Statement on Sterilization deaths in Chhattisgarh
National Coalition Against Two-Child Norm and Coercive Population Policies

The National Coalition Against Two-Child Norm and Coercive Population Policies is horrified at the death of 14 women who had been operated in a routine sterilization camp near Bilaspur, in Chhattisgarh. In absolute defiance of the Supreme Court orders (Ramakant Rai Vs Govt. of India, 2005 and Devika Biswas Vs Govt. of India, 2012) which prescribe that not more than 30 surgeries can be done in one day, eighty-three surgeries were conducted by one surgeon in about six hours at Takhatpur Block of Bilaspur District on 8th November 2014. The procedures were carried out at a hospital which had been shut for 15 years, and by a doctor who had 50,000 such surgeries under his belt. The women who died were young, less than 32 years of age, and several were lactating mothers. The government has announced a compensation of 4 lakh rupees for the families of the dead women, and the doctor who conducted the surgeries has been arrested. The Chhattisgarh government has even suggested that the children of the 14 women will be adopted by the state. However, these superficial measures are not sufficient to address the much greater malaise that plagues India's population policy and programs.

Bilaspur is one in a series of violations of quality of care standards in India's family planning program. Despite the fact that in 2005 the Supreme Court passed strict guidelines for the Government of India to ensure quality assurance, and to implement an Insurance Scheme to provide some measure of recompense to women in cases of complication, failures or death, studies of women's experience of family planning services have shown that quality standards continue to be poor and women suffer many complications and the rates of failure are very high. A large majority have never been even informed of the provisions of the Insurance Scheme.[1] Incidents like that in Kaparfora in Bihar (January 2012) and Manickchak in West Bengal (February 2013) which were reported widely in the press not long before the Bilaspur incident show that the camps continue to be held in blatant defiance of medical standards.[2] Following the Kaparfora incident in Bihar, another PIL was filed in the Supreme Court of India (*Devika Biswas vs. Union of India and Ors. (*W.P. (C) 81 of 2012), asking for the National Guidelines to be stringently followed and for states to submit compliance reports. The PIL cites not just the Bihar incident, but also other instances of coerced and unsafe sterilizations in Kerala, Madhya Pradesh, Maharashtra, and Rajasthan.[3] It is quite clear, therefore, that not much has changed despite the Supreme Court's order.

[1] See for instance, Jayeeta Chowdhury, Melissa Lairenlakpam and Abhijit Das "Have the Supreme Court Guidelines made a Difference? A Study of Quality of Care of Women's Sterilization in Five States" In Reaching the Unreached, 2010, Chapter 2, Page 33-54.
[2] Barrackroom Surgery in Bihar's Backwaters, The Hindu, Shoumojit Banerjee, 23rd January 2012. http://www.thehindu.com/todays-paper/tp-opinion/barrackroom-surgery-in-bihars-backwaters/article2824008.ece
[3] For more information please visit the Human Rights Law Network Website: Read more: http://www.hrln.org/hrln/reproductive-rights/pils-a-cases/884-supreme-court-issues-notices-in-public-interest-litigation-regarding-unsafe-and-unethical-sterilizations.html

The Health Minister has emphatically stated that India's family planning program does not practice coercion and does not impose targets for sterilization and other methods. In the debates and discussion following the Bilaspur incident, the government has repeatedly stated that they do not coerce women to undergo sterilization, but that the demand for sterilization is high. We must be cautious in interpreting this. The overwhelming number of women who are willing to undergo poor quality sterilization is not an indicator of informed choice but of desperation. Women today know about contraceptives and desire to get out of the perennial cycle of reproduction. However there are no other options available – or even if they are in a notional manner, the supply is not consistent. Women are going in for sterilization in large numbers because of a lack of both autonomy and of choices. When compared with urban and educated women, the use of sterilization is higher among the poorer, rural and dalit communities. State governments and district authorities have continued to provide targets for front line functionaries, including the ASHA. While officially terms like ELA or Expected Levels of Achievement are used, in practical terms the officials use the term along with threats of punitive action. The family planning programme in India is mostly driven by the female sterilization programme and this is where the targets seem to be the most at work. The data from Health and Family Welfare Statistics in India 2013 shows that percentage of tubectomies to total sterilisation perfomrd is 97.4% in the year 2012-13 (Source: HMIS Portal – Page no. 193). Incentives continue to be used for acceptors of sterilization, in the new guise of lotteries and prizes. Worse, incentives are provided to health care providers including doctors for conducting sterilization operations, which is a clear violation of informed choice.

It is important that the Bilaspur incident not be looked upon in isolation. The incident calls for an overhauling of India's family planning program, which must be reoriented to ensure voluntary adoption of family planning methods and place utmost importance on quality of care. In this light, the Coalition demands the following:

1) An independent, technically sound and comprehensive investigation of the Bilaspur incident and appropriate action at the level of the doctor, third parties and officials who sanctioned the camp.

2) Set up a committee to review the family planning program in India and reorient it such that it is aligned with reproductive health rights of women, and needs of India's population.

3) Increase the basket of choices available to women, especially that of spacing methods, at the ground level. Ensure that information is provided about various methods available in the government program to all women, with adequate information about pros and cons of each.

4) Abolition of all targets and ELAs based on demographic statistical estimates. Instead, consider 'community needs assessment' to determine the contraceptive demand and prepare the health system to fulfill this demand.

5) An immediate end to all incentives and disincentives related to sterilizations in all policies and schemes of the state and central governments

6) Move away from mass sterilization camps, to static services. All sterilization operations must be conducted in well functioning health facilities and standard operating procedures laid down by the Government of India must be followed.

7) Operationalizing of Quality Assurance Committees as laid down in the Government of India Guidelines, 2005. Routine audit of facilities must be carried out, not only an investigation when there is an adverse event. Strict action must be taken against violators of quality standards.