

# **Hysterectomy in Rural Areas of Andhra Pradesh:**

## **A Retrospective Study**

### **Introduction:**

The concept of reproductive health has gained increasing acceptance since the International Conference on Population and Development (ICPD) in Cairo (1994). Following the International Conference on Population and Development, a major shift has taken place in the ministry of health and family welfare (MoHFW) and led to the introduction of reproductive and child health programme as part of a 'paradigm shift'. The main focus of this shift is to cater to quality of services to all the reproductive needs throughout the life cycle. Despite Government's decision it has become merely rhetoric and less of action. At many health centers, still the major focus is on maternal and child health services and a lot of attention is still required to attend to other reproductive health problems. Improper and lack of timely attention and care to reproductive health problems has been detrimental to women's health. One of such out comes is, women having had to undergo hysterectomy.

A few of the medical professional are critical about the surgery. They opine that hysterectomies are done unnecessarily. Anthony Scialli, director of the obstetrics and gynaecology residency program at Georgetown University hospital in Washington says that, "there are some cases where hysterectomy is the only option, for instance, for some types of cancer...(also) for abnormal uterine bleeding, but it should be the last step, not the first step" (Bren, Linda, 2001). It is reiterated by a few other experts that there has been a concern about how this surgery is being unnecessarily performed as a permanent solution to most of the gynaecological problems. A small but significant proportion of women who undergo hysterectomy have developed new symptoms after the hysterectomy such as pain and depression (Kjerulff, 2000; Carlson, 1994). Thus there has been a concern about the inappropriate overuse of hysterectomy (Broder et.al., 2000; Bernstein, 1993).

International hysterectomy rates suggest that the highest rates are recorded in the United States and the lowest rates in Norway and Sweden. At a rate of 5.6 per 1,000 women, the US hysterectomy rate is three to four times higher than that of Australia, New Zealand, and most European countries. (Agency for Health care Research and

Quality, 1997; Organization of Economic Cooperation and Development Health Data, 1999). In less developed countries the rates of hysterectomy are not well known. In India too there is no national data related to rates of hysterectomy. However, an unpublished study (Padma, Rama G.et.al., 1996) has revealed that in Andhra Pradesh per every 1000 women in the reproductive age group 46 had hysterectomy. The same study also revealed that there are vast regional differences in the rates of hysterectomy. In Coastal Andhra Pradesh as many as 71 per 1000 women had hysterectomy whereas in Rayalaseema and Telangana it is 14 and 13 respectively. In another article Kondalrao (2004) reported that in a small village, Chanrayapalli, Warangal, 30 percent of all the married women had hysterectomy.

Most of the available studies on hysterectomy focus on the medical aspects; which are related to either 'procedure' or 'time' of the surgery and rarely give details about the situations leading to hysterectomy (laufe and Kreutner, 1971; Haynes and Martin, 1979; Atrash et.al., 1982; Loizzi P. et.al.; 1990; Scott et. al., 1997). A few other studies are focused on utero-vaginal prolapse leading to hysterectomy (Datta and Datta, 1994). Studies related to social determinants of hysterectomy are not many. In recent times social researchers attempted to work on a few of the related aspects such as menstrual health, and gynaecological ill health. Some studies have exposed that menstrual disorders constitute major reproductive health problems (Patel, 1994; George, 1994; Bhatia and Cleland, 1995;) and excessive bleeding is considered as a serious illness. Often it is associated with blind belief (Patel, 1994) or as a consequence of a contraceptive usage (George, 1994). Some other studies also have focused on menstrual problems as a consequence of surgical contraception (Puryastha, Bhattacharyya, 1992). Women perceived regular menstruation itself is an inconvenience for daily activities. Once the desired family size is achieved they wish not to have these cycles. A study by Joshi (1998) revealed that some women viewed hysterectomy as a long-term solution to the 'pain' and 'dependency' during the days of monthly menstruation.

A few other studies have highlighted how women do not recognize and neglect to take treatment for reproductive tract infections (RTIs) because these are asymptomatic (Wasserheit et al.1989). Poor women also get increased risk of RTIs because of unhygienic management of menstruation. Untreated lower tract infections are likely to

progress to pelvic inflammatory diseases. The community-based research on women's gynaecological health in India by Rani Bang showed that (1991), ninety two percent suffered from one or more gynaecological problems. This study not only brought about the magnitude of the gynaecological morbidity, but also focuses on the neglect associated with these problems. Christopher Elias in a study revealed that women had specific complaints such as genital sores, vaginal discharge, and pelvic pain (Elias, 1991) is actually related to sexually transmitted diseases (STIs). It is evident from various studies that the stigma associated with STIs discourages women to attend STI clinics. Barely a third of the patients in STI clinics are women (Jeyasigh et al, 1985; Mathai et al, 1991). On the other hand the primary health care programme in India does not have adequate facilities to attend to all sorts of reproductive care. Under these circumstances it is therefore hypothesized that inadequate facilities and timely non-utilization of reproductive health services deteriorate reproductive health situation of women, which in turn leading them to go for hysterectomy. Therefore the present paper attempts to elicit the situations leading or opting to go for hysterectomy by women in rural areas of Andhra Pradesh.

***Presentation of the Paper:***

This paper is organized into nine sections. Apart from mentioning the levels of hysterectomy in various countries and in some parts of Andhra Pradesh, a brief review of literature on gynaecological problems is presented in first section. The second section describes the plan of the study, focusing on the details of sampling areas. The third section discusses on the levels of hysterectomy. The fourth section gives details of the characteristics of the women who had hysterectomy. The fifth section focuses on the various aspects of reproductive health and behaviour. Sixth section elicits the details of women's health prior to hysterectomy and the socio-economic determinants of morbidity prior to hysterectomy. Seventh section gives details of health care seeking behaviour related to hysterectomy and the next section focuses on the post operation experience. Discussion, summary and conclusions comprise the last section.

***Plan of the Study:***

This paper is based on the data drawn from a study on maternal morbidity. The main focus of the study therefore is on morbidity as a consequence of pregnancy and

childbirth. Apart from collecting data on direct maternal morbidities, also information is collected on some of the reproductive health problems. The study is carried out in Mahbubnagar and Guntur, a less developed and a developed district. In both the districts one PHC and a RCWHC (round the clock women health center) are selected purposively. In each of the health centers ten percent of the villages are selected at random. In these villages all the women, with in the reproductive age group (15-49 years), who had undergone hysterectomy are identified for the study. Thus the total women identified in the villages of Guntur are 502 and in Mahbubnagar it is 39. Table-1 gives particulars of study villages and women.

**Table 1: Details of the sample villages and women**

<b>Mahbubnagar</b>		<b>Guntur</b>	
<b>Dharur PHC</b>	<b>Gattu RCWHC</b>	<b>Amruthuluru PHC</b>	<b>Pitlavani Palem RCWHC</b>
<b>10% of Villages</b>	<b>10% of Villages</b>	<b>10% of Villages</b>	<b>10% of Villages</b>
Dharur Jampalli Palcherla Dyaga Doddi Mannapuram Guddem Doddi	Salkapuram Rayapuram Yallam Doddi Mallapuram Chintalkunta Kutcheinerla Chagadona Mitta Doddi Gattu	Moparru Bodapadu	Pitlavani Palem Alluru Kappalavari Palem Komali Koduru Mandevvari Palem
Total households 4474		Total households 3492	
Total eligible women 5746		Total eligible women 3452	
Total women who had hysterectomy 39		Total women who had hysterectomy 502	

As a first step to data collection, detailed discussions were held with a gynecologist to understand the causative factors leading to hysterectomy. Such an exercise helped in listing the symptoms and in improving a correspondence between bio-medical conditions and self-reported symptoms. This in turn led to the systematic development of the interview schedule. Apart from collecting the relevant data through structured tool, to have an understanding on the causative factors leading to the surgery, focus group discussions were organized with a few women who had hysterectomy and auxiliary nurse midwives (ANMs). In-depth interviews were held with informal health-care provider i.e. registered medical practitioners (RMPs) and a few local gynaecologists.

### Levels of Hysterectomy:

At the outset it is worthy to note that there is a huge variation in percent of women who had hysterectomy in both the districts. The number of women reported to have had hysterectomy in Guntur district is 502 out of 3452 women in the reproductive age group and corresponding women in Mahbubnagar district is 39 out of 5746. In other words, 14.5 percent of women in Guntur district had hysterectomy before attaining menopause whereas its equivalent percentage in Mahbubnagar district is 0.7. The startling differences in the rates of hysterectomy in both the districts suggests further probe into differential determinants of hysterectomy in both the regions.

### Background Characteristics of women:

The socio-economic profile of the women who had hysterectomy in the study villages reveals that (Table-2), 65 percent in Guntur and 90 percent in Mahbubnagar are illiterate. Thirty two percent are from backward castes in Guntur and its corresponding percentage in Mahbubnagar is 67. Scheduled castes and tribes together account to 28 percent in Guntur and 10 percent in Mahbubnagar. Nearly 85 percent of the women in both the districts are Hindus. Sixty percent of women in Guntur district and 67 percent in villages of Mahbubnagar district work outside home in some income generating activities. Sixty percent of the sampled households in the study districts have no agricultural land.

*Table 2 Socio-Economic Characteristics of the Women who had Hysterectomy*

Characteristics	Guntur		Mahbubnagar		Total	
	No.	%	No.	%	No.	%
<b>Education</b>						
Illiterate	327	65.1	35	89.7	362	66.9
Up to Primary	82	16.3	3	7.7	85	15.7
Above Primary	93	18.5	1	2.6	94	17.4
<b>Caste/Tribe</b>						
Scheduled Caste	96	19.1	3	7.7	99	18.3
Scheduled Tribe	46	9.2	1	2.6	47	8.7
Other Backward Caste	160	31.9	26	66.7	186	34.4
Others	200	39.8	9	23.1	209	38.6
<b>Religion</b>						
Hindu	427	85.1	34	87.2	461	85.2
Muslim	10	2.0	4	10.3	14	2.6
Christian	65	12.9	1	2.6	66	12.2
<b>Working Status</b>						
Works at home	199	39.6	13	33.3	212	39.2
Works outside home	303	60.4	26	66.7	329	60.8
<b>Total Women</b>	502	100.0	39	100.0	541	100.0

**Reproductive health:**

Reproductive health is largely affected by reproductive behaviour of an individual. Menarche or marriage is the gateway to participate in reproductive behaviour for all the women in the study villages. It is assumed that the conditions leading to hysterectomy may not be always due to a particular health problem but it might have manifested over a period of time. Therefore the present paper looks at reproductive behaviour and related health status of women ever since menarche to hysterectomy. In order to record all the relevant information, considerable time is being spent to develop rapport with the women before proceeding to data collection. This exercise revealed that women do not forget serious health complications and they are free to share their experiences once they feel comfortable.

***Gynaecological Health Prior to Marriage and Health Care Seeking Behaviour:***

The median age at menarche for the women in Guntur district is 12.8 years and in Mahbubnagar it is 13.5 years. Once attained puberty, a majority of the women (97 percent) had menstruation at regular intervals. Prior to marriage eleven percent of them mentioned to have experienced illness during menstruation such as nausea, severe abdominal pain, weakness, vomiting and legs ache. All of them perceived length and volume of menstruation as a natural process and none of them felt the need for a treatment and opined that one has to bear with it. Women by and large are ignorant about causes leading to menstrual related health problems. Prior to marriage 12 percent of women in both the districts suffered from white discharge and urinary infection. Unlike ill health during menstruation, women realised the need to seek treatment for these problems. However on contrary to the opinion, only 4 percent of the women in Guntur district went for a treatment. The others were not permitted by their parents to seek treatment because of the fear of lessening the chances of marriage if one would come to know of her ill health. In Mahbubnagar none sought treatment as they think it is too expensive to go to a private clinic and at public health center they always experienced insults from the paramedical staff. Thus those who initially went to a PHC did not continue the treatment.

### ***Marriage, Sexual Relationship, and Gynaecological Health:***

In both the districts median age of marriage for the women is 15 years and the median time gap between marriage and *gauna* is less than a month. Eighty eight percent of the women in Guntur district and 86 percent in Mahbubnagar were ignorant about coitus until marriage. More than half of them initially have developed a repulsive attitude towards it because of ignorance. Thirteen percent could appreciate it only when they have become pregnant for the first time, 23 percent took a couple of months to develop a favourable attitude towards it. Despite the women's disinterest during early months of marriage, the couple had regular coital relations and husbands never approached other women for sexual pleasures during this phase. However when women were not able to actively participate in coitus, either during pregnancy or after childbirth, some of their husbands (23 percent in Guntur and 21 percent in Mahbubnagar) had extra marital coitus with commercial workers or other women. Those who have admitted are from backward or scheduled castes, illiterates, and are working as daily wagers. Only a few of the women (4 percent from Guntur and 3 percent from Mahbubnagar) know that husbands' sexual practices may impair their gynaecological health. Yet women continued to participate in coitus for the fear of breaking the marital union. Most of these women are not worried of their health. A few, who have realised the need to use condoms in the interest of their gynaecological health, yet could not convince their husbands.

Three to four percent of women have agreed that after the marriage they had experienced burning sensation in vagina, pain in pelvis or abdomen during coitus, and developed urinary problems. Nearly half of these women have at least once attempted to seek treatment. A majority of them consulted unqualified health personnel such as rural medical practitioners or *Dai*. Rarely they went to primary health center or a qualified doctor. These women opine that unqualified health providers are kind in their approach and it is easy to contact them. The other half of the women who did not seek treatment felt that it would bring disgrace on them if they disclosed their illness.

### ***Fertility Behaviour:***

More the number of children, early or later ages of pregnancy, frequent pregnancies is likely to have an impact on uterus, which in turn may lead to hysterectomy. Findings reveal that median number of children ever born per woman in the sampled villages is

2 in Guntur district and 4 in Mahbubnagar district. Median age at first pregnancy in both the districts is 17 years. Whereas median age at last pregnancy is relatively earlier for women in Guntur district (21 years) than in Mahbubnagar district (25 years). The average gap between two successive pregnancies maintained by a majority of these women is 26 and 29 months in Guntur and Mahbubnagar districts respectively. An analysis by parity of women reveals that in Guntur 48 percent of second parity women had hysterectomy and in Mahbubnagar a higher percent of women (64 percent) are of parity four or more (Table-3). Sex composition of the surviving children at the time of hysterectomy reveals that in both the districts higher percent of the women (57.2 in Guntur and 77 percent in Mahbubnagar) with two or more children and with a combination of at least a son and a daughter had hysterectomy than those who had children of same sex. Relatively fewer women with no sons, i.e. who have only daughters (18 percent in Guntur and 5 percent in Mahbubnagar district) had hysterectomy than those who had at least one son. Median age at hysterectomy for women in Guntur district is 24 years and where as for women in Mahbubnagar district it is 38 years. Percent of women who underwent sterilization prior to hysterectomy is more in Guntur (76) than in Mahbubnagar (54).

**Table3 Demographic Characteristics of the Women who had Hysterectomy**

<i>Characteristics</i>	<i>Guntur</i>		<i>Mahbubnagar</i>		<i>Total</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
<b><i>Parity</i></b>						
1	43	8.6	2	5.1	45	8.3
2	240	47.8	6	15.4	246	45.5
3	156	31.1	6	14.4	162	29.9
4+	63	12.5	25	64.1	88	16.3
<b><i>Composition of children</i></b>						
No Children	10	2.0	1	2.6	11	2.0
Only Sons	115	22.9	6	15.4	121	22.4
Only Daughters	90	17.9	2	5.1	92	17.0
1 son & 1 daughter	143	28.5	1	2.6	144	26.6
3 or more children, with at least a son and a daughter	144	28.7	29	74.4	173	32.0
<b><i>Total Women</i></b>	502	100.0	39	100.0	541	100.0

***Obstetric health:***

Certain obstetric health problems may lead to hysterectomy, though not immediately after a childbirth but at some time later in life. Obstetric problems also depend upon number of times a woman is pregnant. Mean number of pregnancies a woman had is

2.6 in Guntur district and 4.74 in Mahbubnagar district. Ninety six percent of women in Guntur district and 43 percent in Mahbubnagar district had antenatal checkup for all their pregnancies. Ninety four percent of the total women had normal delivery for all the pregnancies. Untrained personnel assisted 86 percent of the women in Mahbubnagar and 55 percent of women in Guntur during all the deliveries. Five percent of women had caesarean section during their last delivery. One percent of them (five women in Guntur district) had hysterectomy along with the caesarean section mainly because they were advised by health personal to go for it, as they were undergoing a surgery. Women and their family members were also convinced in favour of hysterectomy because they were satisfied with the number and combination of children they had. Two of the women had hysterectomy as a precautionary measure to avoid gynaecological morbidity in future.

#### **Health Condition Prior to Hysterectomy:**

Women were asked to narrate their health status prior to undergoing hysterectomy so as to assess their health condition leading to the surgery. By and large a higher percent of women in the Mahbubnagar district suffered from multiple morbidities than the women from Guntur district. Overall 99 percent of the women in both the districts said that they had one or the other health complications prior to the operation. Every alternate woman had experienced abnormal vaginal discharge. Four out of ten women suffered from severe lower abdominal pain. One out of five women experienced itching/irritation in vaginal area, bad odour in vaginal area, fullness in the abdomen, and pain during urination. Other problems expressed by the women are given in Table-4. One percent of the women said that they had no specific health problems. Some of the reported symptoms have been grouped to classify them into biomedical-defined morbidities. These are *Prolapse*, i.e. feeling of something (a mass or swelling) coming from the vagina, or leakage of urine when coughing or sneezing; *Urinary tract infection (UTI)*, abnormal frequency of urination, with burning sensation while passing urine; *Dyspareunia*, i.e. pain during intercourse; *Lower reproductive tract infection (LRTI)*, white or coloured discharge from the vagina with bad odour, itching or irritation; *Acute pelvic inflammatory disease (APID)*, lower abdominal pain or vaginal discharge with fever; *Abnormal (dysfunctional) uterine bleeding (DUB)*, i.e.

irregular and unpredictable bleeding, lengthy or heavy menstrual periods; *Uterine fibroids*, as diagnosed by a doctor.

**Table -4 Health problems mentioned by women prior to hysterectomy**

Health problems	Percent of Women		
	Guntur	Mahbubnagar	Total
Abnormal vaginal discharge	50.2	59.0	50.8
Severe lower abdominal pain	40.0	71.8	42.3
Irregular & prolonged menstruation	27.5	46.2	28.8
Itching/Irritation in vaginal area	16.9	38.5	18.5
Fullness in the abdomen	15.7	53.8	18.5
Bad odour in vaginal area	16.5	30.7	17.6
Pain during urination	41.0	15.5	17.4
Fever along with discharge	14.9	38.5	16.6
Pain during / after intercourse	11.0	46.2	13.5
Blood spots after intercourse	8.2	48.7	11.1
Frequent urination	6.2	41.0	8.7
Fibroids in lower abdominal region	5.2	46.2	8.1
Infection / Prolapsed Uterus	4.4	33.3	6.5
Swelling of the lower abdomen	5.4	35.9	7.6
<b>Total</b>	<b>502</b>	<b>39</b>	<b>541</b>

The bio-medical categorization of morbidities reveals that nearly half of the women were suffering from *acute pelvic inflammatory disease* (Table-5). One third of them experienced *abnormal uterine bleeding*. Nearly one-fourth of the women suffered from *prolapse, and urinary tract infection*. One out of five women complained of *lower reproductive tract Infection*. Sixteen percent suffered from *dyspareunia* and eight percent of the women had growth of *uterine fibroids*.

**Table-5 Morbidities faced by women prior to Hysterectomy by Bio-medical Categorization**

Bio-medical categorization of Morbidities	Percent of women Suffered		
	Mahbubnagar	Guntur	Total
Acute Pelvic inflammatory Disease	79.5	48.6	50.8
Dysfunctional Uterine Bleeding	46.2	27.5	28.8
Prolapse	71.8	20.5	24.2
Urinary Tract Infection	61.5	20.3	23.3
Lower Reproductive tract Infection	46.1	21.1	22.9
Dyspareunia	56.4	13.3	16.5
Uterine Fibroids	46.2	5.2	8.1
<b>Total women</b>	<b>39</b>	<b>502</b>	<b>541</b>

A further analysis by women's background characteristics is carried out by logit regression model (Table-6). The odd ratios indicate that in the study villages of Guntur district, illiterates have 0.683 times higher chance to suffer from *acute pelvic inflammatory disease* than the literate women. Also sterilized women are likely to suffer 2.572 times more than the non-sterilized women. *Lower reproductive tract*

**Table 6 Influence of Socio-economic and Demographic Variables on Bio-medical Categorization of Morbidities: Results from Multivariate Analysis by Logit Model**

Socio-Economic & Demographic Variables	Bio-medical Categorization of Morbidities			Socio-Economic & Demographic Variables	Bio-medical Categorization of Morbidities		
	B	SE	Exp (B)		B	SE	Exp (B)
<b>Dysfunctional Uterine Bleeding</b>							
<b>Guntur</b>				<b>Mahbubnagar</b>			
Work	.056	.246	1.058	Work***	2.193	1.049	8.962
Caste	.247	.218	1.281	Caste	1.497	1.055	4.467
Parity	.081	.110	1.084	Parity	.116	.172	1.123
Education**	.760	.242	2.139	Education*	3.508	1.691	33.378
Sterilization	.341	.288	1.407	Sterilization***	-1.751	.878	.174
<b>Dyspareunia</b>							
<b>Guntur</b>				<b>Mahbubnagar</b>			
Work	-.189	.320	.828	Work	1.004	.854	2.730
Caste***	.446	.283	1.562	Caste	.126	.921	1.135
Parity***	.228	.139	1.256	Parity	.046	.168	1.047
Education*	-1.60	.371	.346	Education***	1.853	1.425	6.382
Sterilization ***	.658	.425	1.931	Sterilization***	-1.342	.798	.261
<b>Prolapse</b>							
<b>Guntur</b>				<b>Mahbubnagar</b>			
Caste	.099	.239	1.104	Work***	2.811	1.249	16.6333
Parity*	.318	.117	1.374	Caste***	2.382	1.405	10.832
Education**	-.647	.264	.524	Parity	.179	.215	1.196
Sterilization***	.645	.350	1.907	Education	9.748	45.215	17124.417
				Sterilization	.664	.886	.070
<b>Acute Pelvic Inflammatory Disease</b>				<b>Urinary Tract Infection</b>			
<b>Guntur</b>				<b>Guntur</b>			
Work	.221	.221	1.247	Work***	-.440	.271	.644
Caste	.065	.197	1.067	Caste	.038	.244	1.038
Parity	.050	.098	1.051	Parity	.065	.123	1.068
Education***	-.381	.222	.683	Education*	-.925	.297	.397
Sterilization*	.945	.256	2.572	Sterilization **	.951	.377	2.588
<b>Uterine Fibroids</b>				<b>Lower Reproductive Tract Infection</b>			
<b>Guntur</b>				<b>Guntur</b>			
Work	-.603	.463	.547	Work***	.551	.282	1.735
Caste	.488	.425	1.628	Caste	-.137	.244	.872
Parity	.125	.212	1.133	Parity	-.062	.120	.940
Education***	-.997	.536	.369	Education***	-.537	.291	.584
Sterilization	.145	.567	1.157	Sterilization	.397	.315	1.488

**Note:** 1. The list of background variables selected for the multivariate analysis is

- Work Status (Working =1, Not working = 0)
- Caste (Non-Scheduled =1, Scheduled = 0)
- Parity (continuous)
- Education of women (Literate/Educated =1, Illiterate = 0)
- Sterilization (Yes = 1, No = 0)

2. Each morbidity (Dependent variable) if suffering = 1, No = 0.

3. \* = Indicates significance at .001 percent level.  
 \*\* = Indicates significance at .01 percent level.  
 \*\*\* = Indicates significance at .1percent level.

*infection* is significantly associated with illiteracy and work status, i.e. illiterates are likely to suffer 0.584 times more than the literate women; and those working for daily wages are likely to suffer from 1.735 times more than the nonworking women. *Urinary tract infection* is found to be associated with illiterate, sterilized, and non-working women. That is the odd ratios have indicated that illiterate women are likely to suffer 0.397 times more than the literates; sterilized women suffer 2.588 times more than non-sterilized women; and nonworking women suffer 0.644 times more than the workingwomen. *Uterine fibroids* in the villages of Guntur district it is found to be associated with illiterate women, i.e. illiterate women have 0.369 times higher chances to suffer from *uterine fibroids*. The odd ratios indicate that in Guntur district *dyspareunia* is experienced by illiterates (0.346) women, of high parity (1.256), those opted for sterilization (1.931) and from non-scheduled castes (1.562). In Mahbubnagar *dyspareunia* is negatively associated with sterilization, i.e. non-sterilized women have 0.261 times higher the chances to suffer from *dyspareunia*. In both the districts education of women (the odd ratios of 2.139 in Guntur and 33.378 in Mahbubnagar) is positively associated with *Dysfunctional uterine bleeding*. The findings need to be interpreted with care. This does not mean that educated women are more likely to suffer from the problem. Rather the cultural beliefs have restricted illiterate women to consider it as morbidity. Thus it could be possible that many illiterate women never reported the condition as a problem. In Mahbubnagar the odd ratios indicate that workingwomen (8.962), those from non-scheduled castes (4.467), and non-sterilized women (0.174) have higher chances to suffering from *dysfunctional uterine bleeding* than their counterparts. In the villages of Guntur district parity is found to be positively associated with *prolapse*. In other words higher parity woman may experience *prolapse* 1.374 times more than the lower parity women. Even though women in Guntur had less number of pregnancies than those in Mahbubnagar, yet a significant relation between *prolapse* and parity has to be understood not in isolation but as a combination other exploratory variables. In Guntur again illiteracy (0.524) and sterilization (1.907) are positively associated with *prolapse*. In other words *prolapse* is associated with illiterate sterilized women; who have opted tubectomy only after achieving the desired fertility, i.e. high parity. In Mahbubnagar district the odd ratios indicate that working women, and from non-scheduled castes are likely to experience *prolapse* by 16.6333 and 10.832 times respectively than non-working and scheduled caste women.

## **Health care seeking behaviour related to Hysterectomy:**

### ***Treatment Particulars prior to Hysterectomy:***

Apart from understanding the health status of women prior to hysterectomy, information related to treatment is essential as it helps to identify the processes leading to the surgery. Decisions related to surgery is generally influenced by the advise of the health care provider with whom the morbid person interacts. Thus an analysis of details of treatment pattern of the women is carried out in the present paper. Women when realized their problem, initially they were not comfortable to go to a doctor, because most of these problems are related to 'personal health'. The following comment reflects their typical attitude towards reproductive health.

“How can we tell in the family the problem with which we are facing? Isn't it a shame to disclose these matters to others? It is better to bear it as far as possible rather than making ourselves shameless”.

When the problem has become annoying then they consulted a doctor. Even though when women mentioned to have gone to a private doctor (95 percent in Guntur, 94 percent in Mahbubnagar) on probing it is revealed that many of these women (93 percent in Guntur, 89 percent in Mahbubnagar) have actually consulted a rural medical practitioner (RMP). All the RMPs in the study villages are unqualified medical practitioners. Earlier an RMP had a degree or knowledge in Homeopathy, Ayurveda, Naturopathy or Unani and have passed a qualifying exam during 1970s. Such persons were referred as 'Registered Medical Practitioners'. However these days such persons are not found in the study villages. The present RMPs having acquired some skills while assisting a doctor, who later started treating people by themselves. Women preferred them because of easy accessibility. In most of the villages a RMP is either a village member or from a neighbouring village. Even if an RMP is not a resident of the village, as he regularly visits the village women find it convenient to go to him rather than traveling to a distance to reach a health facility. About visiting public health centers most women feel that the concerned doctor do not visit the center regularly, thus they either end up consulting a paramedical person or return home without having a check-up. Also a few women (3 percent) have mentioned that the paramedical staff uses offensive language when women approach them with gynaecological problems. In contrast women think that RMP is talented than the public paramedical staff, talks to them kindly unlike public health personnel. The

RMPs in turn with or without initial treatment referred the women to a qualified private practitioner. Only five percent of women in Guntur district and 11 percent in Mahbubnagar district have consulted a public paramedical health personnel or a doctor at a primary health center for the illness.

In the study villages, the referred health personnel did not inform about their condition to a majority of the women. The health personnel opine that it is futile to explain to either the patient or her family members, as they would not understand the problem. They in turn believe that it is their responsibility to decide the mode of treatment and instruct the patients to follow accordingly. In 6 percent of cases doctor insisted them to go for an immediate surgery, without explaining the present health status of the women. In 94 percent of the cases doctor though talked to them about their problem, to eight out of ten women in Guntur and one out of ten women in Mahbubnagar district the doctor emphasized that hysterectomy is the solution to their ill health. Neither woman anticipated the doctor to explain their situation nor felt the need to know about the causative factors. Women did not ask for alternate methods of treatment, as a majority of the women thought that hysterectomy would bring a solution to their ill health. Sixty one percent of women in Guntur and 96 percent in Mahbubnagar preferred to undergo medication for few months prior to the surgery, as they were not financially equipped by first visit. Most of them had preferred allopathic and a few (11 percent) went to traditional healers. The median amount of money spent by women towards treatment prior to the surgery by women in Guntur district is Rs.1000, where as women from Mahbubnagar district have spent Rs.3500. This is because the women from Mahbubnagar district have spent longer duration in taking treatment prior to the surgery.

***Place of Hysterectomy:***

In both the districts a majority of women had hysterectomy at private hospitals. District wise differences show that more women in Guntur (93.8 percent) had hysterectomy at a private hospital than in Mahbubnagar (64 percent). Reasons behind selecting the type of hospital in Mahbubnagar are largely influenced by the household financial situation. In addition comparatively women with higher age and parity, those belong to scheduled and backward castes have opted for a government hospital. In Guntur district who had surgery at a government hospital are high parity women from

scheduled and backwards castes. In a majority of the cases where women had hysterectomy at private hospital though a woman's husband/head of the household decided the hospital, it was actually influenced by non-family members. A few women opted for a particular hospital after being referred to them by their neighbour/friend who in turn had such a surgery. In a majority of cases, the health care provider whom women had first contacted had a greater influence on selection of the hospital. Since many of these women have consulted a RMP, they preferred the hospital referred by him. It is because the women and her family members think that the familiarity between the RMP and doctor helps in getting a personal care. Similarly RMPs also feel that they have been doing a favour to women by referring them to a familiar hospital. Though the RMPs did admit that they do get paid some amount as honorarium for referring a patient to a hospital, at the same time the RMPs insist that they are doing a favour to the women by referring to an efficient surgeon. On the contrary a few of the auxiliary nurses did not hesitate to express that the RMPs mislead women in the villages. These paramedical staff opines that the RMPs act as 'commission agents' to private doctors. A gynaecologist working in a PHC in Guntur district expressed that many surgeons at private hospitals are earning at the cost of woman's ignorance. She said,

“Many women are ignorant about physiology of their body. Due to the cultural practices, women take tablets to postpone regular periods. Subsequently, it is natural that the next immediate periods would be lengthy and heavy. Also in some cases, the cycle gets disturbed. Women when approach for a treatment they are treated temporarily to make women believe that hysterectomy is needed to put an end to the menace. It has become a growing business for many doctors in this region”.

Another doctor in Guntur district also similarly commented that the gynaecological health problems might not always necessitate a hysterectomy. She opines that some doctors are more familiar for conducting hysterectomy. According to her, since many years it has been a regular practice for these doctors in Guntur district. Where as in Mahbubnagar, doctors working either at a private hospital or public health centers made no similar comments.

Prior to the surgery a doctor is supposed to advice a patient about the consequences of a surgery. Irrespective of place of the surgery a majority (97 percent) of patients in

Guntur were not briefed by the doctor/surgeon about the health consequences of hysterectomy. Where as in Mahbubnagar district the doctors informed to 70 percent of them. The median amount of money spent towards the surgery by women at private hospital is (Rs.6000) higher than those spent at a Government hospital (Rs.4300). Ninety percent of the women are not aware whether their ovaries were removed during the surgery.

### **Post-operation Experience:**

Any surgery carried out on a person is to improve her health from the prior morbid state. Three out of four women agreed that there is a relief from prior health problems. Twenty percent of the women have said that their health has not improved despite the surgery. Five percent of the women feel that their health has improved partially. Even though many have agreed that their prior health problems have been recovered after the surgery, almost 40 percent of them have admitted that they are suffering from other complications. Twenty five percent of the women are still suffering from gynecological problems such as pain during urination, pain after intercourse, blood spots after intercourse, white discharge, abdominal pain and tumor in abdomen. Fifteen percent are suffering from non-gynecological problems such as weakness, body ache, backache, stomachache, indigestion etc. Two women realized that they are becoming frequently irritated, and at times they experience depression.

### **Discussion and Summary:**

To understand the conditions leading to hysterectomy, it is necessary to analyse from a bio-medical point of view. Medically speaking the specified morbidities does not suggest a need for hysterectomy as the ultimate solution for all women. Morbidity experienced by women prior to hysterectomy suggests that in the study villages of Guntur less percent of women suffered from specific or multiple morbidities than the women from the study villages Mahbubnagar district. For example, only 5 and 4 percent of women have suffered from fibroids and prolapse respectively in Guntur district as against 46 and 33 percent in Mahbubnagar district. However, in the absence of the clinical diagnostic information, it may not be advisable to conclude merely on the basis of self-reported symptoms. Therefore the study attempts to look from non-medical factors associated with hysterectomy.

Though there is no particular age limit for occurrence of a symptom leading to hysterectomy, by and large women are likely to have the associated problems at later reproductive years of life. The present study, however, reveals that nearly 14.5 percent of women in the reproductive age group underwent hysterectomy in Guntur district even before completing half of their reproductive life span as against less than one percent in Mahbubnagar district at an age when three-fourth of their reproductive life span is completed.

The findings also revealed that more women with a combination of children, i.e. a son and a daughter, or women with at least one son had hysterectomy than those who have only daughters. Medically there is no correlation between fertility and hysterectomy. Does this indicate that majority of the women prefer to go for hysterectomy after achieving 'complete and desired family size'? Or can this be interpreted as women/family members who have achieved the 'complete and desired family size' is referred or convinced to go for hysterectomy than the women who have not achieved it? Medically, unlike sterilization, though hysterectomy is not a surgery by choice. However examining the association between hysterectomy vis-à-vis the sex composition of the living children, though statistically not significant, the findings raises suspicion on the decision leading to the surgery.

The statistical findings have shown that there is a strong association between sterilization and various morbidities. Medically speaking sterilization does not lead to hysterectomy. The likely possibility is that iatrogenic infections may have introduced during medical procedures, which in turn could develop, into '*lower reproductive tract infection*' (Olikoya and Elias, 1996; Holmes et al, 1992; Khattab et al, 1993) and if it is not timely treated it may further lead to '*acute pelvic inflammatory disease*' and '*dyspareunia*'. Perceptions of men and women as disclosed during focus group discussions revealed that a majority of women as well as men in Guntur district believe that tubectomy leads to hysterectomy. The local quacks or rural medical practitioners (RMPs) in turn influence the perceptions of most of the men and women. Most of the RMPs opined that the role of reproductive organ diminishes once the desired fertility is attained. Most of these women and men also confess that there is no necessity to retain the reproductive organ if desired number and sex of children are

born. Some of the women do not differentiate between tubectomy and hysterectomy; they perceive that both the surgeries ultimately make women infecund.

The statistical findings have revealed that in Guntur district literacy levels has shown a significant negative association to most of the specified morbidities. In other words more illiterate women suffered from gynaecological ill health than literate women in the villages of Guntur district. Findings of focus group discussions revealed that illiterate women compared to the literates follow poor menstrual hygiene, which in turn may lead to *lower reproductive tract infection*. Untreated *lower reproductive tract infection* may lead to *acute pelvic inflammatory infection*, and *dysfunctional uterine bleeding*. In addition low bargaining position to protect their own sexual health by some of the women when they are very much aware that their husbands have more than one sexual partner has a bearing on their gynaecological ill health. Fear of violence and divorce weakened these women's bargaining position. In the presence of illness, women also viewed hysterectomy could bring a solution to maintain better marital relation with husbands by able to participate in coitus. Women anticipated that by 'obliging' to husband's sexual desires may decrease violence between the couple, which in turn may improve husband-wife relations. Men on the other hand are insensitive towards women's health. They opine that women are susceptible to ill health of one kind or the other, thus it is better to opt for 'permanent' solution.

Studies have shown that utilization of health services is affected by multitude of factors including availability, distance, cost, and quality of services, socioeconomic factors and personal health beliefs. In the context of women Chatterjee (1990) posited the role of need, permission, ability, and availability. In the Indian context, the situation is further complicated by women's perception of illness, which are affected by women's cultural conditioning to tolerate suffering. In the present study as well, women in both the districts did not disclose and sought timely care during initial stages of gynaecological ill health. Low perceptions for the need for a treatment and women's gendered conditioning to tolerate suffering, either due to urinary infection or reproductive tract infection, has delayed in seeking timely care, which in turn might have amplified the gynaecological illness. Prior to marriage women were required to take permission from their parents to seek care. Some of the parents did not like to

acknowledge the existing reproductive health disorders of a daughter prior to marriage, as it might have an adverse effect on the prospects of her marriage. Especially in a society where marriage is considered universal and having an unmarried daughter after certain age brings disrespect to parents, especially the fathers. With already existing social pressures of dowry, fathers prefer to marry off their daughters with out an acknowledgement of any ill health. After marriage women themselves delayed in seeking treatment as perceived need was low.

Even when women had come forward to utilize reproductive health services at a public health center, non-availability of lady doctor, gender insensitive approach of health staff towards patient's privacy, and rude behaviour of health staff has demotivated women to seek health care from the public health centers. Women assessed quality of care largely in terms of behaviour of health personnel rather than the actual treatment. This is particularly if they are suffering from reproductive health problems. Thus the women preferred to consult some one 'humane' and easier to access rather than for the health provider's qualification. Consequently the first person that women approached for a treatment was RMP. On the other hand a majority of the RMPs seem to be insensitive towards women's health in real sense.

An analysis of treatment seeking behaviour related to hysterectomy revealed that women and men, especially in Guntur district, were convinced towards the need for hysterectomy much before they have actually approached a qualified surgeon. Also the reiteration of the surgeon with or without prior diagnostic tests raised no doubts among the women regarding the need for surgery. Where as women in Mahbubnagar district did not anticipate a surgery neither prior or after seeking initial treatment. It is only after repeated visits and initial treatment procedures, the women have been told to undergo hysterectomy. It is in turn evident from the time and money spent on treatment prior to surgery.

Again the 'interest' taken by RMPs in suggesting a surgeon/hospital needs to be understood with prudence. Though the RMPs have mentioned that they are helping the women by referring to an efficient surgeon/hospital, the justification of RMPs vis-à-vis the remuneration they receive for referring each case needs a detailed analysis in this aspect. However such an analysis cannot be carried out for the present paper for

want of more data. Yet again the study reveals that a majority of women in Guntur district had the surgery at a private hospital unlike in Mahbubnagar district. Again in Guntur the surgeons and other health care providers are not interested in briefing neither the patients nor the family members about the consequences of the surgery. It reflects the careless attitude of the health care providers.

Another interesting outcome of the analysis is the women, though in very small percent in Guntur district, opting for hysterectomy as an end to the 'nuisance' of regular menstruation. In these villages women's mobility and to participate in religious functions is culturally conditioned by menstruation. Therefore these women feel it as a forced restriction imposed on them. Women, who have wanted to gain more 'freedom' and feel 'liberated', perceive monthly menstruation is a hindrance. In order to overcome these imposed restrictions, some women perceive that hysterectomy is the solution.

***Conclusions:***

The present study attempts to investigate into the situations leading to hysterectomy in two districts of Andhra Pradesh. However since the study is based on the women who already had hysterectomy and not those women who are showing symptoms of reproductive problems, the findings may not be generalized to total population. Despite its limitations, the study brings out the alarming differences in the rate of hysterectomy in rural areas of two districts. Illiteracy, high parity, work outside home and sterilization came out as the main explanatory variables associated with gynaecological problems among the women who had hysterectomy in Guntur district. In Mahbubnagar district caste, work and parity came out as significant for a few problems. Also it brings out an astounding fact that in a reasonably well developed district, how women are misled, either by themselves or family members or health care providers. Delay in seeking treatment and improper available health services make women to go to quacks. Ignorance about reproductive health continues to mislead to an unnecessary decision against the overall health which otherwise could be avoided. The gender insensitive attitude of the family, health care providers compounds women's reproductive ill health despite various ambitious policy decisions. The recent Reproductive and Child Health Programme of the Government

ambitiously introduced the provision of care for all types of reproductive health requires to be realistic in terms of providing care than mere a rhetoric.

### **Acknowledgement**

I would like to thank Prof. Krishnaji for his comments on an earlier draft of this paper and my sincere thanks to my colleague Dr. James for his comments.

This paper is part of a wider study on Maternal Morbidity in Andhra Pradesh, sponsored by Rockefeller Foundation.

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## **Appendix:**

### ***Perceptions of Women, Men, Health Staff and RMPs about Illness Based on Focus Group Discussions and In-depth Interviews:***

Most of the women and men opine that women's gynaecological ill health is mainly due to multiple reasons. A majority in the villages of Guntur district opined that it is due to having undergone tubectomy. Where as in the villages of Mahbubnagar a majority thought that it is due to weakness. Three fourths of the sterilized women in Guntur district made the following remarks

“I was healthy before I had tubectomy. However, after few years I developed all complications”.

Women by and large believe that if a woman undergoes tubectomy, at a later age hysterectomy becomes unavoidable. More women in Guntur district (87 percent) than in Mahbubnagar district (24 percent) articulated such a notion. Most of the men in these villages think similarly. A common comment by them is,

“Once women undergo tubectomy, their bodies become like a cracked pot. Subsequently a hysterectomy will be a partial relief to their health problems”.

Even though these men opine women's health would deteriorate subsequent to tubectomy yet they want women to opt, otherwise it would affect their productive levels. Some elderly men from Guntur also imagine that opting for sterilization gives a kind of social 'security' for their daughters.

A few non-sterilized women attribute their gynaecological ill health to weakness, restlessness, poor nutrition, and pregnancy and childbirth experiences. A few women said that their husbands' extra-marital sexual behaviour is the cause for ill health. In contrary, some men and women opine gynaecological ill health of wives would motivate men to seek sexual pleasure out side the marriage. These men presume that the duty of wife lies in 'cooperating' with husband in coitus. Most of the women in both the districts also assume similarly. Some women admitted that due to wife's gynaecological ill health they might not participate in coitus, which in turn allows husband to go for extra-marital sexual relations. Thus they feel that hysterectomy is the ultimate solution for women's 'suffering'.

Rural medical practitioners (RMPs) believe that there is an association between tubectomy and gynaecological ill health. Especially in Guntur district four out of five RMPs vehemently think that tubectomy leads to hysterectomy. Where as the medical and paramedical staff working at public health centers differ with this opinion. One of the gynaecologist working as a doctor at a primary health center in Guntur opines that if tubectomy is carried out under specified conditions, and if a woman is given adequate post-operative care, women would not experience any gynaecological health problems.

Another doctor feels that women's ignorance about menstrual and personal hygiene is the main cause for gynaecological ill health. A majority of women have poor knowledge about menstrual hygiene. The usual practice during menstruation is to use a cloth, which is reused after a wash. Even though women have use detergents to wash the soiled cloth, it is culturally restricted to wash during daytime and dry it in Sun. Many women wash at night and dry them either on bushes or in dark corner of

the house. According to the local gynaecologists, this practice may cause lower reproductive tract infections.

In the villages of both the districts a majority of the women complained of *Prolapse* as another main cause to go for hysterectomy. These women opine that during childbirth some may experience a prolapse or usually if they participate in heavy manual labour within in two weeks after a delivery. According to the experiences of women, manual labour varied from lifting of a pot of water, or an older child, or bending and doing some kind of work etc. Knowing that one should have compulsory rest after childbirth many women say that the household conditions do not permit them to have rest.