Acceptance of the millennium development goals was an explicit commitment of the Government of India to achieve universal access to reproductive health by 2015. (Ministry of Health and Family Welfare, 2013) Yet the focus mostly remained on increasing institutional deliveries as the government decided to only monitor indicators, the Maternal Mortality Ratio and proportion of births attended by Skilled Birth Attendants. (Khanna, 2013) Despite significant efforts of health systems strengthening undertaken by the United Political Alliance Government in the form of the National Rural Health Mission (NRHM) (Marten et al., 2014) and the commitment of the subsequent National Democratic Alliance Government to provide health services under the aegis of the National Health Assurance Mission, (Golecha, 2014) the health system is still fraught with several challenges, such as vacant posts of medical personnel, non-availability of medicines, lack of infrastructural facilities and such (Marten et al., 2014).

Preventing maternal deaths is one of the major thrust areas of public health system, yet significant gaps in provision of safe delivery services have been documented in several states. The civil society initiative where selected maternal deaths in ten states of India were documented, revealed that low public investment, encouraging privatisation under NRHM, inadequate investment in medical and paramedical education and shortcomings in governance and accountability are some of the contributing factors to the maternal deaths. (Subha Sri and Khanna, 2014) Yet another example of poor quality of reproductive health services as well as violation of women’s right to care with dignity is the incidence where sixteen young women died after sterilization in Bilaspur District, Chhattisgarh. (Reproductive Health Matters, 2014) These examples illustrate the challenges faced by women in accessing good quality primary health services.
Given women’s biological vulnerability to illnesses due to their natural role in the process of reproduction (Wingard 1984; Sen, Iyer, George 2002), they have several health needs which need medical attention. Secondly, the gender based discriminations in access to resources and in decision making processes accentuate these health needs by making women more vulnerable to poor nutritional status, low levels of education and lack of employment opportunities. (Grown, Gupta and Pande, 2005) Gender here refers to the social construct representing culture-bound conventions, roles, and behaviours for, as well as relations between and among, women and men and boys and girls. (Krieger, 2001) During late eighties, the studies conducted by Bang et al. (1989) had highlighted the significant load of gynaecological morbidities among women. This study significantly contributed in drawing attention of researchers as well as policy makers to the issue of RTIs among women. (Datta and Misra, 2000)

Sen et al. (2002) draw attention to the delayed acknowledgement of gender based inequities in health status as well as in access to healthcare as compared to acknowledgement of inequities arising due to socioeconomic class, race or caste. One of the reasons identified for this delay is the tendency to conflate gender with biological difference, which often attributes gender differences as biological differences. Hence, the need is expressed to distinguish between the biological and social factors impinging on women’s health experiences. It is also acknowledged that gender interacts with other social markers like class, caste to further accentuate these inequities. (Sen, George and Ostlin, 2002)

The intersection of gender with other axes of vulnerability such as class, caste, marital status, and disability, further creates barriers in accessing health services. Studies have highlighted that poor, rural, and lower caste women are further marginalised and they have poorer access to health care than wealthier, urban and higher caste women. (Iyer 2005) Similarly, higher load of untreated morbidities among women as compared to men has been substantiated through studies. (Madhiwala, Nandraj and Sinha 2000; Lingam and Pitre, 2008)
Studies which have looked into lower utilisation of health services by women have shown that women face various barriers in accessing health services, such as cultural barriers as women feel shy to talk about their reproductive problems (Gittelsohn et al., 1994) or financial barriers as they can seldom decide about spending money for their needs. (Iyer, 2005) Acknowledgment of women’s illnesses by women themselves as well as their family members is identified as one of the first hurdles that need to overcome in order to get proper treatment for seeking health care for health problems. (Chatterjee, 1990) NFHS 3 statistics about low proportion of institutional deliveries illustrates this barrier. As per NFHS 3 data, less than 40% of women had delivered in health facility despite several efforts by Government to provide maternity related services. Enquiry into the reasons for this behaviour revealed that in two-thirds of cases the reason was either that it was not considered necessary or the family did not allow. (IIPS, 2007) These statistics confirm the negligence of women’s health by the families and the internalisation of this negligence by women.

Along with negligence by family, other major reason for non-treatment of reproductive illnesses is the stigma and taboos in the society about the matters related to reproductive organs. (Das Gupta, Chen and Krishnan, 1995) Given the omnipresence of reproductive health problems such as white discharge, menstrual problems and chronic backache, women consider it as part of their life and hence do not feel the need to treat these conditions. However, there are certain exceptional situations where women do get opportunity to get treated. Women’s age and parity are important determinants of access to health care. Studies reveal that the gynaecological morbidities among unmarried women are promptly treated as the presence of these health problems could mar their marriage prospects. Similarly, young daughter in law’s reproductive problems are catered to by the mother in law as ignoring these problems may hamper the fertility of daughter in law. (Barua & Kurz, 2001) However, this clearly denotes the cultural significance of women’s ability to produce children and indicates that women are entitled to health care mostly when the health problems have the potential to affect their fertility.
1.1 Changing Paradigms of Women’s Access to Health Care Services

In this milieu of lack of access to health care for several women in India, the problem of over-medicalization of different reproductive events of women’s lives has also started emerging. Increasing number of caesarean sections is an important indicator of this trend. NFHS 3 data has shown that one in four women in the highest wealth index group was delivered by caesarean. (IIPS, 2007) With the advent in medical technologies, India is now also becoming a hub for Assisted Reproductive Technologies. (Sama, 2010)

Another such area where surgical interventions are on rise is the treatment of reproductive tract infections. Different studies (Gopinathan, 2006; Kameswari and Vinjamuri, 2007; Desai, Sinha and Mahal, 2011; Mamidi and Venkat Pulla, 2013) have drawn attention to the trend of hysterectomy among young women in India.

Given the increasing reporting of hysterectomy from different parts of the country, this issue is being discussed in different fora in last five to six years. The famous TV programme ‘Satyameva Jayate’ highlighted the plea of young women from Medak district of Andhra Pradesh who had undergone hysterectomy. (Satyameva Jayate, 2012). Similarly organisations working at the grass-root level have initiated enquiries into specific cases of hysterectomies. (Kameswari and Vinjamuri, 2007) The issue of hysterectomy among young women is being articulated from different viewpoints. In most of the articulations, the hysterectomies among premenopausal have been identified as unjustified or unnecessary surgeries, others also argue that some proportion of surgeries would be essential in this age group also as the health conditions like prolapsed uterus and cancer of reproductive organs is seen among young women as well. (Jain and Kataria, 2012) Hence, there is a need to clearly differentiate between the unwarranted hysterectomies and necessary hysterectomies.

Another issue of debate is what proportion of hysterectomies in a given community can be called as appropriate. Like for caesarean sections, WHO has estimated that up to 15% of deliveries may require caesarean section. (WHO, 1985) Though there are no standard figures about estimated prevalence of hysterectomy in a given community, in a National Consultation organised in 2013 to understand the reasons
for rising numbers of hysterectomies in India, it was enunciated that only about 10% of hysterectomies are actually necessary, these are only those that are performed for cancer. In this consultation, lack of training among the health care providers about new, less-invasive therapies was cited as one of the reasons for performing hysterectomies for reproductive health problems for which other less invasive therapies are known. Another reason was the high remuneration associated with surgery as compared to other treatments. (HRLN, 2013)

It is also important to understand the reasons behind the concerns being raised about hysterectomies among young women. Damage to the ovaries during surgeries or removal of ovaries results in insufficient production of important hormones such as oestrogen which further increases the risk of osteoporosis\(^1\) and heart disease among these women. (Conway, 2000) Different symptoms of varying frequency and severity are associated with menopause, which include vasomotor symptoms, hot flushes and night sweats, vaginal dryness, moodiness, irritability, nervousness, depression, insomnia, headaches, urinary disorders, joint pain, and fatigue. (Ringa, 2000)

There is dearth of research about menopausal problems among Indian women. (Syamala and Sivakami, 2005) Further, there is limited evidence regarding the impact of surgical menopause on women in India. NFHS-3 reveals that around 10% women in their thirties were menopausal which included women who had undergone hysterectomy. (IIPS, 2007) Given this low age at menopause in India, it is essential to understand the impact of these early surgeries on women’s health.

From the reporting of hysterectomies or caesarean sections from different parts of India, one can surmise that similar to epidemiological transition and demographic transition, India is also facing transition in health care access where on one hand there is inadequate access to certain services and for other services the access is inappropriate.

As a researcher, I became interested in this topic when a household survey conducted by SATHI\(^2\), where I was working had revealed significant disparities in the reported

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\(^1\) Osteoporosis is the brittleness of bones which increases the susceptibility of fractures in post-menopausal women.

\(^2\) SATHI is the action centre of Anusandhan Trust based in Pune, which has evolved from CEHAT. http://www.sathicehat.org/
incidence of hysterectomy from different districts. This survey had covered 10 districts of Maharashtra, where 10 per cent women in Satara district had reported to have undergone hysterectomy. On the other hand, less than one percent women in Amravati and Osmanabad had undergone hysterectomy. The state average was four per cent. Since the focus of the study was not on hysterectomies, other details of this phenomenon of wide variations in the number of hysterectomies within the state, the details of the morbidity that preceded hysterectomy as well as the impact of hysterectomy on women’s lives were not studied. (SATHI, unpublished data)

At the same time, around 2009-10, the news reports related to spate of hysterectomies in Andhra Pradesh were getting flashed in the news papers and in electronic media. It was quite perplexing to see the wide acceptance to hysterectomy when access to all other treatments was quite restricted. With this research question, I started the doctoral research with the intention of studying in depth the aspects of health care access for women taking hysterectomy as an illustration. The focus of the study was on the intra-household intricacies of decision making process where the ultimate outcome was hysterectomy. The study looked into the factors influencing this decision such as educational level of women, their socio-demographic background, attitude towards menstruation and knowledge of role of uterus as an organ in the body. The study delved into the component of information received from the health care provider prior to surgery and the perceptions of women about impact of surgery on different domains of their life such as physical health and marital life.

1.2 Structure of the Thesis

The thesis has been divided into eleven chapters. The introductory chapter gives brief overview of the changing paradigms of the health care access for women and the rationale for undertaking the study. The literature review chapter provides gist of studies investigating the social and medical aspects of hysterectomy in India as well as internationally. The subsequent chapter delineates the conceptual framework of the study giving brief introduction about various definitions and models to measure health care access and providing justification for the selection of the theoretical framework. Fourth chapter then elaborates the research methodology of the present study. This
chapter highlights the tenets of the feminist methodology and provides details of various processes adopted for data gathering and analysis.

Given the importance of context of health services in which the access to hysterectomies is being studied, chapter five provides description of the health system in Maharashtra. The subsequent chapter i.e. Chapter 6 introduces the respondents of the study by providing description of their socio-demographic characteristics. Chapter 7 provides description of the reproductive health problems faced by the respondents for which hysterectomy was done. This chapter depicts the lived experiences of the respondents in dealing with these health problems. After describing the reproductive health needs, the thesis then describes the intra-household processes relating to accessing health services. It delineates the ways in which respondents overcame their shyness to talk about the reproductive health problems they were facing. This chapter elucidates the discussions that happen within the household at the time of accepting hysterectomy as a treatment.

Subsequent chapter i.e. Chapter 8, then details out the interactions with the health care providers, the reasons for choosing a particular health facility for hysterectomy, the extent of informed decision making prior to hysterectomy, use of alternative treatments before undergoing hysterectomy and respondents attitudes and experiences of using medical treatment as well as reasons for accepting hysterectomy. After providing these details about accessing health services, Chapter 9 delineates the reasons for which hysterectomy was accepted. In this chapter, an attempt has been made to decipher individual level, household level and health systems level factors that led to the acceptance of hysterectomy. Chapter 10 narrates the experiences of the respondents post hysterectomy. This chapter highlights the impact of hysterectomy on different spheres of women’s lives. The final chapter of the thesis explicates women’s access to health care on the basis of the theoretical framework used in the study.

After this brief introduction to the topic of research and the structure of thesis, the next chapter provides gist of the literature reviewed.