EDITORIALS

Bilaspur sterilisation deaths: evidence of oppressive population control policy

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Introduction

The recent tragic and completely avoidable deaths of 13 women[1] and the critical condition of many more following laparoscopic sterilisation in Bilaspur, Chhattisgarh, signals that nothing has really changed in India's family planning programme over the past several decades. The manner in which the surgeries were performed, in complete violation of all standard operating procedures and ethical norms, amounts to grave violation of the very basic health rights of the affected women (1). In addition, it points to the callous and biased attitudes towards poor women that persist among health functionaries and policy-makers, and the tenacious hold of the "targets" approach in the family planning programme despite statements to the contrary.

The sterilisations that resulted in these deaths were performed at a camp held on November 8, 2014, in Takhatpur block of Bilaspur district. The camp had been organised by the State Department of Health under the National Family Planning Programme to perform laparoscopic tubectomies, and was conducted in the premises of a non-functioning and abandoned private hospital building. A total of 83 women – predominantly dalit, tribal, and OBCs – were subjected to sterilisation within a short span of a couple of hours by one surgeon using an assembly line technique, with one laparoscope and no precautions for asepsis. It was also suspected that the ciprofloxacin tablets given to the women after surgery were contaminated with zinc phosphide, a content of rat poison. According to a subsequent press report (2), the drugs were not toxic but some batches were found to be substandard. The suspected contamination of medicines in this context has been used by the State and the health system as a tool for avoiding their responsibility for ensuring quality of care, without pausing to ask why and how contaminated drugs were distributed during a public sector camp. Additionally, despite having a functioning district hospital and another 650-bedded public sector medical college hospital in the district, a private corporate hospital was used to treat the women who were in critical condition. All this has taken place in a State with poor health indicators and which is a high focus State for the National Health Mission (NHM).

Historical context

To understand the contributors to this tragedy, it is important to revisit history and the debates around India's population policies and family planning programme.

The family planning programme in India has had a long and convoluted history. A constant rhetoric has been the neo-Malthusian concern that too many people reproducing too rapidly retards economic growth, which increases poverty and over-stretches social services. As a consequence, the Indian state was the first in the world to initiate an official family planning programme in 1952. In the 1960s, the government introduced the options of both male and female sterilisation. By 1966, there were official quotas for sterilisation (3–5). The late 1970s and the Emergency were marked by widespread coercion and abuse, particularly of men, who were forced to undergo vasectomies, which led to a major anti-vasectomy backlash in the early 1980s (3–5).That backlash, combined with new techniques for female sterilisation, shifted the focus of the population control programme sharply onto women.

Incidents of coercion and violations spurred active opposition led by the autonomous women's movement in India. The movement against fertility control as part of the agenda of the state to control its numbers gained strength. Women's organisations were involved through the 1980s and the early 1990s in exposing the surreptitious or sometimes overt experiments on women's bodies to control their fertility. Depo Provera and Quinacrine are examples where the women's movement in India highlighted the ways in which contraceptive technology and drugs were often used on women's bodies without their consent or knowledge (6). Moreover, women's health activists strongly critiqued the healthcare system's treatment of women merely as "reproductive beings" whose fertility needed to be controlled, while paying little or no attention to addressing their other health needs or structural factors such as poverty, inequality based on gender, caste, and sexuality, that determine their health.

The International Conference on Population and Development (ICPD) in Cairo in 1994 witnessed a shift in global perspective with nations including India affirming "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." This resulted in the family planning programme becoming "target-free" since 1996, with India reaffirming this approach in its National Population Policy of 2000 by removing its method-specific quotas at the Centre (7). It also saw integration of the family planning programme under the Reproductive and Child Health (RCH) Programme. However, even with these changes, important structural concerns including gender discrimination, inequity, and prevalent economic paradigms were left unaddressed in these programmes.

This historical context of the family planning programme needs to be posited against women's own needs to control their fertility. The National Family Health Survey 2005–06 (NFHS-3) data show that the desired fertility rate is 1.9 as against the existing total fertility rate of 2.7, signalling a felt need for safe, non-hazardous, non-invasive, women-controlled contraceptive methods. Women's narratives documented in various studies show the burden that constant reproduction places on women's lives and health (8). However, this need of women has not been fulfilled by the state, that views contraception as "family planning" and as a state-controlled tool for population control. This approach also precludes the provision of contraceptive services for women outside the traditional marital relationship and socially acceptable reproductive cycle, and negates other needs of women, eg prevention of sexually transmitted infections.

The reality on the ground

In India, contraceptive services have been limited largely to sterilisation, particularly for women. It has been promoted and pushed by the state unilaterally through targets and on a mass scale through a camp approach, largely disregarding other available methods such as condoms, oral contraceptive pills, and IUDs. The District Level Household and Facility Survey (2008) shows that of 54% of the population that reported using any method of contraception, female sterilisation accounted for 34% and male sterilisation accounted for 1% of contraceptive use (9), indicating the gendered focus of the programme, with a disproportionate thrust on women.

Targets and (dis)incentives

On the ground, family planning programmes continue to be implemented with targets for specific methods in spite of the national policy being target-free. This is evident from the letter from the Additional Secretary and Mission Director in the Union Ministry of Health and Family Welfare (MoHFW) to the States conveying that,

> *"…while organizing the camps all out efforts should me made so that (i) around 100 cases are conducted in each of these cases per day"* (10).

Healthcare workers are routinely threatened with disincentives such as cuts in salaries, or threats regarding loss of their jobs if they do not meet their sterilisation targets. For example, in keeping with Rajasthan's goal of 698,604 sterilisations in 2012–13, the health workers in the State were asked to conduct 100,000 sterilisations in the fortnight coinciding with the World Population Day (July 11,2012) (11). Similar instances are seen in many other States.

Interviews with about 50 women health workers including Accredited Social Health Activists (ASHAs), *anganwadi* workers from two predominantly tribal districts in Gujarat, brought to light individual targets and threats to withhold or reduce salary, negative performance assessment, or suspension and dismissals in case of non-compliance (12). In Chhattisgarh, one of the authors met with block-level health officials following the sterilisation tragedy and was informed about the specific numbers as targets for male and female sterilisation for 2014-15, of which female sterilisation targets constituted about 85% of the total. Also in Chhattisgarh, the surgeon who has now got dubious recognition for performing the recent sterilisations that led to the deaths had received an award from the chief minister of the State earlier in 2014 for performing a large number of sterilisations (50,000)(13).

Impact of the camp approach on quality of care

The quality of care of contraceptive services has remained a serious concern. In many States, poorly functioning health systems have resulted in these services being provided in camp settings rather than as part of regular services in functioning health facilities. Civil society efforts with the judicial system on the quality of care in these camps (Ramakant Rai vs Union of India, 2005) (14) resulted in the Supreme Court directing the Government of India to frame guidelines for quality of care for these services. Almost a decade later, the Court had to be approached again as the ground situation had not changed (Devika Biswas vs Union of India, 2012) (15).

The Chhattisgarh camp has clearly showcased these violations, eg an absence of pre- or postoperative care, flouting of all quality of care standards, and an absence of standard infection prevention procedures. However, what is even more tragic is that this camp was not unique in these violations. Such violations of the guidelines have been highlighted repeatedly both in State and civil society reports, including those from the Common Review Missions of the NHM.

Violation of medical ethics

The implementation of the family planning programme raises ethical issues at multiple levels. Any public health programme must provide adequate and complete information, respect the rights of the individuals it addresses and make efforts to ensure equity as part of its ethical framework. By assuming that poor quality services will do for poor, marginalised women, by not providing adequate information or choice, by treating women as passive recipients of services that they need to be cajoled or coerced into accepting, the state violates several ethical principles in the framework and design of the programme. In addition, at the ground level, the state has contributed to the poor quality of care by errors of commission and omission – there are very few trained laparoscopic surgeons in a district, each surgeon is provided with only one laparoscope while guidelines demand the use of at least two, the technically easier minilap technique is favoured less compared to laparoscopic tubectomy which has a higher failure rate, surgeries in camp setting are encouraged compared to fixed day regular services in public health facilities – all these point to active complicity of the state in violating all ethical norms in the provision of contraceptive services. There is evidence to indicate that sterilisations done in camps have more adverse outcomes than those done in hospitals. In spite of this, the state has promoted the camp approach over regular services (16).

The large "unmet need" for contraception has been used by the state to rationalise its camp approach to the conduct of sterilisation surgeries. Poorly functioning health systems with poor contraceptive services seem to have been conveniently forgotten in this discourse. Women are said to be voluntarily opting for tubectomies in camps –what other options has the state provided them with?

At another level, individual clinical services provided as part of a public health programme must also adhere to the medical ethics principles of beneficence, non-maleficence, autonomy and justice. A sterilisation surgery has to be a voluntary choice made by a woman (or man) with full autonomy for decision-making. Such decision-making requires the provision of complete information and counselling. Without such a process, consent is reduced to the mere formality of a signature on the form by women. In Chhattisgarh, the consent process was recollected by most women as signing "some form" before the surgery, "rather like signing a school admission form". The process of explaining to women and to their families the procedure, possible side-effects, and information with regard to compensation in such an eventuality, seemed to have not taken place at all. Moreover, the consent that the women and family members have signed on the document detailing risks related to surgery is used more as a protection for the providers (17).

Similarly, in an elective surgery such as sterilisation, non-maleficence must be high on the list – the lack of attention to quality of care norms with no infection prevention practices makes the entire process grossly unethical.

It is noteworthy that the individual doctor involved in this tragic incident has blamed the systemic pressure of targets on him for the poor quality of care. While the State definitely has to assume responsibility for creating an environment where such poor quality is condoned, rather subtly encouraged, it does not absolve the doctor of responsibility. Doctors are part of the system and cannot distance themselves from it while contributing to its failure; they rarely do so while claiming credit for its successes. Also, rarely do doctors raise systemic issues when nothing seemingly goes wrong, thus losing out on opportunities to put in corrective measures for improvement of the system. This not only raises issues about the poorly equipped public healthcare system, but should also alarm us about the poor professional ethics of at least some in the public health system.

Global players occupying population policy spaces

The Chhattisgarh tragedy also needs to be seen within a larger context. Echoing the earlier Malthusian discourse, there is now a renewed global push for "family planning". The London Family Planning Summit 2012 saw calls being given out to increase global commitments and resources for family planning (18). The involvement of private corporate foundations and international aid agencies in this resurgence of family planning can be seen as a disturbing trend in countries like India where contraception has historically meant population control. Some evidence of coercive programmes coming back with targets is already being seen – at the summit, India made a commitment to cover 48 million couples with family planning services by 2020, again a possible harbinger of targets; and there are reports of postpartum IUCDs being pushed aggressively by States with support from international agencies with very few consent processes in place (19).

Conclusion

What does the Chhattisgarh incident mean for us today? What lessons can be learnt from it?

It is deeply disconcerting that no efforts are being made either by the State or the Central governments to institute corrective action and to ensure better design and implementation of the family planning programme. No Central government official had visited Bilaspur till about a fortnight after the incident, nor had the MoHFW conducted any inquiry into the matter.

The family planning programme in India needs a thorough review and overhauling towards centre-staging women's right to dignity, privacy and bodily integrity. Women's right to make an informed decision regarding their sexual and reproductive health, including contraception, must never be compromised. The public health system must ensure that women, including those from marginalised communities, have access to safe, quality contraceptive services, including information and counselling.

This incident underscores the urgent need for corrective measures to ensure that health policies and programmes are essentially gender-sensitive and that they are equipped to address the woman's needs throughout her life rather than just focus on maternal health, child health and family planning. It has been shown time and again that the camp approach severely compromises the quality of care and dignity of women undergoing sterilisation procedures. The camp approach to providing sterilisation services needs to be discontinued immediately and mechanisms for quality assurance need to be set up, which go beyond tokenism to ensure quality of care during contraceptive services. Targets in any form should be completely eliminated from policies, programmes including budgetary allocations along with abolishing the two-child norm being implemented in different schemes and policies. Incentives should be discontinued at all levels. The responsibility lies with the government to respond to the Bilaspur tragedy immediately and take necessary steps to avert any such mishap in the future. It is important to send a "zero-tolerance" signal when it comes to non-compliance with medical ethics and gender justice norms in the context of women's access to contraceptive services.

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Note

[1] The sterilisations on women in Chhattisgarh also included women from "particularly vulnerable tribal groups" (PVTG), violations which have been substantially discussed in the editorial. However, in the context of the existing regulation vis-a-vis sterilisation of PVTG, the authors did not want to focus on it as it is an area that needs elaborate discussion which may not be possible in this editorial. Women from the particular communities who cannot access sterilisation services due to the regulation have been articulating the violation of their reproductive rights and demanding that their bodily integrity be respected and that they also be allowed to decide whether or not to access sterilisation. The argument of the state of "protecting" dwindling population of these communities also needs to be located and deliberated in the larger context of development and addressing of the various determinants of health – poverty, nutrition, livelihoods, health care, etc.In the Chhattisgarh situation, this was also raised by political parties as an agenda without addressing the fundamental concerns.

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