# Robbed of Choice and Dignity: Indian Women Dead after Mass Sterilisation

## Situational Assessment of Sterilisation Camps in Bilaspur District, Chhattisgarh

Report by a Multi-organisational Team
November, 2014

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# ACRONYMS

| Sl. No. | Abbreviation | Full Form |
|---|---|---|
| 1. | AC | Air Conditioner |
| 2. | AGCA | Advisory Group on Community Action |
| 3. | ANM | Auxiliary Nurse Midwife |
| 4. | ASHA | Accredited Social Health Activist |
| 5. | AWW | Anganwadi Worker |
| 6. | BPM | Block Programme Manager |
| 7. | CHC | Community Health Centre |
| 8. | CIMS | Chhattisgarh Institute of Medical Sciences |
| 9. | CMHO | Chief Medical Health Officer |
| 10. | DLHS | District Level Household & Facility Survey |
| 11. | DPM | District Programme Manager |
| 12. | DQAC | District Quality Assurance Committee |
| 13. | ELA | Expected Level of Achievement |
| 14. | FPAI | Family Planning Association of India |
| 15. | GOI | Government of India |
| 16. | HMIS | Health Management Information System |
| 17. | ICPD | International Conference on Population and Development |
| 18. | ICU | Intensive Care Unit |
| 19. | IEC | Information Education Communication |
| 20. | IUCD | Intra Uterine Contraceptive Device |
| 21. | IV | Intravenous |
| 22. | LHV | Lady Health Visitor |
| 23. | MBBS | Bachelor of Medicine, Bachelor of Surgery |
| 24. | MOHFW | Ministry of Health and Family Welfare |
| 25. | NGO | Non Governmental organisation |
| 26. | NHM | National Health Mission |
| 27. | NRHM | National Rural Health Mission |
| 28. | NSV | No-Scalpel Vasectomy |
| 29. | OPD | Out Patient Department |
| 30. | OT | Operation Theatre |
| 31. | PFI | Population Foundation of India |
| 32. | PHC | Primary Health Centre |
| 33. | PHC | Primary Health Centre |
| 34. | PSS | Parivar Seva Sansthan |
| 35. | RKS | Rogi Kalyan Samiti |
| 36. | RMA | Registered Medical Assistant |

# ACKNOWLEDGEMENTS

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First, we would like to express our gratitude to the affected families in the villages visited, for sharing their experience of the tragic incident. We are thankful to the staff at the Community Health Centre at Takhatpur, the Primary Health Centre at Amsena and the Mitanins who interacted with us.

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And most importantly, we are very grateful to the Ministry of Health and Family Welfare for being supportive of the team's visit, which is a sincere effort to improve the family planning services for the women of India.

**Poonam Muttreja**, Population Foundation of India

**Alok Banerjee**, Parivar Seva Sansthan

**Kalpana Apte**, Family Planning Association of India

**Subha Sri**, CommonHealth

# **EXECUTIVE** Summary

A multi-organisational fact finding team[1] travelled to Bilaspur on November 19-20, 2014 to assess the death of 16 young women and the critical condition of several others following tubectomy at a sterilisation camp in Bilaspur District, Chhattisgarh.

The objective of the visit was to assess the situation that led to the deaths, and to make concrete recommendations so as to prevent such tragic deaths of women seeking family planning services. The team met with district and state officials, visited health facilities and interacted with families of the deceased and women who had recovered. The report covers a detailed sequence of events, the action taken by authorities, treatment provided to women, an assessment of the violations and key recommendations for the state and national levels.

## Sequence of Events

Women with two or more children were motivated to get sterilized by local ANMs and Mitanins (ASHA), who also arranged to bring them to the camp sites. The women started registering for the camp from 10.30 am till 1.30pm. The Laparoscopic Surgeon started the sterilisation procedures at 3.30pm and continued till about 5 pm. A total of 83 women were operated in about one and a half hours, approximately one to one and a half minute per surgery.

As per the information provided, the same gloves, injection needle and syringe, and suture needle were used for all the cases. Only one laparascope was used, while the Ministry of Health and Family Welfare (MoHFW) guidelines prescribe three for a maximum of 30 patients.

All the women were kept in the hospital for half to one hour post procedure and then sent home with their motivators/relatives after a payment of Rs. 600/- as compensation money, as per the MoHFW compensation scheme.

## Violations:

The findings suggest a complete violation of standard protocols for performing Laparoscopic sterilisation and guidelines set by the Ministry of Health and Family Welfare, Government of India for sterilisation in camp settings. There have been violations in regard to the selection of the camp site, number of procedures performed, number of equipment/instruments used, screening and care of the women. The camp was organized in a non functional health facility, compromising the basic standard of cleanliness and care during and post procedure and basic infection prevention practices were missing at every step.

At the camp, there was complete disregard for dignity of women. The women were operated on in an assembly line fashion, with a male ward boy positioning them for surgery in a lithotomy position[2] and carrying them to the mattresses after the procedure.

[1] The team was made up of experts from Population Foundation of India, Family Planning Association of India, Common Health and Parivar Seva Sanstha.

[2] Position in which the patient is on their back with the hips and knees flexed and the thighs apart.

Interactions revealed that couples received no counselling about spacing methods. Health officials saw the family planning programme from a population control perspective rather than in a reproductive rights framework that India had affirmed to at the ICPD in 1994 and in its National Population Policy 2000.

## Other Findings:

The district administration and health officials were of the opinion that the cause of deaths was spurious medicines. However, post mortem examinations of the first seven deaths had suggested septicaemia. These indicate **death by infection** during or after the operation. **Further, according to forensic medicine and toxicology experts, the amount of zinc phosphide required to be lethal for women is 4.5 gms, which is much higher than what could possibly have been consumed by the women in 500mg of Ciprofloxacin.** This also strengthens the argument that it was not the medicines alone that caused these deaths.

Analysing the expenditure on family planning, the team points out that for the year 2013-14, **India spent Rs 396.97 crores on female sterilisation, which constitutes 85 per cent of the total expenditure.** Of this amount –Rs 324.49 crores was spent on incentives and compensation, and Rs 14.42 crores on the camps themselves. **The amount spent as compensation for female sterilisation was two-and-half times the untied grants given to PHCs for infrastructure strengthening.**

## Recommendations:

The report highlights that the Government of India must conform to its commitment of informed free choice and not imposing targets or any form of coercion in the family planning programme. The recommendations include immediate next steps that must be taken by the Chhattisgarh government to ensure high quality clinical training, setting up mechanisms to monitor quality of care, informed choice for the community and policy measures to strengthen family planning.

Some key recommendations include:

1. **Discontinue incentives for all service providers**
2. **Promote spacing methods like oral pills, condoms, IUCDs and add new methods.**
3. **Stop sterilization targets as well as sterilization in camps**
4. **Carry out family planning services on fixed days**
5. **Plan and orient all officials at the block, district and state levels on sterilization procedures and quality assurance.**
6. **Fill all posts of doctors lying vacant in the state and train more doctors in sterilization procedures in the state.**
7. **Strengthen the drug procurement policy.**

The report calls for quick corrective action, for the tragedy in Bilaspur has the potential of completely derailing the country's family planning programme.

# INTRODUCTION

The tragic death of 16 young women and the critical condition of several others following tubectomy at a sterilisation camp in Bilaspur District, Chhattisgarh has once again brought to fore the disregard for dignity of women and the dismal quality of care of India's family planning programme. In recognition of the fact that violations of standard operating procedures and guidelines prescribed by the Ministry of Health and Family Welfare (MOHFW) are not limited to Bilaspur or Chhattisgarh, but are a grave concern across the country, a multi-organisational fact finding team travelled to Bilaspur on November 19-20, 2014 to assess the situation and recommend corrective actions at national and state levels.

The Family Planning Programme is one of the oldest components of India's health care system and has received focused attention over the last five decades. However, it has remained primarily a programme of controlling numbers rather than focussed on reproductive and human rights that India had affirmed at the International Conference on Population and Development (ICPD) in 1994 and in its National Population Policy 2000. As signatory of the ICPD Program Of Action[3] India committed to the principle of informed free choice as essential to the long-term success of family-planning programmes where any form of coercion has no part to play. [...] Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients. (Para 7.12).

It is encouraging to note that as chair of Partners in Population and Development, India recently reaffirmed the commitment to the 1994 ICPD Programme of Action in the Delhi Declaration following the 'International Inter-ministerial Conference on Investing in Demographic Dividend' on November 26, 2014. However, the family planning programme in India has yet to conform to the principles agreed to under ICPD, especially in terms of doing away with targets and incentives. The quality of family planning services ranges from low to abysmally poor. Quality parameters include choice of method, dignity and comfort, privacy and confidentiality, safety of procedure, follow up and referral services as well as space for feedback. While the National Guidelines reflect almost all these components, in reality, most of these parameters are compromised.

The contraceptive choices available in the public sector have remained static over two decades. The choices available through the national programme are limited to: Oral Pills, Condoms, the Intra Uterine Contraceptive Device (IUCD) and Female Sterilisation. Non – Scalpel Vasectomy, though a part of the basket of choice remains under utilized. Moreover, supplies are irregular and users are forced to adopt provider-based methods like female sterilisation and at times the IUCD.

Family planning programme being embedded in the larger health care programme, typically differs across states and reflects the strength or weakness of the particular state level health care system. Unfortunately, it remains a number and incentive driven programme and not a demand driven programme. The demand for sterilization services exists, but it is essentially a false demand as there are neither other long term suitable options available on a regular basis nor is there adequate access to information and counselling on all aspects related to sterilization.

[3] http://www.un.org/popin/icpd/conference/offeng/poa.html

In the Financial Year 2013-2014, India spent Rs 396.97 crores[4] for Family Planning. Female sterilisation constituted 85% of the total Family Planning expenditure (for a total of 39,23,945 female sterilisations). Approximately 1.45% (Rs 5.76 crores) was spent on spacing methods, leaving the remaining 13% for other family planning related activities (like equipment, transportation, IEC, staff expenses, etc.).

## **OBJECTIVE** of the visit

The objective of the visit was to assess the situation that led to the deaths, and to make concrete recommendations so as to prevent such tragic deaths of women seeking family planning services. The team specifically aimed to assess:

- All aspects of quality of care for family planning – both in camp settings as well as static/fixed day services (community perspectives, service provision perspective, monitoring/supervision and accountability)
- Identify systemic gaps at each level that may need to be addressed in order to ensure quality of care in family planning services (community, sub-centre, PHC, district and state levels)

## **TEAM** Members

The fact finding team included the following members:

- Ms Poonam Muttreja, Executive Director, Population Foundation of India (PFI)
- Dr Alok Banerjee, Technical Advisor, Parivar Seva Sansthan (PSS)
- Dr Kalpana Apte, Assistant Secretary General, Family Planning Association of India (FPAI)
- Dr Subha Sri, Member, Common Health
- Ms Sona Sharma, Joint-Director- Advocacy and Communication, PFI
- Mr Bijit Roy, Programme Manager-Community Action and Scaling Up, PFI

## **METHODOLOGY** of Assessment

1. Discussion with State Government Officials: Mission Director, National Health Mission (NHM); District Administrators (Divisional Commissioner and Collector); Programme Managers (Chief Medical and Health Officer - CMHO, District Programme Manager - DPM & Block Programme Manager - BPM);
2. Discussion with Medical Personnel: Superintendents of the hospitals(District Hospital, Chhattisgarh Institute of Medical Sciences - CIMS and Apollo) where the women were treated; Staff of Community Health Centre (CHC)and Primary Health Centre (PHC), visited and peripheral health care workers including the Auxilliary Nurse Midwife(ANM)and the Mitanin[5].

[4] This calculation is based on NRHM and RCH expenditures of all states for the year 2013-14

[5] Mitanin: The ASHA in Chhattisgarh is called a Mitanin

3. Visit to the facilities: CHC – Takhatpur, PHC – Amsena, and the Nemi Chand Jain Charitable Hospital – where the sterilisation camp was held.

4. Visit to the residences of women in Takhatpur block : Three families of women who died and two women who had comeback after recovery.

# **FINDINGS** of the visit

Based on the discussion with personnel at different levels, the following facts were obtained on the family planning camps organized for female sterilisation at the four sites –

## 1. Sequence of events:

1. On November 8 (Saturday), 2014 at Takhatpur Block in Sakri at Nemi Chand Jain hospital - 83 women underwent sterilisation through laparoscopic tubectomy.

2. On November 10 (Monday), 2014, camps were organised in Gaurella block at three PHC sites— Gaurella, Marwahi and Pendra where 23, 16 & 15 women were operated respectively (total 54).

Post procedure all clients were given one strip each of an antibiotic - Ciprofloxacin 500 mg in capsules, and a pain reliever - Ibuprofen tablets with the instructions to consume one tablet of each medicine twice daily, once they got home.

As per the information provided by the officials some of the women started vomiting from Saturday night itself. The discomfort increased gradually and was then associated with burning in throat, pain in abdomen and breathing problems in some. These women first contacted their Mitanin (community health worker)&the ANM. Some of them were given an antiemetic drug, but when their vomiting did not stop, these women were taken to the district hospital where very low blood pressure was recorded for all of them.

To start with three women went to the district hospital on Sunday (November 9), out of whom two died. Subsequently, more women went to the district hospital on the same day with similar symptoms. Sensing the gravity of the situation, some women were shifted to CIMS[6], a government-run tertiary care medical institute. Apollo hospital was also contacted for ICU support for women in critical condition. By Monday night and Tuesday (November 10 and 11) more women became seriously ill, and some more died due to irreversible shock.

The district administration took a quick decision on Monday evening to reach out to all women who had undergone sterilisation in the four camps and bring them in for a check up. Ambulances were sent to all villages and the ANMs and Mitanins along with the Patwaris and Rojgar Sahayaks brought the women to various hospitals. The government provided support and resources to increase the number of beds and Intensive Care Unit (ICU) facilities at Apollo hospital (additional 28 beds) along with their existing ICU facility to cater to serious patients needing intensive care.

Doctors treating the women at all the three hospitals (District Hospital, CIMS and Apollo) informed us that the symptoms and signs in all the women (who had taken Ciprofloxacin - both laproscopic sterilisation cases and few others who had throat/chest infection) were due to “some problem with the drugs”. However at

[6] Chhattisgarh Institute of Medical Sciences

Apollo hospital, **a few cases showed raised levels of *Pro calcitonin* that suggest septicaemia (a life-threatening bacterial infection), and indicating that the women may have had an infection during or after their operation.**

Discussion with the doctor who conducted the post mortem examination at CIMS & the District Hospital on the first seven death cases, **revealed that there was evidence of peritonitis with fluid in peritoneal and pleural cavity, and septic foci in the lungs and kidneys, suggesting sepsis leading to septicaemia.**

In an attempt to identify the cause of the deaths, the administration sought the list of drugs provided to the women post sterilisation in all four camps. Four drugs were common in the list – Diazepam, Ibuprofen and Ciprofloxacin, and Povidine Iodine for external application. Based on the symptoms seen in the affected women, they zeroed in on two drugs – Ibuprofen and Ciprofloxacin. Of these, the Ibuprofen tablets were manufactured in 2013 and were in circulation for some time, whereas the Ciprofloxacin was manufactured in October 2014. Samples of these drugs were sent to various laboratories in Raipur, Kolkata, Delhi, Pune and in some private laboratories for analysis. Preliminary testing confirmed the presence of some toxin in the samples of Ciprofloxacin. However, whether it was Zinc Phosphide as suspected by the doctors and whether lethal amounts were present in the drug, has yet to be established. Some doctors also observed that conditions such as renal (kidney) failure observed in certain women were not a reaction of Zinc Phosphide. Further, according to Forensic Medicine and Toxicology experts, an adult male needs to consume 5 gm of zinc phosphide to die. For average adult woman, this would be 4.5 gm. This, if consumed in one go or slowly over a period whereby it gets 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 500 mg was zinc phosphide, a woman would need to consume a minimum of nine tablets to make the poison fatal, which was not the case with the women who died. So it is amply clear that zinc phosphide in the medicines could not have been the major cause of these deaths, even if we accept that they could have been one of the causes.

In total, 16 lives were lost in this catastrophe. However, it has to be acknowledged that due to quick action by the District Administration to admit all the women who had undergone sterilisation procedures on November 8 and 10, 2014, at the three hospitals for close monitoring of their condition and treatment, many more deaths were possibly averted. The District administration also continued monitoring all women through home visits by a medical team daily for one week following their discharge from the hospital. They will be further assessed with kidney function tests, ECG etc. after one week at the hospital.

The state government has given cheques of Rs. 4,00,000/- to the next kin of the deceased and fixed deposits of Rs. 2,00,000/- for each child in the family. In addition, free education and health care will be provided by the state for the children who lost their mothers.

## 2. Steps followed in Laparoscopic Sterilisation camp on November 8, 2014:

The chronology of actual steps followed during the camps as revealed from discussion with the health care providers involved at the Nemi Chand Jain Hospital camp on November 8, 2014, are as follows –

If the protocols set by the Government of India were to be followed, for a camp with 83 clients three teams are required.

Each team would constitute of three staff in the Operating Room – one lapro surgeon; one OT assistant and one nurse. In addition, the local health centre should have two doctors (including one lady medical officer), four staff nurses, one ANM and two attendants would be required.

The staff involved in the camp were: Four medical officers including two MBBS doctors and two Registered Medical Assistants responsible for general screening of the women and their selection for the sterilisation procedure; Two Staff Nurses (from PHC-Amsena and Takhatpur) to assist in the Operation Theatre; Two ANMs (one each from PHC-Amsena and a nearby Sub Centre) to give pre-medication and inject local anaesthesia outside the OT; Two dressers(from PHC) to stitch the wound after the procedure; Two ward boys (from two PHCs) to bring the cases inside OT, position them on the OT table and shift them after the procedure. A number of ANMs and Mitanins from the field were also present at the hospital as motivators. The Laparoscopic surgeon came with one OT assistant.

Women with two or more children were motivated to get sterilized mostly by local ANMs and Mitanins (ASHA), who also arranged to bring them to the camp sites. The transportation cost to the hospital and back in private vehicles was borne by the women themselves.

The women started coming in for registration in the camp from 10.30 am onwards till 1.30pm. All women were screened by the Registered Medical Assistants, and laboratory tests were done for haemoglobin levels and sugar in the urine. All women after check up were given pre-medication drugs at around 2pm by ANM and made to lie down on mattresses spread on the floor, as there were no beds at Nemi Chand Jain Hospital). To a query by the team about the fumigation procedures followed, the reply was, "Yes fumigation was done. The sweeper cleaned the walls with a mop."

As per Infection Prevention Protocols:

In a running OT (such as in a CHC / District Hospital) fumigation is not recommended under infection prevention practices. The recommendation is mechanical cleaning of OT with plain water followed by swabbing of OT with 0.5% chlorine solution.

However, in case the OT is not in use for several weeks / months (as in the case of Nemi Chand Jain Hospital), or in the case of a new OT then the steps for fumigation practices are:

- Make fumes by burning formaldehyde tablets and seal all outlets. The OT has to be kept closed for 48hrs
- After 48hrs the OT has to be opened and then liquid ammonia should be burnt, then only is the fumigation practice complete.

The Laparoscopic Surgeon with his OT Assistant arrived at the venue around 3 pm (this was also corroborated by family members of the women present at the site) and started the sterilisation procedures at 3.30pm and continued till about 5 pm. A total of 83 women were thus operated in about one and a half hours, approximately one to one and a half minute per surgery. The prescribed standards would take an average of 5-6 min per case, with three laparoscopes. After each surgery the laparoscope has to be sterilized with high level disinfection which would take approx. 20 min (first swabbing with spirit for decontamination, then dipped in Cidex solution for 20 min, followed by immersing it in sterilized/ boiling water) for reuse.

Two operating tables were used inside the OT, which were positioned in 45 degree angled Trendelenburg position[7]. Two nurses were stationed at the two tables and the Surgeon's OT Assistant kept the Laparoscopic equipment in between the two tables.

[7] Trendelenburg position: a position of the body for medical examination or operation in which the patient is placed head down on a table inclined at about 45 degrees from the floor with the knees uppermost and the legs hanging over the end of the table. http://www.merriam-webster.com/medical/trendelenburg%20position

Just outside the OT, probably on a bed/ floor mattress, local anaesthetic injection (Lignocaine) was administered by one ANM on the women prior to sending them inside the OT. The ward boy accompanied the women, and positioned them on the OT table.

The nurse cleaned the navel region of the abdomen with a spirit swab and put a draping sheet with a central hole. The incision around naval region is done by the OT Assistant/dressor; the Surgeon then introduces the Trochar[8] inside the abdomen and then the Laparoscope[9] with the Ring applicator together for tubal occlusion. Pneumoperitoneum (introduction of gas inside the abdomen) was not done except in three cases using atmospheric air (where difficulty was faced in identifying the tubes). After the tubal occlusion was done on both sides, the laparoscope was taken out and the wound stitched with cotton thread by the PHC dresser. The women were then shifted by the Ward boy on to the mattress placed on the floor in the corridor in front of the OT.

As per the information provided to the team, none of the staff changed their hand gloves in between the procedures. The same injection needle and syringe, and the suture needle were used for all the cases. Neither were those sterilized nor new needles taken for each case. The laparoscope after the procedure on each woman, was cleaned by dipping into a big tray containing warm water and betadine, and cleaning with a dry gauze piece before using in next case. Only one laparascope was used, while the Ministry of Health and Family Welfare (MoHFW) guidelines prescribe three for a maximum of 30 patients.

Through meticulously arranged duties for each staff member, the Surgeon performed each procedure without adhering to any degree of Infection Prevention practices and quality of care procedures. The Laparoscopic surgeon did not check any of the women before or after the procedure. After completing the cases, the Surgeon put his signature on the client's case sheets and left.

All the women were kept in the hospital for half to one hour post procedure and then sent home with their motivators/relatives after a payment of Rs. 600/- as compensation money, as per the MoHFW compensation scheme. The post procedure check up was not done by any doctor or nurse. The post procedure instructions and drug packets were given by the ANM/Mitanin to the women once they reached home.

## 3. Medical Treatment to Women following Post Sterilisation Complications

Within 12 to 24 hours, a majority of the sterilized women developed complications manifested as repeated vomiting, burning in throat, pain in upper abdomen and giddiness, and also a rapid fall in blood pressure.

As informed by the officials at the District Hospital, the initial treatment started with IV fluid administration with 5% Glucose saline, antiemetic drug injection, vasopressor drugs[10] like injection adrenaline and steroid Injection Hydrocortisone and oxygen inhalation. These medications could not control the crisis of shock and the women started developing pulmonary oedema (collection of fluid inside lungs). Because of this – IV fluid administration was restricted, and they were given more doses of Injection Hydrocortisone and Cortisone as also Diuretic Injections (Lasix) and a broad spectrum antibiotic (Injection Meropenem 1 gm IV).

[8] Trochar: a sharp-pointed surgical instrument fitted with a cannula and used especially to insert the cannula into a body cavity as a drainage outlet. http://www.merriam-webster.com/dictionary/trocar

[9] Laparoscope: a fiberoptic instrument inserted through an incision in the abdominal wall and used to examine visually the interior of the peritoneal cavity http://www.merriam-webster.com/dictionary/laparoscope

[10] A drug used to raise blood pressure

Women in a critical condition were sent to CIMS and Apollo hospital at Bilaspur for advance life support and care. At the CIMS and Apollo hospital the women were treated with restricted & controlled IV Fluid infusion mainly with Ringer Lactate solution, Injection of Adrenaline & Nor adrenaline, Dopamine, steroids and broad spectrum antibiotics like Injection Vancomycin, Injection Meropenem and Metrogyl as well as oxygen. Majority of the women needed ICU care at both the hospitals and about 30 women were put on ventilator support to maintain their respiration. In 8 to 10 women, dialysis was also carried out, to manage acute renal failure.

No antidote or chelating agent was administered to any of the woman at the three hospitals.

## 4. Findings on other Issues:

### i. Adherence to Standard Protocols/Guidelines, Quality Assurance Norms:

The findings suggest a complete violation of standard protocols for performing Laparoscopic sterilisation and guidelines set by the Ministry of Health and Family Welfare, Government of India for sterilisation in camp settings. There have been violations in regard to the selection of the camp site, number of procedures performed, number of equipment/instruments used, screening and care of the women. The camp was organized in a non functional health facility, compromising the basic standard of cleanliness and care during and post procedure.

Although the surgeon was a competent Laparoscopic Surgeon, the support staff seemed to be untrained. The basic Infection Prevention practices were also missing at every step.

**It is also to be noted here that the very design of the family planning programme, and its implementation, especially the camp approach in its present form are not conducive to maintaining quality standards.** This is substantiated by the following:

- Male sterilisation, which is technically easier and safer as compared to female sterilisation, is not adequately promoted by the government. Instead, there is an undue emphasis on female sterilisation as the figures show. Similarly, temporary methods are not promoted and there is a big gap in provision of services.
- Even in female sterilisation, the technically easier mini-laparotomy surgeries are not promoted. Instead, the technically more difficult laparoscopic sterilisation that also has a higher failure rate is what is being promoted.
- Very few surgeons in each district are trained in laparoscopic sterilisation and possibly none in Minilap tubectomy procedure. This leaves a situation where there are not enough trained surgeons to meet the demand.
- As the existing health infrastructure is not adequate to meet the demand, sterilisation camps as the one described above are organised in conditions that are not conducive to maintaining quality.
- Only one laparoscope is issued per surgeon while the guidelines state that at least three must be used for sterilisation procedure on a maximum of 30 women per camp.
- Supervision and monitoring mechanisms to monitor quality are not in place.

- Instead of focusing on quality, providers are assessed and incentivized based on the number of surgeries they perform. This creates conditions where providers prioritize numbers over quality.

None of the staff met by the team had any knowledge about various documents of Government of India such as *Standard Operating Procedures for Sterilisation in Camps, Guidelines for Laparoscopic Sterilisation Procedure, Guidelines for Camp Services for Sterilisation*, and the Quality Assurance Manual. Although some of the Programme Managers mentioned that they have heard of these documents, they had not seen them.

All elements of quality of care were missing in these camps. The district had no functional District Quality Assurance Committee (DQAC).It was mentioned that the committee had been formed only a few months ago. Therefore there was no quality check on the services provided at the static facilities and camp settings. Due to the paucity of trained and competent Laparoscopic Sterilisation and Minilap Surgeons in the district, fixed day services are not being provided at all, even at the district hospitals. Only three Surgeons trained in Laparoscopic Sterilisation (of which one has retired from Government service) are available in entire district. Therefore sterilisation services are being provided through camps.

Although the District Administrators and Programme Managers categorically stated that no targets were set for the staff, the team found that the peripheral level staff is pressurised to meet targets, particularly for female sterilisation. Information gathered by the team revealed that at Takhatpur Block, each PHC which covers about 35,000 population with four sub-centres, a target of seven sterilisations for every 1000 population is set. Thus a target of about 250 sterilisations has been given to a PHC and Sub-centre staff for the year 2014-15. If the target is not achieved, the staff is threatened and, in some cases, their salaries and increments are withheld. However, the team was informed that there were no targets for spacing methods because of irregular supply and non availability of trained persons to insert IUCDs.

The sterilisation camps are organized every year during the four winter months. In addition to the rush to achieve the targeted number of sterilisations, with funds being released only in October, there is also a pressure to increase fund utilization in the remaining few months of the financial year.

**ii. Women's Rights:**

Discussion with the peripheral level staff (ANM, Mitanin, AWW) revealed that women had no say in choosing their family size, contraceptive use, spacing of children etc.

It was gathered that the family planning programme in Bilaspur district is primarily sterilisation driven (mainly female) in order to reduce the unmet need of about 14% for permanent methods[11]. The ANM and Mitanin mentioned that though they talk about spacing methods like oral pills and the condom to those who have only one child or are newly married, the acceptance rate is very low. Also, regular supplies were an issue. The Mitanins, the team interacted with, did not stock temporary contraceptives. They informed that women who have two or more children are motivated to undergo sterilisation, and the compensation money is an attraction.

[11] DLHS 2007-08

At the camp, there was complete disregard for dignity of women. The women were operated on in an assembly line fashion, with a male ward boy positioning them for surgery in a lithotomy position[12] and carrying them to the mattresses after the procedure. They had no beds to lie on, and were sent home soon after surgery with utter disregard to their health.

Interactions with community members revealed that the Mitanins/ANMs had not counselled the women or men about spacing methods. The families that the team spoke to were not even aware of the contraceptive choices available. Even in the camp there was no option/provision for other methods of contraception. One Mitanin inadvertently revealed that IUCDs are being inserted post delivery in the public sector health facilities, sometimes even without prior consent. The women are informed later on that an IUCD has been inserted, which is a gross violation of their rights.

Discussion with some of the sterilised women who had recovered, revealed that there was no element of counselling and informed consent at the sterilisation camp. The women were asked to sign or put a thumb impression on the consent form, without being given any information on what was mentioned in the form. To quote one woman – *Bataya nahi gaya lekin jaise school ke dakhile ke liye form jama karte hein.. uspar dastakhat karte hein.. vaise hi hoga kuch..* (We were not told what is in the form but just as we sign for admission in school, it must be similar to that). None of the women were told about the procedure, what was to be done, what the potential side-effects could be, and what to do after the procedure. Even the post procedure instruction sheets with drug packets were given to the motivators accompanying the women.

The above facts clearly disclose a total violation of women's rights, especially the right to informed choice and voluntary access to contraception.

**iii. Status of Health Systems:**

Discussions with District Administrators, Programme Managers and various levels of service providers revealed that Family Planning is an isolated entity in the overall public health services. It runs as a vertical programme managed by the Chief Medical Health Officer (CMHO) of the district. There is no inter-departmental co-ordination even within the department of Obstetrics and Gynaecology. All the staff in the ObGyn department felt that family planning is a burden on them and so very few of them participate in any skill training. Therefore there exists an acute shortage of trained/ competent providers to deliver quality family planning services. Further, there is also an overall shortage of staff and a number of positions are lying vacant as detailed in Annexure I. The service providers starting from doctors down to the ANM are not adequately trained on various contraceptive methods, particularly about available options, their effectiveness, how to handle common side effects/problems and the skills to counsel and deliver family planning services. Absent or inadequate initial training on family planning among various levels of service providers makes them less confident in service delivery.

The lack of trained /competent service providers compounded with inadequate infrastructural facility and lack of equipment/instruments, restrict the provision of regular family planning services at the district hospital. The superintendent of the District Hospital categorically stated that providing one day fixed sterilization services would jeopardize the regular surgeries/procedures in the operation theatre (OT) in the hospital as there is only one OT available. Therefore, unless an additional OT is built, fixed day services cannot be provided at the hospital on a regular basis.

[12] Position in which the patient is on their back with the hips and knees flexed and the thighs apart

However, contrary to the reasoning provided by the officials, the team observed from records available at the PHC and CHC, that the OT is unutilized on many days in the month, including the day the operations were conducted in Nemi Chand Jain Hospital on November, 8, 2014. So it should be feasible to prepare a roster for the OT, wherein the fixed day services for family planning can be built-in.

Moreover, the District Hospital has no laparoscope. The three trained surgeons have been provided one laparoscope each by the CMHO and these are kept in each doctor's custody. So even if more doctors are trained, they will not be able to provide laparoscopic sterilization services with the present set of resources.

There is also no assured supply chain management, which leads to periodic breaks in supply and frequent stock out of spacing methods of contraceptives (e.g. oral pills, condoms, IUCDs). The discontinuation of supply creates problems for the service providers as well as the users for spacing methods. Thus the peripheral level service providers also find the permanent method an easy way out, and the officials are convinced that a camp mode is the only alternative to achieve the targets given that the health infrastructure is inadequate for regular services.

The monitoring and supportive supervision at all levels was found to be non-existent. The only monitoring of family planning services is done through monthly meetings, and even in these, the focus is entirely on targets vs achievement. The supervisory visits from district, block or PHC level during service delivery were found to be almost non-existent. The District Quality Assurance Committee (DQAC), was formed recently and the members have not been oriented on their roles and responsibilities, and activities to be carried out, including quality assessment in camp settings. The officials did not seem to be aware of the reporting requirements by a DQAC[13].

**iv. Response from the Administration:**

Officials in the District Administration shared that though they are responsible for overall public health care, they are not directly involved in the implementation of the family planning programme which is the responsibility of the CMHO. The District and Block Programme Managers had heard about GoI Quality Assurance Manual and Sterilisation Standards, but they had not seen the documents. However, based on the GoI directives the DQAC had been formed recently to monitor the quality of family planning service delivery in the district.

In response to the tragic death of women in the sterilisation camps at Takhatpur Block, the district administrators agreed that there had been violations of the Government of India standards and norms for camp services as with the quality control of the drugs. They were of the opinion that the cause of deaths was spurious drugs (Ciprofloxacin) containing Zinc Phosphate and that there had been no problem with the sterilization procedure per se.

Following two deaths on November 9 (Sunday) night, and few more on November 10 (Monday) morning, the district administrators took preventive steps to bring all the operated upon women back to the hospital for constant monitoring. Apart from District Hospital at Bilaspur, the services of Chhattisgarh Institute of Medical Sciences (CIMS) were also taken for management of serious cases.

[13] As per the Quality Assurance Manual, the District QAC should review the autopsy and other reports, discuss the findings, conduct a field investigation, and make recommendations for corrective action. The District QAC should then complete the Death Audit Report.

Later on, to handle more critical cases that required ventilator and ICU support, Apollo hospital at Bilaspur was contracted. The ICU facilities at the hospital were strengthened with supply of required equipment and other supplies. Necessary care and support was provided not only for the women, but also to their family members who accompanied them. The Government of Chhattisgarh has borne all the expenses towards treatment and further care of the women. The women who survived and have been discharged are being followed up daily by the doctors from PHC through home visits and will be called to the hospital after one week for further assessment.

A committee headed by the District Collector has been constituted to monitor the services, the progress of each woman, care and support to the families, especially the orphaned children, and further follow up. The District Programme Officer, Women and Child Development, District Education Officer and CMHO are members of this committee. The members will meet regularly to monitor the well being of the children till they reach 18 years of age.

### v. Community Interaction and their Response:

Interaction with the relatives of three deceased women and two women who returned home after treatment revealed that the women had gone to the family planning camp voluntarily as they did not want any more children. However, this choice was made in a situation when no other option was available to them to limit their family size, and this was the only method known to them. They had either approached the Mitanin themselves or had been told by her of the method and were informed of the camp a few days before it took place.

Family members of one of the deceased women with the two month old infant

The women went to the camp with the Mitanin of the area by paying Rs. 400 each way. The cost was shared by two to three women. At the camp, they had to wait for four to five hours for the procedure. No counselling was done at the camp site and no other family planning method option was given to them. The screening included history of the last menstrual period, pregnancy test and recording of blood pressure. Blood and urine tests were also done. After the procedure, they were made to lie on mattresses on the floor(two women on each mattress) for about half an hour, then sent home with the Mitanin. They received Rs. 600 in cash as compensation money for the sterilisation before they left, as per the Ministry of Health and Family Welfare's Compensation Scheme.

Survivor with family members

All of them blamed the medicines as the cause of the problem as this was the prevalent discourse in the media and among the providers. None of the families of the deceased had the post mortem reports. While, the post mortems had been done, the reports were not given to the families.

The three deceased women, whose families the team met, have left behind very young infants – one, two and three months old. They all had older children under five years of age. The families were worried about how to bring up these children. One grandmother asked for a government job for the son. *"Hum garib ko paisa dene se kya fayada – usse zindagi to nahi vaapas aayegi. Paisa to chala jayega, in bachchon ka paalan poshan kaise karenge?"* (What is the use of giving us poor people money – it will not bring her life back. Money will get spent (on other things), how will we bring up these children?)

As confirmed by family members and women the team met, sterilisation was the first modern method of contraception they had used.

**vi. Interaction and Response from State/District health officials:**

Both State and District health officials stated that 137 women were sterilised at four different camps – one at Takhatpur block and three at Gourella block. Sixteen died following the sterilisation procedure. Women sterilised in all the four camps were brought in and admitted to three different hospitals in Bilaspur (District Hospital, CIMS and Apollo hospital). Six more persons (one man and five women) who were not part of the family planning camps had also died following the intake of Ciprofloxacin, prescribed as treatment for their medical ailment by private doctors. They had thus come to the conclusion that spurious drugs were the root cause for all these deaths. According to them, it was mostly women who were younger in age, malnourished and underweight who had died. They associated the chronology of deaths with the intake of medicines.

However, post-mortem reports accessed by the team revealed that the cause of death for three of these persons was not linked to poisoning.

They said the sterilisation camp was the most common delivery mode used in rural areas as women do not want to travel long distances.

There were also contradictory statements on the responsibility for selection of camp sites. The district officials said the selection of sites was done by the Block Medical Officer based on the prescribed standards, which the CMHO had approved. However, block level officials claimed that these decisions were taken entirely by the CMHO's office. The block officials had no information on the contractual arrangements for provision of sterilisation services at the Nemi Chand Jain hospital.

Further, it was explained that as there were only three laparoscopic surgeons in the district, fixed day services cannot be provided on a regular basis. However they agreed that all standards should be adhered to in the camps as laid down in the guidelines, which was not done. The District Quality Assurance Committee formed only a few months ago needs to be made functional as per the GOI Quality Assurance guidelines. There is need for proper training and supportive supervision which is lacking in the state. The existing District Hospital with 100 beds has only one Operation Theatre and a paucity of service providers.

The state and district health officials emphasised on the need to strengthen soft skills (such as counselling and inter personal communication) and technical training on IUCD and sterilization procedure for doctors, nurses and the paramedical support staff. Training was also required for infection prevention practices. The focus was on female sterilisation as men do not come forward for vasectomy and the acceptance of spacing methods is very low. There are issues of irregular supplies. Although efforts are made to promote interval and Post-Partum IUCD, the acceptance is poor because of prevalent myths and misconceptions regarding these methods.

Though there is a strong focus on providing female sterilisation, a similar focus does not exist for making spacing methods available. Although, Mitanins are supposed to have oral pills and condoms in their kits, these are not available with them due to irregular supply issues. In a situation where a majority of women access sterilisation as their first and only method of contraception, the lack of choice and access to spacing methods like oral pills, condoms, and long acting reversible methods like IUCD and Injectables is a huge gap. Particularly, when these methods do not require operative interventions, and can be provided by trained mid-level providers and can be easily followed up at the sub-centre or PHC level.

Between 2009-2012, 707 women had died in the country because of botched sterilisation procedures, as reported in the Lok Sabha[14]. There is no record of deaths from other contraceptive methods.

There was complete denial about setting targets from the top level. It was explained that for budgetary purpose, the expected level of achievement (ELA) has been worked out at the state level based on the previous year's utilisation of funds for various family planning methods, which is then distributed to all the districts and blocks for compliance. According to the health officials, no punitive action is taken against the staff for not meeting the desired numbers.

Interactions with health officials revealed that the officials saw the family planning programme from a population control perspective rather than in a reproductive rights framework that India had affirmed to at the ICPD in 1994 and in its National Population Policy 2000. This has resulted in the health system focusing on numbers and targets rather than on women's needs and quality provision of services."

ICPD Program of Action:

7.12 Informed free choice being essential to the long-term success of family-planning programmes. Any form of coercion has no part to play. [...] Governmental goals for family planning should be defined in terms of unmet needs for information and services. Demographic goals, while legitimately the subject of government development strategies, should not be imposed on family-planning providers in the form of targets or quotas for the recruitment of clients

7.13 highlighted how investing in quality of family-planning programmes is often directly related to the level and continuity of contraceptive use and to the growth in demand for services. "Family-planning programmes work best when they are part of or linked to broader reproductive health programmes that address closely related health needs and when women are fully involved in the design, provision, management and evaluate on of services".

[14] As reported by Times of India on November 16, 2014

Regarding procurement of drugs, the officials informed that most drugs were supplied by the state to all districts. It was only when the state was unable to procure specific drugs, that the districts were given flexibility to procure them at the local level. In this case the drug (Ciprofloxacin) was supplied by M/S Mahawar Pharmaceutical Co. All capsules of the batch in circulation were confiscated and sent for testing at various laboratories for analysis and toxicity study. They felt there is need for strict quality control measures on drugs manufacturing – not only for efficacy but also toxicity and lethality. As per newspaper reports, "On March 21, 2012, Health Minister Amar Agarwal had informed the State Assembly that the company had been found guilty of selling "duplicate generic drugs" and that "a case was registered against it on February 2, 2012 in the court of Chief Judicial Magistrate Raipur."[15] Records reveal that seven medicines supplied by this company had been banned by the state government for various reasons over different periods of time. This has not been denied by the Government.

The team could not meet the surgeon, Dr R K Gupta who conducted the 83 sterilizations, as he was in jail. However, his last statement before the arrest to the media cited administration pressure to meet targets.[16]

## 5. Visit to Facilities:

**(a) Community Health Centre,Takhatpur -** It has good infrastructure, has one OT, labour room and 17 beds (8 in male ward, 7 in female ward and 2 in the labour room). While most of the support staff positions are filled, the position of four Specialist doctors and one Medical Officer have been lying vacant since the inception of NRHM. Therefore, no specialised services are being provided. The staff in place includes one Nursing Sister, 11 staff nurses, 2 LHVs, 2 Pharmacists, 2 Lab Technicians and one Radiographer. The detailed staffing position is enclosed as Annexure I.


[15] http://indianexpress.com/article/india/india-others/chhattisgarh-sterilisation-tragedy-pharma-firm-was-blacklisted-2-yrs-ago-govt-still-bought-drugs-from-it/#sthash.eBrfuW5K.dpuf

[16] http://www.ndtv.com/article/india/chhattisgarh-sterilisation-deaths-doctor-arrested-alleges-pressure-to-meet-targets-620217

The facility provides curative care for general ailments, medical problems like hypertension, diabetes, asthma and other chest problems, ante natal check up, delivery services, post natal care; immunization for children and pregnant women; delivery of contraceptive methods – rarely spacing methods, but organizes Laparoscopic Sterilization camps (on an average 2-3 camps per quarter); laboratory services like blood test for malaria, HIV, sugar and sometimes Hb% estimation, sputum exam for tuberculosis.

The laparoscopic sterilisations are usually done in a camp mode by visiting surgeons from the district. Three to four camps are held in a month. This Takhatpur Block centre has been given a target of 2121 cases for sterilisation (1800 for female sterilisation& 321 for male sterilisation) for 2014-15 by the CMHO. The numbers are further divided among 39 sub-centres, with 60 cases for the year amongst the female & male health workers. The details of laparoscopic tubectomy camps organized in Takhatpur in the current Final Year 2014-15 is enclosed for reference in **Annexure-2.**

As the centre has no counsellor, the client gets no information on spacing methods. The centre has three Medical Officers, one Medical Officer in Charge, one Lady Medical Officer, two RMAs, one nursing sister and one staff nurse, one Lab Technician, and supporting staff.

**(b) Primary Health Centre, Amsena** – The infrastructure is very poor. It has only two beds, a non-functional OT, one small labour room with one bed. The staff mentioned that most of the equipment present there was brought in only after the tragedy. The toilets have never been used and are choked with rubble. There is no running water available. There are nine full time staff – one Registered Medical Assistant (RMA), one staff nurse, one ANM, Dressor, Ophthalmic Assistant, Data Entry cum Accountant, Pharmacist, Lab Technician and a Sweeper. Most of the staff do not reside at the PHC and travel to and fro from Bilaspur every day. The Medical Officer in Charge is on study leave. Deliveries, which are rarely conducted at the facility, are mostly assisted by the traditional dai. The staff nurse provides support only in case there are any complications. No family planning services are provided, and no stock of any contraceptives was found at the PHC. The staff at the PHC had no idea of the Rogi Kalyan Samiti (Jeevan Deep Samiti) and its roles. In spite of queries, they were unable to show any records of the RKS meetings or recollect any discussions.


Labour Room


Unused Autoclave

Most of the infrastructure and equipment lies in a dilapidated condition, mostly unused. For example, five Shoulder Wheels (equipments for arm exercise) procured for distribution to the sub-health centres, two operation theatre lights, two deep freezers and one autoclave were lying unused. Similarly, while there is a full time laboratory technician, the equipment and slides seem to be unused.

The facility provides curative care for minor ailments like fever, cough/cold, gastroenteritis, skin problems; ante natal check up and post natal care; delivery services; immunisation for children and

pregnant mothers; periodic eye check up camps; and laboratory services like blood test for malaria and sometimes Hb% estimation. Delivery of spacing methods is rare. However, the OPD records showed that only around 10-15 patients were coming to the centre daily. The RMA and the staff nurse were attending to these cases. One of the staff members said, *"Hum to yahan baith ke bekar ho gaye hein. Yahan kuch bhi kaam nahi hota hai. Kuch mareez dekh ke hum sara din paper padhte rehte hein"* (We have become useless sitting here. There is no work at all. We see some patients if they come and read newspapers the rest of the day). The quote aptly describes the state of affairs at the PHC.

Interestingly, the staff kept referring to sterilisation tragedy as –kand, the Hindi word for scam.

**(c) Nemi Chand Jain Charitable Hospital, Sakri** – The hospital building has two floors and an OT room fixed with two ACs. The hospital has not been in use for several months. Only laparoscopic sterilisation camps are organized here. Its rooms, corridors and toilets are filthy. The facility has no beds, only about 20 mattresses that are used in camps. The OT could not be seen as had been sealed for investigation. The walls near the OT and other parts of the building had cobwebs, termites and were completely covered in dust. The building has one chowkidar, who also doubles up as a cleaner, and one attendant. There are two other buildings for residential purpose for the doctors and other staff in the complex. All are unoccupied.

Burnt Medical Waste

Outside OT

## 6. Overall Observations:

- There is a no conclusive evidence till now on what exactly caused the deaths. There are reports of drug contamination, clinical pictures are disparate and inconclusive, blood cultures are said to have not grown anything thus excluding sepsis. But none of this is verifiable as there is no access to any reports. A judicial enquiry has been ordered. However, in this process of establishing the medical cause of death and providing immediate relief, several of the larger issues seem to have been side lined.
- There is no doubt that quality of care, as defined in the protocols issued by the Ministry of Health and Family Welfare, Govt. of India, has been grossly compromised notwithstanding the claim that this was not the immediate cause of death. The team's interactions with health authorities at both state and district levels revealed that they did not seem to see this as a concern. In fact, there seems to be a prevalent belief that the health system is not capable of meeting the demand for sterilisation through regular services at health facilities and therefore such camps are a necessity. Temporary methods, choice, and rights do not even figure in the discourse of health officials.

- There is no focus on provision of a well rounded family planning programme that includes choice for simple spacing methods like Oral pills, condoms and IUCDs. There is no access to counselling and information on various methods for women.
- The poor status of the District Hospital as a centre for tertiary care and emergency response is a matter of great concern. In the present instance, tertiary specialised care was provided in Apollo Hospital, Bilaspur with financial support from the government and the health officials believe the disaster would have been manifold but for this. However, this raises questions on the public health system's readiness to manage crisis and disaster situations.
- There are definite targets for sterilisations at district and block levels. However, there is also a demand from women for permanent contraception. All the families of deceased women we met and as well as women who had survived the surgeries said they desired small family sizes, mainly for economic reasons, and therefore had chosen sterilisation voluntarily. In the absence of temporary methods and regular services for permanent contraception, this was the only service known and available to them.
- The state has been responsible to a large extent, by the design of its programme, for the compromised quality. Targets for sterilisation, incentives to providers motivate them to do more than the prescribed numbers. The lack of trained laparoscopic surgeons in each district capable of performing the procedure, no promotion of the Minilap tubectomy procedure, which is technically easier and has a lower failure rate, only one laparoscope given to each surgeon, indicate the state's complicity in this and needs to be challenged.
- While health budgets remain underutilised up to 20 – 30 %, contraceptive supply remains irregular and unreliable. There is also a shortage of trained staff at all levels. At the state level, 1183 specialist doctors were needed but only 283 were in place. Training budgets also remained underutilized as it was challenging to depute staff from functional facilities.
- There are protests from the medical fraternity against the arrest of the doctor saying he is being made the scapegoat. However, one cannot ignore the compromised quality and medical negligence.
- Another issue of concern is that drugs of poor quality were purchased outside of the established Chhattisgarh Medical Supplies Corporation. The issue of drug procurement, distribution, quality needs looking into.
- The local administration seems to have stepped in speedily once the tragedy unfolded. Women who had not reported to hospitals with symptoms were all apparently traced and efforts made to bring them to hospitals even if they did not show any symptoms., as a precautionary measure - This is indeed commendable. However, most women were subsequently moved to Apollo Hospital, Bilaspur, as the public sector medical college apparently did not have the capacity to treat the complications. The bringing in of monitors, dialysis machines and flying in extra specialists from other Apollo hospitals also helped in saving lives. While this may be a short term solution, this leaves questions about financial implications. What happens to the resources funded by the government in Apollo after this. The State should focus on plans to improve the state's secondary and tertiary care capacities in the public sector.
- The general trust in the public sector has been eroded by this medical disaster and may have implications on all public sector programmes in the near future.
- During our visit 63 women were still in hospital and 58 had been discharged. It seems that most will survive, but the long term morbidity and their care is definitely an issue.

# The **MACRO** Picture

The National Population Policy was adopted by the Government of India in the year 2000, and a National Population Commission was set up alongside to guide its translation into programmes. The policy clearly focused on meeting the unmet need for family planning and having an integrated approach to reproductive health services. It recommended a cafeteria approach, so that women could choose from a range of methods. It also linked population issues to sustainable economic growth and the environment. Most importantly, the policy followed a rights based approach (instead of a targets based one), and included key reproductive health issues such as maternal mortality, and services for adolescents.

However, the target mindset with a strong emphasis on sterilisation continues in the implementation of the family planning programme across states, and prescribed medical guidelines get flouted at sterilization camps. Evidence of high morbidity and even deaths of poor young women have surfaced at sterilization camps over the years. A few cases highlighted in the media in recent years include, Nagaur in Rajasthan, Balaghat in Madhya Pradesh and Araria in Bihar. However, field experiences show that there are many cases that go unreported. The focus of the family planning programme has predominantly been on female sterilisation, as detailed in the analysis below.

## Sterilisation expenditure analysis

A total of 39,23,945 female sterilisations were performed in India in the year 2013-14. In Chhattisgarh 1,142 Female Sterilisation camps were conducted covering 1,19,104 women.

| | National | Chhattisgarh |
|---|---|---|
| Total Expenditure of Family Planning in 2013-14 | Rs.396.97 crores | Rs.15.59 crores |
| Female sterilisation expenditure | Rs.338.91 crores<br>Rs.14.42 crores (camps)<br>Rs.324.49 crores (compensation) | Rs.13.09 crores<br>Rs.0.42 crores (camps)<br>Rs.12.67 crores (compensation) |
| Per woman expenditure rate | Rs864 | Rs.1,099 |
| % of budget spent on female sterilisation | 85% | 85% |
| % of budget spent on spacing methods | 1.45% (Rs5.76 crores) | 1% (Rs14 lakhs) |
| % of budget spent on other family planning related activities (like equipment, transportation, IEC, staff expenses, etc.). | 13% | 15% |
| Untied Grants to PHCs (to improve quality of services in the PHCs, including untied funds and annual maintenance grants) | Rs. 129.38 crores | Rs, 13.40 crores |

Thus at national level, the amount spent as compensation for female sterilisation was two-and-half times the untied grants given to PHCs[17]; while in Chhattisgarh, the amount spent as compensation for female sterilisation is almost same as the total untied grants to PHCs[18]. It is well established that on one hand the monetary incentives act as coercion, especially for the women from the poor communities and on the other it takes away the limited resources from the dire need to improve infrastructure and quality of care in services. The huge spends on compensation/incentives only to bring women to non-functional facilities with poor quality services that are a health risk, is inappropriate and unacceptable.

Ministry of Health and Family Welfare's Compensation Scheme for Tubectomy and Vasectomy[19]

**A. Public (Government) Facilities: (all amounts in Rupees)**

| Sl.No. | Procedure | Tubectomy | | | Vasectomy | |
|---|---|---|---|---|---|---|
| | **Details of the package** | **Existing** | **Proposed** | **PPS** | **Existing** | **Proposed** |
| 1 | Acceptor | 600 | 1400 | 2200 | 1100 | 2000 |
| 2 | Motivator/ASHA | 150 | 200 | 300 | 200 | 300 |
| 3 | Drugs and dressings | 100 | 100 | 100 | 50 | 50 |
| 4 | Surgeons' compensation | 75 | 150 | 250 | 100 | 250 |
| 5 | Anaesthetist/ Assisting MO (if any) | 25 | 50 | 50 | - | - |
| 6 | Nurse/ ANM | 15 | 30 | 50 | 15 | 30 |
| 7 | OT technician/helper | 15 | 30 | 50 | 15 | 30 |
| 8 | Clerks/ documentation | - | 20 | | - | 20 |
| 9 | Refreshment | 10 | 10 | - | 10 | 10 |
| 10 | Miscellaneous | 10 | 10 | - | 10 | 10 |
| | Total | 1000 | 2000 | 3000 | 1500 | 2700 |

**B. Accredited Private/NGO Facilities: (all amounts in Rupees)**

| Sl.No. | Procedure | Tubectomy | | Vasectomy | |
|---|---|---|---|---|---|
| | **Details of the package** | **Existing** | **Proposed** | **Existing** | **Proposed** |
| 1 | Facility | 1350 | 2000 | 1300 | 2000 |
| 2 | Acceptor | - | 1000 | - | 1000 |
| | Total | 1500 | 3000 | 1500 | 3000 |

[17] Rs.324.49 crores as compensation was 2.5 times the untied grants to PHCs. Adding the cost of sterilisation camps also, it was 2.6 times the untied grants given to PHCs

[18] Rs. 12.67 crores as compensation, i.e. 95% of the untied grants to PHCs. If we add the cost of sterilisation camps also, the total expense on female sterilisation is Rs.13.09 crores (98% of the untied grants to PHCs).

[19] The revised compensation refers to the amount listed in a document issued by the Ministry of Health and Family Welfare to 11 focus states on October 20, 2014 for an 'Enhanced Compensation Scheme 2014' for sterilization services in 11 high focus states (Uttar Pradesh, Madhya Pradesh, Rajasthan, Chhattisgarh, Jharkhand, Uttarakhand, Odisha, Assam, Haryana and Gujarat)

# About **CHHATTISGARH** and **BILASPUR**

Chhattisgarh state in central India was carved out of Madhya Pradesh in the year 2000. The state has a predominantly tribal population living in geographically remote and scattered locations. The state also has low literacy levels and one of the lowest Human Development Indices in the country. Chhattisgarh is well known for its mineral resources. It has also been faced with left wing extremism in several of its districts in the recent years. This, coupled with the state's response to it, has resulted in a conflict situation in several districts of the state.

Health indicators in Chhattisgarh have been poor. The public health system in the state faces several challenges in the areas of infrastructure and human resource. In spite of this, Chhattisgarh has also been characterized by several innovations and efforts at health systems strengthening – its Mitanin programme was one of the successful innovations that informed the nation-wide ASHA programme, and the State Health Resource Centre has been well recognized for its role in supporting the public health system.

Bilaspur district in Chhattisgarh consists of 8 tehsils/blocks. The total number of villages in the district is 1635. The headquarters of the district is the city of Bilaspur. It is the second largest city in the state and the seat of the High Court of Chhattisgarh. It is called Nyaydhani (legal capital) of Chhattisgarh.

As per the 2011 Census, Bilaspur, with a population of 2,662,077, is the second most populous district of Chhattisgarh (out of 18), after Raipur. The district has a population density of 322 inhabitants per square kilometre (830/sq mi). Its population growth rate over the decade 2001-2011 was 33.21%. Bilaspur has a sex ratio of 972 females for every 1000 males, and a literacy rate of 71.59% (male 83% and female 60%). The district is also considered the medical hub of Chhattisgarh due to the recently developed public sector medical college hospital Chhattisgarh Institute of Medical Sciences (CIMS) and multi-speciality private sector hospitals. The status of key family planning indicators for Chhattisgarh and Bilaspur district are given below:

| Indicators | Chhattisgarh | Bilaspur District |
|---|---|---|
| Total Fertility Rate (TFR) | 3 | |
| Currently married women age 20-24 who were married before age 18 | 45.2% | 48.9% |
| Current use of Any method of contraception | 49.7% | 47.4% |
| Any modern method | 47.1% | 44.1% |
| Female sterilization | 41.3% | 39.3% |
| Male sterilization | 1.8% | 1.3% |
| Pill | 1.7% | 1.3% |
| IUD | 0.6% | 0.2% |
| Condom | 1.6% | 1.7% |

In 2013-14, Chhattisgarh conducted 1,142 Female Sterilisation camps covering 1,19,104 women (As per MoHFW, this figure is 1,22,130 for Chhattisgarh) for a total expenditure of Rs. 13.09 crores of which Rs. 0.42 crores on camps and Rs. 12.67 crores for compensations (As per MoHFW, it was Rs. 0.40 crores on camps, Rs. 12.73 crores on compensations, totalling Rs. 13.12 crores of female sterilisation in 2013-14) and a total Expenditure of Rs. 15.59 crores for family planning (Rs.15.87 crores, as per MoHFW). Thus Female sterilisation constituted 85% of the total Family Planning Expenditure and 1% (Rs.14 lakhs) was spent on Spacing Methods. The remaining 15% was spent on other FP related activities (like equipment, transportation, IEC, staff expenses, etc.).

# RECOMMENDATIONS

## A: Immediate actions recommended for Bilaspur District and Chhattisgarh:

To begin with, the government **must make public the reports of the various enquiry commissions** set up to probe the incident **immediately and draw up a clear plan of action** with **time frames to ensure quality of care in family planning services.**

**High quality clinical training for providers:**

1. The family planning service providers at all levels must be trained on the concept, components and procedures of Quality of Care, as also on Infection Prevention practices. Introduce competency based training rather than mere completion of training plans.
2. The Gynaecologists and Surgeons at the District hospital and CHCs should be trained in the Laparoscopic and Minilap Sterilisation techniques as well as NSV procedure. They could also be sent to other states for proper skill training.
3. The doctors at the District and CHC levels need to be trained in Minilap Sterilisation and NSV procedure.

**Mechanisms for adherence and supervision of quality standards**

4. District authorities should immediately make the District Quality Assurance Committee (DQAC) functional with special role to assure quality in family planning services.
5. State/Districts must institute fixed days family planning services, particularly IUCD insertion and sterilisation both at the District hospital and CHCs, as per norms set by the Government of India, by making trained and competent service providers available. A roster should be developed for the OT so as to ensure that family planning services can be provided in addition to the regular surgeries at least once in a week. Women should be registered in advance for the services. It must be ensured that not more than 30 women are registered for one day.
6. Activation and strengthening of Rogi Kalyan Samiti ( Jeevan Deep Samiti) and Village Health Sanitation and Nutrition Committees needs to be done to facilitate community participation and oversight of health institutions.
7. Regular supply of condoms and oral pills must be ensured at the community level alongwith counselling.

**Engagement of communities and women to ensure informed choice**

8. Ensure women's right, dignity and confidentiality in providing sterilisation services at the fixed day facility.
9. Ensure proper counselling and provide information and choice to the clients on family planning methods. The doctor in charge of the facility should ensure that these services are provided to clients on a regular basis and made accountable. Mitanins and other frontline workers must be trained and refresher training must be organised on various spacing methods.
10. The incident has been a set back to the family planning programme. It is recommended that the state could develop a comprehensive social and behaviour change communication campaign to restore the confidence of women and men in family planning services.

**Long-term care for the future of families and children impacted by death/injury**

11. While an immediate care and support plan for affected families (including monetary support) has been provided by the state,- a long-term strategy and support is required, especially for affected children.

12. The follow up support needs to focus on appropriate infant feeding practices like cleaning and boiling of bottles, use of clean boiled water and appropriate use of alternatives -- dry milk powder. AWWs should be oriented and deputed to follow up with affected children on a regular basis in the affected area.

**Policy measures needed to improve family planning**

13. Fill the posts, especially of the specialist doctors[20] in CHC Takhatpur and the Medical Officer in PHC Amsena. This will ensure increase in the range and uptake of services at the primary health care level.

14. Allocate increased resources for promoting spacing, which is currently only 1% of the total state budget for family planning

## B. Recommendations for the national level:

The Central Government should establish an independent commission to ascertain the facts in the Bilaspur disaster, including ascertaining the cause of death of the 16 women, given the existing contradictory reports.

**Mechanisms for adherence and supervision of quality standards**

1. Sterilisation in camps, as being done now, must be stopped. The health facilities should be strengthened and equipped to provide regular services for family planning based on demand. In the meantime, fixed day services should be provided only in public health facilities while ensuring adherence to the standard protocols and quality assurance guidelines.

2. All sterilisation services must be supervised and monitored for adherence of Quality of Care by the District and Block level. Programme Managers should be well aware of all quality of care components and parameters.

3. The system of allotment of targets should be stopped. Instead, all clients should be given access to, and eligible couples in particular should be contacted and counselled on various methods of contraception. The frontline worker/provider should only facilitate the couples' decision by providing all information and dispelling myths.

4. Quality of care aspects, including reports by the DQACs must be an integral part of monthly/quarterly reviews at the regional, state and national levels.

**High quality clinical training for providers:**

5. An immediate plan should be developed and executed by the MoHFW to orient all officials at block, district and state levels in the 11 high focus states on the standard operating procedures for sterilisation and quality assurance. The state should prepare a supervision plan to ensure adherence to the protocols.

[20] The position of specialist has never been filled, since the inception of NRHM/ NHM

**Policy measures needed to improve family planning:**

6. The incentive for the providers (doctor, nurse & support staff) as also for the motivator should be discontinued. **Only compensation for wage loss and transportation to be provided to the acceptors.** The money saved out of the incentive should be used for strengthening facilities and for the procurement of equipment and instruments.

7. There is an urgent need to review and strengthen the drug procurement policy, ensuring tests of all drugs for efficacy, toxicity, lethality and composition. The quality control of all drugs must be ensured at all levels on periodic basis. State as well as District authorities should ensure this.

8. Given substantial evidence on the positive impact of increase in contraceptive choices on use of contraceptives, the government should explore feasible options for expanding the basket of contraceptives available in the public sector. The contraceptive choices available and used successfully globally, in neighbouring countries and in similar contexts should be reviewed to identify, learn and apply to an expanded choice within the public sector. Vasectomy/Non Scalpel Vasectomy must be extensively promoted as being the easier and safer permanent method of contraception.

9. The supply chain management should be streamlined for spacing methods including putting in place mechanisms to track and address stock outs.

10. Commission a comprehensive third party evaluation for family planning services in the country.

11. Every state should develop a plan for revision of their existing population policy or developing a new policy through a consultative process, which includes representation from civil society groups and reflects the felt needs of the community.

# **CASE STORIES** of women in the Bilaspur sterilisation camp

## Case Story 1: Dulhaurin Patel

Informants: Mother Gorabai and Mother-in-law Lacchanbai.

Dulhaurin, 27, lived in Lokhandi village of Takhatpur block.She like her husband was a daily wage earner. The day we visited her family, was the day before the end of the mourning period. Her husband had gone out for work. The house was full of extended relatives who had come to attend the funeral ceremonies.

Dulhaurin leaves behind two children – a 3-year old son and a two-month old daughter. Because of their economic conditions, Dulhaurin and her husband decided not to have any more children. The only method anyone in the community seemed to know of was female sterilization. Dulhaurin therefore approached the local Mitanin asking for information about the next sterilization camp. A couple of days before the camp, the Mitanin informed her about it. The couple consulted consulted other family members and Dulhaurin decided to go to the sterilization camp.

On the morning of the camp, Dulhaurin and her husband along with seven other women from the village were taken in a hired private vehicle by two Mitanins of the village to Sakri, where the camp was being held. By the time they returned home, it was past 7 pm. The vehicle dropped her off on the main road of the village and Dulhaurin walked about a kilometre to reach home. She was well that night and had some tea and toast and rested. She also had a tablet each from the two different strips that had been given to her.

On Sunday, the next day, Dulhaurin was well and continued to rest. On Monday morning, she left with her husband on a motorbike to her maternal home about 30 km away to recuperate. There, in the evening she had a couple of episodes of vomiting. Meanwhile, some women in her village had fallen sick after the sterilisation surgery. By late evening on Monday, the Mitanin had been told to bring all of the women back to the hospital in Bilaspur for further treatment. There was a lot of commotion and activity in the village. Several of the village leaders including the Sarpanch came to Dulhaurin's home and when they discovered she had gone to her mother's home, they called there and informed her husband that she needed to be taken to hospital. At around 3 am on Tuesday morning, she was taken by her husband on a motorbike to CIMS. According to her mother-in-law, even there, she had tea and toast for breakfast.

The family does not know what happened thereafter. They learnt that she had later been transferred to KIMS, a private hospital. When her mother reached the hospital during the day, she had great difficulty locating where Dulhaurin was. That evening, they were told Dulhaurin had died.

The family is now trying to look after Dulhaurin's children. The family has bought a tin of baby food powder from the market and were feeding the baby. They have received Rs. 4 lakhs as compensation from the government.

Dulhaurin's sister-in-law is pregnant with her second child; she has not had any antenatal care so far except a dose of tetanus toxoid. She had earlier been contemplating sterilisation after the birth of the baby, but now is too scared to go for it. She does not know of any other method of contraception either.

## Case Story 2: Ranjita Suryavanshi

Informant: Santosh Suryavanshi (Husband) and Mother-in-law

Ranjita Suryavanshi lived in Nirtu village of Takhatpur block. She had three children, a daughter, 7, a son 3, and another son, just one month old.

When the Mitanin of their village informed them of the sterilisation camp, Ranjita decided to have the operation. Her husband was a daily wage earner and the couple had been told by well wishers that a small family was the best way to move forward in life.

On the day of the camp, Ranjita was taken with two others from the village to the camp in Sakri in a private vehicle. Though her husband and mother-in-law accompanied her, they were not allowed inside and had to wait outside with her baby. According to the husband, most women had arrived by noon, but the doctor came in only after 3 pm and left by 5 pm after completing all the surgeries. About ½ hour later, the women were all sent home with a strip each of two tablets. It was about 7.30 pm when Ranjita and her family arrived home.

From the next morning onwards, Ranjita was unwell. She had bouts of vomiting and giddiness – her husband said they occurred every time the tablets were taken. By Monday noon, Ranjita was quite sick. Her father-in-law approached a private practitioner in the village, but was told this was a normal occurrence after surgery and that she would soon recover. He did not prescribe any medication.

That night, around 11 pm, Ranjita complained of severe abdominal pain – her father-in-law again went to fetch the private practitioner. By the time they came back, Ranjita was very sick; the private practitioner could not even feel her pulse. He immediately called for the ambulance. Ranjita was declared dead when she reached the hospital.

The family is now feeding the month old infant tinned formula milk through a feeding bottle. They are unsure of how to care for this baby. The collector visited their house to hand over the Rs. 4 lakh compensation, but the family is not happy. They want the husband to be given a government job to ensure a steady income so he can look after his children. Ranjita's husband wants those responsible for his wife's death to be punished. He is demanding the highest level of political accountability for this tragedy.

## Case Story 3: Rekha Nirmalkar

Ms Rekha Nirmalkar, 22, had come to her maternal home to see her family from Ameri village where she resides after her marriage. During her stay, she came to know that a family planning camp was being organised in the block and decided to go in for sterilisation. She had two children- a daughter aged 2 1/2 years and a son who was four months old. Around 10 am on the morning of November 8, she along with two other women from the village hired a vehicle to reach the family planning camp being organised in Nemi Chand Jain Hospital in Sakri. They waited alongwith several other women at the hospital. Between 12 noon and 1 pm, the nurses conducted the medical examination for all the women. At around 4 pm, she was given an injection and later taken for the operation. All went well and around evening 8 pm she returned home alongwith the other women and her grandmother, Bedan Bai, who is also a dai. They were given Rs 600 in cash. Most of it was spent on the to and fro travel to Sakri. Also, she was given two strips of tablets to consume. However, after the incident the health department staff came and took back all the tablets alongwith the prescription.

She slept well in the night. The next morning at around 7 am she woke up and ate roti with tea and took the two medicines (one tablet each as prescribed). After half an hour, she started to vomit. Bedan Bai contacted the PHC -Amsena staff. The PHC is situated across her house. Rekha was given an injection around 11 am or so. However, as her condition did not improve by 2.30 pm, Bedan Bai decided to take her to the District Hospital. She again hired a vehicle and took her to Bilaspur. The doctors at the District Hospital did a quick check up and referred her to Apollo Hospital. However, Rekha died on her way to the Hospital.

Bedan Bai laments:*"Hame kya malum tha itni badi durghatna hogi! Woh toh hamare sath kuch din rahne ke liye ayi thi. Ab uske do bacchon ko kon dehkega? Baap ko to sarkar ne chaar lakh rupiyee de dia hai- aab kya, woh to jald hi doosri shaadi kar lega- bacchon ko kaun bade karega- hamari bhi umr ho gayi hai aur sansadhan bhi nahi hain."*

("What did we know that there would such a big disaster! She had come to spend a few days with us. Who will take care of her two children now? The government has given four lakh rupees to the father. Now, he will get married again soon. Who will raise the children? I have grown old (70 years) and do not have adequate resources for their up-bringing.")

**As narrated by Bedan Bai (grandmother of the deceased)*
*Village: Amsena, Block- Takhatpur*

## Case Story 4: Santosh Suryavanshi

Santosh Suryavanshi, 31, resides in village Bharni, block Takhatpur. Married at 18 years, she has four children- three sons- aged 13, 4 and 2 years and a daughter who is 9 years old. In her 13 years of marriage she had not used any method of contraception even though she, her sister-in-law and mother-in-law did know about condoms and oral contraceptive pills as methods for spacing. "The ANM, Aganwadi Worker and ASHA never tell us about these methods, nor are contraceptives provided to women in the village. I know some women who were taking the pills. However, after some complications they have stopped taking them. The only method available is operation. So I decided to go for it".

"I went to Nemi Chand Jain Hospital in Sakri in the morning along with my family members. After waiting for sometime, the nurses took my blood and urine and asked me to wait. Rs. 600 was given to me. I was then given an injection; that is all I recollect. Later I was brought home in the evening. I took the first dose at night and the second early next morning. After sometime, I felt giddy and started to vomit. This continued over the day. By evening, as the situation worsened my family took me to the District Hospital in Bilaspur. I was in the hospital for nine days. I was discharged two days ago. The hospital ambulance dropped me home. I was also given a sari, a blanket and some fruits, before being discharged. The hospital staff took good care of me. I am feeling well. Doctors and hospital staff come to see me every day at home. They ask if I am taking my medicines on time and if there any complications. I thank God for saving my life. What would happen to my children without me?"

As she concludes, her youngest child starts crying, thinking that we have come to take his mother away again. Her mother-in-law explains that the children had a traumatic time. "The children have never been away from their mother even for a day. We donot want any women in our village to go for the operation ever in the future".

**As narrated by Ms Santosh Suryavanshi*
*Village: Bharni, Block- Takhatpur*

## Annexure-I (a)

**Human Resource Details, Community Health Center (CHC) Takhatpur**

| SN | Designation | HR Details | | | Remarks |
|---|---|---|---|---|---|
| | | Sanctioned | Filled | Vacant | |
| 1 | Specialist | 4 | 0 | 4 | Never filled |
| 2 | Medical Officer | 2 | 1 | 1 | On deputation from Kota block |
| 3 | Nursing Sister | 1 | 1 | 0 | |
| 4 | Staff Nurse | 10 | 11 | 0 | |
| 5 | Pharmacist | 2 | 2 | 0 | |
| 6 | Dresser | 2 | 2 | 0 | |
| 7 | Laboratory Technician | 2 | 2 | 0 | |
| 8 | Ward Boy | 2 | 2 | 0 | |
| 9 | Sweeper | 1 | 1 | 0 | |
| 10 | Ward Ayah | 1 | 1 | 0 | |
| 11 | Driver | 2 | 3 | 0 | |
| 12 | NMS | 1 | 1 | 0 | |
| 13 | Radiographer | 1 | 1 | 0 | |
| 14 | Auto Operator | 1 | 0 | 1 | |
| 15 | Lady Health Visitor (LHV) | 2 | 2 | 0 | |
| 16 | Chowkidaar | 1 | 1 | 0 | |
| 17 | Bhritya | 1 | 1 | 0 | |
| 18 | Accountant | 1 | 2 | 0 | |
| 19 | Assistant Grade 2 | 1 | 0 | 1 | |
| 20 | Assistant Grade 3 | 1 | 0 | 1 | |
| 21 | NMA | 1 | 1 | 0 | |
| 22 | Health Worker-Female | 1 | 1 | 0 | |
| 23 | Health Worker-Male | 1 | 1 | 0 | |
| 24 | Supervisor-Male | 1 | 1 | 0 | |
| 25 | Block Extension Educator (BEE) | 1 | 0 | 1 | |
| 26 | Dhobi | 1 | 0 | 1 | |
| 27 | Health Worker- Male | 1 | 0 | 1 | |

## Annexure-I (b)

**Block Level Human Resource Details, Block Takhatpur**

| SN | Designation | HR Details | | |
|---|---|---|---|---|
| | | Sanctioned | Filled | Vacant |
| 1 | Nursing Sister | 1 | 1 | 0 |
| 2 | Staff Nurse | 19 | 19 | |
| 3 | Health Worker, Female (ANM) | 48 | 35 | 13 |
| 4 | Health Worker, Male (MPW) | 39 | 28 | 11 |
| 5 | Health Supervisor, Male | 9 | 10 | 0 |
| 6 | Health Supervisor, Male | 10 | 10 | 0 |
| 7 | Rural Medical Assistant (RMA) | 9 | 7 | 2 |
| 8 | Laboratory Technician | 11 | 9 | 2 |
| 9 | Eye Assistant | 9 | 6 | 3 |
| 10 | Pharmacist | 11 | 11 | 0 |
| 11 | Dresser | 11 | 10 | 1 |
| 12 | Specialist Doctors | 4 | 4 | 0 |
| 13 | Medical Officer | 11 | 7 | 4 |

**Annexure-2**

**Laproscopic Tubectomy Camps Details (April 1, 2014 to November 8, 2014)**

| Sl No | Date of LTT Camp | Site of camp | No of LTT cases |
|---|---|---|---|
| 1 | April 3, 2014 | Ganiyari | 12 |
| 2 | April 10, 2014 | CHC Takhatpur | 21 |
| 3 | June 6, 2014 | CHC Takhatpur | 9 |
| 4 | June 19, 2014 | CHC Takhatpur | 28 |
| 5 | June 26, 2014 | Ganiyari | 22 |
| 6 | July 3 & 4, 2014 | CHC Takhatpur | 49 |
| 7 | July 10 2014 | CHC Takhatpur | 57 |
| 8 | July 12, 2014 | Ganiyari | 38 |
| 9 | July 17, 2014 | District Hospital | 9 |
| 10 | August 28, 2014 | Ganiyari | 33 |
| 11 | September 28, 2014 | Nemi Chand Jain Hospital | 65 |
| 12 | September 9, 2014 | CHC Takhatpur | 46 |
| 13 | October 16, 2014 | CHC Takhatpur | 68 |
| 14 | October 10, 2014 | Nemi Chand Jain Hospital | 30 |
| 15 | November 8, 2014 | Nemi Chand Jain Hospital | 83 |
| Total | | | 570 |

Source: HMIS Report, Block Takhatpur

# The **ORGANISATIONS**

**Population Foundation of India** (PFI) is a national-level NGO which promotes and advocates effective formulation and implementation of gender-sensitive population and development policies, strategies and programmes. PFI collaborates with the central, state and local government institutions. PFI was founded in 1970 by a group of socially committed industrialists under the leadership of JRD Tata.

**Parivar Seva Sanstha** has been in existence for the last 30 years. The organisation provides a range of quality, affordable reproductive health services and products in 21 states of India. Parivar Seva has the distinction of being a pioneering organisation engaged in the provision of reproductive health interventions across India.

**Family Planning Association of India,** established in 1949, promotes access to sexual and reproductive health information and services related to family planning, safe abortions, HIV/AIDS and sexuality to poor, marginalised and vulnerable populations including young people. FPA India has a presence in 17 states of India and one union territory.

**CommonHealth** is a membership based coalition of individuals and organisations advocating for better access and improved quality of maternal-neonatal health and safe abortion services. The coalition engages with issues of women's gender and reproductive health and rights through a broad-based advocacy strategy.





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