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Editorial

Pitfalls of Sexual and Reproductive Healthcare of Women in India

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The practice of obstetrics and gynaecology (OB/GYN) has historically been dominated by men and was brought into existence as a replacement for midwifery, a woman-centered model of care, by women, which was deemed unscientific. Instead of improving on this model, they built their own as they considered women weak, naïve, and irrational to understand the 'complex science'.[1] They called midwifery unscientific while conducting unethical experiments on enslaved women without anaesthesia and practicing eugenics.[2] The practice has deep patriarchal origins. They viewed woman as a machine to be repaired. Over time, women started to re-enter the field only to work in the same technocratic and misogynistic model.[3-5]

Looking at the current practice of OB/GYN in India, not much has improved and it remains the same for women of marginalized communities. The quality of care remains poor.[6] The increasing number of women in OB/GYN is not helping in improving the treatment of female patients proportionately. Women face many barriers in accessing healthcare. When they finally do get access to it, their right to health is being denied (Table 1).[7,8]

Table 1. *Acts Comprising Obstetric Violence Against Women in India (N=83)*

	Number	Percent
Non-dignified Care		
Shouting/scolding from staff	36	43.4
Threat to withhold treatment during childbirth	34	41.0
Discriminatory racial commnets	73	88.0
Refusing of providing medicine	49	59.0
Waiting for a longtime to get medical care	53	64.0
Physical Abuses		
Hitting, slapping, pinching and pushing from staff	23	28.0
Inappropriate physical touches	31	37.3
Forcefully pressed abdomen	34	41.0
Forceful vaginal examination	11	13.2
Sexual abuse	07	8.4

Accessing abortion as an unmarried woman is a nightmare in India. In most hospitals, she is asked to bring along her parents despite not being a minor. In government hospitals, obstetricians performed dilatation and curettage (D&C) without anesthesia as a form of punishment.[9] When asked about their experiences with obstetrical care, pregnant women with disabilities reported that they were asked why they had sex in the first place, were denied an intrauterine device (IUD) unfairly, and were verbally abused.[10]

It does not get any easier for a married, abled woman. The husband speaks over her during the appointments about her concerns. Obstetrical care, instead of advocating for the patient, is depriving her of dignity and privacy, particularly in a teaching hospital where women of lower-income and marginalized communities seek care.[11] Obstetric violence is routinely seen there. The doctors do not explain most procedures or obtain consent before conducting them. Every medical student is free to insert his or her fingers into her privates to check for dilatation of her cervix. They are sometimes examined without the blinds drawn. The patients are yelled at and beaten for not pushing hard enough in the labour room and are asked to clean up their feces (Table 1).[7,8,12] The episiotomies are not repaired under anaesthesia. If they undergo a caesarean section, the chances are that they will be prepared and cleaned after surgery, naked, without proper covering. Studies have shown how obstetrical abuse derails a woman's psychological, physical and socioeconomic health.[13] Acharya et al[7] conducted a study in the Bargarh and Sambalpur districts of Odisha, India to determine the extent of obstetric violence in India. They classified it and assessed how it impacts the lives of women who experienced it. Following is the table from the study detailing the various kinds of obstetric violence and the number of women who experienced it.

Rape is significantly underreported and those who muster the strength to report it experience humiliation from healthcare workers. They are subjected to invasive, unnecessary swab collec-

tion, questions on their previous sexual experiences and the validity of their claim. The 'two-finger test', a barbaric method, is used to gauge if the person has had sex in the past. Despite the health ministry's guidelines being direct about not commenting on sexual history, the officials in many states still document it.[14] Trauma-informed care is unheard of at most hospitals.[15] There is minimal literature on intimate partner violence (IPV) in Indian medical education. Post-coital tears are only treated with the husband's consent. In a country where marital rape is not yet criminalized, OB/GYN care, instead of helping the victim, is enabling the abuser.

Though women who can afford private healthcare are not traumatized to the same level as those who cannot, it is not a cakewalk for them either. Many women have expressed on social media under the hashtag #obgyntales, how they were body-shamed for being overweight and how gynecological care made them feel invalidated, how every problem they had was attributed to their weight and that their concerns were only addressed if they were related to child bearing.[16] One in every five adolescent girls in India suffers from polycystic ovarian syndrome (PCOS).[17] Adolescents are highly impressionable. They are bombarded every day with views of what the ideal body type is. Unnecessary surgeries to achieve it are becoming the norm and body dysmorphic disorder is on the rise.[18] So, the gynaecologist needs to have a weight-loss conversation with them without imparting lifelong body image issues. PCOS is hard on a woman. Facial hair, acne, the lack of regular periods, overweight, acanthosis nigricans-every aspect of the disease is stigmatized. Social media pages like 'uteropedia' are educating girls on advocating for themselves in a medical setting.[16] Isn't it the gynecologist's job to stand in their corner? Why should girls as young as fifteen be looking at how to advocate for themselves?

So, the question arises, why is the practice of obstetrics and gynaecology failing women despite being women dominated? The branch of health that is supposed to be about the female body does not respect it enough. The supposed safe havens are becoming the cause of their depression.[19] The current practice where women are expected to be grateful for the bare minimum while being dehumanized should be uprooted. To establish a new, women-oriented practice, doctors, right from their undergraduate stage should be taught humanities and soft skills, to re-examine their biases and to view the patient as a person with emotion, feelings and a social life rather than a problem to be solved. The inequalities in power, information and wealth are responsible for poor care. The lack of knowledge of their rights among women must be addressed. Sexual and reproductive rights violation units must be set up at the district level. Every woman has the right to health and dignity and it is the duty of the healthcare personnel to provide it.

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