

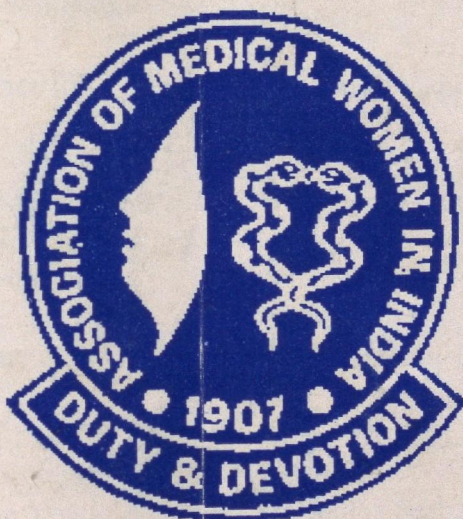
I D E - 1466

LC+1

JOURNAL

OF THE
ASSOCIATION OF
MEDICAL WOMEN
IN INDIA

OR



VOL. LXXXIV

JUNE, 1997

NO. 1

THE JOURNAL OF THE A. M. W. I.

CONTENTS

Sr. No.	Subject	Written by	Page Nos.
1.	Message	Dr. Usha Saraiya	v-vi
2.	Health Security for Women	Dr. Florence W. Manguyu	1-10
3.	The Implications of Domestic Violence on the Health of the Family	Dr. Dorothy Ward	11-17
4.	Female Genital Mutilation	Dr. Shelley Ross	18-22
5.	Gastroesophageal Reflux in Children, Result of Nissen Fundoplication in Ramathibodi Hospital, Bangkok.	Dr. Sani Molagool	23-27
6.	Septic Abortion a Menace to Woamnhood	Dr. Priyamvada Tiwari	28-35
7.	Safe use of Combinations of Local Anaesthetic Agents Epidurally for peurperal Tubal Lagation	Dr. Beverly Domingo	36-41
8.	Sex Education for Young Adults through Mass Media : "How far to go ?"	Dr. Arati Basu-Sengupta	42-45
9.	Role of Education to the Young Adult	Dr. Sudha Seshayyan & Dr. K. Raja Venkatesh	46-50

EXECUTIVE COMMITTEE OF ASSOCIATION OF MEDICAL WOMEN IN INDIA

President	Dr. Tulsi Basu
Vice-Presidents	Dr. Manju Mataliya Dr. Jyoti Trivedi
Secretaries	Dr. Dinoo Dalal
Jt. Secretaries	Dr. Arati Basu Sengupta
Treasurer	Dr. Mehroo Pardiwalla
National Corresponding Secretary	Dr. Jyoti Trivedi
Vice-President Central Asia	Dr. Tulsi Basu

EDITOR OF THE JOURNAL

Dr. M. Ghosh

GUEST EDITORS OF THIS ISSUE

Dr. Dinoo Dalal
Dr. Usha Saraiya
Dr. Sudha Sheth

**MANAGING COMMITTEE
OF
CONFERENCE**

President : Dr. Tulsi Basu

Chairman	: Dr. Manju Mataliya	Vice-Chairman	: Dr. Usha Saraiya
Secretaries	: Dr. Dinoo Dalal Dr. Vandana Walvekar	Joint Secretaries	: Dr. Deepti Dongaonkar Dr. Aarti Basu Sengupta
Treasurer	: Dr. Mehroo Pardiwala	Joint Treasurer	: Dr. Neeta Bhogilal Dr. Kamla Sengupta
Scientific	: Dr. Usha Saraiya	Finance	: Dr. Chandrakant Patil
Registration	: Dr. Aloo Billimoria	Reception	: Dr. Maya Lulla
Souvenir	: Dr. Duru Shah	International Relation	: Dr. Dina Patel
Cultural	: Dr. Kumud Ingle	Exhibition	: Dr. Nalini Pai
Public Relation	: Dr. Manda Purandare	Accommodation & Travel	: Dr. Bakhtaver Vajifdar
Auditorium	: Dr. Vinita Salvi	Hospitality	: Dr. Nayana Dastur
Inauguration	: Dr. Mandakini Megh		

**This
Publication
is
through
Central Asia
Regional
Conference
of
MWIA**

We Thank

CENTRAL ASIA REGIONAL CONGRESS

OF

MEDICAL WOMEN'S INTERNATIONAL ASSOCIATION

hosted by

ASSOCIATION OF MEDICAL WOMEN IN INDIA

for making this publication possible

HEALTH SECURITY FOR WOMEN

MESSAGE

Dear Members of AMWI,

It is with great pride and pleasure that we present to you this issue of our Journal with article from papers presented at Central Asia Conference.

By now you must have heard about the fantastic conference we had last December. India is so vast & travelling is so difficult, so we can understand how many of you could not attend. This issue is meant for you. We would like you to savour this academic feast & read through quietly in the comfort of your home.

Our Association over the years has changed its objectives and priorities. Today's requirements are to satisfy Women's Health needs & our Association is in a vantage position to do.

Today Health is defined as a state of complete physical, mental & social well being and not merely the absence of disease or infirmity. Women are today poised to take charge of their own lives and contribute to the development of a Society. A reproductive evolution is sweeping the globe making women lead a "contraceptive life for several decades". Family size has shrunk to just one or two and women face as much as 1/3 of their life span in so called menopause. These changes are no doubt on the anvil in some parts of the developing world. In most parts the traditional problems of high maternal mortality, chronic malnutrition and physical violence continue.

Dear Members, make a resolution to do something concrete this year to improve the health status of your patients. I know that all of you are talented, creative and feel socially responsible.

As we come to the end of this century and begin a new millennium our Profession has to face many challenges. We ourselves have to accept the changes in our immediate family circle. A biosocial evolution is going to sweep us and we must be ready to face these challenges.

Do share your views with us and let us know your contributions.

I would like to end by saying

"Coming together is a beginning

Working together is a progress

Staying together is an achievement"

Yours,

Usha Saraiya

Dr. Usha Saraiya,

Chirman, Scientific Programme Committee

Guest Editor.

HEALTH SECURITY FOR WOMEN

By Dr. Florence W. Manguyu
President-MWIA

Presented at
Central Asia Regional Congress
1-2 February, 1997, Mumbai - India.

on the theme :

"Health care for women and children Challenges for the 21st Century

It is a great honour for me to be invited to deliver this oration in the memory of Dr. J. Jhirad - such a distinguished colleague. I feel very privileged and would like you to know that I am humbled by this invitation.

Women throughout the ages, and everywhere in the world play a complex role as mothers, workers, members of the family and communities. This reality has not been reflected fairly in the fields of medicine and health. Attention in women's health has almost always focused on their role in reproduction with most of the efforts being centred on the offspring. In essence, women have been treated as mother and wives rather than as individual human beings living whole lives and needing individual attention just as men do. The reasons for this scenario are many, but all have to do with the social status of women and the worth that society accords them.

For women, health as a state of total well-being is not determined solely by biological factors, but also by effects of workload, nutrition, stress, war and migration, economic status, among others. In this context, mortality and morbidity are indicators of what nations are prepared to do to affect the various dimensions of the human environment, their willingness, to extend and improve the quality of life of their people by applying the resources required for longer and healthier survival - education, food, health care, jobs and security - and equitable participation in the economic, political, cultural and social processes that affect their lives. Physical health is just one component of human development. Women's health, ill-health and mortality unfold within, and are shaped by their socio-economic and political contexts.

HEALTH SECURITY FOR WOMEN

Good health is a fundamental basic human right. Disparities demonstrate the fact that this basic right to health is not universally respected and is denied to many people mainly the vulnerable poor women and girls. Women will only enjoy the right to health once progress is finally made in overcoming persistent barriers to equity and choice. The term "Health Security" is the best expression of women's right to health throughout their entire lifespan as it composes all aspects of the basic human right to health :-

- * the right to freedom of choice and personal security
- * the right to food in sufficient quantity and quality
- * the right to live and work in environments where human health risks are controlled and
- * the right to have access to education, information and decent housing.

Health Security therefore, seeks the improvement of people through various forms of socialite and economic support and fuller knowledge and awareness, thus enabling people to make the right choice, cope with the changing patterns of vulnerability and keep healthy.

Health security also encourages the principle of universality in health care, so that all human beings men or women - may live with the knowledge that they can seek and receive quality health care which is also accessible and affordable.

Every woman has the right to be assured that everything that can be done, will be done so that she does not die or suffer avoidable morbidity as a result of pregnancy and childbirth. Every girl and woman has the right to be free of gender-based violence both inside and outside her home. Every girl and woman has the right to reap the benefits of education in both formal and informal environments which are themselves free from health risks. These health rights are the assurance of health security for women.

Human Development

Human development has been defined as the process of enlarging peoples options namely :

- * to lead a long and health life
- * to acquire knowledge, and
- * to have access to resource needed for a decent standard of living.

HEALTH SECURITY FOR WOMEN

The World Development Report 1993 found that reduction in human mortality is closely linked to a country's income growth, improvement in appropriate medical technology, basic education and access to public health services and knowledge. In all regions of the World, the main effect of income growth on health status lies in equity of income distribution and corresponding poverty reduction as well as the extent of public investment directed towards development of human capital, both in health services and education particularly for females. In most countries of the world, and for women particularly, access to health services is a function of costs measured in money, time and distance. All of these in turn affect utilization and interact with perceptions of care and its quality.

FACTORS AFFECTING WOMEN'S HEALTH

a) Poverty and other economic factors

The world's most vicious killer and the greatest cause of suffering is poverty. The majority of the 1.3 billion people living in extreme poverty are women. In all regions of the World, women are more likely to be poor than men and they are the majority of the poorest. Poverty is the main reason why babies are not vaccinated, clean water and sanitation are not provided, and curative drugs and other treatments are not available and why mothers die in childbirth. It is the main cause of reduced life expectancy, of handicap and disability and of starvation. Poverty has a destructive influence at every stage of human life from the time of conception to old age.

During the second half of the 1980s, the number of people living in extreme poverty increased albeit in a world that has enough food for everyone. Poverty goes hand in hand with inequity and for the people in this situation of disease and suffering, a longer life may appear to be more like a punishment than a prize.

Poverty and gender-defined roles limit access to education, especially for girls, denying them the opportunity to break out of the cycle of poverty and ill-health. Poverty limits access to even free health care if a woman cannot afford the costs of medication or transportation to a health facility. But the correlation between poverty and health-care is not always a direct one. A country's growth does not necessarily guarantee better health for women because benefits of economic growth are not equitably distributed. However, a deteriorating economic situation can create severe health risks for women even when they do not live in extreme poverty. In general, the health gap between rich and poor appears to be widening.

Poverty has continued and will continue to be a major obstacle to health development. Poverty is perhaps the major single determinant of individual, family and community health. The number of poor people has increased substantially in the last two decades particularly in the slums of the big cities.

There has been a disproportionate flow of resources from the developing to the developed world-poor countries paying money to rich countries, because of debt servicing and repayment. Structural adjustment policies aimed at improving economic performances of poor countries have in many cases made the situation worse. A worrying trend in this scenario, is growing unemployment especially in developing countries with its negative effects to health. Even in wealthy countries the gap between the richest and the poorest is widening. Health is not a drain on a country's resources, it is a worthwhile investment. Health investment in the poor will not only make the poor more healthy, but also less poor.

b) Lack of Social Status and Opportunities

The generally subordinate status of women has an impact on their health in many ways. The social status of girls and women is a crucial determinant of their health, and the control they have over their own lives. Equal opportunities for women would also directly promote and protect their health and well-being.

Female morbidity and mortality are not just functions of the physical differences between males and females, they are also rooted in differences in roles and status between the sexes. Female health, ill-health and mortality unfold within and are shaped by their socioeconomic and political contexts. No culture, country, religion or societal setting treats its women as well as it treats its men although some countries do better than others.

c) Female Education

The centrality of education in human health is undisputed. Households with more education enjoy better health both for adults and for children. Women's own health and their ability in utilizing available resources are absolutely crucial particularly for children. A child's health is affected more by the mother's schooling than the father's - even more before the child's birth.

Illiteracy, common among women and the poor, continues to impede health and social development, millions of young people still have no opportunity for education, and girls and

HEALTH SECURITY FOR WOMEN

women continue to be under-represented in the classroom. Female literacy remains a key developmental issue. Education allows women to obtain and use information which is especially important in understanding the new threats to health, as well as new opportunities to adopt health behaviours and life styles. Only through education will women be able to actively promote, maintain and protect health. Two thirds of the illiterate people in the world are women. Sixty million of the 100 million children who have no access to primary schooling are girls.

d) Access to Health Care

The concept of health for all has changed the world's thinking about how health should be provided. Health infrastructure is the skeleton which supports health care and without which no health programs can be sustained. Of all factors influencing women's health, access to health care ranks among the most important. Several factors combine to produce inequities in access that directly undermine the ability of women to maintain good health. These include the amount of time needed to use health services, the poor quality of services provided, user fees, cultural factors and lack of decision making. The solution will be to reduce the social economic and cultural inequities that are at the origin of women's unequal and inadequate access to health care.

Education and schooling is one of the most powerful means of improving the health of girls and women. An International legal base for women's right to education is clearly formulated in

- * the convention on the Elimination of all forms of Discrimination Against Women (CEDAW)
- * the convention on the Rights of the Child
- * the International covenant on Economic and Cultural Rights
- * the Universal Declaration of Human Rights and in many national constitutions.

Many countries still lack the understanding that investment in women's education is both giving effect to a fundamental human right and a sound investment in the economy. Despite the large body of knowledge and scientific information which exists on the crucial link between education and health, action at national, regional and international level to act upon this link is lagging.

Areas need - Health Security for Women

Nutrition

Malnutrition is the most widespread and disabling health problem among women in developing countries. It is often the result of a combination of poverty and the status of women. Although the world can and does produce enough food for everyone, about one fifth of the world's population does not have enough food to meet their daily basic need for nutritional well-being. Inequitable distribution of food is the main reason for under-nutrition but in addition underlying ill-health and inadequate knowledge about nutritional value of foods also play a big role. Moreover, in developing countries, millions of people (600 million in 1980) mostly women and children are deficient in micronutrients.

Undernourishment leads to diminished resistance to disease, poor health and productivity with adverse effects on individual, community and national development. In this way a cycle is set-up in which poverty, the root cause of malnutrition, becomes even more widespread. Poorly nourished people are more susceptible to infectious diseases. Malnutrition has a cumulative effect during an individual's lifetime and this can lead to adverse effects on health of the next generation. Although both men and women are affected by nutrition factors, women, for biological reasons have a higher risk of suffering from the health - impairing nutritional deficiencies such as anaemia, stunting, iodine deficiency, goitre and blindness. Women and girls need more iron than men because of menstruation, pregnancy, lactation and other demands on their body's iron supply. In developing countries, 55% of pregnant women and 44% of all women suffer from anaemia, significant disparities exist not only between developed and developing countries but also between different areas of the world.

Reproductive and Sexual Health

Reproductive and Sexual Health was defined at the International Conference on Population and Development (ICPD), and expanded upon in Beijing at the Fourth World Conference on Women, as a fundamental aspect of socio-economic progress and sustainable human development. Reproductive and Sexual Health affects everyone of us and goes beyond the focus on contraception and family planning and should be a priority goal for national health programmes. Like other aspects in health. Reproductive and Sexual Health is a fundamental and basic human right but it is here where the burden of disease is unfairly borne by women,

HEALTH SECURITY FOR WOMEN

it is also in Reproductive and Sexual Health where differences in disease burden between rich and poor, men and women, boys and girls most clearly emerge. In reviewing the health-for-all strategy, specific and deliberate efforts must be developed to address these differences. Reproductive Health impacts on all other aspects of health and well-being of people and is also affected by factors outside of disease and medicine such as poverty, health information, and equitable provision of services.

This month, we celebrate ten years since the Safe Motherhood Initiative was launched. During these last ten years, we have become more aware of factors influencing Reproductive and Sexual Health but motherhood has not become safer. Although it takes two to procreate, it is the woman who bears the burden of pregnancy, childbirth and childrearing, sometimes all alone. It is the woman who dies as a result of complications of pregnancy and childbirth including those of unsafe abortions. Yet, for every woman who dies, many who survive suffer such severe and devastating morbidities that they wish they had died. The knowledge to prevent the suffering and death associated with maternal health is available and within reach of countries. The provision of access to high quality emergency obstetric care is gaining recognition as the most important strategy for preventing maternal deaths in developing countries where maternal mortality rates are high. Political commitment and more allocation of resources is what is mainly lacking.

Sexually transmitted diseases including HIV/AIDS constitute a major public health problem throughout the world. Biologically, women are more susceptible to most STDs than men, at least in part, because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse. The biological factors are compounded by socio-cultural ones. In many parts of the world, women have little or no control over decisions relating to sexuality, nor do they have control over the sexual behaviours of their male partners. It is women who pay the highest toll for untreated STDs which can, result in pelvic inflammatory diseases, infertility, ectopic pregnancy, complications in pregnancy and childbirth and cervical cancer.

Violence Against Women

Violence seems endemic throughout the world and both men and women experience it in many forms with considerable damage to their health. However, violence against women, is linked to the lower social status of women and societal tolerance of human rights abuse against women. Violence against women presents itself in different facets including domestic violence, sexual abuse, rape including systematic rape in situations of political

conflicts, physical battering, psychological bullying and exploitation. Violence against women is not just a social-legal issue, it is also a public health problem and must be addressed as such.

Examples of domestic violence :-

- * Worldwide 20% to over 50% of women beaten by intimate partner
- * South America, one study, 70% of all crimes reported to police were women beaten by husbands.
- * USA - up to 1/3 of women in emergency departments due to injuries of domestic violence.
- * Papua New Guinea - 1/2 married women in cities battered.
- * Alexandria Egypt - one study, 25% of all women to trauma units
- * Kisumu district in Kenya, 42% of women beaten "regularly" by husbands.
- * Jamaica, girls 11-15 years, first sexual intercourse "forced".
- * Canada - national sample 29% of ever married women physically assaulted by husband.

Violence against women destroys the dignity of women and violates many of their human rights including their rights to physical integrity, to survive and to lead full and fulfilled lives.

Work related health hazards for women

Health promotion activities and information often overlook or fail to give enough attention to work related hazards which are gender specific. Work and the workplace represent key avenues for the empowerment of women and greater development of their potential as human beings with positive consequences for themselves, their children's development and that of society, whether in formal or informal sector. The health hazards relating to women's work have been inadequately studied, and as a result are poorly addressed. The special occupational health problems of working women are recognized in both developing and developed countries. In the developing countries, heavy physical work, the double work burden of job and family, and traditional social roles increases the burden of female workers. Many women work throughout their lives starting from when they are young girls and stopping only when they die or when too ill to work. Work done by women is undervalued because it is :-

- * not recognised in the labour market
- * informal

HEALTH SECURITY FOR WOMEN

- * not wage earning
- * domestic, family work, service work
- * petty trading, seasonal and temporary
- * unregistered, illegal

Women are often exposed to violence, sexual harassment and abuse by clients, workmates at the workplace. They may be exposed to dangerous substances and situations, where they are less likely than men to be provided with protective clothing and equipment. These dangerous situations are found in factories and labour intensive industries in which women are more likely to be employed. Exposure to health hazards during pregnancy and lactation may result in spontaneous abortions, premature births, congenital anomalies and stillbirths.

Health of the Elderly

Worldwide life expectancy has increased by 1 & 2 years over the past 5 years. On average, females outlive males by seven years in the developed countries and by two years in the developing countries. Thus women have a biological advantage over men in that they have a longer life expectancy and better survival chances. However, for many women the longer life means more years of sickness. In the least developed countries with high mortality and low longevity, this biological advantage of women over men, is reduced, cancelled or even reversed so that the life expectancy of males may, in some cases, exceed that of females.

Health Security for Women is based on the following principles :-

- * Health is a fundamental **human right**
- * the highest **ethical standards** must be maintained
- * **Equitable relationships** between women and men and **equality of opportunities** must be achieved
- * Services must be **accessible**
- * **Quality of care** must be assured
- * **Individuals, families and communities** must be fully involved in the promotion and protection of their own health
- * a **life-span** approach to health
- * **Partnerships** must be established between health care providers and clients and with sectors other than health
- * **Health services should be integrated** to promote a holistic approach to health care provision

- * to invest in human resources is to invest in social and economic development
- * Optimal use should be made of human and material resources
- * Interventions must be sustainable.

References:

1. *Health Population and Development* - WHO position paper for the ICPD-WHO/FHE/94.1
2. *Women's Health* - WHO position paper for FWCW-WHO/FHE/95.8
3. *Programme of Action* - ICPD
4. *Platform for Action and Beijing Declaration* - FWCW
5. *The World Health Report 1995*
6. *The World Health Report 1996*
7. *R. J. Cook* - Women's Health and Humna Rights
8. *Women's Health Day* - WHO/HPD/96.3
9. Report of the 4th meeting of the Global Commission of Women's Health - WHO/HPD/96.5
10. *Mangury, F. W.* - Human Values and Sustainable Development - International lecture Series on Population Issues.

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

By Dr. Dorothy Ward

Domestic violence is now recognised worldwide as a serious public health issue. The World Health Organisation and the World Medical Association have this high on their agenda for action. The consequences of Domestic Violence are great for all nations of the world affecting the health and wellbeing of the family and it is using scarce health care resources of countries and communities.

The accepted definition of Domestic Violence is aggressive behaviour between intimate partners or ex-partners and should not be confused with family violence. Women are usually the victims - some sources quote 1 in 4 women affected in a partnership others 5-10%. The true figure is not known as it is underreported and hidden by the woman herself through fear and often shame and the unfounded hope that it will not happen again. Hidden by the woman herself it is even condoned in some cultures. A study in Bangkok slums found that 50% of wives are beaten regularly, in USA a woman is beaten every 15 seconds and 4 battered women die every day. In New South Wales, Australia 1-4 homicides occur between spouses. In Peru 70% of all crimes reported to the police are of women beaten by their husbands. In a gynaecological clinic in Norway 25% of patients reported abuse by partners. It is estimated that women are 95% of the victims of domestic violence.

It may take the form of physical, emotional, sexual or economic abuse and can be seen as a means of control by the abuser.

Domestic Violence like poverty is a serious social illness which is ignored. It has reached epidemic proportions because of increased awareness but it is not a new disease and a veil of silence is still drawn by many families. It affects women in all walks of life and is an obstacle to their equality, development and to peace. It is contagious and is passed on from one generation to the other.

Domestic Violence is more common where there is poverty, poor housing, unemployment and excessive substance abuse but it is no respecter of class culture or race. It is found in the poor and the rich homes, in the skilled and unskilled workers and in professional homes.

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

There has been some research mainly in USA but this is a difficult area for research due to different definitions of DV, the unwillingness of some women to discuss it and also of police and health professionals unwillingness to ask too many questions. The research to date is poorly designed. It is very definitely under researched in UK especially within our health care system. This must be remedied and I feel as a family physician that the family doctor and accident and emergency units need to take the initiative as this is often the place that the abused presents initially. Research in USA has shown that where a protocol is drawn up for staff in emergency units to ask direct questions of women's experience of abuse women do respond and are often relieved that someone asked them directly if they had been injured by someone and not accept their usual excuse that they fell or bumped into a door. This research in the USA resulted in an increase from 5.6% - 30% of positive identification of abused women following staff training in the use of an appropriate protocol.

What are the health implications of domestic violence? WHO has defined health as a state of complete physical, mental and social wellbeing and not only the absence of disease or infirmity. The woman who is subject of DV has no complete physical, mental or social wellbeing, she may be physically traumatised, there is no doubt she is mentally and psychologically traumatised and she is not socially well. Her family also suffer mentally and are socially unwell living in fear and often unable to change the situation or help. The whole family may be physically abused but some research suggests that not all wife/partner abusers always abuse the children.

There are physical injuries - bruising, multiple injuries to the face, head & neck - abused women are 13 times more likely than non-abused women to have these injuries - injuries to the abdomen, breasts & genital area. Often the first pregnancy starts the abuse or escalates it. Kicking and punching the abdomen is the usual form of abuse in pregnancy. Abused women presenting with such injuries are 3 times more likely to be pregnant than non-abused women presenting with such injuries. Miscarriage is more frequent among victims of abuse and also low weight babies.

Abused women suffer from many mental health problems and are often treated inappropriately for them the real cause not being identified for their anxiety and depression. Research on the impact of violence on mental health was described by Kock USA as a Post Victimization Distress Response which if not resolved develops into longer term chronic symptom pattern of Post Traumatic Stress Disorders seen in major catastrophes. Too often the physician only diagnoses depression and the true history is not discovered and the woman is treated with antidepressants, sedatives or tranquilliser which are not appropriate. She

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

returns to her abuser and feels none believes her, she feels helpless with only a prescription for unnecessary pills to which she may become addicted.

Several stages of the abuse cycle were described in 1984 by Walker, a New York Psychologist of (1) a period of tension building when the woman has some minimal control over the abusive incidents (2) A period of inevitability when the acute battering incidents occurs and (3) a period of loving contrition and/or no tension.

The response at each stage is shock & denial, terror and in response, attempts at integration and appeasement and finally depression characterised by withdrawn and self-accusatory behaviours. Victims fear confrontation and learn methods of hiding pain to protect themselves denying the abuse. They may even appear compliant and emotionally stable and their situation goes unnoticed.

Women are also subjected to sexual violence within a close relationship. Victims of domestic violence have mental health symptoms of anxiety depression, obsessive and paranoid disorders and sleeplessness. They may turn to abuse alcohol or drugs and may consider self harm. Where there is sexual abuse their sexual health may also be affected. They fear and shun sexual experiences suffering from frigidity and vaginismus. Some may on the other hand become preoccupied with sexual activity. These women may also have physical injuries and unwanted pregnancies. Women with a history of sexual abuse may suffer from pelvic pain and other gynaecological conditions. It has been documented that women with a history of sexual abuse may have unnecessary extensive medical investigations and surgical and gynaecological interventions.

Mental and emotional abuse may be associated with physical and sexual abuse but may occur on its own. Here the woman has no bruises nor scars to alert the outside world. The most common form of emotional abuse is verbal - insults criticism or humiliation in front of family and friends. The withholding of money so that they cannot make ends meet which brings about more criticism. Some women are isolated by their partner who will not allow them to see friends or relatives, not permit her to go out on her own and visitors to the home are made unwelcome. In mental abuse the woman's mind is targeted - her partner spies on her-he threatens to kill or injure her- accuses her of having affairs etc. She may not suffer physical harm but she loses her sense of reality and perspective.

Most of the research which highlights these problems associated with physical, emotional and sexual abuse has been carried out in industrialised countries but it is likely that women in developing countries will have similar health problems associated with domestic violence.

WHAT EFFECT HAS DOMESTIC VIOLENCE ON THE CHILDREN ?

There is growing evidence about the harmful effects on children exposed to abusive partnerships - there is fear and great sadness & helplessness. These children have increased levels of anxiety and suffer from psychosomatic illnesses such as headaches; abdominal complaints, an increased tendency to asthma and lower ratings in school and in social complaints. A boy who grows up in an environment of domestic violence is more likely to use violence as an adult and girls who witness their mothers abuse may accept this as normal and will be less likely to leave a violent relationship themselves. Unfortunately violence including violence towards women can be introduced to every home through the mass media.

Men, too, can be the victims of domestic violence, savagely beaten by their female partners. In one of the few recent UK studies on victims of domestic violence presenting at a hospital emergency department there were 300 cases - 50% women and 50% men. This study "Adult Domestic Violence Health Trends" (Smith & Buchan) found that men received more serious injuries and lost consciousness more often. Male victims may only be 5% of the total but they must not be forgotten.

Violence outside the home is publicly condemned but domestic violence is still condoned as private, even normal and legitimate. It has been with us for centuries where male dominance and aggression stands side by side with female subordination.

A 19th Century English saying typifies this - "A Woman, a spaniel and a walnut tree, the more they are beaten the better they be". It was only in 1829 in England that the law which gave a husband the right to physically chastise his wife was repealed. Few women were however able to use the courts to prove their case as they had not the finances and women continued to be the subject of domestic violence. There was more protection for ill treated animals than for these women.

The public as a whole showed little concern and it was not until the 1970s that the issue became a major public focus through the work of a UK non Governmental organisation "Women's Aid". The first refuge for battered wives, as they were then known, was opened in London at Chiswick in 1971, followed by 3 in Scotland in Edinburgh, 1972, Glasgow 1973 and Dundee 1974.

There has also been some activity by the UK Government with enquiries, Select Committees and studies but the Government response to many clear and constructive recommendations

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

has been poor with little additional resources. NGO's such as our medical women's associations working with others in their countries are important to change attitudes and help to stop the spiral of domestic violence.

I am sure no country is free of domestic violence. At a recent International Conference in Brighton we heard of this problem occurring everywhere. Arumi Soni of the Mumbai's Women's Centre described the many forms of violence against women here in Mumbai where there is a patriarchal society and women's destiny is linked to a man throughout her life-father, brother and then husband. We heard from women throughout this region of violence against women and children.

What can we as women, as women doctors, as members of non-governmental organisations and members of the Medical Women's International Association do to change public attitudes and sensitise governments, legislators, lawyers, school teachers, educators, the police, religious and community leaders and most important of all our own professional health colleagues to this escalating problem which causes so much physical and mental ill health for women and their families ?

Raising the status of women worldwide and ensuring respect for their full human rights is the main goal but until this takes place I believe we, as women and doctors and members of medical women's associations have a specific role to play and I would like to share some thoughts with you now.

There is no doubt that health professionals give women who have suffered domestic violence little support - like the police they sometimes do not want to hear or are unwilling to question too closely the woman who has physical injuries which may suggest violence or who is anxious and depressed or who has symptoms with no obvious physical cause. A study in an industrialised city in Scotland of women who had sought protection and shelter in a place of refuge showed that 80% of these abused women had initially consulted their family doctor but only 25% had mentioned that they had been subjected to violence and the doctor's response to this had been unsatisfactory. Women who are abused do want to be asked about it and not just to be prescribed pills and told to go home and make it up. They do want a listening ear, support, direction towards helping agencies and made to feel that someone will listen and help.

Unfortunately health professionals receive little undergraduate, postgraduate and continuing education in this field so it is not surprising that they do not respond nor are sensitive to

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

women's needs and their cry for help. They have difficulty and embarrassment in asking about domestic violence and unfortunately some do not want to know.

It is essential that all health professionals in emergency departments of hospitals and family doctors (where these women usually present first) receive appropriate training so that they are sensitised to victims of abuse, have a sensitive attitude and a listening ear and are able to ask the woman directly about the cause of her injuries or her mental or emotional state.

They must keep accurate records of the injuries in case evidence is required in court and they should have knowledge of the agencies and resources available to counsel, support and protect her. They should not send her back to her violent partner.

Protocols or guidelines should be drawn up for all staff to use in emergency departments in hospitals and clinics to encourage staff to sensitively question those attending with suspicious injuries. As already stated earlier where staff were trained and followed guidelines there was an increase from 5-30% in the identification of victims of abuse.

As women doctors, especially the more senior of us, we should be active in encouraging the education of students in our medical schools, doctors in training and established doctors in this subject. We must ensure that those who come into direct contact with victims of abuse are appropriately trained - nurses, midwives, health visitors, social workers - and that guidelines are available to assist health professionals in recognising victims of domestic violence. Interviewing the patient in privacy is essential and confidentiality is of prime importance to the woman and should be assured.

Research should be promoted as a priority to find the root causes and the mechanics of domestic violence, its frequency and consequences. This is something we as doctors can support and associate with other NGO's who are working in this field. The World Health Organisation has drawn up a Plan of Action to build a database of victims of violence over the next 3 years and to study the health implications and costs.

We should be willing to highlight to the public and our governments the health implications of domestic violence to encourage them to provide resources to inform and educate the public on this serious issue, to provide support for the victims and to provide counselling and education for the abusers. Similarly we need to bring to the attention of the police, the legislators, the educators and religious and community leaders the health, social and economic consequences of domestic violence so that they become sensitive to and respond to its victims.

THE IMPLICATIONS OF DOMESTIC VIOLENCE ON THE HEALTH OF THE FAMILY

Finally I would summarise what I see as the role of women doctors and members of MWIA

- * Changing the attitudes of the public and the health care professionals
- * Ensuring that domestic violence and its health consequences are included in the education and training of all health professionals
- * Increasing awareness of the health implications of domestic violence
- * Insisting on guidelines for use in emergency departments and primary care centres
- * Encouraging good record keeping of the injuries & effects of violence
- * Promoting the availability of information and sources of help for victims of domestic violence.
- * Initiating and encouraging research into the causes, incidence and prevention of domestic violence in our own countries, its health implications for the family and the socio-economic costs to society and governments.

Our role as women and members of non-governmental organisations whose goal is to improve the status of women is also important and we should support agencies who work with women and their families who are the subject of domestic violence. This will include measures to change the attitudes, provide information and encourage appropriate training for police, social work departments, solicitors, legislators, educators, voluntary organisations, journalists, reporters and all others who may come into contact with victims of domestic violence. We should also initiate and support programmes to rehabilitate perpetrators of violence.

The media requires to be targeted to stop their glorification of any form of violence especially domestic violence. Such violence is viewed in millions of homes throughout the world and may be accepted by many as normal and expected behaviour.

As medical women we must be strong advocates to create violence-free families and improve the health and social wellbeing of women worldwide - this is a real challenge for the 21st century.

Dr. Dorothy Ward,
1st Central Asia Regional Congress,
Mumbai, February, 1997.

FEMALE GENITAL MUTILATION

by Dr. Shelley Ross

Female genital mutilation has long been a problem in Africa. Much as we, as doctors in the developed countries, have condemned this practice, it has not affected us personally, until recently. Vancouver, Canada is seeing the influx of Somalian refugees, and many of these women have had female genital mutilation performed. As many of these refugees are in the child-bearing age, we are having to deal with the practicalities of obstetric care particularly delivery problems associated with this genital mutilation.

Female genital mutilation occurs most commonly in three forms:

1. Type I or Sunna where the clitoral hood is excised with preservation of the clitoris and labia minora; This is the equivalent of male circumcision.
2. Type II or excision where the prepuce and glans clitoris are excised along with parts of the labia minora; This is the equivalent of removing the penis in the male.
3. Type III or infibulation (also known as pharanoic circumcision) where the entire clitoris, labia minora and adjacent medial portions of the anterior labia majora are excised. The two sides of the vulva are then stitched together or stuck together with paste or thorns to obliterate the introitus and leaving only a small opening for the exit of urine and menses. This is the equivalent of removing the penis and the scrotum in the male.

These procedures are performed without anaesthesia or sterile conditions on prepubertal girls.

The origins of the practice are responding to the need for:

1. religious, cultural and social requirements
2. family honour
3. hygiene
4. aesthetics
5. protecting a woman's virginity
6. discouraging infidelities.

FEMALE GENITAL MUTILATION

The immediate health risks are:

1. haemorrhage
2. infection with fever and septicemia
3. tetanus
4. urinary retention and infection
5. emotional trauma
6. death

Long-term gynaecological problems include:

1. dysmenorrhoea
2. dyspareunia
3. pelvic pain
4. recurrent vaginitis
5. chronic pelvic infection
6. infertility
7. keloid formation
8. vulvar dermal inclusion cysts
9. haematocolpos
10. obstruction of urethral orifice leading to calculus formation.

Obstetrical complications include:

1. prolongation of the second stage of labour due to obstructed labour
2. hemorrhage from laceration of the scar tissue
3. fetal asphyxia or death
4. inability to properly assess labour progress due to difficulty performing vaginal examination
5. increased incidence of Caesarean section due to physician inexperience with the condition.

Postpartum Complications

1. Urinary and rectal fistulae
2. Prolapse
3. Cystocele/rectocele

Burnaby Hospital is a community hospital in greater Vancouver doing 2200 deliveries per year. One-half of the deliveries are done by 20 female general practitioners. Burnaby Hospital is capable of caring for neonates 32 weeks gestation and beyond.

In the past year, eight cases of women with female genital mutilation were delivered at Burnaby Hospital.

In the eight cases reviewed at Burnaby Hospital, all were type III or infibulation or pharonic circumcision, with varying degrees of scarring.

Two were delivered by LSCS for fetal distress before full dilatation.

Two were delivered by vacuum extraction.

Four were delivered by SVD.

Of those delivered vaginally, complications included:

1. hemorrhage due to tearing of scar tissue in two with additional blood loss due to a retained placenta in one.
2. Low Apgars in two.

Of those delivered by Caesarean, one required suprapubic cystotomy due to inability to insert a Foley catheter into the urethra past the scar tissue.

So deeply engrained is the need for this female mutilation in their culture, that these women and/or their husbands discussed antenatally that they wished the perineal repair to return the woman to her same anatomy as prior to delivery. The reasons for this deep belief in the procedure are divided into four areas.

1. Psychosexual: the belief that the clitoris is an aggressive organ, challenging the male and causing attenuation of sexual desire;
2. Religious: the mistaken belief that it is perpetuated as a required Islamic custom. In fact, only male circumcision is sunna (meaning tradition), coming from the Prophet Abraham as it is in Judaism;
3. Sociological: the practice used to be an initiation rite, but this has been lost. The practical aspect today is that a bride price cannot be obtained if a girl is not pure. The mother-in-law can use the operation to ensure that the girl is a virgin;

FEMALE GENITAL MUTILATION

4. Hygiene and aesthetics: the clitoris is considered dirty and the aim of infibulating is to produce a smooth skin surface. Rather than making the woman cleaner, the urine and menstrual blood that cannot escape naturally results in discomfort, odour and infection.

In the African countries, the procedure takes place anywhere from age seven days to 24 years. In the Minority Rights Group Report No. 47 of 1982, there is a description of an infibulation. The little girl is immobilized on a stool in a sitting position, with her thighs forced apart and her arms tied behind her back. She is restrained by three women, while the traditional operator first takes her razor and excises the clitoris. The razor is then used to cut from top to bottom of the small lip then scrapes the flesh from the inside of the big lip. This is repeated on the other side. The women then inspect the work, putting their fingers into the area. The operator then applies a paste and ensures the adhesion of the large lips by means of an acacia thorn, which pierces one lip and passes through in the other. She sticks in three or four in this manner down the vulva. These thorns are then held in place either by means of sewing thread, or with horsehair. Paste is again put on the wound. Then the little girl is tied up from her pelvis to her feet to immobilize her to ensure coalescence of the large lips.

A conspiracy of silence has surrounded this topic. In 1958, the Economic and Social Council of the United Nations invited the WHO to undertake a study of the persistence of customs which subject girls to ritual operations and to suggest measures to stop such practices. In 1959 at the 12th WHO assembly, this request was rejected on the grounds that the ritual operations in question are based on social and cultural background, the study of which is outside the competence of the WHO. Nothing happened for 20 years. The first opportunity for discussion by WHO was the seminar on Traditional Practices Affecting the Health of Women and Children, organized by WHO Regional Office for the Eastern Mediterranean in Khartoum, in February, 1979. A major seminar on Traditional Practices affecting the Health of Women and Children was held in Dakar, Senegal in February, 1984, with 21 African countries participating. From this seminar an Inter-Africa Committee was formed to follow up action on the abolition of harmful traditional practices in all countries directly concerned. Certain individuals stand out in the fight against female genital mutilation: Esther Ogunmodede, Fran Hosken, and our own Olayinka Koso-Thomas of Sierre Leone.

The 14th congress of the Federation of Obstetricians and Gynaecologists was held in Montreal, Canada in September, 1994. The recommendation of the meeting was that female genital mutilation is a violation of human right and to this end recommends legal measures to render this practice socially unacceptable and to oppose any attempt to medicalize the procedure or allow its performance in health establishments or by healthy professionals.

Dr. McCaffrey, an Irish obstetrician, reported at the conference that she has opened an African Wellness Clinic in the Harrow neighbourhood of London. Her recommendation is that deinfibulation occur during the second trimester to avoid trauma and chaos during delivery. De-infibulation is performed by making an anterior episiotomy under spinal anaesthesia. Her goal is to deinfibulate women before they become pregnant.

Conclusion

1. Subjugation of women-what is done to women and what women have accepted.
2. Rights of children - the Declaration of the Rights of Children adopted in 1959 by the General Assembly of the UN asserts that children should have the possibility to develop physically in a healthy normal way in conditions of liberty and dignity.
3. Health issue-medical facts show that there is no advantage and many disadvantages to having female genital mutilation performed.
4. Custom seen in the context of underdevelopment - the poor cling to traditions as a surgical mechanism in time of socio-economic change. In societies where marriage for a woman is her only means of survival, and where some form of excision is a prerequisite for marriage, change is difficult.

Recommendations

1. Our voices in the Developed Nations should be speaking out with our African colleagues against female genital mutilation.
2. We should assist our African colleagues in their organizations forcing elimination of these practices.
3. We should lobby for legal jurisdiction banning the procedure in the developed countries as well as the developing countries.
4. We should ban any attempts to medicalize the practice of female genital mutilation.
5. We should encourage research into the best timing for de-infibulation.

GASTROESOPHAGEAL REFLUX IN CHILDREN, RESULT OF NISSEN FUNDOPLICATION IN RAMATHIBODI HOSPITAL

Dr. Sani Molagool

Division of Pediatric Surgery, Department of Surgery

Ramathibodi Hospital, Bangkok, Thailand.

Gastroesophageal reflux (GER) is one of the most common diseases affecting the gastrointestinal tract of infants and children. The most common complications of GER are failure to thrive, aspiration pneumonia and bronchitis. Other complications less commonly encountered are reflux esophagitis, severe dental caries, Barrett's oesophagus, recurrent stridor and even the sudden infant death syndrome. The group most at risk for severe GER include children with neurological impairment, those who had repaired esophagus atresia and those with chronic lung disease. The medical treatments of GER include upright prone positioning, frequent small feeding of thickened formula and medication such as prokinetic drugs and H₂-receptor antagonist. Patients who do not respond to medical treatment in 4-6 weeks are managed by antireflux surgery.

Although antireflux surgery is said to be the commonest major surgical procedure performed by paediatric surgeon in North America. The operation was not as commonly performed in Thailand. So we decided to determine the effectiveness of the procedure and the complications of Nissen fundoplication in our experience.

Material and Methods

80 patients underwent Nissen fundoplication in Ramathibodi Hospital between June 1992-October, 1996. Patients profile are presented in table 1.

Table I - Patients Profile

Sex	male	17(56.67%)
	female	13(43.33%)
Age	range	2m. -12 yrs.
	mean	2.01 yrs.
Neurological status	impaired	24 (80%)
	normal	6(20%)

GASTROESOPHAGEAL REFLUX IN CHILDREN, RESULT OF NISSEN FUNDOPLICATION IN RAMATHIBODI HOSPITAL

Indication for surgery were

1. Prophylaxis fundoplication in 11 neurologically impaired patients with need for feeding gastrostomy.
2. GER in 19 patients the diagnosis was made by clinical history and physical examination and proved by 24 hour pH monitoring and/or barium swallow. The presenting symptoms was listed in label 11.

The medical treatments by positioning, thickening of feeding and Cisapride were tried for 4-6 weeks. Then if no clinical improvement was observed, the child was referred for surgery.

Table II - Presenting Symptoms

Recurrent pneumonia	12(63.16%)
Vomiting	10(52.63%)
Obstructive sleep apnoea	1(5.26%)
Upper airway obstruction	1(5.26%)

The antireflux surgery used in all patients were Nissen fundoplication performed by one of five pediatric surgeons in our hospital. The Nissen technique consisted of 360 degree wrap of gastric fundus around the gastroesophageal junction, together with tightening of oesophageal hiatus. 29 patients also had the gastrostomy performed for feeding purpose.

The results was evaluated in 2 aspects. The follow up time range between 2m.-4 yrs.

1. In the GER group, we evaluated the result of surgery in relieving of symptoms and recurrence of GER.
2. In overall patients underwent fundoplication. The complications both intraoperative and postoperative were reviewed.

GASTROESOPHAGEAL REFLUX IN CHILDREN, RESULT OF NISSEN FUNDOPLICATION IN RAMATHIBODI HOSPITAL

Results

Of the 19 patients in the GER group, the results of surgery was presented in table III.

Table III - Results of Surgery

Effective	17 (84.21%)
Recurrent	2 (15.79%)

The 2 recurrence can be managed successfully by conservative measures.

Concerning the complication of surgery, of the 30 operation reviewed there was no intraoperative complication. There were 7 postoperative complications listed in table IV. 2 of which operative management.

Table IV - Postoperative complications

* UGI bleeding from gastritis	1
detachment of stomach from abdominal wall	
UTI	2
* Wound dehiscence	1
pneumonia	2
bronchitis	1
total	7 (23.3%)

* case which required operative treatment

There were 2 late deaths after discharge from hospital. One was due to underlying disease and one from pneumonia without recurrent GER, proved by normal pH monitoring study.

Discussion

Since GER is the common disease encountered and has serious complication such as aspirated pneumonia and sudden infant death syndrome, attempt to treat this disease has been numerous. Some patients will respond to medical treatment but the remaining will eventually require surgical antireflux procedure. These procedure are effective in eliminating the symptoms, but unfortunately also certain complications range from 5.2%² to 54%³.

In our series we had divided the study into 2 parts. In the study of GER group, the presenting symptoms were the same as in other series^{2,4}. The effectiveness of surgery was evaluated by means of relieving of presenting symptoms. The effectiveness of Nissen fundoplication in our hand was as high as in other series^{5,6,7}. In children with neurological impairment, even with normal postoperative 24 hr pH monitoring, some still had recurrent respiratory infection. This probably caused by their defective swallowing function and recurrent seizure episodes. However, the symptoms had been less severe than before operation. Two patients had recurrent GER proved by abnormal postoperative pH monitoring. One was a severely retarded girl and the other was a case of bilateral cloacal atresia with Di George syndrome. Both can be managed successfully with Cisapride and modified feeding regimen.

In study of all cases who underwent Nissen fundoplicating in our hospital between 1992-1996, we studied about the complications of the procedure. The results were interesting in that we had no common complication as gas bloating, this possibly happened because nearly all of our patients also had gastrotomy and their stomach could be decompressed successfully. However, we had encountered other postoperative complications instead, most of which were not directly related to the procedure but rather to the underlying disease of the patients (i.e., UTI, pneumonia). 2 cases required operative treatment for complication. One was a child with infantile spasm who had wound dehiscence and required secondary closure of the abdominal wall. The second one was a cerebral palsy girl with severe malnutrition. She had postoperative UGI bleeding from gastritis and blood clot had occluded her gastrotomy tube. When attempted to change the tube in 5 postoperative day, her paediatrician had inadvertently detached the stomach from the abdominal wall. She required explore laparotomy to relocate the gastrotomy.

GASTROESOPHAGEAL REFLUX IN CHILDREN, RESULT OF NISSEN FUNDOPLICATION IN RAMATHIBODI HOSPITAL

We concluded that Nissen fundoplication is the effective procedure in the treatment of GER. However, the complication rate of 23.3% was rather high. The prophylaxis fundoplication in neurologically impaired children who need feeding gastrostomy which has been advocated by some author⁸ may lead to an unnecessary complications. So the decision to operate should be considered carefully.

References :

1. Hassall-E. Wrap session: is the Nissen slipping? Can medical treatment replace surgery for severe GER disease in children. *Am-J-Gastroenterol.* 1995 Aug; 90(8) :1212-20.
2. Fonkalsrud-EW. A combined hospital experience with fundoplication and gastric emptying procedure for GER in children. *J-Am-Coll-Surg.* 1995 April; 180(4):440-55.
3. Samuk-I. Nissen fundoplication for GER in children. *Harefuah.* 1994 Mar 15; 126(6):311-5,368.
4. Fonkalsrud-EW. Gastroesophageal reflux i childhood. *Curr-Prob-Surg.* 1996 Jan; 33(1):1-70.
5. Hanimann-B. Complications and long term result of the Nissen fundoplication. *Eur-J-paediatric-Surg.* 1993 Feb; 3(1):12-4.
6. Mira-Navarro-J. Long trm follow up of Nissen fundoplication. *Eur-J-Paediatric-Surg.* 1994 Feb; 4910; 7-10.
7. Kaxerooni-NL. Fundoplication in 160 children under 2 years of age. *J-Paediatric-Surg.* 1994 May; 29(5): 677-81.
8. O'Neil-JK. Care-giver evaluation of anti GER procedures in neurologically impaired children : what is the real life outcome?. *J-Paediatric-Surg.* 1996 March 31(3):375-80.

“SEPTIC ABORTION A MENACE TO WOMANHOOD”

by Dr. (Mrs.) PRIYAMVADA TIWARI, M.B.B.S., M.S., Ph.D., D.F.P., F.R.S.M., F.I.C.OG.
 Director, Dean, Professor & Head Department of Obs. & Gyn.
 at Institute of Medical Sciences, Banaras Hindu University, Varanasi, U.P.

While we are ready to welcome the 21st Century our mentality still remains that of 18th Century. Social status of women appears to be responsible for reproduction and looking after the family. Education of people has made some difference in the outlook of people but not very significant.

A man responsible for rape escapes punishment or even hatred from the society, but the woman victim of rape loses the love, faith the confidence of the family and the society and receives the hatred from the family and the society.

Whatever slogan we may make like “Women’s health is a national Wealth’ etc the discrimination of women will continue unless they are fully educated to understand, discrimination will continue from food to education.

The condition of Septic abortion is an example of atrocity of women dooming her obstetric carrier for which she has to regret throughout her life “Septic abortion is an agony which she has to bear in silence as she has to hide the facts which may be illegal, unethical immoral”. So let us be vigilant, spot and treat such cases before they have gone beyond repair.

Septic abortion is when the abortion is associated with clinical evidence of infection of uterus and its contents.

- 1) There is increase in temperature above 100.4 of more than 24 hours.
- 2) Uterine tenderness with evidence of pelvic infection
- 3) Offensive or purulent vaginal discharge

Incidence - Illegal abortion in India is estimated to be 4-6 million yearly.

- 4) 5-10% of abortion admission in hospital are septic abortion cases.

"SEPTIC ABORTION A MENACE TO WOMANHOOD"**Mode of Infection**

Micro organism causing infection are those normally present in vagina Anaerobic

- Bacteroids group
- Anaerobic Streptococci
- Clostridium Welchii
- Tetanus bacilli

Aerobic

gm +ve

gm -ve

- | | |
|-----------------|---------------|
| * Staphylococci | - E. Coli |
| * Streptococci | - Proteus |
| | - Pseudomonas |
| | - Kleibisella |

MIXED INFECTION IS MORE COMMON**ETIOPATHOGENESIS :-**

Majority of septic abortions are associated with incomplete abortion

- Illegal induction
- Improper sepsis
- Incomplete evacuation
- Inadvertent injury - to genital tract and neighbouring organs like gut.

Source of infection :-

- 80% endogenous
- 20% exogenous

"SEPTIC ABORTION A MENACE TO WOMANHOOD"**IN MAJORITY (80%)**

- 1) Infection is localised to conceptus
- 2) Spreading to myometrium with WBC protective barrier (15%) This may spread to parametrium & Adnexa
- 3) Generalised peritonitis or endotoxic shock (5%)

COMPLICATIONS :

- Acute -*
- * Septic shock
 - * Spreading peritonitis
 - * Oliguria (ARF)
 - * DIVC

CHRONIC :

- * Pyosalpinx
- * Pelvic abscess
- * Chronic PID
- * Infertility

Spread of Infection :-

- * Placental site
- * Anywhere in Ut. Cavity
- * If integrity of uterine wall is impaired - Myometrium
 - Cervix
 - Uterine cavity
- * Invasion of parametrical Tissue may result in
 - Extensive thrombophlebitis
 - Diffuse Cellulitis
 - Peritubal Infection
 - Acute pelvic peritonitis

"SEPTIC ABORTION A MENACE TO WOMANHOOD"**METHODS USED TO INDUCE ABORTION**

- * Medicine - Oralgat, quinine, castor oil, oxytocin
- * Foreign body - stick, Catheter, Metallic objects like needles, crochets.
- * Pot permagnate and mercury - tablet placed in CX/FX
- * Irritant solutions like :- Lysol, Soap solution, Pineoil, H_2O

CLINICAL FEATURES :

H/O. Recent termination of pregnancy

- * Spontaneous abortion followed by curettage

SYMPTOMS :

Pyrexia following of recent spontaneous or induced abortion

- | | | |
|----------------------|---|---|
| Pain lower abdomen | - | due to local tissue trauma infection or pelvic peritonitis - pelvic abscess |
| Vomiting | - | due to sepsis fever, ileus |
| Abdominal distension | - | Acute peritonitis |
| | - | Paralytic ileus |
| | - | Perforation and gas in abdomen |
| Spurious diarrhoea | - | Pus collection |
| | - | Pelvic abscess |
| | - | Paralytic ileus |
| Vaginal bleeding | - | Local trauma |
| | - | In complete abortion |
| | - | Coagulation failure |
| Retention of Urine | - | |

PHYSICAL EXAMINATION

- Consists of the examination of General
- Temperature may be raised or subnormal

- | | | |
|----------|---|---|
| Pallor | - | ± |
| Uterus | - | ± |
| Cyanosis | - | ± |

"SEPTIC ABORTION A MENACE TO WOMANHOOD"

- * Pulse Tachycardia
- Resp-up-hyperventilation
- BP - Normal / Hypotension
- Extremities - Warm / Cold
- State of hydration / Low
- Pedal or whole body oedema

Systemic Examination is an important care of this condition

- * Chest - For presence of Crept, effusion etc. Tuberculous, Parenchyma Lesion
- * C.V.S. - Tachycardia, Pericardial effusion or Presence of Organic heart disease
- * Urinary tract - Injury

ABDOMEN

- * Distension may be present
- * Presence of free fluid
- * tenderness/rigidity/guarding
- * Presence of lump./organomegaly
- * Uterine size
- * Bowel sounds

LOCAL EXAM : The following things should carefully be observed

- * Perineum -presence of laceration
- * Vagina - presence of laceration in vagina
- * Tear in Cervix

Product protruding out of cervix

Bowel loops protuding

Presence of foreign body

Type of discharge

- P / V
- * Condition of cervix
 - * Uterine Size
 - * Presence of Tenderness
 - * Presence of masses

"SEPTIC ABORTION A MENACE TO WOMANHOOD"

GRADING OF SEPTIC ABORTION IS MADE BY ITS SEVERITY

- Gr.1 * Localised to uterus
- Gr.2 * Infection beyond uterus
- Gr.3 * Systemic Spread

INVESTIGATIONS :

- * Culture and Sensitivity of following specimens
 - C } PRIOR TO INT. CHECK UP
 - HV. S }
 - S }
 - C }
 - * Cervical Swab }
 - S }

Culture in anaerobic & aerobic media both

- Blood } Culture
- Pus } &
- Urine } Sensitivity
- Sputum }

GRAM STAINS is useful for selecting immediate treatment

* Haematological studies which needs evaluation are

- Hb -
- WBC
- Haemato orit
- ABO grouping & Crossmatching
- Serum electrolytes

- C
- Blood
- S

Serum creatinine

Coagulation profile

- * Chest / X-ray - For effusion, Tuberculous liaison
- * Plain X-ray of abdomen - For fluid & gas

- Abdomen - Foreign body in abdomen
- USG - Collection of fluid or pus
- Pelvis - in abdomen or below the vital organs.
- Fluid, Foreign body

"SEPTIC ABORTION A MENACE TO WOMANHOOD"

- MANAGEMENT**
- * Principals of management are
 - * Hospitalisation -
For through physical Examination & aggressive management on the lines of treatment formulated :-
 - * Control of infection
 - * Correction of blood volume
 - * Correction of electrolyte imbalance
 - * Removal of source of infection
 - * Constant monitoring of vitals

After stabilising the vitals :-

Assess for status of the case whether medical or surgical management is required.

PRINCIPALS OF ANTIBIOTIC THERAPY

- * Broad spectrum effective for
gm -ve
- * gm +ve
- * Route chosen should be preferably I. V.
- * Special management according to grade

High Risk Patient :-

Critical risk factor for identifying the patient at special risks are :-

- * Developing shock state
- * Signs of peritonitis
- * Cardiovascular instability
- * Coagulopathy

Intra abdominal bleeding

Mid Trimester Septic abortion

Oliguria

Hypothermia

Uterine Perforation

Bowel injury

"SEPTIC ABORTION A MENACE TO WOMANHOOD"**INDICATION FOR SURGERY**

- * Traumatic uterine perforation
- * Suspected injury to gut
- * Presence of foreign body in abdomen
- * Unresponsive peritonitis
- * Septic shock or oliguria not responding to medical treatment

INDICATIONS OF HYSTERECTOMY :-

- * Traumatic uterine perforation
- * Clostridium welch infection
- * Peritonitis and septic shock not responding to medical treatment
- * Development of oliguria in an apparently normovolaemic point.

Laparotomy is done to :-

- * To ascertain extent of intra abdominal injury and infection
- * Bleeding from uterine perforation
- * Hysterectomy if needed
- * Injured bowel is repaired
- * Adequate drainage of peritoneal cavity

In spite of best efforts on the part of obstetrician sequels like :-

- * Chronic pelvic pain
- * Residual tubal infection
- * Secondary infertility

SAFE USE OF COMBINATIONS OF LOCAL ANAESTHETIC AGENTS EPIDURALLY FOR PEURPERAL TUBAL LIGATION

Dr. BEVERLY DOMINGO, M.D., DNB, ANAESTHESIOLOGY

GRANT MEDICAL COLLEGE & SIR J.J. GROUP OF HOSPITALS,

BYCULLA, MUMBAI-400 008.

SUMMARY :

60 patients undergoing post-partum abdominal sterilisation were under taken for study. They were divided into 3 groups of 20 each who received lumbar epidural injections with bupivacaine 0.375% and mixture of bupivacaine 0.375% with lignocaine 1% in concentration of 60 : 40 and 80 : 20. The volume of the solution injected was 20 ml. in all cases.

The difference in time of onset of analgesia, duration of analgesia, speed of spread of analgesia and the motor blockade were studied. We concluded that mixture of bupivacaine and lignocaine in a proportion of 80 : 20 is the most ideal mixture of epidural analgesia because it produces quicker onset of analgesia and also has prolonged duration of analgesia.

INTRODUCTION :

Combinations of local anaesthetic agents have been used for many years. In the present study, bupivacaine 0.375% and lignocaine 1% have been used in a proportion of 80 : 20 and 26 : 40 for epidural analgesia. The trial was undertaken with the following aims.

- * To hasten the onset of analgesia
- * To increase the duration of analgesia.
- * To have an early complete spread of analgesia.
- * To get adequate motor blockage.
- * To study any complications resulting from mixing bupivacaine and lignocaine.

I would like to stress that local anaesthetic agents are used for anaesthesia and analgesia but mixing of two ideal local anaesthetics in an appropriate concentration so as to achieve the maximum benefits of the two agents with the least complications is important.

SAFE USE OF COMBINATIONS OF LOCAL ANAESTHETIC AGENTS EPIDURALLY FOR PEURPERAL TUBAL LIGATION

These combinations of local anaesthetics can be used not only during regional anaesthesia like sub-arachnoid block, epidural block or other regional block but also for local anaesthesia, for analgesia. For post-operative pain relief. Even for very short procedures under local anaesthesia. Infiltration with a combination of sensorcaine and lignocaine is helpful to reduce pain after the procedure is over and thus avoids the use of oral or injectable analgesic; with their side effects like respiratory depression, drowsiness gastritis and other systemic effects.

METHODS :

60 patients of ASA class I. Undergoing abdominal sterilization were given bupivacaine and mixture of bupivacaine and lignocaine EPIDURALLY.

TABLE No. I. : PATIENTS WERE DEVIDED INTO 3 GROUPS.

Group	Number of patients	Drug	Volume
I.	20	Bupivacaine 0.375% (Sensorcaine)	20 ml.
II.	20	Bupivacaine 0.375% AND Lignocaine 1% (i.e.) 60 : 40 proportion	12 ml. 20 ml. 8 ml.
III.	20	Bupivacaine 0.375% AND Lignocaine 1% (i.e.) 80 : 20 proportion	16 ml. 20 ml. 4 ml.

All patients were starved overnight. Informed consent was taken Premedication was avoided in this study. Under all aseptic precautions, epidural anaesthesia was given in the left lateral position with a No. 18 Tuodhy's needle in the L3-4 space after confirmation of the epidural space using loss of resistance technique.

SAFE USE OF COMBINATIONS OF LOCAL ANAESTHETIC AGENTS EPIDURALLY FOR PERIPARTAL TUBAL LIGATION

TABLE No. II. :

Group	Number of Cases	Onset of analgesia in minutes				Mean	S.D.
		0-4	5-8	9-12	13-16		
I	20	-	2	15	3	10.60	± 2.04
II	20	2	14	4	-	6.44	± 2.78
III	20	1	18	-	1	6.80	± 2.05

As seen in the above table. Onset of analgesia was 9-12 minutes in Group I. As compared to 5-8 minutes in group II and III. Thus it was observed that with the addition of lignocaine 1% to bupivacaine 0.375% in a ratio of 20 or 40, onset of analgesia was quicker than when only bupivacaine was used.

TABLE No. III

Group	Number of Cases	Duration of analgesia in minutes				Mean	S.D.
		80-100	101-120	121-140	above 141		
I	20	2	2	9	7	134.00	± 10.47
II	20	11	4	3	2	104.55	± 22.03
III	20	3	7	6	4	127.55	± 25.56

SAFE USE OF COMBINATIONS OF LOCAL ANAESTHETIC AGENTS EPIDURALLY FOR PERIPARTAL TUBAL LIGATION

As seen in table III, the duration of analgesia in group I i.e. only bupivacaine was 134.00 minutes. While in group II i.e. mixture of bupivacaine and lignocaine 60 : 40 was significantly less i.e. 104.55 minutes. In group III with bupivacaine and lignocaine 80 : 20. The duration of action was 127.55 minutes i.e. almost as in group I. So it was concluded that increase in volume of bupivacaine hydrochloride correlates with the increase in the duration of analgesia.

TABLE No. IV :

Group	Number of Cases	Complete spread of analgesia in min.				Mean	S.D.
		5-10	11-15	16-20	21-25		
I	20	-	-	4	16	21.69	± 1.89
II	20	2	9	6	3	14.70	± 3.9
III	20	-	13	6	1	14.80	± 2.12

As shown in the table IV, the spread of analgesia was slow in group I patients mean 21.69 minutes, compared to group II and group III patients. There is no significant difference in the spread of analgesia in group II and Group III patients 14.70 and 14.80 minutes respectively.

No patient had complete motor block. Bupivacaine concentration (by volume) correlates with the degree of block. Incidence of complications was also minimal in this study.

Dermatome levels were studied in all 3 groups. Group I & III showed maximum number of patients with highest dermatome levels between T8-10 while group II patients had T5-T7 dermatome in maximum patients.

A mixture of 0.375% bupivacaine and 1% lignocaine (80 : 20) is the most ideal mixture

with quicker onset of analgesia like lignocaine and prolonged duration of analgesia like bupivacaine.

CONCLUSION :

Thus we conclude that

1. The individual drug in the mixture exerts its action. As if it was injected alone.
2. For lignocaine to exert its quick onset of action, it should be present at least in a ratio of 20 : 80 with bupivacaine i.e. as in group III and this is without any significant reaction in duration of analgesia.
3. The duration of action correlates with the proportion of bupivacaine in the mixture. The B 80 : L 20 mixture has almost the same duration as bupivacaine alone with rapid onset of analgesia.
4. The speed of spread of analgesia increased with addition of lignocaine.
5. Surgeons evaluated muscle relaxation as satisfactory even though the motor block was partial in most of the cases.
6. Safe for mother.
7. Early ambulation.
8. Better maternal-fetal bonding.
9. Minimum systemic effects.

Hence, it can be stated that mixture of 0.375% bupivacaine and 1% lignocaine (80 : 20) proportion can be the most ideal mixture for epidural analgesia as it provides the quicker onset of analgesia like lignocaine and prolonged duration of analgesia like bupivacaine to an optimum extent without any undue disadvantage.

BIBLIOGRAPHY:

1. A comparison of Bupivacaine and Tetracaine in epidural analgesia for surgery Bromate P. R. (1969). Canadian anaesthesia Society Jr. Vol. 16, Page 37.
2. Bupivacaine. A clinical assessment in lumbar extramural block by Drowning J. W. (1969). Br. Jr. of Anaesthesia. Vol. 41, Page 427.
3. Bupivacaine Hydrochloride. A Summary of investigational use in 3274 cases Daniel C. Moore (1972). Anaesthesia Analgesia. Vol. 50, Page 856.
4. Clinical reports : Epidural anaesthesia. With mixtures of bupivacaine and lidocaine by Magee D. A. (1983) Canadian anaesthesia Society Jr. Vol. 30, No. 2, Page 175.
5. A Controlled trial of bupivacaine. A comparison with lignocaine A. P. Rubin (1968). Anaesthesia Vol. 23, Page 327.
6. A Clinical trial of bupivacaine. A preliminary report on a new local analgesic agent in extramural analgesia watt. M. J. (1968). Anaesthesia. Vol. 23, Page 2.

SEX EDUCATION FOR YOUNG ADULTS THROUGH MASS MEDIA : HOW FAR TO GO ?

Dr. Mrs. ARATI BASU-SENGUPTA, B.Sc. MBBS, DGO, MD (Calutta)

Consultant Obst. & Gyn., Calcutta

Secretary - Association of Medical Women of India (West Bengal)

ABSTRACT :

Because of socio-economic and also cultural changes sex related disorders amongst adolescents are on the increase. S.T.D. and teenage pregnancies can be cited as the two leading areas of concern. The menacing increase of HIV cases amongst youth, specially in developing countries like ours, calls for an immediate action to bring order. It is obvious that enhancement of knowledge and information level in the target group will improve the situation. Specially to this end a special radio programme "Sandhikshan" was planned at the Calcutta Station of All India Radio. The broadcast time was thirty minutes twice a week. The year long programme included Narration, Drama and Q & A on various sex related issues. Eminent experts from medicine, gynaecology, psychology and social sciences were invited to speak on selected topics in the form of answers to questions posed.

The author participated in the programme from the planning stages and in this paper reports her unique experience. She further discusses the degree of success and various aspects of such educative radio-programmes on sex. The impact of sex education through print and electric/electronic media on the young adults is also assessed by her.

INTRODUCTION

The importance of sex education amongst the youngs specially the adolescents can never be undermined. There is, at this stage, a profound change in body and mind and one has to cope with the change in an orderly way. This requires a better knowledge of not only the changes which are setting in the body but also of the consequences of not taking the right steps. However, it has been somewhat problematic to transfer the knowledge or information to the youngs reaching adulthood because of the privacy characteristically and socially associated with sex. Several methods of communication have been tried with different degrees of success. Sex education in high schools has been introduced in some countries

SEX EDUCATION FOR YOUNG ADULTS THROUGH MASS MEDIA : HOW FAR TO GO ?

Counselling clinics have also been tried. While sex education through text books is found to be rather impersonal. The clinics requiring personal visits appear exposing. Mass media - specially the TV - have often been blamed, perhaps rightly, to present sex in undesired ways. Radio has never been blamed for broadcasting anything crude or vulgar. Recognising the problems of adolescents, primarily the sex-related ones, a serial had been planned and audience support assessed through the registration of listeners. With responses coming from nearly 28,000 listeners the programme was designed to reach the target group with the required information. The serial was named "Sandhikshan" to indicate the meeting point between childhood and youth or adolescence.

FERTILITY AND SEXUALITY :

It is admitted that sex-related disorders are on the increase in the developing countries with greater poverty and lesser literacy. The STD's have a new menacing addition in HIV-infection and pregnancies outside wedlock are not rare. Most of the time the question of population control through a reduction in teenage pregnancy or delayed marriage / pregnancy receive more importance and that of sexuality of adolescents or young adults overlooked. But adolescence is the stage of self-discovery while facing the adult world with a strong desire to carve a path of one's own. The trials are painful, the pitfalls abominably costly. Sex is undoubtedly the foremost of the many problems confronted at this juncture. It was considered best to present before the listeners the issue in totality and not the sex-related ones in an isolated fashion. The presentation was in two formats : (a) in the form of a serial drama based on a story line with adolescent characters in search of solutions to their personal problems in the maze of adult life around and (b) a session of answers by experts to queries received from registered and also unregistered listeners. Later the serial drama was brought to an end on the basis of a through review by various experts. Short plays on typical problems were broadcasted but experts continued on answering the queries. These were mostly related to sex. Teenage pregnancy and the consequences of sexual intimacy viz. conception before marriage were discussed but the listeners were more interested to learn more about sexuality. Even homosexuality was not left out and few young confessed homosexuals were interviewed. Instead of concentrating on fertility and unwanted pregnancies the major focus of the programme was to dispel the wrong notions regarding sexual desires, behaviours and acts. The reproduction process naturally came in but it had never been the central theme.

INFORMATION Vs. MISINFORMATION :

It transpired from the pile of letters nearly 3500 - from adolescents and also senior adults that the information level was indeed poor. The sources being mostly friends of the same age or slightly older the scientific basis was absent and very queer notions remained undisputed. The letters from the listeners were taken up both individually and collectively and the answers were provided by experts. A panel of experts comprising physicians, gynaecologist, psychologists and social scientists regularly participated in the programme and found the task very rewarding. Discussing sex openly in vernacular was a kind of challenge but the experts very satisfactorily played their important role in stating in simple language the scientific explanations to the various queries from young listeners.

THE RESPONSE :

Besides the numerous letters received by the Radio Station from the target group many other communications and the reviews from the Press helped in assessing the success of the programme. A number of senior citizens complimented the team for this bold and healthy initiative and Press, often critical to other science programmes, was liberal with praise. The overwhelming response from the listeners was a singular reward and letters came even from Bangladesh indicating that it had reached the youth across the border. In fact towards the end it was decided to invite some of the listeners, selected through drawing lots, to the Radio Station to broadcast live the discussion of these young boys and girls with the experts. The exuberance and interest shown by them, and the frankness of their views and queries if taken as a measure of the effectiveness of the programme, it can be said that to a good degree success has been achieved. Since in case of radio no visuals are involved the explanations were purely verbal and the absence of the speaker before the listeners also made a lesser impact. But Radio has a wider reach and much of the possible embarrassment of the young as well as the old of viewing together themes on sex on screen could also be avoided. Perhaps the explicitness could not have been maintained before a camera.

CONCLUSION :

The importance of making the adolescents aware of the sex-related issues has been recognised by both the National and International agencies. For developing countries the

SEX EDUCATION FOR YOUNG ADULTS THROUGH MASS MEDIA : HOW FAR TO GO ?

importance is undoubtedly more in view of the unfavourable social and economic factors. The communication methods adapted in different countries have been reviewed by experts and depending upon the target group various degree of success have been achieved. The present programme through Radio had an overwhelming audience response and in the latter part of the programme young boys and girls were brought to the Radio Station for face to face discussion. A workshop arranged with experts, social workers and NGO representatives also suggested such meets. The author had the good opportunity of meeting the boys and girls in and outside the studio and having a prolonged and frank discussion with them. From the kind of the queries they posed the author is convinced that the confusions regarding sexual behaviour and attitudes of the young can be dispelled to a very good extent by frank discussions. The usual inhibition is to be overcome and judging the benefit the education programmes should be expanded to cover more issues. The author's personal experiences are very rewarding and she feels genuinely encouraged to propagate the education in this and other effective forms. It is also unfortunate, that very little work has been done in the country and the author requests the various agencies to come forward.

The author is grateful to the Calcutta Station of All India Radio specially Mr. Swapnamoy Chakravarty, Producer, Science Division & Dr. Amit Chakravarty, Station Director for their kind help & around support.

ROLE OF EDUCATION TO THE YOUNG ADULT

(in the Context of Reproductive Biology)

by

Dr. Sudha Seshayyan, M.B.B.S., M.S.,

Additional Professor of Anatomy,
Stanley Medical College, Chennai-600 001.

& Dr. K. Raja Venkatesh, M.B., M.S., M.Ch.,(CTS),

Assistant Professor of Cardio thoracic Surgery,
Chennai Medical College, Chennai-600 003.

THE YOUNG ADULT - A PREVIEW

ADOLESCENCE

"We are born twice over - once into existence and the other into life" observed Jean Rousseau. Adolescence, in all probability could be defined as that of birth into life, which in essence, is an exposure to the wide vagaries of the world.

As much as adolescence can be best defined as a developmental phase on a multi-axial frame, that obligatory passage from childhood to adulthood is a period of mixed reactions, behaviour and expressions. Temporally, it usually encompasses the whole of the second decade of life. Nevertheless, "what is expected out of an adolescent?" is a question that evades a singular answer.

ADOLESCENCE - TODAY

In the present day pluralistic society, adolescence is prolonged in duration and ambiguous in responsibilities. It is definitely a period of intrinsic turmoil and extrinsic idiosyncrasies, though no longer can it be classified a period of disharmony within the psychic structure.

However, it is a period of semidependence with an incongruous mixture of liberties and restrictions, a time when more questions are raised about the adolescent and more questions are triggered within the adolescent; a time when both social pressures on behaviour, morality, religion and personality mount on the adolescent and the dimensions of the same pressure viewed and reviewed within the individual.

ADOLESCENT AND PHYSICAL DEVELOPMENT

Physical development manifests the maximum in both sexes during this phase of life. But, the timing and duration of physical growth varies largely.

Studies all over the world have indicated that menarche occurs earlier by a year or two than it was before. It is also commonplace knowledge that girls begin and finish puberty and related physical development atleast two or three years earlier than boys. Thus in the same age group or class, it can often be found that several girls are at an advanced stage of sexual development while several boys would not even be showing initiation of such development.

ROLE OF EDUCATION TO THE YOUNG ADULT

(The factor, seemingly unimportant, will have to be necessarily assessed by the educator to avoid situations of over zealous conflicts, shame, guilt, self-pity, self-deprivation and psychological depressions amongst the adolescents during sessions of education and training).

ADOLESCENT AND PSYCHOSOCIAL DEVELOPMENT

On viewing psychosocial change that transgresses the adolescent period, one factor can be dominantly recognised. Though clear evidence indicates that puberty now occurs at an earlier age, than it did about 100 years ago, psychosocial factors defining adolescence have not undergone comparable and proportionate changes.

Pubertal physical development has been enhanced but the threshold age for the young adult to hold a responsible position in the society has not reduced. On the contrary, greater emphasis on "better" education, supremacy establishment, changing socio-cultural values and trends and redefinitions of societal pressures have, on the overall analysis, raised up the age limit at which an adolescent could settle down to an independent and individual life.

Initial sexual encounters tend to occur at earlier ages than before, unwanted and unexpected pregnancies tend to rise up; and competitive trends place more stress on the youth with regard to education and skills and job opportunities.

Technological and media explosion have indirectly placed traditional and moral values on moot. Phases of cultural transition are being faced by almost every society and community thus leading to questioning of "set" standards, norms and applications of behaviour.

At the same time, advances in information transfer and communication skills allow adolescents to know "something" of physical development and reproduction (and most often, not the right "something" but the "wrong" something).

The situation is more than transparent.

Psychosocial turmoil compounded by the "innate" natural rebelliousness of the adolescent may lead to "experimentative" and or "wanting to know" sexual behaviour.

ADOLESCENCE AND CONFLICTS

As much as several social demands are placed on the adolescent, some social expectations are likely to be in line with the teenager's aspirations.

However, adolescence is most often the period when conflicting standards of autonomy and dependence are struck.

ROLE OF EDUCATION TO THE YOUNG ADULT

The adolescent is offered (and of course, expected to develop) autonomy and independence in certain fields (like educational performance, social behaviour); while the same self-sufficiency is impracticable in other areas (like handling finances, discharging familial responsibilities)

AND THE CONFUSED ADOLESCENT

Social expectation of his/her gender behaviour is quite hard for an adolescent to judge. Adolescence is "the" phase where heterosexual attractiveness is inculcated. The individual yearns to project his/her "image" to members of the opposite sex and to peer group (for adolescence is precisely the time when a positive concept about "self-image" also develops). On the other hand, moral and social condemnation of outrageousness in dress, speech and sexual behaviour preset disturbing standards on the individual.

Especially in a country like India, where several social taboos are laid down even on talks and discussions about sex, adolescent behaviour is bound to be "confused" and "Confusing".

ADOLESCENT EDUCATION

Education to an adolescent, apart from being subject/job/career oriented (thus opening out avenues of future livelihood), should percolate enough into the adolescent mind and thought to mould personality traits.

So, adolescent education should above all have three mandatory regimes :-

- * education regarding physical changes;
- * education to balance psycho-social conflicts
- * education to instill confidence and feeling of normalcy.

Education regarding Physical Development

With regard to what details about physical changes and reproductive biology goes into the adolescent "syllabus", it cannot, but be more emphasized that adolescent education, will have to gradually, but unobtrusively, impact necessary information on prepubertal and pubertal growth phases and associated physical changes. It is important to outline the (a) changes that occur during the said prepubertal and pubertal growth phases, (b) the associated development of secondary sexual characters, (c) the "growth spurt" (including the mean height velocity) and (d) the related hormonal changes.

EDUCATION - METHODOLOGY

The methodology of imparting requisite biological education to the adolescent may have to be varied. Distinction should be made in handling youngsters belonging to the all-girl or all-boy schools on one hand and the students of co-educational institutions on the other.

ROLE OF EDUCATION TO THE YOUNG ADULT

Apart from rendering basic, methodical scientific information about physical changes that occur during adolescence, **it is preferable to offer information about the process of physical changes to girls and boys separately and in small groups.**

A special note about biological education to adolescent girls :-

This "education will have to

- * necessarily provide information about the changes that they are to undergo during the phase;
- * offer them confidence and alleviate the "regular" feelings of insecurity and insufficiency that are likely to crop up;
- * render suggestions and guidance (only guidance and not pedagogic advice) regarding their behaviour.

EDUCATION OF AND FOR BALANCE

Emotional imbalances and maladjustments are more during this phase

It should now be remembered that due to variations in the process of physical growth, in a class of girls, different girls will show different stages of development. Similarly, in a co-ed group of almost of the same age, it can often be found that several girls are at an advanced stage of sexual development while several boys would not even look more than boys.

The educator and the educational content will have to be carefully balanced. Much emotional maladjustment is likely to arise out of the afore-mentioned non-synchro-nisation of peer levels. Education, here, should emphasize on the normalcy of the growing phase of adolescence thus balancing these emotional maladjustments.

In the present day Indian society, which is at cross-roads, the balance is precarious. The adolescent neither grows up with traditional restraints and norms (which, more or less, automatize the process of adolescence) nor envisages the modern changes (which tend to accept the idiosyncracies of adolescence); education could remain the only panacea to build up balance.

ROLE OF EDUCATION TO THE YOUNG ADULT

EDUCATION - EMPHASIS

Adolescent education, at this stage, WILL HAVE TO EMPHASIZE ON DETAILS OF REPRODUCTIVE BIOLOGY WITHOUT JUSTIFYING TERRITORIES OF SEXUAL PERMISSIVENESS.

Necessary, methodical and scientific information about reproductive anatomy and physiology, chromosomal template of gender differentiation, sexual behaviour and sexuality will help adolescents not only understand their stages of life but also aid them in stabilised decision making in their adulthood.

Several of the "so-called" adolescent conflicts could well be tackled by frontier of education.

Thus, education should offer an adolescent the following :-

- a. Confidence in self and in the growth phase
- b. Acceptance to social responsibilities and attitudes.
- c. Better understanding of social expectations.

It should be thought upon that due to factors like,

- i. Better educational opportunities
- ii. Wider exposure to life
- iii. Exposure to media
- iv. General attitude of acceptance to diversities of and in life, more adolescents will be able to accept their phase of growing up as a period of normalcy.

SUMMARY

Education and its affiliated territory of reproductive biology, in the changing world will have to instill confidence in the adolescent; offer respectability to sexual behaviour, provide acceptance to "natural" chromosomal and endocrine attributes; preserve emotional and conceptual integrity; develop interpropositional logic; and more help to develop stabilised longtime, non-deviant interpersonal (especially marital) relationship.

142

<

UNIVERSITY OF HAWAII LIBRARY



10 002405753

UNIVERSITY OF HAWAII

R 97 .A8 1991-97

Journal of the Association of
Medical

100