Harding (1987) defines ‘methodology’ as a theory of how research is carried out or the broad principles about how to conduct research and how theory is applied. Given the topic of research, which is trying to understand how women overcome cultural and financial barriers to seek hysterectomy, this research tries to address the gender relations in the family, taking health care access as the event to understand these relations. This research on women’s access to health care is guided by feminist methodology.

4.1 About Feminist Methodology

As pointed out by Weiner (1994, cited in Burns D., Walker M., 2005), feminist research is critical, political and praxis-oriented. Sandra Harding (1987 cited in Burns D. And Walker M., 2005) has articulated three epistemological positions-

1. Feminist empiricism- The research that excludes women’s voices provides only partial understanding of reality. Inclusion of women’s voices is thus central to feminist methodologies.

2. Feminist standpoint- Harding claimed that, ‘women have a broader perspective on social reality because of their understanding of their own gendered oppression (their standpoint) and that the subjectivity of the researcher is crucial in the research design and must be taken into account in her interpretation.’ (Burns D., Walker M., 2005 pg.67) Standpoint theory argues that some social situations are scientifically better than others to start off knowledge projects. (Harding, 1993)

3. Feminist postmodernism- this position challenges the understanding of ‘women’ as monolithic category and argues that there are many versions of social reality.

As DeVault (1999) enunciates “feminism” is a movement, and a set of beliefs, that problematize gender inequality. She distinguishes feminist research and feminist
methodology, where feminist research is a broader category which includes empirical studies that incorporate or develop the insights of feminism and feminist methodology is methodological discussion that emerges from the feminist critique. She states that feminist methodology views knowledge production as a site which has constructed and sustained women’s oppression.

Another definition of feminist research given by Wadsworth Y. (2001) is that “feminist research is research, which is carried out by women who identify as feminists, and which has a particular purpose for knowing (a `why’), particular kinds of questions, topics and issues to be known about (a `what’), and an identifiable method of knowing (a `how’), which distinctly draw on women's experience of living in a world in which women are subordinate to men.”

Jayaratne and Stewart (1991) have delineated following strategies for practical implementation of a feminist perspective in social science research

- Selection of research topic should be such that the research should have potential to help women’s lives
- Methods should be appropriate for the kind of question asked and the information needed
- Whenever possible, we should use research designs which combine quantitative and qualitative methods
- The research procedures should be bias-free
- Adequate time and efforts should be taken to do quality research
- Political analysis of the findings must be attempted
- There should be active participation in the dissemination of research results

One of the purposes of this present research is to understand that within the context of health, how women face subordination within family, within hospital and within society at large. An attempt would be made to use the findings of the research to reduce this subordination and for furthering women’s reproductive rights.
4.2 Rationale for Using Feminist Methodology for This Study

Feminist lens helps us understand and unpack the deliberate discrimination at household level which results into higher level of morbidity among women. Similarly, it is useful to understand the power relationship between the health care provider and women patients. There are power hierarchies within the family as well as within the health care institutions. Feminist methodology offers valuable lens to explicate these power hierarchies. Some of the key aspects of the research such as the ways in which women overcome the barriers in accessing healthcare, perceptions of women themselves as well as their family members regarding their illness and the ways in which women’s reproductive organs are mistreated for profit making by health sector could be best answered using the feminist methodology.

4.3 My Standpoint

As a feminist researcher it is very important to spell out my standpoint that is my location in the society. Being born in upper caste, middle class family has been advantageous in getting certain privileges in the society. One of the privileges is access to higher education. I have earned bachelor’s degree in Ayurvedic medicine and surgery. After working as a clinician in the field of gynaecology and obstetrics for couple of years, I pursued master’s degree in health sciences. With this educational background, I joined a Non-Governmental organisation working with rights based approach. During my tenure in the NGO, I have been engaged in health research where the focus was on highlighting the inequities in access to healthcare. The research entailed understanding inequities on the basis of class, caste and gender and the intersections of these three. Most of the research undertaken was used for policy advocacy. Considering the criticality of bringing feminist perspective to my work, I undertook post graduate diploma in women’s studies from one of the reputed women’s studies centres in India. The course has been very helpful in sharpening the analysis of inequities. Along with being a researcher, I am part of the coalitions working specifically on women’s health issues and people’s health movement in India. Being part of these campaigns and movements has helped me understand ground realities in a better way.
My degree as a doctor has been helpful in gaining access in public health institutions as well as in the houses of respondents. Respondents were more open to talk about their reproductive morbidities as they thought that being a doctor I would certainly understand their health problems. I received overwhelming response from most of the respondents as they had never imagined a doctor would come all the way from Pune city to talk to them and find out about their problems. Whenever, I sought consent and asked them if they would like to be part of the study, most of the respondents said why we would deny, when you have come from so far. One of the respondents said (in a grateful tone) that even the doctor who operated me, did not enquire so much about me as you are asking. Most of the respondents spoke openly and my medical background helped me answer their health related queries.

Despite conscious efforts to reduce the hierarchy between the researcher and the respondent, I am aware that given my caste, class, urban and educational background, the respondents may have perceived me in higher position than them. As mentioned by Purkayastha et.al. (2003), there are power relations due to the different social locations of the researcher and researched. Despite the difference in the class, caste background between me and the respondents, there were some commonalities between us due to our marital status and experiences of motherhood. The respondents were curious to know about my family and work. These informal discussions created a bonding which was further strengthened during interview. Another advantage I had as a researcher was familiarity with language which sometimes becomes a barrier during interview. Since I belong to Pune city, there were not many differences in the language that the respondents spoke than what I speak. Since conduction of interviews, transcription and translation were done by me, it has resulted minimal loss in translation process.

4.4 Scope of the Study

This study exclusively focuses on women, who have undergone hysterectomy, to decipher the reasons behind acceptance of hysterectomy as a treatment. To understand the phenomenon of hysterectomy in a holistic manner, it would have been desirable to include the perspectives of healthcare providers in the study because to understand the issues related to access to health care services, it is essential to consider demand side
factors as well as supply side factors. However, given the focus of the research which is to bring women’s voices regarding accessing health services for treatment of reproductive health problems to the centre stage, only demand side factors have been study. Supply side factors which are contributing to the decision related to hysterectomy have been culled out from the narratives of the respondents.

4.4.1 Limitations of the Study

This study exclusively focuses on the perspectives and experiences of women who have undergone hysterectomy, whereas the perspectives of health care providers have not been taken in to account. Another limitation is that given the limited geographical coverage of the study, the findings of the study are not generalisable. This study has been conducted in the rural areas and hence the perspectives and experiences of women residing in urban areas are not included in this study.

4.5 Research Method

To obtain data, in-depth interviews were conducted with women, who have undergone hysterectomy. In-depth interviews were used, as they are useful when one wants detailed information about a person’s thoughts and behaviours or wants to explore new issues in depth. (Boyce & Neale, 2006)

As mentioned above, this study has been taken up after a household survey which had indicated significant variations in the reporting of hysterectomy in the state of Maharashtra. In addition, two FGDs were also conducted in the village which had reported highest number of hysterectomies. Hence for getting detailed information regarding women’s choices of health services, about the decision making processes and about their experiences of surgery, in depth interviews were considered as ideal method for data gathering. For conducting IDIs, an open-ended guide was used.

4.6 Different Domains That Were Explored In the Interviews

1. Social location of the respondent

At the outset, basic socio-demographic information of the respondents was elicited to understand the location of the respondent. This section included information about the
caste, education and occupation of husband and the wife, landholding and about the type of family.

2. Experiences associated with menarche and menstruation

After understanding the location of the respondent, then the information about menarche and overall experience of menstruation was sought. The respondents were asked to narrate their impressions or feelings associated with menses, what were the restrictions that they had to follow, what were their attitudes towards these restrictions and such.

3. Access to health services for deliveries

Since all these respondents had undergone hysterectomy, one could surmise that the barrier of familial permission was overcome for the treatment of reproductive health problems these women were facing. However, to know if the families used different criteria for different situations or overall these families had better utilisation of health services, questions were asked about the place of delivery and reasons for home delivery.

4. Acknowledgement of the health needs

Subsequently the domain related to the health problems for which hysterectomy was sought was explored. The respondents were asked questions about when and why did they feel that the problem needs treatment. Questions were aimed at understanding their experience of dealing with these health problems and the spousal communication processes.

5. About the decision making processes within the family at the time of hysterectomy

6. Details of all the health care providers from and the details of the interactions with the provider who performed hysterectomy

7. Impact of surgery on health as well as family life and work
4.7 Fieldwork Experience

In every village that was visited, there were at least few women who fitted the eligibility criteria. General talk with women revealed that the problem of hysterectomy is enormous. In many of the villages which were covered in the study, several women above age of 45 years had also undergone hysterectomy. Many times it happened that all the women who had been operated in one basti/wadi of village gathered at one place and all of them wanted to get interviewed. It was sometimes difficult to explain why I am not including women above 45 years of age. Even though they understood the eligibility criteria, they wanted to share their experiences with me. Hence, in some places I conducted shorter interviews with women above 45 years of age.

Out of all the eligible participants approached for interview, there was only one woman who declined to participate. As mentioned previously, women were feeling privileged to share their experience. It was quite overwhelming for them to see a doctor coming to their house to talk to them about their experiences.

Most of these villages were accessible as there were all weather roads. The proliferation of private transport facilities was evident. There were jeeps for reaching most of these villages. Some of the villages where jeeps did not go, use of two wheelers was seen. Commonest mode of reaching these villages was by hitch-hiking. For the field work in Khatav block of Satara district, I stayed in Tasgaon which was well connected with Khatav. In other three blocks, the travel time was around two to three hours from Pune city. The field work was completed during June 2013 to December 2013. The monsoon period was deliberately chosen to conduct the field work so that in rainy season additional problems for physical access can be detected.

4.8 Sampling Strategy

In the previous household survey, the selection of districts and blocks was done using systematic random sampling method. The state of Maharashtra consists of five geographical regions viz. North Maharashtra, Vidarbha, Marathwada, Konkan and Western Maharashtra. The districts from these five geographical regions were given ranks on the basis of the score obtained by using indicators such as Level of
Urbanization, Hospital Beds per Hundred Thousand Population, Under-5 Mortality Rate, Female Literacy Rate and District Domestic Product. After ranking districts from each region, they were divided into two categories based on the development status. In each region, one district from category of high development and one from the category of low development was selected randomly. Further, within each selected district, the blocks were ranked on the basis of level of urbanisation and then divided into two strata (blocks with higher and lower urbanisation). One block from each of the stratum was randomly selected for the study. As mentioned previously, since Western region had reported highest number of hysterectomies, the subsequent qualitative study was conducted in the same blocks.

Given the focus of the study on women with particular experiences and within certain age group, non-probability sampling was used. Combination of snowball sampling and purposive sampling method was used to identify eligible respondents. Help was sought from the local health functionary to identify eligible respondents and then the respondents themselves gave information about other women in the village who were less than 45 years of age and had undergone hysterectomy.

4.9 Inclusion Criteria

Women below age of 45 years who have undergone hysterectomy were included in the study. After 45 years of age, women would be attaining menopause even naturally; hence, the health problems faced by women who have undergone hysterectomy in this age group would be similar to other women in the same age group who are in the peri-menopausal period. Also, the implications of hysterectomy on the physical health are likely to be more severe in young women than old women as hysterectomy induces menopause, hence women below age of 45 years were included.

4.10 Identification of Eligible Respondents

In the selected blocks, I first visited the primary health centre in that block and informed the local public health functionaries about the study being conducted in the villages under their jurisdiction. In every PHC, there is a fixed schedule for meeting of ASHAs working under that PHC. The researcher informed the ASHAs about the
purpose of the study and the eligibility criteria. In the meeting, many of the ASHAs told that there are women in their area who fit the eligibility criteria of the research. Then the visit to a particular village was fixed in consultation with the ASHA. During the actual visit, in some of the villages ASHAs helped to locate the house of the potential eligible respondent. In other villages, the researcher first visited the Anganwadi Centre and discussed with the Anganwadi worker if there are any women in that village who fit the eligibility criteria. After the interview was over with the identified respondent, she was asked about other women in that village who were eligible for interview. In Pune district, along with ASHAs, health workers of local NGOs had helped in identification of eligible study respondents. At the time of analysis, the respondents were categorised in three different groups depending on the years passed after hysterectomy.

Group 1- Hysterectomy done in last one year
Group 2- Years passed after hysterectomy is more than one year but less than five years
Group 3- More than five years passed after hysterectomy

4.11 Sample Size

Given the nature of enquiry, sampling size was not decided a priori. It was decided that the interviews would be conducted till saturation occurs. However, to study the geographical variations in access, it was decided that the sample would be fairly distributed in the selected blocks and hence 3 to 4 villages from each block were covered and women who fitted the criteria from that village were interviewed.

4.12 Ethical Considerations

The study has been reviewed and certified by the Multi-institutional Ethics Committee of Anusandhan Trust\(^1\). As part of the review process, a detailed checklist outlining the possible risks to the respondents was filled out. Given the overall

\(^1\) The Multi-institutional Ethics Committee (M-IEC) is a multi-disciplinary committee that reviews all research activities, as defined in the Standard Operating Protocol, conducted at institutions affiliated to it. [http://www.cehat.org/go/OrgStructure/Iec](http://www.cehat.org/go/OrgStructure/Iec)
objective of the study, there weren’t any physical or economic risks to the respondents by participating in the research. However, it was pre-empted that in case, if any respondent had any traumatic experiences related to the hysterectomy, it may cause some emotional distress in narrating these experiences. Also, since the study explored the aspects of how women negotiate in the family to seek care, then in case where the respondent has faced difficulties in seeking health care, it was possible that narrating that experience may cause some emotional distress in narrating the experience.

Another ethical issue identified was that during the interview, women may talk about the hierarchical relationships within families and how those relationships created barriers in seeking health care; this may create problems in the family resulting in some backlash for women.

Hence to overcome these problems, it was decided that the interviews would be conducted at a place and timing which is suitable for the respondent and when required complete privacy would be ensured at the time of interview.

To maintain anonymity, names of the respondents have not been used anywhere and other identifiers such as name of the village have also been removed. Before starting interviews, adequate rapport was developed between the researcher and the respondent. Very few respondents wanted to be interviewed in private, most of them were comfortable with the presence of other women from the family or from the neighbourhood. In fact in many cases, neighbours or relatives helped recount the details such as age of children or age at marriage and such. It was decided a priori that if the researcher perceives that the respondent is feeling distressed in narrating any particular experience, then the respondent would be given the option to stop the interview for some time or if required, the interview would be resumed after some gap, to give time to the respondent to overcome the emotional disturbance. However, in reality there was not a single respondent who faced any emotional disturbance. Respondents were quite open in talking about the family affairs in this regard.

The interviews were conducted at such place and time, which was convenient to the respondent. In most of the villages, the respondents were busy with agricultural activities; hence they preferred to be interviewed early in the morning before they left
for field. Care was taken to maintain privacy when the respondent wanted it so that the respondent could share her experience without hesitation.

All the interviews were conducted by the researcher herself and were also transcribed and translated by the researcher. Hence, the confidentiality of data has been maintained. For further analysis, each respondent has been assigned a specific number. Identifiable information such as name of the respondent, address, and such has not been mentioned in the thesis.

Informed consent was obtained by the principle investigator. Before the interview, the respondent was explained about the purpose of the study and the consent letter was handed over to her. Convenient time and place for interview was decided in consultation with the respondent. Most of the respondents opted for written consent. Consent for recording the interview was sought along with the consent for interview.

The interviews were conducted in the house of the respondent, hence there weren’t any costs incurred on travelling for participating in the study. The timing of the interview was decided on the basis of convenience to the respondent; hence care was taken that there is no loss of wage to the respondent.

After the interview was over, a booklet giving information about physiology of reproductive health system was given to the respondents.

To maintain the anonymity of the participants, fictitious names have been used in the present report.

4.13 Data Processing and Analysis

After the interviews were completed, all the interviews were transcribed and translated in English.

Analysis was done thematically, where major themes of analysis were as follows-

a) Women’s knowledge and attitude towards menstruation and role of reproductive organs

b) Acknowledgment of health needs by women
c) Acknowledgment of health needs by the family members

d) Permission from family for seeking care

e) Interactions with health care providers

f) Factors influencing the decision making process in case of hysterectomy

g) Factors related to health care services and their influence on decision regarding hysterectomy

h) Impact of hysterectomy on women’s physical health and marital life

i) Financial implications of hysterectomy

The data emerging from the interviews was classified as per the themes delineated above. Compare and contrast method was used to see the commonalities and differences across various groups.

Ways in which groups were categorised were as follows-

1- Categories according to geographical location- for some themes such as in accessibility to public health facilities, categories were made according to geographical locations

2- Categories according to age group- within the studied population, respondents were divided into two subgroups i.e. from 30 to 37 years and from 38 to 45 years to study if there are any variations according to age

3- Categories according to period after surgery- three categories were made such as where surgery had taken place in last one year, the period after surgery was more than one and less than five years and more than five years had passed after surgery. this categorisation was useful to study the short term as well as long term impact of surgery

4- Categories were also based on the underlying health problem for which surgery was undertaken

Analysis of data was done to bring out the individual level factors, the family level factors and the health system level factors which led to the decision of hysterectomy. Analysis was done using inductive approach. The subsequent chapter delineates the socio-economic context of the state of Maharashtra where these hysterectomies were studied.