Gender Equity and Textbooks of Obstetrics and Gynaecology: A Review

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Action research & Training for Health

July 2004

Background

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. Achutya Menon Centre of Sri Chitra Institute of Medical Sciences, Trivandrum has initiated an effort towards making medical education more gender sensitive. As part of this initiative, a review of medical textbooks are being carried out. This review refers to the 3 textbooks of Obstetrics and Gynaecology.

The framework for review

What should be the role of medical textbooks – is often a point of discussion. 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:

- Evidence based, incorporating new medical knowledge
- Recommend safe techniques, with minimum adverse effects under field conditions
- Avoid over-medicalization and be amenable for use in low-resource settings
- Encourage choice
- 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:
   - Relationship between gender & social inequity and level of that particular health need
   - Relationship between gender & social inequity (e.g. mobility, autonomy, financial constraints), and care seeking behaviour
   - Areas where reproductive rights are likely to be violated by providers
   - Special needs of adolescents and older women

2. Does the textbook 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
- 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 on promotion of women's control over their bodies?Is the quality of care promoted only as a part of professional health standards in service delivery or also as a women's rights issue – with a focus on respect, dignity, choice and confidentiality?5. Do the management protocols
    - relate to the levels of service (primary, secondary or tertiary health facility) where it will be implemented?
    - take into consideration the cost of diagnosis, treatment and follow up visits?
    - feature counselling issues relevant to the problem and guide students for letting women make informed choices? based on the recent evidence, especially that which points to improved access, simpler management or the avoidance of unnecessary procedures or medication? 6. Are the issues related to potential for abuse of technologies (hysterectomy, caesarean, sex determination) discussed?

Selection of textbooks

The selection of textbooks was done on basis of enquiries from lecturers and medical students regarding commonly used textbooks by undergraduates and postgraduates. Following textbooks were reviewed for gynaecology and obstetrics:

- Howkins & Bourne. Shaw's textbook of Gynaecology. Twelfth edition. B.I Churchill Livingstone, New Delhi, Reprinted 2002.
- Textbook of obstetrics including Perinatology and Contraception. DC Dutta, Fifth edition 2001. New Central Book Agency (p) Ltd. Calcutta.
- Holland and Brews Manual of Obstetrics. B.I Churchill Livingstone, New Delhi. Editors: Daftary Shirish N., Chakravarti S., Daftary G. Sixteenth edition. 1998, Reprint 2002.

Although the review has included several topics and chapters, only selected chapters are discussed here.

1. Gynaecological diagnosis

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 and 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. The following description illustrates this.

> *The patient is asked to evacuate the bladder. She is then made to lie in dorsal position with thighs slightly flexed. Abdomen is fully exposed. The examiner stands on the right side of the patient..*
>
> *..Vaginal examination is done in the antenatal clinic. The patient must empty her bladder prior to the examination and placed in the dorsal position with the thighs flexed along with the buttocks placed in the foot-end of the table.* (Dutta's textbook p 81)

2. Contraception

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

> *". The aims of family planning are: (1) To bring down population growth, so as to ensure a better standard of living (2) From economic and social point of view – already existing nearly 900 million are grossly deficient in their basic needs of food, clean water, clothing, housing, education and proper health care. Spacing of birth and small family norm will improve the health of the mother and their children, so that a healthier society can emerge…."* (Dutta's textbook, p 568)

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 the 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 adverse consequences (fear of violence, accusation of infidelity, abandonment etc.) they might face if they insist.

Counselling and consent: In the chapter on contraception, there is no guidance on issues related to counselling and informed choice, in general. Even under specific contraceptives, for example, IUDs, there is no guidance on pre insertion counselling – including showing her a copper-T, informing about side effects, follow-up, removal, etc. The following text illustrates a prescriptive attitude:

> *Thus, during breastfeeding, additional contraceptive support should be given by condom, IUCD, or injectable steroids where available, to complete contraception.* (Dutta, p 573)

In the section on female sterilisation, only the procedure (how to carry out the surgery) has been described -- there is very little guidance on the content of counselling in terms of irreversibility of procedure, comparison of female and male sterilisation, complications etc.

> *Couple must be counselled adequately before any permanent procedure is undertaken. Individual procedure must be discussed in terms of benefits, risks, side effects, failure rate and reversibility. Written consent of the person is a must and the surgeon should be convinced about the family structure of the couple.* (Dutta p 589)

Thus this section does not inform sufficiently on the process of "informed consent", instead it has been projected as a formal necessity. It is also clear that the surgeon is called upon to exercise judgement 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.

Indications (of female sterilisation): (1) Family planning purposes: This is the principle indication for most of the developing countries, India in particular. Intensive motivation is done and even cash incentives are provided to boost up the programme. (2) Socio economic: An individual is adopted to accept the method after having the desired number of children. (3) Medico-surgical indications (therapeutic): Medical diseases such as heart disease, diabetes, chronic renal disease, hypertension are likely to worsen, if repeated pregnancies occur and hence sterilisation is advisable. During third time repeat caesarean section …., sterilisation operation should be seriously considered. (Dutta p 591)

In the above text, several therapeutic indications for female sterilisation are mentioned. For each of these conditions, 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). It would be desirable that the textbook guides students to give choice to women about all the contraceptives that are medically suitable to her, rather than advising female 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.

In India, it is customary to offer a sterilization operation at the time of third caesarean section, and sometimes during second caesarean section. The cases needing sterilization include the mentally retarded woman and those suffering from serious psychiatric disorders like schizophrenia. … A woman who has borne a child with genetic disorder needs genetic counselling and may be advised against future pregnancy. (Shaw's textbook of gynaecology, p 169)

***Discontinuation and switching contraceptives*:** In India, decision for removing IUD is always not always in women's hands, and providers often hesitate in removing IUD. It is therefore important that the textbook guides 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, as seen in text below:

The indications for removal are – (1) Persistent excessive regular or irregular uterine bleeding and /or severe cramp like pain in the lower abdomen (2) Flaring up of salpingitis (3) Perforation of the uterus…. (4) Downward displacement of the device into the cervical canal …. (5) Pregnancy occurring with device in situ (7) Patient desirous of a baby (8) Missing thread (9) One year after menopause (Dutta, p 578)

***Reproductive rights*:** The section on contraception does not orient students to areas where reproductive rights are likely to be violated during the provision of contraceptive services – e.g. overt or covert coercion for sterilization or IUDs, coercion for contraceptives while providing MTP services or caesarean section.

Quality of family planning services: There is no mention of 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. There should be reference to "Standards to sterilisation", published by Govt of India in 1992, which students may consult for further information.

Contraceptive eligibility: There has been considerable scientific progress in areas of contraception, leading to the liberalisation of medical eligibility criteria[1], which has the potential to considerably increase access to contraception. The textbooks, on the other hand recommend unnecessary and excessive requirements for starting a contraceptive, which reduces access for women. For example, Dutta's textbook suggests that breast, blood pressure and pelvic examination are mandatory before starting oral pills. 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.

> *Selection of the patient: History and general examination should be thorough, taking special care to screen cases for contraindications. Examination of the breast for any nodules, weight and blood pressure are to be noted. Pelvic examination to exclude fibroid or cervical pathology, is mandatory. Pregnancy must be excluded. If facilities are available, cervical cytology to exclude abnormal cells, is of help…… Do not prescribe the "pill" to any young woman, whose bone growth is still not completed and who has not reached physical maturity. (Dutta, p 582)*

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 are excessive.

> *Follow up: Examination of the breasts, weight, and blood pressure recording ands pelvic examination including cervical cytology are to be done ….*

Other: 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. On the other hand, 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.

> *Immediate postcoital douching of the vagina with a spermicidal solution for the purpose of washing away the sperms is a fairly common method… . This method can only be effective if it is applied immediately after intercourse and before the spermatozoa had an opportunity to gain access to the cervical canal..* (Shaw's textbook of gynaecology, p 171)

3. Abortion

Rationale to provide abortion services: The section on induced abortion in Dutta's textbook starts with 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

[1] Medical Eligibility Criteria WHO, 2002

for safe abortion, but it does not highlight that access to safe abortion remains a major barrier despite three decades of MTP Act. This has been illustrated 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 150,000 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)

Information on MTP Act and its implications: The MTP Act has been described in brief in Dutta's textbook, which includes indications for abortion, requirements for 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 husband's consent in not required. In light of the fact that several doctors impose unnecessary restrictions e.g. asking for spousal authorization, 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.

Gender inequity and women's need for *abortion*: There is no reference to the relationship between gender inequity and women's need for abortion. It would be desirable if textbooks sensitise medical students on the women's lack of decision making power regarding sex and contraception, its relation 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 lacking in the textbooks.

It is important that women with unwanted pregnancy 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.

Pressure to accept certain contraceptives: 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 sterilization:

> *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 utilized to educate the couple to accept contraception. Women who have completed their families can be persuaded to accept sterilization along with the operation of MTP. (*Shaw's textbook, p 186)

Attitudes of providers: Providers may carry negative attitudes towards women seeking abortion (e.g. those not accompanied by family members, or out of wedlock), which may act as

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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.

Cost: It would be desirable to sensitise the doctors about the cost of services acting 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 anesthesia, and to ensure that costs are not exploitative. However, consideration towards cost issues are absent in the textbook.

Over-medicalization of procedure: Use of general anaesthesia for abortion represents over-medicalization of procedure, and has been deemed as inessential, by WHO. It raises cost, reduces availability of services, does not improve and may even reduce the quality of care[2]. The textbooks, however, continue to recommend the use of general anaesthesia, for vacuum aspiration, and even for menstrual regulation. The following text from the Shaw's textbook illustrates this:

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> *Menstrual regulation: A para-cervical local anaesthetic block or pre operative sedative alone usually suffices but sometimes in an apprehensive patient, general anaesthesia with i.v. Thiopentone sodium may be necessary.*
>
> *Vacuum aspiration: The operation can be generally undertaken satisfactorily under a local anesthetic paracervical block, coupled with some sedation if necessary. Apprehensive patients may need general anaesthesia to allow satisfactory intervention. The procedure involves examination of the patient in an operation theatre observing full aseptic precautions. … In case the pregnancy to be terminated exceeds 8 weeks gestation size, the patient is nulliparous, or there is presence of a scar of previous surgery on the uterus, then general anaesthesia may be preferred out of choice.* (Shaw's textbook, p 186-187)

Abortion methods: The 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. On the other hand, more effective and safer methods, like manual vacuum aspiration, 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 lower cost of MVA equipment, and its greater feasibility to 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.

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> *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, p 186)

Medical abortion (using mifepristone and misoprostol) offers several advantages in terms of improved access, and its potential to be used by practitioners who are not skilled in surgical

[2] Safe abortion: Technical and Policy Guidance for Health systems, World heath Organisation, 2003.

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[3].

> *Medical methods (for first trimester abortion):*
> *Prostaglandins and more recently RU 486 have been extensively investigated as medical methods for MTP in early pregnancy, but up to date, these have not been able to replace the more effective and safe surgical method of vacuum aspiration.*
>
> *1. Prostaglandins. Prostaglandin injections 250 micrograms given i.m. every 3 hours upto a maximum of 10 doses …….. It has not been popular in first trimester abortion because of unacceptable high rate of incomplete abortion.. ..*
> *2. Mifepristone (RU 486). .. A single dose of 600 mg daily for 3-4 days, followed by a single prostaglandin vaginal suppository yields a success rate of about 95% when used within 48 days of gestation. ……* (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 method like repeated doses of misoprostol / gemeprost are not described (Shaw's textbook).

4. Labour care

Place of delivery and birth attendant*:* 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 counseled 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 nineties, as being ineffective. Holland & 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.

> *All women, ideally should be delivered in the hospital. …….. The objective in the rural areas should be to hospitalize the high-risk pregnancies. These may be screened during antenatal care and suitable arrangements made. The mothers in the low risk group may be delivered at home by Trained Birth Attendants (TBA)* (Holland & Brews, p 169*)*

> *Place of delivery: … Effective antenatal care reduces the hazards of delivery significantly but to get an optimum outcome, equally adequate supervised intranatal care is mandatory. Thus ideally, all women should be delivered in the hospital. … the third world countries lag far behind……. In such circumstances, selective hospital admissions*

[3] One tablet of mifepristone costs around 300 rupees.

*of the high-risk groups can be an alternative. These are: Teenaged pregnancy, Grand multipara, Complicated present pregnancy, Cases with previous pregnancy or labour complications. (*Dutta, p 140)

Recommendation of ineffective/ harmful practices: 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: There is no evidence to show that that routine enemas or shaving are beneficial. Even then, these practices are recommended.

*While the uterine cavity is sterile and the upper vagina is only slightly contaminated, the vulva is heavily contaminated with organisms. Thus, its eradication minimizes not only the chance of ascending infection during internal examination but also prevents infection of the episiotomy would, if it is required at a later stage. After shaving, or hair clipping, the vulva is washed liberally… (*Dutta, p 141)

*Bowel: An enema with soap and water or glycerine suppository is given in early stage. .. Emptying the rectum prevents soiling of the perineum during second stage. (*Dutta, p 142)

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 also outdated and incorrect – they are likely to needlessly increase stress in the woman by starving them.

*Fluids and oral fluids should be withheld as soon as possible once the active labour is established. (*Dutta, p 142)

Except for sips of water, nothing is given by mouth. (Holland & Brews, p 171)

Position for delivery: Research has shown that there are considerable benefits from delivering in the upright or traditional squatting positions[4]. The lithotomy position should not be used routinely for delivery. Even then Dutta's textbook does not recommend the upright or squatting positions. The Holland & Brews' textbook mentions the benefits of upright position, but only suggests semi recumbent positions, rather than squatting or upright positions.

(management of second stage) The patient should lie down in bed. …….. Delivery in dorsal position is more widely preferred with the thighs flexed and separated. Some, however, prefer delivery in lateral or lithotomy position. (Dutta, p 144)

Traditionally the mothers are delivered in the dorsal position with the thighs flexed and widely separated or in lithotomy position. These positions do not confer the benefits of gravity on the expulsion of fetus and have psychological appeal for the mother. Many favour a semi recumbent position for mother as it is comfortable and the delivery is aided by gravity. However a semi recumbent position, there may be problems of access to the perineum and control of the crowning of the head unless a suitable bed or birthing chair is used. (Holland & Brews, 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

[4] 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.

heal just as well as an episiotomy so there is no need to cut the perineum unless there is fetal 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.

> *…..When the perineum is fully stretched and threatens to tear specially in primigravidae, Episiotomy is done at this stage after prior infiltration with 10 ml of 1% Lignocaine. Bulging thinned out perineum is a better criterion..* (Dutta, p 145)
>
> *Episiotomy is very often needed to eliminate uncontrolled perineal trauma* (Holland & Brews, p 173)
>
> ***The indications of Episiotomy include:***
> *Anticipating perineal tear – (a) this is widely indicated in primigravidae as an elective procedure. (b) Other indications are: face to pubes or face delivery, big baby, narrow pubic arch……* (Dutta, p 606)

> *A clean and controlled incision through non-traumatised tissues is easy to repair and heals better than a lacerated wound that might otherwise occur. Timely Episiotomy prior to too much and too long stretching of the perineum preserves the strength of pelvic floor. …* (Dutta, p 606)

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[5]. 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, versus seclusion of women. Also, there is no guidance on the provider's behaviour with women and her family, and respecting the women's right to privacy and dignity during labour.

5. Maternal mortality

The issue of maternal mortality is covered very 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 100, 000 live births[6], 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.

Strategies to prevent maternal mortality: 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.

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[5] RHL, 2003
[6] Holland and Brews, p 365

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 (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's and 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:

- *Improvement of nutritional status and literacy…*
- *Early registration of pregnancy ….*
- *Provision to identify high-risk cases and their reference to appropriate referral hospitals…..*
- *About 80 percent 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 are to train traditional Birth attendants (TBA), to upgrade the health centres, to make all kinds of government vehicles available in emergencies and all out increase in the number of health care providers such as midwives, health visitor, social workers and other ancillary personnel……..* (Dutta's textbook. 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 it has 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% maternal deaths occur in postnatal period would allow doctors to pay more attention to the neglected postnatal period.

It is also known that 3 delays (in decision making, in transport, and in receiving care at the hospital) contribute to maternal deaths. The textbook does mention the delays in recognizing the problem and in transferring the patient. However, the delay which is most under the control of doctors is the third delay (delay in receiving care after reaching the health facility) has not been mentioned. The textbook of Holland and Brews (p 366) enlists several shortcoming of 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[7] also delay the decision to seek care. These aspects are not covered in the textbooks.

Shortcomings of health care facilities (obstetric services) and systems

…. The present scenario reveals:

- *Shortage of trained staff at primary health care centre and subcentres*
- *Absence of collaboration … between government organizations and private sector for clients..*
- *Absence of a well established referral system ..*
- *Problems of communication and transport.*

- *Resistance on part of patient or relatives for transfer to other health care facility.*
- *Ignorance of benefits of modern day obstetric care.*
- *Under-utilization of existing Government Hospital services due to non-compliance at various levels.*

(Holland and Brews, p 366)

6. Treatment of life threatening emergencies

For the purpose of this review, most common life threatening obstetric emergencies were reviewed (Postpartum haemorrhage, puerperal sepsis, eclampsia and pre-eclampsia, unsafe abortion, etc.). It has been recognized that the availability of basic emergency obstetric services close to the women' 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 management of emergencies, and often carries out overenthusiastic, and unnecessary referrals to higher levels of health facilities.

Medical students need to be sensitized on the barriers to seeking care for 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:

[7] 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.

Postpartum haemorrhage

The section in PPH describes the definition, incidence, types of PPH, prevention and management. However, it would be desirable to give 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 2 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%, it has been mentioned as 10%) -

> *Postpartum haemorrhage is one of the life threatening emergencies in the third stage. It is responsible for maternal deaths in about 10%, especially in the third world countries.* (Dutta, p 443)

The management of postpartum hemorrhage has several outdated procedures mentioned in it, for example, hot intrauterine douche, intra uterine packing, which have clearly demonstrated to be ineffective and sometimes harmful.

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> *Management of True Postpartum Haemorrhage: …*
> *Atonic uterus*
> *Step I: (a) Massage the uterus:… (b) Methergine …… (c) Morphine: .. .(d) Inj. Oxytocin …. (e) To empty the bladder … (f) To examine the expelled placenta and membranes ..*
>
> *Step II: The uterus is to be explored under general anaesthesia. Simultaneous inspection of the cervix, vagina specially para-urethral region is to be done to exclude co-existent bleeding sites from the injured area. Another dose of ergometrine is given…… If uterus still remains atonic, proceed to the next step.*
>
> *Step III. Bimanual compression:*
> *Procedures: (a) The whole hand is introduced in the vagina in cone shaped fashion …*
> *..… However, with oxytocics and blood transfusion, almost all cases respond well. .. But in rare cases, when the uterus fails to contract, the following may be tried desperately as an alternative to hysterectomy.*
>
> *Step IV: Hot intrauterine douche - It is an effective method to stimulate the uterus to attain its tone. The temperature of the fluid should be around 118 degree F and some antiseptic lotion is mixed in the douche. Air should be driven out of the piping before the douche nozzle is inserted into the uterus to prevent air embolism. The can should not be placed more than 2 feet above the level of the uterus.*
>
> *Step V. Tight intrauterine packing: Intra uterine packing should be done under general anaesthesia. A 5-meter long strip of gauze, 8 cm wide folded twice is required. The gauze should be soaked in antiseptic cream before introduction. …. A separate pack should be used to fill vagina. An abdominal binder is placed. … The plug should be removed after 24 hours, under morphine pre medication and prior intra-muscular administration of ergometrine 0.5 mg.*
>
> *… Angio-graphic arterial embolization using gel foam in some early and selected cases is found effective.* (Dutta, p 447-8).

The sequence of actions suggested in the textbook appears to be going by the assumption 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.

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Eclampsia and pre eclampsia:

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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[8] and secondary[9] health care settings have been defined in manuals by WHO.

> *Scheme for management of pre-eclampsia : Rest…..BP checkup ……*
> *Investigations: Platelet count, Uric acid, Creatinine, LFT, 24 hours urine for protein,* Ophthalmoscopy
> *Fetal well being assessment: DFMC, USG- Doppler, Cardiotocography ….*
>
> (Dutta, p 246)

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 use of other sedative drugs for primary level treatment, as seen below:

> *First aid treatment outside hospital: The patient, either at home or in the peripheral health centre should be shifted urgently to the referral hospitals.* ***There is no place for continuing the treatment in such places.*** *The patient must be heavily sedated before moving her to the hospital. Any one of the available drugs is helpful in maintaining sedation – intramuscular injection of Largactil 50 mg and Phenargan 25 mg……. …* (Dutta, p 248)

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. Following illustrates this point:

> *"ANTICONVULSANT AND SEDATIVE REGIME: The various anticonvulsant regimes that are in use, maintain the fundamental principles …… . The aim is to control the fit and to prevent its recurrence…*
>
> *Magnesium sulphate is the drug of choice. It reduces motor end plate sensitivity…*
>
> *Lytic cocktail regime: Menon (1961) in India employed the regime using chlorpromazine, Phenargan and pethidine and has got satisfactory result with reduction of maternal mortality to 2.2%. …*

[8] Standards for Midwifery practice for safe motherhood. Volume 1:Standards Document. World Health Organization. Regional office on South East Asia, New Delhi, 1999.

[9] Integrated Management o pregnancy and Childbirth. Managing Complications in Pregnancy and Childbirth: A Guide to midwives and doctors. WHO, UNFPA, UNICEF, World Bank. Department of Reproductive Health and Research, World Health Organisation, 2000.

Diazepam therapy (Lean): Diazepam is used in initial doses of 40 mg intravenously….. …. Maternal mortality rate using this regimen is 5.0%.

Phenytoin therapy: Phenytoin is also used to control convulsions…. It is given by slow intravenous route with ECG monitoring. .. Experience with phenytoin is limited.

Other sedative and anticonvulsant drugs that could be used singly or in combination are morphine, chloral hydrate, paraldehyde, barbiturates and sodium thiopentone.(details in chap 33)"(DC Dutta, P 249, and p 547.)

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

Investigation for Puerperal pyrexia
.. History …
Clinical examination …
Investigations include: (1) high vaginal and endo-cervical swabs for culture in aerobic and anaerobic media and sensitivity test to antibiotics. (2) "Clean catch midstream collection of urine for urinalysis and culture…. (3) Blood for total and differential count of white cells and estimation of haemoglobin (4) Blood culture, if fever associated with chills and rigor. (5) Other specific investigations …. such as straight X-ray of chest in suspected Kock's infection or think blood film for malaria parasites. (Dutta, p 470)

Similarly, several impractical steps have been recommended for prevention e.g. throat swabs of all doctor and nurse attending labour cases. This is evident by reading the following text:

Prophylaxis ….
Intranatal:
- *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)

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

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.

7. Sexually transmitted diseases

In the textbooks, 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 etc.

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 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 dominant patriarchal system, as reflected in the following:

> *Sexually transmitted diseases have caused a worldwide problem with their increasing prevalence amongst those with increased promiscuity and multiples sexual partners.* (Shaw's textbook, p 106)

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. Following highlights this point:

> *Diagnosis (of Gonorrhoea)*
> *1.Smears of the urethral and cervical discharge are reliable in acute phase, but yield only 70% positive findings in chronic infection.*
> *2.Culture of discharge on Thayer Martin medium or Mc Loed Chocolate Agar in 5% CO2 moist atmosphere yields purple to black colonies of N gonorrhoea. ….*
> *3.Gonorrhoeal complement fixation test. It employs a standard gonococcal antigen test for the presence of antibody ……*
> *4. Fluorescent tests. Fluorescent tests are still under investigative research.. .* (Shaw's textbook, p 108)
>
> *Diagnosis (Chancroid)…… H. Ducreyi is Gram negative and the bacilli may be arranged like a school of fish in a streak of mucus. It may be cultured on rabbit's serum. The most satisfactory test, however is Ito test: H. Ducreyi vaccine 0.3 ml is injected intradermally… .* (Shaw's textbook, p 110)

(Chlamydia) … Earlier, it was cultured with difficulty and the diagnosis was made on serological test. Now the use of fluorescein – conjugated monoclonal antibody in immunofluorescence tests on smears prepared from urethral and cervical secretion, allows a direct diagnosis of the infection to be made. IgM can be detected in 30% cases of recent infection. Cervical smear shows leucocytes. Elisa test can also detect the antigen. .. (Shaw's textbook, p 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. Following sections on treatment highlights this point:

Treatment (gonorrhoea).
Penicillin is the drug of choice though penicillinase-producing gonococci which inactivate penicillin, have been discovered in 2 % of the population (Philips, 1976). …Kanamycin. Vibramycin .. Tetracyclines.. doxycycline .. erythomycin .. …….

Besides administering antibiotics, drainage of pus from Bartholin's, Skene's and periurethral abscesses is essential for total cure. A periurethral abscess is best opened through the anterior vaginal wall, a Skene's abscess with the help of electrocautery, and Bartholin's abscess at muco-cutaneous junction. .

In the presence of pelvic infection, the patient should be given benzyl penicillin intramuscularly …….

Patients with chronic gonorrhoea should be surgically treated for residual lesions like Bartholin's cyst and Skeinitis. Pelvic diathermy may be required ..

Permanent cure is assumed only after 3 negative smears at weekly intervals. Since syphilis and chlamydia are often associated with gonococci infection, they should be looked for and treated simultaneously.
(Shaw's textbook, p 108)

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

8. HIV/AIDS

Sections on HIV/AIDS do not give sufficient information on HIV infection, while describe symptomatic AIDS in greater detail. For example, the 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. This is illustrated below:

*Investigations are required in those have received blood transfusions and in high-risk group. Ideally every pregnant woman should have serum tested for HIV. (*Shaw's textbook, p 114)

Post test counselling for persons detected to be HIV positive is essential, which could 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 etc. However, there is no mention of the elements of post-test counselling in Shaw's textbook, except the advice against pregnancy and termination of pregnancy if pregnant.

There is no guidance in the textbook on the importance to have non-discriminatory and non-judgmental behavior towards HIV positive patients. On the other hand, the textbook recommends isolation of patient (see box below) -- this is likely to encourage stigmatisation, denial of treatment and rejection of patients.

The women suffering from AIDS should be advised against pregnancy, and if pregnant, termination of pregnancy should be offered. Delivery should be conducted in an isolated ward and all precautions taken against the spread of infection. (Shaw's textbook, p 114)

The universal precautions have not been covered in the textbook, which would create safe working environment for providers. On the other hand, wrong information on the high risk factors and prevention aspects has been given. For example, oral contraceptives have been mentioned as high risk factor, which 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 high risk factors are:

- *Multiple sexual partners, prostitutes.*
- *People suffering from sexually transmitted diseases*
- *Homosexuals, drug abusers*
- *Pregnancy and those on oral contraceptives because they have a suppressed immunity.*

Prevention …. 1. Use of condoms or diaphragms .. .. 2. Screening of blood donors .. .. 3. Use of frozen semen in artificial donor insemination .. 4. Screening of all high-risk cases in the population 5. Cessation of smoking
(Shaw's textbook, p 113-4)

The tests recommended for care of women affected with HIV in antenatal period have no consideration of 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.

9. 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 sensitized on potential for misuse of technologies, and avoiding these.

Another technology in misuse 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, and the PNDT Act.

Given that a large proportion of women in India suffer domestic and other violence, and that the health system might be their only contact with an external agency, health providers must be able to identify and guide women suffering violence. It is known that women presenting with unwanted pregnancy or STDs/ HIV are more likely to have suffered violence. In some countries, inquiry about violence is a routine part of all health care to women. It would be desirable if textbooks gave guidance on detecting women who have suffered violence and 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.

> *".. Similarly, at all times, an informed consent must be obtained from the patient prior to undertaking any surgical intervention or trying out any new or experimental drug or procedure."* (Shaw's textbook, p 46)

Conclusions

1. 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.

2. The textbooks provide guidance for practice in a large hospital setting. This is reflected in the wide range of investigations and treatment options suggested for individual clinical conditions.

This however tends to give an impression to the doctors working in primary or even secondary care setting, that the condition cannot be managed at that level, and that complex investigations and referral would be readily indicated. Unnecessary referrals reduce access and increase the cost of treatment, amounting to denial of treatment for women belonging to lower economic strata.

Clinical protocols that avoid unnecessary procedures or medication can be used in peripheral, low-resource settings, since they lower costs without compromising effectiveness.

3. Clinical protocols that avoid unnecessary procedures or medication that make care more accessible and affordable without compromising effectiveness have often not been included. For example, sections on management of labour continue to recommend enema, shaving and withholding of food during the active stage. In area of contraception, WHO's medical eligibility criteria have relaxed access to most contraceptives, yet the textbooks under review continue to recommend rigid criteria for starting contraceptives and follow-up. Similarly, avoiding general anaesthesia for elective abortion minimises risk while reducing costs and recovery time, yet it has been recommended.

4. At places, outdated practices have been described on detail perhaps out of loyalty to what was popular in another day and age. For example, the textbooks describe in great detail, procedures such as intra-amniotic instillation and aspirotomy for abortion, and postcoital douching as a contraceptive. By contrast, modern and effective methods are not sufficiently discussed -- for example, guidance on injectable contraceptives is far too brief and incomplete to allow a graduate doctor to prescribe them. Similarly, medical abortion and MVA have not been described in sufficient detail to enable them to be considered in a practical manner.

5. 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. For example, the section on STDs makes no mention of partner treatment, or on developing skills for using or negotiating condom use. Similarly, the section on contraception does not guide on offering choices to women, steps or skills of counselling, information on danger signs etc.

5. Government (of India) guidelines on various procedures have not been included. For example, there is no information on eligibility criteria and consent procedures for sterilisation, and for other surgical procedures. Similarly, there is no reference to the RCH programme, while the long concluded CSSM programme does find mention. The textbooks need to be clear on how far public health programmes are to be referred to.

6. The organisation of services for managing obstetric and gynaecologic conditions has not been discussed. These include issues related to deployment of clinical and support personnel, the range of services, arrangements to foster privacy and confidentiality, etc. For example, women seeking abortion services or STD/HIV services face stigma, hence these services need to be provided as part of wider basket of services. There is no guidance as to what role can nurse–midwives 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. Guidance on above would go a long way in helping graduate doctors improve service quality within their clinic practice.

7. Issues relating to gender power relationships and their influence on reproductive health needs; especially contraception, abortion, and STDs/ HIV are not raised at all. An orientation about these would help improve attitudes of providers. Similarly, the guidelines do not take into consideration issues of cost, mobility, time, number of visits required etc. which influence care seeking by women.

8. 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. For example, given the history of poor quality of family planning services, it is important that textbooks orient students on the history of family planning programme and prevailing concerns about poor quality of services. Similarly, in the area of maternal mortality, there is no mention of delays that occur within health facilities.

9. How to provide services to vulnerable groups such as adolescents are 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 nonbiased, non-judgmental manner to adolescents and women out of wedlock.