Preventing Unnecessary Hysterectomy and Improving Gynaecological Care: Learnings from Multi state Roundtable Discussion

Report

15 January 2024

Background

Early hysterectomy, involving the removal of the uterus before the age of 45, has garnered significant policy, legal, and media attention. The prevalence of this intervention varies considerably across the nation, with Andhra Pradesh and Telangana reporting high rates, while the Northeast consistently shows low usage[1]. The median age at which hysterectomy is performed in India is notably lower than in other countries, occurring at around 36 years, a full decade before natural menopause[2]. Indications for hysterectomy, such as abnormal uterine bleeding and pelvic inflammatory disease, highlight its use for benign conditions rather than exploring less invasive options.

Journey to Addressing Unnecessary Hysterectomy in India

Over the span of more than 13 years, the movement to address unnecessary hysterectomy in India has evolved through advocacy, evidence-building, and purposeful collaboration among diverse stakeholders. It began in **2010** with Prayas's fact-finding initiative in villages of Dausa, Rajasthan, followed by SEWA's publication of population prevalence estimates in Gujarat[3]. Community-based organisations and clinical-based studies conducted research studies in response to perceived trends of rising hysterectomies, noted young age of women who had hysterectomy, many years earlier than their natural menopause, and for indications which could have been managed without surgery [4-6].

Activists and public health physicians also illuminated the role of publicly funded insurance schemes through RSBY claims data. In **2013**, to delve deeper into the rising trends, the United Nations Population Fund (UNFPA) supported a national level consultation. It was attended by researchers, women's health advocates, media, Federation of Obstetric and Gynaecological Societies of India (FOGSI), Indian Medical Association (IMA), Ministry of Health and Family Welfare (MOHFW), and the then Planning Commission. The consultation underscored the need to carry out more systematic work to understand the issue and take appropriate measures. Based on the consultation, a recommendation was made to the MOHFW to collect nationwide data on the prevalence of hysterectomy through soon-to-be-launched NFHS 4. This consultation also led to the removal of coverage in private hospitals under Rashtriya Swasthya Bima Yojana (RSBY), with mandatory second opinions for women under 45 undergoing hysterectomy.

The data collected through NFHS-4 was discussed in another national consultation organized in **2018** by Prayas, with support of UNFPA and Population Council. The consultation noted that young-age hysterectomies in India are an important concern in the context of women's health. Recognizing these issues, the Supreme Court responded to a Public Interest Litigation in 2013. A national consultation was called by MoHFW in **2019** on unnecessary hysterectomy which identified three important challenges for women's health:

- Need for appropriate clinical and population-level guidelines on hysterectomy
- Lack of appropriate information on and treatment of gynaecological morbidity at the primary care level
- Need to monitor and regulate the appropriate use of hysterectomy, particularly for the treatment of benign gynaecological conditions and amongst younger women.

After this consultation, a group was constituted to draft the guidelines for the prevention of unnecessary hysterectomies. Following approval from competent authorities, and directives from the SC, the guidelines were released in April 2023 and sent to all the states and union

territories of India for implementation. Throughout this multi-year journey, collaborative efforts have raised awareness, generated evidence, and formulated guidelines, all aimed at effectively addressing unnecessary hysterectomies and safeguarding women's reproductive health rights.

Recent Developments: National Guidelines to Prevent Unnecessary Hysterectomies

National guidelines to 'Prevent Unnecessary Hysterectomies' were issued by the Ministry of Health and Family Welfare in April 2023. The guidelines were formulated after a series of consultations with different stakeholders. Guidelines provide guidance on the prevention of unnecessary hysterectomy through directions to program managers and different levels of public health facilities. They include standard treatment protocols for common conditions, with an emphasis on hysterectomy only as an option after medical management and other alternatives have been tried. The guidelines include audit formats for facilities to track hysterectomy and strategies for community-based awareness.

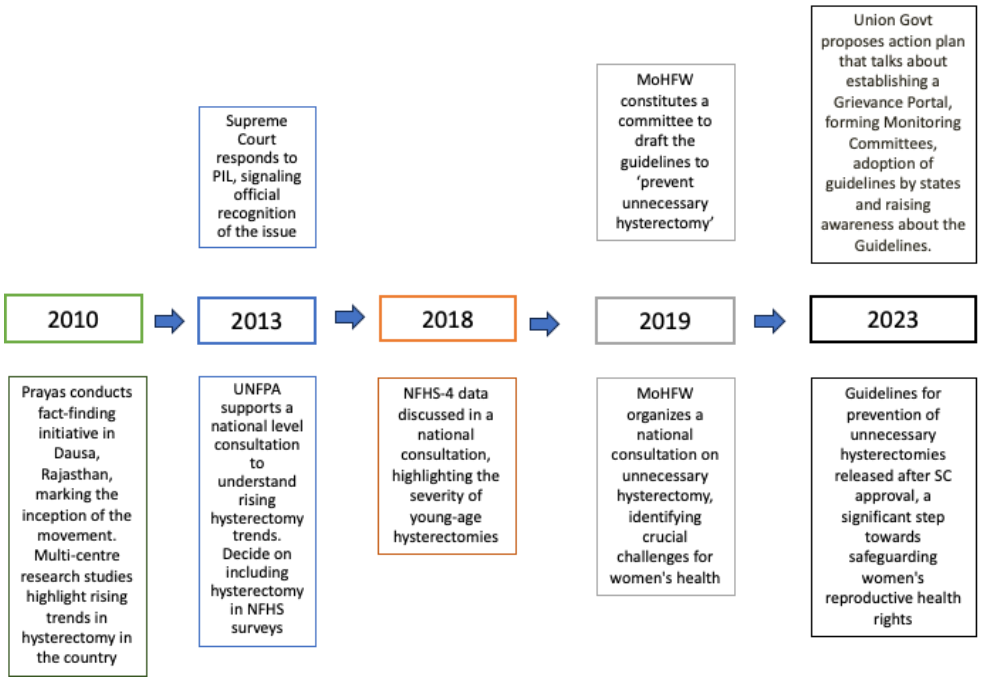
In April 2023, the Supreme Court issued their judgement to a 2013 Public Interest Litigation that emphasized the importance of prevention and monitoring of unnecessary hysterectomies, along with mandatory reporting. The Union Government also proposed an action plan which included:

- Establishment of a Grievance Portal
- Formation of Monitoring Committees at the national, state, and district levels
- All States and Union Territories (S &UT) to adopt the Guidelines within three months and report compliance to MoHFW
- Ensure that all public and private hospitals within their territories are made aware of the existence and importance of the Guidelines

The National Monitoring Committee is chaired by AS&MD, MoHFW and has met twice. They established two sub-committees to develop IEC materials and set protocols for alternative treatment for gynaecological treatment. The IEC subcommittee has met and developed a first draft of materials, partly drawing from insights and recommendations from these roundtable consultations.

As of January 2024, a few states have submitted data to DGHS. Of the six states in this project, only Punjab had initiated the process of forming a committee as directed by the guidelines. Rajasthan and Karnataka indicated intentions to do so soon.

In light of these recent developments and to understand the current state of implementation of guidelines and the action plan mentioned above, Prayas, in collaboration with UNFPA, conducted a series of 6 roundtable consultations in 6 states between October to December 2023. These roundtables allowed us to explore factors contributing to higher or lower rates of hysterectomy in the country and learn valuable lessons. The primary objective of these roundtables was to identify priority areas for action to prevent unintended hysterectomies. Prayas also conducted a trend analysis of hysterectomies across states and nationally using data from NFHS 4 and 5.



Timeline of journey to addressing unnecessary hysterectomies in the country

Overview of Roundtables:

Prayas collaborated with state governments, medical colleges, social science institutes, FOGSI, IMA along with state federations of gynaecologists and civil society partners for each of the 6 roundtables (Table 1). Organisational partners in each state varied based on local interest or existing work on hysterectomy, outreach to gynaecologists and our own pre-existing relationships.

Table 1 Roundtables organized by Prayas with support from UNFPA

State	Location	Date	Organising Partners	Participants
Assam	Guwahati	11 October	FOGSI JHPIEGO TISS Guwahati	77
Rajasthan	Jaipur	21 November	FOGSI OBGyn Society Jaipur	64
Punjab	Chandigarh	30 November	FOGSI PGIMER, Chandigarh	46
Telangana	Hyderabad	8 December	FPA India CESS	86
Karnataka	Bengaluru	18 December	St Johns's Medical College SOCHARA	74
Madhya Pradesh	Bhopal	21 December	NHM,MP OB Gyn Society Bhopal	70

The roundtables were held in the state capitals of Assam; Rajasthan; Punjab; Telangana; Karnataka; and Madhya Pradesh. These states have varying hysterectomy rates including highest and lowest rates in the country, allowing us to explore factors contributing to national variation and learn valuable lessons. Hysterectomy rates are higher in Telangana and parts of Karnataka and Madhya Pradesh, while Assam and Rajasthan had lower prevalence, except for a few pockets. Punjab had previously reported higher prevalence, which has persisted in some districts, but appears to have experienced an overall decline over time.

A total of 417 participants attended the roundtables. Each roundtable had approximately 50-60 participants that included primarily gynaecologists from the public and private sectors, policymakers, public health researchers and advocates, and women's groups/civil society organisations. Each roundtable included: a presentation on the guidelines from the Deputy Director, Directorate General Health Services with questions-answers; an overview of population data in the state; remarks on key priorities by a policymaker/senior doctor; and interactive panel and small groups for participants to identify key issues and priorities for moving forward.

These six roundtables provided insights into: causes of hysterectomy in their specific context, feedback on the guidelines and priorities for action. This report summarises insights from the roundtables and situational analyses of hysterectomy in each state. *Annex 2 includes detailed reports of each state roundtable and panel presentations*.

The National Family Health Survey started collecting data on hysterectomy in Round 4 (2015-2016) followed by NFHS-5 in 2019-21, both amongst women in ages 15-49. The Longitudinal Survey on Ageing in India (2017) estimated hysterectomy amongst women above age 45. Figures 1a and 1b present data amongst women between 40-49 and above 50, respectively, from NFHS-5 and LASI.[7,8]

Prevalence of hysterectomy varies considerably across India, with Andhra Pradesh and Telangana reporting the highest rates, while the Northeast shows consistently low usage (Figure 1).[2] Up to 1 in 5 women in Telangana will have a hysterectomy by age 50, compared to three percent of women in Meghalaya. As expected, population prevalence of hysterectomy increases with age; more women above age 50 will report hysterectomy compared to younger cohorts.

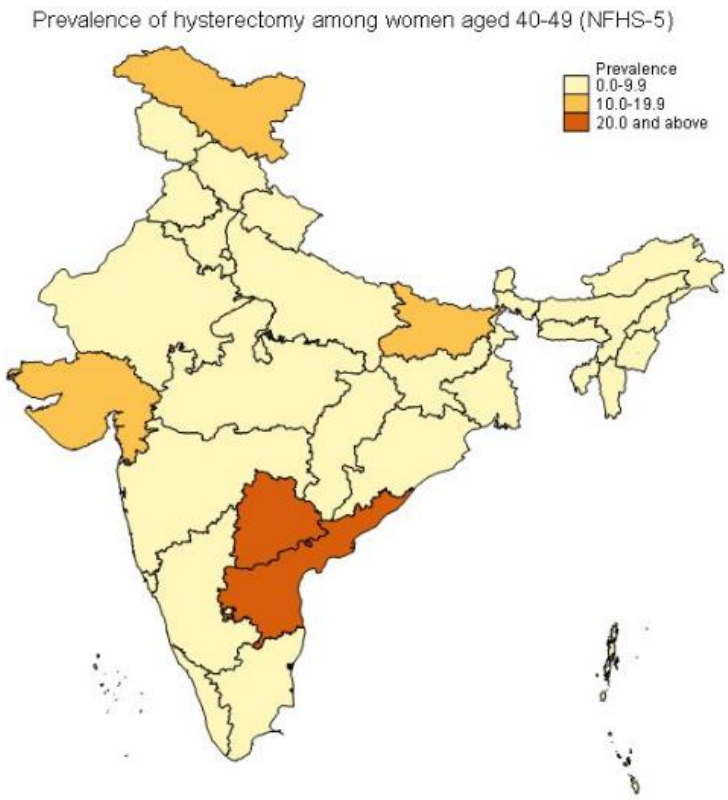


Figure 1a

Given that the median age of hysterectomy in NFHS is in the mid-thirties, the key data indicator of time trends is between rounds of NHFS. Unfortunately, there has been little change in hysterectomy prevalence or patterns between NFHS-4 and NFHS-5 at the state level, though district-level analyses are suggestive of “hot spots” that indicate growth in rates in some areas. [1]

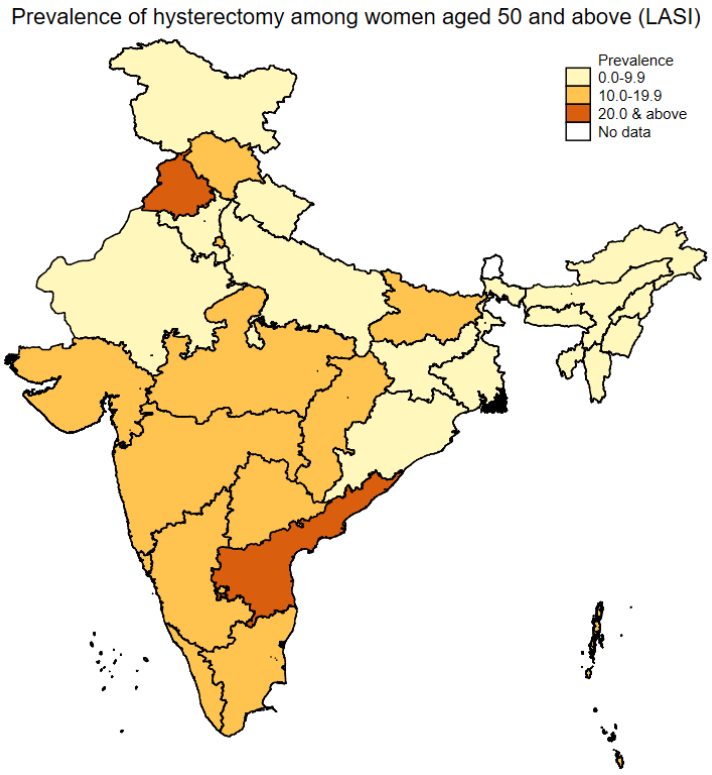


Figure 1b

Table 2 highlights variation in prevalence, median age and use of the private sector across states. Prevalence estimates mask district-level variation, with high prevalence districts in each state (Figures 2-8). Median age is lowest in Telangana, and generally a decade before natural menopause in all states. The leading self-reported reasons for hysterectomy are similar (excessive menstrual bleeding and fibroid/cysts), with variations such as cervical discharge in Karnataka and uterine disorders in Madhya Pradesh. The use of the private sector is high in all states, with departures in the lowest prevalence state (Assam), where only 23% of hysterectomies are in the private sector, and the highest prevalence state (Telangana), where 85% are conducted by private doctors. *See Annex 1 for detailed state situational analyses.*

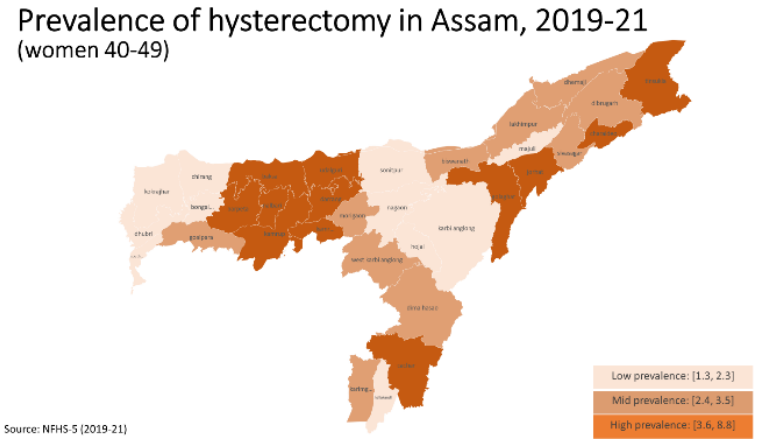
Table 2 Variation in state patterns

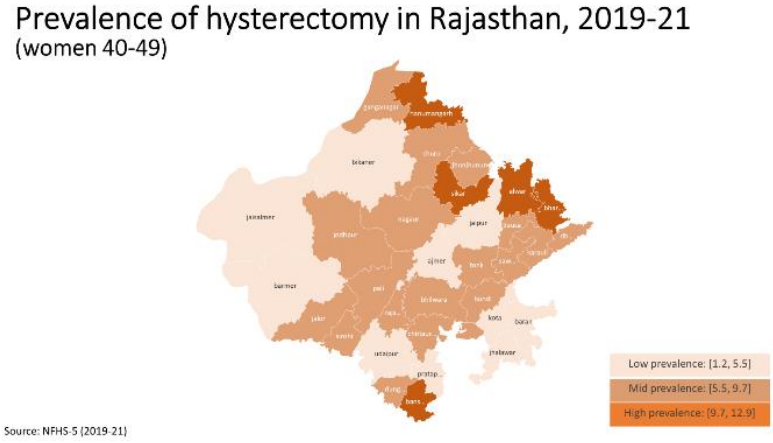
	Prevalence (40-49)	Median age (40-49)	Private sector use	Leading causes
Assam	3.4	35	23%	Heavy menstrual bleeding Uterine disorders/ rupture
Rajasthan	6.9	38	61%	Heavy menstrual bleeding Fibroids/ cysts
Punjab	9.7	38	57%	Heavy menstrual bleeding Fibroids/ cysts
Madhya Pradesh	8.5	36	62%	Heavy menstrual bleeding Fibroids/ cysts Uterine disorders (rupture)
Karnataka	8.9	36	55%	Heavy menstrual bleeding Cervical discharge Fibroids/ cysts
Telangana	21.2	34	85%	Heavy menstrual bleeding Fibroids/ cysts

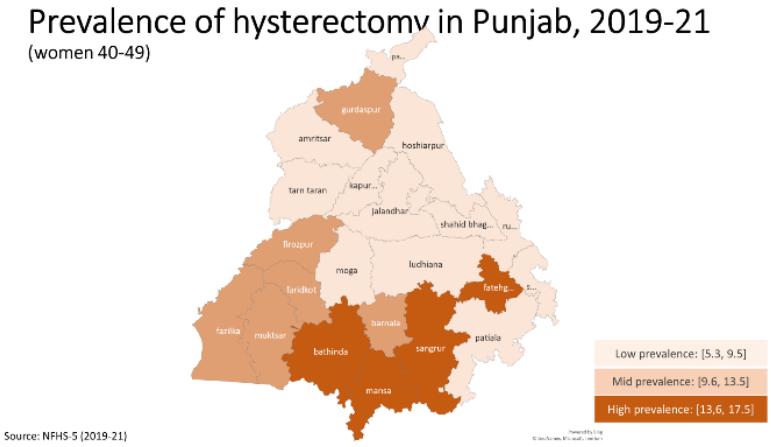
Analyses of NHFS-4[2], NFHS-5[1] and LASI[9] indicate four issues of concern:

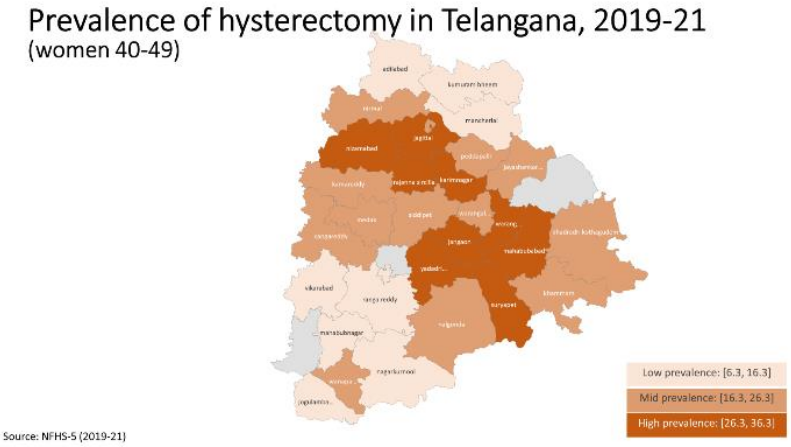
- **Low median age** at the time of the procedure, typically between 35 to 38 years. This is considerably younger than in high-income settings where data are available. Early hysterectomy puts women at risk of early menopause and loss of oestrogen, which in turn are linked to higher risk of a range of non-communicable diseases.
- **Wide variation in prevalence**, ranging from 2.6 to 22.5 percent of women ages 40-49, indicating challenges to women's access to care and likely overuse in some settings.
- **Inequities in utilisation patterns:** women in rural areas with less education have the highest odds of hysterectomy. The majority of procedures are conducted in the private sector, including amongst the poorest – with state-level variations.
- **Use of hysterectomy for common gynaecological complaints:** Heavy menstrual bleeding, fibroids/cysts and cervical discharge are the leading self-reported reasons for women to undergo hysterectomy. Coupled with low utilization of services for menstrual disorders and reproductive tract infections among women, these patterns suggest hysterectomy is being used in place of less invasive options.

Prevalence of hysterectomy at district level

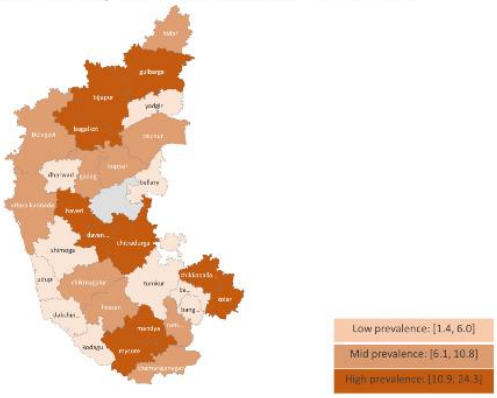






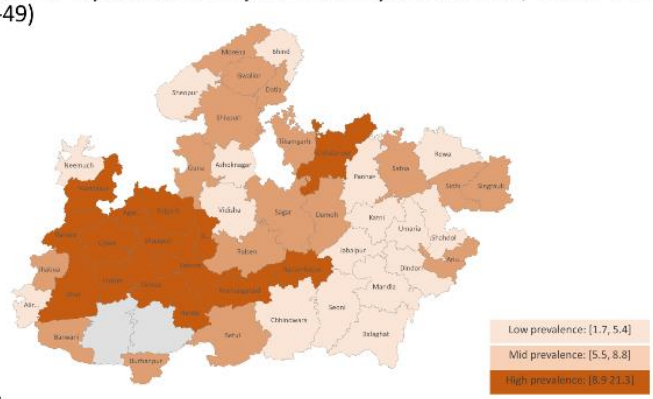


Prevalence of hysterectomy in Karnataka, 2019-21
(women 40-49)



Source: NFHS-5 (2019-21)

Prevalence of hysterectomy in Madhya Pradesh, 2019-21
(women 40-49)



Source: NFHS-5 (2019-21)

The section below summarises common themes across the panels, as well as highlights important variations across the states.

I. *Indications of hysterectomy*

Unindicated hysterectomy is a problem across each state, albeit to varying extents. Causes spanned individual, health system and social causes, and were consistently identified as:

- **Limited Access to Treatment Options**: Lack of affordable, readily accessible treatment options for gynaecological morbidities especially for heavy bleeding. In Punjab, however, LNG-IUS was reported to be widely used in government hospitals, which most doctors believed contributed to a decline in hysterectomies. LNG-IUS is not subsidised in public facilities.
- **Role of Surgeons:** Proliferation of surgeons conducting hysterectomies, either without a gynaecological consultation directly through referral from an RMP or as assisting gynaecologists. This trend was observed in all six states, but particularly in Rajasthan, Karnataka and Telangana.
- **Sociocultural Norms :** Sociocultural norms that create taboos around menstruation, such as not being able to work in turmeric fields in Telangana or enter the kitchen in other settings. Further, many states noted a belief that the uterus had no purpose beyond reproduction, and thus was dispensable post childbearing. In Assam, however, participants pointed to social norms that celebrate menstruation and that women generally wanted to preserve the uterus.
- **Lack of Awareness:** Lack of knowledge on the correct medical indications of hysterectomy. There was generally a perception that women – and some providers – were not aware of treatment options for excessive bleeding or fibroids/cysts. Some doctors felt women demanded the procedure due to its normalisation as a treatment for common ailments, although this led to considerable discussion on the role of doctors to explain options and counsel women. There is virtually no knowledge or communication available on the side effects of hysterectomy, particularly when conducted amongst young women, such as the increased risk of NCDs and lower quality of life.
- **Unethical Practices:** Unethical practices motivated by profit or ease, such as when doctors conduct a hysterectomy because "if I don't do it, someone else will" especially amongst women with limited options or for whom follow-up visits are difficult due to distance and expenditure. In some settings, younger doctors' desire to practice surgical techniques contributed to unnecessary hysterectomy. These are compounded by the "prophylactic" use of hysterectomy to prevent future recurrence of gynaecological morbidity or cancer.
- **Gaps in Infrastructure:** Lack of infrastructure and equipment, such as hysteroscope or lack of proper examination space, led women to seek surgery and doctors to offer hysterectomy rather than ensuring women have a proper examination and alternative treatments. Gynaecologists also expressed limited training on alternatives such as LNG-IUS or ablation techniques.
- **Limited Primary Care**: Absence or near absence of gynaecological care within the primary care or public health system, contributes to women seeking permanent options. Gynaecological care is not widely available through primary health care centres, with the exception of recent introduction of screening for cervical cancer through Health and Wellness Centres.
- **Wide use of tubal ligation** in most states which may contribute to subsequent gynaecological morbidity. In Assam, high use of oral contraceptives was seen as a factor in lower hysterectomy, as these also control excessive bleeding, as well as limited tubal ligation.

II. Feedback and Inputs for implementation and Improvement of guidelines

Participants responded positively to the introduction of the guidelines, actively interacting with Dr. Amita Bali Vohra from DGHS by posing questions and sharing comments. Participants responded positively to the introduction of the guidelines, actively interacting with Dr. Amita Bali Vohra from DGHS by posing questions and sharing comments. Table 3 below highlights the challenges / issues in the guidelines and the possible solutions to address them:

Table 3: Key issues highlighted in the discussions

Challenges identified in the guidelines during the discussion	Possible solutions
Rationale behind the age criteria(<40 years)	The guidelines could provide clarification on the rationale behind age criteria such as why under 40 is chosen instead of 45,.
Clarity around medical indications for hysterectomy in India	A distinction could be made in the guidelines between common uterine related conditions in India (fibroids, cysts, discharge) and this among them where hysterectomy is the first line of treatment .A flow chart, already included in the guidelines, could be included in the upcoming treatment protocols being developed.
Protocol for emergency obstetric hysterectomy and auditing cases of emergency hysterectomy in women < 40)	The indications for emergency hysterectomy should be clearly mentioned in the guidelines. Also, cases of emergency hysterectomies that typically happen in women less than 40 years should not be audited.
Medical Management of Common gynaecological conditions	Drugs prescribed in the guidelines could include protocol for dosage and frequency.
Quality of information collected	The data collection form should include additional columns on the type of referring doctor, specifying whether it was a surgeon or gynaecologist or other type of doctor.

- District committees must guarantee representation from both private and public sectors. They should also provide clarity on the audit procedures and the protocol for punitive actions, including the forms of review and redress. One proposal is to establish advisory boards at the district level to adjudicate cases, ensuring a due process for each review. In Punjab, doctors raised concerns about the possibility of blacklisting occurring without thorough review
- Challenges were noted regarding data collection from private facilities, which is in the purview of district level committees, but it is not clear how this how this process will be mandated.

- The guidelines should be widely disseminated with appropriate capacity building across levels.
- In certain states, notably Rajasthan and Punjab, there have been requests for clearer regulations regarding the prohibition of surgeons from performing hysterectomies. The Directorate General of Health Services (DGHS) will examine data at both the state and national levels. It will then consider recommending the exclusion of specific facilities if deemed necessary. However, there hasn't been any indication of barring surgeons.

III. *Priorities for Action*

Priorities emerged for clinical, health system, community level interventions. Key suggestions were:

Health system: National and State

- Ensure **establishment of State and District level committees** in all States & UTs, with nodal officers at the district and state level to track implementation of the guidelines. The **portal for data entry** should be widely disseminated so facilities can provide inputs.

- **The availability of LNG-IUS** in public facilities and covered under insurance for private facilities, emerged as the most consistent, and widely emphasized, priority to reduce unnecessary hysterectomy.

- **Improved contraceptive mix,** as sterilisation may contribute to gynaecological morbidity and use of oral contraceptives and intrauterine devices can control menstrual irregularity as well.

Clinical/Facility-based interventions

- **Counselling for women** on the indications for hysterectomy, to allay fears of cancer, and to explain side effects. Doctors and community health workers need easily understandable materials for counselling.

- **Clinical governance and peer review** within healthcare facilities to monitor and assess potential hysterectomy cases. Utilize confidential WhatsApp groups for effective tracking, aiming to reduce unnecessary procedures. This approach has been successfully implemented at MGIMS Wardha.

- **Training** for new graduates and established gynaecologists on the guidelines and SOPs for gynaecological morbidity

Community and primary health care

- **Mass Media and IEC materials** to explain anatomy, the importance of the preserving uterus and ovaries, available, non-invasive treatments for common gynaecological conditions and complications of hysterectomy including surgical complications (general anaesthetic, ureter damage, bladder or bowel damage, infection, vaginal problems, ovary failure and early menopause and non-communicable diseases.

- Community-level media is essential to change norms related to menstruation. School-level education must include women's biology and gynaecological health needs. At present, lay health workers are not equipped to provide such information; the HWCs present an opportunity to integrate gynaecological health into primary care by providing IEC materials.

- Initiate and demonstrate the feasibility of treating common gynaecological conditions at the **primary level** to disrupt the pattern of women seeking care directly from RMPs or surgeons for issues such as uterine bleeding or other gynaecological symptoms.

PARTICIPANT FEEDBACK

We approached participants from five states to understand their experience of attending these roundtables and to collect their suggestions for future action. Doctors in general indicated that the roundtables were useful, and there were healthy and informative conversations around the issue of unindicated hysterectomies in their states. Such meetings are particularly useful for young doctors, but also older doctors who have been practicing for a long time but are not associated with academic institutions. The content covered during the meetings gave these doctors a vital opportunity to reacquaint themselves with new technology and alternate treatment methods available for common gynaecological ailments.

> *"....We have to keep the meeting to brush up or knowledge and to brush up for our things which we have to do"*
> -OBGYN from Bhopal, Madhya Pradesh

Private practitioners felt they could contribute to the discourse based on their experiences and were given an equal opportunity as doctors from large teaching hospitals. A few of them shared immediate actions taken by the facilities they practice in. One such doctor from Assam said,

> *"..... Right after the meeting I went back to my college in (Silchar) medical college and there they started asking us to give them the feedback on what are the indications we are doing hysterectomy on"*
>
> -OBGYN in a government medical college, Assam

A few concerns echoed by doctors around deterrents to reducing hysterectomy rates were:

1. Lack of awareness among women, such that they are easily convinced to undergo a hysterectomy (by peers/ non- gynaecologist doctors) and they insist for the surgery thereafter.
2. Lack of understanding around the importance of the uterus in the medical fraternity. Thus, premature decision of removal of the uterus is taken by surgeons and physicians.
3. Young doctors are fascinated by new surgery techniques such as laparoscopic methods, and thus are keen to operate even in situations where a hysterectomy is not required.
4. Monetary gains and compromised ethics among a few doctors is an issue that is driving the rate of unindicated surgeries.

There were a few suggestions that emerged from these feedback conversations with doctors:

1. Regular meetings and follow ups are key to keep the interest going, and also to instil fear of surveillance.
   "....There should be regular meetings, like for mortality"
   -OBGYN from Faridkot, Punjab
2. There is still scope for clarity in the guidelines. Especially for the treatment course to be adopted for women under 40.
   "....It is not clear where to take women under 40. Is there a board, who are the doctors on the board, which hospital? These should be clarified."
   -OBGYN from Bhopal, Madhya Pradesh
3. Strict implementation and audits is key to bringing down rates of unindicated hysterectomies. An OBGYN from Hyderabad said:
   "....For the implementation of the regulations there should be the state body and the district body. Right now, nobody is there, I think in many states."
4. Increased participation of doctors in these meetings. Participation should be invited from other medical societies and remote geographies of the state. Doctors in the medical fraternity beyond the OBGYN community should be included in these meetings.

CONCLUSION and WAY FORWARD

The roundtables provided critical insights into the variation in patterns of hysterectomy across states, as well as identified national and state-level lessons. The wide involvement of gynaecologists was the key achievement of this initiative, as previous initiatives had not engaged the medical fraternity.

The guidelines were consistently well-received, although there will be considerable effort required to support implementation at the state and district level.

Prayas and partners in FOGSI/State OBS-GYN societies and civil society will build on this momentum of six roundtables through key follow-ups:

- Develop a policy brief based on the outcome of roundtable discussion through a UNFPA-Prayas partnership
- Track and support the establishment of State Committees, as most states have not yet established committees. This information will support DGHS in promoting implementation of the guidelines.
- National dissemination meeting, in partnership with FOGSI
- Advocate for data analysis and audits in states, with committees in selected states and at the national level. This could be in the form of a technical partnership with state level organisations.
- Support national/state efforts in the development of IEC materials and promotion of alternative treatments, especially LNG-IUS
- Identify states willing to pilot primary care level treatment for common gynaecological ailments

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Supplementary Table: Prevalence of hysterectomy, by state (NFHS-5)

States	Hysterectomy Prevalence (women aged 40-49)	States	Hysterectomy Rates (women aged 40-49)
Andaman & Nicobar	5.5	Maharashtra	8.8
Andhra Pradesh	22.5	Manipur	5.5
Arunachal Pradesh	5.9	Meghalaya	2.6
Assam	3.4	Mizoram	4.9
Bihar	17.2	Nagaland	4.9
Chandigarh	2.8	Delhi	6.0
Chhattisgarh	5.5	Odisha	6.6

Daman Dadra & Nagar Havel	7.3	Puducherry	5.2
Goa	5.4	Punjab	9.7
Gujarat	11.7	Rajasthan	6.9
Haryana	8.0	Sikkim	2.7
Himachal Pradesh	5.6	Tamil Nadu	7.2
Jammu And Kashmir	9.6	Tripura	5.8
Jharkhand	7.6	Uttar Pradesh	8.6
Karnataka	8.9	Uttarakhand	7.4
Kerala	5.8	West Bengal	8.7
Lakshadweep	4.7	Telangana	21.2
Madhya Pradesh	8.5	Ladakh	11.4
All India Mean	9.7		

	>=20
	15-19
	10-14
	5-9
	1-4

Feedback from participants (names removed)

1. **Guwahati, Assam**

- The meeting was a useful, good platform to disseminate the guidelines
- Women/ patient need awareness
- Young doctors venture more towards surgeries- for monetary gains as well as experience
- Young doctors and older doctors not in medical colleges need awareness of alternate methods- these meetings should involve more such participants

2. **Silchar, Assam**

- In government facilities, only necessary hysterectomies are done mostly.
- Private sector and other places hysterectomy is more prevalent

"..... Right after the meeting I went back to my college in (Silchar) medical college and there they are started asking us to give them the feedback on what are the indications we are doing hysterectomy on"

- Women have very poor health conditions; some have haemoglobin of 2- to save their life we need to do hysterectomy
- In government facilities, alternate treatment methods are not available, thus for lack of alternatives, we go for hysterectomy
- It was a nice talk but let's see how far it can help
- Young doctors are fascinated by laparoscopic methods, and of course there is the money angle
- Its on our conscience to think of the patients first- doctors are very professional nowadays.
- These meetings need regular follow ups to ensure implementation, especially in rural periphery facilities

3. **Jaipur, Rajasthan**

- It was a useful meeting
- There was less participation- everyone was not called
- Now it should be planned in a way that all members of societies- FOGSI, JOGS, etc are made to attend such meetings
- Awareness among all of medical fraternity is required to be made aware of the importance of the uterus
- Surgeons, physicians, all of them should be invited
- Many more such meetings are required

4. **Hyderabad, Telangana**

- For Hyderabad city it was a small gathering, it should have been a larger gathering.
- There are policies on paper, but their implementation is where there is a difference.
- If we want a change, there has to be fear among doctors that someone is watching.

"....For the implementation of the regulations there should be the state body and the district body. Right now, nobody is there, I think in many states."

- Like MTP is implemented strictly, we need regulations tightened around hysterectomy. For example, one hospital in Karnataka was blacklisted. Things like this would spread the concern of surveillance among wrongdoers.
- Finally, it comes down to the conscience of the doctors.
- These days doctor degree is very expensive, so they need to make the money back. Other avenues such as PCNDT, MTP are shut so doctors were doing hysterectomies to make money.
- Times have changed, younger doctors do not care as much.

5. Faridkot, Punjab

- The conversation in the meeting was very healthy, despite some disagreements between public and private practitioners.
- Proper audits are a must, only then will rates come down

  "...Now we are specifying the reason for hysterectomy done for women under 40".

  "....There should be regular meetings, like for mortality"

6. Ludhiana, Punjab

- Non gynae docs are operating on women- surgeons should be included into the conversation.
- Awareness among women is lacking- where to go, which doctors should be approached, especially in rural areas.
- The more we discuss on the issue, it will help.
- *".....It is good when all people come together, more such meetings would help..... We are private doctors; .....these are high load hospitals (PGIMER). Iin such meetings we can also give our inputs"*

7. Bhopal, Madhya Pradesh

"... Of all the things which were talked there which we talked about, we all knew that already. The guidelines has to be followed. The order for that was already given to everybody and everybody has started collecting the data and giving the report they have already started. So, I don't think it that was a very useful thing."

"....We have to keep the meeting to brush up or knowledge and to brush up for our things which we have to do, so that was okay"

- The guidelines have asked for retrospective data (March 23 to Jan 24), which is very difficult for us to do- where women went before they came to us, how do I know.
- *"....It is not clear where to take women under 40. Is there a board, who are the doctors on the board, which hospital? These should be clarified."*
- The guidelines only have theory on issues, practical things are missing.
- The data should only be for future surgeries, past should be let go. We cannot get those details now.

Roundtable on Gynaecological services and surgeries in Assam

Roundtable on Gynaecological services and surgeries in Assam

11 October 2023

Hotel Ratnamouli Palace, BN Saikia Road Basistha, Chariali, BeltolaTiniali, Guwahati

1:00 – 2:00 pm	Lunch and Registrations
2:00 pm	Welcome and Overview: Dr Narendra Gupta, Prayas
2:15 pm	Remarks on Priorities in Assam: Dr Achyut Baishya, Principal & Supdt. Guwahati Medical College & Hospital
2:35 pm	Presentation on trends in Assam: Dr Sapna Desai, Population Council Institute
2:45 pm	National Guidelines to Prevent Unnecessary Hysterectomy: Dr Amita Bali, DDG, Directorate General of Health Services
3:00 pm	FOGSI: Save the Uterus Campaign: Dr Nilakshi Phukan, Guwahati Obs and Gyn Society
3:15-3:30 pm	Tea
3:30 -4:30 pm	Setting the Stage for Action: Priorities for Assam, Dr Arun Madhab Baruah, Sr OB-GYN
	Moderated panel discussion on priorities for primary, secondary and tertiary care
4:30 pm – 5:15 pm	Group discussions on priorities for women's access in Assam
	Presentations of Groups and Open Discussion
	Moderated by Dr Kranti Vora, OB-GYN and researcher
5:15 pm – 5:30 pm	Concluding Remarks
	Dr. Anup Kumar Barman, Director of Medical Education
5:30 pm	Way Forward Dr Sreejit EM, UNFPA

Meeting notes

1. ***Welcome & overview***

Dr Gupta shed light on how reproductive health in India in only a recent topic of discussion. The discourse has largely been around maternal health in India. The first study in Maharashtra in 1989 brought forward startling revelations, that an average woman experienced 3 recognisable gynaecological morbidities in her lifetime. The Cairo conference of 1994 is considered a milestone that initiated a discourse around policy changes favouring women's health in India. Programs and policy have evolved over time, starting from the Reproductive Child health program, followed by the NRHM, which became the NHM and the current RMNCH+A program by the Government of India. However, there is a long way to go to truly understanding women's health and making policy that supports a holistic approach to women and their specific health concerns.

2. **Keynote speaker**

Dr Baishya addressed the core agenda of the event, i.e., hysterectomy. He spoke about why research is important to understand the reasons of why women undergo hysterectomy. He mentioned that there is unmet need of the surgery at one end of the spectrum owing to barriers while unnecessary hysterectomies happen on the other side. He mentioned that he has worked in the field for 22 years and says with confidence that gynae problems are not discussed anywhere outside the FOGSI. Thus, FOGSI has the responsibility to take the agenda of gynae morbidities forward and accumulate the much-deserved attention to this area of women's health. Women's health has so far largely been focussed on maternal health and in Assam the focus has inadvertently been on maternal mortality and how it can be lowered. So far even policies and programs do not cover reproductive health (from Cairo conference up to the RMNCH+A).Currently we are at primitive stage of gynae care. HWCs are not equipped with what they are expected to do. They cannot do cervical cancer screenings at the Sub centre level. Services at most centres are inadequate and it does not afford women sufficient privacy that is required to counsel and then undertake cervical cancer screening. Ground reality must be monitored by FOGSI. There are mandates on paper, but their implementation must be monitored by senior doctors. Culturally, women in Assam do not prefer hysterectomy. They would avoid the doctor who would prescribe a hysterectomy. Assam is faithful to its public health facility system, wherein

in Assam only 30% hysterectomies are done in private facilities (reverse of all India trend). Highest number of gynaecologists in any state across India, at N=202.Assam has the skeleton of a strong health system - but inter linkages must be improved. ASHAs and HWCs are key to that. They can do initial screening and refer to appropriate facilities from their end.

3. Guidelines to prevent unnecessary hysterectomies in India

Dr Bali introduced the guidelines and gave a background on how the guidelines came into existence- the PIL to the Supreme Court filed by Dr Narendra Gupta. So far, a letter has been sent to all states to encourage them to adopt the enclosed guidelines. A portal has been set up in the PMJAY website to address grievances related to unnecessary hysterectomies. This will be monitored by NHMC (National Hysterectomy Monitoring Committee). The NHMC was constituted on 26th June under the maternal health division. The committee has powers to blacklist a hospital found in violation of the guidelines i.e. when consent in not taken from the woman, or unnecessary hysterectomies are being done. Further, states and districts must collect data in a prescribed format on hysterectomies done and details on indications, post operative care etc. Women will also be followed up to understand the aftereffects of hysterectomy. An initiative has been taken to train doctors in other non-invasive procedures as alternatives to hysterectomy. Social media and other media platforms will be used to reach and educate women on aftereffects of hysterectomy to limit elective hysterectomies. DGHS urges the support of FOGSI in the state. There was discussion among audience regarding nuances in implementation and conditions for penalties. The following questions/ points were raised:

- Who will monitor the incidence of hysterectomy and how will it be done?
- How is unnecessary hysterectomy defined?
- Surgeons perform many of the hysterectomies since they are better at surgical procedures such as laparoscopy etc. how do these guidelines take surgeons into account?
- The guidelines should be implemented like the MTPs. Once the law in in place- the numbers will come down automatically.
- Audit for hysterectomies < 40 years of age. Doctors suggest there should be no age cutoff, like C-secs. The govt.'s position is that if all hysterectomies are audited, too much manpower will be engaged in it.

- How was age 40 decided? Experts from medical colleges in Delhi decided age 40. States and institutes have freedom to decide their own age cutoff below which they wish to perform audits or audit all hysterectomies if they want.
- From fear of audit, young doctors will refrain from performing hysterectomy of women< 40 years. They may delay it for age>40, and that may prove to be too late in some cases.
- Sometimes in PHCs or peripheries, a lone doctor must decide urgently for a hysterectomy. A second opinion may not be possible logistically. In such cases, to abide by guidelines may prove to be life threatening for a patient.
- Other factors such as remoteness of facility should be considered.
- What about obstetric hysterectomies? Guidelines exempt emergency obstetric hysterectomies from 2 doctor approval based on case to case.
- Dr Bali suggested that more data on the age question from the ICMR can be shared with states before the next meeting.

4. Presentation on trends in Assam

Dr Desai presented the current status of hysterectomies and other surgeries among women in the state. Among women 40-49 in age, 3.4% have undergone hysterectomy, and Assam is one of the low prevalence states of the country, national average being 10%. The Kamrup district (where the state capital Guwahati is located) reports 9% hysterectomy prevalence. Most hysterectomies happen in the public sector facilities (77%) in the state. The most common self-reported reason for hysterectomy in the state, like other states is excessive menstrual bleeding. Factors associated with hysterectomy in the state are older age, less education, wealthier households, sterilisation and having had children. C-section rate among births in last 5 years (based on NFHS-5 data) is 18%, 16% in rural Assam and 39% births by C-section in urban areas. Assam has a mCPR of 45% with the most common method of modern contraception being the pill (27%), followed by female sterilisation at 9% in the state. This is in contrast to the national pattern with mCPR at 56% with female sterilisation being the leading choice (38%) followed by male condoms (10%). The national prevalence of the pill if 5%. Hysterectomy is found to be related to hypertension, diabetes, and bone/ joint diseases later in life, (findings based on the LASI 2017 data). Further research is needed to establish this relationship, using a life course approach in women's health.

5. FOGSI Save the Uterus Campaign

Dr Phukan presented the 'Save the uterus' campaign run by the FOGSI on a national level. The campaign aims at averting unnecessary hysterectomies at a national level through raising awareness. The presentation is designed to educate the obstetric and gynaecologists' community in alternate methods of treatments for various medical conditions associated with the uterus. The presentation can be seen here.

6. Setting the Stage for Action

Dr Baruah discussed on how learning from Assam can be taken to other states to limit unnecessary hysterectomies. He congratulated gynaecologists in the state in keeping the rates low. He further shared the concern on how these guidelines can be taken right to the grassroots level and ensure proper implementation. Since medicine is a dynamic field, and critical decisions are not always premediated. Doctors have great responsibility, and sometimes must take many life-saving decisions based on the circumstances. He also mentioned a shortcoming based on his experience that most doctors do not document heavy menstrual bleeding. In the absence of that documentation, proper treatment cannot be chosen. Further, there is low literacy among general women population on details of menstruation. That needs to be rectified by spreading awareness

among women about their bodies, at scale, with the help of the many available resources such as social and print media. He insisted that there must be respect for patients and doctors. Periphery doctors and facilities treat in very challenging conditions and decision making cannot be premediated. Sometimes last-minute hurdles change the situation. Thus, the judgement of the doctor on call must be respected.

7. Panel discussion 1

The panel discussion covered a range of concerns and suggestions from the panellists to strengthen the health system response in Assam to hysterectomy and other gynaecological morbidities. Dr Pallipamula emphasised on meta regulation which entails two components- self-regulation and the top-down regulation. He further recommended adapting the concept of clinical governance from the UK, which includes: (i) following standards, (ii) regular audits, and (iii) regular revision based on dynamic evidence.Dr Monideepa Roy stressed that there is a need to implicitly address the problem by sensitising the medical community and that is not an overnight task. Sensitisation is a process that must be initiated with MBBS students, and the whole process of diagnosis and treatment must be undertaken within the ambits of protocol and sensitivity. Dr Manjima Baishya Ganguly urged the community of gynaecologists to introspect and treat patients with the ethics that they began their medical journeys with. To counsel patients and refrain from unnecessary procedures.
Dr Daksha Parmar presented highlights from a study they are undertaking with FLWs at IIT Guwahati. Initial findings suggest that women face stigma in discussing gynaecological morbidity. FLWs need to be sensitised and made aware of the stigma, taboo and trained to deal with it better in the community. There are inequities among women that need to be accounted for in research and implementation. In Assam, women in Chaur areas especially have poor access to health. They sometimes survive maternal deaths but have other poor health outcomes ahead of them. Boat clinics have been revolutionary in helping maternal death rates and such innovative ideas are much needed to address other morbidities among women. Dr Choudhary highlighted specific concerns with the public health system in Assam.

Unfortunately, supply of simple procedure apparatus is lacking in public sector facilities. e.g., endometrium screening.Women are largely unaware of pap smears and gauging heavy menstrual bleeding etc. which proves to be challenging in diagnosing and treating gynaecological morbidity among women. There must be increased screening for cervical cancers with community-based groups participating and funding support from NGOs and private sector companies. Large bodies such as the IMA, menopause society could come collectively to support the cause. Furthermore, there is need for continuum of care in the system. Women with preeclampsia during pregnancy are at high risk of hypertension at later stages in life, thus follow up, and awareness and continuum of care in such cases will aid timely response.

The moderator, Dr Das, summed the key takeaways from the panel. He shared the concern that India has global 1/4th burden of cancer cervix, and that we could learn from successful strategies from other communities, citing the example of Sikkim where all women are vaccinated for HPV.

8. Group and open discussion

Dr Vora led the discussion which was largely focussed on the guidelines. The discussion that ensued is categorised into three sections here forth: (i) contextual factors that inadvertently may increase unnecessary hysterectomy, (ii) recommendations for updating/ changing the guidelines, (iii) implementation concerns and suggestions

<u>Contextual barriers:</u>

- In rural hospitals, some basic methods are also not available e.g. hysteroscopy

- Some emergency hysterectomies are done due to lack of resources. Thus, before audits, we must individualise the cases. The limiting factors are human resource, blood products, gadgets and apparatus, low education in women.
- Insurance (Ayushmaan Bhaarat) does not cover alternate treatments but covers hysterectomy.
- The hormonal drugs that are alternates to hysterectomy are not available in public facilities.
- Sometimes women insist on hysterectomies. There should be more awareness of tumors etc. (prevent cancer scare) and other treatments available.
- Sometime senior doctors refuse hysterectomies, but junior doctors perform them.
- There should be monitoring committees at district level. Data from private facilities is questionable.

Recommendations for updating/ changing the guidelines:

- What does save the uterus mean for trans people. For them uterus removal is not unnecessary, it is related to gender identity. Recommendation for DGHS to make the guidelines diverse, inclusive, and sensitised.
- The guidelines must separate obstetric and gynaecological hysterectomies. Combining them is risky and can lead to harmful consequences.

Implementation concerns and suggestions

- LNG-IUS should be made free in government facilities (for heavy menstrual bleeding- leading cause of hysterectomy)
- There should be regulation on Bilateral salpingo-oophorectomy (BSO), which is also an often-performed surgery on women. Reporting should be tightened.
- This room of participants must take initiative and pressurise the authorities to mobilise into action. Ask for the state monitoring committee.
- There should be quarterly meetings at medical colleges to review hysterectomies.
- HWCs and PHCs can actively screen and refer.

Round Table on Improving Gynaecological Care to Prevent Unnecessary Hysterectomies in Rajasthan

Round Table on Improving Gynaecological Care to Prevent Unnecessary Hysterectomies in Rajasthan

November 21, 2023, Jaipur

Hotel Holiday Inn, 1 sardar Patel Marg, Jaipur

1.00pm – 2.00 pm	Lunch and Registrations
2:00 pm -2.05pm	Welcome – Chhaya Pachauli: Prayas
2.05 pm – 2.15 pm	Overview: Dr Narendra Gupta : Prayas
2.15pm -2:30 pm	National Guidelines on Unnecessary Hysterectomy: Dr Amita Bali - Dy. Director General, DGHS, Govt. of India & Chair National Committee for IEC & Alternative Treatment Options
2.30pm -2:45 pm	Presentation on Trends in Rajasthan: Dr Sapna Desai
2.45pm- 3.00pm	State Campaigns on Hysterectomy: Dr Lila Vyas - FOGSI, Jaipur
3.00pm-4.00pm	Moderated Panel Discussion on Priorities for Primary, Secondary and Tertiary Care for Prevention of Uterus – alternative treatments Moderators: Dr Pushpa Nagar -HoD, OBGY, SMS Medical College, and President Jaipur Obstetrics & Gynaec Society; Dr Veena Acharya - Rajasthan Hospital, Jaipur
4.00pm-5.00pm	Open Discussion on Implementation of Guidelines and Data Collection Format Moderators: Dr Malti Gupta – Sr. Consultant-Plastic and Aesthetic/Cosmetic Surgery Jaipur; Dr Ranu Patni - Senior Consultant, Gynaecological Oncology, Sri Ram Cancer Centre, MGU of Medical Sciences, Jaipur
5.00 pm	Closing remarks and high tea

Meeting notes

1. **Overview**

Dr Gupta briefly narrated the journey of how the guidelines came into existence and are at the juncture of being implemented across all states in India. In 2013, first reports started coming of rampant hysterectomies in Maharashtra. A group of concerned gynaecologists in Delhi came together to look into the issue, and a few case studies in Delhi revealed that women were advised hysterectomy as a first line of treatment for gynaecological morbidities, that could be treated using more conservative methods. This triggered a PIL with the Supreme court of India with additional supporting evidence from other parts of the country. A national consultation was organised with eminent representatives from the government in Delhi in 2013. The push from these consultations resulted in relevant questions being added to the NFHS-4 (2015-16) to estimate prevalence of hysterectomy in India at the national, state, and sub-state level. Studies have found that about 30% women in India in the reproductive age group have AUB (abnormal uterine bleeding), which is the leading self-reported reason for hysterectomy in India. In 2019, the guidelines were drawn up with consultation from medical practitioners and policy experts. In May 2023, the Supreme Court of India mandated that these guidelines be implemented across all states and UTs in India.

2. **National Guidelines on Unnecessary**

Dr Bali addressed the gathering remotely from Delhi and introduced the guidelines to the sitting audience. She gave a background on the guidelines and discussed their need and importance. She further explained the implementation mechanism as indicated in the guidelines, at the national, state and district levels. She informed the audience that states are currently in the process of forming their state level committees and data from some states has started coming in to ICMR (they will analyse this data). A portal has been set up in the PMJAY website to address grievances related to unnecessary hysterectomies. This will be monitored by NHMC (National Hysterectomy Monitoring Committee). The NHMC was constituted on 26th June under the maternal health division. The committee has powers to blacklist a hospital found in violation of the guidelines with evidence in support (e.g., consent in not taken from the woman, or unnecessary hysterectomies are done). After Dr Bali's address, the following issues were raised by the audience:

- A FOGSI member stated that a campaign 'save the uterus' has been run by FOGSI on a national level since 2019, which includes curbing unnecessary hysterectomies. The guidelines have been prepared with inputs from multiple partners, including FOGSI members, and thus the tenets of 'save the uterus' have been addressed appropriately in the guidelines. FOGSI will continue to actively contribute to the guidelines and their implementation, with suggestions for IEC.
- How will hospitals be blacklisted in practice? If any hospital has been blacklisted so far? Hospitals and practices will be scrutinised based on evidence and data, and any hospital found in violation of the guidelines will be blacklisted by removing them from insurance schemes' coverage.
- How are surgeons being brought under the purview of the guidelines? Surgeons cannot be completely prohibited from performing hysterectomies since in some situations, this may prove counterproductive. For instance, in remote areas, in the absence of a gynae, a surgeon may have to perform emergency hysterectomy.

3. **Presentation on trends in Rajasthan**

Dr Desai presented the statistics related to hysterectomy in the state based on NFHS-5 data. In the age group 40-49, 7% women in Rajasthan have undergone hysterectomy at a median age of 38, compared to the national average pf 10%. Districts with highest prevalence of hysterectomy in the age group 40-49 are Alwar (12.9%), Banswara (12.4%), Sikar (11.6%) and Bharatpur (11.5%). The most common self-reported reason for hysterectomy is excessive menstrual bleeding, followed by fibroids/ cysts. State level analysis to examine the factors associated with hysterectomy using multivariate regression revealed that older age, less education, rural residence, wealthier household, having one or more children, and not having undergone sterilisation are associated with a hysterectomy in Rajasthan. Private facilities are more commonly sought (61% statewide) for undergoing a hysterectomy, in both rural and urban areas, and across wealth quintiles. Analyses of LASI data revealed that a woman with hysterectomy had 1.5 times higher odds of hypertension, 1.7 times higher odds of diabetes, 1.5 times higher odds of bones/ joint diseases when compared with women without a hysterectomy. Further research using the life course approach is required to establish causality in these relationships. In Rajasthan the C-section rate is 10% (All India 21.5%), much higher in urban areas (20%) compared to rural areas (8%). Approximately 42% women in Rajasthan have undergone sterilisation (India- 40%) and is the most common modern contraceptive used in Rajasthan, followed by male condom (14%).

4. **State Campaigns on Hysterectomy**

Dr Vyas focussed on hysterectomy among women, especially from the perspective of Rajasthan. She remarked how the OBGYN community is subject to multiple laws and acts such as the MTP act, PCPNDT act and recently the growing focus on C-sections. Her inference was the attention they draw is a consequence of the essentiality of their work. She further stated how the FOGSI is a large community of about 44,000 doctors and their interests and discussions are wide in range, starting from neonatal health (in consultation with paediatricians), adolescent health (with support from of paediatrics), reproductive health, and further maternal health. She expressed her concern that doctors are also bound by the rights of the patients. Thus, gynaecologists often face a dilemma where women demand an elective C-section or hysterectomy. She highlighted that the 'save the uterus' campaign has been active in the state in the last few years and several events have been

organised to discuss these issues across the state, with several FOGSI members in attendance. She made and honest revelation about the ground reality of OBGYN wherein they have a severe shortage of time to properly counsel patients, especially in cases where women demand a hysterectomy. Her observation of why women undergo hysterectomy is the following:

i. Good riddance (monthly menstruation in women)
ii. Fear of cancer
iii. No other alternatives available
iv. It may get tough in an older age to undergo the surgery
v. Access
vi. One stop solution, reduces follow up
vii. Insurance coverage

A key development is that now hysterectomy is not included in the Mukyamantri Chiranjeevi Swasthya Bima Yojana in Rajasthan.

5. **Moderated Panel Discussion on Priorities for Primary, Secondary and Tertiary Care for Prevention of Uterus – alternative treatment**

The panel was introduced by Dr Veena Acharya who shared her experience on why hysterectomies are common. Women consider the uterus to be only useful during childbearing, and once the desired family size is achieved, uterus is not essential. Sometimes women ask doctors for a hysterectomy and as stated earlier, OBGYN have scarcity of time and unfortunately cannot counsel each patient to the desired level. The panel was categorised by gynaecological ailments (reasons for hysterectomy), discussed one by one and panel members suggested ways that hysterectomies for the said ailments could be reduced.

a) <u>Abnormal Uterine Bleeding (AUB)</u>

- Use of alternate treatments must be encouraged such as LNGIUS, which is widely available
- Excessive menstrual bleeding is indicative of socio-economic status as well- such as BMI, PCOD, etc.
- Counselling is key, to explain to patients that surgery is only the last resort, and multiple alternates are available, but require consistency and follow up.
- Doctors and FLWs at the grassroots level must be included in sensitisation so they do not advise hysterectomy to women unless all other options have been exhausted.
- During counselling, hazards of hysterectomy must be shared upfront. Fear of consequences might be an effective deterrent.

b) <u>Vaginal discharge</u>

- Patients often express fear of cancer
- A big issue of recurrent vulva vaginal discharge among women
- Regular follow ups and counselling is key in adherence to treatments
- Patients need to be explained that vaginal discharge is from the vagina, and removal of uterus will not address the problem
- There must be increased awareness around safe sex, menstrual hygiene, testing of sexual partner(s), STIs and RTIs

c) <u>Fibroids</u>

- Now fibroids are very common among women (30-40% women have fibroids)
- Counselling is key to convince women that hysterectomy is a solution confined to very specific and limited cases. Ordinarily there are less invasive but effective measures available for fibroids.
- Availability of MIRENA in government hospitals will help with treating fibroids. Financial aid by government to fund MIRENA will increase access to MIRENA (it is expensive).
- Gynaecologists are generally of the opinion that general surgeons must be prohibited from performing hysterectomies.

- Regular training of doctors for cysts, AUB is critical in bringing down unnecessary hysterectomies.

d) Cervical lesion

- Pap smear and screenings are critical
- There is need to educate public on HIV, HPV vaccinations
- The NCD program must be separated from the cervical cancer program
- Dr Deepesh Gupta from UNFPA suggested that the field must be demedicalised. In the sense that messages that should be spread must be communicated in easy to understand, commonly spoken language. The fear of audit and functional committees at all levels have great potential in bringing unnecessary hysterectomies down.
- The panel witnessed with a disagreement between a present surgeon (Dr Malti) and a few gynaecologists that whether the surgery can be performed by surgeons. Both sides were advocating for why they must have access to performing the surgery. The argument was a demonstration of the dissent between the two communities of doctors on how the surgery must be performed.

e) Inputs from the public health specialists and government representatives were as follows:

- There is a link between contraception, hysterectomy, and anaemia. Contraceptives like Cooper T and DMPA have an effect on the menstrual cycle of women, but there is no primary health care for heavy menstrual bleeding. There is need and scope for a cadre similar to midwives to address the gap in dealing with AUB and heavy menstrual bleeding (HMB) at the ground level. It has been found that methods like LNGIUS pull up anaemia and act as a better contraceptive than copper-T. Methods like sterilisation must be discouraged since they aggravate HMB. There is a need for protocol and management of AUB at the primary health level.
- A government representative (Rajesh Sharma) on the panel informed of the lack of reporting in health systems. Most statistics are reported from medical colleges and district hospitals. Need for consistency in data management and SOP for various treatments for uniformity across the state. Some districts in Rajasthan have a scarcity of gynaecologists. The Rajasthan government has submitted a PIP that also now includes hysterectomy under the ambit of GBV that is included in the SDG of gender equality. He also suggested that surgeons must be included in this discourse around hysterectomies.

6. Open Discussion on Implementation of Guidelines and Data Collection FormatModerated by Dr. Malti Gupta – Sr. Consultant-Plastic and Aesthetic/Cosmetic Surgery Jaipur and Dr. Ranu Patni - Senior Consultant, Gynaecological Oncology, Sri Ram Cancer Centre, MGU of Medical Sciences, Jaipur

The panel was largely moderated by Dr Patni with collected inputs around how the guidelines can be strengthened. She highlighted the lack of basic facilities in PHCs, and periphery hospitals is concerning. A multipronged solution is required to address grassroot level concerns. The concerns and issues are multifaceted, and include lifestyle factors, gender inequality at the household level, economic factors, time shortage with doctors and dynamics of household decision making. Guests on the panel had the following inputs:

- Doctors should be sensitized at the PG level. That will ingrain a sense of responsibility at an early level.
- A major challenge among alternate treatments is follow up. Doctors must be trained to keep patients motivated to follow up regularly as asked by the doctor.
- Shortage of supplies in peripheral facilities is a major challenge, but it can be resolved by bringing to attention of appropriate authorities.

- Some solutions have proved to be instrumental in preventing hysterectomies in case of PPH.
- A real-life challenge is when mentally challenged girls are brought to doctors for a hysterectomy, since they are unable to manage their menstruation, and also puts them at other risks. Some doctors suggested that they still manage to convince families against hysterectomy, and MIRENA is a successful alternative in such cases.
- A panellist suggested that in the reporting structure suggested at the hospital level, there should be column for referral from (to indicate where the patient got information for the current facility).
- Law implementation (like was done with PCPNDT) will deter doctors from performing unnecessary hysterectomies.
- There must be provision for (a minimal) punishment for doctors in the guidelines.
- There could be an advisory board/ committee at the district level to suggest whether to go ahead with a hysterectomy in some doubtful by high-risk cases (especially cases< 40 years).
- Women come to big hospitals after consulting at multiple places and are determined for a hysterectomy by then (based on some earlier advises). Thus, doctors and FLWs must be trained at all levels to not suggest a hysterectomy hastily. Women are especially very comfortable with ASHAs and ANMs to discuss gynaec problems, thus this cadre is key.
- Data collection in private facilities level must be monitored and implemented strictly.
- At the public facility level, an online portal could be established to ease data uploading process.
- Media campaigns for screening, menstrual hygiene etc. will be very useful
- In the data collection form, we could also add the education level of the women into the background characteristics.
- There is dire need for communication and linkage between all levels of health systems (primary, secondary, tertiary). Telemedicine is an example that can provide this linkage. There is strict need for SOPs to uniformalise procedures and treatments adopted across the state. Audit may be a strong term, there could be a preliminary review (peer review) at the facility level for hysterectomies that would encourage doctors to adhere to SOPs. Review meetings should be hosted every 6 months to regularly review data.
- Campaigns and education can be introduced at the community level, which may include posters, poems, ANM group discussions, school health education programs, etc.
- There must be trainings for new PGs and older gynaecologists to bring everyone up to speed with the guidelines and SOPs.
- New technologies like uterus transplants must be introduced.
- Keeping ovaries intact is important, if possible. And efforts must be taken to do so.
- Women need to be educated how removal of ovaries which results in early menopause results in visible ageing. That will discourage them, to voluntarily ask for hysterectomy.
- Rajesh Sharma summed up the second panel as well. He announced that PIPs have been submitted and shortage of supplies at all levels will be taken care of. Grassroots level trainings are important and will be designed in large consultations and will be implemented. The Ayushmaan Bhaarat digital card has started and is slowly being rolled out in all of Rajasthan.
- IEC in newspapers, in simple language will be very helpful in creating awareness among women, and men.

Roundtable on Gynaecological services and surgeries in Punjab

Roundtable on Gynaecological services and surgeries in Punjab

November 30, 2023

Hotel Shivalikview, Chandigarh

04:30 pm - 05:00 pm	Tea/coffee and registrations
05:00 pm – 05:10 pm	Welcome – Chhaya pachauli - Prayas
05:10 pm – 05:20 pm	Objectives of the round table- Dr. Narendra Gupta,
05:20 pm - 05:25 pm	Overview on the need for improving gynaecological care andprevention of unnecessary hysterectomies. Dr. Vanita Suri, Professor and HoD, Dept. of Gynae., PGIMER
05:25 pm - 05:55 pm	National Guidelines for preventing unnecessary hysterectomiesDr. Amita Bali Vohra, DDG, DGHS, MoHFW, Govt. of India
05:55 pm – 06:10 pm	Presentation on trends in hysterectomy in PunjabDr. Sapna Desai, Senior Fellow Population Council Institute, New Delhi and Member National Subcommittee on IEC and Alternative Treatments for Hysterectomy
06:10 pm – 07:00 pm	Panel discussion on priorities for prevention of unnecessaryhysterectomies at primary, secondary and tertiary care Chair: Dr. (Ms.) Umesh Jindal, Director, Jindal IVF, Chandigarh Dr. S.C.Saha, Professor, PGIMER, Chandigarh Dr. Poonam Goel, HoD, Govt. Medical College, Sector 32, Chandigarh Moderator : Dr. Madhu Gupta, Professor, PGIMER, Chandigarh Panellists: Dr. Inderdeep Kaur, State Program Officer, Maternal and Child Health, Govt. of Punjab Dr. Geetanjali Kaur, North India, FOGSI Dr. Parneet Kaur, Professor and HoD, Obgy., Govt. Medical College, Patiala Dr. Yashbala, President COGS and Director, ObsGyn, Cloudnine Hospital,Panchkula Dr. Sunita Agarwal, Associate Professor, Govt. Medical College, Patiala
07:00 pm – 07:15 pm	Reflections and priorities

	Dr. Shalini Singh, Director, ICMR-NICPR (National Institute for Cancer Prevention and Research), New Delhi
07: 15 pm - 07:55 pm	Open discussion on implementation of national guidelines to preventunnecessary hysterectomies. Moderators: Dr. Minakshi Rohilla, Professor, PGIMER, Chandigarh Dr. Snigdha Kumari, Associate Professor, PGIMER, Chandigarh
07:55 pm – 08:00 pm	Vote of thanks- Chhaya Pachauli, Prayas
08:00 pm – 09:00 pm	Dinner

Meeting notes

1. **Overview**

Dr. Gupta welcomed the gathering and highlighted the importance of both doctors and public health researchers. Both public health experts and clinicians each have a unique role in health systems. While doctors deal with individual cases and patients, public health practitioners look at the larger picture of how doctors, patients, and systems interact. Introducing the topic of hysterectomy to the audience, Dr Gupta spoke on his initial experiences with women who had undergone a hysterectomy. Women narrated that their morbidities and concerns that led them to undergo uterus removal were still unresolved and their quality of life had otherwise deteriorated. Upon detailed fact finding, it was found that many of these hysterectomies were unnecessary and/ or the hysterectomies were done poorly and were incomplete. Similar findings emerged from other states.

A national consultation with health and policy experts was organised in 2013. So far, there was no official national level data on hysterectomy, but discussions that started in this consultation led to a question being added to the upcoming NFHS-4 in 2015-16. Evidence presented in this consultation showed that women in India were undergoing pre-menopausal hysterectomies whereas women in the west such as USA were undergoing post-menopausal hysterectomies (between ages 52-54). These revelations triggered important conversations around hysterectomy in India.

NFHS-4 found that the median age for hysterectomy in India was around 34. Findings from NFHS-5 found similar trends and statistics. One interesting pattern from these national level data are that there is wide variation in distribution of prevalence of hysterectomy across states in India. Another national level consultation was organised in 2018 to reflect upon data and it was then decided that guidelines to prevent unnecessary hysterectomy in India must be drawn out. After the PIL in the supreme court in 2013, finally in 2023, the Chief Justice of India endorsed the guidelines and mandated the guidelines to be implemented across the country. Currently, the challenge ahead of us is to implement the guidelines with efficiency and establish link at various levels of health systems.

2. **Overview on the need for improving gynaecological care and prevention of unnecessary hysterectomies*Dr Vineeta Suri, Professor and HoD, Dept. of Gynae., PGIMER***

Dr Suri kept her piece brief and emphasised that we must define unnecessary hysterectomies to begin with, in order to prevent them. She highlighted that women know very little about their bodies, their reproductive system, and the role that each organ plays. There is widespread taboo around menstruation, unnecessary fear of cancer among women and very little cancers screening among women. Women need to be educated that the uterus is an essential organ and has functions beyond childbearing. The ovaries serve as pockets of hormones that are essential to leading a life of quality. She further advised that doctors must be trained and updated with new techniques and alternate treatments for gynaecological morbidities so use of hysterectomy can by limited for only critical cases where no other treatments work. Guidelines like the ones being discussed should be

adopted and implemented with rigour. Her leaving message was that the ovaries and uterus are essential for women to maintain their womanhood and removing them upsets the anatomical balance that nature has so beautifully established in a woman's body.

3. **National Guidelines for preventing unnecessary hysterectomies**

Dr Singh from ICMR virtually presented the guidelines to prevent unnecessary hysterectomy in India. She gave a background on how the guidelines came into existence- the PIL to the Supreme Court with special focus from Andhra and Telangana. So far, a letter has been sent to all states to encourage them to adopt the enclosed guidelines. A portal has been set up in the PMJAY website to address grievances related to unnecessary hysterectomies. This will be monitored by NHMC (National Hysterectomy Monitoring Committee). The NHMC was constituted on 26th June 2023 under the maternal health division. The committee has powers to blacklist a hospital found in violation of the guidelines i.e. when consent in not taken from the woman, or unnecessary hysterectomies are being done. Further, states and districts must collect data in a prescribed format on hysterectomies done and details on indications, post operative care etc. Women will also be followed up to understand the aftereffects of hysterectomy. DGHS urges the support of FOGSI in the state. There was discussion among audience regarding nuances in implementation and suggestions from the audience. The following points were raised:

- Private sector doctors assured that data from private facilities will be regularly shared and updated with ICMR.
- A doctor suggested that AI has evolved immensely and is being successfully used to run interventions via FLWs for safe delivery. Something similar can be done for hysterectomy at the grassroots level.
- Doctors in general agreed that women at large need to be educated and IEC material will be instrumental in doing so. The material must be simple and must have reach to the masses.
- Doctors also revealed that they find it very difficult to convince women to get pap smear tests.
- Sonologists, it was revealed by gynaecologists, in particular sometimes make hasty announcements regarding findings from ultrasounds. They may prematurely diagnose a tumor which convinces a woman to undergo hysterectomy despite what a gynaecologist might have to suggest.
- Laparoscopic training schools have somewhat of a scheme wherein they invite large number of women to get hysterectomies at a cheaper price in camps so as to practice the procedure.
- A participant suggested that ultrasound sonologists, anaesthetists and surgeons together make a combination that needs to be closely monitored so as to reduce unnecessary hysterectomies.
- A practitioner from Bathinda shared a commentary from his experiences. In his experience, most unnecessary hysterectomies are done either by young doctors for practice, or by surgeons and doctors from other departments for monetary gains. There is a network of referrals for gynaecological morbidity on ground where an ASHA/ ANM gets a cut from each referral to the nearest surgeon for a hysterectomy. Further, there a split share agreement between surgeons, anaesthetists, and sometimes quacks (convincing women) for each hysterectomy performed.
- The guidelines are written in a manner where only gynaecologists can benefit from them. They must be adapted to MBBS level practitioners who are not trained in gynaecology.
- The ANM have been advised to refer to gynaecologists but there is sometimes an existing agreement between ANMs and surgeons. How do these guidelines propose to override this transaction. Any punitive action?
- A few doctors strongly suggested that surgeons must be prohibited from performing hysterectomies if we really want unnecessary surgeries to be prevented.
- MCI guidelines must be implemented diligently and all practices including hysterectomies must be scrutinised in accordance with these guidelines only.

- A senior private practitioner advised the room to think more in the direction of women's health at large. Preventing unnecessary hysterectomy is one component to maintaining a woman's health, with other key practices also lacking such as prevention of osteoporosis and early menopause, regular mammography, bone density, pap smear, LNG-IUS, etc. Saving women's health has greater importance than saving the uterus. The courts have no role in regularising gynaecologists since these are conscious doctors and cognizant of their ethics and responsibilities.
- One senior doctor asked what the target prevalence of hysterectomy in India is? given that states in India present such large variation in prevalence. The answer unfortunately is not as direct. Every case must be individualised, and a hysterectomy should only be performed when all other alternatives have been exhausted. Thus, a target prevalence cannot be quantified. Clinical governance must prevail, and the doctors decide the best decision for each patient.
- The MCH state program officer shared her experience, being from Gurdaspur which was once infamous for being the C-section capital of the world (100% C-sections). She proudly announced that so far 8500 midwives have been trained across the state under the new midwives training program. She did however request that LNG-IUS must be introduced in government facilities where Copper-T is the current practice but is also admitted the ill-feasibility because of the high cost associated with the device.
- Women mostly have a multitude of issues such as NCDs, PCOD, prediabetes, and other lifestyle concerns such as obesity, lack of physical activity., stress, etc. but unfortunately, the reproductive systems bears the brunt. There needs to be greater understanding that hysterectomy will not solve many or most of these problems, and they may persist after a hysterectomy. There is a need for understanding of women's health in greater detail.
- Need for large public campaigns and IEC material targeted at reducing hysterectomies by advertising the fact that hysterectomy is not the only solution for gynae morbidities and women must stop asking for hysterectomies and let the doctor advise and try alternate methods.

4. Presentation on trends in hysterectomy in Punjab

Dr Desai presented trends and statistics on hysterectomy from Punjab. Punjab was a state with one of the highest prevalence among 50+ women, with about 24% prevalence. The trend however, has been on the decline with lower prevalence in the age group 40-50 and lower still among women 30-40. Districts with high prevalence of hysterectomy are Mansa, Bathinda, Fatehgarh sahib and Sangrur. Excessive menstrual bleeding and fibroids/ cysts are the most common self-reported reasons for hysterectomy. Older women, with less education, and rural residence are at greater odds of hysterectomy in the state. About 57% hysterectomies are in private facilities, with similar patterns in both rural and urban areas, and across wealth quintiles. Punjab has a C-section rate of 39% and about 23% women have undergone sterilisation. Female sterilisation and male condoms are equally prevalent choices for contraception among married women.

5. Panel discussion on priorities for prevention of unnecessary hysterectomies at primary, secondary and tertiary care

The panel discussed feasible methods to curb unindicated hysterectomies in the state at the primary, secondary and tertiary levels of care. The following points came from the panel:

- Dr Kaur, State Program Officer, MCH announced that the state has already formed a state committee as recommended by DGHS, wherein surgeons were also intimated of the new guidelines. All districts have been informed and are willing to participate in the implementation of these guidelines. The challenge they foresee is community engagement and producing and campaigning the right IEC across the state. She also highlighted that for women, unfortunately preventive health care is not a priority. They would rather spend their money elsewhere than allocate on this front. That is where the mentality of the community is a hurdle to ensuring better women's health.
- One panellist highlighted that the ANM and ASHA cadre is already overburdened. They are already at the forefront of many interventions. There is need for a new cadre of counsellors especially with many counselling interventions in the pipeline such as mental health, post-partum care, adolescent health. Thus, a new cadre trained for counselling is the need with clear responsibilities pre-outlined.
- Many doctors have argued in favour of making the use of LNG-IUS more common and introducing it into the public facilities. Some have gone to the extent of suggesting that putting in the device must be the first course of action, especially in cases of AUB.
- One doctor suggested removing coverage for hysterectomy under insurance schemes to limit rampant hysterectomies.
- Doctors expressed concern with the audits wherein they feel that private sector doctors are subject to bias and prejudice in scrutiny (based on experience*).* Their concerns rise form the subjectivity and the flexibility that the panel of auditors bring to the process, in absence of clear definitions and processes. (*The audits, however, are only in place for course correction, and not for punitive actions.)*
- A panellist suggested added a column to the data form: 'who did the original diagnosis' to better inform the referral network.
- A consensus was seen building around the argument that in the end, the answer to this very complex public health problem is ethical, knowledgeable, moral doctors and further deliberation is needed to study the problem in detail.

6. **Open discussion on implementation of national guidelines to prevent unnecessary hysterectomies**

Dr Rohilla and Dr Kumari summarised the suggestions gathered throughout the evening and presented their data collection methods at PGIMER. They further presented statistics from the hysterectomies in PGIMER in the last quarter (July- October 2023). Most hysterectomies were gynaecological, done abdominally, mostly of women above 50, followed by women between 40-50. Most hysterectomies of women <35 years were obstetric, without USO/ BSO. She did mention that fewer C-sections would eventually lead to fewer hysterectomies (for medical reasons) and that at PGI, medical management is preferred over surgical interventions for gynaecological morbidities.

Round Table on Improving Gynaecological Care to Prevent Unnecessary Hysterectomy in Telangana

Round Table on Improving Gynaecological Care to Prevent Unnecessary Hysterectomy in Telangana

December 8, 2023

Hotel Green Park, Hyderabad

10:30 am	Tea/coffee and registration
11:00 am	Welcome and Overview Dr Narendra Gupta, Prayas
11:15 am	National Guidelines on Unnecessary Hysterectomies Dr Amita Bali Vohra, Dy Director General, Directorate General of Health Services, Govt of India Presentation followed by Q/A and discussion on guidelines
12:00 pm	Presentation on trends in Telangana and Andhra Pradesh Dr Sapna Desai, Senior Fellow, Population Council Institute
12:15 pm	Priorities in Telangana: Panel Discussion Dr Padmaja, Jt Director (MHN), CHFWTS Dr P Malathi, MGMH, Petla Burz Dr D Rajyalakshmi, GMH, Sultan Bazaar Dr Sharmila, Gandhi Medical College Dr Aruna Suman, FOGSI Dr G Rajeshwari, Nilofer Children's Hospital Moderator: Dr Ambuja Choranor, Vice President, FPA India
1:00 pm	Lunch
2:00 pm	Alternatives to Hysterectomy Dr Rathnamala Desai, President FPA India
2:15 pm	Small group discussions on: • Treatment alternatives: implementation priorities • Monitoring and audits • Health interventions for women with early hysterectomy • Community engagement, capacity building and IEC priorities
3:00 pm	Panel Discussion: Group Presentations Reflections: Dr E Revathi, Director, CESS Dr Ashish Martin Chauhan, IMA Dr L Kiranmayi, Academy of Family Physicians India
3:45 pm	Closing Remarks, Dr Amita Dhanu, Dy Director General, FPAI Followed by Tea/Coffee
4.00 pm	Vote of Thanks - Mr Bharath Bhushan, CARPED

Meeting Notes

1. **Welcome and Overview**

Dr Gupta narrated his experiences in studying women's health. In India, women's health has largely meant maternal health, with their bodies considered agents of childbearing. A book 'Our bodies our health' inspired him to see how globally, women are at the backfoot of benefiting from clinical research and therapeutics, and there is urgent need to look into women's health more holistically. In 1989, in Gadchiroli, Maharashtra, one of the first studies with women revealed that about 89% women had recognisable and identifiable gynaecological morbidities, yet they went unattended. Further, in 1994, the ICPD Cairo conference was a landmark event in the journey towards recognising women's health. The Beijing conference furthered this agenda and the RCH program in India was established. This program culminated into the addition of STI/ RTI identification and management and included into the NRHM, where currently it is called the RMNCH+A program.
PRAYAS entered this area in 2013, when large number of women in a district of Rajasthan were found to have undergone hysterectomies. Upon interviewing these women, some concerning facts were uncovered: women approached doctors for gynaecological morbidities and were advised hysterectomy as a first line of treatment. Doctors in private facilities mostly, counselled women that if their aspired family size was achieved, then to prevent cancers, hysterectomy was the most viable option for them.
A PIL was filed in 2013 to prevent unnecessary hysterectomies, based on evidence gathered from other parts of the country, but with similar stories. The journey to the draft guidelines came into 2023 when the Supreme Court made it mandatory for all states to adopt the guidelines, despite health being a state subject.

So far evidence gathering and state level consultations with gynaecologists and public health experts have been very informative. Some of the common challenges across geographies are that gynaecologists enter the treatment pathway at a much later state, wherein women are already committed to undergoing a hysterectomy based on earlier consultations with other practitioners. Thus, there is need to address the problem at the primary level wherein unfortunately lack of resources and services sometimes leads to a hysterectomy advise much earlier than should be.

2. **National Guidelines on Unnecessary Hysterectomies**

Dr Bali addressed the audience in person in Hyderabad. She started her presentation with a background to the concern. How poor and marginalised women have been targeted for unindicated hysterectomies, getting insurance coverage under RSBY. Women in the age bracket 28-36 were undergoing hysterectomy, a worrisome trend, unique to India. The government has mostly been focussed on maternal health, obstetrics, prenatal care, pregnancy, and postnatal care among women. There are scant resources left for discourse on other important aspects of women's health. Women on the other hand are hesitant in discussing gynaecological issues, even within their houses, with husbands or even doctors. This acts as a huge deterrent in care seeking among women. These cultural taboos and inhibitions are a key area that needs to be addressed in improving gynaecological care among women in India.

The current status of the implementation of the guidelines is that the DGHS has so far received data from 3 states and is awaiting data from remaining states. The DGHS is inviting ideas for IEC material that is accurate and is attractive (*Beti Bachao Beti Padhao*, for example). IEC is key in developing awareness among the masses, especially adolescents on concerns such as discharge, spreading the word that hysterectomy must only be the last resort, after other alternatives have been exhausted, and what aftereffects can be expected after the surgery, thus women can make an informed decision. There is a grievance portal for hysterectomy under PMJAY that is managed by the national committee. She shared a few examples from select states such as Chhattisgarh, Bihar etc. on grievances around hysterectomy and action steps taken in certain parts of these states.

There was great participation and discourse from the audience after the presentation:

- Medical records are not maintained properly, and informed consent is not taken in some cases. As medical professionals, caution must be exercised to avoid such oversights.
- Some doctors are conditioned to suggest hysterectomy hastily and avoid procedures such as speculum examination. A doctor shared an example where an examiner during a viva, asked for treatments for chronic cervicitis and shunned a student that suggested conservative methods, and jumped in suggesting hysterectomy as the answer.
- Doctors shared a concern where women come in determined for a hysterectomy and are ready for the repercussions that may follow the procedure. They further requested if a column can be added to the data form to indicate something like a 'maternal request' as in C-sections. Further, there is a lack of 'continuum of care' ethos.
- Doctors from less equipped facilities voiced their personal experiences that unfortunately some hysterectomies have to be performed because of lack of apparatus and resources needed for conservative treatments.
- Some participants were willing to get further trained in new techniques available but are not aware of the procedure to upgrade their education in the field and procedural trainings. Senior doctors suggested that personal motivation and drive is the answer to seek further education.
- Is there a structure prepared for counselling patients?
- Doctors stated that the principle of continuum of care starts by preventing repeated C-sections, especially primary C-sections. Doctors must get regular trainings to stay updated.
- LNG-IUCD has been claimed to be revolutionary in managing heavy menstrual bleeding and must be largely available in facilities, including government facilities.
- A long-standing issue is that patients are not aware, thus insist on hysterectomies, and doctors are too busy to spend the time needed to counsel every woman. Further, some doctors market the idea to women who come for sterilisation that even after sterilisation, heavy menstrual bleeding won't be addressed, thus hysterectomy is a one stop solution.
- Is the government making any rules to make pap smear tests mandatory? ICMR will analyse the incoming data and take appropriate decisions.
- There were concerns that the data form is too long, and doctors are not able to fill them in. They need some training to fill the forms. They further asked what specific steps the GoI will take to ensure implementation of the guidelines till the last intended mile.
- Participants suggested that once the monthly reporting is mandatory, numbers will start coming down for unnecessary hysterectomies.

- Doctors showed great faith in IEC material. They have confidence that like HIV transmission was greatly reduced by IEC, it will have an impact on unindicated hysterectomies. The IEC material must be informed from grassroot level concerns and barriers to address the context well.
- Another observation shared by many doctors is that it's the surgeons who are majorly responsible for performing surgeries on several women they have no case history of.
- One participant shared her experience of conducting a study in 2009 with a sample of 1100 women on consequences of hysterectomy. Key recommendations from the study were steering committees at the mandal level, have participation from the civil society organisations and they should drive the IEC material.
- ASHA and other FLWs are key to motivating women in the correct direction.
- Many participants showed faith in strict implementation of the guidelines, wherein each case must be audited and monitored. Doctors must be trained and must campaign 'save the uterus'. Further, hysterectomies should be removed from insurance coverage schemes.
- Hysterectomies are an income source for RMPs, since women are ready to undergo the surgery assuming the organ is vestigial after intended childbirths.
- Some hysterectomies are done for cultural/ religious reasons. Agricultural workers in turmeric fields do not visit the fields during menstruation due to the fear that they are impure (and turmeric is a sacred article). Thus, hysterectomy is a welcome solution.
- Punitive action will be helpful in making an impact.
- Mindset of women is a difficult characteristic to change.

3. **Presentation on trends in Telangana and AndhraPradesh**

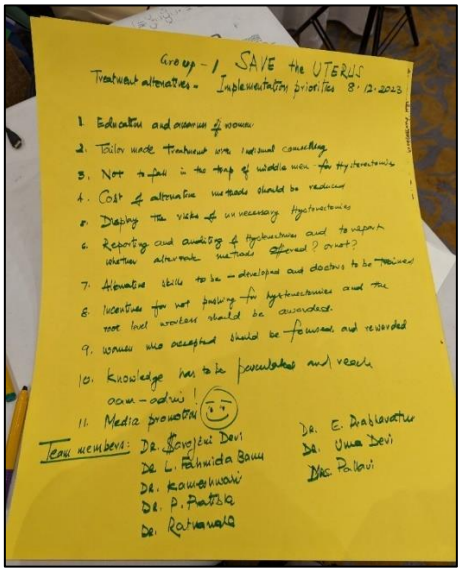
Dr Desai presented statistics on hysterectomy from the state of Telangana, and Andhra Pradesh. Andhra Pradesh and Telangana have the highest prevalence of hysterectomy in the age group 40-49 (one in 5 women have undergone a hysterectomy by age 50), and Andhra Pradesh has the highest prevalence among women aged 50+ of 22%. The median age at hysterectomy in both states for women who have undergone hysterectomy by 50 is 34 years, about 10 years before natural menopause. The highest prevalence in Telangana is reported from the districts of Warangal rural (36.3), Suryapet (31.4), Karimnagar (30.7) and Jangoan (29.7). From Andhra Pradesh, high prevalence districts are Guntur (34.8), West Godavari (31.8), and East Godavari (30.2). The leading self-reported reason for hysterectomy in both states is excess menstrual bleeding, followed by fibroids/ cysts. Results from multivariate regression find that factors associated with hysterectomy are older age, less education, rural residence, wealthier households, and not undergone sterilisation. More than 80% hysterectomies are in the private facilities, and this trend is seen in both rural/ urban areas, and across wealth quintiles. Andhra Pradesh and Telangana have a C-section rate of 42% and 61%, respectively. Female sterilisation is the most prevalent contraceptive method in both states with 62% women in Telangana and 70% women in Andhra Pradesh having undergone sterilisation. New evidence from around the world has linked early hysterectomy to hypertension, diabetes, osteoporosis, and a new study from Sweden suggests even mortality is linked to early hysterectomy.

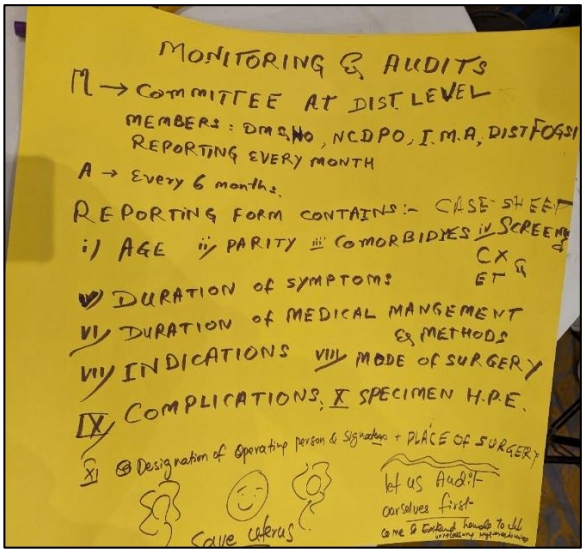
4. **Alternatives to Hysterectomy**

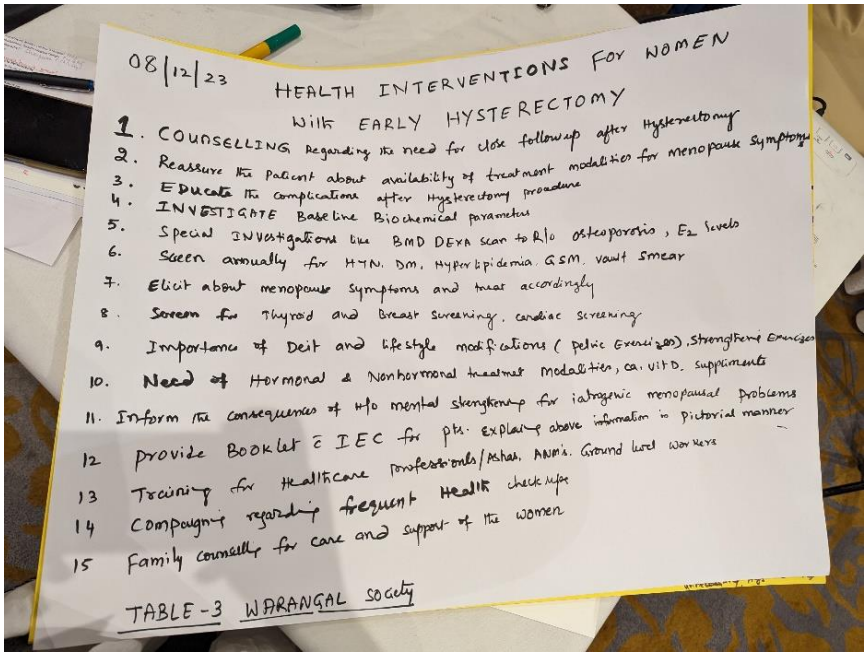
Dr Ratnamala gave a presentation for the gynaecology specialists sitting in the audience. The presentation detailed out new techniques that are alternative to hysterectomy, classified by morbidities. She mentioned that LNG-IUS which is championed by many doctors, is eligible for continuous use for 7 years before it needs replacement, as new studies suggest. Dr Bali said that the government is trying to introduce LNG-IUS in public health facilities.

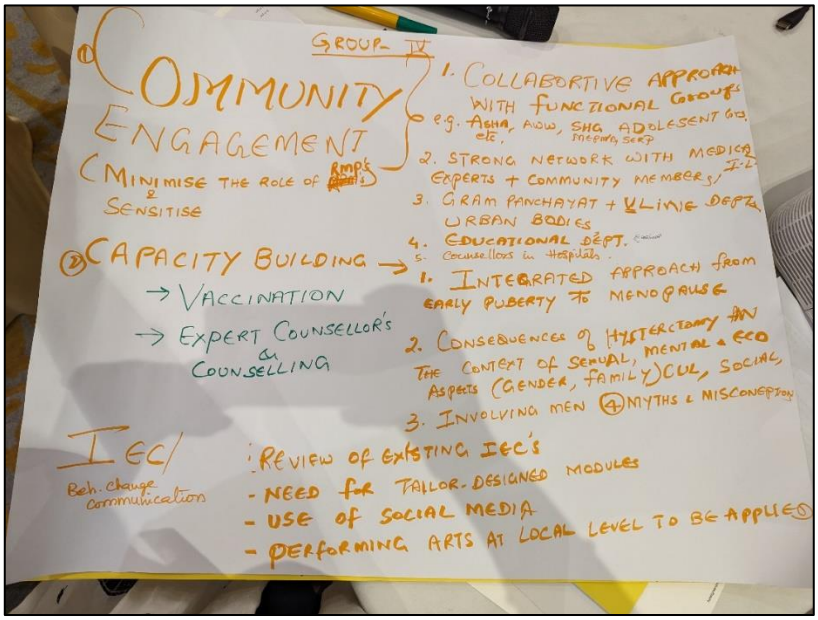
5. Group discussions

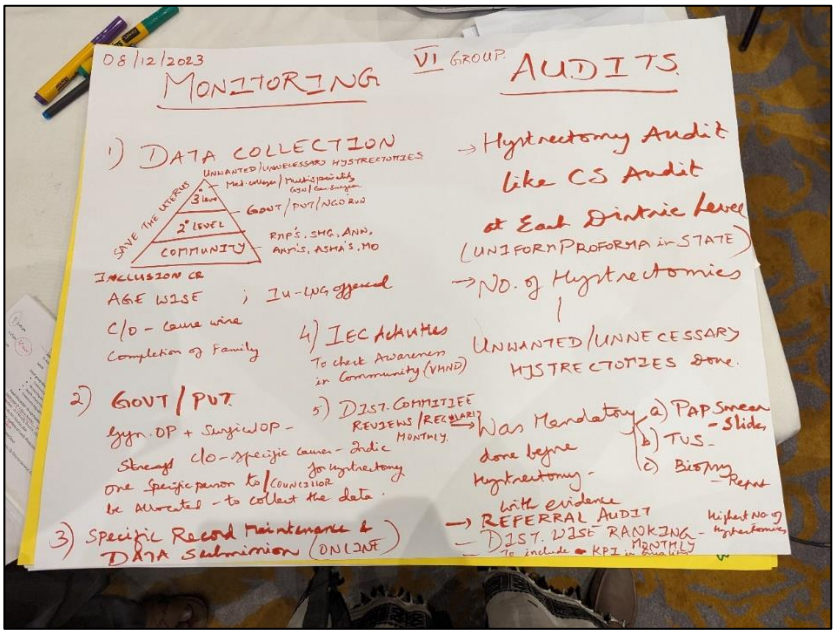
All participants were divided into 5 groups, and each given a topic with about 10-15 minutes for discussion. Innovative solutions came from each theme. The results are as follows:


Group - 1 SAVE the UTERUS
Treatment alternatives - Implementation priorities 8.12.2023
1. Education and awareness of women
2. Tailor made treatment with rational counselling
3. Not to fall in the trap of wildly used term Hysterectomy
4. Cost of alternative treatments should be reduced
5. Display the risks of unnecessary Hysterectomies
6. Reporting and auditing of Hysterectomies and to report whether alternate methods followed? or not?
7. Alternative skills to be developed and doctors to be trained
8. Incentives for not going for Hysterectomies and the non level workers should be awarded.
9. Women who accepted should be followed and rewarded
10. Knowledge has to be percolated and reach common - ordinary
11. Media promotion
Team members: Dr. Sarojini Devi
Dr. L. Rehnida Banu
Dr. Kaweshwari
Dr. P. Prathiba
Dr. Rathnavalli
Dr. E. Prabhavathi
Dr. Uma Devi
Dr. Pallavi


MONITORING & AUDITS
M → COMMITTEE AT DIST LEVEL
MEMBERS : DMHO, NCDPO, I.M.A, DISTFOGSI
REPORTING EVERY MONTH
A → Every 6 months.
REPORTING FORM CONTAINS :- CASE SHEET
i) AGE ii) PARITY iii) COMORBIDITES iv) SCREENING CX & ET
v) DURATION of SYMPTOMS
vi) DURATION of MEDICAL MANGEMENT & METHODS
vii) INDICATIONS viii) MODE of SURGERY
ix) COMPLICATIONS, x) SPECIMEN H.P.E.
xi) Designation of Operating person & Signature + PLACE of SURGERY
Let us Audit ourselves first
Save uterus


08/12/23 HEALTH INTERVENTIONS FOR WOMEN
WITH EARLY HYSTERECTOMY
1. COUNSELLING Regarding the need for close follow up after Hysterectomy
2. Reassure the Patient about availability of treatment modalities for menopause symptoms
3. EDUCATE the complications after Hysterectomy procedure
4. INVESTIGATE Baseline Biochemical parameters
5. Special INVESTigations like BMD DEXA scan to R/o osteoporosis, E2 levels
6. Screen annually for HTN. DM. Hyperlipidemia. GSM. vault Smear
7. Elicit about menopause symptoms and treat accordingly
8. Screen for Thyroid and Breast screening. cardiac screening
9. Importance of Diet and lifestyle modifications (pelvic Exercises), Strengthening Exercises
10. Need of Hormonal & Non hormonal treatment Modalities, Ca. Vit D. supplements
11. Inform the consequences of H/o mental strengthening for iatrogenic menopausal Problems
12 provide Booklet & IEC for pts. Explaining above information in pictorial manner
13 Training for Healthcare professionals / Asha. ANM's. Ground level workers
14 Campaigning regarding frequent Health check ups
15 Family counselling for care and support of the women
TABLE-3 WARANGAL Society





6. Closing remarks

The closing remarks largely summed that self-regulation and medicine with ethics is the answer to curbing unindicated hysterectomies in the state.

Access to Rational Treatment for Gynaecological Morbidities & Prevention of Unnecessary Hysterectomies in Karnataka

Access to Rational Treatment for Gynaecological Morbidities & Prevention of Unnecessary Hysterectomies in Karnataka

18th December 2023

St. John's Medical College (SJMC), Bangalore

12.30 pm - 1:30 pm	Lunch and registration
1:30 pm – 1:50 pm	Welcome: Dr. Shashikala Karanth, Professor & HOD Dept of OBG SJMCH Director, St. John's National Academy of Health Sciences; Rev. Fr. Jesudoss Rajamanickman Dean, St. John's Medical College, Dr. George Dsouza Dr. Ravindranath Meti, District Health Officer, Bengaluru Urban Other Dignitaries
1:50 pm – 2:00 pm	Background and Overview of the Roundtable Dr. Narendra Gupta, Prayas
2:00 pm - 2:05 pm	Human Dignity & Integrity of Body Parts Rev. Dr. J. Chales Davis Associate Director SJMC
2.05 pm – 2.20 pm	National Campaign on Preventing Unnecessary Hysterectomies – a FOGSI initiative. Dr, Hema Divakar, Former FOGSI President
2:20 pm – 2:35 pm	Preserve the Uterus: Awareness and improving gynecological care and prevention of unnecessary hysterectomies. Dr. Shashikala Karanth, Professor & HOD Dept of OBG SJMCH
2:35 pm - 2:45 pm	Public Health and Women's Health Perspectives Dr. Thelma Narayan, SOCHARA
2:45 pm – 3.00 pm	Presentation on trends in hysterectomy in Karnataka Dr. Sapna Desai, Senior Fellow Population Council Institute, New Delhi and Member National Subcommittee on IEC and Alternative Treatments for Hysterectomy
3.00 pm – 3:15 pm	National Guidelines for Preventing Unnecessary Hysterectomies Dr. Rupali Roy, Asst. DG, DGHS, MoHFW, Govt. of India
3:15 pm – 03:25 pm	Data Driven Mentorship Program for Reduction of Unnecessary Hysterectomies. Dr. P S Balu, Chitradurga
3.25pm – 3.35pm	Young Voices – To prevent unnecessary hysterectomies. Senior Residents / PG SJMCH
3:35 pm – 3:50 pm	Tea Break & Photo Session

3:50 pm – 4:50 pm	Open discussion on implementation of national guidelines to prevent unnecessary hysterectomies. (Small group discussions) Moderators: Dr. Shashikala Karanth, Professor & HOD, Dept of OBG SJMCH Dr. Vishnupriya KMN, Associate Professor, Dept of OBG SJMCH Vote of thanks Dr. Madhu Swetha Sharma

Meeting notes

1. Welcome and opening remarks

Dr. Shashikala Karanth, Professor & HOD Dept of OBG SJMCH welcomed the gathering and invited her fellow speakers to the dais.

Director, St John's Medical College, addressed the gathering and narrated a personal experience where long before his birth, his own mother was advised a hysterectomy for her gynaecological ailments. She resisted and opted for herbal therapy, and he is testimony to the fact that some hysterectomies are unindicated, and the underlying causes can be treated by alternate methods.

Dr. George D'Souza, Dean, St. John's Medical College spoke on how a large proportion of ailments do not need an intervention, but unfortunately, because interventions are great sources of income, doctors often suggest them despite knowing that less invasive procedures may work for the patient. Thus, to reduce unnecessary hysterectomies, beyond the courts' intervention, doctors must self-regulate and vow to reduce use of unindicated interventions.

Reverand Dr Charles highlighted that the fundamental ethos of the subject is 'dignity'. He emphasized that human dignity is inseparable from human condition. Vulnerability, integrity, and dignity are vital to consider the intrinsic dignity of human life, and of each part of a human being. He quoted that the human body is sacred, and the foetus and the woman must have dignity. The womb is the beginning of life for all and must be given that respect.

2. **Background and Overview of the Roundtable**

Dr Gupta shared his experience having hosted multiple similar roundtables across the country in Assam, Punjab, Rajasthan, and Telangana. This is the 5th roundtable to discuss *unnecessary* hysterectomies. Dr Gupta discovered rampant use of hysterectomies in 2013, when large number of women in a district of Rajasthan were found to have undergone the surgery. Upon interviewing these women, some concerning facts were uncovered: women approached doctors for gynaecological morbidities and were advised hysterectomy as a first line of treatment. Doctors in private facilities mostly, counselled women that if their aspired family size was achieved, then to prevent cancers, hysterectomy was the most viable option for them.

A PIL was filed in 2013 to prevent unnecessary hysterectomies, based on evidence gathered from other parts of the country, but with similar stories. A national consultation with health and policy experts was organised in 2013. So far, there was no official national level data on hysterectomy, but discussions that started in this consultation led to a question being added to the upcoming NFHS-4 in 2015-16. Evidence presented in this consultation showed that women in India were undergoing pre-menopausal hysterectomies whereas women in the west such as USA were undergoing post-menopausal hysterectomies (between ages 52-54). These revelations triggered important conversations around hysterectomy in India. Another national level consultation was organised in 2018 to reflect upon the NFHS-4 data and it was then decided that guidelines to prevent unnecessary hysterectomy in India must be drawn out. After the PIL in the supreme court in 2013, finally in 2023, the Chief Justice of India endorsed the guidelines and mandated the guidelines to be implemented across the country, despite health being a state subject.

The onus is on the medical fraternity to dispel myths that women will not be rid of all their problems, once their uterus is removed. The reality is that new emerging evidence is suggesting that an early hysterectomy in fact has far reaching consequences such as hypertension, diabetes and mental health issues. There is a need to register each hysterectomy being performed and doctors must be themselves clinically responsible. The courts can intervene, but the final responsibility lies with the doctors to curb the menace of unnecessary use of interventions.

3. **National Campaign on Preventing Unnecessary Hysterectomies – a FOGSI**

Dr. Divakar highlighted that currently there is a trust deficit between the community, government and the OBGYN because of unnecessary practices. FOGSI has about 40,000 members and has several campaigns to sensitize doctors on subjects such as rising use of C-sections and hysterectomies. FOGSI is determined to expand its POV on use of 'ART' model.

A in ART stands for 'awareness/ advocacy'. In Tamil Nadu, 15 years ago, Dr Divakar was running a campaign to prevent cervical cancer. To the disbelief of the research team, a large proportion of women screened for cervical cancer did not in fact have a cervix, because they had undergone a hysterectomy, including removal of cervix. Such large-scale insufficiency of information and awareness in the community, including doctors, has resulted in rampant use of hysterectomies. Campaigns are needed to educate women of the current available alternate solutions. Further, this awareness of new available treatments needs to be extended to gynaecologists too and encourage them to attend certifications through peer group channels.

R in ART stands for 'research'. The environment around hysterectomy is such that there is immense push from families to pursue hysterectomy for young women. Further, doctors have been defensive and do not admit that hysterectomy is unfortunately a common practice. There is sometimes a loss of paperwork/ improper documentation therefore they can't trace the women who've had this done. Surprising that even with the advancement in screening / treating of cervical cancer this is used as a first-choice indication for conducting hysterectomies. This is the big data being captured by FOGSI. Clinicians must commit to reporting honest data for their facilities.

T in ART stands for training. OBGYN must go for regular refresher courses and keep up with new research emerging in the field. They must get trained in new methods available for treatments. For example, use of LNG-IUD which has been shown to work in 8 out of 10 cases where a hysterectomy has been advised. Adapting to new techniques such as telemedicine, to address gap in follow ups. Further, IEC materiel is key in educating women at large. Social media is a great platform to reach a younger population.

Dr Divakar's presentation was followed by an interaction with the audience. The following points were raised:

- Government set ups don't have certain treatment components for e.g., LNG IUD, it is also not made affordable in the government health facilities. There is thus a difference in the management protocols and facilities in different setups.

- The role of gynaecologists is to advocate for LNG-IUD, to be more available and reduce the cost as well. We can't only expect private practice to change without advocating for the same in government set-ups.
- Hysteroscopy facility is similarly unavailable in some setups. How effective would tele counselling be for the women in these areas? It is difficult to do the same in govt setups.
- Initial counselling needs to be done by treating doctors and then they should be connecting the women to specialists.

4. **National Guidelines for Preventing Unnecessary Hysterectomies**

Dr Roy gave a background to the guidelines and presented the implementation plan of the guidelines at the national, state and district level. The purpose of the guidelines is: (i) address unnecessary hysterectomies; (ii) monitor the hysterectomies being done; (iii) provide community awareness on hysterectomies; (iv) clinical guidelines on common gynaecological conditions which have emerged as indications. Programmatic guidance is to provide primary, secondary, and tertiary levels with capacity strengthening, referrals, awareness generation. There is a three-tiered monitoring committee structure present at the national, state and district levels. There must be awareness generation with use of existing platforms like Village Health Sanitation and Nutrition committees, Women's Self Health groups, Mahila Arogya Samities, Rogi /Kalyan Samities, PHC, CHC, District Hospitals.
The present status is that states are in the process of forming committees.

The national committee was formed on 26th June 2023, and met for the first time on 25th August 2023. Currently only 5 states have reported forming a state level committee.

5. **Preserve the Uterus: Awareness and improving gynaecological care and prevention of unnecessary hysterectomies**

Dr Karanth started by saying that Awareness on women's health translates to community health. FOGSI and has been running the preserve the uterus campaign targeted at raising awareness of alternative treatments. It has been found that the most common reasons for hysterectomies are:

- Indian women, especially those living in small towns and villages, have poor knowledge of their reproductive health.
- Fear of cancer
- Abnormal uterine bleeding
- Public health insurance
- Relate all somatic symptoms to uterus.
- RMP/GP-Counsel the patient for hysterectomies
- Lack of integrated broadminded approach among doctors
- White discharge PV
- Attitude towards women's health
- Taboo
- Lack of support from family members for follow up.

Further, the hidden harms of hysterectomy include:

- The surgery is often accompanied by removal of ovaries to reduce the risk of ovarian cancer.
- There may be vaginal burning, increased urinary frequency and early onset of menopause.
- Women who have undergone hysterectomy tend to have increased incidence of heart disease (3-fold) and may also show symptoms of osteoporosis in an early age.
- Depression
- Metabolic disorders
- Dementia

- One study looked at risk by age at hysterectomy and found that "Women who underwent hysterectomy at age 35 years had a 46-fold increased risk of congestive heart failure and a 2.5-fold increased risk of coronary artery disease.

There is an urgent need for raising awareness at all levels to prevent unnecessary hysterectomies.

6. **Presentation on trends in hysterectomy in Karnataka**

Dr Desai presented statistics on hysterectomy from the state of Karnataka. Karnataka has a moderately high prevalence of hysterectomy in the age group 40-49 (about one in 10 women have undergone a hysterectomy by age 50). The median age at hysterectomy in Karnataka age 50 is 36 years, approximately 10 years before natural menopause. The highest prevalence in Karnataka is reported from the districts of Davanagere (24.3%), Bagalkot (20.5%), Bijapur (17.5%), Mandya (15.5%). The leading self-reported reason for hysterectomy is excess menstrual bleeding, followed by cervical discharge and fibroids/ cysts. Results from multivariate regression find that factors associated with hysterectomy are older age, less education, rural residence, and not undergone sterilisation. About 55% hysterectomies are in the private facilities, and this trend is seen in both rural/ urban areas, and across wealth quintiles. Karnataka has a C-section rate of 32% and female sterilisation is the most prevalent contraceptive method in the state with 57% currently married women in Karnataka having undergone sterilisation. New evidence from around the world has linked early hysterectomy to hypertension, diabetes, osteoporosis, and a new study from Sweden suggests even mortality is linked to early hysterectomy.

7. **Public Health and Women's Health Perspectives**

Dr Narayan focused on the importance of community health and how it affects public health. The issue of society and women's health forms an intersection between public health and obstetrics and gynaecology. The women's health charter was developed in 2007. It states the State's obligations to promote and protect women's health rights. The ground level reality is very different. Women are still largely seen as bodies bearing wombs. We as privileged women who are educated, employed, and empowered have a responsibility towards other women, both in the role of clinicians and social scientists. She further emphasized that health services should be gender sensitive.

8. **Data Driven Mentorship Program for Reduction of Unnecessary Hysterectomies**

Dr Balu shared learnings from his years of experience of working in HIV and TB and how they can be adapted to reducing unnecessary hysterectomies in the state. The guidelines in their current form must be seen from a public health angle. The need is to promote evidence-based hysterectomies and support gynecological assessment in rural areas using health and AI (as has been done in CA cervix and breast cancer). The urgent need is to reduce unnecessary hysterectomies. At present, there are 2906 heath care facilities run by Karnataka government and 538 private sector hospitals. We must aim to mentor specific sites of interest. These sites must be chosen using an objective methodology across the state, since auditing every facility in the state is not feasible.

The current community risk assessment forms (part of the NCD programme) can be used to reach women in the community to ascertain statistics of hysterectomy in the state. CHOs in Ayushman Arogya Mandirs can directly e-consult gynaecologists to better treat patients at an earlier stage in their treatment journey. Use systems already a part of other state health programs. Clear roles to be created and communicated. The communication to the women can be through counselling hubs, follow up women who would need to undergo hysterectomies and setting up toll-free numbers. District hospital/sites that have high data of hysterectomy done in women less than 40 should be investigated- is it due to the doctors pushing for it or community preference. We must enquire if health insurance schemes are aligning with National guidelines. First the government facilities data should be in alignment and only then we should proceed to the private sector (Google forms for private facilities may be one suggestion, for regular and authentic data updates).

9. Closing suggestions

Here is a summary of thoughts and suggestions that came from the audience:

- The medical fraternity is where the onus of this cause lies. The responsibility must be balanced with autonomy and respect for the field.
- Competent and ethical care is a key role for doctors.
- "If I don't do it someone else will" "we don't want to work for a cause but for ourselves" in response to this we should be saying "I won't do it and won't let anyone else also do it". Doctors need to be whistleblowers among themselves and use platforms such as FOGSI to voice this collective narrative.
- Ethics must be the underlying ethos of medical education.
- Increase access and availability of the drugs recommended in the guidelines at PHC levels as well and to advocate for them, at all levels.

Access to Rational Treatment for Gynaecological Morbidities & Prevention of Unnecessary Hysterectomies in Madhya Pradesh

Access to Rational Treatment for Gynaecological Morbidities & Prevention of Unnecessary Hysterectomies in Madhya Pradesh

21st December 2023

Hotel MPT Lake View Residency, Bhopal

01:00 pm - 02:00 pm	Lunch and registrations
02:00 pm – 02:10 pm	Welcome – Ms. Chhaya Pachauli
02:10 pm – 02:15 pm	Opening remarks Dr. Manohar Agnani, IAS (Retd.) and Professor, Azim Premji University
02:15 pm – 02:25 pm	Background and objectives of the round table Dr. Narendra Gupta, Prayas
02:25 pm - 02:30 pm	Overview on the need for improving gynaecological care and prevention of unnecessary hysterectomies Dr. Anita Shrivastava, President, Bhopal Obstetrics and Gynaecological society
02:30 pm – 02:40 pm	Role of FOGSI in prevention of unindicated hysterectomies Dr. Kavita Singh, President, AMPOGS
02:40 pm - 02:50 pm	Key govt. interventions in MP for improving gynaecological care Dr. Aruna Kumar, Professor Obst and gynaec , Director Medical Education, Govt. of MP Dr. Archana Mishra, Dy. Director Maternal Health, Dept. of Health and Family Welfare, Govt. of MP
02:50 pm – 03:00 pm	Address by MD NHM Ms. Priyanka Das (IAS), Mission Director, NHM, Dept. of Health and FW, Govt. of MP
03:00 pm - 03:30 pm	National Guidelines for preventing unnecessary hysterectomies Dr. Poonam Shivkumar, Medical Superintendent, Mahatma Gandhi Institute of Medical Sciences (MGIMS), Wardha and former HoD, OBGYN Dr. Sapna Desai, Senior Fellow Population Council Institute, New Delhi and Member National Subcommittee on IEC and Alternative Treatments for Hysterectomy
03:30 pm – 03:40 pm	Presentation on trends in hysterectomy

	Dr. Dipti Govil, Assistant Professor, International Institute for Population Sciences (IIPS), Mumbai
03:40 pm – 4:30pm	Panel discussion on priorities for prevention of unnecessary hysterectomies at primary, secondary and tertiary care Moderator: Dr. Shabana Sultan, Professor GMC Bhopal and Secretary, Bhopal OBGY Society Chairpersons: Dr. Brajbala Tiwari, Former President Indore OBGY Society Dr. Shashi Shrivastava, President Menopausal Society Dr. Monica Jindal, Vice President, Bhopal OBGY Society Panellists: Dr. Yashodara Gaur, Professor and HoD, Gwalior Medical College Dr. Jagrati Kiran Nagar, President, Sagar OBGY Society Dr. Manik Pansey, President, Jabalpur OBGY Society Dr. Nalini Mishra, Professor and Dean LN Medical College, Bhopal Dr. Rekha Wadhwani, Professor and HoD, GMC, Bhopal Dr. Manisha Jain, Professor PCMS, Bhopal and Treasurer, Bhopal OBGY Society Dr. Urmila Tripathi, Professor OBGY, Gwalior Medical College
04: 30 pm – 05:00 pm	Open discussion on implementation of national guidelines to prevent unnecessary hysterectomies Moderators: Dr. Pratibha Sharda, Senior Gynaecologist and Vice President Bhopal OBGY Society Dr. Anant Bhan, Sangath Hub, Bhopal Chairpersons: Dr. Shraddha Agarwal, Senior Gynaecologist, JP Hospital, Bhopal Dr. Kalpana, Senior Gynaecologist, PC Sethi Hospital, Indore Dr. Manisha Khare, Senior Gynaecologist, Bhopal 05:00 pm – 05:10 pm Way forward - Dr. Manohar Agnani, IAS and Professor, Azim Premji University
05:10 pm – 05:15 pm	Vote of thanks. Chhaya Pachauli, Prayas

Meeting notes

1. Opening remarks

Dr Manohar welcomed his fellow colleagues and the audience. He invited suggestions and recommendations to make a roadmap for the state.

He presented findings from selected research studies that can act as case studies to take learnings from.

The first study he cited was "Hysterectomies and Violation of Human Rights: Case Study from India" by Mamidi and Pulla (2013)[1] which found that women from low socio-economic status and with low literacy were vulnerable to unnecessary hysterectomies, and other factors that contribute to the unnecessary use of the surgery are poverty, gender bias, lack of ethical conduct and insurance schemes in the medical profession.

Another recent study by BHU done largely in Eastern UP was done to examine indications of hysterectomy among women<35 years[2]. The findings suggest that the leading causes of

[1] Mamidi, B.B. and V. Pulla, Hysterectomies and violation of human rights: case study from India. International Journal of Social Work and Human Services Practice, 2013. 1(1): p. 64-75.

[2] Rani, A., et al., A survey of hysterectomies in young patients in Eastern Uttar Pradesh: are the wombs being removed unnecessarily? International Journal of Reproduction, Contraception, Obstetrics and Gynecology, 2022. 11(2): p. 390-394.

hysterectomy among women were unevaluated vaginal discharge and pain in the pelvic region. Most reasons found were treatable by alternate treatment methods. A cross sectional study women of low and high SES found that women from different socio-economic status underwent hysterectomy for different reasons. Women from higher socio-economic groups mostly underwent hysterectomy from abnormal uterine bleeding. A study a with SEWA members in Gujarat found that hysterectomy as a surgery in mid-thirties is a prophylactic permanent solution. The study suggested addressing structural determinants of the procedure such as lack of SRH services, provider behavior towards low-income women and attitude towards utility of the uterus. Early hysterectomy has many financial (for both families and systems) and health implications. There is a practice of watchful waiting for prostate cancers among men. A similar approach should be adopted for cancers in women, and hasty decisions should not be taken.

2. Background and objectives:

Dr Gupta narrated a brief history of gynaecological care among women. Obstetrics among women has always been in the focus, with the MCH program running in India for a long time. On the contrary, gynecological care and morbidities have been neglected. A book 'Our bodies our health' inspired him to see how globally, women are at the backfoot of benefiting from clinical research and therapeutics, and there is urgent need to look into women's health more holistically. In 1989, in Gadchiroli, Maharashtra, one of the first studies with women revealed that about 89% women had recognizable and identifiable gynaecological morbidities, yet they went unattended. In 1994, the ICPD Cairo conference was a landmark event in the journey towards recognizing women's health. The Beijing conference furthered this agenda and the RCH program in India was established. This program culminated in the addition of STI/ RTI identification and management and included into the NRHM, where currently it is called the RMNCH+A program.

PRAYAS entered this area in 2013, when large number of women in a district of Rajasthan were found to have undergone hysterectomies. Upon interviewing these women, some concerning facts were uncovered: women approached doctors for gynaecological morbidities and were advised hysterectomy as a first line of treatment. Doctors in private facilities mostly, counselled women that if their aspired family size was achieved, then to prevent cancers, hysterectomy was the most viable option for them.

He urged the audience, and especially large bodies such as FOGSI to lead from the front in reducing unjustified hysterectomies by raising awareness and championing alternative methods to treat gynaecological morbidity.

3. Overview on the need for improving gynaecological care and prevention of unnecessary hysterectomies

Dr Srivastava highlighted facts and statistics on hysterectomy in India. Hysterectomy prevalence in India is about 3.6% (women 30-39) and 9.2% (women 40-49). Two-thirds of procedures are conducted in private facilities. Excessive menstrual bleeding or pain followed by fibroids and uterine disorder are the most common self-reported indications of hysterectomy. Prevalence of 20-23% of women in ages 40-49 in Andhra Pradesh and Telangana (close to high-income countries) at low median age. On analysing AB-PM-JAY data, it was found that 2% of claims submitted for women were for hysterectomy. Six states (Chhattisgarh, Uttar Pradesh, Jharkhand, Gujarat, Maharashtra and Karnataka) had high number of claims (three- quarters of all hysterectomy claims). The most common package covered was hysterectomy with salpingo-oopherectomy.

She emphasized that we must learn from developed countries, where hysterectomies were reduced by encouraging alternate methods of treatment. The OBGYN fraternity must take this seriously as these surgeries are done by doctors only, and not quacks or others. Further, indications of hysterectomy are often vague.

Key takaways from her presentation were learning points for doctors:

- It is a doctor's duty to guide women that hysterectomy for benign conditions is often the last and not the first resort, and certainly not a permanent one
- There is an urgent need to spread information about reproductive and sexual health among the underprivileged populations, so that these women can help themselves by making informed choices. This should be done by mass media and by doctors themselves.
- Provide women with a comprehensive medical workup to determine a correct diagnosis. Once diagnosis is made then educate about their options and discuss with patient which alternatives are available to them for their unique situation as well as the risk and benefits of each.
- Menstrual irregularity and vaginal discharge need a more considerate and broad-minded approach.
- More emphasis should be given to preventive measures and investigations like PAP'S SMEAR, VIA , Colposcopy etc.
- Myths and fear regarding different cancers should be properly addressed. Increase the awareness.
- Chronic pelvic pain requires a sensitised approach that often needs to probe deeper than the textbooks.
- Gynaecologists and Public health initiatives should take more account of women's lack of knowledge of reproductive health and make efforts to disseminate such information by the use of small group meetings, awareness camps,television, radio, socialmedia and newspapers in local languages.

4. Role of FOGSI in prevention of unindicated hysterectomies:

Dr Singh introduced herself as a gynae-oncologist and shared her background and experience of working in the field for many years. She briefed what we know about hysterectomy in the country and the state: Community based studies in India found average age of hysterectomy to be 28- 36 years. Data from NFHS-4 (2015-16) prevalence is 3.6% in 30- 39 years and 9.2% in 40-49 years and mean age at hysterectomy was 37 years. Prevalence was 20-23% in Telangana and Andhra Pradesh. NFHS-5 (2019-21), 8.5% of women age 40-49 in Madhya Pradesh already under went hysterectomy at median age of 36 years. About 75% of hysterectomies were performed in private facilities.

Field based reports suggested that these hysterectomies could have been managed by conservative treatment as majority were done for heavy menstrual bleeding or pain in lower abdomen.

Even news and media have covered high rates of hysterectomy from various parts of the country.

Dr Singh covered the work that FOGSI in MP has been doing. There have been numerous campaigns and events to prevent cancer cervix, which has even been in local news. They have drafted an 'elimination of cancer cervix 2030' that is being widely adopted across the state, which promotes pap smear investigation. FOGSI in MP has been actively pursuing cancer cervix, early identification of ailments, and preventing hysterectomies. She suggested that hysterectomies must be audited like maternal mortalities. She had a few ideas on what further can be done:

- Each FOGSI member should be re sensitized for continued efforts for conservative management of AUB, vaginal prolapse, CIN, PID, STI, ovarian cysts, small myomas etc.
- The priority is to follow appropriate clinical and population level guidelines WHO, GOI, FIGO, FOGSI guidelines.
- Critical need to monitor and regulate the appropriate use of hysterectomy particularly for benign gynae conditions in private sector.
- Promote awareness about side effects and health problems related with unjustified surgery and Increase acceptability and willingness of women for conservative management.

- General surgeons should be called only when indicated and warn them that it's a gynecological field.
- Better discuss, consult, and work with senior gynecologist colleague medico-legally safe.
- Documentation of conservative management is must prior to final surgical decision.
- Always speak against hurried /too early surgical interventions and consequences
- Awareness campaign and counseling about conservative managements prior to surgery
- Community awareness through existing staff at PHC, CHC, DH
- Discussions should focus on removing myths and misconceptions.
- Raising awareness on menstrual hygiene, prevention of cancers, available safer treatment options as first choice of treatment not hysterectomy
- Use of mass media, TV, Radio, and social media

She concluded that one additional advantage to women keeping their uterus is that it acts as an agent in continuum of care. Families and households take women to gynaecologists only until hysterectomy. This support is withdrawn after the surgery and ailments such as STIs/ RTIs and other gynaecological problems go undiagnosed. Further, as in the past in case of female foeticide, we must join hands to bring down unjustified hysterectomies. Audits of all hysterectomies under the age 40 is a must in this direction.

5. National Guidelines for preventing unnecessary hysterectomies

Dr Desai gave a background to the guidelines that were drafted in 2019 after two national level consultations. She presented the implementation plan of the guidelines at the national, state and district level. The purpose of the guidelines is to: (i) address unnecessary hysterectomies; (ii) monitor the hysterectomies being done; (iii) provide community awareness on hysterectomies; (iv) clinical guidelines on common gynaecological conditions which have emerged as indications. Programmatic guidance is to provide primary, secondary, and tertiary levels with capacity strengthening, referrals, awareness generation. There is a three-tiered monitoring committee structure present at the national, state and district levels. There must be awareness generation with use of existing platforms like Village Health Sanitation and Nutrition committees, Women's Self Health groups, Mahila Arogya Samities, Rogi /Kalyan Samities, PHC, CHC, District Hospitals.
The present status is that states are in the process of forming committees.
The national committee was formed on 26th June 2023, and met for the first time on 25th August 2023.

Dr Poonam Shivkumar took forward the presentation with clinical protocols data/ audits and governance. The guidelines detail out treatment modalities available for common conditions: (i) Abnormal Uterine Bleeding/ Dysfunctional Uterine Bleeding, (ii) Uterocervicovaginal Prolapse, (iii) Vaginal Discharge, (iv) Pelvic Inflammatory Disease (PID), and (v) Abnormal Cervix. She shared the data sharing format prescribed for clinicians to report hysterectomies and discussed each indicator in detail.

Further Dr Shivkumar shared data from her experience at MGIMS. Most women who underwent a hysterectomy at MGIMS were from rural areas, had 2 children and were from low socio-economic background. Most hysterectomies were done at an age between 40-50, or over 50 years, however some unavoidable hysterectomies were also performed in women under 40 years of age. In her experience, common alternate methods are either not available, or the cost is too high and poor rural women cannot opt for it.

The medical treatment received with its duration before hysterectomy:
-No women had hysterectomy without medical treatment
-The medical treatment taken was inappropriate as 72.3% took it for only 6 weeks on an average
-Various drugs were used but not given in appropriate doses for appropriate time

-In 67.2% cases progesterone were used, Danazol was used in 6.2% cases OCs in 11.8% cases. GnRH was used in 3 cases

Correlation of duration of symptoms with hysterectomy
-In all 5 years no woman reported with < 6 months menorrhagia or polymenorrhoea
-Pain was one symptom with which all of them came the next month
-Continuous bleeding, severe bowel and bladder symptoms, they all reported the same cycle
-Asymptomatic came once asked by doctors

Dr Shivkumar briefly described a one-year study she did in 4 hospital sites across MP. The objectives of the cross-sectional observatory research were:
To observe the sociodemographic details and the indications of hysterectomy with their histopathological correlations. the outcome measures would be –

i. The age group in which the maximum hysterectomy is done.
ii. Diagnosis and histopathological correlation
iii. Number of demand hysterectomies
iv. Reasons for hysterectomies - women's and provider's perspective

Every case of hysterectomy was shared in a confidential digital group.
Most hysterectomies were done in the age group 40-50, followed by ages 30-40. The most common reported indication of hysterectomy was AUB (>66% cases across sites), followed by displacements and malignancy.

Clients' perspective on hysterectomy were pilot tested as part of the study. Key findings were that:

i. Women didn't know of alternate methods.
ii. All women understood hysterectomy as a choice treatment that was the final solution, it was doctor advised and assured them that there would be no future costs.
iii. In most cases the family decided (husband and mother-in-law). Women had no say.
iv. Women were convinced that they would face some problems after hysterectomy such as pains and palpitations. Thus, they would not get tested for problems after hysterectomy- whatever problems you have are normal- no test or osteoporosis or heart problems.

Perceptions of rural women around why hysterectomy is the preferred choice of treatment included:

- My work suffers, who will earn, if I have bleeding daily
- My husband does not tolerate
- Interfere with sex;
- One time cost
- Can't afford other modalities as very expensive
- After all that one has to do hysterectomy
- Fear of cancer, who will take care of children
- Can't comply with medicines
- Too many side effects
- Feels weak
- USG treatment not good
- Cut in the abdomen, not good experience

Some notable revelations from provider perspectives on hysterectomy were:

- Do not comply
- Not trained well
- Need special skills
- Women do not give consent
- Fear of later medico legal issues if carcinoma develops

- Anyway they have completed their Obstetric career
- We know it will end up in surgery
- Prolonged medical therapy has too many side effects
- If women ready for hysterectomy what is the problem
- Indian women do not have post menopausal issues
- Women not ready
- Demand hysterectomy
- Want once for all treatment
- Not cost effective in rural settings
- Have several issues with husband as no quick relief
- Can not cope-up with side effects
- Taboos and influence of peer groups
- Insurance systems
- Further, it was found that younger doctors would entertain on demand hysterectomies.

Suggestions emerged from the study were:

- Under 40 yrs Hysterectomy to be evaluated strictly
- States with higher younger age hysterectomies need genuine audits.
- Awareness programs explaining that younger age hysterectomy leads to serious side effects
- Lack of education is a very important risk factor so female needs special counseling
- Health insurance needs to be explored
- Great efforts to use less invasive treatments
- Alternate options to hysterectomy for benign conditions to be used more
- Clinical strategies to be developed for further multicentric studies.

Further, some clinical strategies were developed from the study:

- Knowledge questionnaire for women kept in the wards for hysterectomy
- Questionnaire for the Doctors
- Analysis done to find out where can we interfere
- OPEN AUDIT/ Clinical Governance - committee to be made
- Every OT list screened and shared through confidential media group
- Seminars and symposium
- Training the faculty in other methodologies
- Awareness programs in villages

<u>Questions/ suggestions</u>

a. Post sterilisation hysterectomy is much more, why?
   - Ovarian and uterine plexus- complications and menorrhagia sometimes develop after sterilisation, but can be managed by drugs, but doctors hastily go for hysterectomy.
   - Sterilisation may be compounding factor. Post ligation syndrome is considered for 2 years, after that it may not be cause of hysterectomy, but just a covariate.
b. Some doctors found it alarming that doctors have said that hysterectomy is the long term solution– this is a warning situation that must be looked into.

6. Presentation on trends in hysterectomy

Dr Govil presented statistics on hysterectomy from the state of Madhya Pradesh. Madhya Pradesh has a moderately high prevalence of hysterectomy in the age group 40-49 (about one in 10 women have undergone a hysterectomy by age 50). The median age at hysterectomy in Madhya Pradesh age 50 is 36 years, approximately 10 years before natural menopause. The highest prevalence in Madhya Pradesh is reported from the districts of Dewas (21.3), Ujjain (21.2), Sehore (14.9) and Chhatarpur (14.0). The leading self-reported reason for hysterectomy is excess menstrual bleeding, followed by fibroids/ cysts. Results from multivariate regression find that factors associated with hysterectomy are older age, less education, rural residence, wealthier households and not undergone sterilisation. About 62% of hysterectomies are in the private facilities, and this trend is seen in both rural/ urban areas, and across wealth quintiles. Madhya Pradesh has a C-section rate of 12% and female sterilisation is the most prevalent contraceptive method in the state with 52% currently married women in Madhya Pradesh having undergone sterilisation. New evidence from around the world has linked early hysterectomy to hypertension, diabetes, osteoporosis, and a new study from Sweden suggests even mortality is linked to early hysterectomy. Findings from the LASI data suggest that a woman with hysterectomy had greater odds of hypertension, diabetes, cholesterol, heart disease, angina, obesity, and large waist circumference compared to women having natural menopause. Further research using the life course approach is required to understand these relationships in further detail.

Comments:

For doctors, current constraints include availability of resources and alternates and training of doctors in new treatment modalities. For women the constraints are on time, cost, and effort for pursuing alternate methods.

7. Panel discussion on priorities for prevention of unnecessary hysterectomies at primary, secondary and tertiary care*Moderator: Dr. Shabana Sultan, Professor GMC Bhopal and Secretary, Bhopal OBGY Society*

The panel was structured such that comments were invited from panelists for each question asked by the moderator

i) Ideal age of hysterectomy

- Unindicated hysterectomy- at no age is advised.
- Surgical menopause is not advised.
- Each case must be Individualized by indication.
- Uterus must be saved- for as long as possible.

- Hysterectomy must be reported under age 40

ii) Are we following the guidelines in reality so far? What are the guidelines?
- Pap smear has been part of guidelines.
- Disease specific guidelines have been followed- for each condition.

iii) Common indications for hysterectomy these days?
- Some doctors argued that hysterectomy becomes inevitable for mentally retarded girls.
- Other doctors said in response that alternatives are available such as low dose OCP, and progesterone for heavy bleeding.

iv) Why women choose to undergo hysterectomy?
- After childbearing, women request for hysterectomy.
- Fear in the mind- have had deaths in family due to cervical cancer, heavy menstrual bleeding.
- White discharge. They insist on hysterectomy after they discover white discharge as they are very scared of this problem. Community awareness is needed to address this issue.

v) Decision of hysterectomy- women driven or doctor driven?
- Doctors also include family in the decision

vi) Why docs suggest hysterectomy as the most commonly done procedure?
- Young doctors need number of cases
- Fatigue from patient side, after every method is tried and Hb is falling with support- then after 40 go for it
- No follow up from women side
- Longevity is increasing, post-menopausal complications are high- women need to be educated that their uterus and ovaries are protecting them from heart disease etc.
- Women are now told that court has decided that under 40 must not got for hysterectomy unless necessary- so they get convinced.
- Rural India- taboo, regular follow up problem- convince women that hysterectomy is not the solution for all problems- IEC is needed.

vii) What are the responsibilities of Primary, secondary and tertiary health care providers in preventing unnecessary hysterectomies?
- Surgeon doing hysterectomy must be included in the data form as a column- reporting must be done
- Gynae invite surgeons for operative assistance
- Sensitize all FLWs
- Case History documentation must be done
- PS, PV examination must be done
- Like in FP- use cafeteria approach- introduce all alternatives to women
- **In guidelines- clinical examination must be included**
- **The guidelines should expand on dosage, frequency, and duration of drugs**
- Can use AI in screening
- Rural women go to Primary centre for initial problem- they must be referred to a specialist.
- Primary centre medical officers must be trained for screening. Secondary level- must understand limitations of their facilities and refer to tertiary care timely- this will reduce hysterectomies and malignancy.

viii) Challenges and key messages
- Must communicate aftereffects of hysterectomy such as cardiac problems
- Taboos and regular follow up are a big barrier
- Awareness of female bodies- female education is necessary
- Train ASHA workers
- School health education is required- at mass level
- Respect ovaries- preserve them, remove tubes when hysterectomy is being

performed (for surgeons)

- LNG-IUCD must be available in govt setup at all levels
- Counselling is very important- alleviate fears of all women
- Education of female reproductive systems- education is the answer to all these problems
- Doctors have hesitation on communicating sexuality with patients
- Choice, communication, counselling

8. Closing remarks Audience:

Ethical practice is the answer. Clinicians must see inwards. FOGSI in MP has the potential that it can show pathway to the rest of the country. How will FOGSI take the message forward?

Emphasis must be to empower women and educate the girl child. India has historically been forward thinking. Our temples such as in Khajuraho are a testament to that. How are we now more conservative? We should also learn from dental surgeons, they attempt to conserve each tooth, despite the fact we have 32. Why must we hastily remove one organ that is so important to the well-being of women. Further, it is important that we protect innocent clients since they do not know the situation and the treatment well. It has been seen that in poor agricultural communities, after a good harvest it is common to undergo appendicitis and hysterectomy due to sudden availability of funds in the family.

It is also a known fact that women feel liberated after their menses are over and their status rises, even though they may suffer in silence due to many health issues.

The need is to address the problem with all providers, not only gynaecologists, but also other providers that serve the community. Doctors must refuse on demand hysterectomy.

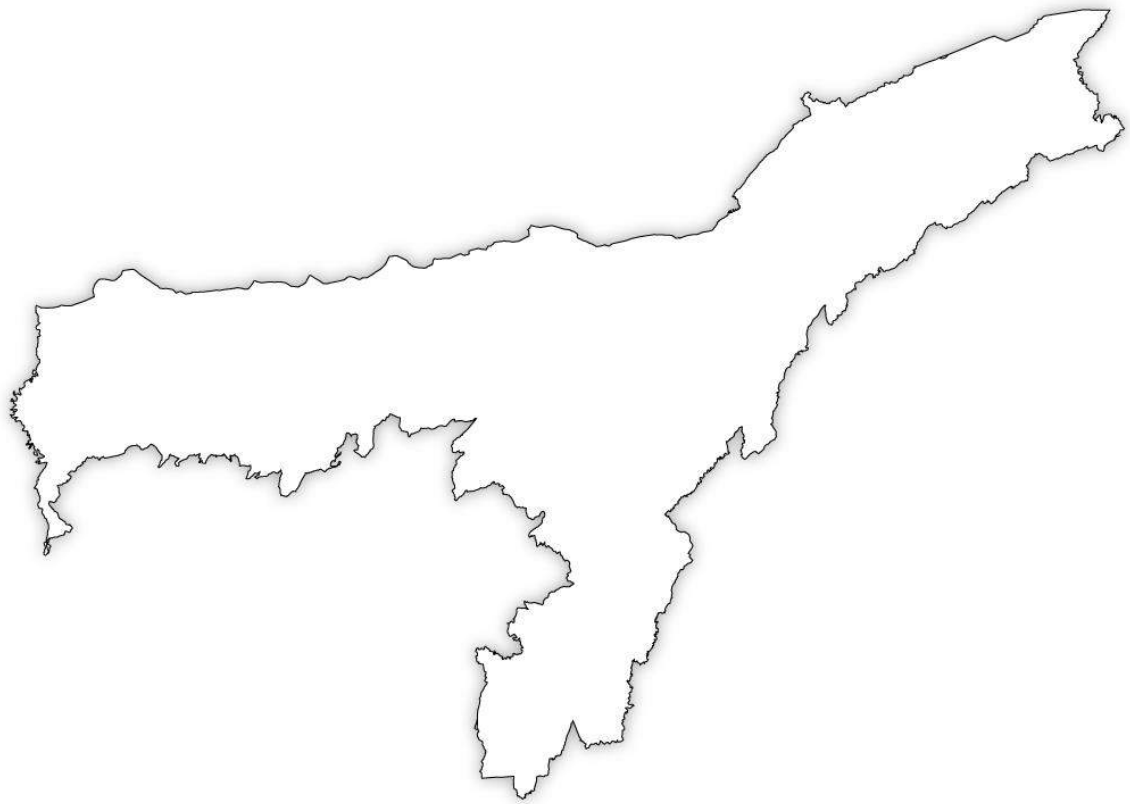
Cut commission practice must be stopped- financial gains if curbed will help.

Dr. Manohar Agnani added that *t*his is a good beginning. FOGSI has a lot of strength and influence in the state, and they have the power to counsel the patients.

Appendix 1

Situational analyses

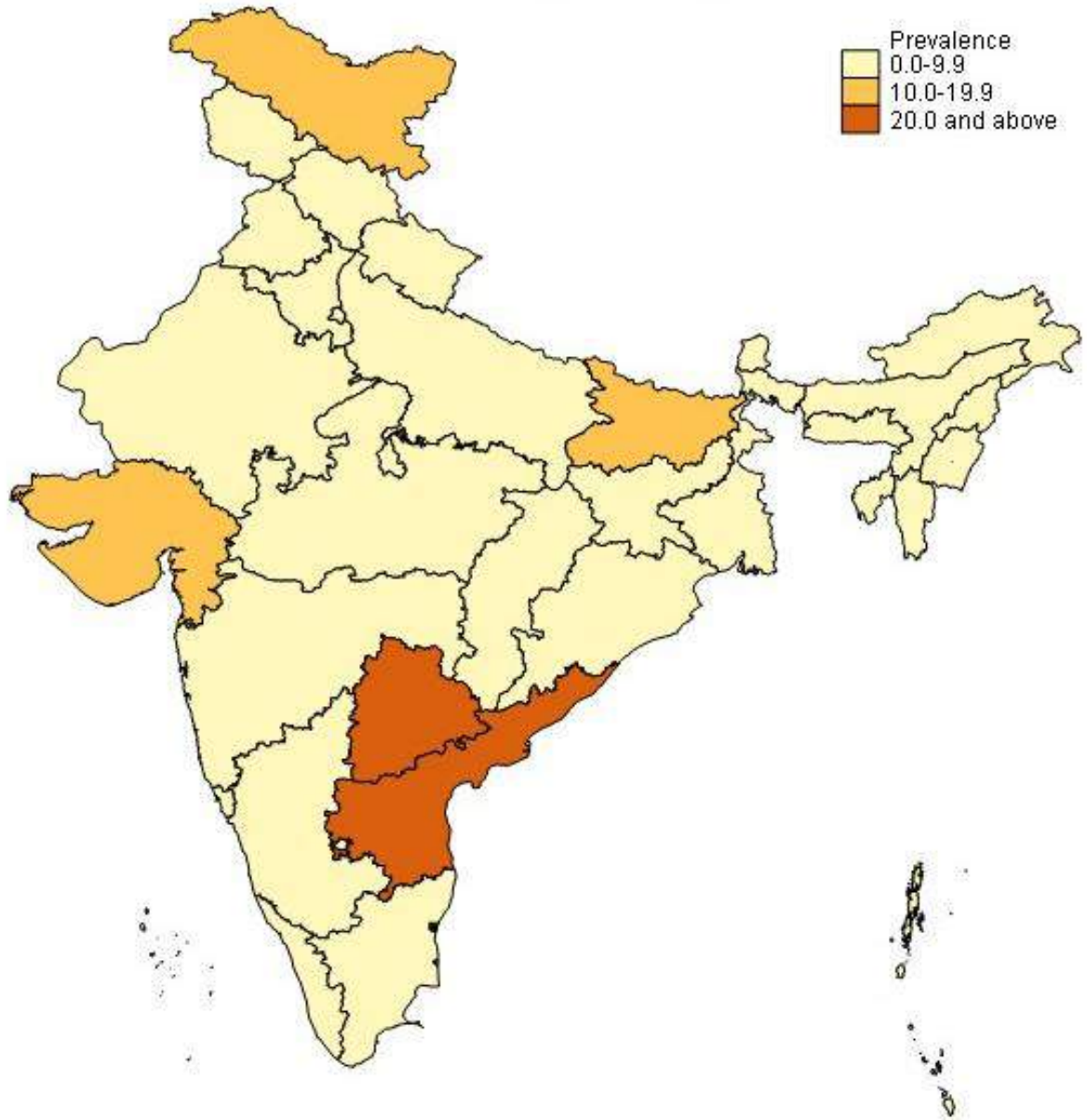
Access to surgery in Assam: overview



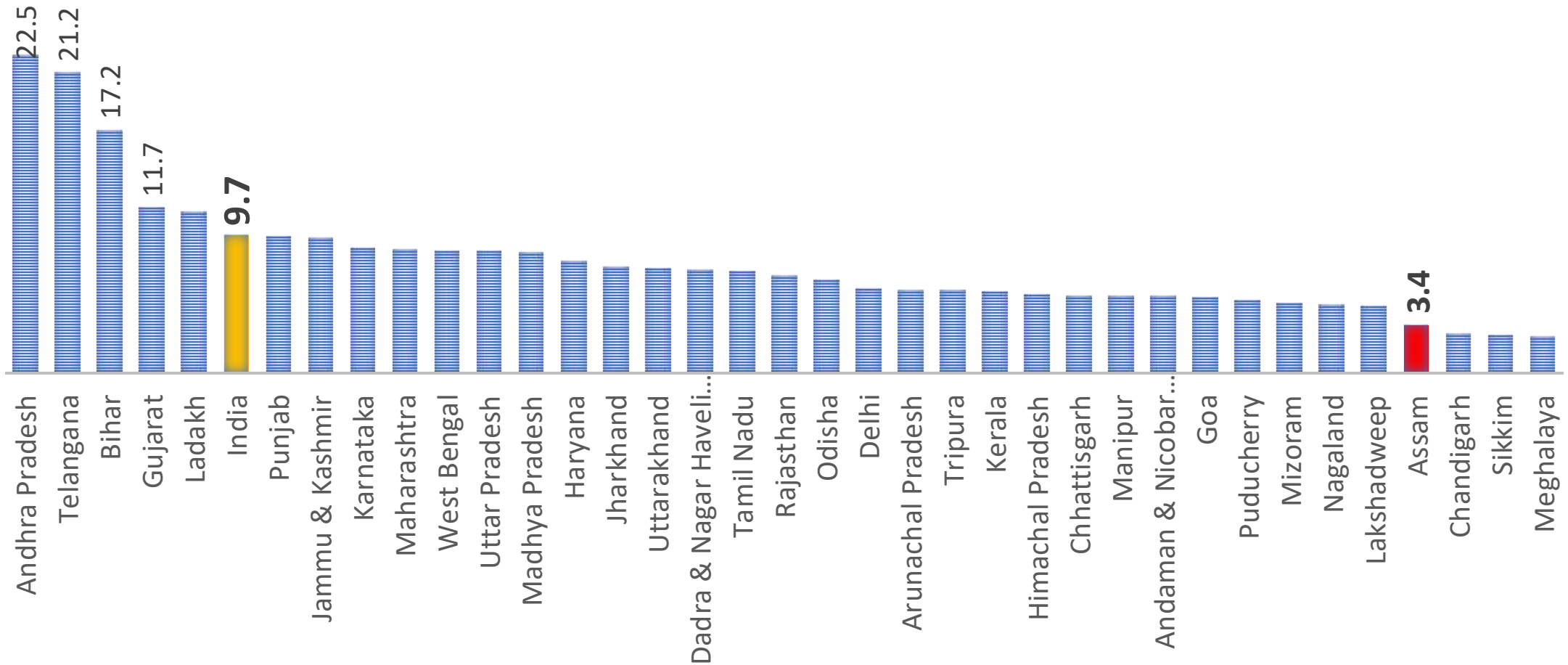
Guwahati Roundtable
October 11, 2023

Hysterectomy

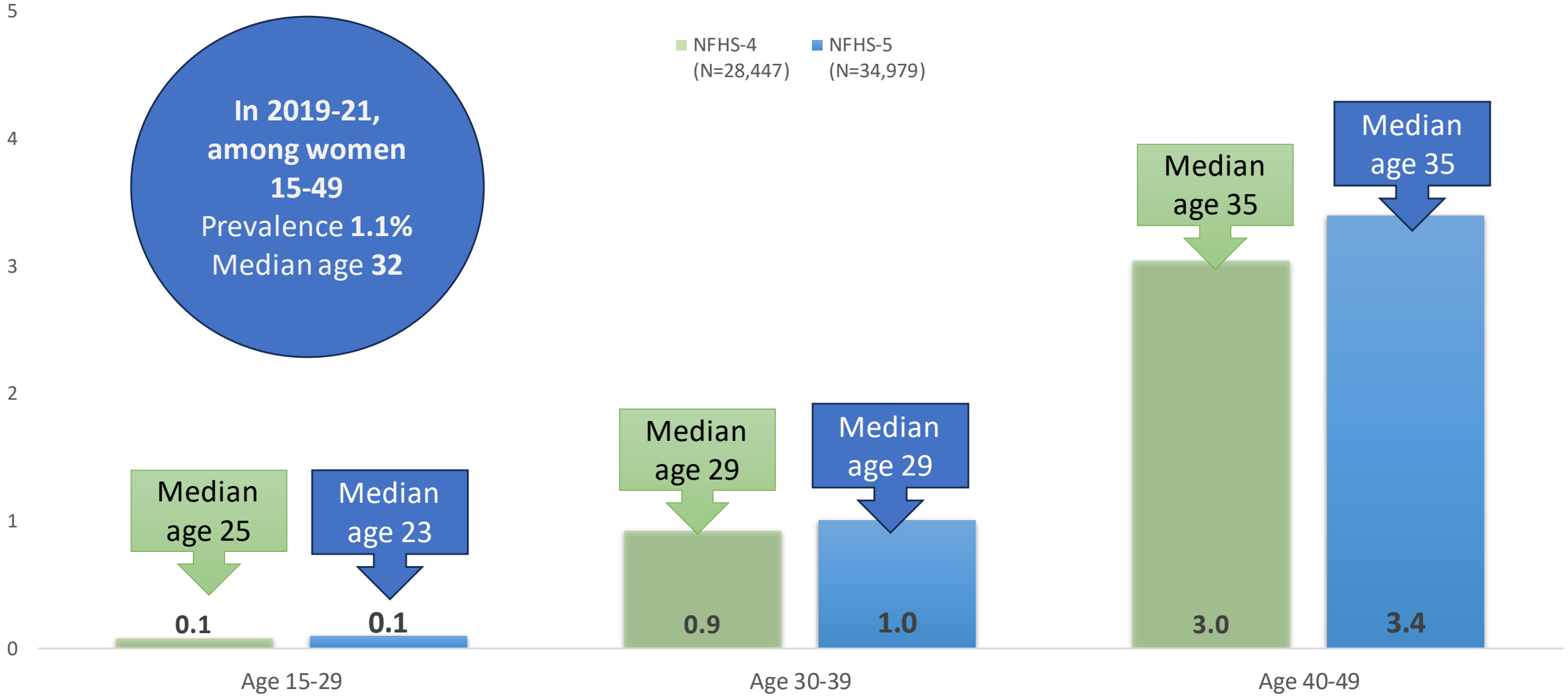
National patterns of hysterectomy



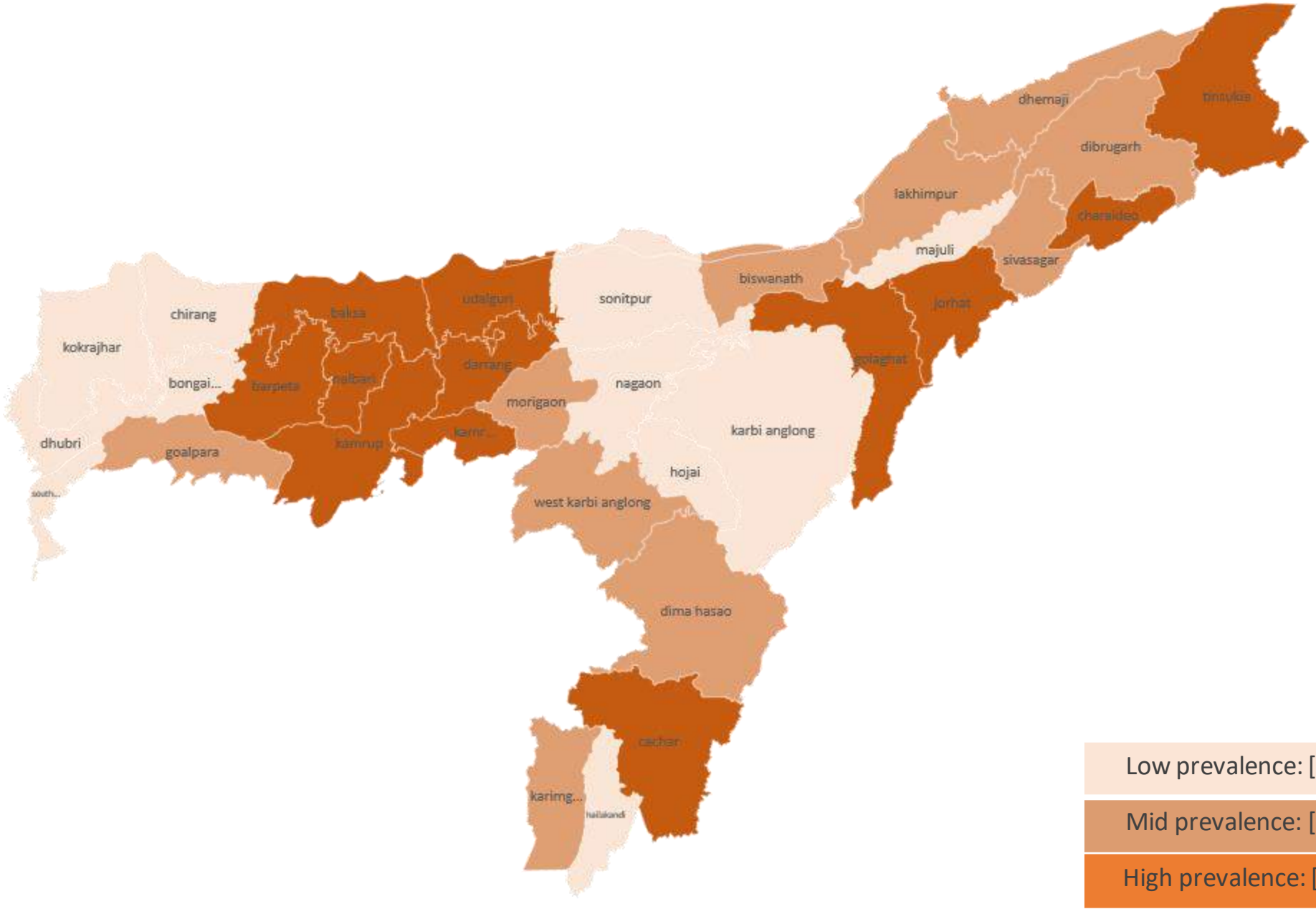
Hysterectomy prevalence by state, 40-49 years



Age specific prevalence in Assam



Prevalence of hysterectomy, 2019-21 (women 40-49)

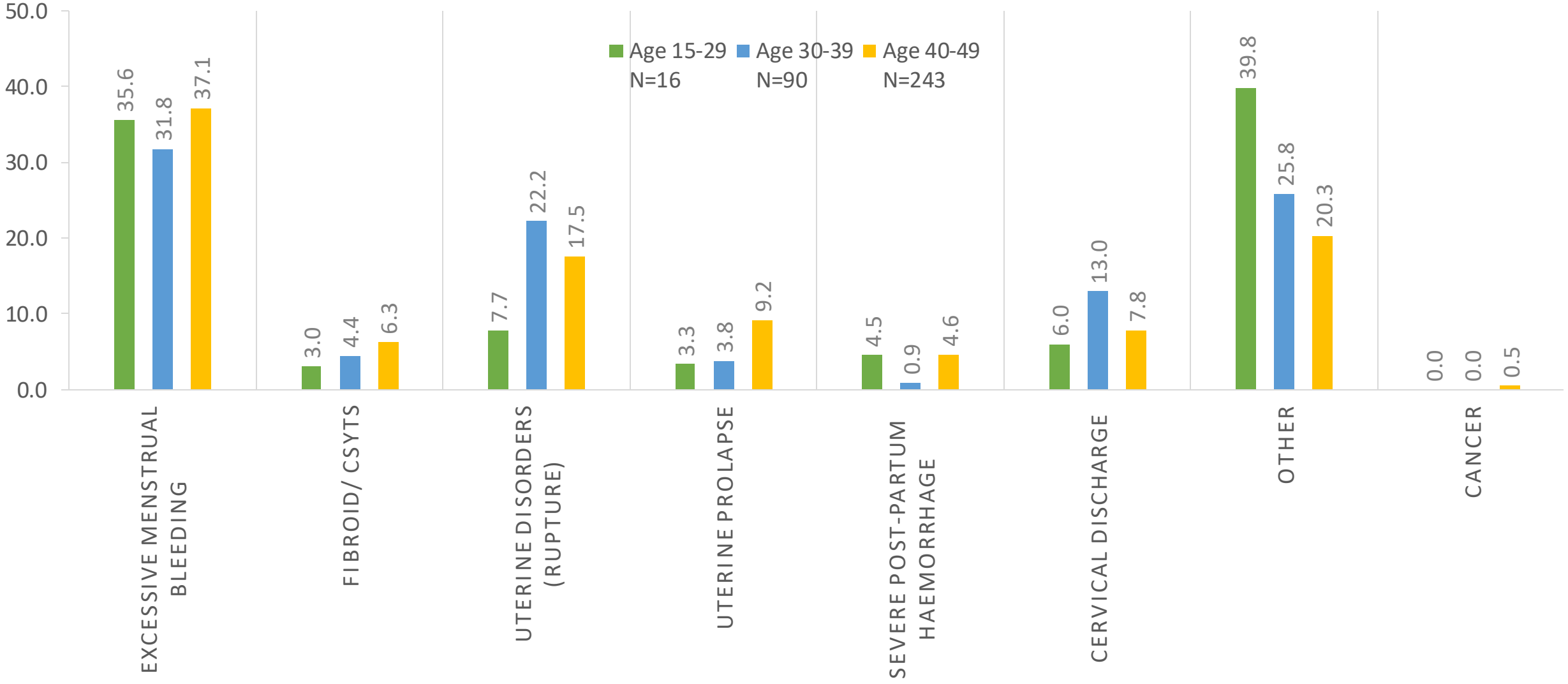


Low prevalence: [1.3, 2.3]

Mid prevalence: [2.4, 3.5]

High prevalence: [3.6, 8.8]

Self-reported reasons for hysterectomy, by age



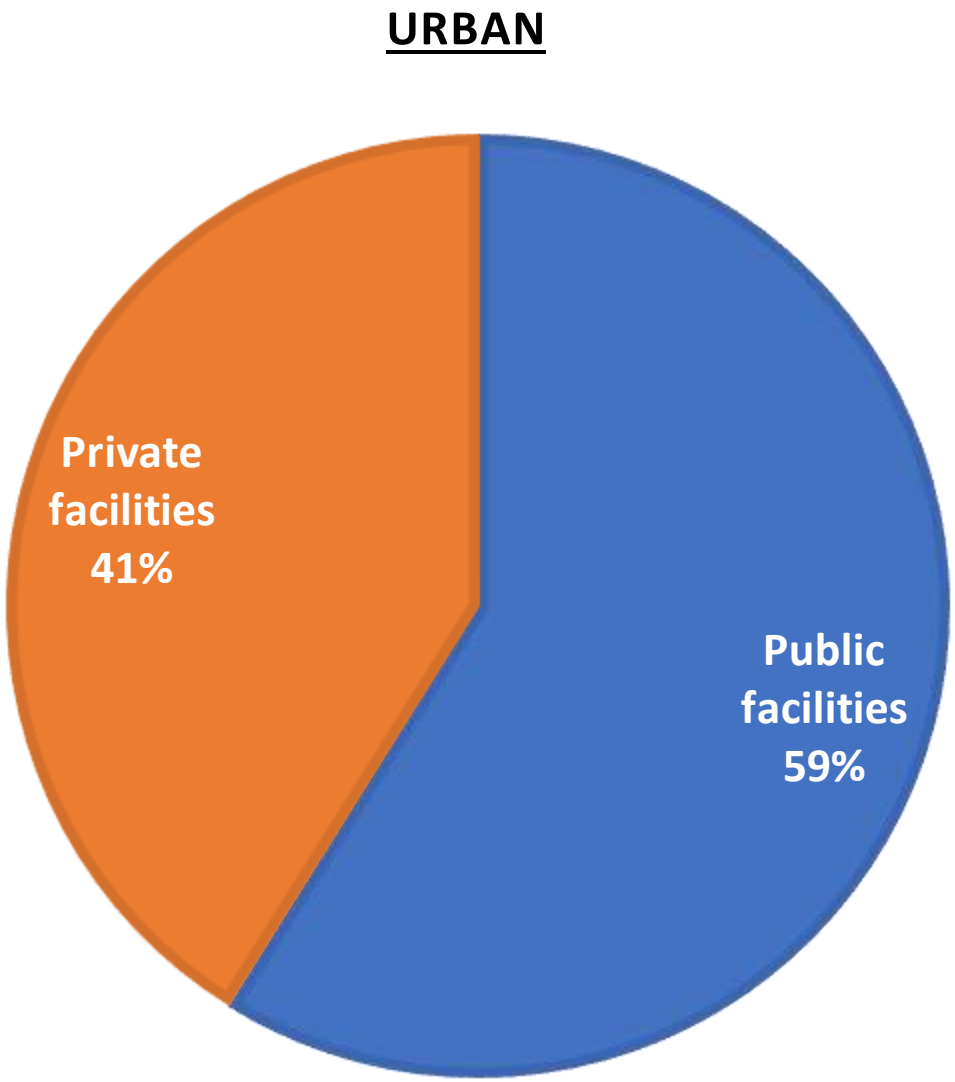
Factors associated with hysterectomy in Assam*

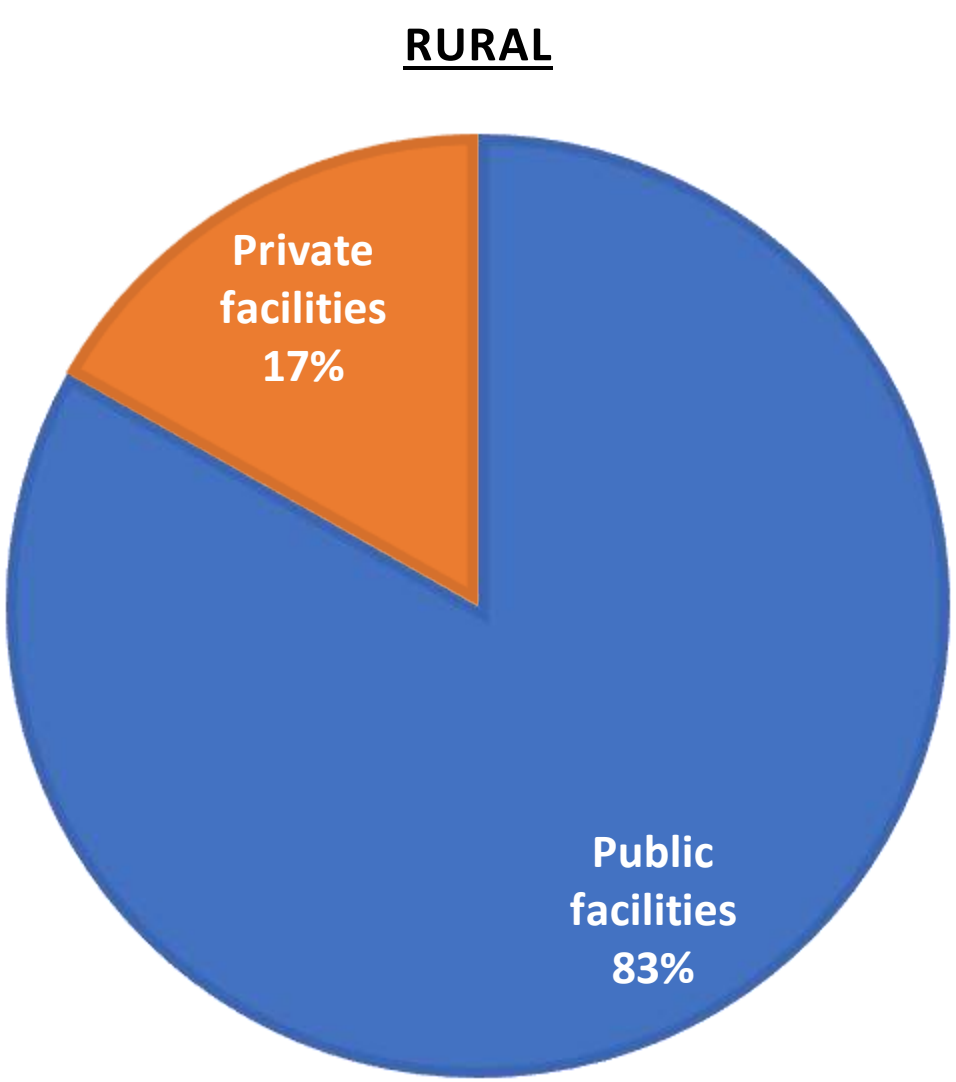
- Older age
  - *6 times greater odds of hysterectomy in age 30-39*
  - *19 times greater odds in age 40-49*
- Less education
  - *Greater odds of hysterectomy in less educated groups*
- From wealthier households
  - *AOR of 5th quintile vs 1st quintile= 2.3*
- Have one or more children
  - *2.5 times greater odds among women with one or more children*
- Have been sterilised
  - *1.6 times higher odds among women who have undergone sterilisation*

* Results from multivariate logistic regression on hysterectomy as outcome variable

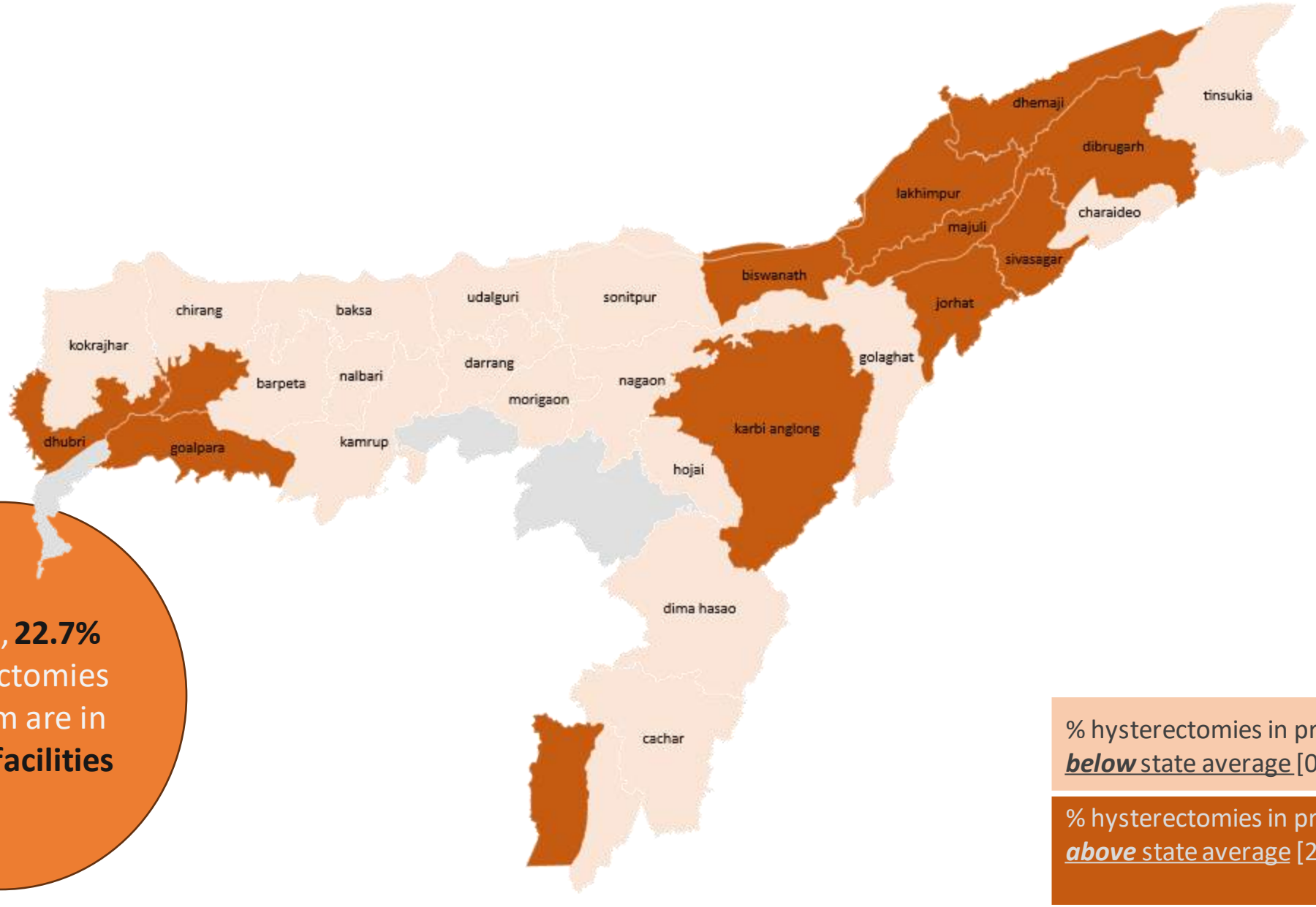
Place of hysterectomy

Place of hysterectomy, by residence





Hysterectomies in private facilities



Overall, **22.7%** hysterectomies in Assam are in **private facilities**

% hysterectomies in private facilities- ***below*** state average [0, 22.6]

% hysterectomies in private facilities- ***above*** state average [22.7,62.8]

Place of hysterectomy, by wealth quintile of households

Hysterectomy and NCDs

Hysterectomy and NCDs later in life

Findings from the LASI study, 2017

A nationally representative sample of women, aged 45 and up in India:

A woman with hysterectomy had….

1.5 times higher odds of **hypertension**

1.7 times higher odds of **diabetes**

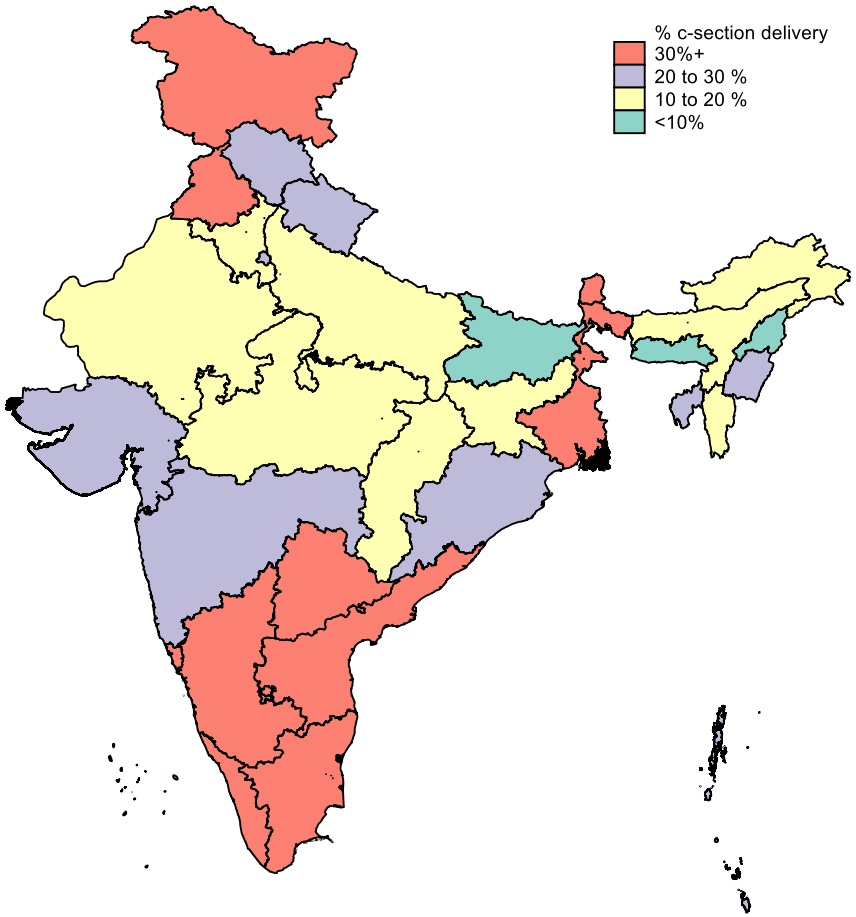
1.5 times higher odds of **bones/ joint diseases**

when compared with women without a hysterectomy

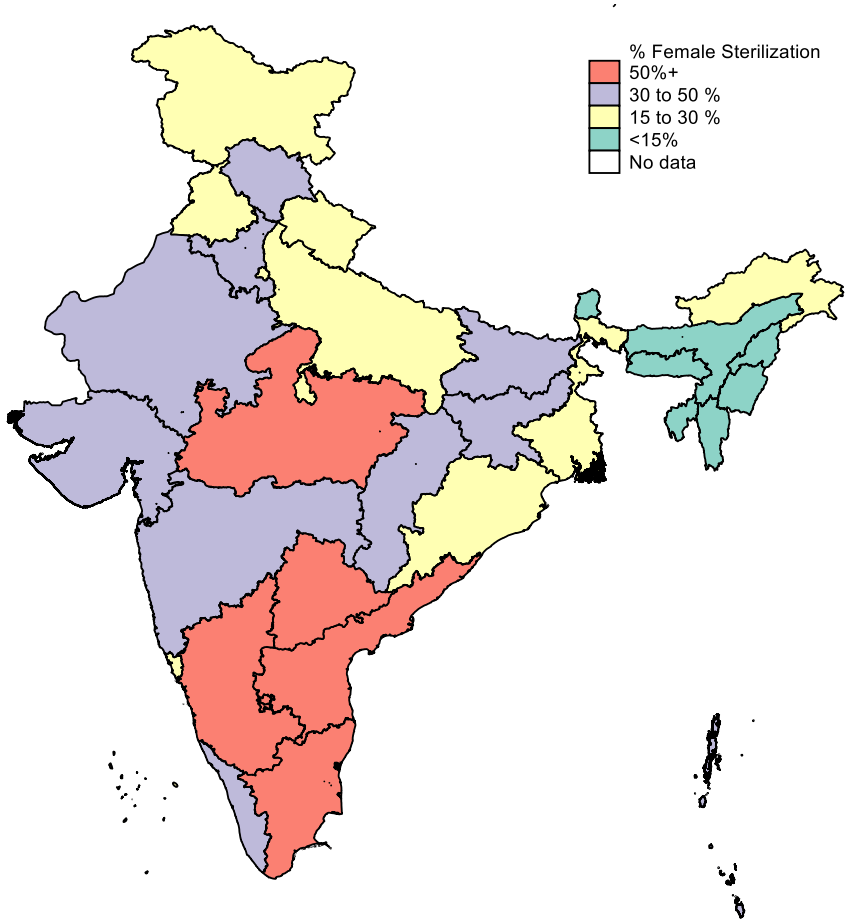
Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

National Patterns

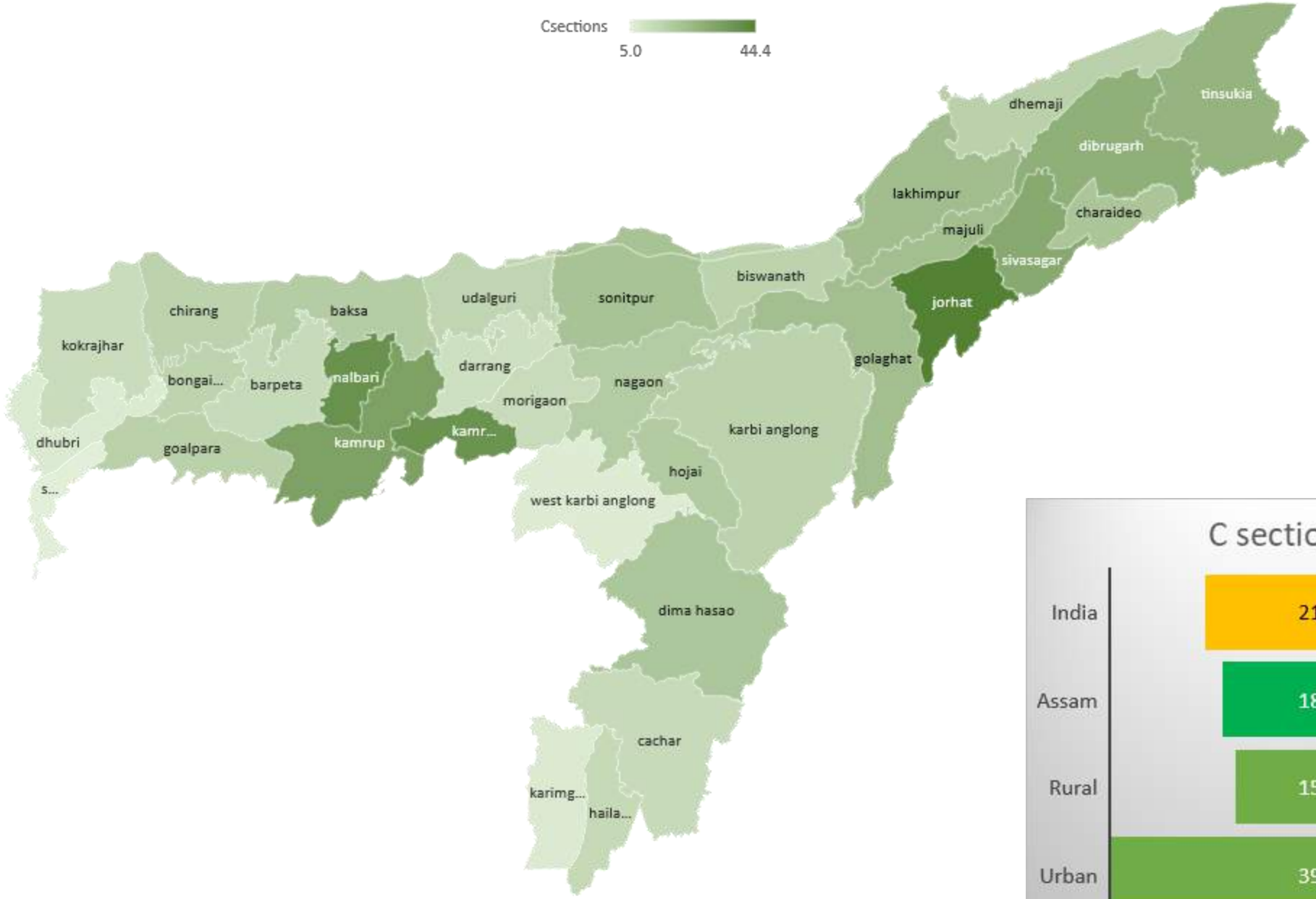


C-section



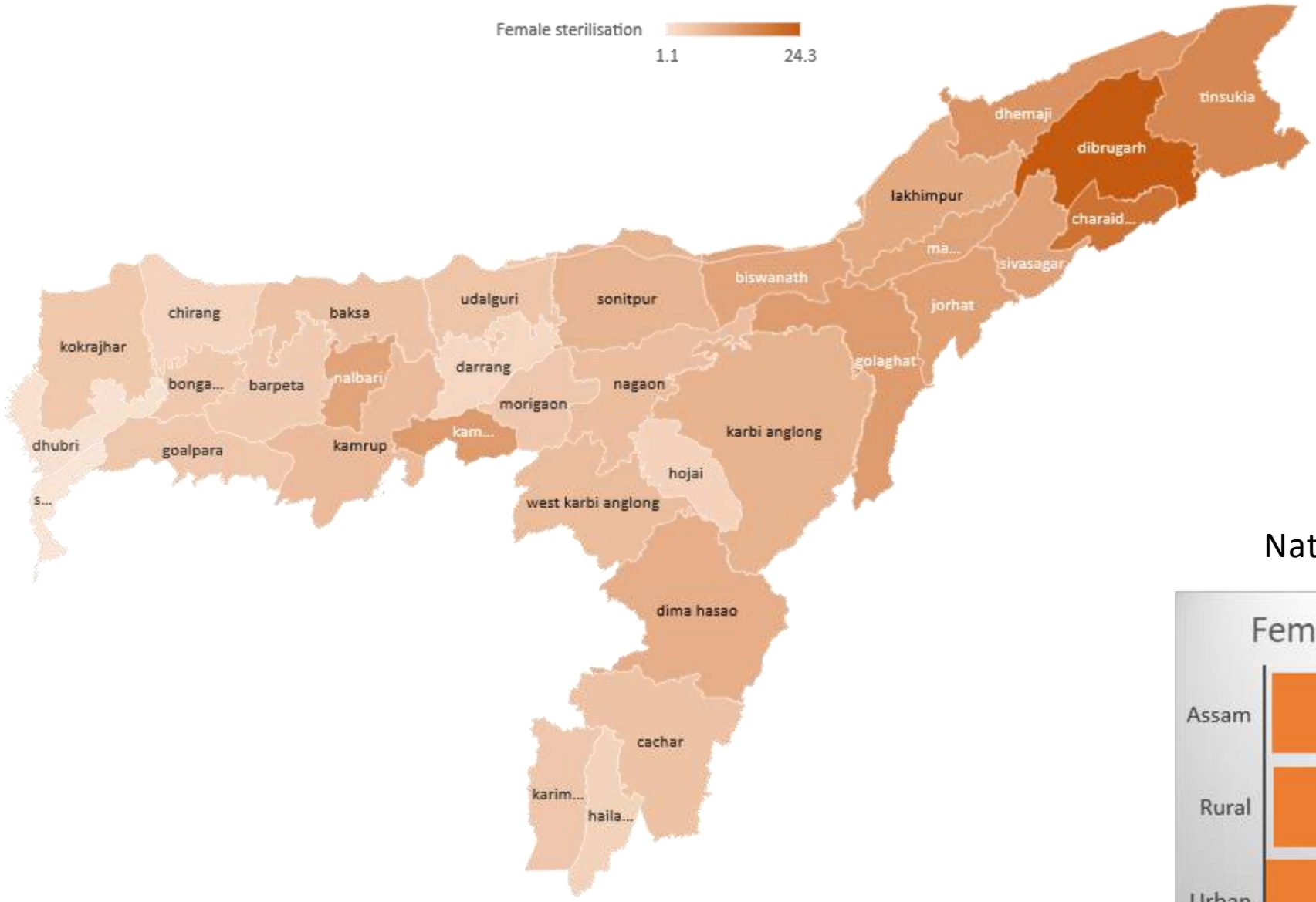
Female Sterilisation

Assam: C-sections in last 5 years*

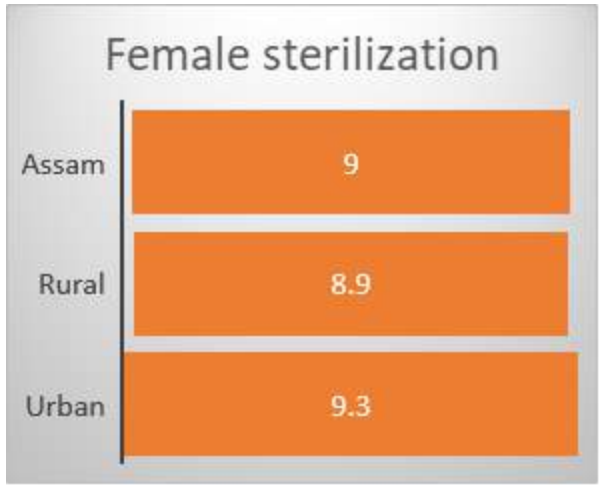


*: all births in last 5 years, NFHS 5 (2019-21)

Assam: Female sterilisation

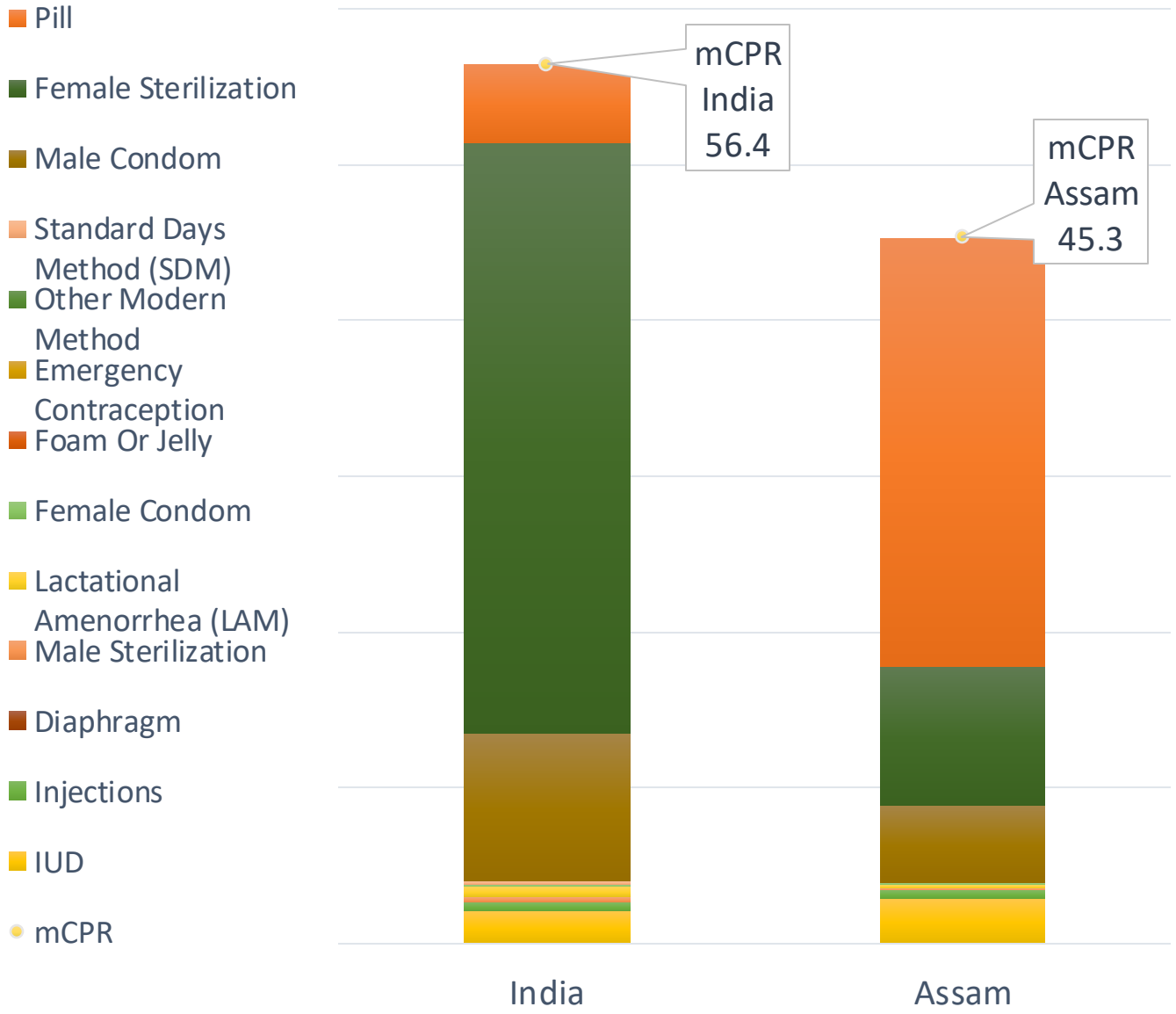


National: 37.9



*: NFHS 5 (2019-21)

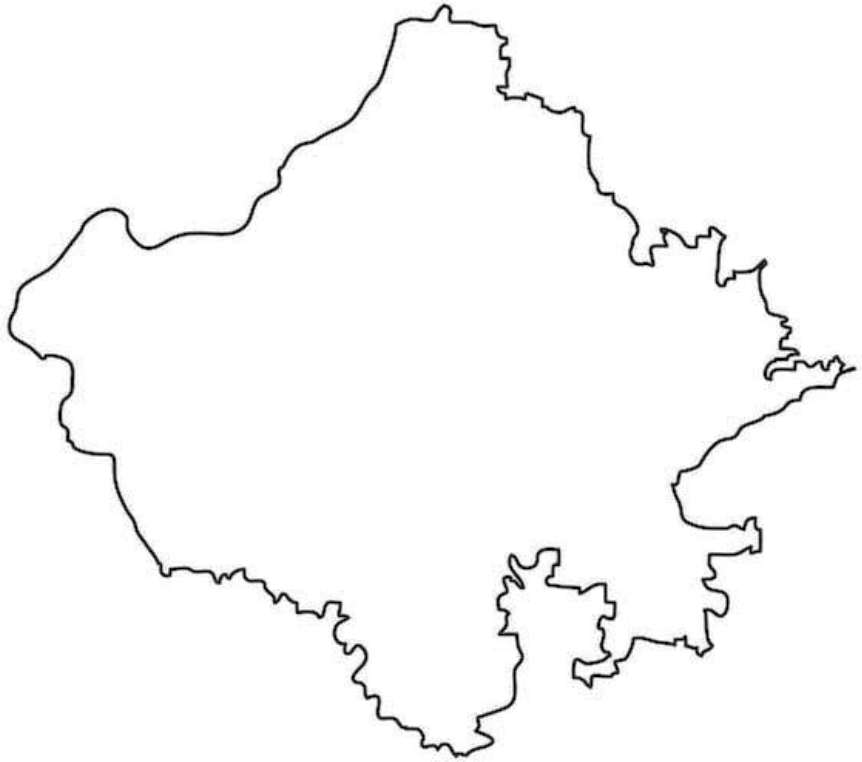
Modern contraceptive method mix, married women 15-49



Method	India	Assam
Pill	5.1	27.5
IUD	2.1	2.9
Injections	0.6	0.5
Diaphragm	0.0	0.0
Male Condom	9.5	4.9
Female Sterilization	37.9	9.0
Male Sterilization	0.3	0.1
Lactational Amenorrhea (LAM)	0.7	0.2
Female Condom	0.0	0.1
Foam Or Jelly	0.0	0.0
Emergency Contraception	0.1	0.0
Other Modern Method	0.0	0.0
Standard Days Method (SDM)	0.2	0.1
mCPR	56.4	45.3

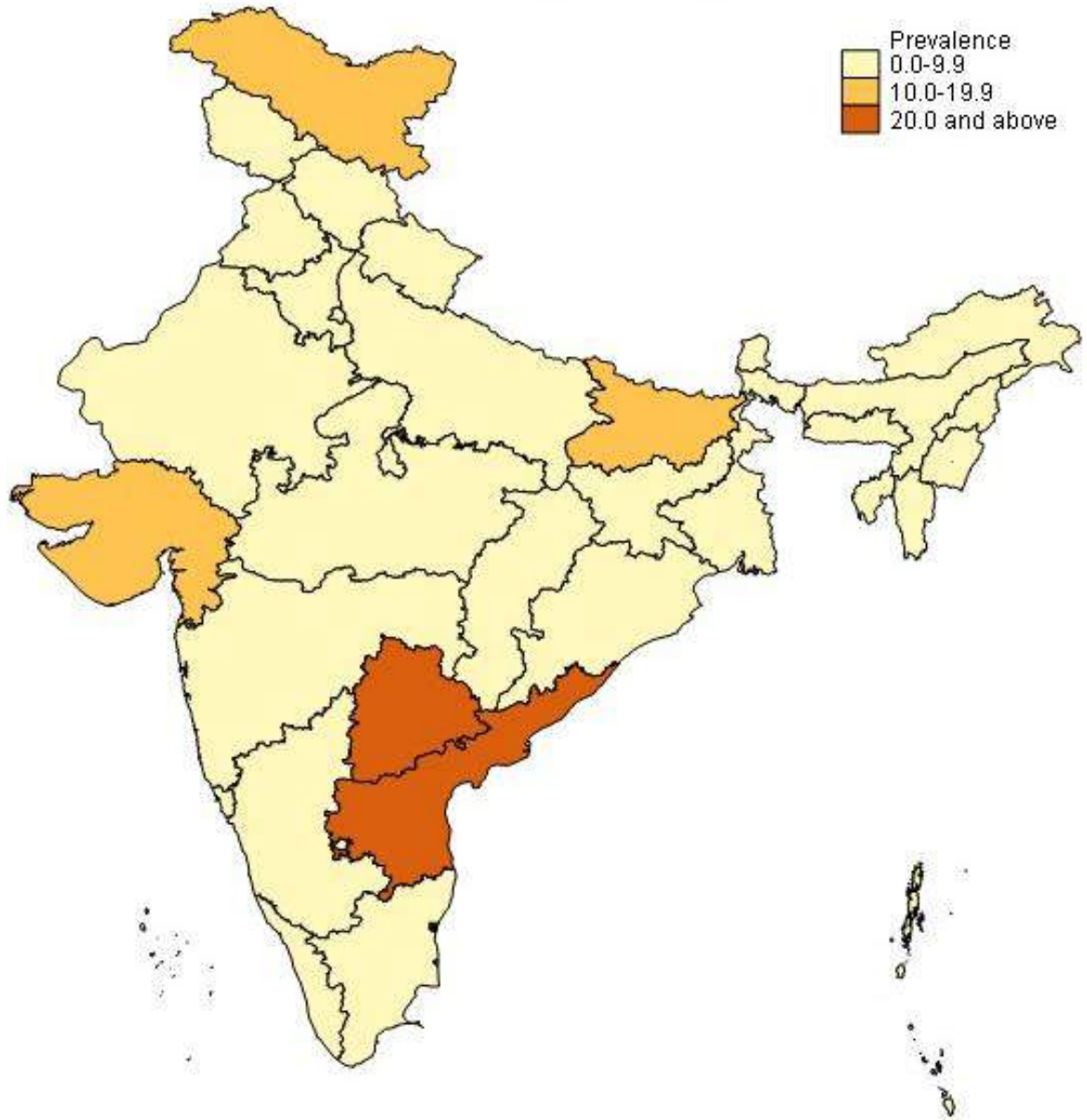
Use of gynaecological surgery in Rajasthan:

Trends from NFHS-5



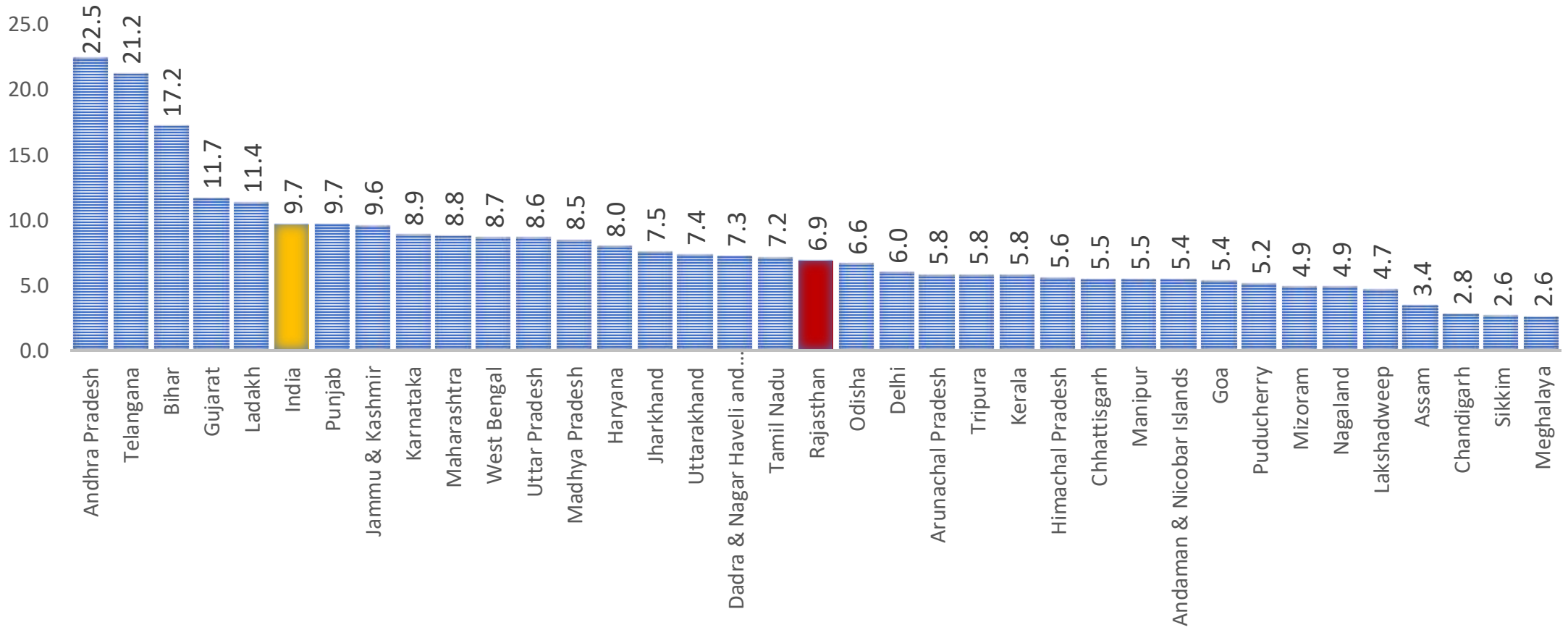
Jaipur Roundtable
November 21, 2023

National patterns of hysterectomy

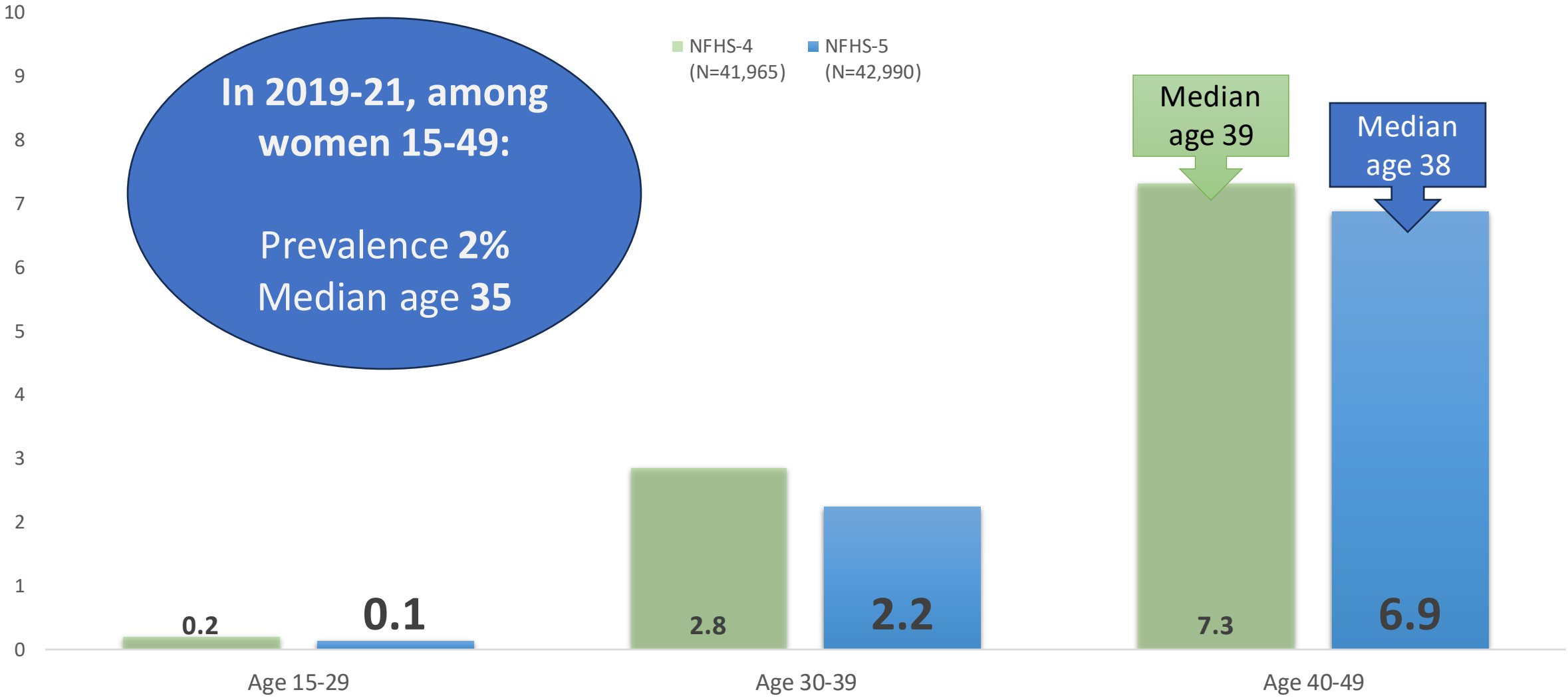


NFHS-5 (2019-2021)

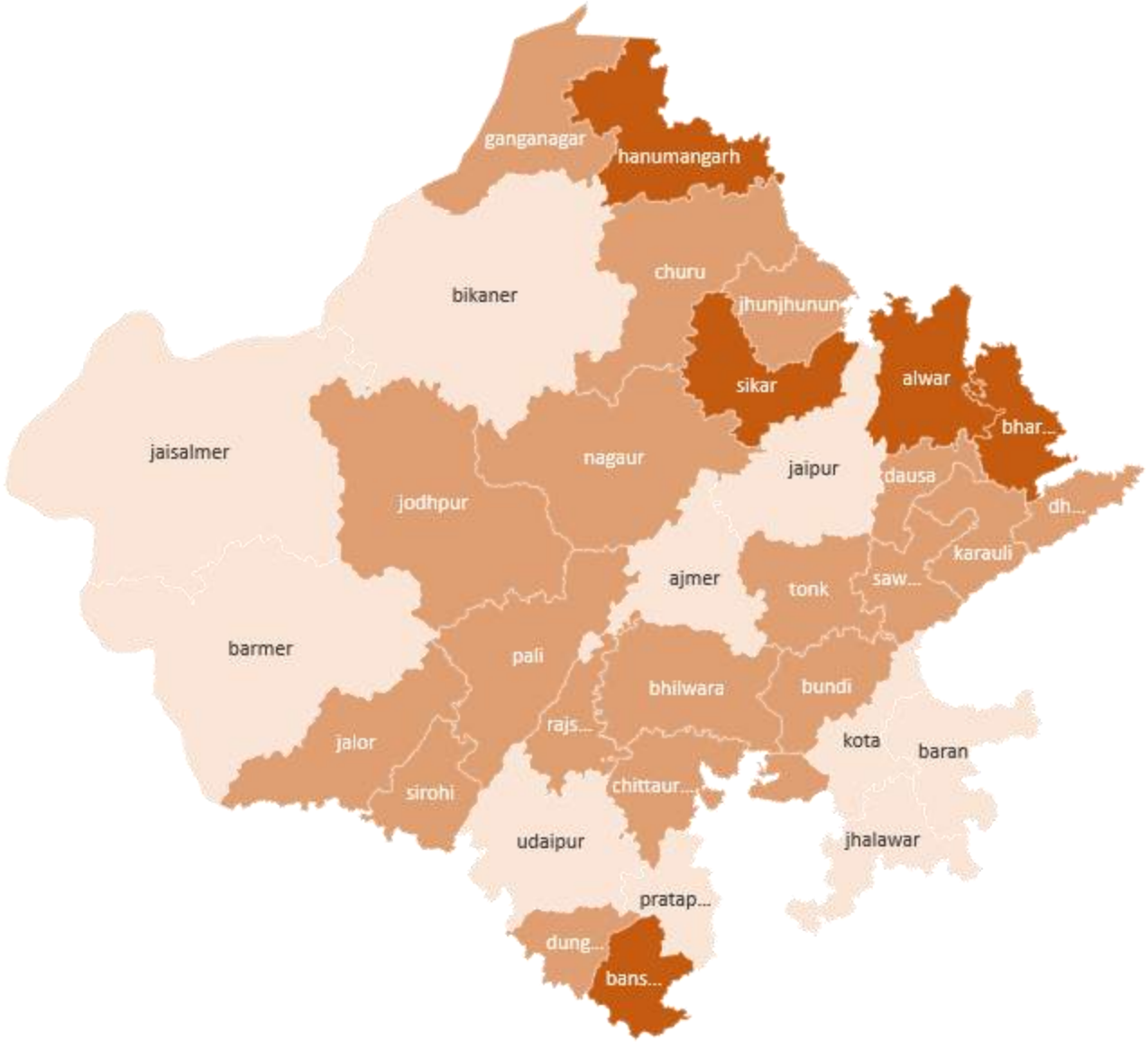
PREVALENCE OF HYSTERECTOMY AMONG WOMEN AGED 40-49 (2019-21)



Age specific prevalence in Rajasthan, NHFS-4/5



Prevalence of hysterectomy, 2019-21 (women 40-49)



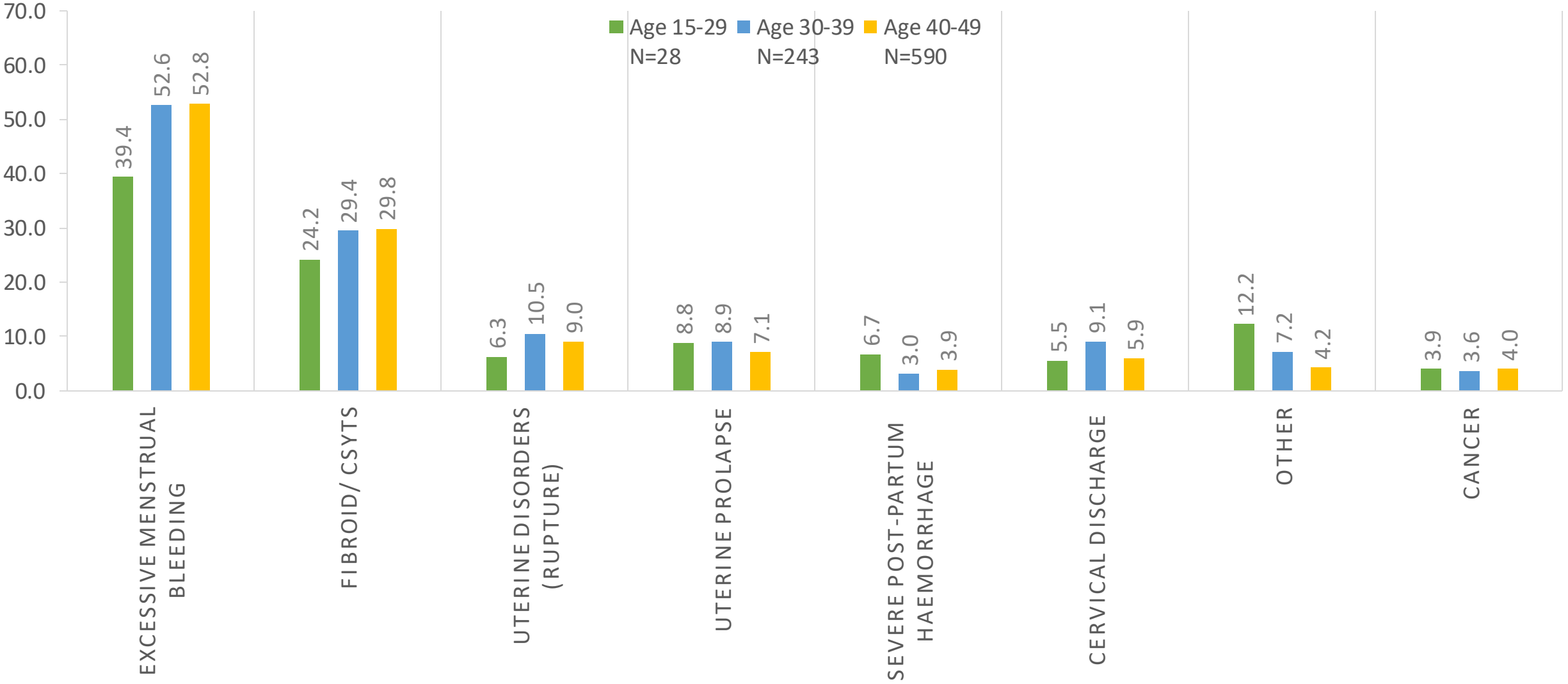
Highest (11-12%):
Alwar
Banswara
Sikar
Bharatpur

Low prevalence: [1.2, 5.5]

Mid prevalence: [5.5, 9.7]

High prevalence: [9.7, 12.9]

Self-reported reasons for hysterectomy, by age



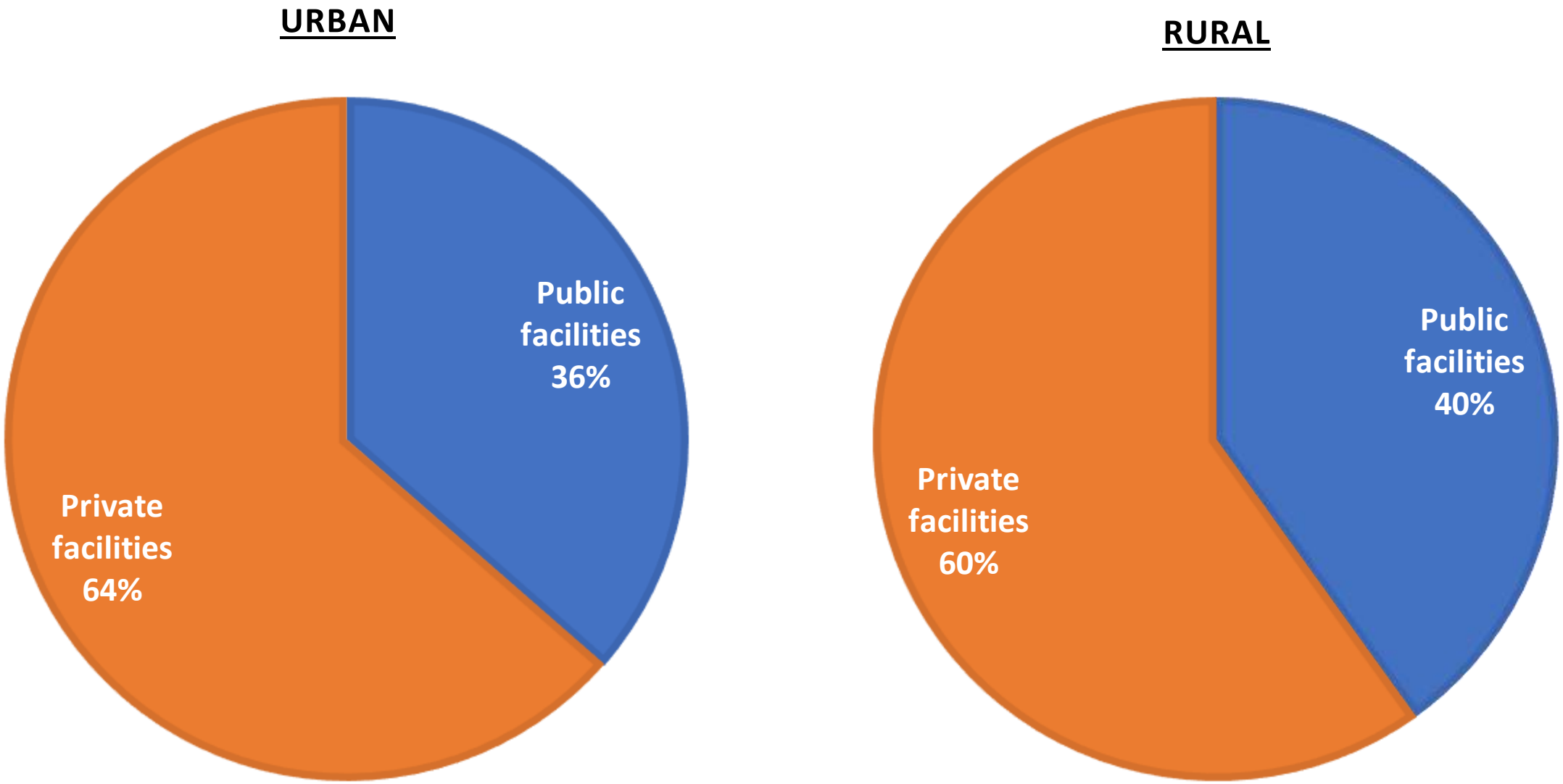
Factors associated with hysterectomy in Rajasthan*

- Older age
  - *12 times greater odds of hysterectomy in age 30-39*
  - *35 times greater odds in age 40-49*
- Less education
  - *Greater odds of hysterectomy in less educated groups*
- Rural residence
  - *Rural women at 1.3 greater odds of hysterectomy compared to urban women*
- From wealthier households
  - *AOR of 5th quintile vs 1st quintile= 1.6*
- Have one or more children
  - *4.3 times greater odds among women with one or more children*
- Have not been sterilised
  - *Lower odds (0.6) among women who have undergone sterilisation*

* Results from multivariate logistic regression on hysterectomy

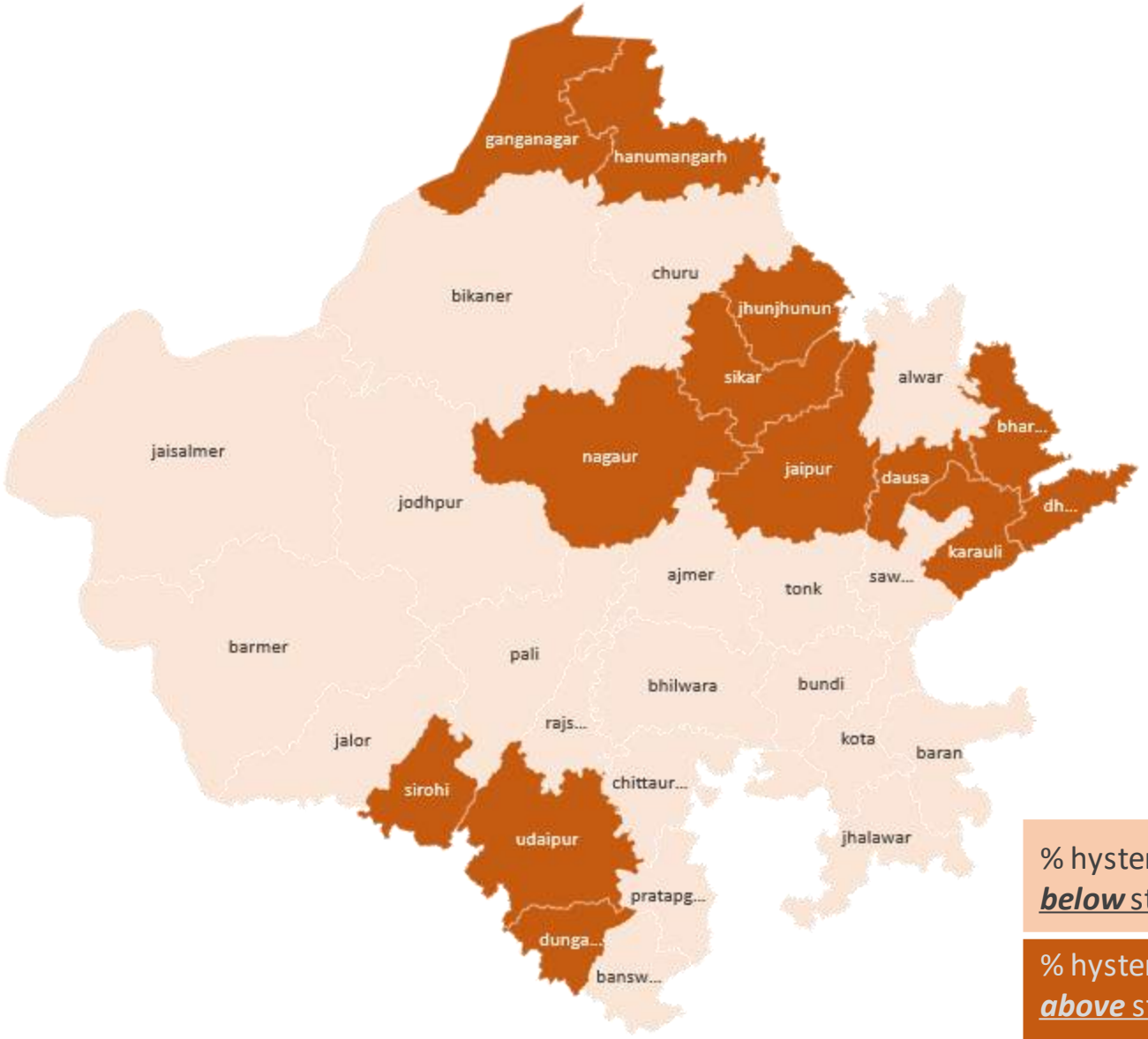
Place of hysterectomy

Place of hysterectomy, by residence



Hysterectomies in private facilities

Overall, **60.7%** hysterectomies in Rajasthan are in **private facilities**



% hysterectomies in private facilities- ***below*** state average [0, 60.6]

% hysterectomies in private facilities- ***above*** state average [60.7, 79.5]

Place of hysterectomy, by wealth quintile of households

Hysterectomy and NCDs

Hysterectomy and NCDs later in life

Findings from the LASI study, 2017

A nationally representative sample of women, aged 45 and up in India:

A woman with hysterectomy had….

1.5 times higher odds of **hypertension**

1.7 times higher odds of **diabetes**

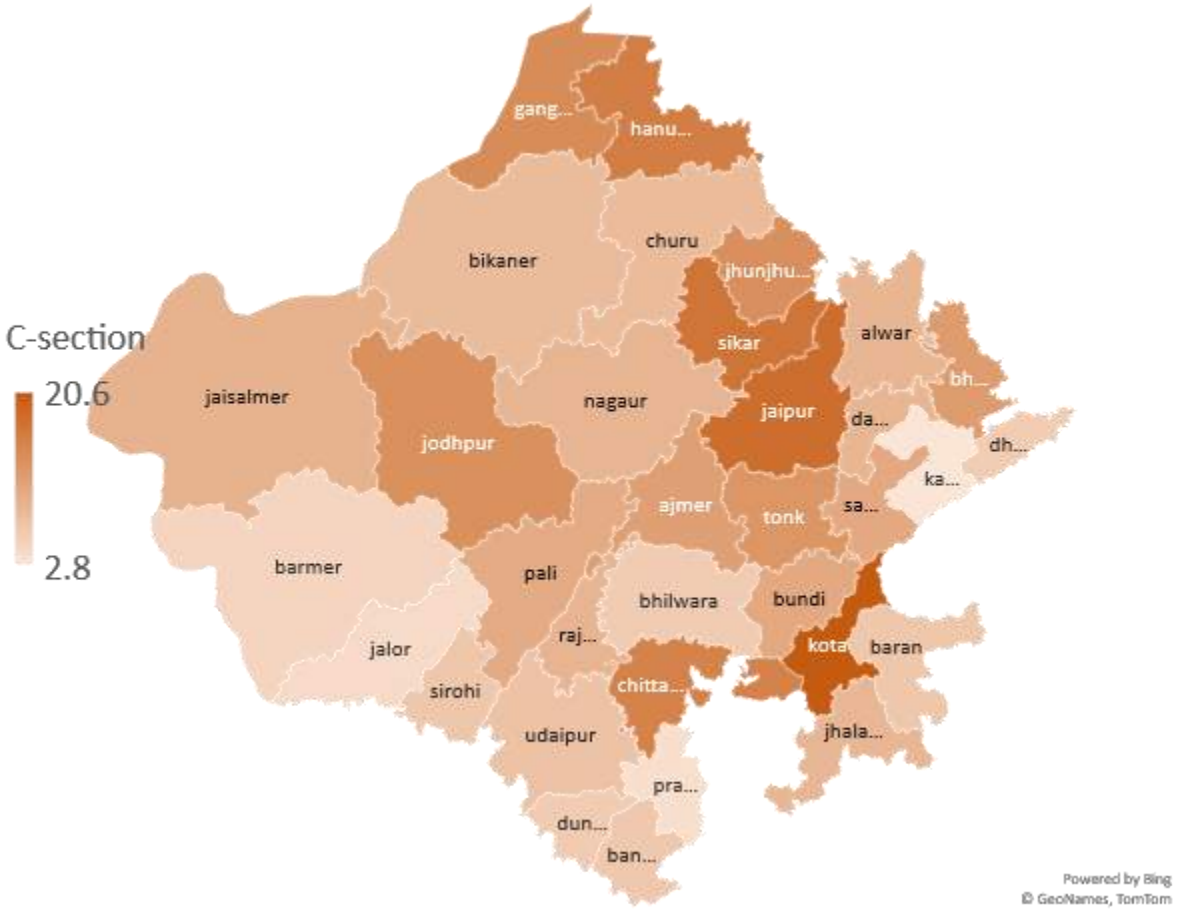
1.5 times higher odds of **bones/ joint diseases**

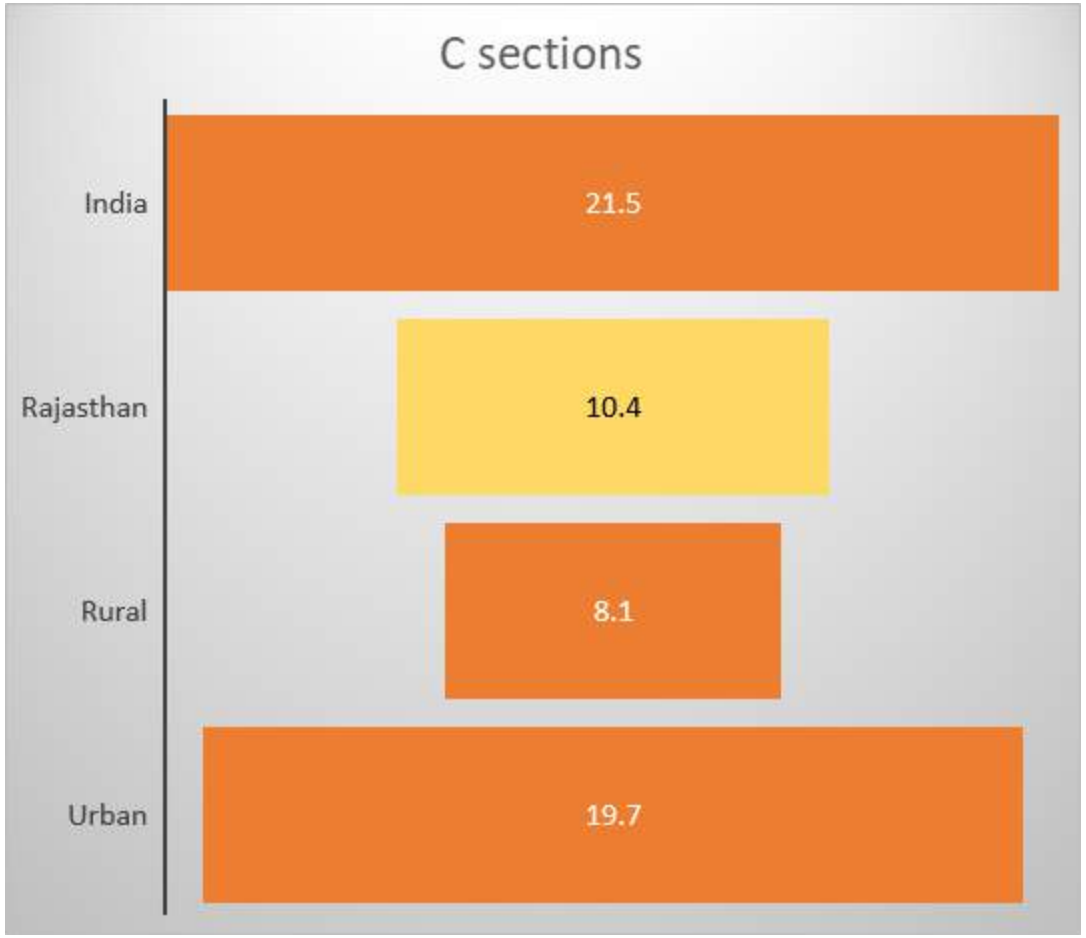
when compared with women without a hysterectomy

Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

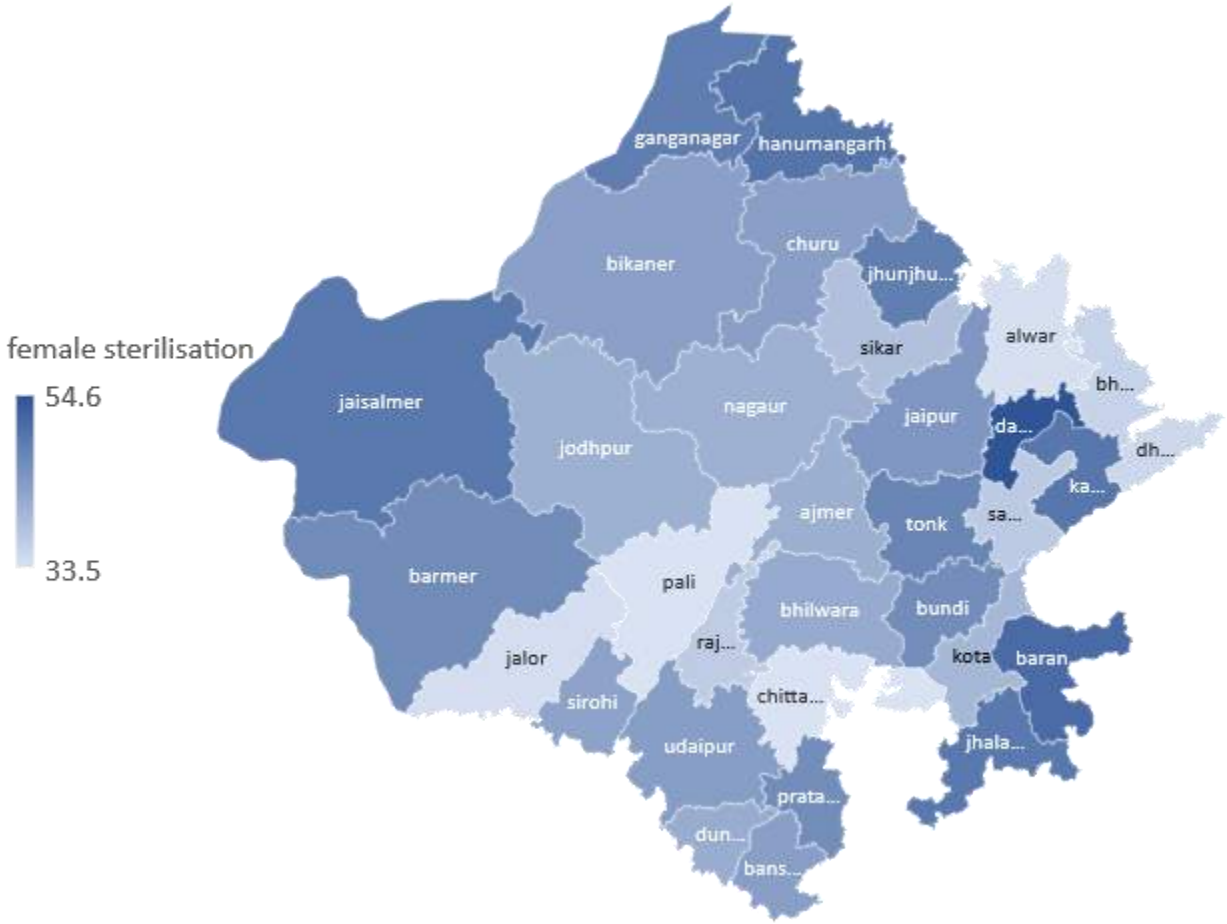
Rajasthan: C-sections in last 5 years*

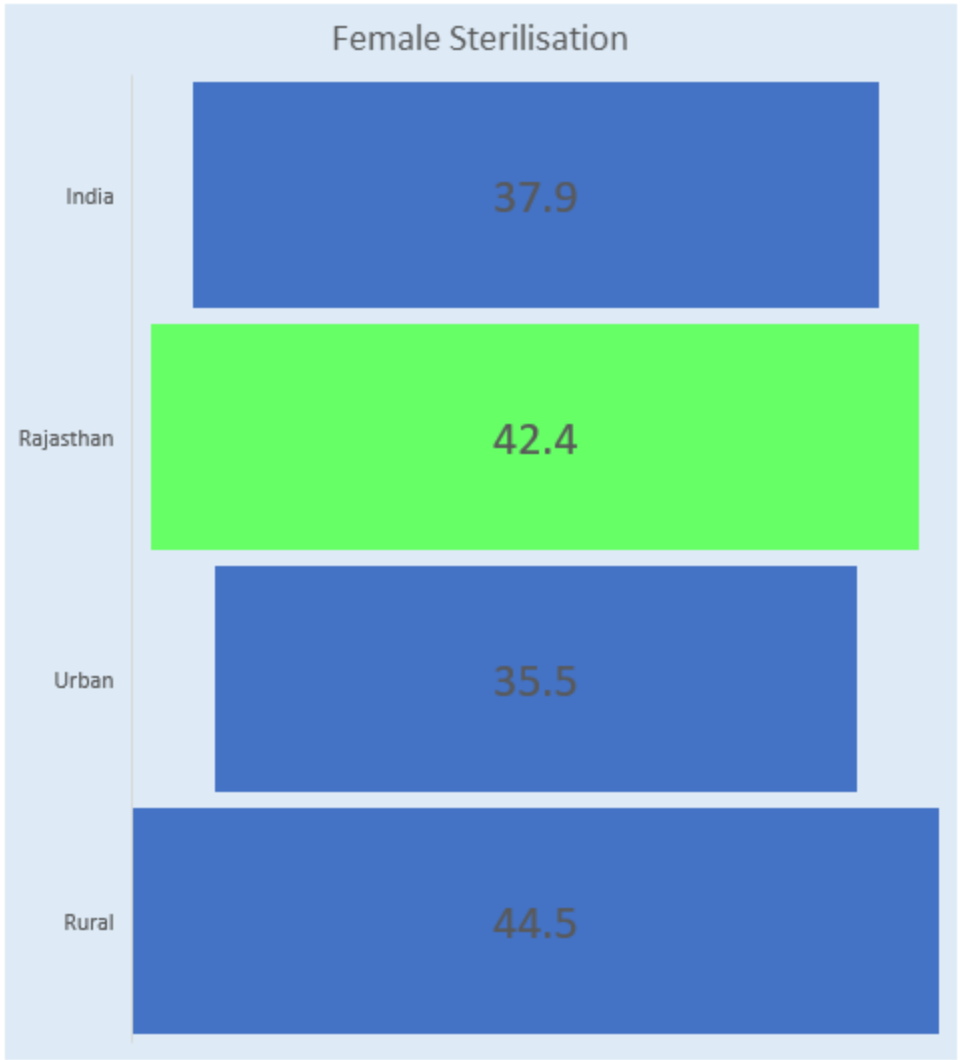




***: all births in last 5 years, NFHS 5 (2019-21)**

Rajasthan: Female sterilisation





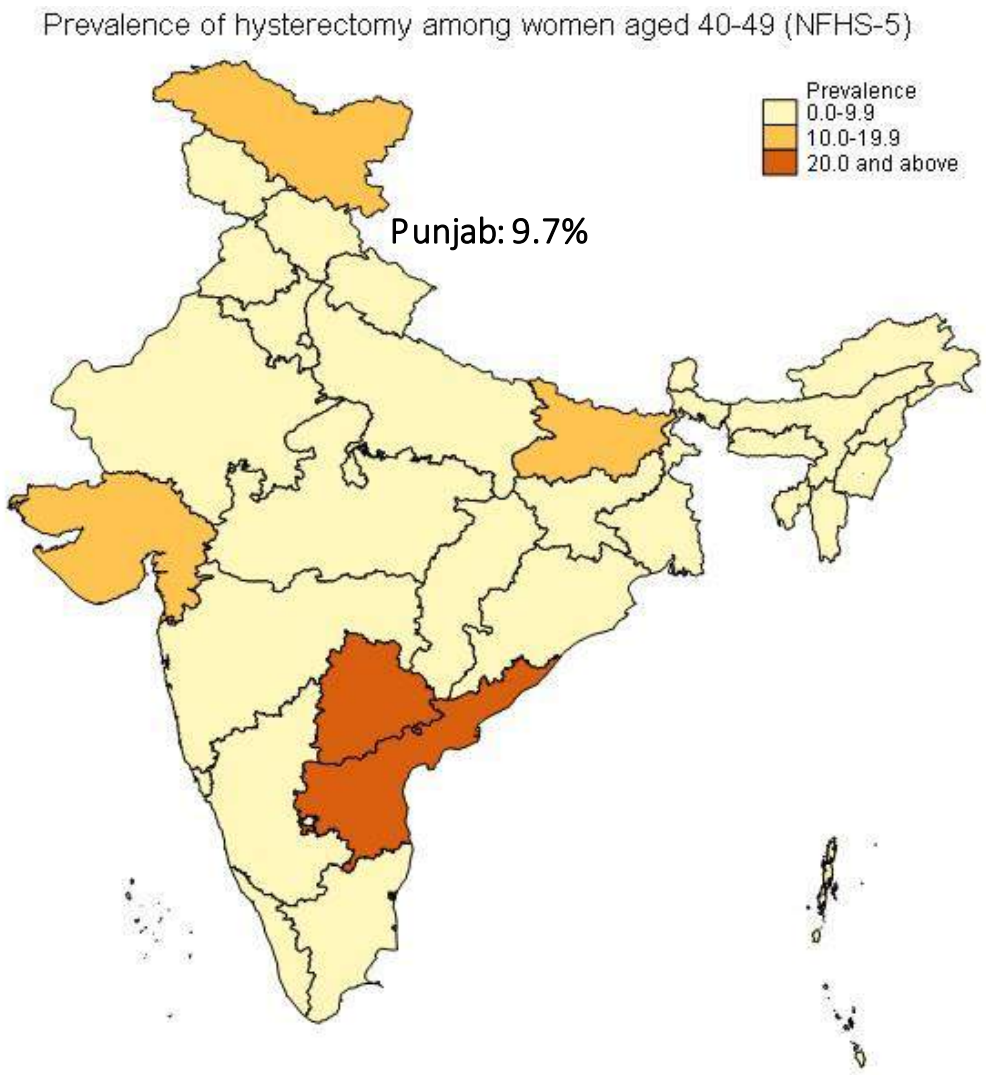
*: NFHS 5 (2019-21)

Use of gynaecological surgery in Punjab:

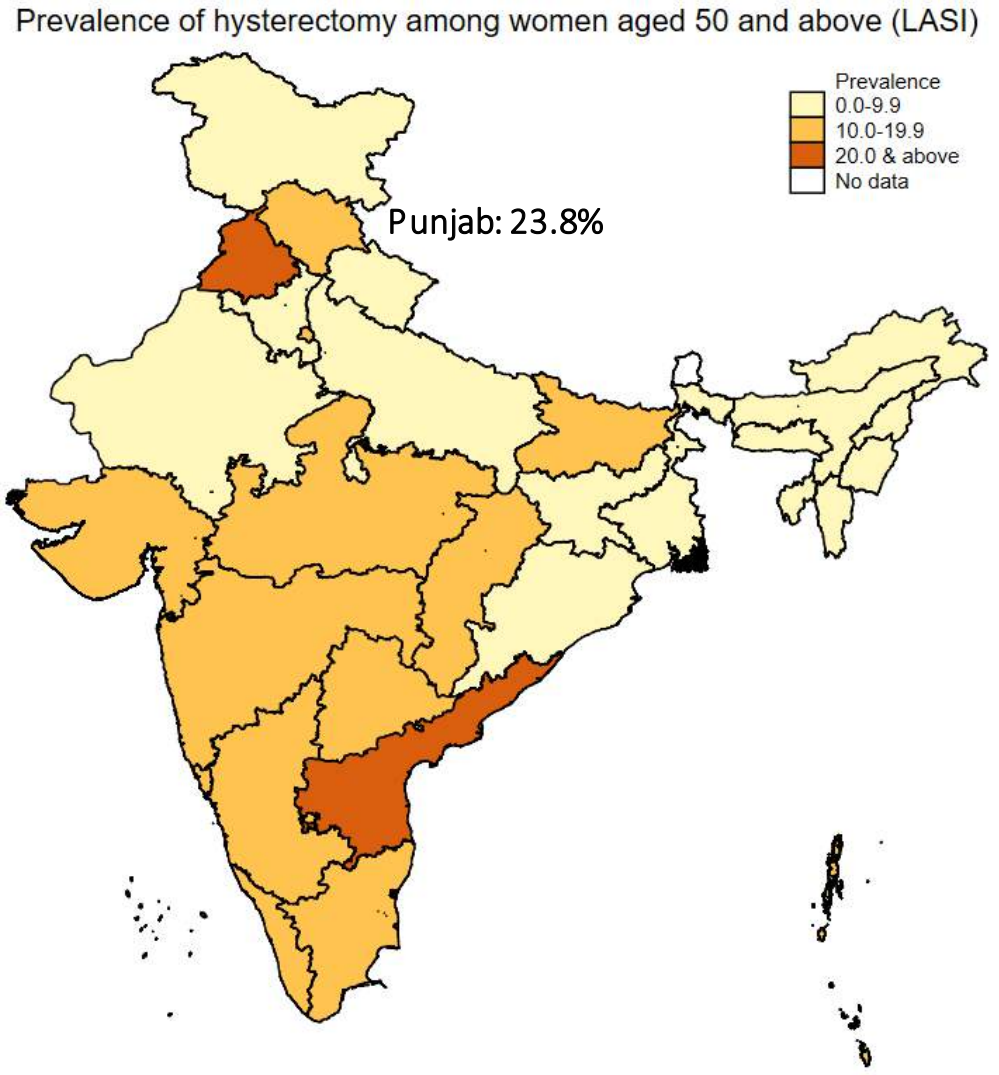
Trends from NFHS and LASI

Chandigarh Roundtable
November 30, 2023

National patterns of hysterectomy (40-49, 50+)

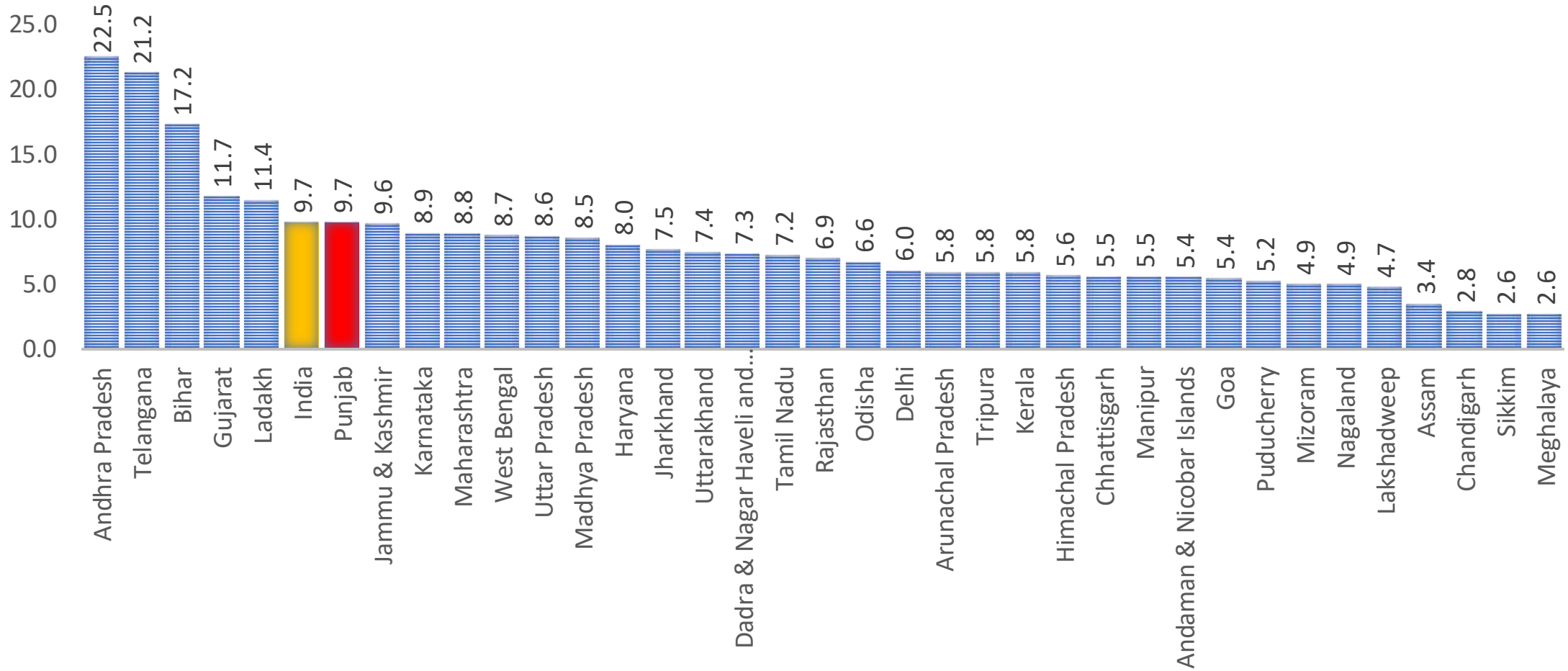


NFHS-5 (2019-21)

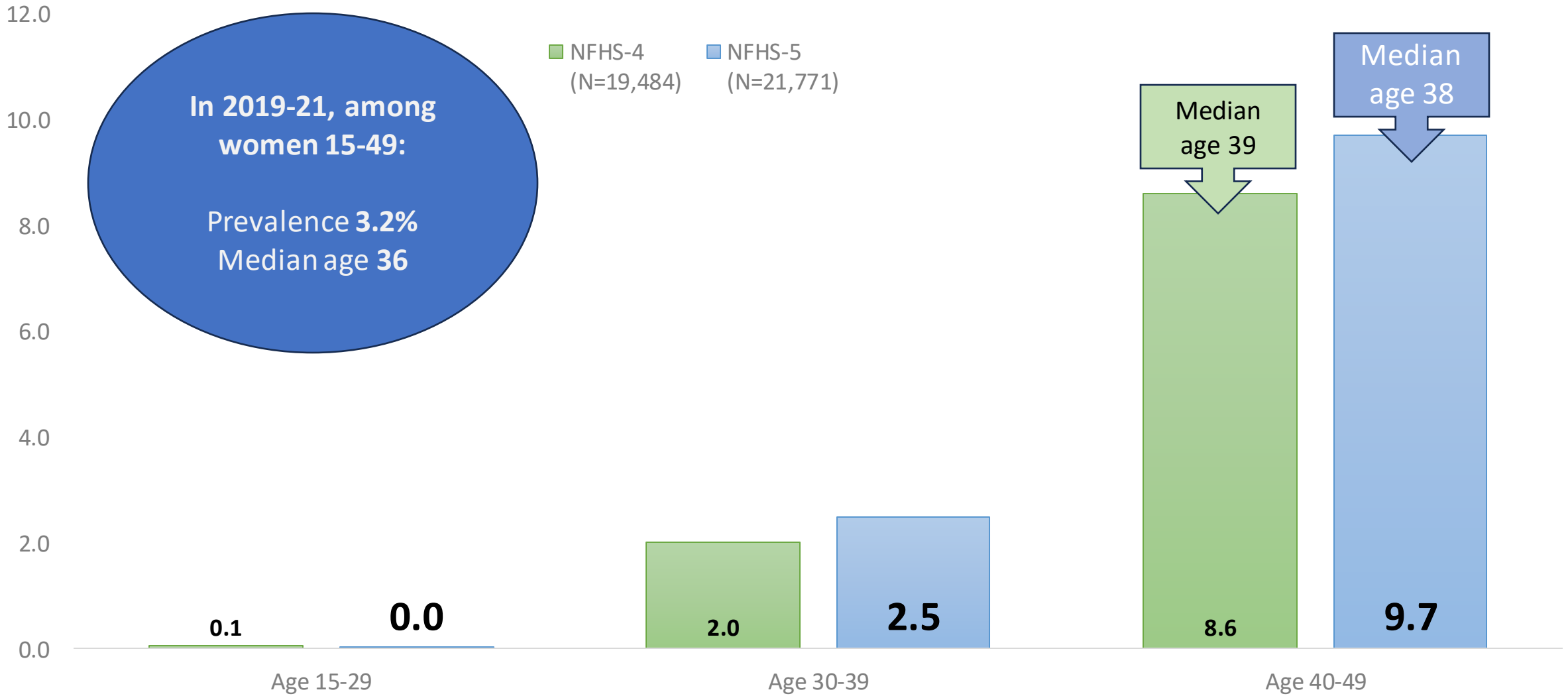


LASI (2017-18)

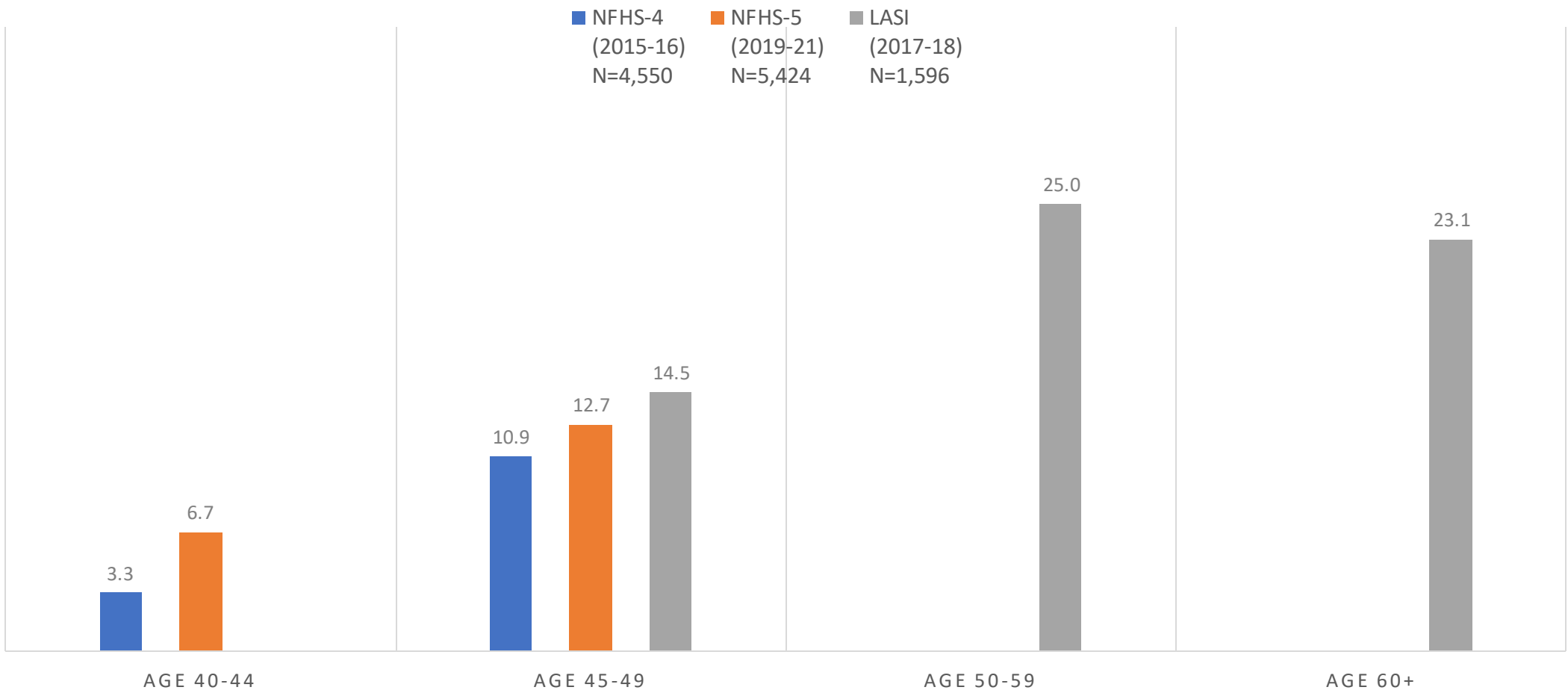
Prevalence of hysterectomy among women aged 40-49 (2019-21)



Age specific prevalence and age at hysterectomy

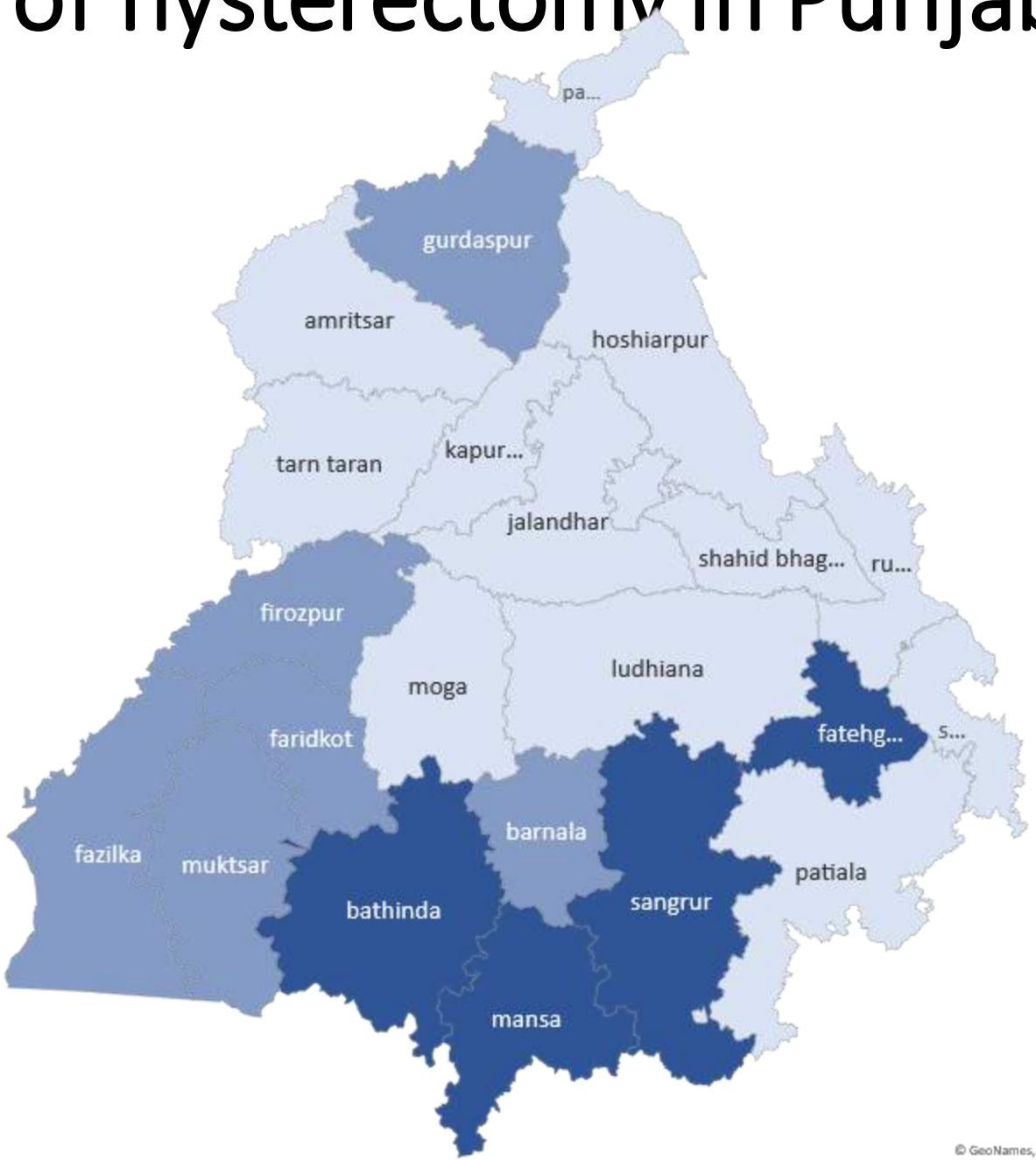


Hysterectomy prevalence in Punjab, women ≥40



Prevalence of hysterectomy in Punjab, 2019-21

(women 40-49)



Highest prevalence:

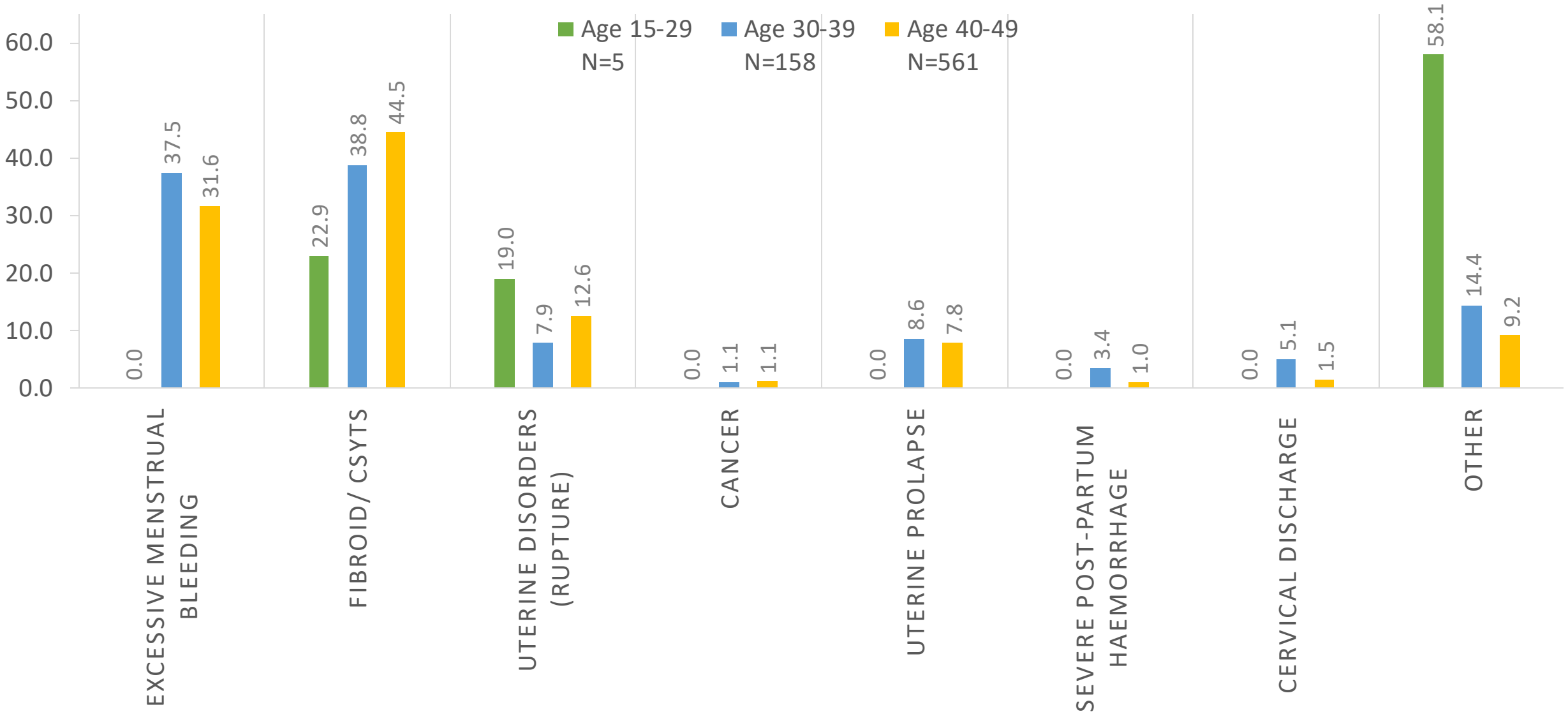
- Mansa 17.5%
- Bathinda 14.2%
- Fatehgarh Sahib 14.0%
- Sangrur 13.9%

Low prevalence: [5.3, 9.5]

Mid prevalence: [9.6, 13.5]

High prevalence: [13,6, 17.5]

Self reported reasons for hysterectomy, by age



Factors associated with hysterectomy in Punjab*

- Older age
  - *Greater odds of hysterectomy in older age groups*
- Less education
  - *Greater odds of hysterectomy in less educated groups*
- Rural residence
  - *Rural women at 1.4 greater odds of hysterectomy compared to urban women*
- Have one or more children
  - *3 times greater odds among women with one or more children*
- Have not been sterilised
  - *Lower odds (0.7) among women who have undergone sterilisation*

* Results from multivariate logistic regression on hysterectomy as outcome variable

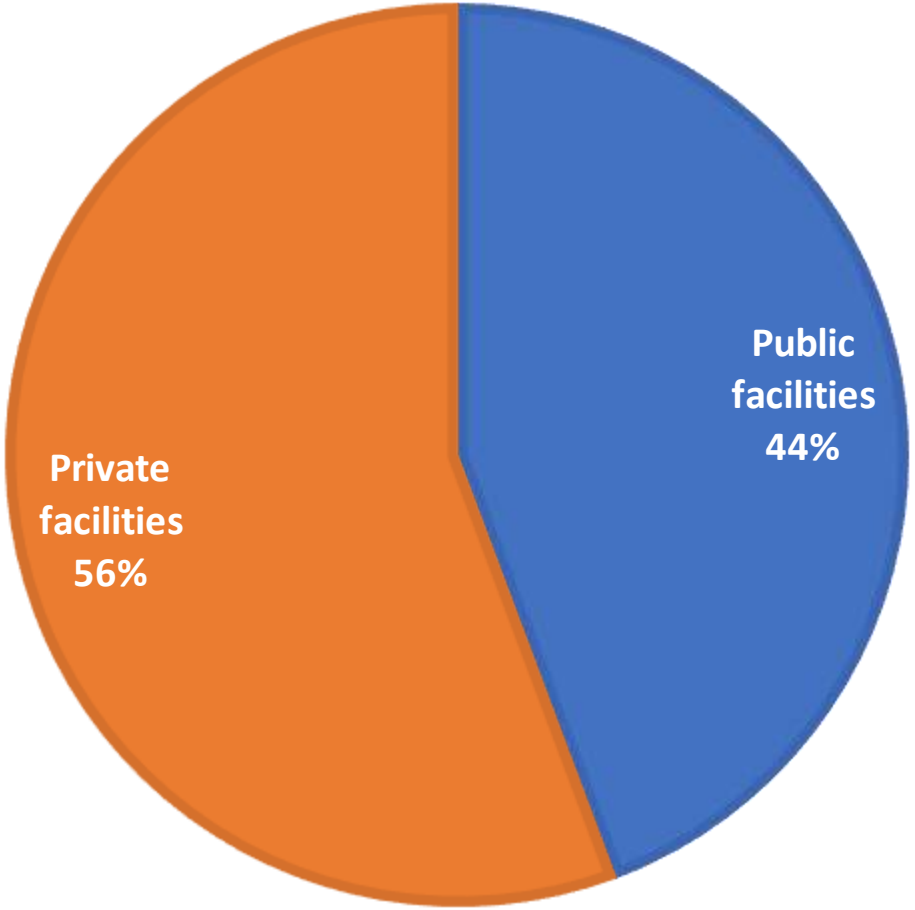
Place of hysterectomy

Place of Hysterectomy

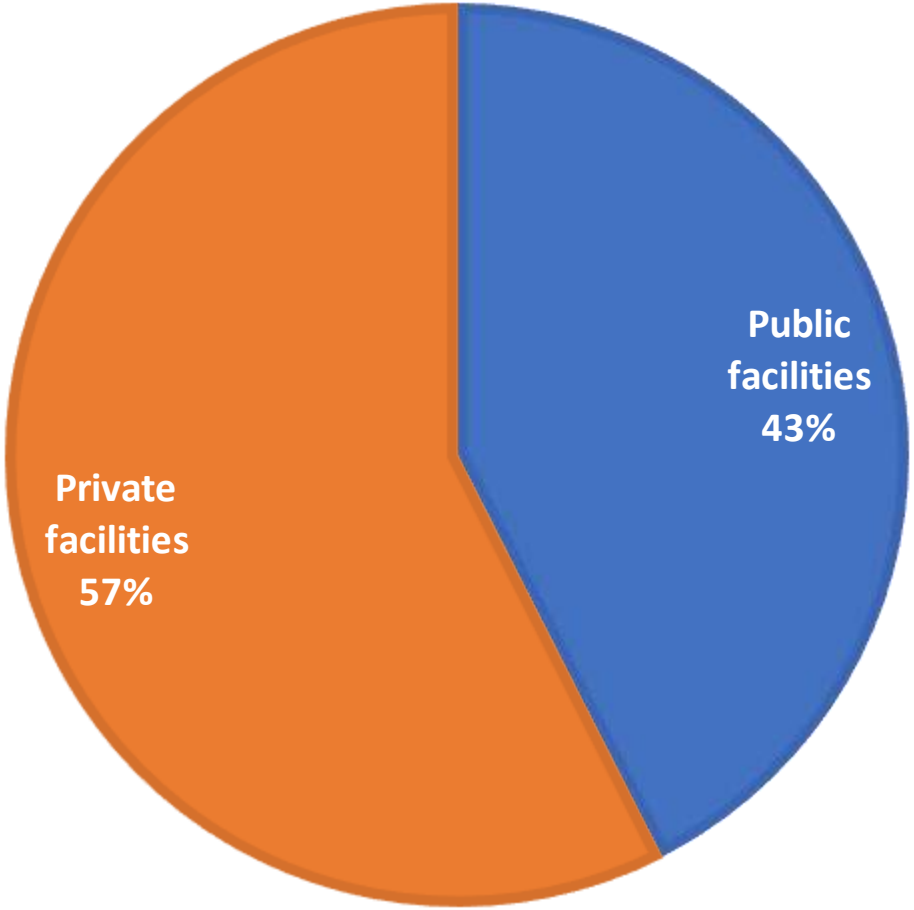
Overall, **56.9%** hysterectomies in Punjab are in **private facilities**

Place of hysterectomy, by residence

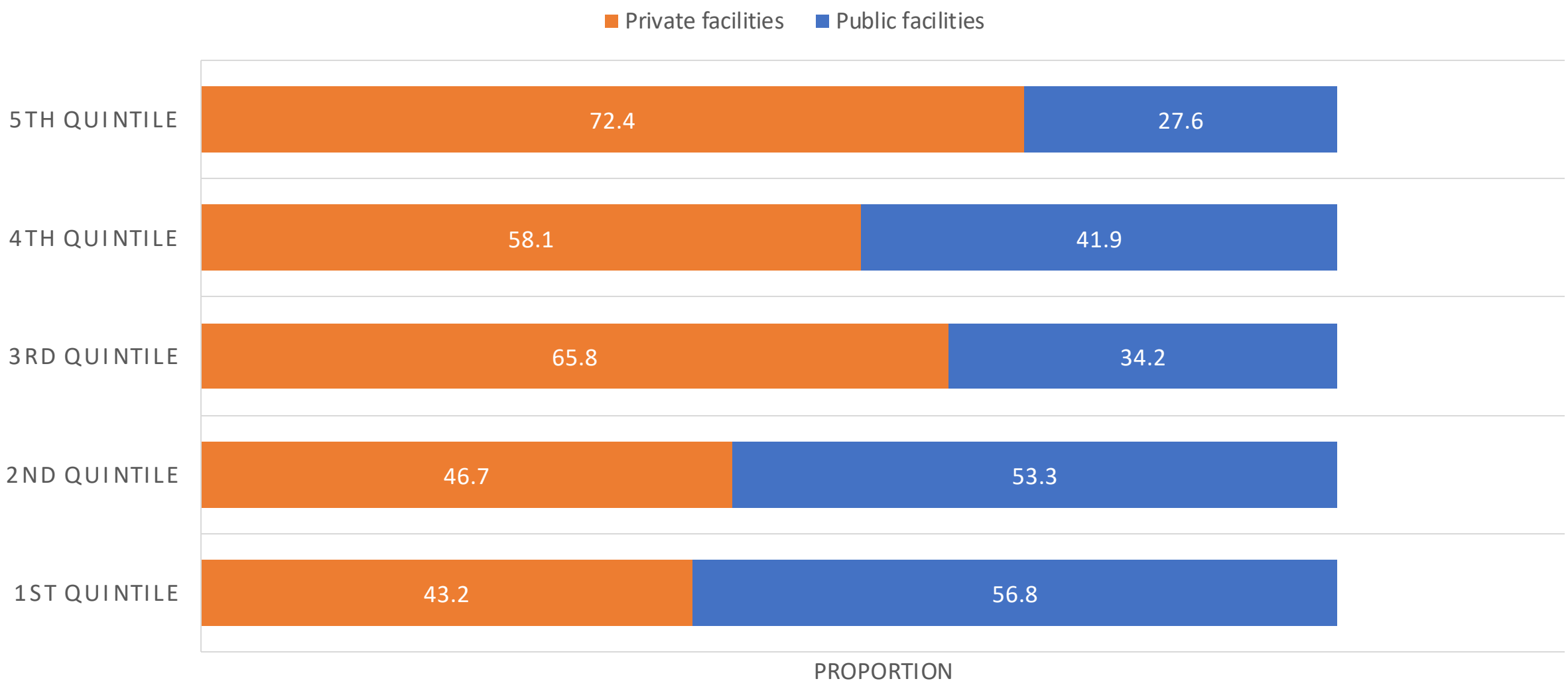
URBAN



RURAL



Place of hysterectomy, by wealth quintile of households



Hysterectomy and NCDs

Hysterectomy and NCDs later in life

Findings from the LASI study, 2017

A nationally representative sample of women, aged 45 and up in India:

A woman with hysterectomy had….

1.5 times higher odds of **hypertension**

1.7 times higher odds of **diabetes**

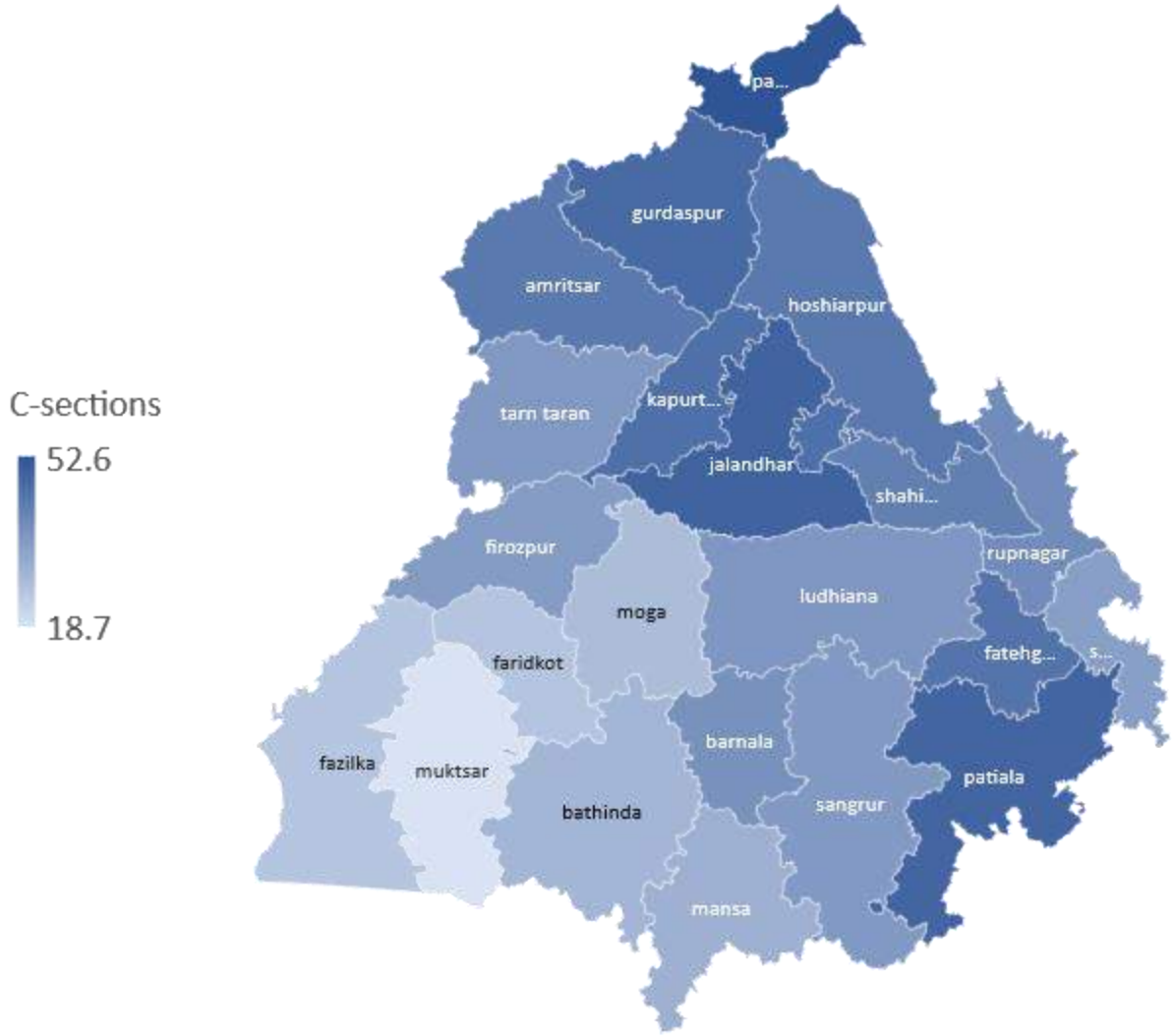
1.5 times higher odds of **bones/ joint diseases**

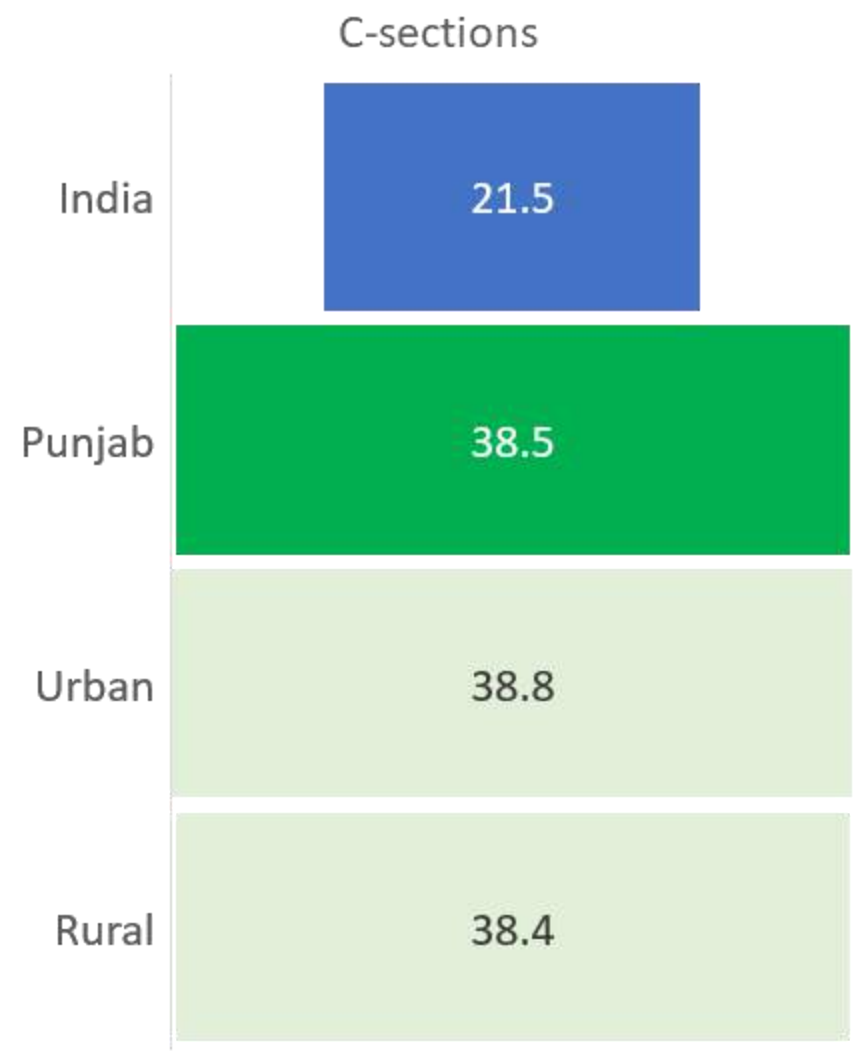
when compared with women without a hysterectomy

Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

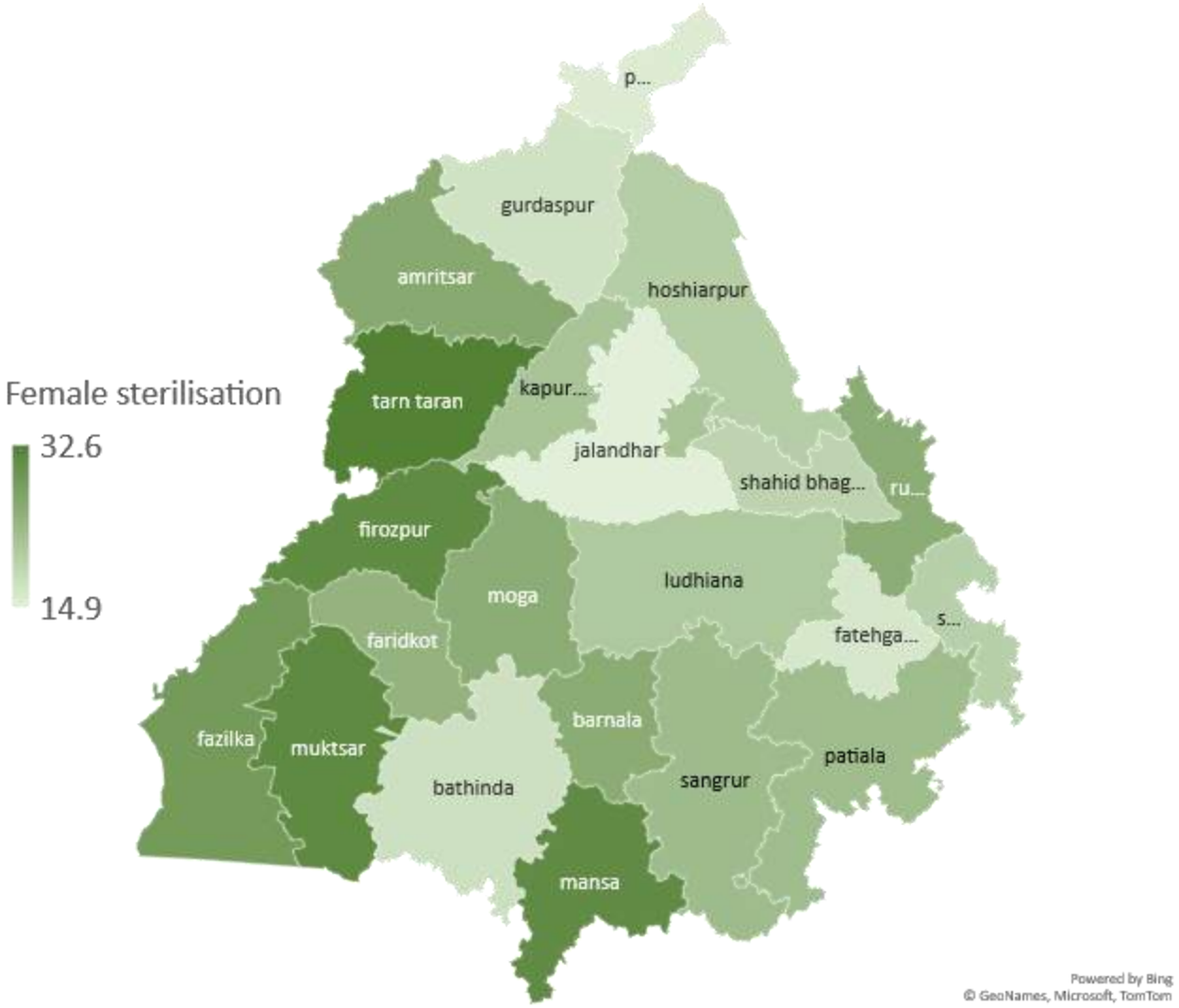
Punjab: C-sections in last 5 years*

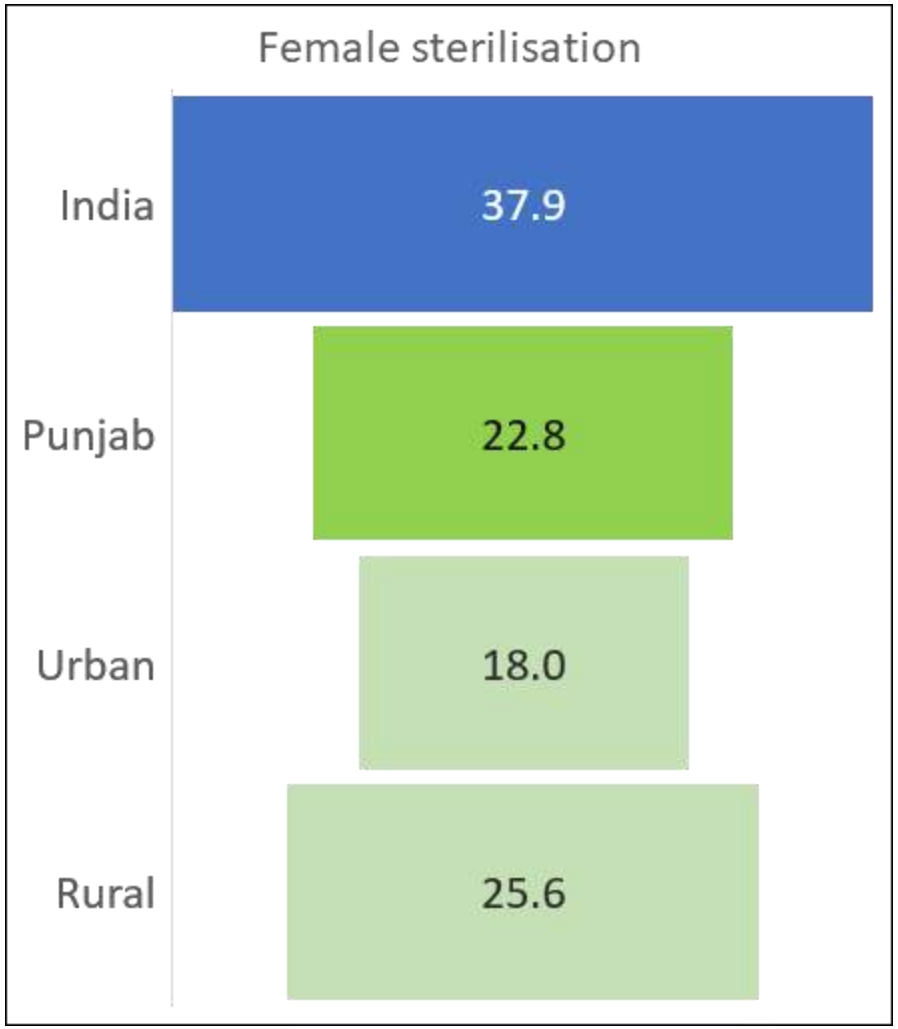




*: all births in last 5 years, NFHS 5 (2019-21)

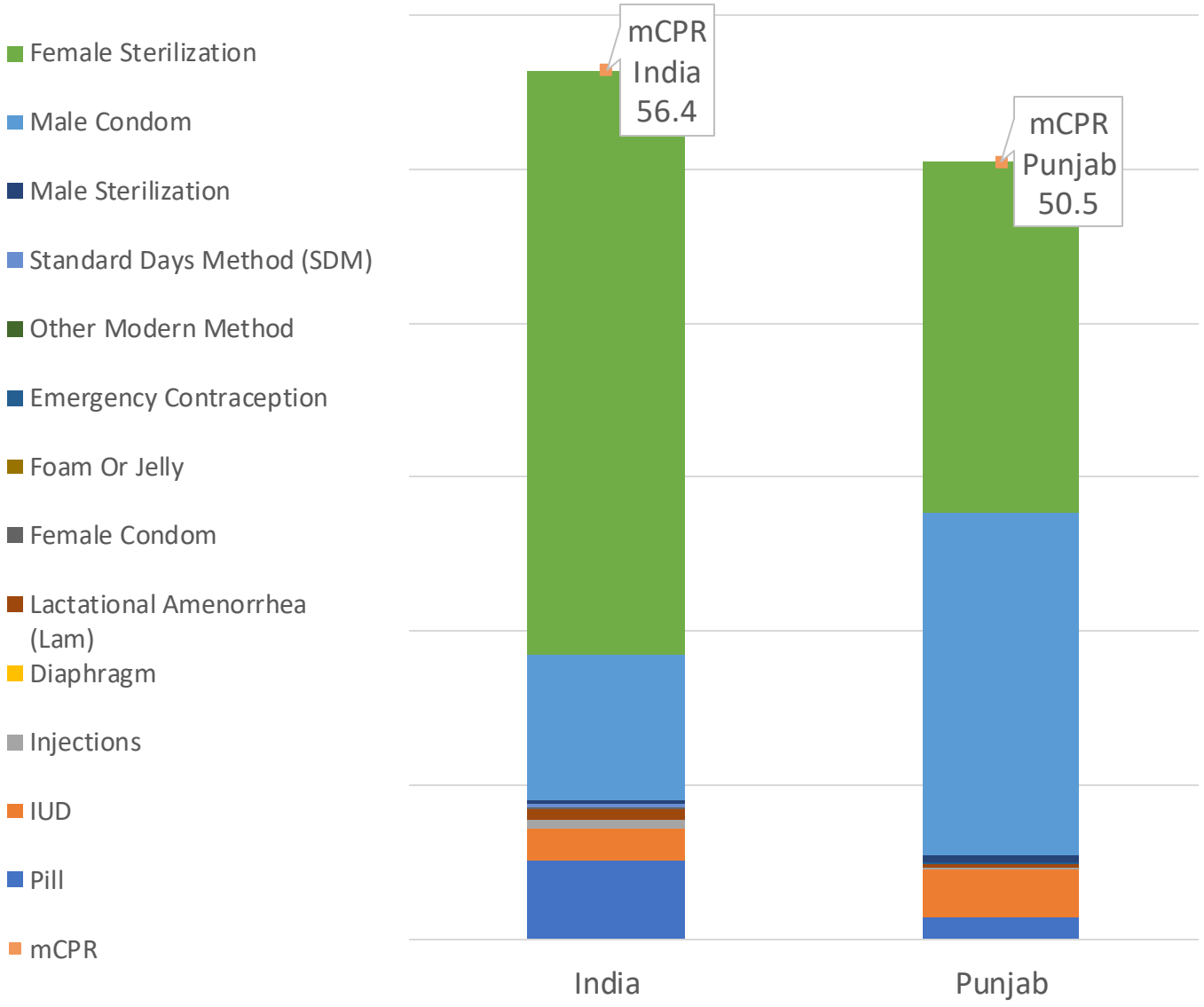
Punjab: Female sterilisation





*: NFHS 5 (2019-21)

Modern contraceptive method mix, married women 15-49



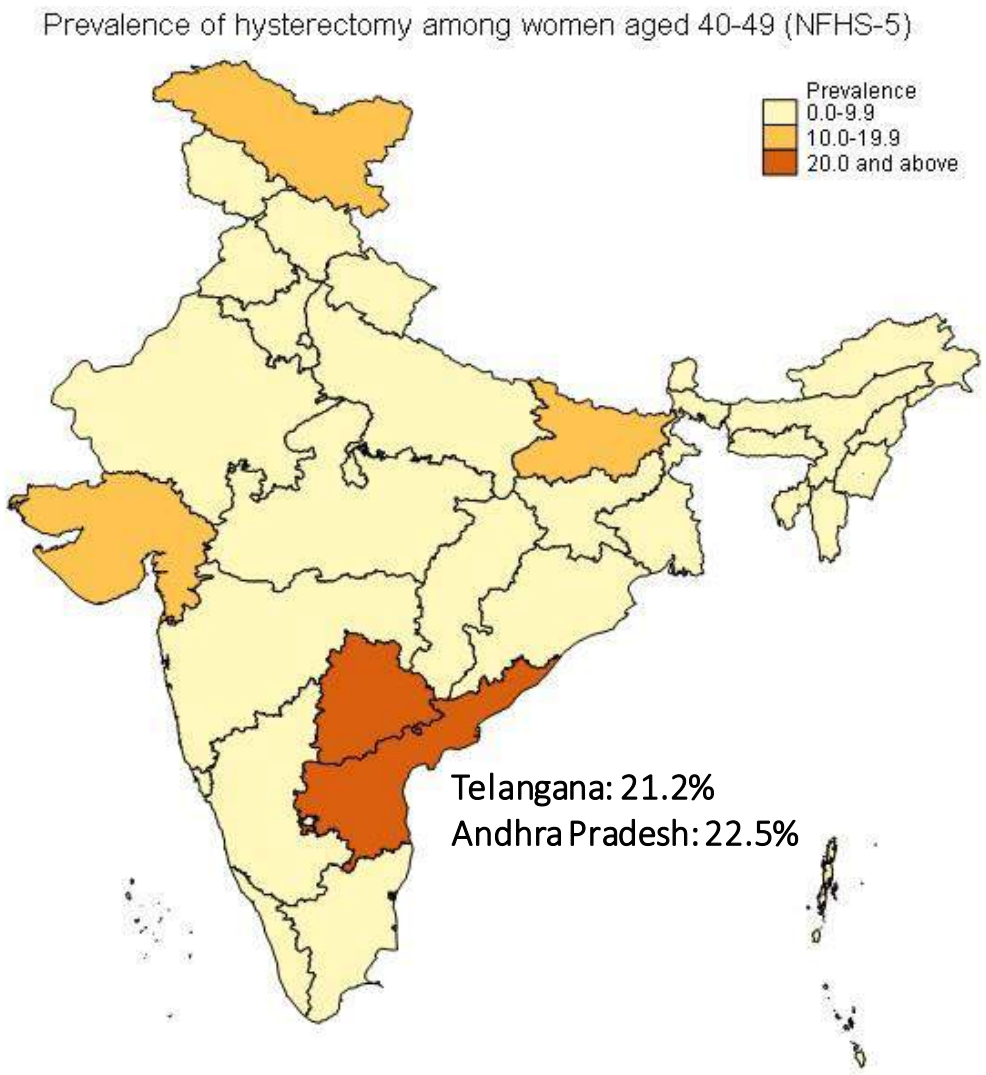
Method	India	Punjab
Pill	5.1	1.5
IUD	2.1	3.1
Injections	0.6	0.1
Diaphragm	0.0	0.0
Male Condom	9.5	22.2
Female Sterilization	37.9	22.8
Male Sterilization	0.3	0.5
Lactational Amenorrhea (Lam)	0.7	0.3
Female Condom	0.0	0.0
Foam Or Jelly	0.0	0.0
Emergency Contraception	0.1	0.1
Other Modern Method	0.0	0.0
Standard Days Method (SDM)	0.2	0.1
mCPR	**56.4**	**50.5**

Use of gynaecological surgery in Telangana:

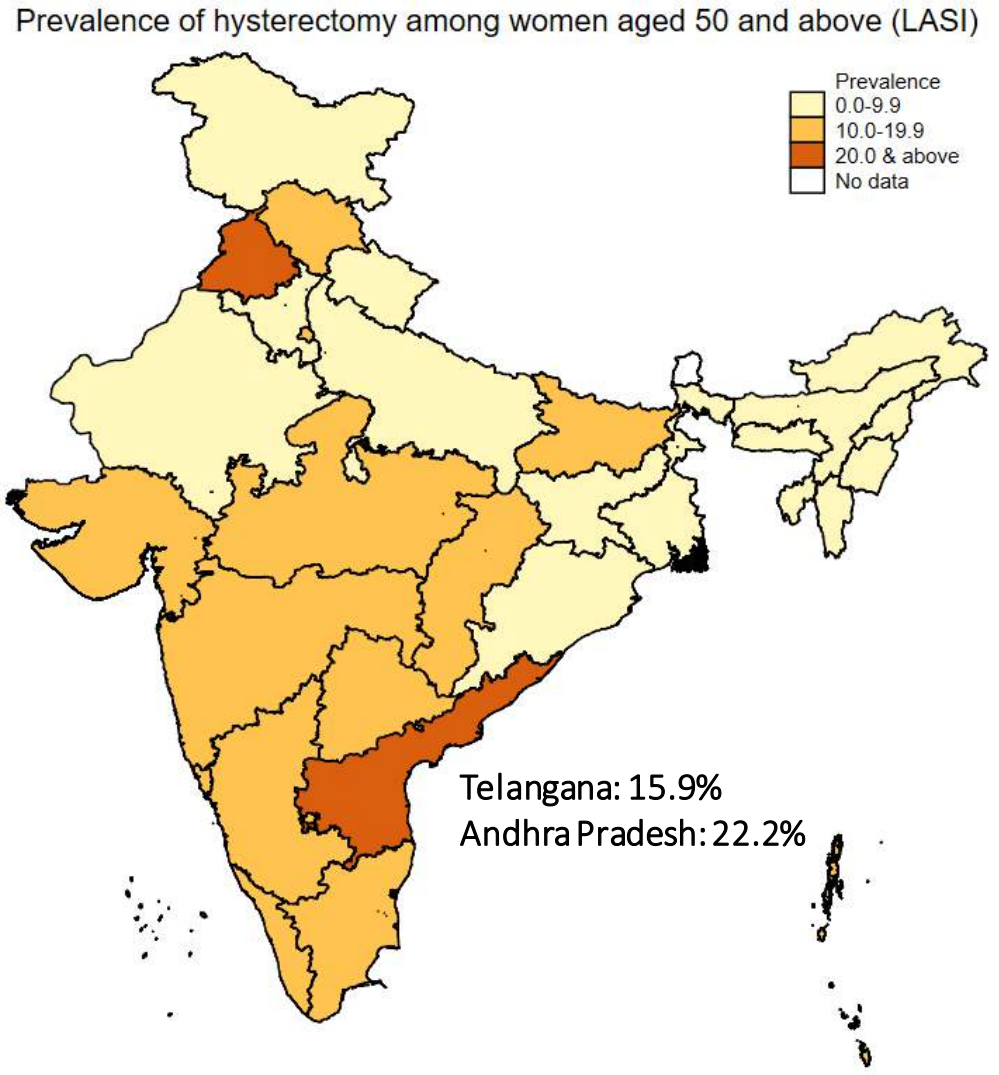
Trends from NFHS

Hyderabad Roundtable
December 8, 2023

National hysterectomy patterns (40-49, 50+)

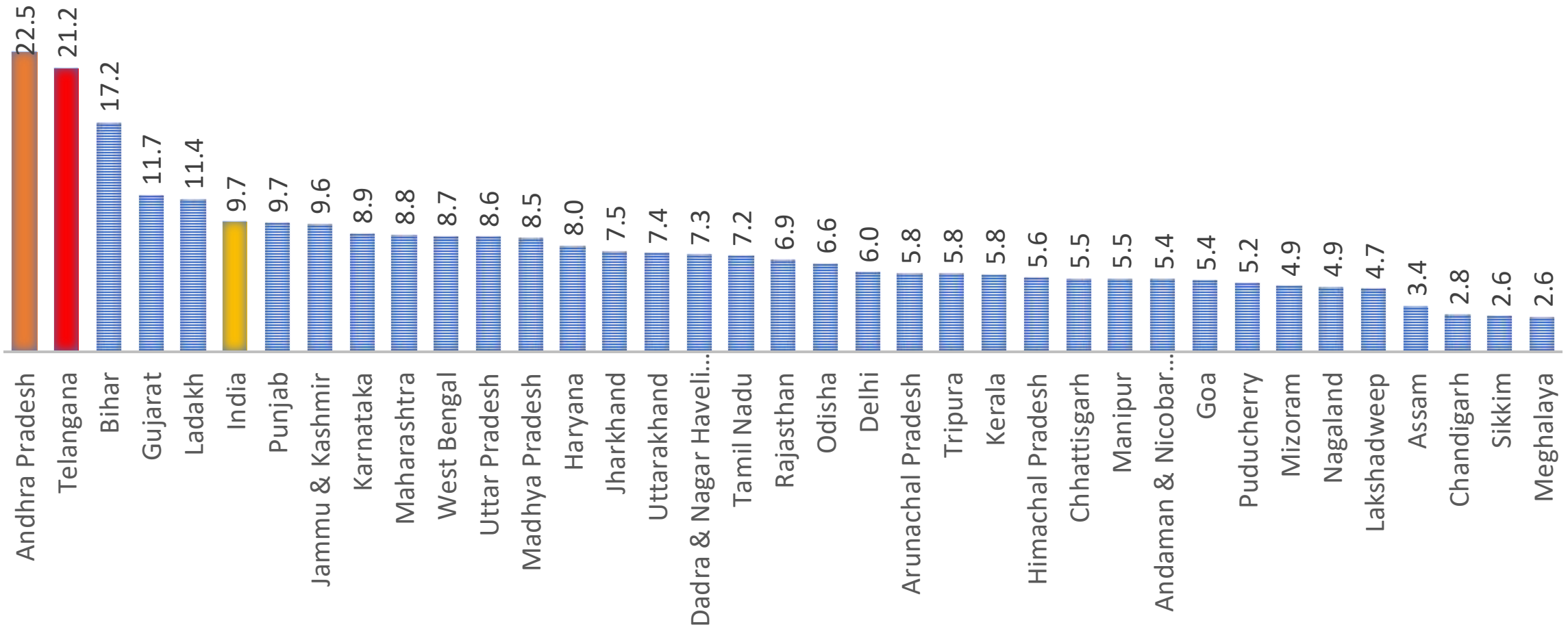


Source: NFHS-5 (2019-21)



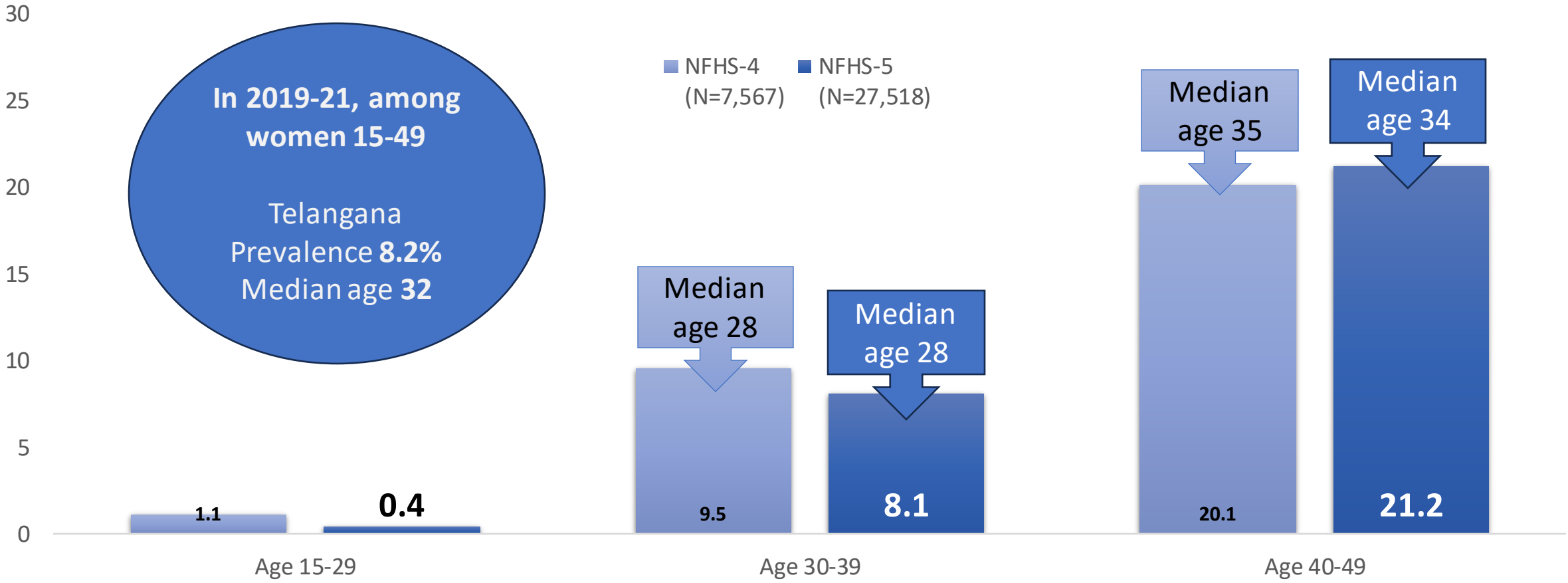
Source: LASI (2017-18)

Prevalence of hysterectomy among women aged 40-49 (2019-21)



Source: NFHS-5 (2019-21)

Telangana: Age specific prevalence and age at hysterectomy



Hysterectomy in Andhra Pradesh

Women 15-49, prevalence 9%, at median age 32

Women 40-49, prevalence 22.5%, at median age 34

Source: NFHS-5 (2019-21)

Prevalence of hysterectomy in Telangana, 2019-21
(women 40-49)

High prevalence (%):

- Warangal rural 36.3
- Suryapet 31.4
- Karimnagar 30.7
- Jangoan 29.7

Low prevalence: [6.3, 16.3]

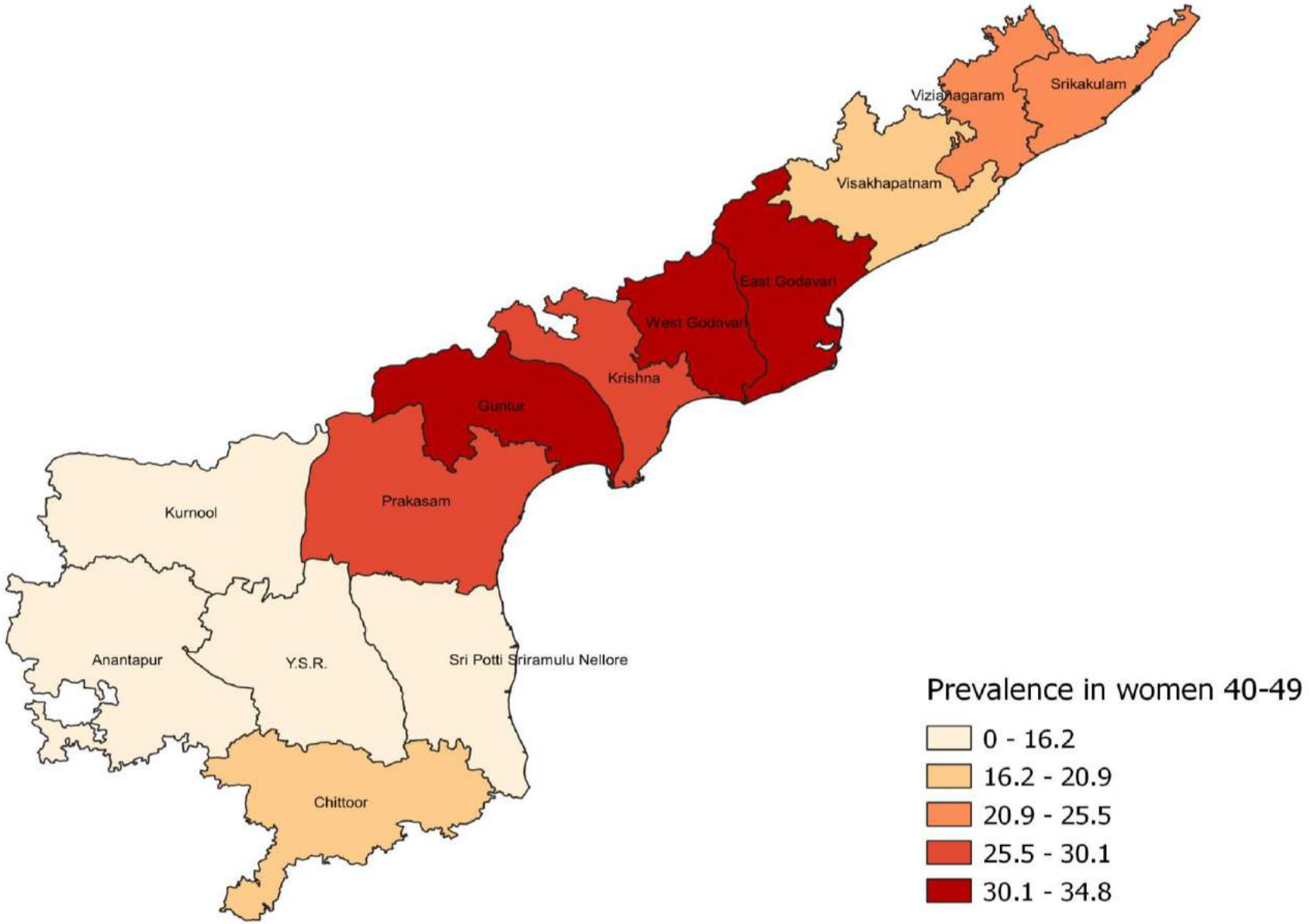
Mid prevalence: [16.3, 26.3]

High prevalence: [26.3, 36.3]

Source: NFHS-5 (2019-21)

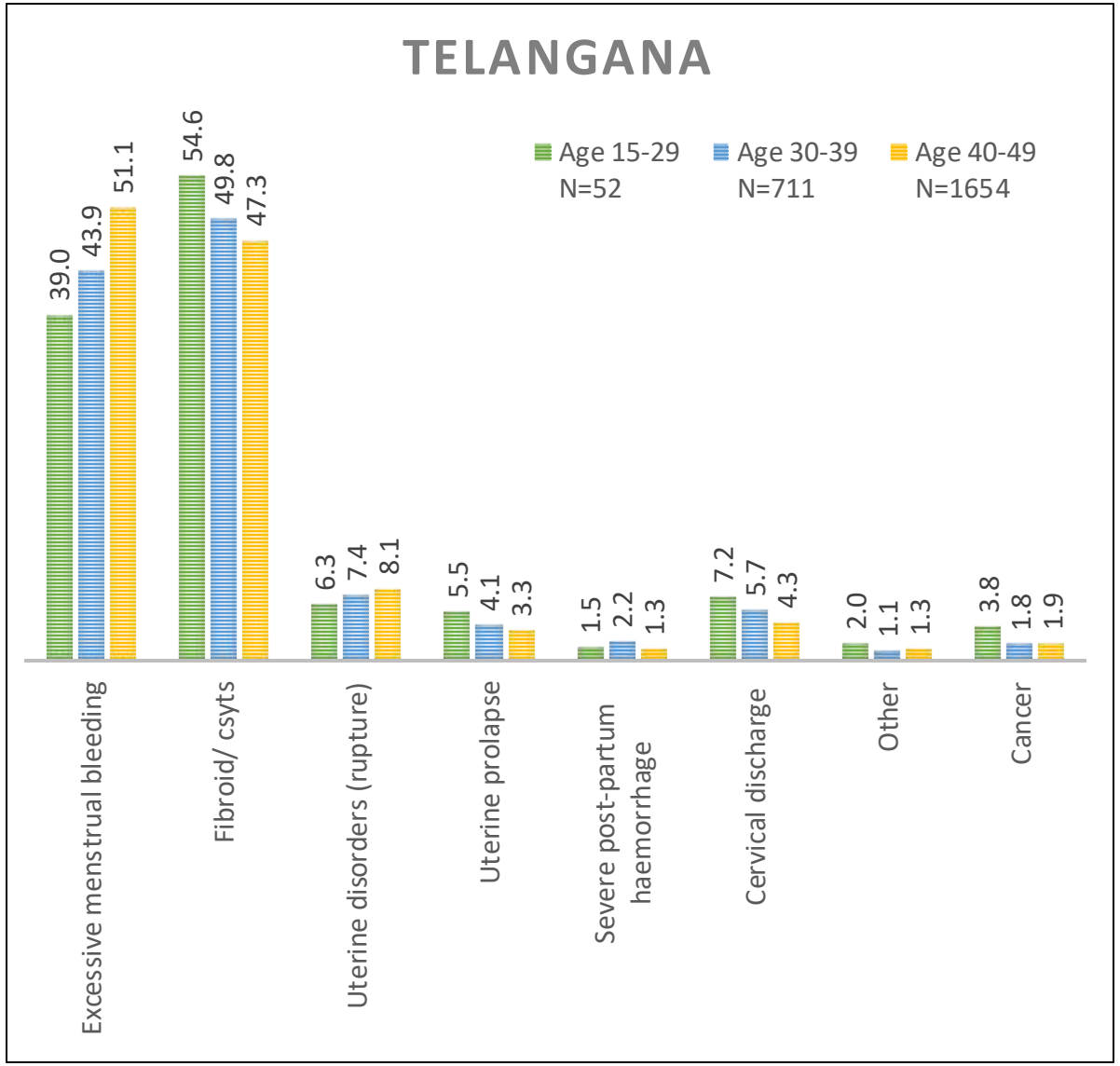
Prevalence of hysterectomy in Andhra Pradesh, 2019-21
(women 40-49)

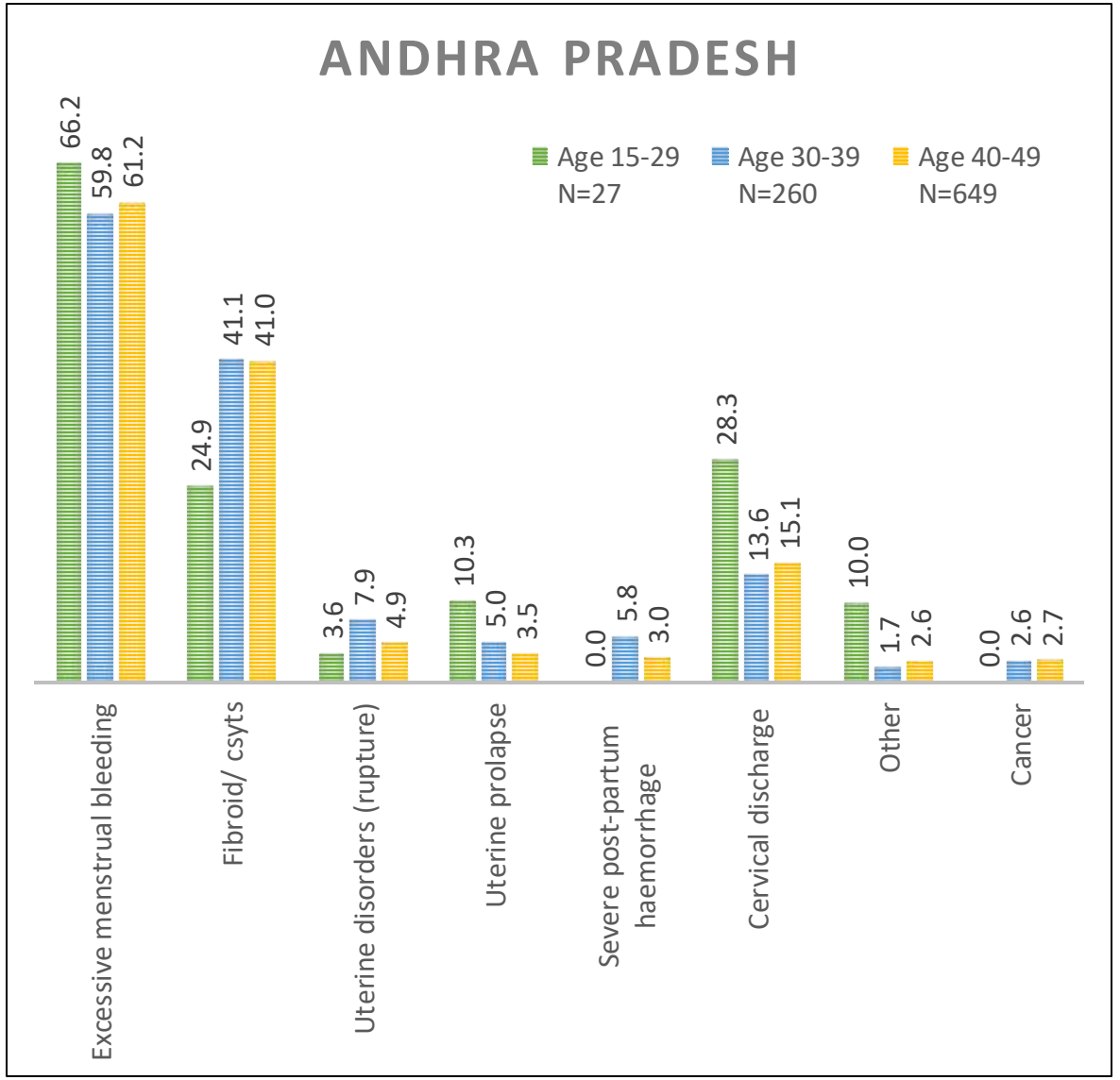
High prevalence (%):	
Guntur	34.8
West Godavari	31.8
East Godavari	30.2



Source: NFHS-5 (2019-21)

Self reported reasons for hysterectomy, by age





Source: NFHS-5 (2019-21)

Factors associated with hysterectomy in Telangana* (& Andhra Pradesh*)

- Older age
  - *Greater odds of hysterectomy in older age groups (TS & AP)*
- Less education
  - *Greater odds of hysterectomy in less educated groups (TS & AP)*
- Rural residence
  - *Rural women at 2.2 greater odds of hysterectomy compared to urban women (AP, AOR=1.9)*
- From wealthier households
  - *AOR of 5th quintile vs 1st quintile= 2.4 (AP, AOR=1.6)*
- Have one or more children
  - *3 times greater odds among women with one or more children (AP, AOR=3.7)*
- Have not been sterilised
  - *Lower odds (0.8) among women who have undergone sterilisation (AP, AOR=0.6)*

* Results from multivariate logistic regression on hysterectomy as outcome variable

Place of Hysterectomy

Hysterectomies in private facilities

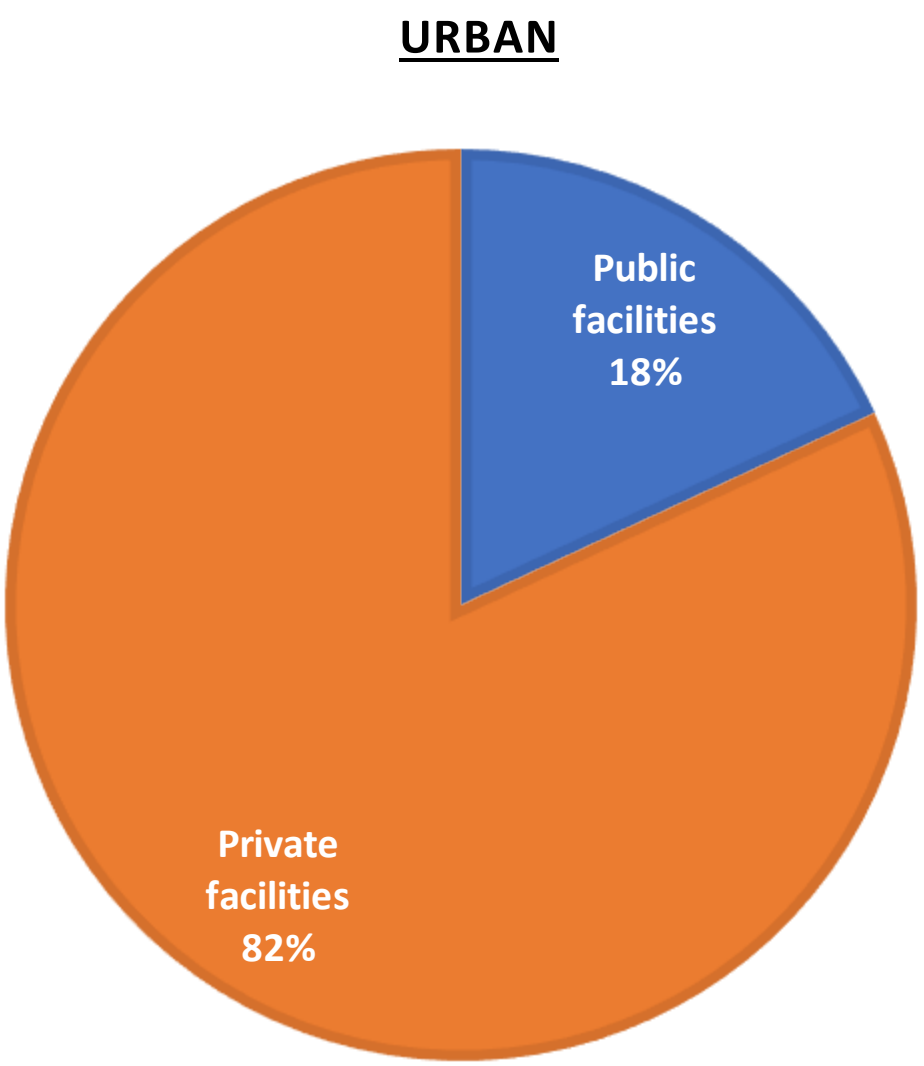
Overall, **85.9%** hysterectomies in **Telangana** are in **private facilities**

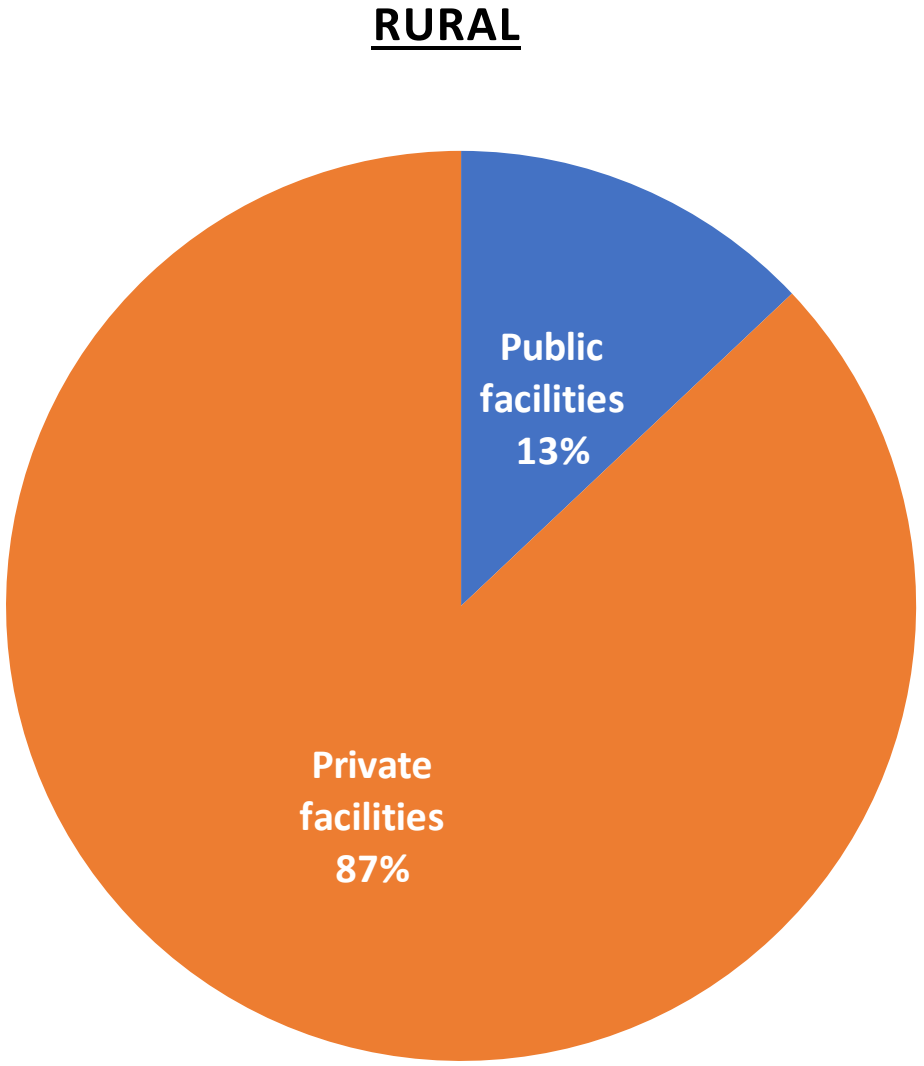
% hysterectomies in private facilities- ***below*** state average [0, 85.9]

% hysterectomies in private facilities- ***above*** state average [86.0,95.6]

Source: NFHS-5 (2019-21)

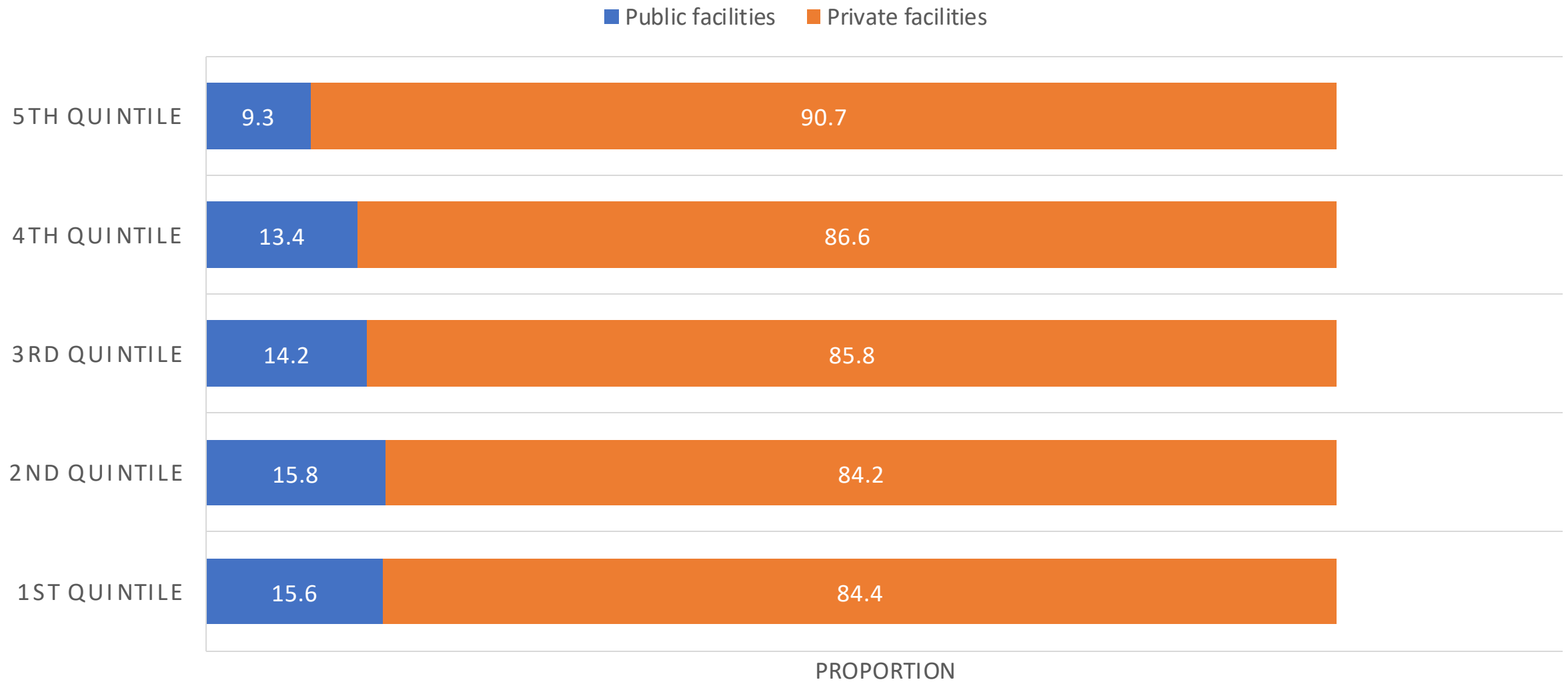
Telangana: Place of hysterectomy, by residence





Source: NFHS-5 (2019-21)

Telangana: Place of hysterectomy, by wealth quintile of households



Source: NFHS-5 (2019-21)

Hysterectomy and NCDs

Hysterectomy and NCDs later in life

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A nationally representative sample of women, aged 45 and up in India:

A woman with hysterectomy had….

1.5 times higher odds of **hypertension**

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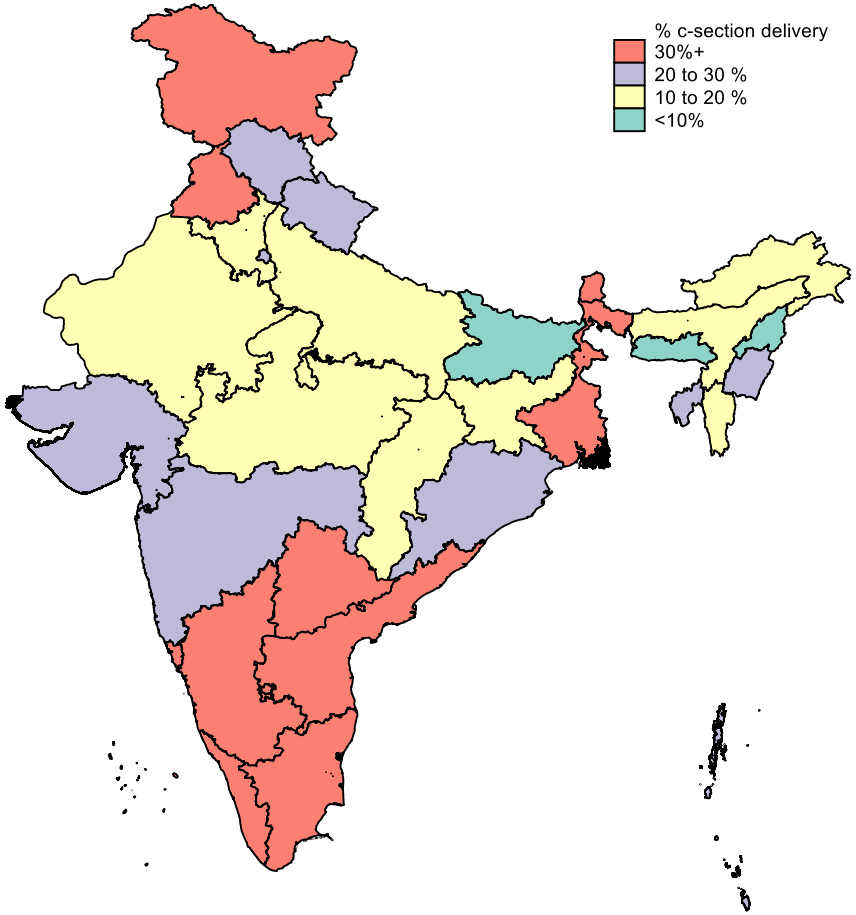
1.5 times higher odds of **bones/ joint diseases**

when compared with women without a hysterectomy

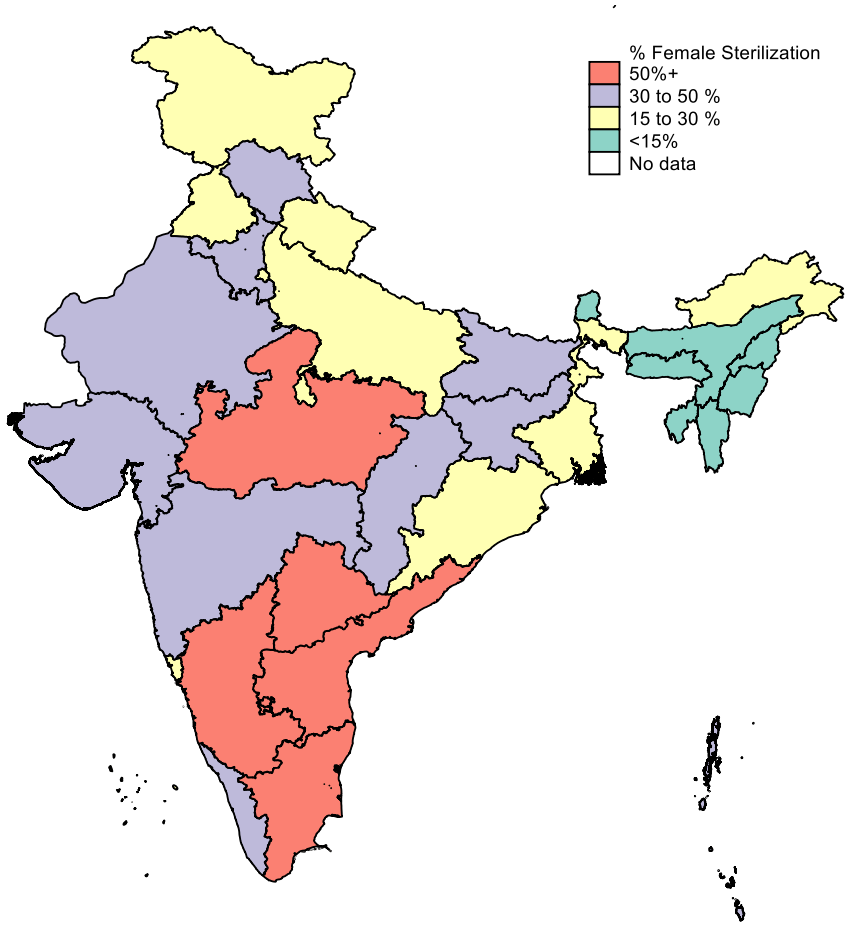
Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

National Patterns



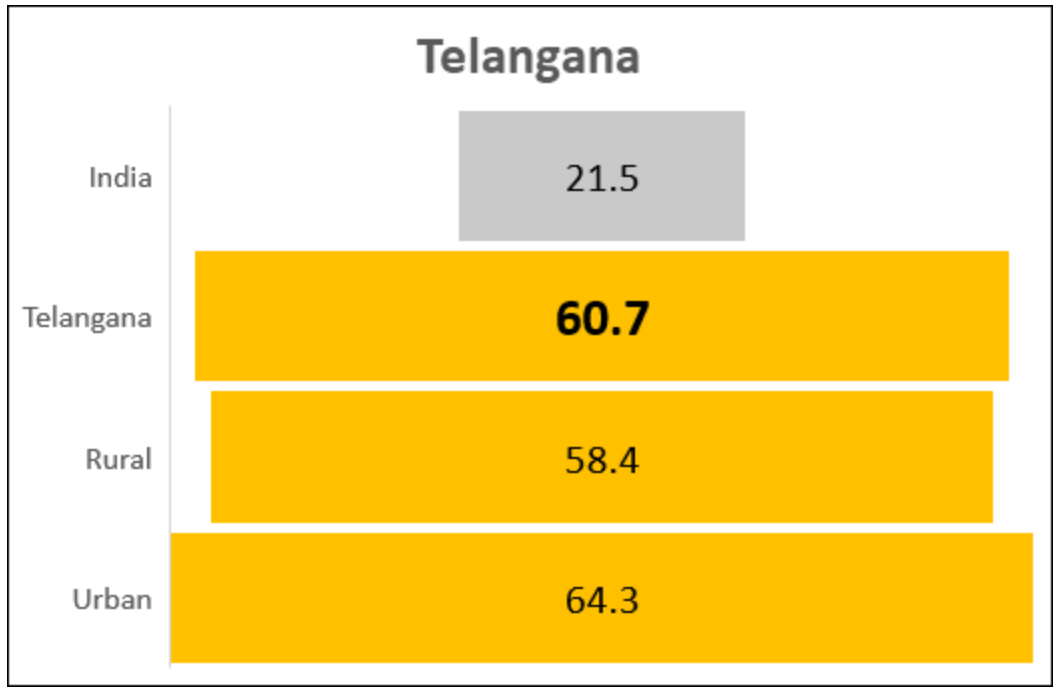
C-section

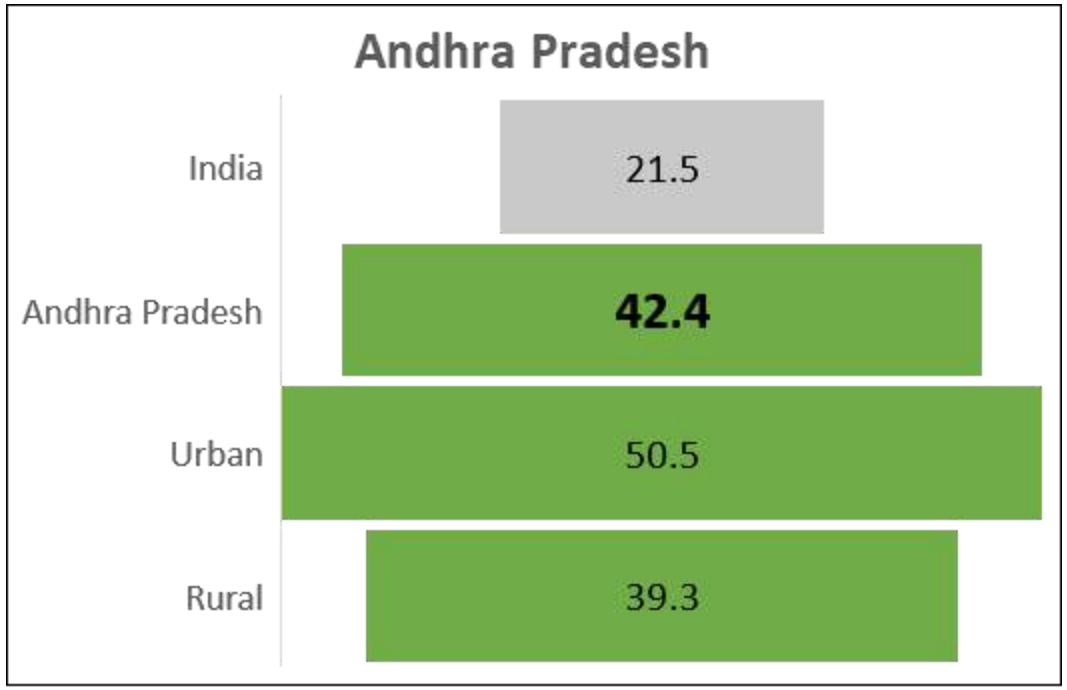


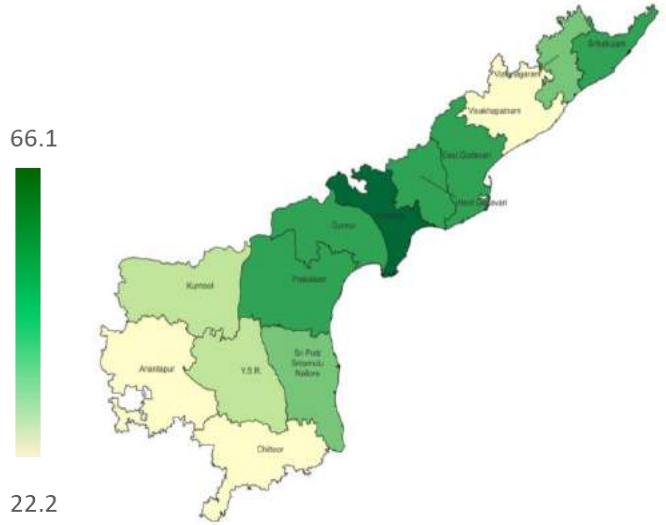
Female Sterilisation

Source: NFHS-5 (2019-21)

C-sections in last 5 years*



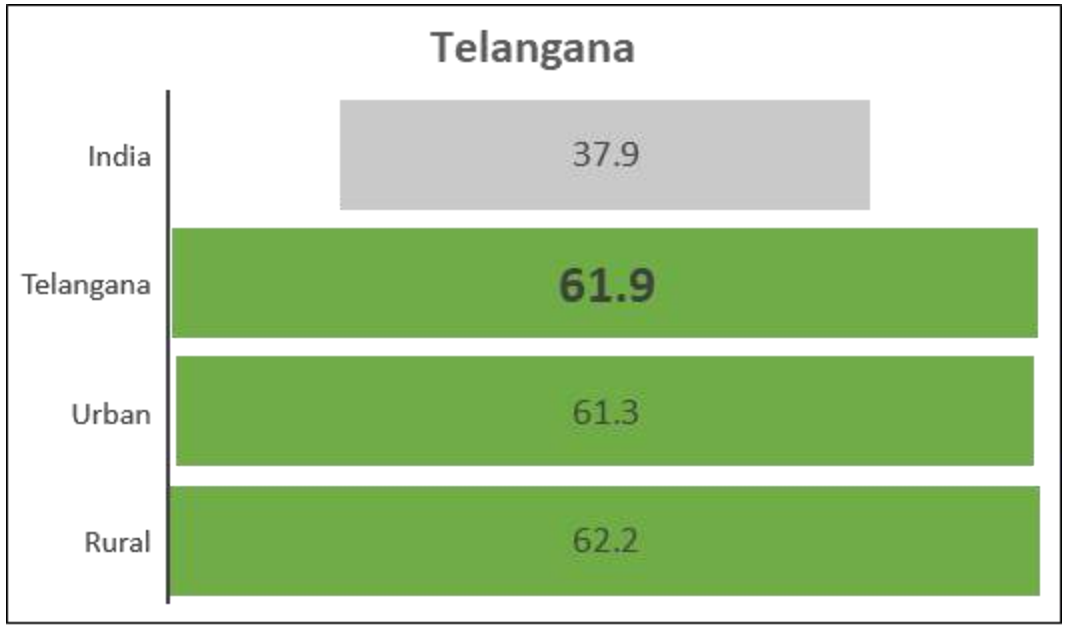


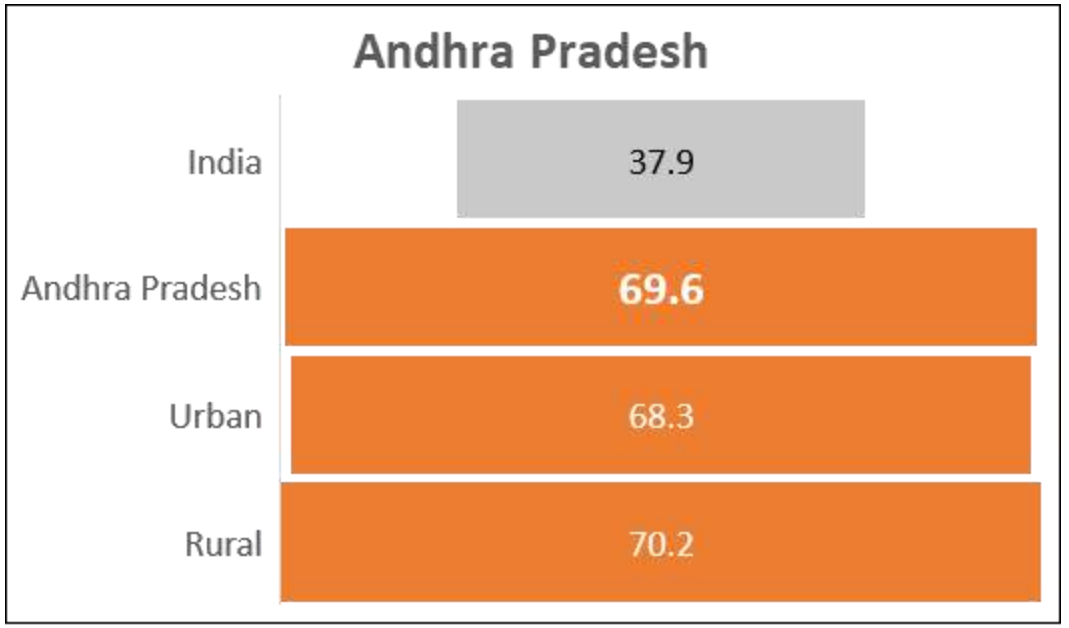


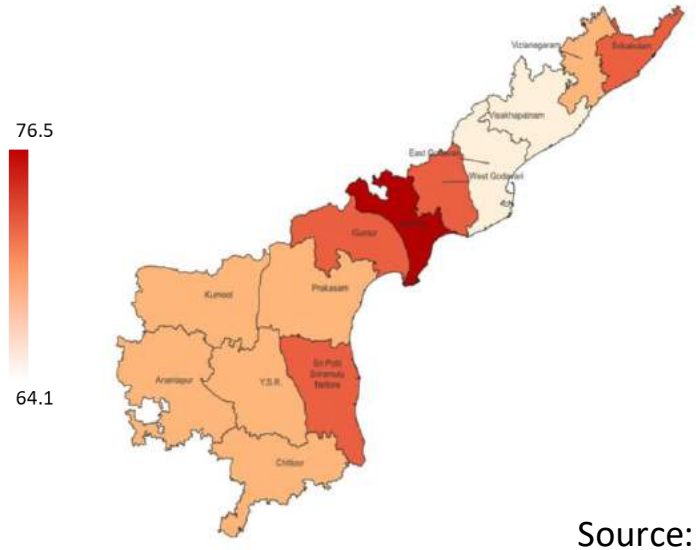
*: all births in last 5 years, NFHS 5 (2019-21)

Source: NFHS-5 (2019-21)

Female sterilisation



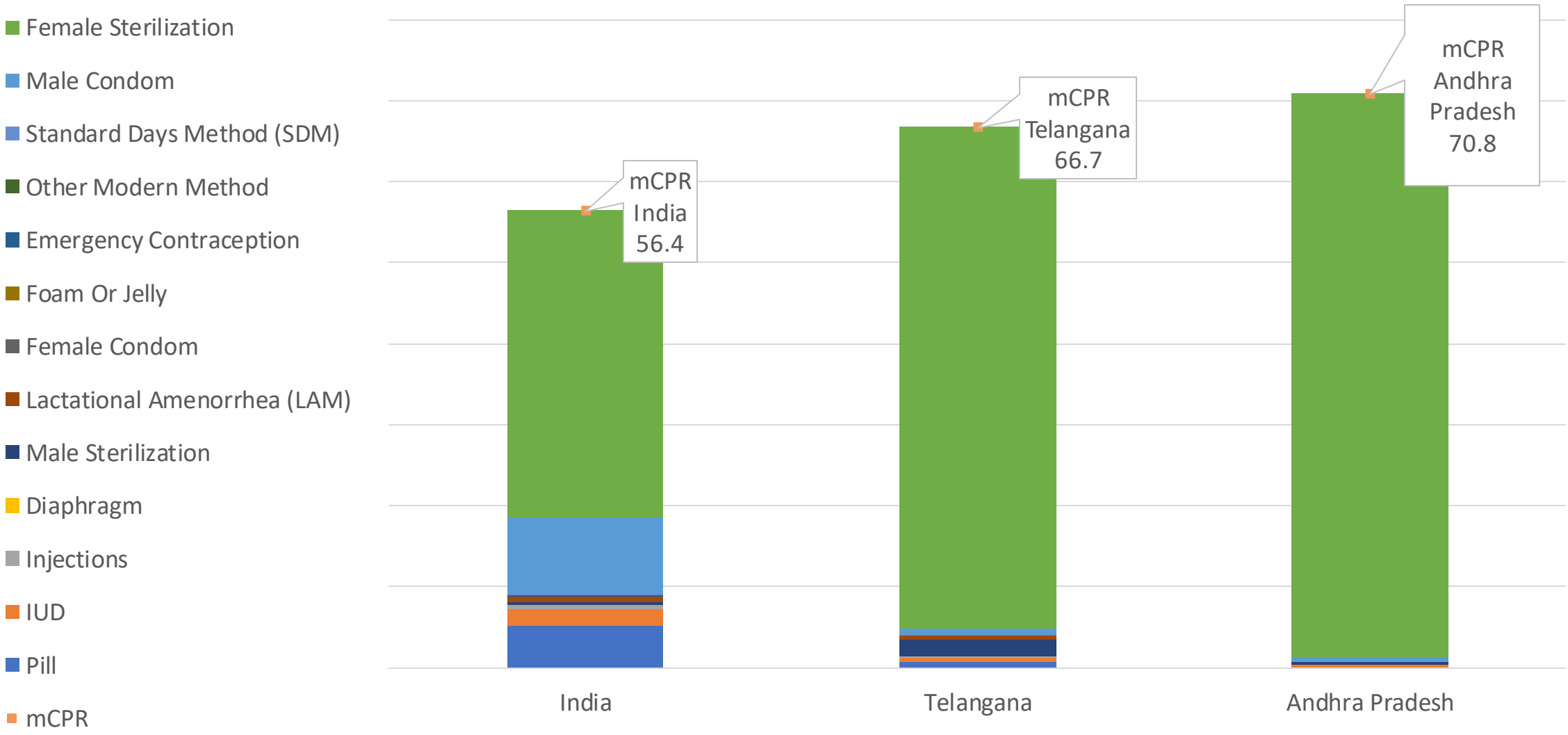




***: NFHS 5 (2019-21)**

Source: NFHS-5 (2019-21)

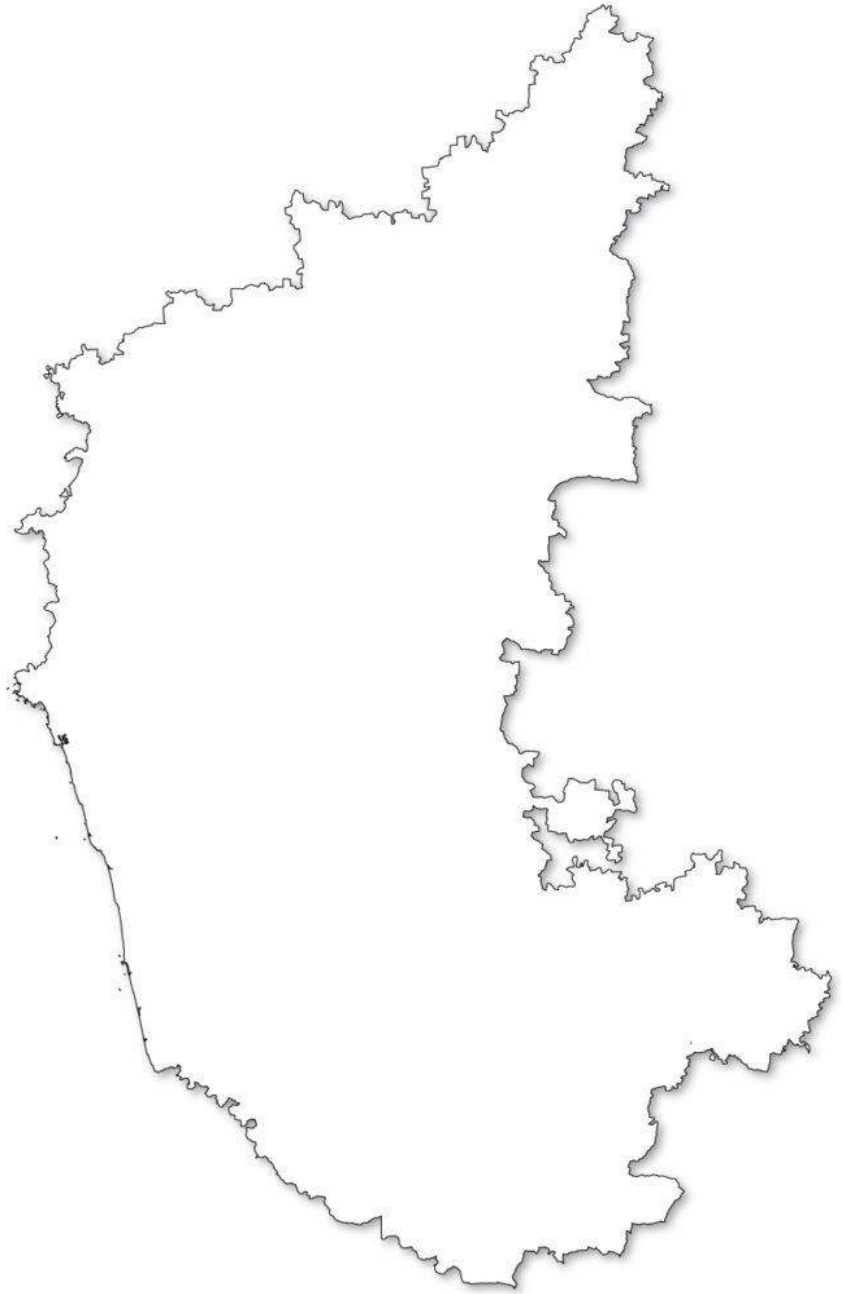
Modern contraceptive method mix, married women 15-49



Source: NFHS-5 (2019-21)

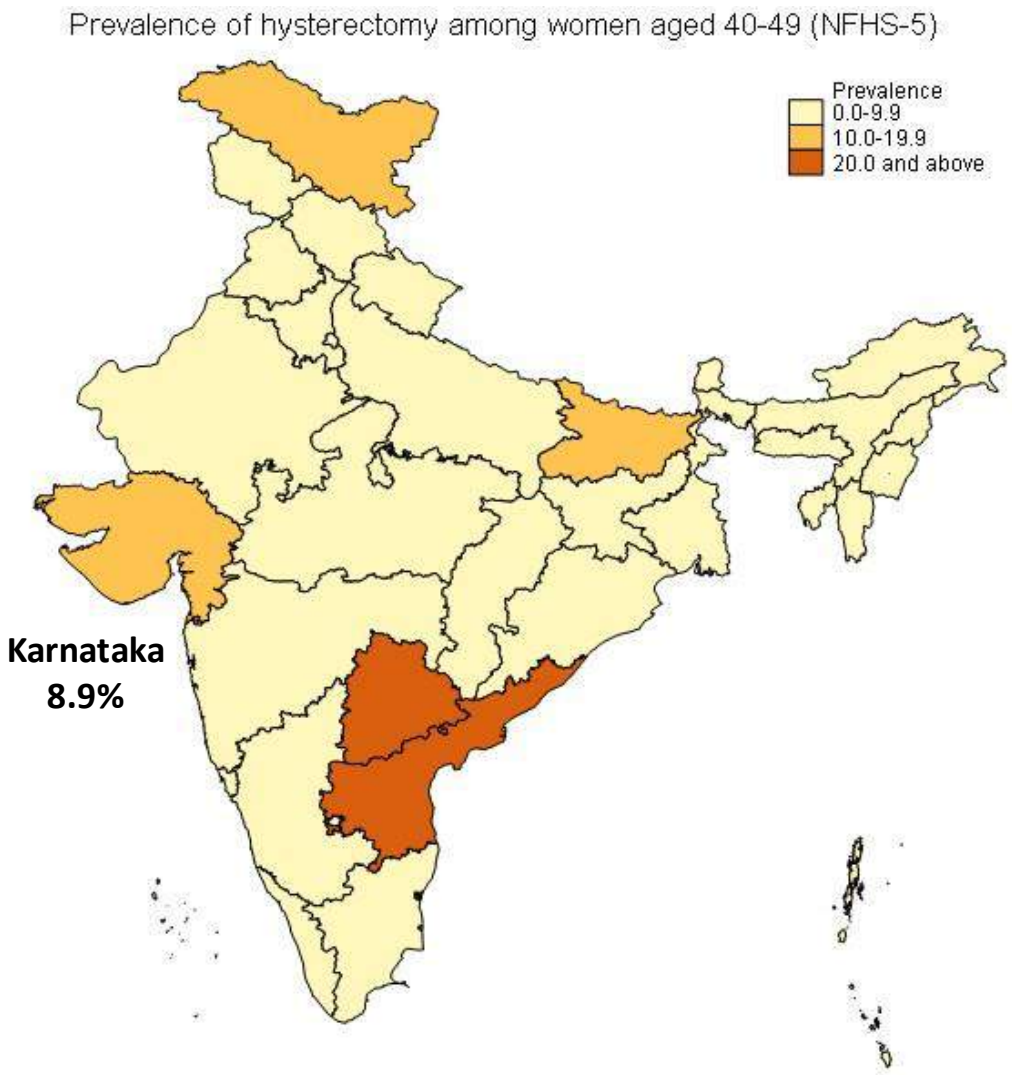
Use of gynaecological surgery in Karnataka:

Trends from NFHS

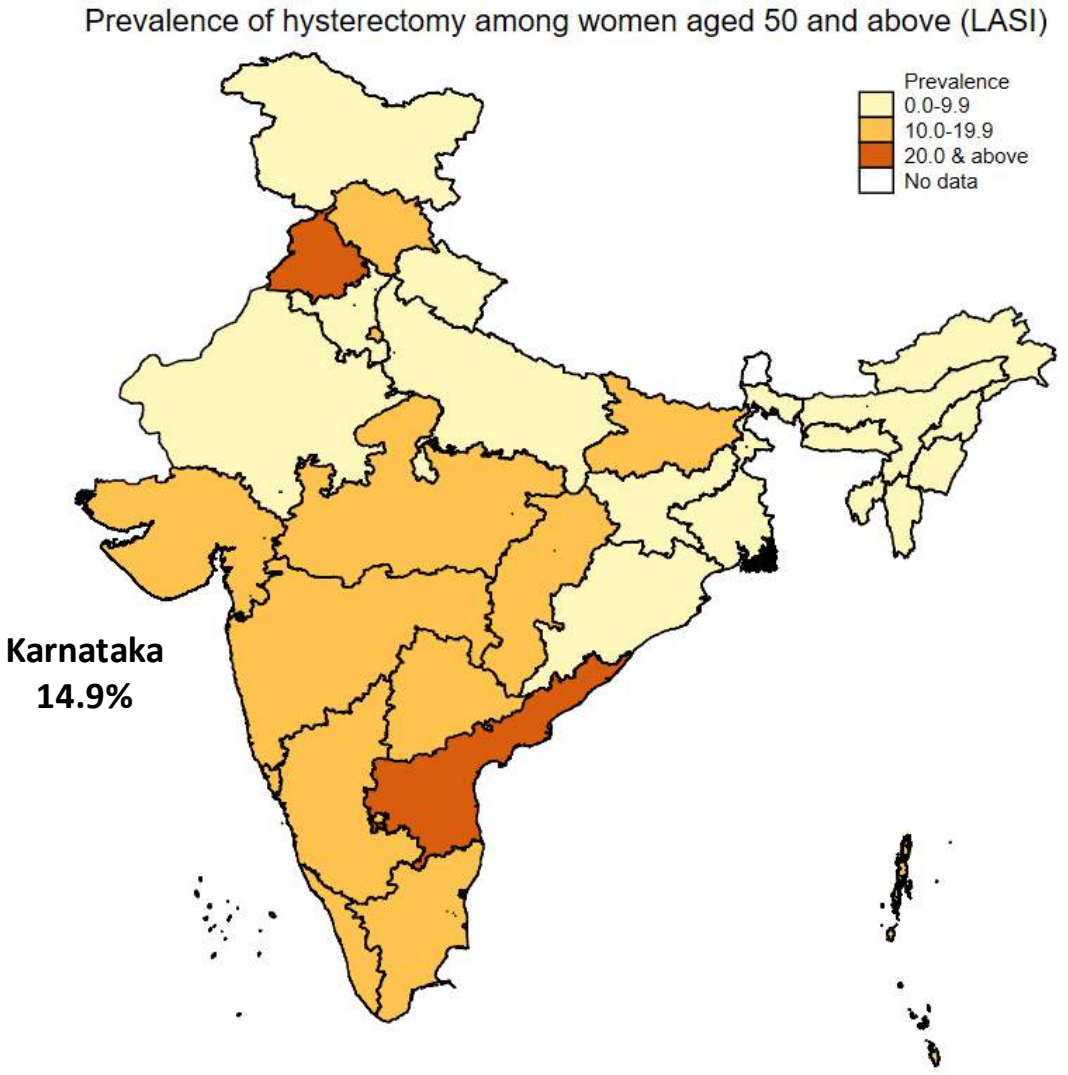


Bengaluru Roundtable
December 18, 2023

National patterns of hysterectomy (40-49, 50+)

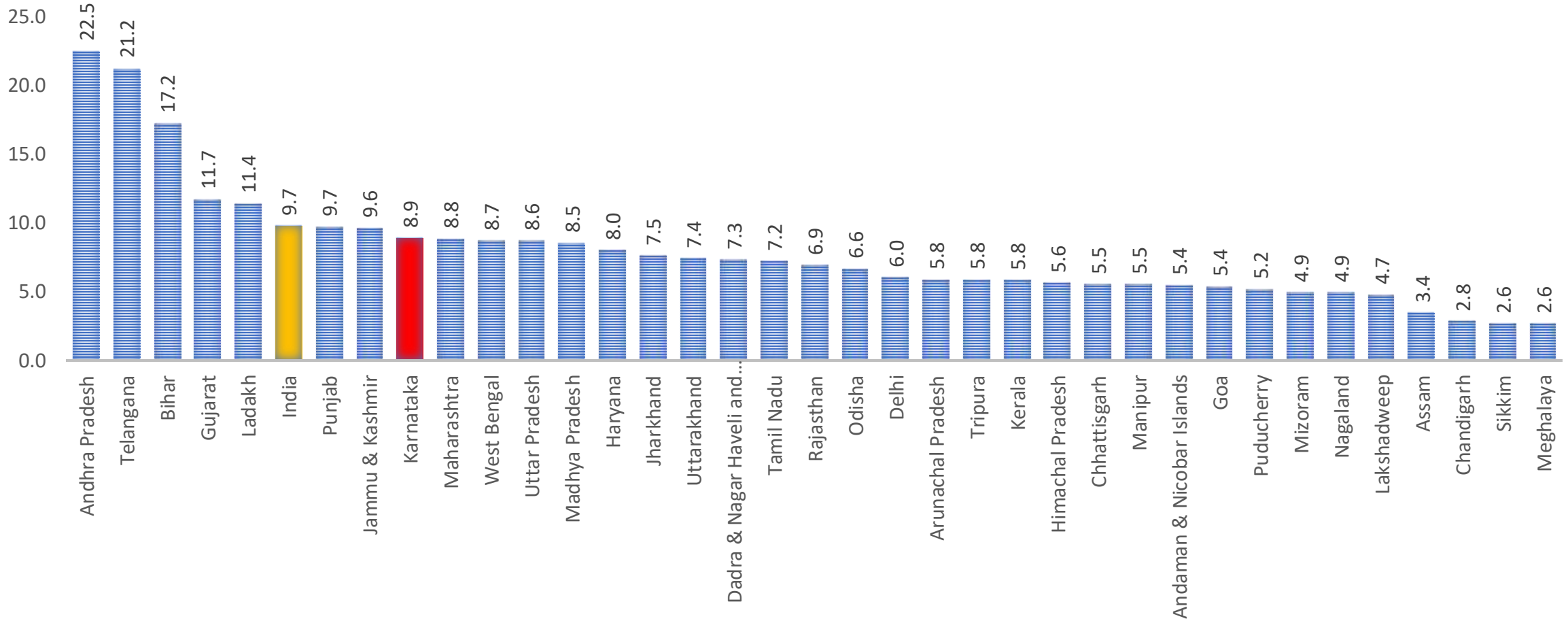


Source: NFHS-5 (2019-21)



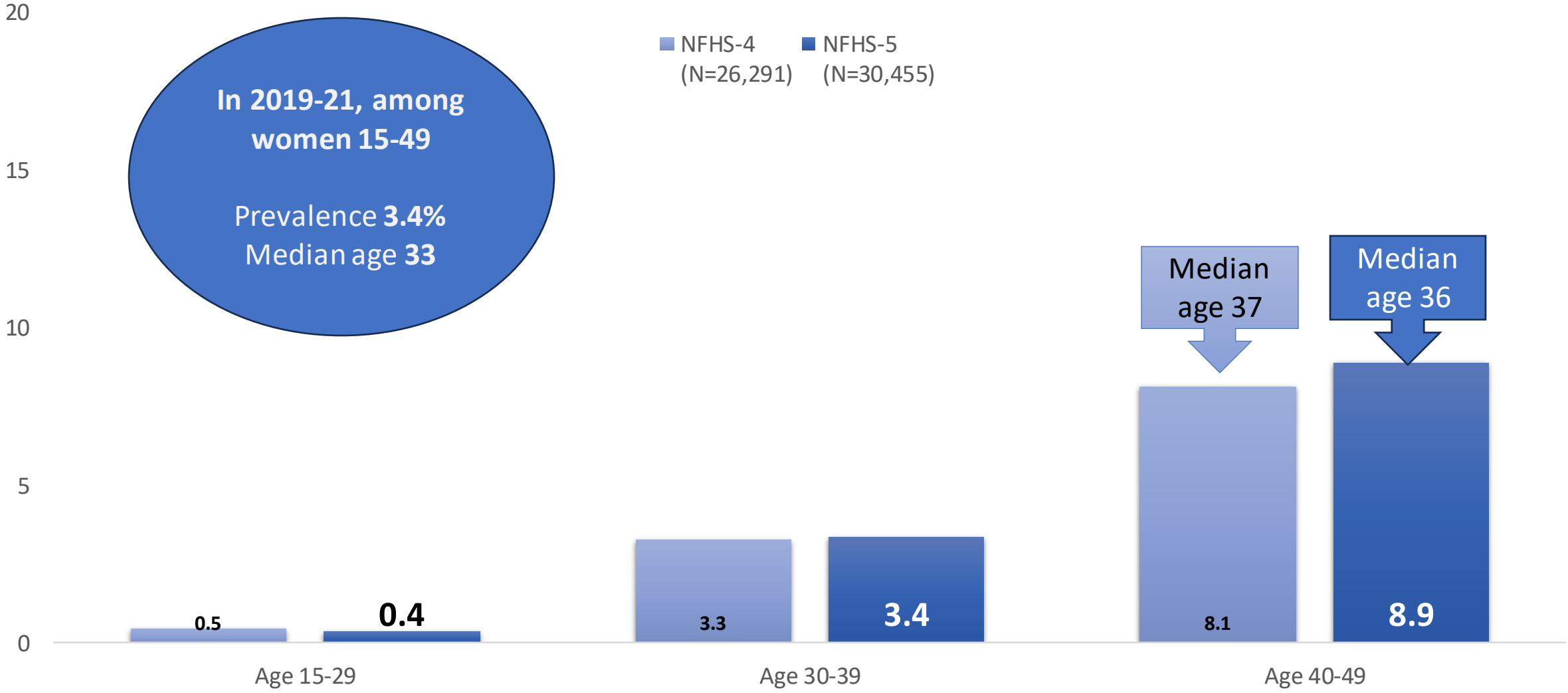
Source: LASI (2017-18)

Prevalence of hysterectomy among women aged 40-49 (2019-21)



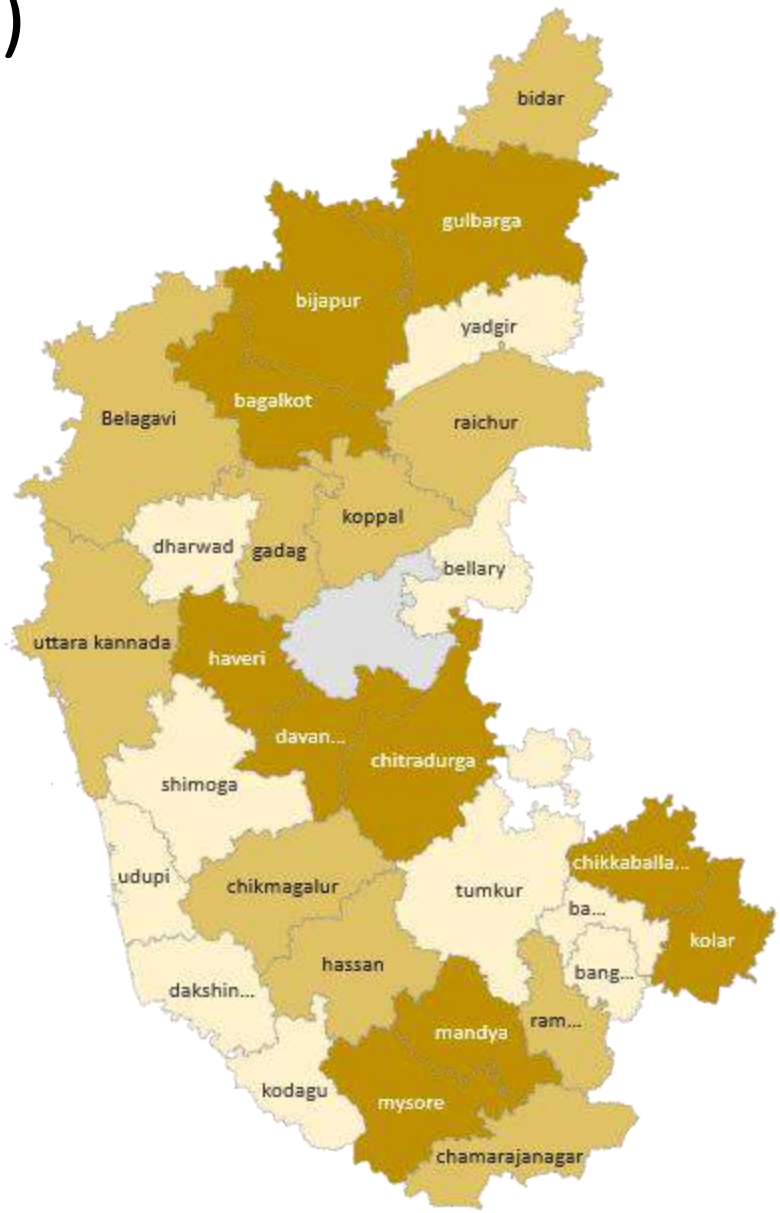
Source: NFHS-5 (2019-21)

Age specific prevalence and age at hysterectomy



Source: NFHS-5 (2019-21)

Prevalence of hysterectomy in Karnataka, 2019-21
(women 40-49)



High prevalence (%)

- Davanagere 24.3
- Bagalkot 20.5
- Bijapur 17.5
- Mandya 15.5

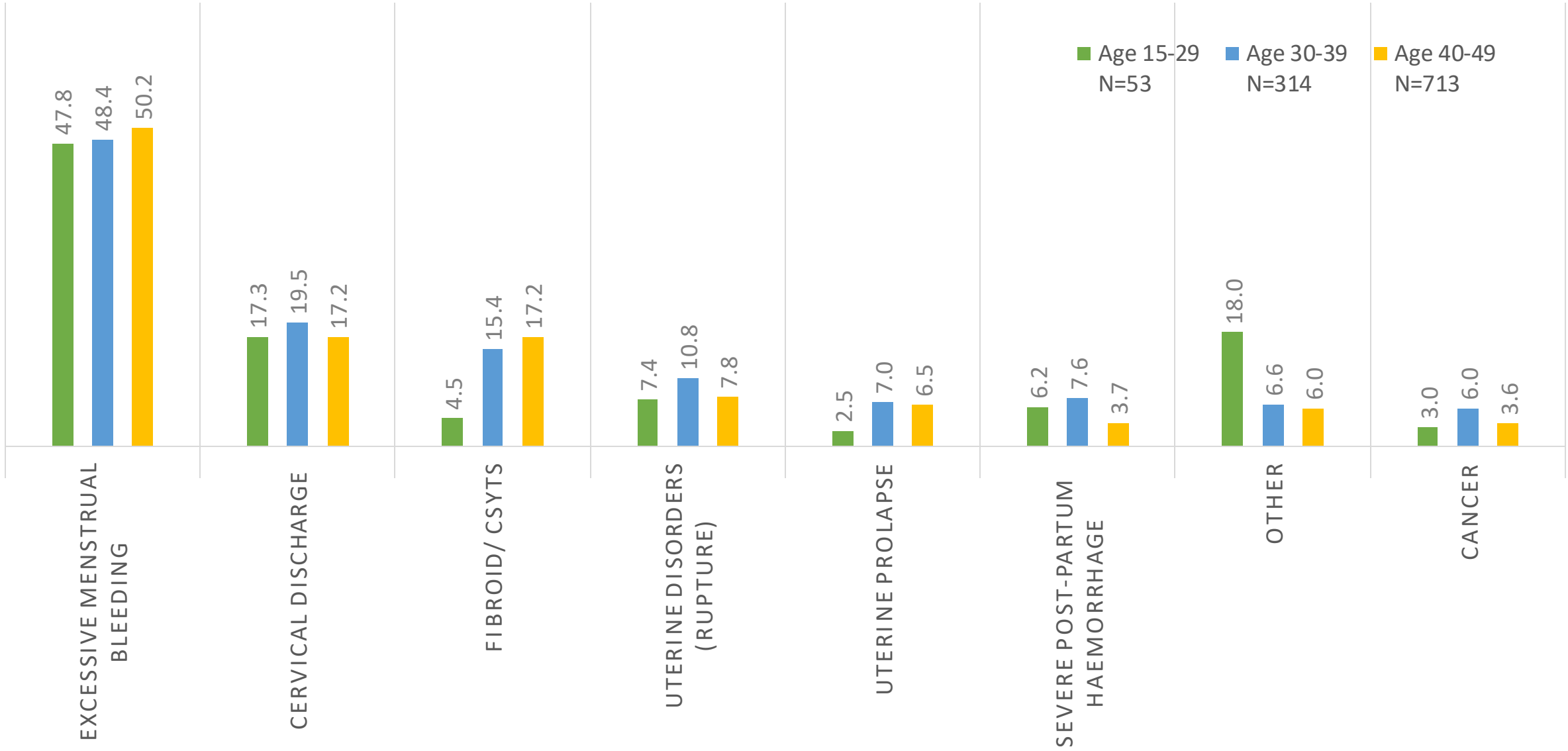
Low prevalence: [1.4, 6.0]

Mid prevalence: [6.1, 10.8]

High prevalence: [10.9, 24.3]

Source: NFHS-5 (2019-21)

Self reported reasons for hysterectomy, by age



Source: NFHS-5 (2019-21)

Factors associated with hysterectomy in Karnataka*

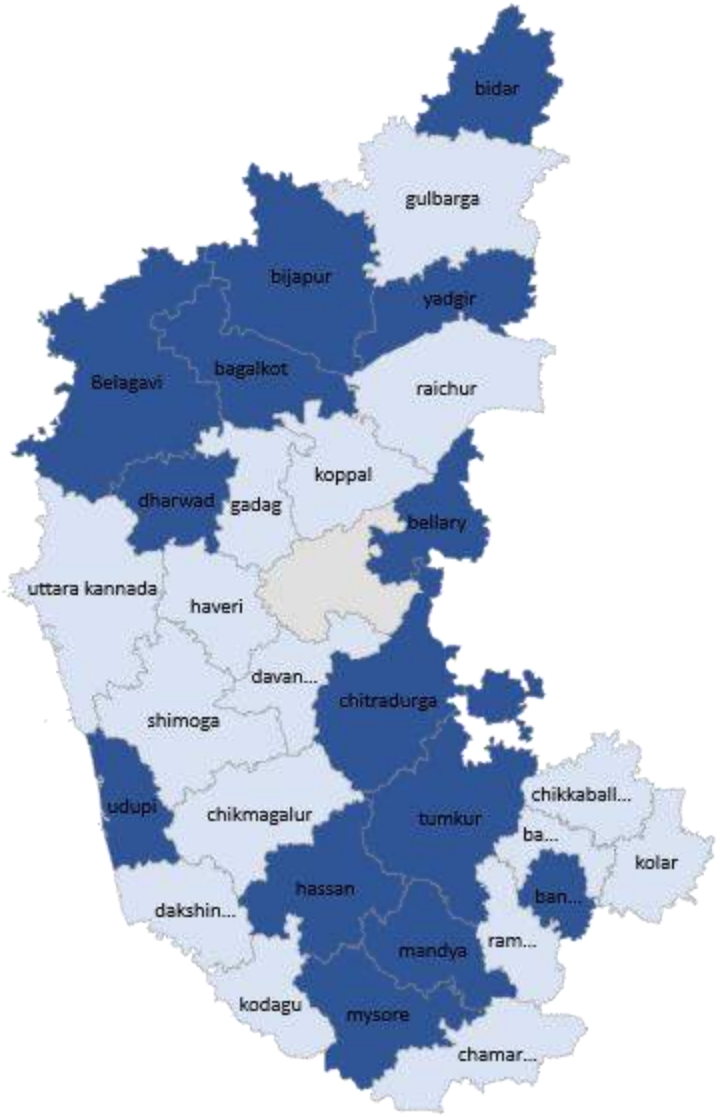
- Older age
  - *Greater odds of hysterectomy in older age groups*
- Less education
  - *Greater odds of hysterectomy in less educated groups*
- Rural residence
  - *Rural women at 1.5 greater odds of hysterectomy compared to urban women*
- Have one or more children
  - *4.1 times greater odds among women with one or more children*
- Have not been sterilised
  - *Lower odds (0.6) among women who have undergone sterilisation*

* Results from multivariate logistic regression on hysterectomy as outcome variable

Place of Hysterectomy

Hysterectomies in private facilities

Overall, **55.2%** hysterectomies in Karnataka are in **private facilities**



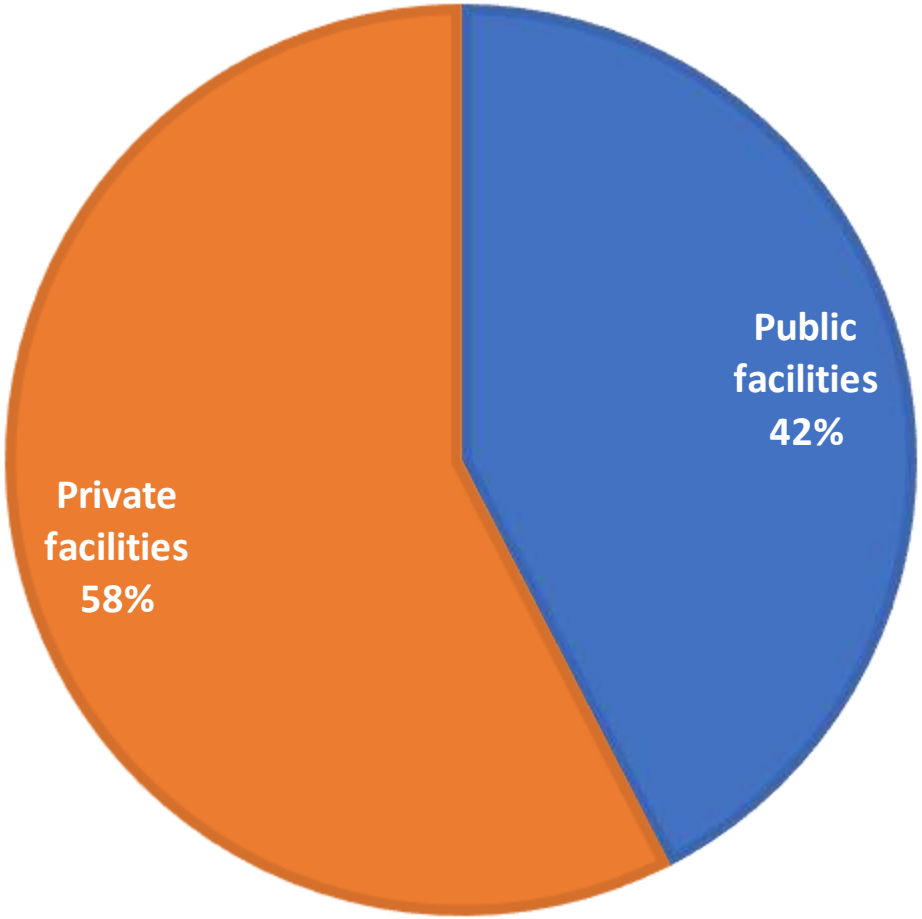
% hysterectomies in private facilities- ***below*** state average [22.4, 55.2]

% hysterectomies in private facilities- ***above*** state average [55.3, 82.4]

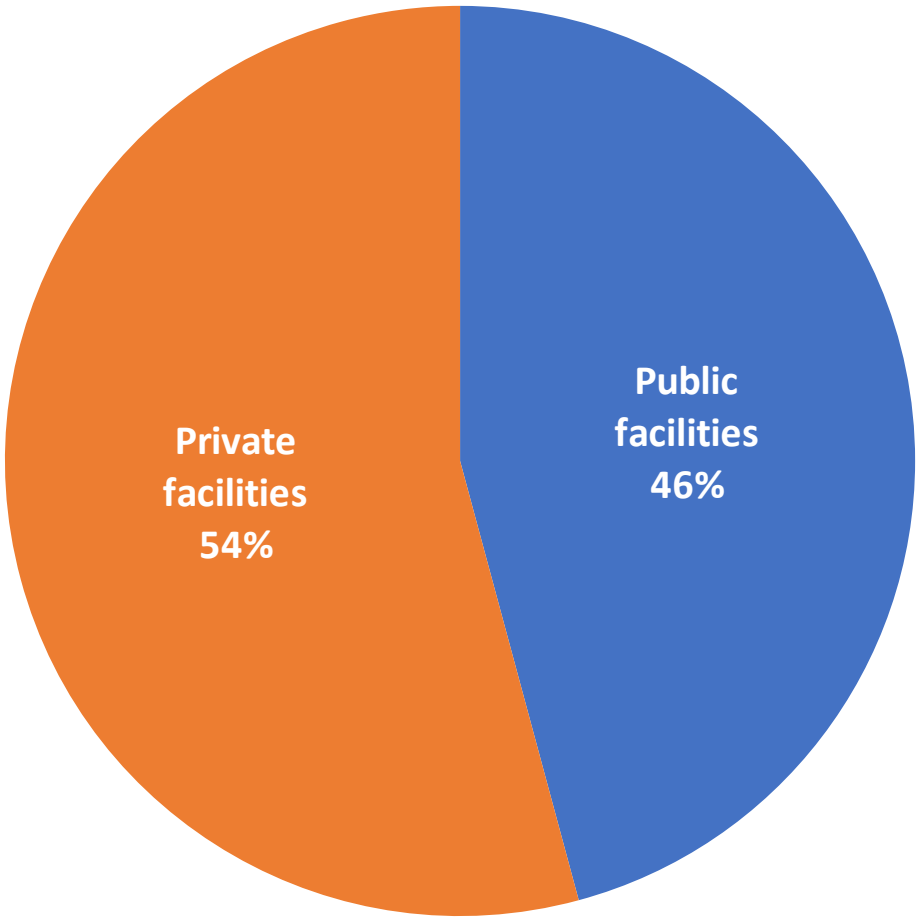
Source: NFHS-5 (2019-21)

Place of hysterectomy, by residence

URBAN

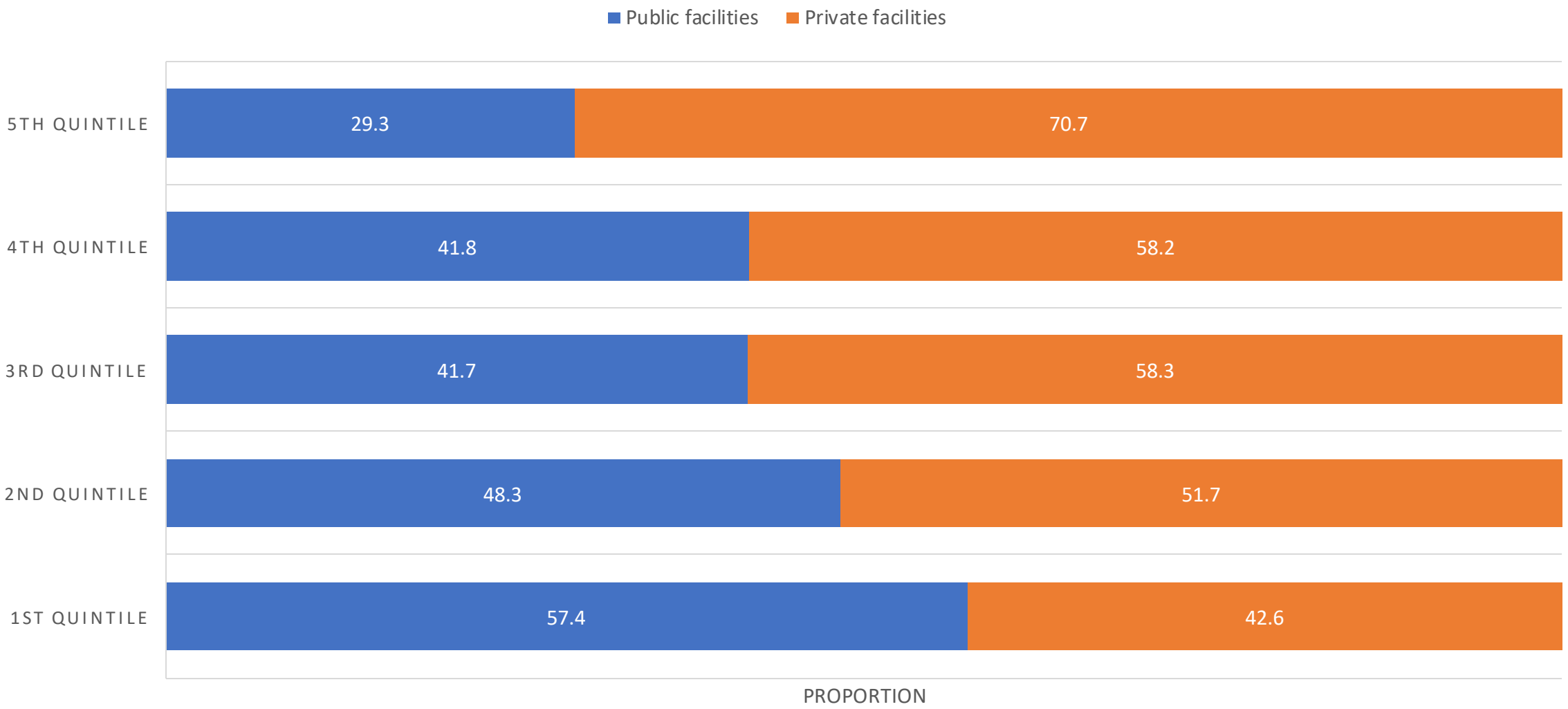


RURAL



Source: NFHS-5 (2019-21)

Place of hysterectomy, by wealth quintile of households



Source: NFHS-5 (2019-21)

Hysterectomy and NCDs

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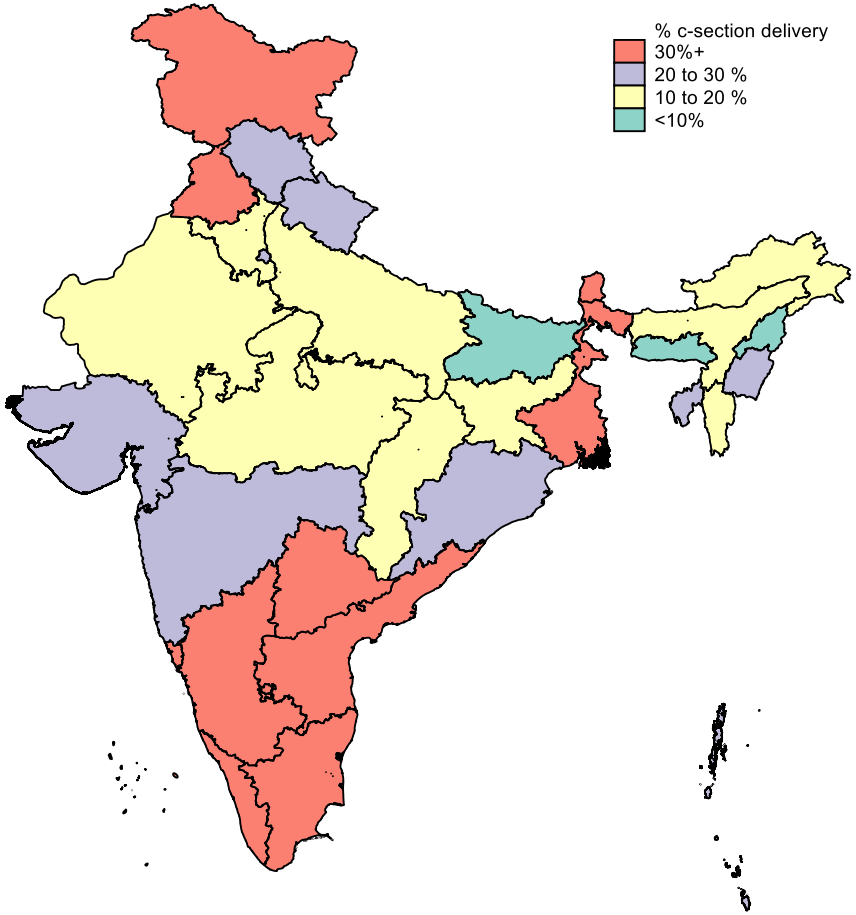
when compared with women without a hysterectomy

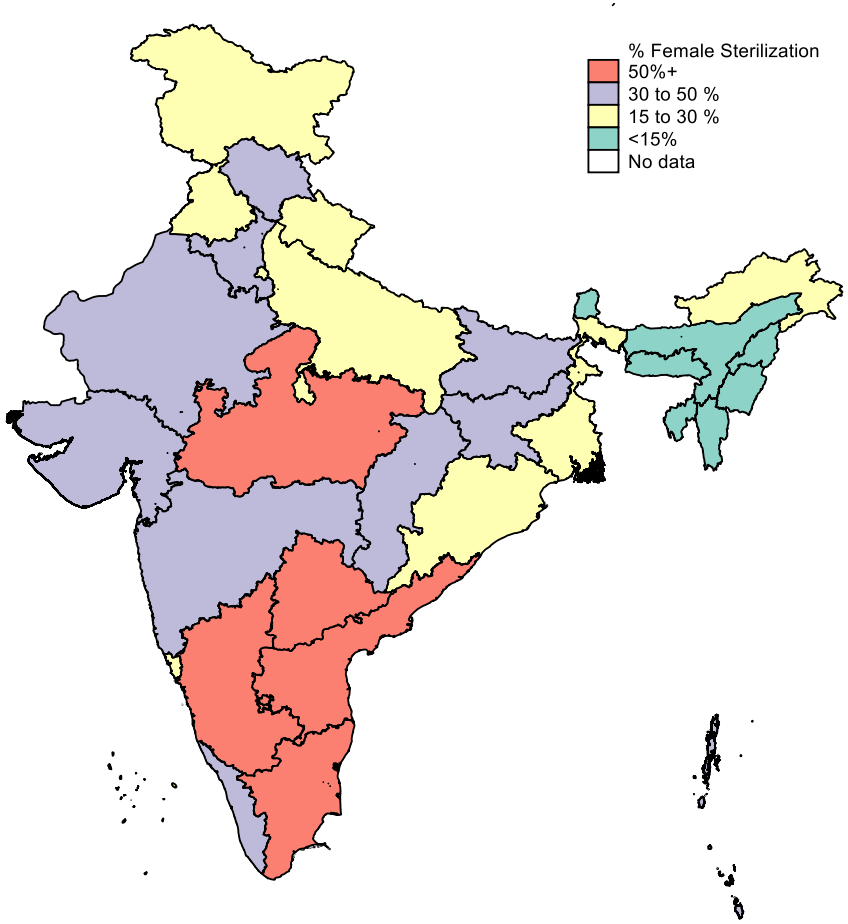
Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

National Patterns



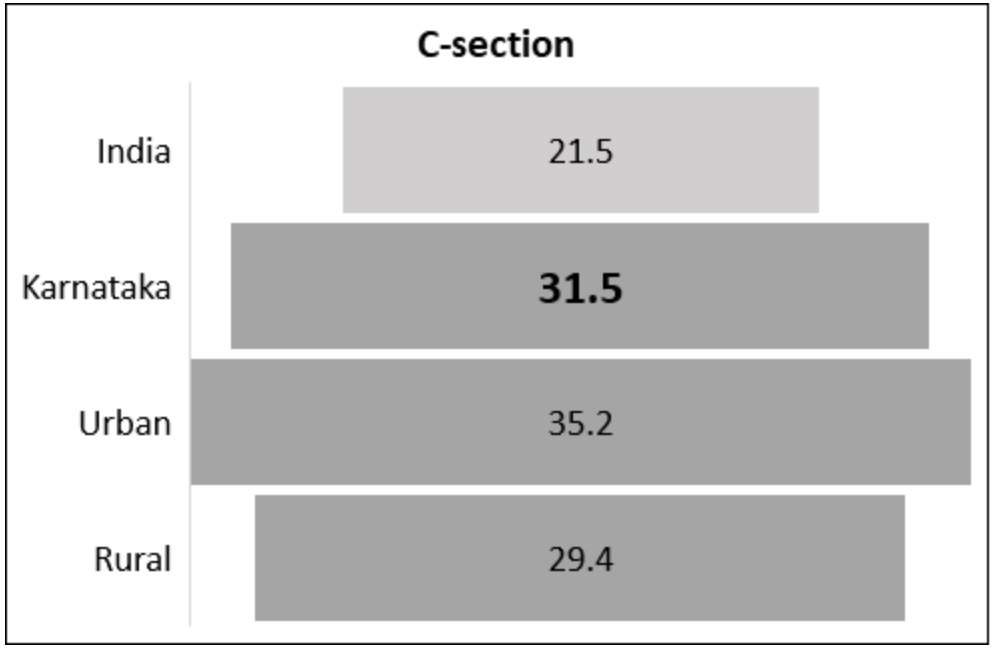
C-section

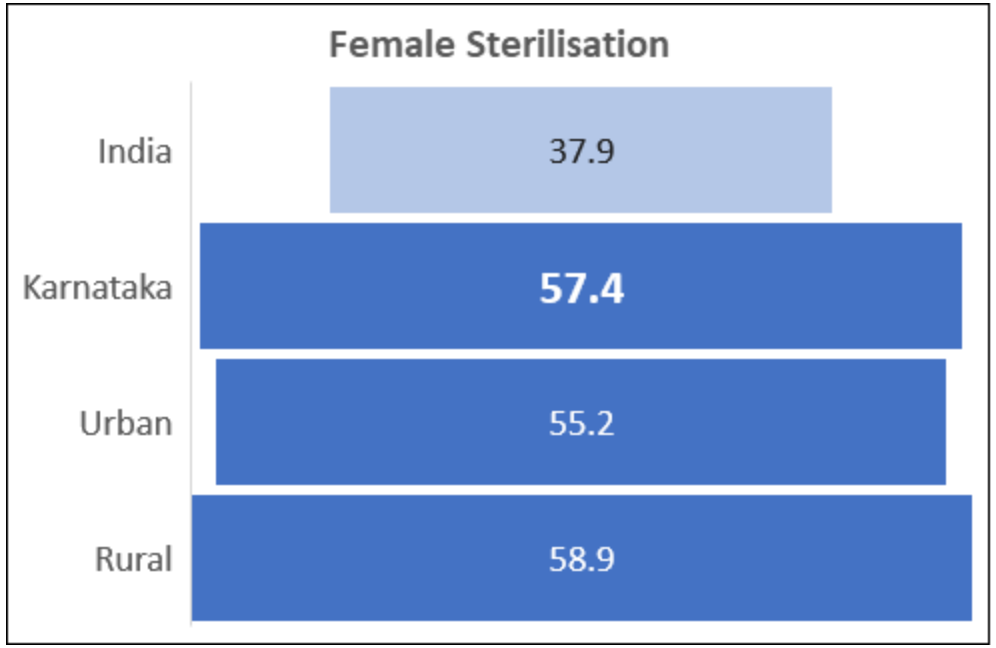


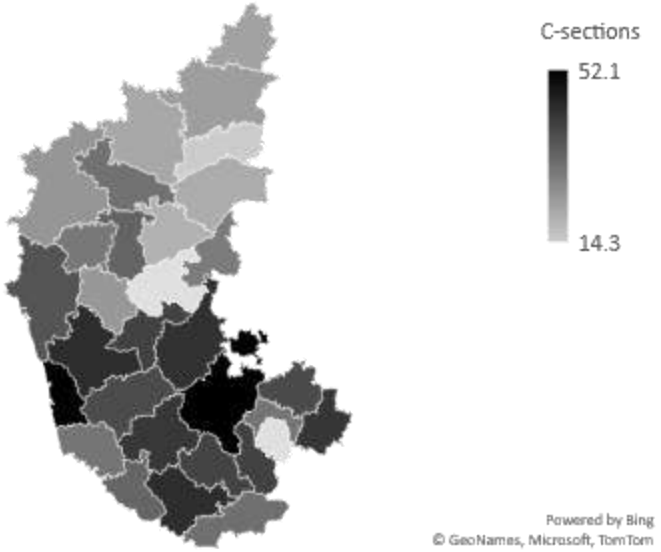
Female Sterilisation

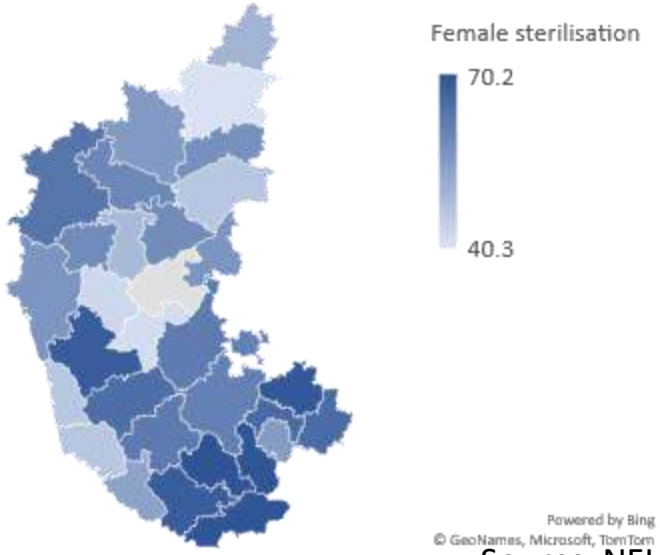
Source: NFHS-5 (2019-21)

C-sections* and Female Sterilisation





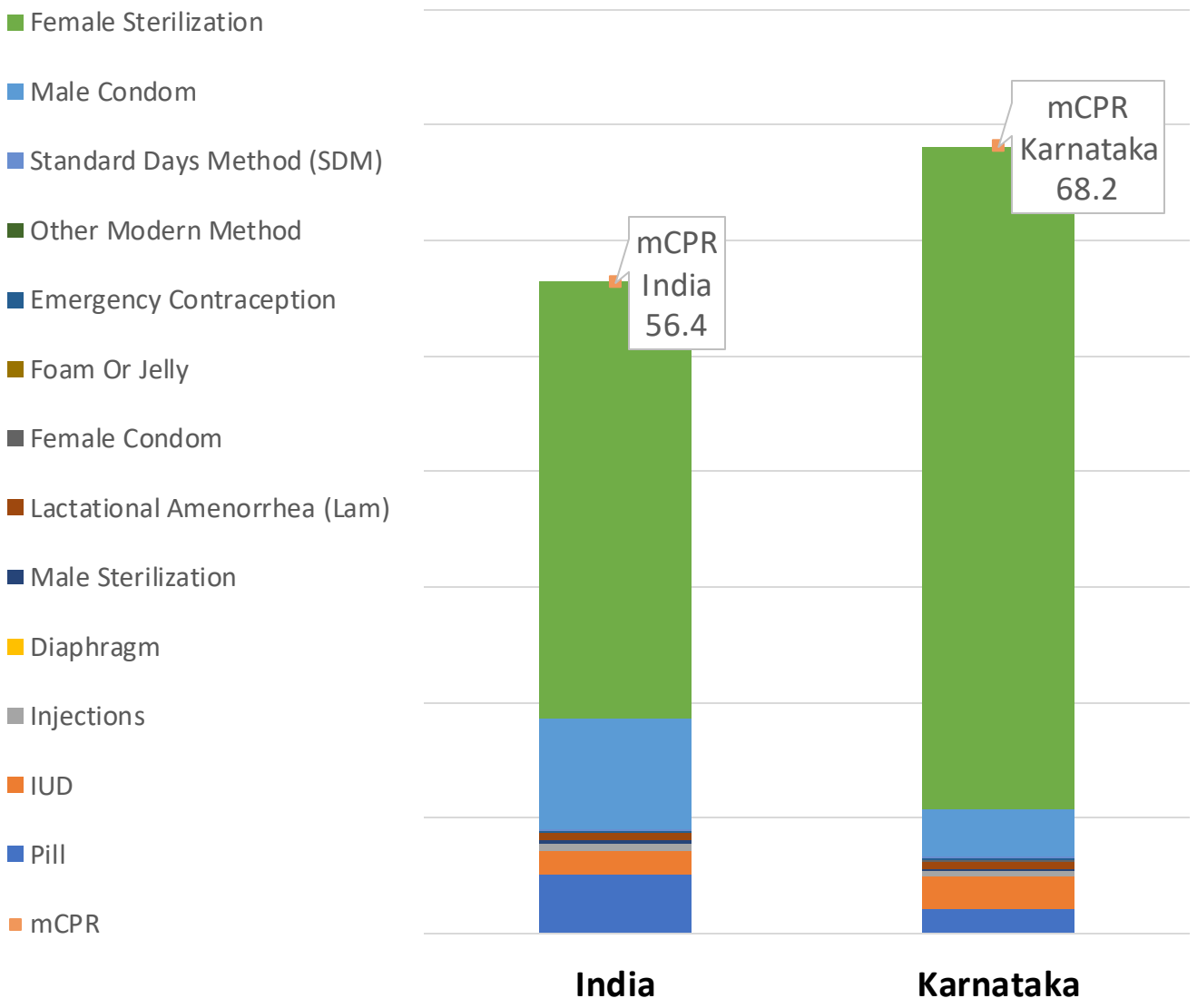




***: all births in last 5 years, NFHS 5 (2019-21)**

Source: NFHS-5 (2019-21)

Modern contraceptive method mix, married women 15-49



Method	India	Karnataka
Pill	5.1	2.1
IUD	2.1	2.9
Injections	0.6	0.5
Diaphragm	0	0.0
Male Condom	9.5	4.1
Female Sterilization	37.9	57.4
Male Sterilization	0.3	0.0
Lactational Amenorrhea (Lam)	0.7	0.7
Female Condom	0	0.2
Foam Or Jelly	0	0.0
Emergency Contraception	0.1	0.1
Other Modern Method	0	0.0
Standard Days Method (SDM)	0.2	0.1
mCPR	**56.4**	**68.2**

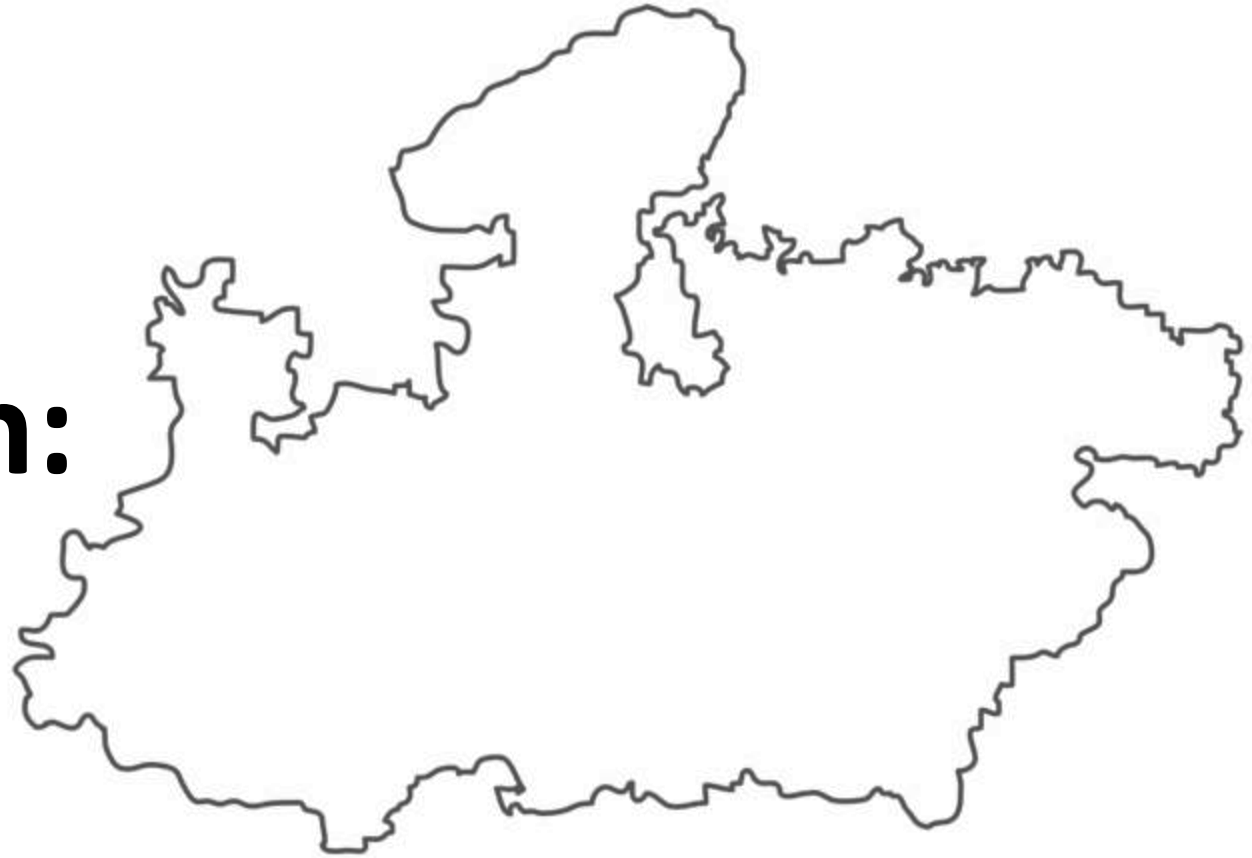
Source: NFHS-5 (2019-21)

Thank you

Sapna.i.desai@gmail.com

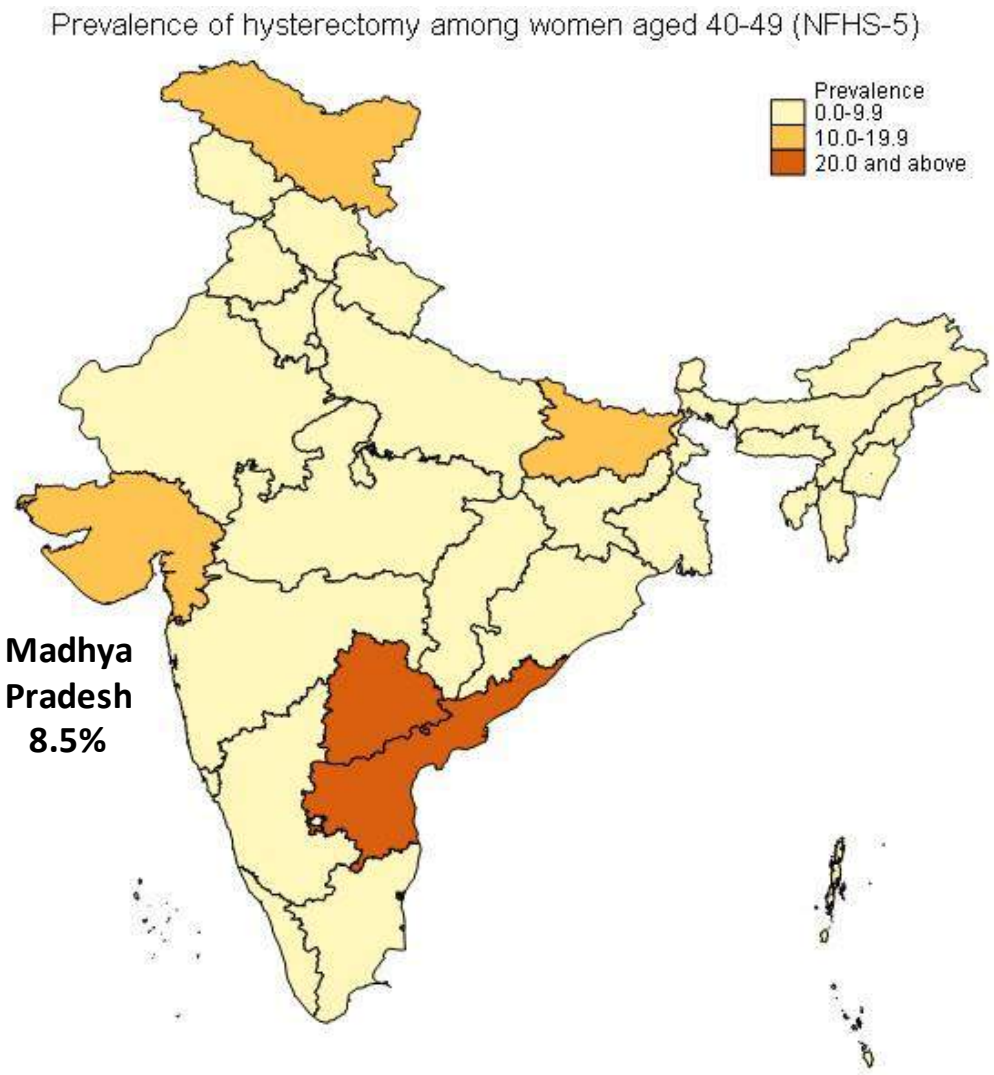
Use of gynaecological surgery in Madhya Pradesh:

Trends from NFHS

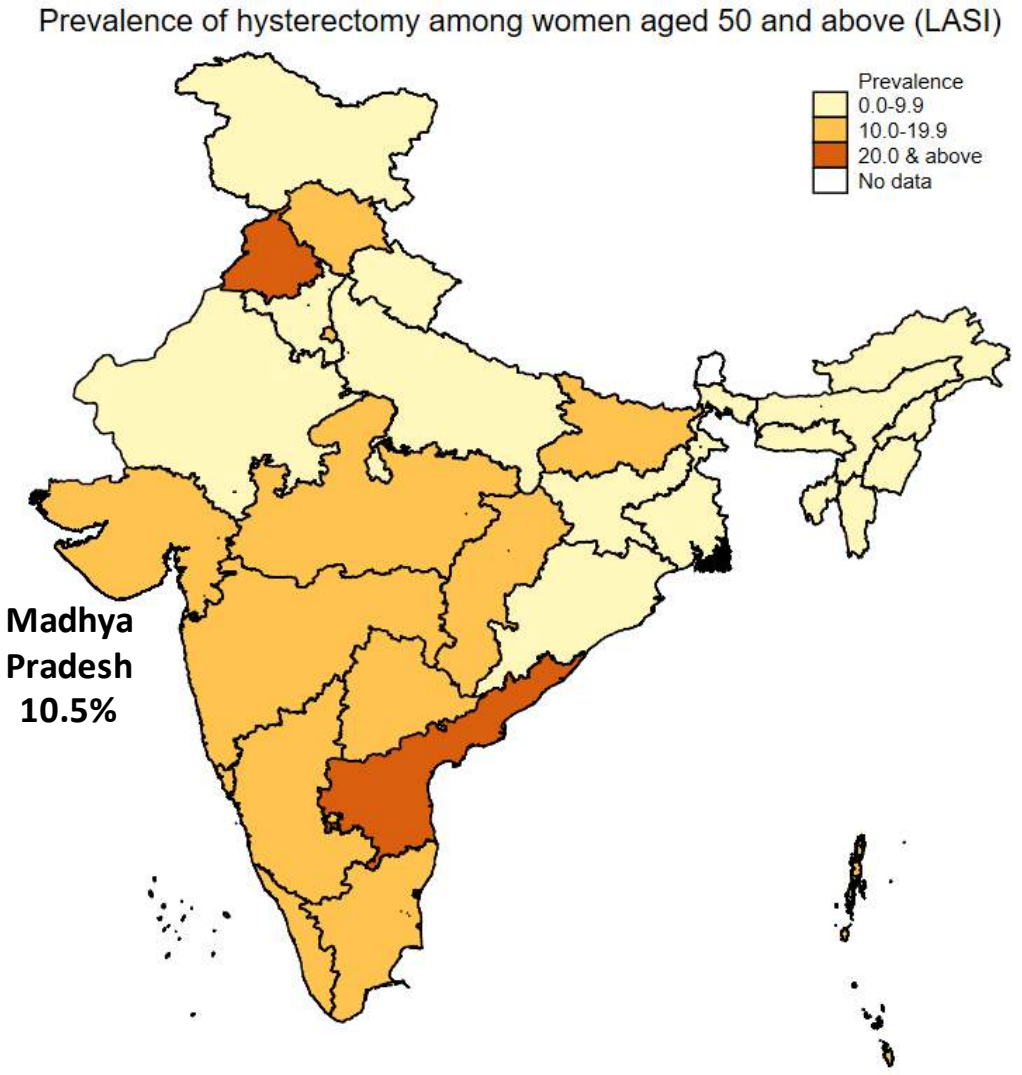


Bhopal Roundtable
December 21, 2023

National patterns of hysterectomy (40-49, 50+)

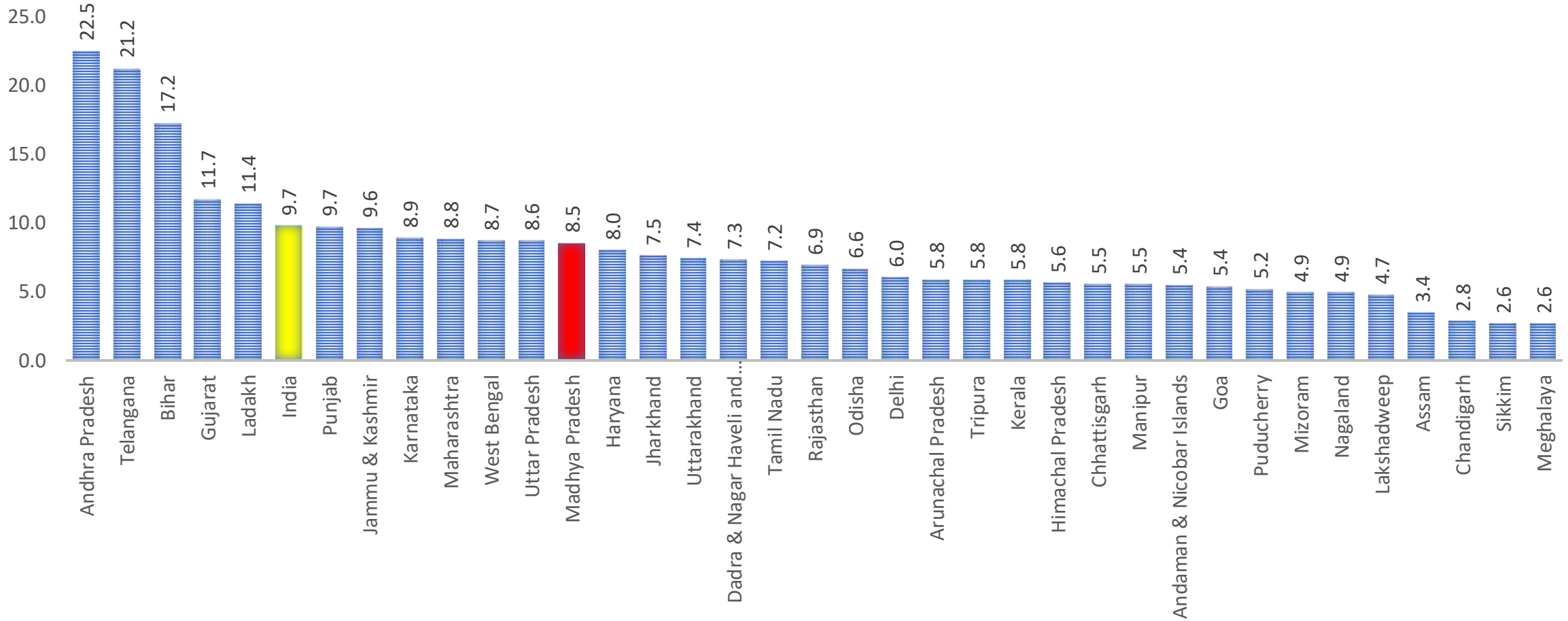


Source: NFHS-5 (2019-21)



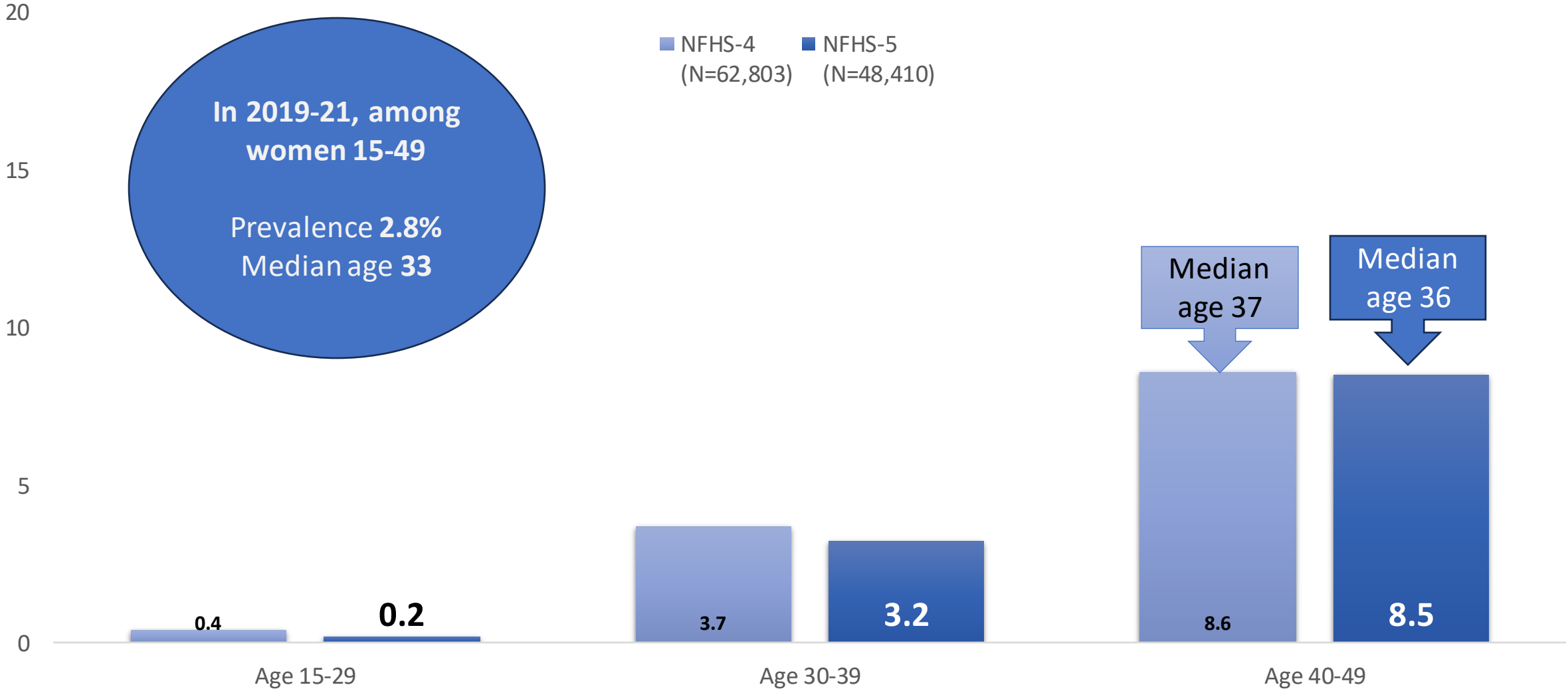
Source: LASI (2017-18)

Prevalence of hysterectomy among women aged 40-49 (2019-21)



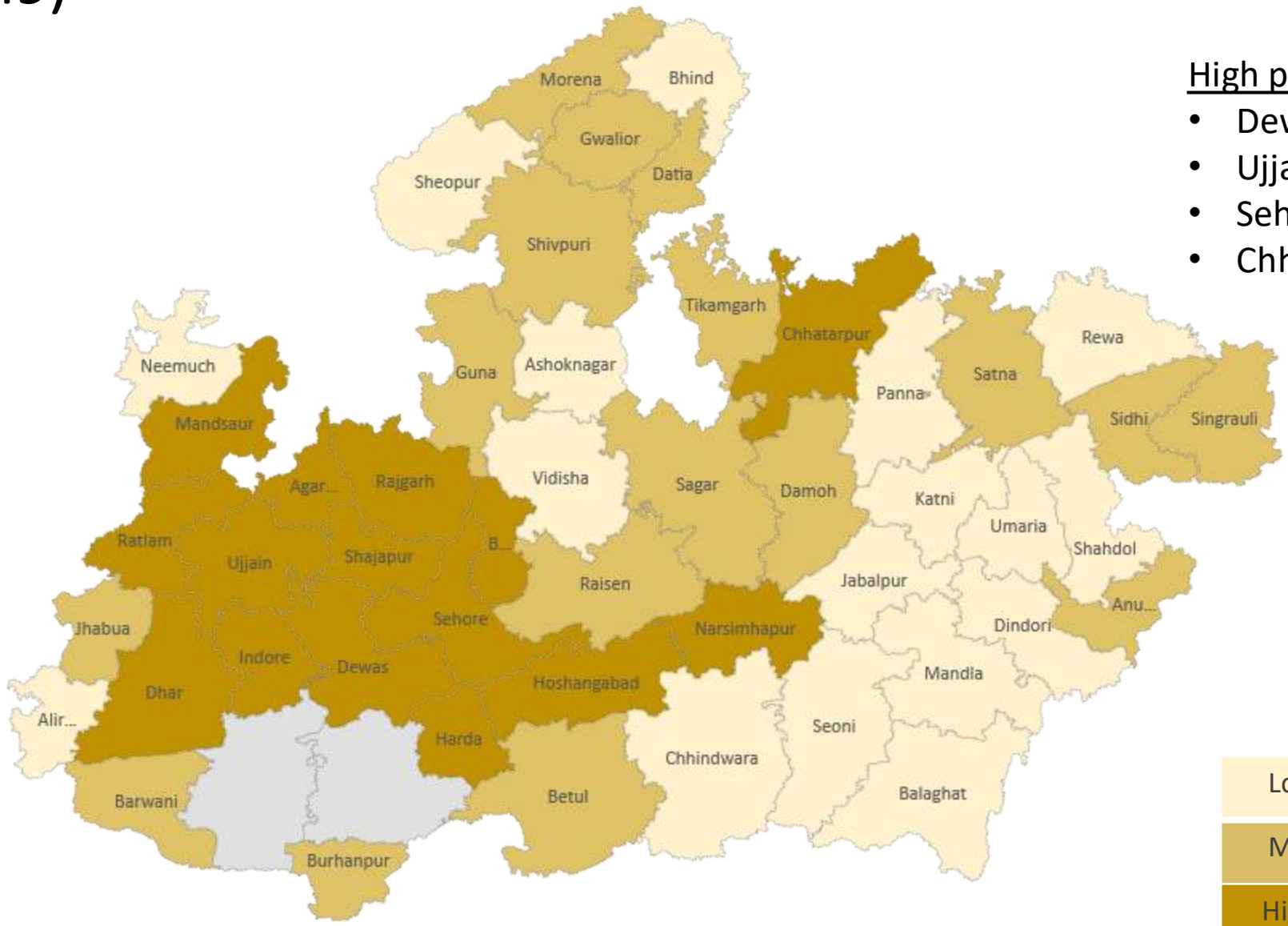
Source: NFHS-5 (2019-21)

Age specific prevalence and age at hysterectomy



Source: NFHS-5 (2019-21)

Prevalence of hysterectomy in Madhya Pradesh, 2019-21
(women 40-49)



High prevalence (%):

- Dewas 21.3
- Ujjain 21.2
- Sehore 14.9
- Chhatarpur 14.0

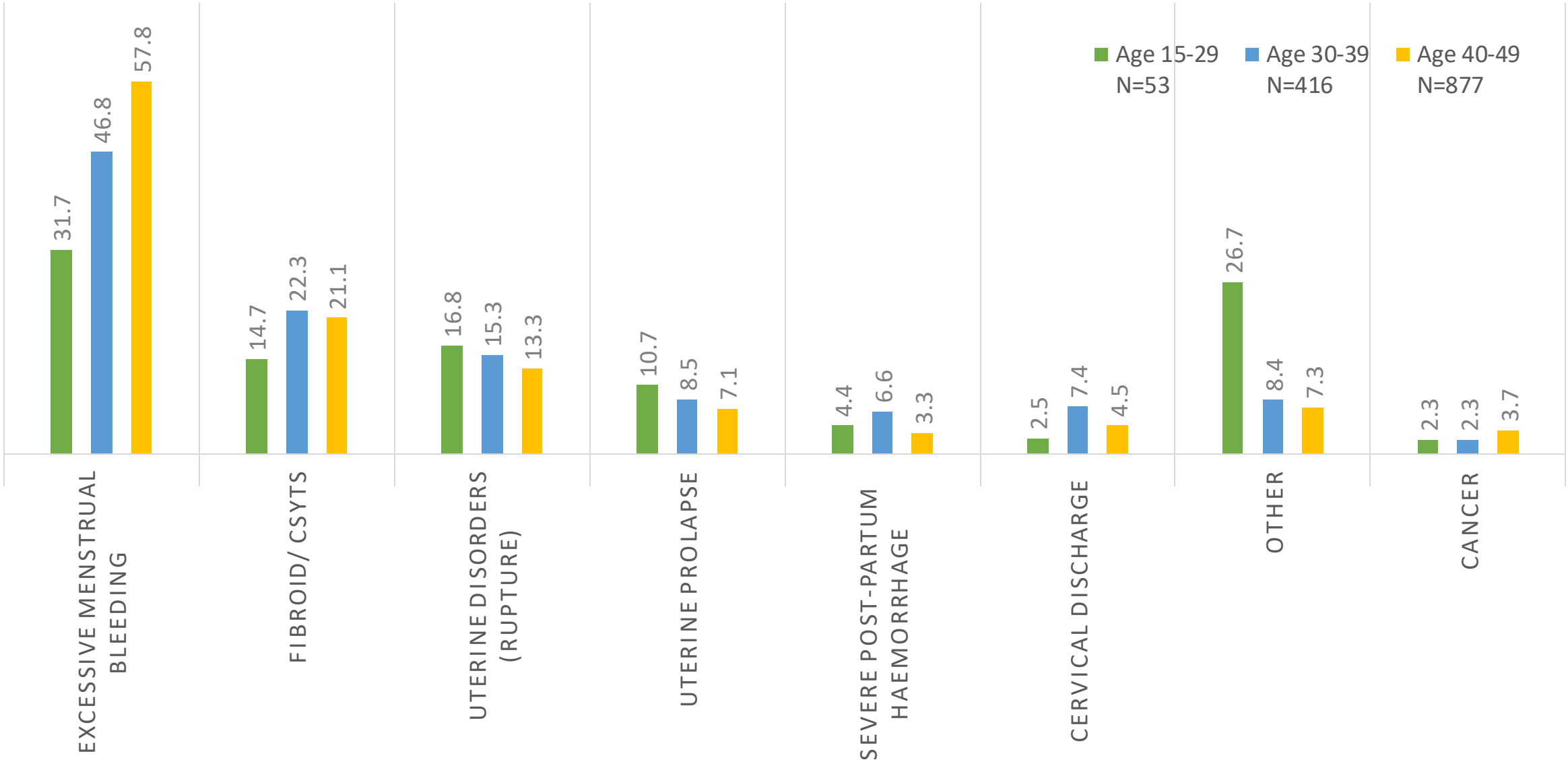
Low prevalence: [1.7, 5.4]

Mid prevalence: [5.5, 8.8]

High prevalence: [8.9 21.3]

Source: NFHS-5 (2019-21)

Self reported reasons for hysterectomy, by age



Source: NFHS-5 (2019-21)

Factors associated with hysterectomy in Madhya Pradesh*

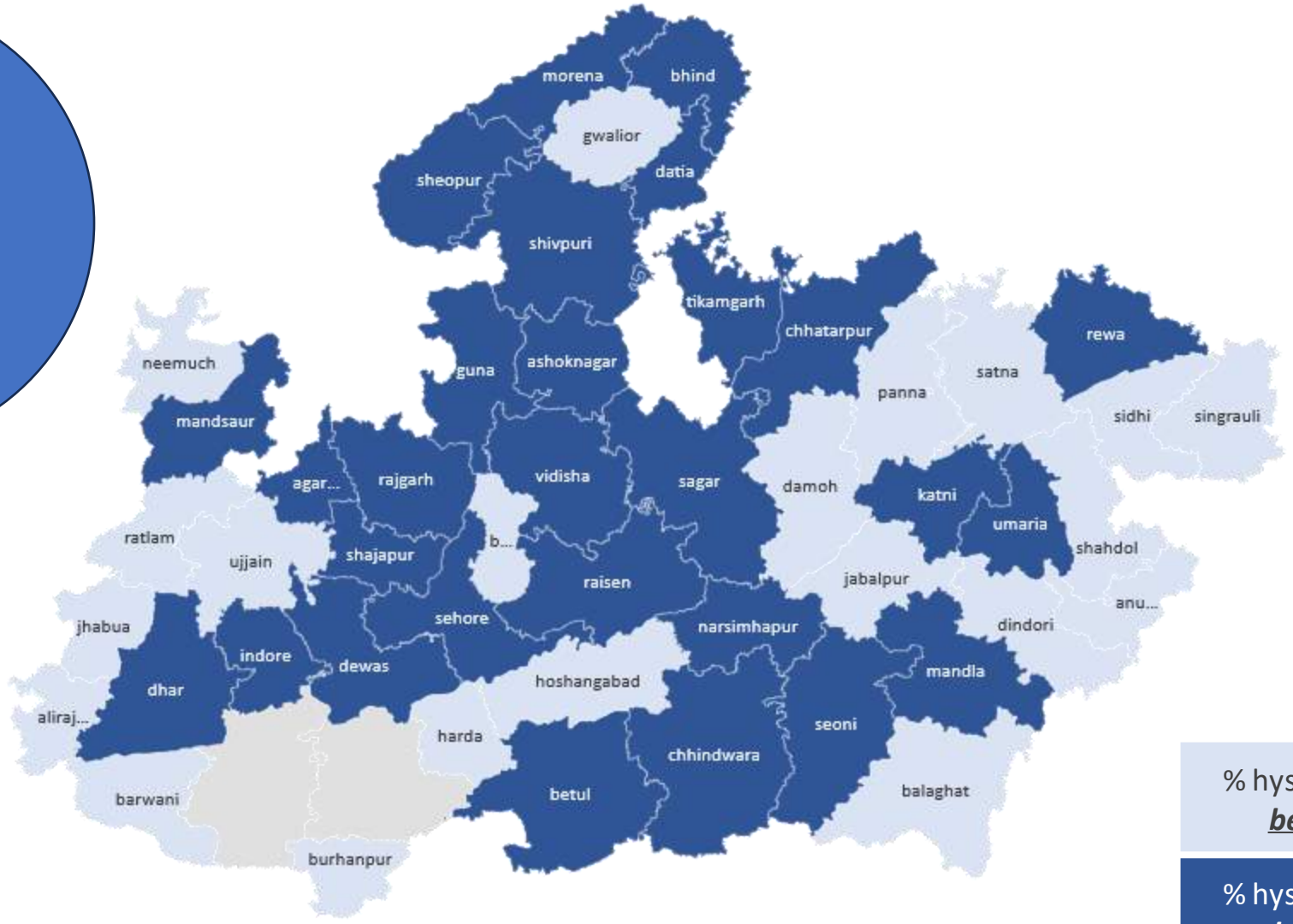
- Older age
  - *Greater odds of hysterectomy in older age groups*
- Less education
  - *Greater odds of hysterectomy in less educated groups*
- Rural residence
  - *Rural women at 1.5 greater odds of hysterectomy compared to urban women*
- From wealthier households
  - *AOR of 5^{th} quintile vs 1^{st} quintile= 4.3*
- Have one or more children
  - *3.8 times greater odds among women with one or more children*
- Have not been sterilised
  - *Lower odds (0.8) among women who have undergone sterilisation*

* Results from multivariate logistic regression on hysterectomy as outcome variable

Place of Hysterectomy

Hysterectomies in private facilities

Overall, **61.6%** hysterectomies in Madhya Pradesh are in **private facilities**



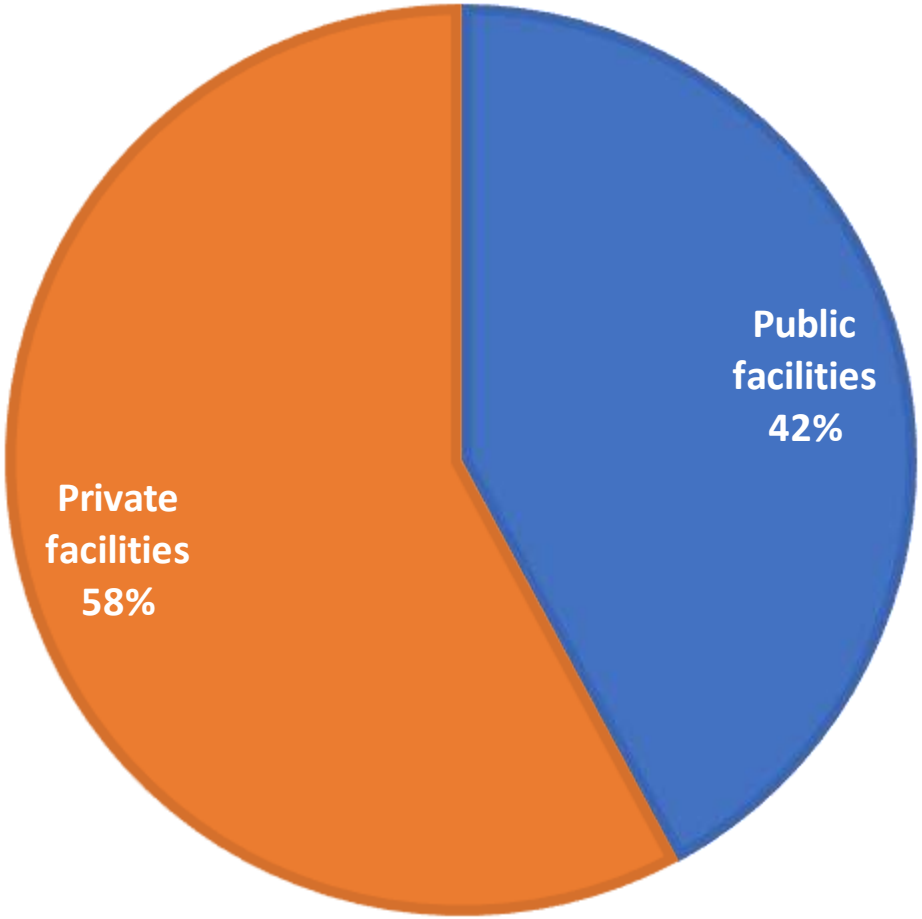
% hysterectomies in private facilities- ***below*** state average [0, 61.6]

% hysterectomies in private facilities- ***above*** state average [61.7, 100]

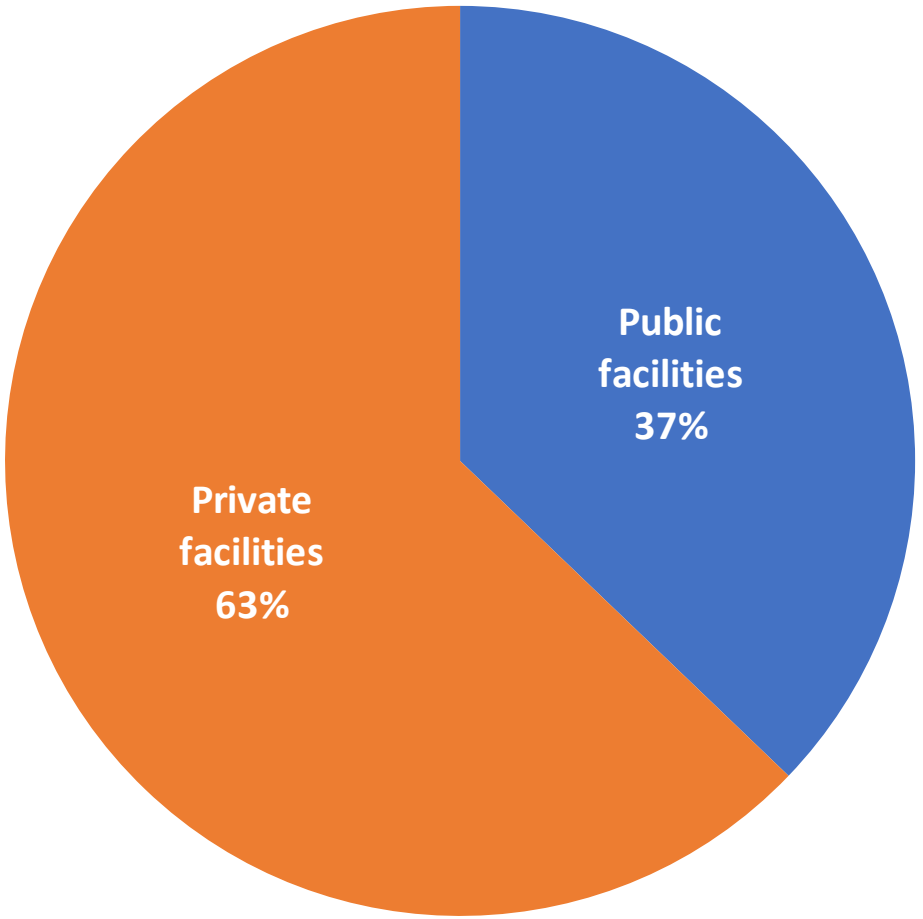
Source: NFHS-5 (2019-21)

Place of hysterectomy, by residence

URBAN

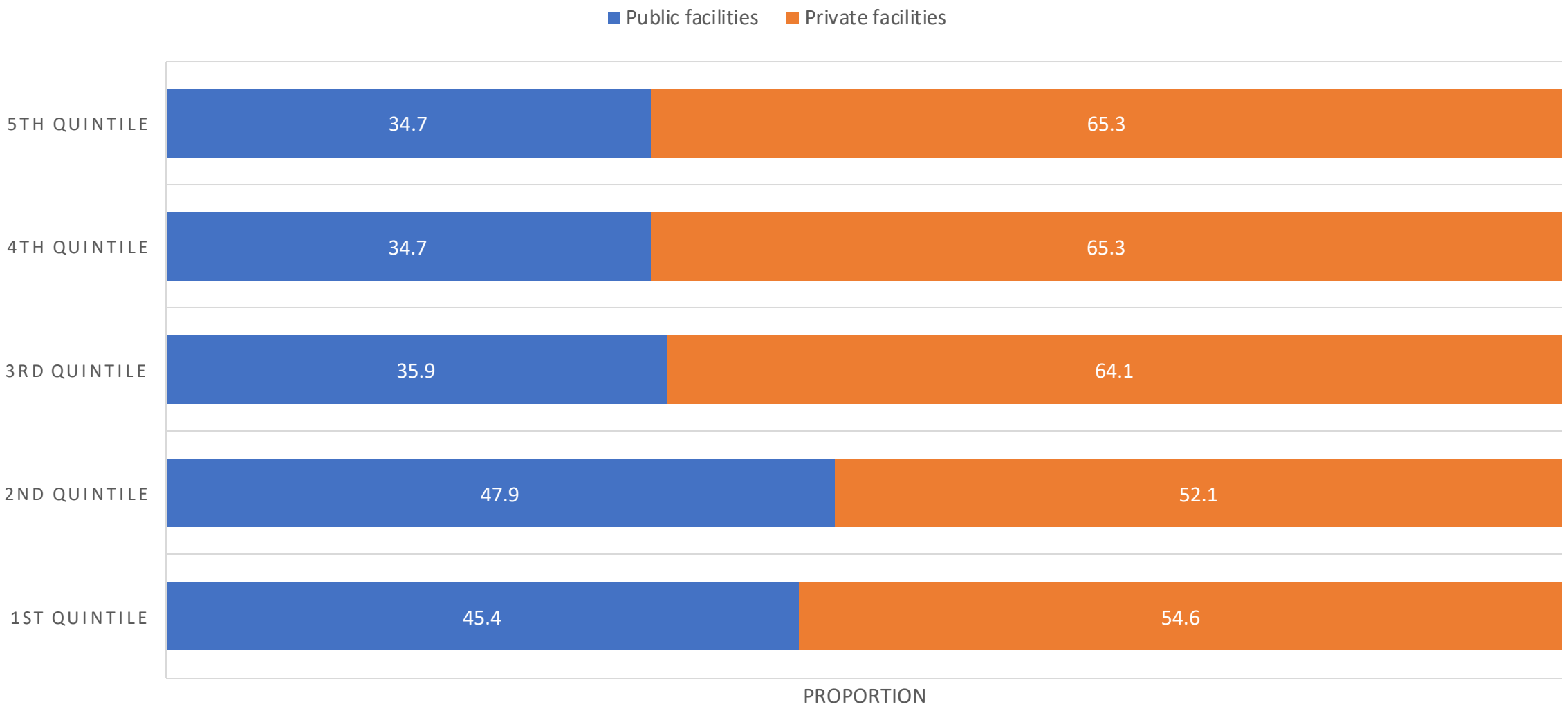


RURAL



Source: NFHS-5 (2019-21)

Place of hysterectomy, by wealth quintile of households



Source: NFHS-5 (2019-21)

Hysterectomy and NCDs

Hysterectomy and NCDs later in life

Findings from the LASI study, 2017

A nationally representative sample of women, aged 45 and up in India:

A woman with hysterectomy had….

1.5 times higher odds of **hypertension**

1.7 times higher odds of **diabetes**

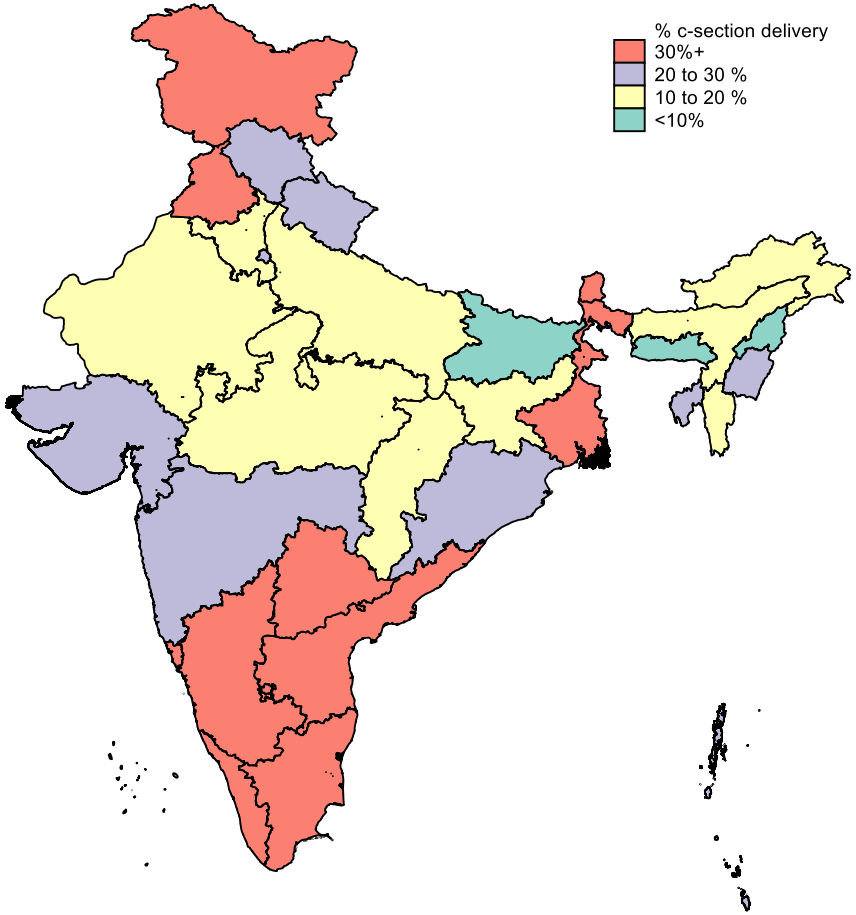
1.5 times higher odds of **bones/ joint diseases**

when compared with women without a hysterectomy

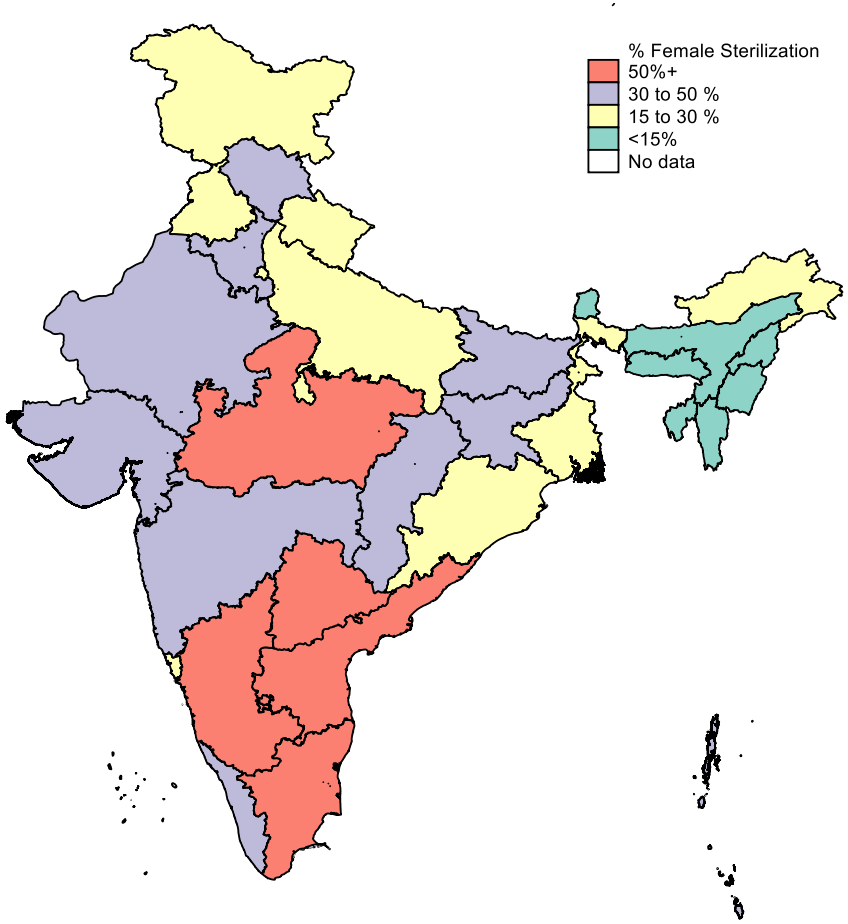
Adjusted for age, education, marital status, wealth status, caste, religion, urban/rural location, BMI category.

C-section and Sterilisation

National Patterns



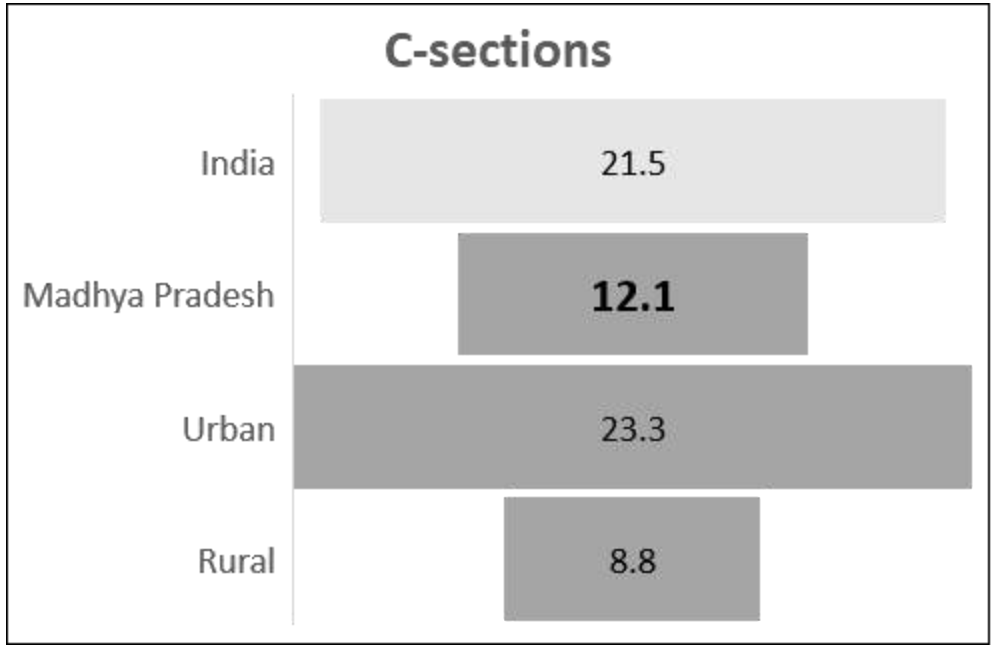
C-section

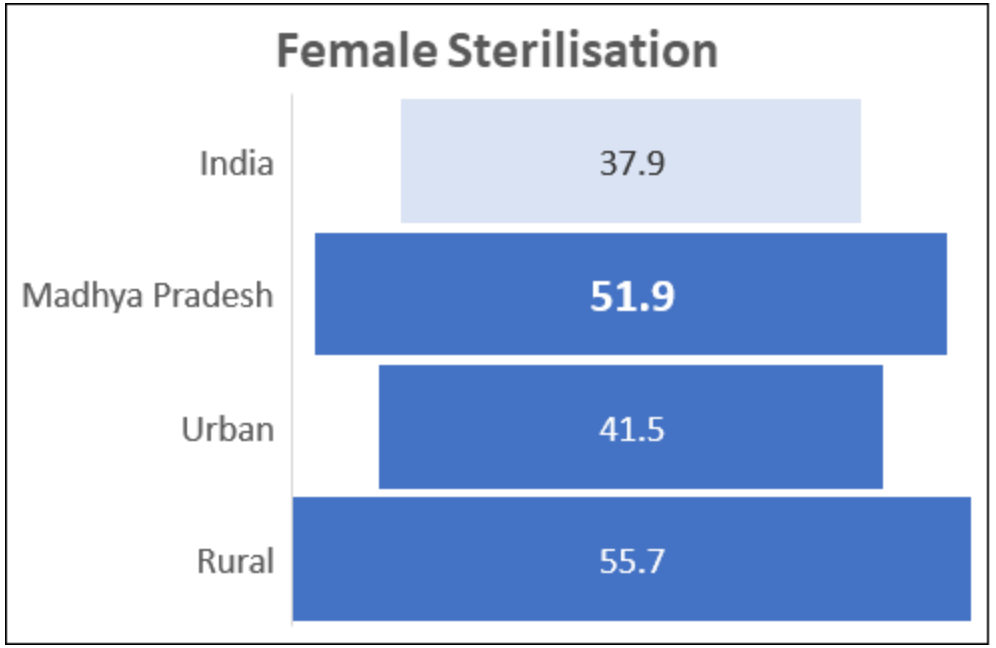


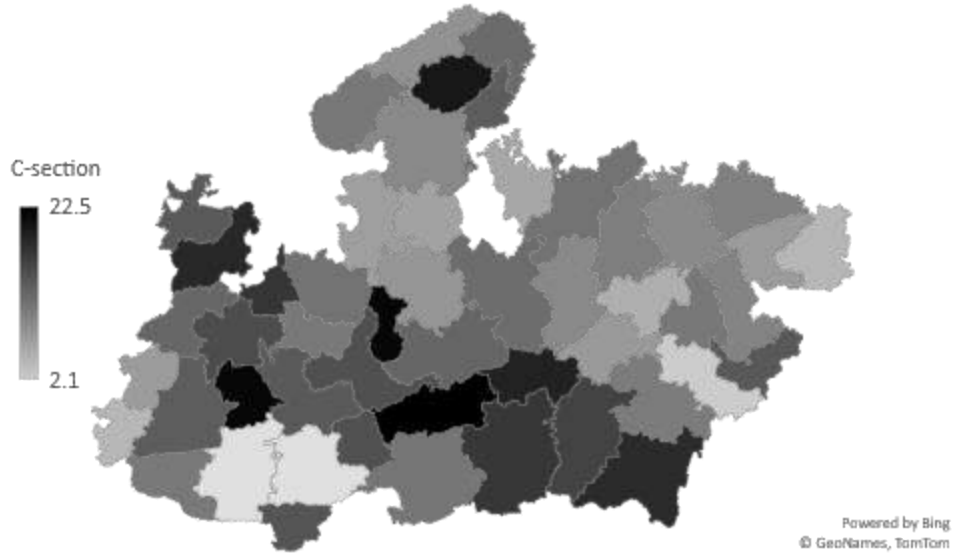
Female Sterilisation

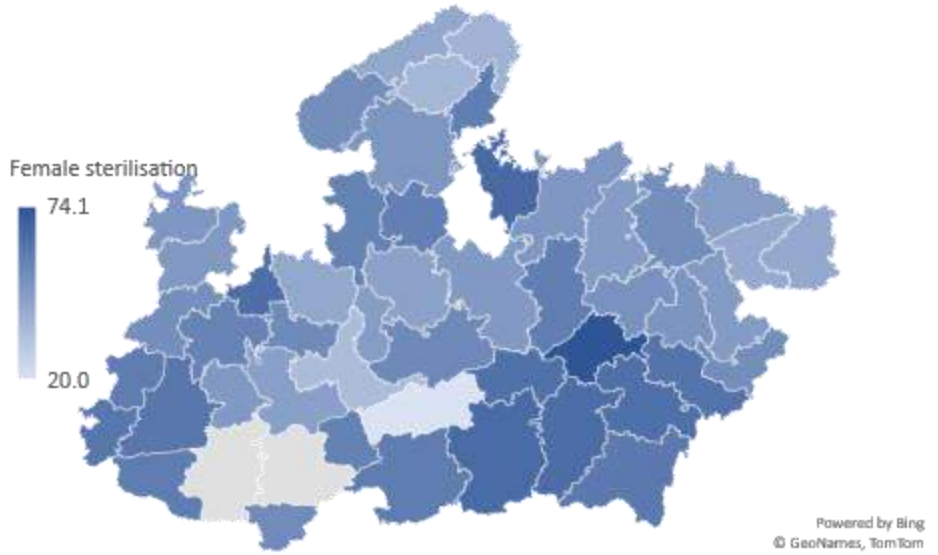
Source: NFHS-5 (2019-21)

C-sections* and Female Sterilisation









***: all births in last 5 years, NFHS 5 (2019-21)**

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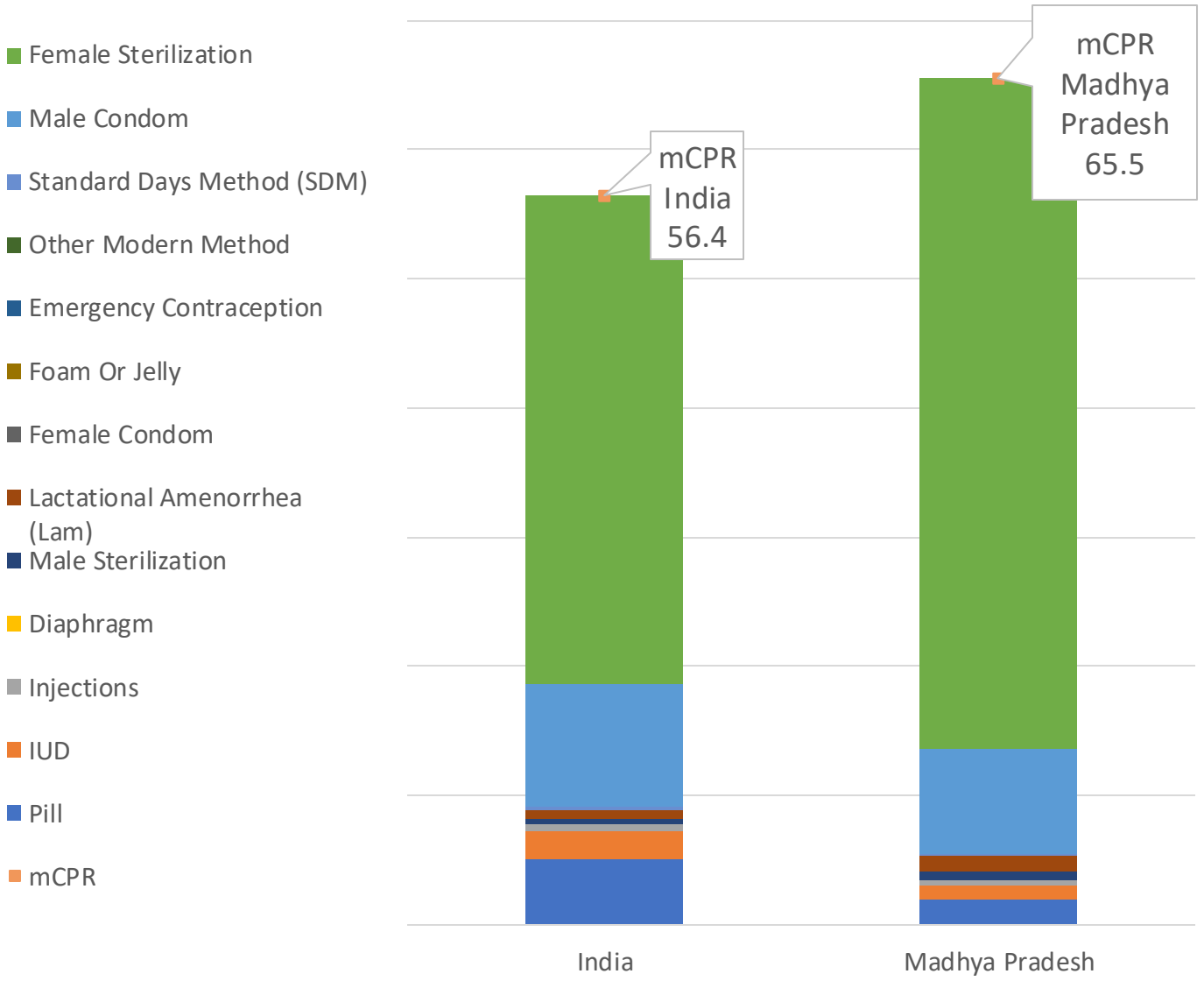
Modern contraceptive method mix, married women 15-49



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Male Condom	9.5	8.1
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Male Sterilization	0.3	0.7
Lactational Amenorrhea (Lam)	0.7	1.2
Female Condom	0	0.0
Foam Or Jelly	0	0.0
Emergency Contraception	0.1	0.0
Other Modern Method	0	0.0
Standard Days Method (SDM)	0.2	0.2
mCPR	**56.4**	**65.5**

Source: NFHS-5 (2019-21)

NATIONAL CAMPAIGN ON HYSTERECTOMY - FOGSI INITIATIVE

Dr. Lila Vyas

Jaipur

Save the girl child .....***let her be bo***

Save the generation next ***Educate her***

Save the mother ***Ensure safe delivery***

Save the uterus

Empower her to age gracefully

Dr P K Shah, Dr Hema Divakar and Ravina Tandon

LEGAL,POLICY AND GRASSROOTS ADVOCACY ON HYSTERECTOMY

EXPERIENCE AND POTENTIAL DIRECTIONS

Year	Name of Doctor	Brief Description of Activity	Location	Event Date
2019	Dr. Kalyan Barmade	Mission Save the Uterus	Palwal, Reveri, Gurgaon	17/08/2019
2019	Dr. Sai Lakshmi Daayana	Mission Save the Uterus	Vizag	28/08/2019
2019	Dr. Kalyan Barmade	Mission Save the Uterus	latur	07/09/2019
2019	Dr. Sripriya Pragasam	Mission Save the Uterus	Pondicherry	07/09/2019
2019	Dr. Srilatha Gorthi	Mission Save the Uterus	Tirupati	08/09/2019
2019	Dr. Kalyan Barmade	Mission Save the Uterus	Varanasi	14/09/2019
2019	Dr. Sai Lakshmi Daayana	Mission Save the Uterus	Hyderabad	22/09/2019
2020	Dr. Preeti Sharma	Mission Save the Uterus	Jaipur	12/10/2020
2020	Dr. Sonal Kumta	Mission Save the Uterus	Jabalpur	19/10/2020
2020	Dr. Kalyan Barmade	Mission Save the Uterus	latur	16/11/2020
2020	Dr. Sai lakshmi Dayaana	Mission Save the Uterus	Hyderabad	30/11/2020
2020	Dr. Rohini Deshpande	Mission Save the Uterus	Solapur	07/12/2020

KOGS 2022

Dear Doctor,

Did you know that

~1 in 3 women suffer from HMB[*1]

~18% of Indian women suffer from Abnormal Uterine Bleeding[2]

83% of women state that HMB has an impact on their daily lives[2]

Bayer & Kota Obstetrics & Gynaecological Society bring to you an initiative to share the current knowledge & evidence on modern methods of management of Heavy Menstrual Bleeding

PRESERVE THE UTERUS

Dr. Shanta Kumari
President, FOGSI

Dr. Madhuri Patel
Secretary General, FOGSI

Dr. Basab Mukherjee
Vice President, FOGSI

Dr. Kalyan Barmade
Chairperson, PAC, FOGSI

We cordially invite you to be a part of this scientific initiative on ***24th June***
at ***Hotel Ortus, Kota*** *from* ***2:00 pm*** *onwards*
and pledge to help ***'Preserve the Uterus'***
****Session will Start after lunch***

Dr. DeshDeepak Gohadkar
President,
Kota Obstetric & Gynac Society

Dr. Ranjana Vaya
Secretary,
Kota Obstetric & Gynac Society

Dear Doctor,

Did you know that

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Bayer & Udaipur Obstetrics & Gynaecological Society bring to you an initiative to share the current knowledge & evidence on modern methods of management of Heavy Menstrual Bleeding

PRESERVE THE UTERUS

Dr. Shanta Kumari
President, FOGSI

Dr. Madhuri Patel
Secretary General, FOGSI

Dr. Basab Mukherjee
Vice President, FOGSI

Dr. Kalyan Barmade
Chairperson, PAC, FOGSI

We cordially invite you to be a part of this scientific initiative on ***23rd June***
at ***Hotel Regenta Central, Court Circle, Udaipur*** *from* ***7:00 pm*** *onwards*
followed by dinner and pledge to help ***'Preserve the Uterus'***

Dr. Sushila Khoiwal
Chairperson,
Udaipur Obstetric & Gynac Society

Dr. Prakash Jain
President,
Udaipur Obstetric & Gynac Society

Dr. Pradeep Bandwa
Secretary,
Udaipur Obstetric & Gynac Society

PTU Attendees Report

Venue	Date	Contact Person	HQ	Region	Attendees
Allahabad	28th May 2022	Kaushlendra Upadhyay	Lucknow	Lucknow	59
Gorakhpur	29th May 2022	Prashant Tripathi	Varanasi	Lucknow	44
Erode	16th June 2022	Muthu Saravanan Nambiraj	Coimbatore	Bangalore	50
Madurai	17th June 2022	Mahboob basha	Madurai	Bangalore	46
Udaipur	23rd June 2022	Ravi Kant Rawat	Jaipur	Delhi	74
Kota	24rd June 2022	Ravi Kant Rawat	Jaipur	Delhi	34
Bangalore	26th June 2022	S. Raghavendra	Bangalore	Bangalore	74
Jabalpur	1st July 2022	Sourabh Jain	Indore	Ahmedabad	95
Rajkot	3rd July 2022	Vrajesh Shah	Ahmedabad	Ahmedabad	58
Durgapur	2nd July 2022	Abhijit Dutta	Ranchi	Kolkata	50
Agra	14th July 2022	Chetan Chauhan	Meerut	Lucknow	86
Cuttack	16th July 2022	Saumya Nayak	Cuttack	Kolkata	54
Bhopal	17th July 2022	Sourabh Jain	Indore	Ahmedabad	40
Siliguri	18th Aug 2022	Rajat Adhikary	Kolkata	Kolkata	38
Midnapore	20th Aug 2022	Rajat Adhikary	Kolkata	Kolkata	23
Jalandhar	2nd Sep 2022	Hardeep Singh	Jalandhar	Delhi	67
Ludhiana	2nd Sep 2022	Gurdeep Singh Kalsi	Ludhiana	Delhi	72
chennai	11th Sep 2022	G Rajkumar	Chennai	Bangalore	74
Muzaffarpur	25th Sep 2022	Amit Kumar	Patna	Kolkata	47
Khammam	29th Sep 2022	Mohd.Shareef Pasha	Hyderabad	Hyderabad	42
Delhi	9th Oct 2022	Robin Rastogi	Delhi	Delhi	52
Dehradun	10th Oct 2022	Ishwar Singh Pundir	Dehradun	Delhi	31
Bokaro	12th Oct 2022	Abhijit Dutta	Ranchi	Kolkata	30
Indore	30th Oct 2022	Sourabh Jain	Indore	Ahmedabad	98
Nellore	30th Oct 2022	Gopi Gabburu	Vijaywada	Hyderabad	53
Gwalior	13th Nov.2022	Sourabh Jain	Indore	Ahmedabad	59
Bhubaneswar	23rd Nov 2022	Saumya Nayak	Guwahati	Kolkata	70
Karimnagar	25th Nov 2022	Bharat Vasili	Hyderabad	Hyderabad	53
Pune	27th Nov 2022	Pavankumar v Kulkarni	Pune	Mumbai	58
Warangal	23rd Dec 2022	Mohd.Shareef Pasha	Warangal	Bangalore	98
				Total	**1734**

Dear Doctor,

Did you know that

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Jaipur Obstetric & Gynaecological Society bring to you an initiative to share the current knowledge & evidence on modern methods of management of Heavy Menstrual Bleeding

2 ICOG Credit Points

PRESERVE THE UTERUS

Dr. Hrishikesh D. Pai
President, FOGSI

Dr. Madhuri Patel
Secretary General, FOGSI

Dr. Alka Pandey
Vice President, FOGSI

Dr. Kalyan Barmade
Immediate Past Chairperson, PAC & National Coordinator

Dr. Priyankur Roy
Chairperson, PAC, FOGSI

*We cordially invite you to be part of the scientific initiative & Pledge to help **'Preserve the Uterus'** program on **29th October** at **Hotel Sunday, 22 Godam Circle, MGF Metropolitan, Jaipur,** from **12:00 pm** onwards : **Lunch followed by academic session***

Dr. Pushpa Nagar
President,
Jaipur Obstetric & Gynac Society

Dr. Aditi Bansal
Secretary,
Jaipur Obstetric & Gynac Society

Chairpersons

Dr. Kusum Gupta • Dr. Shail Shastri • Dr. Premlata Mittal • Dr. Jyotsna Singh • Dr. Ritu Gupta •
Dr. Indu Sharma • Dr. Kusumlata Meena • Dr. Simmi Pokharna • Dr. Santusth Mathur • Dr. Sushila Saini •

Speakers

Dr. Nupur Hooja
MS, (Obs & Gyn.)

Dr. Priyankur Roy
MS, FIRM, FAGE, ORMI (Germany), Dip. Gynae-Endoscopy (Germany), PGDHHM, PGDWLS, FIAOG

Dr. Usha Sekhawat
MS, (Obs & Gyn.)

Dr. Sucheta Panicker
MS, (Obs & Gyn.)

Dr. Poonam Yadav
MS, (Obs & Gyn.)

Moderator

Dr. Priyankur Roy

Panelists

Dr. Sunita Hemani

Dr. Lata Ratnu

Dr. Sudha Saluja

Dr. Vinita Gupta

Dr. Dolly Gupta

Dr. Charul Dhakad

You will invest your time in discussing the following:

Time (min.)	Topic	Speaker
10 min	Introduction & Context Setting	Dr. Aditi Bansal
10 min	Heavy Menstrual Bleeding: Diagnosis and Management	Dr. Nupur Hooja
30 min	Management of Heavy Menstrual Bleeding due to underlying Fibroids, Adenomyosis, Endometriosis	Dr. Priyankur Roy
10 min	Management of Idiopathic Heavy Menstrual Bleeding & Role of LNG IUS	Dr. Usha Sekhawat
10 min	Management of Endometrial Hyperplasia	Dr. Sucheta Panicker
10 min	LNG IUS - Insertion, Counselling and Troubleshooting	Dr. Poonam Yadav
30 min	**Panel Discussion:** Preserve the Uterus	**Moderator:** Dr. Priyankur Roy **Panelists:** Dr. Sunita Hemani, Dr. Lata Ratnu, Dr. Sudha Saluja, Dr. Vinita Gupta, Dr. Dolly Gupta, Dr. Charul Dhakad
	Masters of ceremony	Dr. Richa Gupta & Dr Devendra Benwal

*HMB=Heavy Menstrual Bleeding

Reference:
1. Johannes Bitzer, Marco Serrani, Annalena Lahav. Women's attitudes towards heavy menstrual bleeding, and their impact on quality of life. Open Access Journal of Contraception 2013:4 21–282.
2. Accessed on 28th April 2022 from https://www.nhp.gov.in/disease/gynaecology-and-obstetrics/abnormal-uterine-bleeding

For further information write to
Bayer Zydus Pharma Private Limited, Bayer House, Central Avenue, Hiranandani Estate, Thane (w), India or email - medicalinfo.india@bayerzyduspharma.com

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PUBLIC AWARENESS COMMITTEE, FOGSI
Mirena

PTU Attendees Report 2023

	Venue	Date	Contact Person	HQ	Region	Attendees
1	Kolkata	4/1/2023		Kolkata	Kolkata	
2	Belgaum	05/02/2023	Rajkumar Biradar	Hubli	Bangalore	69
3	Hubli	05/02/2023	Rajkumar Biradar	Hubli	Bangalore	63
4	Tirupati	12/03/2023	Gopi Gabburu	Vizag	Bangalore	93
5	Rewa	19/03/2023	Sourabh	Ahmedabad	Ahmedabad	27
6	Bongaigaon	25/03/2023	Tapan	Kolkata	Kolkata	36
7	Varanasi	07/04/2023	Prashant Tripathi	Varanasi	Lucknow	72
8	Imphal	12/04/2023	Tapan	Guwahati	Kolkata	48
9	Alwar	16/04/2023	Ravikant	Jaipur	Delhi	34
10	Vizag	16/04/2023	Gopi	Vizag	Hyderabad	90
11	Jamnagar	13/05/2023	Vrajesh Shah	Ahmedabad	Lucknow	22
12	Agartala	27/05/2023	Tapan Dhar	Guwahati	Kolkata	46
13	Dibrugarh	03/06/2023	Tapan Dhar	Guwahati	Kolkata	41
14	Hassan	17/06/2023	Manjunath Prabhu	Bangalore	Bangalore	36
15	Hisar	18/06/2023	Sumit Birla	Rohtak	Delhi	35
16	Bidar	16/07/2023	Rajkumar Biradar	Hubli	Bangalore	44
17	Bijapur	29/07/2023	Rajkumar Biradar	Hubli	Bangalore	58
18	Bagalkot	30/07/2023	Rajkumar Biradar	Hubli	Bangalore	43
19	Mysore	9/9/2023	S Raghavendra	Bangalore	Mysore	50
20	Thrissur	10/09/2023	Deepak P	Hyderabad	Thrissur	80
21	Nizamabad	15/09/2023	Bharat	Hyderabad	Hyderabad	41
22	Shimoga	16/09/2023	Raghavendra	Bangalore	Bangalore	65
23	Sikar	16/09/2023	Ravikant	Delhi	Delhi	37
24	Vellore	28/10/2023	Mani	Chennai	Bangalore	79
25	Jaipur	29/10/2023	Ravikant	Jaipur	Delhi	113
Total						1274


Mirena
VAMSHEE
INTERNATIONAL
PRESERVE
THE
UTERUS


TOGS


Mirena

PROGRAMME OUTLINE

- Diagnostic Dilemmas
- Non-hormonal treatment – Need & limitationS
- Hormonal Treatment – Basis & Modalities
- Panel Discussion- Case based Situational Analysis
- Surgical Management (Video or talks)
- Minimally invasive procedures
- TCRE
- Endometrial ablation procedures

FOGSI THINGS TO DO

- REGISTRY
- AUDITS
- SURVEYS
- PRIVATE/PUBLIC/CAMPS/TEACHING SESSIONS

- ISSUES OF REMOVAL OF OVARIES

ONLINE SURVEYS

HEALTH ALERTS

HEALTH WATCH

PROPER MESSAGING

AWARENESS BUILDING

MASTER HEALTH CHECK UPS

MIS INTERPRETATION
ANXIETY PROVOKING

DEMAND AND SUPPLY

WHY WOMEN CHOOSE TO UNDERGO HYSTERECTOMY?

GOOD RIDDENCE – mensus – taboo

FEAR OF CANCER

NO OPTION

MAY BE MORE DIFFICULT AT OLDER AGE

ACCESS

EASE OF ONE VISIT ONE STOP

INSURANCE

INDICATION

indicates ... attitude of obgyns

INDICATION FOR C- SECTION

PRESENCE OF A BABY

INDICATION FOR HYSTERECTOMY

PRESENCE OF A UTERUS

QOUTE – DR P.C. MAHAPATRA PAST PRESIDENT OF FOGSI

DR HEMA DIWAKAR PAST PRESIDENT OF FOGSI

LAWS ARE OF NO USE BECAUSE

Good people do not need laws; while bad people will find a way around the laws.

-Plato

THANK YOU