vimshsj.edu.in

Review Article

Hysterectomies and bodily autonomy in female migratory farm laborers in the unorganized labor sector in Beed district of Maharashtra: A Review Article

***Dr. Amrut Arun Swami*[1], *Ms. Sakshi Rane*[2], *Dr. Sanjay Kumar*[3], *Dr. Rahul Netragaonkar*[4], *Dr. Ashish Kumar Jha*[5]**

[1]*Associate Professor,* [3]*CEO & Professor & Head,* [4]*Professor, Department of Community Medicine, Zydus Medical College, Dahod-389151, Gujarat, India*

[2]*MBBS Student, DVVPFs Medical College & Hospital, Ahmednagar-414111, Maharashtra, India*

[5]*Head, Department of Zoology, Hislop College, Nagpur-440001, Maharashtra, India*

Abstract:

Seasonal labor migration is a vital aspect of livelihood in rural and tribal regions of India. Females are paid less than males for the same amount of work. Contractors are unwilling to hire female menstruating laborers as menstruation and pregnancy are considered as roadblocks. The worry of hefty fines for absence pushes girls to get their uterus removed as menstruation & pregnancy may require them to pass work opportunities. This review aims to summarize the prevalence of hysterectomies among these women, and tries to understand the mindset behind the same. In 2018, 36% of female sugarcane laborers in the State had undergone a hysterectomy. While the rate of hysterectomies among women aged between 15- 49 years at the all-India level is 3.2%, the hysterectomy rate in the state of Maharashtra is 2.6%. Our findings revealed several studies and newspaper articles showing the prevalence of irrational hysterectomies among the unorganized migratory farm laborers as a result of work-related pressures, a grossly unregulated private medical sector and exploitative contractors who hire them.

Key Words: Unorganized sector, Occupational health, Female Labourers, Hysterectomy

Introduction:

The enormous unorganized sector, which contributes around 60% of GDP outside of the regulative reach of the state, is an extraordinary feature of Indian capitalism. The unskilled nature of work, with employers counting on informal labor and flexible employment practices, attaches little significance to education and the improvement of skills. While organized workers get hold of a 3rd of all wages and earning, 36% of the populace survives on earning under the stingy, nutrition- based official poverty line, a figure in excess of the assumed estimates of un-employed or under-employed workers. In 1995, an agricultural laboring family of two adults and a pair of youngsters earned approximately $130 a year.[1] 2/3rd of all landless agricultural labor stays under the poverty line. While, maximum work can be unregulated through the state however the markets for this labor are anything but 'unstructured'.[2] Work is decided through social establishments together with caste and gender. Capitalism isn't dissolving this matrix however reconfiguring it slowly, erratically and in an exceptionally great variety of ways. The matrix nevertheless influences the responsibilities maximum workers do and the terms and conditions of the contracts they may be offered. [1]

Seasonal labor migration is a vital aspect of livelihood in rural and tribal regions of Western India.[3] Such migration isn't simply an accessory to a basically agrarian manner of existence, however is indispensable to the coping, survival and livelihood techniques of tribal farming families. The forces prompting migration are mostly to do with the social relations of dependency and indebtedness which subsistence failure entails, as with ecological decline.

Corresponding Author: *Dr. Amrut Arun Swami*

Email ID: *draaswami@gmail.com*

Address: *Department of Community Medicine, Zydus Medical College, Dahod-389151, Gujarat, India*

ISSN No. *: (p) 2348-523X, (o) 2454-1982*

DOI: 10.46858/vimshsj.9208

Date of Published : *30th June 2022*

The problem isn't of declining manufacturing, but of structures of usurious cash lending, labor contracting and exploitation.[4] The social consequence of migration is furthest from uniform, however formed through class and gender. For a minority of families migration gives fantastic possibilities for saving, funding and meeting contingencies. For the poorer majority, migration is a shielding, coping approach overlaying present money owed and intense financial vulnerability. In combining unequal and individualized profits accrual with the want for joint livelihood techniques, migration has a first-rate effect on household relationships.[3]

Beed is one of the worst draught hit districts in India primarily based on pointers like rainfall deficit, low soil quality and decline in groundwater index.[5] Due to extended drought situations, a remarkable upward thrust in crop failure, debt accumulation amongst farmers, a growth in key in charges of farming along declining output price of crop produce and the shortage of opportunity and employment possibilities, a massive quantity of farmers within this area are driven to the verge of suicide.[6] In such situations, laborers and farmers are compelled to emigrate from numerous districts of Marathwada, mostly Beed, to the sugar belt areas of Western Maharashtra and Karnataka to labor on sugarcane farms at some stage in the harvesting season (October until May). Every year roughly 1 million unorganized agreement laborers, maximum of them from lower castes, migrate to the sugar belt in Western Maharashtra over six months, close to areas where sugar factories are concentrated.[7]

With around two hundred sugar factories, Maharashtra ranks first in sugar manufacturing in India. Sugarcane farming is taken to be tremendously profitable economically as state-backed sugar cooperatives purchase produce without delay from farmers at a charge maintained constant through the authorities, as a result ensuring a local market. However, sugarcane harvesting is an exhausting and a labour-intensive task, levying physical strenuous responsibilities together with tying, loading, unloading and transportation of cane to factories.[8] Labourers regularly work in pairs; a husband and a spouse are recruited and supervised through the mukadams (jobbers-cum-foremen), performing as links between the manufacturing facility and the cane slicing teams.[9] Young children of the labourers additionally tour with them on the migration spot leaving their faculties and schooling behind to assist their mother and father in work, to get trapped into the vicious cycle of bonded labour (making it a generational trap). Marginalised, and vulnerable in the new socio-cultural environment, the sugarcane harvesting lower class labourers face livelihood insecurities. Pregnant ladies and children have to work as well. Exploitation is both apparent and subtle. Still this seasonal existence is a higher possibility for them. A traditional operating day is 12 - 13 hours long, with girls devoting extra time in unpaid home labour like cooking, fetching clean water and childcare. Each migrant couple is paid an uchal, or an advance of Rs. 50,000 and Rs. 1,00,000 (Rs. 250-300 for a day), with a fine, or khada, starting from Rs. 500 to Rs. 1000 for every day of lost work.[1] Females are paid much less than adult males although they do the same amount of work. One of the reasons is that they need to generally tend to their children or they need to take a break during menstruation and additionally during pregnancy or for reproductive tract infections or sicknesses. Since migration occurs for a transient period of seven to eight months, labourers operating as cane-cutters live in small makeshift huts, or cane fields or sugar mills. Since those are short-lived shelters, there's an absence of toilets, clean water and sanitation. Such situations adversely affect the fitness of these labourers, mainly girls who're compelled to exercise risky menstrual hygiene practices that cause rashes and infections, inflicting extreme reproductive issues.

In April 2019, a local Indian newspaper reported a staggering increase in hysterectomies in the Beed district of Maharashtra.[10] The report began with a baffling question - 'Why many women in Maharashtra's Beed have no wombs?' It was reported that the cane cutting contractors are unwilling to hire female menstruating labourers. The belief that menstruation and pregnancy are roadblocks in the everyday labour process, and hinder the physical capacity of female labourers to carry out daily wage work, drives this unwillingness.

According to a study commissioned by the Maharashtra State Commission for Women in 2018, 36% of female sugarcane labourers in the State had undergone a hysterectomy. In June 2019, the Health Minister of Maharashtra, EknathShinde, stated in the Maharashtra Legislative Assembly that, in the last three years, 4,605 female sugarcane farmers underwent hysterectomies. This claim is further substantiated with the figures presented by the National Family Health Survey.

The Survey notes that, while the rate of hysterectomies among women aged between 15- 49 years at the all India level is 3.2%, the hysterectomy rate in the state of Maharashtra is 2.6%. The mukadams claim that they have a strict time frame to achieve production targets laid down by the sugarcane factory owners, which become difficult to achieve if and when female labourers skip work due to menstruation and/or pregnancy. Since these labourers are unorganized, their work day is regulated and controlled by the mukadams and the factory thatowners. For instance, prompt delivery of freshly harvested sugarcane to the factory is highly profitable for the factory owners, for which female labourers are reportedly woken up at 3 am to load the trucks.[3]

However, a vital query arises: Do mukadams coerce the girl farmers to get hysterectomies? The mukadams do not directly coerce girls to get their uteruses removed. However, it's the worry of mukadams extracting hefty fines from the khada, together with consistent precarity surrounding their jobs, which pushes those girls to get their pishvi(uterus) eliminated - due to the fact that menstruation, contamination and being pregnant may require them to pass labour and work opportunities. Most female sugarcane labourers in Beed are married at a younger age, and that they begin harvesting sugarcane as young as 16. The choice to emigrate is taken by the head of the family, commonly the fathers, fathers-in-law and husbands. Despite the precarity of labor and burden of poor living situations, girls have little or autonomy in making choices for themselves or the family.[11]

Women farmers find it hard to invest in sanitary napkins and consequently end up using cloth. Lack of sanitation and suboptimal disinfection of the menstrual cloths in addition increase the threat of reproductive diseases. Additionally, the growth in hysterectomies is likewise pushed through a deeply rooted notion that the womb of a girl is futile as soon as she has produced babies, who're then seen just as surplus labour force. Thus, the elimination of pishvi isn't an final results of coercion. Instead, it's a far-fetched strive toward enhancing ordinary productiveness, at a ugly price- setting their our bodies at irreparable physiological and mental risk.[11] The ordinary lives of girl sugarcane labourers are embedded in a concatenation of circumstances - bad residing situations, extended operating hours, and minimum access to public health services. These deficits have an unfavourable effect on their reproductive fitness. Lack of cheap sanitary napkins, no toilets, unhygienic sanitation practices and open defecation regularly results in more than one infection and grave reproductive issues for girls, with very little scope of skipping a day of work because of the worry of being fined through the mukadams. Amidst a growing state of exploitative labour-worker relationships, together with unfavourable results on reproductive fitness, working as seasonal migrants emerges as the handiest survival tool for the distressed female labour force.[12]

Are female labourers more efficient in fields after hysterectomies? Rarely. The cost of one hysterectomy is INR 35,000 - almost equal to the amount of money which a labouring couple earns in one whole year. This price is seen as a one time funding to reinforce the everyday productivity to carry out labour-rich work. However, it has been found that the reasons for which a pishvi is removed are not very clear. The most common response which these women get from private doctors when they consult them for any gynaecological problem is that the 'womb has gone bad' or there is white discharge. In most of these cases, there is a subsequent lack of post-operative care and counselling which challenges the health of these women. Many women who get their uteruses removed in their 20s and 30s complain of backache and abdominal pain. This also increases the chances of serious psychological problems, further hindering their ability to carry out their day-today work. [11,13,14]

The absence of sufficient public health facilities in Beed helps the ongoing epidemiology of hysterectomies among the female laborers. According to data from the Municipal Council of Beed, in contrast to 63 private hospitals, there is only one government hospital in Beed which further increases the dependency of women on the completely unregulated private medical sector. The inadequate medical facilities for carrying out gynecological operations, counseling facilities and post-operative care in the public medical health sector has transformed the bodies of female sugarcane farmers into 'hunting grounds' for the private medical sector. Networks working on health and women's issues say unwarranted hysterectomies among poor women in Beed and other places are the result of work related pressures imposed on women, plus a grossly unregulated private medical sector and exploitative contractors and sugar factory owners who hire migrant workers". Along with such health hazards, activists claim that women laborers are exploited by the male contractors at the worksite where physical abuse and rapes happen quite often though they are not formally reported. The hardly shared realities, including, women's critical health issues, sexual exploitation, rapes among other sensitive issues of their lives are beyond imagination. [15,16]

Migration stories are often portrayed in a gendered lens, thereby failing to account for the heroic and painful stories of women, and for people from marginal backgrounds who move in search of independence, survival and sovereignty. This is not different to how women's work, especially when exploitative, has been conceptualized to date. Often devised as social-reproductive work, this abstract structure has failed to address the normative reflection that continues to devalue women's work by frequently seeing it in concurrence to productive or valuable work, opposite and subordinate to it. Despite decades of feminist attention to this and sustained efforts at visibilising women's work, it has not yet overcome established patterns of thought that continue to subordinate it and persistent blinders that attempt to render visible the situation of women who migrate for work. [15,17,18]

Focusing on these women's experiences as migrants and workers, and their efforts to address their precarious and exploitative conditions, allows us to not only reflect on the challenges in better conceptualizing these women's lives but more importantly, to identify what these struggles say about the Indian women's movement. The concept of menstrual rights cannot be concretized without reference to socio-economic parameters requiring transformation of entitlements into legal rights as ensued by addressing issues of privacy, gendered inequality, power of social norms categorically, amounting to violence against women and girls.[19] In light of the incident of enforced yet opted practice of mass removal of uterus by the migrant women, labour employed on contractual basis (seasonally) in the sugarcane fields in the Beed District of Maharashtra and the role of medical practitioners, nature of obtaining informed consent of the women for the surgery and whether the consequent failure/ inaction of the State to protect women against discrimination and violence adversely affects women's right to health- dignity and work both within public-private sphere. The recognition to violation of menstrual rights of women as violation of sexual and reproductive health and rights requires institutional and policy intervention coupled with raising awareness for realization of reproductive justice. The operative sphere of menstrual violence extends to anti-feminized labour practices coupled with medicalization of women's bodies reflecting tolerance towards gender inequality resulting in denial of right to development of women and girls.[20]

After wide media coverage about the sporadic rise in hysterectomies in Beed, the National Commission for Women issued a notice to the Chief Secretary, UPS Madan, expressing its concern about the 'pathetic and miserable condition' of women in Beed. Thereafter, a seven-member investigation committee, headed by the Shiv Sena's Neelam Gorhe, Deputy Chairman in the state legislative council, was set up by the Maharashtra Health Department to probe into the rising number of hysterectomies in Beed. The Committee also consisted of gynecologists, social health workers, as well as female politicians. . The Committee was responsible for looking into the total number of hysterectomies and unauthorized hysterectomies that took place in Beed in the past three years.

The Health Department of Maharashtra issued an official order under which all private hospitals in Beed were to be inspected, and it also proposed secret monitoring of these hospitals.[21] The District Collector of Beed issued an order stating that all private hospitals carrying out hysterectomies in Beed need to submit the necessary documents and medical reports of the patient to specific government health officials, only after which official permission to operate will be granted. The Health Department also stated that hysterectomies are to be conducted on only one day of the week, with prior permission from the concerned health officials, without which the hospitals will face serious legal action, including cancellation of registration.[22]

POLICY RESPONSES & THE WAY FORWARD

1. Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA)

MNREGA is a social security act that aims to provide livelihood security through wage labour in rural areas. However, in the face of grave agrarian stress due to a persistent drought in Beed, the failure of MNREGA becomes evident. Due to lack of employment opportunities within Beed, workers are forced to migrate to nearby areas. However, these workers are employed only during the harvesting season. During the months of April to May, the prolonged drought in Beed deepens the plight of these workers. The proper implementation of MNREGA should aim towards creating alternative and sustainable employment opportunities for seasonal migrants within Beed by making it self sufficient especially in terms of water resources.[23]

2. Implementation of Employees Provident Fund (EPF)

In 2014, the Maharashtra state government announced setting up of a welfare board for sugarcane farmers - to improve the working conditions of sugarcane cutters by providing them with social and financial security (Shukla and Kulkarni 2019) However, this move faced a strong opposition from the owners of sugar factories as they felt that such a scheme would increase their financial burden. In 2018, the Maharashtra State Government proposed a scheme to extend the benefits of EPF to sugarcane labourers, with an office in Beed. Despite this scheme being announced in 2018, it is yet to be implemented. There is a strong need to establish a welfare board for sugarcane workers in order to enable access to social security benefits and improved working conditions.[24]

3. The Unorganised Sector Worker's Social Security Act, 2008

The Unorganised Sector Workers' Social Security Act, 2008 aims at providing an effective framework for welfare schemes for workers in the unorganised sector of the Indian economy. According to the Bill, every unorganised worker needs to register themselves with the district administration to avail social security benefits. However, despite the implementation of the Act, there is no change in the working conditions of cane labourers in Beed. Indeed, the Act aims at providing social benefits to the labourers, but it does not delineate any guidelines to improve the working conditions of the labourers in terms of improving living conditions of worksites. There is thus a need to restructure the guidelines of the Social Security Act 2008 along with ensuring the district level registration of sugarcane labourers, especially women so that they can avail maternal health benefits as well as can get access to affordable treatment in government hospitals.[25]

4. The Unorganised Sector Worker's Social Security Act, 2008

According to the official draft of The Maharashtra Clinical Establishments Act, 2014, the registration and regulation of clinical establishments is deemed necessary. The draft proposes to safeguard the rights of patients in order to improve both public as well as private health care facilities in the state of Maharashtra. However, even after five years, this Act is yet to be implemented. There is an immediate need for the implementation of CEA along with effective standard treatment protocols and legal provisions to regulate the quality of care provided by private hospitals in Beed. The implementation of CEA also becomes essential as there is a dearth in government health facilities as opposed to the booming private sector in Beed. There is also a need to equip government and private hospitals with facilities for post-operative care and counselling for patients. However, government policies should have actual implementation at the ground rather than just being on paper.[26]

Importance of occupational health awareness and occupational health departments in medical colleges in India is crucial, the manpower form these departments should keep a track of different organized and unorganized occupations in the district, conduct regular studies and research to have a proper understanding of different problems. [27]

For low-income women in this society, the weight of untreated morbidity, along with views regarding the uterus and a health system ill-equipped to manage women's gynaecological health requirements, has made hysterectomy both medically and socially acceptable. The prevalence and drivers of hysterectomy necessitate immediate action to reduce its apparent widespread usage for illnesses that are amenable to less invasive treatments. Understanding the linkages between sterilisation and hysterectomy, as well as improved access to sexual and reproductive health services within primary health care, is a first step. Provider training and health finance for alternative operations, as well as health education on gynaecological disorders and the potential side effects of hysterectomy and oophorectomy, emerge as critical needs. Population-based research on gynaecological morbidity and mortality is needed pan-India to monitor trends and identify long term effects.[28]

Because migration is linked to inhumane treatment of some of the world's most vulnerable workers, it necessitates a massive policy initiative. The Indian government has to adopt a comprehensive migration strategy that addresses the deplorable conditions in which long-term and seasonal migrants live, work, and are exploited by being paid less than the minimal minimum wage. All migrant workers must have decent employment options, and the policy must respect their fundamental rights, recognise their contributions, and create an awareness of the communities from which they come and the regions where they work.[29]

In addition, specific norms and regulations must be developed in order to be implemented. The COVID-19 pandemic-related lockdowns have brought home not only the enormity of the migrant workforce, but also the magnitude of the migrant workforce. Along with a migration policy, MGNREGA or other similar schemes should be used to create livelihood chances in the districts from which migrants migrate in quest of job. Lastly, to end the vicious cycle, children from migrant families' health and education require immediate, concerted, and inventive solutions. To bring the children out of poverty, we must have a steadfast policy. Children and women, in particular, suffer as a result of the health system's failure. We cannot afford to sacrifice social programmes on the altar of a state's industrial prosperity, even in the medium run.[29]

Conclusion:

Migration is linked to inhumane treatment of vulnerable workers. The Indian government has to adopt a comprehensive migration strategy and address this deplorable condition. Occupational health departments in medical colleges in India is crucial, the manpower form these departments should keep a track of different organized and unorganized occupations in the district and conduct regular research to have a proper understanding of different problems.

References:

1. Harriss-White B, Gooptu N. Mapping India's world of unorganized labour. Socialist register. 2001;37.
2. Harriss-White B. India working: Essays on society and economy. Cambridge University Press; 2003.
3. Mosse D, Gupta S, Shah V. On the margins in the city: adivasi seasonal labour migration in western India. Economic and Political weekly. 2005 Jul 9:3025-38.
4. Taylor M. Liquid Debts: credit, groundwater and the social ecology of agrarian distress in Andhra Pradesh, India. Third World Quarterly. 2013 May 1;34(4):691-709.
5. Kurtkoti V, Paraste G. In India's Richest State, Drought, Farm Crisis Arrive Early.
6. Yashwantrao Chavan Academy of Development Administration. Farmers Suicide: Facts & Possible Policy Interventions. yashada books; 2006.
7. Mazumdar I, Neetha N, Agnihotri I. Migration and gender in India. Economic and Political Weekly. 2013 Mar 9:54-64.

8. Jaleel AC, Chattopadhyay A. Health and Quality of Life of Seasonal Migrant Women Workers Engaged in Sugarcane Harvest in Maharashtra, India. InInternal Migration Within South Asia 2022 (pp. 205-220). Springer, Singapore.
9. Breman J. Seasonal migration and co-operative capitalism: crushing of cane and of labour by sugar factories of Bardoli. Economic and Political Weekly. 1978 Aug 1:1317-60.
10. Chatterjee P. Hysterectomies in Beed district raise questions for India. The Lancet. 2019 Jul 20;394(10194):202.
11. McGivering J. The Indian women pushed into hysterectomies, 2013. The British Broadcasting Corporation (BBC) Available: http://www. bbc. com/news/magazine-21297606, Accessed. 2016 Sep;5.
12. Desai S. Pragmatic prevention, permanent solution: Women's experiences with hysterectomy in rural India. Social Science & Medicine. 2016 Feb 1;151:11-8.
13. Angier N. In a culture of hysterectomies, many question their necessity. New York Times. 1997 Feb 17:1-4.
14. Lonkar K. Labour Welfare and Recognition of Menstrual Rights. PalArch's Journal of Archaeology of Egypt/Egyptology. 2021 Oct 10;18(10):2435-41.
15. Chaudhari M, Jaggi R. Documenting Migrant Lives of Sugarcane Harvesting Labourers in Maharashtra–Autoethnographic Reflections. Rupkatha Journal on Interdisciplinary Studies in Humanities. 2020 Sep 1;12(5).
16. Cloutier-Steele L. Misinformed Consent: Women's Stories About Unnecessary Hysterectomy. Next Decade, Inc.; 2003.
17. Kameswari S, Vinjamuri P. Case study on unindicated hysterectomies in Andhra Pradesh. Life-Health Reinforcement group. Natl. InWorkshop Rising Hysterect. India. August 2013 Aug.
18. Yakushko O, Morgan-Consoli ML. Gendered stories of adaptation and resistance: A feminist multiple case study of immigrant women. International Journal for the Advancement of Counselling. 2014 Mar;36(1):70-83.
19. Pattadath B, Chattopadhyay R, Gopal M, Arocha L. Women, Migration and Labour Exploitation: Challenging Frameworks. Journal of Migration Affairs. 2020 Mar;2(2):22-36.
20. Lonkar K. Labour Welfare and Recognition of Menstrual Rights. PalArch's Journal of Archaeology of Egypt/Egyptology. 2021 Oct 10;18(10):2435-41.
21. Kay M. India will collect data to tackle overuse of hysterectomy.
22. Wagle S, Shah N. Government Funded Health Insurance Scheme in Maharashtra: Study of Rajiv Gandhi Jeevandayee Aarogya Yojana. Mumbai, India: CEHAT. 2017:136.
23. Pellissery S, Jalan SK. Towards transformative social protection: A gendered analysis of the Employment Guarantee Act of India (MGNREGA). Gender & Development. 2011 Jul 1;19(2):283-94.
24. Mohd S. Provident Fund for The Informal Sector: A Case Study of The Informal Sector Workers in Kuala Lumpur, Malaysia. Kajian Malaysia: Journal of Malaysian Studies. 2015 Jul 2;33.
25. India. National Commission for Enterprises in the Unorganised Sector, Academic Foundation (New Delhi, India). Report on conditions of work and promotion of livelihoods in the unorganised sector. Academic Foundation; 2008.
26. Saxena KB. The unorganised sector workers' Social Security Act, 2008: A commentary. Social Change. 2009 Jun;39(2):281-91.
27. Pati S, Sharma K, Zodpey S, Chauhan K, Dobe M. Health promotion education in India: present landscape and future vistas. Global journal of health science. 2012 Jul;4(4):159.
28. Desai S, Campbell OM, Sinha T, Mahal A, Cousens S. Incidence and determinants of hysterectomy in a low-income setting in Gujarat, India. Health policy and planning. 2017 Feb 1;32(1):68-78.
29. Visaria L, Joshi H. Seasonal sugarcane harvesters of Gujarat: trapped in a cycle of poverty. Journal of Social and Economic Development. 2021 Jun;23(1):113-30.