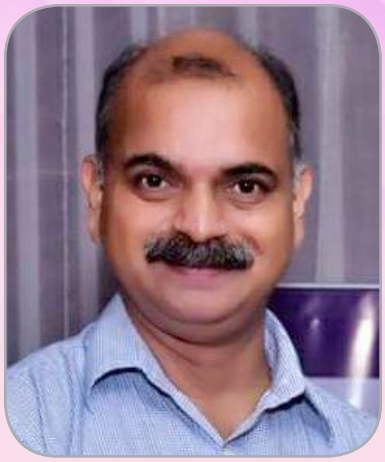
Newsletter - 26 August, 20

FOGSI's SEXUAL MEDICINE COMMITTEE IN ASSOCIATION WITH PUBLIC AWARENESS COMMITTEE

Dr. Parag Patil Memorial Public awareness e-Newsletter



Dr. Parag Patil

~ Public Education Initiative ~

FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA
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SAFETY FIRST FOR INDIAN WOMEN & FOGSIANS

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ADOLESCENCE AND SEXUALITY

Dr. Tripti Sharan

Adolescence is typically a period of transition between childhood and adulthood with the major psychological tasks being to:

- determine identity
- develop power to make decisions and be in control
- and develop a mature sexuality.

Mature sexuality is defined as a 'comfort with oneself and the ability to enter into a relationship in a giving and mutually trusting way'.

In a joint statement in 1998, WHO, UNICEF and UNFPA established the categories of 'adolescent' (those aged 10–19 years) and 'youth' (those aged 15–24 years).

Adolescence is customarily divided into three phases (WHO, 1995) –

- Early adolescence (from 10–14 years of age);
- Middle adolescence (14–17 years);
- Late adolescence (17–19 years and sometimes extended to ages 21 or 22)

Early adolescence

Sexuality at this stage is characterized by individuals being shy and modest.

- Greater interest in privacy, experiment with their body (masturbation)
- Do not usually interact in romantic relationships
- Encounters tend to be awkward, self-conscious, and filled with doubt.
- Relationships tend to be short lived.

Middle Adolescence

Sexuality during middle adolescence tends to be focused on sexual attractiveness

- They frequently change relationships, if culturally acceptable.
- Fear and discomfort may be shown towards the opposite sex (or same sex)
- Feelings of tenderness, love and passion may also develops.

Late adolescence

Sexuality at this age focuses on

- Serious relationships,
- Clear sexual identity, and
- Capacities for tender and sensual love
- Relationships at this point tend to be concerned about the feelings and well-being of the partner although possibility of abusive behaviours remains.

It is during adolescence that sexual identification with homosexuality and/or bisexuality begins. The adolescents may feel isolated or may fear sharing their true feelings. This has significant implications for adolescent sexual and mental health and for helping adolescents to develop life-affirming health behaviours.

- Adolescent sexual health is one of the most important health-care issues of the twenty-first century. Over the years, the need for having specially tailored, sexual health services for adolescents has become more pressing. Societal change caused by industrialization and urbanization has led to loosening of family ties and erosion of the traditional sanctions that previously inhibited premarital sexual activity.
- Coupled with this younger age of menarche combined with delayed average age of marriage means that there is a longer time-period between the onset of sexual maturity and marriage (International Planned Parenthood Federation, 1994).
- Add to it the easy availability of sexually explicit material on internet, liberal sexual behaviour shown on television and movies and peer pressure. We live in an era of changing social and cultural values. There is an acceptance to relationships and more opportunities through the social media.
- A major deficiency lies in the Indian families where discussions on sexual issues are taboo. Adolescents are not able to rely on intergenerational relationships and learn about responsible sexual behaviour. As the gap between the generations grows, they are increasingly forced to learn about sexual issues from their peers or from the media.

Sexual behaviour among adolescents is not new. As part of the transition from childhood to adulthood, all adolescents experience sexual feelings. Some act upon these feelings and engage in sex, some in behaviours that stops just short of intercourse, such as masturbation and others deny these sexual feelings by focusing on non-sexual pursuits. Some of them go through early socially acceptable acts, as in pre-arranged marriages.

Behaviour in adolescence sets the pattern for the rest of an individual's life.

There is a paucity of existing sexual and reproductive health-care programmes for adolescents whose sexual and reproductive health needs should be treated as basic human rights. These should be met while safeguarding their right to privacy, confidentiality, respect and informed consent.

The suppressed needs of adolescents lead them to do things undercover. Suppressed desires have dire consequences, reflected in the rising graph of sexual crime and violence.

Currently we are facing the consequences of unchecked adolescent sexuality which are primarily unsafe abortion and unwanted pregnancies, which are extremely worrying. In addition, inadequate sexual health care contributes to the spread of sexually transmitted infections (STIs) and may lead to damaging effects on an adolescent's lifelong health and fertility.

Teenage Pregnancy

Mark Twin said 'East is east and west is west and never the twain shall meet'. Interestingly, teenage pregnancy is one of the few issues that connects the East with the West.

- WHO reported that more than 15 million girls between the ages of 15 and 19 give birth every year worldwide, and an additional 5 million have abortions. (2004)
- As per a United Nations Population Fund (UNFPA) report released in 2013, about 7.3 million girls under the age of 18 give birth to children, while the relative number of pregnancies is even higher because the girls often give birth to multiple children before they reach their mid 20s.
- A worrying figure shows that in the period between 2000 and 2013, when the UNFPA report was released, India topped the chart of 10 countries with the greatest numbers of women aged between 20 and 24 who gave birth before their age was 18.
- "India will retain the biggest national adolescent girl population, with hardly any net change from 2010 to 2030 (93 million to 95 million)," UNFPA predicted
- As per National family Health Survey (NFHS-4) 2015-16, 11.9% of the 15-19 year old girls were married before age of 18 years in India, with variations across states.
- Amongst the married girls aged 15 to 19 years in India, 31.5 percent were found to have babies.
- Almost a quarter of the married girls in the15-16 years age group had at least one baby while more than a quarter of the married teenage girls had at least one child at age 17 while 31% had a child by age 18.
- Further analysis reveals that 27.3 percent of the married teenage girls have given birth to one child while 4.2 percent have 2 or more children.

More than 1 out of 4 married teenager became a mother (NFHS-4)

Pregnancy is the biggest abuse of childhood.

Prevalence of girl child marriage is found more common in rural areas than urban areas. Poorer the households, higher the chance of girls getting married early. The contributory factors are

- Marriage as a prevention to sexual assaults especially in rural areas
- Dowry demands and

- 'Suitability issues' increases with age.

High fertility and discontinued education after marriage, remain other facets of concern. Completion of secondary education is much lower amongst married teenage girls than the unmarried girls amongst 15-19 age group across all states.

The societal control on women sexuality, lack of comprehensive sex education, poor access to contraceptive services by adolescents and youth are some of the reasons for this unprecedented rise.

While in a developing country such as India, early marriages and traditional gender roles are to be blamed primarily for early pregnancies, in the developed nations maximum teenage pregnancies occur out of unplanned sexual activities, an issue which is gradually gripping the Indian urban teenagers as well.

Medical consequences of pregnancy in adolescence

Compared to the pregnancies of women in their 20s, adolescent pregnancies have higher mortality and morbidity. This is generally because of

- Less antenatal care and delayed intrapartum care
- Obstructed and prolonged labour due to an undeveloped pelvis
- Increased rates of pre-term labour and stillbirth
- Higher incidence of medical complications such as anemia, hemorrahge and hypertension
- The chance of dying in the first year of life is more than 60% higher for babies born to those under-18 than for those born to older mothers.
- Higher incidence of unsafe abortions
- Psychological manifestations of an unwanted pregnancy
- Malnutrition
- Sexually transmitted infections and cervical cancers

Women who begin childbearing early are more likely to fall into a pattern of having births closely together, and having larger families

- Every time you prevent pregnancy, you prevent the risk of dying from pregnancy related complication
- Every time you practice safe sex, you also prevent sexually transmitted infections

Social and personal consequences

Once an adolescent girl gets pregnant, even if she has an abortion the consequences on her social, personal and educational status may be irreversible.

- Unmarried young women who become pregnant are often stigmatised. A history of abortion before marriage can make her a social outcast.
- They might be considered a bad influence on other girls and are forced to give up school
- A pregnancy at this age may preclude social, educational and employment development of the girl and she loses the ability to achieve full status in society
- This further leads to a spiral of low self-esteem, further pregnancies, plus intergenerational early pregnancy, early childbearing, and poverty

Gender and cross cultural influences

- Gender stereotypes and role expectations often put adolescents at serious health risk. Very often adolescent men are taught that being sexually active is an especially important part of being a "man".
- They might be ridiculed for not being sexually active, or teased as being homosexual; they might be encouraged to obtain sexual initiation without using condoms; and sexually transmitted infections may be regarded as a "rite of passage" for masculinity.
- Female adolescents on the other hand are often socialized to be non-aggressive, and to abstain from sexual activity until marriage. Female adolescents therefore receive positive reinforcement for being quiet, innocent and unaware of sexual matters.
- Adolescent females who marry early get typically married off to older men who are better economically. It makes her precociously, an adult. Yet the difference in age, financial status confers a relationship imbalance which makes it difficult for her to be assertive, decide upon timing and number of children, contraceptive use, and protection from sexually transmitted infections.

Social influences

Societies are reluctant to address the sexual and reproductive health needs of adolescents due to either an inherent hesitation or an unwillingness to consider adolescents as individuals with rights and an identity separate from children and adults both. This can lead to serious health problems such as

- Lack of access to health information and services (services do not exist, negative staff attitudes are a barrier, and/or services are not affordable).
- Disparity in educational access for boys and girls leaving girls disadvantaged when trying to access information
- Lack of sexual and reproductive health education within the educational system.
- Lack of laws or their enforcement to prevent early marriage, particularly for girls.
- Lack of laws or their enforcement against violence including rape, sexual assault, incest, and commercial sexual exploitation.

- Lack of policies, laws, enforcement and multidisciplinary approaches for eliminating female genital mutilation.
- Lack of support and avenues for adolescents to generate income to help protect them from sexual exploitation.
- Adolescent women are more vulnerable to HIV/AIDS and other STIs than adolescent men and restrictions on sexual and reproductive health information and services makes it very difficult for adolescents to protect themselves.

Unsafe Abortions

India has an astoundingly high maternal mortality rate – a staggering 130 per 100,000 live births (2016).

Unsafe abortion, the third leading cause of maternal deaths in the country, contributes to eight per cent of all such deaths annually. Nearly 6.4 million pregnancies are terminated every year in India.

Every day 13 women die in India due to unsafe abortion-related causes.

As per a WHO report, between 2010–2014, on an average, 56 million women with unintended pregnancies chose induced (safe and unsafe) abortions worldwide each year.

Nearly half of these, around 25 million were unsafe abortion, almost all in developing countries

- Each year between 4.7% – 13.2% of maternal deaths can be attributed to unsafe abortion, making it a leading cause of maternal mortality.
- Around 7 million women are admitted to hospitals every year in developing countries, as a result of unsafe abortion

Every 8 minutes a woman in developing country dies of unsafe abortion.

Of those who survive unsafe abortion, nearly 5 million will suffer long-term health complications.

WHO deems unsafe abortion, one of the easiest preventable causes of maternal mortality and a staggering public health issue.

Lack of (or no access to) safe abortion services (unmarried adolescents decide to terminate their pregnancies more frequently than other groups, resulting in 1–4 million adolescents undergoing unsafe abortions, and the attendant consequences).

A liberal MTP (medical termination of pregnancy) act, yet women are still dying of unsafe abortions. In a study about 80% of women did not know that abortion was legal in our country

An unsafe abortion is defined as *"a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both"*.

Unsafe abortion is strongly associated with complications such as heamorrhage, sepsis and trauma, leading to maternal mortality.

Barriers to accessing safe abortion include:

- Restrictive laws in some cultures
- Poor availability or accessibility of services
- High cost, stigma & the conscientious objection of health-care providers and
- Unnecessary requirements, such as waiting periods, mandatory counselling, misleading information, and medically unnecessary tests that delay care.
- Obsession towards having a male child
- Easy availability of the abortion pills from the chemist without prescription

While the law requires the consent of only the woman if she is over the age of 18 years, in practice, many providers also ask for consent from the spouse or another relative. This pushes women towards clandestine operators and unsafe abortions.

Poor, young and unmarried women are more likely to delay abortion because they are often poorly informed; they may not understand the signs of pregnancy, possibility or legality of obtaining the abortion and the location of safe services. Termination at advanced stages of pregnancy is fraught with dangers especially when done by an unqualified person.

Most pregnancies in India still happen within the context of a marriage. The family takes her to an unqualified person because of deep rooted belief. Despite legal restrictions these 'quacks' are rarely reported. The cultural and social norms, the community acceptance keeps the law enforcement away.

Adolescents who are 15-19 years of age are at the highest risk of dying from an abortion related complication.

The risks of unsafe abortion, and of death related to abortion, were higher among

- Uneducated women,
- Low socioeconomic status
- Women in rural settings
- Those with poor access to health care

More than half (56.28%) of the abortion-related deaths in a study were shown to be due to a lack of access to appropriate healthcare (ie, delay in receiving healthcare at facility, inadequate care at health facility and lack of transport to the facility).

About 70% of India's population live in rural settings, but safe abortion services are rarely available at rural facilities.

The high prevalence of unsafe abortion in India demonstrates a critical public health problem.

There is an immediate need to address these issues . We must ensure access to family planning, early abortion services and management of post-abortion complications. Urgent work is needed to understand

the barriers to safe abortion in India despite the conducive legal environment to reduce unsafe abortions and deaths, particularly in populations identified to be at a higher risk.

Contraception and adolescents

Young women with little contraceptive knowledge and experience are especially at high risk of an unwanted pregnancy and preventing pregnancy in adolescents is a high priority in all countries.

- Fertility should always be by choice and not by chance.
- It is a basic requirement for women's survival, wellbeing and quality of life. It not only prevents unwanted pregnancy but also prevents unsafe abortion.
- Compounding all the problems associated with sexual intercourse before marriage in adolescents is the low level of contraceptive use.
- Most methods, barring sterilization, that are appropriate for healthy adults are also appropriate for healthy, post-pubertal adolescents.
- Adolescents need to understand the importance of protection against pregnancy and also against STI/HIV.
- The decision should be informed, voluntary and appropriate.

Contraceptive methods available for use by adolescents

a: Dual protection and dual method use

b: Barrier methods

c: Emergency contraception

d: Harmonal contraceptives

- Low-dose combined oral contraceptives (COCs)
- Combined injectable contraceptives (CICs)
- New hormonal delivery systems
- Progestogen-only pills (POPs)
- Progestogen-only injectables
- Progestogen-only implants

e: Intrauterine devices (IUDs) – Not used commonly in adolescents

f: Natural family planning/fertility awareness based methods

- Lactational amenorrhoea method (LAM)
- Withdrawal

g: Male and female sterilization – although adolescents are medically eligible for this, these methods should only be rarely recommended.

a: Dual protection and dual method use

There are two approaches (other than abstinence) that simultaneously protect against pregnancy and STIs.

Dual protection - This is the exclusive use of condoms to provide such "dual protection". However, condom use also requires a willingness and ability to use emergency contraception in the event of condom slippage, breakage or failure to use.

Dual method - This involves always using a condom plus another method that has a lower contraceptive typical-use failure rate.

b: Barrier method

Given the transient relationships at this age and the high probability of multiple, sequential sexual

partners prior to marriage, condom is the single best protective option for many adolescents. The failure rate is higher in adolescents than adults.

For typical use a failure rate of 14% is usually quoted.

The disadvantage of condoms -

- They are coital-related
- Require user comfort/familiarity with his/her genitalia.
- Self-assurance is needed to purchase the condom.

Yet condom use should always be encouraged as it protects from STIs

c: Emergency Contraception

It has become a very commonly used contraceptive these days because of its easy availability and much advertisement.

- Emergency contraceptive pills (ECP) do not interrupt pregnancy.
- The failure rate of emergency contraceptive pills ranges from 1 to 3 per hundred women.
- They have high dose of progestrones and should be used only in exceptional emergency circumstances like rape, slipping of condoms.
- Though the amount of hormone administered during the sporadic use of ECPs is considered too small to cause chronic or acute, serious adverse events, it should not be used to promote irresponsible behavior, used frequently or as routine contraceptive just because it's convenient.

Parents of adolescents should also be aware of the existence of emergency contraception because they may be willing to advise their youngsters about this option if they confide in them about their sexual relations

Types available

Two main types of ECPs are available, namely:

- Combined oral contraceptives (COCs) at a higher dose than that used for continuous contraception
- Progestogen-only pills (POPs) at a higher dose than that used for continuous contraception

It requires two equivalent doses of ECPs, 12 hours apart, preferably within 72 hours of unprotected intercourse.

Each dose of COCs should contain at least 100 ugm of EE and at least 300 ugm of levonorgestrel (LNG).

Each dose of POPs should contain 750 ugm of LNG.

The need for a second dose of ECP if vomiting occurs within two hours of ECP administration and the risk of menstrual disturbances that might follow use of ECP should be explained

The contraceptive effect of ECPs is transitory, and return of fertility is immediate.

The need for a regular method of contraception therefore needs to be reinforced.

- Copper intrauterine devices (IUDs).
    - A copper IUD inserted within five days of unprotected intercourse is another option for emergency contraception.
    - It is not a very popular method in adolescents except in those at low risk for STIs, desiring a long-acting contraceptive method, as in case of a parous adolescent where it may be an appropriate emergency contraceptive choice.

Low dose COC pills

The term "low-dose" refers to COCs containing 35 ugm or less of ethinyl estradiol. COC formulations also contain one of many different synthetic progestogens. The most widely available COCs contain the progestogens levonorgestrel (LNG) or norethisterone (NET) which is also known as norethindrone.

In the 1980s three new third generation progestogens (norgestimate, desogestrel and gestodene) were introduced having less androgenic side effects. Cyperoterone and Drosperinone have marked antiandrogenic effects and drosperinone has mineralocorticoid effect as well.

Any low-dose COC available to a programme can be prescribed safely to adolescents; and any low-dose COC will result in mild to moderate acne improvement.

There are no restrictions on COC use related to young age and nulliparity.

Adolescents are more compliant with 28-day pill packaging (which does not require a 7-day pill-free interval between packs). It is important for the formulation to be easily available.

Failure rate - With the perfect-use of COC, it is 0.1 pregnancies per 100 women during the first 12 months of use. Depending on the population of adolescents, failure rates as high as 15 pregnancies per 100 adolescents have been reported.

The disadvantages of COC use in the adolescent are

- Need to take the pill every day, preferably at the same time each day.
- Lack of protection against STIs.
- The cost of the pill can be another prohibitive factor.

Side Effects

- Nausea, dizziness,
- Mild headache,
- Breast tenderness,
- Mood changes and
- Breakthrough bleeding which usually subsides within the first three months of use
- Though there is no statistically significant increase in weight gain and is generally because of faulty lifestyle and diet, some adolescents may be particularly sensitive to weight gain.

The long-term safety of COCs has been very reassuring.

Non contraceptive benefits

It is particularly important in adolescents in situations such as

- Regularising the menstrual cycle in conditions like PCOS and harmonal imbalance
- Relief from heavy periods and painful menstruation,
- Relief from mittelschmerz
- Acne
- Prevention or improvement of anaemia.

Combined Injectable contraceptives (CIC) - CICs are similar to COCs since they contain both a progestogen and an estrogen. CIC injections are repeated every four weeks and should be started within seven days of menses. However, clinical experience with CICs in adolescents is limited

Other delivery systems – Nuvaring vaginal and transdermal patches

Though they are more convenient to use but not many studies are there to tell us the suitability in adolescents or whether adolescents will choose and correctly use them.

Progesterone only pills (POPs)

- These pills contain only a progestogen, LNG or norethisterone.

- The POPs are generally used only for lactating adolescents, or those who are medically unable to take estrogen.
- They have the disadvantage of more frequent and persistent irregular bleeding episodes.
- Accidental pregnancies due to incorrect use are thought to be more frequent with POPs than with COCs. Hence POPs are generally less well suited for adolescents than COCs

Progesterone injectable contraceptives – DMPA , NET-EN

With a failure rate of 0.3 per 100 women in the first 12 months of use for DMPA and NET-EN, progestogen-only injectables are one of the most effective reversible hormonal contraceptives now available.

Non contraceptive benefits

- The prevention of anaemia
- Improvement in painful menstruation
- The long-term protection from benign breast disease and endometrial cancer,
- Reduction in frequency and severity of epileptic seizures, and sickle cell disease crisis may also be relevant for some adolescents.

The main concern about DMPA use in adolescents is increased risk of osteoporosis. Because of bone-mineral density changes, the use of these injectables may require special, as yet undefined, follow-up or management in adolescents from menarche to 18 years. There is no restriction due to nulliparity.

Progesterone only implants

- Norplant is the only implant that is widely available and with a failure rate of 0.1 pregnancies per 100 women in the first 12 months of use, is one of the most effective, reversible hormonal contraceptives available.
- It needs to be changed every 5 years.
- The high contraceptive effectiveness, its duration, and easy compliance are important advantages for adolescents who desire long-term contraception.

Intra uterine contraceptive devices

- While there are no restrictions based on age or parity for IUDs, many adolescents still will not qualify as candidates.
- Ideal candidates for IUDs are those who are in long-term mutually monogamous relationships, are parous, and do not have unexplained vaginal bleeding and are low risk for STIs.
- The levonorgestrel IUD has non-contraceptive benefits, yet there are limited studies of its use in adolescents. It may be used as a spacing method in parous adolescent.

- The main concern with IUD use is development of PID which can lead to sequelae such as infertility and chronic pain.
- The relationships between sexual behaviour, STIs, PID and infertility should be understood by the user.

The use of IUDs in adolescent women requires careful evaluation of each individual case.

Natural family Planning method

- These methods of fertility control rely on the avoidance of intercourse during times of peak fertility.
- Fertility awareness-based methods can be used in combination with barrier methods during fertile time periods.
- Although there are no reports on the effectiveness of fertility awareness-based methods in adolescents, it is recognized that adolescents are very frequently unable to comply with the stringent requirements for the correct and consistent use of natural family planning methods.
- These methods are therefore not usually recommended for adolescents.

Lactational Ammenorrhea method (LAM)

- LAM may be considered an appropriate contraceptive choice for postpartum adolescents planning to breastfeed.
- The success of the method will depend on whether the adolescent is exclusively or nearly exclusively breastfeeding the infant.
- There are no special considerations for the use of LAM in adolescents, and the same guidelines for use of LAM as in adults apply.

Withdrawal

- Withdrawal requires a high degree of motivation and discipline, which may be quite difficult for a young adolescent couple.
- While withdrawal is acknowledged as frequently-used method by adolescent couples, no precise data on the use of this practice exist.

Sexually Transmitted Infections

STIs (sexually transmitted infections) is a rising concern, the problem more serious than those of pregnancy, with long term consequences like infertility. HIV is the tip of iceberg. Cervical cancer, the second most common cancer amongst women in India is again a sexually transmitted disease.

Young women and female adolescents are more susceptible to STIs compared to their male counterparts because of their biological characteristics. During puberty and young adulthood, specific cells (columnar epithelium) are especially sensitive to invasion by certain sexually transmitted organisms.

Women and female adolescents may also find it more difficult than men to implement protective behaviors, partly because of the power imbalance between men and women

A new report published by the Centers for Disease Control and Prevention (CDC).2017

- Young people aged 15-24 years develop half of all new sexually transmitted diseases (STIs),
- 1 in 4 sexually active adolescent females has an STI
- One-quarter of adolescents and young adults in high-risk age groups for STIs do not have health care coverage.
- Only 11 percent of teenagers surveyed reported getting most of their information regarding STIs from their parents or other family members.
- Nearly 70 percent of students in the twelfth grade have had sexual intercourse and 27 percent of twelfth-grade students have had sex with more than one partner.
- Knowledge and awareness of STIs among the public is poor; almost two-thirds of women,18-60 years of age surveyed knew nothing or very little about STIs other than AIDS.
- Even among prime-time network television shows, there is only 1 portrayal of protective behavior or comment regarding STIs for every 25 instances of sexual behavior shown.

"This epidemic is one result of a sexually saturated culture and the myth perpetuated that latex, contraception and vaccines can make all sexual behavior risk free."

And as the CDC data demonstrates, it is our young people who are suffering the most.

Cancer cervix is the leading cancer in Indian women and the second most common worldwide. The precancerous changes start early, usually in the twenties, once the women are sexually active and if undetected and untreated, may turn into a full blown cancer by the time the woman is in her 50s.

Ironically, there are several 'good' things about this cancer.

- It is a preventable cancer with
- A known etiology, a HPV (Human Papilloma Virus)
- A known mode of spread i.e sexually transmitted
- A particularly good and inexpensive screening test called PAP smear which identifies it several years ahead at a precancerous stage making it amenable to prevention and early treatment with good prognosis.
- An effective vaccine

But unlike some STIs (sexually transmitted infections) it is not fully protected by condoms.

The high-risk factors are those with

- Multiple sex partners

- Early initiation of sexual activity
- Poor knowledge of contraception
- Hesitation in using barrier method by male partners
- Low socio-economic status with poor access to health care services, including Pap tests
- Prostitutes, prison inmates, drug addicts, and those attending STI clinics
- Smoking, low immunity status like HIV, use of birth control pills for > 5 years, being younger than 17 at the time of first delivery, multiparity i.e having 3 or more children.

Even the first wife dying of a cervical cancer places the second wife at high risk.

Yet despite the familiarity with the disease, it continues to kill women. An effective vaccine lay underutilised because of unawareness and sometimes non affordability.

The only way to curb the rising STIs amongst adolescents is by :

- Inculcating responsible behaviour

Sounds like a cliché but if you do not take a detailed sexual history of your partner on your date, you don't know him well enough to have sex.

And

'Safe sex' is sex with your faithful spouse!

- Enforcing Pap Smear in sexually active women (21-65 years of age) at least every 3 year (even in those previously vaccinated with HPV vaccine), or combining it with HPV testing every 5 years (>30 years of age).

  "screen-and-treat" and "screen, diagnose and treat" are both valuable approaches

- Promoting cervical cancer vaccine; may be a government initiative making the vaccine cost effective, mandatory or even free to all adolescent girls.
  - For girls less than 15 years, only 2 doses (0, 6) are recommended.
- Tracing contact/ partner & treatment for STIs

Adolescent sexuality has far profound implications and is public health perspective especially in developing countries.

There are several ways suggested to deal with the undesirable consequences of adolescent sexuality

- Call of the day is delaying marriage of girls as most pregnancies in India still happen within the context of marriages
- The most significant factor in delaying the age of marriage is completing the education of girls.
- We need to talk to your children. Learn to share and win over their confidence.

- Responsible behaviour needs to be taught and also shown to them. Charity begins at home.
- Not simply promoting but we also need to simplify access to contraception and abortion services.
- Sensitise the health care providers. No moral preaching or looking down upon these women. We need to help them out especially teenagers and single women.
- There has to be some provision in law for those suffering some abnormality of the unborn baby, rape victims, unmarried girls to have safe abortions. Upper limit for termination in the MTP act needs to be relaxed for them. Not everyone can go to the courts.

We need awareness drives at large scale for awakening the society from a scary limbo of ignoring and forgetting this steady and silent epidemic. Let us wake up before our future gets sacrificed at the altar of this epidemic.

Let illiteracy, economic disparity, and gender discrimination not kill our children and young women!

Safe sex, safe abortion & safe motherhood is the fundamental right of every woman!

Dr Tripti Sharan
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Author / Poet And Blogger

ABOUT AUTHOR

Dr. Tripti Sharan is a senior consultant in the Dept of Obstetrics & Gynae, at BLK SuperspecialityHospital, New Delhi.

She has been especially vocal for spreading awareness about adolescent sexuality, teenage pregnancy, unsafe abortion and STIs.

Author of 'The Chronicles of a Gynecologist', 'House of Doctors', 'Being Radha' and award-winning poetry books, she is an active blogger and a columnist with NDTV everylifecounts, The Better India, Different truths workingin familiarizing people with the medical world and the plight of women.

With her dual role of a doctor-author she occupies a significant place amongst medical and literary enthusiasts.

TO ATTEND LIVE QUESTION ANSWER SESSION ON THIS SUBJECT

Chief Guest
Dr. Shantakumari
President Elect FOGSI
2021

Introducion of Subject
Dr. Padmini Prasad
Senior Sexologist

Date : 4th September 2020

Time : 7 pm

Link : **www.eractx.in** (Register now)

Moderator : **Dr Apurba Kumar Dutta, Dr Yogini Roleker**

Faculty : **Dr. Tripti Sharan**

Dr. Niraj Jadav
Chairperson Sexual Medicine Committee Fogsi 2020-22
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