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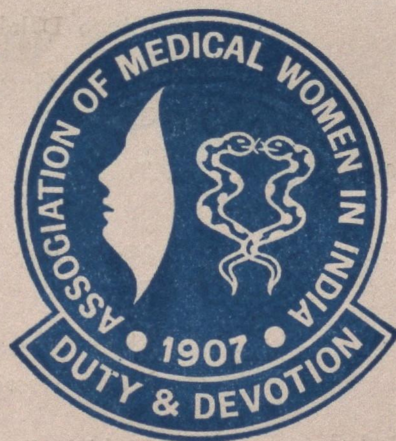


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# POVERTY AND RESISTANCE TO FAMILY PLANNING

by

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and

C. M. Alwani,** M.D., D.G.O.

## Introduction

We are faced with the problem of increasing population and the problems associated with it. Inspite of intense propangada which is being done, there are still sections of society even in urban area who do not willingly come forward to accept family planning due to various reasons. In an effort to study the co-relation of poverty and their acceptance or non-acceptance to family planning, and the reasons for the same, a survey was conducted in a small slum situated right in the heart of the city at New Jaifal Wadi situated along the hill top at Tardeo.

The huts are constructed with Asfalt or metal roofing and walls are made of clay, metal, patra or cement. They get water from municipal common taps and have common latrines which become filthy and muddy in rainy season. Each hut has 64 to 80 square feet area. Huts are kept neat and clean. People come from Maratha, Vanjari, Kunbi, Cobbler and Harijan Community of Nasik, Satara and Ratnagiri district of Maharashtra and from Saurashtra. Most part of the year specially during harvesting season, women and children stay at their native place for agriculture work, separating them from husbands for some time. During the vacant period the hut is either rented or occupied by relatives. Because of ever rising cost and poverty, both husband and wife work to make both ends meet. Most men have rotating duty at work making a total stranger to his own offsprings, thereby making himself as "the invisible" father, who comes home infrequently just to be-get another child, and the mother, who beaten down by the intolerable stress of circumstances, may either actively resent her children or be too tired or working too hard to play her proper maternal role.

This is the traditional society, where the modern system has not been accepted though seen. Men are engaged in mill, industry or offices while women are engaged in domestic work at the posh houses of Pedder Road area or work as dai/aya in hospital or private sick person.

A welfare centre called Apnalaya is run by a group of people. They have full time trained social workers and carry on various activities like nursery school, adult literacy class, craft, needle-work classes, educative

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get-togethers, all for the hutment dwellers. Yet alcoholism and absentism from work is the common problem.

Even with pressure and effort from welfare workers, the school dropouts and playing truants among teenagers is common. The women are too busy to take proper care of their own children, as most of the time they are kept busy with their own housework and job.

Information for study was collected from the respondents by the interview techniques on a structured schedule. One woman from each hut was interviewed. Total 200 women were interviewed, but 50 women were not included in our study as they were not fertile women.

## Age

TABLE I

| Age at present | No. of women | Percentage |
|---|---|---|
| 18 to 29 yrs. | 54 | 36% |
| 30 to 39 yrs. | 63 | 42% |
| 40 to 49 yrs. | 24 | 16% |
| 50 and above | 09 | 6% |
| Total | 150 | 100% |

The highest number of women i.e. 54 fell in the age group of 18 years to 29 years. 63 women were in the age group of 30 to 39 years. 24 women were in the age group of 40 to 49 years. While remaining 9 women, were in the age group of 50 and above years.

TABLE II

| Age at marriage | No. of women | Percentage |
|---|---|---|
| 13 to 20 yrs. | 149 | 99.3% |
| 21 to 25 yrs. | 001 | .7% |
| Total | 150 | 100% |

Age at marriage when asked 149 women were married between 13 to 20 years while only one woman was married at 22 years.

## Occupation

TABLE III

| Occupation of husband | No. of men | Percentage |
|---|---|---|
| Clerical | 7 | 4.7% |
| Skilled labourer | 35 | 33.3% |
| Unskilled labourer | 108 | 72% |
| Total | 150 | 100% |

The highest number of men fell in the category of unskilled labour i.e. 108. While 35 men were engaged in skilled labour only 7 of the men were engaged in clerical posts.

TABLE IV

| Occupation of wives | No. of women | Percentage |
|---|---|---|
| Unskilled labourer | 143 | 95.3% |
| Not working | 07 | 4.7% |
| Total | 150 | 100% |

Among the women 143 were engaged in unskilled work and only 7 women were not doing work. Unskilled work included here, are hamals at the station, vendors, machine work, domestic servant, dayi and ayah, while skilled work mean fitter, welder, assembly work in factory.

### Shift Duties

TABLE V

| Shift duties husband | No. of men | Percentage |
|---|---|---|
| Yes | 047 | 31.3% |
| No | 103 | 68.7% |
| Total | 150 | 100% |

Among men only 47 men had shift duties and 103 had no shift duties. Among women only 1 woman had shift duties who worked in a hospital as an ayah.

### Economic Aspects

TABLE VI

| Total income of family | Family | Percentage |
|---|---|---|
| Rs. 100 to Rs. 500 | 91 | 60.7% |
| 500 and above | 59 | 39.3% |
| Total | 150 | 100% |

The data in Table 6 gives the distribution of income per household. The highest number of families belong to low income group that is 60.7%, in 100 to 500 rupees per month income group while 39.3% families come in Rs. 500 and above per month income group.

**Family Type**

TABLE VII

| Type of family | No. of couples | Percentage |
|---|---|---|
| Nuclear | 108 | 64% |
| Joint | 42 | 36% |
| | 150 | 100% |

Table 7 shows that 108 families are nuclear and 42 families are joint families. Here the family lives for a short period for the sake of earning. Most of them own agricultural land at their native place, which is their permanent abode, having all the elderly members of the family living at the native place.

**Total Number of Pregnancies**

TABLE VIII

| Total No. of pregnancies | No. of women | Percentage |
|---|---|---|
| 1 to 3 | 75 | 50% |
| 4 to 6 | 50 | 33.3% |
| 7 and above | 25 | 16.7% |
| | 150 | 100% |

The pregnancy every woman had is shown in Table 8. 75 women (50%) had 1 to 3 pregnancies while 50 (33.3%) women had 4 to 6 pregnancies and 25 women (16.7%) had more than 7 pregnancies.

**Total Number of Living Children**

TABLE IX

| Total No. of living children | No. of women | Percentage |
|---|---|---|
| 1 to 3 | 82 | 54.7% |
| 4 to 6 | 57 | 38% |
| 7 and over | 10 | 7.3% |
| | 150 | 100% |

To find out how many children are living, again the reply was that 82 women (54.7%) had 1 to 3 living children while 57 women (38%) had 4 to 6 living children, and 11 women had more than 7 living children (7.3%).

**Counselling in Family Planning**

TABLE X

*Did you ever get counselling on Family Planning?*

| Answer | No. of women | Percentage |
|---|---|---|
| Yes | 147 | 98% |
| No | 3 | 2% |
| | 150 | 100% |

These women were asked whether they ever received counselling for family planning 147 women (98%) have heard of family planning in the hospital, but did not agree while 3 women (2%) never heard of family planning methods because they had lived in a remote village where no medical facilities are available. They had home deliveries so there was no question of information on family planning.

**Family Planning Acceptance**

TABLE XI

*Acceptance of the F. P. according to Parity*

| Parity | No. of couples | Total % | Non Acceptance | Acceptance | Total % of Acceptance |
|---|---|---|---|---|---|
| 1 | 25 | 16.7% | 23 | 2 | 1.3% |
| 2 | 18 | 12 % | 14 | 4 | 2.7% |
| 3 | 20 | 13.3% | 8 | 12 | 8 % |
| 4 | 29 | 18.7% | 12 | 17 | 11.3% |
| 5 | 28 | 19.3% | 13 | 15 | 10 % |
| 6 | 18 | 12 % | 11 | 7 | 4.7% |
| 7+ | 12 | 8 % | 10 | 2 | 1.3% |
| | 150 | 100 % | 91 | 59 | 39.3% |

Even though 150 women were exposed to counselling in the hospital, the acceptance of family planning spacing methods was very poor. 53 women (26.5%) had tubal ligation done and 7 males had vasectomy performed. Only 6 patients (4%) had accepted oral contraceptives and only 4 patients (2.7%) had accepted I.U.C.D. Surprisingly only 2 patients acknowledged that they use condoms.

**The Reaction of those accepted. Family Planning Method**

TABLE XII

| | No. of cases | Percentage |
|---|---|---|
| Refusal | 60 | 40 % |
| T.L. Cases | 53 | 35.3% |
| Motivated | 18 | 12 % |
| Vasectomy | 7 | 4.7% |
| Oral | 6 | 4 % |
| I.U.C.D. | 4 | 2.7% |
| Condom | 2 | 1.3% |
| | 150 | 100 % |

To find out the opinion of those who accepted the contraceptives, they were asked to give their view. As explained in Table 11, 1 woman (.5) stopped after taking 4 cycles' oral pills as she had side effects like palpitation and indigestion, 1 woman changed to I.U.C.D. after getting side effects with the oral pills for nearly 1 year. 10 women have continued with the I.U.C.D. or oral packets for spacing purpose. One notable thing is that all those 13 women were young with modern thoughts. 53 women (26.5%) had tubectomy to complete the family, while 7 men had undergone vasectomy.

TABLE XIII

| | Reasons | No. of women | Percentage |
|---|---|---|---|
| 1. | Husband out of area | 8 | 4.0 |
| 2. | Ignorance of methods | 3 | 1.5 |
| 3. | Husbands refusal | 5 | 2.5 |
| 4. | Blunt refusal | 15 | 7.5 |
| 5. | Children may not survive | 13 | 6.5 |
| 6. | All children girls | 7 | 3.5 |
| 7. | All children boys | 3 | 1.5 |
| 8. | Natural spacing due to lengthy lactation | 49 | 24.5 |
| 9. | Sterilisation done or taking some method | 71 | 35.5 |
| 10. | Sterility cases | 20 | 10.0 |
| 11. | Secondary sterility | 06 | 3.0 |
| | Total cases studied | 200 | 100 |

**Conclusion**

A vicious circle is somehow found in the low income group class of people due to various reasons. They have desire to have more children because of the following reasons:

(1) To have more hands to help them in their work. Even a girl of 10 years looks after her 4-5 younger kid brothers and sisters when parents are out to work.

(2) Desire to have more male children.

(3) Increased perinatal mortality due to low nutrition, lack of proper antenatal and post natal care, hence they desire to have more children always arguing that at least 2-3 will survive—a really pitiable state.

(4) Ignorance regarding Family Planning spacing and the fear of hearsay bad effects of family planning methods also makes them more resistant to family planning. Often doors are slammed on the family planning social worker as soon as the word family planning is mentioned.

Hence increase in number of children, low nutritional poverty leads to higher death rate in children. The anxiety and tension to cope with the children and their problems leads to alcoholism, wife and children beating, creating other problems. What then is the solution? The following suggestions can probably help to diminish the problem if effectively carried out.

(1) Education of the masses is the most important factor. Once education and awareness is there in the minds of people, at least the resistance will not be so hard.

(2) Establishing maternal and child health care centres to educate and help to improve the mother's and children's health and nutrition. Once parents are reasonably sure that the chances of survival of their children are enhanced, probably they themeslves will not like to have more number of children.

(3) Effective and persistant motivation for family planning should be done.

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# ACCIDENTS IN CHILDREN

by

**Daksha Pandit,*** D.P.H., M.D. (P.S.M.

and

**S. S. Jha,**** D.P.H., M.D. (P.S.M.

Accidents do not just happen, they are caused. Owing to the marked advances in medicine and public health, the tide of infectious diseases has receded in most of the countries of the world. In destructiveness the accident has replaced devasting epidemics which in the past have swept the country.

(1) Accidents which have been described as an illness of society occupy sixth place as killers in India. It is not only as a cause of death that accidents in childhood are important, the number of nonfatal accidents is very much larger. The loss of life and the incapacity resulting from accidents is as great as or greater than any other disease entity. Yet the medical profession has not accepted the urgent challenge for a scientific study of accident causation and prevention i.e. its aetiology. It is a challenge which must be taken up. The diseases which used to cause devasting epidemics have been almost eliminated by medical control, and accidents demand equally effective attention.

## Material and Methods

This is a retrospective study of three hundred and eighty five cases of accidents in paediatric age group admitted to B.Y.L. Nair Charitable Hospital, Bombay, during a period of one year. First sample size was determined and then the cases were selected by systematic random sampling. As this is a charitable hospital, most of the patients attending this hospital come from low-socioeconomic strata of the society. The type, nature, cause of accidents, time, place, age and sex distribution was studied. Duration of stay in the hospital, time interval between the accident and admission in the hospital, condition of the patient at the time of accident and at discharge was also studied.

## Results and Discussion

TABLE I

*Distribution of cases according to type of accidents*

| Type of accident | Number of cases | Percentage |
|---|---|---|
| Domestic Accident | 254 | 65.98 |
| Transport | 47 | 12.21 |
| Miscellaneous | 84 | 21.81 |

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Out of 385 cases, domestic accidents were 254. Domestic accidents were more common in children than the transport accidents. In miscellaneous group there were 84 accidents. Most of these accidents were due to falls but history was not sufficient to know whether the falls were domestic falls or falls on grounds or roads. Accidents due to transport are on increase due to increased traffic congestion and over crowding. Due to shortage of playgrounds children play on the road without realising the danger to which they are exposed.

In the present study number of domestic accidents is maximum. In developing countries like India, the housing is very crude. Overcrowding, unsafe methods of cooking, heating and lighting take a huge toll of lives. The mother has difficulty in looking after the safety of small children when domestic operations such as cooking and washing have to be carried out under crowded conditions Danger is ever present when saucepans or kettles containing hot fluids have to be placed on the floor for lack of space, when there is no cupboard in which medicines or dangerous substances can be stored or when fire occupies a prominent position in a small room. Again where families are in a poor socio-economic circumstances and the mother has to go out to work, young children are apt to be left at home for considerable periods with inexperienced or no care at all.

**TABLE II**

*Type of domestic accident*

| S. No. | Type of accident | No. of cases |
|---|---|---|
| 1. | Falls (in and around the house) | 142 |
| 2. | Burns and Scalds | 39 |
| 3. | Poisoning | 45 |
| 4. | Foreign body ingestion | 18 |
| 5. | Sharp instrument injury | 5 |
| 6. | Electrocution | 3 |
| 7. | Drowning | 2 |

In domestic accidents the number of accidents due to falls was maximum. These accidents are in and around the house. Maximum number of falls were from staircase. 3 cases of fall from mother's lap. 10 cases of fall were from cots in which cases the child was left on the cot alone when the mother was busy with her domestic work. Poisoning ranked second. Out of 45 cases, 20 cases were of kerosene poisoning. Other cases of poisoning were due to Benzyl Benzoate, sapat lotion, phenobarb tablets, liniment, bleaching powder, alcohol and food poisoning. All these medicines are very much commonly used for household

purposes. The keeping of drugs in cupboards where they can be easily reached by children is often an important contributory factor.

Out of 39 cases of burns, 29 cases were due to falling of hot liquid such as tea, curry on the body. Burns due to fire-4 cases, stove-2 cases, kerosene lamp-3 cases, crackers--1 case. Out of 39 cases 4 expired due to burns. Other cases of domestic accidents were foreign body ingestion in the form of coins and beads-18 cases. Sharp instrument injury due to broken glass or knife-5 cases, 3 cases or electrocution and 2 cases of drowning due to fall in a tank or fall in a bucket full of water.

TABLE III

*Age and sex distribution*

| Age distribution | Male | Female | Total |
|---|---|---|---|
| 0< 1 year | 13 | 16 | 29 |
| 1< 4 years | 74 | 46 | 120 |
| 4<10 years | 117 | 60 | 177 |
| 10 years and above | 45 | 14 | 59 |
| Total | 249 | 136 | 385 |

Analysis by sex as well as age reveals important differences. In the present study 249 cases were males and 136 cases were females.

There is a marked preponderence among boys of injuries associated with outdoor activities. Fractures and head injury and other injuries were more common in males but there was no significant difference between males and females in cases of burns and foreign body ingestion. Different ages bring different problems. In infancy the physical weakness of the young child exposes it to such injuries as mechanical suffocation, unduly serious effects of falls from cot or choking by food or other objects taken into the mouth. In the preschool age the child has become active and goes out to face hazards, instead of just taking them as they come. In the earlier period (1 to 2 years), when the child is yet unstable in balance, a larger percentage of deaths are caused by children upsetting or falling into hot liquids. At the later period (3 to 4 years), love of exploration plays a larger part, leading to injury from playing with matchbox or by probing into electrical fittings. Maximum number of poisoning cases are in this period.

In the school age, children and especially boys become more adventurous. In the present study (Table 4) out of 137 head injury cases 89 cases of head injury are in this age group only and more common in males as compared to females. Cases of fractures are also maximum in this age group.

TABLE IV

*Age and sex distribution according to type of injury*

| Age Distribution | Burns | | Poisoning | | Foreign body ingestion | | Head injury | | Fractures | | Soft tissue injury | | Other injury | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F | M | F | M | F | M | F |
| 0< 1 Yr. | 2 | 7 | 6 | 3 | — | — | 4 | 4 | — | 1 | 2 | 1 | — | — |
| 1< 4 Yrs. | 13 | 7 | 15 | 14 | 7 | 2 | 28 | 14 | 3 | 2 | 6 | 6 | 1 | 1 |
| 4<10 Yrs. | 4 | 5 | 2 | 2 | 5 | 3 | 52 | 22 | 46 | 23 | 8 | 4 | 1 | — |
| 10 Years and above | 2 | 1 | 2 | 1 | 1 | — | 12 | 3 | 20 | 3 | 5 | 4 | 3 | 2 |

TABLE V

*Relation of time to the Accident*

| Time | Number of cases |
|---|---|
| Morning | 113 |
| Afternoon | 71 |
| Evening | 115 |
| Night | 30 |
| Time not mentioned | 56 |

In the present study 113 cases occurred in the morning and 115 in the evening. Accidents are more common in morning and evening than night. Several investigators have reported increased accident rate in the evening due to physical and mental fatigue.[4] Among other factors the importance of decreased blood sugar level has been stressed in children. The study of physical conditions at the time of accident is also important. In the present study 10 cases were ill at the time accident, 6 had T.B., 2 mentally disturbed due to a domestic problem, 20 physically handicapped due to polio, 5 epileptic, 5 mentally retarded and 2 had diminision of vision.

TABLE VI

*Time interval between the accident and admission in the Hospital*

| Time Interval | No. of cases |
|---|---|
| 0<1 Hour | 125 |
| 1 Hr <4 Hours | 53 |
| 4 Hrs <12 Hours | 44 |
| 12 Hrs <24 Hours | 6 |
| 24 Hours and above | 18 |
| Time interval not mentioned | 135 |

Quick hospitalisation is very important to prevent further consequences and early recovery. In the present study maximum number of cases were brought to the hospital in 1 hour.

TABLE VII

*Duration of stay in the hospital*

| Duration | No. of cases |
|---|---|
| 0< 1 day | 146 |
| 1< 5 days | 187 |
| 5<10 days | 22 |
| 10 days and above | 30 |

Duration of stay in the hospital will depend upon the seriousness of the accident. In the present study maximum number of cases stayed in the hospital for 1 to 5 days. In the present study maximum duration of stay in the hospital was 28 days in a burns case.

**TABLE VIII**

*Seasonal distribution of cases*

| Season | Total No. of cases | Average No. of cases per month |
|---|---|---|
| Winter (Oct. to Feb.) | 134 | 40.8 |
| Summer (March to May) | 157 | 34.8 |
| Rainy Season (June to Sept.) | 94 | 24.4 |

This is statistically significant. Maximum number of cases occurred in the summer when the children are having holidays. The circumstances under which many children spend their holidays are obviously too dangerous.

**TABLE IX**

*Outcome of cases*

| Sr. No. | Outcome | No. of cases | Percentage |
|---|---|---|---|
| 1. | Discharged with complete recovery | 325 | 84.4 |
| 2. | Discharged with residual deformity | 7 | 1.8 |
| 3. | Expired | 15 | 3.8 |
| 4. | Left against medical advice | 38 | 10.0 |

84.4% cases were discharged with complete recovery. Mortality was 3.8%. There were 7 cases with residual deformity due to contractures developed due to burns. 15 cases expired, 11 expired due to head injury, and remaining 4 expired due to burns. Out of these 6 cases of head injury were due to transport and 5 cases of head injury due to domestic falls. All those who died were in preschool group i.e. 1 to 4 years age group.

**Conclusion**

There is a widespread belief that accidents are inevitable. This fatalistic attitude must be prevented. It has been aptly stated that "if accident is a disease then education is its vaccine".

The cardinal basis of accident prevention fall into 3 categories.

(1) Health education

(2) Engineering

(3) Regulation and law enforcement

and last but not least is, "Accident Service Organisation". Emergency

care begins at accident site, continues during transportation and is concluded in hospital emergency room. At any of these stages a life may be saved or lost depending on the skill of attending physician and the availability of needed emergency equipment.

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# INTESTINO—UTERINE FISTULA

## A RARE COMPLICATION FOLLOWING ABORTION

by

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The internal communication of the viserae have been noted and been seen in many of the cases either due to congenital defects or following injury or due to intra-abdominal diseases. The fistulus communication with the neighbouring viserae in the abdomen was known as Intestino-Vesicle or Utero-Colic or Colo-Vesicle etc. following Crohn's or ulcerative colitis or diverticulitis. Tuberculosis of the intestine has also been complicated by internal fistulae—so also malignant growth of the stomach, Intestine, Colon etc. But the internal communication of uterus with the small intestine has rarely been reported or described. Here we are presenting one case of Intestino-Uterine fistula following curetting operation for abortion.

### Case Report

A female of 40 years with low nutrition, severely anaemic and exhaustive patient, was brought to us in our clinic with a history of passing offensive faecal smell discharge per vagina for the last 3 weeks. But the patient gave no history of previous Abdominal disease nor complained of any intestinal obstructive features. But the party gave the history of operation for termination of pregnancy about 3 months back and only for the last 3 weeks had she developed the above complaints.

### On Examination

A female of 40 years with low nutrition very ill, weak having discharge per vagina with offensive smell. On further examination it revealed that the patient was running fever from 100°F to 102°F daily, her pulse rate was 120/minute, respiration was only 22/minute. On vaginal examination it was seen that the discharge was coming from the uterus. Internal examination did not reveal any abnormality excepting the discharge. Considering this the patient was investigated. Her Blood urea and sugar were within normal limits. The Blood routine analysis with E.S.R. was normal except for 40% Hb. Vaginal swab was sent for culture and sensitivity, The culture showed E. Coli. The Barium meals follow

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through could not be done early due to some limitation. The patient was put on conservative treatment with proper anti-biotic and 2 bottles of blood was transfused. After a little improvement of the general condition, decision was taken to explore the Abdomen and 10 days after the conservative treatment the abdomen was explored through lower mid-line incision. To our surprise we saw that a part of the circumference of a loop of Ileum on the anti mesentric border was entangled into a opening at the fundus of the uterus. Fig. 1. With proper disection the intestine was disected out of the uterus. Resection anastomosis of the affected intestine was done and the rent at the fundus of the uterus was closed in two layers with the help of catgut. The abdomen was closed and the patient had uneventful recovery and was discharged on the 12th day of the operation.

Fig-I. Intestino-Uterine Fistula

**Discussion**

The fistulae communications in the uterus and the Vagina have been known due to congenital anomalies e.g.—Vagina might have internal communication with Rectum and anal canal or with urinary passage—either with urethra or Bladder itself. So is the case with acquired pathology where the vagina might have the communication with urinary tract following a difficult total or sub-total Hystrectomy.

There are also reports of fistulae communication between urinary pasage and vagina following cancer of the uterus or even after the draspic measures taken by Radiation therapy following cancer. During curetting of the uterus there is always a vulnability of internal injury like uretero ureteral, vesico vaginal, colo-uterine etc. But the bringing down of the part of the circumference of a small gut through the fundus of the uterus is one of rare complication. So we are presenting the case with a utero Intestinal fistula following a history of curetting for termination of pregnancy who presented with H/O passing offensive discharge per Vagina. Small intestine (i.e. a part of the circumference of Ileum)—on the antimesentric border had been dragged down and had got entangled in the uterine cavity through the small fundal perforation. Subsequently

the part sloughed out and lead to a faceal fistula through the vagina—but even then the patient never developed any Intestinal obstructive features.

**Summary of the case**

An interesting case of Intestino—Uterine fistula following curetting operation for abortion was described. The diagnosis and treatment was done and the patient ultimately saved of this complication due to timely surgical interference.

**Acknowledgement**

We are grateful to staff of Nursing Home for allowing us to publish the case. We are also indebted to the staff of Bio-Chemistry and Pathology Department for their Co-operation.

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## MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

Dear Colleagues:

**New MWIA Secretariat:**

The new Secretariat will be installed in BRISTOL, England. The Official opening date of the new office will be July 1, 1983.

The British Federation of Medical Women will appoint a new Honorary Secretary and a new Executive Secretary in due course. Dr. Corner has kindly promised to assist the new staff in the beginning.

**Manila Congress:**

The Preliminary Programme contains the schedule for each day, including the time planned for the scientific sessions, the business meetings and the social events. Most entertainments are by invitation of the generous Philippine Association, even the Banquet.

The scientific programme is being built up as the papers come in.

In view of the fact that the deadline for the submission of papers had obviously been set too early, it has been decided that names of speakers and titles of papers, accompanied by an abstract of 150 words, may be sent to the Vienna Secretariat until OCTOBER, 1981.

A new subheading of the topic "Humane Management in Medicine" has been added: Humane Management in Obstetrics and Neonatology. Papers dealing with this subject may be submitted.

The Scientific Congress Committee, Manila will write to the authors regarding the acceptance of their papers.

More details will follow.

**Election of Officers 1982-1984:**

The following candidates have been proposed for election in Manila:

| | | |
|---|---|---|
| President | : | Dr. Trinidad GOMEZ, Philippines |
| President-elect | : | Dr. Beverley TAMBOLINE, Canada |
| Honorary Treasurer | : | Dr. Marta HOLMSTROM, Sweden (who has agreed to stay on for another term) |
| Honorary Secretary | : | to be chosen and proposed by the British Federation of Medical Women |

| Vice-Presidents | : | |
|---|---|---|
| Northern Europe | : | Dr. Brita SILVERSTOLPE, Sweden |
| Central Europe | : | Dr. Gertrud ZICKGRAF, Germany |
| Southern Europe | : | Dr. Fernanda BENEDETTI, Italy |
| North America | : | Dr. Patricia TUDBURY, USA |
| Ibero America | : | no candidate proposed so far—the countries the Vice-President should originate from were:<br>Brazil — proposed by 3 associations<br>Mexico — proposed by 4 associations<br>Peru — proposed by 3 associations |
| Near East and Africa | : | Dr. Dinah JARRETT, Sierra Leone<br>Dr. te WATER-NAUDE, South Africa |
| Central Asia | : | Dr. Marie CATCHATOOR, India—re-election |
| Western Pacific | : | Dr. Il-Ok CHOO, Korea<br>Dr. Ayako SANO, Japan |

**Lovejoy-Jubilee Fellowship Fund:**

As you know this Fund was established to award a grant of SF 1,000 each to three members to assist them to attend a MWIA Congress and to participate actively in the scientific programme. The applications must be sent to the Secretariat.

MWIA is unfortunately not in a position to finance the full cost of travel and registration and accommodation expenses, however, the sum of SF 1,000 may help to cover these partly.

The Executive decided to grant one award to a Philippins medical woman living in the southern part of the country and working in the Moslem area who could otherwise not afford to come to Manila.

This leaves two more awards for suitable candidates to be chosen. The applications must come from the national associations and not from the candidate directly. We should be glad to receive your suggestions not later than NOVEMBER 1981.

(Interested candidates should contact National Secretary Dr. J. Desa Souza).

**Policy Resolution:**

The Policy Resolution received from the German Association, asking for a 10% increase of the subscription dues for members of industralized countries and a 60% reduction of the dues for members from

developing countries, had been brought to your attention at the Birmingham Congress.

The full text of the Resolution was then sent to all associations together with the request to let us have their opinion. Only 16 associations have replied: 7 were for the accptance of the resolution and 9 against.

The Executive decided that the Resolution be brought before the General Assembly in Manila. The vote will be by secret ballot.

**MWIA Book—Volume II:**

You will recall that Dr. Buerk, Chairman of the Project Committee and responsible for the publication of "Women Physicians of the World" had been asked to proceed with Volume II.

Unfortunately the US Publishers had to inform Dr. Buerk that the publication of a second volume was not feasible at the present time.

Therefore the Executive agreed to abandon the plan—atleast for a number of years.

**19th MWIA Congress—1984:**

Dr. Tamboline reported that the 19th MWIA Congress will be held in VANCOUVER, July 29-August 4, 1984.

The topic already chosen will be MEN AND WOMEN—BIOLOGICAL AND BEHAVIOURAL DIFFERENCES.

The Canadian Association will present details on the Congress they will be organizing at the time of the Manila Congress.

**20th MWIA Congress—1986:**

We have previously received an invitation from South Africa.

If you intend to invite MWIA to hold this Congress in your country, please let us know.

Two topics have been proposed by the Frnench Association.

— Sexually transmitted Diseases —

and — Cancer and Environment —

Please let us have more suggestions.

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