Camp of Wrongs:

The Mourning Afterwards

A fact finding report on sterilisation deaths in Bilaspur

Sama Resource Group for Women and Health
Jan Swasthya Abhiyan
National Alliance for Maternal Health and Human Rights

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16-18 November 2014

Report by

Sama Resource Group for Women and Health

Jan Swasthya Abhiyan

National Alliance for Maternal Health and Human Rights

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Abbreviations

AHS	Annual Health Survey
AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife
BSU	Blood Storage Unit
CEDAW	Committee on the Elimination of Discrimination against Women
CHC	Community Health Center
CIMS	Chhattisgarh Institute of Medical Sciences
DH	District Hospital
ELA	Expected Level of Achievement
FRU	First Referral Unit
HMIS	Health Management Information System
ICU	Intensive Care Unit
IUCD	Intra Uterine Contraceptive Device
IV	Intravenous
LTT	Laparoscopy Tubectomy
MPW	Multi Purpose Worker
NFHS	National Family Health Survey
NHM	National Health Mission
OBC	Other Backward Classes
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PVTG	Particularly Vulnerable Tribal Group
SC	Scheduled Caste
SDH	Sub District Hospital
SRS	Sample Registration Survey
ST	Scheduled Tribe

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Camp of Wrongs

The tragic deaths of the 13 women, all in their 20s or 30s and the critical condition of the 70 other women, following procedures of laparoscopic sterilisation in Bilaspur district, Chhattisgarh, raise grave questions once again about the callous treatment of women, the poor and marginalised as well as the clear violations of ethical and quality norms in the health care system. This unacceptable incident calls urgent attention to the unsafe, unhygienic conditions and the slipshod manner in which the sterilisations were conducted resulting in deaths and morbidities among the women.

On 8th and 10th November 2014, four sterilisation camps for women were held at Sakri Pendari, Gourella, Pendra and Marwahi in Bilaspur district. Nearly 140 women were brought to these camps for sterilisation. The largest of these camps for 83 women was conducted within a short span of 3-4 hours, in the abandoned private charitable Nemichand Jain Hospital and Research Centre in Pendari. The building is located 6 kilometres from Bilaspur city. It is a non functional health facility that had been abandoned for the past many years.

Twelve of the 13 unfortunate deaths were of women who had undergone sterilisations in the camp held at the Nemichand Jain hospital building. Amongst those who died were women from dalit, adivasi / tribal and OBC (Other Backward Classes) communities. Most of the families were landless and their main source of income was daily-wage work. Many women who lost their lives had up to 3 children. Some of them, with infants as small as 3 months old, had undergone the sterilisation surgeries.

The surgeries were performed by Dr R. K. Gupta, a surgeon, who was assisted by a team of fellow medical professionals. Dr R.K. Gupta had been honoured previously by the State government for the 'distinction' of conducting the 'maximum number of sterilisations'. Dr Gupta was subsequently arrested on charges of negligence and attempted culpable homicide following this tragedy. Indian Medical Association, Chhattisgarh Unit called for state wide strike on Saturday, 15th November, 2014 in support of Dr RK Gupta.

There were also reports of the women having fallen ill after consuming ciprofloxacin tablets that were provided to them following the surgeries at the Camp. State officials initially said that they believed that the women had contracted infections because of the poor conditions in the camp. It was also suspected that the ciprofloxacin tablets given to the women post surgery were contaminated with zinc phosphide, a rat poison. The Police detained Ramesh Mahawar and Sumit Mahawar – father and son, who run Mahawar Pharmaceuticals Pvt. Ltd., a Chhattisgarh based pharma company, which supplied the ciprofloxacin. This is currently being investigated by the State government. While the post mortem reports have been kept under wraps, the officials suspected that it could well be a combination of both septicaemia and toxicity arising from the contaminated antibiotic.

I. Family Planning and Population Control in India

India was the first country to have a National Family Planning Programme way back in 1951. The words "family planning" or "family welfare", were mere euphemisms for "population control", that have focused on top-down target-setting, along with incentives and disincentives to achieve these targets. Over the decades, the state's pre-occupation with population control has continued, despite the current population growth rate at its lowest in the past 50 years. The prevailing anxiety over population growth and the resulting coercive population control measures that invariably target women, particularly those poor and underprivileged, be it sterilisations, through incentives and disincentives or the two child norm which disqualify benefits or entitlements.

In spite of protestations to the contrary, the principal method of population control, which the Indian Government has promoted, is female sterilisation. The public health system is a scandal in many parts of the country – a function of gross under-funding and poor planning. Yet this collapsing public health system is systematically used as vehicle for promoting illusory population control goals. Women rarely receive care through the public system for a range of illnesses that they suffer from. Yet the system spends enormous resources only to control their fertility especially of marginalised women – the poor, dalit, adivasi, muslim women. There is no public education on men's responsibility within sexual relationships and male methods of contraception are not promoted. Condoms are distributed in the context of HIV prevention so become associated with use of sex workers, and therefore inappropriate for 'monogamous' relationships. As a result women who are already vulnerable to ill-health are willing to go in for a terminal method such as sterilisation.

This gendered approach takes full advantage of women's lack of sexual and reproductive autonomy and their desperation to end their childbearing. Women's early marriages and inability

Sterilisations performed upon women in India		
Year	Percentage of female sterilisation to total number of sterilisations	Actual numbers of tubectomies performed
1980-81	78.6%	16,31, 861
1985-86	87%	42,62,132
1990-91	93.8%	38,70,650
1995-96	97.2%	42,98,571
2000-01	97.7%	46,25,247
2005-06	96.5%	45,39,739
2010-11	95.6%	49,20,606
2012-13	97.4%	44,58,546

Source: HMIS portal, quoted in the Health and Family Welfare Statistics in India 2013

to negotiate contraception leads to pregnancies while they are still very young, and the lack of safe spacing methods leads to frequent repeat pregnancies.

The State's intervention on when and how such control is to be executed undoubtedly violates all reproductive and sexual rights. This has continued notwithstanding India's 'promise' to the International Conference on Population and Development (ICPD) in 1994 to pay greater attention to male responsibility in contraception and to the special needs of adolescents rather than to a 'population control' approach. In keeping with the ICPD, India emphasised the importance of assessment of community needs and providing access to reproductive services, including contraception. However, mere addition of methods of contraception, particularly those that are unsafe, hazardous, provider-controlled does not guarantee women's health and rights, or reproductive justice.

In India, sterilisation, particularly tubectomy, has been vigorously promoted and pushed by the state through centrally- decided targets and on a mass scale through a camp approach, largely disregarding other currently available methods such as condoms, oral pills, IUDs. In fact, sterilisation constitutes 75 percent of India's total contraceptive use, which is the highest proportion anywhere in the world by a wide margin. From the mid-1980s, the numbers of tubectomies in India have risen steeply and average 4.5 million surgeries performed each year.

Comparatively, the percentage of male sterilisation or vasectomy has been steadily declining over the past few decades to below 3 percent today.

In states like Madhya Pradesh, Bihar, Chhattisgarh, Rajasthan and Uttar Pradesh, and other states, sterilisation through 'camps' are frequently conducted in schools, abandoned buildings, makeshift camps with poor quality services. These are recipes for disasters waiting to happen – evident from the significant number of deaths and failures resulting from sterilisation of women in the country. The argument commonly put forth in favour of the camp approach is the "unmet need" of women – a need that is constructed upon the absence of any other options for contraception for women that are safe, non hazardous and the skewed policy approach that does not sufficiently promote the responsibility of men in this regard.

The Indian State seems to ignore these gross violations and the voices vehemently opposing them. India's promises at the recent Family Planning 2012 Global Summit in London, runs the risk of reinforcing the pressures of meeting 'targets', which has dangerous and long-term implications for the health of the people.

Furthermore, sterilisation for women is promoted as a 'safe' option, with women going for sterilisations never counselled about possible adverse effects in the short and long term. The sub-standard conditions in which these surgeries are often performed create further complications. This was studied in 2002 by a civil society alliance Healthwatch Uttar Pradesh, and submitted in a Writ Petition to the Supreme Court (Ramakant Rai and Healthwatch UP vs Union of India, Writ Petition No. 209 of 2003). As a result, the Supreme Court issued orders to the Government in 2005, based on which quality standards for sterilisation were reviewed, Quality Assurance Committees mandated in each district and an insurance cover (currently indemnity cover) set in instances of death or failures following female sterilisation. The present tragedy in Chhattisgarh and many others preceding it, however, are sordid symbols of the non-adherence to the various guidelines and standards that exist.

II. Brief Profile of Chhattisgarh and Bilaspur

Chhattisgarh was formed in the year 2000. It is the 9th largest state in terms of area with total population of 2.6 Crores (Census 2011). There are 27 districts, 146 blocks and 20,126 villages in Chhattisgarh and around 44 percent of the area of Chhattisgarh is covered in forest area.

A quarter of the population of the state is from the Scheduled Tribes and 9 percent of the population is Scheduled Caste. Chhattisgarh is one of the poorest states in the country. As per NFHS-3, nearly half (47 percent) of under-3 children in the state are underweight. As high as 58 percent of women are anemic and 43 percent of women are malnourished. Chhattisgarh has the second highest percentage of women with BMI below 18.5 in the country. Chhattisgarh has been witnessing a series of medical disasters – blindness and even deaths of patients following cataract operation camps in 2011; the scandals of a large number of unnecessary hysterectomies only to extract "Smart Card" payments, and a large number of malaria deaths.

Indicator	Chhattisgarh	India
Total Population (In crore) Census 2011)	2.55	121.1
Decadal Growth (%) (Census 2011)	22.59	17.64
Crude Birth Rate (SRS 2011)	24.9	21.8
Crude Death Rate (SRS 2011)	7.9	7.1
Natural Growth Rate (SRS 2011)	17.0	14.7
Infant Mortality Rate (SRS 2011)	48	44
Maternal Mortality Rate (SRS 2011)	269	212
Total Fertility Rate (SRS 2011)	2.7	2.4
Sex Ratio (Census 2011)	991	940
Child Sex Ratio (Census 2011)	964	914
Schedule Caste Population (In crore)	0.24	16.6
Schedule Tribe Population (in core)	0.66	8.4

Source: http://nrhm.gov.in/nrhm-in-state/state-wise-information/chhattisgarh.html

As can be seen from the Table below, the maternal mortality rate, infant mortality rate and total fertility rate for Chhattisgarh are above the national average. The birth rate of the state is 25.3 and the death rate is 8. The natural growth rate of the state is 17.3 (SRS 2011).

Particulars	Required	in position	shortfall
Sub-centre	4904	5111	*
Primary Health Centre	776	755	21
Community Health Centre	194	149	45
Health worker (Female)/ANM at Sub Centres & PHCs	5866	16943	*
Health Worker (Male) at Sub Centres	5111	2514	2597
Health Assistant (Female) at PHCs	755	749	6
Helath Assistant (Male) at PHCs	755	153	602
Doctor at PHCs	755	435	302
Obstetricians & Gynecologists at CHCs	149	18	131
Pediatrician at CHCs	149	19	130
Total Specialists at CHCs	596	71	525
Radiographers at CHCs	149	87	62
Pharmacist at PHCs & CHCs	904	611	293
Laboratory Technicians at PHCs & CHCs	904	444	460
Nursing Staff at PHCs & CHCs	1798	552	1246
Source: http://nrhm.gov.in/nrhm-in-state/state-wise-information/chhattisgarh.html			

Human Resources in the Health System

The issue of scarcity of human resources for health in Chhattisgarh is a critical concern. There are huge numbers of positions vacant at all levels in the health system in Chhattisgarh. A review of the vacant positions gives an idea of the severe shortages of human resources for provision of health care.

Overall, a number of vacancies exist at all levels with a few exceptions. The vacant positions particularly at the level of the CHCs are stark. As on March 2014, according to Rural Health Statistics (RHS), there were several vacancies as is evident from the table above.

Cumulatively, there were only 71 specialists at CHCs for a state with population of more than 2.5 crores. These vacant positions reflect the lack of any serious intent of the government in providing health care and indicate severe crisis in Chhattisgarh in terms of shortfall in human resources.

The Family Planning Programme in the State	
Indicator	Chhattisgarh*
Total Fertility Rate (TFR)	2.7
Currently married women aged 20-24 who were married before 18 years of age	33.1%
Rural women aged 15-19 who were pregnant or mothers at the time of the survey	40%
Rural women aged 20-24 reporting 2 or more pregnancies	44%
Rural women reporting 3 or more births	30%
Live birth spaced less than three years apart	54%
Use of any family planning methods among currently married women aged 15-49 years	60.7%
Female sterilization among currently married women aged 15-49 years	49.5%
Male sterilization (current usage)	1.1%
Condom use	3.6%
Total unmet need for family planning services (both spacing and terminal methods)	24.4%
Annual Health Survey 2012-13 (Vital Statistics Division, Office of the Registrar General & Census Commissioner, India, New Delhi)	

The data above indicates trends and issues with regard to family planning in Chhattisgarh, which are not sufficiently addressed in the state's plans and budgets. The data clearly shows that men's role in family planning and contraception is very low; only about half the births were spaced beyond three years and the total unmet need for contraception is almost 25%.

The Targets in the Programme Implementation Plans (PIPs)

The Programme Implementation Plan (PIP) 2014-15 of the National Health Mission (NHM) indicates targets for female and male sterilisation. The funds were approved for the Chhattisgarh state in October 2014 whereas the financial year starts in April 2014. This effectively means that the state has to meet these annual targets in the rest of the six months. Selected indicators and their targets are indicated in the table from the PIP 2014-15 below:

The above table shows a target of 1,50,000 tubectomies for the current financial year and increase in targets to 1,75,000 and 1,90,000 tubectomies in subsequent years. Comparatively, the proposed targets for male sterilisation remain miniscule, reflecting the disproportionate emphasis on sterilisations for women. The PIP also contains the conditionalities for various services provided under the family planning programme as follows:

PROJECTION OF KEY INDICATORS (2014-15)				
Indicators	Current Status		Target/ELA	
		2014-15	2015-16	2016-17
Goal indicators				
Total Fertility Rate	2.8 AHS 2012	2.4	2.3	2.2
Unmet Need	24.8 AHS 2012	24	22	20
IUCD-Total	1,00,157 (HMIS 2013-14)	1,70,000	1,9000	2,00,000
Post-partum IUCD (Subset of IUCD-Total)	8356	17,500	20,000	25000
Female sterilization	124032	150000	175000	190000
Male sterilization (HMIS 2013-14)	4263	8000	10000	15000
Fixed Day service delivery				
Sterilization	FS:27DH daily 106 CHC weekly	DH daily +all FRU bi weekly	DH Daily+All FRU+50%Non FRU CHCs bi weekly	DH Daily+All FRU+100% Non FRU CHCs bi weekly
Source: Chhattisgarh NHM PIP 2014-15 Chapter 4 page 30				

Conditionalities for 2013-14: Family Planning			
Indicator	Target/FLA-2014-15	Minimum Level of Achievement	
		By end of Sep. 2014	By end of March. 2015
Goal (target)			
Reduction in TFR 2013	2.4	2.4	2.4
Service delivery (ELA)			
IUCD	1,70,000	1,05,000	1,70,000
PPIUCD	17,500	8,750	17,500
Interval IUCD	1,52,500	76,250	1,52,500
Sterilization	1,61,500	64,225	1,61,500
Tubectomy	**1,50,000**	**59,000**	**1,50,000**
Post-partum sterilization (subset of tubectomy)	3,500	1,225	3,500
Vasectomy	8,000	4,000	8,000
Chhattisgarh NHM PIP 2014-17 Chapter 4 page 31			

The above table indicates the targets for family planning to be completed by the end of September, 2014 and by the end of March 2015. Thus, despite the claims by the state that there were no targets, the budget plans continue to have targets for sterilisations. Locating these targets in the context of shortage of specialists in the health system, implies enormous pressure to meet the targets in the given time.

PROJECTION OF KEY INDICATORS (2014-15)				
Indicators	Current Status		Target/ELA	
		2014-15	2015-16	2016-17
Goal indicators				
Fixed Day service delivery				
Sterilization	FS:27DH daily 106 CHC weekly	DH daily +all FRU bi weekly	DH Daily+All FRU+50%Non FRU CHCs bi weekly	DH Daily+All FRU+ 100% Non FRU CHCs bi weekly
Source: Chhattisgarh NHM PIP 2014-15 Chapter 4 page 30				

The PIP also states that the female sterilisation services are provided daily at 27 District Hospitals and weekly at 106 CHCs under the fixed day service delivery as per the table below:

If the services are supposed to be provided daily at the district hospital and weekly at the CHCs, it is not clear why the camp approach was being adopted for the provision of sterilisation services and also raises doubts about the daily conduct of sterilisations at the District hospital and at the CHC.

Bilaspur District

Bilaspur district has 7 blocks with 898 villages and a population of 4, 52, 851. Bilaspur city is the second largest after Raipur in Chhattisgarh.

In terms of health infrastructure, according to Rural Health Statistics (RHS 2014) there are 274 Sub Centres, 55 PHCs, 8 CHCs, a Sub District Hospital and a District hospital in Bilaspur district. In terms of referral level health infrastructure, there are five designated first referral units (FRUs) in the district, of which only two were functional.

As indicated in the above table, with the exception of Bilha and the District hospital, the 3 other designated FRUs were not functional due to non-availability of gynaecologists, anaesthetists and blood storage units. Key indicators of the family planning programme in Bilaspur are as follows:

List of FRUs in Bilaspur and their functional Status				
Sr.no.	Name of FRU Civil Hospital	CHC/DH/ on Nov- 13	Functional as Non functional	Reason for being
1	Bilha	CHC	Fz	
2	Gourella	CHC	N	Gynae not available
3	Kota	CHC	N	BSU not functional
4	Masturi	CHC	N	Anae not available, BSU not functional
5	Distt. Hosp.	DH	F	
Chhattisgarh NHM PIP 2014-17 Chapter 4 page 48				

Similar to the statistics for the entire state, Bilaspur also indicates similar trends with a high percentage of the women married and pregnant between the age of 15-19 years. The table also shows very low male sterilisation rates and nearly 30 percent unmet need for spacing and permanent family planning methods.

The second maximum number of Laparoscopy Tubectomies (384) in the state have been reported under the Takhatpur CHC in the current year, which is not even designated as an FRU. This means that if there are any adverse effects the CHC does not have enough infrastructure and human resource to provide referral level services.

The indicators of the family planning services in Chhattisgarh, like most other Indian states, reflect the over-riding concern with controlling women's reproductive capacities. The calculations are top-down and reflect demographic anxieties, rather than what women or couples want. There are no clear calculations of how good quality sterilisation services will be made available in a district that barely provides sufficient skilled health workforce in its referral units. There are no planned actions to address informed choice or improve men's responsibility for contraception.

Indicator	Bilaspur*
Total Fertility Rate (TFR)	2.9
Currently married women aged 20-24 who were married before 18 years of age	39.3%
Rural women aged 15-19 who were pregnant or mothers at the time of the survey	48.4%
Rural women aged 20-24 reporting 2 or more pregnancies	44.3%
Rural women reporting 3 or more births	35.7%
Live birth spaced less than three years apart	52.8%
Use of any family planning methods among currently married women aged 15-49 years	63.1%
Female sterilization among currently married women aged 15-49 years	47.2%
Male sterilization (current usage)	0.7%
Condom use	5.8%
Total unmet need for family planning services (both spacing and terminal methods)	29.7%
**Annual Health Survey 2012-13 (Vital Statistics Division, Office of the Registrar General & Census Commissioner, India, New Delhi)*	

III. Methodology

The fact-finding team's visit to Bilaspur was preceded by the reports of the incident from JSA Chhattisgarh members. A meeting among concerned health activists and researchers was held at Delhi on 14th November to discuss the tragedy that was unfolding and to plan follow up action and response. A fact finding visit to Bilaspur was planned and areas for investigation by the team were discussed.

During the visit, the team was able to meet with the family members of the deceased women as well as those undergoing treatment. Interactions were carried out with health care providers and government officials as well as Meetings held with local organisations. The team visited the concerned health facilities and documented its observations. Verbal consent was obtained for the interviews.

The interviews and visits are listed in the following table:

SN	Interview with	Place
Day 1: 16 November, 2014		
1	Family of Shivakumari	Ganiyari
2	Family of Purnima	Beltukri
3	Meeting with Jan Swasthya Sahayog Team, Ganiyari	Ganiyari and Bilaspur
Day 2: 17 November, 2014		
4	Family of Rekha	Amsena
5	Family of Phulbai	Amsena
4	Family of Sitala	Amsena
6	Visit to Chhattisgarh Institute of Medical Sciences, Meeting with HOD	Bilaspur
7	Visit to District Hospital Bilaspur	Bilaspur
8	Meeting with Divisional Commissioner	Bilaspur
Day 3: 18.November, 2014		
9	Family of Dipti Yadav	Dighora
10	Meeting with JSS team at Ganiyari	
11	Visit to Nemichand Jain Charitable Hospital and Research Center Meeting the Watchman	Pendari
Other interviews across 3 days		
11	Mitanins	*
12	Mitanin Trainers	*
16	Staff members of one of the PHC (Medical Officer, Pharmacist and ANM)	*
**The locations of Mitanis, Mitanin Trainers, and PHC Staff have been removed for the purpose of anonymity*		

After the field visit, the notes were compiled by the team. The health indicators and profile of the state of Chhattisgarh and District Bilaspur were collated. Various government Standard Operating Procedures (SOPs), Guidelines, Supreme Court orders, policies were reviewed for the purpose of the report.

Limitations

The team was able to visit only 4 villages and meet the families and could meet families in the district hospital but were unable to have any in-depth interactions. Due to paucity of time, the team was unable to visit the Apollo hospital, interact with the District Magistrate, or travel to other villages.

IV. Findings

The findings that follow are based on interactions with the family members of women who had lost their lives following the sterilisations, as well as the families of those women who were admitted in hospitals with complications. These are also based on the discussions with government officials, PHC staff, Mitanins, Mitanin trainers, the members of Jan Swasthya Sahayog (JSS) and observation from the visits to Hospital sites.

a. Home visits and meetings with family members

The following is a list of women who had lost their lives according to the government and other news reports:[1]

	Name	Husband	Age	Caste	Village	Place of death
1.	Shivkumari	Bahorik Kevat	26	OBC	Ganiyari	Apollo
2.	Rekha	Jagdish Nirmalkar	24	SC	Amsena	District Hospital
3.	Phulbai	Rupchand	28	OBC	Amsena	Apollo
4.	Dipti	Dhanna Lal Yadav	28	OBC	Dighora	District Hospital
5.	Chandrakali	Tirath Ram	22	OBC	Bharari	Apollo
6.	Neera	Rajaram	30	-	Vindhasar	CIMS
7.	Ranjita	Santosh Suryavanshi	25	SC	Neertu	CIMS
8.	Janki	VIdyasagar	26	SC	Chichirda	CIMS
9.	Pushpa	Ramswarup	25	ST	Nanchuwa	CIMS
10.	Nembai	Ramavatar	30	SC	Ghuru	CIMS
11.	Sunita	Ramanuj	25	OBC	Ghutku Parsada	Apollo
12.	Dularin	Dinesh	25	OBC	Lokhandi	CIMS
13.	Chaiti Bai[1]	Budh Singh	30	ST	Dhanauli	On the way

i. Interview with Shivkumari's mother and husband Bahorik Kevat

Shivkumari had studied upto Class 10. Her husband, Bahorik Kevat had studied till Class 5. They did not own any land and he worked in a brick kiln. Their three children were 6 years, 3 years and six months respectively.

[1] Chaiti Bai, a Baiga (Particularly Vulnerable Tribal Group) died post sterilisation in Gourella block. After this tragedy, questions have been raised about PVTG women accessing sterilisation, as PVTGs are a 'protected' tribe, and said to be dwindling in numbers. This flags critical issues about the reproductive rights of the PVTG women.

According to Bahorik, the Mitanin had approached Shivkumari two or three times but had never informed them about male sterilisation. After Shivkumari got pregnant for the third time, the Mitanin reports that Shivkumari wanted to undergo sterilisation. A year later, the Mitanin informed her about the camp on on 8th November at Pendari.

Shivkumari, her mother and her two younger children along with Mitanin went by an auto to the camp at Pendari. The medical team registered Shivkumari and then conducted some examinations for blood pressure, urine and so on. They gave her an injection and when she had breastfed her baby, gave her another injection and took her inside after ten minutes. Her mother sat outside with the children for an hour and then Shivkumari came out. They stayed there until 5 pm and then came back with the Mitanin around 7 pm or 8 pm.

The medical team gave two kinds of medicines but no information was given about what was to be done if any adverse effects were experienced. The Mitanin gave them Rs. 600. After returning home, Shivkumari took the medicines after eating food as told by the Mitanin around 9 pm.

Around 11 pm that night she woke up with pain and repeated vomiting. By the next morning (9th November - Sunday) she hadn't stopped vomiting and was rushed to the nearby Primary Health Centre at Ganiyari. The staff there put her on IV Fluids (two bottles) then got an ambulance and moved her to the Chhattisgarh Institute of Medical Sciences (CIMS) in Bilaspur. They treated her there for four to five hours and then moved her to the Apollo hospital around noon. She received treatment for two nights at Apollo Hospital but passed away on 12th November. Her body was brought back to CIMS for post-mortem.

On 16th November the local Vidhayak visited the family and handed over a cheque for Rs 2 lakh. The District Collector and other officials also visited her home and gave another cheque for Rs 2 lakh to Bahorik. He does not have a bank account yet. He wanted some support from the government for his children as he was now a single parent. He felt that after these deaths, people will be afraid of such camps in future.

ii. Interview with Rekha's grandmother, Bedanbai

Rekha had studied till Class 10 and was married to Jagdish Nirmalkar, a daily wage labourer from the Dhobi caste (Nirmalkar). He had studied till Class 8. They had two children - the older one was two and a half years and the younger one was four months old. Her husband lived in Karilkunda from where health services are not very accessible. When she decided to go for sterilisation, she preferred to access services from her natal home in Amsena.

The nurse from the local PHC informed Rekha about the camp on 8th November. Rekha's grandmother accompanied her to the camp where she was registered and some tests were conducted before taking her inside around 4 pm. Her grandmother mentioned that when they arrived, there was someone sweeping the place to get it ready for the surgeries. Rekha left the camp around 6 pm and returned home with some medicines, which she took around 9 pm.

Sometime close to midnight, Rekha began vomiting repeatedly. The family checked with others in the village who had gone to the same camp, and found that they were all very sick. The next morning all the women reached the PHC and Rekha was admitted and was on IV fluids. Around 1.30 pm, they were all moved to the Bilaspur District Hospital by ambulance. While being treated there, Rekha's condition became serious, so they arranged for her to be shifted to the Apollo hospital. But she passed away as she was being taken to the ambulance.

The older son was with her husband Jagdish and the younger child was with Rekha's sister during the visit.

iii. Interview with Phulbai's husband Rupchand

Rupchand had studied upto Class 12 and is a barber. They have three living children - the first-born, a girl, had died, then they had a son (8 years), a daughter (4 years) and another son (1 year old). They decided that Phulbai would undergo *nasbandi (*tubectomy) as they did not want any more children on 8th November, Phulbai was accompanied to the camp by the 'Dai' (also referred to as 'nurse'). After the surgery, Phulbai returned home and took the medicines in the night. She had pain and discomfort all night. The next day, 9th November, she took the medicines both in the morning and evening; then she began vomiting repeatedly. On Monday, around noon, the Nurse from the local PHC, came to Phulbai's house and said that she should be hospitalised. She was taken to the local PHC nearby, and an IV-line started. Later, she was taken to the district hospital where she was given three bottles of IV fluids.

Phulbai was able to talk and had stopped vomiting, but they said her condition was serious and referred her to CIMS where again, they gave her four bottles of IV fluids. Rupchand recalls that both at the District Hospital and at CIMS, and the officials came to see the affected women admitted in the wards. The CIMS doctors said that her BP was too low so they referred her to Apollo hospital. They put her in a wheelchair, although Phulbai was still able to talk and she also breastfed her baby.

At 8 pm, her husband was asked to sign on papers regarding her admission in Apollo but was not asked to pay anything. After half an hour, around 8.30 pm, the doctors came to see her and said her 'heart stopped functioning' but they were trying to save her. Later around 11 pm at night, they informed her husband that she had passed away. Her husband went in to see the body and then accompanied the body to the morgue. Next morning, the body was sent to CIMS for post-mortem. Then he was provided an ambulance to take the body back home and was accompanied by police. Rupchand was later given Rs. 4 lakhs from the health department and from the Chief Minister's Relief Fund.

iv. Interview with Dipti's husband Dhannalal Yadav and mother-in-law

Dipti was 26 years old and married to Dhannalal Yadav. They have three children - 6 years, 5 years and the youngest 3 months old. Dhannalal had studied upto class 5 and is a daily wage worker at a nearby factory. They live in a joint family of seven brothers and sisters. Dipti took care of household work and also helped with farming on their one acre land. Since they already had three children, Dipti was planning to go for sterilisation.

After birth of their youngest daughter, they had decided that they would not have any more children so that they could provide care to their children. (We have to care for them too, don't we? - *Bachhon ko paalna bhi hai na?*) Dipti could not undergo sterilisation immediately after the birth of their daughter as the Mitanin had suggested that the sterilisation should be done after the baby gets three months old. The Mitanin went to Dipti's house on the day of the camp (8th November) and told the family about the camp.

Dipti went to the camp with her mother-in-law, her youngest daughter and the Mitanins. She took her daughter as she had to breastfeed the child. They went to Pendari camp in an auto as there is no other transport facility in the village.

Once they reached the camp, the medical team entered Dipti's name in a register and asked her to wait outside for half an hour. Later, they did some investigations, checked her urine and blood pressure. She breastfed her child. They gave her an injection and then within half an hour they took her into the OT where the mother-in-law was not allowed to go in. The camp got over between 4 pm -5 pm. Many other women were there too. When Dipti came out of the operation room she looked a bit drowsy and we all took the local transport and came back home. The Mitanin handed over Rs 600 to her.

At night Dipti complained about pain and then began vomiting. The ANM came next day and said that all those women who had gone through the sterilisation were vomiting and so they had

to be taken to the hospital. First they went to the PHC where they put Dipti on IV fluids. Her husband did not go in the ambulance; the ambulance went with Dipti and three other women and health workers. The husband went later, on his own with the baby. From PHC, she was taken to CIMS where she was put on IV fluids again. From CIMS, she has been shifted to Apollo hospital at midnight. On Wednesday, Dipti passed away and her body was kept in a morgue. The next day, her body was released and taken to CIMS for postmortem.

A cheque for Rs. 4 lakhs was handed over by the local Member of Legislative Assembly and the District Magistrate who visited the family on 17th November. Dhannalal was very concerned about their three children, and worried how he would take care of them and educate them. Dhannalal had heard the media reports that the medicine was contaminated by rat poison and wondered why such medicine was given and why it was not tested prior to use.

v. Interviews with Purnima's mother-in-law and father-in-law

Purnima is 27 year old from Beltukri who got married 4 years back. Both she and her husband work as daily wage labourer. They have 3 children – two daughters and a son, who is five months old. The Mitanin told her about the camp eight days before it happened. Purnima had asked the Mitanin to take her for the operation as she already had two daughters and a son. Her husband also wanted her to go for sterilisation.

On 8th November, the Mitanin took her to the Pendari camp in an auto along with three other women. It costs about Rs. 10 per person to reach a place near the camp hospital and return. When they reached there at 11 am, the nurse wrote down Purnima's name . They took Purnima's signature on a form. They did the blood and urine examination, along with internal examination. Then the medical team took women into the operation theatre one by one. The Mitanin accompanying her was not allowed to go inside. Once Purnima came out after surgery they left for their village. Once reaching home, her mother fed her tea and bread (roti) so that she could take the medicine. Purnima vomited just after she ate the food. Later in the evening she took one dose of tablet that was given to her. Throughout the night, Purnima kept vomiting. In the morning on the 9th November, the family called the local MPW who came and gave her an injection and some medicines.

Her vomiting stopped thereafter. She had taken only one tablet and she was able to eat and there was no fever. She did not vomit the next day, 10th November. Then again she started vomiting in the evening and the MPW came around 6 pm and told the family to take her to Bilaspur. However, there was no ambulance available and hence they went to the JSS hospital and received treatment. On 10th November Monday night around 2 am, the patwari came and told the family that Purnima needed to be sent to the government hospital. They called the 102 ambulance, which did not come. So the 108 ambulance was called and the family (husband, mother and children) accompanied her to the hospital. She was at CIMS at the time of the fact finding visit and her husband and mother were with her.

vi. Interview with Sitala's father

Twenty three year old Sitala Yadav and her husband Sanjay lived with Sitala's parents along with their three children. Sitala's three children are aged 5 years, 3 years and the youngest is 11 months. Her oldest son has a speech impairment. On 8th November, the village Dai came to ask

her whether she wanted to go to the sterilisation camp. Sitala went with her along with two other women (PhulBai and Rekha) of the village. Once she came back from the camp she fell ill at night. On Sunday 9th November, the Dai came and told them that all women who had gone for the camp were falling ill and took her to Bilaspur District Hospital. On Monday (10th) she was shifted to CIMS. Subsequently, she was identified as one of the more severe cases and shifted to Apollo where she has been on a ventilator until the time of this interview (18th November).

Sitala was on ventilator at Apollo hospital. With Sitala's husband and mother at the hospital along with the youngest child, her father is taking care of the other two children alone at home. The youngest child was with Sitala's mother and husband, Sanjay Yadav at the hospital.

Her father was not able to leave the house to go and see her. "But at the hospital only one person is allowed to see her at one time therefore many relatives who have come from far away have had to go back without seeing her" he said. "I have not seen her for nearly 15 days as I had gone elsewhere to work and returned only after I got news of her admission into hospital" he added, very distraught. Her grandmother keeps crying and says: "Why did she have to go now for this operation? She was a *derhauli* [i.e. she would conceive every one and a half years or *derh saal*] and could have waited."

Her father said that at Apollo, her husband and mother were being provided space to stay and also given food. They don't have to spend any money for treatment. However, the doctors don't regularly give news of how she is doing. As a result the whole family is very anxious. Till now no financial aid has been given by the government though compensation of Rs. 50,000 has been announced. The family is in dire straits. Her father lamented, "I can go to work because I have to take care of the children and the house, my paddy is standing in the field ready for harvest but there is no one to cut it. We have to spend money to travel to Bilaspur frequently and we don't have any money left now. The government has also not sent us any money. What do I do?"

Her father showed Sitala's picture, taken with her younger brother. He said: "The kids cry for her every night. They are not eating well. We just want her back."

b. Meetings with Mitanins and Mitanin Trainers

The Mitanins[2] are the frontline health workers / volunteers in Chhattisgarh, selected from and by the communities, who have been playing a key role in provision of health information as well as in facilitating access by the communities to health services. They form an important link between communities and the health system.

Four Mitanins and two Mitanin Trainers were interviewed during the visit to Bilaspur. According to the Mitanins, they were asked to motivate women to have 'smaller families' and 'leave a gap of three years' between their pregnancies. Some of them denied that there was pressure on them to meet targets but acknowledged there was an expectation that they could bring around three cases each to the 'camps'. They were not, however, equipped with any supplies of contraceptives

[2] Mitanin means "friend" and Swasthya Mitanin – friend of the village for health care needs. The broad objectives of the Mitanin Programme begun in 2002 included health education and improved public awareness of health issues. (for more details, see http://cghealth.nic.in/ehealth/studyreports/Mitanin%20Programme%20draft...pdf)

for spacing such as condoms or oral contraceptive pills that they can hand out to people in the community. They know about the Copper-T but not all know about male contraception methods like vasectomy, especially the myths and misconceptions.

One Mitanin said that the ANM was given targets, but these were not imposed upon the Mitanins. While the Mitanin receives an incentive if she motivates women for sterilisation, the ANM adds the numbers to fulfil her target. She shared that she had been taking Mala-N (oral contraceptive pills) for nearly 10 years, which she discontinued due to rumours about it leading to cancer and other problems. She then conceived 12 years after her last child and gave birth to a son.

With regard to this particular incident, the Mitanins were asked to inform women, whom they had already identified in the community, about the sterilisation 'camp' to be conducted at the Nemichand Jain hospital building in Pendari on 8th November. Some of them accompanied the women, others travelled back home with the women after the sterilisations were done. They paid the women the Rs. 600 which was provided by the health department . They also received a small fee as 'motivators' for sterilisations, which was around Rs 150 per person.

According to Mitanins, after the sterilisation the women who had surgery were given two kinds of tablets, which should be taken after having food. However, when the women began falling sick and some of them died, the Mitanins were shocked. Some of them also felt very threatened in the community. However, they visited the families where the women had fallen sick and helped in the identification of women for referral and treatment before they were shifted to Bilaspur. A Mitanin said, "It's a good thing that only one woman from my village who I took to the camp has lost her life; otherwise if there had been three or four, the villagers would have set fire to my house and burned me alive." Another Mitanin said that they were subject to verbal abuses in the community following this incident, which they cannot escape as they have to live in the same community.

During our visit we observed that all the Mitanins and trainers looked worried and traumatised. One of the Mitanins was upset and worried that people would blame her as she had motivated women to go for tubectomy. She felt guilty that she had taken them for this fatal operation, and was also concerned that the community would challenge her even if she was to mobilise them for polio vaccination. She felt that people may not socialise with her following this incident which would make life difficult since she had to continue to live in the same community and village.

Another Mitanin said that there were two of them in the same village and during the last Mitanin meeting, they had been told to motivate women to come for sterilisation. Following this, both of them divided the task and she had motivated two women for the camp on 8th November. The other Mitanin took one woman from the village as she herself also wanted sterilisation. That other Mitanin is now in Apollo Hospital in critical condition. The Mitanin Trainer was worried about this other Mitanin from her village who was in Apollo hospital. She was also concerned about one of the Mitanins who was not eating well, was very upset and constantly crying since the death of the woman whom she had motivated. She was also worried about the other Mitanin from her village who was in Apollo hospital.

The Mitanin trainer, when asked about the probable cause of the deaths, said that there could be many reasons such as negligence by the doctor, or poor hygiene because of contaminated gloves and needles. Contaminated medicines can also be the reason. There were no in-patient facilities at the hospital and women were usually discharged within one to two hours following deliveries.

c. Interactions with Health Care Providers and Government Officials

i. Interaction with PHC staff

The PHC staff described their quick response in this episode of referring the patients to higher centers such as CIMS and District hospital. They said that it was really unfortunate that such an incident had taken place. They recalled that there was a diarrhea epidemic recently in the villages in that area, but fortunately no life was lost as they managed to treat the patients effectively. They were really satisfied about their work then. The sterilisation camps had been organised like this for a long time and there had never been an incident like this. However, they said that the deaths in the camps took place because of the faulty medicines. The staff admitted that they were now circumspect in prescribing any medicine because of this episode. They stated that they had surrendered all their tablets of ciprofloxacin, even if they were from a different company, and they were not prescribing them anymore.

ii. Visit to CIMS and meeting with a Head of Department

Thirty-three patients from the camp were admitted to the CIMS hospital at the time of the visit. It was reported that there were four women in the intensive care unit (ICU). There were also 18 patients who were not in the sterilisation camps and did not undergo sterilisation but suffered similar symptoms as those from the camps.

A committee had been formed at the CIMS hospital for decisions regarding the discharge of the patients. For discharge of any patient, it was mandatory to consult any four of the doctors from this committee. The women from the camp were kept in the surgery ward. Ten ventilators were available at CIMS, which were being used for these patients. The workload was quite high. The Apollo Hospital had back up from Apollo Hyderabad and Bhubaneshwar.

Regarding the treatment being provided to the women at the CIMS hospital, the doctors said that the women were being treated for symptoms, as there have been various theories about what happened. It could be infection, or as a result of contaminated drugs but the cause was not clearly

known. They were being given oxygen; some of them needed suction and some of them were on ventilators. In the microbiology investigation, no bacteria had been found yet. But to reach a conclusion, reports from the clinical investigations, post mortem reports and micro-biology reports needed to be corroborated. Whether septicaemia was an issue or not, no one can justify a doctor doing so many surgeries at a time. The HoD felt that there could be many causes of death such as septicaemia, cardiac reasons, neurological reasons or hypovolemic reasons where there is excessive loss of body fluids such as blood. The autopsy and viscera reports had not come yet which could give an indication of what exactly happened. As of now there are similar symptoms of patients due to drug toxicity and the sterilisation camps and so they were all being treated for drug toxicity.

According to HoD, the government had announced that they would take responsibility of the education of the children of the women who had died. According to him, "Mahavar company had been supplying drugs to the government since 1996. The procurement happened through a proper process of bidding and tender."

ii. Interview with Mr. Sonmoni Bora, Bilaspur Divisional Commissioner

According to the Commissioner, the total deaths were 13 and there was absolutely no need for the government to hide any deaths. Some women were still critical and on the ventilator; most of the women's kidneys and lungs were affected and several were going through dialysis. Some of them were going through dialysis and around 33 women were still in critical condition at the time of the interview (17th November 2014).

Regarding the response to the situation, the Commissioner thought that he had done his best to contain the tragedy and treat the women in an emergency situation. The Commissioner stated that reports of 16 deaths was unfounded. He also said that the government had paid compensation to the families and survivors of the 13 women who had passed away. There could have been 50-66 victims of the tragedy given that vomiting may not have been taken seriously medically but it was not ignored.

There were reports coming in from other places too and hence the Commissioner had instructed that all the women should be brought in immediately, even though the distance was 120 kilometres to the District hospital. Ambulances were sent to every village and all those who underwent the sterilisation at that particular camp were identified and brought to hospitals. Despite this, one woman had died on the way.

The Commissioner shared that the government had called a team of doctors from All India Institute of Medical Sciences (AIIMS) New Delhi, who spent a day and gave inputs on the line of treatment. Since the District hospital and CIMS did not have enough ICUs or ventilators they have shifted women who were critical to Apollo, a private corporate hospital. On the same night 13 ICUs were created at Apollo hospital immediately to treat the women who were coming in.

There were 66 women at Apollo at the time of the team's visit. Equipment and human resources were urgently required which were provided by nearby hospitals. AIIMS Raipur has provided 8 ventilators to CIMS. In addition, Apollo Hyderabad, Kolkata, and Bhubaneshwar had sent their staff. Apollo was made the base of the treatment operations— the 'simple cases' were sent to

CIMS, the more complex ones to Apollo hospital. The State of Chhattisgarh paid Apollo hospital certain amount in advance to ensure that treatment was started immediately.

According to the Commissioner, Rs. 2 lakhs out of the total 4 lakhs compensation had been paid immediately to the spouses and families of the deceased. However, the remaining amount of Rs. 2 lakhs would be paid to the children of the deceased women in the form of a fixed deposit that could be accessed on reaching 18 years, keeping in mind that the husband may eventually remarry and the children might be neglected. Rs 50,000 would be paid to the survivors. The Chief Minister had announced that for the children whose mothers had died, their education would be taken care of by the state till they reached 18 years. The children were also being provided with an Apollo Medical Health Card that they could use till 18 years of age. The Commissioner stated that Apollo hospital cards were being provided instead of public/ government hospitals, as the latter did not have the facilities that Apollo hospital had. "It made no sense to give them cards to access medical services that are insufficient."

The Commissioner said retired District and Sessions Judge Anita Jha, had been appointed as the one-member judicial inquiry commission by the Chhattisgarh government to probe the sterilisation deaths; however the ToR states that "during the course of enquiry/investigation the commission can take assistance of any organisation/expert on technical subjects/points."

The Commissioner stated that as soon as they were informed that spurious drugs may have been used, the batches were confiscated. An advisory was sent to all the hospitals – both public and private, and this was also put up on the government website. The drugs had been sent for testing, and results were awaited. Septicaemia could not be ruled out completely but would be clear from reports, including the forensic reports.

The surgeon who performed the sterilisations was arrested and the owner of the Mahavar Pharma company was also arrested.

iii. Visit to Nemichand Jain Charitable Hospital and Research Centre Building

The sterilisations took place at the Nemichand Jain private charitable Hospital Building. It had not been in use for many years. A closer look at the hospital revealed evidence of disuse—broken window panes and a reception area hurriedly assembled for the sterilisation camp. The place was rife with cobwebs, thick dust, and rusted frames. The biomedical waste was thrown at many places on the campus. Most rooms of the building seemed locked for a long period of time. It was difficult to imagine any activity there, let alone surgeries.

The Operation Theatre (O.T.) remained sealed during the visit and could not be accessed to ascertain whether it met with the necessary standards for conducting sterilisations.

According to the watchman of the hospital, it was opened in 2007 and it functioned on and off for two to three months. There was a plan to donate the building to an Ayurved hospital but that did not happen. The same Dr Gupta, according to him, must have performed around 2500 operations in the hospital. On the day of the surgeries, they usually hire someone for cleaning up the place, or the government staff goes for cleaning. No other camps happen there except for sterilisation camps. The watchman said that before the camp on 8th November, another camp took place on 18th October. On 8th November, all the women were healthy at the time of discharge, according to him. After the surgeries, the women were given durries on the floor where they rested. He said that the lab tests were done outside the operation theatre (not in the lab room).

iv. Visit to the Bilaspur District Hospital

At the time of the visit, a total of 14 patients were in the In-Patient department of the district hospital. The discharge papers were ready for 11 of them. Three patients were under observation for some more time. According to a nurse, the patients were stable. She also said that the women had been vomiting at the time of admission to the hospital. Initially, 10 patients from the Pendari camp were referred out, and later two more patients were referred to CIMS. The women were being given Piperacillin Tazobactam and IV fluids such as DNS and RL.

v. Meeting with the members of Jan Swasthya Sahyog (JSS)

The fact finding team had a series of interactions with the Jan Swasthya Sahyog team in Bilaspur. The JSS, literally People's Health Support Group, which is located in Ganiyari, Bilaspur has been running a community health programme in rural Chhattisgarh for the last 15 years with a focus on providing rational, effective and low cost health care to the people of this region. JSS also offer a choice of various contraceptives for both men and women including mini laparatomy method of tubal ligation for women and vasectomy for men.

Meetings with the JSS team Suhas, Anil, Ben, Manju, Sharayu and others also provided important information towards understanding the sequence and details of the tragic events in Bilaspur. Three women, who had attended the sterilisation camp on 8th November at Pendari, were from Ganiyari village itself. Of these, one woman had died and the others were in hospital with complications. Some of the JSS team members also accompanied the fact- finding team to Ganiyari village to meet the families of the women. Discussions with Dr Yogesh Jain and Dr Raman Kataria, and Dr Rachna Jain provided key information about the health care context in Bilaspur and critical insights into the sterilisation, and the subsequent state response. According to Dr Yogesh Jain and Dr Raman Kataria, this was a tragedy waiting to happen given the way targets were prescribed and camps were held. The Chhattisgarh government had set itself a target of sterilising 1.5 lakh women in the current year. And this avoidable tragedy should be a lesson to urgently reorient public systems, and build equity - not merely in terms of accessibility or costs, but also in terms of quality.

V.Emerging Issues

The shocking incident in Chhattisgarh, where 13 women died and many more fell severely ill after undergoing surgeries for sterilisation illuminates many aspects that are wrong with the public health system in India. This episode is also a clear indictment of the population control agenda of the Indian government, which has, for decades, been characterised by targeting and coercion of poor women with gross human rights violations.

The following section raises serious concerns at multiple levels emerging from the fact finding team's investigation into these sterilisation deaths and complications.

A. Systemic Issues

i. Issues regarding Location, Infrastructure and Human Resources

The sterilisation camp conducted at Pendari village on 8 November 2014 flags several medical, systemic, administrative, and ethical issues. This camp is symbolic of the pervasive apathy of the system and blatant violations of accepted standards in sterilisation camps, which have been normalised and justified as responding to a large 'unmet need'.

As per the Standard Operating Procedures (SOPs, March 2008) for the sterilisation operations in camps[3],

> *"A sterilization camp is defined as alternate service delivery mechanism, when operating team located at a remote facility (District HQs/Medical colleges/ FRUs) conducts sterilization operations at a sub district health facility, where these services are not routinely available."*

The place where the sterilisation surgeries were conducted was neither a 'remote facility' (just 6 kilometres from the city of Bilaspur), nor was it a government health facility, displaying clear violation of the SOPs; instead the camp was organised in an abandoned private facility.

As per the SOPs, the facility in-charge is to be the 'Camp Manager', who has the overall responsibility for effective organisation of the camp. In the case of the camp at Pendari, the evident absence of the Camp Manager and the non- functioning facility draws urgent attention to the violation of the most fundamental requisites for organising a sterilisation camp. Further, the camp was organised in a derelict private non- functional facility, largely abandoned after 2007, except for a few stray sterilisation camps that had been organised there previously. There was no maintenance of aseptic conditions, This has serious implications for management of coordinated and quality services. For example, the Camp Manager is responsible for ensuring the aseptic conditions of the Operation Theatre (OT) and for availability of all emergency medicines and other supplies. The responses from the interactions were uniform with regard to the unhygienic

[3] Though reference is being made to the 'Standard Operating Procedures for Sterilisation Services in Camps (2008) in this document, there is need for a review of these SOPs themselves. The reference to them is due to lack of any other updated reference document.

conditions of the premises. Given the situation of the facility and the fact that surgical camps had been organised there previously, point to repeated lapses in adhering to the SOPs by the state health department.

Although the SOPs specify a separate area for counselling services, for pre operative care, as well as a separate room for post operative care, discrete areas were not provided despite availability of space. This neglect of the SOPs compromised quality and safety norms towards prevention of infections. With regard to the specific camp on 8th November 2014, none of those who were interviewed mentioned any IEC activities in the community, pre-operation counselling, a uniform registration process, lab investigations, or pre operative and post operative care.

ii. Procedural Issues

One of the gravest facts about this camp was the conduct of 83 sterilisation surgeries within a few hours. By some accounts, the surgeries were conducted in merely 2 ½ hours. This has serious implications for the maintenance and use of sterile equipments, instruments like the laparoscope and other reusable items. Given the limited duration in which all 83 sterilisations were conducted, the time for each procedure and the time between procedures was evidently minimal, suggesting serious compromises with regard to the safety and the quality of the procedures. Furthermore, the use of a single laparoscope for 83 women in the limited time as was done in this camp is undeniably appalling and a gross violation of standards of asepsis.(The OT remained sealed at the time of the visit and hence could not be observed.)

Following the surgeries, the women, some with their children as young as 3 ½ months were made to lie down on durries that were placed in the corridors, immediately outside the operation theatre. Following surgery, the post operative area must be necessarily restricted to prevent post operative infections, which was entirely overlooked here. There were no designated post operative recovery rooms where the women could be shifted. The corridor was also unclean filled with cobwebs. The processes in the camp thus caused tremendous risks to the health of all the women who underwent the sterilisation procedures in the camp.

The discharge of the women within an hour or two of the surgeries, which is the routine practice in such camps, is responsible for many of them losing their lives. The quick discharge does not take into account that the villages from where the women may have come do not have proper transport facilities, except emergency ambulances (108 / 102). Discharging women within a few hours of the surgeries took them far away from health care services, reducing the chances of the adverse symptoms being picked up early and delaying the emergency response. Their early discharge delayed their access to critical health care; women could not access transportation on time when they started having complications, and experienced delay in reaching health care facilities, where they either died within a short while after reaching or required prolonged and intensive care.

iii. Issues around Consent

The basic principle with regard to person's consent is that "Every human being of adult years and sound mind has the right to determine what should be done with his/her body; and a surgeon who performs the operation without the patient's consent commits an assault for which he is

liable for damages."[4] This principle has been accepted in cases of sterilisations and reiterates the fundamental principle that every person's body is inviolate and performance of medical operations without consent is unlawful. It is imperative that the physician / treating doctor, explains the procedure, the risks on the particular course of action and the alternatives available to the patient. This is the overall obligation of the doctor, with a disclosure of choices with respect to proposed procedure and the dangers inherent.

Some of the families mentioned signing a form, prior to the surgeries, and some said that signatures of the person accompanying the women were also sought. However, this was not preceded by any process of counselling or provision of information regarding the sterilisation that would facilitate 'informed consent' by the women. The process of explaining to women and to their families the procedure, possible adverse effects of seeking treatment or options for obtaining compensation in such an eventuality, seemed to have not taken place at all. Alternatives to sterilisation were also not explained. As mentioned before the male surgical procedure was also not offered as a safer method.

Merely obtaining signatures on the consent form, does not amount to consent. The surgeries flouted norms of medical ethics and the principle of informed consent.

iv. Right to Medical Records

The four bereaved families who were interviewed had almost no medical records whatsoever. Only one of the husbands was able to show a death certificate of his wife; others had received compensation but no death certificate. No copies of the cause of death and post-mortem reports were given to any of these families. Neither did any one mention having received copies of the form consenting to sterilisation, or any information about the insurance cover in case of adverse effects, or the discharge summary. This raises serious ethical issues about the lack of formal documents available to the women and their families, including any documented evidence of having undergone sterilisation. Access to his / her medical records is the right of any person and is imperative for seeking justice. Witholding of the medical records and documents raises presumptions against the accused, as prior to any surgery, express, written informed consent is required to be taken. Even under the Code of Medical Ethics,[5] the medical records of the patients should be given to them within 72 hours of the request to the same.

v. Absence of Quality Assurance and Monitoring

Fundamental questions about the conduct of mass-sterilisation camps with inadequate personnel and equipment remain unanswered. These operations are not urgent and are elective. However, the seriousness of this surgery - requiring skills, high quality sterilised equipments, adequate

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[4] 1. *Schoendorff vs. Society of New York Hospital,* (1914) 211 NY 125
2. *In Re : F.* 1989(2) All ER 545
Both these cases have laid down the principles which are followed in India, and has been quoted in judgements of the SC in India, in Samira Kohli v. Prabha Manchanda, AIR 2008 SC 1385

[5] Code of Ethics Regulation, 2002 (amended upto 2010). Accessed at http://www.mciindia.org/RulesandRegulations/CodeofMedicalEthicsRegulations2002.aspx last accessed on 15.9.2014

time and high standards of sanitation and hygiene –is routinely undermined, placing the women undergoing the procedures in a precarious situation. Such a camp approach where the operations are carried out in unused, unhygienic surroundings, unfit to be a locale for surgical procedures, conducted in an extremely short time, makes it akin to assembly-line processes, with the inevitability of complications and the danger to the women's health and lives.

Although all of this can and should be easily avoided, they were blatantly and consciously not done due to the total apathy and laxity in attitude of the government and the staff involved in the entire procedure.

The District Quality Assurance Committee (DQAC) is supposed to monitor at least 10 percent of the camps in the district. The question arises how the DQAC was monitoring quality of sterilisations in Bilaspur and whether they are a functioning committee. In fact, even after 9 years of the Supreme Court order of 2005 in the Ramakant Rai case, there was non-compliance and blatant neglect of processes for monitoring and quality assurance.

vi. Issue of Medicines: Spurious, Contaminated or Approved?

Tablets of the antibiotic ciprofloxacin (Ciprocin 500), manufactured by Mahawar Pharma Pvt. Ltd., were seized by the government under suspicion that the medicines contain zinc phosphide, a known rat poison. Mahawar Pharma is a small-scale manufacturer, which supplies medicines to the state government. Immediately after the deaths, batches of ciprofloxocin were confiscated from all drug stores in the district and an advisory[6] was issued by the state health department to all doctors (both private and public) not to use medicines manufactured by Mahawar Pharma. The seized medicine samples were sent to Delhi, Kolkata, and Nagpur for chemical and biological analysis. Though the above advisory has been widely circulated, leading to wide ranging speculations in the media, the preliminary reports of the analysis have not yet been made available to the public until the time of this report ten days after the incident. Neither has there been any official communication regarding the forensic and viscera reports. At least one newspaper has mentioned that one of the deaths was due to septicaemia (thus discounting the link of the deaths with zinc phosphide contamination).[7]

Families of victims and community members seem convinced by the theory linking the deaths to contamination of medicines with rat poison and have vehemently expressed their anger towards the pharma company and concerned health officials for the negligence. The advisory has generated panic in the local community as regards medicine prescribed in government hospitals. One of the Mitanins reported that some people in the village even started doubting Polio vaccine, saying that it may result in some disease.

Though causality has not been proven as yet, by transferring the entire blame to a single drug manufacturer, the overarching issue of targets and violation of the Supreme Court's guidelines – which lie at the heart of the tragedy - has been bypassed. Discussions in the national and international media have started focusing on the supposed poor quality of generic drugs, produced

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[6] http://cghealth.nic.in/ehealth/2014/DHS/Sawdhani_Chetawani.pdf
[7] http://in.reuters.com/article/2014/11/14/india-health-sterilisation-chhattisgarh-idINKCN0IY0J620141114

by Indian manufacturers. Even if the drugs manufactured by Mahawar Pharmaceuticals were contaminated with zinc phosphide, this in itself does not constitute proof that all Indian generics are of poor quality. In fact, there are numerous examples where branded drugs, manufactured by reputed manufacturers, were found to be sub-standard. The target of ire should be the quality control system in place and not generic medicines, per se.

Some states in India (such as Tamilnadu and Rajasthan) have developed a transparent process for the procurement of medicines for public facilities that takes into account both the price of the medicines and the quality of medicines being procured. The state government of Chhattisgarh is to blame if it was not following best practices as regards pooled purchase of medicines. We understand that in the state, medicines were being procured from manufacturers who quoted the lowest prices, in response to tenders that were floated, without any regard for quality. Further, the quality control infrastructure is seriously undermined by lack of quality control laboratories and qualified drug inspectors. Only a few states have laboratories that can test the quality of medicines. Thus in Chhattisgarh, which doesn't have such laboratories, the samples had to be sent to laboratories in other states. Such a situation also ensures that test results take a long time to be received back, thus making a mockery of the entire system, as in the meantime, the concerned drug has already been consumed by a large number of patients.

This unfortunate incident, irrespective of the final test results, must spur action in radically overhauling and improving the quality control system for drugs in the country.

B. Response of the State and Central Governments

i. Treatment for Affected Women

The findings indicate that there were some efforts by the Chhattisgarh government and local health officials to respond promptly by identifying and bringing all the women who had undergone sterilisation in the four camps to nearby health facilities – both public as well as private - for observation and treatment. The local authorities attempted to grade the women's health status and referred them to the Bilaspur district hospital, CIMS and Apollo hospital in case of mild, moderate or serious conditions respectively. Senior officials were taking regular stock of the situation in the hospitals and enquiring after the treatment of the women. Families of the women indicated that most of them did not incur any costs for admitting the sick women to hospital. There were ambulances arranged to take the women to higher referral centres and families also got a place to stay with the small children in the hospitals, while they waited for the women to get better.

ii. Emergency Team's Visit to Bilaspur

Although the outrage of those protesting the deaths of the women after sterilisation is largely directed at the Chhattisgarh government, and to good reason, yet the Central Government's Ministry of Health and Family Welfare cannot be exonerated. The Government of India appears to follow the general trend of shifting the onus of what happened to the Chhattisgarh government. There was no response from the Union Minister of Health and Family Welfare beyond saying that India does not follow a 'target-oriented approach' and shrugging off any further responsibility. The sending of a team from AIIMS New Delhi appears to be mere tokenism, as the AIIMS team

did a perfunctory day-long visit and did not stay on to help the local doctors and provide top-quality care to the suffering women. They were content with briefly checking the line of treatment being followed at the private Apollo hospital and at the CIMS hospital, and returned to Delhi soon after.

iii. Enquiry into the Tragic Events at Bilaspur

The Chhattisgarh government set up a Judicial Enquiry that is to submit a report within three months. However, the single person enquiry does not comprise independent experts from diverse fields, who could examine the multiple dimensions of this tragedy and provide specific analysis and directions on how these may be avoided.

The Terms of Reference (ToR) for the Judicial Enquiry to inquire into the sterilisations and the consequent deaths that took place must be clear towards a comprehensive understanding of what transpired. The Terms of Reference are extremely limited and necessitate substantive additions to it. Currently the ToR appears to be a series of queries to lead the Enquiry, whereas the terms should also clearly state the scope, objectives, purpose and detail the areas and aspects of this important Enquiry. While the ToR states that other experts can be contacted for this enquiry, the committee itself should comprise of other experts from the fields of medicine, pharmacology, social sciences, epidemiology etc.

It is important for the Commission to assess the location of the camps, reasons for conduct of the camp, the conditions in the camp during the sterilisations - sterilisation of all equipment used during the procedure, and the facilities in the camp to deal with any medical condition that the women might face during or after the procedure, including emergency facilities, equipment such as laparoscopes, numbers and duration of surgeries, etc. The post operative situation, procedures must also be inquired into. Standard Operating Procedures as well as a range of guidelines for sterilisations by the government exist and should inform the enquiry.

Systems for procurement, storage of medicines and their prescription must be looked into. Specifically in the current situation, who procured the medicines for the camp, in what conditions were the medicines kept, who manufactured the medicines, and was there any chance of the medicines getting contaminated at any point of time, right from manufacturing to the camp. Were the medicines approved by the Drug Controller and have there been checks on the manufacturer by the Drug Inspector to ensure the quality and content of the drugs manufactured? While looking at the question of standard medicines used, the commission should look at the liability including the vicarious liability, i.e. what medicines were prescribed, who gave/ administered the medicines to the women, were the medicines checked for their expiry date.

The Commission must enquire into the follow up response by the state government once the tragedy unfolded immediately after the sterilisations. It would also be important to determine whether the women who survived are facing any temporary or permanent disability, or discomfort. The enquiry must assess what health care is being provided in the longer term for the women and also about the payment of compensation.

While the focus of the Commission would be the current tragedy in Bilaspur, the enquiry and its terms should also be able to provide lessons for setting up systems in the short and long terms to ensure that such tragedies have an end.

iv. Compensation

Clearly it has been shown that healthy young women in their early and mid twenties have died due to the negligence, callous attitude and conditions in which the sterilisation surgeries had taken place. Though the government has announced ex-gratia compensation to the families of the women who have died, there does not seem to be any assessment of the actual loss of life of the women in each family, and the actual pain and suffering that the families have gone through, the dependence of children on the mother (where some children were disabled, some below 5 years of age, and some infants, as young as 3 months old who will all be deprived of the nutrition and care that the mother could have given). Further the women who have survived, have been unwell and have gone through pain and suffering, yet have not been provided compensation for their ill health pursuant to the sterilisation procedure, loss of earnings, etc. No compensation has been calculated to compensate the women and the families for their pain and suffering, including their physical, social and mental pain and loss.

Four families of women who died stated that they had received the compensation cheques within a few days of the death, and it was personally given to the husband or family in the village during the visit of the District Collector and MLA.

It is hoped that a system would be developed to ensure that these families are supported as promised and would not have to run around from one government department to another to obtain the promised education and health support for the children. However, thus far, there have been no public announcements about reviewing the government's provision of family planning services and ceasing to expose women to such life-threatening procedures in the name of 'contraception'.

C. Accountability of the Government of India: the Larger Malaise

i. Violation of Policies, Norms and International obligations

- **Violation of its own Policies:** On paper the government has committed in its National Population Policy (NPP 2000) to a coercion-free, target-free approach to providing services and fulfilling the unmet needs for contraception among the people - "National Population Policy (2000) affirms the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services." (Para 6, Introduction, NPP 2000, GOI). However, as the data from the State plans indicate, the Central Government is permitting states to adopt a target-oriented approach to method-specific contraceptives like female sterilisation and condoning the absence of enough alternative options of women's preference. The word 'target' has now been euphemistically replaced by 'Expected Levels of Achievement (ELA)'. But it has full potential for misuse, a fact that the GOI is cognizant of since it has been taken to court on this issue in the Ramakant Rai v. Union of India and ors. Writ Petition (Civil) 209 of 2003 (order dated 1.3.2005, disposed of in 2007) and Devika Biswas v. Union of India Writ Petition (Civil) 95 of 2012 (pending case).

From Ramakant Rai & Healthwatch UP Vs UOI (Writ Petition (CIvil) No. 209 of 2003 - Order of the Hon. Supreme Court dated 1 March 2005

(4) Each States shall set up a Quality Assurance Committee which should, as being followed by the State of Goa, consist of the Director of Health Services, the Health Secretary and the Chief Medical officer, for the purpose of not only ensuring that the guidelines are followed in respect of pre-operative measures (for example, by way of pathological tests, etc.), operational facilities (for example, sufficient number of necessary equipment and aseptic conditions) and postoperative follow ups. It shall be the duty of the Quality Assurance Committee to collect and publish six monthly reports of the number of persons sterilized as well as the number of deaths or complications arising out of the sterilization.

(5) Each State shall also maintain overall statistics giving a break up of the number of the sterilizations carried out, particulars of the procedure followed (since we are given to understand that there are different methods of sterilization), the age of the patients sterilized, the number of children of the persons sterilized, the number of deaths of the persons sterilized either during the operation or thereafter which is relatable to the sterilization, and the number of persons incapacitated by reason of the sterilization programmes.

(6) The State Government shall not only hold an enquiry into every case of breach of the Union of India guidelines by any doctor or organization but also take punitive action against them. As far as the doctors are concerned, their names shall, pending enquiry, be removed from the list of empanelled doctors

- **Violation of Norms:** Following the orders from the Supreme Court in the Ramakant Rai Vs. Union of India and ors. Writ Petition (Civil) 209 of (2005), the GOI formulated its Family Planning Insurance Scheme (2006) and a set of guidelines for the quality standards to be maintained during female and male sterilisation. The DQAC was mandated to provide oversight on the compliance of these standards. However, the numbers of sterilisations approved in the PIP for Chhattisgarh state, and the actual numbers of surgeons/doctors available in the public sector in the state, especially in peripheral areas, do not match. The data from the PIP clearly shows that the GOI condoned the use of mass-sterilisation camps to be performed by doctors, obviously without adequate measures. The camp approach is a severely retrograde step in India's family planning programme.

- **Violation of International Obligations:** As mentioned earlier, the government is obliged as signatory to the ICPD agreement and conventions such as the CEDAW and ICESCR to fulfil the right to health of its people, and ensure all reproductive rights, including of all women. Even as the government was signing the ICPD at Cairo in 1994, the numbers of women undergoing tubectomy increased by three times during the years 1980-1995. The fact that four and a half to five million women in India are made to go through surgery in such inhuman conditions each year in their effort to access contraceptive services is an unacceptable violation of their rights to health. While sterilisation is aggressively promoted through incentives and disincentives, the quality of care provided remains abysmal. Moreover the lack of attention to the needs of young couples, and to men's responsibility for contraception is a glaring omission today.

ii. Failure of the Public Health Care System to Provide Care: - Subsidising Private Sector

The tragedy and its aftermath indicate disturbing trends in the manner of the engagement of the Chattisgarh government with the private sector. Firstly, the conduct of the camp in the non functional private Nemichand charitable hospital despite a functioning district hospital and a medical college hospital in the area, raises questions for enquiry. When the women developed complications and began dying, advance payment was made to Apollo Hospital for treatment

to be provided to the women referred there. The women with "severe" symptoms were sent to Apollo based on Apollo's ability to draw on its "back-up team of doctors" from other cities. However, this does raise questions about the government's tertiary care health system. The fact that the government 'provided' 'best-possible treatment' to the most serious victims at Apollo Hospital shows the state health system in an even poorer light. It reflects years of neglect and undermining of the public health system by the state government and is bound discredit what the government health care providers are trying to provide to the poor. According to the news reports the government has paid Rs 1 crore to Apollo hospital Bilaspur; of this Rs 15 lakhs was paid as an advance and Rs 85 lakhs was paid on 24th November 2014[8] - an indication of the state subsidising the private health sector.

It is time that the government stopped such camps and instead put its resources into strengthening the government health care system towards quality health care, which can be accessed by the poor even in remote areas. The government does have the money to pay Apollo hospital but obviously lacks the will to make health care an urgent priority.

Conclusion

Every tragedy has a potential to bring about a change for the better, so that the loss is never repeated. But the governments at both the Centre and the State do not seem to care about the grave losses that have occurred and have not taken substantive measures to reflect, contemplate, and understand the great harm that has occurred.

Negligence was at various levels - wrongful target oriented policy, absence of any procedures to protect the rights of the people, particularly the reproductive and sexual rights of women; the lack of informed consent, and absence of mechanisms of monitoring and quality assurance. Though negligence has occurred at many levels, only a few have been held accountable so far. For example, at the policy level and at implementation level when the camp itself and its location was approved. Moreover, there have been severe lapses and negligence in approval of drug manufacturing and in the procurement systems. As a result of this negligence, the safety and well being of the people attending the camps has been grossly compromised and right to health has been violated.

[8] Raipur Patrika, http://epaper.patrika.com/381885/Raipur-Patrika/25-11-2014#page/1/2

VI. Recommendations

"The woman's right to make reproductive choices is also a dimension of personal liberty as understood under Article 21 of the Constitution of India. It is important to recognize that *reproductive choices* can be exercised to procreate as well as to abstain from procreating. The crucial consideration is that the woman's right to privacy, dignity, bodily integrity should be respected. This means that there should be no restriction whatsoever on the exercise of reproductive choices such as a woman's right to refuse participation in sexual activity or alternatively to insistence on use of contraceptive methods. Furthermore, women are also free to choose birth control methods such as undergoing sterilization procedures." Suchita Srivastava Vs. Chandigarh Administration, AIR 2010 SC 235.

At the Bilaspur / Chhattisgarh Level

- All necessary steps must be taken for continued follow up with all the surviving women who had undergone the sterilisations in the four camps to ensure access to health care, and to address any complications that the women may be experiencing.
- Ensure provision of compensation and access to indemnity schemes to all families / children of women who died following the sterilisations and those who experienced morbidities.
- Make public the reports of the forensic tests and tests of viscera analysis; reports conducted on the drug samples, including the estimated quantity of zinc phosphide found (if at all).
- Make public, in the case of the camp in Bilaspur, the following information:
  - How many trained doctors were available at the camp?
  - What was the infrastructure available at the camp for maintaining asepsis, and what were the procedures used to do so?
- Provide certificates of sterilisation and all other documentation they are entitled to for all the women and to the families of women who died, as evidence of the surgeries that they have undergone, as mandated by the government's guidelines.
- Ensure that the abandoned Nemichand hospital that was the location of the current camp as well as previous camps, is not used any further for this purpose.

At the Policy Level

Women and men's sexual and reproductive rights should be well articulated in all policies. Women's right to dignity, privacy and bodily integrity has to be respected, and women's right to make an informed decision regarding her sexual and reproductive health, including contraception must not be compromised at any cost.

- The family planning programme in India needs a thorough review and over-hauling, towards centre-staging these rights. Thus, the contrary but prevalent policy perspective and push to "control population" needs be urgently changed.

- Discontinue immediately incentives and disincentives or 'camp approach' towards this 'population control', typically equated with control of fertility of women – particularly poor and marginalised women.
- Do away with the continued emphasis on female sterilisation in the name of reproductive rights and reproductive health.
- All target based sterilisations must be stopped. The targets in any form – official or unofficial – should be completely eliminated from policy and programmeas well as in practice.
- Abolish all coercive population policies, the two child norm being implemented across different government departments and schemes.
- Review all existing guidelines, SOPs on contraception services, sterilisation through consultative processes.

Strengthen Access to Safe and Quality Contraceptive Services

- Provide routine contraception services through an improved public health care system offering safer contraceptive methods such as condoms, oral pills and encourage male responsibility. Sterilisation should only be offered as one of the options among other safe, non hazardous, non invasive, methods of contraception, regardless of marital status, age, gender identity, etc.
- Strengthen public health care institutions - make them functional by improving infrastructure, availability of doctors and other health personnel, counselling, medicines, etc.
- Strengthen capacities of human resources at all levels of the health system, to ensure provision of comprehensive information, adequate response to the needs of persons wanting to access contraceptive services.
- Ensure ethical processes such as informed consent, provision of medical documents, consent formats to all those accessing services.
- Promote male responsibility in contraception through health and sexuality education and provision of information and services through adequately trained male health workers in addition to ASHA/Mitanin.

Strengthen implementation of SOPs and Quality Assurance

- Implement and strictly monitor guidelines and standards for sterilisation services.
- Ensure the functioning of the Quality Assurance Committees (QAC). The regular monitoring must ensure that such acts of negligence are not repeated and the underlying deficits are addressed effectively.
- Review systematically the evidence from implementation of sterilisations across different states to assess issues in programme design and implementation.

Ensure Thorough and Systematic Enquiry

- The Judicial Enquiry which has been set up by the State government must speak with the women who had gone for sterilisations, as well the families of the women who lost their lives. In addition, the Commission must procure and study all relevant documents – registration, discharge summaries, consent forms, postmortem reports of the women who died. All the reports should be available on the public domain.
- Ensure that the Terms of Reference of the Judicial Enquiry Commission is comprehensive and incorporates critical aspects that emerge from the tragic events in Bilaspur. The terms should also clearly state the scope, objectives, purpose and detail the areas and aspects of this important Enquiry
- Expand the Commission to include other experts so that the Enquiry Commission is enabled to carry out a thorough and indepth enquiry declaring conflict of interest.
- Accountability and culpability need to be clearly fixed for the deaths of otherwise healthy women following a medical procedure. That would be one of the first steps towards ensuring that mistakes and lapses are not repeated and such tragedies do not recur.
- An independent and comprehensive epidemiologically-sound investigation into this incident should be carried out. A thorough, impartial and unimpeded investigation with a team of experts (following their declaring of absence of conflict of interest) from different backgrounds -including social sciences, medicine, pharmacology, epidemiology, etc. to be conducted.
- Negligence and contributory negligence may be fixed on all parties involved, including those providing contaminated surgical equipment, medicines, etc. State is vicariously liable and ought to pay higher compensations for the lives lost and also to those who are sick. On the basis of the findings, responsibility must be fixed in terms of criminal negligence not only on the medical team, which performed the operations, but also in identifying other officials who sanctioned and were involved in managing this particular camp.

The tragedy in Chhattisgarh was waiting to happen. These avoidable deaths and complications not only reflect the malaise of the public health system but are also an emphatic and sad reminder of the State's preoccupation with population control and targets. These 13 lives lost and the experiences of complications are symbols of the apathy and violations of basic human rights. The tragic incidents in Bilaspur were not the first but there is fervent hope that this will be the last.

About the Cover image

Marni Nahavan

A local ritual performed after death, where women return home in silence in a row after a dip in the lake. This bathing ritual continues for ten days after the death of a family member as a symbol for cleansing and mourning. This image is from Amsena village where one of its women died following the sterilsation.

A report by
Sarojini N, Jashodhara Das Gupta, Vaibhao Ambhore,
Deepa Venkatachalam and Sulakshana Nandi.