ABSTRACT

Access to health care services for women in India has been an area of investigation for last few decades especially post-ICPD where the dearth of evidence regarding this issue was underscored. Studies have explicated lack of access to health care for women revealing various barriers faced by women such as lack of familial permission, non-availability of health services and financial barriers. In the same milieu, we are witnessing increased reporting of surgical interventions such as caesarean sections and hysterectomies among certain groups of women. The present study uses the theoretical framework of access proposed by Meera Chatterjee (1988) to understand the ways in which women overcome the barriers in accessing reproductive health services, the reasons for accepting hysterectomy as well as the implications of hysterectomy on women’s health and work life. Chatterjee enunciates that access requires negotiation of barriers beginning with the individual and progressively involving family, and ultimately the state/market in health care. (Iyer, 2005) This model of access to health care talks about barriers faced by women in accessing health services such as barriers in acknowledging the reproductive health needs of women, barriers in seeking permission from the family for accessing health services, non-availability of services and financial barriers. In addition, two other aspects of health care access specified in Penchansky’s model (1981) viz., accessibility and acceptability of health services have been investigated in this study.

The study included women who had undergone hysterectomy and were less than 45 years in age at the time of interview. Eligible respondents were identified with the help of ASHAs in the selected villages and using snowball sampling method. Total forty-four interviews were conducted from fourteen villages from Pune and Satara district in the state of Maharashtra. From Pune district, Velhe and Purandar blocks and from Satara district, Wai and Khatav blocks were included in the study.

In the present study, lowest age recorded at which hysterectomy was performed was 22 years. Majority of the respondents (19) got operated between 36 to 40 years of age. Median age of surgery was 35 years. There were seven respondents who were operated in the last one year. For 21 respondents, time lapsed after surgery was more than one year but less than five years, whereas in case of 16 respondents, more than
five years had passed after surgery. Among the respondents, longest duration after surgery is 15 years and shortest duration was 8 days. Menstrual problems such as prolonged menses, frequent menstruation and heavy bleeding during menses were reported by majority (24) of the respondents. Second most complaint was pain in abdomen which was reported by 22 respondents. One fourth (12) of the respondents reported that they suffered from prolapsed uterus at the time of surgery. White discharge was reported by 15 respondents. Majority of the respondents started facing reproductive health problems by the age of 30 years. The respondents acknowledged their health problems only when it started to affect their work. Shortest duration between onset of symptoms and surgery was less than seven days whereas longest duration was 28 years. Out of the 44 respondents, 14 respondents got operated within one year of onset of problems, whereas there were four respondents who suffered for more than ten years before undergoing hysterectomy. Out of 44 respondents, 18 respondents had consulted one health care provider, whereas remaining had sought care from two or more than two health care providers. Out of 44 surgeries, 39 were performed in private hospitals, two in public hospitals and three in trust hospitals, indicating that private health sector was mostly preferred for hysterectomies.

This research highlights the role of community beliefs about reproductive illnesses that these illnesses lead to cancer and the belief that hysterectomy can prevent this as one of the major reasons behind acceptance of hysterectomy. Most of the models and theories about health care access focus on individual factors. Whereas this study finds that community acceptance of particular treatments influence individual’s decision to great extent. Gynaecological morbidities impacted women’s work life significantly which propelled them to seek care. Secondly, belief that delay in seeking care may lead to fatal complications such as cancer, anxiety about children in case of death due to the reproductive illness, improved educational level and negative attitude towards menstruation were some of the individual level factors which has led to acceptance of hysterectomy in case of respondents of this study. At the level of household and community, strong belief that gynaecological illnesses lead to cancer, treatment of cancer being considered as costlier and futile, educational status of husband, normalisation of hysterectomy as treatment for gynaecological illnesses and lack of faith in treatments other than hysterectomy were some of the factors which facilitated this decision of hysterectomy. At the level of health system, wider availability of
health services in private sector, absence of primary care treatment for gynaecological problems in public health facilities, gender biased attitude of doctors, propagation of the fear of cancer by the doctors, doctors’ attitude of belittling the effectiveness of alternative treatments and unethical practices such as not giving adequate information about the disease or hysterectomy emerged as the factors which had led to the acceptance of hysterectomy.

The access to health care for women is largely influenced by the patriarchal social context which obliges women to bear children and further they are expected to fulfil the responsibility of raising children, managing household chores, taking care of elderly and contribute to household economics. The present study denotes that akin to normalization of reproductive morbidities, now the surgical procedures such as hysterectomy as a treatment for reproductive health problems of women are also getting normalised in the community.

There is dearth of literature regarding medical ethics and whether the patients receive ethical health care such as taking informed consent prior to surgery. In this study, it was seen that most of the respondents were given very cryptic information about the illness or the consequences of the hysterectomy. The decision of undergoing hysterectomy did not qualify as informed decision. Health outcomes are one of the indicators of the quality of care received. However, several women in the present study were facing various health problems which they perceived to be due to hysterectomy and some were also suffering from the same health problem for which surgery was done, raising doubts about the quality of care received. In the area where the study was conducted, women often referred to uterus as ‘bag’ and believed that the role of uterus is to carry child. In Indian context, role of women’s reproductive health system is often confined to its function as child producer. Hence, once the role of reproduction was over, neither the doctor nor the women or their husbands raised any concerns regarding the impact of hysterectomy on women’s sexuality despite the fact that removal of ovaries leads to decrease in the production of female sex hormones, thus affecting women’s sexuality negatively.

In the study, most of the hysterectomies were performed by the doctors in the private health sector. Given the declining investment in public health sector by the
Government (Duggal, 2013), most of the public health facilities lack equipment as well as trained staff for conducting surgeries. Hence, most of the surgical interventions such as caesareans, hysterectomies and assisted reproductive procedures are relegated to the private health sector, which have state of the art facilities.

Overall in this area the availability and utilisation of health services was higher than the state averages. Given that these districts belonged to high income areas of Maharashtra, financial access was not mentioned as constraint by majority of the participants. Since at the individual and household at both levels the acceptance for hysterectomy was there, thus the permission from family for hysterectomy was easy.

Given the lack of regulation of private medical sector, there are no audit mechanisms of these surgeries which can tell us whether the surgeries were appropriate or not. Given the increasing prevalence of surgical intervention in the arena of women’s health such as caesarean sections, hysterectomies and ARTs, there is an urgent need to conduct enquiry in these areas and also need to regulate the health services so that only evidence based rational care is provided.

The study highlights the need for large scale quantitative survey to find out the geographical as well as socio-demographic variations in prevalence of hysterectomy in India. Along with understanding demand side factors which lead to acceptance of hysterectomy as a treatment, it is necessary to delve into supply side processes which promote the demand for hysterectomy. Additional research is required to find out the proportion of unjustified hysterectomies. At the policy level, there is a need to develop and enforce standard treatment protocols for the treatment of reproductive health problems and as well as the RCH programme should strengthen the component of prevention and treatment of reproductive health problems. For awareness in the community, it would be important to make the information available in vernacular languages and have a slot on television and radio where women can seek advice through a dial-up-service.