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ORIGINAL ARTICLE

A COMPARATIVE STUDY OF ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH PRACTICES (ARSH) AND ADOLESCENT GYNAECOLOGICAL PROBLEMS AMONG THE GIRLS IN SWEDEN AND INDIA

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ABSTRACT: AIM: To undertake a comparative study of ARSH practices and gynaecological problems of Sweden and India with a view to offer inputs for corrective measures. **METHODS:** A total of hundred Swedish and hundred Indian youth were studied for ARSH practices. A total of hundred Swedish and hundred Indian adolescent girls were included for the study of gynaecological problems. **RESULTS:** ARSH practices were safe in Sweden in sharp contrast to India. Gynaecological problems were similar in the adolescents of both countries.
KEYWORDS: Adolescent Reproductive and Sexual Health (ARSH), Gynaecology, Menorrhagia, Oligomenorrhoea, Dysmenorrhoea.

INTRODUCTION: Adolescence is a period of transition from child hood to adulthood. The young people during this age mature to become adults, but do not assume the roles and responsibilities of adults. They begin to explore their sexuality and develop high risk behaviours. Adolescents face specific physical and psychosocial problems irrespective of their social and racial background Information about their sexual behaviour helps us to frame preventive strategies which has become the basis of this study.

One fifth of world population are between ages of 10 and 19 years. Approximately 8 to 9 percent of these live in developing countries.(1) Adolescents are now attaining biological maturity earlier than previous generation, as witnessed by gradual decline in the average age of puberty and menarche.(2) The sexual and reproductive health needs of adolescents remain poorly understood and largely unmet. The health problems faced by adolescents are numerous due to early and unprotected sexual intercourse.(3) Women are more vulnerable to sexually transmitted diseases than men.(4) The adolescent gynaecological problems need special care and attention as they are not aware of the seriousness of problem. These issues formed the basis of the present study.

MATERIALS & METHODS: A questionnaire was adopted as a quantitative research tool while interviews and focus group discussions were relied upon as qualitative research tools. Respondents comprised of hundred Swedish youth from Lund university (Malmo, Sweden) during 1st to 6th June 2009 national training programme and hundred junior college students from Hyderabad. Hundred school girls from Malmo Sweden and hundred 9th and 10th class students from Hyderabad were selected for gynaecological evaluation. The work was done during 2010 by Obstetrics and Gynaecology department and Yuva Centre of Niloufer hospital, Hyderabad. Age

group of all the respondents was between 14 and 19 years. A total of 400 respondents were included in this study.

RESULTS: A total of 400 students were included in the study. We got an opportunity under National training programme (NTP) to visit Malmo Sweden, to study the Arsh practices, gynaecological problems in adolescents (1 to 6 June 2009)

Indian study groups from Hyderabad included (school, Jr. College, Yuva centre and Niloufer hospital).

In the present study of Arsh practices. The youth included 50 males and 50 females from Sweden and also 50 males and 50 females from Hyderabad. The pretested Questionnaire was given to them.

1. Knowledge on Anatomy/physiology of reproduction system.
2. Knowledge regarding sexually transmitted disease/HIV.
3. Knowledge of how to prevent HIV/ STD.
4. Knowledge and usage of contraceptives and specially condoms.
5. Alcohol, drug abuse, sex abuse, details were avoided as many did not want to reveal.
6. Pre-marital sex was made compulsory question (whether with a known person or prostitute).
7. Marriage: if married age at marriage, Teenage pregnancy, abortion details enquired.

None of the youth respondents were married or reported unwanted pregnancy. 68/100 Swedish youth had pre-marital sex with a known person. None of them visited a prostitute as compared to 8 of 100 youth in India. ¼ of the youth who had pre-marital sex that is 2 had visited a prostitute. One of them was not aware ARSH practices and did not use condom. As seen in Table 1.

Awareness of HIV/STD & ARSH practices was 100 % in Swedish youth. Only 60% of Indian youth were aware of it. All the Swedish youth had visited youth friendly Health services which are located near their campus at least once as compared to Indian youth who have never visited such centres.

These are the statistics representing educated, city based youth and it is difficult to imagine the state of uneducated youth in rural India.

In the study of gynaecological disorders age at menarche showed significant difference. The mean age of menarche was 12 years 5 months among Swedish girls compared to 13 years 2 months in Indian girls (Table 2)

60 out of 100 Swedish girls had regular menstrual cycles compared to 58 among Indian girls. 12/100 Swedish girls, 8/100 Indian girls suffered from menorrhagia (Table 2).

Dysmenorrhoea ranked the top most problem 36 Swedish and 38 Indian girls were suffering with it. Only 2/100 could not attend school on 1st and 2nd day of menstrual cycle. School absenteeism was similar in both countries.

Oligomenorrhaea was report 10/100 in Swedish and 12/100 in Indian girls. The concern regarding while discharge was seen more among Indian girls. 4/100 swedish girls reported occasional white discharge and 14/100 Indian girls reported the same. All the 4 swedish girls had visited a doctor but None of the Indian girls had done so.

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Questionnaire	Sweden (Number)	India (Number)
Awareness of ARSH Practices	100	60
Premarital sex	68	8
Sex with a prostitute	None	2
Whether used condom	All	1
Teenage pregnancy	Nil	Nil
Utilising youth friendly health services(YFHS)	100	None

Table 1

Gynaecological problems in both countries		
Questionnaire	**Sweden**	**India**
Age at menarche	12 years 5 months	13 years 2 months
Regular menstrual cycles	60	58
Dysmenorrhoea	36	38
Menorrhagia	12	8
Oligomenorrhea	10	12
Amenorrhoea	Nil	1
White discharge/infections	4	14
Consulted a doctor	4	None
School Absenteeism due to dysmenorrhoea/menorrhagia	2	2

Table 2

DISCUSSION: The present study shows that none of the Swedish and Indian respondents were married, or reported unwanted pregnancy. In Sweden a distinguished feature is that buying sex was a crime but not selling sex. People therefore avoid prostitutes. Society there has adopted a liberal attitude towards teenage sexual relations. Awareness and adoption of safe sexual practices with a marked focus on condoms and contraceptives have ensured a much lower rate of sexually transmitted infections. Indian society is traditional but lack of acceptability and awareness is resulting in high risk behaviour of youth.

In Sweden all the youth always use condoms, every sexual act was safe. Their knowledge regarding ARSH practices were 100%.

This scenario is in sharp contrast to India where only 60% had knowledge of ARSH practices. 68 of 100 youth agreed having premarital sex in Sweden. The youth in India did not open up only 8 of 100 agreed of having pre-marital sex. Out of which ¼ that is 2 of them bought sex and half of them that is one of them did not use condom. These high risk sex behaviours are resulting in spread of HIV/STD in India.

In the analysis of gynaecological disorders in the present study though there are racial differences in both groups menstrual disorders are the commonest problems faced by

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adolescents. Dysmenorrhoea ranked topmost concern amongst adolescents. In the present study, 36 Swedish girls suffered from dysmenorrhoea compared to 38 Indian girls. Out of which only two of them could not attend the school on the first and second day of menstrual cycle. Severe dysmenorrhoea causing absenteeism was similar in both countries.

The mean age of attainment of menarche was 12 years 5 months in Swedish population, In Indian girls it was 13years 2 months.

In the study conducted by Snehal santosh central India the attainment of menarche was 12 years 6months. Various authors like Chaturvedi et al 1996, Agarwal et al 1997 reported mean age as 13 years 7 months.

60% Swedish girls had regular menstrual cycles as compared to 58% among Indian girls. 12% Swedish girls and 8% Indian girls suffered from menorrhagia, this is comparable to the study conducted by Samanth et al Int J. Rep. contracept. Obstet Gynecol 2014, which shows 9.86% of adolescent girls suffered from menorrhagia. A similar data was observed from a Gynaecological clinic at AIIMS. Menorrhagia was 16% amongst adolescent girls oligomenorrhagia was seen in 10/100 Swedish girls and 12/100 reported from Indian group. Amenorrhoea or pregnancies were not reported in the Swedish group. Only 1 in the Indian group had primary amenorrhoea which needed gynaecological follow up. Incidence of oligomenorrhoea in the Indian groups was comparable to the study conducted by central India (Samanth et al)-(12.82%).

The concern regarding white discharge was utmost among Indian study groups (14 girls) compared to Swedish girls.[4]

All the 4 Swedish girls consulted a clinic/YFHS and none of the 14 girls consulted a clinic/specialist. This is remarkable where adolescent girls in India are not reaching out to clinics.

CONCLUSION: 200 youth -100 swedish 100 Indian studied for ARSH practices 200 (Adolescent school girls) 100 swedish 100 Indian for gynaecological disorders Awareness of ARSH practices were 100% in Swedish youth when compare to 60% amongst Indian youth. Sexual practices were safe though Sweden is an open society. In India though society is traditional, selling sex & unsafe sexual practices are major problem leading to spread of HIV & STD's.

Majority of adolescents had regular cycles in both countries. Dysmenorrhoea was the primary concern in both countries. School absenteeism was very less in both countries during the 1st and 2nd day cycle.

Utilizing youth friendly health services (YFHS) was 100% among Swedish and none among the Indian youth utilized Youth friendly health services (YFHS).

RECOMMENDATIONS:

1. Encourage school health camps and counselling sessions involving science teachers and parents/doctors at every school.
2. Youth friendly health services to be established at all places in India.

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