

Majority of the students have overweight (48 %), with 28 % students are in the pre-obesity stage and 20 % are obese. Skin manifestation like acne and hirsutism are absent in many cases, but 16 % of students have hirsutism and 40 % have acne problems. Accordingly, majority of students (60 %) have regular menstrual cycle, but also 40 % of students have irregular menstruation.

Table 2 shows the duration of the menstrual cycle and number of bleeding days and amount of bleeding of students who have irregular menstruation: among them 16 % have been already diagnosed for PCOS and others are not. Students have been diagnosed for PCOS by doctors earlier, some had come with symptoms like oligomenorrhea and some had hyperandrogenism. Doctors have prescribed them to follow special diets or to take contraceptive pills which helps to control menstrual cycle and lower androgen levels.

Table 2 — Menstrual function in interviewed students

Students with irregular menstruation					
Duration of menstrual cycle		No of bleeding days		Amount of bleeding	
>35 days	80 %	<7 days	60 %	30–40ml	60 %
No menstruation for last 3 consecutive months in last 12 months	10 %	7days — 1 month	20 %	40–80ml	30 %
< 9 cycles per year	10 %	>1 month	20 %	>80ml	10 %

Conclusion

Results of the research shows that 16 % have been diagnosed with PCOS, but 84 % are not. But 40 % students, even without a previously PCOS, had a menstrual cycle disorder (oligomenorrhea). And 56 % had a BMI different from normal, 20 % are obese, which could be one of the causes of menstrual dysfunction. Among the people who have still not been diagnosed for PCOS 24 % are having irregular menstrual cycle and some skin manifestations or sexual hormonal imbalance. Those are at risk of having PCOS, so need to direct them to do hormonal tests or ultrasound scans of the ovaries to confirm the diagnosis and provide students with increased BMI with recommendations for lifestyle changes.

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AN OVERVIEW OF FAMILY PLANNING IN SRI LANKA AS A DEVELOPING COUNTRY: SATISFACTORY OR NOT?

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Introduction

Access to safe, voluntary family planning is a human right. Family planning is central to gender equality and women's empowerment, and it is a key factor in re-

ducing poverty. Yet in developing regions, an estimated 218 million women who want to avoid pregnancy are not using safe and effective family planning methods, for reasons ranging from lack of access to information or services to lack of support from their partners or communities [1]. This threatens their ability to build a better future for themselves, their families and their communities. Family planning is the information, means and methods that allow individuals to decide if and when to have children [2]. This includes a wide range of contraceptives including pills, implants, intrauterine devices, surgical procedures that limit fertility, and barrier methods such as condoms as well as non-invasive methods such as the calendar method and abstinence. Family planning also includes information about how to become pregnant when it is desirable, as well as treatment of infertility.

Aim

The purpose of this scholarly article is to review the concept of family planning in a developing country, taking Sri Lanka as an example. Developing countries struggle with lot of problems that Developed countries do not, like poverty and under developed Infrastructure facilities. But having said that, it may not stop the nation from providing good healthcare to its population. The goal of this article is to review whether Family planning provided in Sri Lanka is satisfactory or not.

Material and Methods of the research

This article is written with the data collected from Family Health Bureau of Sri Lanka, Department of Census and Statistics of Sri Lanka, Sri Lanka Journal of Gynecology and Obstetrics, National family Planning Program of Sri Lanka, World Health Organization website and from Previously published PubMed articles.

The results of the research and their discussion

The Democratic Republic of Sri Lanka with a population of 22, 034, 594 in 2020 is an island country in South Asia [3]. It is a developing nation with multi-ethnic and religiously diverse population. In Sri Lanka the sex ratio of the total population based on the 2012 Population and Housing Census is estimated to be 93.8 males to 100 females [3]. However, in Sri Lanka the sex ratio is skewed in favor of females which is largely attributable to the higher life expectancy of women. The population lives predominantly in rural areas, (77.4 %) while 18.2 % live in urban areas and 4.4 % live in the estate sector. Life expectancy at birth for 2011–2013 was 72 years for men and 78.5 for women [4]. Sri Lanka has also one of the fastest ageing populations among developing countries.

Sri Lanka defines those between the ages of 10–19 as adolescents, 15–24 years as youth and those between the ages of 10–24 as young people [5]. According to the 2012 Census, adolescents (10–19 years) comprise 16.1 % of the total population. Youth contribute 15.6 % of the total population. Knowledge of sexual reproductive health issues including Family Planning is poor among this age group. The National Youth Health Survey 2012/2013 found that overall knowledge on basic sexual reproductive health knowledge was not satisfactory. For instance, only 45.6 % of girls knew that pregnancy could take place even at the first sexual intercourse. About 14.7 % of the sample were sexually active during the preceding year. Among unmarried 15–19 year olds 9.7 % of boys and 2.5 % of girls had engaged in sexual intercourse [6].

Sri Lanka has an exceptional health sector. The remarkable success in reducing maternal and infant mortality to very low levels, i.e., 33.7 per 100,000 live births and 9.9 deaths per 1,000 live births respectively is partially the result of the extended availability of effective and integrated Maternal and Child Health services for the last half century [7]. These indicators are better than most developing countries and many lower-middle-income countries. Almost all deliveries are attended by skilled personnel [8]. In 2015 there were 113 maternal deaths reported throughout the country to the Family Health Bureau. Unmet need accounted for 26 deaths (23 %) [9]. There were 4 maternal deaths attributed to abortion. Abortion in Sri Lanka is illegal

except when a pregnancy endangers the life of the mother. Sri Lanka is classified as a HIV low prevalence country (HIV prevalence in those more than 15 years of age is less than 0.1 %) but the number of people living with HIV AIDS has increased steadily over the years. The cumulative total of HIV cases stood at 2,436 (1,597 males and 905 females) by the third quarter of 2016 [10]. Sri Lanka is ranked 73rd out of 187 countries on the Human Development Index (2015) and was also on track to achieving most of the targets of the Millennium Development Goals (MDG) according to a review conducted in 2014 [11, 12]. These achievements are in large measure due to free health care provision since 1931, and free education from kindergarten to University introduced in the mid-1940s. As a result, Sri Lanka has achieved human development outcomes comparable to those of high income countries.

In Sri Lanka, the first state run family planning clinic was opened in 1937, but it was not continued. In 1965, family planning was combined with maternal and child health programs and three years later the Family Health Bureau (FHB) was established to coordinate family planning under the Ministry of Health. Which gave free family planning services through government-run facilities, such as hospitals, clinics, health posts, health centers and through government fieldworkers. Public health nurses and midwives provide maternal and child health as well as family planning services at the grass root level. Oral contraceptive methods and condoms are available without prescription from pharmacies and government and private sector facilities are available island-wide. Over the years the government has built up a nationwide network of health facilities. A healthcare facility can be found on an average not further than 4.8 km from any home in the country [13]. Since the introduction of family planning (FP) to Sri Lanka in 1965 and the establishment of the National Family Planning Program (NFPP) the country has made considerable progress in providing a wide array of Family Planning services. In the mid-1970s one in three married women aged 15–49 were using a contraceptive method. By the mid-1980s, use of contraception increased to almost two in three women. During the period 1993–2000 the overall prevalence increased from 66 to 70 % [7]. The National Family Planning Program offers a wide choice of contraceptives. The modern temporary methods available are combined oral contraceptive pills (OCP), DMPA injections, intra uterine contraceptive devices (IUD), condoms and implants. Modern permanent methods include vasectomy and female sterilization. Women's education is widely acknowledged as being one of the most important determinants of contraceptive use. Only 5 % of women with no education use traditional methods. Studies worldwide show that modern contraceptive use is lower among poor women [1]. Even with substantial investments in female primary and secondary schooling over the years, UNICEF's Child Marriage Baseline Estimates show there are more than 20,780 girl children between the ages of 12 and 17 in Sri Lanka who are married or in cohabiting relationships and often have children before they reach 18 years of age [14]. The Census of Population and Housing 2012 indicates that 10.4 % of girls between the ages of 15–19 years are married. Teenage pregnancy in Sri Lanka is relatively low. According to 2010/11 SLDHS, overall only 6 % of women age 15–19 are already mothers or are pregnant with their first child. About 17 % of 19 year-olds were already mothers or pregnant for the first time.

Conclusion

Based on the statistics and data discussed above and previously published scholarly articles, we can see Sri Lanka's Family Planning is in good level comparatively to the other developing countries. Family planning efforts achieved considerable success in Sri Lanka during the late 20th century; however, overall levels and trends may mask relatively high levels of unmet need under certain conditions. Considering everything, we can come to the conclusion that Sri Lanka has a satisfactory Family Planning Program.

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CLINICAL SYMPTOMS OF COVID PNEUMONIA DURING PREGNANCY

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Introduction

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) responsible for coronavirus disease (COVID-19), along with other coronaviruses, can cause a spectrum of disease manifestations ranging from the common cold to pneumonia to severe acute respiratory syndrome (SARS). This disease has important implications for gravid patients. Pregnancy is a unique condition with many changes in the immune system, which may lead to increased susceptibility to severe infections involving the activation of the immune system. This is highly likely to be the case in COVID-19 pneumonia as the immune system and cytokine storm play a major role in the pathophysiology [1]. Pregnant women are at greater risk for developing pneumonia presenting with fever, cough, and dyspnea when infected with COVID-19. Pregnant patients are more likely to experience severe complications such as multisystem inflammatory syndrome involving myocarditis when also suffering from COVID-19.

Aim

The purpose of this article is to compare the clinical symptoms of COVID-19 pneumonia in pregnancy among patients in both India and Belarus.

Material and methods of the research

The data were collected from the Gynecology department of PRS Hospital, India. Study was conducted from May 1st, 2020, to April 30th, 2021, at Postgraduate Institute and YCM Hospital Pimpri Pune (Maharashtra), a dedicated COVID hospital