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OBESITY IN PREGNANCY

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Obesity is a growing health pandemic. World Health Organisation (WHO) defines obesity as abnormal or excessive fat accumulation that may impair health with body mass index (BMI) of 30 kg/m² or more. Prevalence of obesity is increasing across the globe, with current estimates of 20–36% seen in women of reproductive age.

Effect of Obesity on Pregnancy and Newborn

Increasing BMI which is higher than the normal range is associated with more complications to the mother and the baby with rising morbidity and mortality rates. Higher gestational weight gain also leads to certain rise in the complications.

Maternal Complications due to obesity

Period	Problem/Complication
Pre-pregnancy	Infertility Rise in Non-communicable diseases
First Trimester	Miscarriage Eating disorders
Late Trimesters (2nd and 3rd)	Hypertension Gestational diabetes mellitus (GDM) Venous thromboembolism (VTE) Psychological issues Prolonged Pregnancy
Intrapartum	Preterm Birth Increase incidence of Induction of Labour. Failed Induction. Shoulder Dystocia Rising Instrumental Delivery Caesarean Deliveries Increase. Caesarean time and complications. Increase Anesthetic Complications
Postpartum	PPH Wound infection
Puerperium	Postnatal Depression Breastfeeding challenges

Fetal Complications due to obesity

Period	Problem/Complication
Pregnancy	Congenital Malformations. Difficulties in Fetal surveillance. Macrosomia/ LGA. Stillbirth. Shoulder Dystocia. Fetal Distress
Postnatal	Preterm Birth. Jaundice Hypoglycemia Respiratory Distress NICU Admission Neonatal Death
Long Term Complications	Childhood obesity. Metabolic syndrome (DM, Obesity) Neurodevelopmental differences

Women who have rise in BMI of around 2 units from one have increased risk of gestational hypertension, GDM or LGA by 20–40%. Likewise Preconception weight loss of at least 3–5% of body weight with stabilization can help in reducing the metabolic derangements like Sugar levels, Triglycerides, etc. Weight loss increases the chances of successful vaginal birth after caesarean (VBAC) section.

Pre conceptional folic acid supplementation of 5 mg/day at least one month prior is recommended.

Weight Gain

There is lack of consensus on optimal weight gain.

Rather, focus should be on healthy diet. (GCP)

Current Institute of Medicine (IoM 2009) guidelines for weight management in pregnancy should be known.

BMI (kg/m ²) (WHO) ¹	Classification	Singleton pregnancy Total weight gain range	Rates of weight gain in 2nd & 3rd trimester (kg/week)
< 18.5	Underweight	12.5-18 kg	0.51 (0.44-0.58)
18.5-24.9	Normal	11.5-16 kg	0.42 (0.35-0.50)
25-29.9	Overweight	6.8-11.3 kg	0.28(0.23-0.33)
30	Obese	5-9 kg	0.22 (0.17-0.27)

Provisional weight gain for multiple pregnancies is 17-25 kg for normal weight, 14-23 kg for overweight and 11-19 kg for obese women at term

as per FIGO committee recommendations as well, weight gain should be limited to 5-9 kg.

These women are at higher risk for venous thromboembolism, pulmonary embolism and in them weight based dosing of LMWH is recommended.

For BP measurement, appropriate size cuff use is very important. The cuff size should be documented in medical records. (level C)

Large cuff of bladder width 16 cm should be used for arm circumference > 34 to 44 cm and bladder of 20cm for arm circumference 45-52 cm should be used.

Risk of pre-eclampsia is increased with obesity >type II. (level B)

Tablet aspirin 150 mg daily starting at 12 weeks may be offered to women with more than one moderate risk factor like BMI > 35kg/ m², 1st pregnancy, maternal age >40, multiple pregnancy, family history of PE. (level B)

The risk of 'no result' with NIPT is increased. (consensus-based recommendation)

In pregnant women with obesity, influenza and COVID 19 vaccination are strongly recommended. (consensus-based recommendation)

Increased anesthesia risks with obesity in pregnancy include difficulties with airway management, difficult bag mask ventilation, failed intubation, higher risk of desaturation and postoperative atelectasis. (evidence level 2-)

The risk of stillbirth is slightly increased. (level D)

In obese women, elective induction of labour may reduce chance of cesarean birth without increase in risk of adverse outcomes. (level B)

Progress of labour is delayed in obese patients. Incidence of still birth is higher in obese gravidas compared to normal weight gravidas.

It is recommended to allow longer first stage of labour before performing caesarean section (Level B)

Electronic fetal monitoring in active labour to be considered. (Level C)

Obesity in pregnancy is a unique condition which multiplies risk of maternal/ fetal complications manifold. Besides recognising and addressing obesity before onset of pregnancy can optimise outcomes. Hence this issue should be recognised and discussed in various public awareness activities.



IMPORTANT VACCINE SCHEDULE IN ADULTS

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The recent 2019 Covid pandemic, reminded the world, that despite extensive understanding and advanced managements of pathogens, infectious diseases are still capable of causing immense damage to mankind. Vaccine preventable diseases, continue to be a significant public health problem 1,2, especially in Low middle income countries, like India. With increase in average life expectancies worldwide, the burden of vaccine preventable diseases (VPDs) is shifting to older individuals 3. So, protecting the adult population against communicable diseases becomes equally important.

Unlike universal paediatric immunisation, adult immunisation is selective, is dependent on the person's previous immunisation status, is different for different target groups and varies from region to region.

Adult immunisation boosts immunity, helps in creating herd immunity thereby helping in disease control or elimination efforts. Lastly it takes care of specific risks such as travel, high risk behaviour and immunocompromised state.

According to the various major guidelines adult vaccination is recommended according to the following categories 4,5,6

Vaccines recommended for all healthy adults- These are Covid 19, DPT, MMR, Influenza (>50 years plus all pregnant women), Pneumococcal (>65 years), HPV (9-26 years) and Zoster (>60 years)

Vaccines recommended for high-risk individuals - Hep B, Hep A, Meningococcal, HiB (Hemophilus influenza B), Typhoid, Rabies, Cholera and Japanese Encephalitis (only in special circumstances)

Vaccines recommended for all susceptible health care workers - Hep B, Influenza, MMR, Varicella, Tdap

Vaccines recommended for all pregnant women - Women of child bearing age should be vaccinated for Hepatitis B, Varicella, MMR, HPV and Influenza pre pregnancy. Avoid conception for at least 4 weeks after MMR or Varicella vaccine.

Pregnant women are recommended to have one dose of Td (tetanus and diphtheria) early in pregnancy, followed by second dose 4 weeks after Td1, or only one Td Booster if pregnancy occurs within 3 years of last pregnancy and 2 Tds were received in previous pregnancy. Second Td or Td booster may be replaced by Tdap through 27 to 36 weeks.

Influenza vaccine is given after 26 weeks. If risk of Flu is high as during an epidemic, Flu vaccine may be given earlier in pregnancy. Pregnant women at risk for exposure to wild type poliovirus can be given IPV. Pregnant women travelling to yellow fever prevalent areas may be vaccinated after adequate counselling. Hep B can be administered when indicated. MMR or varicella is contraindicated during pregnancy, however if given accidentally should **not** be an indication for termination

All vaccines except typhoid and yellow fever can be given as catchup immunization during lactation

Vaccines recommended for travellers

Mostly governed by the requirements of the country of destination (eg Yellow fever and meningococcal vaccination is a mandate for Hajj pilgrims travelling to Saudi Arabia)

Vaccinations advised for all adults and those in special situations have been tabulated.

Immunisation for all adults with normal immune status.

Vaccine	Group	Immunised	Not immunised	Vaccine and dose
COVID-19	Universal	Single dose Second dose for > 65 years 4 months after 1st dose of Bivalent vaccine	Single dose Second dose for > 65 years 4 months after 1st dose of Bivalent vaccine	Monovalent/Bivalent 0.3 ml IM into deltoid
Td/Tdap (Tetanus, Diphtheria, and Acellular pertussis)	Universal unless contraindicated*, including pregnant women as per schedule in pregnancy	18-64 years, booster dose of Td vaccine once every 10 years till the age of 65 years, in case of major trauma, give Td/Tdap plus immunoglobulin (if immunised > 5years ago)	3 doses of Td vaccine, 2 doses are given 4 weeks apart, 3rd dose, 6-12 months after 2nd dose. In case of minor trauma, give Tdap if not immunised or immunised > 10 years ago) In case of major trauma, give Td/Tdap plus immunoglobulin	0.5ml IM anterolateral thigh or deltoid
MMR	Recommended in adults but contraindicated in pregnancy and immunocompromised conditions	Not indicated	Single dose, women to defer pregnancy for 4 weeks after injection	Live vaccine 0.5 ml SC (Subcutaneous)
Influenza	Recommended for all including pregnant women and high risk +	One dose every year through Oct to May	One dose every year through Oct to May	Inactivated 0.5 ml IM in anterolateral thigh or deltoid LAIV: nasal spray into each nostril
Pneumococcus	For all > 65 years < 65 years at high risk@	Single dose PPSV repeated after 5 years for at risk	Single dose PCV 13 followed by PPSV after 8 weeks for at risk	0.5ml IM in anterolateral thigh or deltoid
Varicella	For all who are not immune	Booster doses are not needed if titres are adequate	Two doses given 4-8 weeks apart	Attenuated live 2 doses 0.5ml in deltoid area SC
HPV(Human Papilloma Virus)	For young adults 15-26 years	For adults who are already immunised with 2 doses in childhood (9-15 years) booster is not needed	For 15-26 years, 3 doses at 0,1, and 6 months. Women are advised to avoid pregnancy for 4 weeks after vaccination.	0.5 ml IM in deltoid muscle
Zoster	In > 60 years	Single dose	Single dose	0.65ml SC on deltoid

* Tdap / Td is contraindicated in persons with a history of anaphylaxis to any component, Tdap is contraindicated in any situation of neurological or acute illness.

+high-risk subjects for receiving Flu vaccine include those with chronic medical, especially respiratory disease, metabolic diseases, pregnancy, health care personnels, household contacts of children, elderly > 50 years, and immunosuppressed individuals.

@ High-risk adults through 19-64 years for Pneumococcal vaccine include those with chronic illness (CKD, liver, heart or lung ds), immunocompromised states (HIV, cancer or absent spleen), people with cochlear implants and cigarette smokers

Immunisation for adults in special situations

	Risk groups	Immunised	Not immunised	Vaccine and dose
Hepatitis A*	At risk	Single dose if high risk	2 doses , 0 and 6 months	Inactivated 0.5ml IM Live 0.5ml SC
Hepatitis B@	At high risk	Not indicated	3 doses, 0, 1, and 6 months	Recombinant and plasma derived 1ml(20 microgram) IM anterolateral thigh or deltoid, never in gluteal region
Combined Hep A and Hep B	At high risk	Not indicated	3 doses, 0, 1, and 6 months alternatively, a 4-dose schedule, administered on days 0, 7, and 21 to 30 followed by a booster dose at month 12 may be used.	
Meningococcal	Not recommended routinely High risk travellers(eg Hajj) and during epidemic	Single dose for non high risk	2 doses 4 weeks apart in high risk single dose for non high risk	Purified bacterial capsular polysaccharide and conjugated vaccine 0.5 ml administered IM
HiB(hemophilus influenza B)	At risk	Single dose of HiB in high risk	Single dose of HiB in high risk Immunisation for adults in special situations	Polyribose antigen or outer membrane protein with tetanus toxoid conjugate or diphtheria protein carrier 0.5ml IM anterolateral thigh or deltoid
Rabies	Pre exposure only for high risk groups, otherwise indicated post exposure	Preexposure for high risk. For those immunised 0 and 3rd day, no immunoglobulin needed	Pre exposure two doses 0 and 7 day. Post exposure 0,3,7,14 and 28 days with RIG(Rabies immunoglobulin) / Rabies monoclonal antibody over deltoid	Human diploid cell vaccine, (1 ml IM) purified chick embryo cell vaccine(0.1ml ID) and purified duck embryo vaccine 1ml im on thigh or deltoid 0.5ml IM for purified verocell vaccine
CholeraS	High risk patients Not useful during an outbreak	For high risk 2 separate doses, 2 weeks apart , 1 week prior to exposure	For high risk 2 separate doses, 2 weeks apart , 1 week prior to exposure	bivalent inactivated whole cell containing 2 serotypes ready to use liquid orally
Typhoid +	High risk travellers or outbreak	If immunised booster every 3 years	Three doses of typhoid 21 a capsules/sachets are administered on alternate days series repeated once in every 3 years as booster dose	Vi vaccine single SC/IM 0.5ml anterolateral thigh or deltoid
Zoster	In > 60 years	Single dose	Single dose	0.65ml SC on deltoid
	Those who did not have chickenpox	Booster doses are not needed if titres are adequate	To 8 weeks apart	Attenuated live 2 doses 0.5ml in deltoid area SC
Japanese encephalitis#	Not routine	Single dose		Inactivated vero cell, mouse cell IM or live attenuated or live recombinant 0.5ml SC
Polio	Adults travelling to polio infected countries	Single dose of IPV	3dosesof IPV, 2 doses 2 months apart followed by 3rd dose 6 months of the previous dose	Inactivated polio vaccine 0.5ml IM anterolateral thigh

*HepatitisA: Vaccination is advised for persons with chronic liver disease, men who have sex with men, persons who use illegal drugs, persons infected with other hepatitis virus, persons who receive clotting factor concentrates, liver transplant recipients, food handlers.

@Hep B Indications of hepatitis B vaccination in Indian adults include adults who are at high risk of exposure via percutaneous, mucosal, intravenous or sexual contact.

Prevaccination screening in general population has not been found to be cost-effective in India.

+Typhoid Ty21a should not be used during pregnancy.

#Japanese Encephalitis: Women are advised against pregnancy for 3 months after vaccination

\$Cholera: High risk include people living in or travelling to, pilgrimages, fairs, and kumbh melas

Conclusion: Adult vaccination is a cost-effective method of preventing morbidity and mortality from vaccine preventable diseases. Creating more awareness regarding the availability and practice for Adult Vaccination schedules can go a long way in ensuring Public Health as regards Infectious diseases.

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VIOLENCE AGAINST WOMEN - ROLE AND SCOPE OF GYNECOLOGISTS

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WHAT IS VAW

Violence against women (VAW) is a grave condition with serious effects on women's lives and health and a gross human rights violation.

United Nations defines VAW as "Any act of gender- based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private".

How Common is VAW?

Worldwide 736 million women, that is 1 in 3 women are subjected to physical and/or sexual Violence by Partner, sexual violence by others, or both at least once in their life.

Out of 81000 homicides, 47000 died at the hands of an intimate partner or a family member, which equals to a woman or girl being killed every 11 minutes in their home. *

The Roots of VAW

- Toxic Masculinity
- Gender Bias Patriarchal Society -
- Gender Stereotyping.

VAW is manifested in various types– Intimate Partner Violence -IPV, Domestic Violence -Violence in the home by family members, partners, Sexual Violence by partner or others, honour killing, feticide, female genital mutilation, Sexual assault, rape, eve teasing, bullying, cybercrimes, online abuse, voyeurism, etc. The various forms are physical, emotional, sexual, verbal, social economic and spiritual. The cycle of abuse is known to occur throughout the life span of a woman, starting from prebirth sex selection to various forms throughout her life. The spectrum of health effects due to violence are manifold and grave in nature⁶. IPV-Intimate Partner Violence and effects on maternal and women's health across life span is shown in fig -1 6(Pathways and health effects of intimate partner violence. Source: World Health Organization, London School of Hygiene and Tropical Medicine (LSHTM), and the South African Medical Research Council (2013).)

42% of women experience injuries, twice as likely to suffer from depression, twice likely to have alcohol abuse ,4.5 times more likely to attempt suicide,1.5times more likely to have HIV infection, two times more likely to have an abortion, 16% increased incidence of low-birth-weight baby. Its unbelievable but true that data shows that 38% of all murders/homicides by women are committed by intimate partners.

Why Gynecologists need to know and Talk about VAW?

Most of the Serious health problems of women are rooted in violence.

Serious health problems during pregnancy have roots in violence.

The OBG specialists are the PRIMARY CARE GIVERS and FIRST POINT OF CONTACT for Women's Health Issues in their Lifetime.

Women are likely to disclose Violence / Abuse with them.

The OBG specialist, if trained and sensitized can identify, give first aid, treat, refer, and collect evidence of the survivors of Violence who approach them.

Types of VAW: Physical Violence: *Acid Attacks, Honour Killings, Femicide, Sexual Violence*

Psychological Violence: Financial Manipulation, Emotional Abuse, Bullying, Stalking, Eve Teasing, Criminal Intimidation

Combination: *Domestic Violence*

How to Address VAW in your Clinic

1. Do no harm.
2. Identify violence, if necessary, by Clinical inquiry
3. Empathetic response
4. Clinical care
5. Referrals as needed.
6. Documentation
7. Medico-legal evidence
8. Advocacy as community role models

Protection by Law:

- **Acid Attack Attempt:**
Section 326B IPC, imprisonment 5 -7years and or fine
- **Acid Attack:**
Section 326A IPC imprisonment of not less than 10 years, to life, Fine to meet the medical expenses of victim.
- **Sexual Assault:**
Section 354 IPC, with 1-5 years and a fine, Nirbhaya Act, 2013, Section 375 IPC -against Rape
Section 354 A IPC against Sexual harassment and unwanted physical contact,
- **POCSO Act 2012** protects minors from sexual abuse. Stalking:
Section 354D IPC imprisonment for 1-3 years, and liable to fine.
- **Voyeurism:**
Section 354C IPC, imprisonment for 1-3 years on first conviction, 3-7years for more.
- **Eve teasing:**
Section 294 for a maximum of 3 months.

- **Sexism**

Section 509 IPC punishes men who acts or uses an object to insult a woman with jail term for up to 3 years.

- **Criminal Intimidation:**

Section 503 IPC -imprisonment for up to 2 years, or a fine, or both.

- **Sexual Harassment:**

Section 354A IPC- up to 3 years of imprisonment.

- **Domestic Violence:**

Domestic Violence Act 2005 covers physical, sexual, verbal, and economic abuse, grants immediate protection, Punishes the abuser with imprisonment upto 3 years.

How to prevent/ stop VAW-

1. Believe the victim, don't blame the victim- Listen Believe and Support.
2. If you see the distress signal: check in with the person safely to find out what they need and what you can do,
3. If you find a threat of danger call the local police and the helplines.
Be an active "Bystander": 5Ds: You may Distract, Delay, Delegate, Document and Direct.
4. Never publicize another person's traumatic experience or never share footage or images on social media, this is no way going to help.
5. Only intervene, if it's safe for you to do so, if not safe, call the police or the Child Helpline.V

Whom To Contact?? Helpline Numbers:

India Women Helpline-Women in Distress: 1091

1. Women's Domestic Abuse Helpline: 181
2. National Commission for Women: 011-26942369, 011-26944754
3. Child helpline: 1098
4. Police: 100
5. Local bodies: NGOs, Police Station
6. Local City Helpline Numbers should be found and shared with Groups/ Schools.

**IOLENCE AGAINST WOMEN IS A SOCIAL, EVIL WITH HUGE IMPACT ON WOMEN'S HEALTH.
LET'S VOW TO ERATDICATE VAW.**



NATIONAL PROGRAMS FOR MATERNAL SAFETY IN INDIA

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India is a vast and diverse country with significant variations in healthcare access and infrastructure across different regions.

India has made considerable progress in reducing maternal mortality over the years, but the MMR still remained relatively high compared to developed countries. As of 2017-2019, the estimated MMR was 113 deaths per 100,000 live births, which accounted for a significant portion of global maternal deaths. The trend in maternal mortality showed a decline over the past few decades, but progress was uneven across states. Some states and regions experienced greater improvements, while others lagged behind in reducing maternal deaths.

National Maternal Health Programs

India has implemented several programs and initiatives to improve maternal safety and reduce maternal mortality. These programs aim to enhance access to quality maternal healthcare, promote institutional deliveries, and address the underlying factors that contribute to maternal health issues. Here are some of the key programs for maternal safety in India:

1. **Janani Suraksha Yojana (JSY):**
 - JSY is one of the flagship programs of the Government of India aimed at promoting institutional deliveries and reducing maternal and neonatal mortality.
 - Under this scheme, pregnant women from economically disadvantaged backgrounds are provided financial assistance to encourage them to deliver in healthcare facilities.
2. **Pradhan Mantri SurakshitMatritva Abhiyan (PMSMA):**
 - PMSMA, launched in 2016, aims to provide comprehensive antenatal care to pregnant women, especially those in rural and underserved areas.
 - On the 9th of every month, pregnant women can avail of free antenatal check-ups at government healthcare facilities.
3. **National Health Mission (NHM):**
 - NHM is a comprehensive program that encompasses various initiatives, including the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) strategy.
 - RMNCH+A focuses on improving maternal and child health by providing essential healthcare services and promoting behavior change in communities.
4. **Janani Shishu Suraksha Karyakram (JSSK):**
 - JSSK, launched under the NHM, aims to eliminate out-of-pocket expenses for pregnant women and newborns.
 - It provides free and cashless services to pregnant women, including free delivery, drugs, diagnostics, and postnatal care, and free transport to healthcare facilities.
5. **Rashtriya Bal SwasthyaKaryakram (RBSK):**
 - While primarily focused on child health, RBSK also aims to identify high-risk pregnancies and ensure timely referral and appropriate care to pregnant women.
6. **Maternal Death Surveillance and Response (MDSR):**
 - MDSR is a data-driven approach to review and respond to maternal deaths systematically.
 - The program aims to identify the causes of maternal deaths and implement interventions to prevent future deaths.
7. **National Iron+ Initiative:**
 - Anemia is a significant health concern for pregnant women in India. The National Iron+ Initiative aims to provide iron and folic acid supplementation to pregnant women to prevent and manage anemia.

8. Urban Health Mission:

- The Urban Health Mission focuses on improving healthcare services in urban areas, including maternal health services.
- It aims to increase institutional deliveries and improve the overall health of women and children in urban settings.

9. ASHA (Accredited Social Health Activist) Scheme:

- ASHAs are community health workers who play a vital role in promoting maternal and child health at the grassroots level.
- They facilitate awareness, mobilization, and uptake of maternal health services in the community.

These programs, among others, have contributed to significant improvements in maternal health indicators in India. There have been further developments in maternal health programs in India beyond my last update. For the latest information, it is essential to refer to official government sources and reports.

MNCH+A) strategy, which aims to improve the health and well-being of women and children across the country.

LaQshya Program of GOI

LaQshya (meaning "New Beginning" in Hindi) is a program initiated by the Government of India (GOI) to improve the quality of care in labor rooms and maternity operation theaters in public health facilities. The primary focus of the LaQshya program is to enhance the quality and safety of care provided during childbirth, with the aim of reducing maternal and newborn mortality and morbidity. Key features and components of the LaQshya program include:

1. Objective:

- The main objective of the LaQshya program is to ensure that all public health facilities providing labor and delivery services meet defined standards of quality care.
- The program seeks to promote a positive birth experience for mothers and improved health outcomes for newborns.

2. Focus Areas:

- The program emphasizes specific areas of improvement, including infection prevention, hygiene, early recognition of complications, and timely and appropriate management of complications during childbirth.

3. Quality Standards:

- The program sets clear and measurable quality standards for labor rooms and maternity operation theaters in public health facilities.
- These standards encompass infrastructure, equipment, human resources, clinical protocols, and hygiene practices.

4. Capacity Building and Training:

- Healthcare staff, including doctors, nurses, and support staff, receive training and capacity building to improve their skills in providing quality care during childbirth.
- Training focuses on emergency obstetric care, infection prevention, and maternal and newborn resuscitation.

5. Monitoring and Feedback Mechanism:

- LaQshya incorporates a robust monitoring and feedback mechanism to assess the progress and performance of healthcare facilities against established quality standards.
- Regular monitoring helps identify areas for improvement and corrective actions.

6. Incentive-Based Approach:

- The LaQshya program adopts an incentive-based approach to encourage healthcare facilities to improve the quality of care.
- Facilities that meet the defined quality standards are eligible for financial incentives.

Conclusion

Maternal health is a critical aspect of public health, and efforts to improve maternal safety and reduce maternal mortality are of utmost importance. National programs and initiatives play a significant role in addressing the challenges faced by pregnant women and ensuring that they receive appropriate and timely healthcare services. National programs for maternal safety, such as the ones implemented in India, are multifaceted endeavors that require collaboration among government agencies, healthcare institutions, and various stakeholders. By addressing the root causes of maternal mortality, enhancing access to quality maternal healthcare, and promoting awareness, these programs can bring about positive changes in maternal health indicators and ultimately save lives.

HOW TO COMMUNICATE ABOUT SEX EDUCATION TO SCHOOL AND COLLEGE STUDENTS

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We as obgyn should support broad access to comprehensive sex education, wherein all children and adolescents have access to developmentally appropriate, evidence-based education that provides the knowledge they need to:

- Develop a safe and positive view of sexuality.
- Build healthy relationships.
- Make informed, safe, positive choices about their sexuality and sexual health.

Comprehensive sex education involves teaching about all aspects of human sexuality, including:

- Anatomy.
- Consent & Sexual abuse.
- Cyber solicitation/bullying.
- Healthy sexual development & Interpersonal relationships.
- Body image.
- Sexual orientation & Behavior.
- Gender identity.
- Pleasure from sex.
- Sexual reproduction & Abstinence.
- Sexually transmitted infections (STIs) & Contraception.
- Reproductive rights, responsibilities & coercion.

Comprehensive sex education programs have several common elements:

- Utilize evidence-based, medically accurate curriculum that can be adapted for youth with disabilities.
- Employ developmentally appropriate information, learning strategies, teaching methods, and materials.
- Provide basic functional knowledge around 6 key topics:
 - Human development, including anatomy, puberty, body image, sexual orientation, and gender identity.
 - Relationships, including families, peers, dating, marriage, and raising children.
 - Personal skills, including values, decision making, communication, assertiveness, negotiation, and help-seeking.
 - Sexual behavior, including abstinence, masturbation, shared sexual behavior, pleasure from sex, and sexual dysfunction across the lifespan.
 - Sexual health, including contraception, pregnancy, prenatal care, abortion, STIs, HIV and AIDS, sexual abuse, assault, and violence.
 - Society and culture, including gender roles, diversity, and the intersection of sexuality and the law, religion, media, and the arts.
- Create an opportunity for youth to question, explore, and assess both personal and societal attitudes around gender and sexuality.
- Focus on personal practices, skills, and behaviors for healthy relationships, including an explicit focus on communication, consent, refusal skills/accepting rejection, violence prevention, personal safety, decision making, and bystander intervention.
- Help youth exercise responsibility in sexual relationships.

- Include information on how to come forward if a student is being sexually abused.
- Address education from a trauma-informed, culturally responsive approach that bridges mental, emotional, and relational health.

Comprehensive sex education should occur across the developmental spectrum, beginning at early ages and continuing throughout childhood and adolescence :

- Sex education is most effective when it begins before the initiation of sexual activity.
- Young children can understand concepts related to bodies, gender, and relationships.
- Sex education programs should build an early foundation and scaffold learning with developmentally appropriate content across grade levels.
- Sex education is often the first experience that youth have with understanding and discussing their gender and sexual health.
- Youth deserve to a strong foundation of developmentally appropriate information about gender and sexuality, and how these things relate to their bodies, community, culture, society, mental health, and relationships with family, peers, and romantic partners.
- Decades of data have demonstrated that comprehensive sex education programs are effective in reducing risk of STIs and unplanned pregnancy. These benefits are critical to public health. However, comprehensive sex education goes even further, by instilling youth with a broad range of knowledge and skills that are proven to support social-emotional learning, positive communication skills, and development of healthy relationships.

Health service providers are pivotal in ensuring that young people can access the SRH services they need and to which they are entitled. Part of CSE is informing young people about the services available to them and supporting their access to these services. By engaging health workers, CSE programmers in and out of school can support the integration of youth-friendly SRH services that prioritize the needs and concerns of young people within the community health system.

Successful strategies for engaging and working with health care providers in providing CSE.

- Training support is critical for health staff, so include them in any school based or community level capacity building on CSE and SRH. Do not assume they know.
- Let them play their expert role – even without youth friendly training, healthcare practitioners, whether specialised medical practitioners or community-based extension staff, have important information. Invite them along as guest speakers whenever you can to build good working relationships.
- Include young health professionals in the system – either new trainees or at community level – this will make them much more approachable to in and out-of-school youth.
- When talking to parents, find a mature and respected health professional who is a champion for adolescents – this will carry more weight.

Engaging health providers: Tips

- Identify health providers who have regular contact with children and young people.
- Invite health providers to sessions on the rationale behind CSE and share evidence on impact.
- Ask health providers to deliver factual information within the context of CSE sessions or in activities aimed at engaging parents and other community members.
- Ask for feedback from health providers about gaps in information and knowledge that they have identified in children and young people who access referral services.
- Prepare health providers to interact with and respond to more informed young clients. When health literacy increases, it is expected that children and young people will more willing to ask questions about their choices and treatments. Health providers, in turn, should be ready to answer and encourage this active participation from clients during the provision of services.



TITLE: LECTURE ON PERINATAL MENTAL HEALTH IN INDIA

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Introduction

The term 'perinatal period' in obstetrics includes pregnancy and six weeks postpartum. However, in mental health, it has been broadly defined from the time a woman plans her pregnancy to 24 months following childbirth. This 'perinatal period' is considered to be one of the highest-risk periods for women to develop common mental disorders (CMD) and severe mental illness (SMI). Postpartum psychosis, one form of SMI, has a specific onset in the perinatal period. The 'perinatal period' is also very well suited for interventions as the woman is in frequent contact with the healthcare system. Mental health professionals can play a significant role in helping mothers optimize their well-being and work on mother-fetal to mother-infant attachment. With the implementation of enhanced obstetric care protocols and a substantial decrease in maternal mortality rates resulting from obstetric and medical ailments, the prominence of maternal mental health has increased as a cause of morbidity and mortality.

Mental health problems in the perinatal Period

Common mental disorders (CMDs) such as stress, anxiety, and depression are frequently encountered during pregnancy, particularly in low- and middle-income countries, with prevalence rates ranging from 15% to 20%. Anxiety disorders may manifest differently during pregnancy, characterized by concerns pertaining to the well-being of the newborn or the process of childbirth. The presence of tokophobia and the fear of childbirth may lead to excessive demands for caesarean section or premature termination of pregnancy. Mothers who have undergone assisted reproduction treatments (ART) may experience high rates of mental health problems such as anxiety and depression with mother-infant interaction difficulties. Obsessive-compulsive disorder (OCD) may have a perinatal onset or exacerbation during the perinatal period and may include obsessions relating to harm to the baby or fetus. Infant care and mother-infant bonding may be impaired if these go undetected.

Postpartum psychiatric disorders can be classified into three categories: postpartum blues, postpartum psychosis, and postpartum depression. The occurrence of postpartum blues, with a prevalence rate of 300-750 per 1000 mothers worldwide, typically resolves within a few days to a week, poses minimal adverse consequences, and typically necessitates reassurance alone. On the other hand, postpartum psychosis, which is observed in 0.89 to 2.6 per 1000 births globally, is a severe disorder that manifests within four weeks postpartum and may necessitate hospitalization. Furthermore, postpartum depression can manifest shortly after childbirth or as a continuation of antenatal depression and necessitates appropriate treatment. The worldwide prevalence of postpartum depression has been estimated to be 100-150 per 1000 births. Postpartum depression has the potential to predispose individuals to chronic or recurrent depression, which can impact the mother-infant relationship as well as the growth and development of the child.

Postpartum psychosis, the most severe manifestation of perinatal psychiatric disorder, presents as an emergency psychiatric condition that bears grave implications for both the mother and the infant in the absence of timely intervention. Early intervention in a specialized environment is imperative for the early treatment of mothers with postpartum psychosis to prevent any potential harm to the infant and to the mother, as well as to avoid separation

of the infant from the mother.

Untreated mental health disorders may have a detrimental impact not only on the overall welfare of the mothers but also on the development of the fetus, the bonding between the mother and the fetus, and an increased likelihood of obstetric complications. Inadequate nutrition, weight gain and irregular antenatal appointments have been seen in women with antenatal mental health issues. Children born to women who have depression have been seen to have diarrhoea, malnutrition, infections and hospital admissions, especially in LAMICs. Breastfeeding is also often affected when mental health problems occur during the postpartum period.

In the mothers, one of the most serious consequences may be suicidality. Suicidality has been found in 7.6% of mothers in a study on a cohort of pregnant women in India. Younger age, perceived lack of support, past history of suicidality, depressive symptoms, and domestic violence have been seen to be predictors of the same. Assessment and management of the risk of harm to mother and child is critical in this population.

What can be done?

- Expanding reach of the District Mental Health Programme, which can offer a useful platform for training and referrals and increasing focus on neonatal health in public health systems. The National Health Mission of the government has begun discussing methods of integrating perinatal mental health into mother and child programmes.
- Screening tools such as GAD-7 for perinatal anxiety and PHQ-9 and EPDS for perinatal depression have been validated for use in perinatal populations. However, a lack of vernacular language adaptations often comes in the way of using these tools on a large-scale level.
- There is an urgent need to create low-resource, culturally-sensitive mother and infant psychiatric facilities in district and teaching hospitals for women with more severe mental illnesses. The National Institute of Mental Health and Neurosciences (NIMHANS) mother and baby unit in Bangalore has demonstrated that it is possible to develop an Indian version of mother and baby units (MBU) where families contribute to caregiving. The new Mental Health Care Act 2017 mandates mother-infant joint care till three years of age.

A multilayered, interdisciplinary strategy is most suited for dealing with issues related to prenatal mental health. The best course of action is to integrate stepped-care with the community's current postpartum and pregnant women's health services.

For CERTIFICATE COURSE IN PERINATAL MENTAL HEALTH you can apply here :-
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