How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?

Several health needs are a result of gender inequity, and care seeking is affected by constraints emerging from gender, social and economic disparities. Gender sensitive provision of health care, especially obstetric and gynaecological services aimed at reducing gender inequity would allow women to overcome social constraints, even empowering them. This is the perspective informing a critical review of three textbooks in the two disciplines. The review aims to explore whether the textbooks sensitise students to the relationship between gender, social inequity and care-seeking behaviour, areas where reproductive rights are likely to be violated by providers, and the special needs of adolescents and older women.

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Gender inequity within health care results from an interplay of several factors, many of which may not have been triggered by health service systems themselves. However, gender sensitive provision of health care can reduce such gender inequity, and in some cases empower women. Medical doctors, who are often the leaders of a team providing services, often carry patriarchal values that influence their professional actions and thereby increase gender inequity. The content and process of medical education has an important role to play in shaping the attitudes and values of doctors.

This review was based on the premise that medical textbooks not only need to guide students on arriving at a clinical diagnosis and treatment of a condition, but also need to guide a student on providing health care. This review is also based on the view that several health needs are a result of gender inequity, and that care seeking is affected by constraints faced due to gender inequity, combined with social inequity and economic deprivation. Gender sensitive provision of health care can reduce gender inequity, allow women to overcome these constraints and at times empower them.

Certain key attributes determine the extent to which medical technology influences access and hence gender equity. The service protocols recommended by textbooks should therefore be: (i) evidence based, incorporating new medical knowledge; (ii) recommend safe techniques, with minimum adverse effects under field conditions; (iii) avoid over-medicalisation and be amenable for use in low-resource settings; (iv) encourage choice and (v) contain costs and the need for repeated visits.

For the purpose of the review, an attempt was made to answer the following questions:

(1) Does the textbook sensitise students to: (a) the relationship between gender and social inequity and level of that particular health need; (b) the relationship between gender and social inequity (e g, mobility, autonomy, financial constraints), and care seeking behaviour; (c) areas where reproductive rights are likely to be violated by providers, and whether they account for the special needs of adolescents and older women.

(2) Do the textbooks address how services might be organised in a way that addresses inequity: privacy, confidentiality, dignity and choice; deployment of female medical and paramedical staff and resources; health provider attitudes and behaviour and its effect on care seeking, and access and range of services available.

(3) Is the rationale for providing services such as contraception based on population growth, or as a measure of women's and children's health or does it assist in the promotion of women's control over their bodies? Is the quality of care promoted only as a part of other professional health standards in service delivery or also a women's rights issue – with a focus on respect, dignity, choice and confidentiality?

(4) Do the management protocols relate to the levels of service (primary, secondary or tertiary health facility) where it will be implemented? Do they take into consideration the cost of diagnosis, treatment and follow-up visits? Do they feature counselling issues relevant to the problem and guide students for letting women make informed choices? Are they based on the recent evidence, especially that which points to improved access, simpler management or the avoidance of unnecessary procedures or medication?

(5) Are the issues related to the potential for abuse of technologies (hysterectomy, caesarean, sex determination) discussed?

The selection of textbooks was done on basis of enquiries from lecturers and medical students regarding commonly used textbooks by undergraduates and postgraduates. The following textbooks were reviewed for gynaecology and obstetrics: *Shaw's Textbook of Gynaecology*, Howkins and Bourne, 12th edition, B I Churchill Livingstone, New Delhi, Reprinted 2002. *Textbook of Obstetrics including Perinatology and Contraception*, D C Dutta, Fifth edition 2001, New Central Book Agency, Kolkata; *Holland and Brews Manual of Obstetrics*, Shirish N Daftary, S Chakravarti, G Daftary (edited), 16th edition, 1998, B I Churchill Livingstone, New Delhi, (Reprint 2002). Although the review has included several topics and chapters, only selected chapters are discussed here. It is encouraging to find that Shaw's textbook refers to certain ethical principles, including respect, beneficence, and justice. The reference to respect for the patient includes issues of information giving her right to make decisions. In the sections on examination of women in the Dutta's textbook, there is no mention of how to make women comfortable, the need for a chaperone, and explaining to the woman beforehand why and how the examination will be done (p 81).

Contraception

In Dutta's textbook, the rationale for providing contraceptive services is based primarily on population growth, and only secondarily to improve women's and children's health (p 568). Family planning has not been projected as women's need or their right, to control their own fertility.

The textbook does not have any reference to the relationship between gender inequity and use of contraception. It would be desirable to orient medical students as to how unequal gender relations put women at risk of unwanted pregnancies and how they affect women's mobility, decision-making and access to contraceptives. For example, in the section on condoms, students need to be aware of the difficulties that women face in negotiating condoms use and the adverse consequences (fear of violence, accusation of infidelity, abandonment, and so on) they might face if they insist.

In the chapter on contraception, there is no guidance on issues related to counselling and informed choice, in general. Even under the section on specific contraceptives, for example, IUDs, there is no guidance on pre insertion counselling – including showing her a copper-T, informing her about side effects, follow-up, removal. The text usually adopts a prescriptive standpoint (p 573). In the section on female sterilisation, only the procedure (how to carry out the surgery) has been described – there is little guidance on the content of counselling in terms of irreversibility of procedure, comparison of female and male sterilisation, complications and other factors.

This section does not have sufficient information on the process of 'informed consent' which has been projected as a formal necessity (see for instance, p 589). It is also clear that the surgeon is called upon to exercise judgment about family structure, and hence the need for sterilisation. There is no guidance on how to determine whether or not woman has made an independent decision free of any pressure or coercion. Indications for female sterilisation include reference to 'intensive motivation' and 'cash incentives to boost up the programme', but do not discuss their appropriateness (p 591).

Several therapeutic indications for female sterilisation are mentioned for each of which more than one contraceptive can be used. (e g, women with repeat caesarean section or renal disease can use condoms, oral pills or injectables or their husbands can undergo vasectomy). Textbooks should guide students to offer a choice of contraceptives to women, rather than advise sterilisation. Similarly, sterilisation has been advised for women with mental retardation or schizophrenia. Schizophrenia is a treatable condition and women suffering from schizophrenia and mild degrees of mental retardation can bear children. Advising sterilisation for these women is a violation of their reproductive rights (*Shaw's Textbook of Gynaecology*, p 169).

Discontinuation and switching contraceptives: In India the decision to remove IUD is not always in the women's hands, and providers often hesitate to do so. Textbooks should guide the students on the right of a woman to discontinue a contraceptive on choice, and for non-medical reasons such as family opposition or death of a child. In the textbook, the indications for removal of IUD include only the medical indications (see for instance, Dutta p 578).

The section on contraception does not orient students to areas where reproductive rights are likely to be violated during the provision of contraceptive services as for example overt or covert coercion for sterilisation or IUDs, coercion for contraceptives while providing MTP services or caesarean section.

There is also no mention of the quality of services in the section of contraception. In light of the evidence for poor quality of family planning services in India, and its effect on utilisation and popularity of various methods, it is crucial that students are oriented on maintaining quality of services. At various places under the section on sterilisation, there is mention of camps, but there is no reference to quality issues that need to be taken care of during camps. (The government of India's 1992 published, *Standards to Sterilisation* finds no mention).

There has been considerable scientific progress in areas of contraception, leading to the liberalisation of medical eligibility criteria (*Medical Eligibility Criteria*, WHO 2002), which has the potential to considerably increase access to contraception. The textbooks, on the other hand recommend unnecessary and excessive requirements for begining a contraceptive use, which reduces access for women. For example, Dutta's textbook suggests that breast and pelvic examination and checking blood pressure as mandatory before starting oral pills (p 582). However, recent WHO guidelines do not consider these necessary – oral pills can be started through non-medical people (e g, CBD agents) by using a checklist.

The recommendation of not prescribing the pill for "young women who have not reached the physical maturity" is without basis and likely to reduce the contraceptive access to adolescents. Similarly, the recommendations for followup with "examination of the breasts, weight, and blood pressure recording and pelvic examination including cervical cytology" are excessive requirements.

Even though injectable contraceptives have been available in India for nearly a decade, there is no guidance on screening for eligibility, and there is no guidance on managing side-effects when they occur. Strangely, the Holland and Brews and Shaws textbooks describe ineffective or obsolete methods such as post coital douching, cervical cap, Dumas cap, contra cap, immunological methods, etc.

Abortion

The section on induced abortion in Dutta's textbook starts with the MTP Act and then discusses methods of termination. Dutta's textbook does not give any information on the rationale to provide abortion services, e g, link between unsafe abortion and maternal mortality, lack of access to safe abortion and high levels of illegal abortion, etc. On a positive note, Shaw's textbook has discussed the link between maternal mortality and policies for safe abortion, but it does not highlight that access to safe abortion remains a major barrier despite three decades of MTP Act. This is better explained below.

> … In third world countries, the desired family size is larger, and access to effective contraception often limited, hence the need to terminate unwanted pregnancy is more common. Worldwide, approximately 26-31 million legal abortions and approximately 10-22 clandestine abortions take place every year [Henshaw and Morrow 1990]. In countries with liberalised abortion laws, induced abortions are generally safe, however, where abortions have not been legalised, complication rates are unacceptably high and about 1,50,000 women die every year as a result of … illegal abortions. Societies cannot prevent abortions, but enlightened governments can certainly … provide for safe pregnancy termination under

sanitary conditions, under supervision of trained and competent health professionals. (*Shaw's Textbook of Gynaecology*, p 185)

The MTP Act has been described in brief in Dutta's textbook, which includes indications for abortion, requirements on persons, consent, etc. However, there is very little information on the implications of this Act for service providers, except that Dutta's textbook mentions that the husband's consent in not required. In light of the fact that several doctors impose unnecessary restrictions, e g, asking for spousal authorisation, denying services to single women, etc, it is important that textbooks include sections on interpretation of the act, including how its provisions related to confidentiality and consent give women space for taking enlightened decisions, thereby reducing gender inequity.

There is no reference to the relationship between gender inequity and women's need for abortion. Textbooks should sensitise medical students on women's lack of decision-making power regarding sex and contraception, the relation of contraception to unwanted pregnancies and the constraints that women, especially poor rural women face in seeking access to abortion, in terms of approval from the family, cost of services, mobility, issues related to confidentiality, lack of information, etc. These aspects are missing in the textbooks.

It is important that women with unwanted pregnancies are provided counselling on several issues, including whether they wish to terminate or continue, issues related to the procedure (pain, time taken, cost, choice for the procedure, etc) contraception and STI/HIV prevention. However, there is no section on pre-abortion counselling and provider-patient communication for abortion.

It is known that women requesting abortion sometimes face pressure to accept certain contraceptives, more often in public facilities. As a result of this, they may be pushed away from less expensive public facilities towards more expensive and unaffordable private services, thereby reducing women's access to abortion. The textbook in subtle ways recommends persuading women to accept sterilisation:

> Repeated abortions are not conducive to the health of women. .... Since the woman undergoing abortion is more receptive and motivated to accept contraceptive advice, this opportunity should be optimally utilised to educate the couple to accept contraception. Women who have completed their families can be persuaded to accept sterilisation along with the operation of MTP (*Shaw's Textbook of Gynaecology*, p 186).

Providers may carry negative attitudes towards women seeking abortion (e g, those not accompanied by family members, or out of wedlock); this may act as barrier to care seeking. Providers need to be sensitive towards special needs of adolescents, for example, their lack of information on aspects related to sexuality and contraception, the difficulty they face in talking to adults on such matters and their financial constraints, which results in delay in care seeking. Medical textbooks need to provide guidance that allows students to acquire appropriate skills in handling adolescents, and assure confidentiality while dealing with all women.

It would be desirable to sensitise doctors about the cost of services which often acts as a major barrier, forcing women to seek unsafe services. They need to be guided to keep cost-related issues in mind, while prescribing laboratory tests, medicines, or anaesthesia, and to ensure that costs are not exploitative. However, consideration towards cost issues are absent in these textbooks.

Use of general anaesthesia for abortion represents over-medicalisation of procedure, and has been deemed as inessential by WHO. It raises costs, reduces availability of services, does not improve and may even reduce the quality of care (*Safe Abortion: Technical and Policy Guidance for Health Systems*, World Heath Organisation, 2003) The textbooks, however, continue to recommend the use of general anaesthesia, for vacuum aspiration, and even for menstrual regulation (*Shaw's Textbook of Gynaecology*, pp 186-187).

These textbooks continue to describe obsolete, less effective or dangerous methods for abortion like aspirotomy, intra-amniotic instillation. Even ethacrydine lactate, which is widely used in India for second trimester abortion, is no more considered the most appropriate choice nowadays. More effective and safer methods, like manual vacuum aspiration (MVA), which can be used upto 12, or even 14 weeks has been referred to as menstrual regulation, to be carried out within 42 day of missed period. Considering the lower costs of MVA equipment, and its greater feasibility of use in rural areas where electric supply is irregular, recommendation to use MVA only upto 42 days, and not beyond, would reduce access by undervaluing the technique.

> Menstrual regulation. This consists of aspiration of contents of uterine cavity by means of a plastic cannula… It is carried out effectively within 42 days of the beginning of the last menstrual period. (*Shaw's Textbook of Gynaecology*, p 186)

Medical abortion (using mifepristone (RU 486) and misoprostol) offers several advantages in terms of improved access, and its potential to be used by practitioners who are not skilled in surgical abortion. In several countries, it has become the preferred method of termination. However, the textbook suggests surgical abortion to be more effective and safer. The guidance on medical abortion is not scientifically correct, e g, it is projected as an option only upto 48 days of gestation, while it can be used upto 63 days in first trimester, and again for second trimester. Moreover, a much higher dose (600 mg for 3-4 days) than necessary (200 mg only on one day) has been recommended which would drastically increase the cost. (One tablet of mifepristone costs around Rs 300). (*Shaw's Textbook of Gynaecology*, p 188).The guidelines for second trimester abortion do not reflect recent experience and research, they continue to describe obsolete methods like intra-amniotic method, while safer and newer methods like repeated doses of misoprostol/gemeprost are not described (*Shaw's Textbook of Gynaecology*).

Labour Care

There is now recognition that majority of maternal deaths occur during or soon after labour, and that the presence of a skilled attendant at delivery is the most crucial intervention to prevent maternal deaths. Women need to be counselled to deliver through a skilled attendant, at women's home or a facility. In both obstetric textbooks (Holland and Brews and Dutta's textbooks), the hospital delivery is projected as ideal. As an alternative, there is recommendation to screen high-risk cases and advice them delivery in a hospital – this approach known as 'risk approach' has been given up in the 1990s, as being ineffective. Holland and Brews textbook also recommends that low risk mothers be delivered through traditional birth attendants (TBAs), a strategy that has proven to be ineffective in reducing maternal deaths. There is no mention of the role of skilled birth attendants (including nurse-midwives) in managing labour at home or in peripheral institutions.

Several practices recommended by the textbooks are ineffective and/or serve to needlessly medicalise childbirth. These have been briefly outlined below.

Enema and pubic shaving: Even though there is no evidence to show that that routine enemas or shaving are beneficial these practices continue to be recommended.

Food and drink in labour: Research has shown that there are no advantages and potential disadvantages to withholding fluids and light easily digestible food from woman with uncomplicated labour. However, the textbooks' guidance on diet during labour is outdated and incorrect and if advocated, likely to needlessly increase the woman's by starving her.

Position for delivery: Research has shown that there are considerable benefits from delivering in the upright or traditional squatting positions. ('Standards of Midwifery Practice for Safe Motherhood', Volume 3, Notes on advances in practice, World Health Organisation, Regional Office for South-East Asia, New Delhi, 2000). The lithotomy position should not be used routinely for delivery. Even then Dutta's textbook does not recommend the upright or squatting positions (p 144). The Holland and Brews' textbook mentions the benefits of upright position, but only suggests semi-recumbent positions, rather than squatting or upright positions (p 173).

Episiotomy: Research has shown that routine episiotomy is harmful. The view that routine episiotomy for primigravidas will have long-term benefits in preserving the integrity of the perineum has not been supported by evidence. Research also shows that second-degree tears heal just as well as an episiotomy so there is no need to cut the perineum unless there is foetal distress or the probability of third degree perineal tear involving the rectum. Textbooks, however, do not state this aspect clearly, and continue to recommend episiotomy as an elective procedure.

Not including effective/beneficial practices: Social support to women in busy, technology-oriented settings reduces the need for pain relief with a positive labour experience, and is a beneficial form of care. It could also lower caesarean section rates, number of infants with low apgar scores and duration of labour. In the textbooks, however, there is no guidance on allowing women to be accompanied with a second person of their own choice during labour. Also, there is no guidance on the provider's behaviour with women and her family, and the need to respect the women's right to privacy and dignity during labour.

Maternal Mortality

The issue of maternal mortality is covered inadequately, considering that this is a health risk of reproduction that only women face, and its levels are very high in India. The textbook of Holland and Brews gives the information on hospital maternal mortality ratio (MMR), which is known to be a very inaccurate and insufficient estimate. The level of maternal mortality ratio mentioned is 340 per 1,00,000 live births [Holland and Brews, p 365), much below most reliable recent estimates. It would be desirable if the textbooks use more recent estimates from SRS or NFHS for giving information on level of MMR.

The textbooks mention a long list of disjointed statements, without prioritisation as to which strategies are more and less effective. The list also includes several strategies which impact on child mortality, but not directly on maternal mortality, e g, children's immunisation, immunisation against tetanus, and promotion of breastfeeding. Moreover, it is now known that while nutrition improves overall health of women, it does not have a direct impact on maternal mortality.

> Direct health care strategies (for safe motherhood): (a) Widely available family planning services; (b) quality antenatal, intranatal and postnatal care; (c) immunisation against tetanus; (d) children immunisation programme; (e) to improve nutritional status of girls and women; (f) prevention and treatment of anemia and (g) promotion of breast feeding (Dutta, p 642).

On the other hand, some proven effective strategies such as access to safe abortion services and skilled attendants find no mention among the steps to reduce maternal mortality. In Dutta and the Holland and Brews textbooks, there is no clarity on the issue of birth attendant – they do not mention the importance of skilled attendants, while continuing to recommend training of TBAs. The following section on steps to reduce maternal mortality illustrates this:

> Steps to reduce maternal mortality:
>
> Programme initiatives: (a) Improvement of nutritional status and literacy; (b) early registration of pregnancy; (c) provision to identify high-risk cases and their reference to appropriate referral hospital; (d) About 80 per cent of the rural mothers deliver at home and majority are attended by untrained birth attendants. The quickest and cheapest means to provide safe delivery services to mothers in these areas is to train traditional birth attendants (TBA), to upgrade the health centres, to make all kinds of government vehicles available in emergencies and to ensure an all out increase in the number of health care providers such as midwives, health visitor, social workers and other ancillary personnel (Dutta p 647).

Over last few years, there has been greater clarity on understanding maternal mortality, e g, what are the time intervals between various complications and death, what proportions of deaths occur during ante-intra, and postnatal periods, etc. Such information would benefit doctors to provide better services, yet these have not been included in the textbooks. For example, if doctors have the information on the average time interval between individual complications and death, it would help them in dealing with emergencies at speed. Similarly, if they are aware that nearly 60 per cent of maternal deaths occur in postnatal period, this would allow doctors to pay more attention to the neglected postnatal period.

It is also known that three delays (in decision-making, in transport, and in receiving care at the hospital) contribute to maternal deaths. The textbook does mention the delays in recognising the problem and in transferring the patient. However, the delay, is most under the control of doctors, is the third delay (delay in receiving care after reaching the health facility) and has not been mentioned. The textbook of Holland and Brews (p 366) lists several shortcomings of the health care system in the section on maternal mortality. However it ascribes, at places, the responsibility for not seeking care to the woman and families ("ignorance of the benefit of modern day obstetric care" and "resistance on part of patients or relatives for transfer to other health care facility"). Clinicians need to understand that women and families might be unwilling to seek care because of reasons related to providers attitudes and behaviour, poor communication with women and their families, high cost of treatment and insensitive alien environment. Fear of over-medicalised and poor quality of care[1] also delay the decision to seek care. These aspects are not covered in the textbooks.

Treatment of Life Threatening Emergencies

For the purpose of this review, the most common life threatening obstetric emergencies were reviewed (postpartum haemorrhage, puerperal sepsis, eclampsia and pre-eclampsia,

unsafe abortion, etc). It has been recognised that the availability of basic emergency obstetric services close to womens' homes, can prevent majority of maternal mortality. In the management of these problems, there appears to an assumption that all services would be delivered at a tertiary health care setting. As a result, a doctor working at primary health care setting is often unclear about the management of emergencies, and often recommends overenthusiastic and unnecessary referrals to higher levels of health facilities.

Medical students need to be sensitised about the barriers to care for provisions life threatening emergencies, especially those operating at health facility level. For example, women coming with life threatening emergencies are sometimes scolded in a tertiary institution for various reasons such as coming too late to the hospital, producing too many children, seeking services from unsafe abortion providers, opting for home delivery through a TBA. In addition, lack of privacy, confidentiality, and concerns about high cost of treatment also delay rural families to seek care. At times of emergencies, women and their families want to receive correct information about the nature of problem, treatment plan, prognosis, likely duration of hospital stay, likely cost, etc. Medical textbooks do not guide students on information and counselling during obstetric emergencies.

Following are some observations regarding the management of specific emergencies:

Postpartum haemorrhage (PPH): The section on PPH describes condition, incidences, types, prevention and management. However, there is no information on case fatality rate and time between complication and death. For example, if a doctor were aware of the fact that PPH can kill women in an average time of two hours, s/he would be more vigilant to detect and treat it urgently. There is no information on these aspects, while the information on the contribution of PPH to maternal deaths is incorrect (instead of 20-25 per cent, the figure quoted is 10 per cent).

Under the management of postpartum haemorrhage several outdated procedures have been mentioned, for example, hot intrauterine douche, intra-uterine packing, which have clearly been demonstrated to be ineffective and sometimes harmful.

Moreover, the sequence of actions suggested in Dutta appears to assume that a woman with PPH would be seen in secondary or tertiary care setting. For example, exploration of uterus under general anaesthesia (a step requiring anaesthesia and more skilled personnel) has been mentioned as a step to be followed even before bimanual compression of the uterus (a simpler and effective step that can be carried out in cases of atonic uterus).

However, the section on prevention gives a long list of 13 steps (p 443), without highlighting which are the most effective steps. For example, active management of third stage has been mentioned somewhere down the list after vague steps such as 'improvement of health status'. Such guidelines can confuse the students.

Eclampsia and pre-eclampsia: The management of pre-eclampsia has been described for a big hospital setting. The investigations recommended include platelet count, uric acid, creatinine, LFT, 24-hours urine for protein, ophthalmoscopy, cardiotocograhpy, etc. There is no guidance as to how a doctor can manage a case of pre-eclampsia at primary or secondary

health care setting (PHC or CHC). Such guidelines for primary and secondary health care settings have been defined in manuals by WHO.

The guidelines for management of eclampsia before transferring the patient are not based on recent evidence. It is now well known that magnesium sulphate is the most effective drug for the control of eclamptic fits and should be the drug of choice, both at primary and secondary health care level. The textbook, however, continues to advise the use of other sedative drugs for primary level treatment.

For referral hospital level management, magnesium sulphate has been mentioned as the drug of choice. The textbook also describes several other regimes in detail, without giving information on the findings of research comparing magnesium sulphate to Diazepam, Lytic Cocktail, and Phenytoin regimes. This can leave the student confused about the regimes.

Puerperal sepsis: Like in other emergencies, the management of puerperal fever also assumes that the woman is being managed in a large hospital setting. Several investigations which have been advised (e g, blood culture, culture of endocervical swab) are not available at the primary or secondary care settings either. (Dutta p 470)

Since a majority of cases with puerperal sepsis are likely to visit primary care facilities, the textbooks need to include guidelines for doctors working at the primary care level, along with referral criteria.

Similarly, several impractical steps have been recommended for prevention, e g, throat swabs of all doctor and nurse attending labour cases. All staff (doctors and nurses) attending the labour cases should have nasal and throat swabs taken before attending their duties. If offending organisms like staphylococci or streptococci are detected, they should be treated accordingly; such persons should be kept off duty. Patients having respiratory tract or skin infection should have swabs taken for culture and should be admitted in septic ward (Dutta, p 471).

Unsafe abortion: Unsafe abortion has been dealt with in the sections on septic abortion (Dutta, p 176-179, Holland and Brews, p 122-123). The women undergoing unsafe abortions are more likely to be residing in peripheral rural areas, which do not have access to safe abortion services. However, the management has been described for a tertiary level facility. Early cases of septic abortions can be managed at primary and secondary levels of care, and medical students need guidance on the same.

Sexually transmitted diseases

The section on STDs describes etiology, pathology, symptoms and signs, diagnosis, and treatment of individual infections such gonorrhoea, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, chlamydia, herpes genitalis, molluscum contagiosum, AIDS, and so on. However, for proper management of STDs, it is crucial that medical students learn about several other aspects, for example, what social and economic factors make women vulnerable to STDs and HIV. Women are less aware on how STDs/HIV are transmitted and prevented, because of lack of education. Even when they suspect their partner has STD/HIV, they often cannot refuse sex, or insist on condom use because of 'culture' norms that dictates that 'good' women are expected to be ignorant about sex, and fear of violence and abandonment. Women's economic vulnerability makes it less likely that they will leave a relationship that they perceive to be risky. However, there is no reference to these issues in the textbook. On the other hand, values of authors/editors conveyed in textbooks appear to be guided by the dominant patriarchal system.

A doctor needs to recognise whether a person is at risk for STDs by asking a few standard questions in a sensitive and proper manner. This is necessary for example, before inserting intrauterine devices, and desirable while dealing with those with unwanted pregnancies or antenatal care. However, there is no guidance in the textbooks on these issues. Most doctors, as a result do not assess STD risk of their clients because they find it awkward. As a result, even when women are at risk of STDs, they do not receive counselling on its prevention and treatment.

Doctors need to arrive at a provisional diagnosis on the basis of clinical symptoms and signs. In recent years, syndromic approach has been used in several developing countries. In the textbook, although symptoms and signs of individual STDs are described, there is no reference to syndromic approach for recognising STDs. The diagnostic protocols described include several investigations, including cultures on various media, compliment fixation tests, immunofluorescent tests, etc, most of which are not available at primary and secondary levels of care (See Shaw's textbook pp 108,110,99-100).

The textbooks describe treatment protocols for individual STDs, that include drugs and surgery. However, there is no guidance on counselling women with STDs on issues related to compliance, protection of partners or further prevention by changes in sexual behaviour or condom use. The treatment makes no mention of partner treatment, which puts women at risk of recurrence Shaw's textbook, p 108).

Medical students need to be sensitised about the barriers to care seeking, e g, they need to know that accessing services for STDs can be highly stigmatising for women, since talking about sex is a taboo and virginity/monogamy of wife are highly valued in Indian culture. STD services, therefore should be linked to other reproductive health services. The doctors also need to be nonjudgmental in their behaviour and maintain strict privacy and confidentiality while dealing with STD patients. There is no guidance in the textbooks on these aspects.

HIV/AIDS

Sections on HIV/AIDS do not give sufficient information on HIV infection, while they describe symptomatic AIDS in greater detail. For example, Shaw's textbook does not describe window period and does not highlight the long asymptomatic period of HIV infection.

There is no guidance as to how to counsel a person before the test (pre-test counselling). The textbook does not guide the students about the necessity or the process of taking informed consent before advising HIV testing. In absence of such information, doctors are likely to carry out the test without consent. There is no guidance on interpretation of results, and on the need to maintain confidentiality about the test results.

Post-test counselling for persons detected to be HIV positive is essential. This would include aspects related to the likely course of events and their prognosis, nutritional and family support, safer sex practices, birth control, pregnancy planning and how to cope. However, there is no mention of the elements of post-test counselling in Shaw's textbook, except the advice against pregnancy and if pregnant, termination of pregnancy. There is no guidance

in the textbook on the importance of having non-discriminatory and non-judgmental behaviour towards HIV positive patients. However, the textbook recommends isolation of patient This is likely to encourage stigmatisation, denial of treatment and rejection of patients. Other universal precautions, which would create safe working environment for providers have not been covered in the textbook.

Wrong information on high risk factors and prevention aspects. or example, oral contraceptives have been mentioned as high risk factors; these are not known to have any link to HIV infection, nor do they reduce immunity. Similarly, prevention makes mention of diaphragms, which do not prevent HIV infection, while female condoms, far more effective for HIV prevention are not mentioned.

The tests recommended for care of women affected with HIV in antenatal period do not take into consideration cost and availability. In Dutta's textbook, several tests have been recommended which are costly and may not be available even in secondary care settings, (e g, tests for cytomegalovirus, toxoplasmosis, T lymphocyte count in each trimester, P24 antibody, rising level of beta microglobulin).

The counselling in antenatal period appears to give only one option – termination. Effectiveness of antiretroviral therapy is not mentioned, and it is recommended only if T lymphocyte count falls below a certain level. The issues of cost of drugs and its affordability in India are not mentioned in the textbook. It is now known that long course regimen of AZT is not affordable to most women in developing countries, and therefore alternatives of Nevirapine (much cheaper antiviral drug) or short course AZT are being recommended for developing countries. However, the textbooks do not recommend short courses.

Other Observations

Several gynecological and obstetric technologies are misused. For example, it is widely known that unnecessary caesarean sections and hysterectomies take place due to commercial considerations. As a result, several women suffer the ill effects and morbidities related to surgeries. Hysterectomy is frequently associated with removal of ovaries too, which, in addition, leads to menopausal symptoms. The textbooks describe the procedure of surgeries and indications. However, it would be desirable if they also sensitised on potential for misuse of technologies, and avoiding these.

Another technology widely misused is sex determination technology and sex selective abortions, partly responsible for a decline in sex ratio in India. The textbooks do not offer any guidance on this issue or the PNDT Act.

The textbooks offer no guidance on identifying and offering help to women who have suffered violence nor any advice on referring them to appropriate social or legal agencies. Similarly, there is a reference to taking informed consent, but it has been mentioned as a formality to be completed before trying new therapies or surgical procedures as seen in the text below. Very often, consent is obtained only in form of signatures before surgery and women are not explained the expected side effects of surgery, e g, women undergoing hysterectomy may not be explained whether their ovaries would also be removed, and about the menopausal symptoms expected. The textbook needs to guide the students on as to how to obtain consent, and the choice and option given to client for refusing the treatment.

Conclusions

It is encouraging that Indian authors are editing internationally renowned textbooks, which gives them an opportunity for making the text relevant to Indian situations. This is especially advantageous for making the textbooks contextually relevant for gender and social equity.

The textbooks provide guidance for practice in a large hospital setting. This, however, tends to give an impression to the doctors working in primary or even secondary care setting, that several of the medical conditions cannot be managed at that level, and that complex investigations and referral would be readily indicated. Clinical protocols that avoid unnecessary procedures or medication can be used in peripheral, low-resource settings, since they lower costs without compromising effectiveness.

At places, outdated practices have been described on detail perhaps out of loyalty to what was popular in another day and age. Counselling issues have either not been covered or have been mentioned very inadequately. At places, there is the appearance of a patronising approach wherein the doctor is aware of the best choice and what remains, is for the woman too, to be convinced of it. The organisation of services for managing obstetric and gynaecologic conditions has not been discussed. There is no guidance as to what role nurse-midwives can play in reproductive health care, and particularly in maternal health. Clinicians also need to pay attention to the kind of arrangement that can ill decrease stress levels, particularly in the labour room.

Issues relating to gender power relationships and their influence on reproductive health needs, especially contraception, abortion, and STDs/HIV are not raised at all. Other barriers to services e g, access and quality of services are not discussed. Quality of care needs to be promoted not only as a part of professional health standards at the core of service delivery, but also as a women's rights issue – with a focus on respect, dignity, confidentiality and choice.

How to provide services to vulnerable groups such as adolescents is not discussed. It is important that the textbook guides students on special needs of adolescents, their lack of decision-making power in matters of sexuality and in the use of services, the barriers they face in terms of cost, confidentiality, etc. This would allow graduate doctors to provide services in a non-biased, non-judgmental manner to adolescents and women out of wedlock. EPW

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Note

1 In some hospitals, women from poor rural backgrounds are at higher risk for poorer quality monitoring, and are likely to be operated by junior doctors. Urban women from higher socio economic backgrounds are likely to receive quick care, better monitoring, and are likely to be operated from more experienced surgeons.

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