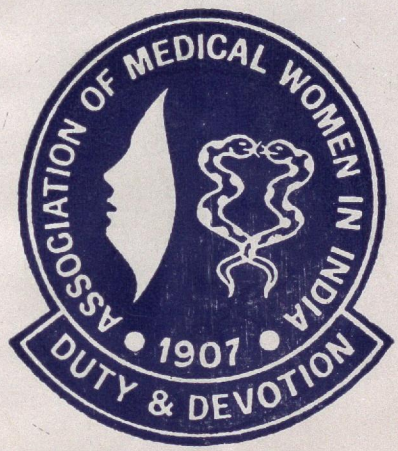
JOURNAL

OF THE ASSOCIATION OF MEDICAL WOMEN IN INDIA



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AN APPEAL

Journal of Association of Medical Women was a quarterly journal initially. Then it became bienniel. For the last few years it is coming out only once a year. There are many problems facing the journal, but there is one main problem regarding which members can help. We are always very short of articles. If members take interest and contribute articles, the journal can come out at least twice a year. Journal is an important outlet for expressing their views & communicating their experiences. I appeal to all of you to co-operate & help this journal which has a tradition to keep up.

Thanks you.

Editor

We wish you all

a happy

New Year

THE FURTURE OF WOMEN DOCTORS AND THEIR PRACTICE
" THE MWIA HIGHWAY "

DR. JHIRAD ORATION DELIVERED BY DR. LILA S. KROSER
NOW PRESIDENT OF MEDICAL WOMEN INTERNATIONAL ASSOCIATION.

I am honored to be the recipient of the Dr. Jerusha Jhirad Memorial Plate. Her carrer is an inspiration to all and I thank the Association of Medical Women of India and especially Dr. Tulsi Basu for her constant support and committment to the medical womens international association.
From thank you's I would move on to challenges.

Those of you who know me well, know I would rather tell stories than make speeches. I am reminded that in 1861, Dr. Edwin Fussel, professor of the female medical college of Pennsylvania and an avid supporter of women's medical education, peered out over the new graduates and asked the question which in the mid 19th century was on everyone's mind :

"Ladies, why are we here ?" I quote, "Had society no allurements for you, the embroidery needle no seductions? could you not be satisfied with being the life of the drawing room or reigning belle of the ball ? Were there none on whose energies and means you could subsist without effort of your own ? Was there no father, brother or friend on whom you could depend, like a parasite on an oak ? could you not have been teachers at half the salaries of men ? Could you not get behind the counter and at $3.00 a week and haggle over a yard of ribbon ? Were there no factories where you could work your fingers raw, within whose dusty walls you could grow pale. Ladies, could you not be content to do nothing and to be nothing ?" as I prepare for this three year journey as your MWIA President and as I travel the MWIA highway.

As I start this journey, I am taking with me a lifetime of experiences that have shaped this person who stands before you. They are my memories of medical school, the challenge of making it in a man's field, my years of practice as a family physician, marriage, motherhood, raising three wonderful children and the work I have done in organized medicine on the city, state and national level. On my journey, I also take with me the history that throughout the almost 80 years of its existence, the MWIA has provided an international forum for the interchange of information. My dear colleagues, we are the embodiment of the answer to Dr. Fussell's question. As women physicians, we have been on a journey toward success that takes courage, commitment, dedication and scientific professionalism. Success in any endeavor is a journey, not a destination. What then is the future practice of the women physician ?

I cannot change yesterday, I can only make the most of today and look with hope toward tomorrow. A wise person once said, "Always have your bags packed, you never know where life's journey is going to take you. "I couldn't agree more and I have my bag with me always. My old original well used traditional black bag that physicians have carried with them for generations. My bag is packed and ready to go, vital medical problems with worldwide implications. MWIA has provided a place where medical women can work together toward common goals. The decisions at the association congresses and meetings have been of inestimable value to the participants, women in medicine, who will bring to the healing arts a unique and special quality.

Drastic changes are taking place in health care systems. The implications for medical education show that physicians of the next century will practice in networks and be paid by capitation or salary rather than fee for service. Technology will be at a high level and will change medical care delivery. The focus will be on prevention and maintenance of function instead of cure. More social accountability and community outreach will take place.

Training to meet these challenges will involve re-evaluation of academic missions, research and lifelong learning. Health will be redefined in regard to populations and a review of medical cultural interactions will be needed to demonstrate future approaches to physician training that will be multiprofessional, interdisciplinary and socially accountable.

These issues will especially focus on women physicians and their practice. The number of women practicing throughout the world has dramatically increased. Women physicians are 45-50% of all medical school classes and 30% of practicing physicians in most countries.

Women physicians in their future practices will face the challenge of reducing poverty, changing consumer behavior, protecting and improving the environment on a global basis, including prevention of illegal waste and finding global action plans to reach fair and ongoing development especially for children and adolescents. Concerned with maternal, Family and child health throughout the world, we all are mentors to other women physician colleagues no matter where they practice. We offer our technological expertise, advanced research and compassionate concern. We are the present and future women physicians practicing our art. The results of increased dialogue, interaction, networking and exchange of ideas, lead to common purposes. Even through the words may be in different languages and the customs from other cultures, the shared problems lead to common knowledge and adaptable ideas to our invididual environments. A shared unity prevails.

I always pack some tangible items in my bag, symbolic representation of my priorities. I want to share these items and priorities with you [so that our answer to Dr. Fussell will be we want to do something and be something]. As we travel the MWIA highway, I need your help. Let me start with this ! it's my stethoscope.

I'm carrying this with me because I **am** a practicing physician. It serves to remind me and all of you that our primary responsibility is to the patients we serve and the care we give.

My responsibility to them and all of you is to advocate for and champion the causes that are important. This means hearing through my stethoscope the cues, the problems the needs of diverse cultures and to be able to present measurable answers at the WMA, WHO and UN. With unity physicians represent a force to be heard. With one voice a visible change can be made. Future medical practice demands attention to government and political forces.

I look forward to advocating for the human rights of all populations, for doctors, for patients, for our profession. As your spokesperson I can be a voice for all, as we go forward.

We need to do more than just discuss health care in each country, issue by issue. We must also look at the big picture and that's why I'm taking this along with me as well.

It's a flashlight. I hope this will shed light not only on the problems among the health impoverished and needy, but will illuminate the answers and actions that can change health care delivery systems where we practice. We need to take medical decision making out of the hands of politicians, employers and insurance companies and put it back in the hands of physicians where it belongs. As women physicians, our practices need to light the way.

MWIA is an association in transition at a time when the forces shaping medical care are rapidly changing. The gulf between care and caring widens daily. The difference between acceptance and advocacy is monumental.The way to improve cohesive care and advocacy for our patients is to be focused within the organized structure of professional ethical colleagues. That's why I carry this in my bag, the membership brochure for MWIA. A visible symbol for an association whose priorities are to bring quality health access to their patients, worldwide, educate each other and our patients, cooperate in universal commitment to human rights. We recommit to ethics and professionalism by teaching these lessons at every level of medical training and by looking at these time honored principles in a more personal way. That's why I am carrying this with me. It's MWIA resolutions and statements. These are the principles we strive to uphold. These coordinate the thinking of generations of delegates and women doctors. These need public awareness. Only you can carry these principles to your national medical association, communities, civic association, political parties, medical schools. The principles of medical ethics demand competent medical service, compassion, respect for human dignity. We must lead the way in dealing honestly with patients and colleagues. We respect the law but to also recognize the responsibility to seek change where change is in the best interest of the patient. The women physician should continue to study, apply and advance scientific knowledge embracing both the art and science as well and finally recognize her

responsibility to participate in activities contributing to an improved community.

These, my friends are a paraphrased list of ethical statements long embraced by MWIA. Make them known widely. For them to be a vital fact of our lives is in your hands. This brings me to the last item in my bag and that's the MWIA update. Communication is the link, the cement if you will, that brings us together, provides a network and examples of how we affect medical practice, medical leadership individually and collectively. I am asking your help in getting more members in helping them to know us and our principles and travel the MWIA highway with us. We must make sure our patients know what guides our work. Hippocrates has said, "Wherever the art of medicine is loved, there is love of humanity." I believe the important things that I have packed that will be with me and all of us on our travels of a lifetime, will echo our experience and the valuable lessons learned. Our road leads us to real answers for the crisis facing patients in our future, recommittment to ethics and professionalism, communication and dedication. Because of our unique heritage, our special qualities as women doctors we are the most suited to effect quality health care and guarantee human rights for all.

I solicit everyone of you to steer this course with me to "Do something and be something" remembering the quotation from the entrance of the medical college of Pennsylvania :

"The women physician, daughter of science pioneer, tenderness
hath banished fear, woman and leader in thee blend,
physician surgeon, student, friend."

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CONGENITAL ADRENAL HYPERPLASIA - OUR EXPERIENCE

Dr. Sujoy A. Das
Dr. Jyotsna M. Kirtane

Congenital adrenal hyperplasia (C.A.H.) is a condition wherein due to inherent defects in the enzymes of the adrenal glands there are elevated levels of the precursor enzymes giving rise to sexual ambiguity with life threatening disorders. The first case of C. A. H. was a female pseudo hermophrodite described by De Kriok in 1865. It is an autosomal recessive disorder and hence siblings of either sex can be affected.

Among the various enzymes described the following enzymes are responsible for sexual ambiguity.

1. Desmolase dificiency.
2. 3-β Hydroxy steroid deficiency.
3. 21 - Hydroxylase deficiency.
4. 11β - Hydroxylase deficiency.
5. 17α - Hydroxylase deficiency.
6. 17 - 20 Lyase deficiency.

Among all these 21 - Hydroxylase and 11 - B hydroxylase deficiency accounts for 90 percent of the cases with an incidence of 1 in 15,000.

Material & Methods :-

Over the last ten years among the various intersex cases that came to us, we had six patients of C.A.H.

No.	Age of Presentation	Presentation	Karyotype	Deficiency	Treatment
1)	1 mt.	Ambiguous genitalia, loss of weight, loose motions, abdominal distension and vomiting	46 XX	21-OH	Expired
2)	3 mts.	Ambiguous genitalia, Fused labioscrotal folds.	46 XX	21-OH	Reducation clitoroplasty & Vaginoplasty
3)	1 yr	Being reared up as a male. Presented with (B) undescended testes with hypospadias	46 XX	21-OH	- do -
4)	2 yr	Being reared up as a male. Presented with (B) undescended testes with shawl scrotum.	46 XX	21-OH	- do -
5)	3 yr	Virilisation Being reared up as a male child	46 XX	21-OH	- do -
6)	7 yr	Started developing increase in size of the clitoris, excessive gain in height.	46 XX	21-OH	- do -

DISCUSSION :-

Ambiguous genitalia with the most patients being reared up as males was the commonest mode of presentation, with only one patient presenting with loose motions and electrolyte imbalance. All our pateints were below 12 years as above the age of 12 years patients were not referred to us. After a

detailed clinical examination. We did the following investigations :

a) Karyotyping b) Sr-17 OH progesterone levels and urinary 17-OH steroid levels.
c) Sr-Electrolyte levels d) Ultrasound of the adrenals, to look for the size of the adrends and also to see for the presence of the uterus and gonads. e) Genitography f) Cystovaginoscopy.

We started the patients on steroids and after a month, we took them up for one stage Passerini-Glazels redecution clitoroplasty and vaginoplasty. This is an operation where by we reduce the size of the enlarged clitoris, making a mucosa lined introitus using the corpus spongiosum and using the labioscrotal folds with the adjacent skin to make a tube and suture it to the upper 1/3 of the vagina. This is a good operation which can be done in a single sitting and with excellent cosmetic results. We could not evaluate the functional results of our vaginoplastry as these children were in the paediatric age group.

The medical treatment of CAH includes cortisone which replaces the deficient corticosteroids and reduces the ACTH drive to the adrenal cortex. The dose has to be adjusted according to 17 hydroxy progesterone levels, somatic growth and bone maturation. In salt losing patients, fluclro cortisone needs to be given. A maintanance dose is required throughout the childs life and the patients must be warned about increased steroid reguirements during times of illness or any major stress.

Now-a-days with advances in endocrinology and molecular genetic study a prenatal diagnosis can be made, by measuring 17 - Hydroxy progesterone in amniotic fluid by second trimester of pregnancy and by chorionic villous biopsy diagnosis can be made even in the first trimester. Prenatal treatment by giving dexamethasone to the mothers can be instituted, though there have been a few complications reported in these pregnant women.

The aim should be to treat these patients at an early age and prevent a gender identity crisis. Patients who present late are given intensive psychotherapy and their entire family is involved to develop a strong support system.

In summary we conclude that :-

1. C. A. H. detected early can be treated with excellant results with these patients being able to enjoy a normal life.
2. Passerini-Glazell's reduction clitoroplasty and vaginoplasty is excellant operation with good cosmetic results.

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SAFE MOTHERHOOD IN INDIA & OBSTETRIC CARE IN THE COMMUNITY

* Dr. Arati Roy, M. B. D. G. O. F. R. C. O. G.

India is a vast country. The people of different states have different social & cultural norms, and also use various languages. Here lies the difficulty to extend uniform obstetric care throughout the country. India has only 2.4% of the world's land and shares only 1.4% of world's domestic products but she bears 15.5% of the global population.

Rural population - 80%.
Urban population - 20%.
9% of rural and 90% of urban women have institutional deliveries.
35% of rural and 5% of urban women are delivered by DAIS or TBAs.

Motherhood is not considered safe in India because of its high maternal mortality.
Maternal mortality in India is 350/100,000 (1991) live births. While in developed countries it is 10-15/ 100,000 live births.

Maternal deaths are due to some direct, indirect and contributory causes :

i) Direct causes are haemorrhage, sepsis, toxaemia and unsafe abortion constituting 70-80%.
ii) Indirect causes are due to medical complications like anaemia, heart disease, jaundice constituting 20-25%.
iii) Contributory causes social, environmental and organisational. Social Factors - poverty, female illiteracy, early marriage & deficient fertility control.

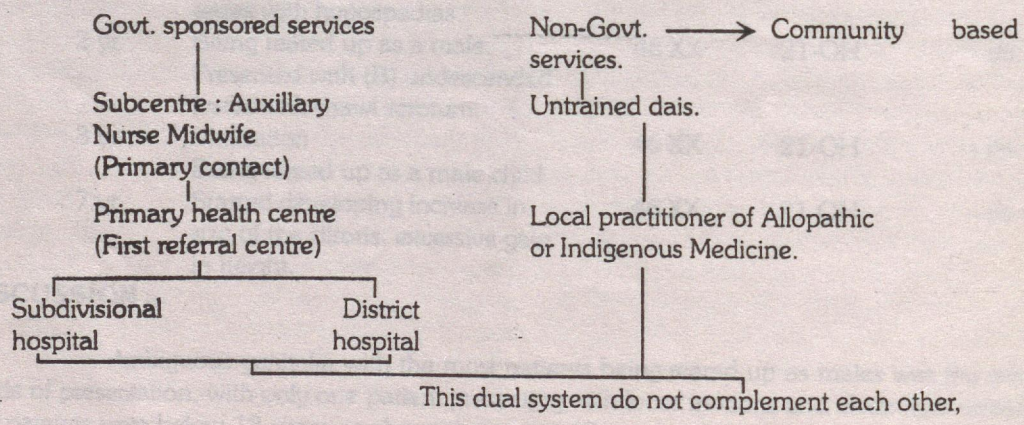
Main contributory factors are :-

a) Less access to health facilities.
b) Inadequate trained birth attendants.
c) Too poorly equipped facilities and also poor efficiency of workers to identify or handle the complications of child birth.
d) Too deficient in the quality of care.

In India 80% of the population belong to rural area and she shares 18% of the global births. Hence most of the childbirth occur in rural areas and hardly 33% of the childbirths are supervised by trained attendants.So the complications go undetected till labour is well advanced. In order to reduce the maternal and perinatal mortality and to make the motherhood safe community maternal health care has to be taken into account.

COMMUNITY MATERNAL HEALTH CARE

The existing community health care facilities prove to be insufficient. Obstetric facilities at the level of the community block reveals two alternative systems of care.



* Retd. Professor & Head of Dept., R. G. Kar Medical College, Calcutta, Consultant Sri Arabinda Seva Kendra, AMWI Missio Hospital, Calcutta.

With the intention of Safe Mothethood Programme reorientation of Govt. plan for community care has been implemented from 1991-92 for 7 years, which showed encouraging results.

With population of 853 million in 1990 the programme for proper community care includes :

1) **Subcentre (130,000)** - Each serving a population of 5,000. Staff - ANM with 18 months training.

2) **Primary Health Center (12,000)** - Each serving a population of 30,000 to 80,000 (av. 50.000).

Staff - Medical officers - 3
Trained nurses
Health assistants
Health educator
Sanitarians

3) **Upgraded Primary Health Centre :- (2,000).**

Staff - Graduate obstetrician
Paediatrician
Equipped with theatre facilities.
Each serving a population of 100,000.

They feed smaller Taluks, Subdivisional and District Hospital.

The consultant of the District Hospital will supervise the hospital, take account of the activities and will teach and guide them whenever necessary.

4) In addition there is a large **Uncoordinated Private Sector** of over 400,000 Practitioners who help 585,000 trained TBA who are also linked to ANM of 10 districts.

The work loads of the Govt. community services are so heavy that help of non-Govt. community workers will be of great help. Moreover local people rely more on them than the Govt. workers. So if these two types of community workers help each other - gradually the untrained workers will pick up basic things and will be helpful in community care.

India Govt. has taken the initiative to improve the working facilities in the community such as :-

A) Facilities for First Referral Centre :-

i) Well equipped to deal with all obstetrical emergencies.
ii) It should be closer to primary health centre and also to community.
iii) Nurses and medical staff - to be trained for Essential Obstetric Function.

B) On job training session by :-

i) Lady health visitor
ii) Public health nurse.
iii) Family welfare visitor.

C) To improve community acceptance :

i) Health education to village women.
ii) Group discussions.
iii) To contact women of household.
iv) Flip charts for illiterate audiences.

D) Training for the young doctors :-

Young doctors having an exclusive hospitalised orientation may be unfamiliar with some of the procedures which are essential for community care. So reorientation training is necessary.

E) Proper supervision and evaluation of the works are essential

In conclusion Health Programme should fit with the local setting, services have to be extensive and also comprehensive, continuous, spiced with enthusiasm and laced with common sense.

IMMUNOLOGICAL STUDIES ON HUMAN MILK FROM MILK BANK

* Dr. (Mrs.) Manita T. Williamson, Ph. D.
** Dr. (Mrs.) Prema K. Murti, B. Sc. (Hons), MD.
*** Dr. (Mrs.) G. V. Koppikar, M. D.

ABSTRACT :

Effects of duration on storage in glass and steel containers up to seven hours and storage temperature on the concentration of cellular and humoral factors of 400 human breastmilk samples were studied. E - rosetting of sheep RBCs by T - lymphocytes and phagocytosis of S. cerevisiae by phagocytes was carried out to estimate the cellular functions. For humoral studies, Immunoglobulin (Ig) levels were quantitated by single radial immunodiffusion technique (SRID).

Cell counts and their viability reduced during the storage period, but were greater than 60 percent of baseline values. IgG, IgA and IgM levels in human breastmilk did not show significant decline after storage ($p>0.01$). Human breastmilk stored in glass container yielded a greater number of functional cells during storage period as compared to steel container.

INTRODUCTION :

The importance of breastmilk goes back to the Vedic ages and to the time of Hippocrates who stated 'One's own milk is beneficial, other's harmful.'

The Past : The employment of wet nurses or 'dais' was common among the mothers of nobility in the 17th and 18th centuries. Animal milk soon replaced wet nurses in the 18th and 19th centuries and with it came bottle feeds, with its frequency of serious life threatening infections. The need for breast feeding and an alternative to wet nursing was then felt, and a breast milk bank was introduced in the 20th century. Thus the first milkbank was started in Vienna at the beginning of the century. Soon a number of breastmilk banks sprung up in Europe, USA, Australia and Germany.

The Present : In our own city of Bombay, a resurgence of interest in human breastmilk banking was felt during the last three decades. In Kamatipura Maternity Home (where this study has been carried out), there has been an average of 2600 deliveries per year. 27% of them are low birth weight infants (<2.5 kg.), high risk infants needing special care. Of these 20-25% need stored milk. The answer to this would be the use of donor breastmilk, appropriately stored in a milkbank. Thus one of the first few milkbanks was started at Kamatipura maternity home. Simple methods are used, i.e. milk is expressed in steel vatis and stored in the ordinary refrigerator compartment at 4^0 C.

There is ample evidence in literature regarding the bacteriological analysis of stored breastmilk and its immunoglobulin levels, in our own Institute and elsewhere.

There is however comparatively very little information on the effects of storage conditions like time, temperature and kinds of storage containers on the quality or quantity of the cellular and humoral contents of human breastmilk. Such a study has not been reported in India.

Therefore a multiparametric study was undertaken at the B. Y. L. Nair Charitable Hospital with the following aims and objectives :

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** Professor and Head, Department of Microbiology, D. Y. Patil Medical College, New Bombay.

*** Professor and Head, Department of Microbiology, Topiwala National Medical College and B.Y. L. Nair Charitable Hospital, Bombay - 400 008.

To study the effects of the types of containers at different temperatures and duration on :

1. Immunoglobulins
2. Total cell count
3. Functions of macrophages, neutrophils and lymphocytes in colostrum and mature milk.

MATERIAL & METHODS :

1. Manual expression of breastmilk with aseptic precautions in siliconised glass test tube.
2. Transported to Laboratory within 30 mins.
3. Stored in steel and glass container at room and refrigeration temperature.

Processed : 400 samples

a. Measurement of volume
b. Study of Total Count, Differential Count and Cell Viability.
c. Centrifuge at 1500 rpm, 20 min.
d. Decant fat layer.
e. Supernatent for Igs by SRID.
f. Sediment subjected to Ficoll -- Hypaque density gradient technique for cell separation.
g. Leucocyte studies for phagocytosis.

RESULTS & DISCUSSIONS :

Total counts did not change significantly from 0- 7 hours but did so by 50% at the end of 24 hours, and 75% by 48 hours. The highest number of cells were observed in colostrum as compared to mature milk.

In both glass and steel the mean total count at zero hour was found to be 2292.90 cells / cu. mm . This reduced to 1730.22 cells / cu. mm in glass and 1512.38 cells /cu. mm in steel i.e. the mean percentage change in total count in steel reduced by 37.58% at the end of 7 hours, whereas in glass container it reduced by only 12.45% (1 / 3rd of steel). This difference is statistically significant ($p < 0.05$).

It was also found that the morphology of all the cells (irrespective of its type) were better retained in glass containers as compared to steel ones.

Adherence patterns or retrieval of cells from container surface was studied by total count and viability count under varied conditions. The disassociation of cells from the container surface has an important bearing on milk storage for milk banking. Glass vessels gave a higher yield of viable cells after 7 hours as compared to steel ones.

All the above experiments lead to the simple inference that glass is the better container of choice for human milk banking. Most interestingly, report of Hopkinson et al (1991) strengthens the present findings. According to them, the common admonition that human milk should not be stored in glass containers was based on an earlier report by Goldblum et al (1981) who reported that leucocyte counts were lower in milk stored in glass containers as compared to polythelene and polypropylene containers. However, later studies that accounted for length of storage and other factors, important to optimal storage conditions, have indicated that glass should be the storage container of choice.

In the present study steel was chosen because it is more commonly used for storage in our country. Here again,by analysis of the various results of Total count, cell viability and adhesion tests it was observed that glass gave a greater percentage of free live cells in suspension after storage of milk. Furthermore, it is known that stainless steel contains about 18% of nickel. This could have some oligodynamic or poisoning effect on live cells, especially when milk is stored for such long periods of 7 hours or so.

Phagocytic functions of macrophages :

1. More than 70% macrophages showed phagocytosis.
2. The phagocytic capability of milk macrophages stored for 7 hours did not decline significantly irrespective of the containers.
3. Optimal ingestion time of yeasts was 30 minutes.
4. The mean phagocytic index of yeast remained almost constant at 6 for macrophages and 4 for neutrophils.

Lymphocytes constituted only 10-15% of total milk cells. 50% of lymphocytes were T cells as judged by E- rosette studies. There was no significant fall in the numbers of T lymphocytes during the time interval of 0-7 hours ($p>0.05$). The lymphocytes were effectively preserved in spite of the physical manipulations they were exposed to in the present study.

The presence of lymphocytes in milk is very significant and useful to the newborn. Goldblum et al (1984) suggested that sensitized lymphocytes from the maternal intestinal tract homed to the mammary gland and provided the infant specific immunologic protection against the potential enteric pathogens.

Humoral studies :

Colostral IgA level was found to be the highest as compared to IgM and IgG levels. The mean levels were as follows :

IG	1ST DAY	4 DAYS LATER
IgA	250-350 mg / dl.	60-113 mg / dl.
IgM	100-200 mg / dl.	40-50 mg / dl.
IgG	0-39 mg / dl.	very less.

An important noting was there was no significant fall in the immunoglobulin levels from 0 to 7 hours irrespective of time, temperature and storage container. The nature and function of IgA is worth mentioning here. IgA present in milk is secretory in nature (11S sIgA). It coats the mucus membranes and protects them by preventing adherence of microorganisms. It also protects by binding viruses and bacteria and preventing them from invading the mucosa.

If milk has to be used for milk banking this aspect of storage, viz., duration and optimal temperature are important variants to influence the safe preservation of IgA.

SUMMARY & CONCLUSIONS :

1. Storing of human milk in refrigerators has minimal detrimental effect on its antibody content, but alters cellular content stability beyond 7 hours.
2. The data also suggests that viability and cell functions though reduced from the time of expression to the time of testing, maintained more than 50% of their baseline values after storage. This indicates that refrigeration for short periods of time offers an effective means of supporting milk cells on storage.
3. By cell viability, total count and cell adhesion studies, glass emerged as the superior container and leads us to prefer such a container for future use in human milk banking.

K A P STUDY ON FAMILY PLANING METHORDS IN A VILLAGE OF BENGAL

* Dr. Ratna Sanyal, M.B., D.G.O. M.D. (O. & G.).
** Dr. Meenakshi Ghosh, M.B., D. G. O. F.R.C.O.G.

ABSTRACT

A study on knowledge, attitude and practice of Family planning methods and its effect on maternal & child health was made in a village of W.B. 22 km. away from Calcutta. The result correlated with different national & international studies. 53.3% women were illiterate, 56.3% girls were married below the age of 18 years. While 26.7% women had 5-10 living children, 44.6% children had not been immunised at all. It was found that 35.5% were keen to accept some method but 64.3% did not accept any method, as a cause of that 68.9% said they did not have enough knowledge. Tubectomy was accepted by highest number of women but unfortunately most of them grande multipara and operation was performed as puerperal ligation when they were admitted to the hospital for deliver.

INTRODUCTION :

Women want better lives for themselves, their children, their family and their community. Family planning is one important way that women can take control of their own lives and make more choices possible. Without choices & without opportunities a person cannot hope for a better future. Although poverty and lack of education often limit choices and opportunity for both men and women in developing world, in general women's choices are specially limited. Family planning can help women meet their need to perform conventional role more effectively. It is unfortunate that women of developing world are lagging behind due to poverty, lack of education and information about contraception. This is clearly reflected in their health as well as their children's health 5, 6.

METHOD & MATERIAL :

This study was undertaken in a village of Bengal, India, known as Banhoogly 22 km. away from Calcutta, the study was aimed at assessment of female education, awareness of FP and its effect on MCH. This village has a population of 11,000, with 764 women at reproductive age. Unfortunately only 493 could be interviewed the rest denied. This was done in collaboration with NGO 'Dhankhet Vidyalaya'. We have prepared questionary and the volunteres of the said NGO interviewed the women. We have analysed the result and organised few group talks with women of that area. It was undertaken between January-March 1988.

ANALYSIS OF RESULTS :

Early marriage is still prevailing in rural Bengal and this is singularly responsible for poor maternal and child health.

Table I - had analysed age at marriage, it was surprising that 56.3% girls were married before 18 years of age and quarter was married before 15 years of age.

Table II - Distribution of income of husband had revealed that 83.2% had an income of Rs. 500/pm i.e. 6000/per anum.

Table III - depicted educational status of both husband and wife the picture was very gloomy, 37.5% of husband and 53.3% of wives were illiterate.

Table IV - gives us an idea of no. of living children per women, it is shocking that 55% of women had 3 or more children and 26.7% had 5 or more children.

* (Associate Professor, Dept. of G. & O., Calcutta National Medical College).
** (Consultant Gynecologist Lohia Matri Seva Sadan, AMWI Mission Hospital, Calcutta.

Immunisation of existing children.

Table V evidenced a poor picture as 44.5% had no immunisation at all. Only 1.6% had been fully immunised.

Distribution of knowledge in Table VI had showed that 44% had no knowledge of FP methods.

Table VII depicted the source of knowledge and it was found that 53.5% learnt it from their friends & only 2.4% received the knowledge from health workers.

Attitude of the women is found in **Table VIII**, we saw that 16.8% only were against accepting any FP method, 35.5% were keen to accept and these comprise of younger educated women.

Table IX showed the FP methods accepted by them. 64.3% did not accept any method, highest number accepted tubectomy (17%). On enquiry it was found that most of the tubectomy accepters were grande multi and they were operated in the puerperium as they were admitted in the hospital for delivery.

Table X - Analysed causes of nonacceptance - it was observed that 68.9% could not accept because they had no knowledge, 13.6% could not accept due to male bias & elder bias.

Table XI revealed the availability of FP material it was reported by 75.9% that contraceptive material was not available to them. The fact may be relevant that the PHC is 10km. from the village and there is no other vehicle but cycle, even that does not run during rainy season.

DISCUSSION :

By enabling a women to control her own fertility and choice of contraception can help meet a woman's practical need in several ways. Safe contraception contributes to good health, when women avoid unwanted pregnancy they avoid the risk of child-bearing or abortion. Family planning programme can demonstrate to the community that women have a right to be informed and their decision to be respected (5, 6). In developing countries 1:50 women die from causes related to childbearing, 20-40% being due to abortion. Important agenda for policies to give women more opportunities are encouraging female education & improving women's health (5).

If we go through last census report of India we will find that two states of Kerala & Tamilandu having high female education have shown a related increase in CPP and reduction in CBR as well as IMR (4, 2). In West Bengal also the district of Bardhaman has high female education rate and it has shown high achievement in CPR and immunisation programme (4). In demographic and Health Survey (5) of different countries in 1986-92 it was found that in countries with contraceptive prevalance more than 40%, median age at marriage was 20.6 whereas countries with less than 40% contraceptive prevalence median age at marriage was 18. Years spent in pregnancy was 2.6 for countries with contraceptive prevalence more than 40% and 4.5 for contraceptive prevalence less than 40%. In our study there were less than 40% acceptance and 56.3% were married below 18 years and 55% had 3 or more children.

It was clearly demonstrated in various studies in post partum programme that low literacy rate with social & cultural bias prevents adequate utilisation of services (3). Our study tallies well with the observation, 53.3% women were illiterate and 68.9% admitted that they did not have enough knowledge about contraceptive. P.P. programme also found out that one cause of failure was inadequate knowledge regarding various objective and functioning of P. P. centre resulting in lack of proper planning & support by service delivery system (3). Our centre was 10 km. from the PHC but only 2.4% were contacted by the health workers. It is a disgrace that 35.5% were keen to accept some method but they could not do so for nonavailability. Important recommendation of International Congress on population & development at Cairo 1994 (3) includes the following :-

1. Principle of voluntary choice.
2. Emphasis on education & voluntary means rather than incentive and disincentive.
3. Provide accessible and complete and accurate information about FP methods.

Role of education in MCH has also been correlated in a study in costa Rica (1). High fertility was higher in population group with poor education, low income & rural area so was our experience. They

have also found teenage pregnancy in 537% cases and in 38% grande multipara the pregnancy was unwanted. In our study 60.6% had no desire for any more child and 56.3% girls were married below 18 years of age.

UNICEF has first drawn attention to female education and FP through GOBIFFF programme (Growth, Oral rehydration, Breast feeding, Immunisation, Family planning, Famale education and food supplementation (5). Unfortunately the 3 F's were eventually omitted in the initial part & so the desired effect was not obtained. Role of female education on child health can easily be detected, if we compare our child immunisation with that of W. Bengal. In our study 44.8% children were not immunised and only 1.6% were fully immunised whereas in 1991-92 W. B. have achieved 89.69% in polio, 87.89% in DPT, 98.29% in BCG and 73.89% in Measles (4).

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TABLE - I

Age of Women at marriage

Age.	No.	%
10-12	18	3.6
13-15	101	20.5
16-17	159	32.2
18-20	182	36.9
21-33	33	6.7
Total	**493**	**99.9**

TABLE - II
Income of the husband

Income (Rs.)	No.	%
Nil	003	0.6
500	410	83.2
500-1000	75	15.2
1001-2000	02	0.4
2000	03	0.6
Total	**493**	**100.00**

TABLE - III
Education

Yr. of Schooling	Husband No.	Husband %	Wife No.	Wife %
Nil.	184	37-5	264	53.5
1-4	195	39.5	142	29
5-10	106	21.5	85	17
Higher	008	1.5	02	00.4
Total	**493**	**100.00**	**493**	**99.9**

TABLE - IV
No. of Living children

Child	No.	%
Nil	47	9.5
1-2	175	35.5
3-4	139	28.2
5-6	78	15.8
7-9	51	10.3
	3	0.6
Total	**493**	**99.9**

TABLE -V
Immunisation fo Children

Immunisation	No.	%
No.	220	44.6
Incom.	265	53.7
Comp.	008	1.6
Total	**493**	**99.9**

TABLE - VI

Knowledge of FP Methods

Knowledge	No.	%
Nil	240	44
Condom	11	02
Pill	110	20.2
CuT	35	6.4
Tubectomy	129	23.7
Vasectomy	03	0.6
Others	17	3.1
Some of them knew more than one.		

TABLE VII

Source of Knowledge

Source	No.	%
None	167	33.9
Friend	263	53.5
H. Worker	14	02.4
Radio	41	08.5
TV	01	00.2
Acceptor	07	1.4

TABLE - VIII

Attitude to contraception

Attitude	No.	%
Against	83	16.8
Neutral	143	29
Hesitant	92	18.7
Keen	175	35.5
Total	**493**	**100.0**

TABLE - IX

Practice of contraception

Method	No.	%
None	317	64.3
condom	3	0.6
Pill	37	7.5
CuT	33	6.7
Tubectomy	84	17.0
Vaesctomy	4	0.8
Others	15	3.0
Total	**493**	**99.9**

TABLE - X

Causes of no-acceptance

Cause	No.	%
No. knowledge	340	68.9
Superstition	20	4.1
Male bias	41	8.3
Elder bias	26	5.3
Gossip	66	13.4
Total	**493**	**100.00**

TABLE - XI

Availability of contraceptive

Availability	No.	%
Not available	374	75.9
Poor quality	59	11.9
Commercial	37	7.5
Can't afford	23	4.7
Total	**493**	**100.0**

XXIV M.W.I.A. CONGRESS

Sao Paulo, BRAZIL, 8-13 October 1998

The important topic "Women's Health in the Twenty-first century" was the focus of a meeting of women physicians world wide who met in the host city of Sao Paulo, Brazil, October 8 through 13, 1998.

This meeting of international importance was sponsored by the XXIV Congress of the Medical Women's International Association (MWIA), the XXIV Congress of the Pan American Medical Women's Alliance (PAMWA), the 1st Latino American Congress of the MWIA, and the XIX Congress of the Brazilian Medical Women's Association.

On the threshold of the third millennium, it is particularly proper that women physicians of the world gather together to address women's health for the future. The rich scientific program was presented in lectures, thematic roundtables, workshops and plenary sessions. The official languages were portuguese, Spanish and English with simultaneous translation.

Opportunities for personal networking and collaborations and information exchange were ample and appreciated by the participants.

The meeting was opened by a ceremony and official welcome at the Sao Paulo legislative assembly chambers, a fact attesting to the respect and recognition accorded women physicians of the world.

The objective of this meeting was clearly stated "To discuss the importance of improving the health of women as the primary strategy to improve the health of the population in general and the development of a country and its people".

Dr. J. Jhirad Oration was delivered by Dr. Lila Stein KROSER then president elect of M. W. I. A. and now president, on "Challenges of M. W. I. A. in coming millenium" Dr. Tulsi Basu gave a short C.V. of Late Dr. Jhirad before oration and perhaps this is first time quite a few female pysicians came to shake hands, that they had not known such a jewish Indian doctor and existed. Silver plaque was presented to Dr. Lila Kroser, with standing ovation in memory of Dr. Jerusha Jhirad.

The scientific presentations were organized around the topics of "Postpartum Maternal Morbidity", presented by Dr. Florence Manguyu, president of MWIA, and the "Patient and the Tecnology of Modern Medicine" presented by professor Dr. Luis Venere Decourt, Emeritus professor of the Sao Paulo Medical School. Other papers were organized under eight medical subthemes; internal medicine, surgery, anaesthesiology, pediatrics, alternative medicine, infectious diseases, psychiatry and neurology, gynecology and obstetrics. Discussions were animated, inclusive and wide ranging and incorporated the status of women physicians and the profound impact of politics on the health of women.

Dr. Basu chaired round table on "Clinical Surgery and Anaesthesia" and presented a paper "UN FAIR HEALTH IN FAIR SEX".

In plenary sessions nineteen resolutions and three bylaws changes were discussed and adopted by vote of the membership. Additionally, two position statements were presented and adopted. One statement condemned the actions in Afghanistan that endanger women and forbid women physicians there to practise, and the other condemned traditions and customs that harm women and violate their human rights in countries where such traditional practices exist.

In business sessions, election of officers were held. Dr. Lila Stein Kroser of U.S.A. was inaugurated president, Dr. Shelley Ross (Canada) President-Elect., Dr. Waltraud Diekhaus (Germany) Secretary General and Dr. Cajsa Rangniti (Sweden) Treasurer. In addition 8 regional Vice-Presidents were chosen. In the closing ceremony Drs. Dorothy Ward and Carolyn Matzel were awarded honorary membership.

5 new National Associations were welcomed to MWIA, namely, Argentina, Hungary, Mexico, Nicaragua and Panama. The membership of 21 individual members from 14 countries was ratified by the General Assembly.

Dr. Kroser expressed satisfaction in the fact and generous communication and showed un1erstanding of goals that transcends diversity. The focus of her presidency will be to promote and serve women's health now and in the future.

In April 2001 the MWIA will hold their next congress in Sydney, Australia.

MWIAS contribution towards AMWI MISSION HOSPITAL :

MWIA helped and AMWI is grateful, to American Medical Women Association the Chair Dr. Rubin Robertina executive secretary MARIE Glanz for their yearly donation to Mission Hospital. AMWI are also grateful to Dr. YOKO Hashimoto of Japan, Doctors from Italy, Mrs Barbara Francis from England.

AMWI (W.B.) is grateful to MWIA Secretariat especially Dr. Casper Chair Person of young forum Dr. Corolun Motzel and Dr. Hannah Sanders for funding Mission Hospital and sanctiong project.

For all the funding and donations etc. were through the kind offices of Dr. Lila Stein Kroser.

Dr. Gaye Casper has not only helped by young forum donation but off and on sending some useful medical equipments from Australia.

The AMWI Mission Mospital has been receiving donation from Lutheran World Service, the Menonites the ARMENIAN CHURCH and many private donars and expresses its gratefulness to all of them.

DR. TULSI BASU

ASSOCIATION OF MEDICAL WOMEN IN INDIA

Registration No. E 1567 (B)

Balance Sheet as on 31st March 1995

Funds & Liabilities	Rs.	Rs.
Capital Fund		
Balance as per last Balance Sheet		6,447.52
Conference Fund		
Balance as per last Balance Sheet	5,959.98	
Add : Bank interest	2,070.34	
	8,030.32	
Less : Bank Charges	154.00	7,876.32
Golden Jublee Fund		
Balance as per last Balance Sheet	42,995.82	
Add : Bank interest	1,700.08	44,695.90
Diamond Jubilee fund		
Balance as per last Balance Sheet	12,572.08	
Add : Bank interest	1,163.19	13,735.27
Building Fund		
Balance as per last Balance Sheet		6,505.00
Life Membership		
Balance as per last Balance Sheet		9,389.00
Liabilities for expenses		2,750.00
Advances from Trustees		200.00
		91,599.01

Properties and Assets	Rs.	Rs.
Furniture		
Balance as per last Balance Sheet	3,212.00	
Less : Depreciation @ 10%	321.20	2,890.80
Capital fund investment account		
Balance with Grindlays Bank A/c. 3240	—	
Fixed Deposit with Central Bank of India	2,500.00	2,500.00
Conference fund investment Account		
Balance with Grindlays Bank A/c. 3241	12,286.14	
Fixed Deposit with Grindlays Bank	15,000.00	27,286.14
Golden Jubilee fund investment A/c.		
Fixed Deposit with Central Bank of India	15000.00	
Balance with Central Bank A/c. 40285	5,184.64	20,184.64
Diamond Jubilee fund investment A/c.		
Fixed Deposit with Central Bank of India		10,000.00
Cash & Bank Balance		
Fixed Deposit with Central Bank of India	6,500.00	
Current A/c. with Grindlays A/c. 12378	—	
S.B. with Central Bank A/c. 16585	7,004.77	
Cash on hand	40.00	13,544.77
Income & Expenditure Account		
Deficit during the year	19,936.11	
Less : Balance as per last Balance Sheet	4,743.45	15,192.66
		91,599.01

As per our report of even date

The above Balance sheet to the best of my lour belief contains a true account of the property & assets to the Trust.

Place : Bombay
Dated : 9 March 1996

Sd/- Atul N. Kulkarni
Chartered Accountants
Auditors

Mehroo S. Pardiwalla
Trustees

D. S. Dalal
Trustees

ASSOCIATION OF MEDICAL WOMEN IN INDIA

Registration No. E 1567 (B)

Income & Expenditure Account for the year ended on 31.03.95

Expenditure	Rs.	Rs.
To **Establishment Expenses**		
Bank Charges	142.00	
Miscellaneous expenses	525.00	
Typing charges	700.00	
Postage & Telegram	930.00	2,297.00
To Professional fees		250.00
To Audit fees		1,000.00
To Depreciation		321.20
To Affiliation fees		35,335.00
		39,203.20

Income	Rs.	Rs.
By **Interest on Bank Account**		
S.B. interest	851.25	
Interest on Bank FDR	905.84	1,757.09
By **Income from other sources**		
Affiliation fees		17,510.00
By Deficit carried over to Balance Sheet		19,936.11
		39,203.20

As per our report of even date

Sd/- Atul N. Kulkarni
Chartered Accountants
Auditors

Mehroo S. Pardiwalla
Trustees

D. S. Dalal
Trustees

Place : Bombay
Dated : 9 March 1996

ASSOCIATION OF MEDICAL WOMEN IN INDIA

ASSOCIATION OF MEDICAL WOMEN IN INDIA

Registration No. E 1567 (B)

Balance Sheet as on 31st March, 1996

Funds & Liabilities	Rs.	Rs.
Capital Fund		
Balance as per last Balance Sheet		6,447.52
Conference Fund		
Balance as per last Balance Sheet	7,876.32	
Add : Bank interest	2,135.66	
	10,011.98	
Less : Bank Charges	—	10,011.98
Golden Jublee Fund		
Balance as per last Balance Sheet	44,695.90	
Add : Bank interest	1,885.88	46,581.78
Diamond Jubilee fund		
Balance as per last Balance Sheet	13,735.27	
Add : Bank interest	—	13,735.27
Building Fund		
Balance as per last Balance Sheet		6,505.00
Life Membership		
Balance as per last Balance Sheet		9,389.00
Liabilities for expenses		2,750.00
Advances from Trustees		200.00
		95,620.55

Properties and Assets	Rs.	Rs.
Furniture		
Balance as per last Balance Sheet	2,890.80	
Less : Depreciation @ 10%	289.80	2,601.00
Capital fund investment account		
Fixed Deposit with Central Bank of India		2,500.00
Conference fund investment Account		
Balance with Grindlays Bank A/c. 3241	9,680.80	
Fixed Deposit with Grindlays Bank	15,000.00	24,680.80
Golden Jubilee fund investment A/c.		
Fixed Deposit with Central Bank of India	15,000.00	
Balance with Central Bank A/c. 40285	2,070.52	17,070.52
Diamond Jubilee fund investment A/c.		
Fixed Deposit with Central Bank of India		10,000.00
Cash & Bank Balance		
Fixed Deposit with Central Bank of India	11,500.00	
S.B. with Central Bank A/c. 16585	1,047.76	
Cash on hand	40.00	12,587.76
Income & Expenditure Account		
Deficit during the year	10,987.81	
Add : Balance as per last Balance Sheet	15,192.66	26,180.47
		95,620.55

As per our report of even date

The above Balance sheet to the best of my lour belief contains a true account of the property & assets to the Trust.

Sd/- Atul N. Kulkarni
Chartered Accountants
Auditors

Mehroo S. Pardiwalla
Trustees

D. S. Dalal
Trustees

Place : Bombay
Dated :18 Feb 1997

ASSOCIATION OF MEDICAL WOMEN IN INDIA

Registration No. E 1567 (B)

Income & Expenditure Account for the year ended on 31.03.96

Expenditure		Rs.	Rs.
To	Establishment Expenses		
	Bank Charges	100.00	
	Miscellaneous expenses	—	
	Typing charges	700.00	
	Postage & Telegram	330.00	1,100.00
To	Professional fees		250.00
To	Audit fees		1,000.00
To	Depreciation		289.80
To	Rent		720.00
To	Printing & Stationery		165.00
To	Contribution to Medical Women's International Association		33,741.00
			37,265.80

Income		Rs.	Rs.
By	Interest on Bank Account		
	S.B. interest	128.00	
	Interest on Bank FDR	2,049.99	2,177.99
By	Income from other sources		
	Affiliation fees		24,100.00
By	Deficit carried over to Balance Sheet		10,987.81
			37,265.80

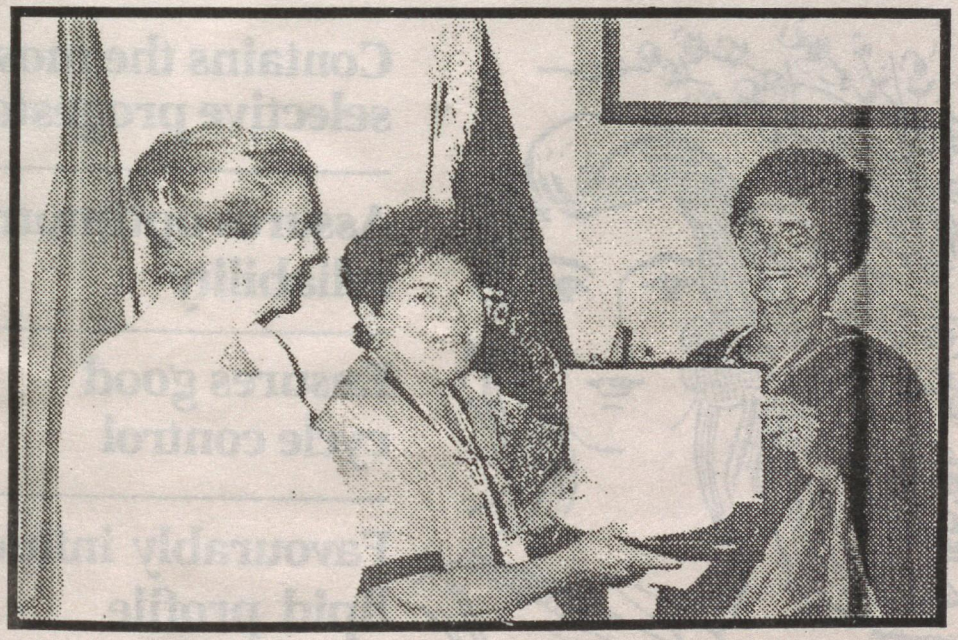
As per our report of even date

Sd/- Atul N. Kulkarni
Chartered Accountants
Auditors

Place : Bombay
Dated : 18 Feb 1997

Mehroo S. Pardiwalla
Trustees

D. S. Dalal
Trustees



DR. JHIRAD ORATION SILVER PLAQUE
being presented to Dr. LILA S. KROSER,
President, Medical Women International Association
by Dr. TULSI BASU.

Dr. MOTZEL, Ex - Secretary General M.W.I.A.
on left of DR. KROSER.

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