Integrating Gender in Medical Education

SUBJECT: OBSTETRICS & GYNAECOLOGY

COURSE: MBBS

A Guide for Medical Teachers

Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

Muhammad University of Health Sciences

Directorate of Medical Education and Research, Government of Maharashtra
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Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai
Maharashtra University of Health Sciences
Directorate of Medical Education and Research, Government of Maharashtra
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For additional copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (E)
Mumbai - 400055.
Tel: (91) (22) 26673154, 26673571
Fax: (91) (22) 26673156
Email: cehat@vsnl.com
Website: www.cehat.org

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Preamble

The work done by CEHAT, the Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) to increase the knowledge and understanding of medical students about gender considerations (gender inequality, gender roles and behaviours, gender bias) as important social determinants of health and health care is to be commended.

This important effort directly responds to recommendations made at a 2006 meeting organized by WHO on Integrating gender in the curricula for health professionals that included to: Ensure that doctors and other health professionals are offered training with a gender-competent and human rights perspective; encourage and train health professionals to advocate for gender equality and health equity and to serve as agents for change; offer this training across all disciplines and along the learning continuum from undergraduate through continuing professional development; and work towards establishing accreditation standards on gender competencies within curricula.

Medical education for long used the 70 kg male as the norm for determining, for example, dosages of drugs. It is only in the last few decades that awareness has grown about the fact that sex-based differences in women’s bodies, related to size, distribution of fat, hormones and other characteristics, mean they may metabolize drugs differently and may at times require different dosages. It has taken time for medicine to pay attention to biological differences between women and men, beyond those related to the reproductive system, and to understand how these differences may manifest themselves in specific diseases or conditions, such as cardiovascular disease. Better understanding has developed also on how social constructions of femininity and masculinity (i.e., gender norms and behaviours) and the related unequal power relationships between women and men (i.e. gender inequality) are important risk factors and can impact negatively on health. Biological differences interact with gender inequality in ways that adversely affect the health of women and girls in many societies. Furthermore, gender interacts with other inequalities related to class, caste, ethnicity, migrant status that can exacerbate the negative health impacts. Gender biases may also affect the treatment and care they receive.

It is important that doctors have a clear understanding of how both biological differences and gender and other inequalities impact different aspects of health, how disease manifests itself, as well as the capacities of patients to protect themselves from disease. Doctors with this competency are more likely to provide appropriate and relevant care to their patients, be aware of the doctor-patient power differential and communicate
sensitively with patients of different ages, status and cultures. They are also more likely to identify and assist women and children affected by violence and abuse, an extreme manifestation of gender and other inequalities.

The content in these modules has been developed with attention to how to integrate gender-related content within existing topics and with minimal additional time requirements which make it more likely that this material will be used beyond this initial group of medical colleges.

A new generation of physicians with this knowledge and competency can lead to better medicine and better health care for all.

Claudia García-Moreno E
World Health Organization

*This is not an endorsement of all the content in the modules. The views expressed are my own and do not necessarily represent the views or policy of the World Health Organization.
Foreword

I am pleased to inform you that Maharashtra University of Health Sciences (MUHS) has taken an important step towards “Gender mainstreaming” and “Gender sensitization” by suggesting gender-integrated modules in the existing MBBS curriculum. It is a known fact that recognition of social determinants of health can inform and make health services gender sensitive. It is with this objective that an innovative project on Integration of “Gender in Medical Education” was implemented under the aegis of Maharashtra University of Health Sciences (MUHS) by Directorate of Medical Education and Research (DMER), Centre for Enquiry into Health and Allied Themes (CEHAT) and was supported by UNFPA.

The gender-integrated curriculum was rigorously reviewed at different stages, as is the case with any new additions to the academic curriculum. The Authorities of the University has resolved to implement the gender integration modules with an intention that it would complement the existing MBBS teaching and these modules are available on the University website www.muhs.ac.in.

I am happy to announce that these modules may be implemented soon in the Medical curriculum. Medical educators in Maharashtra are being trained to use these modules. I am pleased to state that MUHS is the first university to implement the directions of NHP (2017) which speaks of the urgent need towards gender mainstreaming. Integration of Gender in medical education is definitely a step forward in that direction

Prof. Dr. Deelip G. Mhassekar
Preface

Integration of “Gender in Medical Education” (GME) has been a unique and challenging initiative of the Department of Medical Education (DMER), Maharashtra University of Health Science (MUHS) and Centre for Enquiry into Health and Allied Themes (CEHAT) supported by UNFPA. The Project was undertaken in seven medical colleges of Maharashtra with the aim to sensitise medical students and health professionals to gender inequity in health. As an outcome of the project a cadre of GME trained educators emerged, who enthusiastically participated in teaching gender integrated modules to the medical students.

An important contribution of this project has been the development of “Gender Integrated Modules” for the undergraduate medical curriculum for 5 disciplines namely Obstetrics and Gynecology, Community Medicine, Internal Medicine, Forensic Medicine and Toxicology and Psychiatry. These modules have been specifically developed by trained medical educators in collaboration with CEHAT and experts in the field of gender equity and health. As this is the first such initiative in India, rigorous reviews of these modules were carried out by the board of studies and academic council of MUHS, Maharashtra.

The efficacy of these modules was tested by undertaking a research study in three of the seven medical colleges of Maharashtra. The study findings show a positive change in the overall gender attitude of medical students like a gender informed understanding of communicable and non communicable diseases, gender sensitive approach to the issues of violence against women (VAW), and sexual violence. Care had to be taken that the number of teaching hours are not increased. Hence, the focus was on using innovative teaching techniques such as case studies, role plays, games and quizzes to enhance learning and enable interactive sessions.

I would like to congratulate the medical educators and CEHAT for having undertaken such an important activity of developing gender integrated modules for five disciplines. I urge medical educators from different medical colleges of Maharashtra to use these modules with medical students so as to create gender sensitive doctors in the state of Maharashtra.

Dr. Pravin H. Shingare
Director Medical Education & Research,
Mumbai
CEHAT has been working on the issue of women and health since its inception. It has been able to generate critical evidence on issues of access, discrimination and neglect of health equality in policy, programmes and practice. It has also been at the forefront in policy and legal advocacy on the issues of access to abortion services, gender insensitivity in healthcare response to VAW and sex selection/determination. The work also involved gender sensitisation of health providers and has been ongoing. A common issue that emerged was the need to impact the medical curriculum and make it gender sensitive so that doctors are sensitive to gender concerns when they enter the field.

The Integrating Gender in Medical Education (GME) initiative of CEHAT, DMER, MUHS and UNFPA was conceptualized after a lot of deliberation. Building on the earlier experiences in India and abroad, CEHAT decided to work closely with medical professors across 7 medical colleges in Maharashtra to train them as core faculty and bring about changes in medical curriculum in consultation with them. This was probably the best strategy as once the 19 professors completed the GME training; they were able to identify the gender gaps in their curriculum. The gender gaps were identified for every lecture of the UG MBBS curriculum as prescribed by the MUHS. Later, the CEHAT team along with the mentors and gender experts developed the gender content for each lecture. This was again reviewed by all the 19 trained faculty, mentors and gender experts.

The modules are supplementary efforts to existing MBBS curriculum and are structured with key messages for medical educators, and knowledge, skills and attitude changes expected in medical students. The section on content in the modules specifically provide examples of gender concerns related to health conditions and evidence snippet of steps by which gender can be integrated in a medical topic that is being taught by an educator. Each module has listed details of resources which can be read by the educator at their convenience. Case studies, debates, group discussions have been included as participatory exercises to assist medical educators in engaging students on gender and health.

Sangeeta Rege,
Coordinator, CEHAT
Acknowledgement

At the outset we acknowledge the contribution of several individuals and agencies in the preparation of these modules. We are grateful to Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) for guidance and encouragement received at all stages of the GME project, in particular Dr. Pravin Shingare who led the entire initiative. We also thank the Board of Studies and Academic council of MUHS (2016-2017) for supporting the Integration of Gender in Medical Education and approving the modules. We extend our heartfelt thanks to UNFPA for their funding support in carrying out this activity.

These modules have been developed jointly by the CEHAT team, the trained GME faculty, our mentors and gender experts. We thank each of them for their valuable feedback and suggestions on each draft. We would like to thank Dr. Shrinivas Gadappa and Dr. Priya Prabhu for guiding us at CEHAT through the project phase for administrative, strategic and intellectual inputs. They were always available and helped us navigate the system. We thank Dr. Hrishikesh Wadke for coming on board for developing the modules and helping in the pilot testing of the tools for the impact study. We are grateful to Anagha Pradhan for her extensive inputs in developing the modules for Community Medicine.

We also extend our sincere thanks to external reviewers for their critical feedback. We thank Dr. Manisha Gupte and Dr. Padmini Swaminathan for reviewing all the modules, Dr. Asha Oumachigi for Obstetrics and Gynaecology module, Dr. Rakhal Gaitonde for Community Medicine module, Dr. Rajendra Bangal for Medicine and Forensic Medicine and Toxicology module and Dr. Roopali Shivalkar for Psychiatry module. We thank Tejal Barai-Jaitly for critically reviewing the modules and helping in the finalisation of the content. We are grateful to Dr. Padma Prakash for language and content editing of the modules. We also thank Priyanka Shukla, Apurva Joshi and Vijay Sawant for helping us with referencing of the modules. We are grateful to Saramma Mathew for proof reading of all the modules.

We take this opportunity to thank our former colleagues from CEHAT who have contributed to the development of modules; we would like to thank Asilata Karandikar, Shreya Sen and Lakshmi Priya Menon who were involved in initial stage of module development. We would like to acknowledge Priya John and Ameerah Hasnain for their contribution in the content development for the Intervention modules related to the gender in medical education action research.
List of Contributors

The gender integrated modules have been a product of the joint efforts of 20 GME trained medical educators from seven medical colleges of Maharashtra in collaboration with CEHAT.

**CEHAT Team**

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Abbreviations

ANC - Antenatal Care
ANM - Auxiliary Nurse Midwife
ART - Anti Retroviral Therapy
ASHA - Accredited Social Health Activist
Ca- Cervix, Ca-Cx - Cervical Cancer
CEDAW - The Convention on the Elimination of all Forms of Discrimination Against Women
CHC - Community Health Center
CHW - Community Health Worker
CPD - Cephalopelvic Disproportion
CSA - Child Sexual Abuse
DV - Domestic Violence
EC - Emergency Contraception
ECV - External Cephalic Version
EID - Early Infant Diagnosis
FGD - Focus Group Discussion
FIR - First Information Report
GBV - Gender Based Violence
GDP - Gross Domestic Product
HBV - Hepatitis B
HBsAg - Hepatitis B Surface Antigen
HCP - Health Care Providers
HIV - Human Immuno Deficiency Virus
HRT - Hormone Replacement Therapy
ICDS - Integrated Child Development Services
IMR - Infant Mortality Rate
IPV - Intimate Partner Violence
IUGR - Intrauterine Growth Restriction
IUD - Intra Uterine Device
JSSK - Janani-Shishu Suraksha Karyakram
JSY - Janani Suraksha Yojana
MCH - Maternal and Child Health
MCQ - Multiple choice questions
MCTS - Mother and Child Tracking System
MLC - Medico-Legal Case MMR - Maternal Mortality Rate
Semester 4: Obstetrics

1. Sex, gender and health (Additional Lecture)

Gender content added: Concept of gender and sex, Interaction between gender and health

Lecture name: Sex, gender and health (Additional Lecture)

Subject: Obgyn

Semester no: 4

Duration: 2 hour

Methodology: Activities, Lecture

Resources:


This is a foundation lecture aimed at building a perspective on gender and sex.

**Key Points**

1. Gender is a socially constructed concept that affects the health of men and women. Gender analysis is an important tool in recognising health inequities.

2. Social disparities across class, caste, gender, religion, sexual orientation, and disability contribute to health inequities.

3. Doctors are also subject to same social conditioning and are likely to have similar biases as the rest of society. It is important to carefully explore their existing notions of gender and help them to develop a critical understanding.
4. Doctors need to understand how gender affects health seeking behaviour and health outcomes across social categories.

**Note to Educator:** Start by explaining why sex and gender may not be used synonymously and what the differences are between the two terms. Your lecture will introduce concepts such as gender roles, gender norms, patriarchy and how these affect men and women differently. The foundation lecture will lay emphasis on how gender affects the lives of all men and women including doctors. Further, the lecture will draw attention to social inequities as a result of caste, class, religion, sexual orientation, disability and its relation to health. This awareness will be critical for doctors to develop gender responsive health care practices.

Given below are four activities, each of which explores a different concept on gender. A participatory approach to teaching leads to better retention of concepts.

**Activity 1: Use of statements related to gender and sex**

Read out the statements and ask students to identify which statements relate to gender and which to sex. After the exercise, facilitation notes provided in the lecture content may be used. Explain the difference between sex and gender.

**Activity 2: Story of Munna and Munni for explaining social construction of gender**

You can adapt the activity on social construction of gender (Munna-Munni) to suit the needs and profiles of different groups of students (urban or rural) and include appropriate examples. You can substitute the original pictures with pictures of girls/boys, women/men at different life stages to come up with a different activity.

**Activity 3: An exercise that helps students to understand the concept of patriarchy**

For this ask students to recall names of ancestors from mother’s side and father’s side.

**Activity 4: Case Studies to explain the concept of intersectionality**

Case studies on the concept of 'intersectionality' will help students understand how social location related to caste, class, religion, sexual orientation, disability, amongst others; lead to inequities. For these case studies, you may divide students into several discussion groups.
Activity 1: Statements that help establish difference between sex and gender

Start the session with a game (Activity 1-Statements). The game is intended to show students that features that people are born with; i.e., biological; constitute what is termed 'sex' and features that are socially constructed constitute gender. Read out the statements one by one. Ask the students to raise their hand only if they think the statement is related to biological aspect "sex" and not if an aspect is related to "social influence". Read out the statements quickly without giving the students time to consult with their peers.

Statements used:

Women are gentle by nature.

Men are better at playing cricket than women are.

Women menstruate.

Women are better cooks than men.

Men are violent by nature.

Women have long hair.

Men have moustaches.

Women are better housekeepers than men.

Men cannot do housework.

Men cannot control their sexual desire.

Men grow bald as they grow old.
Women are protected from heart disease in their youth.

Women eat after the men have eaten their food.

Girls play with dolls and boys with cars.

Women have ovaries.

Men have more hair on their bodies than do women.

Women bear violence silently.

Boys' voices change as they grow up.

Men are not able to look after young children.

The body of a young girl gets more rounded as she grows up.

Women leave their mother's home when they marry.

**Key Points for Discussion after the Activity**

After the activity, pick up a few examples to discuss characteristics closely related to biological sex. Most physical characteristics like menstruation, childbirth, breastfeeding are definitely biological characteristics, therefore students would have identified them as biological. Biological sex is largely permanent while gender can be dismantled. One cannot prevent a man's voice from cracking; nor can he be enabled to have children.

You may use statements such as "women have long hair" to point out that both men and women can sport long hair, although the characteristic of long hair is associated with women and therefore has acquired a gender element. Such social conditioning starts at a young age and hence subconsciously long hair are associated with being a woman.

Make sure that students recognize that even biological sex is not just of two types - male and female. Some persons may be born with sex characteristics that do not fit the binary of male and female. They are called ‘Intersex’ and the term is used as a blanket term for different biological possibilities and variations which may include,
for instance, a large clitoris, absence of vagina, congenital absence of gonads among others. There could also be persons whose gender identity is not based on physiological appearance. Variations could also include people who may have female sex organs but identify themselves as men or vice versa. There are ways to change biology in those cases, if a person so desires. They are called ‘transgender’ and these include cultural categories such as hijras, transvestites as well as transitioning or post-operative transpersons. Transgender people may identify with either male or female gender identity, both, or neither.

Often if a baby is born with ‘ambiguous’ sex organs, parents are confused and scared and the attending doctor will try to straight jacket the child into either male or female at the behest of the parents. A surgery is commonly advised immediately to assign binary or male / female sex.

The prevalence of gender identity disorder (GID), now termed gender dysphoria (GD) is estimated to be approximately 1 in 30,000; although researchers have suggested that it may be significantly higher. The term gender identity disorder gave way to the term gender dysphoria in May 2013, the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV) replaced the term GID with gender dysphoria, recognizing that a mismatch between one’s birth gender and identity was not necessarily pathological. This shifts the focus from ‘treatment of an abnormality’ to ‘resolving distress over the mismatch’, dropping the loaded term ‘gender identity disorder’ to the more objective ‘gender dysphoria’ which in the latest ICD is names ‘gender incongruity’.

Activity 2: Munna and Munni story

The second concept introduced to students is Social Construction of Gender.

Narrate the story of Munna and Munni, a pair of twins -

**Situation 1**

*Let us imagine that twins, a boy and a girl, have been born to someone we know. We go to visit them in the hospital. They are wrapped in cloth from below the neck. Can we identify the sex of the children? When can we start identifying whether children are boys or girls? Do we have to wait until puberty when secondary sexual characteristics change?*

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Situation 2

Munna and Munni are three months old. They are both hungry. Does Munni cry less? Does she sacrifice her share of the milk for Munna? She does not. So how can we say that women are sacrificing by nature? Even when the twins are one year old, they both fight equally for toys, sweets, or their parents’ attention. So why do they become so different when they grow up? We need to visit the twins again to find out.

You may pose questions to students such as, 'when the mother breastfed both Munna - Munni while they were 3-4 months old, did Munni cry less if she was hungry, or say that she would drink less and let her brother to drink more or that she would drink later? It is important to reflect on what leads Munni at 12-years of age to serve food to Munna or clean his plate? When she fought over toys with her brother when they were a year old, why does she, post marriage, not ask her brother for her share of the property? These roles and behaviour are indoctrinated at a very young age and this is gender. Biological changes, on the other hand, would occur without any prompting. Whether or not a girl is told that she will menstruate, or a boy is told that his voice will change, both these things will occur at puberty naturally. This is biological sex. Identification of a girl or boy through external characteristics is possible only with the development of secondary sexual characteristics at puberty such as roundedness of hip, fat storage in buttocks among girls and growth of facial hair and cracking of the voice among boys. The identification of a girl or boy is difficult until the child reaches puberty. But based on the colour of clothes, length of hair on boys and girls, dress and accessories, a boy and a girl is identified as early as 1½-2 year of age.

Situation 3

The twins are now two years old. Munna is dressed in shirt and shorts. Munni gets frocks and dresses. Do the children choose their own clothes at the age of two? No. We decide this. Because Munna is a boy, he is expected to wear a shirt and not a frock. Next, because Munni is wearing a dress, she is asked to sit properly with her legs and feet close together and is told not to climb or jump in a way that reveals her underclothes. In time, she is told not to shout, and not to laugh loudly. The list never ends.
Situation 4

The twins are now six years old. We have been invited to their birthday party. We go to a toyshop to buy presents for them. What is the question the shopkeeper asks us even before he enquires about our budget? Whether the present is for a boy or a girl isn’t it? If it is for a boy, he shows us cars, bat and ball, planes, guns, mechanic sets, and so on, and if it is for a girl? Dolls, kitchen sets, embroidery and stitching sets, items to 'pretty up' such as hair clips, miniature cosmetics, fancy combs, and so on, are shown. We decide to buy a bat and ball for Munna and a doll with the kitchen set for Munni. Are these the children's natural desires? How do these expectations surface? What are the ramifications of these presents on the children?

Situation 5

Munna plays with the bat and ball outside in the open, away from home. Therefore, Munna gets a chance to go out, to learn to cross a road, to learn to negotiate with children of his age (or even older children, when they snatch his toys); he gets fresh air, his muscles develop, his appetite grows and he learns to face the big bad world outside his home. He becomes tough; he learns to handle situations on his own, and soon earns the confidence of his parents. They begin to trust him with outdoor work, and they begin to involve him in decision-making too.

On the other hand, Munni plays with the doll and the kitchen set inside the house, in the kitchen or in the corner of the living room. What is the script used when she is playing? "Feed the baby"; "Kiss the baby, its sleepy now"; "What have you cooked today"?; "What does your baby like to eat?"; etc. Munna can enter the house, banging his bat on the staircase, but if Munni bangs her doll on the wall, we immediately tell her not to hurt the baby!

What values are we inculcating in them? How are we preparing them for the roles that they will be expected to play when they grow up? How does this upbringing define what eventually comes to be considered 'natural' in men and women?
Situation 6

After a few days of playing with their own toys, the twins get bored and want to exchange their presents. Munni picks up the bat and ball and gets ready to go to the playground. What is our response to that? "You'll be the only girl, how can you play with the boys",

"What will the neighbours say?", "You'll tear your nice dress", "What will you do if someone follows you or harasses you?", "Why are you behaving like a tomboy?" etc. On the other hand, if Munna gets tired of going out and wants to play at home with Munni's doll, what would our response be to that? "Oh no, he's going to be a sissy when he grows up", "Why does he want to behave like a girl", "Where did I go wrong in bringing him up", "I hope no one notices him playing with the dolls, or they'll ridicule him in school", "He should be playing outside, not sticking to his mother's apron like this," and so on. If children refuse to play the gender roles we assign them, it creates a great deal of anxiety within us. We make them change their behaviour according to what we think is appropriate for their sex. We punish them if they resist. We even go to counsellors for behavioural therapy. Therefore, accepting a prescribed gender role is not as natural as we would like to believe; it is forced upon us by society.

What are the manifestations of such gender norms on Munna and Munni when they grow up?

Situation 7

Munna and Munni are now 20 years old. Munni will soon be married to a boy her father has chosen for her. She knows how to cook and clean, and is good at needlework and mending clothes. She has a degree in home science. Her parents have saved money for her dowry. They will give Munna the house and Munni the dowry. Munna has a degree in hotel management and is a chef in a good restaurant. He has a decent salary. Munni’s fiancé is a dress designer and designs clothes for a boutique. He also has a good annual income. The dowry from Munni's parents will help him establish his own shop.
We often say that women are better cooks than are men. Then why are most restaurant owners and world famous chefs men? If men do not mend their own clothes because they do not know how to stitch, then how is it that most tailors are men?

Roles that men and women perform are entirely socially determined and therefore gendered. Both men and women are able to perform a variety of roles, but certain roles are socially assigned to men and others to women. For instance, in most families, the woman cooks. However, in a restaurant, the chefs are mostly men. Similarly, it is the woman who normally mends clothes in the house, but most professional tailors and many dress designers are men. However, men as chefs or tailors and dress designers bring economic returns; but women carrying out these same activities are seen to be merely doing their duty towards family and household. Moreover, men are assumed to have characteristics such as competitiveness and the ability to negotiate in the world of commerce. This is a gendered perception and not always the reality. Gendered roles instilled in children are strengthened through institutions such as education system, media, market and medical system besides law and state policies.

Key points to be discussed after the narration

1. All the situations (in boxes) described above reiterate that "biological sex" at birth is the only natural phenomenon, whereas roles and responsibilities are based on gender. Behavioural traits too are socially determined. They are not biological constructs. Men and women both have feelings of anger, but they handle it and express it in different ways. Society accepts men being aggressive, but, expects women to be gentle.

2. The imposition of gender roles impact on women disproportionately. For instance, if girls wear jeans, they are seen to be 'diluting' culture, although men may wear western dress and not the traditional dhoti, kurta and topi, with impunity. Such personal matters as the length of hair, and whether it may be cut or not, are prescribed on the basis of gender. In a patriarchal set up, women may not be able to take the decision of cutting their hair without consulting their families.

3. Society accepts the concept of 'sadva' and 'vidva'. A married woman (sadva) does not cut her hair, but the moment she becomes a widow (vidva) she is expected traditionally to shave off her hair. In most cultures, hair symbolizes in convoluted ways; sexuality, sensuality and a measure of beauty.
Activity 3: An exercise that helps students to understand the concept of patriarchy

Ask students to recall the names of their ancestors—names of their grandparents, great grandparents, and so on. Follow this up by asking students to name mother's natal name, her mother's name, her maternal grandmother's and so on. Discuss why most students are unable to recall the names of ancestors on the mother's side. Get students to explore the reasons for the selective information they possess.

**Key Points from the Activity**

In simple terms, patriarchy means 'rule of the father'. Historically and sociologically patriarchy also encompasses the fact that not only are resources owned by men, but that they are also passed on from the father to the son. Decisions in the home, the community, the society, or in the spheres of politics, religion, or the economy are all taken by men. This power gets transferred from one generation to another through the passage of wealth and privileges to the sons of the family. In fact, over the centuries, this patriarchal power system has taken deep roots in society.

Discuss with the students the ways in which men's names are more easily remembered because they form the middle (father's) name. Women's names or family names are easily forgotten. Thus, women are obliterated from the family history and what is recorded in a long string of men's names.

**Elaborate on the five aspects of patriarchy**

1. **Property:**
   Traditionally, women do not inherit from the families they are born into. Further, they are also seen as a liability due to the tradition of dowry, which though illegal, continues to be rampant across the country. Dowry is given in kind or cash to the husband and the marital family at the time of marriage. The woman has no right over it nor does it ensure her of any rights in the marital family. The demand for dowry often persists even after getting married as well, leading to harassment and domestic violence (DV).

2. **Production:**
   In general men and women are socially assigned different work. This means that men's and women's work is differently recognized and assigned a gender-related value which gets translated as different wages for the same work. Further, men and women do not have the same degree of control over resources or earnings.
3. Reproduction:
Reproduction is not just a biological phenomenon; it's also a gendered phenomenon. Pregnancy within marriage, especially with the expectation of a male heir is a matter of celebration. However, a pregnancy and birth outside marriage is considered a matter of shame and despair. Before marriage, a woman is not expected to have a child at any cost, and after marriage she is duty bound to have a child at all costs. These notions translate to attitudes and behaviours even in a setting where a woman comes seeking an abortion. If an unmarried woman seeks an abortion these socially embedded notions may compromise her access to safe abortion services. In yet another setting, camps for sterilization are tacitly only meant for women who are married. What happens when a widow comes for sterilization? These are some examples of ways in which patriarchy seeps into medical systems.

4. Sexuality:
Control over women's sexuality ensures an overt assertion of men's power over all aspects of a woman's life. It also ensures that blood lines of progeny are kept clean and the 'heir' is truly a legitimate progeny of the husband. There is an expectation that a woman needs to be a virgin at the time of marriage. Rape and threat of rape is another way in which women's sexuality is controlled through notions of 'shame', 'honour' and 'family honour'.

5. Mobility:
Control over sexuality also leads to control on a woman's mobility. The imposition of purdah restriction on leaving the house and limits on interaction between the sexes, are some of the ways by which the patriarchal society controls women's mobility and freedom of movement. The cultural belief is that only a woman who has been "chaste" can be a victim of rape. The origin of the two finger test can be traced to the concept of chastity. The focus of such a test is not on sexual violence but on supposedly detecting the loss of virginity.

Activity 4:
This activity orients medical students to the concept of intersectionality. The activity involves dividing students in three groups and giving them case briefs. Each case brief has profiles of three women who have come for treatment.

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**Case Brief 1:** A 40 year old woman who sells balloons, has 2 children and a sick husband. Another woman is 25 year middle class deserted by husband, living with parents with no children. And third one is a 30 year old tribal woman, living in conflict and her brother is a part of extremist group.

**Case Brief 2:** A 30 year old woman who is serving life imprisonment for killing her violent husband. Second is a 35-year middle class rural woman who is a second wife of her husband. The third is a 20 year old lesbian woman in love with a 30 year old married woman. Her family members want her to get married and are looking for groom.

**Case Brief 3:** A 30 year old widow, living in rural area and her husband died of HIV-AIDS a year earlier. Second is a 25 year old Dalit sex worker. Her boyfriend had sold her into a brothel when she was 15 year old. Third is a middle class, 20 year old. She had an accident 4 year ago and has been in wheelchair since then.

Students are asked to discuss in small groups:
What brings these women to you?
Are you going to have same strategy for all, is there variation? If yes why and if not, why?
Can you identify some of the social structures from which these women have come?

**Key Points to Facilitate Discussion Related to Group Work**

Concept of intersectionality is a tool for analysis, advocacy and policy development. 'Gender' alone is not the axis of discrimination, other identities of a person like caste, class, age, ethnicity, disability and sexual orientation also determines the person's position in the society. An intersectional approach to gender equality acknowledges that people have different experiences based on their social location such as caste, class, religion, sexual orientation, disabilities amongst other. Thus women or men cannot be seen as having a homogenous identity.

1. There are important sources of power. Generally men have more power than women. Further if a person belongs to the majority religion, is a heterosexual, belongs to the economically privileged class, is educated, employed, owns property, lives in an urban locality, is married, able bodied (i.e. does not have any physical disability), free from being institutionalised, is a citizen (not a refugee), he can have far more power than the one who is not. The higher the possession of these characteristics, the greater the power.
2. Men or women are not a single homogenous group. Within patriarchy some women are less victimised than others; especially those women who follow the rules by getting married, bearing sons; may be in a powerful position as compared to women who are widowed, separated, divorced, childless or have only girls.

3. Similarly, the position of power that a person enjoys is not permanent and can change. For example, the wife of a rich man in a village who owns fields has far greater power than a labourer working on her fields on daily wages. She can scold the labourer, but not her husband. However, when her husband is away in the city leaving her alone with the labourer at home, power can shift to the labourer as she becomes sexually vulnerable.

4. Gender and Religion: Women belonging to the minority community have to face majority as well as minority fundamentalism. After the muslim-targeted riots, Muslim women stopped voicing abuse by their husbands out of fear that the husband would be charged with grave offences and never be released. Thus they trade their human rights for the freedom of their men. Minority women are left with few options.

5. Sexual Orientation: Another important and much debated aspect is the sexual orientation of people. Under Section 377 of the IPC, homosexuality has been condemned and called unnatural. The recent change in law is important as it decriminalises homosexuality.

6. Transgenders and Intersectionality: When a transgender person comes to the health facility, there is confusion as to which ward the person will be admitted to - the male ward or the female ward or which toilet the person will be allowed to use. Health systems are not sensitive to such people. They are denied other rights too, such as the right to education. Such violation of their rights by the society leaves them with few options to earn a livelihood. They turn to begging and prostitution, which results in further ostracization.

I. Gender and Medical Professionals

The concepts discussed above focused on developing a perspective on the concept of sex, gender and patriarchy. It is important to understand that doctors also come from the same social environment and therefore doctor - patient relationship is also affected by these notions.
Some of the common gender stereotypes that we see in relation to patients are:

- Male patients better understand the approach of doctors than female patients.
- Female patients have relatively more unreasonable expectations of doctors than do male patients.
- Women, more frequently than men, want to discuss with doctors problems that do not belong in the Out Patient Department (OPD). Women have unreasonable expectation of emotional support from doctors.
- Male patients are less demanding than female patients.
- Men do not go to a doctor for minor health problems.
- Women access health care facilities more than is actually needed.
- Medically unexplained symptoms develop in women because they complain excessively about their health.
- It is easier to find causes of health complaints in men because men communicate in a direct way.
- Women tend to be hysterical owing to their uterus.

Gender stereotypes also exist in relation to doctors and the medical profession

- Forensics and Surgery are not appropriate fields for women doctors because women are not able to deal with corpses. Nor are they capable of performing surgical interventions.
- Orthopaedic doctors are mostly men because this field requires physical strength.
- Women doctors are unable to do field work or research work.
- Male doctors should not take up Obstetrics and Gynaecology.
- Preventive and Social medicine is best for women doctors.
Doctors should recognize these stereotypes, which are a consequence of social construction of gender that impacts personal lives as well as professional lives. The medical profession too is prone to gender bias and discrimination.

With stereotypical characteristics and gender roles, patriarchy creates an unequal power hierarchy between men and women. Men with their stereotypical characteristics and role in the society are valued more than women. This creates a system of discrimination in access to resources and control over them.

In a society where a male child is valued as a future financial support system for the parents, he is more likely to be better fed and better educated than female children. In a society where men are seen as the decision makers in a family unit, a woman may not have control over financial resources or its use, even though she may be a wage earner.

**Role of Doctor**

- Doctors must recognise the difference between gender and sex. Gender should not be understood as a binary. It is also important to recognise how gender stereotypes are formed about patients as well as about men and women in the medical profession.

- An understanding on gender can provide doctors with the perspective on men, women, trans gender persons, their unique health problems, challenges in access to health care and health outcomes.

- This is a foundation lecture aimed at building a perspective on gender and sex. Specific aspects of gender as a social determinant of health will be taken up in subsequent topics in the curriculum so as to develop gender sensitive health services.
2. Physiology of menstruation

Gender content added: Management of menstruation in adolescent girls

Lecture name: Physiology of menstruation
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion, Role play
Resources:

Handouts:

**Key Points**

1. Reliable and accurate information around menstruation and menstrual practices are largely unavailable to adolescent girls.

2. Menstrual taboos are discriminatory and can worsen health conditions such as anaemia.

3. Unhealthy and secretive practices to manage menstruation may have health consequences such as reproductive tract infections.

4. Conducting hysterectomy on adolescents with intellectual disability to prevent their menstruation severely affects their physical and mental health and it needs to be avoided.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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<tbody>
<tr>
<td>Student should know that lack of knowledge about menstruation is common among adolescent girls in India</td>
<td>Student should be able to impart accurate knowledge about menstruation and menstrual hygiene to adolescent girls</td>
<td>Student should be sensitive to the implications of living conditions and socio-economic background of adolescents on menstrual hygiene</td>
</tr>
<tr>
<td>Student should be aware that adolescent girls face difficulties in menstrual management</td>
<td>Student should be able to precisely explain appropriate menstrual management and suggest practical ways of doing that to girls.</td>
<td>Student should be sensitive while dealing with problems of adolescent girls about menstrual hygiene and advise them about menstrual hygiene</td>
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**Context:** During menarche lecture

**Note to Educator:** Students should be equipped to advise adolescent girls regarding menstruation and its proper management. The student should be skilled to overcome inhibitions while imparting knowledge about menstruation to adolescent girls (this skill should be reiterated in clinics as well) and advise appropriately regarding menstrual hygiene.

Content

I. **Menstruation is a natural physiological process and menarche is one of the many physiological changes that occur in adolescent girls**

   A) Cultural practices and taboos

   In several communities in India, menarche is seen as a significant milestone in a girl's life and is marked by rituals that celebrate it. Menarche is celebrated as it marks the beginning of a fertile phase in a woman's life. But the onset of menstruation is also intertwined with menstrual taboos, making it an unpleasant experience for girls.
Priya, 13 years old, lives in peri-urban Kanpur. Despite having limited disposable income, Priya's mother sends Priya to coaching classes (after-school private lessons) in addition to school. Priya does not like going to school on the days she menstruates because the school toilets are dirty. More importantly, Priya is frustrated by the fundamental shifts occurring in her life: "I wish it (menstruation) would not happen to me. Since I got my period, my mother told me I cannot play outside, I should come home straight from school, I should not sleep next to my brother and I should behave like a grown up." (Excerpt from 'Menstrual Health in India: Country Landscape Analysis', report by FSG, pp.4, 2016)

'Culture of silence' prevails around menarche and menstruation, which creates considerable confusion, shame and secrecy around menstruation among adolescents. Numerous social taboos related to menstruation restrict mobility and access for menstruating women and girls. For example, menstruating women and girls have restricted access to cooking areas or places of worships. As menstruating girls and women are considered "unclean" many religious places, do not allow women of reproductive age to enter the worship places / temples.

B) Lack of Sanitation and Hygiene in Schools

Due to the social stigma girls may feel ashamed or embarrassed to dry their menstrual cloth in the open, leading to unhygienic practices such as reusing cloth that are not completely dry. In a meta analysis of menstrual hygiene management among adolescent girls in India, 64 studies reported on school absenteeism associated with menstruation. Girls' reasons for absence were physical discomfort or pain, lack of water, hygiene and disposal facilities in school toilets, fear of staining their clothes and restrictions imposed by relatives or teachers. In addition, use of cloth was associated with school absenteeism.4

A study conducted in 2012 showed that 40% of all government schools lacked a functioning common toilet and another 40% lacked a separate toilet for girls.5

Several studies report that girls do not change pads in schools, or that girls would go to school if proper toilet facilities existed.

Adolescent girls from poor communities do not have access to sanitary napkins and are unaware of how to use and dispose of napkins. Adolescent girls coming from a lower socio-economic section most commonly use cloth as an absorbent, which is reversed after washing. However, lack of privacy and access to resources like water, soap, washing space, drying space and storage space can affect the practices related to maintenance of menstrual hygiene. Thus, education of adolescent girls especially in rural areas where there are lack of toilet and sanitation facilities is compromised with initiation of menstruation. Further, there are few sources available to adolescent girls to attain accurate information about menstruation and know about hygienic practices to manage it.

The lack of accurate information about menarche and menstruation, the social taboos and the absence of proper management of menstruation can lead to many adverse effects on the physical, mental and emotional health of adolescent girls.

In a study carried out in Nagpur among 224 adolescent girls, 65.18% girls were found to have suffered from one or more menstruation related morbidity. High prevalence of dysmenorrhea (53.60%) was found among adolescent girls. Backache was a common morbidity (41.52%). Only 37.67% girls sought health care, while 62.33% remained silent without approaching health care as they felt no need or reason for treatment.

There is a high prevalence of anaemia among young girls in India. As per the National Nutrition Monitoring Bureau Survey (2006) the prevalence of anaemia among adolescent girls in the age group of 12-14 years is 68.6% and in the age group of 15-17 years is 69.7%. The NFHS-4 data shows that 53.5% women in the age group of

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15-49 years are anaemic.\textsuperscript{10} Along with poor diet, heavy menstrual bleeding can contribute to the anaemia.\textsuperscript{11}

Most of the iron deficiency anaemia is preventable with a proper diet. However, adolescent girls often face discrimination in the distribution of resources within the households and are unable to meet their nutritional requirements. Further, during their menstruation, restrictions such as avoiding certain kinds of food, access to kitchen and food, taboo on sleeping on the bed, etc. are applied. Such discriminatory practices can lead to worsening of women’s health during menstruation.

C) Menstruation and Adolescents with disabilities:

From the above discussion, it is quite evident that puberty-menarche and menstruation can be stressful events in the life of an adolescent. For girls with disabilities, managing menstruation can be quite a challenge.

Adolescent girls as well as women with physical and/or mental disabilities and mental health conditions are often forced to undergo hysterectomy as it is assumed that they are incapable of taking care of their menstrual hygiene.\textsuperscript{12} Hysterectomy should be done only when medically indicated as it can have serious consequences on the mental and physical health of adolescents.

Additionally, since hysterectomy prevents pregnancy, sexual abuse by caretakers in institutions or guardians at home often goes undetected.

Performing hysterectomy when not medically indicated is a violation of the bodily integrity of the girl / woman. It is an unethical practice with serious health implications for the patient.

Guardians or caregivers should be educated about the management of menstruation for disabled adolescents.


Alternative strategies are suggested to avoid unindicated hysterectomies among mentally disabled girls, such as:

- Increasing personnel, financial and infrastructural support to the state run institutions for the mentally disabled.

- Qualitatively and quantitatively improving the number of homes for the mentally disabled.

- Provision of physical, intellectual and psychological stimulation to mentally handicapped children without preconceived biases.

- Training mentally handicapped children in personal hygiene (including menstrual care) through repeated and innovative inputs. Providing adequate undergarments and menstrual pads to all girls in state homes.

- Changing the form and content of training for teachers and caretakers so that biases against women’s bodies and menstruation are countered.

- Ensuring that mentally handicapped are not subject to sexual and physical abuse in any homes for the mentally disabled.

- Increasing the health care budget for the disabled in absolute terms and as a percentage of the Gross Domestic Product (GDP).

- Providing financial support, crèches, day care centres, counselling services, rest and recreational support to the parents of mentally disabled.

**Role of Doctor**

- A doctor can play an important role while dealing with adolescent girls coming in with menstrual problems. The doctor can deal sensitively with their queries and misconceptions. He/She can also provide accurate information about menstrual management to the girls.

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• It is important for a doctor to be mindful of the social taboos around menstruation and advise both adolescent girls and their guardians about appropriate and evidence based care that must be taken during menstrual period. When women and girls seek advice on postponing menses on account of religious functions, doctors should educate them on the health consequences of taking these medications, particularly over a long duration.

• Doctors need to seek the extent of information that adolescents have about menstruation and provide necessary information in simple terms, maintain privacy while discussing these issues and provide appropriate treatment, where required.

• Doctors need to be sympathetic and sensitive to the needs of girls with physical and mental disabilities. Hysterectomy should be recommended only if medically indicated. Doctors should be aware of alternative strategies to avoid un-indicated hysterectomies as mentioned above. Special attention should be paid if the girl / women are suspected to have been sexually abused. In such cases, necessary immediate action should be taken.

**Tools**

Medical educator can read the case study to carry out discussion on menstrual taboos and ways in which doctors can handle such a situation

**Case Study:**

*Rani is a 14-year-old girl. She began to menstruate a year back. Since nobody had told her about menstruation, she was scared when she first saw the blood. Her mother told her to not discuss it with anyone. She also warned her to keep away from the kitchen and places of worship at home, and not to enter temples. She gave Rani some old cotton cloth and told her to use it during menstruation. Rani now feels very awkward and shameful when she gets her period. She suffers from heavy bleeding during menstruation but she was told it is normal. She now had burning sensation during urination. When it was unbearable she told her mother and she was brought to the hospital. During a medical check-up in her school, the doctor also found that she is anaemic.*
Questions for Discussion

Q. What do you think is the cause of burning micturition in case of Rani?
A - The educator can flag issues related to secrecy around menstruation, practices that make young girls shameful about menstruation and its effects on their health. There is a lack of discussion between the mother and daughter about menstruation and how to maintain hygiene. Rani does not have any source of information. Lack of information about use of absorbent pads, cleaning private parts with water, changing pads at intervals may be reasons for contracting a urinary tract infection.

Q. What are the ways to elicit history in such cases?
A - The educator should be able to take Rani in confidence and speak to her about menstrual practices. Questions related to use of cloth, frequency of changing the cloth, washing and drying, nature of diet can assist the doctor in understanding Rani’s context. Rani should be made comfortable and the aspect of menstruation should be discussed as a biological feature and therefore dispel myths about pure and impure blood.

Q. What advice should the doctor give Rani and her mother?
A - The doctor should discuss with Rani and her mother, the reasons for UTI. Not changing sanitary pads / cloth for long duration leads to skin irritation which can later lead to an infection when the skin breaks. Practices such as cleaning from back to front anus to vagina leads to introduction of bacteria from bowel to vagina. If the cloth used to soak menstrual blood is not washed properly and dried in sunlight, the bacteria from it will not be killed and they can travel back in the vagina. After this information is provided, doctor should also discuss with Rani’s mother in order to dispel myths and how these lead to unsafe unhygienic and irrational practices during menstruation.

Role Play

The educator can also encourage students to carry out a role-play to practice how to advise adolescent girls regarding menstruation. One student plays the part of a doctor and another of an adolescent girl. The scenario to be enacted is as follows: An adolescent girl comes to the clinic; she has questions regarding menstruation, which she puts to the doctor (questions are mentioned below).

Students can be asked to prepare responses around usual questions adolescents may ask about menstruation -
● Why does menstruation occur?

● Why do women have stomach ache, backache and nausea during periods? How much bleeding is 'normal'?

● Do irregular periods cause weight gain?

● How can cleanliness be maintained during periods? What kind of exercises should be done during periods?
3. Puberty and menopause

Gender content added: Importance of adolescent sexuality education, Sexual violence faced by adolescent girls

Lecture name: Puberty and menopause
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion, Role play
Resources:

Handouts: ---

Key Points

1. Recognising adolescence as a stage related to being in relationships, becoming sexually aware and active.

2. Recognising that adolescent girls are vulnerable to sexual abuse and violence.

3. Ensuring sexual and reproductive health and rights of adolescents can promote safe sexual practices, improve access to safe contraception and abortion and encourage health-seeking behaviour.
## Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should know that adolescents face number of challenges related to their sexual and reproductive health</td>
<td>Student should be able to impart sex education to adolescents in easy and understandable language</td>
<td>Student should acknowledge that adolescents can also be sexually active and have a sensitive and unbiased approach towards it</td>
</tr>
<tr>
<td>Student should know that girls face different types of violence during puberty</td>
<td>Student should be able to recognise signs of violence in adolescent girls</td>
<td>Student should be sensitive while dealing with girls who are survivors of violence and ensure that they do not revictimise them</td>
</tr>
</tbody>
</table>

### Context:
During lecture on Puberty

### Note to Educator:
Adolescent sexuality should be explained in the context of sexual and reproductive rights of adolescents so that students can promote safe sexual practices and encourage health seeking behaviour of adolescents.

### Content

#### I. According to the World Health Organisation (WHO), Adolescence is defined both in terms of age (spanning the ages between 10 and 19 years) and in terms of a phase of life marked by special attributes. These attributes include:

- Rapid physical growth and development.

- Physical, social and psychological maturity, but not all at the same time. Sexual maturity and onset of sexual activity.

- Experimentation.

- Development of adult mental processes and adult identity.

- Transition from total socio-economic dependence to relative independence.
Adolescents face challenges at various levels, like at the family or household level. The barriers include lack of family support, unequal gender norms and limited communication between parents and adolescents on sexual and reproductive health matters. The existing health system does not recognise the diverse needs of youth and is not conducive to or supportive of providing unbiased services to adolescents, particularly those who are unmarried.

The differential process of gendered socialization of boys and girls continues and intensifies during adolescence. This can have a serious impact the sexual and reproductive health of adolescent girls and boys, due to which they suffer from a number of health issues even later in life.14

The sections mentioned below provide an overview on how young boys and girls are socialised -

A) Socialisation of adolescent boys:15

Gender role differentials intensify and widen during adolescence, when boys enjoy new privileges reserved for males such as autonomy, mobility, opportunity and power; while girls endure restrictions when their parents curtail their mobility, withdraw them from school and closely monitor their interactions with males.

Some of the typical stereotypes associated with boys are that they should be 'active', 'aggressive' and 'assume leadership'. It has been argued that since boys have to assume major responsibilities in their families when they grow up they are prepared for these roles. It all leads to the construction of stereotypical masculinity. Masculinity and sexuality are linked through sexual health anxieties, coercive sexual behaviours and sexual control.

Pressure from peers and adults influence the way men approach sexual relationships and often encourage them to engage in risky sexual behaviour.

Gender stereotypes of "submissive" females and "powerful" males may restrict access to health information, hinder communication and encourage risky behaviour among men and women in different but equally dangerous ways. Ultimately they increase

vulnerability to sexual health threats such as violence, sexual exploitation, unplanned pregnancy, unsafe abortion and sexually transmitted infections (STIs) including human immuno deficiency virus (HIV). These differing social disadvantages have many direct and indirect effects on adolescent sexual and reproductive behaviour and future health and well-being.

B) Socialisation of girls

Families restrict social and physical mobility of their young girls by confining them to the domestic sphere. The reasons for this confinement are two-fold: keeping them out of public arena to protect them from sexual abuse or engaging in any consensual sexual activity and keeping them in the household to prepare for their lifelong role as wife and mother.

They are expected to assist their mother and other female relatives with domestic duties of childcare, food preparation, agricultural work, etc. They are encouraged to be docile and compliant. Highly restricted mobility for girls are also often justified on the grounds of their protection from harm and are borne out of concerns about girl's sexuality and sexual safety.

Girls are associated with stereotypes of being 'beautiful', 'affectionate', and 'emotional' and 'caring'. Dictated by patriarchal institutions and values women are socialised to be good, obedient and sacrificing daughters, wives and daughters-in-law. They are trained not to challenge discrimination, subordination, exploitation and subjugation at various levels in the society and systems.

The power imbalance between men and women make it impossible for women to refuse unwanted and unprotected sex and negotiate condom use or use contraceptives use. Women in general, and adolescent girls in particular, cannot even initiate discussion or action on adoption or using contraception, since matters of sexuality or reproduction are considered 'shameful' and in the male domain.

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An emphasis on preserving women's virginity before marriage, in fact, increases their vulnerability and mobility. Fears that people will suspect they are sexually active prevent many young women from even asking questions about sex or seeking reproductive or sexual health services.

C) Impact of gendered socialisation on adolescent girls

Early marriage—Despite the law prohibiting marriage of girls before the age of 18 years, significant numbers of young girls continue to be married before they turn 18 years of age.

A youth study conducted shows that only 28% women aged 15-24 were practicing contraception. Adolescent girls were only one-third as likely as young women (20-24 years old) to currently use contraceptives, and young women from the poorest households only as half as likely as those from the richest households to do so.\(^{20}\) This also brings forth the issue of access to contraception for women belonging to different classes.

Consequent to early marriage, child bearing is initiated early and multiple pregnancies characterize the life of even young adolescent girls.

Unplanned pregnancy and abortion—Unplanned pregnancy is experienced by considerable number of young women. NFHS 3 reported that as many as 14% and 18% of births to adolescent mothers and young mothers were unplanned.

Young women, irrespective of their marital status are more disadvantaged in seeking abortion. A major factor delaying timely access to safe abortion services is the lack of awareness among the young about the legality of abortion as well as information on facilities providing safe and legal abortion or providers of legal abortion services.

A study showed that unmarried adolescents usually sought informal providers and travelled to considerable distance out of their place of residence to seek abortions. These adolescents reported that they did so to keep the pregnancy a secret from the community, repeated visits and judgmental attitude of the providers in public hospitals were some of the facts guiding them in their choice of providers.\(^{21}\)


Adolescent girls also face physical and sexual violence, which can have a detrimental effect on their health. Forced or coercive sexual relationships also put them at a risk of getting infected with STIs and HIV/AIDS. Thus, adolescent girls have a number of unmet needs with regards to their reproductive and sexual health.

Example of Good Practice of dealing with adolescent sexual issues -

Sweden has youth friendly health services in youth centers, present in most of the municipalities. Medical care is free for those who are under 20 years old in most parts of Sweden. Young people can attend any medical service unit without their parent’s permission or knowledge. Preventive services including school health and sexual reproductive health services are free. All communities offer contraceptive services. The youth center has a mid wife, social worker and or psychologist or a part time physician. The core competence of the youth centers is in health promotion and sexual reproductive health problems, but they also offer psychological support and counselling. Condoms are freely distributed in youth centers and contraceptive pills are generally subsidised, as is the morning after pill for those under age of 20 years.

Similar youth centers are also present in countries like Georgia, United Kindom, Portugal, Russia, Switzerland, etc.

In India, the Ministry of Health & Family Welfare has launched a health programme for adolescents, in the age group of 10-19 years, which would target their nutrition, reproductive health and substance abuse, among other issues -

Rashtriya Kishor Swasthya Karyakram (RKSJ), GOI. 2014
(Source: [http://nhm.gov.in/rashtriya-kishor-swasthya-karyakram.html](http://nhm.gov.in/rashtriya-kishor-swasthya-karyakram.html))

The key principle of this programme is adolescent participation and leadership, equity and inclusion, gender equality and strategic partnerships with other sectors and stakeholders. The programme envisions enabling all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well being and by accessing the services and support they need to do so.

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The RKS programme, or the National Adolescent Health Programme, seeks to comprehensively address the health needs of the 243 million adolescents in the country. It introduces community-based interventions through peer educators, and is underpinned by collaborations with other ministries and state governments.

To guide the implementation of this programme, MOHFW in collaboration with UNFPA has developed a National Adolescent Health Strategy. It realigns the existing clinic-based curative approach to focus on a more holistic model based on a continuum of care for adolescent health and developmental needs.

The Objectives are:

- Improve Nutrition
- Improve Sexual and Reproductive Health
- Enhance Mental Health
- Prevent Injuries and violence
- Prevent substance misuse

**Role of Doctor**

- Doctors need to understand and acknowledge that adolescents have sexual desires. Doctors need to be especially sensitive to the needs of adolescents and learn to communicate with them about sexuality and mutually respectful relationships with partners. They should acknowledge without prejudice that many adolescent boys and girls are sexually active.

- Doctors can actually play an instrumental role in addressing the issues surrounding sexual and reproductive rights of adolescents. Sexual education should be imparted to them in an understandable language.

- Adolescents should be made aware of the contraception options available, and they should be encouraged to choose the most suitable method from the different options.

- In case of unwanted pregnancies, particularly among unwed adolescent girls, medical termination of pregnancy (MTP) services should be provided without prejudice.
4. Physiology of ovulation / conception / implantation

Gender content added: Gender aspects of infertility

Lecture name: Physiology of ovulation / conception / implantation
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion, Case study

Handouts: ---

Key Points

1. It should be recognised that both partners are responsible for conception.

2. Couples need to be explained that infertility has to be investigated in both the partners.

3. The couple should be counselled regarding management of infertility.

4. It needs to be appreciated that childless women and to some extent men are stigmatized in the society and it can be an underlying cause of violence in case of women.
Learning Outcomes

<table>
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<tr>
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<tbody>
<tr>
<td>Student should be aware that it is must for both the partners to be tested for infertility</td>
<td>Student should be able to convince the couple (especially male partner) to get tested</td>
<td>Student should refrain from using language like 'at fault' and have an emphasis on treatment</td>
</tr>
<tr>
<td>Student should know that women face violence if they are not able to give birth to children</td>
<td>Student should be able to ask about violence</td>
<td>Student should be sensitive while dealing with women facing violence owing to infertility / childlessness</td>
</tr>
</tbody>
</table>

Context: While teaching conception

Note to Educator: The educator should emphasise the point that both partners should be tested for infertility.

Content

I. Magnitude of infertility in India

- The WHO estimates that the overall prevalence of primary infertility in India to be between 3.9 and 16.8%.
- According to a recent report on infertility in India reproductive anomalies or disorders in the males account for nearly half the of infertility cases.

II. Social Consequences of infertility

- Childless men and women are stigmatized and are likely to be discriminated against. Often the ill effects of childlessness are far more severe for women than they are for men. Women who fail to give a live birth are often branded as being inauspicious.

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• Childless women also face social discrimination in many forms (restriction on their participation in social celebrations, for example) and allowing husband to remarry.

• Evidence suggests that women diagnosed with infertility are subjected to marital violence. The burden of infertility falls unequally on women and they face a lot of stigma and discrimination. Data collected by NFHS-3 from 23,722 women in reproductive age group by household survey shows that 2,023 (8.5%) women were infertile and 21,699 (91.5%) women were having at least one child. Out of total 2,023 infertile women, 1,574 (77.8%) have experienced physical and/or sexual violence in last 12 months. Out of total 21,699 women having at least one child, only 1,332 (6.1%) have experienced physical and/or sexual violence in last one year. This shows that there is significant association between Infertility and GBV (p<0.001). Based on the study findings the recommendations are: (i) Infertility management should be coupled with counseling on GBV; (ii) Appointing a professional counselor in infertility management team; (iii) Infertility management specialist should be sensitized about the GBV\textsuperscript{25}.

**Role of Doctor**

• A doctor should be sensitive in dealing with cases of infertility.

• A doctor should encourage testing of both the partners.

• A doctor should also explain the links between health conditions such as STIs, genital tuberculosis (TB), tubal blockages; which can lead to infertility and encourage treatment on those accounts.

• A doctor should be alert to recognize signs and symptoms of violence that a woman may be subjected to owing to infertility.

• There should be privacy when the doctor is seeking the woman’s history and when examining her. Only if the woman asks that the accompanying family member / friend be brought in to the examination space should the doctor initiate it.

Doctors should take care that her/his language should not be judgmental and should not attempt to fix fault. The approach should be to let the couple know about the health issue and what steps needs to be taken.

Medical educator can start the session with the use of a case study -

Case Study:

Sarita is a 25 year old woman, has been married for two years. She has come to the clinic along with her mother-in-law, who complains that her daughter-in-law has irregular menses and has not been able to get pregnant. She regards this as a 'fault' in her daughter-in-law and wants to know what is wrong with her. When asked about Sarita’s husband, the mother-in-law says that he travels frequently for work. Sarita is silent throughout the conversation and does not utter a single word.

Question and Points for Discussion

What will be your response to the case as a doctor?

The educator should flag the following points:

1. Requesting the mother-in-law to wait outside, so that a doctor can discuss problems with the woman in private.

2. During taking sexual history ask simple questions to understand the nature of sexual relationship and its frequency such as "Does your husband work at night", "Does your husband travel a lot", "Do you have a room for yourself". Answers to these questions will help to understand if Sarita has a private room/ space to have sexual relations, if the couple is able to engage in sexual relations at the frequency required to become pregnant, if Sarita has information on what leads to pregnancy etc. This way the doctor explores the nature of sexual relationship between the couple.

3. Doctor should be able to stress that childlessness could also be because of male infertility. The doctor should explain the importance of the woman’s husband being tested and explain how it can affect the treatment process. In addition, the doctor should insist that the couple come together for the next visit.
4. The doctor should sensitively ask the woman if she is facing violence at home owing to the childlessness, and should seek to know if she is physically assaulted for not bearing a child, if she is taunted and excluded from social and religious activities, or if she is threatened about the husband’s remarriage or divorce. A doctor should be sensitive while posing these questions.

5. A doctor should refrain from using discriminatory language and lay stress on treatment rather than labelling or assigning fault.
5. Early development of human embryo

Gender content added: Determination of the sex of the foetus, Hereditary passing on of genetic disorders

Lecture name: Early development of human embryo
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion
Resources: ---

Key Points

1. A baby's sex is determined at the time of conception. When the baby is conceived, a chromosome from the sperm cell, either X or Y, fuses with the X chromosome in the egg cell, determining whether the baby will be female (XX) or male (XY). Despite the science behind determining sex, women are often blamed for producing girls. Doctors can have an important role to provide the correct information to family members and women.

2. Pregnant women and their partners should be screened for genetic disorders and the planning of the pregnancy should be done accordingly.
# Learning Outcomes

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<tr>
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<tbody>
<tr>
<td>Student should be aware that in many situations women are blamed for giving birth to daughters</td>
<td>Student should be able to effectively send across the message to the woman and her family that it is the 'X' or 'Y' chromosome bearing sperm from man that decides the sex of the foetus</td>
<td>Student should be sensitive to the fact that women are blamed and discriminated for giving birth to girl children</td>
</tr>
<tr>
<td>Student should be aware that women are blamed for passing on genetic disorders to the child, even though it may be passed on from the father</td>
<td>Student should be able to counsel the couple about hereditary and passing on of genetic defects and that it can involuntarily pass from either of the parents and nobody (either the mother or father) should be blamed</td>
<td></td>
</tr>
</tbody>
</table>

**Context:** While teaching early development of human embryo

**Note to Educator:** The educator should emphasise that it is necessary to explain convincingly to the couple/relatives that "X" or "Y" chromosome from the man is responsible for the determination of the sex of the child. Doctor needs to effectively convey that genetic disorders are likely to be passed on to the child not only from the mother, but also from the father.

## Content

Indian society in general shows a strong son preference. Religion, culture, family and community all reiterate son preference. A woman is held responsible for giving birth to daughters.

Women who do not give birth to sons face discriminatory practices, and can face violence from her husband and her in-laws. She is often excluded from certain rituals, deserted or face remarriage of husband.
Hence it is necessary to explain effectively that man has "X" and "Y" chromosomes, while female has two "X" chromosomes, hence it is the man who has two different chromosomes, so during fertilization if a "X" chromosome comes from the male partner "X X" would lead to the formation of a female foetus, while if "Y" chromosome comes from the male partner it would lead to the formation of a male foetus, hence it is the male partner who is responsible for determining the sex of the foetus.

**Genetic stigmatisation:**

Certain diseases or syndromes are passed on by heredity either from father or mother or in some cases from grandparents to the next generations.

Both men and women are identified as carriers of a recessive gene associated with disease, or who are affected by a genetic condition. They may face a range of social and psychological consequences, including stigmatization by the community.

For example a gene causing a trait or disorder can be linked to the X chromosome or Y chromosome. However, it is a woman who reaches antenatal clinics and so the tests are done on her. If discovered that she has a X linked disorder which will get passed to the baby, she can face repercussions due to it. There is no mechanism / protocol for testing the man. The burden of blame for passing a genetic condition falls more on women.26

Some examples of such conditions being passed from the woman to the foetus are haemophilia and Duchenne Muscular Dystrophy (DMD); which are X- linked recessive chromosomal disorders that primarily affect male offspring. Due to the fact that a woman has two X genes, she is the carrier of the DMD; she gets blamed for producing a son suffering from DMD. The care giving aspect of male child with DMD also rests with the woman.

An example of a syndrome that affects men through heredity is called 'Y linked infertility'. It is a condition that affects the production of sperm, making it difficult or impossible for affected men to father children. An affected man's body may produce no sperm cells (azoospermia) or a smaller than usual number of sperm cells (oligospermia). But because there are no specific symptoms related to this disorder, therefore they may be diagnosed at a late stage in the context of infertility.27

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Role of Doctor

- Doctor should explain the process by which sex of a foetus is determined in a simple and non-technical language to the woman, her husband and her family. This would help them to understand that it is not the woman alone who determines the sex of a foetus and so women cannot be blamed for giving birth to female children.

- A doctor should make women, their husbands and families aware of hereditary and genetic conditions, they should encourage couples to undergo tests to pre-empt genetic illnesses, particularly those who have family history and are planning a pregnancy.

- It should be conveyed that genetic disorders are likely to be passed on to the child not only from mother but also from father.

- The emphasis should also be on stressing the point that nobody particularly women, should be blamed for passing on of a genetic condition.
6. Ante natal care, nutrition in pregnancy, detection of high risk pregnancy

Gender content added: Pregnancy in adolescents and older women can be high risk, Domestic violence in pregnancy can cause medical complications

Lecture name: Ante natal care, nutrition in pregnancy, detection of high risk pregnancy
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion

Resources:

Handouts:

Key Points

1. Pregnant teenagers may be at a higher risk due to stigmatizing factors such as fear of disclosure about pregnancy owing to taboos, lack of access to confidential health services, lack of financial resources and lack of family support. They may also be at a higher risk of eclampsia, Intrauterine Growth Restriction (IUGR).
2. Advanced maternal age of pregnant women may also be considered as a risk factor. It is important for doctors to recognise underlying reasons for late pregnancies. Multiple pregnancies due to son preference in the family, infertility treatments, accessing assisted reproductive technologies are some of the examples for why there may be pregnancies in advanced maternal age.

3. Domestic Violence (DV) has been considered as a risk factor for pregnant women, a doctor is in a unique position to identify signs and symptoms of it and provide information on mitigating the violence.

**Learning Outcomes**

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<td>Student should be aware that adolescence and increased maternal age are risk factors for pregnancy</td>
<td>Student should be able to deal with high-risk pregnancy considering the factors associated with it</td>
<td>Student should be sensitive while dealing with teenage pregnancies and pregnancies among women with increased maternal age</td>
</tr>
<tr>
<td>Student should be aware that DV could cause pregnancy related complications</td>
<td>Student should be able to ask about domestic violence to women coming for antenatal care (ANC)</td>
<td>Student should have a sensitive attitude towards women facing violence during pregnancy</td>
</tr>
</tbody>
</table>

**Context:** Screening of high risk cases.

**Note to Educator:** Adolescent pregnancy and pregnancy at an advanced age are recognised as high risk pregnancies. Growing global evidence also suggests domestic violence in pregnancy as a risk factor. Medical students should be made aware of the underlying factors leading to risks which may be located in social conditions of women.

**Content:**

**I. Adolescent pregnancy**

- The global adolescent birth rate has declined from 65 births per 1000 women in 1990 to 47 births per 1000 women in 2015. Despite this overall progress, because
the global population of adolescents continues to grow, projections indicate the number of adolescent pregnancies will increase globally by 2030.

- As per NFHS-4, 8% percent of women age 15-19 years have already begun childbearing, 5 percent of women have had a live birth and 3% of women are pregnant with their first child. In numbers, the NFHS 4 reported that 1,21,833 adolescent girls were pregnant between 2015-2016 of which 1,02,822 were not married. NFHS 4 points to the mistimed, unwanted pregnancies in this age group as well as the lack of access to contraceptive methods to prevent pregnancies. Lack of antenatal services particularly in geographically remote areas increases the risks for adolescents who are pregnant. Though several efforts are being made by the Government of India towards institutionalised delivery, NFHS 4 still shows that the women in general and adolescents in particular in rural and tribal areas have no access to maternal and infant health services.

- The combination of poor nutrition and early child bearing expose adolescent girls to serious health-risks during pregnancy and childbirth, including damage to the reproductive tract, pregnancy-related complications, such as anaemia, pregnancy-induced hypertension, preterm labour, cephalopelvic disproportion, maternal mortality, perinatal and neonatal mortality and low birth weight.

- In a clinical prospective study carried out in the Department of Obstetrics and Gynaecology, at a tertiary care centre in Madhya Pradesh in India, it was found that out of 672 teenage pregnancies, 357 were associated with complications (53.12%). Amongst 61 teenagers admitted during the first trimester, abortion was the most common complication, seen accounting for 85.24% of first trimester complications. The most common complication associated with teenage pregnancy during third trimester was pre-term labour. 29 pregnant teenagers were found to anaemic of which 2 had mild, 12 had moderate and 15 had severe anaemia.

- Complications from pregnancy and childbirth are the leading cause of death in young women aged 15 to 19 years in developing countries. Adolescents and young women

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aged 15-24 years account for 46% of maternal deaths, while they account for 28% of non-maternal deaths.  

Role of Doctor

- Doctor should be able to recognise factors underlying pregnancy in adolescent girls and also discuss whether it is a wanted or unwanted pregnancy. In case it is an unwanted pregnancy, abortion service must be made available.

- In case the adolescent wants to continue pregnancy, a doctor should provide information about nutrition, utility of antenatal check-ups and enable access to safe delivery mechanisms. In case there are no available institutional delivery facilities, she should be advised to seek locally available trained birth attendant so that she seeks care at the right time. This can also help in accessing timely care and avoiding complications.

II. Pregnancy in advanced maternal age

- Several risks are associated with advanced maternal age (> or =35) such as still birth, pre term births, IUGR and chromosomal abnormalities.

- Evidence from different countries suggest that reasons for pregnancies in advanced ages can be attributed to women pursuing higher educational levels, lack of work environment support in male dominated fields, lack of child care facilities at workplaces, policies that signal to women that they cannot be both a wage earner and a mother, inadequate housing facilities and lack of supportive family structures amongst others. In India, the desire to have a male child may further push women to get pregnant at a later age.

- In India, inadequate attention is being paid by health systems towards the issue of advanced maternal age at pregnancy. Efforts are required to bring about awareness related to health problems encountered in pregnancy at an advanced stage such as

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gestational diabetes, hypertension and chromosomal abnormalities due to deteriorating quality of ova owing to advanced age.\textsuperscript{32}

Educator can open the discussion on pregnancy in women over 35 years with students using the following case study.

\textit{Case Study}\textsuperscript{33}:

\begin{quote}
Urmila is one such a 35 year old migrant worker in cotton mills, she had a past history of tuberculosis that had been treated. Of her three previous deliveries, one was at a construction site where she worked and the next two at home. In her fourth pregnancy, she had had only one antenatal care visit at a PHC where only a tetanus toxoid injection was given and she was handed ten tablets of iron folate. No haemoglobin or BP check had been done. Urmila subsequently developed severe breathlessness and after desperately seeking care at seven different facilities over five days, her family gave up and took her back home where she died.
\end{quote}

- Educator discusses the above mentioned case study and asks students to identify factors that led to Urmila's death.

- Urmila's obstetric history, lack of antenatal services, nature of physical labour, inadequate nutrition put her in high risk category of pregnancy. However these seem to have been missed by health care provider in the PHC. The educator can draw attention to the fact that Urmila being a migrant labour does not have any maternity related entitlements. Unlike women in the formal sector who receive 26 weeks of paid maternity leave, women in the informal sector have no social security.

- Activists rallied for ensuring maternity benefits to women in informal sector. This led to the development of policy "Maternity Benefits Programme". It was expected to be integrated in to the National Food Security act in 2013. All pregnant women were to receive an amount of Rs. 6000/- under the scheme to enable access to nutrition


and other social security. However, this scheme has remained on paper as the Government of India has not made any financial allocation towards the scheme citing lack of funds.

- It is important for doctors to therefore understand that a pregnant woman’s contact with the health care provider may be the only opportunity for her to discuss her health and wellbeing.

**Role of Doctor**

- Doctor should be aware of risk factors associated with teenage and advanced age pregnancies. While dealing with these women and girls, a non-judgmental attitude will be useful to adopt so that they could discuss their concerns in an uninhibited manner with the doctor.

- It is important to provide contraception counselling to all girls and women. Efforts should be made to also speak to the partner. Such information can assist them in prevention of pregnancy

**III. Violence during pregnancy**

- A global systematic review described a prevalence of 1% to 20% for domestic violence during pregnancy. The prevalence rate of DV was reported to range from 4% to 48%, and a review of Indian studies reported a prevalence of 21-28%.

- Violence against women (VAW) during pregnancy has severe health consequences including depression, pregnancy related bleeding, miscarriage and premature labour.

- Women who suffered violence during pregnancy are twice more likely than other women to miscarry, and four times more likely to give birth to a baby of low birth weight.

- The children born to battered women are 40 times more likely to die before the age of five than children of non-battered mothers are.

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• This is a matter of great concern, as women who have suffered violence are significantly more likely than other women to delay antenatal care owing to stigma around domestic violence and fear of consequences upon disclosure.\textsuperscript{35}

• In a population based cross-sectional sample survey among married women with a history of at least one full-term pregnancy (n=1525) in Orissa, West Bengal and Jharkhand showed that the prevalence of physical, psychological and sexual domestic violence during a recent pregnancy was found to be 7.1%, 30.6% and 10.4%, respectively and the lifetime prevalence during all pregnancies was 8.3%, 33.4% and 12.6% respectively. Factors such as higher prevalence of undesirable behaviours like denying adequate rest and diet, demand for more sex, not providing antenatal care and pressure for male child were described as forms of DV in pregnancy.\textsuperscript{36}

• In a study carried out in all six zones of India, that is northern, southern, eastern, western, central and north east zones it was found that antenatal care/ immunisation was higher in women not facing domestic abuse (86%) while the antenatal care seemed less where such incidence was found (76%). The difference was considered extremely statistically significant.\textsuperscript{37}

Routine enquiry of all women in ANC clinics:

The WHO recommends routine enquiry of DV for all women coming to ANC clinics, after minimum requirements are fulfilled; such as trained health providers and protocols for enquiry. There are several tools available, but the following one has been adapted to Indian context by CEHAT as part of its study on assessing efficacy of counselling interventions for pregnant women facing violence.

Doctors and nurses can be trained to use this form for routine enquiry at the time of delivering antenatal services. This should be done in the course of examination by assuring privacy while speaking to the woman and confidentiality of the information being disclosed by her.


Tool for routine enquiry at ANC clinics

Start by making the following statement and asking the questions below: Many women experience violence with their husband or partner, or some other family member and are unaware of the fact that this violence can lead to all kinds of health problems. Because violence is so common in many women’s lives, and because there is help available at X hospital for women being abused, we now ask women at the ANC about their experience with violence. Please be assured that your answers to these questions will be kept strictly confidential.

1. Are you currently afraid of your husband (partner) or someone else in your family?
   Yes / No. IF yes, from whom?

2. Does your husband give you money for household expenditure?

3. Does your husband or someone else in your family demand money, vehicle, house or anything else from you?

4. Has your husband (partner) or someone else in your family threatened to hurt you or physically harm you in some way?
   Yes / No

5. Has your husband (or Partner) forced you into sex or to have any sexual contact you did not want?
   Yes / No

6. Since you have been pregnant, are you facing any of the above mentioned problems?
   Yes / No. If yes, which one?

The Following are signs and symptoms that can be indicative of violence in pregnant women: 38, 39

<table>
<thead>
<tr>
<th>MTP cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reversal of tubal ligation (TL).</td>
</tr>
<tr>
<td>Chronic Leucorrhoea.</td>
</tr>
<tr>
<td>Injury marks on labia, breast, and or other sexual organs. History of assault.</td>
</tr>
<tr>
<td>Pelvic Inflammatory Disease (PID).</td>
</tr>
<tr>
<td>History of fall during pregnancy</td>
</tr>
<tr>
<td>Delayed ANC registration</td>
</tr>
<tr>
<td>Repeated pregnancy. Multiparity</td>
</tr>
<tr>
<td>Postpartum psychosis</td>
</tr>
<tr>
<td>Single mothers, pregnant widows</td>
</tr>
<tr>
<td>Repeated birth of a girl child.</td>
</tr>
</tbody>
</table>

**Role of Doctor**

- A doctor should look for signs and symptoms of abuse in every women coming for ANC service. He/she should familiarise herself about how to do routine enquiry.

- If a woman discloses violence, basic emotional support shall be provided by the doctor WHO recommends LIVES (Listen, Inquiry, Validate, Enhance safety and Support). This could be done by letting her know that she believes the woman, help is available, and she can refer her to a counsellor who can provide comprehensive support. A doctor can assess safety of the pregnant woman by asking simple questions as described in the screening form and if the woman is unsafe make provisions for her admission at the hospital and connect her to a counsellor.

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7. Normal labour-physiology, mechanism, clinical course and management, pain relief in labour

Gender content added: Importance of birth companion, judicious use of episiotomy

Lecture name: Normal labour-physiology, mechanism, clinical course and management, pain relief in labour

Subject: Obgyn

Semester no: 4

Duration: 1 hour

Methodology: Lecture, Discussion

Resources:


Handouts:

Key Points

1. Medical attitudes and practices lead to birthing as an isolated experience. Women in labour do not have access to a person who is empathetic, listens to women’s fears and helps her to feel confident of giving birth. Such a role can be played by a birth companion given the limited number of doctors and nurses to provide support.
2. Use of episiotomy without clinical indication has been considered as an indicator of obstetric violence. Excessive use of episiotomies increases the risk of perennial trauma in the woman.

3. Standard guidelines recommend the use of episiotomy only with specific clinical indications.

**Learning Outcomes**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise the role of birth companions in making women get a nurturing environment as well as enable the woman to understand the process of birthing</td>
<td>Student should recognise Simple techniques related to breathing, change of positions, can help to relieve pain. These techniques can be imparted to</td>
<td>Student should recognize that having birth companion will enable women to be informed and comfortable to deal with the process</td>
</tr>
<tr>
<td>Student should recognize negative effects of episiotomy and lack of evidence related to it</td>
<td>Student should be able to develop labour ward protocols to arrive at specific conditions in which episiotomy is required</td>
<td>Student should recognize that informed consent is an important aspect of enabling women to decide upon medical procedures</td>
</tr>
</tbody>
</table>

**Context:** While teaching normal labour

**Note to Educator:** This should be revised in the 8th semester during the clinical hours, teacher should do demonstrate how to use checklist of good and gender sensitive practices to be followed during normal labour should be prepared.

**Content**

- The process of birthing has increasingly become a biomedical event; hence women in labour have no contact with friends and family. In the course of labour women are examined by completely unfamiliar attendants such as anaesthetist, nurses, resident
doctors, medical students and nursing students. Doctors do not inform women about the different stages of labour and what she should expect over the period of labour. It is important to recognise that isolation and immobility during labour increases fear which in turn increases pain. Women do not have access to information on positions that may relieve her of pain. It may be useful to ensure that women in labour receive a birth companion who assists her and familiarises her with the stages of labour and delivery. This would reduce fear experienced by women.

- Doctors are often unavailable through the process of labour from the beginning to the end and hence they themselves are unfamiliar with the process of individual women's labour. Hands on skills such as physical support, change of positions and massage are not seen as clinical and hence discarded. As these doctors are being trained to become obstetricians, they look down on these techniques. However these techniques have been evolved by those involved in midwifery and women's experiences indicate that these methods do reduce pain, instil confidence in labouring women and prepare them for different stages of labour.40 These are replaced by surgical, often irrational, interventions such as C sections to hasten the process of delivery.

- Another invasive procedure that is used rampantly in obstetrics is Episiotomy. It is one such procedure, the rates of which rose substantially during the 20th century. At that time there was also an increasing move for women to give birth in hospitals and for physicians to become involved in the normal uncomplicated birth process. Episiotomy has now become a routine affair. It was introduced due to concerns such as perineal tears, preventing damage to the baby's head and preventing pelvic floor from becoming overstretched. Yet evidence shows that episiotomy was introduced in clinical practice without strong scientific evidence of its benefits.41

- A study carried out in a large maternity hospital in Phnom Penh, Cambodia, with a random sample of 365 patients found that 345 women (94.5%) had had an episiotomy. The reasons given by midwives and obstetricians were: fear of perineal tears, the strong belief that Asian women have shorter and tighter perineum than others, and lack of time in overcrowded delivery rooms.42

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• A cross sectional study undertaken in Chennai with a rural population was done to estimate the rate of episiotomies undertaken in type of health facilities and nature of health care providers. It was found that out of 442 women who had vaginal delivery during 2005 in rural part adjoining Chennai, 296 women underwent episiotomy; the rate of episiotomy was 67% as against the normal acceptable episiotomy rate of 30%.43

• Forced or coerced medical interventions such as routine use of episiotomies have been termed as a form of obstetric violence.44

• There is an urgent need to therefore promote evidence based practices in health care. Respectful Maternity Care is being increasingly seen as a human right of every woman in labour and of a child bearing age. Quality of services, dignity in health care is important consideration in ensuring respectful maternity.

• This means developing policies of two kinds, one is to encourage women to have a birth companion in the process of labour and delivery and second is to develop a protocol for ensuring evidence based services, dignity in birthing, assuring confidentiality, privacy, access to equitable care and freedom from harm and ill-treatment at health facilities.

• The role of the birth companion is to comfort women in labour, build their confidence, learn basic techniques from doctors related to massage and understand the progress and stages of labour. Such training can be offered at different levels of the health system by a team of doctors and nurses.

Role of Doctor

• Doctors should recognize the importance of a birth companion and the role she can play in the course of women in labour. In the absence of such a person, doctor can enable the same services through the team of nurses and support staff available at the labour room.

• Assistance of birth companions can enable doctors to recognise the progress of labour and then determine on best possible options if the labour is difficult.

• Doctors should explain to the woman there as on for difficult labour and if she needs to undergo episiotomy. Informed consent for such a procedure must be sought from the woman.
8. Normal puerperium and breast feeding

Gender content added: Importance of contraception counselling in antenatal services. Issues faced by women in breast feeding, especially HIV+ positive mothers

Lecture name: Normal puerperium and breast feeding
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion, Role play
Handouts: ---

Key Points

1. Contraception counselling offered in the course of antenatal period, can provide women with adequate time and knowledge to choose contraception. It can also help to prevent post-natal and unplanned pregnancies.

2. The postpartum period is period of transition, adjustment and adaptation along with significant biological, social and psychological changes. Hence women may not be in the frame of mind to make informed choices.

3. HIV positive mothers require interventions that address the health and social implications of their HIV status.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognize the importance of contraception counselling.</td>
<td>Student should be able to put forth different contraception options and let the woman choose without coercion</td>
<td>Student should be sensitive that woman has the right to choose contraception which she feels is suitable for her</td>
</tr>
<tr>
<td>Student should be aware about the challenges that HIV+ women face in breast-feeding</td>
<td>Student should be able to explain different feeding options to HIV+ mothers with their pros and cons</td>
<td>Student should have a sensitive and non-judgmental attitude towards HIV+ mothers</td>
</tr>
</tbody>
</table>

**Context:** While teaching normal labour and breast feeding.

**Note to Educator:** The educator should explain that puerperium is an important component of obstetric care and that most maternal deaths occur during this period.

Content

I. **Gaps in contraceptive counselling**

- Ideally, contraception counselling should be provided during the antenatal period itself.

- Women may believe that traditional practices such as postpartum abstinence from sex and prolonged breast-feeding may prevent pregnancies, but in the absence of comprehensive information about lactation amenorrhea method, there may be unwanted pregnancies.

- Inadequate information on lactation amenorrhea is also seen amongst doctors and nurses. They may not be aware that it can work only with three conditions necessary for effective pregnancy prevention—the woman must breast-feed exclusively, must not have resumed menstruation and must be less than six months postpartum.
• Besides doctors and nurses, ASHA workers can be trained to impart comprehensive information related to lactation amenorrhea practice. This discussion can be initiated during antenatal meetings. Currently this is missing in the antenatal services.

• Spacing methods have received limited attention and information on it is not adequately imparted. Studies suggest that providers tend to focus their counselling on limiting methods and find it challenging to counsel young couples about spacing methods. Hence there seems to be a gap in skill base of health care providers to discuss different spacing methods.\textsuperscript{45}

• In addition, the lack of decision-making power about contraceptive use among young women makes providers view this counselling as futile.\textsuperscript{46} This must be recognized a gender issue.

• No efforts are made to discuss with the woman about calling the male partner to discuss contraceptive use. If a woman consents to involving her partner, doctors would be in a better position to discuss contraceptive choices with the couple in a manner that focuses on the health of the woman. There is an opportunity to discuss and promote use of male contraceptive devices and its effectiveness.\textsuperscript{47}

II. Breast feeding

• Breast-feeding is over emphasised without recognising barriers faced by women owing to gender issues.

• Gender norms allow men to occupy public spaces, while women belong to private spaces (indoors, home). Though breast-feeding is a biological function, breasts are sexualised, therefore breast-feeding in public is often frowned upon.

• Working mothers especially, face problems related to breast-feeding. While at one level there is emphasis on exclusive breast feeding to new born till six months but they may be allowed limited paid maternity leave. Women in the informal sector have no maternity benefits. Health programs do not consider these aspects. Even


within the formal sector there is poor access to infant and child care facilities rendering it impossible for women to carry her infant or breast feed it.

- Several challenges are faced by lactating mother even within their households. Women may be saddled with house work, may receive inadequate rest and lack of adequate nutrition. Women’s nutrition is often discussed in the context of production of breast milk and whether she is adequately able to feed the baby ignoring the health needs of women. The male partner is often uninvolved and no one considers his role in assisting the woman who has recently delivered.

- As Health care providers it is pertinent to be cognizant of challenges faced by women and advise women accordingly on the issue of breast feeding.

III. HIV positive mothers and disclosure:

- It is well known that HIV infected women face stigmatisation and pregnancy adds to their vulnerability. All pregnant women, under the current National AIDS Control Program (NACP) are tested for HIV. Once there is a disclosure that a pregnant woman is HIV positive, she does not receive any support from the family, community.

- Women who suspect that they may be HIV positive may also come alone for ANC services and may be apprehensive about mistreatment and abandonment upon finding out their HIV status. Doctors need to develop a health plan that takes in to account not just her HIV status but also her immediate emotional needs. Disclosure of HIV status often occurs mechanically without recognising the social consequences on the pregnant woman such as mistreatment, abuse and desertion. Doctors need to discuss with the woman about whom she would want to confide in about her status and how will she ensure access to healthcare.

- It is important for doctors to counsel women on the methods of feeding available to women and their related risks. When counselling for breast feeding HIV positive mothers, it must be remembered that most women in India cannot afford to give their babies adequate top feeds nor ensure clean drinking water to prepare the feeds. Doctors need to be mindful of prescribing such top feeds and develop plans.
The National AIDS Control Organisation (NACO) guidelines for prevention of parent to child transmission (PPTCT) programme suggest specific healthcare and women should be informed about these:⁴⁸

- All pregnant and breast feeding women living with HIV receive lifelong triple-drug ante retro viral therapy (ART) regimen regardless of CD4 count or WHO clinical stage.

- Postpartum ART initiation to mother and ARV (Nevirapine) Prophylaxis to child are aimed at improving HIV free child survival by reducing HIV transmission through breast feeding.

- HIV exposed infants should be followed-up and managed as per the National Guidelines on "Care of HIV exposed infants and children".

- Doctors must be well versed with the NACO guidelines and emphasise on the ART regime and norms for breast feeding prescribed therein. They must not mindful of myths about HIV positive status of mothers which stigmatise them further.

- Doctors must discuss exclusive breastfeeding up to six months, followed by gradual weaning and complementary food along with breast milk at 6 months as suggested by WHO / NACO Guidelines 2010. Efforts must be made to enable women to follow up for their own testing as well as that of the child; this will also help doctors to monitor the growth and nutrition of the mother and child. It may be a challenge for HIV positive women to follow up for their health care as well as that of their children. The doctors must seek consent and involve supportive family members for ensuring that women receive comprehensive support at home to be able to avail and access health services.

**Role of Doctor:**

- Contraceptive counselling must be initiated by doctors in the antenatal period. They should be able to offer comprehensive information on spacing methods and also involve the male partner after seeking consent of the woman.

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• A doctor should dispel myths regarding post-partum amenorrhea and the necessary conditions to use lactation amenorrhea as spacing methods. A doctor should explain all the spacing methods to women in easy and understandable language.

• The doctor should be sensitive to the unique needs and issues of HIV+ mothers and approach the aspect of disclosure in consultation with the woman. Comprehensive information about feeding practices and health rights of HIV+ mothers should be communicated to them.
9. Contraception-introduction and basic principles

Gender content added: Recognising disproportionate focus of contraceptives on women, Discussion and promotion of male contraceptives, Challenges faced by women in use of contraception

Lecture name: Contraception-introduction and basic principles
Subject: Obgyn
Semester no: 4
Duration: 1 hour
Methodology: Lecture, Discussion

Key Points

1. The International Conference on Population Development (ICPD) held in Cairo in 1994 agreed that population policies should go beyond family planning and address the social development. This meant advancement of women and enabling autonomy related to decision making of contraceptives.

2. Despite the agreement to shift from family planning to sexual and reproductive health and rights of men and women, there is very little effort to engage men on use of contraception.

3. Inability to use contraceptives may be related to control by a male partner and his refusal to allow use of contraceptives. Including men/boyfriends in contraception counselling can increase the chances of women being able to use contraception methods suited to her, and doctors can get an opportunity to sensitise male partners against perpetuating violence.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should adopt a holistic approach to reproductive health of women and recognise problems with following the family planning approach</td>
<td>Student should develop skills to counsel couple about different contraceptive methods and be able to dispel myths about vasectomy and explain its benefits</td>
<td>Students should be respect s reproductive and sexual health needs and rights of all individuals</td>
</tr>
<tr>
<td>Student should be aware that coercion and control by male partner may restrict women from use of contraceptives</td>
<td>Student should be able to probe for possibility of abuse so as to understand women’s inability to use contraceptive methods and should be able to discuss contraception with the male partner</td>
<td>Student should not blame a woman if she does not use contraception and create an enabling environment for discussion with men about contraceptive use</td>
</tr>
</tbody>
</table>

Context: When discussing contraception

Note to Educator: The educator can emphasise that when women reach the hospitals with a failed contraception or in a state that they cannot use contraception, women should not be blamed for it. The reasons stem from their inability of making these choices, as it is often the male partner determining if the woman can or cannot use contraception. The educator can also draw attention of students to the issue of coercion and violence from the male partner when a woman decides to use contraception.

Content

India, besides other 180 countries, reached a consensus on how population issues should be approached at the International Conference on Population and Development held in Cairo in 1994. In keeping with this commitment India launched the reproductive and child health program. Efforts were made to move away from "family planning" to provision of contraceptive services. This is because the term 'family planning' is inherently biased in that it suggests that the services are only for those within the context of a family or a married couple.
Despite India's commitment to have a 'target free' approach to family planning, state and
district level health officials are often assigned targets for every contraceptive method
including female sterilisation and IUD insertion. Health workers may even face salary
cuts or dismissals if they are unable to meet these targets. Very often, health workers, in
turn, pressure women to undergo sterilisation or insert IUDs without providing sufficient
information about the procedure, its outcomes, possible complications, reversibility etc. 49

Patriarchal gender norms put women in a position of limited power where they may not
be able to negotiate with their male partners for contraception. But, doctors and society
expect women to shoulder the responsibility of using contraception as reproduction and
its management is seen as women’s responsibility.

National Health Programmes have always focused on female sterilisation; it still continues
to be the main contraceptive method in India with female sterilisation at 34%. The National
Health Statistics of 2010–2011 shows that tubectomies performed were at 95.6% as against
vasectomies which were 4.4% of all sterilizations.

Despite introduction of non-scalpel vasectomy and campaigns to promote male involvement
in family planning and reproductive health, the acceptance of vasectomy remains
negligible. Various studies have shown that acceptance of vasectomy is very low in the
country and number of myths like tubectomy being simpler, fear about procedure, inability
to do hard work after the procedure, general weakness and reduced sexual performance
are attached with vasectomy. Myths associated with vasectomy are thus related to
masculinity, with stigma attached with it. 50,51

Oftentimes, those falling outside the marital relationship are not considered as users of
contraception. The indirect implication is that unmarried adolescents and young people,
single women, sex-workers and others who have a need to prevent pregnancy but may
not be part of a "family" are not legitimate clients of the programme. Hence, there is an
urgent need to recognise contraceptive needs of sexually active adolescents and young
people, women and men of all ages and diverse sexualities. Comprehensive contraceptive
information and services refers to the provision of information and services for all methods

rights-based provision of contraceptive information and services in India. Sahaj and
practices among literate men in Punjab, India. International Journal of
Reproduction, Contraception, Obstetrics and Gynaecology, 3(2), 418–423.
doi:10.5455/2320-1770.ijrcog20140627
vasectomy among married men in central India: Causesandsuggestedstrategies. Journal of
Psychology & Psychotherapy, 3(4). doi:10.4172/2161-0487.1000120
of contraception without imposing programme-based or provider-based restrictions of specific contraceptive methods.

In order to ensure uptake of male contraceptive services it is useful to present positive examples where men have accepted vasectomy. In a study carried out in Uttar Pradesh, one of the triggers for accepting vasectomy was the awareness of or experience with problems associated with other family planning methods. The same study showed that the idea that non-scalpel vasectomy is a simple and painless procedure was most appealing to men. Awareness of cases of male sterilisation that had been successful was, although unfortunately rare, was one of the most powerful drivers of improving attitudes toward and even increasing uptake of vasectomy.\textsuperscript{52} Quotes from men having undergone vasectomy are presented below:

"Male sterilisation is good, as it is permanent. In the case of Copper T, there is a chance of infection. In the case of pills, you have to take it multiple times. If you have completed your family, you should go for male sterilisation", my friend said.

"In my village, a man went for the operation and he has not faced any problem after the operation, he said the operation was very simple... On my mother's side, seven men got themselves operated on in a government hospital. All are well and have no problem. Now people have a positive attitude toward the sterilised man."

Citing such positive examples where men have accepted vasectomy, a doctor can play an important role in debunking myths around vasectomy and promoting it among married men who have completed their families.

\textbf{An Exercise:}

Simple questions can be posed to students to understand barriers faced by women in using contraceptives

1. Does the woman have enough privacy to use the suggested method of contraception?

2. Does she have support to use the contraception?

3. Does she have access to medical care or support systems in case of side effects?

Couple counselling for contraception use enables men to understand that contraception's shared responsibility and not just the onus of the woman alone. Though couple counselling can prove to be useful in promoting contraception use, the doctor should initiate it only after a woman consents because she would be the best person to judge her situation and explain to the doctor the possible reaction / response from her partner. The safety of women should be first taken into consideration. If possible, the partner/husband should be counselled separately regarding contraception use.

**Role of Doctor:**

- A doctor should recognise contraceptive needs of all people including adolescents, men and women outside the institution of marriage, and persons with different sexual orientations.

- He/she should be aware that domestic violence against women can affect their contraceptive use

- A doctor should recognise the importance of including men in contraception counselling, provide positive examples and promote temporary and permanent methods of contraception for men.
10. Maternal mortality and morbidity, perinatal mortality and morbidity, National Health Programme-safe motherhood, reproductive and child health, social obstetrics

Gender content added: Gender, caste, class, religion, education, economic status impact access to health care and contribute to maternal mortality and morbidity

Lecture name: Maternal mortality and morbidity, perinatal mortality and morbidity, National Health Programme-safe motherhood, reproductive and child health, social obstetrics

Subject: Obgyn

Semester no: 4

Duration: 1 hour

Methodology: PPT, Use of case studies, A Bubble exercise

Resources:


Handouts: ---

Key Points

1. Gender and other social determinants are key contributors to maternal mortality hence here is a need to integrate such an understanding within technical interventions, in order to prevent maternal deaths and for better maternal health.\(^{53}\)

2. An understanding of three levels delay model can enable doctors to recognise risks faced by pregnant women in access to health services.\textsuperscript{54}

3. Overemphasis on institutional deliveries has led to the phasing out of traditional birth attendants (TBA). TBA’s can play a crucial role in preventing maternal mortality and morbidity in remote areas and villages.\textsuperscript{55}

Learning Outcomes

<table>
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<tr>
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<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise that social factors and gender aspects are key contributors to maternal mortality, morbidity and perinatal mortality</td>
<td>Student should provide sensitive and appropriate health care to women seeking emergency obstetric care</td>
<td>Student should be sensitive to role of gender and other Social Determinants of Health(SDH) while providing health care to women seeking care during pregnancy and having complications</td>
</tr>
</tbody>
</table>

**Context:** While teaching maternal mortality and morbidity.

**Note to Educator:** Educator should explain the various factors that affect maternal mortality and morbidity. The educator can start with an exercise called "bubble exercise" listed at the end of the session. This can enable students to understand the different factors underlying the issue of mortality and morbidity in pregnant women.

**Content**

The Indian government has taken several efforts to reduce maternal mortalities and morbidities in women. Since the inception of National Rural Health Mission (NRHM), 2005, steps such as incentivising institutional deliveries, provision of travel facilities for pregnant women, ensuring health care for sick neonates in the hospitals through Janani-Shishu Suraksha Karyakram (JSSK) have been actions put in place. Additionally the entire


cadre of ASHA workers has been equipped to counsel women about antenatal registration benefits and seeking institutional deliveries. In spite of all these efforts on the part of the government and implementation of different schemes, maternal mortality and morbidity in India still remain high at 173 per 100,00 live births. Analysis shows that the technical information does not incorporate social reasons and conditions that may keep women away from accessing health facilities.

The sections mentioned below list different factors that increase women’s health vulnerabilities and therefore these aspects must be considered by doctors while delivering health care to pregnant women.

I. The different socio demographic vulnerabilities women face which can lead to maternal deaths

Early marriage has been seen as a major problem affecting the health of women. NFHS 3 showed that 47% of young women in the country were married by the age of 18 years. Women who have a pregnancy at a very young age face a high risk of morbidity and mortality.

At the other end of the spectrum are older women with a history of several pregnancies. It is well known, that they are a high-risk group for complications both because of their age and because of multi-parity.

It is well documented that the majority of the maternal deaths occur among women who belong to schedule tribes, schedules castes and other social groups who have been historically deprived of improved facilities and may not be able to access health facilities.

Along with domestic responsibilities many women are involved in income generating activities; those belonging to lower socio- economic class generally work as daily wage workers, may not be able to rest and may have to work till the last day of pregnancy.

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Another group of vulnerable women that are not covered by the health system are migrant workers; migrant women are not covered by antenatal services or ICDS services because they often lack the documentation required for seeking these services.

Women’s lack of decision-making, a lower value placed on their lives and the health system’s neglect are the issues that affect pregnant women in getting proper maternal care.

II. Problems with institutionalisation of deliveries

The educator can read the case study and then ask students to list factors that led to the death of Heena. (Case from the Report: Dead Women Talking)\textsuperscript{59}

Heena was a 22 year old tribal woman who lived in Kendujhar district of Odisha. Both she and her husband were illiterate. They did not own any land, were certified to be below the poverty line, and according to her husband, often did not have enough to eat. They lived in a remote hamlet where the nearest motorable road was 10 km away, and the nearest ambulance pick up point was 40 km away. This was Heena’s second pregnancy. Her first child had died at the age of 6 months due to an infected abscess. The nearest sub-centre was 6 km away and though the ANM did visit once a month, the hamlet could not be reached in inclement weather. Heena did not seek or receive any care during this pregnancy. When Heena’s labour pains started, her husband tried to arrange for some form of transport to take her to a health facility. It took him about 8 hours to do so—they did not have the number of the Janani Express, nor did they receive any help from the ASHA or ANM. They set out to the nearest CHC that was 50 km away, but Heena delivered on the way and died soon after, probably due to excessive bleeding.

**Key Points for Discussion**

- Heena despite being certified as being economically underprivileged did not have access to antenatal services.

- Heena was not documented as high risk pregnant woman despite lack of access to nutritional services, difficulties faced in first delivery and death of the first infant at six months.

- Heena lived in a remote hamlet, there was no outreach of health services and there was no ASHA to orient her about the utility of antenatal service and schemes of government to access nutritional food, supplements or transport.

- ANM did not connect Heena to a dai or any other service available beyond the hamlet considering the remoteness of the hamlet. Suggestions such as arrangement of stay in the hospital a few days / weeks before the date of delivery would have enabled Heena to survive. These aspects were missing in the treatment plan.

**III. Three level delay model to recognise causes of maternal mortality and morbidity**

This model can assist doctors in recognising reasons for mortality and morbidity in pregnant women.

1. Delay in decision to seek care due to:
   - The low status of women.
   - Poor understanding of complications and risk factors in pregnancy and when to seek medical help.
   - Previous poor experience of healthcare.
   - Acceptance of maternal death.
   - Financial implications.
2. Delay in reaching care due to:
   - Distance to health centers and hospitals.
   - Availability of and / or cost of transportation.
   - Poor roads and infrastructure.
   - Geography e.g. mountainous terrain, rivers.

3. Delay in receiving adequate health care due to:
   - Poor facilities and lack of medical supplies.
   - Inadequate trained and poorly motivated medical staff.
   - Inadequate referral systems.

IV. Institutionalised birthing and phasing out of traditional birth attendant

   - Despite incentivising institutional deliveries and deploying ASHA workers to create awareness on antenatal services, there is a lack of understanding at the level of providers about the three delay model. In the absence of access to institutional deliveries, there is lack of plan for ensuring that pregnant women survive the delivery. Availability of trained birth attendants (TBA) at the village level can play an important role in preventing morbidity and mortality. TBAs are trained to identify risks in pregnancies, hand hold women through the delivery process, and assist in delivery. But increasing focus on medicalised institutional deliveries has led to phasing out of these skills which are inherent in communities and villages. Since the launch of NRHM in India in 2005, there has been an overwhelming emphasis on increasing institutional births by way of incentives.

   - Hence though the government is pushing for institutional deliveries there is a gap in providing services for women to reach an institution. At the same time traditional birth practices is a dying profession and women are left in between, neither with proper institutional care nor traditional birth attendant.

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Childbirth practices have been a part of social, political, economic and hygienic reforms in India since the 19th century in an attempt to combat infant and maternal mortality. From the 19th century to the beginning of the 21st century, reproductive reform was dominated by the ideas of overpopulation linked with general underdevelopment and poverty.

The reforms with regard to childbirth included providing a new setting for childbirth from home to hospital and a new attendant, replacing the Traditional Birth Attendant (TBA) with a qualified midwife or physician, otherwise known as a Skilled Birth Attendant (SBA) as is the current practice.

With emphasis on institutionalised deliveries, there has been a phasing out of the 'dai' or 'Traditional Birth Attendant' (TBA). These women are considered illiterate, unskilled and difficult to train in handling pharmaceutical drugs during birth emergency. What is not explored is an important role that they can play in enabling safe deliveries for women.

The TBA has been steadily replaced by ASHAs, whose main job is to register pregnant women and encourage them to seek care at government facility. But the field reality is that a ASHA gets Rs.600 per live delivery in a government facility and is expected to bear the costs of transporting the pregnant woman and other costs along the way.

If the delivery takes place outside the hospital premises, the ASHA does not get paid anything, and also she is unable to intervene in the child birth as she does not have training in midwifery.

While a few TBA turned into 'ASHA', the literacy criterion ensured that the vast majority of them got excluded, though they had skills gained through experience.

TBAs provided a real service by operating in areas far away from the centre and dealt with pregnant women who are often anaemic, malnourished and have no access to safe drinking water.

V. System induced vulnerabilities

A mother and child tracking system (MCTS) has been initiated since 2009 under National Health Mission (NHM) whereby pregnant women and children can be tracked for their ANCs and immunization along with a feedback system for the ANM,
ASHA, etc to ensure that all pregnant women receive their ANCs and post-natal care (PNCs); and children receive their full immunisation.

Though the benefits of the tracking system are intended to reduce maternal morbidity and mortality, this system assumes that all pregnancies are desired. Hence if there is a woman who seek an abortion because it is an unwanted pregnancy, or a pregnancy resulting from rape, or she is an adolescent and does not want to carry ahead the pregnancy; the system has the potential to compromise her access to safe abortion, forcing her to resort to unsafe ways, thus adding to maternal morbidity or mortality.

**Medical educator can carry out this exercise in the class.**

Group exercise to identify gender issues in maternal mortality and morbidity. The activity is called Bubble exercise.

Total time required: about 1.40 minutes altogether. (Step 1:20 minutes, Step 2:40 minutes, Step 3:40 minutes)

**Step 1: What the teacher starts with**

The class is divided into groups and each group has to work with one of three statements:

- "A woman with eclampsia arrives at a health facility but dies of complications"
- "A woman seeks induced abortion services from an untrained provider"
- "A woman in labour dies of hemorrhage on her way to the hospital"

This can be done even with a large class. The participants can remain seated wherever they are, but work on the task individually or with their neighbours depending on how the groups are divided. The teacher may seek responses from each group one at a time, and complete one statement before going on to the next.

**Step 2: Instructions for what students have to do [time] 20 minutes**

Give the students a hand-out with the following extract, telling them what they have to do. Write the statement given to you on the left-hand corner of a sheet of white paper. Starting with the statement (for example), "A woman with eclampsia arrives at a health facility but dies of complications" ask yourself "But why" and write the reason you come up with on
a circle next to the statement on the big piece of paper. Keep asking "But why?" until the line of argument is exhausted. Each reason has to flow directly from the one before, and be written directly next to the previous reason's circle. Then begin again at the original statement and explore another reason why the woman did not deliver in a health facility. Each circle should contain a single specific issue. Do not use general terms such as 'culture' as a reason; articulate which aspect of culture is causing the problem.

The figure below illustrates a series of reasons why for a different problem.

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**Step 3: Ask for responses from students (40 minutes)**

Start with the statement on eclampsia, write it on the blackboard on the left hand corner. Then ask for students' responses and write these down as shown in the figure above, in circles one coming out of the other if they are related and separate if they are different pathways altogether. Discuss which circles have been identified as gender-related and why. It would be good also to discuss what can be done at the health facility level or by the health sector to change the situation.

Repeat the same with the remaining two statements, on abortion and haemorrhage respectively.

Key messages: Underlying many deaths and morbidities, there are many social reasons including gender-related reasons. There are at least some of these that the health providers and health sector can change, thus reducing avoidable morbidity and mortality.
Role of Doctor

- A doctor should recognise obstacles such as long distance, lack of financial resources, and unavailability of transport services in remote locations have an adverse effect on pregnancy outcomes and can lead to maternal mortality and morbidity. Doctors should therefore give comprehensive care and information relevant to the women in the visit with the understanding that this may be her only critical window of opportunity.

- A doctor should be unbiased in providing services to women/girls who are unmarried, adolescents, thus preventing the risks of risky abortions and childbirths.
11. Development of genital tract, congenital anomalies and clinical significance, chromosomal abnormalities and intersex

Gender content added: Recognise that "Transgender" and "Intersex" persons can report to the hospital with reproductive health problems

Lecture name: Development of genital tract, congenital anomalies and clinical significance, chromosomal abnormalities and intersex
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion
Resources:

Key Points

1. There is a need to appreciate differences between intersex and transgender persons and have a sensitive approach towards them.

2. Biases against intersex and transgender community affect their access to healthcare.

3. Using sensitive and appropriate terminology and a non-judgmental attitude towards the health concerns of intersex and transgender people can help them disclose their health concerns to doctors.
4. There are gaps in health sector response to intersex people.

**Learning Outcomes**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should know the difference between &quot;intersex&quot; and &quot;transgender&quot; (TG)</td>
<td>Student needs to use gender sensitive language and communication strategies to treat TG patients</td>
<td>Student should be aware about the existing discrimination and biases against TG and intersex persons in medical institutions</td>
</tr>
</tbody>
</table>

**Context:** While teaching development of gential tract.

*Note to Educator:* Students need to understand differences between intersex and transgender. The educator should clarify that intersex genitals are not an abnormality but a variation from the binary of male and female genitals. It is important to recognise health issues of transpersons and inter sex persons and create a gender sensitive approach in dealing with their health issues.

**Content**

I. Gender stereotypes, expect men and women to play rigid gender roles and behave in particular way that is either 'feminine' or 'masculine'. Patriarchal systems often enforce gender norms and discourage behaviour that falls outside gender binary. Hence, people who do not fit the gender norms or sex categories of male or female are often discriminated.\(^{61}\)

a) Differences in Transgender persons and Intersex persons\(^{62}\)

Transgender is an umbrella term to signify individuals who defy rigid, binary gender constructions, and who express or present a breaking and/or blurring of culturally prevalent stereo typical gender roles. This can include transpersons who are pre-operative, post-operative or non-operative. A transperson may strongly identify with gender opposite to their biological sex. A male- to-female transgender person is referred to as 'transgender woman' and a female-to-male transgender person, as 'transgender man'.
Intersex is a term used for persons whose anatomy is not considered typically male or female. Intersexed genitals are not a medical problem. They may signal an underlying metabolic concern, but they themselves are not diseased; they just look different. Variations, which may include, for instance, a large clitoris, absence of vagina, congenital absence of gonads among others. Metabolic concerns if present in intersex persons should be treated medically, but inter sex genitals themselves are not in need of medical treatment.

b) Current response of health facilities towards transpersons

- The health system is not equipped to respond in a sensitive manner to trans persons.
- Specific barriers faced in accessing healthcare
- Insensitive outpatient registration procedures.
- Ignorance of or insensitivity among providers about the issues of TG people.
- Lack of assignment of specific toilet facilities and wards for admission if treatment requires the person to stay.
- Biased language such as 'abnormality' or 'anomaly' further adds to the marginalisation of certain gender groups.
- Inconvenient operating hours—especially for TG in sex work.
- Lack of same-day HIV test results (prevent people from collecting results or to come for repeat testing). Lack of male regular partner treatment or insistence by providers on male regular partner screening / treatment.

II. Current response of health facilities towards Intersex people

- Though babies born with intersex genitalia are not rare, medical personnel are still not equipped to understand finer nuances at birth and how to counsel the family.

- The arrival of a new-born is a highly emotional event and gender plays a key role. In the Indian scenario, assigning gender is not easy, because most patients with ambiguous genitalia may end up as females.

- There are several documented ethical concerns related to assigning sex at birth; birth registration and naming ceremony; getting investigations carried out expeditiously; deciding on gender; timing of surgery; telling the parents the truth and the like. Medical professionals also feel that untreated intersex conditions can lead to depression and suicides amongst people born with intersex genitalia.

- Medical problems such as urinary infections and metabolic disorders need to be treated but these should not be confused with surgery to assign a specific sex.

- The health system has no scope for providing psychosocial support to parents of such children and neither are there any support groups to guide these families.

III. Gender sensitive care for intersex persons

- It is recommended that no vagino plasty be done in children; clitoro plasty only in more 'severe cases'; and no vaginal dilation before puberty. It also stated that the functional outcome of genital surgeries should be emphasised, not just cosmetic appearance. Perhaps most importantly it acknowledges that there is no evidence that early surgery relieves distress.

- Health providers have to believe that an intersex person has a right to self-determination where her or his body is concerned. Assignment of intersex infants as male or female is very common; but the medical community needs to reflect upon consequences of carrying out these surgeries immediately after birth. An individual may decide later in life to change their gender and therefore this scope should be made available for those born with intersex features. Fixing children with ambiguous

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genitals as a male or female takes away the scope for self-determination. Children with intersex conditions have significantly higher rates of gender transition than the general population, with or without treatment. That is a crucial reason why medically unnecessary surgeries should not be done without the patient's consent; the child with an intersex condition may later want genitals (either the ones they were born with or surgically constructed anatomy) different than what the doctors would have chosen. Surgically constructed genitals are extremely difficult if not impossible to "undo," and children altered at birth or in infancy are largely stuck with what doctors give them.

- Psychosocial support is integral to care, that on-going open communication with patients and families is essential and that it helps with well-being; that genital exams and medical photography should be limited; and that care should be more focused on addressing stigma not solely gender assignment and genital appearance.

- Lastly health providers have to get rid of biased language such as 'hermaphroditism' because the focus should not be on correcting genitals but on the real health problems encountered by intersex persons which go beyond their genitals.

IV. Gender sensitive health care for trans persons65

- The medical profession must also develop and monitor implementation of guidelines related to gender transition and sex reassignment surgery (SRS) if an adult person seeks to undergo such a surgery. The health provider must clarify the ambiguous legal status of sex reassignment surgery and provide gender transition and SRS services (with proper pre- and post-operation/transition counselling) for free in public hospitals in various parts of India.

V. Responding to survivor of sexual violence

Medical practitioners must recognize that transgender and intersex people (TG/IS) are vulnerable to sexual violence due to the marginalization and discrimination they face. It is not uncommon for transgender and intersex persons to experience ridicule in the health facilities. Health professionals often ignorant of the variations in biology and gender identity and also tend to ‘pathologize’ them. Guidelines as per the GoI-MoHFW, 2014:

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• Primacy should be given in the record to the survivor’s stated gender identity and appropriate names and pronouns used.

• Transgender and intersex people may be unwilling to report the case to law enforcement for fear of being exposed to inappropriate questions and abuse, therefore adequate care should be provided for those who do approach health institutions.

• Information on the intersex variations or transgender status of the survivor must be treated as confidential and not to be revealed without the survivor’s consent.

• The inadvertent discovery during examination or history taking that a person is transgender or intersex must not be treated with ridicule, hostility, surprise, shock, or dismay. Such reactions convey that the person is being judged and is likely to make them uncomfortable in the health care setting.

• It is important to be aware of the possible health consequences that the sexual violence may have resulted in. For instance, transgender male individuals who still have ovaries and a uterus can become pregnant even when they were using testosterone and/or had not been menstruating. Similarly, intersex variations which include non-typical genital appearance may still put some intersex women at risk of pregnancy. Health professionals must be aware of these variations and must anticipate health consequences accordingly.

• Though Indian laws do not recognize gender identity-based hate crimes, it is important for the health professionals to record the survivor’s account of the assault as part of the procedural history-taking, making note of the survivor’s perception of the reasons of the assault, if so stated.

• Information about referral agencies that provide services to transgender or intersex survivors of sexual violence must be provided where available.

**Role of Doctor**

• A doctor should use appropriate and accurate terminology (e.g.: 'Variation' in place of 'anomaly') which will help to create a respectful environment where marginalised gender groups such as transgender and inter sex individuals can disclose their health concerns.
● It is essential to counsel parents with accurate and complete information about the intersex conditions and clarify that the condition is a variation and not an abnormality. Parents should be advised against surgical intervention unless there is an accompanying health condition such as urinary disorder.

● A support group of parents with intersex children is necessary to help couples giving birth to intersex babies, so that surgical interventions are not made in a hurry.

● While treating health problems of transgender people, health providers should develop gender sensitive means and competency to treat health problems related to sexual health.
12. Menstrual disorders

12.1 Amenorrhoea owing to sexual abuse

Gender content added: Amenorrhea owing to sexual abuse

Lecture name: Menstrual disorders: amenorrhoea owing to sexual abuse
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion, Case study

Resources:

Handouts: ---

**Key Points**

1. Hormonal imbalance, thyroid malfunctions, anaemia and conditions such as PCOD lead to amenorrhea. Sexual abuse can also be a possible cause of amenorrhea.

2. HCPs need to create a safe space for adolescents to disclose their history of abuse.

3. Medical examination of a child survivor must be done sensitively and without causing any further trauma to the child.
4. Providers play an essential role in both offering emergency medical care as well as conducting medical examination in such cases.

Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise the role of sexual abuse as possible cause for amenorrhea</td>
<td>Student should be able to deal with sexual abuse cases sensitively and comprehensively</td>
<td>Student should be sensitive to the possibility of sexual abuse among young female patients</td>
</tr>
</tbody>
</table>

*Note to Educator:* Students should be explained that amenorrhea among young girls can be a result of child sexual abuse and hence there is a need to enquire about such a possibility.

The educator should begin the session with the case study of Anita and seek responses to questions from medical students. Points mentioned in the content can be used to summarise the issue of sexual violence and role of doctors.

Content

I. Understanding sexual violence^{66,67}

- Sexual abuse can be a difficult and traumatic experience for children and their caregivers. In cases of rape by a close family member, safety of the child may be further compromised and may add to the caregiver's helplessness and anxieties around the family's safety or financial security.

- Incest is 'Sexual activity between family members or close relatives'. This typically includes sexual activity between people in consanguineous relationship (blood relations), and sometimes those related by affinity, such as individuals of the same household, step relatives, those related by adoption or marriage, or members of the same clan or lineage.

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India has the world's largest number of child sexual abuse (CSA) cases: One child, less than 16 years is raped every 15th minute. Every 13th hour a child under 10 years is raped, and one in every 10 children is sexually abused at any point of time. Some indicators of CSA are:

a. Pain on urination and / or defecation.
b. Abdominal pain / generalized body ache.
c. Inability to sleep.
d. Sudden withdrawal from peers/adults.
e. Feelings of anxiety, nervousness, helplessness.
f. Weight loss.
g. Feelings of ending one's life.

An adolescent girl may have above mentioned problems in addition to amenorrhea. These should alert the doctor to enquire about underlying sexual violence.

However children and adolescent rarely reach a health setting alone. Family members and / or others may be accompanying the child for treatment. The doctor needs to consider this before initiating any probe related to sexual violence. Therefore, for any disclosure to take place, the doctor should be able to create a safe and private space.

If there is suspected sexual abuse, following are some guidelines to follow when interacting with children about their experience of abuse:

- Explain that the role of the doctor is to treat and provide care. Explain to the adolescent that he/she is trying to understand the reasons underlying Amenorrhea.

- Obtain permission to talk about the abuse from the child and their trusted caretaker by taking their informed consent. But if the doctor suspects that the accompanying person is the offender, discuss that hospital policy requires examination in private space and if it is a girl child a female attendant will be present in the examination room.

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● Maintain a relationship of equality with the child so as to promote an environment of trust and respect.

● Ask children above the age of seven for permission to speak with them so they can give their assent to talk about their experience (even if they are unable to give their legal consent). Children below 12 years of age have capacities to understand questions and discuss what happened to them, when a health care provider engages with a child it demonstrates that the provider takes the child seriously and recognises capacity of the child to provide information.\(^69\)

II. Medico legal response to sexual violence: Student should be asked to refer to the MoHFW guidelines and protocols for medico legal care for survivor / victim of sexual violence.

Consent of the child:

● A child of 12 years and above can consent to medical examination to determine sexual violence hence written consent of the child must be taken. This process would include giving the child and her/his family information about the medical examination process, giving them enough time to process this information and ensuring the child agrees to the examination voluntarily.

● If the child is too young to give consent, consent should be taken from the child’s guardian / trusted adult.

● When a doctor has reason to suspect that a child has been or is being sexually abused, he / she is required to report this to the appropriate authorities (i.e., police or the relevant person with their organization who will have to report it to the police).

Seeking details about the episode :

● Questions should be simply worded, open ended and not leading.

● Further probing can be done through statements like "tell me more" or "and then what happened"?

• Focus should be on finding out medical and family history of the child.

• Using the child's language for body parts or using drawings or toys to help the child describe where they have been touched might help the child to have difficult conversations around the abuse.

• Help the child feel prepared for the examination by showing them the required equipment and explaining the process in a simple language.

• In case of children with special needs, the doctor needs to ensure that the child is communicated with in the manner they understand and supported in any way required (for instance, helping in getting on and off the examination table).

• Doctors must be cognizant of the fact that this may be the first time the child is undergoing a medical examination. They have limited knowledge of reproductive health issues and may not even be able to identify the abuse or their feelings around the incident.

Therapeutic care:

• Therapeutic care comprises of psychological first aid and medical care.

• Adolescent / child must be comforted and reassured that she is in a safe space. Efforts to remove the blame from her should be undertaken with simple messages such as it is not your fault.

• If the examination reveals an unwanted pregnancy, a sexually transmitted infection, white discharge or any other health condition, it must be treated immediately.

• If the adolescent / survivor has been brought immediately after sexual assault, emergency contraception must be offered to prevent pregnancy.

• Follow up should be emphasized as there could be pain or infection that may appear at a later stage.

Documentation:

• Doctors must document who was present with the child.
Questions asked to the child must be documented along with the child's answers (in the child's own words).

Record medical history to cover any known health problems, immunisation status and medications. Some questions that could help may be "Have you seen a doctor or nurse lately?", "Have you had any operations?" and "Do you suffer from any infectious diseases?".

Forensic evidence must be carefully collected and preserved. Clothing collection is critical in this process as it is the most likely site for evidentiary DNA.

Scene investigation, including collection of linens and clothing should be done early as evidence from clothing and other objects is more likely to be positive than evidence from patient's body.

Referral:

- Wherever necessary, the child should be referred to for counselling.
- Wherever applicable, the child should be referred to for testing for HIV and other STIs.

**Case Study:**

Anita, 14 years of age, was brought to a government hospital by her mother to terminate a pregnancy. Since her mother was working in a faraway place for previous two years, Anita and her younger brother had been staying with their father. The mother's work did not permit her to visit the children often. Anita attained menarche at the age of 12, and since then has had irregular periods.

Anita was subjected to sexual abuse (at least twice a week) by her father over the past year. Initially, the father would beat her if she protested. She was afraid to disclose this to anyone for the fear that she may not be believed. Anita missed her periods but never suspected pregnancy. She regarded the amenorrhea as part of her irregular cycles. Anita had no idea that such an act could lead to pregnancy. When the mother returned from her contract work, Anita complained of constant pain in
abdomen. The mother brought Anita to the hospital. The doctor upon carrying on tests detected pregnancy. Anita disclosed to her mother about sexual abuse from her father.

As her treating doctor how will you respond to Anita?

Questions for Discussion

Q1. How would you discuss the barriers faced by Anita to disclose the abuse to her mother?
A - Children fear not being believed by their own family members. Additionally, like Anita, many other adolescents may not have adequate information about menstruation, sexual abuse and how sexual contact can lead to an unwanted pregnancy.

Q2. Could the doctor in her routine enquiry have probed about sexual abuse?
A - Anita was 14 years of age, while seeking general history and examination the doctor should have asked about menstrual history, or if she had any health complaints. Such sensitive probing could have helped Anita to disclose about sexual abuse. Had there been a discussion on menstrual cycle and if there were any irregularities, enquiry by the doctor would have enabled Anita to disclose which would have prevented pregnancy or further abuse.

Q3. What would be components of doctor’s response to Anita? What are the steps to provide her with medico legal care and treatment?
A- The first and foremost responsibility of the doctor would be to provide therapeutic care, in this case it would comprise of a termination of pregnancy. The procedure can be explained to Anita and her mother in simple language. Anita’s mother can also be asked if there was any supportive family member or friend whom she would be able to speak to about the sexual violence.

The doctor will also provide information about their legal rights. Doctor should encourage the mother and Anita to report the case to police under Protection Of Children from Sexual Offences Act (POCSO, 2012) and help she can avail under it. Anita and her mother need to be provided with psychosocial counselling considering the trauma caused by sexual violence and the consequences of likely arrest of the husband. Taking into account that the abuser is the father, Anita and her mother should be asked if they require a provision of shelter. Anita should be provided with sex education, information about pregnancy, contraception.
12.2 Over use of hysterectomy to deal with menstrual problems and concerns of differently-abled women

Gender content added: Overuse of hysterectomy to deal with menstrual problems, Uncritical use of hysterectomy in differently abled women

Lecture name: Over use of hysterectomy to deal with menstrual problems and concerns of differently-abled women

Subject: Obgyn

Semester no: 5

Duration: 1 hour

Methodology: Lecture, Discussion, Case study


Handouts: ---

Key Points

1. There is over emphasis on hysterectomy as treatment for most menstrual health issues, but it needs to be realised that 'hysterectomy' is not a panacea for every case of menstrual disorder.

2. Increasing availability of treatments and making accurate information accessible to women can help counter injudicious use of hysterectomy.

3. There is need to appreciate that hysterectomy can have physical and psychological effects on the woman (like feeling loss of feminity).
Learning Outcomes

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</tr>
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<tr>
<td>Student should gain an understanding about the consequences of uncritical acceptance of hysterectomies</td>
<td>Student should be able to assist women to manage certain menstrual problems.</td>
<td>Student should appreciate that uterus has important functions other than reproduction.</td>
</tr>
</tbody>
</table>

Context: When discussing menstrual problems

**Note to Educator:** The educator can explain to the students that hysterectomies are often perceived as a cure for menstrual problems. However, routine use of hysterectomy can affect the woman's health disproportionately.

Content

- As per the NFHS-3, 12.7% women in the age group of 30-45 years reported that they had undergone hysterectomy. A study conducted in Andhra Pradesh revealed that the average age at which hysterectomies were performed was as low as 28.5 years.

- Hysterectomy is often seen as a cure for all menstrual problems occurring in a woman after she has children or after the couple has achieved the desired family size. Such notions are common among doctors as well as public.

Why do women opt for hysterectomies?

- Women living in poverty lack access to information about the implications of hysterectomy and alternate forms of treatment for menstrual problems. Other factors such as menstrual taboos, difficulty in managing menstruation related problems may

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drive women to opt for this without realizing the ill effects of removal of uterus. Often, women don’t have the time or resources for repeated visits that a medical management may entail and therefore, may prefer a quick fix solution like hysterectomy.

**How do Health Providers view hysterectomy?**

- Most health care programmes look at a woman in the role of a 'mother', placing great emphasis on a woman's reproductive health during her childbearing years. The uterus is almost considered redundant once a woman has given birth to children. The uterus plays an important role in maintaining women’s health but doctors often ignore it when women report with gynecological morbidity such as fibroids, white discharge and so on. The removal of uterus is offered as quick solution to managing the gynecological morbidity.

- Hysterectomies are commonly conducted under the Government funded health insurance scheme as they ensure high payments to the providers particularly the private providers. The procedures are carried out even when not medically indicated for mercenary reasons.

**Effects of indiscriminate use of hysterectomy:**

- The emphasis on hysterectomy as a 'cure all' treatment for most gynaecological health concerns such as white discharge and irregular menstrual bleeding, has adverse health consequences for women such as early menopause, post-operative complications, hormonal problems. Unnecessary hysterectomy must be considered a violation of their sexual and reproductive health rights.

- Hysterectomy affects production of estrogen, which is important to maintain health of women and can protect women from degenerative loss. Long-term complications could include premature menopause, vault prolapse, delayed diagnosis of ovarian malignancy if the ovaries have been left behind but are not regularly screened, dyspareunia, and sexual dysfunction can also occur.
Case Study: The case study can be used by the educator to initiate a discussion on hysterectomies

Nirmala has come to the gynaecology OPD suffering from heavy menstrual bleeding over the past 15 days. Nirmala is 40-years-old and has three children. During the initial talk with the doctor, she said that she did not wish to have any more children. The doctor immediately suggested that she should undergo hysterectomy as she no longer wishes to have any children. The doctor also added that hysterectomy would free her from the monthly pain and heavy bleeding from which she suffers. Nirmala tried to find out if there were any other treatments, but the doctor convinced her that hysterectomy was her best option. After some thought she agreed to the procedure as she was convinced by the doctor that she would be free from the monthly hassle of managing the menses and its related pain and heavy bleeding.

Questions for Discussion

Q1. Do you think hysterectomy is the only solution for curing problems related to heavy bleeding in older women?
A- The educator should point out that there are alternative treatment options as well.

Q2. Do you think hysterectomy can have ill effects on a woman’s health?
A- The educator should point out that hysterectomy should not be conducted unless it is absolutely imperative to treat a patient and after all interventions have been tried. The uterus has functions other than pregnancy. The importance of estrogen and its function to postpone degenerative health problems should be emphasised.

Q3. Why do you think women who have achieved their desired family size opt for hysterectomy?
A- The educator should point out that there is a general perception among women that once they have achieved their desired family size there is no function of the uterus. Also, women could look at it as freedom from managing menses and its associated problems. The doctor can make women aware of the role of ovaries and uterus and how it can prevent women from calcium depletion amongst other health concerns.
Role of Doctor

- The doctor should be sensitive in handling menstrual disorders and judicial use of hysterectomies wherever necessary should be carried by qualified doctor.

- Health education on gynaecological ailments and treating them in time is critical. Such services can be provided at the primary health care centres too.
13. Menopause and HRT

Gender content added: Gender factors affecting menopause, Recognising menopause as an important life stage

Lecture name: Menopause and HRT

Subject: Obgyn

Semester no: 5

Duration: 1 hour

Methodology: Inclusion of key points while teaching Menopause and HRT

Resources:


Handouts: ---

Key Points

1. The social construction of gender and the importance given to femininity, beauty and fecundity attributed to women can convert to fear and sense of loss during menopause and ageing in women. It is therefore important to delink femininity from menopause and discuss menopause as a natural ageing process.

2. Women may seek Hormone Replacement Therapy (HRT) as they may be anxious about losing their youthfulness and fear not being able to have a sexual relationship with their partner. In such situations, a doctor can discuss menopause as a transitory...
phase of life, and discuss the effects of HRT, especially with women at risk of breast cancer.

**Learning Outcomes**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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</thead>
<tbody>
<tr>
<td>Student should be able to understand menopause as a ageing process rather than a medical disorder</td>
<td>Student should be able to explain menopause as a process of ageing and explain the scope and consequences of using HRT</td>
<td>Student acknowledge that social construction of gender leads women to fear menopause as a stage where they lose femininity</td>
</tr>
<tr>
<td>Student should be aware about sexual needs of older women and effect of menopause on sexual needs</td>
<td>Student should be able to demonstrate a non-judgmental attitude and discuss stages and effects of menopause on women in non-medical language. They should also encourage seeking support from the partner in this life stage in order to enable a mutually satisfying sexual relationship</td>
<td>Menopause should be understood as a important biological and natural life stage for women and not a bio medical problem. The doctor should become sensitive towards the physical and psychological effects of menopause ranging from hot flashes to mood swings</td>
</tr>
</tbody>
</table>

**Context:** While teaching menopause

**Note to Educator:** The medical educator can draw attention of the students to ways in which social construction of gender compels women to see menopause as a loss of being feminine, youthful and attractive. Media messages as well as the pharmaceutical companies create a certain image of women as youthful which compel women to adopt means to stay young. But doctors should not promote HRT as a solution to stay youthful, explaining the risks and benefits of HRT.

**Content**

- Menopause should not be labelled as a disease because it does not limit physical or psychological capacities. It is a progression of natural ageing and women should be
counseled to understand the emotional and physical changes they may experience in the course of menopause. Though menopause is primarily a biologically influenced variable, studies have shown that the age at menopause varies across socio-economic groups. The average age at menopause varies notably with geographical region, level of development the countries have reached, and various biological and behavioural characteristics of the population.73

- Gender and socio-economic status has a severe effect on nutrition of women. Cultural practices of women being the last members to eat in the family leave women with insufficient amount of food, quantity as well as quality wise. Women coming from lower socio-economic status are more adversely affected; they do not get a share of calcium rich food like milk, which has an adverse effect on the bone health, thus making them pre-disposed to osteoporosis. These effects become evident in menopausal women.

- A recent study conducted by The Institute of Economic and Social Change (ISEC) has shown that nearly 4% of Indian women experience signs of menopause between the ages of 29 to 34 years, which is very premature as compared to world standards.74

- Though several women may feel different symptoms related to menopause such as physical changes, menstrual changes, and hot flushes, thinning and greying of hair. It may be difficult for women to differentiate between signs of menopause and signs of ageing. It is a myth to relate all changes in mid life of women to menopause and consequently connect it to the reproductive cycle of a woman’s life.

- One of the first medical treatments to deal with menopausal signs was estrogen replacement therapy (ERT). Massive advertising campaigns along with prestigious physicians and researchers brought forth ERT and claimed to deal with vaginal dryness, cancer, heart trouble, enable women to be sexually active and prevention of osteoporosis. However by mid-1970's, studies showed several health problems such as gall bladder diseases, endometrial cancer amongst others.

- HRT a combination of progesterone in combination with estrogen is being increasingly used. HRT is also being promoted by the pharmaceutical industry. Hence there is no

focus on non-medical approaches to deal with menopause. Exercise, balanced diet, adding vitamins, minerals and calcium to their daily life, relaxation techniques such as meditation have been found to relieve women of some of the menopausal discomfort.

- Though HRT is used for women in menopause to relieve them of the health concerns the experiences of menopause are restricted to cure for individual women without changing any aspect of the social environment, which perpetuates function of reproduction and youth in the society.

**Role of Doctor**

- A doctor should be able to explain to women that menopause is a natural process of ageing and not a disease. She / he can equip the woman patient to understand symptoms associated with it and develop a plan to deal with them. Family members and partners may be involved after seeking consent of the woman to help her to deal with the psychological and physical consequences in menopause.

- A doctor should be equipped to deal with women’s anxieties, be sensitive about her sexual needs and feeling in the course of menopause the fact that women undergoing menopause may have reduced desire to engage in sexual activity, which may lead to abuse from their partners. Hence, the issue of sexual needs and concerns needs to be broached in a sensitive manner.

- A doctor should dispel myths about menopause being a process leading to loss of femininity and should explain it as a natural process of ageing and myths related to HRT being a way of staying youthful and attractive and explain medical indications of using HRT.
14. Infections of genital tract

Gender content added: Sexual violence as a cause of STIs, sexual health problems of LGBTIQ individuals

Lecture name: Infections of genital tract
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion, Case study

Section 1

Key Points

1. Infections of genital tract can be related to sexual practices and SV.

2. Sexuality of a person is profoundly influenced by prescribed gender roles and norms and is strongly linked to gynecological and reproductive health.

3. Being aware of violence as an underlying factor for STIs can help the doctor to assess the treatment and care needs of the patients.
## Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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<tbody>
<tr>
<td>Student should be able to explain the concept of &quot;sexuality&quot; and understand how gender influences it</td>
<td>Student should be able to deal with cases of People belonging to different sexual orientations sensitively and assist them in sexual health concerns with care</td>
<td>Student should be sensitive to sexual and reproductive health needs and rights of women and diverse sexual orientation</td>
</tr>
<tr>
<td>Student should know that violence can be an underlying cause of STI</td>
<td>Student should explore violence as an underlying cause when dealing with cases of STI</td>
<td>Student should be sensitive towards women who are survivors of violence and suffering from STI</td>
</tr>
</tbody>
</table>

**Context:** When teaching STIs

**Note to Educator:** The educator must explain to the students that it is necessary to appreciate the fact that gender strongly influences infections of genital tract, also that violence can be an underlying cause of RTI/STI and hence there is need to adopt sensitive approach in management of infections of genital tract.

*The educator should herself / himself be comfortable about diverse sexual orientations and should be able to talk about the same without bias or disrespect.*

*The health care needs of people with diverse sexual practices may be different. They should get quality health care as a right, without stigma, humiliation or discrimination.*

## Content

### I. Barriers to talking about sexuality

Despite the close link between sexuality and health, issues related to sexuality are often unaddressed in provider-patient interactions.

Sex and sexuality are considered private matters that cannot not be discussed with or by others. Also, sexuality is an area which is bound by morality and societal
prescriptions of what is considered 'good' and 'bad' or 'moral' and 'immoral'. These moralistic values and attitudes prevent us from expressing our true opinions around sexual matters. As a result, one also finds that there is an absence of an acceptable language / vocabulary to talk about sexuality.

Due to the above reasons, HCPs generally prefer not to talk to their patients about the sexual dimensions of their health conditions or any issues related to sexuality. If they discuss these matters, then they talk in strictly bio medical terms, without any reference to the social realities or emotional concerns of the patient. This makes it difficult for the patients to better understand their conditions and deal with the concerns.

II. Biases about women's sexuality

We find that biases and hesitancy about women's sexuality may prevent health care providers from dealing with health concerns in a holistic manner. It is often assumed that single/unmarried women are not sexually active. As a result; providers do not discuss the sexuality related concerns that unmarried women may have. It is important that providers take cognisance of the sexuality of unmarried women to ensure proper treatment and care for related concerns e.g. STIs.

Lesbian women are not recognised as a risk category for STIs. Counselling lesbian patients about the use of dental dams can help them practice safe oral sex.

Married women could contract STIs from their partners who may be have multiple sexual relations.

Certain vulnerable groups such as sex workers are often subjected to coercive health care practices to minimize the risk of STIs especially, HIV. There is a heavy emphasis on the use of condoms among sex workers but, information about and access to other forms of contraception and health care is lacking.

Considering these barriers in talking about sexuality among health care providers, it would be useful for health care providers to understand the following definitions and concepts. In addition, while doctors treat these infections, history taking from the patient forms an important component of the treatment plan. For that purpose also the understanding of sexuality and related concepts in necessary.
III. Understanding sexuality

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.

Sexual and Reproductive Health Rights: Sexual rights embrace human rights that are already recognised in national law, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence to:

The highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services:

- Seek, receive and impart information in relation to sexuality.
- Sexuality education.
- Respect for bodily integrity.
- Choice of partner.
- Decide to be sexually active or not
- Consensual sexual relations.
- Consensual marriage.
- Decide whether or not and when to have children.
- Pursue a satisfying, safe and pleasurable sexual life.

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IV. Why should doctors know about the concept of sexuality?

- It is impossible to determine if sexuality is determined by biology alone or includes social forces. Because we can only ever view biology through our social, human lens of comprehension, it can be argued that our biological conceptions are in themselves socially constructed. As a doctor it is important to know how sexuality is influenced by social, political structures, and vice versa.

- Society perpetuates certain stereotypes centered on the sexualities of men, women and the third gender. Some of the examples are:

  'Sexual desire is lower in women than in men', 'Men are always ready to have sex', 'Men should be embarrassed if they are unable to get an erection during sex', 'It disgusts me when I see a man acting like a woman'.

- An individual's sexuality is influenced most profoundly by prescribed gender roles—the social norms and values that shape the relative power, responsibilities and behaviours of men and women. For e.g. women's prescribed role in sexual relations is to be passive partners. Women are not encouraged to make decisions regarding their sexual partners, to negotiate with their partners the timing and nature of sexual activity, to protect them from unwanted pregnancy and diseases or even to acknowledge their own sexual desire.

- Men, on the other hand, are socialised to 'conquer women' to prove their manhood. Men are encouraged to think primarily of their sexual performance. Women's sexual pleasure is valued usually as a proof of male performance. Often, the proof of their performance is sought in the form of fertility i.e. the ability to have children.

- Men's and women's mutually reinforcing gender roles have particularly debilitating consequences for reproductive health and contraceptive practice. These gender roles place a woman's health at considerable risk. These gender roles may lead to neglected health, abuse and violence in the form of forced sex, STDs, unwanted pregnancies and unsafe abortions.

V. Violence as a cause of reproductive tract infection:

- The extent to which a woman is able to negotiate the terms of a sexual relationship defines her capacity to protect herself against unwanted sexual acts, pregnancies or sexually transmitted infections.
• Thus, violence can be an underlying factor of contracting STIs / RTIs. Being aware of different forms of violence can help in assessing the treatment and care needs of patients. Some examples of how violence can lead to infections are as follows:

• Among married women, infections could be a result of [a] a sexual assault by husband / partner, [b] not being aware of husband’s / partner’s infected state and [c] husband / partner’s refusal to use condom / or practice safe sex.

• There are certain violent and oppressive superstitions in society that target girls and women. For example, as per the ‘virgin myth’ it is believed that STIs in men would be miraculously cured if the infected men can have sex with girls who are virgins.

**Role of Doctor**

• A doctor should be able to demonstrate non-judgmental attitude and discuss sexuality, sexual behaviour and sexual orientation in an uninhibited manner.

• Counselling single men, women and couples on safe and consensual sexual practices can help prevent violence.

• He / she should be alert to the signs / symptoms of violence. The doctor should ensure privacy while discussing any aspect of sexual behaviour ranging from, contraception, STIs/RTIs etc. The doctor should ensure that complete records are maintained of any signs suggestive of violence that is recognised during examination.

**Activity**

**Case Study for Discussion:**

*Meena is 45-years-old and reports to the doctor with genital herpes. She is a lesbian woman and in relationship with another woman. While the doctor prescribes her medication, she is hesitant to speak to the doctor. She wants to know how to protect her partner from getting infected. But is worried about the doctor’s reaction if she discloses. How would you approach the issue with her?*
**Key Responses**

- As her examining doctor, do not assume that Meena is single or that she is not in a sexual relationship. It would be important to probe about sexual relation of Meena to understand the underlying reason for the infection. The doctor should not assume that Meena is in a heterosexual relation. Hence neutral language such as "Do you and your partner, use protection?" Does your partner suffer from an infection? Such communication can help Meena think that the doctor is not assuming that she has a boyfriend/ husband and therefore may be more understanding of her relationship.

- Doctor can also discuss with Meena if it is possible for her to use contraceptive such as condoms / dental dams to create a barrier for preventing infection.

- Doctor should also be comfortable in exploring nature of sexual relations such as oral, vaginal, anal and with use of objects. Such information will assist the doctor in helping Meena to develop a treatment plan that her partner safe from infection too.
15. Genital Prolapse, genital tract displacement

Gender content added: Poverty and Gender as factors leading to prolapse

Lecture name: Genital Prolapse, genital tract displacement
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion, case study and exercise

Handouts: ---

Key Points

1. Gender roles and poverty put certain women at risk of prolapse.

2. Interventions to reduce / prevent prolapse must address immediate concerns and needs at the community level but also larger structures of class and gender-based discrimination.

3. Integrated health interventions between gynaecology and physiotherapy help women recover faster.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should understand how poverty and gender discrimination increases the risk of Prolapse</td>
<td>Student should be able to ask specific information on predisposing factors related to treat women with prolapse with consideration to factors like discrimination and poverty</td>
<td>Student should be sensitised about how poverty and gender discrimination can increase the risk of prolapse</td>
</tr>
<tr>
<td>Student should be aware of the strategies to reduce occurrence of prolapse</td>
<td>Student should be able to treat women with prolapsed, especially older women with sensitivity and not use hysterectomy if not medically indicated</td>
<td>Student should be sensitized that treatment options other than hysterectomy are available for treating prolapse</td>
</tr>
</tbody>
</table>

**Context:** While teaching genital prolapsed.

**Note to Educator:** The educator should explain the social factors that affect genital prolapse and to adopt an empathetic approach towards women suffering from prolapsed.

**Content**

- While gender discrimination is prevalent across all strata of society, women living with poverty have several multiple disadvantages that make them more susceptible to the consequences of such discrimination.

- In fact, some physiological factors can have an origin in gender discrimination and poverty, such as higher number of births, malnutrition, inappropriate birthing practices, inability to adequately rest after childbirth, strenuous work, etc.

- Women face gender discrimination right from childhood to old age, which have long lasting ill effects on her sexual and reproductive health as well as general health, causing health complications such as prolapse.
• Painful sexual intercourse is often a consequence of this condition and may trigger violence in women's lives

I.a) Poverty and gender discrimination and its association with prolapse:

• Multiple pregnancies (often, in order to bear sons).

• Physical labour during pregnancy or immediately after childbirth or abortion.

• Adolescent pregnancy.

• Lack of control over sexual relationships.

• Lack of control over reproduction.

• Lack of adequate nutrition.

• Being subjected to physical violence.

• Reluctance/inability to seek medical care till it can no longer be avoided.

• Often significant degrees of prolapse can lead to sexual difficulties and may even contribute to violence.76

But the current medical practice does not take these multiple factors in to account. In fact a prevalent notion is that doctors should restrict themselves to the medical condition with which a patient reports to them and not probe in to underlying reasons which may lie in a sociological context. But such a practice is erroneous. In order to deliver services effectively and to ensure better health; it is pertinent that doctors seek additional information which on the face may not look clinical but directly impacts health. For example a doctor may continue to treat a recurrent RTI without understanding that the cause lies in the nature of sexual relationship, whether it is painful sex, whether contraception is not being used and the infection is a result of unprotected sex amongst other reasons.

b) Steps to address this concern

- Prolapse can cause other gynecological morbidities in women as well; doctors should manage these morbidities as well while treating women with prolapse.

- Ensure that families are aware of the physical needs of pregnant and postpartum women for rest and nutrition. Women and families are aware of the early signs and can seek medical help. Making appropriate medical help available is one of the interventions.

- As we have already seen, gender roles and poverty are leading risk factors for the occurrence of prolapse, so in this situation it becomes important for a doctor to take individual factors like occupation, socio-economic status, her pregnancy history, presence of violence into consideration.

- For poor women who may not be in a state of good general health, strenuous manual and heavy work, such as standing for long hours in bent position, sitting, squatting, and lifting heavy loads, soon after delivery can be an important factor associated with uterine prolapsed. Other factors could be frequent child bearing or trauma to the pelvic floor following a surgery.

- In addition, it is necessary that a doctor should listen as the woman explains in her own words the health problems, which she is facing. The patient may use local terms, report vague symptoms; but a doctor needs to understand that women may not be comfortable to discuss such matters related to reproductive and sexual health due to the culture of silence and taboo around it.

- The doctor has an important role in counselling husband and family to create a support system. Discussing with pregnant women and their families on how to prevent prolapse by avoiding strenuous work immediately after delivery would be useful. Similarly, teaching women pelvic floor exercises in post-natal period would also be useful for women to strengthen pelvic muscles.

- An important conversation that the doctor should have is about birth spacing and control methods. All efforts must also be made by the health system to make them more accessible.
Role of Doctor

- Doctors should focus on preventive measures and provide appropriate care for women who are in 'labour' and guide on care post-delivery. They should also be taught pelvic floor exercises when they come in for other gynaecological problems.

- A doctor should also opt for alternative treatment options such as physiotherapy for treating early prolapse.

**Case Study**

Rehana is a 30-year-old woman living in an urban slum. Her parents got her married to a man who lived in a city so that she could escape the hard life and poverty of the village. Rehana took a long time to adjust to the highly crowded slum, the lack of privacy, and an extremely small home. She has two children. Six years ago, her husband lost his job at the factory as it shut down without notice. The money he received was used up to pay the heavy deposit on their present room. Her husband, who was a hardworking man, now has to go in search of daily labour. He feels frustrated and has begun to drink. Rehana has been suffering from backache for the past two years but she can get no rest. She also has white discharge. When she mentioned this to her husband, he told her to ignore it and bear up. Of late, she has been experiencing an odd sensation as if there is something between her thighs. Sometimes when she coughs or presses down hard during defecation, she feels as if something is coming out of her body. She finds it very difficult to have sex and suffers from severe pain after intercourse. Because she avoids sex, her husband has begun to get suspicious of her. Last night, Rehana's husband forced her to have sex. After intercourse, Rehana started bleeding, which scared her husband. He promised to take her to the hospital if she promised not to disclose this to anyone. This morning, Rehana, along with her husband, went to the nearest government hospital where they had to wait for two hours in the gynaecology OPD before they could get to see a doctor. Her husband lost the day's wage because of this delay. When the doctor finally saw

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her, she could sense that he was disgusted with her condition. Rehana was told that she needed surgery, but because there would be no one to take care of her children when her husband went to work, she refused surgery and told the doctor she had to go home. The doctor was angry with her but wrote out some medicines for her to take. When she asked if she could get the drugs free in the hospital, he said that the government had now stopped giving free medicines and that she would have to buy them herself. Rehana left with the prescription, knowing that she had no money to buy them. She also knew that the doctor would be angry if she went back again without having taken the prescribed medicines. So now she does not know where to go now.

Questions for Discussion

Q1. What are the various problems that Rehana has faced in her life?
A- Rehana had problems in adjusting to her life in the urban slum. Her husband was unemployed and had become an alcoholic. She was also facing gynaecological problems, such as white discharge, prolapsed uterus, and pain during and after intercourse. She is also scared of her husband as he is suspicious of her because she avoids sex. However, she is forced to have sex. Her husband dominates her all the time and does not even allow her to confide her problems to the doctor.

Q2. What are the different factors in her life that Rehana has little control over?
A- Rehana had no control over the selection of her husband. She had no choice regarding where she lived, her financial problems and her husband’s behaviour. She has no freedom from household chores. She’s constrained even in informing her doctor of the problems that she is facing in her life.

Q3. Why did she return from the hospital without receiving any real help?
A- She returned from the hospital because the health care providers were not sensitive to her problems. She refused the surgery because her children would be left alone at home. She also had financial problems and the operation would lead to further expense. She did not even have the money to get medicines for herself.

Q4. What do you think will happen now?
A- Rehana will continue to suffer from the illness and may come to the hospital when her condition deteriorates further. She may go back to her native place, seek some
quack's services that may be less expensive. Overall, her condition will deteriorate with no medical treatment and support.

Q5. What can be done at the level of the hospital to make the services more meaningful for women?

A- The hospital staff can be made more sensitive to women. Help can be sought from the social workers in terms of financial aid, counselling and motivation for surgery. The health care provider should also attempt to know the proper medical history of the woman, as well as that of her relatives. This should be linked to the larger question about how medical community must be part of the larger movement for universal health care, etc., so that even if they cannot be held responsible for poverty, they can make treatment easier for poor people, families.
16. Urinary disorders in Gynaecology, perineal tears, genital fistulae, RVF and VVF

Gender content added: Obstetric violence as a cause of fistulae and perineal tears

Lecture name: Urinary disorders in Gynaecology, perineal tears, genital fistulae, RVF and VVF
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture and Discussion
Resources:
Handouts:

Key Points

1. 'Obstetric violence 'is described in seven categories as physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities.

2. Unnecessary medical interventions like unnecessary cesarean sections, routine use of episiotomies and augmentation of routine labour have also been recognized as obstetric violence.

3. Obstetric violence predisposes women to medical conditions such as perineal tears and genital fistulae which are preventable. Comprehensive and sensitive obstetric care can prevent such medical conditions.
Learning Outcomes

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<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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<tbody>
<tr>
<td>Student should be able to recognize different forms of Obstetric Violence'</td>
<td>Student should develop skill to prevent perineal tears and genital fistulae</td>
<td>Student should develop a sensitive attitude towards women in labour room for</td>
</tr>
</tbody>
</table>

Context: While teaching urinary disorders.

Note to Educator: The educator should discuss different forms of obstetric violence and its health impact on women. Students should be equipped to provide sensitive and attentive care so as to prevent negative health consequences on women in the course of delivery.

Content

- The World Health Organization (WHO) has raised concern about excessive medicalisation of birth since 1985. Unnecessary caesarean sections were common in middle and higher income countries. But non evidence based medical intervention is not the only form of obstetric violence. Globally women experience poor treatment during child birth, physical and verbal abuse as well as disrespect.

Globally one of the most comprehensive categorisation of the term "Obstetric violence" was developed by Bowser et.al and Tesser et. al 78,79 :

1. Physical abuse
2. Non consented care
3. Non confidential care and denial of privacy
4. Non dignified care
5. Discrimination based on specific attributes
6. Abandonment and neglect and refusal to grant assistance
7. Detention in services

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Most studies have been found in the western context but few are also available in the Indian context. Some evidence is available on women’s experiences of obstetric violence. A study carried out with rural women in Varanasi district of Uttar Pradesh documented the nature and extent of reported disrespect and abuse by Health Providers. The study presented different forms of violence experienced by women such as being forced to pay money to support staff for cleaning the floor/room post delivery, being beaten and use of restraint in the course of delivery and comments on women’s sexual lives.80

A study carried out by CEHAT in Mumbai to understand the experiences of Muslim women at the level of health facilities showed that their experiences in the labour room were particularly distressing and they felt ridiculed and humiliated, but could not raise these concerns at the health facilities for fear of retaliation. The forms of violence ranged from rude behaviour, biases, negative remarks and criticising women especially from minority communities about their choices towards planning pregnancies and discriminating behaviour in the labour rooms.81

Additionally failure to meet professional standards such as lack of confidentiality, lack of informed consent procedures, improper and painful medical examinations have also been added to the different forms of obstetric violence.

Description of different forms of obstetric violence include:

1. Untimely and ineffective attention to obstetric emergencies.

2. Forcing the woman to give birth in a supine position, with legs raised, when the necessary means to perform a vertical delivery are available.

3. Impeding the early attachment of the child with his/her mother without a medical cause thus preventing the early attachment and blocking the possibility of holding, nursing or breast-feeding immediately after birth.

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4. Altering the natural process of low-risk delivery by using acceleration techniques, without obtaining voluntary, expressed and informed consent of the woman.

5. Performing delivery via caesarean section, when natural childbirth is possible, without obtaining voluntary, expressed, and informed consent from the woman.

Genital fistulae are also a result of obstetric violence. The United Nations Population Fund (UNFPA) defines obstetric fistula as, 'A childbirth injury that has been largely neglected, despite the devastating impact it has on the lives of affected girls and women. It is usually caused by prolonged, obstructed labour, without timely medical intervention—typically an emergency caesarean section. During unassisted, prolonged, obstructed labour, the sustained pressure of the baby's head on the mother's pelvic bone damages soft tissues, creating a hole-or fistula-between the vagina and the bladder and/or rectum. The pressure deprives blood flow to the tissue, leading to necrosis. Eventually, the dead tissue comes away, leaving a fistula, which causes a constant leaking of urine and/or faces through the vagina.'

**Direct and indirect factors leading to genital fistulae:**

1. Poverty, malnutrition, inadequate health systems, detrimental traditional practices, limited access to emergency care and gender inequality have also been stated as contributing factors for fistula.

2. Adolescents and young girls are at further risk of developing a fistula from obstructed labours because their bodies are not physically mature.

3. Rare causes of fistula are sexual abuse, complications from unsafe abortions and surgical trauma and gynecological cancers (and related radiotherapy treatment).

4. Genital fistulae besides being a health consequence also have far reaching social consequences on women.

5. Along with these physical health consequences women suffering from genital fistulae also face social isolation due to the odour and smell of urine.
Role of Doctor

- A doctor should be able to develop as sensitive approach and prevent all forms of obstetric violence in the labour room.

- A doctor should ensure that women are provided assistance throughout the different stages of labour. Nursing staff can also be trained to be attentive to specific risks in different stages of labour and can alert the doctor to avoid obstructed labour in a timely manner and also prevent unnecessary episiotomies and C-sections.

- A doctor should be able to recognize that timely and comprehensive care in labour can play a critical role in prevention of genital fistulae.

- Additionally a doctor can also employs strategies to discuss prevention of genital fistulae while carrying out activities related to Health promotion and Family planning.
17. Contraception - temporary methods, permanent methods

Gender content added: Contraceptive decision making in women

Lecture name: Contraception - Temporary methods, permanent methods
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion, case study and exercise

Handouts: ---

Key Points

1. 'Many women feel embarrassed, ashamed and confused about sexual experiences. Women outside the institution of marriage hesitate to discuss contraception with a doctor for fear of being judged.

2. Women are often not able to make contraceptive choices that suit them because the medical system decides the nature of contraceptives women should use.

3. Despite evidence on unequal gender roles and limited autonomy that women possess, they are burdened with the responsibility of contraception.

4. Though the term contraceptives have been adopted by the health system, the perspective of health institutions has been on population control.
## Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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</thead>
<tbody>
<tr>
<td>Student should know that often a woman selects contraception with inadequate information regarding other options</td>
<td>Student should counsel the woman about different choices of contraception along with their side effects and contraindications</td>
<td>Student should believe that a woman should have a basket of choices of contraception to choose from</td>
</tr>
<tr>
<td>Student should know that informed consent should be taken from the patient prior to performing family planning procedures</td>
<td>Student should provide adequate information and take informed consent of the woman before performing family planning procedures</td>
<td>Student should be aware that informed consent ensures that the patient understands the procedure and is willing to adopt it</td>
</tr>
<tr>
<td>Student should know that women bear the burden of contraception use and limiting the family size, in spite of little control over reproduction</td>
<td>Student should counsel and encourage men to use contraception</td>
<td>Student should be sensitive to the need to involve men as well in the use of contraception</td>
</tr>
</tbody>
</table>

**Context:** While teaching methods of contraception

**Note to Educator:** It is important to explain to the students that "population control" has dominated the discourse on contraception. It is also important to discuss that the term 'family planning' is a biased term because it takes in to account married couples and provides a message that sex is a means of procreation only. Doctors will benefit from a perspective on contraceptive needs of single men, women, TG people and sex workers. They are often disadvantaged as they are kept outside the gamut of national programmes which are based on population control and do not recognise health implications such as prevention of pregnancy and sexually transmitted infection.
Content

- Gender roles and norms for women do not allow them decision-making powers and therefore limit their contraceptive decision making. Decisions regarding when to have children, desired number of children and period of spacing between children often are outside their realm. Despite this, it is seen as a woman's responsibility to prevent pregnancy.

- Safety and effectiveness are important factors while making a contraceptive choice. Because many women have limited knowledge about their bodies and no information contraceptives, they are unable to weigh and determine choice of contraceptives.

- Despite this reality the burden of the use of contraception invariably falls on women, the family planning programmes in India focus disproportionately on women.

- Most men and women in the society assume that the responsibility of birth control is that of women. Such an assumption is not correct. Most policies related to family planning in India focus only on women, though hassle free options such as condoms or permanent options such as vasectomy are available.

- Doctors often do not provide comprehensive options of temporary methods of contraception and push for permanent methods. This may also occur due to lack of commodity supply and misconceptions about efficacy of temporary methods.

- An important method called the ovulation method was founded by an Australian couple Evelyn and John Billings for spacing and prevention of pregnancy. This method was developed to enable an understanding of vaginal discharge. This method sought to explain different types of discharge from the vagina and determine fertile period based on the nature of mucus. The method allows women to understand dry days, mucus days, types of mucus related to fertility and days of safe sex. It is important for doctors to gain more knowledge on these methods as they offer women more control over their bodies and can carry out the assessment themselves.
I. Contraceptive decision making: A human rights approach to contraceptive choices.83

Single women and transgender people have been left out of the realm of contraception for safe sexual practices largely because contraception has become exclusively associated with 'population control' and therefore, reproduction.

A human-rights-based approach has two major features. One, it takes the position that ensuring access to education, health-care and other basic needs and amenities for all its citizens is not contingent on the goodwill of governments, but obligations they are required to fulfill as a result of their ratification of international and/or regional human rights treaties. Two, rights-based approach integrates international, regional and national human rights standards, principles and processes into plans, policies and programmes.

Doctors often do not provide comprehensive options of temporary methods of contraception and push for permanent methods. This may also occur due to lack of commodity supply and misconceptions about efficacy of temporary methods. Despite both the partners and their equally important role in contraception, the burden is always on the woman.

II. Importance of informed choice

Women who know about all available contraceptive methods and their side effects can make better choices about which method to adopt. Information given to the patient must at least include:

• How the method works.

• Correct use of the method.

• Understanding the relative effectiveness of the method.

• Common side effects.

• Health risks and benefits.

• Signs and symptoms that would require medical attention.

• Return to fertility upon discontinuing the method.

• Information on protection against STIs.

It is unethical to seek consent for post-delivery contraception immediately after childbirth, when the patient is still recovering.

A doctor should facilitate informed decision-making based on the following principles laid down by the WHO:\textsuperscript{84}:

• Non-discrimination.

• Availability.

• Accessibility.

• Acceptability.

• Quality.

• Informed decision making.

• Privacy and confidentiality.

• Participation.

• Accountability

\textbf{Role of Doctor}

• A doctor should recognise the difference between family planning and use of contraception. She / he should be able to understand the limited power that women have to decide upon the contraception and so must make efforts to counsel the patient about the benefits and consequences of different available methods of contraception.

along with their side effects and contraindications, but at the same time, it needs to be remembered that consent from the woman should not be sought when she is unable to make an informed choice like before childbirth or immediately after delivery.

- A doctor should always create an enabling environment to provide information and discuss her apprehensions and seek an informed consent from the woman before providing any contraception or sterilization. Doctors should also counsel the male partner after seeking informed consent from the woman to promote use of contraceptives among male patients.

- The doctor can use the case study approach to discuss the problems in health care services to women with a specific reference to sterilisation.

**Activity 1:**

**Case Study:**

*Bilaspur sterilisation deaths: 13 women from Bilaspur, Chattisgarh died on November 8, 2014 following laparoscopic sterilisation. The sterilizations that resulted in these deaths were performed at a camp held at Takhatpur block of Bilaspur district. The camp had been organised by the State Department of Health under the National Family Planning Programme to perform laparoscopic tubectomies and was conducted in the premises of a non-functional and abandoned private hospital building. 83 women, predominantly dalit, tribal and OBCs, were sterilised within a short span of a couple of hours by one surgeon using an assembly line technique with one laparoscope and without ensuring adequate aseptic condition.*

Q. Can you think how the above-stated WHO principles were violated in the case?

**Key Responses by the Medical Educator**

The educator can use points from the content session here and ask students to list ethical principles that were violated.
• Privacy and confidentiality: No privacy and confidentiality of women is maintained in sterilization camps.

• Participation: With the coercive camp approach there is a high possibility that the participation of women was not voluntary and the consent taken was not informed. Women did not have details of the procedure, method related to it, possible health consequences, and how should she take care of her health after sterilisation.

• Quality: Quality of procedures was compromised, because of use of the same laprascope on 83 women, not having sterilized instruments, not having maintained a specific conditions, only one doctor carrying out the procedure on 83 women are the different factors that lead to compromising quality of sterilisation camp and subsequent death of women.

**Points that the educator can reiterate at the end of the lecture**

1. A woman's individual consent is paramount while carrying out sterilisation and she should be provided adequate time and information to make such a choice.

2. It is unethical to carry out family planning procedures by seeking consent of the husband.

3. A woman should not be made to choose contraception without providing her information of her options and their consequences.

4. An effort should also be made to involve men in the process of choosing contraception and in taking responsibility to use contraceptives too. Male use of contraception should also be strongly promoted.

5. It is unethical to seek consent for post-delivery contraception immediately after childbirth, when the patient is still recovering.

*Exercise 2: Medical educator can also give the exercise mentioned below as group work*

The group can discuss how to develop a contraceptive programme that enables men and women to make informed choices by focusing on key principles of confidentiality, privacy, consent, and acceptability.
Section 2: Emergency Contraception

Key Points

1. It is necessary to understand that emergency contraception (EC) is effective in preventing an unplanned pregnancy.

2. It is essential to note that EC should not be denied and should be offered based on need irrespective of age and marital status.

Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
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</thead>
<tbody>
<tr>
<td>Student should be aware that EC can be an effective way of preventing unplanned pregnancy</td>
<td>Student should be able to effectively give the message that EC should not be used as a regular contraception and explain the negative health consequences of it</td>
<td>Student should have an unbiased attitude towards women coming in for EC irrespective of their marital status</td>
</tr>
</tbody>
</table>

*Note to Educator:* The educator should be sensitive and non-judgmental about people coming to the clinic for EC. It must be given immediately and without moralising. No contraception should be forced upon the woman after she comes in for EC. Counselling the woman and her partner to avoid repeated unwanted pregnancies should emphasise male responsibility in using contraceptives. EC should be made available for survivors of rape.

Content

- Use of EC pills need not be inherently risky as there are no direct health risks associated with their use. However, due to issues of access, women often have to use ECPs in lieu of regular contraception.

- Repeated use of EC pills is unscientific and does not provide protection from STIs the way certain forms of regular contraception do.
Therefore, it is important to give women information about all forms of contraception and family planning methods available to her and explain the benefits and risks of repeatedly using ECP or choosing it as a contraceptive choice.

**Role of Doctor**

- A doctor should provide EC to all women irrespective of their marital status and age.

- A doctor should emphasise that EC should not be used as a regular method of contraception.

- If a woman regularly demands EC, she should be counseled about other options.

- In addition, a doctor should explore if a woman is experiencing DV or sexual abuse because of which she is not able to use regular contraception.
18. MTP Act and procedures of MTP in first and second trimester

Gender content added: Right to choose continuation or discontinuation of pregnancy, Difference between MTP and PCPNDT, Women centred post abortion contraceptive services

Lecture name: MTP Act and procedures of MTP in first and second trimester
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Lecture, Discussion, Case study and Group Exercise
Resources:

Handouts:
Key Points

1. The MTP Act, 1971 does not grant abortion as a “right” but rather states conditions under which abortion can be considered legal. The doctor is the gatekeeper and needs to approve of the reasons for termination. There is a proposed amendment to the MTP act, which allows access to abortion for all women up to 12 weeks on demand.

2. Planning for post-MTP contraception must be done with informed consent of the woman.

3. The Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT) Act, 1994, amended in 2003 does not criminalise abortion and directs itself only to the sex determination.

Learning Outcomes

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<tbody>
<tr>
<td>Student should know that it is a woman’s right to make a choice about continuing pregnancy or terminating pregnancy</td>
<td>Student should offer MTP services without being judgmental about woman’s decision to discontinue pregnancy</td>
<td>Student should have an unbiased attitude for providing abortion services to any woman</td>
</tr>
<tr>
<td>Student should know the difference between the MTP Act and the PCPNDT Act.</td>
<td>Student should provide abortion services to all women, even if they are in their second trimester</td>
<td>Student should be unbiased towards the women approaching them for abortion services, and should not assume that all second trimester abortions are for sex selection</td>
</tr>
</tbody>
</table>

The student should also know the prevalence of beliefs and practices around the two acts

Context: When teaching MTP Act

Note to Educator: The educator should explain that it should be a woman’s decision to continue or terminate her pregnancy and doctors should demonstrate sensitivity towards women seeking abortion

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Content

I. Access to safe abortion as a right

- HCPs are seen to discriminate against abortion seekers based on their marital status. For instance, despite practitioners having the immunity of providing abortion 'in good faith', women are asked intrusive questions to verify their identity/marital status.

- The husband’s signature is often requested, even though this is not required under the MTP Act.

- Similarly, public health systems make abortion conditional to women opting for post-MTP contraceptive, thus violating the woman's autonomy and decision-making.

- The MTP Act expects health care providers to provide services to all women who are carrying an unwanted pregnancy. However, women coming in for an abortion in their second trimester, especially those who already have daughters, are always suspected of having undergone a sex determination test to find out if the foetus is female and denied the service.

II. Post abortion contraception

- Comprehensive contraceptive counselling is very important to prevent unintended pregnancies, which is the one of commonest reason for needing an abortion.

- The counselling should include information on all forms of contraception options, including limiting and spacing methods, available to a woman and/or her partner.

- While offering information about all options of available contraception, it is important that the health care provider also provide information about EC.

- In limiting methods, information about vasectomy being the simplest procedure should be provided. Common myths related to vasectomy must be dispelled.

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Obstetrics and Gynecology
• In case the woman prefers to undergo sterilisation the HCP can opt to provide a surgical abortion followed by sterilisation instead of giving a medical abortion and asking the woman to return later for sterilisation.

**A doctor should remember:**

• The decision to terminate pregnancy is often a difficult and agonizing process for the woman. The social norms prevailing around abortion make a woman feel guilt and grief about the abortion.

• Even though it is evident that Indian women have few or no negotiating powers about the use of contraception and avoiding pregnancy, a woman is still held responsible for getting pregnant.

• In addition, the social and moral contexts of motherhood ensure that a wish or a decision to terminate a pregnancy by a woman comes to be regarded as a moral lapse. It is unfortunately widely believed that women should bear the child that she has conceived. This can have many catastrophic results for the woman and the child.

• There is also a need to reinforce positive norms surrounding decisions regarding contraception use, unwanted pregnancy and abortion. It is important that couples are encouraged to decide together if they want to have children.

**III. Reasons for delay in seeking abortion services**

Usually it is a combination of factors that result in delay in seeking abortion, the greater the barriers faced by women, the later they will reach a health facility. Women, who have the least knowledge, the least access to resources, and are the most isolated geographically, or have been facing abuse, are the ones who face the greatest barriers, in other words; women who reach the health facility later in the pregnancy are usually more vulnerable,.

It should be the pregnant woman’s decision to have an abortion since only she has a right over her own body.

**IV. Understanding prevalent beliefs and practices around PCPNDT Act and MTP Act**

• The MTP Act, 1971 and the PCPNDT Act, 1994 do not contradict each other and, in fact, regulate completely different procedures.
• The MTP Act specifies the conditions in which abortion is legal, where, by whom and with whose consent abortion can be performed.

• The PCPNDT Act, on the other hand regulates the use of pre-natal and preconception diagnostic techniques. The law criminalises the use of preconception methods to select foetal sex and conducting tests to determine the sex of the foetus.

• The PCPNDT Act does not criminalise abortion. It refers to techniques to identify or select sex of the foetus and therefore criminalises sex determination and selection.

V. PCPNDT Act and challenges to Second Trimester Abortions

As the sex of the foetus can be determined by ultra-sonography after 12 weeks, all second trimester abortions are currently being looked upon with suspicion.

Although very few second trimester abortions are sex elective, the notion that women routinely access abortion after having undergone sex determination is predominant among health care providers. This is due to the misguided implementation of the PCPNDT Act which is targeting abortion providers, tracking pregnant women to see if they terminate pregnancy, asking for sex of abortus amongst others. As a result, health providers in public and private sector are reluctant to offer second trimester abortions to avoid reporting and scrutiny of their medical records. This is also a misconception propagated by media and policy makers that abortion is legal only up to 12 weeks and those seeking abortion after 12 weeks are coming only to abort female foetuses.

The HCPs should understand that many women lack access to health care services for several reasons such as lack of financial resources, restriction on mobility, refusal by the family to allow women to terminate pregnancy, geographically difficult locations and poor connectivity; and may reach the health service late, possibly in the second semester, for abortion.

Role of Doctor

• A doctor should always ensure that the woman’s consent alone is enough for the MTP procedure and it is woman’s decision to continue / terminate her pregnancy.

• A doctor needs to be sensitive to a woman seeking abortion and provide abortion services in an unbiased manner
- A doctor should counsel the women and their partners about post-abortion contraception.

- A doctor should not assume that all second trimester abortions are sought for sex selection.

- Doctors should be sensitive to all women who come in for abortion services.

The medical educator can use any of the 2 case studies to get students to participate in a discussion to elaborate upon difficulties faced by women seeking MTP services.

**Case Study 1:**

*Ahilyabai is pregnant for the fourth time. Because of her extreme poverty, she has been unable to gather the money needed to go to a government health centre for terminating her pregnancy for several months. It is now just past the 16th week of pregnancy, and Ahilyabai has finally managed to reach a health centre known to provide abortion services. But when she gets to the centre, the health workers and the doctor accuse her of coming for a sex-selective abortion. Ahilyabai’s unable to understand what is going on; she pleads with them to help her, but does not know whether or not they will terminate her pregnancy.*

**Questions for Discussion**

Q1. What will be the consequences if the doctor refuses to perform the medical termination of pregnancy?
A- Ahilyabai may have to continue with the unwanted pregnancy to term and give birth to the child. Or Ahilyabai could also turn to local healers or a quack for an unsafe abortion endangering her life.

Q2. How can doctors ensure that women like Ahilyabai are not denied access to safe abortion services?
A- Doctors should have an empathetic approach towards women who belong to marginalised sections of the society. Doctors must understand that DV, poverty, lack of resources and/or access may prevent women from coming in time for an abortion. Doctors should understand that not all women coming for an abortion after 16 weeks do so for a sex selective abortion.
Case Study 2:

Miss X, is a 20-year-old woman, was pregnant as a result of rape by her fiancé who had falsely promised to marry her. She was 24 weeks pregnant with a deformed foetus. She challenged the 20-week cap on the period at which a medical termination of pregnancy can be performed according to the MTP Act. Her contention was that 20 weeks limit was unreasonable and arbitrary. It also violated her life and equality. Her lawyer argued that continuing the pregnancy could cause "grave injury to her physical and mental health". The Supreme Court Bench gave an important judgment challenging the MTP Act of 1971 and allowed Miss X to terminate the pregnancy.

Questions for Discussion

Q1. She was granted termination of pregnancy under Section 5 of the MTP Act, which is allowing termination if it is causing grave injury to her physical or mental health. Why did the woman have to appeal to the Supreme Court when the law could have applied by the doctor/health facility and allowed access to abortion?

A. It is important to note that MTP Act in itself does not ask for opinion of any medical board for applying sections of the law including Section 5; but empowers the treating doctor to take decision in the best interest of the survivor. In fact the opinions provided by medical boards in the past several cases were well within the scope of the treating doctor of rape survivors and in keeping with their existing mandate of the MTP act. But doctors distance themselves from providing much required care if the pregnancy is beyond 20 weeks and advise the families to go to court. Many rape survivors in recent times have been forced to go to court and rulings have been inconsistent in ensuring their access to abortion. There needs to be mechanism for evaluating such situations at the hospital level so that decisions can be taken. The recent amendments to the rape laws make it mandatory for all public and private hospitals to provide immediate treatment to rape survivors. (Section 357C CrPC and Rule 5 of POCSO 2012 Rules). However these laws are not being stringently implemented.
19. Violence against women (Additional Lecture)

Gender content added: VAW as a public health issue, Recognising signs and symptoms of violence, Gender sensitive healthcare for survivors

Lecture name: Violence against women (Additional Lecture)
Subject: Obgyn
Semester no: 5
Duration: 1 hour
Methodology: Case study to identify signs and symptoms of VAW, Presentation on VAW as a health issue, role play on how to respond to women reporting VAW

Resources:

Handouts:

Key Points

1. Violence against women is a public health issue. Discussion around Violence Against Women (VAW) is of critical importance in Obstetrics and Gynaecology as many health complications such as unwanted pregnancy, multiple pregnancies, unsafe abortions, sexual abuse are a result of VAW and it is the Obstetrics and Gynaecology personnel who treats these women.
2. Hence, it is important for doctors to recognise signs and symptoms related to any form of violence and its health consequences. They should develop skills in using screening protocol for pregnant women at the level of antenatal services. This will enable them to discuss alternatives with the woman and mitigate consequences of violence on her.

3. All health professionals should impart psychological first aid and this should not be relegated to the counsellors. It comprises basic aspects like providing emotional support, and explaining to the woman that violence is not her fault.

4. Health professionals must ensure that all medical procedures, consent-taking, medico-legal documentation and evidence collection is done in a gender-sensitive manner.

**Learning Outcomes**

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Student should recognize that HCPs have a role in assessing and addressing the health problems of survivors of violence</td>
<td>Student should demonstrate competence in asking about abuse and provide psychological first aid appropriately to survivors of violence</td>
<td>Student should be sensitive and non judgmental when women disclose about violence</td>
</tr>
</tbody>
</table>

**Context:** Any form of violence leads to health consequences. Doctors need to recognise consequences of domestic violence and sexual violence against women

**Note to Educator:** The educator needs to create an understanding among students that "gender" pre-disposes women to high risk of violence. It is important to demonstrate the importance of sensitive care while managing a victim of violence

**Content**

**I. Violence against Women as a Public Health Issue**

VAW is a worldwide issue, with intimate-partner physical violence (i.e. any act of violence perpetrated by an intimate partner such as husband or live-in partner), sexual violence,"

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or both, affecting one in three women, leading to substantial health effects that are important determinants of morbidity and mortality.

Violence results in injuries, bruises, fractures, burns, vaginal tears, psychiatric problems, miscarriages and so on. This happens to many women; hence it is not a personal matter limited to a few individuals in society. One of the largest killers of women in the reproductive age group in India is violence. Violence results in long term physical and psychological ill health. The health effects range from low birth weight babies to anaemia, from depression to suicide, from vague bodily complaints to severe illnesses such as pelvic inflammatory diseases, from repeated abortions to chronic pain syndromes, unwanted pregnancies and unsafe abortion to HIV/AIDS, pregnancy complications to maternal mortality, from memory loss to heightened anxiety, from fear of sexuality to low self esteem.

Health and disclosure of illness increase the element of violence in women’s life. Women with tuberculosis, mental illness or HIV/AIDS are likely to be thrown out of the house, and therefore they are reluctant to disclose their disease to their families or get their illness diagnosed. Thus, women are more vulnerable to illness because of their low status in society and low access to food, rest and recreation. This, in turn, increases the probability of violence in their lives. A vicious circle is this set in motion.

Women’s access to health care is limited. A married woman has to depend on her husband and/or mother-in-law to accompany her to the hospital, to make decisions regarding her treatment, and to pay the bills. The consequences of speaking out are very grave for a woman, they fear not being believed, being blamed for the violence they face and they may even be deserted and may end up being homeless. These concerns inhibit women from speaking out on the other hand; this very silence can ultimately kill her.

People in health care delivery set up are not trained to look at domestic violence. Often doctors are not aware of how to preserve evidence in the event of rape, or how to collect forensic evidence in a gender sensitive manner. They are not taught how to look for clues that may reveal domestic violence, or to see beyond their specialties when women come to them.

Definitions of different forms of violence against women as per Indian Penal code (IPC):

Domestic Violence, according to the Protection of women from domestic violence Act 2006, is defined as any act that Harms, injures, endangers, the health, safety, life, limb or
well-being of the person or tends to do so. This includes physical, sexual, emotional and financial abuse. The law also lists various forms of physical, sexual, emotional and financial violence. Additionally it also states that any intent to coerce a woman or any person related to her to meet any unlawful demand for dowry or any other property /valuable security and which has the effect of threatening her or any person related to her.

The Criminal Law Amendment to rape (CLA2013) defines sexual violence as non-consensual insertion of the penis, any object or part of the body (not being the penis) into the vagina (including the labia majora), urethra or anus or, applying the mouth to the vagina, urethra or anus or manipulating the woman's body in order to cause penetration. This is important as rape was earlier defined only as peno-vaginal penetration. The latest definition includes all forms of sexual violence as rape such as vaginal, anal and/or oral.

II. Sexual violence and its forms

Section II to Section VIII are extracted from Clinical and Policy guidelines issued by WHO in 2013 for Low Middle Income Countries'.

The World Health Organization (WHO) defines Sexual Violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/advances and acts to traffic or otherwise directed against a person's sexuality, using coercion, threats to harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work"

Forms of sexual violence include

- Coerced / forced sex in marriage or live-in relationships or dating relationships
- Rape by strangers.
- Systematic rape during armed conflict, sexual slavery.
- Unwanted sexual advances or sexual harassment.
- Sexual abuse of children.

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• Sexual abuse of people with mental and physical disabilities.

• Forced prostitution and trafficking for the purpose of sexual exploitation.

• Child and forced marriage.

• Denial of the right to use contraception or to adopt other measures to protect against STIs.

• Forced abortion and forced sterilisation.

• Female genital mutilation

• Inspections for virginity.

• Forced exposure to pornography.

• Forcibly disrobing and parading naked any person.

III. Magnitude of the problem

Globally, 7% of women have been sexually assaulted by someone other than a partner. WHO, 2013

In India there were 1,19,406 cases of sexual violence against women and children as per NCRB 2016. NFHS 4 shows that almost 29% which means 1 in 3 women continue to face some or the other form of violence in their domestic lives. There is a variation seen in NFHS and NCRB estimates. This may be because NCRB figures only take into account those cases that have been reported to law enforcement agencies. The figures may well be an underestimation, as the great stigma attached to sexual assault discourages reporting.

A nationwide survey on child abuse was conducted by the Ministry of Women and Child Development in 2007 across 13 states, covering over 12,000 children between ages of 5-18 years. The study found that more than half of the children reported having faced some

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form of sexual abuse. Moreover, 21% of children reported severe sexual abuse (which included sexual assault, making the child fondle private parts, making the child exhibit private body parts and being photographed in the nude). About 51% reported other forms of sexual abuse (which included forcible kissing, sexual advances during travel and marriages and exposure of pornographic materials.\textsuperscript{89}

IV. Health consequences of violence

Burns, poisoning, knife assaults and abetting suicide are some of the ways in which women are killed within the family. The health effects range from low-birth-weight babies to anaemia, from depression to suicide, from vague bodily complaints to severe illnesses such as pelvic inflammatory diseases, from repeated abortions to chronic pain syndromes, from unwanted pregnancies and unsafe abortions to HIV/AIDS, from pregnancy complications to maternal mortality, from memory loss to heightened anxiety, from fear of sexuality to low self-esteem, and so on.

V. Role of HCPs in dealing with survivors of violence

In this context, a sensitive approach by doctors is especially helpful for women who face domestic or sexual violence. HCPs are in a unique position to address the health and psycho-social needs of women who are experiencing violence. Upon facing abuse, a woman is more likely to approach a doctor for help than a lawyer or the police. A sensitive and non-judgmental treatment could help the survivor to disclose and discuss the abuse. HCPs can also provide assistance by offering support and referral services, providing appropriate medical services and follow up care and gathering forensic evidence.

a) Signs and Symptoms that can help in identifying violence

When recording the medical history of a woman, the following signs and symptoms can be considered as an indicator that she is in a violent relationship -

- History of assault.
- Repeated pregnancy.
- Repeated birth of girl child.

• Spontaneous abortions.
• MTP cases.
• Reversal of TL.
• Unwed mothers/pregnant widows.
• Chronicle ucorrhea.
• Postpartum psychosis.
• Injury marks on labia, breast or other sexual organs.
• Abruptio of placenta.
• Pelvic Inflammatory Disease.
• Multiparity.
• History of fall during pregnancy.

In 2013, the World Health Organization published its landmark Clinical and Policy Guidelines on Responding to Intimate Partner Violence and Sexual Assault. The interventions include:

b) Identification of domestic Violence

• Probing for abuse may either be carried out routinely or in specific situations such as when indicators of abuse are identified.

• Services such as Casualty, Psychiatry, Gynaecology and ANC are likely to see a large number of women who may be abused and provide a window of opportunity to help women.

• The HCP must look out for the signs and symptoms of abuse in every woman patient that she/he sees.
- If the doctor suspects that a woman is being abused, probe with a great deal of sensitivity. Whether or not she reveals abuse is inextricably linked to how sensitive the doctor is.

- The doctor should assure her of confidentiality.

- The doctor should tell her that he or she has often seen women who report violence and reassure her that she will not be judged or endangered by disclosure. Considering the stigma associated with abuse, it is understandable that she may not be open to sharing her private oppression with the doctor.

c) First line of support

- The doctor should, as a minimum, offer first-line support when women disclose violence.

- Being non-judgmental and supportive and validating what the woman is saying.

- Providing practical care and support that responds to her concerns, but does not intrude.

- Asking about her history of violence, listening carefully, but not pressuring her to talk.

- Acknowledging that it must be very difficult for her to live in a violent home, but assuring her that she is not alone and that help is available.

- Conveying to her that violence is not her fault and that every person has the right to live a life free of violence.

d) Medical care for survivors of intimate partner violence and sexual assault

- It is the HCP's primary duty to provide treatment for all the woman's injuries. It is important to be sensitive but thorough while recording her history and examining her.
• Ensure that both current and past episodes of violence are talked about. Look for other injuries or scars that might be present as a result of the violence and attend to them.

• Women with a pre-existing diagnoses related to a mental health condition or partner violence-related mental disorders (such as depressive disorder or alcohol use disorder) who are experiencing intimate partner violence should receive health-care professionals with a good understanding of violence against women.

e) Documentation

• Every woman who reports injury caused by violence is expected to be registered as a medico-legal case.

• Inform her that that the information she provides and allows to be documented in the hospital can be used by her in a court of law.

• The history that the health care provider elicits from the woman should include details of resulting injury / injuries and of the violent episode (such as location of incident, relationship to abuser, severity and frequency of earlier episodes of violence, and other health consequences not apparent at the time of the medical visit). All these details along with the findings in examination should be recorded in the MLC registers well as on the case paper.

• Even if the doctor does not work in Casualty, if she / he comes across any abused woman in the OPD or in the wards, the violence must be documented as part of the history in her Indoor / OPD papers and she should be referred to Casualty to get a medico-legal case (MLC) recorded.

• Under the PWDVA, a doctor cannot refuse treatment to an abused woman is not allowed under any circumstances. Also, her medical report should be recorded free of cost.

• She must be referred to the Protection Officer in the area.

f) Giving information and referrals

• It is the doctor’s duty to inform every abused patient that there is no excuse for violence and that it is illegal in every form.
• Explain the importance of filing a police complaint-the significance of both a non-cognisable Complaint (NC) as well as a First Information Report (FIR).

• In the case of a woman facing domestic violence, she must be informed of the Protection of Women from Domestic Violence Act (PWDVA), 2005 and the rights that she has under this Act.

• Make inquiries regarding her safety. If she is not safe to go back home, should be given information about shelters or should be referred to one, if possible. She can also be given her information about legal aid, counselling services for violence survivors or support groups. It is always good to keep a list of such shelters, support groups and counselling centres handy.

Case Study:

Naseem aged 28 years, has come to the Casualty reporting assault by husband. She has injured her eye and reported blows in the stomach. She is nine months pregnant. Her husband hit her for not cooking food on time. The doctor registered a medico legal case and referred her to the labour ward. She was admitted after a sonography was done. Her husband works as plumber and his earnings are not enough. She has 3 daughters and 1 son. Her eldest child is 6 years old. She delivered a male child the next day. Her natal family, though very poor, was by her side. As per the hospital rule, any woman delivering a third child has to pay Rs.500/- as fine.

Educator discusses what can be done by doctors in this case? After eliciting responses from students, she / he summarises 5 simple tasks -
'LIVES' approach by WHO

LISTEN
Listen to the woman closely, with empathy, and without judging. (Probe into reasons that led to multiple pregnancies without judging, communicate that you trust her).

INQUIRE ABOUT NEEDS AND CONCERNS
Assess and respond to her various needs and concerns - emotional, physical, social and practical. (Discuss effects of violence on her health. due to multiple pregnancies and inadequate intervals between them and lack of rest she may develop severe health concerns seek her consent and involve a person from family that Naseem trusts. Communicate the urgent need for Naseem to take rest and have access to nutritious food).

VALIDATE
Show her that you understand and believe her. Assure her that she is not to blame. (Discuss that you do not blame her for having multiple children, explain to her that violence she faces is not her fault.

ENHANCE SAFETY
Discuss a plan to protect her from further harm If violence occurs again. (probe about whether she is safe to go back home, arrange for her to extend her stay in the hospital till alternate arrangements are made, encourage her to make a police complaint, put her in touch with the hospital social worker/ NGO for additional support to deal with violence. Approach social worker to waive off 500rs fine from poor box fund).

SUPPORT
Support her by helping her connect to information, services and social support.
An Exercise

Educator can ask few students to volunteer for role play so that skills in responding to sexual violence are developed. Students should be asked to enact the role of examining doctor in both situations.

Situation 1
Adolescent girl was brought to the hospital by a mother who wants her daughter to undergo an abortion.

Key Point for Discussion

It is critical to have in-depth history seeking as in case this abortion is conducted she would be under age; but that does not mean that the history and details leading to the pregnancy should be sought from the mother. The first effort should be carried out with the girl to understand circumstances that led to the pregnancy. If the history reveals that it was a consensual sexual relation, refrain from suggesting marriage as an option, as the situation does not have the scope for it. Instead discuss contraception that can prevent pregnancies in the future. In case it is a case of sexual violence provide support to disclose details of the assault. After sufficient rapport discuss with the girl and mother steps for making police complaint, and also initiate MTP procedure for the girl. Ensure support of a counsellor to the girl to deal with trauma of sexual violence.

Situation 2
Case of child sexual abuse, where the daughter is refusing to eat or talk to anyone and more so, her father.

Key Point for Discussion

Doctors should recognise that speaking to children requires basic skills. Often children have no vocabulary to express what has happened, especially in case of sexual abuse. Using dolls has been found to be useful to elicit history. It is important to speak to the child alone, even in the absence of his/her mother. In this case the doctor needs to talk to the child in a manner that the child feels supported. Simple questions such as "Are you afraid of your father?" Is there something you would like to discuss?" Could be used as opening remarks to establish rapport. Referral to hospital social worker / NGO to mitigate effects of trauma should be emphasized and the safety of the child should be given prime importance.
Dos in sexual violence and health care

• While seeking informed consent from the survivor, the doctor should provide information about medical procedures that will be performed as a part of medico legal examination and treatment.

• If a woman refuses, any of the examination or full examination, her decision should be respected and treatment should be provided to her unconditionally.

• It should be noted that 12 years is the age for consent pertaining to examination and treatment, the doctors should develop ways of communicating with survivors of 12 years of age.

• The doctors should remember that there is no obligation to mandatorily report the case to police. Mandatory reporting against the wishes of the survivor is illegal.

• The doctors are responsible to document particulars of survivors, history of assault, marks of injuries and collection of medico legal evidence.

• The doctors should try to elicit a detailed sexual assault history using a gender sensitive sexual assault proforma that emphasised on eliciting a detailed sexual assault history not restricted to peno vaginal assault but should also include peno anal, peno oral assault, masturbation of the survivor, use of objects etc.

• Activities undertaken post assault such as urinating, douching, and bathing that can lead to the loss of evidence should be noted.

• In cases where age determination is required, the age estimation should include three methods-physical age, dental age and radiological age. This ensures that the 'range' of age estimated in narrower and hence more accurate.

• The doctors should ensure that emergency contraception, treatment for injuries, STI testing and prophylaxis are made available to all survivors of sexual assault.
Don'ts in sexual violence care:

The doctors should not rule out sexual assault if there are no physical injuries. Absence of injuries does not mean the survivor has consented to sexual activity.

As per the law, if resistance was not offered that does not mean the person has consented.

- 'Two finger test' must not be conducted for establishing rape/sexual violence and the size of the vaginal introitus has no bearing on a case of sexual violence. This should not be confused with the per vaginum examination which may be required for clinical purposes.

- The status of the hymen is irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. An intact hymen does not rule out sexual violence and a torn hymen does not prove previous sexual intercourse. The doctors should not make comments such as 'she is habituated to sexual intercourse as there is an old tear in the hymen' as this may work against the survivor in getting justice and as stated earlier, it is also unscientific.

- The doctors while documenting the general mental condition of the survivor should not record statements like 'appears unaffected' or 'does not show signs of distresses'. Health professionals may expect a survivor of sexual assault to appear distraught and crying uncontrollably, but this may not always be the case. It is possible that she / he has overcome the trauma and approached the health care facility or she may be too shocked to display emotions.
20. Complications in early pregnancy - hyperemesis gravidarum / abortion / ectopic pregnancy / gestational trophoblastic disease

Gender content added: Asking about violence as part of ANC

Lecture name: Complications in early pregnancy - hyperemesis gravidarum / abortion / ectopic pregnancy / gestational trophoblastic disease

Subject: Obgyn

Semester no: 6

Duration: 1 hour

Methodology: Lecture, Discussion

Resources:

Handouts: ---

Key Points

1. Pregnant women should be screened for domestic violence as global evidence suggests that violence in pregnancy affects women and unborn foetus.

2. Safe sexual practices should be discussed with pregnant women.

3. In cases of spontaneous abortions, woman and her partner / family should be counselled about keeping a gap between spontaneous abortion and next pregnancy giving the woman required time to recover.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise that violence in pregnancy leads to poor health for women and foetus</td>
<td>Student should develop basic skills in sensitive screening for violence in pregnant women</td>
<td>Student should be sensitive and not blame women for delay in reaching facility</td>
</tr>
</tbody>
</table>

**Context:** While teaching complications in early pregnancy. The content taught in semester 4 in the topic on antenatal care, nutrition in pregnancy includes detailed section on how to identify if a pregnant woman is facing violence. The content here is reiterated briefly here.

**Note to Educator:** The educator should explain that a doctor needs to demonstrate empathy to women suffering from obstetric complications, both early and late and appreciate that these conditions can affect adversely the health of women and thereby predisposing them to increased morbidity and mortality.

Content

I. Violence during pregnancy

- Pregnancy does not protect women from IPV.
- A global systematic review described prevalence during pregnancy of 1-20%.

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• Review of studies in Asian countries 4-48%, and a review of Indian studies 21-28%.

• In another study in a Mumbai Slum, a large proportion of women associated their miscarriages with violent assaults by their spouses.96

• Women may suffer more or graver violence during pregnancy than at other times. Women may furthermore suffer miscarriages and stillbirths as a result of STIs transmitted during unsafe coerced sex.97

• Along with spontaneous abortions, violence may also force women to undergo induced abortion.

• Pregnancy may accentuate both physical and verbal violence if husband does not want the child (for e.g. later order birth or a girl child), or suspects that pregnancy is due to the wife being unfaithful to him.

Lack of Care after spontaneous abortion:

• Often women do not get required medical care after a spontaneous abortion; also if a woman suffers from incomplete abortion it can prove to be fatal for the woman.

• This lack of care contributes to maternal morbidity and mortality.

• Often women may be forced to immediately get pregnant after an abortion, which compromises her reproductive and sexual rights.

• It also can prove a threat to her health, as the woman does not get sufficient time to recover from the earlier miscarriage or abortion.

• This may be particularly true in the case of sex selective abortions, where the family wants a son and hence forces a woman to immediately undergo pregnancy.

**Role of Doctor**

• A doctor should recognise that repeated abortions or miscarriages may be an indicator of violence.

• A doctor should ensure that women who undergo spontaneous abortions should also get adequate post-natal care along with psychological first aid.
21. Obstetric complications during pregnancy. APH - accidental haemorrhage, placenta praevia

Gender content added: Anaemia as a major contributor to maternal mortality

Lecture name: Obstetric complications during pregnancy. APH - accidental haemorrhage, placenta praevia

Subject: Obgyn

Semester no: 6

Duration: 1 hour

Methodology: Lecture, Discussion


Key Points

1. A life cycle approach should be adopted for treating anaemia among girls and women, right from childhood to old age. Treating anaemia only in pregnancy will not be effective if the focus is on improving overall health of women. The initiation of ensuring better hemoglobin starts from childhood. This entails adequate nutritional facilities besides supplements. Administering iron folic supplements in the absence of nutrition will not lead to desired results of treating anaemia.

2. Anaemia in pregnancy is not caused only due to medical reasons, but it is interplay of different socio cultural factors.
### Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognize that anaemia is a major contributor to maternal mortality.</td>
<td>Student should be able to diagnose and treat anaemia appropriately</td>
<td>Student should be able to recognize the obstacles that women face in identifying and seeking treatment for anaemia</td>
</tr>
<tr>
<td>Student should take a life cycle approach in treating anaemia in women</td>
<td>Student should develop skills to identify anaemia at different stages of a woman's life</td>
<td>Student should acknowledge early onset of anaemia based on discrimination against women in accessing nutritious food</td>
</tr>
</tbody>
</table>

**Context:** While teaching obstetric complications.

**Note to Educator:** The educator should explain that 'gender bias' plays an important role in the poor nutrition of a girl child and that pre-existing poor health (anaemia) along with other complications can further lead to maternal morbidity and mortality.

### Content

- Maternal anaemia is a common problem in women, especially from marginalised and disadvantaged groups.

- Anaemia in pregnancy is commonly considered a risk factor in pregnancy leading to poor pregnancy outcome and can result in complications that threaten the life of both woman and foetus.

- It has been long recognised that anaemia is a major public health problem, especially among poorer segments of the population, in developing countries such as India, Pakistan and Bangladesh.

- According to NFHS 3 more than half of the women in India (55%) are anaemic.
Pregnant women are slightly more likely to be anaemic (59%) than non-pregnant women (55%).

a. Severe maternal anaemia - <8gm/L increases the risk of death due to rapid cardiac decompression even without the additional stress of true post-partum hemorrhage. <500ml blood loss during delivery could be fatal.

b. 20 per cent maternal deaths are attributable to anaemia in India.

c. Weakness is assumed a normal condition during pregnancy and majority of Indian women do not seek treatment for anaemia unless symptoms become severe.

Intergenerational Cycle of Anaemia

It is not sufficient to address anaemia only in pregnant women, as the cycle of anaemia starts right from birth.

Patriarchy, gender, poverty and poor nutrition have an important interplay in prevalence of anaemia in women.

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• With strong son preference, the nutritional requirement of girls is often neglected, especially in the poorer sections of the society, making them undernourished and anaemic.

• The start of menstruation and consequent blood loss makes adolescent girls more prone to anaemia. When these anaemic girls enter the reproductive phase, pregnancy accentuates anaemia, causing threat of maternal morbidity and mortality.

• Thus, gender biased food allocation and an exaggerated workload are frequent causes of anaemia and malnutrition among girls and women.

• Poor environmental sanitation, unsafe drinking water and inadequate personal hygiene, and iron loss due to parasite load (e.g. malaria, intestinal worms) are other causes of iron-deficiency anaemia among women.

• Public health issues like poor environmental sanitation, unsafe drinking water and inadequate personal hygiene and iron loss due to parasite load (e.g. malaria, intestinal worms) are other causes of iron deficiency anaemia.

• In order to prevent maternal mortalities caused due to anaemia, it is necessary to take a life cycle approach to deal with the issue, with a special focus on adolescent girls.

**Obstacles in treatment seeking**

• Although haemoglobin assessment is supposed to be done for all pregnant women under NHM, it is not uniformly followed.

• If the woman is found to be anaemic, nothing more is done than just handing the folic acid tablets. No information on care and better food intake is provided. There is no discussion on available food which is locally produced and accessible is discussed nor is it probed as to what keeps women away from consuming nutritious food in pregnancy and post delivery.
Role of Doctor

- A doctor should take a life cycle approach in the treatment of anaemia in all stages of women life, childhood - adolescence - pregnancy, post partum, menopausal age and in older women. As gender has an important role in access to nutritional food, doctors must develop treatment plan based on locally available and inexpensive food and grains.

Activity

The educator can share a hand out on how to take action to prevent and treat anaemia. Students should be asked to familiarize themselves with the chart and then develop a policy for health providers on how to deal with anaemia at different stages. The exercise should also involve a multi sectoral approach, roping in ICDS, Gram Panchayat and other functionaries that can play a role in prevention and response to anaemia.
22. Infections in pregnancy, urinary tract diseases, sexually transmitted infections including HIV, Malaria, TORCH

Gender content added: Malaria during pregnancy, Hepatitis B, 
Social consequences of HIV in pregnant women

Lecture name: Infections in pregnancy, urinary tract diseases, sexually transmitted infections including HIV, Malaria, TORCH

Subject: Obgyn

Semester no: 6

Duration: 1 hour

Methodology: Lecture, Discussion

Resources:

Handouts:

Key Points

1. Gender plays an important role in infectious diseases like malaria, HIV and Hepatitis B.

2. Pregnant women with HIV or Hepatitis B face severe stigma considering its sexual route of transmission.

3. It is the basic human right of everyone who undergoes HIV testing to receive the 5 Cs: Informed Consent, Confidentiality, Counselling, Correct result and Connection to care.
## Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should be aware that malaria in pregnant women can lead to severe consequences including maternal death</td>
<td>Student should recognize the need for immediate care and treatment of malaria in pregnant women</td>
<td>Student should acknowledge malaria as a high risk to the lives of pregnant women</td>
</tr>
<tr>
<td>Student should recognize that Hepatitis B is an STI</td>
<td>Student should treat Hepatitis B with the same seriousness as it could have fatal implications for women</td>
<td>Student should have a non-judgmental attitude towards women suffering from hepatitis and maintain confidentiality</td>
</tr>
<tr>
<td>Student should recognize the social consequences of HIV infection in pregnant women</td>
<td>Student should develop skills to communicate with HIV positive women sensitively and respond to their needs</td>
<td>Student should be non-judgmental towards HIV positive women and maintain confidentiality</td>
</tr>
</tbody>
</table>

**Context:** While teaching infections in pregnancy

### Note to Educator: The educator needs to explain that anaemia is the interplay of several factors: poor nutrition, socio cultural taboos, environmental factors and medical conditions like malaria.

### Content

#### I. Malaria during pregnancy

Pregnancy is known to make women vulnerable to malaria. Nutrition, nature of work undertaken by women can make women more prone to malaria.

In case the pregnant woman is suffering from nutritional anaemia this is compounded by malaria-induced anaemia, leading to severe anaemia with potentially life threatening complications, which may result in maternal deaths.
Ia) Burden of malaria in pregnancy:

- An important finding from a Jharkhand study showed that only about half of pregnant women (51.2%) diagnosed with malaria were symptomatic. This means that a large number of women infected but not showing symptoms may not receive any treatment or care.

- A study in Gomia in Jharkhand reported that women and men in poor households who become sick with malaria are also weakened because of inadequate nutrition when sick. All they have survived on has been rich starch liquid called 'maar'. Women including pregnant ones were harassed by husband and in-laws for the expenditure they had incurred for malaria treatment and also for being unable to work in the house.

- About half of the pregnant women went to compounders for treatment because they could then make payment in installments. The husband and in-laws believed that the woman's medical treatment was her parent's responsibility. The treatment women were able to get depended very much on how much their parents were able to spend. There was no time for rest and recovery and the woman had to start doing household work soon after the fever ended.

What can be done?

- Malaria may be contributing significantly to maternal and neonatal mortality and morbidity in India. Antenatal care should comprise of intermittent screening and treatment of malaria in pregnancy. Prevention and control of malaria in pregnancy needs to be integrated into safe motherhood programmes.

- Special precautions are required for pregnant women living in endemic areas. Regular home visits by front line workers to pregnant women during malaria outbreaks can help to identify those who are infected with malaria and initiate proper treatment.

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II. Hepatitis B

Hepatitis B is a viral infection that attacks the liver and can cause both acute and chronic disease. The virus is transmitted through contact with the blood or other body fluids of an infected person. Hepatitis B is spread through sexual route.

Since India has one-fifth of the world’s population, it accounts for a large proportion of the worldwide HBV burden. India harbours 10-15% of the entire pool of HBV carriers of the world.

IIa) Hepatitis B among pregnant women:

- It is a unique challenge to manage HBV infection in pregnant women, with consequences to both mother and the newborn.

- Studies in the Indian subcontinent have looked specifically at the prevalence of hepatitis B surface antigen (HBsAg) positivity in pregnant women. The prevalence rate of HBsAg positivity in pregnant women varies from 1-9% in different parts of the country.

- Though Hepatitis B is also a sexually transmitted disease and its infection can be passed down from mother to child, no adequate measures are taken to prevent the transmission as is done in the case of HIV/AIDS.

- Testing and counselling component should be included for pregnant women.

III. HIV Infection in Pregnant Women:

- In India, 38% of the estimated 2.4 million people living with HIV are females.

- Approximately, 49,000 of these women become pregnant and deliver each year, many without antenatal care, antiretroviral prophylaxis to prevent HIV transmission to their infants, or institutional delivery.

- While the Government of India has made some progress increasing the availability and accessibility of prevention of mother-to-child transmission of (PMTCT) HIV services, only 23% of pregnant women received an HIV test in 2010, and about one-in-five HIV-positive pregnant women received anti-retroviral treatment to prevent transmission of the HIV virus to their infants.
• The World Health organization (WHO) has explicitly enumerated human rights protections required for HIV testing. These basic rights entitle all people undergoing HIV testing to receive the 5Cs: Informed Consent, Confidentiality, Counselling, Correct Result, and Connection-to-care.

However, these rights are often compromised in health care settings. At many places no informed consent is sought from the woman, nor is there pre-test and post-test counselling provided. The report is disclosed without consent with husband or family members compromising the confidentiality of women.

**Role of Doctor**

• Confidentiality of HIV status of the pregnant woman should be maintained, and the results should not be disclosed to her husband or family members without her consent. A plan to disclose it to a close family member whom the woman trusts should be devised.

• Caution should be taken in case of discordant couples, where the woman tests positive and her partner is negative. It should be kept in mind that in these situations women may face severe violence at home, stigma and ostracisation and desertion.

• Woman should be given an option whether she wants to continue the pregnancy or not. Safe options for MTP should be suggested if she wishes to terminate pregnancy and her decision should be respected.

• Different feeding options should be provided to the woman and she should be helped to make an informed choice.

• A doctor should consider gender and other socio cultural factors while treating malaria, HIV and Hepatitis B.

• The importance of testing for hepatitis B should be equally emphasised as is the case with HIV.
Semester 6

23. Gynaecology and surgical conditions in pregnancy, fibroid with pregnancy, ovarian tumours, acute abdomen, genital prolapse

Gender content added: Gender and Genital prolapse

Lecture name: Gynaecology and surgical conditions in pregnancy, fibroid with pregnancy, ovarian tumours, acute abdomen, genital prolapsed

Subject: Obgyn

Semester no: 6

Duration: 1 hour

Methodology: Lecture, Discussion, Case study


Key Points

1. A preventive approach should be adopted in treating prolapse instead of just a curative approach.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
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</thead>
<tbody>
<tr>
<td>Student should recognize that laborious work undertaken by women</td>
<td>Student should discuss preventive practices like adequate rest, physiotherapy and exercise to prevent prolapse among post-partum women</td>
<td>Student should adopt a preventive and promotive approach for dealing with prolapse rather than just a curative approach</td>
</tr>
</tbody>
</table>

**Context:** While discussing etiology and treatment of genital prolapse, educators should discuss the socio-cultural reasons leading to genital prolapse. Prevention of prolapse needs to be initiated at the antenatal stage where women are oriented to aspects such as pelvic floor exercises, importance of adequate rest in post partum stage and so on. These aspects have also been discussed in Semester 4 in topic on genital prolapse and genital tract displacement. Learning must be reiterated in this topic too.

**Content**

- Prolapse of uterus is one of the most common sequelae of a difficult child birth. A woman with prolapse may complain of a lump in the vagina or a feeling of "something is coming down", back ache and a bearing down sensation, abdominal pain, vaginal discharge, disturbances of micturition, frequency and dysuria, stress, incontinence, difficulty in defecation, profuse periods, irregular bleeding and stress incontinence.

- Gender roles and socio cultural factors play an important role in the experiences of women who suffer from prolapse. Frequent child bearing or trauma to the pelvic floor following a surgery can also be contributing factors. The condition may worsen in the absence of adequate rest and strenuous work.

- Uterine prolapse seriously compromises the quality of life of the women affected. It has far reaching consequences not only for their physical health, but also for their sexual lives, their ability to work and earn a livelihood.

- Treatment seeking can also be challenging as women face number of barriers ranging from women’s reluctance to seek treatment, to lack of familial support, ineffective treatment and high monetary and opportunistic costs.
“I went to the hospital more than 10 years ago. They said I would get better with drugs and no surgery was required. I did not get any better. So I stopped taking the drugs, and did not go again.”

What can be done?

- Health care providers can make efforts to initiate a prevention strategy at the antenatal care itself to limit women’s exposure to uterine prolapse at an early age by providing required information.

- Efforts should be made to minimise and alleviate problems in day-to-day life faced by women affected and make appropriate medical help accessible to them. Family members may not be sensitive to consequences of genital prolapse, hence it is pertinent to discuss health consequences and garner support for women to follow up for treatment.

- Birth spacing and birth control methods should be made more accessible to all women. Contraceptive counselling must also include a discussion on factors that lead to prolapse. Women should be encouraged to adopt contraceptive suitable to them to avoid unwanted pregnancies and thereby preventing multiple pregnancies.

Role of Doctor

- A doctor should be sensitive to women coming in with prolapse and keep in mind different reasons for its cause other than medical reasons.

- A doctor must appreciate that the condition can be prevented by adopting some measures like rest, good nutrition and exercise. Physiotherapy should also be recommended to those in early stages of genital prolapse.

- In cases of prolapsed uterus, and depending on the stages, alternatives such as use of pessary may be suggested, which can help to keep the uterus in place and to avoid surgery. Comprehensive advice on use of pessary must be provided.

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24. Abnormal position and presentation, occipito posterior, breech, transverse, face and brow, compound, cord presentation and prolapse

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Gender content added: Role of ECV in breech presentation and avoiding unnecessary C section

Lecture name: Abnormal position and presentation, occipito posterior, breech, transverse, face and brow, compound, cord presentation and prolapsed

Subject: Obgyn

Semester no: 6

Duration: 1 hour

Methodology: Lecture, Discussion


Handouts: ---

**Key Points**

1. Use of External Cephalic Version (ECV) in breech position can be useful in avoiding C-Section.

**Learning Outcomes**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Student should be aware that alternatives treatments</td>
<td>Student should be able to diagnose breech</td>
<td>Student should avoid the</td>
</tr>
<tr>
<td>are available for breech position like ECV</td>
<td>presentation and counsel regarding ECV</td>
<td>unnecessary use of C-section</td>
</tr>
</tbody>
</table>

**Obstetrics and Gynecology** 181
Context: While teaching abnormal position and breech position

Note to Educator: The educator should explain to the students that it is necessary to detect a normal occipito anterior position. If they find anything other than normal then they should refer to an experienced colleague.

Content

- Breech presentation complicates 3-4% of all term deliveries and a higher proportion of preterm deliveries. It is more common where there has been a previous breech presentation.

- The incidence of caesarean section for breech presentation has increased markedly in the last 20 years.

- External cephalic version (ECV) is the manipulation of the foetus, through the maternal abdomen, to a cephalic presentation.

- Women with a breech baby should be informed that attempting ECV lowers their chances of having a caesarean section. Women should be counselled that, with a trained operator, about 50% of ECV attempts will be successful but this rate can be individualised for them.

- It is also important to inform women that they can stop ECV procedure at any time if they find it uncomfortable / painful.

Role of Doctor

- A doctor should make different options to deliver for women including the use of ECV for a normal delivery

- A doctor should use ECV in cases of breech position as a regular practice, and recognise that measures like ECV, use of partogram can increase the chance of vaginal delivery. This will reduce complications (anesthetic and surgical).

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Semester 6

25. Abnormal labour - abnormal uterine action, CPD, obstructed labour, uterine rupture

Gender content added: Use of partogram

Lecture name: Abnormal labour - abnormal uterine action, CPD, obstructed labour, uterine rupture
Subject: Obgyn
Semester no: 6
Duration: 1 hour
Methodology: Lecture, Discussion
Handouts: ---

Key Points

1. Understand that "partogram" is a useful tool to monitor progress of labour due to abnormal uterine actions or mechanical factors.

Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should acknowledge that routine use of partogram in labour can help in early diagnosis and management of obstructed labour</td>
<td>Student should be able to use partogram in labour as part of routine practice.</td>
<td>Student should understand the role of partogram in monitoring women in labour</td>
</tr>
</tbody>
</table>

Context: While teaching abnormal labour
Note to Educator: The educator should explain that it is necessary to appreciate that obstructed labour can be prevented by careful antenatal care by detecting mechanical factors leading to prolonged labour.

Content

Use of patrogram to determine uterine condition

Women in labour are often left unattended. The lack of health providers with women impedes the process of monitoring the progress of labour.

The health care system also does not recognise the importance of a birth attendant. A birth companion can provide an empathetic support to the woman in a highly medicalised environment and also assist doctors and nurses in the monitoring of labour.

However it is important that comprehensive in-service training for implementing partogram is given to doctors and nurses

Though monitoring by partograms is an inexpensive method, however it is not being implemented adequately.

Role of Doctor

- A doctor should use a partogram regularly to monitor the progress of labour.
26. Puerperial sepsis and other complications in puerperium

Gender content added: Importance of continuum of post partum care, Nutrition after the prescribed period of six weeks

Lecture name: Puerperial sepsis and other complications in puerperium
Subject: Obgyn
Semester no: 6
Duration: 1 hour
Methodology: Lecture, Discussion

Handouts: ---

Key Points

1. Postpartum care should not be restricted only to 6 weeks to prevents maternal morbidities

2. Proper nutritional care of the woman should be taken even after 6 weeks
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student recognize that gender role of women and limited access to nutritious food influences their health adversely even after 6 weeks of delivery</td>
<td>Student should take steps to ensure that postpartum care post-delivery goes beyond 6 weeks and follow up mechanisms are developed to assess the health of the woman even after 6 weeks</td>
<td>Student should recognize that maternal mortality and morbidity can occur 6 months post partum</td>
</tr>
</tbody>
</table>

**Context:** While teaching post partum care.

**Note to Educator:** Post partum care after six weeks of child birth should be emphasised. If nutritional deficiencies like anaemia are left untreated they can have an adverse impact on woman and her health.

Content

- The World Health organization (WHO) describes the postnatal period as the most critical and yet the most neglected phase in the lives of mothers and babies; most deaths occur during the postnatal period.

- While the World Health organization guidelines underline the importance of follow-up examinations by an experienced, trained health care professional during the post partum period to prevent maternal morbidity and subsequent mortality, there a general indifference to postpartum care in most developing countries. This is not only reflected in government policy documents but also in the literature, where research on effective interventions is scarce.

- It is generally observed that once the baby is born all the focus of care and treatment is shifted from the mother to the baby, neglecting the needs of the mother.

- Her nutrition is seen in the light of her capacity to breast feed the baby, but her own nutritional needs are often neglected. Anaemia, which could have been present in the woman throughout the pregnancy, is ignored. Anaemia persists and may get addressed only when she comes to the health care facility at the time of her second pregnancy.
• In a study done in rural Rajasthan on postpartum care for women within the first week after delivery a total of 4,975 women, representing 87.1% of all expected deliveries in a population of 58,000, were examined in their first postpartum week during January 2007-December 2010. Haemoglobin was tested for 77.1% of women (n=3,836) who had a post-natal visit. The most common morbidity was post partum anaemia: 7.4% of women suffered from severe anaemia and 46% from moderate anaemia\textsuperscript{102}.

• Various socio demographic factors also play an important role in the quality of post partum care received by the woman.

• In a study to understand the prevalence of postpartum morbidities and factors associated with treatment-seeking behaviour among currently married women aged 15-49 years residing in rural India (using the nationally representative District Level Household Survey from 2007-2008), morbidities were found to be more prevalent among poor, illiterate, Muslim, and high-parity women. Women belonging to ST community were less likely to seek post partum treatment, ST are socio-economically disadvantaged indigenous groups living in the mountains, dense forests, and typically inaccessible villages, where health care providers and facilities are sparse. Further, the existing health care facilities in these secluded areas are crippled by a lack of accessibility, poor infrastructure, large-scale absenteeism, a shortage of human resources, and poorly trained, unmotivated manpower.

• Post partum depression should be understood as maternal morbidity. Two prospective studies on pregnant women, in the states of Goa and rural South India, detected depressive disorder in 23% and 16% respectively, with depression persisting six months after child birth in 11-14% of women. In these studies gender based factors emerged as being highly important, with intimate partner violence, unhappiness about the gender of the child, poverty and having a living female child being identified as risk factors both for the occurrence of post-partum depression and for chronicity\textsuperscript{103}.

• Government of India in the past decade has focused on reduction in maternal mortality but maternal morbidity continues to remain a neglected area despite its adverse effects on women’s physical, mental and sexual health. The focus of maternal and child


health programs have been mainly on antenatal care, skilled birth attendance, and institutional delivery. But there is a lack of comprehensive follow-up care post delivery and no mechanism for follow-up exists post 6 weeks of delivery.

The level of post partum care in India is one of the lowest among developing countries, and women frequently fail to seek medical care and consultation from health care providers. As a result, the burden of postpartum morbidities in India is as high as many other developing countries.

What should be done?

- A comprehensive health care plan post six weeks after delivery to address problems like anaemia, post partum depression and overall health. In remote areas where women are not able to access the health care facility easily, ANMs / ASHA should be trained to visit and look out for symptoms of morbidity even after 6 weeks of post partum period.

- Doctors and other health providers must discuss importance of nutritious food for the woman who has delivered. An assessment of family’s response should also be done in the context of birth of a girl child. Such an assessment can assist the health provider to determine the nature of support the woman may / may not receive.

**Role of Doctor**

- A doctor should be sensitive to the fact that morbidities can arise even after six weeks, and in order to prevent those, a follow-up plan after six weeks should be devised. Women should be counselled to recognise the importance of returning for follow-up.
27. Drugs used in obstetric practice

Gender content added: Recognising womens agency to use over the counter abortifacient drugs, Enabling access to medical abortions

Lecture name : Drugs used in obstetric practice
Subject : Obgyn
Semester no : 6
Duration : 1 hour
Methodology : Lecture, Discussion


Key Points

1. A woman coming in with an incomplete abortion or complications should not be blamed for taking over the counter abortifacients; she may have done so due to lack of access to safe and confidential abortion services.
Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should be aware of barriers that women face while accessing safe abortion services</td>
<td>Student should provide safe abortion services to women without being judgmental</td>
<td>Student should be sensitive to the fact that lack of access to safe abortion services forces women to use over the counter drugs like misoprostol and face its adverse consequences</td>
</tr>
</tbody>
</table>

**Context:** While teaching drugs used in obstetric practice.

**Note to Educator:** The educator should explain that abortion drugs should be provided to women without being judgemental and irrespective of their marital status.

**Content**

- Medical abortion with mifepristone and misoprostol is a very safe option for termination of pregnancy when consumed under medical supervision with a success rate of 92-97% up to 9 weeks of pregnancy.

- The MTP Act, 1971 of India permits medical abortion through pills till 49 days and stipulates that abortion pills be prescribed by only registered medical practitioners and not by non allopathic doctors or by pharmacists. WHO recommends that medical abortion can be provided up to 63 days the person or facility prescribing abortion pills should have a backup health care facility in case of failed or incomplete abortion.\(^{104}\)

- Access to medical abortions continues to be a challenge for women in India, and more so for those belonging to economically marginalised groups. Restriction on female mobility prevents women from accessing services when she needs an abortion. It becomes all the more challenging for women who are single because of moralistic view of providers and they also impose procedures such as getting a relative / partner to seek permission for abortion. In the public sector abortion facilities are available

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only at the district hospitals, while services in the private sector are highly expensive. All of these access issues result in a situation where women desperate to terminate a pregnancy often resort to procuring over the counter abortion pills.

- In such scenarios women may prefer undergo medical abortion in the safety of their home with periodic visits to a health provider. But health providers do not offer this option as they believe that women may not follow up and if there is a complication owing to medical abortion, they will be held responsible Unsafe and invasive methods of abortions can injure and kill women, especially if carried out by untrained providers and in unsafe settings. About 13% of abortion related deaths are a result of it.\textsuperscript{105}

- Evidence from a study brought out that not literate women have also been able to use medical abortion pills successfully. This study explored women’s experiences and perceptions of home use of misoprostol and of the self-assessment of the outcome of early medical abortion in a low-resource setting in India. An important finding pointed that women preferred home use of misoprostol because it averted inconvenience of travel, difficulties in completing housework, and making arrangements for child care if they had to go to the clinic. The recommendations of this study stated the urgent need for revision of service delivery guidelines to allow women to have medical abortion with fewer visits. This would serve two purposes, one that it will allow women to do more tasks on their own, rather than repeatedly calling them to the clinic. Second health providers would spend lesser time on medical care for women using misoprostol. The study stated that a few extra minutes on counseling and instructing women on how to use misoprostol at home, and how to conduct and interpret their pregnancy tests should form a part of the treatment plan for medical abortion\textsuperscript{106}

- Women coming with incomplete abortions should be treated promptly and with sensitivity and the situation be considered a medical emergency rather than blame the woman for having come late or not having reported the side effect of a medical abortion. It is important to understand factors that led to delay in reaching the hospital.


Role of Doctor

- Doctors should enable women to access medical abortions and recognise the role it plays when women are unable to travel, spend money on their healthcare needs etc.

- Doctors should be equipped to inform women about the process of medical abortions and symptoms they may face as a consequence of abortion. Clear guidance on follow up in case of unanticipated medical problems should be provided to women.

- A doctor should be sensitive to women coming in with incomplete abortions; the woman should not be blamed for using over-the-counter drugs for abortion.
28. Operative procedures in obstetrics: caesarean section, instrumental vaginal delivery, forceps, vacuum

Gender content added: Lack of access to caesarean sections for women belonging to economically deprived communities

Lecture name: Operative procedures in obstetrics: caesarean section, instrumental vaginal delivery, forceps, vacuum
Subject: Obgyn
Semester no: 6
Duration: 1 hour
Methodology: Lecture, Discussion
Resources: ---
Handouts: ---

Key Points

1. Lack of life saving C-sections is related to the issue of maternal mortality.

2. There is strong relationship between wealth quintiles and delivery by C-section. Mothers in households in highest wealth quintile are much more likely to deliver through C-section (36%) than mothers in households in the lowest wealth quintile (4%).

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### Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise unmet need for caesarean section in underprivileged sections of society leads to maternal mortality and morbidity</td>
<td>Student should be skilled to recognise high risk cases and make provisions for offering caesarean section</td>
<td>Student should acknowledge that pregnant women may reach hospital in a delayed manner due to lack of access to resources</td>
</tr>
</tbody>
</table>

Note to Educator: Educators need to create awareness that lack of timely C sections can lead to maternal mortality and morbidity

### Content

- A figure below 5% at the community level implies that a substantial proportion of women do not have access to surgical obstetric care.\(^{108}\) NFHS 4 indicates all India C section rate is at 4.4%.

### Case Study

Anita, a 22-year-old woman with sickle cell anaemia was admitted in full dilatation in a PHC in Gadchiroli district of Maharashtra for her first delivery. As a primi, or woman delivering her first baby, she would be expected to deliver her baby within 2 hours of reaching full dilatation; a delay beyond this would be considered a need for intervention by either instrumental delivery or caesarean section. Yet, Anita was referred after waiting for 5 hours, after she had been given an episiotomy (which was bleeding and which had to be re-sutured before referral) and still had not delivered. Anita died before she could be admitted in the District Hospital. It is to be noted that the fact that her sickle cell anaemia placed her at high risk for complications during labour and she would have needed special care - the fact that she was not even provided standard care is telling.

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Case Study

Geeta, a woman who had had two caesarean sections previously was admitted in labour in a district hospital in Odisha. This would have warranted immediate surgery as her two previous caesareans put her at risk for rupture of the uterus. However, she was not operated on for 8 hours as she could not buy the essential supplies for a caesarean and died in the district hospital. It is noteworthy that this was a large district hospital with facilities to perform an emergency caesarean section.109

The case studies mentioned demonstrate that Anita was in a high risk pregnancy due to sickle cell anaemia. The antenatal medical care should have recognised her case in advance and given advice to her about reporting to the health facility in advance. The case of Geeta already indicated a need to conduct c section owing to her past 2 C-section deliveries, but she was also not recognised as high risk pregnancy which led to her death.

The Government of India has made efforts to increase institutionalization of deliveries under Janani Suraksha Yojana. But institutionalisation has not translated into a safe delivery. Non recognition on part of doctors about high risk pregnancies, inability to provide c sections in time particularly in the context of emergency care raises an alarm. Standard protocols for high risk pregnancy management are not followed and there are no monitoring mechanisms to bring these concerns to notice unless there are cases of maternal mortality.

Rural Health Statistics (2014-15) indicate that there is still a shortfall in the required number of Sub-Centres, Primary Health Centres and Community Health Centres, despite the investments in NRHM over more than a decade. Similarly, there is a shortfall of human resources, particularly specialists in rural areas. These deficiencies have seriously hampered improvement of health outcomes 110.

A significant rise in institutional and C-section delivery is found between 1992-93 (NFHS-1) and 2007-08 (DLHS-3) in most of the states in India. The scheme like Janani Suraksha Yojana (JSY) may have a great impact on accepting institutional deliveries by poor women. Rising institutional delivery may be a reason of the increase of CS in India. Among all


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other factors, perhaps place of delivery (private or public medical institution) is becoming the strongest one influencing CS. An increase in the rates of caesarean section delivery is a burden on health system. Unnecessary caesarean delivery also put strain on family and may complicate maternal and child health. Therefore, the decision to perform a C-section delivery must be chosen carefully and should not be profit oriented. Utilization of ANC, better doctor- patient communication, doctor's commitment to reduce the rate of CS, government's intention to develop better health care infrastructure and strict vigil on the private health institutions may help to reduce the high and increasing rate of caesarean delivery. Access to caesarean sections as a part of emergency obstetric care must be recognized as an important indicator for universal access to reproductive health.\footnote{Shewli, S. (n.d.). \textit{Caesarean section delivery in India: causes and concerns}. Retrieved from https://jussp.org/sites/default/files/event_call_for_papers/Caesarean\%20section\%20delivery\%20in\%20India_0.pdf}

**Role of Doctor**

- Doctor - patient communication, recognition of high risk pregnancies on the part of the doctor and her / his commitment to reduce CS rates will enable doctors to define situations in which C sections must be provided as a part of obstetric emergency care

29. Preventive oncology

Gender content added: Importance of screening for Ca- Cervix and Breast cancer irrespective of marital status

Lecture name: Preventive oncology
Subject: Obgyn
Semester no: 7
Duration: 1 hour
Methodology: Lecture


Key Points

1. The focus of screening for cervical cancer is restricted to married women. Cervical cancer screening programs assume that only married women are sexually active. Thus single women and women in same sex relationship are often missed by screening programs in India.

2. Screening programs at the level of primary health care are not available. Though NHM in 2015 launched a program to screen for non communicable diseases including cancer little is known about its success.
3. HPV vaccination cannot replace cervical cancer screening. Therefore even if these vaccines are introduced it is important to have a comprehensive and robust screening plan at primary, secondary and tertiary level of health system.

Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should be aware that there is a high incidence of Ca-cervix among women in India and should have adequate information on screening protocols for identification</td>
<td>Student should have skills to discuss sexual relationship as it is a common route of transmission of HPV</td>
<td>Student should be sensitive to the fact that all women irrespective of their marital status and sexual preferences need screening for cancer</td>
</tr>
</tbody>
</table>

Context: While teaching preventive oncology

*Note to Educator:* The educator should explain to students to appreciate that all women irrespective of their marital status need to be screened for cancer.

Content

- In India, high incidence rates have been reported for breast cancer, cancer of cervix, and ovary, which together accounted for 59% of all cancers in women. Worldwide, cervical cancer claims the lives of 231,000 women annually, over 80% of whom live in developing countries.\(^{112}\)

- Studies have shown that appropriate and timely screening can be useful to detect these cancers at an early stage. Though screening facilities are available at health centres, women specifically from rural areas face barriers in accessing these services. Education and awareness materials in the health sector do not comprise of simple information on how women can contract HPV. Additionally economic barriers (time

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and money), logistic barriers (child care, transportation, waiting times etc) as well as social barriers like lack of family support impede access to services.\textsuperscript{113}

- Sexual activity and HPV infection are the key underlying factors necessary for development of Ca Cx. Sexual activity takes place outside of marriage. Though the legal age of engaging in sexual activity is 18 years, young people are initiated in sexual activity at a much younger age. 9.3% pregnancies are accounted to be in the teenage group as per NFHS 4. Therefore screening should be offered to anyone who is sexually active irrespective of marital status.

- Infection can also occur in same sex relationship/ lesbian women. Lesbian women may find it difficult to disclose sexual orientation for fear of being judged by health providers. Hence health providers should be comfortable to discuss same sex sexual relations and possibility of HPV infections in that context.\textsuperscript{114}

- Women should be screened for cervical cancer as per WHO guidelines between 30 to 49 years, but could be extended if there is a higher risk for a woman/ girl. Visual inspection with acetic acid is an inexpensive method and front line workers if trained adequately can carry it out.

**Role of Doctor**

- A doctor should have comfort in discussing sexual practices in the context of seeking history for screening girls and women for HPV.


30. Ultrasonography and radiology in Gynaecology

Gender content added: Judicious use of ultrasound sonography in pregnancy

Lecture name: Preventive oncology
Subject: Obgyn
Semester no: 7
Duration: 1 hour
Methodology: Lecture, Discussion

Handouts: ---

**Key Points**

1. Ultrasound should be used judiciously during pregnancy.

**Learning Outcomes**

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should be informed about the protocols for use of ultrasound in pregnancy at different stages</td>
<td>Student should carry out judicious use of ultrasound in pregnant women</td>
<td>Student should refrain from unnecessary use of ultrasound</td>
</tr>
</tbody>
</table>

**Context:** While teaching ultrasonography.
Note to Educator: The educator should emphasise the point that like any other investigative procedures, USG should be judiciously used. Monthly ultrasound sonography may not yield any results in low risk pregnancies, instead they add to cost of health care.

Content

Unnecessary ultra sound sonography adds tremendously to increasing health care costs. Families get pushed in to carrying out unnecessary investigation, resulting in a situation where they may not have adequate resources to spend when any complication for the woman or her baby arises.

As per the guidelines of the MoHFW obstetric ultrasound should be done during pregnancy between 18 and 19 weeks of pregnancy as part of routine Ante Natal Care (ANC) package. Additional ultrasound examinations can be done if clinically indicated. Routine USG in first trimester has not been able to provide any benefit in low risk pregnancies, except for the diagnosis of ectopic pregnancy.

One ultrasound scan before 24 weeks' gestation (early ultrasound) is recommended by WHO for pregnant women to estimate gestational age, improve detection of fatal anomalies and multiple pregnancies, reduce induction of labour for post-term pregnancy, and improve a woman's pregnancy experience. Therefore doing more ultrasounds than this without a clear indication would constitute irrational practice.

Ethical procedures such as informed consent must be sought for women undergoing ultrasound.

Role of Doctor

- A doctor should be judicious in use of USG; though it is a very useful procedure, its overuse should be avoided.

31. High risk pregnancy

Gender content added: Social factors creating risk in pregnancy

Lecture name: High risk pregnancy
Subject: Obgyn
Semester no: 7
Duration: 1 hour
Methodology: Lecture, Discussion
Resources: ---
Handouts: ---

Key Points

1. Doctors need to be alert to pregnant women living in conditions such as migration, in remote locations, in period of armed conflict and communal riots. These conditions increase risks for women who are pregnant.

Learning Outcomes

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skill</th>
<th>Attitude</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student should recognise Women who are migrants/live in remote locations/or live in armed conflict face challenges in accessing health</td>
<td>Student should be able to identify how these social risk factors affect pregnant women’s health</td>
<td>Student should be sensitive to social determinants as a contributor to health outcomes in pregnancy</td>
</tr>
</tbody>
</table>

Context: While teaching high risk pregnancy

Note to Educator: The educator should discuss the fact that social factors such as living in remote areas, being migrant people and those living in situations of conflict have an
increased vulnerability and therefore have high risks in the context of pregnancy. As Doctors, it would be useful to review not just medical but also social risks to develop a comprehensive treatment and care plan.

Content

- Migration: Migrant women may face a significant disadvantage as they not have access to health services. Most interstate migration is from low-resource states to high resource states. However there is an overall neglect of planning for health care of those in migrant jobs. Migrant workers lack registration and hence often do not have access to public distribution system (PDS) for subsidised food supplies. Migrant women who are pregnant may not have access to antenatal services because they are often not documented in a specific state. Post partum care may also be unavailable for migrant women.

- In an exploratory study of health status carried out among prawn harvesters who are seasonal migrants along the coastal areas of Gujarat, it was found that of the 288 respondents, 37 (13%) reported having delivered one or more children while at the temporary settlement (44 births). Only one woman had received IFA tablets and TT injections during pregnancy at the temporary settlement. Of the 30 deliveries that took place at home, only four (13%) were attended to by a trained dai. The rest were assisted by untrained dais or women from the family assisted in other cases. There is no post partum care available at the temporary settlement. The study brought out the apathy of public sector health care providers. Women from the study reported instances where an ANM refused to visit the temporary settlements citing poor road conditions. Thus migrant women experienced indifference, lack of or delayed response and disrespectful behaviour of the public health sector HCPs.\(^{116}\)

- Remote Locations: Maternal health facilities are not easily accessible to the population living in remote areas. Women living in remote hamlets are may not receive proper ANC services. A civil society report on maternal deaths in India brought out that out of 124 maternal deaths 31 women died on the road. Out of these 7 deaths took place before reaching the first facility, 22 women died while travelling from one facility to another. The report describes cases where pregnant women died as the nearest road to the tribal hamlet was 10 km away and the vehicle could travel only up to the point of road access these were the women who did not receive any antenatal care during

pregnancy. There are also cases where ANMs did not visit as scheduled because of geographical inaccessibility and pregnant women were not immunised. Due to all these reasons women deliver at home under unsafe conditions or cannot reach the health facility in time and may suffer from maternal morbidity or mortality.\textsuperscript{117}

- Armed Conflict and challenges to health access: A study conducted in Kashmir valley reveals a poor state of reproductive health services for women. The findings show that the conflict situation inflicted many restrictions on women, specifically ban on family planning. Many of the health centres and dispensaries are non-functional, giving rise to numerous local doctors (quacks) as people find them more reliable. There is lack of medical supplies. The study describes experiences of women who had to deliver on the floor and did not get a bed even after the delivery highlighting that district and sub district hospitals are not geared for caesareans.\textsuperscript{118}

**Role of Doctor**

- The treatment plan needs to recognise hardships and difficulties encountered by women to reach the health facility. All efforts should be made to design and implement protocols to enable access to pregnant women in situations of migration and armed conflict.


# Gender Sensitive Clinical Practice

**CHECKLIST TO ENSURE GENDER-SENSITIVE APPROACH IN OBSTETRICS AND GYNAECOLOGY CLINICS**

<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedures in place to ensure privacy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Having an enclosed space to talk to the patient that ensures auditory and visual privacy, e.g. Curtains, some amount of soundproofing</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. During history taking</td>
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<tr>
<td>b. During abdominal and pelvic examination</td>
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<tr>
<td>• Ensure that you speak with the patient alone, apart from speaking in the presence of relatives or accompanying persons</td>
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<td></td>
</tr>
<tr>
<td><strong>Information obtained from patients to be treated in a confidential manner</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Ensure that information given by the patient remains confidential in any form, verbal, written, recorded or computer-stored, and is not revealed to any person without the patients' consent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Not discussing patient with other staff or in front of other patients, with family or friends</td>
<td></td>
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</tr>
<tr>
<td>• Sharing of information in case of minors and of individuals involving legal issues has to be shared with their parents and / or guardians and those patients also should know the reason and necessity behind this disclosure communication</td>
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<td></td>
</tr>
</tbody>
</table>

121 The following checklist was developed by the mentors and GME faculty under the Integrating Gender in Medical Education project in Maharashtra. It was felt that this must be taught to students before they are placed for their clinical postings. The checklist was reviewed by 37 medical educators across Maharashtra in a Workshop on Evolving Evidence based Clinical Practice held on 24th - 25th November, 2017 in Mumbai. This was organized by CEHAT in collaboration with the DMER, UNFPA, Seth GS Medical College and K.E.M.Hospital.
<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
</table>
| • Making patients aware of and getting consent for reasons for which the information given by them needs to be communicated to any other person:  
  a. Other doctors  
  b. Partner and family members  
  c. Police / lawyers  
  
  Information pertaining to HIV + status, incidence of domestic violence or sexual abuse and also of suicidal thoughts and/or previous suicide attempts may need disclosure to intimate persons in the family. This disclosure should be done in a sensitive manner with consent of the person |     |    |    |
<p>| Details of sexual and reproductive health i.e. menstrual history, childbirth / pregnancy, obtained in sensitive manner |     |    |    |
| • Maintaining a non-judgmental attitude, being sensitive and maintaining confidentiality towards disclosures about abortion, sex selection, sexual orientation, sexual practices and gender identity |     |    |    |
| Physical examination done in a manner that respects patient's privacy and dignity |     |    |    |
| • Auditory and visual privacy ensured |     |    |    |
| • Appropriate covering of patient |     |    |    |
| • Ensuring chaperone wherever necessary |     |    |    |
| • Informed consent explaining indication, details of procedure |     |    |    |
| • Adequate lubrication, instruments at comfortable temperature (avoid hot / cold instruments) |     |    |    |</p>
<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Explaining findings, discuss diagnosis and further management plans after examination sensitively and countercheck to confirm that patient understands</td>
<td></td>
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<tr>
<td>• Be non judgemental about patients / clients during examination irrespective of clinical conditions they present with - e.g. STI, pregnancy out of marriage</td>
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<tr>
<td>• Be respectful in language and behaviour</td>
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<tr>
<td>• Recognise and respect autonomy of patient / client - right to refuse examination</td>
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<tr>
<td>• Enable access to sex of the provider of patient’s choice (health care provider to be male or female)</td>
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</table>

**During pregnancy - abortion**

Wantedness of pregnancy assessed

- If unwanted, options for termination / continuation of pregnancy to be discussed sensitively with allowing woman autonomy to choose
- If woman desires termination of pregnancy, offer MTP / refer to appropriate services for the same
- Not insist on spousal / other consent for MTP

Abortion service not to be made conditional to acceptance of contraception

**During pregnancy - antenatal care**

Domestic violence screening for all pregnant women in a safe and private space
<table>
<thead>
<tr>
<th>Items</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
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</thead>
<tbody>
<tr>
<td><strong>During labour and childbirth</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Auditory and visual privacy ensured</td>
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<tr>
<td>• Appropriate covering of woman</td>
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<tr>
<td>• Information on progress of labour, any complications provided</td>
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<tr>
<td>sensitively and consent sought for any procedure / intervention</td>
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<tr>
<td>• Woman treated with dignity and respect</td>
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<tr>
<td>• Avoid un-indicated procedures - for e.g. Enema, shaving,</td>
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<tr>
<td>routine episiotomy</td>
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<tr>
<td>• Birth companion allowed into labour room</td>
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<tr>
<td>• Woman's choice regarding position, pain relief etc. Respected</td>
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<tr>
<td><strong>Contraceptive services</strong></td>
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<tr>
<td>• All available options discussed with woman and if she desires</td>
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<tr>
<td>so, with her partner</td>
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<tr>
<td>• Informed consent - with adequate information on advantages,</td>
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<tr>
<td>side effects and complications provided</td>
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<tr>
<td>• Provision of contraceptive service of choice/referral to</td>
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<td>appropriate service for the same</td>
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<tr>
<td>• No coercion or conditional provision of contraceptive service</td>
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<tr>
<td><strong>Adolescent services</strong></td>
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<tr>
<td>• Non judgemental attitude regarding marital status, sexual practices,</td>
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<tr>
<td>sexual orientation, request for contraception</td>
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<tr>
<td>Items</td>
<td>Yes</td>
<td>No</td>
<td>NA</td>
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<td>------------------------------------------------------------------------------------------</td>
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<tr>
<td>• Provision of services - information, contraception, abortion</td>
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<tr>
<td>• Consent of adolescent regarding disclosure of information to parent / guardian</td>
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</table>

**Surgeries / procedures**

• Informed consent

• Indication discussed with patient/family

• Unindicated CS / hysterectomy not done
1. Gender is --------constructed.
   a. Socially
   b. Biologically
   c. Psychologically
   d. Physically

2. State True/False for the following statement related to biological aspect "SEX"
   a. Men are violent by nature-
   b. Men grow bald as they grow old.
   c. Women are protected from heart disease in their youth.
   d. Women eat after the men have eaten their food.
   e. Girls play with dolls and boys with cars.
   f. Women have ovaries. Men have more hair on their bodies than do women.
   g. Women bear violence silently
   h. Boys’ voices change as they grow up.
   i. Men are not able to look after young children.
   j. The body of a young girl gets more rounded as she grows up.
   k. Women leave their mother’s home when they marry

3. -------- on adolescents with intellectual disability to prevent their menstruation severely affects their physical and mental health and it needs to be avoided.
   a. Hysterotomy
   b. Hysteroscopy
   c. Hysterectomy
   d. Hysterosalpingography

4. According to WHO, Adolescence is defined both in terms of age -------- and in terms of a phase of life marked by special attributes.
   a. Spanning the ages between 10 and 19 years
   b. Spanning the ages between 11 and 20 years
   c. Spanning the ages between 12 and 21 years
   d. Spanning the ages between 14 and 25 years.
5. According to a recent report on infertility in India -------- account for nearly half of the infertility cases.
   a. Unovulation
   b. Disorders in the males
   c. Tubal blockage
   d. Antisperm antibodies

6. Apart from medical disorders in pregnancy, ------- has been also considered as a risk factor for pregnant women.
   a. Domestic violence
   b. Spontaneous onset of labour
   c. All of the above
   d. None of the above

7. All pregnant and breast feeding women living with HIV receive -------- triple-drug ante retro viral therapy (ART) regimen regardless of CD4 count or WHO clinical stage.
   a. 6weeks peripartum
   b. 12 weeks Antepartum
   c. Lifelong
   d. Intrapartum

8. Contraceptive counselling should be initiated from
   a. Before conception
   b. Antenatal period
   c. Intrapartum period
   d. Postpartum period
1. Sex & Gender
2. Menstrual Hygiene
3. Gender issues of menstrual practices in adolescent girls
4. Rashtriya Kishor Swasthya Karyakram (RKS K), GOI. 2014
5. Social consequences of Infertility
6. Genetic Stigmatisation
7. Domestic Violence during pregnancy
8. Birth companion
9. Use of Episiotomy
10. Respectful maternity care
11. Breast feeding in seropositive mothers
12. Contraception counselling in postpartum period
13. Three level delay model to recognise maternal mortality and morbidity
14. Gender sensitive care for transgender & intersex while dealing with sexual and reproductive health issues.
15. Social factors as aetiology of prolapse of uterus.
16. Key factors related to Obstetric violence
17. Emergency contraception
18. MTP act
19. PCPNDT act
Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people’s health movements and for realizing the right to health care. CEHAT’s objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT’s projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients’ Rights, (3) Women and Health, (4) Violence and Health.

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