National Consultation

on

Understanding the Reasons for Rising Numbers of Hysterectomies in India

11th August 2013

Preface

Hysterectomy is the most frequently performed major surgical procedure performed in many countries in the industrialised world. Facility-based data in the United States, United Kingdom and Germany, for example, largely find that hysterectomy is the leading reason for women's admission into inpatient facilities. Studies of the population prevalence and epidemiology of hysterectomy have primarily been conducted in Western countries, with the exception of an early study in South Africa. The vast majority of women who undergo hysterectomies in developed countries do so after the age of 45, primarily for benign gynaecological conditions. By age 65, the lifetime risk of hysterectomy ranges from 1 in 5 to 1 in 3 women in the United States, United Kingdom and Germany. Women with lower education levels and lower socioeconomic status are more likely to undergo the procedure.

A crucial study on hysterectomies was carried out to find out hysterectomy prevalence in a 2010 cross-sectional household survey of 2,214 rural and 1,641 urban, insured and uninsured women in low-income households in Ahmedabad city and district in Gujarat, India. The study investigated why hysterectomy was a leading reason for use of health insurance by women insured by SEWA, a women's organisation that operates a community-based health insurance scheme. It was found that of insured women, 9.8% of rural women and 5.3% of urban women had had a hysterectomy, compared to 7.2% and 4.0%, respectively, of uninsured women. Approximately one-third of all hysterectomies were in women younger than 35 years of age. Rural women used the private sector more often for hysterectomy, while urban use was almost evenly split between the public and private sectors.

Thus, while many women might actually require a hysterectomy what also appears clearly is that too many hysterectomies are performed in the country every year and that many women could have avoided surgery had they been aware of other alternatives and treatments. Most of the rural women are vulnerable to various forms of coercion in their medical decision making. For example, the withholding of other medical care by linking it to the patient's consent to undergo hysterectomy is ethically unacceptable. Some experts state that only about 10% of hysterectomies are actually necessary, these are only those that are performed for cancer.
Several times doctors cite heavy bleeding as a reason for removal of uterus but with advances in medical science hysterectomy is no more the only available option. Women with heavy menstrual bleeding can opt for oral remedies, intra-uterine devices (IUD) or endometrial ablation. Ideally, doctors should resort to hysterectomy only when all other treatments fail to give results. Patients with a problem of excessive menstrual bleeding (menorrhagia) can also consult an alternative medicine practitioner. There has been unnecessary hysterectomy performed by the doctors in several corners of India. There could be several reasons which might be leading to this rampant practice of hysterectomies amongst health service providers. One of the reasons might be lack of knowledge and training on new, less-invasive therapies. The other reason when doctors are quick to recommend this surgery is cancer prevention. The knowledge on the individual effects of this operation amongst doctors might be very limited. However one of the major reasons for recommending hysterectomy is very clearly the greed to make more money.
Background

Access to quality health care services is a critical issue for rural women in India especially related to their reproductive and sexual health. While it is believed that the public health system is being expanded and strengthened, at the grass root level systematic and comprehensive quality reproductive health care services are virtually non-existent. The high maternal mortality ratio, high prevalence of reproductive tract related morbidity and poor knowledge about contraception are glaring examples that health facilities and the providers have not been able to build any effective reach. It indicates that there are very few health facilities that can deal with their problems with sensitivity, more so in the rural & tribal areas. There are instances when health care is regularly denied to people in the government health facilities in the form of non-availability of care providers, long distances to cover and high cost of medicines. Given the above scenario most of the people in rural areas are left with no other option but to access health care services either from private health care providers or from unqualified practitioners (quacks or traditional faith healers). Many of these practitioners are often untrained and unregulated and function with the chief objective of exploiting patients to make more money. This often leads people to become prey of unethical and irrational health care practices and huge expenditure on health care.

Amidst various unethical and irrational health care practices rampant in the country one which has recently made an entry into the list and has raised lots of eyebrows is the large numbers of hysterectomies taking place. Hysterectomy is the complete or partial removal of the uterus, and sometimes ovaries, cervix and fallopian tubes. A doctor may suggest hysterectomy to a woman in case of medical conditions such as:

- Fibroid tumors (nonmalignant tumors)
- Endometriosis (a condition in which endometrial cells grow outside of the uterus, attaching themselves to other organs in the pelvic cavity, resulting in chronic pelvic pain, pain during sex, and prolonged or heavy bleeding)
- Abnormal uterine bleeding (this is often due to endometrial hyperplasia, an over-thickening of the uterine lining that may cause abnormal bleeding)
- Cancer (cervical, ovarian, or endometrial cancer hysterectomies)
- Blockage of the bladder or intestines by the uterus or a growth

Hysterectomy may also be suggested to a woman in case of uterine prolapse (the uterus drops down into the vagina), or in the presence of chronic pelvic conditions, such as pelvic pain or pelvic inflammatory disease that do not respond to other treatments. However experts believe that with advances in medical science, hysterectomy need not be a necessity. Women can opt for oral remedies, hormonal injections, intra-uterine devices and endometrial ablation to get rid of problems like heavy bleeding and fibroids. Experts also suggest that doctors should resort to hysterectomy only when all other treatment options fail. While there exist no exact statistics to show the prevalence rate of hysterectomy in India, what is largely believed is that it is the second most common surgery performed on women, second only to caesarean section.

Although hysterectomy is one of the most common operations in gynecological departments, it has recently been surrounded by controversies after there were reports from several states of India of needless hysterectomies being conducted on women in abnormally large numbers giving it all a projection of mass hysterectomies conducted by
private medical practitioners in a spree to make more money. In fact, a Right to Information Act (RTI) application filed in Dausa district of Rajasthan recently revealed that between April and October 2010, out of a total of 385 operations reported by three private hospitals, 286 of these were hysterectomy operations. Many of these women were under the age of 30, with the youngest being 18 years old. Similar incidents were reported from Chhattisgarh and Bihar too highlighting high number of hysterectomies being performed in the states and also linking it to the roll-out of the Rashtriya Swasthya Bima Yojna (RSBY) insurance scheme. What makes the procedure more attractive is that being covered by the RSBY or other government sponsored insurance schemes, it is free. Women are neither informed about its long-term consequences, nor the alternative medical treatments available. Over 16,000 hysterectomies, most of them "unnecessary", have been reported at private hospitals across Bihar during last one year allegedly to "avail insurance benefit" under the RSBY. In fact in 2010, the Andhra Pradesh government had to tweak its state-sponsored insurance scheme to disallow hysterectomies in private hospitals after surveys revealed that uterus of a number of beneficiaries were removed merely to claim higher insurance amounts. Incidentally, learning from the Andhra experience, Maharashtra doesn't allow hysterectomies in private hospitals under the insurance scheme launched last year for the economically weaker sections, called the Rajiv Gandhi Jeevandayee Arogya Scheme.

One crucial study on hysterectomies was carried out to find out hysterectomy prevalence in a 2010 cross-sectional household survey of 2,214 rural and 1,641 urban, insured and uninsured women in low-income households in Ahmedabad city and district in Gujarat, India. The study investigated why hysterectomy was a leading reason for use of health insurance by women insured by SEWA, a women's organisation that operates a community-based health insurance scheme. It was found that of insured women, 9.8% of rural women and 5.3% of urban women had had a hysterectomy, compared to 7.2% and 4.0%, respectively, of uninsured women. Approximately one-third of all hysterectomies were in women younger than 35 years of age. Rural women used the private sector more often for hysterectomy, while urban use was almost evenly split between the public and private sectors.

Thus, while many women might actually require a hysterectomy what also appears clearly is that too many hysterectomies are performed in the country every year and that many women could have avoided surgery had they been aware of other alternatives and treatments. Most of the rural women are vulnerable to various forms of coercion in their medical decision making.
Objective

- To have a wider understanding of prevalence, epidemiological and facility use for the procedure
- To understand, what are the medical reasons upto which it's necessary to perform the procedure
- To understand the role of insurance sector and private sector in it.
- To understand the indications, determinants and women own's perception.
- To understand the side effects of early hysterectomy; Short term & Long term.
- To understand the gynaecological & other morbidity caused to a women and different treatment alternatives available to them.

Brief Outline of Consultation

The consultation was carefully designed to cover most of the issues concerned with the subject. Ms. Vimala Ramchandran started with Introductory session who gave a brief introduction to the Health Watch Trust; it's origin, brief history, significant projects, studies and surveys; and current status of affiliation Dr. Narendra Gupta with Prayas.

First session was all about introduction to the subject, creating a background and objectives of the consultation. This session provided the flavour for further discussions and presentations by various speakers during the day.

Second session captured review of the problem discusses by the panelists which included a study and a discussion on medical ethics.

Third session was about the legal, policy and grassroots advocacy on hysterectomy: Experience and potential directions.

In fourth session, action groups were made in which a subject was given to each group and they had to put their views and suggestions on it. Three groups presented and delineated the problems and suggestions regarding the subjects allotted to them.

At last the valedictory session was held and each session was closed at its stipulated time. Enough time was kept after each session to have an open discussion.
Session-wise Details

Welcome and Background to Consultation

Ms. Vimala Ramchandran

The consultation began at 9.45 am with Ms Vimala Ramchandran who gave a brief introduction to the Health Watch Trust -- its origins; brief history; significant projects, studies, and surveys; and current status of affiliation with Dr Narendra Gupta and Prayas. She also introduced the topic for consultation and acknowledged that could be a cause of concern.

Dr. Narendra Gupta

Welcome note and background to the consultation was given by Dr. Narendra Gupta from Health watch trust and Prayas. He extended warm welcome to the speakers and participants and succinctly provided overview of the consultation. He thanked all the speakers and participants to attend and address the consultation on the behalf of Health Watch Trust and Prayas. Dr Narendra Gupta also contextualized the day’s consultation by providing a background to the questions surrounding the issue of rising hysterectomies and delineating the desired objectives of the meeting. He explained the need for the consultation by pointing out that there has been a rise in the number of hysterectomies reported in India, many of which could possibly be unrequired. Yet, there is a lack of definite studies to explain this phenomenon. He mentioned one such
epidemiological study undertaken by Sapna Desai of LSE, which, though of a small sample size, is fairly indicative of trends. Some of the key findings of the report highlighted by Dr Gupta:

- It found that hysterectomies are the most common surgical procedure under the State-sponsored Arogyasree health insurance scheme.
- In India, though the number of hysterectomies is lower than many developed countries (where data is available), the mean age of a woman undergoing hysterectomy is much lower. E.g. the mean age in US and UK is 55-65 years, whereas in India it is 30-40 years, and even more significantly lower in Andhra Pradesh (24 years)
- Medical audits undertaken in UK, US and Germany indicated that:
  (a) many hysterectomies are for benign conditions and are avoidable;
  (b) there is a significant rural-urban and socio-economic divide;
  (c) the number of hysterectomies rose in areas where there was an increased concentration of gynecologists and surgeons;
  (d) When medical and clinical audits were done more often, number of hysterectomies fell.

Dr. Gupta raised the questions of whether hysterectomies can be optional, in terms of different kinds of hysterectomies and alternatives to hysterectomies. He briefly summarised his case study of 28 women's testimonies from Dausa village, in which the women were often not given options and were subject to insufficient medical investigations. He also noted that as part of the Save Uterus Campaign of 2010 under FOGSI, gynecologists discourage elective hysterectomies, indicating that there exists significant demand for the procedure. He also said that studies have indicated that hysterectomies have possible side effects including decreased life expectancy, lower cardio-vascular function, reduced bone density etc. In the light of these points, he underlined the need to deal with the issue, developing protocols and procedures to understand the factors at play.

**Shri. Dinesh Baswal**

The Keynote address was next given by Dr Dinesh Baswal. He too noted the lack of studies in India, small sample sizes of existing studies, and delineated the problem: reducing mean age of hysterectomies is a cause of concern.

After noting the high incidence of hysterectomies in Andhra Pradesh, Bihar, Rajasthan, Chattishgarh, especially those under the RSBY and Arogyasree, he said that the government had issued guidelines to avoid unnecessary procedures. The RSBY guidelines, he said, were too simply that “proper investigation was necessary” before a hysterectomy. But the Arogyasree guidelines are more specific in terms of conditions under which hysterectomies can be sanctioned (these include age, cervical malignancy etc.)
He stressed on the need to forge a way forward by the following means:

- Ethical medical practice needs to be re-affirmed
- Medical auditing should be made more regular
- Internal monitoring by professional organisations such as FOGSI should take place, with possible debarring of members engaged in unethical practices
- More surveys to gauge the extent of the problem. (It can be included in NFHS-4)
- Complications post-hysterectomies need to be recorded and followed up
- Government of India guidelines would soon be finalized; features like a citizen’s report card could act as a diagnostic and/or accountability tools; a proper assessment of hidden costs etc.

Review the problem from various aspects

Dr. K. Srinath Reddy (In Chair)

Dr. K. Srinath Reddy noted that the challenge was not just to identify causes but also to find ways to counter the rising incidence. Private practice was driven by monetary motivations; often government practice also feeds into private practice. Dr Reddy stressed the need for public education about health, partly to clarify procedures, partly to protect against medical malpractice. Medical audits run the danger of fudged or inadequate records. Therefore, there is a need to maintain medical records along with patient interviews. He also called for a higher level of ethical awareness in medical education itself.
Dr. Amar Jesani

Dr. Amar Jesani next spoke about medical ethics. He said that in the mid-1980s, when he started work on medical malpractice and to make the profession accountable, the focus was on negligence manifested through death or injury of patient. He found that the profession was so tightly knit that accountability became difficult. For instance, due to the tacit understanding that there’d be “co-operation and competition” among the fraternity evidence of experts as testimony in court was not often forthcoming.

He said that the medical council needs to supplement ethics education with determined mechanisms such as disciplinary action; there’s a need to reactivate state level medical councils. He foregrounded some of the contentious issues at hand:

(a) In case of elective procedures being brought under the ambit of negligence, is one interfering with patient’s agency?

(b) if primary reproductive healthcare is unavailable, does this agency effectively apply? How does that affect the element of choice in hysterectomy?

(c) How should the balance between Regulation Vs Prohibition be assessed?

He also talked about the extent to which changes in the medical practice have affected its ethical practices. With the accumulation of capital, the medical profession is looking for increased profitability, resulting in a de-emphasis on primary healthcare. Also, the
private sector is invading public health, and its approach is not preventive healthcare. Taking an example to illustrate the how markets can shape ethical viewpoints, he pointed out that in the 1970s, abortion was the major money spinner followed by caesarian section and hysterectomy. Now, since doctors are more conscious of abortion ethics, the incidence of abortion has decreased. Other factors such as development of abortive pills and drugs have further eroded the market for surgical abortions, making C-sections and hysterectomies more lucrative procedures.

Assessing the rising demand for hysterectomies, he said that there is a great deal of internalization of the need for procedures such as C-sections or hysterectomies. This, he pointed out, is a “therapeutic misconception” of doctors and patients.

As social insurance spreads, there is an increase in the rate of services, as shown by the experience of developed countries. While earlier hysterectomies were more prevalent among the middle classes, now higher insurance coverage has resulted in a rise in the procedure among the lower classes. He said, the problem needs interventions on the level of ethics education and systemic changes in hospitals such as

(a) good record-keeping
(b) medical audits
(c) medical councils and/or other such bodies that can, like tribunals, facilitate punitive action
(d) an authority accessible to patients

He also made a distinction between informed versus involved consent, favouring the latter. He pointed out, definition of consent too is complicated: what exactly is consent? How far is it voluntary and what amounts to coercion? There can be coercion by the system and circumstances which can go unrecognized. Lack of choice can also amount to coercion. Therefore, instead of having a knee-jerk response against rising hysterectomies and withdrawing insurance cover for it, we need to factor in coercion better to prevent the need of women from being unethically exploited and commercialized. Regulation, thus, needs to be backed up by primary reproductive healthcare.
Dr. S.V. Kameswari

Dr SV Kameswari presented her case study on unindicted hysterectomies in Medak district of Andhra Pradesh. Some of the findings of studies conducted on rural women who engaged in spinning were:

(a) Prevalent rates: 92 per 1000 women in Andhra Pradesh under the age of 30, as compared to 5.4 per 1000 women between 40 and 44 years of age in the US;

(b) in the sample of 15 villages in Munipalle mandal, the surgical history of registered rural women showed that all had had hysterectomies, 95% in private hospitals;

(c) most of these women were small farmers and agricultural labourers;

(d) 82.5% were BC/SC/ST/MM.

She noted that in several cases, hysterectomy was accompanied by appendectomy as well, which was a matter of concern.

After describing the sample of the study and methodology, including how age of the women was assessed, she explained the research question: does hysterectomy affect ovarian function?

The study calculated ovarian function by FSH values; results were: 59% women had normal FSH ranges, 41% had menopausal range. This is significant in the light of the fact
that the incidence of natural premature menopause is 0.1%. Correct assessment is affected by the fact that consecutive samples of FSH values are difficult to get. Discharge summaries post hysterectomies are just outpatient slips, either do not mention age or make an approximation, and have no status of ovarian function.

Problems of methodology, such as how to calculate bone density in young women, gives rise to many clinical dilemmas. She pointed out that after hysterectomy, one cannot assess ovarian function or gynecological problems by menstrual symptoms, requiring a multi-disciplinary team to make even a simple gynecological intervention. This has negative implications for rural primary healthcare which struggles with insufficient resources.

She noted further limitations to knowledge such as

(a) It cannot be clearly assessed how long ovaries will work after hysterectomies. In most Western countries, menopausal and post-hysterectomy changes can be clubbed. This is not so in India where the mean age is much lower;

(b) It is difficult to treat natural menopause issues in such situations;

(c) the paracrine function of uterus on ovarian function is difficult to assess;

(d) physicians tend to see the uterus as only linked to childbirth;

(e) the logic behind oophorectomy is to prevent cancer. However, the incidence of cervical cancer is rare (82 per 1 lakh women) when related with the incidence of hysterectomies (92 per 1000 women), creating an artificial clinical situation.

She then talked about the need to research into how lost ovarian function can be replaced. The low weight, low abdominal fat and poor immunity of rural women makes them more vulnerable to estrogen depletion and loss of ovarian function. She noted the possibility of using flaxseed as an alternative to HRT and medication because of its cost effectiveness, highlighting the funding crunch that faces such initiatives. There was an urgent need to increase awareness, develop protocol, strengthen primary gynecological care, develop alternative methods of hysterectomies, program assessment of ovarian function at least once a year for at least 10 years in women post-hysterectomy.

She also talked about other India-specific complications that make Western studies questionable in its case. For example,

(a) the links between tubectomies and hysterectomies. Laproscopic tubectomies usually done in camps are unsterile increase the risk of future hysterectomies;

(b) the women marry and give birth at a very young age before menstruation is naturally regularized and are then tubectomised, putting them at higher risk of complications leading to unnecessary hysterectomies;
(c) huge gaps in gynecological care also enhance the complications caused by STDs. In case of white discharges from STDs, partners are often not treated, nor is regular gynecological treatment provided.

**Conclusion**

Dr Reddy summarized the discussion by suggesting some immediate measures:

(a) writing to the ICMR asking for a larger study;

(b) convening meetings to finalise appropriate research questions;

(c) conducting studies on health insurance and their impact on women's reproductive health, publically funded by the Planning Commission.

**Legal, Policy and Grassroots Advocacy on Hysterectomy: Experience and Potential Directions**

**Chair** : Poonam Muttreja (Executive Director, Population Foundation of India)

Dr. Hema Diwakar

Dr Hema Diwakar introduced FOGSI and its initiatives, primarily one KEY programme (Keep Educating Yourself) – the FOGSI-Torrent-Sensa KEY programme of 2013 called
“saving the uterus.” She talked about the demand and supply issues such as diagnostic and surgical problems, use of HRT versus non-HRT treatments.

Exploring the demand side, she shared some possible reasons for the high incidence of hysterectomies:

(a) taboo associated with menses;
(b) cancer scare;
(c) lack of options;
(d) desire to avoid problems in older age;
(e) ease of access;
(f) convenience – surgery becomes a one-stop solution;
(g) insurance.

She talked about an interim survey being conducted by FOGSI in tier 1, 2, and 3 cities in Karnataka which will try to assess why elective hysterectomies are on the rise. She then highlighted challenges and action plans needed:

(a) need for a registry of hysterectomies;
(b) audits by an external body;
(c) surveys of various settings, public, private, camps etc.;
(d) develop guidelines and protocols;
(e) master health checkups;
(f) online or SMS based alerts;
(g) standardized discharge cards.

She pointed out some lacunae such as absence of benchmarks, incomplete and inconsistent record keeping, need to gauge links between hysterectomies and heart disease or osteoporosis and creation of a “consortium of co-morbidities.”
Ms. Kerry McBroom

Ms Kerry McBroom next represented the HRLN’s reproductive rights initiatives and talked about the PIL as an valuable tool. The PIL, she explained, is

(a) a way of holding governments and actors accountable;

(b) a way of soliciting a definite reply;

(c) an advocacy as well as accountability tool since it bases the problem within a rights framework, pitches it as a fundamental rights violation, brings media attention to it, creates a record of proceedings, and offers a genuine chance of making changes through government mandate and possibly clear laws.

She then talked specifically about the PIL filed with Dr Narendra Gupta as the chief petitioner and Rajasthan, Chattisgarh and Bihar as the respondents. The PIL outlines facts from states and case studies. More broadly, it looks at general health and contraception issues as well since a rights-based approach makes it necessary to look at the public healthcare system as a whole, and it gives the picture that hysterectomy is one part of a wider reproductive health failure.

She outlined the legal violations linked to general failure of Article 20 (Right to Life, Health etc.), Article 14, 15 – equality before law and discrimination (to bring in gender discrimination), International Law (Article 12), Failure to comply with general rights by
JSY-NRHM. She brought up the issue of informed consent, in relation to the Supreme Court ruling on Sameera Kohli versus Union of India and others, in which the SC agreed that unless it is a lifesaving procedure doctors have to comply exactly with a consent form. Consent needs to be informed as well as involved with a clear sense of advantages, disadvantages and alternatives to the patient. The SC acknowledged that consent does not mean anything in India and called for the need to develop a rights-based consent framework. She talked about role of ethics regulations & doctors cannot solicit patients; and briefly spoke about Consumer Protection Act.

She gave an overview of the prayers: (a) compensation for the women in the fact finding studies and removal of violating doctors; (b) M&I body to ensure accountability, an independent RSBY monitor; (c) findings published in online form accessible to all; (d) investigation into village level health problems; (e) education and awareness camps; (f) evaluation of RHP. She pointed out that the response of the Chattisgarh government was just a page long letter to two large files of petitions.

**Dr. Narendra Gupta**

Dr Narendra Gupta then presented Sapna Desai’s study on prevalence of hysterectomies, determinants and education. The study, conducted between 2010 and 2012 in collaboration with SEWA, was a population study and a health education intervention on hysterectomy in Ahmedabad city and district. It highlights lack of population studies in Asia, Africa, Latin America and India. It uses interviews with patients and other informants.

Some findings:

(a) provider choice was more private than public;

(b) common reasons were fear of cancer, convenience, trust and cost effectiveness;

(c) insurance played virtually no role in decision;

(d) health systems were unavailable at tertiary levels; (e) there were distance and cost barriers to early care; (f) no cancer screening was done on the women. After the health education initiative by SEWA, the number of hysterectomies fell in a two-year period.

Chief areas of concern identified by the study: (a) young age; (b) gynecological morbidity; (c) gendered view of women’s bodies; (d) lack of primary care; (e) no systematic assessment.

Dr Gupta also presented an overview of the fact finding study in Dausa in which the following was found:

(a) four clinics conducted most of the hysterectomies;
(b) these clinics were also recognized for JSY and so could be mined for information under the RTI Act;
(c) women on the whole said that their original complaints did not disappear after hysterectomies;
(d) no prior treatment was given before removal;
(e) private hospitals came recommended by relatives and friends;
(f) the sequence of events from diagnosis to surgery was very hasty, often it happened on the same day itself;
(g) other causes of painful abdomen and bleeding in rural women could not be ruled out given their lifestyle conditions.

**Action groups**

The group dismantled into three small working groups, each of which presented their recommendations after a discussion.

**Track 1: Evidence on incidence, indications, epidemiology, OOP expenditures**

Track one summarized their points of discussion and recommendations as follows:

(a) limited epidemiological knowledge available;
(b) hospital data incomplete and unreliable, perhaps community-based data could be sourced through community surveys;
(c) the need to assess difference in provider-institute relationships, the role of insurance, increase in supply side;
(d) can we map providers and the correlation with number of hysterectomies;
(e) some of the questions were about the origin of indications of hysterectomies – whether post-tubectomy, post-birth, or post-menopausal;
(f) how changes in dietary and life practices may have led to changes in hysterectomy immunity, e.g. effect of change from a millets to rice diet in Andhra Pradesh?
(g) relation of contraceptives and family planning to indications.

They also made a distinction between Real, False, and Fear indicators and made the observations that symptoms were falsified to construct a disease. Anxiety and lack of information was used and there is a need for in-depth information and records, out-patient notes and admission records. Media should inform about indicators and there is a need for improved information of menstrual system and endrocinology.
Track 2: Role of professional associations - FOGSI, IMA and ASI - STGs for management of common uterine disorders.

Track 2 highlighted the following:

(a) need for protocols, independently and within medical associations;

(b) need for monitoring and evaluation of adherence to protocols in the form of medical audits;

(c) need to maintain records and discharge cards;

(d) effective Continuing Medical Education;

(e) certification and ethical protocols to be organizational and independent;

(f) enhanced gynecological care at the PHC level;

(g) the compulsory rural practice programme for post-graduate medical students should not be opposed by medical associations;

(h) implications of hysterectomies should be made known;

(i) gynecologists could perhaps collaborate with other experts, such as bone doctors, to assess damage by hysterectomies;

(j) there is a need to look at drug pricing and the interest of pharmaceutical companies – How could the stakes of big business such as calcium tablets be linked, if at all; (i) clarity needed on what correlations exist; (ii) need for an expert group consensus meeting that gives some interim guidelines instead of waiting for the WHO or other such official guidelines to come about; (iii) medical audits should include clauses that can be employed such as whether admission procedure was followed, hygiene conditions, diagnostic processes between detection, diagnosis and surgery.

Track 3: Demand side, alternative/independent sources of information on need for hysterectomies

Track 3 After acknowledging the asymmetry of information, the following recommendations were made regarding the content of information:

(a) basic information on anatomy and physiology to be provided to women and children;

(b) source of information should not only be those who have stakes in doing the procedures;

(c) information on non-invasive and other contraceptions necessary in tackling misinformation;
(d) information about cancer, STIs etc. to counter paranoia about cancer as a possible inflator of demand;

(e) awareness of patients' bill of rights to include informed consent, right to second opinion with all relevant reports and case papers, post-operative information, and optional measures;

(f) gender sensitization in school health education curricula;

(g) information about common ailments such as anemia;

(h) healthcare providers, including ANMs and ASHAs, to have information on laws and regulations, patient rights etc.;

(i) improving community information channels by targeting students and school curriculum, information helplines such as call centres and medical hotlines, production of video skits and community radio programmes;

(j) co-ordination and dialogue between overlapping government schemes such as NRHM, Family Planning, ARSH etc.

Conclusion

Dr. Narendra Saini: He acknowledged that gynaecological level doctors are available only at tertiary level, distance of health facility and cost are the biggest factors which affects their health seeking behavior. Cancer screening is not available at primary or secondary level government health facilities. He said that an investigation regarding this will be done to figure out the loopholes in the system and malpractices by doctors.
Valedictory Session

In Chair: Dr. Syeda Hameed

Dr Syeda Hameed was briefed about the proceedings of the conference in the valedictory session. During a discussion with the participants and panelists, these significant points were brought up:

(a) we do not have the last word on insurance or commercial aspects of the problem;

(b) given that the problem is often of morbidity not mortality, one of the significant consequences is the economic unproductivity of women, which could well become a food security issue. This can be seen from the example of Andhra Pradesh in which loss of ovarian function in women has had consequences for general health and productivity of women;

(c) It was pointed out that alternative treatments, such as IUDs, do not get reimbursed by social insurance. However, the discussion stressed the need for solutions that would be commensurate with ground realities, e.g. focus on preventive PHC, creation of strong indicators which take into account regional, socio-economic and other contextual factors;

(d) Mr Niranjan Pant pointed out the need for regulatory mechanisms which incorporated a layer of external regulation in the self-regulation of the medical profession;

(e) Dr Narendra Saini of IMA suggested an investigation into practices of hysterectomy which are clearly malpractices such as those in Dausa.