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Research Article

Marginalisation through Migration: Hysterectomy, Gendered Labour, and the Lived Experiences of Women Sugarcane Workers in Maharashtra, India

Dnyaneshwar Prakash Jadhawar[1] and Madhavi Reddy[2]*

[1] School of Humanities and Engineering Sciences, MIT Academy of Engineering, Alandi, Pune, Maharashtra, India; affiliated with Savitribai Phule Pune University, India
[2] Department of Media and Communication Studies, Savitribai Phule Pune University, Pune, Maharashtra, India

* **Corresponding author:** dnyaneshwar.jadhawar@mitaoe.ac.in

ORCID iDs: D. P. Jadhawar: 0009-0000-1912-8301; M. Reddy: 0000-0002-3374-3009

Abstract

Seasonal migration for sugarcane harvesting is central to Maharashtra's agrarian economy, yet the reproductive health experiences of migrant women workers remain inadequately understood. This study explores the lived experiences of women sugarcane workers who have undergone hysterectomy and examines how labour conditions, migration, and healthcare inequalities influence their reproductive health decisions. Guided by the perspectives of Structural Violence, Reproductive Justice, and Gendered Labour Migration, the research adopts a qualitative multi-sited ethnographic design. Data were generated through participant observation and twenty-six semi-structured interviews with women sugarcane workers, healthcare professionals, community health workers, and labour contractors across major sugarcane-producing districts of Maharashtra.

The findings show that hysterectomy is closely associated with demanding labour conditions, debt-based employment, inadequate sanitation, poor access to reproductive healthcare, and the need to sustain continuous work during the harvesting season. These structural constraints often limit women's

reproductive choices and contribute to long-term physical and emotional health challenges. The study argues that hysterectomy should be understood within the broader context of labour exploitation, gender inequality, and institutional neglect rather than solely as a medical procedure. The study advances scholarship on migration, gender, and health justice, advocating integrated policies for labour rights, reproductive healthcare, and institutional accountability.

Keywords:

Hysterectomy, Women Sugarcane Workers, Seasonal Migration, Gendered Labour, Structural Violence & Reproductive Justice**.**

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Introduction

Seasonal migration is a defining feature of India's informal rural labour economy, particularly in drought-prone regions where agriculture alone cannot sustain livelihoods. The state of Maharashtra is one of the largest sugar-producing states in India and heavily depends on seasonal migrant labour for harvesting sugarcane. Thousands of labour-contracting families from the economically depressed districts of Beed, Dharashiv (Osmanabad), Latur and Solapur move to different districts to provide labour for six to eight months each year, subject to the terms of the contract, which often include debt, insecure jobs, working long hours, and little social protection (Adhikari & Vanishree, 2020; Breman, 1978). Women make up almost half of this migrant workforce and are also doing physically intense farm work, along with doing housework and taking care of children. Despite their essential role in the sugar economy, women sugarcane workers remain marginalised in multiple ways due to gender inequality, labour precarity, lack of health-care facilities and low institutional support.

One of the many problems facing migrant women sugarcane workers has become a public health and social justice issue, namely, the increasing incidence of hysterectomy. There are reports of a significant number of hysterectomy surgeries being conducted on women who are harvesting sugarcane in Maharashtra, particularly in Beed district (Chatterjee, 2019; Shukla & Kulkarni, 2019). Even though hysterectomy is a well-established surgery for certain

gynaecological disorders, there is evidence that women undergo the surgery at relatively young ages due to poor menstrual hygiene facilities, high workload, and debt burdens during the harvest season, and because of longstanding reproductive health issues (Kulkarni et al., 2020). Therefore, hysterectomy is not simply a personal choice but one that depends on wider structural inequalities and labour relations.

The socio-economic conditions, seasonal migration, occupational risks, and reproductive health of sugarcane workers have been well documented in existing studies (Adhikari & Vanishree, 2020; Gore et al., 2013; Kulkarni et al., 2020). Yet, little is known about the impact of the experience of hysterectomy from migrant women workers' perspectives or about the complex intersections between labour practices, migration, health systems and state policy on reproductive health care decisions. The literature is dominated by public health or policy standpoints, with somewhat fewer ethnographic studies hearing from the voices of women and their daily lives. A lack of understanding of this gap will result in a lack of understanding of the structural conditions that impact women's health and labour pathways.

The theoretical frameworks of Structural Violence, Reproductive Justice and Gendered Labour Migration guide this study. Structural violence can be understood as the systematic production of unequal health outcomes as a result of poverty, labour exploitation and institutional neglect (Farmer, 2004). Reproductive justice places the topic of reproductive health in the broader context of social justice and access to healthcare and bodily autonomy (Ross & Solinger, 2017), and gendered labour migration draws attention to the unequal effects of seasonal migration on women. Using a qualitative multi-sited ethnographic approach, this study draws on participant observation, twenty-six semi-structured interviews, and documentary analysis to examine migrant women sugarcane workers' lived experiences of hysterectomy. It contributes to scholarship on migration, gender, labour, and health while informing policies on labour rights, reproductive healthcare, and institutional accountability.

Literature Review

The study of seasonal migration in India has consistently shown that it is both an economic survival strategy and an expression of structural rural inequalities. The sugar industry in Maharashtra is heavily reliant on migrant workers from the drought-prone districts, where the poor performance of agriculture, high indebtedness, and lack of employment in the local area make it necessary for families to migrate to harvest sugarcane (Breman, 1978; Adhikari & Vanishree, 2020). Labour recruitment is often undertaken by intermediaries (mukadams), leading to informal employment contracts with many features, such as advance payments, debt bondage, excessive working hours, and a lack of legal protection. Women form a significant part of this workforce, but are subjected to several disadvantages due to gender, caste and class inequalities.

Much scholarship details the conditions of migrant sugarcane labourer’s lives and work. Women labourers are engaged in physically strenuous farming tasks and also bear the burden of household tasks, childcare, and family caregiving during migration (Desai & Mahajan, 2013). Gore et al (2013) and Kulkarni et al (2020) found that a number of occupational health issues are occurring across the

board, including musculoskeletal problems, dehydration, malnutrition, anaemia, and poor access to sanitation and healthcare facilities. Seasonal migration also affects children's access to education and the failure to transfer welfare services from the source to the destination country (Das et al., 2022).

Hysterectomy is a surgical procedure that has recently garnered great interest in scholarly and public circles because of the rise in its occurrence among women sugarcane workers. Abnormally high rates of hysterectomy surgery have been reported among women harvesting sugarcane, mostly from the Beed district in Maharashtra (Chatterjee, 2019; Shukla & Kulkarni, 2019). While hysterectomy is a well-known medical procedure for certain gynaecological conditions, scientific evidence indicates that the perceived need for labour, menstrual management difficulties, poor reproductive health care, and economic insecurity affect many women's decisions to undergo surgery (Kulkarni et al., 2020). Unnecessary surgical procedures, poor counselling and lack of post-surgical care in rural areas have also been highlighted (Chatterjee, 2014; Ghosh & Gupta, 2017).

Researchers have focused not only on the health impacts of migration on women workers but also on its various social implications. Children's educational discontinuity, higher care demands for women, and employment vulnerability and gender-based violence (GBV) among children and women are the side effects of seasonal migration (Das et al., 2022; Neymat, 2019). Even though there are welfare schemes like MGNREGA and the Public Distribution System, migrant workers are often unable to avail of job guarantees, health and medical services, and food security, as benefits are limited to their place of residence (Adhikari & Vanishree, 2020). Such institutional constraints increase socio-economic fragilities and further amplify labour precarity.

Although a number of studies have provided valuable evidence on migration, labour conditions, and women's health, important gaps persist. Many publications focus on public health, policy or economic views, while few describe the life experiences and lived reality of women who have had a hysterectomy. Moreover, there is a lack of studies that explore the issue of hysterectomy using an integrated theoretical approach in which labour migration, structural inequality and reproduction are interconnected. In this study, the gaps were addressed using a qualitative ethnographic approach and grounded in the concepts of structural violence, reproductive justice, and gendered labour migration. The study foregrounds women's stories to offer deeper insights into how labour regimes, health care systems, and institutional responses shape reproductive health decisions and everyday life for migrant sugarcane workers.

Aim

This study aims to analyse the socio-economic, health, and psychological effects of hysterectomies on migrant women labourers in Maharashtra's selected sugarcane industry sites and to evaluate the level of governmental response and support towards these issues.

Objectives

1. To understand the socio-economic background and working conditions of migrant women labourers in the sugarcane industry in Maharashtra.

2. To investigate the reasons behind the high incidence of hysterectomies among migrant women.

3. To assess the health and psychological impacts of hysterectomies on these women.

4. To evaluate the awareness and effectiveness of government policies addressing the health and welfare of sugarcane labourers.

5. To recommend strategies for improving the health and working conditions of migrant women in this sector and for enhancing governmental intervention.

Research Design and Theoretical Orientation

This study uses a qualitative ethnographic research approach embedded in the interdisciplinary fields of migration studies, gender studies, medical sociology, and labour studies. The study aims to explore the socio-economic, health, and psychological impacts of hysterectomy on migrant women sugarcane workers in Maharashtra and to understand the structural conditions that influence these impacts. An ethnographic approach was considered most suitable, as it enables a contextualised understanding of lived experiences, everyday practices, and social relations embedded in labour migration systems (Hammersley & Atkinson, 2019).

Three interrelated theories inform the study: Gendered Labour Migration Theory (Mahler & Pessar, 2006; Pessar & Mahler, 2003); Structural Violence (Farmer, 2004; Galtung, 1969); and Reproductive Justice (Ross & Solinger, 2017). All of them inform the research design, data collection and interpretation of findings.

Gendered Labour Migration Theory offers a lens for understanding seasonal migration as a gendered process shaped by differential labour relations, patriarchal norms, and access to resources. Women in sugarcane occupations typically work only two jobs, as wage earners and as primary caregivers and thus face a dual burden, one that is often overlooked in traditional labour studies. Structural Violence allows for an analysis of how institutions (such as health institutions and inequalities, labour institutions and exploitation, and policy institutions and failures) create negative health outcomes for marginal communities (Farmer et al., 2006). The Reproductive Justice framework also extends the analysis by highlighting issues related to bodily autonomy, access to health care, reproductive rights, and socioeconomic factors that limit women's capacity to make meaningful reproductive choices (Luna & Luker, 2013; Ross & Solinger, 2017).

These theoretical lenses combine to shift the analytical lens away from the medical decision-making process and toward the structural processes that shape the production and experience of reproductive health outcomes within the political economy of sugarcane labour migration.

Figure 1 illustrates the study's conceptual framework, linking structural violence, gendered labour migration, reproductive health, and hysterectomy to interpret the lived experiences of migrant women sugarcane workers.

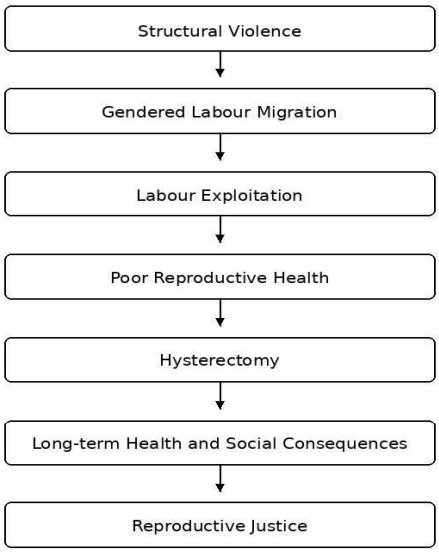

Figure 1: Conceptual Framework of the Study

Source: *Authors' conceptualisation based on Farmer (2004), Ross and Solinger (2017), and field data (2023–2024).*

Study Area and Research Context

The study was carried out in some districts in the sugarcane-growing areas of Maharashtra, such as Beed, Dharashiv (formerly Osmanabad), and Solapur. This selection was made purposefully, as these are known to be major centres for sugarcane cultivation and seasonal labour migration, and areas where the prevalence of hysterectomy amongst women cultivating sugarcane is particularly high, as per various government reports, media investigations, and studies conducted in the past. (National Human Rights Commission [NHRC] 2018)

It has been observed that the sugarcane economy in Maharashtra is heavily dependent on migrant labour hired under labour contracts by labour contractors, locally known as 'mukadams'**.** Thousands of rural households migrate seasonally between drought-prone and sugarcane-growing areas each year for two to eight months. The labour process is marked by long working hours, debt-bondage recruitment, job precarity, poor hygiene facilities, and lack of health insurance. Women are involved in harvesting activities to great extent and also have the responsibility of household management, child care and other reproductive unpaid work.

The chosen districts are also important locations for investigating the links between migration, labour exploitation, reproductive health and gender inequalities.

Ethnographic Approach

The research strategy used is multi-sited ethnographic. One way to explain the usefulness of multi-sited ethnography for the study of migration is that it permits researchers to study social processes across multiple sites rather than just one place (Marcus, 1995). It allowed the researcher to analyse differences in experiences of migration, labour conditions, access to healthcare, and the role of the State across districts, as well as uncover common structural patterns.

Ethnographic studies emphasise the experiences of participants, particularly at the Beed, Dharashiv, and Solapur sites, and aim to comprehend social realities from their perspectives. As a result, the study was not just about documenting cases of hysterectomy but about women's understanding of their experiences as well as their negotiation of labour demands, access to health care services, and engagement with state institutions.

The ethnographic approach also enabled a discussion of the impact of broader social institutions (gender norms, labour practices, health care systems, and policies) on day-to-day decisions regarding reproductive health.

Sampling Strategy and Participant Selection

Participants were recruited using purposive and snowball sampling methods. To identify people with firsthand information or experiences relevant to the research goals, a purposive sampling strategy was used at the beginning of the research (Patton, 2015). The participants were selected based on their involvement in sugarcane labour migration, their experiences of hysterectomy, their participation in healthcare provision, and their knowledge of labour recruitment practices.

After the first phase of recruitment, snowball sampling was used to seek out needed respondents through referrals from the initial respondents. This approach proved helpful as it was a way to engage in the sensitive and personal experiences that could be discussed when discussing reproductive health, hysterectomy and labour exploitation within networks of trust.

Twenty-six semi-structured interviews were carried out with various participants. The sample included:

Table 1 presents the profile of the study participants included in the ethnographic fieldwork.

Table 1. Profile of Study Participants

Participant Category	*Number (n)*
Women sugarcane labourers who had undergone a hysterectomy	**12**
Healthcare practitioners (gynaecologists and medical officers)	**5**
Community health workers and Accredited Social Health Activists (ASHAs)	**4**
Labour contractors and local intermediaries	**5**
Total Participants	**26**

Source: *Authors' fieldwork (2023–2024).*

The inclusion of multiple participant groups facilitated triangulation and enabled the study to capture diverse perspectives on the issue.

Participant Observation

The ethnographic research process was centred on participant observation. The villages, labour settlements, sugarcane-harvesting fields, means of transport, and community areas associated with the migratory season were observed.

The researcher noted working conditions, work arrangements, family relations, labour contractors, access to sanitation and healthcare facilities, and daily reproductive health practices. Detailed field notes were kept throughout the research process, recording observations, informal conversations, and contextual information.

Participant observation revealed important aspects of labour and health that did not necessarily feature in the formal interviews, thereby enriching the picture of the participants' experiences.

Semi-Structured Interviews

The data collection techniques used were mainly semi-structured interviews. This approach enabled the participants to tell their stories and the researcher to delve into specific aspects important to the research goals (Kvale & Brinkmann, 2015). Questions focused on migration experiences, working conditions in the sugarcane sector, reproductive health experiences, decisions about hysterectomy, economic pressures and debt, and government welfare programmes and healthcare policies. The interviews were conducted in Marathi, the main language spoken and lasted between 45 and 90 minutes.

Documentary and Archival Research

The study also involved rich documentary and archival research to supplement the ethnographic information gathered. These comprised information from National Human Rights Commission reports, Maharashtra State Commission for Women reports, public health statistics and institutional databases, academic

research articles and books, newspaper archives and investigative journalism reports, and policy documents on labour welfare and reproductive health.

Data Management, Translation and Transcription

Interviews were conducted in Marathi on audio with the consent of the interviewees. These were then literally transcribed to maintain the integrity and accuracy of the participants' voices.

After the transcription, interviews were translated into English for analysis. The researcher cross-checked the translated transcripts against the original recordings and field notes to minimise meaning loss during translation. Special focus was given to culturally specific terms, local expressions and meanings of labour, health, and migration experiences.

Systematic organisation of field notes, interview transcripts, and documentary material took place throughout the research process, with the security of their storage ensured.

Thematic analysis was used to interpret data from the qualitative data sources. Thematic analysis is a commonly used method in qualitative research to identify, organise, and interpret patterns within various data sets (Braun & Clarke, 2006). The coding process was both inductive and theoretically guided. Themes were identified in participants' narratives, and the analytical framework was built on concepts from Gendered Labour Migration Theory, Structural Violence, and Reproductive Justice.

Key themes included:

I. Gendered labour exploitation
II. Seasonal migration and precarity
III. Reproductive health vulnerabilities
IV. Economic pressures and indebtedness
V. Healthcare accessibility
VI. Institutional neglect and policy failures
VII. Gaps in Government Schemes

The integration of empirical themes with theoretical concepts enabled the study to connect individual experiences with broader structural processes.

Ensuring Trustworthiness and Rigour

The credibility and trustworthiness of the findings were achieved through methodological triangulation using a combination of sources of evidence (interviews, participant observation, field notes, archival materials, and policy documents) (Lincoln & Guba, 1985). The triangulation helped the researcher validate information from various participants and data sources. Moreover, extended exposure to the field context allowed for a greater understanding of participants experiences and increased the reliability of the interpretation. Field notes were kept reflexively throughout the research process to record methodological decisions, analytical reflections, and the researcher's positionality.

Ethical Considerations

Ethical issues were paramount throughout the research process, especially when discussing the issue of hysterectomy, reproductive health, labour exploitation, and economic vulnerability. Before participating in the study, all respondents were briefed on the study's purpose, the voluntary nature of participation, and their right to withdraw without consequences. All participants gave verbal informed consent prior to beginning interviews.

To protect the anonymity of the participants, pseudonyms have been introduced in the text, and, where necessary, details such as village names, ages, and family situations have been changed or abstracted. Audio recordings, field notes and transcripts were kept safely, and only the researcher had access to them. Special attention was given to avoiding retraumatization of participants during the interviews. Participants were not forced to answer questions they felt uncomfortable with, and interviews were conducted in an environment that ensured privacy and dignity.

Table 2 summarises the major themes emerging from the ethnographic analysis, highlighting the recurring experiences and challenges reported by migrant women sugarcane workers and stakeholders.

Table 2. Major Themes Emerging from Ethnographic Analysis

Theme	***Key Issues Identified***
Seasonal Migration	Drought, debt, unemployment
Labour Conditions	Long working hours, physical strain
Reproductive Health	Menstrual problems, chronic pain
Hysterectomy	Limited treatment options, delayed care
Healthcare Access	Distance, overcrowded hospitals
Family Life	Children's education, caregiving
Government Support	Poor implementation of welfare schemes

Source: *Authors' fieldwork (2023–2024).*

Findings / Analysis

Seasonal Migration and Everyday Life

Seasonal Migration was a constant theme in the lives of all interviewees for this research. Women did not talk of migration as an alternative means of livelihood, but as a necessity in economic terms due to recurring drought, uncertainty about agricultural livelihoods, indebtedness, and lack of stable employment in their villages. Farmers from villages and districts like Beed and Dharashiv used to go to the sugar mills for six months to harvest sugar. Families were forced to migrate as a whole family, including women, men and children,

resulting in women and families being left in difficult living and working conditions.

The majority of the participants described that when the labour contractors paid in advance (uchal) for their work, the migration cycle began. The advance helped families make ends meet immediately, but at the same time imposed a debt burden on them, making it necessary for them to work through the harvesting season even if they were ill or otherwise unable to work. Every woman spoke of migration as a necessity and not a choice.

Surekha, a 35-year-old sugarcane worker from Kaij, explained:

> *"We do not receive government help; we go to work in another district. We don't have enough farmland or work here, so we have to go for sugarcane cutting. It is very difficult to manage the education and health of my family."*

Her account illustrates how seasonal migration extends beyond employment and affects multiple aspects of family life, including access to healthcare and children's education.

Living arrangements at sugarcane worksites were described as temporary and inadequate. Families stayed in makeshift shelters without reliable access to drinking water, sanitation, electricity, or healthcare facilities. Women performed agricultural labour during the day while continuing domestic responsibilities such as cooking, collecting water, and caring for children before and after work. Several participants reported that these living conditions left little opportunity to rest or recover from illness.

Women also described the physical demands of sugarcane harvesting as relentless. Daily work frequently exceeded twelve hours and required repetitive bending, lifting heavy bundles of cane, and travelling long distances between fields. Participants explained that work could not be easily interrupted because payment depended on meeting contracted harvesting targets. Missing work often resulted in wage deductions or increased debt.

Labour Conditions and Women's Health

The hard labour associated with sugarcane cultivation was consistently associated with participants reproductive health issues. Poor working conditions and a lack of sanitation facilities and menstrual hygiene support led to substantial physical disadvantages. Women reported recurring abdominal pain, heavy bleeding, urinary infections, and not receiving treatment for sexual and reproductive health issues despite still engaging in heavy farm labour.

Sugarcane worker Savita, 32, said that her health had declined until she had a hysterectomy.

> *"My name is Savita. I got married when I was only 15. Last year I felt pain while I was urinating, so I went and saw the doctor, then I was given medicine, but it did not help, so then they said that there is a lump, surgery is necessary so we took the money from the contractor, went to a private*

hospital, they removed my womb and came back to work in sugarcane, and started repaying our debt."

Savita's story represents the hard choices women had to make when access to public health care services was restricted, and financial obligations loomed. Household economic pressures, together with delays in treatment in the public health system, influenced the decision to seek private medical care, even if it meant incurring debt.

Similarly, Pushpa, a 39-year-old sugarcane worker, mentioned repeated pregnancies, childbirth challenges and restricted access to maternal health services during migration. She explained:

"At the age of 22, I had my third child, which started too early when we were working, and my fourth when we were too poor to pay the hospital bill, which resulted in infections of the uterus followed by a hysterectomy."

Participants often linked reproductive health issues to the lack of medical care as well as to continuous physical work, and did not consider these as individual health issues. Treatment delays were reported by many women, due to the effects of absences on their household livelihoods or on their reliance on labour contractors.

Observations in the field also showed that women had limited opportunities for open discussion of reproductive health issues at worksites. Worry about health was frequently an "accepted" part of daily work, and participants reported working through chronic pain, fatigue, and physical ailments. Employment remained the most urgent priority for many women, as migrant's income helped families survive and pay their debts.

Experiences of Hysterectomy

Many women who had a hysterectomy were not at all expecting it or freely choosing to have it. Participants reported having gastrointestinal issues for many years before they received treatment. Bleeding problems, chronic pelvic pain, frequent urinary infections and weakness were common symptoms. Most of the women, however, described how these symptoms became unendurable as they had to labour continuously during the harvesting season without getting sufficient rest, sanitation facilities and medical care.

Menstruation was mentioned by a few participants who said it was an anxious time during migration. Menstrual hygiene was severely compromised due to the lack of toilets and bathing facilities, as well as privacy, at temporary settlements. Severe pain and excessive bleeding led to wage deductions and additional financial strain for the family if the worker missed work.

Vaishali, a 34-year-old sugarcane worker, reflected on her experience:

"During menstruation, we had no place to bathe or change clothes. We worked even when we were in pain because if we stopped working, we would lose wages. After several years of suffering, the doctor advised surgery. We believed it was the only way to continue working."

For many participants, hysterectomy represented not only a medical procedure but also a strategy for coping with demanding labour conditions. Women explained that surgery was often presented as a permanent solution to recurring reproductive health problems, allowing them to continue earning an income without interruptions caused by menstruation.

Chandubai, who had spent more than fifteen years working as a migrant sugarcane labourer, described how economic necessity influenced her decision:

> *"I had pain for many years. Every month, I suffered while cutting sugarcane. The doctor said removing the uterus would solve the problem. We had already taken an advance from the contractor, so I could not stop working. I underwent the operation and returned to work within a short time."*

Participants also described limited opportunities to seek second medical opinions. Several women relied on private hospitals because government hospitals were overcrowded or located far from their temporary settlements. Many reported that they received little information regarding alternative treatments or the long-term consequences of hysterectomy.

An ASHA worker who regularly interacted with migrant women explained:

> *"Most women ignore their health problems for years because they cannot afford to stop working. By the time they visit a doctor, surgery is often recommended. Very few women receive counselling about other treatment options."*

Healthcare practitioners interviewed for the study also acknowledged that delayed treatment was common among migrant women. One gynaecologist observed:

> *"Women usually come to the hospital only when their symptoms become severe. Many have been living with infections or excessive bleeding for a long time. Continuous physical labour and delayed healthcare make treatment more complicated."*

Figure 2 illustrates how seasonal migration, labour conditions, and limited healthcare collectively contribute to hysterectomy among migrant women sugarcane workers.

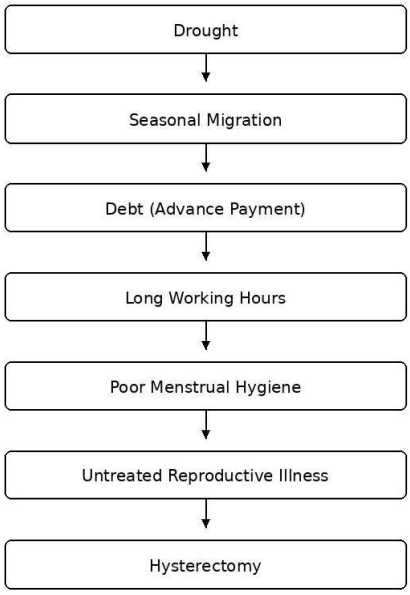

Figure 2: Pathways Leading to Hysterectomy

Source: *Authors' conceptualisation based on Farmer (2004), Ross and Solinger (2017), and field data (2023–2024).*

Across interviews, women consistently described hysterectomy as a consequence of prolonged hardship rather than an isolated medical event. Their narratives revealed how decisions regarding surgery were shaped by work obligations, financial insecurity, family responsibilities, and restricted access to timely healthcare.

Living After Hysterectomy

For many participants, while they thought that surgery would have helped them, they found that physical and emotional problems persisted after the procedure. Some women reported a decrease in excessive periods, but also reported withering body pain, tiredness, weakness and reduced physical stamina. Multiple participants reported being affected by these health issues in physical farm work.

Surekha explained:

> *"After the operation, I thought my problems would end. But I became weaker. I get pain in my back and legs while working, yet I cannot stop because my family depends on this income."*

Similarly, Savita shared:

> *"The doctor removed my uterus, but nobody told me what would happen afterwards. I feel tired all the time. Sometimes I cannot even lift the sugarcane bundles, but I still have to work because there is no other source of income."*

One common finding was that participants were disappointed that surgery had not brought them the relief they expected. Most reported that within a short period (within a few weeks) of surgery, they were still able to harvest sugarcane, as the recovery was too costly. Often, strenuous work before full recovery worsened their physical discomfort.

In addition to physical effects, several women spoke about the emotional effects of hysterectomy. Anxiety and sadness about their own health and their future health were very prevalent. Some individuals expressed concerns about premature ageing and/or diminished physical ability, whereas others voiced concern about their inability to perform their household duties as before.

Pushpa said:

> *"After the surgery, I became afraid of falling sick again. Earlier, I could work continuously, but now I get exhausted quickly. Even then, I have to manage the house, cook for everyone, and work in the fields."*

Field observations found that most women continued to harvest sugarcane, as seasonal migration remained their main source of livelihood, despite health issues. Their economic situation was not affected by the operation, and many still performed physically strenuous work and domestic duties, while facing chronic health problems.

Table 3 summarises the physical, emotional, and socio-economic consequences of hysterectomy, highlighting its long-term impact on women's health, work, and daily lives.

Table 3. Reported Post-Hysterectomy Experiences

Health Consequence	***Participant Experiences***
Chronic pain	Persistent back and body pain
Fatigue	Reduced work capacity
Weakness	Difficulty performing heavy labour
Emotional distress	Anxiety and uncertainty
Economic impact	Returned to work early due to debt

Source: *Authors' fieldwork (2023–2024).*

Healthcare Access, Family Responsibilities, and Expectations from the State

One of the major difficulties faced by migrant women sugarcane workers was access to healthcare. It was consistently reported by participants that migration affected their capacity to get timely medical care, especially for women's reproductive health issues. Mobile homes near sugarcane fields were frequently far from public health centres, and the heavy workload left limited time for health care. A couple of women described how they waited until they experienced symptoms that were causing them great pain before seeking care due to the fear of losing their employment and adding to their household debt.

An ASHA worker who regularly worked with migrant families observed:

> *"Most women continue working despite severe pain because they cannot afford to lose even a day's wages. They usually seek treatment only when the condition becomes serious. By then, surgery is often considered the quickest solution."*

Healthcare practitioners interviewed during the study also recognised the barriers migrant women face. One gynaecologist noted:

> *"Many women arrive at the hospital after suffering for months or even years. Regular check-ups are rare because migration, financial hardship, and continuous labour prevent them from accessing healthcare at the right time."*

Participants also highlighted the financial burden of private healthcare. While government hospitals were viewed as more affordable, long waiting periods, overcrowding, and the distance from worksites frequently compelled women to seek treatment in private hospitals by borrowing money from labour contractors. Consequently, medical treatment often resulted in additional debt, further reinforcing the cycle of economic dependence.

Migration also had profound consequences for family life, particularly for children's education and well-being. Most participants travelled with their children during the harvesting season because there were few childcare options in their villages. As a result, many children experienced interrupted schooling or dropped out altogether. Women expressed concern that seasonal migration was limiting their children's educational opportunities and reproducing the cycle of poverty experienced by earlier generations.

Sunita reflected on this challenge:

> *"When we migrate, our children either come with us or stay with relatives. Their studies suffer every year. We know education is important, but we have no other option because we need everyone together during migration."*

Despite experiencing multiple hardships, the women interviewed did not present themselves as passive victims. Rather, they repeatedly expressed aspirations for secure livelihoods, accessible healthcare, and better educational

opportunities for their children. Participants emphasised that they preferred stable employment in their villages rather than seasonal migration.

One participant summarised this aspiration:

> *"We do not want sympathy. We only want to work near our village, proper hospitals, and schools for our children. If we could earn enough at home, none of us would leave our families every year."*

Field observations also showed how resilient migrant women were in the face of economic insecurity, physically strenuous work and limited institutional support. Through their stories, they show that migration is not simply a form of work in motion, but a reality of life intersected by multiple inequalities which impact health, family and future prospects. Resilient and determined, participants kept going through this with hope and the expectation of finding a job, better health care, and meaningful state support to create more stable lives for themselves and their families.

Discussion

The current study explored the lived experiences of migrant women sugarcane workers in Maharashtra who had undergone hysterectomy from the theory of Structural Violence, Reproductive Justice and Gendered Labour Migration. The ethnographic results served as input to the presentation of the participants' migration, labour, health care and family life stories, but this discussion placed them within a broader social, economic and institutional framework. The conclusions suggest that the decision for a hysterectomy for women who work on sugarcane plantations cannot be viewed as simply a medical choice, but as a result of labour precarity, gender inequalities, insufficient healthcare and structural exclusion.

Figure 3 illustrates how seasonal migration, labour exploitation, and reproductive health interact to reinforce vulnerability and social exclusion among migrant women workers.

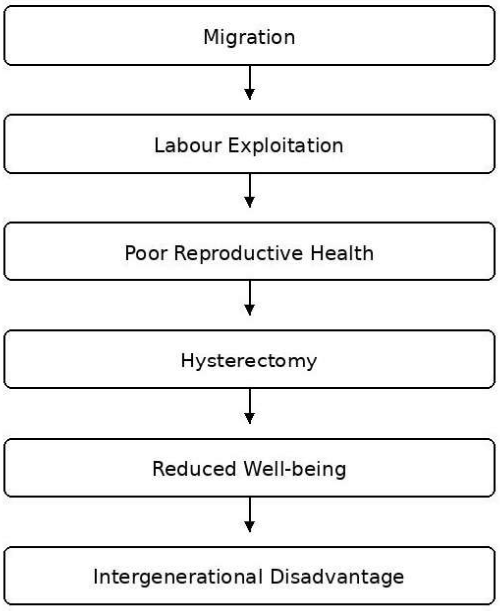

Figure 3: Migration, Labour and Reproductive Health

Source: *Authors' conceptualisation based on Farmer (2004), Ross and Solinger (2017), and field data (2023–2024).*

The concept of Structural Violence (Galtung 1969; Farmer 2004) has proved useful for the understanding of the circumstances that affect women's reproductive health. Structural violence is the unequal opportunities and limited access to basic necessities that result from the systemic nature of social, economic, and political institutions. The stories in this study show how poverty, frequent droughts, debt, underinstitutionalised working conditions and the inadequacy of welfare programs can all interact to affect women's health and well-being. Seasonal migration was repeatedly referred to as an economic imperative and not a matter of choice. Taking cash in advance from labour contractors placed financial demands on the women, even when they were ill or suffering from serious reproductive health issues. The present study is an extension of this understanding as it reveals the direct impact of these structural conditions on women's reproductive health decisions.

The study also identifies barriers to care in the health care system. Women mentioned issues with government hospitals, such as delayed response time, financial difficulties with private hospitals, and crowding. As such, many only sought treatment once their symptoms were already quite advanced and often borrowed money from labour contractors or made advances to pay for treatment. The results indicate a need to improve health infrastructure and access to reduce women's vulnerability and to break cycles of debt and labour dependence. These institutional failures are not just administrative lapses, but evidence of wider structural inequities that impact health outcomes for marginalised communities.

The findings are further enriched by the context of Reproductive Justice. Reproductive justice also highlights women's reproductive health and autonomy as essential to women's social, economic and political context (Ross & Solinger, 2017). The participants did not often consider the surgery of hysterectomy as a discrete decision for themselves. Instead, they reported that the lack of a history of reproductive health issues, hard labour, lack of hygiene, and the necessity of working all the time had a significant impact on their decision to have surgery. In many instances, the hysterectomy was seen not only as a cure for gynaecological disease, but as an option for continuing to work on the land.

The results match the conclusions of Chatterjee (2019) and Shukla and Kulkarni (2019), who had raised the question of the unusually high prevalence of hysterectomy among women sugarcane workers in the state of Maharashtra, India. This work, however, brings some new insights by placing women's voices at the forefront. Participants provided limited information on alternative treatments or the long-term health effects of surgery. Persistent fatigue, chronic pain and diminished physical vitality after hysterectomy were reported by many, and it was economically inconceivable to refrain from working long-term jobs in agriculture and/or manual work. From these experiences, it is clear that reproductive health choices are not only influenced by unequal labour relationships, but are also dictated by economic necessity, rather than just medical factors.

The notion of Gendered Labour Migration is another way of accounting for the double burden women face. The findings show gender differences in migration, as women are involved in agricultural activities both in the field and at home, which is considered domestic work. Women recounted starting their day by cooking and taking care of the children, working long hours picking sugarcane and after returning to the temporary settlements, taking care of domestic duties. Their overlapping duties caused physical exhaustion and decreased chances for rest and healthcare. The value of women's role in agricultural production, although significant in the sugar economy, is also undervalued, as observed by Desai and Mahajan (2013).

Migration had other profound effects on family life. There was a concern about school closures for children and the emotional burden of school and other responsibilities associated with working for wages. The results confirm the findings of Das et al. (2022), who reported the educational disadvantage suffered by children of seasonal migrants. The present study also shows that educational disruption is part of a broader continuum of social exclusion experienced by migrant families.

In general, this study contributes to the literature by bringing together the concepts of structural violence, reproductive justice, and gendered labour migration with ethnographic evidence. This study has a different focus from previous research, which tends to look at hysterectomy from a public health or policy perspective, by focusing on the lived experiences of migrant women and highlighting the close relationship between reproductive health and labour exploitation, migration, and institutional neglect.

To conclude, the experiences of migrant women sugarcane workers reveal that hysterectomy is not only a surgical intervention but rather a symptom of the

structural inequalities that are inherent in rural labour regimes. This study brings together the links among women's reproductive health, labour, and social justice, thus adding to the understanding of the working class, one of the most marginalised groups in Maharashtra, and highlighting the need for integrated, women's-rights-based policy interventions.

Figure 4 presents a policy framework recommending coordinated interventions to strengthen healthcare, labour rights, and social protection for migrant women sugarcane workers.

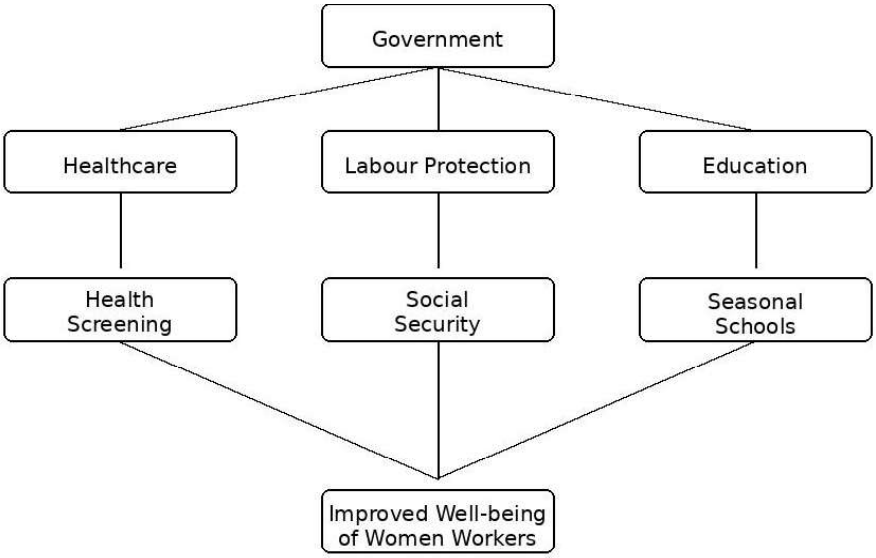

Figure 4: Policy Intervention Framework

Source: *Authors' conceptualisation based on Farmer (2004), Ross and Solinger (2017), and field data (2023–2024).*

Conclusion

This study explored the experiences of migrant women workers engaged in sugarcane harvesting in Maharashtra who had undergone hysterectomy, and examined them in the broader context of seasonal migration, gendered labour, and reproductive health. The study used a qualitative multi-sited ethnographic approach, and it was concluded that hysterectomy for women sugarcane workers is not just a medical procedure. Rather, it is closely tied to physical exertion, poverty, indebtedness, poor reproductive health services and insufficient public welfare benefits. The stories told by participants showed that the decision to make a reproductive health choice is influenced by structural inequalities, not only by a person's own choice.

The study builds upon previous scholarship by incorporating the structural violence, reproductive justice and gendered labour migration lenses to better understand the impacts of labour exploitation and institutional neglect on the health and well-being of women. The findings also show that seasonal migration impacts children's education, family life and access to health care and government welfare programmes, thereby perpetuating economic and social inequalities and

poverty. These difficulties did not deter participants from showing great resilience, and their expectations for a safe job, access to health care, and improved educational opportunities for their children were high.

The study relies on qualitative data collected from selected districts of Maharashtra; the findings are not statistically representative but are rich in ethnographic detail, deepening understanding of the intermingling of Migration, labour, gender and health. The study foregrounds the voices of migrant women sugarcane workers and suggests the need for more inclusive labour and health policies that take cognisance of the lived experiences of this marginalised community. The analysis adds to the current discussion on labour justice, reproductive rights, and social policy and offers a platform for further research on the migrant farm labour in India.

Recommendations

Findings highlight the need for integrated policies to improve the health, working conditions, and social protection of migrant women sugarcane workers. Accessible reproductive healthcare, including regular health check-ups, mobile clinics, menstrual health education, and timely gynaecological services, should be considered a high priority. the Strongest regulation of the private healthcare is important to ensure informed consent and appropriate medical care before hysterectomy. Labour protections should include safe workplaces, written contracts, sanitation facilities, maternity benefits, and portable welfare schemes. Educational support for migrant children and the active participation of women workers in policymaking are equally important for promoting health, dignity, and social justice through coordinated institutional action.

Author contributions

Dr Dnyaneshwar Jadhawar conceptualised the study, conducted fieldwork and ethnographic interviews, collected and analysed data, and prepared the original manuscript draft.

Dr Madhavi Reddy supervised the research process, designed the methodology and reviewed and edited the manuscript.

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Ethics and consent

This qualitative ethnographic study did not require formal approval from the Institutional Ethics Committee, as it involved non-invasive interviews and participant observation with adult participants. The research adhered to established ethical principles for qualitative social science research, including voluntary participation, confidentiality, anonymity, and respect for participants' rights and dignity.

Formal institutional ethical approval was not required because the study involved minimal-risk qualitative interviews and participant observation with adult participants and did not include clinical interventions, biomedical procedures, or experimental research. Ethical safeguards were maintained throughout the study in accordance with accepted principles of qualitative research.

Prior to each interview, participants were informed about the purpose of the study, the voluntary nature of participation, their right to withdraw at any time, and the measures taken to protect confidentiality. As most women sugarcane workers had limited literacy, verbal informed consent was obtained and documented before data collection. Healthcare professionals, community health workers, and labour contractors also provided verbal consent.

Data availability

The data supporting the findings of this study are not publicly available because they contain sensitive qualitative interview data and field notes that could compromise participant confidentiality. De-identified data may be made available by the corresponding author upon reasonable request, subject to ethical considerations and the protection of participants' privacy and informed consent.

Competing interests

The authors declare that they have no financial, professional, personal, institutional, or other competing interests that could have influenced the work reported in this article.

AI-use declaration

Name and version of the tool:

I. Grammarly (latest available version)
II. Novivo (AI writing assistance tool)

Purpose for which it was used: Grammarly and Novivo were used solely for language editing, grammar correction, sentence refinement, and readability. AI-assisted design tools were also used to prepare conceptual figures and diagrams.

Sections or activities affected: Language editing and proofreading of the manuscript, sentence restructuring for clarity, and preparation of conceptual

figures. No AI tool was used for data collection, data analysis, interpretation of findings, or generation of research results.

How the output was reviewed and verified by the authors: All AI-assisted outputs were carefully reviewed, edited, and verified by the authors. The authors take full responsibility for the accuracy, originality, interpretation, and integrity of the manuscript. All research design, fieldwork, data analysis, conclusions, and final content are the authors' own work.

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