moved quickly between two beds where he conducted the surgeries. Eventually she woke up on a plastic sheet on the floor. She received Rs. 600/- and a health worker told her to go home, eat, and take two medicines. When she reached home she felt sick and chose not to take the medicine. The next day she took the medicines and felt fine. After other women at the camp died, the mitanin brought her to CIMS. As a result of this experience, she feels terrified of doctors and hospitals.

**10. Name: Sukhvaiya; Age: unknown; Number/Age of Children: 5 (Ages 14 months to 1 month); Camp: Gaurella; Interviewed at CIMS.**

Sukhvaiya is a tribal woman. She heard about this camp from a doctor. She never received antenatal care during her pregnancies and delivered all five children at home. She is not familiar with any forms of non-permanent contraceptives. She has had very little

interaction with formal doctors or the public health system. When she reached the camp, she put her thumb print on a form, but she does not know the contents of the form. She does not understand anything about the surgery. She only remembers waking up on the floor. She did not receive an incentive payment. The mitanin had arranged for a jeep to take her home. She vomited after she took the medicines and the mitanin took her to the district hospital.

**11. Name: Mankuuwa; Age 35; Number/Age of Children: 5 (Ages ranging from 17 years to 2 years); Camp: Gaurella; Interviewed at CIMS.**

Mankuuwa had Antenatal Care at the Anganwadi Centre for all five pregnancies and delivered at home each time. She could not name spacing methods. She was feeling unwell and could not have an in depth conversation with the fact-finding team. When she reached the camp, she put her thumb impression on a form, although she did not know the contents of the form. After the surgery, she woke up on the floor. She received Rs. 500/- as incentive and had to pay Rs. 100/- for transportation to and from the camp. She did not receive post-operative care instructions or documentation proving that she had undergone sterilization. When she reached home, she took the medicine and starting vomiting after the third dose. She traveled to CIMS for care.

**12. Name: Neepa; Age 22; Number/Age of Children: 2 (Ages three years and three months); Camp: Sakri; Interviewed at CIMS.**

Neepa had antenatal check-ups at the Anganwadi Centre during both pregnancies and delivered at home with the help of a Dai and a mitanin. She did receive counselling on spacing methods, including the copper-T. She wanted to have two children and then have the surgery. She did not receive counselling for sterilization; she only knows that the surgery prevents pregnancy.

On the day of the camp, she traveled to the hospital in an auto with four people from the village. Neepa signed a consent form, although she did not read it. After this, she had a blood test and a urine test. She told the fact-finding team that she trusts the

mitanin with everything related to her healthcare and she did not feel comfortable asking questions about the tests. She felt pain during the operation and remembers male health workers moving her to the floor for her stitches. Ten to fifteen minutes after the surgery, she woke up on the floor surrounded by other women. She received Rs. 600/- and two medicines. She did not receive any documentation of the sterilization or post-operative instructions. When she reached home she took the medicine she was given with food and felt fine initially. However, she started vomiting about 24 hours later (on 9<sup>th</sup> November) and went to the hospital for treatment on 10<sup>th</sup> November. Neepa informed the team that she felt better now and wished to return home.

**13. Name: Chandrika; Age 22; Number/Age of Children: 4 (Ages 10 years, 6 years, three years, and 2 months); Camp: Sakri; Interviewed at CIMS.**

Chandrika had Antenatal Care at her local Anganwadi Centre, but she never received counselling or information about contraception. She delivered at home with help from her mother. The mitanin told her about sterilization fifteen days before the camp, but she did not receive any information about the procedure. She traveled an hour to the camp in an auto with five people from the village – other couples and the mitanin. She received a consent form. However, she does not know how to read or write and no one explained the contents of form to her. Next, the health workers tested her blood, blood pressure, and urine. A nurse gave her five injections. During the surgery, she remembers seeing something “pulled out” of her body. The medical team chatted with Chandrika during the surgery to distract her from the pain. After, male health workers transferred her to a bed for stitches. About 30 minutes later, she woke up on the floor in pain. A health worker gave her husband two medicines and Rs. 600/-. She did not receive documentation of the sterilization or post-operative instructions. When she reached home, she took the medicine with toast and tea and felt fine. She vomited once, on the way to the hospital, after the State Government called all camp patients in for treatment. She feels healthy now and is looking forward to returning home.

## 7. Interviews with families of the deceased

### 1. Gunyari Village. Deceased: Shivkumari, aged 27. 3 children, ages 4 years, three years, 6 months. Husband: Bahorik. Camp: Sakri

The mitanin told Shivkumari about the sterilization camp on several occasions, but never discussed non-permanent forms of contraception with the family. A few days before the camp in Sakri, the mitanin came to her home to encourage her to participate. Shivkumari and her mother went to the camp together. They reached home around 8pm. Shivkumari felt tired post surgery, but she did not vomit or complain of great pain. She took the medicine at 9pm and began vomiting at 11pm. In the morning, she went to the government hospital (PHC). The PHC referred her to CIMS which in turn referred her to the private hospital, Apollo. The family reached Apollo around 9pm. Shivkumari died days later at Apollo on 12 November 2014. The family did not receive a copy of the death certificate or an official cause of death. The family received a check for Rs. 2 lakh and the family told the team that they would receive an additional Rs. 2 lakh. Bahorik does not have a bank account. He lives in a joint family and his relatives will be able to assist in caring for the three children.

The team also met with Shivkumari's sister-in-law. She is 24 years old and has three children of ages five years, three years, and eight months. She delivered two children in the hospital and received her incentive payments under the JSY scheme.

Shivkumari never received counselling or information about contraceptives during her antenatal care check-ups or deliveries. She went to a sterilization camp in July or August 2014. The mitanin told her about the camp, where over one hundred women turned up for surgery. She signed her name to the consent form, but she did not know the contents of the form. She had basic tests and received her five anaesthesia shots while lying on the floor. She remembers "everything" from the surgery including that she saw the doctor "pulls something out" and that the whole surgery lasted five minutes. When she woke up after the surgery she was in extreme pain and recovering on the floor. She received

two medicines and Rs. 500/- as in incentive payment. She never received any post-operative instructions, information on the Family Planning Insurance Scheme or proof of sterilization.

**2. Dhanauli Village. Deceased: Chaiti Bai, aged 22. Two children, ages 6 years and 7 months. Husband: Budh Singh. Camp: Gaurella.**

Chaiti Bai lives three hours from the District Hospital. She delivered her first child at home and her second at the hospital, for which she received Rs. 1400/- under the JSY scheme. She did not use any contraception between pregnancies. The fact-finding team interviewed her family including her husband and sister and some neighbours. On the day of the camp, Chaiti Bai's husband, Budh Singh, went into the field to work when the mitanin came to the house to speak with Chaiti Bai. The mitanin had never been to their home before. Chaiti Bai had been sick with jaundice for a month and the mitanin told her that she could go to the Community Health Centre for treatment. The mitanin never mentioned sterilization or family planning during this visit.

Chaiti Bai, her husband, and the mitanin travelled to the CHC together in an auto, bearing out-of-pocket expenditure. They reached the Hospital at 3pm. Chaiti Bai's husband received a blank form to sign. Both could read and write, but there was no text on the consent form. He signed the form for her treatment, without understanding that his wife was going to be sterilized. After he signed the form he had to wait outside with other family members. A few hours later, the mitanin told him to go inside and retrieve his wife. He went into a room with women all over the floor. His wife was semi-conscious. A health worker gave him some medicine and told him to give her the medicines with food. He did not receive additional instructions, proof of sterilization, or an incentive payment.

After the surgery, Chaiti Bai stayed with her mother. She had tea, biscuits, and the medicine around 10pm. In the morning she took the medicines again and her husband made sure she felt well before he went to work. The next day she returned home and by the evening she began vomiting. The following day she

went to the Community Health Centre where she had an IV drip. She lost consciousness and the doctor referred her to the District Hospital in Bilaspur (a three hour drive). They reached Bilaspur that evening. In the ambulance, Chaiti Bai woke up and started complaining about chest pains. Shortly thereafter, still en route to Bilaspur, Chaiti Bai died. Budh Singh received a check for Rs. 2 lakh from the government, but he does not have a bank account. He does not have family members to help him with his children. He earns only Rs. 60-70 a day. He wants justice for his wife's life and a secure future for his children.

**3. Lokhandi Village. Deceased: Dularin, aged 24. Two children, ages 4 years and 2 months. Husband: Dinesh. Camp: Sakri.**

Dularin had antenatal care check ups during both pregnancies and delivered both children at home. Two weeks before the camp, the mitanin came and told women at her village about the camp. She informed them that it was best to have a small family. On the day of the camp, women from the village travelled to the camp in two autos. Each person paid Rs. 100/-. When they reached the camp, a male health worker filled out a consent form for the husband and wife to sign. Neither Dularin nor Dinesh knew how to read or write, but they knew it was some sort of consent form. Dularin's husband waited outside for six hours. He thought the facility was filthy and worried about his wife's safety. He told the team, "There were no facilities for the women, no place for them to sit or lie down". Five hours later he took their baby into the hospital so Dularin could breastfeed. She walked to the auto, but he saw male health workers carrying other women to the autos. He received one week's worth of medicine and a health worker told him to give her medicine in the morning and at night. He did not receive proof of sterilization or additional post-operative instructions.

The mitanin visited Dularin at home and gave her tablets. She did not experience any side effects for two days after which she started vomiting. On the morning of 10 November, she went to CIMS. That night the Sar Panch received a message to send all women from the camp to CIMS. Dularin left the ICU at CIMS for a private hospital, Kims, where she later died. CIMS conducted a



post-mortem, but the family never received a cause of death or a death certificate. Politicians have visited the family and promised to care for Dularin's children. Five women from Lokhandi were still at Apollo Hospital in serious condition when the team visited Dularin's family.

**4. Chichirda Village. Deceased: Janaki, aged 24. Three children: ages 7 years, three years, and nine months. Camp: Sakri.**

Janaki was the first woman to die as a result of the unsafe and unethical sterilization camp in Sakri. Both she and her husband work as labourers. They belong to Scheduled Caste. The team spoke with Janaki's mother, family, neighbours, and the village Panch. Janaki was a 24 year old mother of three children aged seven years, three years and nine months. She had heard about the camp just days before. The mitanin did not provide detailed counselling about the surgery; she only told her that doctors advised women to have this surgery "once you have enough children". Janaki travelled to the camp with her husband on his motorcycle and the mitantini and Janaki's mother travelled by auto. They reached the facility at noon. Janaki's mother does not know if she read the consent form. The government health workers took her for tests, but no one explained the tests or the results. She was inside the facility for two hours. Janaki was unconscious on the floor when her mother saw her after the surgery. A nurse gave Janaki's mother medicine but did not provide sterilization documentation or additional instructions. They received Rs. 600 and spent Rs. 300 for an auto to their village.

They reached home at 7pm on 8 November 2014 (Saturday) evening. Janaki felt dizzy and nauseated after she reached home. She felt worse the next evening. On the morning of 10 November, her family called a 108 ambulance and travelled to the District Hospital. The hospital put her on a drip and she died at 8:30am on the 10th. The Hospital wanted to do a post-mortem investigation. Janaki's mother disagreed and asked them, "why would you cut her open when you know she died because of the surgery?" But the hospital insisted and performed the post-mortem around 10 am. At noon, other women from the same camp started arriving at the district hospital. The family received a death certificate

and left the Hospital at 2pm. They have received Rs. 4 lakh as compensation. Her mother told the team that she has lost faith in public hospitals: "They killed my daughter, now I won't go again."

**5. Ghuru Village. Deceased: Neem Bai, aged 37. Five children, ages 18, 14, 10, 8, and 3 months. Camp: Sakri.**

Neem Bai went to the camp with the mitanan. The team could only speak to Neem Bai's brother, and he did not have full details of the camp. He told the team that after the camp, Neem Bai felt very weak. Two women had to carry her into the house after the camp. She took her medicines as prescribed with some tea and bread. On Monday (10 November), the mitanan came to the house and gave her an injection. She took her next dose of medicine and immediately started vomiting. The family called the 108 ambulance and an auto. The auto arrived before the ambulance and by the time they finally reached CIMS, Neem Bai was unconscious. She died about an hour later in the ICU. The family received two checks for Rs. 2 lakhs.

**6. Nirtu Village. Deceased: Ranjita, aged 25. Three children, ages 7, 3, and 2 months. Husband: Santosh. Camp: Skri**

The mitanin came to Ranjita's home a few days before the camp. She told Ranjita that she should attend the camp because she already had three children. Ranjita left for the camp with four other women from the village in an auto paying Rs. 200/- per family. Both Ranjita and her husband, Santosh, signed a consent form, but neither of them had time to read the form. Santosh waited outside for two-three hours. The doctor camp at 3:30 and later, he saw the workers at the camp placing women on the floor for recovery. When Santosh went into the hospital to collect Ranjita, she was in pain. She received Rs. 600/- and medicines but no post-operative instructions or a certificate proving her sterilization. They left the camp when Ranjita regained consciousness.

They reached home at 7:30 pm and she took the tablets and vomited just ten minutes after. She continued to vomit and called the doctor home the next morning. When she continued to vomit for another 48 hours, the doctor called the 108 ambulance.

Ranjita died on the way to the CIMS. The family received a check for Rs. 2 lakh, but they do not have a bank account.

## **8. Facilities & Health Workers**

### **1. CHC Gaurella:**

This Community Health Centre conducts camps twice a week to meet its goal of 800 female sterilizations per year. The facility conditions are extremely unhygienic. In violation of Indian Public Health Standards, the facility does not have specialists or a blood storage unit.

The beds in the maternity ward do not have sheets. Every Monday and Thursday about 10-20 women visit the CHC for sterilization. A surgeon and an OT technician travel to the facility to conduct the operations. The doctors at the facility try to place women on beds for recovery, but if more than eight women show up for the camps - which is almost always the case - they have to recover on the floor. Every month, at least two or three women return to the facility with problems related to their sterilization surgery. Chaiti Bai died after undergoing sterilization at this facility. After the camp she came to the CHC vomiting and showing signs of shock. The doctor at the CHC referred her to the District Hospital, over three hours away. She died in the ambulance on the way to the camp.

The facility usually reaches about 60-70% of the target sterilizations. When they do not meet the target, the doctors receive a reprimand from the seniors and a show cause notice.

### **2. Nemichand Jain Hospital and Research Centre**

This hospital, where the sterilization camp on 8 November 2014 took place, has not been regularly used as a medical facility for years. Community members report that the government uses the facility for sterilization camps every few years. Otherwise, it is an abandoned building. The facility does not have regular cleaning.

Authorities sealed the OT, but the fact-finding team could see the open room where the women recovered through the doors;

the room did not have beds. Old equipment, piles of waste, and rusting furniture littered the halls of the facility. The Hospital does not have emergency equipment.

### **3. Mitanin, Chichirda Village.**

This Mitanan did not want to give the team her name because local officials have told her not to speak with outsiders. She gives infants polio drops and takes women for antenatal checkups. Her seniors have told her to tell women that small families are best. She does not have access to condoms or mala-D. People are afraid that these non-permanent forms of contraception damage the uterus. The mitanan also had a sterilization surgery in similar conditions. She told the team that it is completely normal to conduct so many surgeries in a single camp. If women ask her about sterilization now, she will send them to the district hospital. She will never send a woman to a sterilization camp again.

### **4. Mitanin, Lokhandi Village**

The Mitanin has had much training on family planning, but she does not know about non-permanent forms of contraception. In her work, she works mostly to get women access to Antenatal Care and safe delivery services. If a woman has three children, the mitanin will tell them to undergo sterilization. She says the conditions “are always the same”. After this camp, she received medicines for the women. When the women started vomiting, she called the ANM, who came to the village and checked the women’s blood pressure. Five women from this village ended up at Apollo Hospital in critical condition.

### **5. Mitanin, Chorbati Village**

On 1st November a high-level government official held a meeting with mitanins where he told them that they should each bring three women in for the next sterilization camp so they could meet their 1 lakh sterilization target. The mitanin brought four women in for the surgery. She does not have any information on the procedure and she has never received training on counselling women. Once a woman has two children, the mitantin tries to “force them” to go for sterilization. Of the four women she brought

for the surgery, three are in critical condition at Apollo. She told the team that the same bad conditions exist at all camps. After this experience, she stated that she will never bring a woman to a sterilization camp again.

## Recommendations

In the wake of this tragedy, the fact-finding team urges the Supreme Court of India to pass the following orders:

1. Ensure access to justice for all women who have suffered fundamental rights violations at camps in Bilaspur. Women should receive compensation for undignified and unsafe medical care. Provide all women with documentation of sterilization, information on the Family Planning Indemnity Scheme, and instructions for accessing free, quality medical care for future potential medical complications.
2. Ensure access to justice for families of the deceased. In addition to financial compensation, the State should ensure a long-term care plan for the children, employment guarantees for the parents or primary caregivers, and access to adequate nutrition, especially for infants.
3. Ensure transparency during all investigations and Judicial Inquiry Commission investigation. Post findings on the State NHM website. Create posts for three civil society representatives on the investigation team. The Union of India should also provide a member for the investigation team.
4. End sterilization camps. All public facilities with operating facilities, sufficient beds, adequate staff, appropriate equipment, and exemplary hygiene standards can conduct fixed day sterilization services. The State should provide free transportation to fixed day services where maximum 30 women will undergo sterilization per the Standard Operating Procedure. The Chief Medical Officer will observe all fixed day sterilization services to ensure compliance with Sterilization Guidelines and respect for fundamental rights.
5. End inherently coercive and ineffective sterilization targets.

6. Immediately establish a Quality Assurance Committee at the State and District Levels. The DQAC must undertake Quality Assurance measures outlined in Ministry of Health and Family Welfare guidelines, take action for those responsible for guideline breaches, and report regularly to the State QAC.
7. Roll out a state-wide training programme for mitanins and all facility staff on all contraceptives, counselling, the Standard Operating Procedures for Sterilization Services, and women's entitlements under the National Health Mission, Family Planning Indemnity Scheme, and Constitution of India. Involve civil society members including representatives from the Population Foundation of India (PFI) and National Alliance for Maternal Health and Human Rights (NAMHHR) in this training.
8. Create posters in local languages outlining the guidelines in the Standard Operating Procedure for Sterilization Services and post these in all government health facilities. The posters should include a free number to the DQAC that women, health staff or family members can call or SMS to report guideline breaches.
9. Immediately fulfil the posts for specialists, especially gynaecologists and obstetricians and nurses throughout Chhattisgarh.

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## 9. The Way Forward for India's Sterilization Programme

As has been established, sterilization in India is a major issue and often there is a complete lack of oversight and responsibility among those who are charged with providing these services, including the State and other healthcare professionals. India's family planning programme has unwisely placed sterilization at the centre of population control measures. Callousness, negligence, and apathy has led to this policy resulting in several human rights abuses and the deaths of many women. If the government continues to promote sterilization it must be ensured that these procedures are safe, consensual, uphold the dignity of the patient, and do not target certain groups.

Unfortunately, however, the deplorable conditions existing prior to the order of the Apex Court in the aforementioned case continue to prevail today. Evidence of tragedies in Bihar and Chhattisgarh, merely two examples in a catalogue of other tragedies, confirm the assertion that the State's barbaric and inhumane practice of enforced sterilization continues to violate every reproductive right of men and women. The constitution of India bars endangered tribes such as Baiga Tribe from undergoing family planning measures. This has forced women from these communities to travel to different state for illegal sterilization out of desperation when they end up having large families that they cannot support. Sterilization can be a viable, valuable option if it is made safe and non-coercive, providing quality services and upholding the dignity of women.

Sterilization may be a solution to a booming population growth, but it is a drastic one, a solution that must be driven by informed choice rather than calculated coercion and targeting. Even where it is done on people who willingly come forward for the

procedure, sterilization has been known to be done in the poorest of conditions, endangering the life and health of one and all.

Illegal sterilization surgeries continued to be conducted in the various states and Union Territories of India in unhygienic and unethical conditions even after the order of the Supreme Court dated 1.1.2005 in the case of *Ramakant Rai vs Union of India*. In response to this violation of fundamental rights protected by Article 21, Article 14 and Article 15 of the Constitution of India, Human Rights Law Network and Devika Biswas sought specific directions from the Supreme Court.

1. The system of 'sterilization camps' should be struck down. Delicate procedures such as tubectomy and vasectomy must not be conducted in makeshift facilities set up in schools or abandoned hospitals. It should only be allowed in accredited medical health care centers. Also, the persisting culture of sterilizing people en masse should be avoided to keep a reasonable workload on the service providers.
2. The State should take responsibility for the existence of low-level targets set by medical authorities at the state and district level. The State should also declare sterilization targets as inherently coercive and in violation of the rights to bodily integrity, individual autonomy and health.
3. All States and Union Territories should implement in letter and spirit Standard Operating Procedures for Female and Male Sterilization (2006), Quality Assurance Manual for Sterilization Services (2006), Standard Operating Procedures for Sterilization Services in Camps (2008) issued by the Government of India after the decision of this Court in Ramakant Rai's case in order to ensure that poor women in rural areas are treated with respect and dignity when they undergo sterilization operations;
4. Quality Assurance Committees should be set up at State and district levels to ensure that the basic standards of hygiene and medical propriety are maintained wherever such sterilization services are being provided. This will help strengthen the implementation and monitoring of the family planning programme.



5. Ensure that women are made aware, in a language that they clearly understand, of all available methods of family planning, of the fact that sterilization is permanent and that women understand what happens before, during, and after the surgery, its side effects, and potential complications, including failure.
6. Ensure that women make an informed decision for sterilization voluntarily, are encouraged to ask questions and are told that they have the option of deciding against the procedure at any time without being denied their rights or other reproductive health services.
7. Ensure that all pre- procedure clinical assessments as per section 1.4.2, including demographic information is recorded, each patient's medical history is taken and that every woman has physical examination including blood pressure, pulse, pelvic examination, and laboratory examinations for hemoglobin, sugar, aluminum and pregnancy.
8. Ensure that consent is not obtained under coercion or when the client is under sedation, and that the client signs the sterilization consent form before the surgery.
9. Ensure that all sterilization camps are organized only in established Health Care Facilities- either CHCs or PHCs. And that each surgeon is restricted to conducting a maximum of 30 laparoscopic tubectomies, 30 vasectomies or 30 minilap tubectomies or 50 surgeries per day with additional surgeons, support staff, instruments, equipment, and supplies.
10. Surgeons and gynecologists should verify that each client has been adequately counseled and screened, by filling out a checklist before conducting the procedure. Requisite equipment, instruments and supplies, as well as emergency and surgical procedures should be provided. Post-operative instructions on the records of all cases should be documented.
11. Ensure that all post- operative procedures are followed, in particular the client is monitored, the client is only discharged at least 4 hours after the procedure when the vital signs are stable and the client is fully aware, has passed urine and can walk, drink and talk, and the client has been evaluated by a doctor.

12. The state should also ensure that ASHA workers follow up with clients 48 hours after surgery and women should report to a health facility after seven days to have their stitches removed.
13. To have increased and active involvement of civil society members by including civil society members in the State Quality Assurance Committee for monitoring and training mechanism.
14. The state should publicize on radio and television the content of the orders passed by the Supreme Court in Ramakant Rai case and information about family planning insurance schemes. Further, the medical authorities should provide documentation of sterilization procedures done to the families of the deceased or anyone incapacitated by the procedure.
15. The focus of family planning in India should be broadened. The budgets for sterilization services should be cut and instead must be pooled in a larger campaign for spreading family planning awareness in the society, especially amongst men. People should be made aware of alternative family planning options.
16. The state should be directed to provide Rs. 1 lakh compensation to the 68 surviving women who underwent sterilization at Sakri on 8th November 2014 and the 53 women who survived sterilization at Gaurella, Marvahi and Pendra on 10 November 2014.
17. The State should develop a long term care plan for the children of the sixteen deceased women and any other women who die as a result of these camps including employment guarantees for the primary caregivers, access to long term adequate nutrition, free health services, and education up to college for the children.
18. The state should roll out a state-wide training programmes for mitanins, ASHAs and other facility staff on all contraceptives, counselling, the Standard Operating Procedures for Sterilization Services, Women's entitlements under the National Health Mission, the Family Planning Indemnity Scheme, and the judgments of the Courts of India, and in these trainings to consult and involve civil society members including

representatives from the Population Foundation of India (PFI) and National Alliance for Maternal Health and Human Rights (NAMHHR).

It is important that ministry of health and family welfare be encouraged, to promote gender equity in the family-planning programmes pointing towards the introduction and availability of a greater number of contraceptive choices for both men and women and greater participation of civil society organizations in delivering quality family-planning services. Family planning is not just about women but also about men and the need for their increased involvement in the family planning. It must be highlighted in our programmes that the sterilization programme cannot be primarily targeted towards women but must also actively include men.

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## 10. SUMMARY OF THE JUDGMENT

In *Devika Biswas Vs Union of India*<sup>114</sup> the honorable Supreme Court of India passed a much-awaited landmark judgment on the 14th September 2016. The judgment concluded a five-year long fight against the mass sterilization drives. The judgment noted that evidence of poor quality of care during sterilization camps leading to deaths in several cases has been reported from other states including Chhattisgarh, Uttar Pradesh, Kerala, Rajasthan, Madhya Pradesh and Maharashtra during the course of hearing.

The civil society organizations have welcomed the judgment as it calls for strengthening of health system, to improve the quality of care of the Family Planning programme and accountability of government. The Supreme Court recognized deaths, failures, complications and coercion as a result of female sterilization have implications for women's Rights to life.

1. The judgment directs the government to phase out camp approach in next three years and instead strengthen health facilities for better services.
2. Coercive methods are not justified and are not even effective in meeting the goals of population control. Improved access, education and empowerment should be the aim.
3. One of the fundamental errors pointed out by the Supreme Court was that Union of India in many of its affidavits stressed that "implementation of sterilization programme is a state concern" as it is public health" issue as per the Entry 6 of List II in the Seventh Schedule (the State List) of the Constitution. However the Union of India completely overlooked the more appropriate Entry 20A in the Concurrent List,

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<sup>114</sup> *Devika Biswas Vs Union of India and Others* (Writ Petition (Civil) No 95 of 2012)

“Population Control and Family Planning” (Constitution (Forty-second) Amendment Act, 1976). As pointed out by the Supreme Court, population control and family planning has been a national campaign over many decades. The Union of India has taken great interest in promoting and has spent large amounts of public funds encouraging it. Hence, the Supreme Court ordered that UOI should treat the sterilization programme as a public health issue, and not leave it to the state governments. The court pointed out that the government of the Union of India must take ownership of the family planning programme, which is included in ‘Concurrent List’ of the Constitution. The responsibility of success and failure of the family planning must rest squarely on the shoulders of UOI and it cannot ‘pass the buck’ to the state government.

4. The judgment confirms the allegations that the overwhelming number of sterilization procedures is targeted towards women and there is virtually no attention paid to male sterilization.
5. Contents of the checklist should be explained to the proposed patient in a language that he or she understands and the proposed patient should also be explained the impact and consequences of the sterilization procedure to avoid ‘incentivized consent’.
6. State Government and Union Territory to ensure that targets are not fixed for health workers which amount to a forced or non-consensual sterilization.
7. Quality Assurance Committees at the State and District Level should publish details of committee members on the website of the Ministry of Health and Family Welfare as well as the corresponding Ministry or Department of each State Government and each Union Territory, in a bi-annual report containing the number of persons sterilized, the number of deaths or complications arising out of the sterilization procedure, non-statistical information in the form of a

report card indicating the meetings held, decisions taken, work done and the achievements of the year etc.

8. Regular audits to be conducted of failures and deaths and Annual Reports of the Quality Assurance Committees must include details of such audits held and remedial steps taken. The first Annual Reports should be published before March 31 2017.
9. The quantum of compensation fixed under the Family Planning Indemnity Scheme (FPIS) deserves to be increased substantially and the Government of India and the State Government thereof must equally share the burden.
10. The Supreme Court declared it to be more than a pity, for a country to not have any health policy. The draft of a National Health Policy, 2015 was put up on the website on the Ministry of Health and Family Welfare of the Government of India in December 2014 for comments, suggestions and feedback but even after more than one and a half years, the website of the said Ministry shows that the National Health Policy has not been finalized. Hence the court directed Union of India to finalize the National Health Policy on or before 31st December 2016 keeping issues of gender equity in mind.

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# 11. CONCLUSION

The Indian Government's efforts toward population control through sterilizations are ill-informed and based upon a patriarchal structure which does not take into account important intersections of gender, socio-economic status, or geographical location (rural or urban) of the people upon which the policies are implemented. By mapping the course through which the FPP in India came into being, one can see that it has its roots in the Malthusian theory of population growth and control. Many countries including the country it originated in, have negated the theory and have gone for a more humanistic approach towards family planning, focusing more on education and spread of information, as we have seen in the chapter dealing with international rules and regulations regarding sterilization and family planning. In policy and in practice, sterilization efforts target poor women for unsafe procedures, rarely with informed consent. Unable to make decision on her own, with little or no control over her body. Policy makers see her as the very reason of population growth. Further, her status in the Indian society makes her the perfect scapegoat for the vertically implemented family planning programme, which is solely focused on sterilization giving little weight to the ability of women to use other forms of contraception. Incentive schemes for sterilization also target poor women, giving them little choice when they must choose between sterilization and survival of themselves and their family.

The Indian government must move away from its current quota-based system, which incentivizes hasty, unsafe sterilizations like the ones that killed so many women in Chhattisgarh. The government should instead focus on providing women and men around the country with a full range of safe contraception choices, including but certainly not limited to sterilization. The government should rework the incentive scheme so that it encourages both men and women to partake in family planning. Any incentive scheme

must take into account the desperation of many, especially poor, women. Measures should also be taken to eliminate quotas for sterilization, which encourage coercion and force to be used against disadvantaged people by health workers. This will have the additional, indirect effect of improving damaged relations between health workers and patients.

Empowering women to choose if and when to have children is essential to addressing social issues that plague India. Coupled with increased awareness and education, the government must address many issues arising under the blanket of overpopulation such as high rates of poverty and maternal deaths. It has been shown that improving literacy rates, for example, reduces fertility rates.<sup>115</sup> Further as many field reports have shown, any such programme requires integration from the grass roots level. ASHA workers and ANMs must be trained properly and not kept in the constant threat of losing their jobs due to unreached targets. Several discrete issues must be addressed, such as the provision of appropriate technology in order to prevent the unnecessary deaths and health issues caused by using out-dated and unsafe instruments, including bicycle pumps.

The Indian government should work to improve education regarding family planning and family planning resources as well as improving relations between healthcare/family planning providers and their clientele. In addition, campaigns to destigmatize and educate the people of India about family planning should be accompanied by acknowledgement of the patriarchal system, which places the onus of childcare and domestic activity on women. The Indian government should address the fact that women are sterilized, often in unhygienic and unsafe conditions, so much more often than men. The government ought to launch campaigns combatting harmful gender roles and challenge systems of inequality in India. Until these changes occur, women will continue to suffer at the hands of the very government that is meant to protect them. These horrendous violations of the rights of women must end.

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<sup>115</sup> *How Female Literacy Affects Fertility: The Case of India*. (1990). East West Center. Retrieved 16 February 2018, from <https://www.eastwestcenter.org/fileadmin/stored/pdfs/p&p015.pdf>



## 12. ANNEXURES

### SUPREME COURT OF INDIA

RECORD OF PROCEEDINGS

Writ Petition (Civil) No. 209/ 2003

RAMAKANT RAI & ANR.

Petitioner (s)

VERSUS

UNION OF INDIA & ORS.  
(s)

Respondent

Date: 01.03.2005

CORUM:

HON'BLE MRS. JUSTICE RUMA PAL

HON'BLE MR. JUSTICE ARIJIT PASAYAT

HON'BLE MR. JUSTICE C.K. THAKKER

UPON hearing counsel the Court made the following

### ORDER

Several states have filed affidavits setting out the steps taken by them to regulate sterilization procedures with regard to the male and female patients in their respective states. However, it is apparent that there is no uniformity with regard to the procedures nor the norms followed for ensuring that the guidelines laid down by the Union of India in this regard are being followed. Taking the best of what is being followed by some states, we direct that the States shall:

1. Introduce a system of having an approved panel of doctors and limiting the persons entitled to carry on sterilization procedures in the State to those doctors whose names appear on the panel. The panel may be prepared state-wise, District-wise or Region-wise basis. The criteria for including the names of the doctors on such panel must be laid down by the Union of India as indicated subsequently. Until the Union of India lays down uniform qualification criterion for the empanelment of doctors, for the time being no doctor without gynecological training for at least 5 years post degree experience should be permitted to carry out the sterilization programmes.
2. The State Government shall also prepare and circulate a checklist which every doctor will be required to fill in before carrying out sterilization procedure in respect of each proposed patient. The checklist must contain items relating to (a) the age of the patient, (b) the health of the patient, (c) the number of children and (d) any further details that the State Government may require on the basis of the guidelines circulated by the Union of India. The doctors should be strictly informed that they should not perform any operation without filling in this checklist
3. The state Governments shall also circulate uniform copies of the proforma of consent. Until the Union Government certifies such proforma, for the time being, the pro forma as utilized in the State of U.P., shall be followed by all the States; and
4. Each States shall set up a Quality Assurance Committee which should, as being followed by the State of Goa, consist of the Director of Health Services, the Health Secretary and the Chief Medical officer, for the purpose of not only ensuring that the guidelines are followed in respect of pre-operative measures (for example, by way of pathological tests, etc.), operational facilities (for example, sufficient number of necessary equipment and aseptic conditions) and postoperative follow ups. It shall be the duty of the Quality Assurance Committee to collect and publish six monthly reports of the number of persons sterilized as well

as the number of deaths or complications arising out of the sterilization.

5. Each State shall also maintain overall statistics giving a break up of the number of the sterilizations carried out, particulars of the procedure followed (since we are given to understand that there are different methods of sterilization), the age of the patients sterilized, the number of children of the persons sterilized, the number of deaths of the persons sterilized either during the operation or thereafter which is relatable to the sterilization, and the number of persons incapacitated by reason of the sterilization programmes.
6. The State Government shall not only hold an enquiry into every case of breach of the Union of India guidelines by any doctor or organization but also take punitive action against them. As far as the doctors are concerned, their names shall, pending enquiry, be removed from the list of empanelled doctors.
7. The state shall also bring into effect an insurance policy according to the format followed by the state of Tamil Nadu until such time the Union of India prescribes a standard format.
8. The Union of India shall lay down within a period of four weeks from date uniform standards to be followed by the State Governments with regard to the health of the proposed patients, the age, the norms for compensation, the format of the statistics, checklist and consent proforma and insurance.
9. The Union of India shall also lay down the norms of compensation which should be followed uniformly by all the states. For the time being until the Union Government formulates the norms of compensation, the States shall follow the practice of the State of Andhra Pradesh and shall pay Rs. 1 lakh in case of the death of the patient sterilized, Rs. 30,000/- in case of incapacity and in the case of post-operative complications, the actual cost of treatment being limited to a sum of Rs. 20,000/-.

All the States have responded except the State of Jammu and Kashmir. Needless to say that the State of Jammu and Kashmir will also follow this order.

Let the matter be placed eight weeks later by which time the Union Government and State Governments should indicate the steps taken by them in compliance of this order.

USHA BHADWAJ

MADHU SAXENA

COURT MASTER

### **SUBMISSIONS OF THE PETITION IN DEVIKA BISWAS CASE (WRIT PETITION (C) NO: 95 OF 2012)**

#### **The Petitioner Described**

1. The Petitioner, Devika Biswas, (MA, Econ. PGDip, PM & IR) is a native of Araria and has extensive professional experience in the development and health sectors. As a health rights activists she has worked in Uttar Pradesh, Delhi, Jharkhand, and Bihar. After she conducted a fact finding mission on sterilizations in her native district of Araria, she felt compelled to file this petition to ensure that sterilizations nation-wide are conducted as per the legal norms and to see that the victims in Bihar receive compensation for their injuries.

#### **The Petition Summarized**

2. In the Petition the fact finding report prepared by the petitioner and by Mr. Francis Elliot of The Times, London, annexed at page 169 onwards reports the manner in which 61 women were sterilized on 2.1.12 under torch light at night on the school desks. (15 onwards). The guidelines allow only 30 women to be sterilized with three laparoscopes in a day. The school was used without authorisation. An NGO Jai Ambe Welfare Society (R-4) was given a contract by the State to perform the sterilizations. At page 173 of the Petition, it is stated that each operation was done within about three minutes. A pregnant woman was also sterilized. They fell unconscious. Some of the women were profusely

bleeding. The surgeon left the place with the NGO staff. It is said at page 174 that FIRs were lodged at the Kisorakanta Police Station. No action was taken. It is stated at page 174 onwards that the medicines used had passed their expiry dates.

3. Despite this, government officials maintained that there were no lapses at all. (156, 166, 176).
4. The fact finding report gives details of the statements made by members of the public. (180 onwards) The public (about 100 local inhabitants of Kaparfora and nearby villages) gave oral witness to Mr. Elliot and the Petitioner that they came to know about the sterilization camp only when the woman sterilized, motivated by all ASHA workers started pouring in the government middle school campus of Kaparfora, and the organizing accredited NGO workers were enlisting them in the noon of 7.1.2012.
5. The present mukhiya wanted to know from them the package of compensation, the candidates would receive from them and they said that it is going to be free medicine. For the first time, the cash compensation was not given, hence, public wanted to see the office order in this regard.
6. According to the public, no arrangements were made by the NGO. The paddy-straw was brought by the guardians of sterilized persons for night stay for their wards. The operation room (one of the classrooms) was not clean; the school desks (high benches) were used as operation tables without any disinfected covers. No arrangements for candidates' disinfection of clothes, or running water or any other arrangements for pre-operative counselling, physical checkup or any test took place. All women were given anesthesia (by injection) just before they were brought in the operation room by the untrained NGO youths. Four women were operated in 10 minutes time and the next four women were sent in. No change of gloves by the doctor and all operations took place in dim bulb light and torch light. No post-operative care was given to the women. All women started crying in pain and some were bleeding. But the so-

called doctor who came in same vehicle left the place immediately after completing 53 operations without visiting any sterilized women. There were these sterilized women left at the camp in the care of NGO workers who did not pay any attention to the cries of women in the night.

7. The school Authority: The school in charge, Mr. Dilip Verma and other teachers told that nobody asked for permission to use the school building for sterilization camp purposes. The room where the operation took place and where the women spent the night were not locked. It being a Saturday, the school staff left the school by 11:30, so they do not know about the incident.
8. The statements of the sterilized women were recorded and is set out at page 183 onwards to the effect that they were not counseled, they were not medically examined, that thumb impression was taken on a blank consent form, they were made to lie down bleeding on the floor, the next day they went to private doctors to remove the stitches, and a pregnant woman was sterilized. Interviews with the sterilized women are set out from page 191 onwards.

### **Similar report regarding sterilizations in Maharashtra, Rajasthan, MP**

9. A similar fact finding report done by a group from Maharashtra together with photographs regarding the unhygienic conditions under which women were being sterilized in utter disregard of the Ramakant Rai guidelines is to be found from page 203 onwards. The Rajasthan report is at pages 112 onwards and the MP report is at page 221 onwards.

### **Reliefs sought in the petition**

- a. Issue a mandamus or any other appropriate writ order or direction establishing a committee such as the National Alliance for Maternal Health and Human Rights (described in page 40). To investigate and submit a report within 12 weeks regarding the facts stated in this petition and recommendations for additional guidelines if necessary.

- b. Issue an order a writ of mandamus directing the State of Bihar to initiate departmental proceedings against the Government officials involved in the sterilization camp and the granting of permission to the NGO (Respondent No.4) to carry out sterilization.
- c. Issue an order a writ of mandamus directing the state of Bihar to file a status report in this court regarding the criminal proceedings instituted against the Government officials and the NGO (Respondent No.4) and thereafter, to make appropriate orders for the speedy trial of the offenders. Issue an order a writ of mandamus directing the state of Bihar to deregister and debar the Respondent No.4 from carrying out any public health activities including sterilization.
- d. Issue an order a writ of mandamus directing all the respondents states to, in all cases obtain the informed consent of the patients in the manner prescribed in guidelines for female and male sterilization (2006).
- e. Issue an order a writ of mandamus directing all the Respondent States to file the status report on the implementation of this court's directions in Ramakant Rai's case as well as the Guidelines for Female and Male Sterilization (2006) and to ensure that both these guidelines are adhered to throughout the country.
- f. For an order directing payment of Rs 5 lakhs compensation for each of the 53 women who were sterilized on 7 January 2012 at Kaparfora Government Middle School, Jai Ambe welfare society sterilization camp.

### **No action taken by State of Bihar**

10. Even till today no official has been punished departmentally, no criminal proceedings has been instituted, the NGO has been debarred but no action has been taken against its members and no compensation has been paid.

## Post Ramakant Rai (I)

11. After the decision of the Supreme Court, Union of India published “Standards for Female and Male Sterilization Services (2006) at page 49 of the petition, Standard Operating Procedure for Sterilization Services in Camps (2008) at page 142 of the counter affidavit of Union of India dated 13.4.15, Standards & Quality Assurance in Sterilization Services (2014) page 189 of the counter affidavit of Union of India dated 13.4.15 and the “Manual for Family Planning Indemnity Scheme”(2013) (Annexure 42 of the of the counter affidavit of Union of India dated 13.4.15), and the “Reference Manual for Female Sterilization (2014)”at Annexure 40 of the of the counter affidavit of Union of India dated 13.4.15.

## Standards for Female and Male Sterilization Services (2006)

12. Petitioner has annexed this Government of India manual at page 49 onwards. This manual was prepared after the decision in Ramakant Rai case. It provides, inter alia, for qualified doctors to be put on a panel (53), the physical infrastructure required (53, 86), informed consent (54), and that the women should be married, be between the ages of 22 – 49 years and have at least one child above the age of 1 year. The manual sets out the nature of counselling that should be done so that an informed decision can be made. In particular, women are required to be informed of all the available methods of family planning (55) and that they have the option of refusal (56). The procedure for sterilization operations is set out at page 57 onwards. This includes medical examination and monitoring after the operation (63 onwards). The post operative care requires that the woman be kept overnight at the facility (67 onwards). It is stated that all failures of complications are required to be documented (72) and that cleanliness be maintained (73 onwards), and that sterilization be done of needles, linen etc. (80 onwards).

## Standard Operating Procedure for Sterilization Services in Camps (2008)



13. This document lays down extensively the operating procedures to be followed in camps which includes that camp timings should be between 9am and 4pm (151), that 30 laparoscopic tubectomy operations can be done in a day for a team with three laparoscopes (151), and that sterilization camps can be organized “only at established healthcare facilities as laid down in the standards of GoI” (151). The required staff, the equipment, instruments and supplies and required the laboratory tests to be done are set out from pages 150 onwards. The responsibilities of the officials and others carrying out the activities are set out from pages 157 onwards. Prevention of infection is set out from page 165 onwards. Assurance of quality is set out from page 171 onwards. Management of emergency is set out at page 179 onwards.

### **Standards & Quality Assurance in Sterilization Services (2014)**

14. This document is set out at page 189 of the counter affidavit of Union of India dated 13.4.15. The eligibility criteria is set out at internal page 5 and is, inter alia, as under:

“Client should be married.

Female clients should be above the age of 22 years and below the age of 49 years.

The couple should have at least 1 child whose age is above 1 year.”

15. Counselling and informed consent/choice is set out at internal page 6 onwards and is, inter alia, as under:

The following steps should be ensured before the client signs the consent form:

- a) Clients have been counselled wherever required in the language they understand.
- b) Clients have been informed of all the available methods of family planning and procedures.
- c) Clients have been made to understand what may happen before, during and after the surgery, its side effects and potential complications.

d) Clients have made an informed decision for sterilization voluntarily

### **Informed Choice and Informed Consent (Section 1.5 of Standards in Sterilization Services, 2014)**

16. The concepts of informed choice and informed consent are related but quite different in their intent. The purpose of informed choice is to ensure that all clients choose the best option/s for their health care needs after getting full information about all available options. Informed consent means that a client understands the surgical procedure and other options and then decides to receive the care.
17. It is set out in the standards that prior to surgery the medical history of the clients should be studied, physical examination and laboratory investigations should be done as set out from page 9 onwards.
18. From internal page 13 onwards it is stated that client monitories must be a routine practice, medical records are to be maintained and post-operative care done. Conditions are laid down for when it is appropriate to discharge a patient and that whenever necessary the client should be kept overnight at the facility, should be accompanied by an adult while returning home and those medicines should be provided. Post-operative care is set out from page 15 onwards. A discharge card has to be given giving full details of the institution and the surgery performed together with the post-operative instructions. A certificate of sterilization is to be given. This document also provides for treatment of complications and side effects as well as failure of operation leading to pregnancy. Quality assurance is described at page 45 onwards. In particular, quality assurance committees are required to be formed at the State and District level to ensure that standards are followed (internal page 46 onwards). At the state level there are 10 members and at the district level there are 9 members. These committees are required to monitor/review the quality of the sterilization activities and to make reports as well as to adjudicate claims for compensation under the National Family Planning

Indemnity Scheme in cases of deaths, complications and failures. These quality assurance committees are to check the records of the facility as well as the clients, the informed consent forms and other records and make reports of monitoring visits. Client exit interviews are to be conducted (internal page 51 onwards). Detailed reports of the deaths are to be done. The death audit report is to be prepared and reviewed by the quality assurance committee. Similarly reports on complications and failures are to be reported and reviewed.

### **Manual for Family Planning Indemnity Scheme (2013)**

19. This is to be found at page 192 onwards of the counter affidavit of Union of India dated 13.4.15. Certain payments are made by government on sterilization. Compensation is paid for loss of wages, transportation, diet, drugs, dressing etc. Certain payments are made for death, failure etc. The procedure for claim settlement is set out at internal page 11 onwards.

### **Reply of the UOI in affidavit dated 13.4.15 Regarding compliance with the Ramakant Rai (I) guidelines**

20. A perusal of the affidavit shows that all the States/UTs have reported to the UOI full compliance with the Ramakant Rai (I) Guidelines. However, no details are provided at all. Apart from cryptic reporting that the guidelines are being followed there are no annexures and no details given. It is also clear that UOI has not bothered to verify or spot check even in a limited manner compliance regarding a single guideline even in a single state.

### **Continuing reports of Sterilization deaths and complications**

21. On 23.05.2012, Kolayat Hospital in the state of Rajasthan sterilized 72 women. The same hospital had earlier been reported to have sterilized another 42 women on 25.04.2012. These sterilizations, all done en masse were in violation of the guidelines which prescribe that no more than 30 sterilizations may be done by a team with three laparoscopes in a single

- day. Further, post-surgery, the women were not put under observation for the required period of three hours. In the absence of recovery rooms, they were forced to lie on the crowded and dirty floors of corridors for recovery. None of these women had ever been counseled on any other forms of contraception. Further, over 80 percent of these women stated to have been unconscious when discharged. ("The Horrors of India's Population Control Programmes" issued by the Caravan Magazine dated 12.11.2014).
22. In an incident dated 05.02.2013 in the Manikchak Rural Hospital in Malda, West Bengal, 103 women were sterilized in 'Mega Female Minilap Ligation Camp' by the State authorities. As per the written record, three doctors conducted 103 Minilap operations.
  23. The hospital was used as a makeshift facility for the sole purpose of sterilization and had a capacity of only 60 beds with dirty and torn mattresses thus the aseptic part was completely overlooked. The patients were made to lie on the open dirty grounds of the hospital in a painful, semi-conscious state, attended to only by concern family members. There was no adequate counselling regarding what will happen before, during, and after the surgery, its side effects, and potential complications, including failure. The consent forms on which women gave their consent for the operations were not translated in the local language and were in English. There were no post-operative examinations conducted or any post-operative instructions given to the women. There were no discharge cards indicating the name of the institution, the date and type of surgery, the method used, and the date and place of follow-up as mandated by MOHFW given to the women after the surgeries.
  24. It was in this regard, that local health officials acknowledged the appalling conditions of the programme and notices were sent by the NHRC to the District Magistrate in Malda and the Principal Secretary, West Bengal. ("103 Women sterilized in a day at West Bengal; probe ordered" issued by NDTV dated 08.02.2013").

25. On 07.11.2013, a young man was taken to a local Community Health and Welfare Centre in Rajasthan when he complained of abdominal pain. The public health workers performed a non-consensual vasectomy on the young man. This instance of sterilization on a 27 year old man, where the complaint was solely with regard to abdominal pain, is reflective of the attitude of health workers to forcibly and without proper and informed consent, carryout sterilizations on many hapless people. (Annexure A-5 of Original Petition).
26. In Jalandhar, Punjab on the 25th of July, 2013, a woman died during a sterilization operation at a Tubectomy camp. The camp was organized at the Badapind Village Community Health Centre. The victim, hailing from Uttar Pradesh died due to severe internal bleeding caused by negligent and inadequate operative care provided by the surgeons on duty. An inquiry was herein instituted, without any punitive action being taken against the surgeons, as was required by a guideline in Ramakant Rai and compensation amounting to Rs 2,00,000 was disbursed to the husband of the deceased (Woman dies during sterilization operation, probe ordered issued by India TV dated 25.07.2013).
27. On 22.11.2013, another tragic victim of India's reckless sterilization plan came to the fore. At a camp attended by dozens of young and old women in Bargarh, Odisha, one of them, Shanti Mahanand passed away due to shock caused by excessive bleeding. In the said case, the doctors had reportedly carelessly severed one of Shanti's veins during her laparoscopic Tubectomy. There were no adequate emergency care services available at the camp which was why she couldn't be treated on-site. (Annexure A-6 of Original Petition).
28. In November 2014, one of the worst tragedies in India's history with sterilization drives befell the state of Chhattisgarh. On 08.11.2014, Dr. R.K Gupta performed 140 laparoscopic tubectomies in the Bilaspur District of the State, including 83 which he had completed within a period of six hours. Two days later, a majority of them fell ill and were subsequently

- admitted to nearby hospitals. By the 13th however, 13 women, some with babies as young as 14 months, died as a result of this Tubectomy and further seventy women remained in hospital with serious complications.
29. The preliminary report on the deaths, mostly women from poor families, was attributed to either septicemia or peritonitis. The said programme breached numerous guidelines owing to the no. of such procedures to be conducted. The evidence shows the use of unsterilized medical instruments, spurious medicines, lack of pre and post-op examination coercion in admission and lack of informed consent on the part of the patients. It is safe to say that almost all the women's right to life, dignity, health and the various reproductive rights stood violated. It had also been perhaps rightly suspected, that the doctors were under pressure to meet the targets set by the programme. It was later held and acknowledged by a Judicial Commission in December 2015 that 'severe negligence' on the part of the authorities, especially pertaining to the Standard Operating Procedures, was a fatal factor in the deaths of the 13 women in Bilaspur district of Chhattisgarh (Annexure 1, Application for impleadment of the State of Chhattisgarh filed by the Petitioner, I.A No. 4 of 2014 on 25.11.2014)
30. In a shocking incident that was reported in the Angul district of Odisha, a sterilization camp in Banarpal village led by Dr. Mahesh Prasad Rout on 01.12.2014 used a bicycle pump to substitute for standard medical instruments during laparoscopic tubectomies. On questioning, he admitted to having used and having knowledge of bicycle pumps being used for years in rural camps, where modern-day equipment was unavailable. Here, the pump was used in place of an insufflator, used primarily to regulate air pressure in the abdomen of a woman during a sterilization procedure. Further, Dr. Rout claims that he has been commended for the almost 60,000 tubectomies he has performed in the past ten years (Annexure A-10 of I.A No. 6 of 2015)

31. In a continuing trend of medical laxity and negligence, in the Mandi district of Himachal Pradesh on 12.12.2014, a drunken doctor performed five sterilizations and fell asleep during the course of his sixth laparoscopic tubectomy in the Primary Health Care Centre in the village of Thunag. It was informed that the doctor had locked himself up in a room to sleep while he left the sixth patient after the administration of anesthesia. The doctor in question was credited to have performed hundreds of surgeries over the past few years. However, the said doctor was later suspended and it was further suspected he had a previous record of intoxication at work and had also fallen asleep during the course of a previous sterilization procedure (Annexure 11, I.A No. 6 of 2015)
32. A case that significantly shed light on the failing and inadequate state of India's family planning, and specifically its sterilization programmes, 40 women were sterilized in Jharkhand at a state-run health clinic on 09.01.2015. However, the most disturbing part of the report is the fact that all these surgeries and operations were conducted in pitch-dark, the only light coming from a single torch used during the said operations. It was claimed that torchlight was used as the facility was out of power that night, a decision that severely risked the lives of these women. Further, after such sterilization, the women were made to sit and lie outside in the corridors without any post-op medical care, or the use of blankets and stretchers (Annexure A-12, I.A No. 6 of 2015)
33. A similar shocking incident was recorded in Azamgarh in the month of February 2015 where 60 women were sterilized within 4.5 hours under a mobile and torch light since the electric power was being used to cool the mobile vaccines. The operations were carried out in the evening, in unsanitary and inhumane conditions in the hospital which lacked even basic infrastructure and facilities like beds. A number of women operated for sterilization were left unattended on the hospital floor in cold weather ( "In Azamgarh fifty women sterilized in torch, mobile light in four hours flat" issued by Twocircles.net dated 14.03.2015")

34. In yet another instance of impropriety in sterilization initiatives in India, a 15-year old boy was tricked into having a vasectomy done. On 22.11.2015 on pretext of a vaccination camp, a boy, a daily-wage worker, had been promised a 'free vaccination' by an ASHA worker. The boy was asked to lie about his age and marital status at the local civil hospital in Gurgaon. The doctor in question didn't object or question his claims as the norms required. The boy was later paid a sum of Rs 1,100 for having 'volunteered' for the procedure, even as he had been tricked into a vasectomy instead of a vaccination as he was promised ("Teen tricked into sterilization surgery, was told it was vaccination camp" issued by Times of India dated 21.03.2015")
35. Another shocking incident to come to light, as many as 14 women were operated and laparoscopic tubectomies performed on by nurses, instead of trained, professional doctors and surgeons as was necessitated on 23.12.2015. These procedures were so conducted as part of a medical camp organized by the Health authorities in Piththorgarh, Uttarakhand. By the use of untrained nurses to do such a complex medical procedure, the authorities had abetted the risk to the lives of these 14 women and later, the Uttarakhand Human Rights Commission rightly demanded that the District Magistrate institute an inquiry into the matter (Times of India report "Inquiry on medical camp as nurses performed surgeries").
36. Under Family Planning Programme, within 17 days, three women died after undergoing sterilization in three different districts namely Seedhi, Umariya and Anupur in Madhya Pradesh. The camps violated the guidelines of the Ministry of Health and Family Welfare's Standard Operating Procedures.
37. In Chandiya CHC, District Umariya, a 26 year old woman named Rekha Kaul, W/O Kumahre Kaul was sterilized on 19th December 2015. Rekha developed complications on 24th December 2015 and was referred to District hospital in Umariya. Rehka died during treatment on 25th December 2015. The post Mortem report states that the woman's intestines were sticking.



38. In district Seedhi, village Meera Khaddi, a young woman named Kiran Singh, aged 26 years, W/O Pushpraj Singh underwent sterilization on 23rd December 2015 at PHC, Danha Vikaskhand Rampur Naikin. The surgery was conducted by Dr. Deepa Rani Israni (Gynecologist). Kiran was referred to Medical College in Reeva but she died on the way to Medical College. The CMHO at Seedhi, in his report to Joint Director stated that the woman's family has been compensated with Rs. 50,000/- .
39. In Anupur, a similar case of negligence came into light when a woman died after her sterilization in a camp. Soon after operation the woman developed complications, complained of pain in her stomach and her condition deteriorated. She was referred to District Hospital at Anupur. The woman died during treatment.
40. In all the three deaths, the families of the deceased have been compensated with Rs. 50,000/- with a promise of 1.5 lakh to be given later. However, it is a clear case of medical negligence, yet no action has been taken against the doctors involved in the operation.
41. In December, 2015 the Times of India reported that a doctor in Indore conducted 196 sterilizations surgeries in one day on December 12, 2015 to achieve his target in Punsia block of Khandwa District. The act was in clear violation of guidelines of Ministry of Health and Family Welfare. Dr. DC Mahadik, a government doctor who performed surgeries in Punsia told Times of India, "You cannot question the capability of doctors working 24/7 for patients. Given a chance, I am ready to conduct 1,000 surgeries" (Times of India report "In a day, Indore doctor conducts 196 sterilizations" dated 17.12.2015).
42. In May, 2015 the Times of India reported that six doctors were in the dock in Chhattisgarh as they achieved only 11 percent of their targets of conducting 8,300 cataract surgeries during the last fiscal year, which contradicts that the state government does not fix targets for surgeries for doctors. Director Health Services (DHS) R Prasanna said

- the targets, under the National health scheme in 2014-15, had not been met by the doctors despite the fact that all facilities were available in district hospital (Times of India report, "Six doctors in dock for not meeting surgery targets in Chhattisgarh" dated 17.05.2016).
43. In December, 2015, Uttar Pradesh, the Deccan Chronicle reported that a doctor allegedly carried out sterilization surgeries on 27 women in an hour at a primary health centre without proper arrangements in place (Deccan Chronicle report "Doctor performs 27 sterilization surgeries in just 60 minutes" dated 05.03.2015).
  44. The Indian Express reported that within a week of Chhattisgarh Sterilization massacre, 26 women were sterilized in one hour at a camp in Bilaspur. One woman died (The Indian Express report "Chhattisgarh sterilization tragedy: Despite deaths, 26 more tubectomies were done in one hour in another camp" dated 13.11.2014).
  45. The Hindustan Times, 2014 reported that less than two weeks after the Chhattisgarh camp, 132 women were sterilized in 5 hours at night in a camp in Madhya Pradesh. The camp lacked stretchers and beds (Hindustan Times report "Madhya Pradesh: 132 women sterilized in 5 hours in Chhatarpur" dated 19.11.).
  46. As reported by Times News Networks (TNN) in late December, a woman at a camp in Orissa had her esophagus slashed during a sterilization procedure (Times News Networks (TNN) report "Orissa Doctor 'cuts' woman's food pipe" dated 05.01.2015).
  47. Times of India reported in early January, 2015 that 45 women were sterilized at a camp in Uttar Pradesh; the camp officials left the women on the floor after the surgery (Times of India report "No bed for women undergoing sterilization in Azamgarh" dated 03.01.2015).
  48. In January, 2015, Deccan Herald reported that 73 women were sterilized in four hours in a camp in Uttar Pradesh. The

women were not given beds after the procedure, but were left on the floor (Deccan Herald report "73 women sterilized in 4 hours in Varanasi" dated 31.01.2015).

## NGO reports

49. In several fact-finding missions to places like Bundi district of Rajasthan (2012) (Annexure P-5 of Original Petition), Araria district of Bihar (February and May-June 2012) (Annexure P-15 of Original Petition and Annexure P-3 of Rejoinder), Asansol (January 2013) (Annexure R-16 of the Status Report submitted with Original Petition) & Malda (February 2013) (Annexure R-17 of the Status Report submitted with Original Petition) in West Bengal and Chhattisgarh (November, 2014) conducted by the Human Rights Law Network the many States of India, violation of the guidelines given by the Court was uniformly observed. Some observations so made during the course of such fact-findings include, a significant number of women attending such sterilization camps were not counseled on the permanency of a sterilization procedure or any side-effects that may accrue from them. In fact, there is a general lack of awareness and information with regard to alternative forms of contraception.
50. Most of these procedures were performed by a single surgeon without the assistance of nurses or technicians in unsanitary, unhygienic makeshift facilities that were far from adequate, with insufficient medical supplies and no provision for drinking water or emergency services.
51. Women were not being screened for pre-op illnesses or immunizations and post-operative care was virtually non-existent. Preliminary medical tests such as Urine and Blood tests were performed on only few women present for the sterilization programme and even in such cases, the reports were often withheld from them.
52. Further, a camp observation report was conducted by the Coalition against Coercive Population Policies and the National Health Alliance for Maternal Health in April 2015, in the state of Uttar Pradesh (Annexure A-4 of Status Report

submitted on behalf of Petitioner in May, 2015). This report was based on observations made at government-held camps in Chitrakoot, Azamgarh and Mirzapur. The following observations were thus made (a) poor counselling and lack of documentation was prominent in all camps. (b) Consent forms were not read in local languages and no woman was informed of the compensation scheme, as against the failure of sterilization.

53. In all the camps, none of the women were provided discharge slips or sterilization certificates, nor was anyone provided with test reports that they had undergone before the procedure of sterilization.
54. In camps held in Chitrakoot, there was no separate room for women after sterilization and were accommodated on the verandah of the hospital. Further, no service providers bothered to check up with the patients and provide any post-op care.

**Robbed off choice and dignity:  
Indian Women dead after mass sterilization  
Report by a Multi-organisational team  
1.12.14**

55. A multi-organizational fact finding team travelled to Bilaspur on November 19-20, 2014 to assess the death of 16 young women and the critical condition of several others following their tubectomy at a sterilization camp at Bilaspur District, Chhattisgarh.
56. The women started registering for the camp from 10:30am and registration continued until 1:30pm. The Laparoscopic Surgeon started the sterilization procedures at 3:30pm and continued till 5:00pm. A total of 83 women were operated on in about one and a half hours, which amounts to a duration of one to one and a half minute per surgery.
57. As per the information provided, none of the staff changed their hand gloves in between the procedures. The same injection needle, syringe, and suture needle were used

for all the cases, neither of those was sterilized. Only one laparoscope was used for all the 83 surgeries, while the Ministry of Health and Family Welfare guidelines prescribe three for a maximum of 30 patients. That one laparoscope was cleaned only by dipping it into a big tray containing warm water and betadine before each procedure.

58. The surgeon performed each procedure without any adherence of the Infection Prevention practices and Quality of Care procedures. The Laparoscopic surgeon did not check any women before or after the procedure and proceeded to blindly put his signature on the patient's case sheets.
59. At the camps there was also a complete apathy for the dignity of women. The women were operated on in an assembly line fashion, with a male ward boy positioning them for surgery in the lithotomy position and carrying them to the mattress afterwards. They had no beds to lie on, and were sent home almost immediately after the surgery with utter disregard for their health.
60. The officials revealed that some of the women started showing discomfort and symptoms including, vomiting, breathing problems and abdominal pain. These women first contacted their community health workers, some of them were given an antiemetic drug, but when their vomiting did not stop, the women were taken to the district hospital where very low blood pressure was recorded on all of them.
61. At the beginning three women went to the district hospital, out of which two died. Within a span of 12-24 hours a majority of the sterilized women became grievously ill developing complications and some died due to irreversible shock.
62. If the protocols set by the Government of India were to be followed, for a camp of 83 patients, three teams would be required. Each team would constitute three staff in the operating room, one laparoscopy surgeon, one operation theatre assistant and one nurse. In contrast the staff involved

- in the camp was only four medical officers, two staff nurses and two auxiliary nurse midwives in total.
63. In response to a query by the team about the fumigation procedures followed, the reply was, "Yes, it was done. The sweeper cleaned the walls with a mop."
  64. Contradictory statements on the responsibility for selection of campsites, with block level officials claiming that the decision was taken entirely by the Chief Medical Officers and the district officials saying the selections were done on the advice of the Block Medical Officers. A typical blame game revealing that there was no actual planning. (Page 20)
  65. Furthermore, it was revealed that there were only three laparoscopic surgeons for the entire state when the number should have been around 85. The officials all agreed that the standards adhered to in the camps were very poor and no guidelines were actually followed. The District Quality Assurance Committee was formed only a few months ago and had yet to actually begin functioning.
  66. None of the staff met by the team had any knowledge of the Standard Operating Procedures for Sterilization in Camps, the Guidelines for Laparoscopic Procedure and the Quality Assurance Manual.
  67. One of the workers revealed that an Intrauterine Contraceptive Device was inserted post-delivery, without the prior consent of the woman. The woman was only later informed, which is a gross violation of her rights.
  68. Analyzing the expenditure on family planning, it is pointed out that for the year 2013-14, India spent Rs. 396.97 crores on female sterilization programmes, which constitutes 85 percent of the total expenditure for all sterilizations done in the country. The amount spent as compensation was two and half times the total grants given to Primary Health Centre's for infrastructure strengthening. A total of 39, 23,945 female sterilizations were performed in 2013-14, with 1,142

in Chhattisgarh. Out of the 15.59 crore rupees spent by the state on sterilization, 13.09 crores were spent on women, thus female sterilization constituted 85% of total Family Planning Expenditure. Out of the 13.9 crore rupees spent, Rs.12.67 crores was spent on compensation and only 0.42 crores on the camps themselves (Page 26). (Annexure A-2, Application for Directions, 2014)

## **CAMP OF WRONGS**

### **A Fact Finding Report on Sterilization Deaths in Bilaspur**

#### **Sama Resource Group for Women and Health**

#### **Jan Swasthya Abhiyan**

#### **National Alliance for Maternal Health and Human Rights**

69. Percentage of female sterilization in the year 2012-2013 was 97.4% while percentage of male sterilization has been declining and is just 1.1% as per the reports of Family Planning and Population control in India. Target for 2015-16 was 10000 for male sterilizations and 175000 for female sterilizations. (Annexure 7 I.A 6 of 2015 Application for permission to find additional documents dated 16/01/2015, Namahar Report)
70. This reflects the disproportionate emphasis on sterilizations for women. These targets in the context of shortage of specialists in the health system, implies enormous pressure to meet the targets in the given time. Camp approach provision for sterilization services raises doubts about daily conduct of sterilizations at the District hospital and at the CHC.
71. Mitanins are the frontline health workers who provide provision of health information and form a link between communities and the health system. They are given incentives for motivating women for sterilizations
72. Mitanins get upset and worried that people would blame them as they are the ones who motivate women for sterilization.
73. The issues behind so many deaths of women due to sterilization includes whether the location is sterilized or not or the infrastructure of the place is proper enough where the

procedures could be conducted. Surgeries were conducted in merely in two and a half hour which has serious implications for the maintenance and use of sterile equipment, instruments and other reusable items. The post-operative area must be restricted to prevent post-operative infections, which was overlooked. Discharge of the women within an hour or two of the surgeries is responsible for many of them losing their lives. Seriousness of this surgery – requiring skills, high quality sterilized equipment, adequate time and high standards of sanitation and hygiene is routinely undermined, placing the women undergoing the procedures in precarious situations. Negligence at various levels led to the safety and well-being of the people attending the camps grossly compromised and right to health has been violated.

**HUMAN RIGHTS LAW NETWORK FACT FINDING REPORT,  
SONIA VIHAR, DELHI  
(Annexure, A-8, I.A No. 5 6 of 2015: Application for permission to  
file additional documents dated 16.01.2015)**

74. The ground reality of female sterilization in Delhi was submitted through additional documents filed by the petitioner on 28/1/2015. From the fact finding conducted by Human Rights Law Network in Sonia Vihar, Delhi, it is evident that, women are not provided full and informed consent. It was seen that the address list provided by the government was faulty the addresses were not taken down properly. Asha workers were also not aware of the FPIS Scheme
75. Kailash Devi of Sonia Vihar, Delhi was sterilized after her husband impulsively provided consent on her behalf. The husband was worried that his wife, who had already undergone 5 pregnancies and an abortion once, would not survive another pregnancy. The husband was not made aware of the procedure, its repercussions and most importantly its permanent nature. Nobody explained or read out the consent form to him. While Kailash Devi was in labor, she was asked to sign the consent form. She misunderstood it to be consent for cesarean surgery without being aware that it was for the purpose of the sterilization. This is a case of



negligence and violation of the health rights of Mrs. Kailash Devi. Neither the hospital nor the local dispensary where she went for check-up during her pregnancy conducted any prior tests on her to see if she is suitable for tubectomy. She was given medicines but she was not given any other instructions. Neither did she receive any incentive, compensation or JSY money, nor was she given any document showing that she has undergone tubectomy.

76. It was observed that there had been some aspects of default in the manner of conducting the whole procedure. None of the women who underwent sterilization in this camp received any money under FPIS, either because they were not aware or because the process itself is too cumbersome and there is no initiative on the part of the authorities to ensure implementation of guidelines. Lack of information and improper procedure for conducting the sterilizations makes it a dangerous option for women to utilize this method of family planning.

### **HUMAN RIGHTS LAW NETWORK FACT FINDING REPORT, MADHYA PRADESH (JANUARY - 2016)**

77. Between 5th to 8th and 11th to 14th January 2016, a team of social activist and researcher from Human Rights Law Network and partner organisations conducted a fact finding in districts of Madhya Pradesh. The team investigated the situation of sterilization camps, with regard to adherence of, quality assurance for sterilization services (2006), standards for male/female sterilization (2008) and SOP (2008) by interviewing the ASHA, doctors at camps and hospitals, sub centres, assistants, pharmacists and women who had undergone the procedure. The team also visited 2 camps in the district of Satna in Madhya Pradesh.
- a) Satna District PHC camp Kulgadhi- Block Unchehera
  - b) Satna District CHC camp Nagaur- Block Unchehara
78. The team witnessed clear violation of the guidelines issued by the Hon'ble Supreme Court in Ramakant Rai vs. Union of

India & Ors. And guidelines lay down by Ministry of Health and Family Welfare. It was discovered that sterilizations continue with apathy for the lives of poor women.

79. The sterilization camps continued to flout basic norms of medical ethics, maintained a target based approach to sterilization and breached almost all of the guidelines. The facts in Madhya Pradesh illustrate the callous attitude of Medical Officers like Dr. K.L Nandio, the surgeon at PHC Camp, Satna District Kulgadhi- Block Unchehera who informed the team, that he can complete an operation within 2 minutes. On further enquiry, he revealed with pride that he had once operated 262 women in a single day.
80. All women, except one, that were interviewed had not been provided any counselling on sterilization, potential complications, failure, side effects or mandatory pre-surgery health screenings. Sterilizations were carried out in CHCs and PHCs, which were highly unhygienic and unsafe.
81. The report demonstrates that informed consent and care were ignored. There wasn't any uniform method followed to give incentives to women, some received Rs.1400/-, some received 1300/- and others got only 600/-. The consent forms were not available in the local language;
82. None of the women had received post-operational care, exit check-up, information about follow-up care or proper medication. All women that were interviewed were asked to go back home within 1.5 hours of sterilization surgery.
83. Six women were interviewed on 8th January 2016 who informed that 45 to 50 women were operated on 12th Dec 2015 in CHC Mundai by a single doctor. The women did not know anything about the number of laparoscopes used.
84. One woman also shared that on 20th December 2015, in a camp at PHC Moondi, around 30-35 women were operated. One woman informed the team that 200 other women were operated at the same time with her.

85. 25% of the 13 interviewed ASHA workers were not aware of major health issues and what should they counsel women on and 25% talked about the targets for sterilization and that they receive an incentive of Rs. 200 per surgery.
86. Situation at the camps: Both the camps started late. An assistant at Satna District PHC camp Kulgadhi-Block Unchehera filled the forms of "free and informed consent" on behalf of the women. The consent forms were incomplete. 18 women were sterilized within 1.5 hours.
87. Since a surgeon gets Rs. 75/- per operation, the concentration is more on making money, this practice leaves room for infections, negligence and jeopardizing women's lives.
88. At both the camps, there was no post-operative care provided to women, there were no anesthesiologists available, most of the staff seemed unaware of post-operative care. The patients were manually being carried like sacks of vegetables post-surgery, made to lie on floor. There were no beds or even mattresses.
89. The toilets were in a filthy condition, no ambulance service was provided and sterilized women had no other option but to go back home on their own. One woman was even seen traveling on a bicycle post-operation. Women were left on the dirty floor without any disinfection or proper hygiene.
90. On 11th January 2016, at the hospital in Chintipur, the leading pharmacist informed that there is only one laparoscope available while monthly 20-30 women in a camp are sterilized. The surgeon operates in many camps (sometimes 4 – 5 a day). There is no register maintained for deaths. No pre- operational check-up list is available.

## **HUMAN RIGHTS LAW NETWORK FACT FINDING UTTARAKHAND (JANUARY - 2016)**

91. In Uttarakhand, service utilization or acceptance is very low for different aspects of healthcare. There are significant differences in the trend of service utilization or acceptance between urban and rural areas.

92. Further, there are a large number of vacancies in the various Government health facilities. Appointments of personnel on contractual basis have not succeeded in filling the gap effectively. The lack of trained personnel impacts the utilization and demand of services.
93. Each hospital was understaffed, and had infrastructure in need of urgent upgrade. Public amenities and washrooms were unhygienic, as were the wards where women stayed. Women commonly reported receiving incomplete information regarding sterilization, and a lack of access and information regarding alternative contraceptive methods.
94. The fact-finding team first visited Champawat District Hospital. This facility was opened in 2010. The Hospital does not have its own ambulance service; the only ambulance that works in the whole of district is the government's service of "108". There was also no functional blood bank.
95. Two of the permanent gynecologists were on leave; in their place a single gynecologist with only a year's experience was looking after all the patients. Furthermore, we were informed that the nurses were responsible for delivering babies. Basic hygiene standards were otherwise not observed; there were blood stains on the floors, pillowcases and linens; medical waste including blood-stained gauze were left on a tray on the side of the room; and the floors and lower part of the walls were covered in grime and dirt.
96. The washrooms were very dirty and foul smelling. There was a large puddle of dark water on the floor, and the taps and lights were not working. The sink was clogged and filled with rubbish.
97. The fact-finding team next visited Lohagat CHC, which was located in the town centre. The CHC is 30 bedded hospitals. Lohaghat CHC is the only CHC for the districts of Champawat and Pithoragarh, and serves as the prime health centre for villages as far as 62 km away. The hospital has recently been undertaken into a public-private partnership.

98. After some enquiries, it was discovered that a total of 30-40 women were operated on that day. The women were from the village of Madlak located on the border of Nepal over 100km away. All the women came to the CHC by their own transport which cost them total Rs. 400/-.
99. The conditions at Lohagat CHC were abysmal. A large pack of stray dogs was found behind the main building. There was no waste disposal mechanism. The waste was dumped in an area just behind the hospital.
100. The washrooms were extremely unhygienic. The taps were broken and the sinks were clogged with dirt. It is unclear when the urinals were last cleaned; a thick layer of grime along the lower part of the walls and floor was clearly visible. Urine covered the floor.
101. Upon further exploration, the fact-finding team found evidence of complete disregard for asepsis and infection control measures, in direct violation of the Indian Public Health Standards (IPHS).
102. The Pithoragarh District Hospital has a different building for women and therefore separate male and female wards.
103. Inside the consultation room, there was an evident lack of privacy. The hygiene and sanitation levels of the hospital was concerning. The washrooms were in a terrible state of cleanliness.
104. Further, in an interview with women who had undergone sterilization in the Pithoragarh, Chamapawat district hospital and Lohaghat CHC, informed us that since the health centres do not have hygiene and clean environment they don't feel comfortable to get admitted at the hospitals. The following failures were observed in the implementation of the guidelines
105. All interviewed women were aware of the available methods of family planning but they opt for sterilization because it's a permanent method and moreover women get paid for it.

But they are not aware of the potential complications and its side effects. This hospital authority has failed to give proper counselling to women and instead motivates the women to opt for sterilization in order to fulfill the targets.

106. Out of 10 interviewed women, 8 women reported that before the surgery medical history and physical examination were not recorded. Only the laboratory examination including blood and urine was examined. This shows poor quality of care at the camps.
107. In many cases, women were not given thorough post-operative instructions other than to rest and take medicines provided. This violates a woman's right to health (Constitution of India Article 21; ICESCR Article 12).
108. In the majority of instances the provision of partial or incorrect information is directly related to the incentive-based, target-driven approach to family planning which forces health workers to withhold information that may be prejudicial to their own self-interests. Additionally, consent forms were not explained to women in their own language, and in one case the nurse signed on behalf of a woman without any further information.
109. Research shows that financial barriers exclude poor and uneducated women from accessing modern contraceptive methods. 10% of women had to pay to access sterilization services in the public sector, while 32% had to pay to access IUD, 24% had to pay for the OCP and 30% had to pay for condoms.

## THE CHHATTISGARH INCIDENT

110. Chhattisgarh's entire family planning programme focuses on female sterilization. The National Health Mission Project Implementation Plan (PIP) sets targets for female sterilization and allocates 85% of the family planning budget exclusively for female sterilization. The Annual Health Survey 2012-2013 shows that Bilaspur district has a 29.7% unmet need for family planning services, which means that almost 30% of married

women in Bilaspur district of Chhattisgarh who want to prevent pregnancy do not have access to contraceptives. Instead of strengthening facilities, counselling capabilities, women's understanding and education of access to different spacing method (copper-T, oral pills, condoms), the Government of Chhattisgarh pursues the sterilization targets through camps. (I.A No.5 of 2014 Application for Directions page no.3).

111. On 8 November 2014, 83 women underwent sterilization through laparoscopic Tubectomy at Nemichand Jain Hospital and Research Centre, Takhatpur Block, Sakri. This was an unused hospital without beds, regular cleaning services and emergency services. As of December 2014, 13 women have died as a result of treatment at this camp. (I.A No.5 of 2014 Application for Directions page no.4).
112. On 10 November 2014, the government held camps in Guarella block at three PHC sites- Guarella, Marwahi and Pendra were 23, 16 and 15 women underwent sterilization (total 54). (I.A No.5 of 2014 Application for Directions page no.4) One woman died as a result of the sterilization camp in Gaurella.
113. Immediately following the news of the deaths in Bilaspur it was widely reported in the newspaper and local advocates as well as experts from other parts of the country conducted fact findings. These teams met with women sterilised at the four camps, families of the deceased, field level health workers (Mitani) inspected government health facilities and visited the site of the 8 November 2014 camp.
114. All the fact findings regarding the Chhattisgarh incident show that no panel of doctors existed as required by the Ramakant Rai Guidelines. There was admittedly a huge shortage of doctors to perform sterilizations. Medical investigations prior to operations were not done. Informed consent was not taken. Thumb impressions were taken mechanically sometimes on blank paper. The women were not counseled nor informed about possible complications, their right to post operative care and of other methods of family planning.

The Quality Assurance Committees were not functioning. The standards set by UOI of doing 30 sterilizations in a day if three laparoscopes were available were often breached with 100 women found in a camp in July 2013. Women were put on the floor after the operation. The women were not made aware of the insurance schemes. (I.A No.5 of 2014 Application for Directions page no.5)

115. Experts from a multi organizational team with members from Population Foundation of India, Parivar Seva Sansthan, Family Planning Association of India and CommonHealth also undertook a fact finding in the wake of the sterilization. ('Robbed of Choice and Dignity: Indian Women Dead after Mass Sterilization Camps in Bilaspur District, Chhattisgarh dated 1 of December 2014).
116. The facts in both the reports uncover widespread flagrant and negligent failures to comply with the Standard Operating Procedure for Sterilization Services issued by the Ministry of Health and Family Welfare 2008.
117. These documents show that women were rarely counseled and that health workers were inserting IUCD's immediately post delivery without consent. Tests required to be done in accordance with the standards (blood, urine, sugar etc.) were not done. Despite the Government of India laying down standards that sterilization ought to be done only in PHCs, CHCs and government hospitals, sterilizations continued to be done in non functional facilities which were unused and filthy, where there was no privacy for the women, where infrastructure and equipment did not exist to handle emergencies and where post operative care was not provided. The practice of using a single laparoscope without proper sterilization and sometimes even using the same needle was observed. Women's clothing was not changed. The staff did not use surgical gowns. The linen was dirty. The state and district quality assurance committees were nonfunctional. (I.A No.5 of 2014 Application for Directions page no.18)



## **ANITA JHA REPORT (August 2015)**

### **Judicial Investigation Report: State of Chhattisgarh**

- 8.11.14, Nemichand Trust Hospital Sakri Town, Bilaspur district,
- No consent taken from the women 18, 19, 65, 66, 70, 73, 77 onwards, 145, 146
- Utterly filthy conditions 18, 20, 74, 80
- Breach of guidelines and standard operating procedures 22, 26, 35, 36, 44, 48, 51
- Targets for sterilization were issued by the central government 45, 46, 149
- Only a few minutes for each surgery 50-52, 58
- Trainee doctor present 52
- Gloves not changed 53
- Negligence, dirty floors and dirty sheets 54
- Check list kept blank on health indicators 60, 64
- Drugs. Spurious? 119, 120, 121, 122, 123, 124, 133 onwards
- Post mortem report 135
- Drug Purchase Committee
- Deaths due to infection and drugs
- Guilty named 36, 44, 45, 141
- Recommendations 143
- Quality Assurance Committee 149
- Failure of Insurance Scheme 148, 149

118. Directions Sought by the Petitioner dated 8.5.14

- a. For a declaration that sterilization surgeries conducted in the various states and Union Territories of India even after the order of the Supreme Court dated 1.1.2005 in the case of Ramakant Rai vs Union of India, have been done in unhygienic and unethical conditions which represent a fundamental rights violation under Article 21, Article 14 and Article 15 of the Constitution of India.

b. For an order directing all States and Union Territories to implement in letter and spirit Standard Operating Procedures for Female and Male Sterilization (2006) (Petition page 49-103), Quality Assurance Manual for Sterilization Services (2006), Standard Operating Procedures for Sterilization Services in Camps (2008) issued by the Government of India after the decision of this Court in Ramakant Rai's case in order to ensure that poor women in rural areas are treated with respect and dignity when they undergo sterilization operations; and in particular:

1. The States shall establish Quality Assurance Committees (QAC) and facility-level Quality Circles that will meet every three months to conduct a Medical Audit of all that deaths related to sterilization, to collect all information on hospitalizations related to sterilization, to process cases of failure, complication requiring hospitalization, and deaths following sterilizations, to ensure facilities meet the standard operating guidelines, and to make minutes of the meetings signed by those present.
2. Ensure that women are made aware, in a language that they clearly understand, of all available methods of family planning, of the fact that sterilization is permanent and that women understand what happens before, during, and after the surgery, its side effects, and potential complications, including failure.
3. Ensure that women make an informed decision for sterilization voluntarily, are encouraged to ask questions and are told that they have the option of deciding against the procedure at any time without being denied their rights or other reproductive health services
4. Ensure that all pre procedure clinical assessments as per section 1.4.2, including demographic information is recorded, each patient's medical history is taken and that every woman has physical examination including blood pressure, pulse, pelvic examination, and laboratory examinations for hemoglobin, sugar, aluminum and pregnancy.

5. Ensure that consent is not obtained under coercion or when the client is under sedation, and that the client signs the sterilization consent form before the surgery.
6. Ensure that all sterilization camps are organized only in established Health Care Facilities- either CHCs or PHCs. (section 2.1 of SOP).
7. Ensure that space has a reception area, waiting area, private counselling area, laboratory, clinical examination room, pre-operative preparation room, hand washing area, sterilization room, isolated operation theatre with adequate lighting, a spacious and well ventilated recovery room with beds adequate toilets, and an office area.
8. Ensure that each surgeon is restricted to conducting a maximum of 30 laparoscopy tubectomies, 30 vasectomies or 30 minilap tubectomies (section 2.2) or 50 surgeries per day with additional surgeons, support staff, instruments, equipment, and supplies (section 2.2).
9. Ensure that all sterilization camps take place between 9am and 4pm (section 2.3).
10. Ensure that all sterilization camps are adequately staffed with the staff as set out in section 4 (a).
11. Ensure that ANMs provide counselling for all the clients, ensure documentation of informed consent, ensure sufficient material including linen, instruments, ensure emergency equipment confirms the pre procedure of clients, and monitor clients during the procedure and assist in post-operative care.
12. Ensure that the surgeon/gynecologist verifies that each client has been adequately counseled and screened, fill a checklist before conducting the procedure, ensure requisite equipment/instruments and supplies, ensures emergency and surgical procedures, documents post-operative instructions on the records of all cases, thus a post-operative checkup, and deals with emergencies.

13. Ensure that all sterilization camps staff adheres to the mandatory infection prevention procedure laid out in section 5. In particular, all staff should wash their hands, wear gloves maintain methods of environmental cleanliness; ensure the proper processing of instruments and other items and follow proper waste disposal practices.
14. Ensure that all post-operative procedures in section 1.5 are followed, in particular the client is monitored, the client is only discharged at least 4 hours after the procedure when the vital signs are stable and the client is fully aware, has passed urine and can walk, drink and talk, and the client has been evaluated by a doctor. The client must be accompanied by the responsible adult while going home and any medicines must be prescribed as necessary.
- c. Ensure that ASHA workers follow up with clients 48 hours after surgery and women should report to a health facility after seven days to have their stitches removed.
- d. For an order directing all states and Union territories to ensure that the village health and sanitation committees, the PHC monitoring and planning committees, the block monitoring and planning committees, the district health monitoring and planning committees, and the state health and monitoring committee, a monitor all sterilization camps operating within their jurisdiction, ensure full compliance with standard operating procedure for female and male sterilization (2006), Standards & Quality Assurance in Sterilization Services (2014) and Standard Operating procedures for sterilization services on camps (2008) and maintain a written record of the said monitoring and inspections duly signed by the members of the said committee.
- e. For an order directing all states and UTs to induct on the district health monitoring and planning committees as well as the state health planning committees and monitoring committees, as well as the sterilization District Quality Assurance Committees, and the State Quality Assurance

Committees a nominee of the National Alliance for Maternal Health and Human Rights.

- f. For an order directing the establishment of a Court commission headed by Mr. A. R. Nanda, retired Secretary, health and family welfare, GOI and retired executive director or the Population Foundation of India, who shall be permitted to put together a team of Co-Commissioners from the states/UTs who are eminent health experts to monitor the implementation of the guidelines of government of India and the orders of this Hon'ble Court.
- g. For an order directing the Respondents to publish in state languages a summary of the guidelines of the Government of India above mentioned and the order of Supreme Court dated 1.1.2005 in Ramakant Rai's Case as well as orders passed in this matter and to have said orders pasted on all PHCs, CHCs and District hospitals throughout the state.
- h. For an order directing the Respondents to publicize on radio and television the substance of the orders passed by the Supreme Court in Ramakant Rai's case, the order in this case and information about the family planning insurance scheme.
- i. For an order directing the Respondent No.2 (State of Bihar) to provide 5 lakh in compensation to the women sterilized at the Kaporfora Sterilization camp in Araria district, Bihar.
- j. For an order to the Respondents to review and update State list of empanelled doctors as directed in Ramakant Rai's case

119. Directions Sought by the Petitioner regarding Chhattisgarh

**I.A. 5 dated 3.12.14**

1. For an order of this Court directing the State to provide Rs. 1 lakh compensation to the 68 surviving women who underwent sterilization at Sakri on 8<sup>th</sup> November 2014

and the 53 women who survived sterilization at Gaurella, Marvahi and Pendra on 10 November 2014.

2. For an order of this Court directing the state to provide the families of the deceased and all surviving women with documentation of their sterilization surgery along with information about the Family Planning Insurance Scheme and guidelines/schemes for accessing free medical care for future complications.
3. For an order to the State to develop a long term care plan for the children of the 16 deceased women and any other women who die as a result of these camps including employment guarantees for the primary caregivers, access to long term adequate nutrition, free health services, and education up to college for the children.
4. For an order of this Court directing an independent inquiry by senior respected persons into the fact stated in this application and to ascertain the criminal and other culpabilities of the persons concerned.
5. For an order prohibiting sterilization operations in camps or any other place other than Community Health Centres, hospitals and clinics with operating theatres, sufficient beds, adequate staff, appropriate equipment, and exemplary hygiene standards with fixed day sterilization services.
6. For an order directing all States and Union Territories to provide free transportation to sterilization services.
7. For an order to all states and UTs to adhere to the maximum of 30 women per day in accordance with the Standard Operating Procedure and to ensure that the senior most officer of the establishment is specifically instructed to supervise the operations and assume responsibility.
8. For an order to declare sterilization targets inherently coercive and in violation of the rights to bodily integrity, individual autonomy and health.

9. For an order to the Respondents to immediately establish a Quality Assurance Committee at the State and District Levels in accordance with the Ramakant Rai [WP (C) 209/2003] order and to ensure that they function in accordance with the guidelines filed with the petition.
10. For an order to the Respondents to roll out a state-wide training programmes for mitanins, ASHAs and other facility staff on all contraceptives, counselling, the Standard Operating Procedures for Sterilization Services, Women's entitlements under the National Health Mission, the Family Planning Indemnity Scheme, and the judgments of the Courts of India, and in these trainings to consult and involve civil society members including representatives from the Population Foundation of India (PFI) and National Alliance for Maternal Health and Human Rights (NAMHHR).
11. For an order to the Respondents to create posters in local languages outlining the guidelines in the Standard Operating Procedure for Sterilization Services and post these in all government health facilities, and to make them available free to the public with information regarding the raising of grievances.
12. For an order directing the Respondents to immediately fill all sanctioned posts for specialists, especially gynaecologists and obstetricians and nurses.
13. For directions to the Respondents in terms of recommendations outlined on pages 161 to 168 of Annexure A-2, Robbed of Choice and Dignity: Indian Women Dead after Mass Sterilization: Situational Assessment of Sterilization Camps in Bilaspur District, Chhattisgarh.

**ADDITIONAL AFFIDAVIT WAS FILED ON BEHALF OF THE PETITIONER FOR THE CIVIL SOCIETY ORGANISATIONS TO BE CO-OPTED AS MEMBER OF STATE QUALITY ASSURANCE COMMITTEE FOR MONITORING AND TRAINING MECHANISM.**

The names that were suggested on 20th day of April 2016 were:

State	Name	Mail Id	Org
Delhi	Mr. A R Nanda	<a href="mailto:arnanda65@gmail.com">arnanda65@gmail.com</a>	Former Secretary MoHFW – proposed Commissioner
Delhi	Dr. Abhijit Das	<a href="mailto:abhijit@chsj.org">abhijit@chsj.org</a>	Health and Social Justice, Member AGCA (NHM)
Delhi	Sarojini N.B.	<a href="http://Sama.genderhealth.org">Sama.genderhealth.org</a>	(SAMA) Member MSG
Delhi	Jashodhara Dasgupta	<a href="mailto:jashodhara@sahayogindia.org">jashodhara@sahayogindia.org</a>	SAHAYOG & National Alliance for Maternal Health & Human Rights, former member HLEG on UHC
Delhi	Dr Aparajita Gogoi	<a href="mailto:agogoi@c3india.org">agogoi@c3india.org</a>	Centre for Catalyzing Change
Delhi	Dr Leila Varkey	<a href="mailto:lvarkey@c3india.org">lvarkey@c3india.org</a>	Centre for Catalyzing Change
Delhi	Mr. Gopi Gopalakrishnan	<a href="mailto:gopi@worldhealthpartners.org">gopi@worldhealthpartners.org</a>	World Health Partners
Delhi	Dr Vijay Aruldas	<a href="mailto:varuldas@yahoo.com">varuldas@yahoo.com</a>	AGCA member
Delhi	Ms Poonam Muttreja	<a href="mailto:pmuttreja@populationfoundation.in">pmuttreja@populationfoundation.in</a>	Population Foundation of India
Delhi	Jayashree Satpute	<a href="mailto:info@nazdeek.org">info@nazdeek.org</a>	NAZDEEK
Bihar	Sandeep Kumar Ojha	<a href="mailto:sojha@c3india.org">sojha@c3india.org</a>	Centre for Catalyzing Change
Bihar	Dr. Shakeel	<a href="mailto:contact@charm.org.in">contact@charm.org.in</a>	CHARM
Bihar	Devika Biswas	<a href="mailto:devikabiswas@gmail.com">devikabiswas@gmail.com</a>	Health Watch Forum, Bihar
Maharashtra	Dr Abhay Shukla	<a href="mailto:abhayshukla1@gmail.com">abhayshukla1@gmail.com</a>	SATHI- CEHAT



India's Family Planning Programme

State	Name	Mail Id	Org
Maharashtra	Adv Anubha Rastogi	-	TLC, Mumbai
Maharashtra	Dr Rani Bang	-	SEARCH, Mumbai
Maharashtra	Dr. Arun Gadre	sathicehat@gmail.com	SATHI, Pune
Andhra Pradesh	Dr M Prakasamma	<a href="mailto:answers.mytri@gmail.com">answers.mytri@gmail.com</a>	Academy of Nursing Studies (ANSWERS)
Assam	Jenny Liang	contact@theant.org	The Ant, Chirang
Gujarat	Ms Indu Capoor	chetna@chetnaindia.org	CHETNA
Gujarat	Renu Khanna	sahajindia@outlook.com	SAHAJ
Gujarat	Neeta Hardiker	info@anandi-india.org	ANANDI
Gujarat	Ms Mirai Chatterjee	<a href="mailto:social@sewass.org">social@sewass.org</a>	SEWA
Odisha	Dr Nabin Kumar Pati	nkpati@yahoo.co.in	Paul foundation
Odisha	Dr Saraswati Swain	<a href="mailto:niahrd@gmail.com">niahrd@gmail.com</a> ; <a href="mailto:niahrd@hotmail.com">niahrd@hotmail.com</a>	Secretary General, NIAHRD
Odisha	Gouranga Mohapatra	-	Jan Swasthya Abhiyan
Jharkhand	Mr. Sanjay Kumar Paul	spaul@c3india.org	Centre for Catalyzing Change
Rajasthan	Ms Smita Bajpai	suma@chetnaindia.org	CHETNA
Rajasthan	Dr Sharad Iyengar	<a href="mailto:sdiyengar@gmail.com">sdiyengar@gmail.com</a>	ARTH
Rajasthan	Narendra Gupta	Prayasjaipur17@gmail.com	PRAYAS
Rajasthan	Mamta Jaitly	Vividha_2001@yahoo.com	VIVIDHA
Uttar Pradesh	Sangeeta Maurya	<a href="mailto:Sangeetam@sahayogindia.org">Sangeetam@sahayogindia.org</a>	SAHAYOG, Lucknow
Uttar Pradesh	Adv Urmila	-	IBTEDA Seva Sansthan, Chitrakoot

State	Name	Mail Id	Org
Uttar Pradesh	Rajdev Chaturvedi	Gps.azm@gmail.com	Grameen Purnanirman Sansthan, Azamgarh
Uttarakhand	Sunita Shahi	prayas@yahoo.co.in	PRAYAS, Nainital
Uttarakhand	Kanchan Bhandari	<a href="mailto:vimarsh_nainital@rediffmail.com">vimarsh_nainital@rediffmail.com</a>	VIMARSH, Nainital
Jharkhand	Kalyani Meena	<a href="mailto:info@prernabharati.org">info@prernabharati.org</a>	Prerana Bharti
Jharkhand	Murari Chowdhury	<a href="mailto:needspostmaster@gmail.com">needspostmaster@gmail.com</a>	NEEDS
Jharkhand	Dr. PK Tripathy	<a href="mailto:prasanta.ekjut@gmail.com">prasanta.ekjut@gmail.com</a>	EKJUT
Madhya Pradesh	Smriti Shukla	<a href="mailto:sathyapariwar@gmail.com">sathyapariwar@gmail.com</a>	SATHIYA Welfare Society
Himachal Pradesh	Subhash Mendhapurkar	<a href="mailto:sutrahp@gmail.com">sutrahp@gmail.com</a>	SUTRA
Chhattisgarh	Dr. Yogesh Jain	<a href="mailto:janswasthya@gmail.com">janswasthya@gmail.com</a>	Jan Swasthya Sahyog Bilaspur
Chhattisgarh	Sulakshana Nandi	<a href="mailto:chattisgarh@phrindia.org">chattisgarh@phrindia.org</a>	PHRN
West Bengal	Sujoy Roy	<a href="mailto:sujoy.wrai@gmail.com">sujoy.wrai@gmail.com</a>	Child in need Institute
West Bengal	Dr. Rajat Das	<a href="mailto:asharajat@yahoo.co.in">asharajat@yahoo.co.in</a>	ASHA
West Bengal	Anchita Ghatak	<a href="mailto:anchita.ghatak@gmail.com">anchita.ghatak@gmail.com</a>	Parichiti, A Society for Empowerment of Women
Punjab	Dr Manmeet Kaur	<a href="mailto:mini.manmeet@gmail.com">mini.manmeet@gmail.com</a>	Indian Public Health Association, Chandigarh
Karnataka	Dr Thelma Narayan	<a href="mailto:thelma@sochara.org">thelma@sochara.org</a>	Community Health Cell
Karnataka	Dr. Akhila Vasani (KJC)	-	KJC
Karnataka	Dr. Thelma Narayan	<a href="mailto:chc@sochara.org">chc@sochara.org</a>	SOCHARA
Karnataka	Dr H Sudarshan	<a href="mailto:drhsudarshan@gmail.com">drhsudarshan@gmail.com</a>	Karuna Trust

State	Name	Mail Id	Org
Telengana & Andhra	Veena Shatrugna	anveshirc@gmail.com	ANVESH
Tamil Nadu	Dr. Subhashree B	-	Common Health
Tamil Nadu	Dr. Subhasri B	ruwsec@vsnl.com	RUWSEC
Tamil Nadu	Ameer Khan	chc@sochara.org	SOCHARA
Kerala	Aleyamma Vijayan	sakhi@md2.vsnl.net.in	SAKHI

## ANITA JHA -JUDICIAL COMMISSION REPORT

### IN THE SUPREME COURT OF INDIA CIVIL ORIGINAL JURISDICTION WRIT PETITION (CIVIL) NO. 95 OF 2012

**Devika Biswas ...**

**Petitioner**

**versus**

**Union of India & Ors. ....  
Respondents**

## J U D G M E N T

**Madan B. Lokur, J.**

1. This public interest petition raises very important issues concerning the entire range of conduct and management, under the auspices of State Governments, of sterilization procedures wherein women and occasionally men are sterilized in camps or in accredited centres. The issues raised also include pre-operation procedures and post-operative care or lack of it. A sterilization surgery does not appear to be complicated and yet several deaths have taken place across the country over the years. Undoubtedly, this needs looking into by the Government of India and the State Governments and remedial and corrective steps need to

be taken. Persons who are negligent in the performance of their duties must be held accountable and the victims and their family provided for. It is time that women and men are treated with respect and dignity and not as mere statistics in the sterilization programme.

2. The petitioner Devika Biswas is a public spirited individual of Araria district in Bihar. She is a health rights activist with extensive professional experience in the development and health sectors. She has worked in Uttar Pradesh, Delhi, Jharkhand and Bihar in her capacity as a health rights activist. She has also been associated with the Integrated Child Development Scheme in Bihar and has published articles and books in her field of specialization.
3. Sometime in 2005 the issue of sterilization procedures for females and males under the Population Control and Family Planning programme or the Public Health programme of the Government of India came up for consideration before this Court in a petition filed by Ramakant Rai. The petition was substantially decided by this Court on 1<sup>st</sup> March 2005 by passing several directions. The directions are reported as **Ramakant Rai (I) & Anr. v. Union of India & Ors.**<sup>116</sup>
4. Pursuant to the directions given by this Court, the Government of India published a Quality Assurance Manual for Sterilization Services (in 2006); Standards for Female and Male Sterilization (in 2006); and Standard Operating Procedures for Sterilization Services in Camps (in 2008). These manuals really form the procedural and substantive basis for conducting sterilization procedures both of females and males in the country under the population control and family planning programme or the public health programme.
5. 5. What seems to have provoked Devika Biswas in filing a writ petition under Article 32 of the Constitution in this Court is that on 7<sup>th</sup> January 2012 as many as 53 women underwent a sterilization procedure in a camp in highly unsanitary

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<sup>116</sup> (2009) 16 SCC 565

conditions in Kaparfora Government Middle School, Kursakanta, Araria district in Bihar between 8pm and 10pm through a single surgeon. In fact, some of the broad issues concerning the sterilization camp held on 7<sup>th</sup> January 2012 as found on investigation by Devika Biswas, included an absence of pre-operative tests on the women or proposed patients; they were not given any counselling of any kind at all; they had no idea about the potential dangers and outcomes of the sterilization procedure; the sterilization procedures were carried out in a school and not in a government hospital or a private accredited hospital; running water was not available at the site; the sterilization procedures were carried out under torch light with the women being placed on a school desk; the surgeon did not have any gloves or at least did not change the gloves available with him; no emergency arrangements were made etc. etc. Essentially, the entire camp was conducted in unsanitary conditions, in an unprofessional and unethical manner. What is worse is that the camp was conducted under the auspices of an NGO called Jai Ambey Welfare Society who had been granted accreditation by the District Health Society only a few months earlier that is on 29<sup>th</sup> November, 2011 apparently without following any formal and transparent procedure.

6. As a result of the sterilization camp, many women who were operated upon underwent tremendous physical pain and anguish and were traumatized. Consequently, a series of complaints were filed and they were registered at Kursakanta Police Station on 8<sup>th</sup> January 2012 being S.DE No.135/12, 136/12, 137/12 and 144/12. Some of these complaints were inquired into by the State authorities and it was found that the sterilization camp was a success except that an expired medicine had been given to the women. On the other hand, the study and the investigations carried out by Devika Biswas along with a journalist called Francis Elliott concluded that the sterilization camp did not meet any of the requirements laid down by this Court or by the Government of India and that this was confirmed by the women who were operated upon as well as their relatives.

7. Devika Biswas then felt compelled to file a public interest litigation in this Court to ensure that sterilization procedures nationwide are conducted in accordance with accepted legal norms, medical procedures and the provisions of the manuals and that those women and men who suffer due to the failure or complications in implementing the norms, procedures and provisions are given adequate compensation. That is really the core issue raised by Devika Biswas and that such instances are not repeated.
8. In this context, Devika Biswas says in her writ petition that on 9<sup>th</sup> February 2008 the State Health Society in Bihar issued a memorandum to the Civil Surgeon in each district in the State. The result of this memorandum was that sterilization procedures could now be conducted in accredited private health facilities also in a camp mode. The memorandum also mentioned that the State Government would provide funds to the private facilities and the motivators as per the Government of India norms for conducting sterilization procedures. However it was made clear that extra funds for camp management, transportation etc. would not be provided by the Government to the accredited private facilities.
9. This was followed by another memorandum dated 9<sup>th</sup> February 2009 regarding sterilization procedures carried out at government institutions by empanelled private doctors. The memorandum issued by the State Health Society of Bihar to the Civil Surgeon in all districts stated that an empanelled private doctor might also be permitted to carry out family planning sterilization procedures in government institutions. The Quality Assurance Committee of the district was entitled to employ private doctors including contractual doctors whose term had expired for carrying out the sterilization procedures.
10. The petition filed by Devika Biswas goes on to say that in 2010 a Non Governmental Organization (NGO) called the Centre for Health and Social Justice released a report concerning the quality of care and consequences of female sterilization

procedures in Bundi district of Rajasthan in 2009-10. According to the report 749 women (mainly underprivileged) were sterilized at Public Health Centres, Community Health Centres or Camps. Researchers who found that a significant number of them were not counseled about the permanent nature of the sterilization procedure and almost 88% of them told the researchers that they did not receive any information about potential complications, failures or side effects of the sterilization procedure interviewed them. The report indicated that while the internationally accepted failure rate is 0.5% the failure rate in Bundi district in Rajasthan was 2.5% that is 5 times the acceptable international standard.

11. Similarly, in February 2012 a Fact Finding Mission by a social activist reported that sterilization procedures carried out in three districts in Maharashtra, that is, Nagpur, Chandrapur and Gadchiroli found that sterilization camps were routinely conducted in unsanitary and unsafe facilities.
12. Again in February 2012 a sterilization camp in Madhya Pradesh was conducted in Balaghat district without following any of the established procedures and tribals were lured into sterilization camps by motivators who collected a substantially large amount over and above the financial norms fixed by the Government of India.
13. In Kerala also a similar story was repeated in July 2011 highlighting that sterilization procedures were not conducted in accordance with the prescribed requirements of law or the procedures laid down by the Government of India. In paragraph 40 of the writ petition, Devika Biswas submits "In July 2011, a local journalist in Wayanad and the Chief of the Kattunayakan tribe, who serves as the President of the Primitive Tribal Association, met with health workers in Kerala. They shared stories of men and women who were told by the government health workers that it was compulsory to undergo sterilization. The Chief is concerned about government coercion and compulsion in sterilization and its effect on the tribe's population."

14. In this background, Devika Biswas prayed for a series of directions including setting up a committee to investigate the facts relating to the sterilization camp held on 7<sup>th</sup> January 2012 and to initiate departmental and criminal proceedings against those who were involved in the sterilization camp. It is also prayed that the guidelines given in the manuals prepared by the Government of India should be scrupulously adhered to so that such incidents do not recur in any part of the country and if they do, additional compensation should be paid to the women in distress.
15. In this writ petition, we are primarily concerned with the affidavits of the Union of India, the States of Bihar, Kerala, Madhya Pradesh, Maharashtra and Rajasthan since allegations have been made in respect of sterilization camps held in these States only. However, during the course of hearing of this writ petition, allegations surfaced with regard to sterilization camps conducted in Bilaspur district, Chhattisgarh [between 8<sup>th</sup> and 10<sup>th</sup> November 2014] and so we are also concerned with the allegations made in respect of the camps conducted in that State as well.
16. What was brought to our notice with regard to the sterilization camps conducted in Bilaspur district was that as many as 137 women were subjected to a sterilization procedure and unfortunately 13 of them died. Many others complained of problems such as vomiting, difficulty in breathing, severe pain etc. They were taken to nearby hospitals and discharged after necessary treatment. It appeared that some women who had not undergone a sterilization procedure also had similar complaints and some of them died thereby increasing the number of deaths to over 13. Undoubtedly, this was a matter of great concern brought to our notice during the pendency of the writ petition.

### Orders passed by this Court

17. Notice in the writ petition was issued on 2<sup>nd</sup> April 2012 and thereafter the petition was taken up for active consideration only on 30<sup>th</sup> January 2015 when the Social Justice Bench of



this Court was seized of this matter and after completion of pleadings and instructions received by the learned Additional Solicitor General from the Union of India.

18. On 30<sup>th</sup> January 2015 after hearing learned counsel, a request was made by us to the learned Solicitor General to ensure that a chart be prepared giving the status of implementation of each direction given in

Ramakant Rai (I). Details with regard to the implementation of the Family Planning Indemnity Scheme, 2013 were also sought particularly with regard to the release and utilization of funds under the said Scheme.

19. During the hearing, the events in Bilaspur, Chhattisgarh (mentioned above) also came up for consideration and so the State of Chhattisgarh was required to file an affidavit stating the steps taken to ameliorate the conditions of the persons who had faced the recent tragedy. The State Government was also required to indicate the action taken against the doctors involved and steps taken to educate the people in Chhattisgarh with regard to the sterilization procedure and its impact.
20. The petition was then taken up for consideration on 20<sup>th</sup> March 2015 when it was noted that even though Chhattisgarh had filed an affidavit dated 19<sup>th</sup> February 2015, it had not given sufficient particulars and details with regard to the action taken subsequent to the mishap in the sterilization camp. Chhattisgarh was therefore required to file a proper and detailed affidavit including a copy of a sample FIR, post mortem report and charge sheet filed, if any.
21. With regard to an affidavit filed by the Union of India in relation to the implementation of the Family Planning Indemnity Scheme, 2013 it was noted that the manner of utilization of funds was not indicated. The learned Solicitor General assured this Court that full details in this regard would be furnished and also an audit would be conducted to ensure that the funds are utilized for the purpose for which they have been given by the Government of India to the

State Governments. Unfortunately, these details have not yet been furnished and we have only the figures giving the budget approved as well as the expenditure incurred by the State Governments and Union Territories.

22. On 17<sup>th</sup> April 2015 the writ petition was again taken up for consideration and as an interim measure the Secretary in the Ministry of Health and Family Welfare of the Government of India was directed to hold a meeting with his counterparts in the States and the Union Territories to arrive at a consensus on the effective implementation of the various schemes relating to sterilization [of females and males], the Family Planning Indemnity Scheme, 2013 and the directions given in Ramakant Rai (I).
23. Chhattisgarh was also required to file a Status Report on the progress made by a Commission set up by it (the Ms. Anita Jha Commission) to look into the tragedy that had occurred in the sterilization camps held in Bilaspur.
24. The learned Advocate General appearing for the State of Chhattisgarh stated that he would look into the issue of taking action against the manufacturer of the drug used in the sterilization camps and the feasibility of filing a charge sheet against the offenders and to step up efforts to arrest the absconding persons or if necessary to declare them proclaimed offenders.
25. In the hearing on 14<sup>th</sup> August 2015 it was noted that the Secretary in the Ministry of Health and Family Welfare had held a meeting, as earlier directed, on 15<sup>th</sup> May 2015. It was noted that one of the suggestions given in that meeting was that similar high-level meetings should be conducted every six months. Accordingly, we expected the Secretary in the Ministry of Health and Family Welfare to conduct a similar meeting after six months that is on or about 15<sup>th</sup> November 2015.
26. As far as Chhattisgarh is concerned, it was noted that it had filed an affidavit and the learned Advocate General stated

- that the Ms. Anita Jha Commission submitted its report on 10<sup>th</sup> August 2015 and that the report was likely to be considered by the State Cabinet in the next couple of weeks.
27. The learned Advocate General informed us that two charge sheets had been filed in connection with the tragedy and that no FIR was pending investigation. He further stated that some scientific reports were expected from a Forensic Science Laboratory and a supplementary charge sheet would be filed, if necessary, immediately thereafter.
  28. With regard to two absconding persons concerned with the tragedy, it was stated by the learned Advocate General that they had been declared proclaimed offenders and a reward had also been announced for their whereabouts.
  29. In the hearing on 4<sup>th</sup> December 2015 we were informed that the report given by Ms. Anita Jha had since been accepted by the State Cabinet. Subsequently, on 29<sup>th</sup> March 2016 we were informed that an Action Taken Report on the Ms. Anita Jha Commission Report had been placed before the Legislative Assembly.
  30. Since the proceedings in this case were not adversarial in nature we requested the learned Additional Solicitor General appearing in the matter as well as the learned Senior Counsel to sit down and give suggestions on how to implement the Standard Operating Procedures and the Guidelines laid down by the Union of India in the matter of sterilization procedures.
  31. On 4<sup>th</sup> August 2016 when we heard the writ petition, we were informed that a meeting was in fact held between the learned Additional Solicitor General, learned Senior Counsel for Devika Biswas and officials of the Ministry of Health and Family Welfare of the Government of India and that an affidavit in this regard had also been filed. We then heard learned counsel for the parties and reserved judgment.

## Affidavits filed by the Union of India

32. The Ministry of Health and Family Welfare of the Government of India have filed as many as 10 (ten) affidavits. It is not necessary to traverse each of them in detail. However, it is necessary to highlight the broad submissions made. These are:
- i. It is admitted that the Union of India received a complaint with regard to the sterilization camp held on 7<sup>th</sup> January 2012 and a report had been called for in this regard. A report has since been received from the concerned authorities in the State of Bihar and Dr. Abhay Kumar Chowdhary, a contract physician at the Primary Health Centre had since been dismissed and it had further been ordered that he may not be employed in any government work in future. First Information Reports (FIRs) were lodged in respect of the events of 7<sup>th</sup> January 2012, investigations have concluded and charge sheets filed.
  - ii. The Government of India has published several Manuals for the guidance of the State Governments and Union Territories in respect of sterilization procedures and conducting such camps. These are:
    - a. Standards for Female and Male Sterilization, 2006;
    - b. Quality Assurance Manual for Sterilization Services, 2006;
    - c. Standard Operating Procedures for Sterilization Services in Camps, 2008;
    - d. Fixed Day Static Approach for Sterilization Services, 2008;
    - e. Family Planning Insurance Scheme;
    - f. Compensation Scheme for Acceptors of Sterilization (revised on 31<sup>st</sup> October 2006 and improved with effect from 7<sup>th</sup> September 2007);
    - g. Standards and Quality assurance in Sterilization Services, 2014 including Standard Operating Procedure for camps;
    - h. Reference manual for Female Sterilization, 2014;

- i. Reference Manual for Male Sterilization, 2013;
  - j. Manual for Family Planning Indemnity Scheme, 2013 (updated in 2016)
  - k. Frequently Asked Questions, 2016.
- iii. Public Health is a State subject occurring in Entry 6 of List II of the Seventh Schedule of the Constitution. The Government of India only plays a supportive and facilitative role in achieving health welfare schemes and it is essentially the State Government that is in the best position to monitor the quality of services in accordance with agreed benchmarks.
- iv. The following funds have been approved and utilized (in lakhs) by the States under the Family Planning Indemnity Scheme, 2013:

Approval	Expenditure	Approval	Expenditure
2013-14	2013-14	2014-15	2014-15 (till end of 3 <sup>rd</sup> quarter)
1566.69	675.59	1485.80	828.19

At this stage it may be mentioned that the coverage under the Family Planning Indemnity Scheme is as follows:

Section	Coverage	Limits
1.	Death following sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital	Rs. 2 lakh
2.	Death following sterilization within 8-30 days from the date of discharge from the hospital	Rs. 50,000/-
3.	Failure of sterilization	Rs. 30,000/-

Section	Coverage	Limits
4.	Cost of treatment in the hospital and upto 60 days arising out of complication following sterilization operation (inclusive of complication during process of sterilization operation) from the date of discharge	Actual not exceeding Rs. 25,000/-
5.	Indemnity per doctor/health facilities but not more than 4 in a year	Up to Rs. 2 lakh per claim

The Union of India has given no clear-cut answer regarding audit of disbursement of the amounts, except to say that the States and the Union Territories are required to follow the financial management system and are required to submit statutory audit reports, utilization certificates, quarterly summary on concurrent audits etc. Whether this is being adhered to by the States and the Union Territories is not mentioned. It is also not clear whether the accounts of the various organizations involved in sterilization procedures are in fact open for inspection by the sanctioning authority and audit including the Comptroller and Auditor General of India and the internal audit of the Ministry of Health and Family Welfare of the Government of India.

- iv. The Union of India has issued an advisory to all the States and Union Territories on 30<sup>th</sup> December 2014 to adhere to the standard operating procedures at all levels to prevent and preempt incidents that might adversely affect the health of clients due to sterilization procedures.
- v. In the high level meeting held on 15th May 2015 (pursuant to orders passed by this Court) the following key action points were agreed upon:
  - a. Sterilization services must be provided in a client friendly manner in a conducive environment after taking informed consent. Safety of those who opt for it should be ensured.
  - b. A mechanism is put in place wherein service providers or managers are not victimized or arrested without instituting a proper enquiry by the district/State quality assurance committees.

- c. All States to conduct workshops on quality in sterilization services orienting its programme managers and service providers both at the State and district level on the updated manuals on standards, male and female sterilization and family planning indemnity scheme.
- d. All Government of India guidelines to be strictly adhered by the States.
- e. A periodic assessment of all the facilities and fixed day camps by 1-2 members of the sub-committees under the SQAC/DQACs [State Quality Assurance Committee/District Quality Assurance Committee] on implementation of the infection prevention protocols as well as the efficacy of the services provided, should be carried out (as laid down in the Manuals).
- f. The issue of shortage of pool of providers for sterilization could be addressed by resorting to compulsory training of MBBS medical officers when they join government service.
- g. Onsite Training/mentoring is initiated by identifying high caseload facilities (first) to undertake sterilization trainings. This will ensure the service provider is available at the facility to undertake their primary task of providing services to the clients in addition to provide training to prospective trainees.
- h. Retraining of providers who are either short on confidence or have high failure rates.
- i. There should be more thrust on Minilap Sterilization as it leads to fewer failures and complications.
- j. The scope of increasing the basket of contraceptive choices like injectables/implants and weekly pills like 'Saheli' is explored urgently to provide more choice.
- k. The idea of mobile teams or clinical outreach teams needs to be encouraged to address the issue of shortage of surgeons.

- l. Every case of sterilization death must be audited as per format laid down and reported to the Government of India.
  - m. Line listing of deaths and failures to be undertaken district/ facility wise and surgeon wise. Disbursal of claims for deaths, failures and complications should be computerized.
  - n. To address the issue of sterilization failures, sterilization certificates should be issued after at least one month in case of female sterilization and after three months in case of male sterilization.
  - o. States to take urgent steps to rejuvenate the Family Planning Programme with the ultimate aim of reducing the maternal and infant mortality and morbidity in addition to achieving population stabilization
  - p. Government of India to conduct high level meeting like the instant one with all States to acquaint them with the latest policies and programmes of the Government of India on a yearly basis.
- (vi) In the high level meeting held on 17<sup>th</sup> November 2015 (pursuant to orders passed by this Court) the following key priority areas were shared with the State Governments and Union Territories:
- a. Uniform consent forms should be available in all facilities, which should be duly filled in, and the consent of the client should be taken prior to the procedure in all cases.
  - b. State Quality Assurance Committee (SQAC)/District Quality Assurance Committee (DQAC) and State Indemnity Sub Committee (SISC)/District Indemnity Sub Committee (DISC) to be constituted as per the GOI guidelines.
  - c. All the Family Planning guidelines should be printed and disseminated at the State/district as well as facility level.
  - d. State/District level orientation of all the programme managers and providers for the guidelines and protocols to be completed in all States.



- e. Members of SQAC and DQAC should conduct periodic supportive supervision visits as per quality protocols. The findings of the same are to be documented and corrective actions should be taken.
- f. Training calendar for training newly recruited doctors is to be prepared and updated in each State.
- g. Line listing of all the sterilization providers needs to be prepared and periodically updated by all States.
- h. Every death attributable to sterilization should be audited.
- i. Sterilization certificates should be issued as per existing guidelines.

The aforesaid meeting was held through video-conferencing. The representative of Uttar Pradesh could not attend due to a State holiday and since the office of the National Informatics Centre in the State was closed. It may be mentioned that this is somewhat odd and suggests that responsible officers in the State of Uttar Pradesh seem to give more importance to State holidays rather than issues relating to Family Planning. This is most unfortunate, to say the least.

(vii) A National Summit on Family Planning was held on 5<sup>th</sup> and 6<sup>th</sup> April 2016. As a result of several workshops and summits held from time to time on issues relating to family planning and the directions given by the Court from time to time the following practical and pragmatic measures were proposed by the Government in addition to the new guidelines proposed to be undertaken:

- a. Conducting annual review workshops of the programme in all States of India with the State and district programme managers and service providers.
- b. Monthly monitoring of at least 2 public health facilities and 1 accredited private/NGO facility by SQAC/DQAC.
- c. Replacement of operational 'Camps' by regular 'Fixed day services' over the next three years.

- d. Further Strengthening of the State Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC) mechanism.
  - e. Close monitoring, reviewing and collection of reports of deaths attributable to sterilization by the Government of India.
  - f. Conducting Client exit interviews of 10% cases as per the prepared checklist.
  - g. Feedback from beneficiaries by Maternal and Child Health Tracking Facilitation Centre (MCTFC).
- viii. Our country has adopted a comprehensive RMNCH+A (Reproductive, Maternal, Neonatal, Child and Adolescent Health) strategy under which the Family Planning programme is being emphasized to promote reproductive health and reduce maternal, infant and child mortality and morbidity.
- ix. The States of Tamil Nadu, Maharashtra, Sikkim and Goa have already phased out the holding of sterilization camps. During the course of submissions we were informed by the learned Advocate General for Chhattisgarh that that State has also phased out such camps. As far as the Union of India is concerned, it proposes to ensure the phasing out of such camps over the next three years.
- (x) Several improvements have been made in the Family Planning programme and sterilization procedures. They are:
- a. Decline in deaths following sterilization from 140 in 2014-15 to 89 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
  - b. Decline in the number of failures from 5928 in 2014-15 to 2093 in 2015-16 (as per data available on the web based HMIS till 31.3.2016);
  - c. The empanelled list of providers is available in every district;
  - d. Surgeons are not performing more than 30 cases per day;

- e. Camps are being held only in public health facilities or accredited private/NGO facilities.
- f. Workshops relating to Family Planning programme have been held in 28 out of 29 States (as on 21<sup>st</sup> July, 2016). Unfortunately, no such workshops were held after 24<sup>th</sup> August 2015.
- g. The number of deaths attributable to sterilization procedures in 2014-2015 was 140 but it has come down in 2015-2016 to 113.
- h. In 2015-2016 clients exit interviews have been conducted in respect of 1,06,055 persons.
- i. Monitoring and supervision of facilities by SQAC/DQAC in 2015-2016 in regard to public facilities is as high as 12,044 and with regard to private accredited facilities it is as high as 2,984.
- j. The amount allotted for quality improvement which includes training, family planning equipment, other service delivery activities, human resource cost, infrastructure share, planning and monitoring (including quality assurance) and family planning commodities is as follows:

Year	2013-14	2014-15	2015-16
Amount in Crores	1000.7	1648.07	1243.9

The sum and substance of the affidavits is that it is not as if the Ministry of Health and Family Welfare of the Government of India is sitting idle and not taking adequate interest in the success of the Family Planning programme and particularly in sterilization procedures in public and private health facilities. While deficiencies and faults have been pointed out, there has also been considerable improvement in an ongoing exercise of national importance.

Affidavits filed by the State of Bihar

- 33. The State of Bihar has filed two affidavits, a Status Report and Written Submissions.

34. The broad allegations made by Devika Biswas have been accepted and it is accepted that a sterilization camp was conducted by Jai Ambey Welfare Society (NGO) late in the evening of 7th January 2012 in violation of the orders of the concerned Civil Surgeon. An FIR has been lodged against the NGO not only for violating the directives but also for distributing expired medicine to the beneficiaries of the family planning camp.
35. It is further stated that the NGO has since been blacklisted and steps have been taken for giving compensation to some of the women who had developed complications during the surgeries.
36. The blacklisting is confirmed by respondent No. 4, that is, Kumar Nath Choudhary, Secretary of Jai Ambey Welfare Society who filed an affidavit on 14<sup>th</sup> January 2013 in which it is stated that hue and cry was made about the sterilization camp by anti-social elements and as a result three FIRs, namely, Kursakanta P.S. Case No.03/2012, Case No.05/2012 and Case No.14/2012 have been lodged against the NGO.
37. Two charge sheets have been filed in respect of Kursakanta P.S. Case No.03/2012 and Case No.05/2012.
38. As regards Kursakanta P.S. Case No.03/2012, Charge Sheet bearing No. 23 of 2012 dated 09.03.2012 and supplementary Charge Sheet No. 167 of 2012 dated 31.12.2012 have been submitted. Cognizance of the offence has been taken and thereafter Revision Application No. 44/369/12 has apparently been filed by the accused persons and that is pending in the District Court in Araria.
39. As regards Kursakanta P.S. Case No.05/2012, Charge Sheet No. of 2012 dated 12.03.2012 and supplementary Charge Sheet No. 87 of 2013 have been submitted. Cognizance of the offence has been taken on 28.06.2012 and a Revision Petition has apparently been filed by the accused bearing No. 31/226/13 which is pending in the District Court in Araria.
40. As regards Kursakanta P.S. Case No.14/2012 is concerned, the details are not available on record.

41. We have also been told that an FIR has been filed against the NGO Jay Ambey Welfare Society for distributing expired medicines to the beneficiaries of the Family Planning camp held on 7<sup>th</sup> January 2012. A Charge Sheet has been filed in this regard and cognizance of this offence has also been taken by the Trial Court, but again the details are not available.
42. It is also admitted by the State of Bihar that inquiries into the events that took place on 7<sup>th</sup> January 2012 have been concluded and show cause notices have been issued to the Medical Officer in charge in the Primary Health Centre in Bausa, Purnia as well as Kursakanta, Araria and also to the Civil Surgeon, Purnia.
43. 43. That the situation in Bihar has not improved is clear from the fact that in Saran district the accreditation of Gunjan Maternity and Surgical Clinic at Chhapra to conduct sterilization procedures was cancelled on 4<sup>th</sup> March 2012, just a few months after the incident in Araria district.

#### **Affidavit filed by the State of Kerala**

44. The State of Kerala has filed a Statement of Facts through a letter dated 15<sup>th</sup> March 2013. The Statement of Facts is not accompanied by an affidavit and the first page of the Statement of Facts is not on the record of this case. However, the letter states, inter alia, that "In Kerala sterilization camps are conducted only in well equipped centres (usually in first referral units and above hospitals) where there are operation theatre facility, lab facility, referral facility are in place." It is also stated "sterilization procedures are carried out in hygienic, well equipped hospitals under the control and supervision of qualified empanelled doctors." This is reiterated in an affidavit dated 1<sup>st</sup> July 2013 filed by the State of Kerala.
45. In response to the submission made in the writ petition, the State of Kerala states in paragraph 11 of its affidavit:

"[The] tribal population of Kerala State is accorded special consideration for its dealing members. There

is no compulsion of promotion of sterilization as part of Government policy. At the same time family planning services are not denied to this segment of the population if demanded. Felt need of the community is assessed by the Health Worker and various options are put before them explaining the merits and demerits of each method and encouraging to make right choice."

There is therefore no specific denial of the submission made by Devika Biswas in her writ petition.

### **Affidavit filed by the State of Madhya Pradesh**

46. The State of Madhya Pradesh has filed only one affidavit dated 7th August 2013 and the allegations made by Devika Biswas have not been denied in that affidavit.
47. However, the State of Madhya Pradesh denies coercive sterilizations and asserts that sterilization is undertaken only after informed consent of the patient. The State further submits:

"The State Government has issued instructions for taking due precautions for sterilization operations. The State Government has formed Quality Assurance Committee in each District of the State, which is headed by the Chief Medical, and Health Officer of the district. The function of the Quality Assurance Committee is to review all types of cases where there is some complication and take necessary steps to rectify the same."

There is no specific denial of the events in Balaghat district.

### **Affidavit filed by the State of Maharashtra**

48. The State of Maharashtra has filed only one affidavit dated 14th August 2012 in which it is generally stated that the family planning programme is being conducted satisfactorily and a large number of statistics have been given in support

of this submission. However, with regard to the sterilization camp held in Nagpur, Chandrapur and Gadchiroli districts it is stated as follows:

“It is respectfully submitted that in the light of facts submitted in the Petition by the Petitioner, detailed report has been called from the Civil Surgeon, Gadchiroli, Chandrapur and Nagpur District which is marked and annexed as Annexure-1. However, keeping in view the gravity of such instances reported, State has taken immediate corrective action and instructions have already been issued to all the District Health Officers and Civil Surgeons to perform the family planning operations as per the standards prescribed by Govt. of India in hygienic conditions.”

No detailed report has been annexed and no further affidavit was filed by the State of Maharashtra regarding any action taken against any officer responsible for the mishap, any compensation paid or any further action taken in this regard.

#### **Affidavit filed by the State of Rajasthan**

49. The State of Rajasthan in its affidavit filed on 23rd November 2012 does not specifically contradict the contents of the report relating to the sterilization procedures carried out in Bundi district but only affirms that the standard operating procedures are being followed and that the failure rate is in conformity with the failure rate prescribed by the Government of India.
50. The State of Rajasthan maintains that the proposed patients are sufficiently instructed and advised with respect to both the sterilization itself as well as post-sterilization care. The State further mentions that continuous efforts are made by the health employees “to motivate females to take up sterilization surgery”. The failure rate at Bundi district “is in conformity to the failure rate prescribed by the Government of India”. The State submits that sufficient steps have been

taken for implementation of the directions in Ramakant Rai (I) as well as the guidelines of the Government of India.

### **Affidavits filed by the State of Chhattisgarh**

51. The State of Chhattisgarh has taken up the issue of mismanagement of the sterilization camps in Bilaspur district with due promptitude and seriousness and has filed detailed affidavits that not only specify the ameliorative steps taken but also the preventive steps against recurrence of a similar tragedy.
52. Chhattisgarh has confirmed that sterilization camps were organized in Sakri village of Bilaspur district on 8th November 2014 and in Gorela, Pendra and Marwahi in Bilaspur district on 10th November 2014. In all 137 operations were conducted and many of those operated upon complained of vomiting, pain and difficulty in breathing. Consequently, all of them were admitted in nearby hospitals for treatment. Unfortunately, 13 deaths took place despite relief measures including bringing in a team of doctors from the All India Institute of Medical Sciences in New Delhi.
53. Apart from these 137 persons, 37 persons who were not operated upon also had similar complaints and 5 (five) of them died thereby bringing the total number of deaths to 18. It appears that the cause of death of these 5 (five) persons was not related to the sterilization procedure but was due to consumption of Ciprocin 500 tablet.
54. By way of monetary compensation, the State Government has given Rs. 4 lakhs to the families of those who died and Rs. 50,000/- to those who were discharged from medical institutions. The children of the deceased have been adopted by the State Government which has taken the responsibility of providing them free education and health care till they are 18 years of age. The State Government has also put in an amount of Rs. three lakh in a fixed deposit for children of the persons who died in the tragedy. The children would be entitled to the amount on attaining the age of 18 years.



55. Departmental action has been taken against the doctors involved in the sterilization camps. Two of them have been dismissed from service while two others have been suspended pending a departmental enquiry. The Licensing Authority has also been suspended.
56. A Judicial Commission of Inquiry headed by a retired District Judge Ms. Anita Jha was set up to give its findings on the criminal culpability and accountability of the persons concerned. The report given by the Ms. Anita Jha Commission has been accepted by the State Government and also acted upon.
57. Criminal proceedings in the form of Charge Sheet No.19/2015 dated 15th February 2015 has been filed in the Court of Judicial Magistrate, First Class at Bilaspur against Dr. R.K. Gupta, Ramesh Mahawar, Sumit Mahawar (manufacturers of Ciprocin 500 tablets), Rajesh Khare, Rakesh Khare and Manish Khare (suppliers of Ciprocin 500 tablets). Rakesh Khare and Manish Khare have since been declared proclaimed offenders and their property attached and a reward for their arrest and information of their whereabouts has also been announced.
58. As regards measures taken to prevent the recurrence of such an incident, Chhattisgarh has begun placing greater emphasis on spacing measures, which will be more effective in population control. Greater emphasis is being placed on vasectomy for gender equity. An advisory has been issued that Ciprocin 500 should not be consumed and efforts are being made to educate people about the importance, benefits, methods and availability of services in health facilities. A mass awareness campaign has also been launched and several other proactive measures have been taken.
59. All in all, the State of Chhattisgarh has reacted positively to the tragedy and has not sought to hide inconvenient facts under the carpet.

### Further submissions of Devika Biswas

60. 60. Devika Biswas has pointed out in various affidavits filed during the pendency of this writ petition that the campaign for sterilization is effectively a relentless campaign for female sterilization. The web portal of the Ministry of Health and Family Welfare of the Government of India provides statistics on the number of sterilization procedures conducted in the country for 2012-13. The portal indicates that 97.4% of all sterilization procedures during this period were of women. Devika Biswas alleges that the entire family planning programme of Chhattisgarh focuses on female sterilization and the National Health Mission Project Implementation Plan sets targets for female sterilization and allocates 85% of the family planning budget exclusively to female sterilization.
61. More or less confirming the allegations made by Devika Biswas, the affidavits filed by Madhya Pradesh, erstwhile Andhra Pradesh and Goa reflect the fact that the overwhelming number of sterilization procedures is targeted towards women and there is virtually no attention paid to male sterilization.
62. Devika Biswas has also pointed out that data released by the Ministry of Health and Family Welfare during the period 2010-13 shows that at least 363 people have died as a result of sterilization procedures, a very large number of such procedures have failed and that there have been severe complications in respect of several persons who underwent a sterilization procedure. This has resulted in payment of compensation of at least Rs. 50 crores.
63. 63. The principal problem pointed out by Devika Biswas is with regard to the implementation of the various processes and guidelines issued by the Government of India from time to time. Mere issuance of guidelines by the Government of India does not guarantee their implementation. It is pointed out (for example) that the list of empanelled doctors is not readily available; consent forms are not available in the local language except in the Union Territory of Puducherry;

unrealistic targets have been set for sterilization procedures with the result that non-consensual and forced sterilizations are taking place, including of persons who are physically or mentally challenged. Some young persons have been sterilized to meet targets and by and large illiterate persons are sterilized. Devika Biswas is opposed to setting of targets and says that she has the support of the Government of India in this regard, but unfortunately State Governments and Union Territories are still setting informal targets for sterilization.

64. 64. It is further pointed out that there is inadequate monitoring of sterilization camps and facilities. There is little or no monitoring in most camps and health centres, accountability measures are not in place and the rights of thousands of women who undergo sterilization procedures are violated. It is not enough for the Government of India to show that it is merely playing a supportive and facilitative role since the campaign is a national campaign and if it is not properly implemented, it merely leads to passing the buck with the State Government blaming the Government of India and vice versa.
65. The strengthening of the Quality Assurance Committees (QAC) and the District Quality Assurance Committees (DQAC) is crucial to the success of a family-planning programme of which sterilization procedures is one of the elements. Details of the constitution of QACs and DQACs are not available on the website of the Ministry of Health and Family Welfare. There is also no indication of the steps and decisions taken by them or the minutes of their meetings or reports submitted by them. In other words, vital information is simply not available. Devika Biswas doubts whether these Committees meet on a regular basis although it would be appropriate for them to have at least quarterly meetings if not meetings every six months.
66. According to her, unless these existing institutions function effectively and efficiently or are made to function effectively and efficiently, it is very unlikely that any meaningful progress will be made in the family planning programme of the

Government of India, of which sterilization is an important component.

67. With regard to the Family Planning Indemnity Scheme, it is pointed out that regular reviews are not carried out; the utilization of funds made available under the Scheme are mere figures since the details of disbursements in case of death, failure, complication etc. are simply not available anywhere. There is no indication of the number of claims filed, the number of claims rejected and the reasons for the rejection and the amount provided to each successful claimant. The Scheme requires a death audit to be carried out but that is more or less missing in every instance. It is stated that specialists who are conversant with the Scheme are not available at sterilization camps and health centres to explain the Scheme in detail so that there is no difficulty or complication faced in the event of an unfortunate mishap. It should be the duty of such a specialist to ensure that each person proceeding to undergo a sterilization procedure has a copy of all the required documents so that there is no difficulty faced later on. This will also ensure that each person gives an informed consent to the sterilization procedure in a language that he or she understands. In fact, all information that is disseminated with regard to the sterilization procedure should be made available in the local language at all Government health facilities and accredited private facilities.
68. It is high time, according to Devika Biswas, for the Government of India to look at the quality of care made available to persons post a sterilization procedure. As is clear from various documents on record including the Ms. Anita Jha Commission Report, after-care facilities in terms of counselling, assistance, follow-up etc. are totally absent.

### **Is it a public health issue?**

69. 69. The fundamental error that the Union of India is making (and it has repeated that in its affidavits) is by asserting that the effective implementation of the sterilization programme

is the concern of each State since it is a "Public health" issue covered by Entry 6 of List II in the Seventh Schedule (the State List) of the Constitution. Apart from the fact that the various entries in the Seventh Schedule relate to legislative power, the error made by the Union of India is in completely overlooking the more appropriate Entry in the Concurrent List that is Entry 20A which is "Population Control and Family Planning". This was inserted by the Constitution (Forty-second) Amendment Act, 1976. If the sterilization programme is intended for population control and family planning (which it undoubtedly is) there is no earthly reason why the Union of India should refer to and rely on Entry 6 of the State List and ignore Entry 20A of the Concurrent List. Population control and family planning has been and is a national campaign over the last so many decades. Therefore, the responsibility for the success or failure of the population control and family planning programme (of which sterilization procedure is an integral part) must rest squarely on the shoulders of the Union of India. It is for this reason that the Union of India has been taking so much interest in promoting it and has spent huge amounts over the years in encouraging it. It is rather unfortunate that the Union of India is now treating the sterilization programme as a Public Health issue and making it the concern of the State Government. This is simply not permissible and appears to be a case of passing the buck.

70. 70. As regards Entry 20A of the Concurrent List, the Justice Sarkaria Commission had this to say in Chapter II titled Legislative Relations in paragraph 2.21.08:

"Only one State Government has suggested that this Entry should be transferred to the State List. According to them family planning facilities should be an integral part of the health facilities, which is a State subject and the present dichotomy between the two facilities, hampers their adequate integration. Population control and family planning are a vital part of the national effort at development. This Entry was inserted by the Forty-second Amendment to the Constitution recognising the importance of

this matter. It is well known that a significant part of the fruits of development is neutralised by the high growth in population. With more mouths to feed, fewer savings are available for development. Large addition to the population has its impact on every aspect of the nation's life. Many of the ills of the society can be traced back to large numbers who are unable to find a rewarding employment. It is necessary to recognise this inter-dependence between family planning and other sectors. We are, therefore, of the view that Population Control and Family Planning is a matter of national importance and of common concern of the Union and the States."

Notwithstanding the view of that one State Government, the Union of India did not transfer Entry 20A to the State List, thereby making its intentions quite clear and obvious.

71. 71. When the Union of India formulates schemes of national importance such as family planning, their implementation is undoubtedly dependent on the State Governments since they have the requisite mechanism for implementing the schemes and can also take into account the needs that are particular to the State and its people. In this manner, the cooperation of the Union of India and all State Governments is indispensable to the success of such national programmes. Adverting to the provisions of the Constitution that allow for such coordination between the Union and States, the Justice Sarkaria Commission held that these provisions are not repugnant to but instead further the principle of federalism.
72. In the same manner, it is imperative for both the Union of India and the State Governments to implement schemes announced by the Union of India in a manner that respects the fundamental rights of the beneficiaries of the scheme. Given the structure of cooperative federalism, the Union of India cannot confine its obligation to mere enactment of a scheme without ensuring its realization and implementation.

73. Apart from anything else, by not giving the sterilization programme the importance it deserves (apart from other methods of population control and family planning) and trying to pass the buck to the State Governments, the Union of India is attempting to find an excuse for failure in its duty of effectively monitoring a programme of national importance. This game of passing the parcel and treating a national programme as a public health issue has to stop and somebody must take ownership of the Population Control and Family Planning programme.

### **Draft National Health Policy**

74. To compound the problem and it is much more than a pity; our country does not seem to have any health policy. The draft of a National Health Policy, 2015 was put up on the website on the Ministry of Health and Family Welfare of the Government of India in December 2014 for comments, suggestions and feedback but even after more than one and a half years, the website of the said Ministry shows that the National Health Policy has not been finalized.
75. The draft National Health Policy states that its primary aim is to "...inform, clarify, strengthen and prioritize the role of the Government in shaping health system in all its dimensions..." The draft recognizes the correlation between health and development and also recognizes the high inequity in access to health care.
76. With respect to sterilization, it states that sterilization related deaths are a direct consequence of poor health care quality and is a preventable tragedy. It also recognizes that female sterilizations are safest if performed in an operation theatre, which is functional throughout the year and, by a professional team with support systems, which are in constant use. Camp mode for such operations itself becomes a reason for unsatisfactory quality. More monetary and human resource investment is required for the National Rural Health Mission.
77. Increase in the proportion of male sterilization in the total sterilizations from the existing 5% to at least 30% is stated to be

another policy imperative under the health policy. Coercive methods are not justified and are not even effective in meeting the goals of population control. Improved access, education and empowerment should be the aim.

78. 78. Under the head of 'Governance' the draft National Health Policy states:

“One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Center and the States. Though health is a State subject, the Center has accountability to Parliament for central funding – which is about 36% of all public health expenditure and in some states over 50%. Further it has its obligations under a number of international conventions and treaties that is a party to. Further, disease control and family planning are in the Concurrent list and these could be defined very widely. Finally though State ownership has been used by some states to become domain leaders and march ahead setting the example for others, the Center has a responsibility to correct uneven development and provide more resources where vulnerability is more.”

Surely, someone should be concerned that we do not have a national health policy or is it that we do not need a national health policy and ad hoc measures are good enough?

### **Female versus male sterilization**

79. A perusal of the various affidavits on record indicates that the sterilization programme is virtually a relentless campaign for female sterilization. This is more or less confirmed from the figures available on the website of the Ministry of Health and Family Welfare of the Government of India which indicate the following:



YEAR	2013	2014
Female sterilizations	1,57,431	1,49,262
Male sterilizations	8130	5085
Total sterilizations	1,65,561	1,54,347
% Female sterilizations	95.09%	96.7%
%Male sterilizations	4.91%	3.29%

80. 80. The issue of male versus female sterilizations was debated and discussed during the course of the hearings and it was conceded by all the learned counsel that the sterilization programme cannot be targeted primarily towards women but must also actively include the sterilization of men as well. It appears to us, without going into the merits and demerits of the incentives given for undergoing the sterilization procedure, the documents on record indicate that the incentive given to males for undergoing a sterilization procedure is less than it is for females and that may perhaps be one of the reasons why the percentage of males being sterilized is so remarkably low as compared to females. This is an area that the Union of India must address itself to, if nothing else then at least for reasons of gender equity.

### Right to life

81. 81. The manner in which sterilization procedures have reportedly been carried out endanger two important components of the right to life under Article 21 of the Constitution – the right to health and the reproductive rights of a person.

(i) Right to health

82. 82. It is well established that the right to life under Article 21 of the Constitution includes the right to lead a dignified and meaningful life and the right to health is an integral facet of this right. In *C.E.S.C. Limited and Ors. v. Subhash Chandra Bose and Ors* dealing with the right to health of workers, it was noted that the right to health must be considered an aspect of social justice informed by not only Article 21 of

the Constitution, but also the Directive Principles of State Policy and international covenants to which India is a party. Similarly, the bare minimum obligations of the State to ensure the preservation of the right to life and health were enunciated in *Paschim Banga Khet Mazdoor Samity v. State of W.B.*

83. In *Bandhua Mukti Morcha v. Union of India & Others* this Court underlined the obligation of the State to ensure that the fundamental rights of weaker sections of society are not exploited owing to their position in society.

84. That the right to health is an integral part of the right to life does not need any repetition.

(ii) Right to reproductive health

85. 85. Over time, there has been recognition of the need to respect and protect the reproductive rights and reproductive health of a person. Reproductive health has been defined as “the capability to reproduce and the freedom to make informed, free and responsible decisions. It also includes access to a range of reproductive health information, goods, facilities and services to enable individuals to make informed, free and responsible decisions about their reproductive behaviour.” The Committee on Economic, Social and Cultural Rights in General Comment no. 22 on the Right to Sexual and Reproductive Health under Article 12 of the International Covenant on Economic, Social and Cultural Rights observed that “The right to sexual and reproductive health is an integral part of the right of everyone to the highest attainable physical and mental health.”

86. 86. This Court recognized reproductive rights as an aspect of personal liberty under Article 21 of the Constitution in *Suchita Srivastava v. Chandigarh Administration*. The freedom to exercise these reproductive rights would include the right to make a choice regarding sterilization on the basis of informed consent and free from any form of coercion. The issue of informed consent in respect of sterilization programmes was considered by the Committee on the Elimination of

Discrimination Against Women in *A.S. v. Hungary*, where the Committee found Hungary to have violated Articles 10(h), 12 and 16, paragraph 1(e) of the Convention on the Elimination of Discrimination Against Women by performing a sterilization operation on A.S. while she was brought in for a caesarean by making her sign a consent form that she did not fully understand. The Committee found that it was not plausible to hold that, in the brief period of 17 minutes commencing from her admission in the hospital to the completion of the surgical procedures, that the hospital personnel provided her with sufficient counselling and information about sterilization, as well as alternatives, risks and benefits, to ensure that she could make a well-considered and voluntary decision to be sterilized. The Committee held:

“Compulsory sterilization ... adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.” The sterilization surgery was performed on the author without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity.”

87. It is necessary to re-consider the impact those policies such as the setting of informal targets and provision of incentives by the Government can have on the reproductive freedoms of the most vulnerable groups of society whose economic and social conditions leave them with no meaningful choice in the matter and also render them the easiest targets of coercion.

Article 12: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in

connection with pregnancy, confinement and the post- natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

Article 16: 1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women - (e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

The cases of Paschim Banga Khet Mazdoor Samity and Bandhua Mukti Morcha have emphasized that the State's obligation in respect of fundamental rights must extend to ensuring that the rights of the weaker sections of the community are not exploited by virtue of their position. Thus, the policies of the Government must not mirror the systemic discrimination prevalent in society but must be aimed at remedying this discrimination and ensuring substantive equality. In this regard, it is necessary that the policies and incentive schemes are made gender neutral and the unnecessary focus on female sterilization is discontinued.

### Supplementary directions

88. On the basis of the submissions before us, we have highlighted some key issues that need active consideration. In addition, our attention was repeatedly drawn to the guidelines given by this Court in Ramakant Rai (I) and while it is generally the case of the Union of India and all the States that the guidelines are being followed, we find that at least in respect of some of them, there is still much more that needs to be done for their effective implementation not only in letter but also in spirit. Some fine-tuning is also necessary in view of the passage of time, change in circumstances and the need to use technology to the optimum. Accordingly, we find it necessary to issue the following supplementary directions:

1. The State-wise, district-wise or region-wise panel of doctors approved for carrying out the sterilization procedure, must

be accessible through the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory. The list should contain all necessary particulars of each doctor and not merely the name and designation. This exercise should be completed on or before 31<sup>st</sup>

December, 2016 and thereafter the list be updated every quarter that is by 31<sup>st</sup> March, 30<sup>th</sup> June, 30<sup>th</sup> September and 31<sup>st</sup> December of every year.

2. The contents of the checklist prepared pursuant to the directions given in Ramakant Rai (I) should be explained to the proposed patient in a language that he or she understands and the proposed patient should also be explained the impact and consequences of the sterilization procedure. This can be achieved by (a) ensuring that the checklist is in the local language of the State; (b) it should contain a certificate duly signed by the concerned doctor that the proposed patient has been explained the contents of the checklist and has understood its contents as well as the impact and consequences of the sterilization procedure; (c) in addition to the certificate given by the doctor, the checklist must also contain a certificate given by a trained counselor (who may or may not be an ASHA worker) to the same effect as the certificate given by the doctor. This will ensure that the proposed patient has given an informed consent for undergoing the sterilization procedure and not an incentivized consent.

Sufficient breathing time of about an hour or so should be given to a proposed patient so that in the event he or she has a second thought; time is available for a change of mind.

The checklist prepared pursuant to the direction given in Ramakant Rai (I) with the aforesaid modifications should be prepared in the local or regional language on or before 31<sup>st</sup> December 2016.

3. The Quality Assurance Committee (QAC) as well as the District Quality Assurance Committee (DQAC) has been set up in every State and District in terms of the directions given in Ramakant Rai (I). However, it is only the designation of its members that has been made available. The details and necessary particulars of each member of the QAC and DQAC should be accessible from the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory on or before 31st December, 2016 and thereafter updated every quarter.
4. In addition to the six monthly reports required to be published by the QAC containing of the number of persons sterilized as well as the

Number of deaths or complications arising out of the sterilization procedure, as already directed in Ramakant Rai (I), the QAC must publish an Annual Report (on the website of the Ministry of Health and Family Welfare of the Government of India as well the corresponding Ministry or Department of each State Government and each Union Territory) containing not only the statistical information as earlier directed, but also non-statistical information in the form of a report card indicating the meetings held, decisions taken, work done and the achievements of the year etc. This will have a significant monitoring and supervisory impact on the sterilization programme and will also ensure the active involvement of all the members of the QAC and the DQAC.

The first such Annual Report covering the calendar year 2016 should be published on the websites mentioned above on or before 31<sup>st</sup> March, 2017.

5. As many as 363 deaths have taken place due to sterilization procedures during 2010-2013. This is a high figure. During this period, more than Rs. 50 crores has been disbursed towards compensation in cases of death. Apart from steps taken by Bihar and Chhattisgarh during the pendency of the writ petition to mitigate the sufferings of the patients, we have

not been told of any death audit conducted by any State Government or Union Territory in respect of any patient, nor have we been informed of any steps taken against any doctor or anybody else involved in the sterilization procedure that has resulted in the death of a patient or any failure or any other complication connected with the sterilization procedure. There is a need for transparency coupled with accountability and the death of a patient should not be treated as a one-off aberration. Therefore, it is directed that the Annual Report prepared by the QAC must indicate the details of all inquiries held and remedial steps taken.

6. With regard to the implementation of the Family Planning Indemnity Scheme (FPIS), there does not seem to be any definitive information with regard to the number of claims filed, the claims accepted and in which category (death, failure, complication etc.), claims pending (and since when) and claims rejected and the reasons for rejection. The QAC is directed to include this information in the Annual Report and the Ministry of Health and Family Welfare of the Government of India as well as the State Governments should make this information accessible on the website, including the quantum of compensation paid under each category and to the number of persons.

We have mentioned above that the learned Solicitor General had assured us on 20th March 2015 that full details of the funds utilized under the FPIS would be furnished but that information has not been given as yet, necessitating the direction that we have passed.

In addition to the direction relating to the FPIS, the Ministry of Health and Family Welfare should conduct an audit to ensure that the funds given by the Government of India have been utilized for the purpose for which they were given for the period from 2013-14 onwards.

7. The quantum of compensation fixed under the Family Planning Indemnity Scheme (FPIS) deserves to be increased substantially and the burden thereof must be equally shared

by the Government of India and the State Government. The State of Chhattisgarh has shown the way in this regard and it would be appropriate if others follow the lead. Every death or failure or complication related to the sterilization procedure is a setback not only to the patient and his or her family but also in the implementation of the national campaign. We decline to fix the quantum of compensation but would suggest, following the example of the State of Chhattisgarh, that the amount should be doubled and shared equally.

1. The Union of India is directed to persuade the State Governments to halt the system of holding sterilization camps as has been done by at least four States across the country. In any event, the Union of India should adhere to its view that sterilization camps will be stopped within a period of three years. In our opinion, this will necessitate simultaneous strengthening of the Primary Health Care centres across the country both in terms of infrastructure and otherwise so that health care is made available to all persons. The significance of having well equipped Primary Health Centres across the country certainly cannot be over-emphasized. Therefore, we direct the Union of India to pay attention to this as well, since it is absolutely important that all citizens of our country have access to primary health care.
9. The Union of India should make efforts to ensure that sterilization camps are discontinued as early as possible but in any case within the time frame already fixed and adverted to above. The Union of India and the State Governments must simultaneously ensure that Primary Health Centres are strengthened
10. Although the Union of India has stated that no targets have been fixed for the implementation of the sterilization programme, it appears that there is an informal system of fixing targets. We leave it to the good sense of the each State Government and Union Territory to ensure that such targets are not fixed so that health workers and others do not compel persons to undergo what would amount to a forced or nonconsensual sterilization merely to achieve the target.



11. The decisions taken in the high level meetings held on 15th May 2015 and 17th November 2015 as well as the National Summit on Family Planning held on 5th and 6th April 2016 should be scrupulously implemented by the Ministry of Health and Family Welfare of the Government of India. The said Ministry should also ensure effective implementation of the decisions taken keeping in mind that the sterilization programme is a part of a national campaign.
12. The Union of India is directed to ensure strict adherence to the guidelines and standard operating procedures in the various manuals issued by it. The Sterilization programme is not only a Public Health issue but also a national campaign for Population Control and Family Planning. The Union of India has overarching responsibility for the success of the campaign and it cannot shift the burden of implementation entirely on the State Governments and Union Territories on the ground that it is only a public health issue. As the Justice Sarkaria Commission put it "Population Control and Family Planning is a matter of national importance and of common concern of the Union and the States."
13. We are pained to note the extremely casual manner in which some of the States have responded to this public interest petition. What stands out is the response of the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala in respect of which States allegations were made concerning mismanagement in at least one sterilization camp. None of these States have given any acceptable response to the allegations and we have no option but to assume that the camps that have been referred to in the writ petition were mismanaged as alleged by Devika Biswas. However, the matter should not end here. We direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the High Court in the States of Madhya Pradesh, Maharashtra, Rajasthan and Kerala for being placed before the Chief Justice of the High Court. We request the Chief Justice to initiate a suo moto public interest petition to consider the allegations made by Devika Biswas in respect of the sterilization camp(s) held in these States (the allegations

not having been specifically denied) and any other similar laxity or unfortunate mishap that might be brought to the notice of the Court and pass appropriate orders thereon. We also direct the Registry of this Court to transmit a copy of this judgment to the Registrar General of the Patna High Court for being placed before the Chief Justice of the High Court. We request the Chief Justice to ensure speedy completion of the investigations and proceedings relating to the mishap on 7<sup>th</sup> January 2012 in the sterilization camp in Kaparfora Government Middle School, Kursakanta, Araria district as well as the mishap in Chhapra in Saran district that led to cancellation of the accreditation of Gunjan Maternity and Surgical Clinic on 24<sup>th</sup> March 2012.

14. The State of Chhattisgarh is directed to implement the recommendations given in the Ms. Anita Jha Report at the earliest and with all sincerity.
15. We have already expressed our sadness at the fact that the National Health Policy has not yet been finalized despite the passage of more than one and a half years. We direct the Union of India to take a decision on or before 31<sup>st</sup> December 2016 on whether it would like to frame a National Health Policy or not. In case the Union of India thinks it worthwhile to have a National Health Policy, it should take steps to announce it at the earliest and keep issues of gender equity in mind as well.

## Conclusion

89. With the above supplementary directions, the writ petition is disposed of. We must record our appreciation for the efforts put in by Devika Biswas in bringing this vital issue to the notice of this Court and to all the learned counsel and concerned officers of the Ministry of Health and Family Welfare of the Government of India in not treating the public interest litigation as an adversarial proceeding but as a collaborative effort to find a remedy to some problems and improve the wellbeing of the citizens of the country.

(Madan B. Lokur)

New Delhi; (Uday Umesh Lalit) September 14, 2016

## GUIDELINES

### STANDARDS FOR FEMALE AND MALE STERILIZATION SERVICES (2006)

#### INPUTS

##### 1. Eligibility of Providers for Performing Female Sterilization

Service	Basic Qualification Requirement of Provider
Minilap Service	Trained MBBS doctor
laparoscopic sterilization	DGO, MD (Obst. & Gynae.), MS (Surgery) (trained in laparoscopic sterilization)

2. The state should constitute a district-wise panel of doctors for performing sterilization operations in government institutions and accredited private/NGO centres based on the above criteria. Only those doctors whose names appear on the panel should be entitled to carry out sterilization operations in the government and/or government-accredited institutions. The panel should be updated quarterly.

##### 1.2. Physical Requirements

Physical Requirements for Female Sterilization

Sr.No	Item	Requirements
1	Facilities	Well-ventilated, fly-proof room with concrete/tiled floor, which can be cleaned thoroughly Running water supply through tap or bucket with tap Electricity supply with a standby generator and other light source

Sr.No	Item	Requirements
2	Space Required	<p>Area for reception</p> <p>Waiting area</p> <p>Counselling area which offers privacy and ensures avoidance of any interruptions</p> <p>laboratory with facilities for blood &amp; urine examination</p> <p>Clinical examination room for initial assessment and follow up</p> <p>Preoperative preparation room for trimming of hair, washing, changing of clothes and premedication</p> <p>Hand washing area near the OT for scrubbing</p> <p>Sterilization room, near the OT, for autoclaving, washing and cleaning equipment, preparation of sterile packs</p> <p>Operation theatre: should be isolated and away from the general thoroughfare of the clinic, it should be large enough to allow operating staff to move freely and to accommodate all the necessary equipment. Lighting should be adequate.</p> <p>Recovery room: must be spacious and well ventilated, number of beds will be determined by the available space, should be adjacent to the OT.</p> <p>Adequate number of toilets: sufficient number of sanitary type toilets with running water for the clients and the staff.</p> <p>Storage area</p> <p>Office area for keeping records</p>
3 Equipment and Supplies		

Sr.No	Item	Requirements
3A	Examination Room Requirements	Examination table Foot stool Blood pressure apparatus Thermometer Stethoscope Examination light Weighing scale Instrument for pelvic examination
3B	Laboratory	Haemoglobinometer and accessories Apparatus to estimate albumin and sugar in urine Reagents
3C	Sterilization Room	Autoclave Boiler Surgical drums SS Tray Glutaraldehyde solution 2%
3D	Cleaning Room	Hand brushes Utility gloves Basins Detergents Chlorine solution 0.5%

Sr.No	Item	Requirements
3E	Operation Theatre	Operating table capable of Trendelenburg position Step-up stool Spot light in OT Instrument trolley Minilaparotomy kit laparoscopy kit Blood pressure instrument Stethoscope Syringe with needles Emergency equipment and drugs Room heater Iv stand Waste basket, storage cabinet, buckets, basins for decontamination Box for used linen Puncture-proof box for needles
3F	Recovery Room	Patient's cot with mattress, sheet, pillow, pillow cover, and blankets Blood pressure instrument Stethoscope Thermometers Iv stand Emergency equipment and drugs as per list

Sr.No	Item	Requirements
4	Equipment and Supplies	Stethoscope Blood pressure instrument Oral airways guedel size 3, 4, 5 Nasopharyngeal airways size 6, 6.5 , 7.0 Suction machine with tubing and two straps Ambu bag with mask size 3, 4, 5 Tubing and oxygen nipple Oxygen cylinder with reducing valve and flow metre Blanket Gauze pieces Kidney tray Torch Syringes and needles, including butterfly sets, IV cannula Intravenous infusion sets and fluids Sterile laparotomy instruments Endotracheal tube size 6, 6.5 , 7, 7.5, 8.0 laryngeal mask airway size 3, 4, 5 Combitube Cricothyroidectomy set

Sr.No	Item	Requirements
5	Essential Drugs	Injection Adrenaline Injection Atropine Injection Diazepam Injection Deriphylline Injection Physostigmine Injection Xylocard Injection Hydrocortisone (Dexamethasone) Injection Pheniramine Maleate Injection Promethazine Injection Pentazocine Injection Ranitidine Injection Metoclopramide Injection Calcium Gluconate/Calcium Chloride Injection Sodium Bicarbonate (7.5%) Injection Dopamine Injection Mephenteramine Injection Frusemide Injection Methergine Injection Oxytocin Water-soluble jelly Electrode jelly IV fluids Ringer lactate 0.9% sodium chloride (normal saline) 5% Dextrose Heta Starch (HES 6%) Glucose 25%



### 1.3 Case Selection

(Self-declaration by the client will be the basis for compiling this information.)

- 1.3.1. Clients should be married (including ever-married).
- 1.3.2. Female clients should be below the age of 49 years and above the age of 22 years.
- 1.3.3. The couple should have at least one child whose age is above one year unless the sterilization is medically indicated.
- 1.3.4. Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).
- 1.3.5. Clients must be in a sound state of mind so as to understand the full implications of sterilization.
- 1.3.6. Mentally ill clients must be certified by a psychiatrist, and a statement should be given by the legal guardian/spouse regarding the soundness of the client's state of mind.

## PROCESSES

### 1.4. Clinical Processes

Preparation for surgery includes counselling, preoperative assessment, preoperative instructions, review of the surgical procedure, and post-operative care. It is essential to ensure that the consent for surgery is voluntary and well informed, and that the client is physically fit for the surgery. Preoperative assessments also provide an opportunity for overall health screening and treatment of RTIs/STIs.

#### 1.4.1. Counselling

Counselling is the process of helping clients make informed and voluntary decisions about fertility. General counselling should be done whenever a client has a doubt or is unable to take a decision regarding the type of contraceptive method to be used. However, in all cases, method-specific counselling must be done.

The following steps must be taken before clients sign the consent form:

- 1.4.1.1. Clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes this operation is a permanent one.
- 1.4.1.2. Clients must make an informed decision for sterilization voluntarily.
- 1.4.1.3. Clients must be counselled whenever required in the language that they understand.
- 1.4.1.4. Clients should be made to understand what will happen before, during, and after the surgery, its side effects, and potential complications.
- 1.4.1.5. The following features of the sterilization procedure must be explained to the client:
  - It is a permanent procedure for preventing future pregnancies.
  - It is a surgical procedure that has a possibility of complications, including failure, requiring further management
  - It does not affect sexual pleasure, ability, or performance. It will not affect the client's strength or her ability to perform normal day-to-day functions. Sterilization does not protect against RTIs, STIs, or HIV/AIDS. Clients must be told that a reversal of this surgery is possible, but that the reversal involves major surgery and that its success cannot be guaranteed.
- 1.4.1.6. Clients must be encouraged to ask questions to clarify their doubts, if any.
- 1.4.1.7. Clients must be told that they have the option of deciding against the procedure at any time without being denied their rights to other reproductive health services.

### **1.4.3. Timing of the Surgery**

Procedure Interval sterilization should be performed within 7 days of the menstrual period (in the follicular phase of the menstrual

cycle). Post-partum sterilization should be done after 24 hours up to 7 days of delivery. Sterilization with medical termination of pregnancy (MTP) can be performed concurrently. Sterilization following spontaneous abortion can be performed provided the client fulfils the medical eligibility criteria. Laparoscopic tubal ligation should not be done concurrently with second-trimester abortion and in the postpartum period.

#### **1.4.4. Informed Consent**

- 1.4.4.1. Consent for sterilization operation should not be obtained under coercion or when the client is under sedation.
- 1.4.4.2. Client must sign the consent form for sterilization before the surgery. The consent of the spouse is not required for sterilization.

#### **Post-operative Care**

- a. The client is monitored as described in 1.4.7.c (iii)
- b. The client may be discharged when the following conditions are met:
  - After at least 4 hours of procedure, when the vital signs are stable and the client is fully awake, has passed urine, and can walk, drink or talk.
  - The client has been seen and evaluated by the doctor. Whenever necessary, the client should be kept overnight at the facility.
- c. The client must be accompanied by a responsible adult while going home.
- d. Analgesics, antibiotics, and other medicines may be provided and/or prescribed as required.

#### **1.5.1. Post-operative and Follow-up Instructions**

The client is to be provided with a discharge card indicating the name of the institution, the date and type of surgery, the method used, and the date and place of follow-up (Annexure ). Both written and verbal post-operative instructions must be provided in the local language.

The client must be advised to:

- Return home and rest for the remainder of the day.
- Resume only light work after 48 hours and gradually return to full activity by two weeks following surgery.
- Use medicines as instructed.
- Resume normal diet as soon as possible.
- Keep the incision area clean and dry. Do not disturb or open the dressing.
- Bathe after 24 hours following the surgery. If the dressing becomes wet, it should be changed so that the incision area is kept dry until the stitches are removed.
- In the case of interval sterilization, the client may have intercourse one week after surgery, or whenever she feels comfortable. Sterilization procedures do not interfere with sexual pleasure, ability or performance. The client must report to the doctor or the clinic if there is excessive pain, fainting, fever, bleeding or pus discharge from the incision, or if the client has not passed urine, not passed flatus, and feels bloating of the abdomen. Follow-up contact with all tubectomy clients at home by the female health worker in a government health institution or reporting by the client to the clinic should be established within 48 hours of surgery. The second follow-up should be done on the seventh post-operative day for the removal of stitches and post-operative check-up. A pelvic examination may be done, if indicated. The third follow-up should be done after one month or after the client's first menstrual period, whichever is earlier. The client must return to the clinic if there is a missed period/suspected pregnancy within two weeks of the missed period. If she has missed her period or is experiencing any menstrual abnormality, she must be examined to rule out pregnancy. Instructions should be given on where to go for routine and emergency follow-up. If the client has any questions, she should contact the health personnel or doctor at any time.

### **1.5.2. Certificate of Sterilization**

A certificate of sterilization should be issued after one month of the surgery or after the first menstrual period by the Medical Officer of the facility.

## **2. STANDARD OPERATING PROCEDURE FOR STERILIZATION SERVICES IN CAMPS (2008)**

### **1. Counselling**

Counselling is the process of helping clients makes informed and voluntary decisions about their fertility. Method specific counselling should be done whenever a client is unable to take a decision or has a doubt regarding the type of contraceptive method to be used. In the case of clients found eligible for sterilization the following steps should be taken before she/he signs the consent form for sterilization:

- Clients must be informed of all the available methods of family planning and should be made aware that for all practical purposes, sterilization is a permanent one.
- Clients must make an informed decision for sterilization voluntarily.
- Clients must be counseled in the language that they clearly understand.
- Clients should be made to understand what will happen before, during, and after the surgery, its side effects, and potential complications, including failure

In situations where the camp is providing other FP methods, method specific counselling should also be provided.

### **2. Camp Timings**

Camp timings should preferably be between 9 a.m. and 4 p.m.

### **3. Probable Client Load**

Estimation of likely number of clients to turn up for accessing services will help in determining number of teams. For maintaining quality service, each surgeon should restrict to conducting a maximum of:

- 30 laparoscopic tubectomy (for 1 team with three laparoscopes) or
- 30 vasectomy (NSV or conventional) or
- 30 minilap tubectomy cases.

\* With additional surgeons, support staff, instruments, equipment and supplies, the number of procedures per team may increase proportionately. However, the maximum number of procedures that are performed by a team in a day should not exceed 50.

## **ROLES AND RESPONSIBILITIES OF PROGRAMME MANAGERS AND SERVICE PROVIDERS**

### **1. Pre-camp Activities (beginning of the year)**

#### A. District chief medical officer

- To update the list of empanelled surgeons and circulate to all camp managers
- To notify/designate camp managers at the facilities likely to organize sterilization camps during the year
- To organize availability of funds from RCH 2 programme at the facility level
- To constitute teams for camps in consultation with I/C District hospital/ FRUs from where the providers are going to be sent to camps.

#### B. District nodal officer for FP (ADHO, Dy CMHO, DPM or others)

- Develop block-wise quarterly camp calendar specifying date and site in consultation with camp in-charge
  - To ensure communication to the operating teams in advance
  - To keep ready a list of standby staff so as to meet any contingency requirements
  - To keep a stock of equipment such as laparoscopes/NSV equipment ready and also arrange for AMC/repairs
  - To ensure that all necessary supplies required for the camps are made available in adequate quantities before the commencement of the camp

- To ensure that adequate funds are available with the camp manager for disbursement as incentives.

C. Camp manager/sub-district hospital/FRU/CHC/PHC (campsite)

- To coordinate the team activities with the district nodal officer
- To arrange for the required funds for organizing the camps
- To ensure availability of the local team members
- To ensure availability of equipment, instruments and other supplies for each camp
- To ensure intense IEC activities regarding the camp in his area in coordination with the District authorities.

### 3. STANDARDS & QUALITY ASSURANCE IN STERILIZATION SERVICES (2014)

#### 1.3. Eligibility Criteria for Case Selection

(Self-declaration by the client will be the basis for compiling this information. No eligible client should Standards in Sterilization Services, 2014 be denied family planning services)

- 1.3.1. Clients should be ever married.
- 1.3.2. Female clients should be above the age of 22 years and below the age of 49 years.
- 1.3.3. Male clients should be above the age of 22 years and below the age of 60 years.
- 1.3.4. The couple should have at least one child, whose age is above one year unless the sterilization is medically indicated.
- 1.3.5. Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization).
- 1.3.6. Clients must be in a sound state of mind so as to understand the full implications of sterilization.
- 1.3.7. Mentally challenged clients must be certified by a psychiatrist and a statement should be taken from the legal guardian /spouse regarding the soundness of the client's state of mind.

## 1.4 Counselling

Counselling in family planning is the process of facilitating and enabling clients to make well informed, well considered and voluntary decisions about fertility and to choose a contraceptive method. Counselling is a client centered approach that involves communication between a service provider/counsellor and client. Counselling enables the service provider to understand client's perception, attitudes, values, beliefs, family planning needs and preferences and accordingly the counselor can guide her/him towards decision making. The provider/counselor should be non-judgmental. Privacy (auditory and visual) and confidentiality should be maintained during the process of counselling.

Clients may not have complete information about sterilization and its effect which is further compounded by misconceptions and concerns. These should be dispelled by providing correct information.

1.4.1 General Counselling: Should be done for all the clients seeking family planning services. The main aim of general counselling is to provide informed choice to enable them to take a decision regarding the type of contraceptive method to be used. However, in all cases method-specific counselling on the chosen method must be done.

1.4.2 Method Specific Counselling: During counselling for sterilization, use of simplified schematic diagrams can be helpful (refer to diagrams in 'Reference Manual for Female Sterilization (2014)')

The following steps should be ensured before the client signs the consent form:

- A. Clients have been counselled wherever required in the language they understand.
- B. Clients have been informed of all the available methods of family planning and procedures.
- C. Clients have been made to understand what may happen before, during and after the surgery, its side effects and potential complications



D. Clients have made an informed decision for sterilization voluntarily.

E. The following features of the sterilization procedure should be explained to the client:

- It is a permanent procedure for preventing future pregnancies.
- It is a surgical procedure that has a possibility of complications, including failure, requiring further management.
- It does not affect sexual pleasure, ability or performance.
- It will not affect the client's strength or ability to perform normal day-to-day functions.
- After vasectomy, it is necessary to use a backup contraceptive method until azoospermia is achieved (usually this takes three months).
- Sterilization does not protect against RTIs, STIs and HIV/AIDS.
- A reversal of the surgery is possible but the reversal involves a major surgery the success of which cannot be guaranteed. viii) In the unlikely event of any complication/failure/death there is a redressal mechanism available in the form of indemnity coverage.

1.4.3 Follow-up Counselling: The information provided after the procedure is reinforced. Service providers need to listen attentively and be prepared to answer questions the client may have and address problems she/ he has experienced after undergoing the procedure. This helps the client cope with common problems or side effects.

Female Sterilization : Advise client to return to the facility if there is any missed period/no periods, with in 2 weeks to rule out pregnancy.

Male Sterilization : Advise client to return to the facility after three months for semen examination to see if azoospermia has been achieved. If semen still shows sperm return to facility every month till 6 months.

## 1.5 Informed Choice and Informed Consent

The concepts of informed choice and informed consent are related but quite different in their intent. The purpose of informed choice is to ensure that all clients choose the best option/s for their health care needs after getting full information about all available options. Informed consent means that a client understands the surgical procedure and other options and then decides to receive the care. However, informed consent alone does not constitute informed choice.

The consent of the partner is not required for sterilization. However the partner should be encouraged to come for counselling.

### 1.5.1 Documentation of Informed Consent

The client's signature or putting her thumb impression on an informed consent form is the legal authorization for the sterilization procedure to be performed. The client must always sign or put her/ his thumb impression on the consent form. In case of thumb impression a signature of a witness (any person not associated with the service facility and chosen by the client) is a must (Annexure1).

Consent for sterilization should not be obtained when physical or emotional factors may compromise a client's ability to make a carefully considered decision about contraception

## 4. MANUAL FOR FAMILY PLANNING INDEMNITY SCHEME (2013)

OPERATIONAL PROCEDURE FOR CLAIM SETTLEMENT FROM 1-4-2013:

## SECTION I

### 8.1 CLAIMS PROCEDURE:

1. On receipt of the information of any claim from the acceptor of Sterilization under Section-I, the beneficiary, through their designated hospital and doctors, shall immediately fill up claim form.(Annexure I)
2. If such covered cause is detected "during examination of the acceptor in health facility", the health facility shall ensure to get the claim form filled from the beneficiary on the spot without loss of time. The health facility shall forward the claim papers along with necessary documents to the designated officer of the district.
3. On receiving the claim papers, proper acknowledgement must be made by the designated district official by putting the stamp on all documents, for further processing and payment of the claims. Based on the following documents, claims shall be processed by the designated district level officer under different sections of the scheme. (Annexure III)
4. The claims processing under Section-I death, complications and failures following sterilization operation will continue to be processed by the District Quality Assurance Committee (DQAC) and put up to SQAC. The SQAC could perform the role hence carried out by the Insurance Company in terms of scrutinizing the documents and calling for any new and relevant material missing from the recommendation of the DQAC. The SQAC would thus review every single case in the state and recommend release of funds to the district wherever applicable. (Annexure XI)
5. For the purpose of verification and medical evaluation of the claim lodged by the beneficiary, the State Government has formed/shall form the Quality Assurance Committee (QAC) and for all purposes the authority shall be with CMO/CDMO/CMHO/CDHMO/DMO/DHO/ Joint Director designated for this purpose at district level designated by respective States/UTs.

6. The “Claim Form cum Medical Certificate” in original duly completed in all respects by the beneficiary submitted through their designated hospital and doctors shall be authenticated by the CMO/ CDMO/CMHO/ CDHMO/ DMO/DHO/Joint Director designated for this purpose at district level.(Annexure I)
7. Duly completed “Claim Form cum Medical Certificate” along with documents as specified below shall be the basis of lodging claims under Section-I of the scheme. The “Claim Form cum Medical Certificate” shall be duly completed in all respects by the beneficiary and shall be authenticated by the CMO/ CDMO/ CMHO/ CDHMO/DMO/DHO/Joint Director designated for this purpose at district level.
8. The claims processing shall be decentralized at State level and District level, along with the required documents as specified below, preferably within 30 days from the date of detection of the covered cause is documented under the scheme.
9. Stipulated time limit for settlement of claims under Section-I of the scheme would be 15 working days in case of death and 21 days in case of others, after submission of all required documents.

#### **8.1.1 DEATH FOLLOWING STERILIZATION (SECTION-I -A & I-B):**

- a) In case of claims for death of the acceptor under Section-I following sterilization operation (inclusive of death during process of sterilization operation), copy of death certificate issued by hospital/ municipality or any other authority designated and copy of Proof of Pre and Post Operative Procedure/Discharge Certificate duly attested by the convener of QAC/CMO/ CDMO/CMHO /CDHMO/DMO/DHO/Joint Director designated for this purpose at district level.(Annexure VI)
- b) Claims under Section-1-A death following Sterilization (inclusive of death during process of sterilization operation) in hospital or within 7 days from the date of discharge from the hospital and under Section-1-B Death following sterilization

within 8-30 days from the date of discharge from the hospital) shall be paid equally in favour of the spouse and unmarried dependent children whose names are appearing in the Consent Form/Claim Form. In case of no spouse, the payment shall be made to the unmarried dependent children. State Health Society/District Health Society under Section-I-A will first reimburse Rs 50,000/- to RKS of the district, in case this amount is paid by RKS as ex-gratia and the balance amount will be paid to other eligible members of the deceased.(Annexure VII)

c) In the event of death as per Section-I-A above, the State Health Society /District Health Society would be paying to the first kin of the deceased if, death of the acceptor has taken place following sterilization(inclusive of death during process of sterilization operation),during hospitalization or within the 7 days from the discharge of the hospital.

If dependent children are minor, the payment shall be made by the District Health Society in the name of minor children. The cheques, in this case would be issued by the District Health Society in the name of minor beneficiary with the following endorsement (overleaf);

**“Amount to be deposited as FDR in the name of minor Sh / Ku ..... till the minor attains the maturity. No premature payment of FDR is allowed. Quarterly interest may be paid to the guardian”.**

In case, there are no surviving spouse/unmarried dependent children, the claim shall then be payable to the legal heir of the deceased acceptor subject to production of legal heir certificate.

DOCUMENTS REQUIRED FOLLOWING STERILIZATION (SECTION-I-A & I-B):

- a. Claim Form cum Medical Certificate in original duly signed and stamped by the convener of QAC/CMO/CDMO/CMHO/ CDHMO/ DMO/DHO/Joint Director designated for this purpose at district level.(Annexure I)

- b. Copy of Consent Form duly attested by the convener of QAC/CMO/CDMO/CMHO/ CDHMO/DMO/DHO/ Joint Director designated for this purpose at district level. (Annexure II)
- c. Copy of Sterilization Certificate duly attested by the convener of QAC/CMO/CDMO/CMHO/ CDHMO/DMO/ DHO/Joint Director designated for this purpose at district level. .(Annexure IV)
- d. Copy of Proof of Post Operative Procedure/Discharge Certificate duly attested by the convener of QAC/ CMO/CDMO/ CMHO/CDHMO/DMO/DHO/Joint Director designated for this purpose at district level.
- e. Copy of Death certificate issued by Hospital/Municipality or authority designated duly attested by the convener of QAC/ CMO/CDMO/ CMHO/ CDHMO/DMO/DHO/Joint Director designated for this purpose at district level.

### **FAILURE OF STERILIZATION (SECTION-I-C)**

The claims under Section-I-C (Failure of Sterilization) & I-D [(Complication following Sterilization operation (inclusive of complication during process of sterilization operation))] shall be paid in the name of beneficiary.

In case of a male beneficiary who has undergone sterilization operation and motility is noticed in the semen test report after three months of sterilization operation; the designated district level officer shall process and provide compensation to the person having undergone sterilization as per the limit specified in Section I C of the schedule.

**DOCUMENTS REQUIRED FOR FAILURE OF STERILIZATION (SECTION-I-C):**

- a) Claim Form cum Medical Certificate in original duly signed and stamped by the convener of QAC/ CMO/ CDMO/ CMHO/ DMO/ DHO/Joint Director designated for this purpose at district level.(Annexure I)

- b) Copy of Consent Form duly attested by the convener of QAC/CMO/CDMO/CMHO/CDHMO/ DMO/DHO/ Joint Director designated for this purpose at district level. (Annexure II)
- c) Copy of Sterilization Certificate duly attested by the convener of QAC/CMO/CDMO/CMHO/ CDHMO/DMO/ DHO/ Joint Director designated for this purpose at district level.(Annexure IV)
- d) Copy of any of the following Diagnostic Reports confirming failure of sterilization duly attested by the convener of QAC/CMO/CDMO/CMHO/ CDHMO/ DMO/DHO/Joint Director designated for this purpose at district level.

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Female sterilization in India overwhelmingly dominates the contraceptive method mix used across the country, at a colossal 75%. In addition to this, 85% of the family planning budget is used for promoting and implementation of female sterilization through camps in rural India. Through these camps, women continue to be pushed into the procedure, often with a glaring lack of informed consent. Sterilization in India has long been used as a means of target-driven population control, disregarding the reproductive autonomy of women in favour of curbing population growth. Although the National Population Policy 2000 broke new ground in prioritizing reproductive rights over population control, the existence of sterilization camps and the rampant, disproportionate promotion of the procedure demonstrate that implementation 18 years on remains to be fully realized.

In 2015, the *Devika Biswas v Union of India* case challenged appalling sterilization camps that were taking place across the country, rounding up poor women and loading them like cattle into abandoned schools, sterilizing them in barbaric and highly unsanitary conditions, without anesthesia. These camps resulted in many deaths, and in the overwhelming majority of cases, the women did not consent to the procedure – many of them were young and in the reproductive age group of 18-39. In a landmark judgment, the Supreme Court outlawed the camps and directed various states to provide compensation to the families of the victims.

Nevertheless, sterilization in India is still problematic. Ground level health workers are heavily incentivized to encourage women to undergo the procedure, rather than promoting condom or oral contraceptive pill usage. Sterilization remains a procedure that is performed at a disproportionately high rate when compared with other nations. This book will look at sterilization through a rights-based lens, to shed light on how sterilization has been used for years as a weapon to impede reproductive autonomy and champion coercive population control tactics, at the expense of women's bodies. The book also highlights the struggle through the use of law to change the way family planning programmes especially female sterilization was being implemented

