

Examining the Family Planning Programme in India

Findings from Civil Society Monitoring Initiatives between 2015-2018

National Report on The State of the Region Report on Sexual and Reproductive Health and Rights: ICPD+25







Breaking the Barriers:

National Report
on

The State of the Region Report on Sexual and
Reproductive Health and Rights: ICPD+25



NATIONAL REPORT

Examining the Family Planning Programme in India: Findings from Civil Society Monitoring Initiatives between 2015-2018

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SAHAYOG and National Alliance for Maternal Health and Human Rights (NAMHHR)

A-240, Indira, Nagar, Lucknow, Uttar Pradesh, India-226 016

Telephone: +91-522 2310747, 2310860

Email: sahayog@sahayogindia.org

Website: <http://www.sahayogindia.org/>

Facebook: [sahayoglucknow](https://www.facebook.com/sahayoglucknow)

Twitter: <https://twitter.com/sahayoglucknow>

YouTube: [youtube.com/channel/UC_fWiHtGyU58_egJg7ZRfUw](https://www.youtube.com/channel/UC_fWiHtGyU58_egJg7ZRfUw)

Asian-Pacific Resource and Research Centre for Women (ARROW)

1 & 2 Jalan Scott, Brickfields, 50470 Kuala Lumpur, Malaysia

Telephone: (603) 2273 9913/ 9914

Email: arrow@arrow.org.my

Website: www.arrow.org.my

Facebook: The Asian-Pacific Resource and Research Centre for Women (ARROW)

Twitter: @ARROW_Women

YouTube: [youtube.com/user/ARROWomen](https://www.youtube.com/user/ARROWomen)

Production Team:

Writer: Dr. Y.K.Sandhya

Reviewers: Jashodhara Dasgupta, Dr. Sana Contractor, Sai Jyothirmai Racherla, Shamala Chandrasekaran

Copy Editor: S. Lalita

Layout Design: Kishor Goswami

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Y.K. Sandhya

LIST OF ACRONYMS

ANM	– Auxiliary Nurse Midwife
ASHA	– Accredited Social Health Activist
CBO	– Community Based Organisation
CEDAW	– Convention on Elimination of Discrimination Against Women
CHC	– Community Health Centre
CSO	– Civil Society Organisation
FGD	– Focused Group Discussion
IUD	– Intra Uterine Device
KII	– Key Informant Interview
LGBTIQ	– lesbian, gay, bisexual, transgender, intersex and queer
MHRC	– Maternal Health Rights Campaign
MOIC	– Medical Officer In-charge
NAMHHR	– National Alliance for Maternal Health and Human Rights
NEET	– Not in Education, Employment, or Training
OCP	– Oral Contraceptive Pill
PPIUC	– Post Partum Intra Uterine Device
PHC	– Primary Health Centre
PRI	– Panchayati Raj Institutions

EXECUTIVE SUMMARY

The 1994 International Conference on Population and Development (ICPD) occurred at a defining moment in the history of international cooperation. With the ICPD Programme of Action (POA), governments set out an ambitious agenda to deliver inclusive, equitable and sustainable global development. This agenda has guided policy and helped secure advances in equality and empowerment for women, global health and life expectancy, and education for girls. Adopted by 179 governments, the ICPD Programme of Action marked a fundamental shift in global thinking on population and development issues. It moved away from a focus on reaching specific demographic targets to a focus on the needs, aspirations and rights of individual women and men. The POA recognised that human rights, including reproductive rights, were fundamental to development and population concerns.

The aim of this report is to examine India's Family Planning program; its objectives, its achievements, its failures against the ICPD POA, and to offer recommendations. A major part of the document seeks to bring into focus the results of monitoring efforts by civil society organizations in the States of Madhya Pradesh, Uttar Pradesh, Bihar, Rajasthan and Odisha, from 2015 to 2018. The observation of sterilization camps, services in public health facilities, documentation of failures and a thorough research of the attitudes, practices and knowledge prevalent in the community regarding family planning have been included.

India's population which counted at 1.324 billion in 2016 constitutes 17% of the world's population. Although India was the first country to adopt a family planning program in 1952, it was limited to focussing on sterilization and the concept of targets to achieve this. The main focus of sterilization was women; data showing that it continues to be still so. On the contrary, male sterilization remains abysmally low. The concept of spacing between children is almost non-existent; as evidenced in the use of modern methods of contraception. The government has, since 1994, started different policies and schemes to fill the lacunae in the existing system. Official policies have attempted to do away with target based implementation and on limiting methods. Yet, data gathered by government and other agencies show the contrary to be true.

Regarding female and male sterilization, the government issued many guidelines to improve standards and care. However, even after 10 years, quality care, compensation and proper counselling are lacking. In particular is the case of tubectomy; which is mainly handled by the public health sector. More than 87% and 72.6% of women in rural and urban areas respectively, took recourse to tubectomy. Yet, it was found in the States mentioned earlier, that the quality of services was poor; leading to complications and even death in many instances.

The Government of India announced the Mission Parivar Vikas in 145 districts on July 11th 2016. The main objective of this mission is to focus on providing quality family planning services, spreading awareness and improving the supply of modern methods of contraception. Also, the Supreme Court of India, in September 2016, passed the landmark judgement of ending all camp based sterilization. Proper documentation, list of doctors and appointment of trained counsellors was stressed upon. Remedial steps like compensation and family planning indemnity scheme was advised. It thus seems that India is reorienting its National Family Welfare Programme away from a target-driven approach and towards a service-oriented one that emphasizes improved quality of care. This shift seems to reflect the spirit of the ICPD Programme of Action, which emphasizes that Governments should define family planning goals in terms of unmet needs for information and services, rather than targets or quotas for the recruitment of clients. This report hence examines whether the India family planning programme in reality has realigned itself to the ICPA POA.

1. INTRODUCTION

The International Conference on Population and Development was historic. It was in Cairo 25 years ago that 179 Member States endorsed the ICPD Programme of Action and agreed to shift the population debate from one of human numbers to one of human rights, to the recognition that investing in individual capabilities, dignity and human rights is the foundation of sustainable development. The ICPD agenda remains as relevant today as it was 25 years ago and as the world moved into the SDG era in 2015, ICPD commitments were integrated into the broader transformative agenda.

Across India there have been great gains in the past 25 years and the situation of women in the country has improved. The median number of years of schooling for females has increased from 1.9 years in 2005-06 to 4.4 years in 2015-16 (NHFS -3 and NHFS-4); over the same period, the percentage of females with no schooling decreased from 42 percent of females to 31 percent. The total fertility rate in 2015-16 is 2.2 children per woman (which is just above the replacement level of fertility of 2.1 children per woman) when compared to 2005-06 when it was 2.7 children per woman. More and more women desire to limit the size of their families with 84 percent of women with two living children (including those who are sterilized) not wanting any more children (NHFS -4, 2015-16).

However, the journey is far from complete; the prospects for the 10 year old girl are far from certain. Too many women and girls are still left behind and are not able to contribute their full potential. These women and girls often belong to the most vulnerable and marginalised communities as is evident from the data which shows that women with no schooling have an average of 3.1 children as compared with 1.7 children for women with 12 or more years of schooling, women in the lowest wealth quintile have an average of 1.6 more children than women in the highest wealth quintile (TFR of 3.2 children versus 1.5 children). Although teenaged child bearing has reduced over a decade (eight percent of women aged 15-19 had begun childbearing, which is half of the level in 2005-06); however it is relatively higher in rural areas, with nearly 1 in every 10 women in rural areas in the age group 15-19 having begun childbearing. Further, poorer girls are more likely to become teenage mothers - 11 percent of teenage girls in the lowest two wealth quintiles have begun childbearing, compared with 3 percent of teenage girls in the highest wealth quintile (NFHS 4).

While, knowledge of contraceptive methods is almost universal in India today, with 99 percent of currently married women and men age 15-49 knowing at least one method of contraception; modern contraceptive use by currently married women has remained unchanged, at just under 50 percent, between 2005-06 and 2015-16 (NFHS 3 & 4). Female sterilization is still the most popular contraceptive method, used by 36 percent of currently married women in 2015-16. What is a matter of concern is that 13 percent of currently married women have an unmet need for family planning, almost the same as the estimate in 2005-06 (14 percent), indicating that the government has not been able to meet the need for contraceptives in a decade. The total wanted fertility rate in India was almost the same in 2005-06 (1.9 children) and 2015-16 (1.8 children) (NFHS 4). The gap between the actual and wanted fertility rates indicates that there is a failure to prevent unwanted pregnancies.

Family Planning is defined as “educational, comprehensive medical or social activities which enable individuals, including minors, to determine freely the number and spacing of their children and to select the means by which this may be achieved.”¹ Family Planning services are an integral part of the gamut of reproductive health services, the latter being a recognized human right in several International Conventions.

¹ “National Child Abuse and Neglect Data System Glossary”. hhs.gov.

The Programme of Action adopted at the International Conference on Population and Development Cairo, 1994, states that reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. Family Planning methods are means for the fulfilment of these rights. Eligible and willing families, individuals and couples must have access to a range of safe and effective family planning methods and most importantly, they must have the opportunity to make an informed choice of any method with knowledge of the benefits and impacts of each method.

Further, Article 16 of the Convention on Elimination of Discrimination Against Women (CEDAW) places responsibility on the signatory States to take all appropriate measures to ensure, on the basis of equality of men and women, the same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.

This report examines India's Family Planning Programme which is rooted in India's Population Policy and its obsession with population control. It encourages a target based approach with incentives and the aggressive promotion of female sterilization to control the fertility of women, particularly poor and marginalised women. Even today, family planning and contraception is still largely seen as 'a woman's problem'. The result of this is a family planning programme that is not rights based – it lacks a focus on increasing women's autonomy in reproductive decision-making, which is compounded by poor male involvement in sexual and reproductive health matters. Female sterilization, a terminal method, has for decades, remained the mainstay of the national programme.

For all India data and state level data, this report draws from the National Family Health Survey and other government sources of data. A central part of this report however, presents the results of monitoring efforts by civil society organizations in a few selected states of India between 2015 and 2018. These reports include observation of sterilization camps, observation of static day/fixed day services in public health facilities, documentation of cases of sterilization failure and deaths and a qualitative research study on knowledge, attitude and practices of the community related to family planning.

2. CONTEXT

2.1 Country context in terms of gender equality and sexual and reproductive health and rights:

India had a total population of 1.324 billion in 2016 which constituted about 17% of the world's population². It is the world's sixth-largest economy and one of the fastest growing economies, with a growth rate of 7.2% in 2016-17.³ However, this economic growth is limited in its inclusivity with 1% of India's richest owning 53% of its wealth⁴ and 1/3rd of the population (224million) people living below the International US\$1.90-a day poverty line⁵. Further, the 2017 Economic Survey of India⁶ presents a grim picture of employment in the country. The report says that although the Indian economy is growing substantially, job creation and employment opportunities have not kept up with it, and India's rate of employment has actually declined. India has one of the largest youth population (15-29 years) in the world but 30% are NEET - neither employed nor are they pursuing an education or undergoing training.

Further, India does not favour females as is evident in the fact that India is ranked 87th on the gender gap scale calculated from a range of indicators such as health and education to economic and political participation⁷. Out of the 144 countries ranked, India scored low on female labour participation (136th), educational attainment (113th rank) and health and survival (142th rank); the only area in which India scored better was political empowerment (9th rank). The unfavourable attitude towards females is also manifested in the well documented phenomenon of son preference which has implications on the sex ratios (949 females to 1000 males; 919 child sex ratio), increasing rates of sex selection and higher child mortality rates for girls (ibid). India also has a high maternal mortality rate of 176⁸ or in other words about 45,000 women or 5 women die every hour of childbirth related causes annually. India contributes to 17% of the maternal deaths globally. Women in India mostly lack autonomy in sexual and reproductive decision-making.

2.2 Reproductive Health and Rights Situation in India:

India was the first country to adopt a Family Planning Programme in 1952. Limited resources, rising population and the fear of 'population explosion' had skewed the resources in favour of family planning at the cost of other health services for several decades. The mainstay of much of the Family Planning programme was focusing on permanent methods and providing targets to frontline workers to achieve sterilizations. As pointed out earlier, much of the focus of these permanent methods has been on women. This may be attributed to the

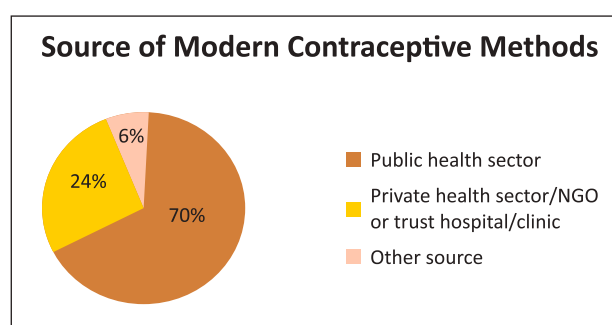


Fig. 1

² Registrar General and Census Commissioner. Population Projections for India and States 2001-2026, Report of the Technical Group on Population Projections Constituted by National Population Commission 2006

³ <https://www.weforum.org/agenda/2017/06/these-are-the-world-s-fastest-growing-economies-in-2017-2/>

⁴ The Inclusive Growth and Development Report 2017, The World Economic Forum, 2017

⁵ Poverty and Shared Prosperity 2016: Taking on Inequality, World Bank Group, 2016

⁶ Organisation for Economic Cooperation and Development (OECD)

⁷ The Global Gender Gap Report, The World Economic Forum, 2016

⁸ World Health Statistics, 2016

political outcry, due to forced male sterilizations during The Emergency⁹. After the 1994, International Conference on Population and Development, Cairo, national governments committed to shift focus to align their population policies within the framework of reproductive health and rights. Although the reformed National Population Policy, 2000 has done away with target based and incentive based approaches, and talks of fulfilling unmet needs, data shows that permanent methods continue to be the most popular method and male participation in adopting these are negligible.

An examination of the data shows that female sterilization has remained unchanged in 10 years at 36%, while male sterilization rates have dropped to 0.3% from 1.1% in the same period¹⁰. The overall uptake of modern methods of contraception remain low at 47.8% and informed consent remains an issue with only 46.5% of current users told about side effects (ibid). Further, almost seven in 10 (69%) modern method contraceptive users obtained their contraceptives from the public health sector (see Figure 1). Further, this dependence on the public sector is higher in rural users (76%) than among urban users (58%).

Since 1994, India has developed many policies and schemes across sectors that address several critical reproductive rights issues including policies on health, youth, and women, like the Reproductive and Child Health Programme (RCHI and II), National Population Policy (2000), and National Health Policy (2002). However, quality of care and informed choice has long been areas of concern in India's family planning program. After the ICPD in 1994, the official policy of the Government of India has moved away from targets, but it is well known that targets for family planning still exist in implementation. There is an over emphasis on limiting methods as opposed to spacing methods, although the latter is what is required as evidenced in the fact that 48.1 million pregnancies in India were unintended and 15.6 million pregnancies ended in abortions¹¹. This despite the fact that the emphasis on family planning in a rights-based framework has increased after India's commitment first at the 2012 London Summit on Family Planning and then in the Sustainable Development Goals in 2016.

However, government data (AHS 2011), paints a different picture from the commitments made and reveals that substantial focus continues to be given to permanent contraceptive methods, especially female sterilizations as is evident from table 1:

The data clearly shows that female sterilization remains the highest method of contraception and methods that are meant to increase spacing are not used much, perhaps because they are not being promoted by the system.

What is an issue of concern is the very low (almost negligible) male sterilization that is taking place in India which as pointed out earlier, has actually seen a decline in a decade from the NHFS 3 to NHFS 4 (from 1.1 in 2005-06 to 0.3% in 2015-16). Further, the unmet need remains high, showing the system's failure to

Table 1: Current Use of Family Planning Methods (currently married women age 15–49 years)

Type of Contraception	Percentage
Any method	53.5
Any modern method	47.8
Female sterilization	36.0
Male sterilization	0.3
IUD/PPIUD	1.5
Pill	4.1
Condom	5.6
Source: NFHS - 4, 2015-16	

⁹ In India, "the Emergency" refers to a 21-month period from 1975 to 1977 when Prime Minister Indira Gandhi had a state of emergency declared across the country. The order bestowed upon the Prime Minister the authority to rule by decree, allowing elections to be suspended and civil liberties to be curbed. For much of the Emergency, most of Gandhi's political opponents were imprisoned and the press was censored. Several other human rights violations were reported from the time, including a forced mass-sterilization campaign spearheaded by Sanjay Gandhi, the Prime Minister's son. The Emergency is one of the most controversial periods of independent India's history.

¹⁰ National Family Health Survey - 4, Ministry of Health and Family Welfare, GOI, 2015-16

¹¹ Singh S, Shekhar C, Acharya R, et al. The Incidence of abortion and unintended pregnancy in India, 2015. Lancet Glob Health 2018; 6: e111–20

meet the demand for contraception, as is evident from the table 2:

Further, despite female sterilization being the mainstay of family planning in the country, quality of care remains questionable. Guidelines on Standards of Female and Male Sterilization were issued by the Government of India in order to improve the quality of family welfare services and ensure the well-being of the person undergoing sterilization. However their non-implementation prompted the filing of a writ petition in the Supreme Court of India (Ramakant Rai Vs Union of India). As a response to this, in 2005 the Supreme Court ordered State Governments to take immediate steps to comply with the Guidelines and regulate doctors and other health-care providers who perform sterilization procedures. They also ordered governments, to compensate women who suffer complications due to sub-standard practices and the relatives of victims who may die from botched operations. However, even 10 years after this order, problems such as poor quality of care, poor execution of family planning training programmes and lack of proper counselling with regard to modern methods of contraception continue to plague the delivery of family planning services. This target oriented family planning has raised several questions on the quality of care in sterilization camps. Like any surgical procedure, tubectomy carries the risk of complications. Ectopic pregnancies, where an embryo gets implanted in the fallopian tubes can also occur in some cases. A few studies indicate that tubectomies can increase the risk of abnormal uterine bleeding. Overall, tubectomies fail in one out of every 200 cases¹², with the risk of failure increasing with every year after the procedure. This is something women should be warned about before they are sterilized so that they can seek immediate medical help. However only 42.1% of women are informed about possible side effects and even fewer (35%) are informed about what to do if it failed/there was a complication (NFHS-4, 2015-16). Further, 48.2% women are never told by a health worker of other methods that could be used (ibid).

Table 2: Unmet need Family Planning (currently married women age 15–49 years):

Total unmet need (%)	12.9%
Unmet need for spacing (%)	5.7%
Source: NFHS -4, 2014-16	

More than 87% women in rural areas and 72.6% women in urban areas who accepted sterilization, underwent the procedure in the public health sector. However the poor quality of services offered by the public health sector has at times resulted in morbidity and mortality. In states like Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh for instance, 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. A national outcry on the condition of sterilization camps erupted, when 13 women died due to medical negligence, after undergoing sterilization operations performed in the state of Chhattisgarh in November 2014. Nearly 140 women were brought to the camps and in the largest of these camps, 83 women were sterilized within just 3 to 4 hours in an abandoned private charitable hospital that was non-functional.

Following this incident, on 11th July 2016, the Government of India announced the Mission Parivar Vikas (Family Development) in 145 districts located in the seven high focus, high TFR states of Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand and Assam that together constitute 44% of the country’s population. The main objective of ‘Mission Parivar Vikas’ is to accelerate access to high quality family planning choices based on information, reliable services and supplies within a rights-based framework. The key strategic focus of this initiative was on improving access to contraceptives through delivering assured services, dovetailing with new promotional schemes, ensuring commodity security, building capacity (of service providers), creating an enabling environment along with close monitoring and implementation.

¹² Date SV, Rokade J, Mule V, Dandapannavar S. Female sterilization failure: review over a decade and its clinicopathological correlation. Int J Appl Basic Med Res2014;4:81-5

An analysis of expenses incurred on family planning in three financial years from 2015 to 2018 reflects the relative lesser importance being given to spacing methods with the expenditure hovering between 15% to 20% of the total expenditure incurred on Family Planning in three financial years (refer to Table 3) and that of campaigns on family planning fluctuating between 2% to 5% of the total expenditure

Table 3: Expenditure incurred on Family Planning:			
(in Rs. lakhs)	2015-16	2016-17	2017-18
Expenditure incurred on Family Planning programmes	63035	62843	68463
Total expenditure for spacing methods	10223 (16.22%)	12973 (20.64%)	11864 (17.33%)
Expenditure on Family Planning Campaigns	3249 (5.15%)	1359 (2.16%)	4017 (5.87%)
Source: Lok Sabha Unstarred Question No.s 1781, 2051			

In the same year, the Supreme Court of India, gave another landmark judgment in September 2016, in the PIL filed by Devika Biswas on account of a sterilization camp organized in Araria district of Bihar. In the month of January 2012, 53 women were sterilized within 2 hours in unhygienic conditions in a Kaparfora Government Middle School that lacked basic amenities like running water and sterilizing equipment. The Supreme Court in its judgement directed that all States should put an end to the camp approach for providing sterilization services by 2019 while also emphasizing that the list of empanelled doctors must be made available online, quality of care checklist must be made available in local language, appointment of trained counsellors, and keeping aside an hour's time per woman opting for sterilization, to ensure inquiries. Further, the Order gave directions on remedial steps to be taken in case of deaths and failures through the implementation of the Family Planning Indemnity Scheme¹³. This judgement was welcomed by many as it gave clear directions for putting an end to the camp approach.

However despite this judgment, media coverage shows that sterilization operations continue to be held without much concern for quality. A review of newspaper articles that appeared in early 2018, alone shows the continuing disregard for quality, safety and standards:

- Woman dies in the operation theatre- Dungarpur, Rajasthan, Dainik Bhaskar, 9th Jan 2018
- Urinary bladder of two women accidentally cut during sterilization procedure in Jharkhand, Prabhat Khabar, 12th Jan, 2018
- Garhwa District in Jharkhand, officials are being rebuked for not having completed their targets – could complete only 2250 female sterilizations by 15th Jan 2018 against the target of 72,000 for the 2017-18 FY, On Live Hindustan, 15th Jan, 2018
- ANM reveals that they are forced to get women for sterilization, Dainik Bhaskar, 17th Jan 2018
- Varanasi doctor leaves syringes inside woman's body during sterilization operation - Times of India, 11th Feb 2018

More recently there is a push towards acceptance of post partum IUCD, but community needs are still not being addressed through this continued prevalence of method-specific targets. There is a dearth of information in the community about the full range of available services as well as rights and entitlements vis a vis services. Further, despite the intent of making the family planning programme Rights Based, an examination of the current State policies within the 'Mission Parivar Vikas' shows that it continues to be driven by the logic of financial incentives without creating a clear vision of

¹³ Devika Biswas v. Union of India (2016) 10 SCC 726

increasing male responsibility, although it does include newer spacing methods. Incentives offered for various contraceptive methods under the Mission have increased not just for the acceptor but for the motivator as well (refer to Table 4).

Table 4: Incentives for uptake of Contraception under the Mission Parivar Vikas

Method	Incentive for Acceptor in INR		Incentive for Motivator in INR	
	New	Old	New	Old
Female Sterilization*	2000	1400	300	200
Post Partum Sterilization*	3000	2200	400	300
Vasectomy*	3000	2000	400	300
Post Partum IUCD	300		150	
Injectable contraceptive or Centchroman	100 per dose		100 per dose	

Source: Ministry of Health and Family Welfare, Government of India, Department Order on Mission Parivar Vikas (D.O. No. N. 11023/2/2016 - FP)

* For these procedures, the incentive amounts increased for all staff involved including the surgeon, aesthetician, nurse, OT technician, clerks/documentation person

Hence the current report will attempt to examine the shifts in India's Family Planning programme in the following areas:

1. Removal of targets: Has the population policy moved away from coercion and removal of targets?
2. Issues around the Quality of Care: What are the quality of services being provided both for terminal and spacing methods? Is consent being taken and full information being provided? Where are terminal methods being offered - are they being provided on fixed days in health facilities or are they being held in camps, are the pre-operation tests being done, are the standards prescribed by the Supreme Court of India being observed?
3. Shifting the focus from Limiting/Terminal methods to spacing methods: Are spacing methods of contraception (pills, condoms, information on IUCDs, injectables, etc) adequately available in facilities and with frontline workers
4. Shifting the burden of Family Planning away from women: What steps are being taken by the government to promote male responsibilities in family planning and encourage men to adopt contraception

2.3 Research Objective

To explore the shifts in the family planning programme in a few poorly performing states (Bihar, Madhya Pradesh, Rajasthan, Odisha and Uttar Pradesh) of India, around issues related to the removal of targets, issue around Quality of care in contraception (including choice, consent and information), issues related to terminal and spacing methods and shifting the burden of family planning from women to men

2.4 Research design

Method of data collection:

- A. Review of Secondary Data was undertaken, which includes Civil Society monitoring reports¹⁴ and cases of sterilization failures and deaths, the details of which are given below
 - i. Observation of Sterilization Camps and Public Health Facilities in Madhya Pradesh and Bihar
 - ii. Case documentation of sterilization deaths and failures from the selected states
- B. Exploring the knowledge, attitude and practices related to family planning through:
 - i. Conducting KII with selected government functionaries, community men and women and CSO actors in Uttar Pradesh
 - ii. Conducting Focused Group Discussions (FGDs) with community men and community women in Uttar Pradesh



¹⁴ All the CSOs are members of the National Alliance for Maternal Health and Human Rights (NAMHHR)

3. METHODOLOGY

3.1 Instruments

- i. For observation of sterilization camps and public health facilities an observation check list was used created by HealthWatch Forum Uttar Pradesh and Bihar. This has been used in the past to observe sterilization camps. They are based on the government guidelines of how camps should be organised and on the Supreme Court orders related to quality of care standards to be observed during sterilization. CSOs who were part of the camp and facility observation were trained on the tools and data collection methods prior to commencing the observation and data collection.
- ii. Sterilization deaths and failures from selected states were documented based on a case documentation checklist which has a series of questions that allows for details of the case to be recorded. This was created by SAHAYOG and is being used for several years now. The checklist aimed to capture information related to pre-operative procedures including test, recording the age of the woman and her previous obstetric history, taking informed consent, giving information on danger signs and precautions to be observed, observation of the actual camp including number of paramedical staff, doctors, instruments, cleanliness, post operative care including where the women were made to lie down, when and in what condition were the women discharged, advice given on discharge and whether the women were given certificates as proof of the procedure being done.
- iii. For conducting KIIs with government functionaries an interview guide was specially created and a second interview guide was used for interviews with community men/women as well as CSO actors. These interview guides were created by SAHAYOG and covered domains around demand and utilization of family planning services, supply of contraception, issues around family planning, perceptions of doctors and frontline service providers on family planning and engaging men.
- iv. For conducting FGDs with community men and women a FGD guide was used which was also specially created for this purpose. Separate FGDs were conducted for men and women. These interview guides were also drafted by SAHAYOG. The FGDs covered domains around awareness of family planning among community men and women; demand and utilization of family planning services, supply of contraception; and issues regarding family planning and community perceptions about engaging men in family planning.

All the data collected using the various tools was done by CSOs who were trained in tools and methods of data collection. Details of the period of data collection are:

- a. The Camp Observation was conducted in the state of Madhya Pradesh, where 11 member organizations of the Maternal Health Rights Campaign (MHRC)¹⁵ who are on the Steering Committee of the National Alliance for Maternal Health and Human Rights (NAMHHR), observed 35 camps held in and around their working areas between the months of November and December 2016. A total of 1296 women were sterilized in these 35 camps. All the camps took place in a government institution organised by the government officials. One took place in the district hospital, 20 in community health centres (CHC), 13 in primary health centres (PHC) and 1 in the AYUSH hospital.

The observation of fixed day services in public health facilities was done by members of HealthWatch

¹⁵ The MHRC or the Matritav Swasthya Haqdari Abhiyan is a network of more than 50 organisations. The group came into existence in 2013 to advocate on the issue of maternal health and rights in the state of Madhya Pradesh.

Forum, Bihar (also a SC member of NAMHHR) where they observed 50 facilities for fixed day services spread across 28 districts of Bihar in the month of August 2017. However only 38 facilities were found to be providing fixed day services and a total of 460 women were sterilized during this period.

- b. Case documentation - 17 cases of sterilization death and failures that occurred between 2015 and 2018 in the states of Bihar, Madhya Pradesh, Rajasthan, Odisha and Uttar Pradesh. Except Uttar Pradesh, all the cases from the other states were documented by staff of Prayaas, a member of NAMHHR. Of these 17 cases, six were cases of sterilization deaths, nine were cases of sterilization failure resulting in pregnancy and in two cases the woman was already pregnant at the time of sterilization which was not detected by the providers¹⁶. The cases from Uttar Pradesh were documented by HealthWatch Forum which is also a member of NAMHHR.
- c. KIIs and FGDs - These were conducted between June to July 2018 by SAHAYOG in the districts of Hamirpur, Chandauli, Barabanki, Pratapgarh and Jalaun of Uttar Pradesh. A total of 40 KIIs and 14 FGDs were conducted, the detail of which are given below:

Key Informants	Number of Interviews
Community Men	18
Community Women	5
Health Providers/Managers	9
Community Leaders (including PRI representatives, CBO partners, women leaders)	8
TOTAL KIIs	40
Focused Group Discussion with Men	8
Focused Group Discussion with Women	6
TOTAL FGDs	14

3.2 Data analysis:

All the analysis of primary data and case documentation was done by the writer of this report who is a SAHAYOG staff who has been trained in the analysis of qualitative data. The secondary data used by the writer was analysed by the following key organisations:

- i. The analysis of the data from the Madhya Pradesh camp watch was done by the research team of the Centre for Health and Social Justice (CHSJ) who are a Secretariat of NAMHHR
- ii. The analysis of the data from observation of static day services in public health facilities was done by the Core members of HealthWatch Forum Bihar

3.3 Ethical considerations

In all the cases where data collection was done, consent was obtained from the respondents. The forms clearly described the objectives of the study and the precautions to keep the data secure. The voluntary nature of the study was stressed which included the choice to drop out at any time during the interview/FGD or refusal to answer any question. Further no incentive in cash or kind was given to participate in the research, hence reducing the possibility of it being coercive. Recording of interviews

¹⁶ Guideline mandate that the menstrual history of the woman including the date of last menstrual period and current pregnancy status must be ascertained before conduction sterilization. Further, Interval sterilization can be performed only within 7 days of the menstrual period (in the follicular phase of the menstrual cycle).

was done only after obtaining permission for the same. In cases where the respondents were non-literate, the consent form was read out to them in the local language.

Privacy and confidentiality was maintained throughout. FGDs were conducted in a private space, so that women did not feel threatened or embarrassed (by members of the household) in sharing their experience with contraceptive usage. No names or other identities of participants have been disclosed or published during data processing, analysis or in the report. Data presentation has been done in aggregate forms. Finally the recordings are password protected and none other than the research team had access to the data.

3.4 Limitations:

This study is based on Civil Society reports for five poorly performing states of India. Analysis of the family planning programme in the other states is beyond the scope of this report.



4. FINDINGS

4.1 Removal of targets

Although government documents have done away with the word ‘target’, but at the grassroots, the target based approach which focused on permanent methods remains a key feature of the family planning programme. As one frontline worker puts it:

“Sterilization comes first and foremost because our population is rising. So people should have fewer children. They should not have more than 2. In my previous posting I used to get 15 cases in a year. But here the environment is different. Here at the most I get 2-3 cases in a year. No one understands it here. I try very hard.”

(ANM in a village of Uttar Pradesh)

On probing she tells us that they get targets of about 33 cases (including male and female sterilization) in a year but it is hardly possible to meet those targets. One MOIC informs that although the earlier system of compulsory targets for sterilization has been done away with, some targets were provided to frontline health workers to keep them motivated (IH04J). It is clear however that, at the grassroots, the target based approach which focused on permanent methods remains a key feature of the family planning programme.

This pressure to achieve targets, has led to serious rights violations as is illustrated in a case in Madhya Pradesh, where soon after delivery, the doctor and medical staff repeatedly pressurized the family members to get Mona (name changed) sterilized. The family members were reluctant to do so because of her weakness. Despite this objection, Mona’s sterilization operation was conducted on the 10th of May, 2016. Severe bouts of fever followed the sterilization and Mona’s condition deteriorated. No proper medical assistance was provided despite her deteriorating health. Her body was wiped with a wet cloth after which she passed out due to lack of proper medication. Mona was then referred to the District Hospital but no transportation was provided by the hospital and the family had to organise for transportation and bear the travel expenses. After being hospitalized for two days, early in the morning of the 13th of May 2016 Mona’s condition worsened and she died (MP2). Denying allegations of medical negligence by the staff, the doctor said that Mona was already suffering from fever and convulsion at the time of delivery.

This focus on targets coupled with the shortage of providers trained in the procedure of sterilization often meant that doctors were running from one camp to another to fulfil the “targeted numbers”. The pressure to reach the numbers also led to a disregard for the guideline which directs that for maintaining quality of services each surgeon should restrict to conducting a maximum of 30 laparoscopic tubal occlusion (for 1 team with 2 laparoscopes) or 30 minilap tubectomy operations or if combination of the two was being provided, not more than 30 women should be operated in a day. However, findings from the camp observations in Madhya Pradesh show that this was adhered to in only 9 of 35 camps; in other camps as many as 80 women were sterilised in a day with one team only. Such a violation in



Women waiting to be examined at a Madhya Pradesh camp in 2016

numbers of sterilizations conducted can result in neglect, sometimes leading to death (see Box 1).

The pressure to meet targets is not just limited to the number of sterilizations rather it permeates the entire family planning programme in India. Providers and frontline workers are given targets for every facet including the number of eligible couples contacted, the number of contraceptives distributed and recently this has been extended to the number of post partum Intra Uterine Contraceptive Devices (PPIUCDs) inserted. ASHAs reported being reprimanded if they did not meet said targets and providers were rewarded for fulfilling these targets. Like in the case of sterilization, the fixing of a target for PPIUCD insertions have led to rights violation - women were not counselled on PPIUCDs while pregnant and in fact were asked if they wanted an insertion while in labour. When the woman was unable to take a decision the relative accompanying her was told that this was the best option and was convinced to accept it on the woman's behalf. In other cases stealth insertions of PPIUCDs have also been reported in Madhya Pradesh and Uttar Pradesh, with the device being inserted without the woman being informed, let alone consent being taken; as is illustrated in the case of Meera of Gorakhpur district in Uttar Pradesh. After her seventh delivery in a Primary Health Centre, the nurse inserted a PPIUCD without informing Meera that she was doing so. Soon after the insertion, she began bleeding heavily, but the nurse ignored it and discharged Meera. Two days after the delivery, while passing urine, Meera felt the strings of the IUD and without knowing what it was tried to pull it out. This triggered massive bleeding and she was rushed to the same PHC where she delivered. The doctor declared that her condition was serious and referred her to the district hospital. On reaching the district hospital she was immediately referred to the medical college as a blood transfusion was required. At the Medical College the doctor told Meera's daughter to arrange for two units of blood which she procured with immense difficulty after seven hours of running around. The blood was finally transfused and Meera was discharged after two days by which time her family had spent 15,000 INR which they had to borrow at an interest rate of 5%, sending the already poor family into indebtedness.

4.2 Quality of Care

The quality of India's Family Planning programme is still not fully assured and it is possible that till women remain the targets of the programme (given the levels of gender inequality), quality will remain suspect leading to deaths of poor marginalised women. Guidelines related to quality of care are often violated as shown by the findings from the observation of sterilization camps in Madhya Pradesh conducted in December 2016 (soon after the Supreme Court order) and documented cases of sterilisation deaths, failures and morbidity. In these camps not all the pre-operative procedures¹⁷ were observed; according to the guidelines, the laboratory examination should include blood test for haemoglobin, urine analysis for sugar and albumin. The finding showed that of the 35 camps observed, all women were tested for haemoglobin in 25 of camps, all women underwent urine tests in 31 camps, the blood pressure was checked for all women in 26 camps, all women were weighed in 14 camps and abdomen examinations were done for all women in 18 camps only. Counselling is a critical part of the pre-operative procedures, however counsellors were present in only 13 of the 35 camps and even where they were present all the mandated information was not provided. Thus it was found that in only 6 camps women were given information on the probable complications that might arise due to sterilization. In 18 camps the women were told that it was a permanent non-reversible method and in only in 5 camps were all women given the crucial information regarding compensation in case of failure, complications or death. Informed consent is another area that was neglected with the attempt

¹⁷ Guideline state that preparation for surgery must include counselling, preoperative assessment, preoperative instructions, review of the surgical procedure, and post-operative care. It is essential to ensure that the consent for surgery is voluntary and well informed, and that the client is physically fit for the surgery. Preoperative assessments also provide an opportunity for overall health screening and treatment of RTIs/STIs

being made in only 7 camps to read out the form and to explain what it meant to the women in their local language; in the remaining camps, the women were made to sign the form without the form either being read out or being explained to the women.

This neglect of following pre-operative procedures was not due to a shortage of time. The findings show us that many of the women had to wait long hours before the operation commenced. There were no fixed timings for arrival of the doctors and women waited for between 2 hours to more than 5 hours in 15 camp and for as long as 10 hours in one camp. Further in most of the camps, there were no fixed areas where women could wait and in some camps, no staff were not present at the site to guide the women. Further, according to the guidelines operations should not be conducted beyond 5pm but in 8 camps operations went on as late as 11.30 pm. In another 10 camps the operation started before 5pm but continued beyond the prescribed time and as late as 8pm. Only in 17 camps, adherence to time was observed.

Like the pre-operative procedures, post-operative procedures were also neglected; with women in 31 of the 35 camps being made to rest on the verandas or hall floors sometimes on mattresses, sometimes on floor rugs and sometimes on the bare floor. The pulse of women in 6 camps only was checked as mandated and all the women in 9 camps only were checked by a doctor before being discharged. Informing about potential risks, danger signs or post surgical care at the time of discharge was given to all the women in 10 of the 35 camps only. The discharge time also varied in the camps, with women being discharged in less than 4 hours in 21 camps and in 2 camps women were discharged immediately after the procedure. In one camp women were actually sent back home in an unconscious state. This was in complete violation of the norms that mandates that women be discharged only after 4 hours or after the vital signs are stable, the women are fully conscious, have passed urine and can walk, talk and drink. Only in 9 of the 35 camps were norms observed and women were discharged after 4 hours and in a conscious state.

Receiving a discharge slip is important and mandatory as it serves as a valid document for proof that the woman underwent sterilization until the receipt of the sterilization certificate which is given much later. It was observed that the women in only 9 camps were given discharge slips.

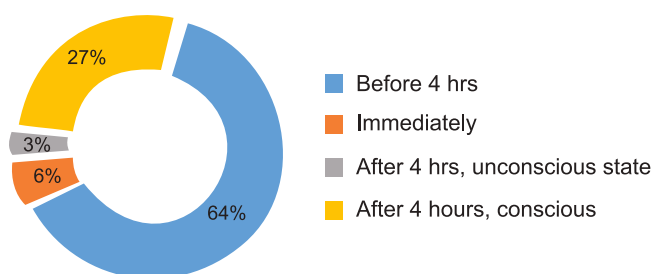
Another important dimension of quality of care relates to the health system's response to failures. Human rights accountability implies that independent reviews are done and in cases of violation, remedy and redress are provided. However, it is clear from our case documentations, that except one woman in Uttar Pradesh who received Rs. 1000/- none of the other women were awarded compensation and it took legal intervention for compensation to be awarded in 12 cases. Further, except in one case (sterilization death, UP3) in none of the other cases did the providers offer support to the women or their families to claim compensation. In one other case (UP4, pregnancy detected within 10 days of operation), the staff initially refused to believe that the woman was pregnant, saying that the pre-operative tests had shown that she was

Box 2

"Women started coming around 10:00 a.m. but there were no healthcare providers to attend to them. There was no sitting arrangement at the centre for women and their attendants. All of them sat under a tree or by the side of the road. The hospital supervisor came around 12:00 p.m. and thereafter registration started.

Observer, PHC, Mauganj, Rewa

Discharge Time



not pregnant, but finally a nurse conducted a pregnancy test which confirmed the woman's pregnancy. The ward boy of the hospital offered to help and advised the woman's husband not to get an abortion done. He said, "I will help you get a compensation of Rs. 50,000. However for this you must be willing to incur an expense of Rs.15,000 as many palms will need to be greased." In all the remaining cases, the reaction of the providers ranged from denial to apathy in cases of failure, to even complete denial of responsibility in the case of death; as is evident from these excerpts:

When the woman discovered that she had conceived 10 months after sterilization, she went to the facility, but the staff dismissed the possibility of a failure and told the woman that she was probably already pregnant at the time of sterilization (B5).

In another case of sterilization death, the doctor who had performed the surgery said, "the woman died of a heart attack and not due to the sterilization procedure", while the MS of the CHC told the mother-in-law, "no one is to be blamed except her fate, who can avoid what was destined." (UP1)

Following the Supreme Court judgement in September 2016, which ordered that all sterilization camps be phased out, the National Health Policy 2017 holds it imperative to move away from camp based services to a situation where these services are available on any day of the week or at least on a fixed day. It has been observed that this is being followed and there have been progressive changes with no camps being organised in 2018 in the states of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan. Women are being offered fixed day services in public health facilities; a survey of 50 selected public health facilities across 28 districts of Bihar in the month of August 2017 by HealthWatch Forum, Bihar, revealed that 38 were offering Static or Fixed Day services. A total of 460 women were sterilized in these facilities during the survey period. The findings shows that, there is some improvement in the adherence to pre-screening norms - the blood pressure, haemoglobin and urine were tested in all these facilities and anaemic and pregnant women were not sterilized. However medical and obstetric history (as laid down in the Medical Record and Checklist for Eligibility), was not taken from any of the women. Further, contrary to the claims by providers, norms related to counselling, post operative danger signs and adverse effects of the operation were violated, as none of the women were provided with this information. The only information that the women were asked to provide was related to their personal details (name, age, father's name, number of living children, sex of the children, name and age of spouse, BPL status, occupation and address). Further it was observed that women were made to sign (or put their thumb impression) on the consent cum Informed Choice form before the operation; however the contents of the form were not read out to the woman, neither was it explained to them. The women were not kept under observation after the operation and neither were any measures taken to ensure aseptic post operative conditions. In most cases the women were made to lie down on durries without spreading a bed sheet on them, however in all cases the women were discharged only after spending a whole night at the facility. Sterilization certificates were not issued as a matter of course, but women were given the certificate when they demanded for it which took 3 weeks to a month. None of the women were given information about the indemnity scheme and the compensation claiming procedure in case of failure, complication or death. The incentive provided to the women acceptors has been increased to 2,000 but it is transferred into their bank accounts directly and is often delayed.

Thus to conclude both in the camps and during fixed day services, limited measures were taken to ensure aseptic post operative conditions. In most cases the women were made to lie down on the mats on the floor. However there was an improvement in discharge time and unlike in the camps, during fixed day services all the women were discharged only after spending a whole night at the facility. But in both camps and fixed day services, sterilization certificates were not issued as a matter of course and none of the women were given information about the indemnity scheme and the compensation claiming procedure in case of failure, complication or death. Thus, it was observed that while the quality of services being offered during Fixed Day has improved in some areas such as pre-operative tests including screening (turning away anaemic and pregnant women) and discharge timings (women

were sent home on the following morning), there is still a long way to go where informed consent, information about compensation and quality of post operative care is concerned.

4.3 Moving from Permanent to Spacing Methods:

4.3.1 Contraceptive Services: Is a basket of choices available?

The emphasis on permanent methods as the primary method of 'family planning' remains. Family planning is a term which signifies various methods towards planning the number and spacing between children. Although a larger number of methods, including temporary and permanent ones are available today, often the term 'family planning' is associated with permanent methods alone. This was apparent from discussions during 11 of 14 FGDs. During one of the FGDs, when the discussion moved to Family Planning, the participants were asked what they understood by Family Planning. The response was telling; women said 'operation', implying that permanent methods are the only ones associated with family planning. On asking –“Does family planning mean operation? ”, the women collectively replied 'Yes'. (FW04P). The heavy reliance on permanent methods over temporary methods also became clear from discussion in other FGDs. When women were asked about family planning methods, they said that they did not know about any family planning methods because they have already undergone sterilization - “I have never used these methods. I have got an operation now. So I have no idea” (FW01H). In another FGD with women, when they were asked what they did if they did not want more children, one woman said that they took pills if they got pregnant (FW02J). In this particular instance, the participant was talking of abortion pills. This is indicative of unwanted pregnancies and unmet family planning needs for which women have to resort to abortion pills. In another FGD it was mentioned that ninety percent women in the village had undergone sterilization and they were only aware of the 'operation' as the primary means of family planning (FW06C). This group women reported that several of them were suffering from problems like body ache and back ache, which they attributed to sterilization. As a result, fewer women in that village wanted to adopt the permanent method now.

The excess reliance on permanent methods must be linked to the family planning policy. The near universal knowledge and acceptance of female sterilization as the primary family planning method, would not be possible without a thrust in this direction by health personnel. For instance an ASHA put a great deal of focus on permanent methods; while she was aware of all the family planning methods and she provided temporary methods for family planning, her ultimate aim was getting couples to agree to sterilization. According to her, she tried to encourage couples to adopt permanent methods because she considered it foolproof (IH02H). This thrust on permanent methods by the ASHA may be linked to the incentive that is provided to ASHAs for motivating couples to undergo sterilization.

It was found that sterilization and oral pills were the most widely known contraceptive methods recognized by both men and women. In the FGDs, the participants were asked to name some contraceptive methods for women. Oral contraceptive pills (like Mala D) and female sterilization were mentioned in 11 of the 14 FGDs. In one men's FGD, and one women's FGD (both in Hamirpur



district), the participants were not able to name any other contraceptive method for women (FM01H, FW01H). There is much lower awareness of intrauterine devices (IUDs) like Copper-T and injectable contraceptives like Antara. In some of the groups, only a few members were aware of Copper T and injectable contraceptives.

Even while some research participants were able to name the contraceptive methods, actual information about how and when it should be used was lacking. For example in one FGD (with women), when participants were asked, if they knew how to use the different contraceptive methods, for example how often pills needed to be taken or how a Copper T was used, most group members did not know the answer. In this group, none of the women had ever used contraceptive pills (FW01H). Similarly in one FGD with men, one of the participants had named Copper T as a contraceptive method. However on further probing it became clear that they were not aware how it was used as is evident from the experience shared by a 34 year old village man who is a graduate with 2 children; he mentioned that he did not know how to use family planning methods to space his children. Although he was aware of oral contraceptive pills, he did not have complete information about how it could be used for spacing. So both his children were born with very little gap. He says,

‘Samajh nahi thi but ichchaye thi ki bachcon antar rahe’

(I wanted to space the children, but did not have the information for it) (IS17V).

Of late, a number of new or changed family planning methods have been introduced in the basket of choice, for example Post Partum Intrauterine Contraceptive Devices (PPIUCDs) for 5 years (Cu IUCD 375) or 10 years (Cu IUCD 380A), the Antara injectable contraceptive and the non-hormonal weekly Centchroman pill, Chhaya. However, the study shows that there is very little information about these even among the frontline health workers themselves. Similarly, the emergency contraceptive pill¹⁸ is now part of the contraceptives provided under the family planning programme. It was found that there was limited information about the exact purpose and indications for use of emergency contraceptives. In one FGD (with men), the group was shown two sets of pills (oral contraceptive and emergency pills) and asked if they knew the difference. While the group knew about oral contraceptive pills, there was not much clarity about the emergency pill (FM02J). Similarly in other groups where this was discussed, the participants had never heard of emergency pills (FW01H, FM06C).

Not only was awareness low among the general population, even health workers did not have complete information about purpose and indication for the use of emergency contraceptive pills. In her interview, one ANM said that the emergency contraceptive pill can be taken on a regular basis (IH01H). One senior doctor (MOIC of a CHC) was of the opinion that frontline health workers should not be provided emergency contraceptive pills at all, as there was poor knowledge about its uses, and women's health would be at risk (IH04J). In this regard, the head of a Community Based Organisation mentions:

“We had recently organised district level workshop on family planning in collaboration with the government and in these workshops it was evident that, those responsible for the implementation of family planning programme at the district level, and especially health workers at the block level, did not have complete or correct information about various choices for family planning, including information such as, who it is appropriate for, how it can be used and the possible side effects. Even the little information that they do have, has not yet penetrated to the village level”

¹⁸ This is a pill which must be taken within seventy two hours of having unprotected sex. It is not for regular consumption, and can have adverse health effects if taken after conceiving.

4.3.2 Stock and Supplies of Contraceptives

The availability of contraceptives is not only an important dimension of quality but will also determine whether the basket of choices is available at all times. Often, contraceptive supplies ran out at the village level and frontline workers were unable to distribute them on demand. One of the community men mentioned that the CHC in his block centre was not able to provide adequate services. Giving the example of condoms, he recounted an incident where he had gone to the CHC and it had not been easy to get condoms. He said that when he had approached the CHC staff for condoms, they had asked him 'why do you need it?' After some heated argument, they agreed to give him 'a few condoms'. He also mentioned that the condom vending machines at the CHC were often empty. (IS08B). On speaking to the medical officer of the same CHC regarding the steps he took to ensure that different contraceptives reached the village, he responded,

“Whatever health supplies are available for the community, like iron folic acid tablets, Zinc, ORS, condoms, etc are given to the ASHA. Then it is not my headache what she does with it. She may be distributing it, throwing it away or does whatever she wants to do with it”.

Thus we see a lack of initiative on the part of the doctor to demand accountability from his staff. Rather, he places the responsibility squarely on the community, and mentioned that since he had not received complaints against the ASHAs, he could not take action against them. The doctor blames the community for not having any interest in getting new information and he felt that the acceptance of family planning was low since *'the demand for tubectomies was 30 and that for vasectomies were 10 -15 in a year'* (IH05B). He completely ignored issues related to availability and utilization of temporary methods like condoms.

The above case demonstrates the attitude of some health providers, who put the blame of poor utilization of health services, squarely on the shoulders of the community, without an appreciation for the whole host of reasons which lead to their poor utilization. In contrast, it demonstrates the real experiences of those who have approached the health system, and do not have faith in it due to their past experience.

4.3.3 Premarital counselling on Contraception

Premarital counselling on contraception is clearly lacking; nearly all the participants who were asked if they had prior knowledge of family planning before getting married said they did not have any such information. This lack of information was not only overwhelmingly found in older women, but even in younger, relatively educated women. For example, one female FGD participant who married 5 years back, says that she had no information about contraceptive methods, or even about how men and women had sex when she got married (FW01H). On asking if they felt adolescent girls had correct information about FP methods, the group felt that such information was lacking. In another FGD, a woman in her late twenties said that she was married at the age of 9 and started co-habiting 4-5 years later. She had no idea of family planning and had 3 children by the time she was 20 (FW02J).

Preeti (name changed) 23, got pregnant, almost immediately after her wedding. She seemed embarrassed to mention this. She says that she had not known about any method of contraception when she got married. She did not discuss it, or actively seek information from her friends either. She felt it was wrong for an unmarried girl to discuss such things and even got angry if her friends were discussing such things. After her wedding her first source of information was her husband, who himself did not have complete knowledge of contraceptive methods. Although her husband knew about condoms, they did not have complete information about it. She says

“ He knew about it, but did not know for how many days we needed to use it. We used it for 2-3 days, and then stopped using it.” They were not aware that condoms needed to be used every time they had intercourse. (IW01H)

Similarly another 24 year old says that she got pregnant immediately after her wedding. The older women in her community had expected the couple to conceive after a while and hence had not given her information soon after the wedding. However, when she conceived within the first month of her marriage, the older female relatives and the ASHA finally gave her information about contraceptive methods (IW05B). There is clearly a need to counsel young men and women, as well as newlywed couples about family planning, and encourage them to adopt contraception to delay the first pregnancy.

There is often much resistance in providing such information to adolescent girls and boys, and schools do not have a component of sexual education in their curriculum. Unmarried youth, are usually left out of family planning programmes and the targets and outreach plans of front line health workers and other medical staff do not include this population¹⁹. Another finding which emerged was regarding attitude towards unmarried men seeking contraceptives. An ASHA mentioned that once two unmarried men had come to the centre to ask for condoms. She does not feel this is a good thing and it makes things awkward for her (IH02H). While boys and men do have mobility and access to chemist shops, mobile phones and other sources of information (sometimes misinformation), girls lack this mobility and access to technology and do not get information on sexual health or contraception through any channels. A study by The YP Foundation showed that there are various challenges for young unmarried women to access the counselling services on contraception. One of the key reasons includes the attitude of the counsellors towards young unmarried women, which is often disrespectful²⁰. The study also showed that experiences of being morally policed by the counsellor upon seeking counselling on contraceptives are very common. Since the family planning programmes function within the framework of “marriage”, information is often denied to young unmarried women at the centres. In a group



¹⁹ Prakash, Jejeebhoy and Kumar Singh S. 2014

²⁰ The YP Foundation. 2015. Seen, Not Heard: Youth Led Audit of Sexual and Reproductive Health Services in Lucknow

discussion with 20 unmarried women, it emerged that there is an unmet need of contraception amongst them and none of the participants knew where to access the information on contraception (ibid). In a preliminary audit of government and non-government health centres which impart comprehensive sexuality education, in and around communities in the National Capital Region, it was found that requests for contraception by young unmarried people were met with either strategic silence or overt moralising where health care practitioners instead of playing the role of facilitators, either consciously or unconsciously, slipped into the role of gatekeepers²¹. The findings also showed that it was not easy to obtain contraceptives from the chemist shop in the facility premises it required a doctor's permission to buy them. One of the mystery clients from the audit study narrates,

When one of the ANMs in Hamirpur was asked what she would do if unmarried men came to ask her for condoms. She replied, "We don't have such persons coming to us. I will not give it to them. It is illegal." On being asked if she would ask them (unmarried men) to go somewhere else, the ANM said, "I will not say anything". (IH01H)

"Firstly, we were sent to three different rooms to get the CMO/doctor's permission. In the third room, a female assistant lashed out at us saying, 'Sharam nahi aati? Parents ki izzat mitti me mila di (Aren't you ashamed of yourself? You are ruining your family's honour).' It would have been downright humiliating for any person let alone a distressed young girl. In the end, I wanted to be out of the hospital as soon as possible."

On the other hand, counseling young men and women who are about to get married, or young newly married couples may be much more acceptable to the community. Thus the family planning programme only attempted to cater the needs of married and procreative couples. The contraception and safer sex counselling needs of LGBTI population is non-existent as they are seen as being non-procreative.

4.4 Shifting the burden of Family Planning away from women: Increasing male responsibility and participation

As pointed out earlier, the emphasis has largely been on contraceptive methods for women and there has been little effort to involve men in family planning. The Indian family planning programme's near-total dependence on women is evident from the fact that the male versus female ratio for sterilization in 2016-17 stood at 1:52 (Ministry of Health and Family Welfare). Half of the women who undergo sterilization have the operation by the median age of 26.5 years while for men it was 31.4 years (NFHS-4, 2015-16) One of the most consistent themes emerging from all the districts where the research was conducted by SAHAYOG was the widespread acceptance of myths about male sterilization. Even though male sterilization is much simpler than female sterilization, women continue to be the ones who opt for this method.

Myths and misconceptions about male sterilization are rampant which further exacerbated the problem. There is a strong belief both among men and women that male sterilization will result in loss of physical strength and virility. The near universal acceptance of myths about male sterilization, raises serious questions about the government's health education efforts. While messages through mass media seem to have failed to penetrate villages, village level health education programmes too, seem to be inadequately implemented. One health provider, the MOIC of a CHC, agrees that community level health education programmes are lacking. According to him, much needs to be done, but the

²¹ Vasudevan, Manasa Priya. 2016. Youth Ki Awaaz, Available at: <https://www.youthkiawaaz.com/2015/11/sexual-and-reproductive-health-in-india/>

Health Education Officer is usually busy and has to juggle many responsibilities, and some of the posts in his CHC are yet to be filled. High workload of health personnel was pointed out by a CBO partner too

“This poor reach (of health information) at the community level can be partly attributed to high workload of the health workers and partly to lack of motivation to undertake community level information dissemination” (IC02H).

While some health providers agreed that their health education programme needed strengthening, there were those who felt that the blame lay with the community. One health provider (MOIC of a CHC) was asked about his perception about poor uptake of sterilization by men as compared to women. The MOIC was clear that the community was to be blamed for this. According to him, it was women who often prevented men from undergoing sterilization. Although he concedes that frontline workers like ASHA form an important link between the general health services and the community, he does not believe he should take responsibility for what they do in the villages. He said, “I cannot monitor the ASHAs all by myself”.

In a context where acceptability of permanent method of family planning among men is abysmal, and female health workers are unable to approach men, the entire burden is shifted to women. All efforts are directed at women to adopt the permanent method, even though the procedure is much simpler for men. There is a clear need for a more comprehensive understanding of family planning, among health workers and need for providing balanced information about all available contraceptive methods in the community, instead of considering sterilization acceptance as a primary criteria for success of the family planning programme.



5. SUMMARY AND DISCUSSIONS

The Government does not seem to be keeping up with the demographic transition that is underway in the country. Couples and individuals in India, for the most part, no longer want more than two children. In this situation, spacing is the most important option that couples need. While couples are increasingly opting for small families, access and availability of family planning services and correct information about available methods is lacking. There is large unmet need for family planning services and information, which the health system is not able to adequately fulfil. This was apparent during interviews with key informants, as there were several informants who reported that, they had more children than they wanted, or had an unplanned pregnancy, because they were not aware of family planning. NFHS 4 data also shows that 48.1 million pregnancies in India were unintended and 15.6 million pregnancies end in abortions and the total unmet need is 12.9% while the unmet need for spacing is at 5.7%. The findings in the four themes that were analysed in this report show that:

The findings show that despite policy documents claiming to follow a target free approach, in reality, targets remain an integral part of the family planning programme and is used to reward or reprimand successful or erring staff. This pressure on the providers and frontline workers has often led to serious violation of human rights. These may take the form of conducting many more sterilizations than mandated or insertion of PPIUCDs without the knowledge and consent of the concerned women themselves. The pressure to meet the targeted numbers has led to failures, morbidities and mortalities. It was also found that instead of facilitating access to the indemnity scheme in such case, the reaction of the health providers ranged from denial to apathy in cases of failure, to even completely denial of responsibility in the case of death; thereby depriving the women and their kin of the compensation promised by the government.

The findings also showed that the quality of services provided during sterilization (both through the camp method and recently through static or fixed day services in health facilities) and spacing methods are still not fully assured. They do not comply with the quality guidelines on Standards of Female and Male Sterilization, that were issued by the Government of India; in order to improve the quality of family welfare services and ensure the well-being of persons undergoing sterilization. While a few pre-operative tests are being conducted, collection of obstetric histories of women and providing pre and post operative counselling informing about potential risks, danger signs or post surgical care was often not given. Post operative care provided is variable in both camps and fixed day services, sterilization certificates were not issued as a matter of course. Further full information is not being provided to acceptors on the side effects of different spacing methods.



Although new long acting methods have been added to the family planning programme in recent years, these too, do not aid in delaying of pregnancies, which is the need of young couples. Premarital counselling on family planning is clearly lacking; nearly all the participants who were asked if they had prior knowledge of contraception before getting married said they did not have such information. Further, both the data and the field experiences show that terminal methods like female sterilization are the ones which are being promoted and provided the most.

The emphasis of the Indian Family Planning programme has largely been on contraceptive methods for women and there has been little effort to involve men in family planning. Myths and misconceptions about male sterilization are rampant which further exacerbated the problem. The Indian family planning programme's near-total dependence on women is evident from the fact that the male versus female ratio for sterilization in 2016-17 stood at 1:52 (Ministry of Health and Family Welfare). Under Mission Parivar Vikas, in name of male participation, the new thrust is to promote vasectomies but the uptake is low as the government has failed to address the myths and fears around it through instituting a robust health education and communication plan in villages and communities.



6. CONCLUSIONS AND RECOMMENDATIONS

To conclude, India's Family Planning programme in effect is caught in a time-warp, providing services which were appropriate twenty or thirty years ago for a population of older couple with four or five children to a younger population with a desire for a small family size. It would appear that while the rhetoric of the 'small family' has succeeded the family planning department hasn't yet adapted to this change. The community should not be seen as passive actors who must be pushed to fulfill the larger goal of 'population control' for the greater good. Rather it is important to build messages for family planning with an approach to empower families, provide greater agency to women over their bodies, provide equal value to women's health and make men equal participants in family life through their participation in family planning.

The following measures are recommended for the Government of India to ensure that women, men and couples in India are freely able to exercise their reproductive right to informed choice to safe and effective contraceptive services and have the ability to access these towards fulfilment of their reproductive rights and the right to health for all

1. Set up a High-level expert Committee to review the family planning program in India and reorient it such that it is aligned with reproductive health rights of women, and needs of India's population.
2. Maintain a National Registry of complications, deaths and failures in sterilization operations as a surveillance mechanism.
3. Shift the distorted focus of annual budgets away from sterilization of women and promote meaningful involvement of men in taking contraceptive responsibility and promotion of spacing methods.
4. Review the indicators for the family planning programme to include informed choice, quality of care and adequate promotion of spacing methods. Instead of targets/ELA's, consider 'community needs assessment' to determine the contraceptive demand and prepare the health system to fulfill this demand.
5. Address the contraceptive needs of young couples, and adolescents by making available a variety of spacing methods. Conduct research on what young people consider most appropriate methods of contraception and FP programmes should focus on those in promotion of contraception for young people including the LGBTIQ persons.
6. Allocate resources (funds, human and skills) and provide comprehensive sexuality education to young people, adolescents, men and women
7. Expand and make available a basket of contraceptive choices to women, especially spacing methods, at the ground level along with complete information about its use and side effects so that they are able to make informed choices related to their reproductive lives. Methods that are less invasive and woman controlled must be included in the public health program.
8. Increase awareness about entitlements vis a vis contraceptives in the community and involve the community in monitoring of the quality of contraceptive services.

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APPENDICES

Tool used for data collection

STERILIZATION CAMP OBSERVATION FORMAT

General Instructions

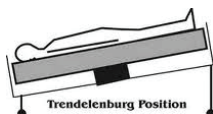
Thank you for agreeing to be a part of this observation.




This checklist must be filled by the investigator who will be observing the sterilization camp that might be organised in a Community Health Centre (CHC), Primary Health Centre (PHC) or in any other place. To fill this checklist the investigator will need to interview women, health providers as well as make detailed observations of the camp. The investigator is expected to spend the entire day in the sterilization camp to avoid missing important information. Please keep the following in mind while filling up the camp observation checklist

1. Please put a ✓ sign for questions that have a yes/no answer option
2. In case you have any additional comments/observations, please make sure to write them down in the space provided at the end of this format
3. In case you were not able to obtain information for any particular question, please write 'information not available'. Please remember that the absence of information is also important data

1.1	Name the organisation undertaking the camp observation	
1.2	Name of the investigator and phone number undertaking the observation	
1.3	Date of observation	
1.4	District where the camp was organised	
1.5	Block where the camp was organised	
1.6	Village where the camp was organised	
1.7	Where was the camp organised (District Hospital/CHC/PHC/School/Charitable Home/others)	
Section 2: Description of the Camp		
2.1	At what time did the women reach the Camp	
2.2	At what time did the physical examination of the women begin	
2.3	At what time did the doctor arrive	
2.4	At what time did the first operation start	
2.5	At what time was the last operation done	
2.6	At what time did the doctors leave the Camp	
Section 3: Information related to Human Resources		
3.1	Who organised the camp (Government or a non-governmental organisation) If the latter then specify the name	
3.2	How many surgeons performed the sterilization operations	Number: _____
3.3	Give the name of the surgeons	
3.4	Were the surgeons performing the sterilization trained in the procedure	

3.5	How many sterilizations did each surgeon perform	Number:_____
3.6	Number of nurse present in the operation theatre	Number:_____
3.7	How many women were sterilized during the camp	Number:_____
3.8	How many women underwent the mini-lap (mini-laparotomy) procedure	Number:_____
3.9	How many women were sterilized using the laparoscopy technique	Number:_____
3.10	How many women were sent back without being sterilized	Number:_____
Section 4: Information related to diagnostic tests (examine documents provided to the women and in cases of doubt cross check with the individual woman)		
4.1	Was a blood test done for all the women who came for the sterilization procedure (tick one of the options)	All women Some women None
4.2	Was a urine test done for all the women who came for the sterilization procedure (tick one of the options)	All women Some women None
4.3	Was the blood pressure checked for all the women who came for the sterilization procedure (tick one of the options)	All women Some women None
4.4	Were all the women who came for the sterilization procedure weighed (tick one of the options)	All women Some women None
4.5	Were all the women who came for the sterilization procedure asked their age	All women Some women None
4.6	Was an abdominal examination done for all the women who came for the sterilization procedure	All women Some women None
4.7	Were all the women who came for the sterilization procedure asked how many children they had and the age of the youngest child	All women Some women None
Section 5: Documentation maintained during the Camp		
5.1	Was a written record of the information related to the women (their age, number of children, etc) kept during the camp? (tick one of the options)	Yes No
5.2	Were the women given written reports of their test results?	Yes No
5.3	Where the women given discharge slips before being discharged	Yes No
Section 6: Counselling (Observe as well as ask women the following questions)		
6.1	Was there a separate room for counselling	Yes No
6.2	Were counsellors present	Yes No

6.3	Were the women given information about other family planning/contraceptive options	All women Some women None
6.4	Were the women counselled on the benefits of sterilization before they were operated upon	All women Some women None
6.5	Were the women counselled on the side-effects/health risks/adverse outcomes of sterilization before they were operated upon	All women Some women None
6.6	Were the women told that sterilization is a permanent method of contraception	All women Some women None
6.7	Before the sterilization operation, was the consent form read out and explained to the women in a language that they understand? (If possible obtain a copy of the consent form)	All women Some women None
6.8	Did the women understand the contents of the consent form?	All women Some women None
6.9	Were the women told about the indemnity scheme and the compensation that would be given in the event of failure, complication or death	All women Some women None
Section 7: Facilities at the Camp		
7.1	Was a laboratory present in the Camp	Yes No
7.2	Was running water available in the Camp	Yes No
7.3	Were functioning toilets available in the Camp (cleanliness with water facilities)?	Yes No
7.4	Was power back up (generator, etc) available in the camp?	Yes No
7.5	Was a torch available in the Camp for use in an emergency?	Yes No
	Was a vehicle available in the Camp to transport women who might need a referral?	Yes No
Section 8: Information on the Operation Theatre (If possible visit the operation theatre)		
8.1	Was there a separate operation theatre (OT) where the sterilization was performed in the Camp?	Yes No
8.2	If no, then where were the operations being conducted?	Yes No
8.3	Did the (OT) have electricity connection and light bulbs?	Yes No
8.4	Could the height of the operation table be adjusted as shown under 	Yes No

8.5	How many operation tables were installed in the OT?	Number: _____
8.6	How many laparoscopes were being used in the Camp	Number: _____
8.7	Was the doctor wearing gloves while conducting the operation?	Yes No
8.8	Was a cycle pump used to inflate the women's abdomen during the operation?	Yes No
8.9	Was a boiler present in the Camp to sterilize the instruments used for the operation 	Yes No
8.10	Was an autoclave available and being used in the Camp 	Yes No
	Was a surgical drum available in the camp 	Yes No
Section 9: Post operative care		
9.1	Was there any designated and separate room for the women to recover after the operation	Yes No
9.2	If yes, what were the arrangements there (were women made to lie down on beds, or mattresses or on the floor)	
9.3	If no, then where were women made to rest (please specify the place)	
9.4	Was the pulse of the women checked at an interval of every 15 minute for an hour after the operation (tick one of the options)	All women Some women None
9.5	How many hours after the operation were the women discharged	Less than 4 hours After 4 hours and in a conscious state After 4 hours but while still unconscious

9.6	Were the women examined by a doctor before being discharged	All women Some women None
9.7	Were the women given post operative advice (care and precaution to take) before being discharged?	All women Some women None

Guidelines for taking photos

- Photos of the place where the camp was being conducted
- Photos of women arriving and leaving the camp
- Photos of the operation theatre
- Photos of the place where women were made to recover after their operation
- Photos of the laboratory
- Photos of dustbins kept in the camp. In case the camp had separate dustbins for bio hazardous waste please click photos of these (red and blue)
- In case gloves, bandages, syringes, cotton, and other consumables were thrown on the floor then take photos of them
- Photos of the toilets

Any Other observations or notes:

CASE DOCUMENTATION CHECKLIST

(Use of documentation of sterilization deaths/failures)

General Information:

1. Name of woman:
2. Age:
3. Education:
4. Religion
5. Caste:
6. Full address:
7. Marital Status:
8. Number of Children with age:
9. Occupation of woman:
10. Occupation of spouse/father if applicable:
11. Sources of family income:
12. Observe and note:
13. Physical and mental condition of the woman if alive
14. Economic status of woman's family
15. Other past information (medical history, links with political persons, relatives in the government, etc)
16. About the Incident:
17. Note details about the incident starting from the beginning with dates. Find out what happened, where it occurred and other actors involved in the incident.

INTERVIEW SCHEDULE TO DOCUMENT COMPLICATIONS AFTER FEMALE STERILIZATION

1. Name of the woman
2. Name of the husband
3. Age, Caste and Education of woman
4. Full address of the woman
5. Location of interview, date, name of the interviewer
6. How often the women got pregnant?
7. How many living/alive children are there?
8. What is the age of the youngest child?
9. Have you used any type of contraception method before? Give complete information
10. Why did you opt for sterilization?
11. Was anything offered to you in return of sterilization?
12. Who told you about female sterilization?
13. Were you told about any other birth control/contraception method other than female sterilization?
14. Were you told about the advantages/disadvantages of female sterilization?
15. How did you go for sterilization?
 - I. Who went with you?
 - II. At what time did you arrive there?
16. Was any written consent taken from you before/for sterilization? If you are non-literate then had anyone read the consent form to you?
17. Was any checkup done during the sterilization? Who did the checkup?
18. What kind of checkups were done? Please describe in detail.
19. At what time you were called?
 - I. How long it took to finish the sterilization process?
 - II. At what time did you come out?
20. How many doctors were there for the sterilization?
 - I. How many surgeons were there?
 - II. Was there any female doctor?

- III. How many tools were there?
 - IV. Describe was the place where the sterilization was done?
 - V. Where other women being sterilized at the same time? What was happening with other woman?
21. What happened after sterilization?
- I. Was there any place to take rest?
 - II. How was the place?
 - III. How much time was given to you to relax there?
22. Did anyone come to do a checkup?
- I. What checkup was done?
 - II. What did they ask?
 - III. Was any medicine given?
23. Was anything told about the insurance?
- I. What was told?
 - II. Did you get any written information?
24. Was any money received by you after sterilization?
- I. How much money did you get?
 - II. Was there any problem in receiving the money?
25. When did you get discharged?
- I. How did you go back to your house? (Was there any ambulance available?)
 - II. How was your health at that time?
 - III. Did you wanted to relax more for a while?
26. What happened after that?
- I. Did you face any problem after that? Please tell in detail
27. What was done for your treatment?
- I. Has the government helped you?
 - II. Did you face any difficulty in getting help from the government?
 - III. Did you receive any documents from the hospital? (Certificate of Sterilization)
28. Any other information

KEY INFORMANT INTERVIEW – COMMUNITY MEN

KII ID _____

Date _____

Name	
Age	
Educational Qualification	
Marital Status	

1. Please tell me something about yourself (profession, age at marriage, number of children, engagement in any other social activities)
2. Are you aware of family planning methods?
3. Had you ever sought FP services yourself/your wife?
4. Why do you use this method/s
5. In your peer group, among your friends, does discussion around family planning ever come up? Do they feel they have a role to play in family planning? If no/yes Why?
6. In your opinion, is it easy or difficult to get men involved in family planning?

KEY INFORMANT INTERVIEW –COMMUNITY WOMEN

KII ID _____

Date _____

Name	
Age	
Educational Qualification	

1. Please tell me something about yourself and your family. When did you get married? How many children do you have?
2. When you got married, did you know anything about family planning methods?
3. After your marriage did you ever have a discussion with your husband about how many children you wanted or about spacing?
4. Can you tell me about some family planning methods that you are aware of?
5. From where did you first learn about family planning methods?
6. Have you ever used any family planning methods? Are you using them now?
7. Have you ever approached any frontline provider for information and services related to family planning?
8. If you do, who is responsible for using FP methods? You or your husband?
9. In your opinion, do women in the community discuss FP with their husbands? If not then why?

KEY INFORMANT INTERVIEW – COMMUNITY LEADERS

KII ID _____

Date _____

Name	
Age	
Educational Qualification	

1. What do you know about family planning?
2. Can you please name all the methods of contraception that you know about?
3. What are the methods of contraception that are used by you/your family members/in your neighbourhood and why?
4. What are the steps being taken at the panchayat level to promote family planning?
5. Do you think the panchayat has a role in promoting family planning? Please explain in detail.
6. Do you think that men should play an active role in family planning and adoption of contraception?
7. Please explain why?
8. Are there any steps that are being taken by the panchayat to promote greater male engagement in family planning

KEY INFORMANT INTERVIEW – SERVICE PROVIDERS

KII ID _____

Date _____

Name	
Age	
Educational Qualification	

1. What are the contraceptives methods offered/available in your health facility?
2. Which is the method that is most in demand?
3. Do you/your staff motivate men to adopt family planning methods?
4. Do you have a family planning counselor appointed in your health facility?
5. Who seek more information on family planning and contraception in your health facility - men or women?
6. Does your health facility organise programmes to promote family planning and contraception in the community? If yes what has been its impact on the community?

FGD GUIDE- MEN

Name of the Village:

1. Please introduce yourself (name, marital status, number of children)
2. When you got married, did you know about FP methods? After marriage did you have any discussion with your wife about FP?
3. Can you tell me about some methods of family planning
4. Did any of you plan, space your children using family planning methods?
5. Who uses FP method between you and your wife? Why?
6. Have any of your wives adopted permanent methods? (IF yes). [Probe- Did you have a discussion with your wife before she went in for tubectomy? Did you offer to undergo the procedure]
7. In your observation, do men discuss or use FP with their wife? What is the reason for those who don't
8. Have any of you interacted with ASHA/ANM about information or services for FP? Do you have any hesitation in talking to female health workers?

FGD GUIDE - WOMEN

Name of the Village:

1. Please introduce yourself (name, marital status, number of children)
2. When you got married, did you know about FP methods? After marriage did you have any discussion with your husband about FP?
3. Can you tell me about some methods of family planning
4. Where/from whom did you get this information related to contraception?
5. Did any of you plan, space your children using family planning methods?
6. What is the most commonly used method of contraception used by women in your village?
7. Does the use of any specific method of contraception lead to complications? If yes can you describe what these complications are?
8. Who uses FP method between you and your husband? Why?
9. In your opinion are women able to motivate their husbands to use contraception?
10. What in your opinion is the role of men in family planning?
11. Have any of you interacted with ASHA/ANM about information or services for FP? Do you have any hesitation in talking to them?



This research is part of State of the Region Report on Sexual and Reproductive Health and Rights: International Conference on Population and Development (ICPD+25) monitoring initiative by ARROW. This initiative includes 13 partners and generates monitoring evidence around twenty-five years of implementation of the ICPD Programme of Action (ICPD POA) in the respective countries for advocacy. The evidence from the report is expected to inform the Mid-term Review of the 6th Asia Pacific Population Conference (APPC) in 2018 at the regional level, the national policy dialogues in 2019 at the national level, and the ICPD+25 review in 2019 at the international level.

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

SAHAYOG is a non-profit voluntary organisation working to promote gender equality and women's health from a human rights framework since 1992. Its key activities include advocacy and strengthening partnerships. SAHAYOG works with the mission of promoting gender equality and women's health from a human rights framework by strengthening partnership-based advocacy

SAHAYOG

A-240, Indira Nagar, Lucknow,
Uttar Pradesh 226016, India