WOMEN'S EXPERIENCE WITH
POST PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE
Fact Finding - Delhi

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1. INTRODUCTION

1.1. The Context

The family planning programme in India has had a long and somewhat turbulent history. It has, over the years, adopted a number of different strategic approaches including a coercive target approach, a policy articulating a reproductive health and rights paradigm, contraceptive-specific incentives, and a family planning camp approach, among others. Fifty years later, the impact of the programme remains uneven and somehow has also endangered the lives of the young women in the reproductive age group.

The Family Planning Programme in India currently provides spectrum of choices which are IUCD, Condom and Oral Contraceptive Pills (OCPs).

In 2008, the Government of India (GoI) took the initiative to revitalize the Post Partum Intra Uterine Contraceptive Device (PPIUCD) services in the country. This initiative was undertaken to address the increasingly unrealised need for Post Partum Family Planning (PPFP) services beyond sterilization, and help improve pregnancy spacing, which would contribute in improving maternal and child morbidity and mortality status throughout the country. PPFP services, defined as family planning services provided during the extended postpartum period (through first year after delivery) are services which are crucial and need to be addressed by maternal, neonatal or child health or reproductive health/family planning programmes.

Post Partum Intrauterine Contraceptive Devices (PPIUCD) are increasingly included in our national Post Partum Family Planning (PPFP) programmes, but there have been many concerns raised by PPIUCD users.

The Indian women who rely on government hospitals for their health care typically have access to only one type of PPIUCD: the Copper-T. As part of a target-oriented family planning policy, many hospitals in India routinely insert PPIUCDs with or without a woman's knowledge or consent after childbirth and abortion.

These insertions often are done without informed consent or counselling resulting in violation of the rights of the women to informed consent and choice.

1.2. Focus

The situation in the slums of Delhi has implications on the maternal health and well being of women. A fact finding team comprising of health activists, activists from Urban Rights Forum for the Homeless[1] and volunteers visited some of the slums in Delhi on 26th August, 27th April and 1st April 2016. The team focused on three issues primarily:

a. To assess whether insertion of PPIUCD takes place through informed consent;

b. To probe whether counselling is provided to women on spectrum of contraceptives provided by National Family Welfare Programme which are - Sterilization, IUDs, Daily Oral contraceptive pill and condom.

c. Provider-patient relationship and quality of care in family planning.

The fact finding team comprised of following participants.

S.No.	Team	Place	Date
1	Pritisha, Madhulika, Prabhu Dayal	Baljeet Nagar, Patel Nagar, Delhi	26th August 2016
2	Pritisha, Madhulika, Divya Kumra, Mohd. Saleem	Chilla Khadar, Jhuggi camp, Mayur Vihar, Phase Iand Dhobi Ghat, Kalyanpuri, Block no. 13, Delhi	27th April 2016
3	Pritisha, Madhulika, Divya Kumra, Anna, Shanta Devi	Chilla Khadar, Jhuggi camp, Mayur Vihar, Phase I and Dhobi Ghat, Kalyanpuri, Block no. 13, Delhi on 27th April 2016	1st April 2016

[1] A network of twenty three organisations working on issues of homelessness and housing rights in Delhi

2. METHODOLOGY

The fact finding team focused on the slum cluster of Baljeet Nagar and Chilla Khadar. The team collected, collated and verified the information provided by the affected respondents from the filed through the following methods:

a) Focus Groups

The focus group discussion through its participatory approach was conducted with women who are PPIUCD users in the slum clusters. The focus was to enable PPIUCD users to share their experiences in a friendly and inclusive environment.

b) Case Studies

The team visited the homes of women who are PPIUCD users and documented case studies through face to face interviews. This helped the researchers to have an insight into the real situation at the ground level.

C) RTIs filed on:

RTIs were filed to get responses from the government on the following:

1. Budget allocation for Post Partum IUCD/Copper-T in Lal Bahadur Shastri Hospital for the year 2014-2015 and 2015-2016?
2. Budget allocated for family planning services in the Lal Bahadur Shastri Hospital for the year 2014-2015 and 2015-2016?
3. Number of PPIUCD surgeries that were performed on an average in the year 2014-2015, 2015-2016?
4. Number of documents that have to be signed by the patient or her husband regarding the acceptance/ consent for the use of PPIUCD. And if the hospital maintains any records of those documents? If yes, then, in how many cases there was no consent given by the couple and the surgery was still performed?
5. If the hospital has any counselling cell for IUCD patients? (For both, before and after the surgery)
6. Number of cases reported in the hospital for the removal of IUCD/PPIUCD?

In response to the RTI, the Lal Bahadur Shastri Hospital has provided limited information. There have been 2195 PPIUCD surgeries in the year 2014 and 1407 surgeries in year 2015. Lal Bahadur Shastri hospital also informed that on an average there are 4-5 cases of

PPIUCD/IUCD removal every month. Lal Bahadur Shastri hospital has a counselling cell where they provide information for alternative contraception.

On the basis of the interviews conducted with women from slum cluster Chilla Khadar, it was observed that none of the women had been provided any counselling or gave their consent for PPIUCD insertion.

The identities of many women interviewed are not disclosed due to reasons of privacy.

1.1 STATE PROFILE: DELHI

Source: https://en.wikipedia.org/wiki/Civil_Lines,_Delhi

Delhi is located in northern India between the latitudes of 28°-24'-17" and 28°-53'-00" North and longitudes of 76°-50'-24" and 77°-20'-37" East. Delhi shares borders with the

Figure 1:Figure 1 – Map of the State of Delhi

states of Uttar Pradesh and Haryana and has an area of 1,483 sq. kms. Its maximum length is 51.90 kms and greatest width is 48.48 kms.

Delhi is situated on the right bank of the river Yamuna at the periphery of the Gangetic plains. It lies a little north of 28 latitude and a little to the west of 78 longitude. To its west and southwest is the great Indian Thar desert of the state of Rajasthan, and to its east lays the river Yamuna across which has spread the greater Delhi of today. The ridges of the Aravalli range extend right into Delhi proper, towards the western side of the city, and this has given an undulating character to some parts of Delhi. The meandering course of the river Yamuna meets the ridge of Wazirabad to the north; while to the south, the ridge branches off from Mehrauli. The main city is situated on the west bank of the river.

1.2 URBAN SLUMS IN DELHI[2]

Slums are urban phenomena which come into existence on account of industrialization in and around cities, thereby attracting migration of population from country side. Though slums are a rich source of un-skilled and semi-skilled manpower, they tend to result in being burden on the existing civic amenities.

Delhi has the second largest slum population in India. Nearly 1.8 million people live in slum areas in the capital of India - New Delhi. These people are mostly unemployed or daily wage workers who cannot afford even the basic necessities of life.

Slum Population in India by States

State	2011	2017 (Projected)
Maharashtra	1.81	2.05
Uttar Pradesh	1.1	1.2
Andhra Pradesh	0.81	0.86
Madhya Pradesh	0.64	0.71
Gujarat	0.46	0.52

[2] http://des.delhigovt.nic.in

Delhi	0.31	0.37
Source: Census of India 2011		
All figures in crores		

3. FINDINGS

3.1 BALJEET NAGAR, PATEL NAGAR, DELHI

Baljeet Nagar is a settlement within Anand Parvat. It is a JJ Cluster, comprising of immigrants from nearby states, primarily Rajasthan and Bihar. The settlement was established around 20 years ago. Baljeet Nagar has around 15000 jhuggis. A large number of populations living in Baljeet Nagar are Dalits, SC and ST and the area is gravely under served in terms of health facilities and sewage systems, proper houses, water facility and sanitation. People in this cluster are mostly daily wage labourers, vegetable sellers, domestic workers etc.

3.2 INTERVIEWS/CASE STUDIES–BALJEET NAGAR, PATEL NAGAR, DELHI

The fact finding team conducted a focus group discussion with approximately 20 women in the reproductive age group of 18 to 30 years old. All these women were PPIUCD users and had at some point allowed insertion of Copper-T in public health services. These were the women who did not choose to use an IUD, but who received an IUD nonetheless because of a policy of routine insertions. These women suffered socially and psychologically because the IUD was inserted against their will and/or without their knowledge, and this was made worse if any adverse effects were experienced.

Case Study 1: Rinku Devi

Rinku Devi informed the team that she must be 19 or 20 years old but on paper her age has been recorded as 25 years old. Rinku has two children, a son who is almost three years old and a daughter who turned 1 year old on 6th July 2016. Rinku belongs to an economically

weaker segment. She is a stay at home mother while her husband works in the laundry at Ram Manohar Lohia Hospital. The monthly income of the family is around Rs. 6000/-.

Soon after the delivery of her second child, the doctors at Sardar Vallabh Bhai Patel Hospital forcibly inserted Copper-T without Rinku's consent. Rinku and her husband were not in favour of Copper-T. However, the couple were not counselled about the side effects or management of the most common problems related to intrauterine contraception.

After one and a half month when Rinku visited Sardar Vallabh Bhai Patel Hospital for check up, she was informed by the service provider that Copper T could be misplaced as the thread of the device was not visible. The service providers advised Rinku to get an ultrasound done and referred her to Deen Dayal Upadhyay Hospital (DDU). After three visits, Rinku finally managed to get the ultra sound done. The report suggested that through the thread was missing, the copper T was in lace, Rinku urged the hospital staff to remove the Copper T. However they refused. Rinku's health has taken a turn for the worse. . Her menstrual cycle is heavy and prolonged because of which she complains of giddiness and weakness. She is weak and anaemic. However the service provider of DDU hospital have told her the copper T will be taken out only when her child completes two years and then they can finally permanently sterilize her.

Case Study 2: Sandhya

Sandhya is 22 years old and has studied till 8th standard. Sandhya belongs to economically poor background. Her son is one and a half years old and was delivered at Sardar Vallabh Bhai Patel Hospital. Sandhya was a victim of forceful insertion of PPIUCD.

During Sandhya's delivery, the service providers inserted copper T without informing her. She was never provided any counselling. While in labour, she was in no condition to understand or give her consent for Copper-T. Her mother in law and husband who were

present in the hospital were also not informed, yet the doctors went ahead and inserted it without her knowledge soon after the delivery of her first child.

Sandhya experienced a lot of discomfort and lower back and abdomen pain. She faced massive health problems while doing household chores. After one and a half week of delivery, the copper-T expelled from her body by itself and she bled heavily for fifteen days.

During Sandhya's delivery the hospital staff had asked her mother in law to put her thumb impressions on a paper, which she had done. Sandhya's mother in law is illiterate and she had put her thumb impression on the form wherever she was asked to. She is not aware of where all she put her thumb impression and nobody read out any form to her. Sandhya and her mother in law strongly felt that the service providers used force and coercion instead of counselling and making self informed choice.

Sandhya and her mother in law also told the team that that doctor at Sardar Vallabh Bhai Patel hospital forcibly inserted Copper-T in all the women who had delivered at that hospital. Hence they felt that it is no longer a question of choice, consent or deliberating on it and that it is part of the entire procedure of delivery now.

The doctors at the hospital have failed at providing counselling on contraceptive methods, taking consent of people, monitoring and follow up visits. The team tried to explain about the range of choices, but was not surprised when it found out that women did not know about condoms or if men could also take any kind of precaution and share equal responsibility.

Case Study 3: Jyoti

Jyoti is 24 years old and has studied B.Com. She has a thirteen month old son. Jyoti was referred from Sardar Vallabh Bhai Patel Hospital to Deen Dayal Upadhyay Hospital where she delivered her baby. Her husband is an engineer and is able to earn 10-15 thousand rupees a month. Jyoti, like the other women in the slums, is not aware of her rights and does not have basic knowledge on contraceptives.

Jyoti shared with the fact finding team about her horrific experiences during her delivery where without her consent and any counselling, the health care providers inserted a copper T. Jyoti also informed the team that since the doctors had inserted copper T in all the women who had delivered, she was in position to question the health care providers. Jyoti shared this with her husband and in law who wanted the copper T removed. However the health care provider of DDU refused to remove it.

During her last visit to the hospital, the doctors have given her a slip that will help her get copper T removed if she wanted to. However this has not helped Jyoti much as no health care provider is willing to remove the copper T.

It has been thirteen months since her delivery and insertion of copper T yet she continues to suffer from several heath related problems and side effects like body pain, back ache, weakness and has problem urinating. Jyoti's menstruation cycle is heavy and she bleeds for 15 to 20 days a month.

She desperately wants to get the Copper-T removed for which she has visited DDU hospital several times. However each time she visits the doctor, they refuse. Jyoti is constantly worried and does not seem to be gaining weight. Since she has been complaining of back pain and periods that last for many days, doctors have given her medicines for relief but are not willing

to remove the Copper-T. Jyoti further shared that the medical staff at the hospital had got many forms signed by her before delivery but she was not aware of the content.

Case Study 4: Pooja

Pooja is about 22 years old and has two children. Her elder daughter is around 4 years old and her younger daughter is 1year old. Pooja shared with the fact finding team that soon after the delivery of her second child, the health care providers at Sardar Vallabh Bhai Patel hospital inserted Copper-T. Pooja shared that insertion of copper T took place without her consent and knowledge. She was not counselled on spectrum of contraceptive choices provided by family planning programme. Pooja and her husband were not in favour of copper T. Despite Pooja's strong objections, the doctors were disrespectful in their interaction using harsh words like, *"will you keep producing babies all the time"* and went ahead with the insertion of copper T.

Pooja was informed by the medical staff that the Copper-T will be effective for 10 years of use. At the time of delivery, she was made to put her thumb prints on forms. Pooja is illiterate and does not know what was written in the forms. No one from the hospital read out the form to her or explained the adverse effects of Copper-T, management of the problems related to Copper-T and its monitoring/follow-ups.

Pooja has experienced lot of discomfort and severe health related complications like excessive bleeding, back pain, weakness, nausea, vomiting etc.

Case Study 5: Kamla

amla is about 34 years old and has five children. Three of her daughters are 15 years, 13 years and 5 years old whereas her son is 9 years old. Kamla's youngest child is about 2 years old who was delivered in Deen Dayal Hospital. Kamla shared with the team that soon after the

delivery of her youngest child, the health care providers inserted Copper-T without her consent.

Kamla has had a prior experience of copper T. She described it as an uncomfortable, painful experience. Kamla had to undergo a lot of health complications like pain in abdomen, heavy bleeding and weakness. Kamla had to get the copper T removed.

However, she is going through similar ordeal ever since the health care providers inserted copper T again after the birth of her youngest child. Kamla, like other women in the slum cluster was not provided any counselling at any point of time. She was not in favour of copper T. She has never received any kind of guidance on adverse effects of Copper-T and its management. The insertion of PPIUCD as a family planning method was certainly not her first choice.

Kamla continues to face several health related problems. She also feels helpless because it is difficult for women like her to convince doctors against copper T.

Case Study 6: Sangeeta

Sangeeta is also a resident of Baljeet Nagar and mother of two children. She has a five year old son who was at Lady Harding Hospital. Sangeeta delivered her second child at Ram Manohar Lohia Hospital. Her daughter is 8months old. Sangeeta's daughter was delivered through caesarean operation. Sangeeta shared with the fact finding team that soon after her delivery the medical staff had inserted Copper-T without her knowledge. She had no prior information about doctor's decision of copper T

insertion.

She was only informed about Copper-T which will be effective for 10 years of use after she gained consciousness. Sangeeta was hesitant to talk about contraceptives because she did not have much knowledge about it. Sangeeta turned out to be yet another case of lack of information and awareness about contraceptive measures. She has never had any counselling on choices of contraceptive methods that she and her husband can use. Sangeeta did not give her consent for copper T.

Case Study 7: Mamta

Mamta is 27 years old and has three children- a girl (10 years) and two boys (8 years & 1 year old). Mamta had delivered her youngest child in Sardar Vallabh Bhai Patel hospital last year. Since Mamta has had an experience of copper T insertion earlier also and did not want to go through the procedure again. The first time she got Copper-T, it did not suit her, led to health related complications and she had to get it removed.

Mamta asked the doctors to permanently sterilize her after the delivery. Mamta thought that sterilization is the only measure she can take to avoid future pregnancies. Mamta has never been provided any counselling on spectrum of contraceptive choices.

After the delivery of her third child through C-section, the doctors informed Mamta that since she was weak, the sterilization operation was not possible. The doctors inserted Copper-T instead. Despite the fact that Mamtahad problems with Copper-T earlier, she did not oppose to getting Copper-T.

Mamta requires proper counselling and guidance. She has never been counselled before and during her ante natal checkups or told about pros and cons of getting a Copper-T. In fact, none of the women were fully informed about their contraceptive options. Mamta is now

desperately waiting for the weather to be favourable for her to remove the Copper-T and have a permanent sterilization as a solution for avoiding unwanted pregnancies.

3.3 OBSERVATIONS:

Family planning was clearly a central issue for the women who were interviewed, both in terms of the maternal health care and in terms of how health workers treated them during childbirth followed by insertion of PPIUCD. Routine insertion of IUDs was one of the topics of concern raised by many of the women during conversation.

The responses of the women during interview to the practice of routine insertion of IUDs were not varied. Women did not choose to use an IUD, suffered socially and psychologically because the IUD was inserted against their will and/or without their knowledge, and this was made worse if any adverse effects were experienced.

The women shared that insertion of PPIUCD as a family planning method is not their preferred choice. Coerced insertion of PPIUCD like Copper-T in all the cases have occurred in case of poor and marginalized women. Despite women's denial, they have been **c**ompelled to undergo the procedure soon after their delivery and that has led to severe health related complications for all the women like excessive bleeding, back ache, weakness, nausea, vomiting etc.

Most of the women talked about operation (permanent sterilization) which they believed as the only method to avoid pregnancy once they had 2-3 children. None of the women that were interviewed in this cluster had ever been counselled or given any information on contraceptive measures.

It was also given to understand that family planning is only women's burden. There were present women who had not objected to insertion of Copper T because other women around them had gone through similar experience. Women, while discussing, shared that even though there are four *anganwadis* in the entire cluster, there is no ASHA worker. It is evident that teaching poorly educated women in remote communities how to use pills or contraceptives is more expensive than the mass sterilisation campaigns and forceful insertion of PPIUCDs, and despite successive years of economic growth, governments have systematically chosen the cheaper option.

The interviews of only those women are being documented who allowed the team to do so.

4.1 CHILLA KHADAR AND DHOBI GHAT, KALYAN PURI, BLOCK NO. 13

Chilla Khadar is a cluster stretched across a long piece of fertile land near Yamuna Bank. It is connected to the main city by a semi-built road, which also divides the area in two parts with an approximate population of 2000 people. The general living condition in the area is as dismal. There are no roads or provision of sanitation for people in these clusters. The people here are mostly daily wage labourer of work in fields.

4.2 INTERVIEWS/CASE STUDIES– NANGLI YAMUNA KHADAR, JHUGGI CAMP, CHILLA KHADAR (HANUMAN MANDIR), JHUGGI CAMP, MAYUR VIHAR PHASE-I and DHOBI GHAT, KALYAN PURI, BLOCK NO. 13

The team conducted face to face interviews with a few women in the slum cluster of Chilla Khadar and Kalyanpuri.

Case study 1: Savita

Savita, 23 years, is a mother of two children. She has a girl (2 years old) and a boy (6months at the time of interview). Savita has been married for 4 years now. She has studied till class 10^{th} and was soon married after that.

Savita has never been counselled on contraceptive methods, side effects of Copper-T, range of choices and monitoring.

She also informed that soon after delivering her second child the Copper-T (PPIUCD) was inserted for birth control with her knowledge. Savita does not remember giving any consent for insertion of Copper-T. Savita informed the team that she and her husband did not know much about Copper-T, its management or side effects. Since most of these women and their families come from poor economic background, it is difficult for them to reason out with hospital staff/management.

Savita's case has never been followed up after that. Savita does not even know if there should be a follow up. Savita has never seen any ASHA worker in Chilla Khadar. Savita was not given any discharge papers, any forms or discharge slip from the hospital.

Case study 2: Tulsi

Tulsi with a calm posture shared that she is about 27 years old and has been a resident of Chilla camp since 2008. Tulsi has two children - a girl (7 years old) and a boy (one and a half years old). Tulsi also shared that she comes from a poor family and her husband works in the fields. They manage to earn somewhere between 6000-7000/- per month. This is meagre for a family of four.

In the year 2009, Tulsi delivered her first child in Lal Bahadur Shastri hospital. Since it was a caesarean delivery, Tulsi was admitted for about eleven days and spent 3-4 thousand rupees at the hospital. Tulsi delivered her second baby in Arwind hospital in the year 2014. This was again a caesarean delivery and Tulsi was discharged after approximately six days. Tulsi ended up spending more than 15, 000/- for her second delivery.

Tulsi also shared with the team that after the birth of her second child, the hospital wanted to insert Copper-T as a family planning method. Despite her strictly refusing, the hospital staff did not pay heed to her choice and went ahead with inserting the Copper-T. She is not aware if the doctors properly informed her husband about Copper-T or took his consent instead.

Tulsi and her husband were not counselled on the side effects of copper T and the management of common health problems that might arise due to copper T.

Tulsi also shared with the team that she has been experiencing lot of health problems ever since the insertion of Copper T. She has pain in her back and feels weak. She had to pay for her treatment of back pain and weakness due to PPIUCD. Tulsi also shared that common/basic medicines are available in the public hospitals but patients normally have to purchase expensive medicines on their own.

After coercive insertion of Copper-T, there has been no follow up from hospital or ASHA worker.

Case study 3: Bindu

Bindu Devi, a 38 year old woman is a mother of five children. Bindu Devi narrated tales of disrespect and abuse at the hands of medical staff at Lal Bahadur Shastri Hospital. She lives in Chilla Khadar Camp, Mayur Vihar and the nearest government hospital is Lal Bahadur Shastri Hospital at a distance of nearly 2 kms.

Bindu Devi was little hesitant to talk about her children but soon shared that after the birth of the youngest child, the hospital staff had inserted Copper-T without her permission. Bindu also shared that it is common to find women with more than two children to be openly disrespected, physically and verbally abused for having many children. Bindu Devi has five children of her own but informed the medical staff that she has only two children because she was afraid that she might be subjected to humiliation.

Bindu Devi had her youngest child in 2012 and that is when the medical staff at Lal Bahadur Shastri Hospital had inserted Copper-T despite her refusal. She was not provided any information, counselling or gave her consent for PPIUCD for spacing method. She was not asked to sign any consent form. Bindu Devi started facing severe medical problems. She was constantly complaining of pain in her back and legs. She felt nauseas, vomiting and could hardly do anything. Bindu Devi bled profusely and once fainted due to heavy bleeding. During this time she visited Lal Bahadur Shastri hospital several times and insisted on having the Copper-T removed. None of the hospital staff took notice of her condition or provided any medical assistance. She was repeatedly sent back.

In 2014, Bindu's condition had deteriorated; and she had to be carried to Lal Bahadur Shastri hospital. The Copper-T was removed in 2014 and Bindu had to be admitted in the hospital for about ten days. During her treatment Bindu and her husband had to buy the medicines on their own. Bindu shared with the fact finding team that women from poor background sometimes do not want to go to hospitals owing to ill treatment.

Case study 4: Neelam

Neelam, a mother of three, 2 girls aged three, and one and a half years old, and one boy aged 21 days, got married in 2012 and is living in Nangli Khadar, Mayur Vihar Phase-1 cluster with her husband Mukesh.

Neelam shared that she was never visited by the ASHA worker during her third pregnancy. All information about registration and Ante Natal Check-ups (ANC) was passed on to her by other women living in her village. During her pregnancy, for all her ANC check-ups, she visited Lal Bahadur Shastri Hospital. Neelam and her husband, like other couples in the settlement have had to spend money from their own pocket on transportation to the hospital, medicines etc.

Neelam has studied till class 10^{th} before she was married. She shared the story of how the medical staff insisted her to get PPIUCD (Copper-T) even though Neelam and her husband were strictly against it.

Neelam and her husband is just one couple that was able to exercise their will. However, other couples could not.

Case study 5: Minti Devi

Minti Devi is 25 years old and was nine months pregnant at the time of interview. She has three children - 4 year old son, 6 and 3 years old daughters. Minti has delivered two of her children at home while her youngest child was delivered in the hospital.

Soon after the delivery of her third child, the health care provider had inserted Copper-T with her knowledge and consent. Minti shared that no one had ever counselled her about any of the family planning methods or options. Minti was never asked to sign on any consent form hence she is not aware if there are any forms.

Minti highly doubts if her husband's consent was taken or even if he understood what PPIUCD was, since she had to undergo a lot of pressure and disapproval for contraceptives of any kind from her family.

Minty did not get any cooperation from the hospital staff when she wanted to get the Copper-T removed. It was only removed after the completion of three years. Minti faced a difficult time at home and in hospital.

She faced health issues like heavy bleeding between the menstrual cycles after the insertion of Copper-T, cramps which are usually different from that experienced during menstruation. She was constantly complaining of pain in her back and legs. She felt giddiness, vomiting and could hardly do anything. Minti also shared that people at the Lal Bahadur Shastri hospital ill treat women hence she was afraid to approach them. There have been no follow up visits and doctors seem unwilling to provide care.

4.3 OBSERVATIONS

Women in Chilla Khadar and Kalyanpuri settlements shared their experiences of being poorly informed about IUCD, side effects of using copper T and its management. These side effects can be common as well as precise depending on the health of the woman as well. It is advisable to contact the doctor whether one is in perfect condition for insertion of copper T. Also, information and counselling regarding postpartum care along with family planning need to be initiated during antenatal care[3]. However this component has been missing completely in all women's case.

[3] Counselling for Postpartum Family Planning and Postpartum IUCD Reference Manual 2012

Some of the women shared stories of being humiliated by the medical staff, pushed around and being shouted at and in some cases even physically abused by the medical staff for having more than two children. All the women that were interviewed did not give their consent, or provided any counselling or were guided by the government hospital or health care worker about the side effects or benefits of the PPIUCD. In several cases Copper-T has been inserted without the knowledge of the woman, or there is no opportunity given to seek consent with no follow up or monitoring.

All the women seemed severely malnourished and had developed health related issues due to Copper T. Some of them are still experiencing health issues. In fact, the mainstay of our population control strategy comprises two methods targeted at women — tubectomy (female sterilisation surgery) and insertion of an intrauterine device (IUD) also known as Copper-T. Neither method is known to be suitable for all women. Yet, in the rush to meet targets, these methods are widely promoted and their adverse effects on women ignored.

The public health infrastructure is not geared to manage contraception, the staffs are not trained in counselling women or seek their informed consent, and pain is considered an acceptable side-effect. Women from these clusters were not given any counselling, deprived of full contraceptive choices and hence lacked the ability to successfully manage possible side effects of PPIUCD.

After months of suffering pain, some women visited private hospitals and some women visited the government hospital (like Lal Bahadur Shastri Hospital) to get the PPIUCDs removed and were largely refused to do so. These women coming from poor families, barely managing to make their ends meet, had to extra money to get relief or some kind of treatment by private doctors. Forced temporary sterilization is a method of medical control of a woman's fertility without the consent of a woman. Essentially involving the large number of women violating her physical integrity and security, forced sterilization constitutes violence against women.

4. RESULTS AND DISCUSSION

While memories of the 21 months of Emergency in 1975-77, survives even today in the minds of Indian men as the fear of forced sterilisation, the country's population control policies have shifted over the years since then to target the politically less powerful and vulnerable poor

women. Almost the entire burden of what is euphemistically called “family planning” is today borne by women. And it has taken a toll on the health of large sections of women in the country.

The incidences of involuntary “acceptance” of a method of contraception - the epitome of lack of choice - were not uncommon. This was especially true in the case of IUD insertions. Women shared during the interview of being in pain and heavy menstrual bleeding following insertion of an IUD without their knowledge

Information about contraceptive choices and quality of services is sacrificed when it comes to marginalised women. Poor women soon after delivering a child are hounded to opt for reversible contraception without proper information and are left to deal with negative reproductive health consequences which are perceived as successful.

There are several evidences of poor quality information and lack of informed consent in slums of Delhi. The quality and nature of information that health workers provide to women and their families to convince them to opt for IUCD is questionable and raises doubts about informed consent.

The common side effects that women shared in the three settlements were menstrual changes, longer and heavy menstrual periods, bleeding or spotting between periods, more cramps or pain during menstruation. Uncommon side effects include severe cramps and pain beyond first three-five days of insertion, heavy menstrual bleeding or bleeding between periods, possibly contributing to anaemia and weakness. This is followed by medical negligence and absence of follow-up and monitoring.

5. CONCLUSION & RECOMMENDATIONS

An interaction with women in the three clusters proved that women whose PPIUCD insertion was involuntary, reported psychological and physical side effects. Moreover, many of these women were subsequently unwilling to use public hospital services for fear of another coerced PPIUCD insertion.

The health providers in India have failed in disseminating information regarding contraceptives to couples. Women living in the slums in urban areas are particularly susceptible to this distortion of information as a result of low literacy and educational levels,

representing inherent discrimination in violation of the non-discrimination provisions under Article 15 of the Indian Constitution. This endemic misinformation is responsible for the negation of the right to make informed reproductive choices and nullifies the exercise of sexual and reproductive autonomy, which are legal rights enshrined in Article 21 of the Constitution.

The most effective approach that perhaps that does not compromise fundamental human rights is through the following:

1. To translate within the national programme, the fundamental concept of informed contraceptive choice which, despite rhetoric, has remained a mirage for the people of India.
2. Immediate removal of PPIUCD if a woman experiences any side effects or discomfort.
3. Immediate interim relief should be provided to women who undergo physical and mental trauma due to insertion of PPIUCD.
4. Urgent need to provide a choice of contraceptive methods to enable couples to achieve their reproductive goals, instead of pushing for forcible coercive PPIUCD and female sterilisation as the mainstay of the national programme.
5. Prohibit coercive and forced medical practices and adoption of non-coercive measures such as the promotion of education for girls/women, along with awareness and counselling. And to ensure all women enjoy full sexual and reproductive rights and have access to a full range of acceptable reproductive health services.
6. Mandating informed consent to be transmitted verbally and in writing and ensure documentation of informed consent.
7. To ensure that women are provided proper counselling, made aware, in a language that they clearly understand, of all available methods of family planning, and that women understand side effects, and potential complications, of contraceptives.
8. Ensure that consent is not obtained under coercion or when the client is under sedation, or in labour and that the client signs the consent form before the surgery. Including allowing for sufficient time between the explanation of the PPIUCD procedure to the patient and the time when consent is sought

a. There is a need to establish strong referral mechanism when women need counselling and services. . However in majority of the slum the ASHAs who are the one to

provide counselling services are not placed resulting in a huge gap in provision of family planning services especially in the unserved and underserved areas.

9. To roll out a training programmes for ASHAs, ANMs and other health care providers on all contraceptives, counselling and respectful care and monitoring.
10. To set up an investigation committee to look into incidents of coercive insertion of Copper-T in government hospitals like Lal Bahadur Shastri Hospital, Sardar Vallabh Bhai Patel Hospital and Deen Dayal Upadhyay Hospital.
11. Women carry the burden of family planning. Men should be empowered and encouraged to opt for sterilization which is less complicated procedure for men and share the burden.
12. There is a need to establish a strong grievance redressal mechanism which addresses the issue of violence by health care providers in obstetric and family planning care.

Health facilities are mandated to provide care, especially to the society's most vulnerable people. When hospitals and clinics allow forced and coerced measures to control a woman's reproduction, these facilities become places of abuse and torture. The medical profession should take collective responsibility for ending this abuse which is the very antithesis of health care. Advocates should support efforts to inform affected communities of their rights and help victims receive justice. Government representatives and leaders must make strong and clear commitments to end coercive practices in health care.

6. ANNEXURES

1. Background

In 1952, India launched the world's first national program emphasizing family planning to the extent necessary for reducing birth rates "to stabilize the population at a level consistent with the requirement of national economy". Since then, the family planning program has evolved and the program is currently being repositioned to not only achieve **population stabilization** but also to promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.**

The objectives, strategies and activities of the Family Planning division are designed and operated towards achieving the family welfare goals and objectives stated in various policy documents (NPP: National Population Policy 2000, NHP: National Health Policy 2002, and NHM: National Rural Health Mission) and to honour the commitments of the Government of India (including ICPD: International Conference on Population and Development, MDG: Millennium Development Goals and others).

Since 1995 India has been undergoing a transformation in the conceptualisation and implementation of its family planning policies and programmes, moving away from a target-based approach at central and state government levels towards a broader reproductive health agenda with the locus of decision-making moved to the local level. Under policies initiated in the late 1960s, government health workers have been required to 'motivate' set numbers of eligible men and women to 'accept' contraception. Similar numerical targets were established for public hospitals and district and state governments, creating an elaborate system of competition to attain the requisite number of acceptors. The All India Post-Partum Programme was established in 1970 as a 'maternity-centred hospital approach to family welfare' in national, state and district hospitals.

The Programme was later extended to the sub-district (taluk) hospitals as well. The Programme's mandate was 'to motivate women within the reproductive age group 15-44 or their husbands to adopt the Small Family Norm (two-child family) particularly during the ante-natal, natal and postnatal periods.' This Programme was intended to supplement other maternal-child health (MCH) programmes such as immunisation and the distribution of iron pills in hospitals, but its primary goal was to involve all hospital staff attending births and abortions in the family planning campaign. It was within this Programme that

contraceptive targets were set for post-partum and post-abortion women attending these hospitals.

During the mid-70s, especially during the political emergency in India (1975-77), family planning became a priority at the top-most level of government. Public officials as well as public service employees of virtually every type were directed to fulfil family planning targets and were penalised for failing to do so. Many of them eventually resorted to coercive means in order to achieve these targets.

The 'Emergency' is often remembered for the ways in which human rights were flouted, and particularly for the forced sterilisation of men.2 Family planning tactics have not been as draconian since the Emergency; however, the system of targets continued until 1996, though confined to the health sector. Targets were set for many categories of health workers, and for hospitals, zones, districts and states. Punishments and rewards were meted out based on achievement rates.

2. Current Situation

The first and perhaps, the most important strategy that must be underscored is the need to translate within the national programme, the fundamental concept of informed contraceptive choice which, despite rhetoric, has remained a mirage for the people of India. It is imperative that the principle of “the rights of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so” is operationalised within the national programme. The need to do so is greater now than ever before because couples in India want to both limit family size and space their births. There is, therefore, an urgent need to provide a choice of contraceptive methods to enable couples to achieve their reproductive goals, instead of pushing for forcible coercive PPIUCD and female sterilisation as the mainstay of the national programme

India's family planning programme claims to follow a “cafeteria approach” with a “basket of choices”. The method-mix in this programme includes five official methods — female sterilisation, male sterilisation, intrauterine contraceptive device (IUCD), oral contraceptives, and condoms. However female sterilisation and insertion of IUCD are the only two methods pushed across by the states. This is a matter of concern that the programme has not been successful in providing contraceptives to delay the first birth and

space subsequent births. Nor has it been able to reach men. Even though non scalpel vasectomy technique has greatly simplified the procedure of male sterilisations, however condoms and male sterilisation has not been promoted seriously by the state and the central government. Thus men's engagement in family planning and contraceptive choice has yet to become a reality for the people of India.

Health care providers have been most unresponsive and abusive to women while providing reproductive and child health care services. Family planning programme which is a big initiative under the reproductive and child health programme has always been coercive and forced upon unwilling women. It is made worse by a culture of impunity where the health providers know that they can get away with it.

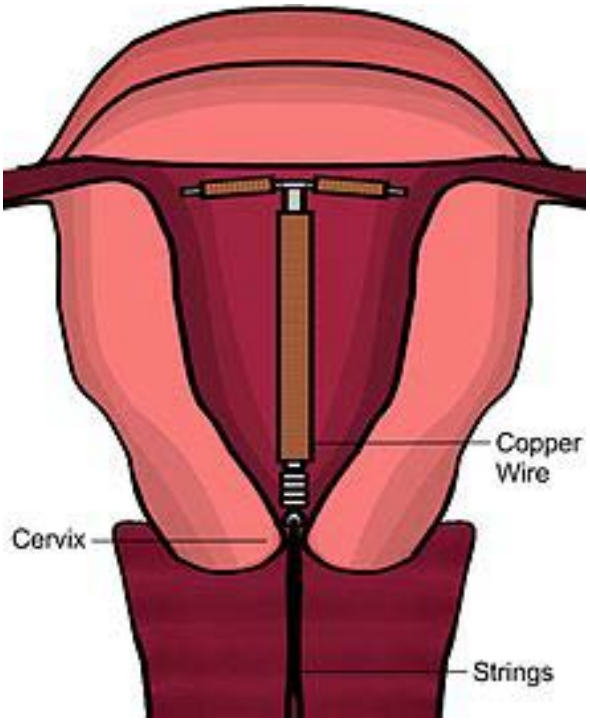
Early marriage continues to be the norm in India. Data from the NFHS 3 show that more than two fifths of all women aged 20-24 years were married before the legal minimum age of 18. And the fact that less than 10% of these young couples had used any form of contraception. A sizeable population of adolescents are giving birth putting their lives at risk. The government of India through the states had implemented adolescent friendly health services however these services are hardly available and young adolescents put their lives at risk as they are not aware of the various spacing methods available. There is a need for the government to specifically focus on strengthening the adolescent friendly health services and focus on trained health care providers who can provide adequate counselling to this vulnerable group.

3. OVERVIEW OF INTRA UTERINE CONTRACEPTIVE DEVICE (IUCD)

WHAT IS POST PARTUM INTRA UTERINE CONTRACEPTIVE DEVICE (PPIUCD)

An intrauterine device (PPIUCD or coil) is a small contraceptive device, 'T'-shaped, often containing either copper or levonorgestrel, which is inserted into the uterus.

They are a form of long-acting reversible contraception which are most effective types of reversible birth control.



What is a Copper-T?

The Copper-T is a intra-uterine device (PPIUCD) made of a flexible "T" shaped piece of plastic wrapped with a thin copper containing wire. This shape is chosen as it fits the area around the uterus, allowing for the Copper-T to sit in place.

When inserted, the ends of the "T" are folded and inserted into the patient with a straw-like tube. Once in place, the spermicidal effects of the Copper-T are in effect, and the tiny piece of plastic and copper becomes a birth control device

How does it work?

Copper ions destroy biochemical structures — they confound enzyme structures, making them useless. The ions can also bore holes into cell membranes, by interacting with the cells lipid bilayer, spilling the contents of the cell into the surrounding environment.

Once a Copper-T is in place, copper ions separate from the coiled copper wire and begin to alter the biochemistry around the uterus. The copper ions leach into uterine fluids and the cervical mucus — when these fluids come in contact with sperm.

Copper ions prevent pregnancy by inhibiting the movement of sperm, because the copper-ion-containing fluids are directly toxic to sperm. Even if an aggressive little spermatozoa fertilizes an egg, the copper ion laden environment prevents implantation of the fertilized egg, and thus pregnancy.

Side Effects of Copper-T are:[4]

1. Menstrual Cycle- Many women have bleeding between the menstrual cycles after the insertion of Copper-T. Many women report about cramps occurring, which is usually different from that experienced during menstruation.
2. Allergy- It is only in rare conditions that any woman is allergic to Copper-T and that is also because of the covering of copper on the PPIUCD device. Usually itching and rashes are seen when someone is allergic to it. The device should be immediately removed under these circumstances and a non-copper PPIUCD can be used instead.
3. Physical – Many women have complained about back pain, headache, nervousness, mild dizziness, nausea, vomiting, bloating, breast tenderness or pain.
4. Automatic Ejection- Expulsion of Copper-T is not usually seen and is rare. When it is pushed out of the uterus, the woman can get pregnant. Even if this expulsion occurs it goes unnoticed. So yearly check upis must after the insertion of Copper-T.
5. Chances of Miscarriage - While using Copper-T when any woman gets pregnant, the chances of miscarriage are very high. This happens because the egg gets fertilized elsewhere than the uterus wall, resulting in lot of complications, which consequently results in miscarriage.

Dangers of Using Copper-T:

- Uterus gets pricked and if the Copper-T is not removed immediately it can move to other parts of the body. In this case the only solution left is surgical removal of the device.
- There can be infection in the tube and if not treated in time, it can be hazardous too.
- If a woman gets pregnant during wearing Copper-T, it has the risks of pregnancy outside the uterus. This is very dangerous and full of complications as well. In most cases it results in miscarriage if the device is not removed quickly.
- Women get pregnant while using Copper-T because many devices are expelled from the uterus and they come out. The woman is unaware as it is unnoticeable.

[4]http://www.indiaparenting.com/alternative-healing/375_3587/side-effects-of-copper-t.html

- Heavy bleeding during periods and clotting between the periods are experienced for first few months. Some women continue with this problem for longer time also.
- It is better to get examined before and after wearing Copper-T and consult freely with your doctor regarding the queries.

4. GUIDELINES

As per the IUCD Reference Manual for MOs and Nursing Personnel- September 2013:

a. Removal or Replacement

- The Cu IUCD should be replaced or removed no later than the full lifespan of IUCD (10 years in case of Cu IUCD 380 A and 5 years in case of Cu IUCD 375), from the date of insertion.
- These can be removed at any time when women want, before completion of the total duration.

b. Counseling

Counseling is a very essential component of our Family Welfare Services and could concern individuals, couples, families and groups. Here the service provider helps ensure that the clients make free, informed and well-considered decision about their own contraceptive practices, child bearing and spacing.

c. Counseling on Postpartum Family Planning (PPFP) and PPIUCD

Key Messages for PPFP Counseling

- Importance of initiating a family planning method soon after childbirth, spontaneous or induced abortion for maintaining healthy spacing of at least 3 years between two children.
- Fertility may return within four to six weeks for women who are not exclusively breastfeeding and as early as 10-14 days after an abortion.

- Women who are practicing Lactational Amenorrhea Method (LAM) should change to another family planning method before the baby is six months old.

Note: A woman should NOT be counseled for the first time about PPIUCD during active labor as she may not be able to make an informed choice due to stress of labor.

d. Post Insertion Counseling

Following insertion of the IUCD, reinforce the key messages related to PPIUCD and inform the woman regarding follow-up visits. A follow up card providing all relevant instructions may be given to her on discharge from the facility.

- Points to be stressed are importance of exclusive breastfeeding and assurance that the IUCD does not affect breastfeeding.
- To return after six weeks for IUCD/Postnatal Care (PNC)/newborn check-up.
- To come back any time if she has any concern or experiences any warning sign or if the IUCD is expelled.

e. Follow-Up Care and Counseling

Follow-up care of the PPIUCD acceptor is very important to ensure client satisfaction and continuation of the accepted method. A woman should come for check-up at 6 weeks and thereafter as and when necessary. If the woman lives far from the facility where the PPIUCD was inserted, telephonic follow-up or follow-up through ANM/ASHAs, can be possible. While counseling clients, the provider should follow the steps mentioned in Post Partum IUCD Counselling Checklist (Annexure 6 of the IUCD Reference manual).

5. National and International Legal Protections

There are numerous legal and policy protections which protect the citizens' rights to access healthcare in an equal manner, independent of socio-economic status, geography, gender, and other factors. Four categories of legal protections can be distinguished: constitutional protections, case law, national healthcare schemes and policies, and international legal protections. An overview of the most important national and

international legal protections and State obligations in the domain of the right to health are as mentioned below:

6. Constitutional Protections

The Constitution of India has provided various rights to its people, who can avail these rights without any discrimination.

- Under Article 21 of the Constitution of India are guaranteed the right to life and personal liberty, including the right to health and medical assistance, right to live with dignity, right to food, right to a clean environment, and right to adequate drugs, right to be free from torture and cruel, inhuman, or degrading treatment, and right to emergency health care. The Supreme Court held that preservation of human life is of paramount importance. Failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment is a violation of right to life guaranteed under Article 21of the Constitution.

- Article 14 guarantees equality before the law and equal protection by the law. The Supreme Court has described gender equality as one of the "most precious fundamental rights guaranteed by the Constitution of India."

- Article 15 prohibits discrimination on the grounds of religion, race, caste, sex or place of birth. It also empowers the state to make special provisions for women and children. While the burdens of pregnancy and childbirth are inequitably borne by women, the ability to reproduce should not increase women's chances of death, disability, or illness. There is no similar cause of death for young men in India. States should ensure and protect the life of a woman.

- Finally, Article 47 provides that the state should ensure the nutrition and the standard of living of its people and improve public health, which guarantees access to medical services, regardless of (socio-economic) status.

7. Case Law

The Supreme Court of India and various High Courts have issued orders and judgments to ensure women's reproductive rights, including the right to survive pregnancy, the state's

duties and responsibilities to run and maintain health institutions, and to provide all medical services to which every person is legally entitled. The following case laws have set a strong precedent and legal foundation for the improvement of public health in India, in general, and for the protection of maternal and child healthcare in India, in particular.

- In *Bandhua Mukti Morcha v. Union of India and Ors*, [AIR 1984 SC 802], the Supreme Court held that "right to live with human dignity' also includes right to "protection of health."

- In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, [1996 SCC (4) 37], the Supreme Court held that providing "adequate medical facilities for the people is an essential part" of the government's obligation to "safeguard the right to life of every person." It also held that it is the primary duty of a welfare state to ensure that medical facilities are adequate and available to provide treatment and if the state fails to do so, this constitutes a violation of right to life of the person who suffered from inadequate healthcare.

- In *LaxmiMandal v. DeenDayalHarinagar Hospital &Ors.*, [W.P. (C) 8853/2008], the Delhi High Court held that an inalienable component of the right to life is "the right to health, which would include the right to access government health facilities and receive a minimum standard of care. In particular, this would include the enforcement of the reproductive rights of the mother."

- In *Francis Coralie Mullin v. Union Territory of Delhi &Ors.*, [1981 (1) SCC 608], the Supreme Court held that the right to live with dignity and protection against torture and cruel, inhuman or degrading treatment are implicit in Article 21 of the Indian Constitution.

- In *Consumer Education and Research Centre v. Union of India*, [1995 SCC (3) 43], the Supreme Court held that Article 21 of the Constitution of India includes a fundamental right to health, and that this right is a "most imperative constitutional goal".

a. International Legal Protections

In addition to legal protections in the Constitution, case law, and national health schemes and policies, India has signed and ratified various international treaties which provide international legal protections for the right to life, the right to health and other related human rights. India as a party to these conventions has an obligation to fulfil their provisions. The relevant conventions which provide for the right to life and the right to health include the Universal Declaration of Human Rights (UDHR), Declaration of Alma-Ata, International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic Social and Cultural Rights (ICESCR), and Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).

- **Article 25(1) of the Universal Declaration of Human Rights (UDHR)**
  Art. 25(1) of UDHR stipulates that everyone has the right to an adequate standard of living including the right to health, which includes food, housing, and medical care with necessary social services and the right to security in the event of sickness, disability, old age etc.

- **Article 12 of the International Covenant on Economic and Social and Cultural Rights (ICESCR)**
  The ICESCR was adopted by the United Nations General Assembly on December, 16, 1966 and entered into force on January 3, 1976. Article 12 of ICESCR establishes: “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” This Article lists some of the steps which are to be taken by State parties such as: the reduction of stillbirths and infant mortality; ensuring the healthy development of children; improving environmental and industrial hygiene; the prevention, treatment and control of diseases; and access to medical care for all.

- **Article 10(h) and 12 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW**)
  CEDAW was adopted in 1979 and came into force in 1981. It deals with women’s health, particularly reproductive rights. Article 10(h) states that women have the right to "specific educational information to help to ensure the health and well-being of

families, including information and advice on family planning." Article 12 of CEDAW relates to women's health. It obliges State parties: (1) to "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" and (2) to "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." Article 14 mandates that State protect such rights for rural women: "[t]o have access to adequate health care facilities, including information, counselling and services in family planning."

India, as a State party of all conventions listed above, has an international legal obligation to implement these provisions to protect and provide its citizens with the right to life along with the right to healthcare and medical treatment.