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Contents of the Issue

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Obstetric Violence in the Perspective of Health Professionals: The Naturalization of Gender Violence as Part of Childbirth Care

By Amanda Reis Trajano & Edna Abreu Barreto

Universidade Federal do Pará

Abstract- The pattern of childbirth care widespread in our society is marked by the uses of interventions and technologies, permeated by obstetric violence in terms of excessive medicalisation and loss of female autonomy. This is an exploratory research made with a qualitative approach through semi-structured interviews, which analyzed the obstetric violence witnessed and pointed out from then arrative of health professionals who provide childbirth care, analyzed from Bardin's content analysis. In this research we show that childbirth care is surpassed for many violences forms: physical and verbal abuses, moves restriction, physical exposure, lack of consent and orientation, from the trivialization of individuality and the female autonomy, as of the trivialization of good practices assistance on the childbirth and birth.

Keywords: *obstetric violence. maternity. childbirth.*

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Obstetric Violence in the Perspective of Health Professionals: The Naturalization of Gender Violence as Part of Childbirth Care

A Violência Obstétrica Na Visão De Profissionais De Saúde: A Naturalização Da Violência De Gênero Como Parte Da Assistência Ao Parto

Amanda Reis Trajano [α] & Edna Abreu Barreto [σ]

Resumo- O modelo de atenção ao parto difundido em nossa sociedade é marcado pelo uso de intervenções e tecnologias, perpassado pela violência obstétrica no que tange o excesso de medicalização e a perda da autonomia feminina. Esta é uma pesquisa exploratória com abordagem qualitativa, por meio de entrevistas semiestruturadas, que analisou as formas de violência obstétrica presenciadas e apontadas a partir da narrativa de profissionais de saúde que realizam assistência ao parto, analisadas a partir da análise de conteúdo de Bardin. Evidenciamos que a assistência ao parto é transpassada por diversas formas de violência: abusos físicos, verbais, restrição de movimentação, exposição física, falta de consentimento e orientação, a partir da banalização da individualidade e da autonomia feminina, bem como da trivialização das boas práticas assistenciais no parto e no nascimento.

Palavras-chave: *violência obstétrica. maternidade. parto.*

Abstract- The pattern of childbirth care widespread in our society is marked by the uses of interventions and technologies, permeated by obstetric violence in terms of excessive medicalisation and loss of female autonomy. This is an exploratory research made with a qualitative approach through semi-structured interviews, which analyzed the obstetric violence witnessed and pointed out from then arrative of health professionals who provide childbirth care, analyzed from Bardin's content analysis. In this research we show that childbirth care is surpassed for many violences forms: physical and verbal abuses, moves restriction, physical exposure, lack of consent and orientation, from the trivialization of individuality and the female autonomy, as of the trivialization of good practices assistance on the childbirth and birth.

Keywords: *obstetric violence. maternity. childbirth.*

I. Introdução

O parto e o nascimento são fenômenos ímpares na vida das mulheres que vivenciam a maternidade. São eventos complexos que envolvem aspectos sociais, emocionais, espirituais, culturais e levam à interação de pessoas e grupos sociais distintos em instituições de saúde (SENS; STAMM, 2019).

Historicamente a gestação e o parto sempre pertenceram à privacidade do universo feminino. A assistência às parturientes e aos recém-nascidos era realizada em domicílio por mulheres conhecidas como parteiras, aparadeiras ou comadres (BRENES, 1991; AGUIAR, 2010).

No século XIX sucedeu a consolidação da medicina como saber científico, trazendo consigo a visão da medicalização dos corpos. A medicina transformou as mulheres em objetos de intervenção, numa ideologia que presume que o corpo feminino é patológico. Esse discurso médico pautado no modelo anatomopatológico permitiu que os profissionais que ofertassem cuidados às gestantes pudessem intervir a qualquer sinal anatômico que indicasse "risco". Para tal, foi necessário transferir o parto para o ambiente hospitalar, resultando na elaboração e na proliferação de rituais sobre a parturição e o nascimento, revelando um medo extremo da nossa sociedade tecnocrata aos processos naturais (BRENES, 1991; DAVIS-FLOYD, 1992 *apud* DINIZ, 2005; SILVA; GOTARDO, 2007; AGUIAR, 2010).

Na atualidade, vigora um modelo de atenção no qual o parto é assistido com intensa intervenção de profissionais e uso massivo de tecnologias, resultando em iatrogenias. Este modelo leva distância entre a mulher e o profissional de saúde e reflete uma assistência obstétrica frágil, por não conseguir articular a tecnologia e o cuidado de modo a garantir a interação entre as partes envolvidas e principalmente o respeito à totalidade da mulher (DINIZ, 2001; DOMINGUES; SANTOS; LEAL2004; SILVA; GOTARDO, 2007).

Na expectativa de ampliar o debate acerca da violência obstétrica no Brasil, contribuir com o aprofundamento sobre o tema e subsidiar medidas para a melhoria da assistência oferecida às parturientes, este artigo discute[1] como profissionais de

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[1] São apresentados alguns resultados da monografia de conclusão de residência em enfermagem obstétrica, defendida em 2018, trabalho para o qual foram entrevistados profissionais de saúde

saúde (médicos e enfermeiros obstetras, além de residentes de medicina e enfermagem em obstetrícia) percebem a violência obstétrica que as mulheres sofrem na atenção ao parto, com o objetivo de analisar as formas de violência observadas por eles a partir das recomendações da Organização Mundial de Saúde (OMS)para assistência ao parto e nascimento.

a) Caracterização do termo violência obstétrica

A violência obstétrica foi tipificada no art. 15 da *"Leyorgánica sobre elderecho de lasmujeres a una vida libre de violência"* (Lei Nº 38.668, de 23 de abril de 2007, Venezuela) como a apropriação do corpo e dos procedimentos reprodutivos das mulheres por profissionais de saúde, utilizando-se de tratamento desumano, excesso de medicalização, considerando processos naturais como patológicos, levando à perda de autonomia e capacidade de decisão sobre seus corpos ou sexualidade.

Essa forma de violência contra a mulher ganhou relevância e foi legitimada como problema de saúde pública.No Brasil, alguns estados, como São Paulo (Lei Nº 15.759/2015) e Santa Catarina (LeiNº 17.097/2017), e municípios tais como Diadema (Lei Nº 3.363/2013) passaram a adotar em suas legislações o conceito de violência obstétrica, como forma de interromper uma realidade que afeta 1 em cada 4 mulheres brasileiras (FUNDAÇÃO PERSEU ABRAMO, 2010). Os atos de desrespeito e abuso durante o parto abrangem violência física, humilhação, violência verbal, procedimentos médicos coercivos ou sem consentimento, falta de confidencialidade, violação de privacidade e negligência na assistência, gerando complicações evitáveis, levando a possíveis riscos de vida, sendo equivalentes a uma violação de direitos humanos fundamentais (DINIZ*et al*.,2015; WHO, 2014).

A violência sofrida por parturientes durante o trabalho de parto e parto é uma realidade com tamanha gravidade no Brasil que foi citada na Comissão Parlamentar Mista de Inquérito (CPMI) de Violência Contra Mulher no Brasil, realizada pelo Senado Federal. Em seu relatório final, a CPMI recomenda que as ações do Ministério da Saúde sejam intensificadas para prevenir e punir tais ações de violência (BRASIL, 2014).

b) Programas e políticas públicas voltadas para assistência às mulheres

Algumas medidas para a melhoria da assistência às gestantes foram tomadas ao longo dos anos. O Programa de Atenção Integral à Saúde da Mulher, (PAISM) elaborado pelo Ministério da Saúde, caracteriza a assistência ao parto como um ponto crítico para a saúde da mulher e apresenta, entre outros objetivos, o propósito de melhorar a assistência ao parto com profissionais treinados que realizem o acompanhamento dos estágios do trabalho de parto (dilatação, expulsão e dequitação), garantindo que ocorram, sempre que possível, de maneira natural com a gestante participando ativamente deles. À vista disso, desde a década de 80 já era apresentada a recomendação para a preservação dos eventos no trabalho de parto como naturais, conservando a autonomia da parturiente (BRASIL, 1984).

Em 1996, temos a divulgação do documento da Organização Mundial de Saúde (OMS) com a classificação das práticas utilizadas no trabalho de parto, contraindicando uma série de procedimentos de rotina que desrespeitavam a autonomia da mulher e tinham comprovações científicas de prejuízo para a saúde da parturiente e/ou do feto, tais como uso rotineiro de episiotomia, manobra de *Kristeller,*venóclise, ocitocina, toques vaginais frequentes, e outros(BRASIL, 2001).

Através da PortariaGM/MSNº569, de 1 de junho de 2000, é instituído o Programa de Humanização no Pré-natal e Nascimento pelo Ministério da Saúde. O programa se baseava em dois aspectos fundamentais: o dever da instituição de saúde em atender a mulher, seus familiares e o neonato com dignidade, ambiente acolhedor, evitando o isolamento da mulher; e a adoção de uma assistência com práticas comprovadamente benéficas ao parto e nascimento, evitando intervenções desnecessárias que não beneficiam o binômio mãe e filho.

Em 2003 é lançada a Política Nacional de Humanização, que busca qualificar e aprimorar a assistência em saúde e gestão desenvolvida pelo Sistema Único de Saúde (SUS). Posteriormente, foi instituída a Política Nacional de Atenção Obstétrica e Neonatal, a partir da Portaria do Ministério da Saúde Nº 1.067, de 4 de julho de 2005, que tem como princípios e diretrizes o direito da gestante ao atendimento digno e de qualidade, à assistência humanizada e segura, a ter acompanhante (instituído pela Lei federal Nº 11.108 de 2005), entre outros. A portaria ainda discorre sobre procedimentos a serem adotados, como: oferecer líquido via oral, respeitar a escolha da mulher sobre o local do parto, fornecer explicações, permitir liberdade de posição, oferecer métodos não invasivos de alívio da dor, usar a episiotomia de maneira restrita, e outros (BRASIL, 2005a).

Em 2008 a Agência Nacional de Vigilância Sanitária (ANVISA) lança a RDC 36/2008, que aborda o regulamento técnico para o funcionamento dos serviços de atenção obstétrica e neonatal, com o objetivo de estabelecer padrões para o funcionamento do referido serviço, com fundamentação na qualificação e na humanização da atenção aos usuários. O documento discorre ainda sobre a garantia do acompanhante, a promoção da ambiência acolhedora, o estabelecimento de rotinas de acordo com as evidências científicas, a

(médicos e enfermeiros obstetras, além de residentes de medicina e enfermagem em obstetrícia) sobre violência obstétrica praticada contra mulheres no trabalho de parto e parto.

garantia de privacidade eo uso de métodos não farmacológicos de alívio da dor (ANVISA, 2008).

A partir da Portaria do Ministério da Saúde Nº1.459, de 24 de junho de 2011, é instituída a Rede Cegonha no SUS. A Rede Cegonha vem aprimorar a assistência prestada durante a gestação e o nascimento, garantindo às mulheres o direito ao planejamento reprodutivo e à atenção humanizada à gravidez, ao parto e puerpério, a partir de quatro componentes: Pré-natal; Parto e Nascimento; Puerpério e atenção integral à saúde da criança; e Sistema logístico – transporte sanitário e regulação. No que se refere ao componente parto e nascimento, a melhoria da assistência é garantida pela suficiência de leitos, ambiência das maternidades conforme a já citada RDC Nº36/2008 da ANVISA, realização de práticas de atenção à saúde baseadas em evidências científicas, garantia de acompanhante, acolhimento e classificação de risco, e estímulo às equipes horizontais do cuidado. Uma das diretrizes da Rede Cegonha é justamente a utilização de boas práticas e segurança na atenção ao parto e nascimento (BRASIL, 2011).

Em fevereiro de 2017 são aprovadas as Diretrizes Nacionais de Assistência ao Parto Normal, a partir da Portaria Nº 353/2017. Esse documento sintetiza e avalia a informação científica disponível com relação às práticas frequentemente utilizadas durante o trabalho de parto e nascimento, fornecendo orientação com relação à assistência a ser realizada, com o objetivo de promover mudanças na prática clínica, uniformizar e padronizar as práticas mais comuns utilizadas; diminuir a variabilidade de condutas entre os profissionais; reduzir intervenções desnecessárias durante a assistência; difundir as práticas baseadas em evidências científicas e recomendar boas práticas de atenção ao parto e nascimento (BRASIL, 2017).As diretrizes disponíveis para a atenção humanizada ao parto e nascimentono Brasil, anteriormente descritas, consolidam práticas que podem interromper a violência obstétrica e que ainda são comuns na realidade de muitos hospitais.

II. Metodologia

Foi realizado um estudo exploratório com abordagem qualitativa, implementado a partir de entrevistas com profissionais que realizam assistência às mulheres durante o trabalho de parto e parto, em hospital público, conveniado ao SUS, localizado em Belém do Pará/PA, no setor de Pré-parto, Parto e Puerpério (PPP). Os atendimentos são realizados a partir de referências dos municípios do estado do Pará e por demanda espontânea, com atendimento de urgência de maneira ininterrupta. A instituição atende aproximadamente 900 partos por mês e é caracterizada como uma maternidade que vem fortalecendo ao longo de sua história as ações de melhoria na assistência à saúde da mulher (VIANNA, 2014).

Foi utilizada uma amostra de conveniência com 20 entrevistas de um universo de 79 profissionais elegíveis para o estudo. Foram incluídos os profissionais das áreas de medicina e enfermagem que tivessem concluído o ensino superior, residentes de medicina e enfermagem obstétrica que estivessem atuando na sala de parto e realizassem assistência direta às mulheres durante o trabalho de parto e parto. Foram excluídos profissionais que atuavam como professores ou preceptores de instituições de ensino, uma vez que se tratava de um hospital-escola, ou seja, foram excluídos aqueles que não tinham vínculo profissional com a instituição e os que atuavam em período noturno, uma vez que a coleta de dados ocorreu durante o período diurno.

Todas as entrevistas foram realizadas na sala de parto, durante os intervalos de atendimento, de maneira individual, com a prévia exposição dos objetivos da pesquisa, de seus riscos e benefícios. Vale ressaltar que as entrevistas foram gravadas, com autorização prévia dos participantes, e transcritas. Após a transcrição, as falas dos participantes foram codificadas e categorizadas. As categorias aqui analisadas se referem ao critério de tipos de violênciasobstétricas observados na instituição, conforme apontado nas entrevistas. Sendo assim, foram encontradas 5 subcategorias: abuso físico; abuso verbal; falta de orientação sobre o atendimento e procedimentos; exposição e restrição de movimentação; e posição no parto. Por fim, foi realizada a análise de conteúdo dessas categorias e a interpretação dos dados com o enfoque de Bardin (BARDIN, 2011).

O estudo foi avaliado e aprovado pelo comitê de ética e pesquisa da instituição de ensino superior ao qual está vinculado, com CAAE: 69070117.4.0000.5172, e pelo comitê de ética da maternidade escolhida, com CAAE: 69070117.4.3001.5171. Todos os participantes da pesquisa assinaram o termo de consentimento livre e esclarecido.

III. Resultados e Discussão

Foi realizada a abordagem de 23 profissionais durante os intervalos de atendimento, porém, 3 profissionais não participaram deste estudo, pois dois deles alegaram que, devido à rotina de atendimento, não possuíam tempo para realizar a entrevista, e outro alegou não concordar com a proposta do estudo, recusando-se a participar.

A maioria dos participantes da pesquisa era do sexo feminino, representada por 16 entrevistadas (80%). A respeito da categoria profissional, 11 entrevistados eram médicos (55%), somando-se médicos em especialização e médicos já especialistas. A maioria

dos participantes estava realizando especialização durante a coleta de dados, caracterizados como residentes, com 16 participantes (65%). A idade dos entrevistados variou entre 23 e 56 anos, com predominância na faixa etária de 20 a 29 anos, com 11 entrevistados (55%).

O perfil dos participantes está disposto na Tabela 1.

Tabela 1: Distribuição dos participantes, por características demográficas e profissionais – Belém/PA, 2018

Variável	N	%
Sexo		
Feminino	16	80%
Masculino	4	20%
Categoria profissional		
Residentes de enfermagem obstétrica	6	35%
Residentes de medicina em ginecologia e obstetrícia	7	35%
Ginecologistas obstetras	4	20%
Enfermeiros obstetras	3	15%
Idade		
20 - 29 anos	11	55%
30 - 39 anos	2	10%
40 - 49 anos	5	25%
50 - 59 anos	2	10%

Fonte: Elaboração própria.

1. Abuso verbal

Neste estudo, 12 participantes (60%) puderam identificar o abuso verbal como uma prática rotineira na unidade. Destacamos as falas mais relevantes:"Tem as violências verbais que eu imagino são essas, de técnico falando frases desse cunho, como eu já tinha dito, né, ah... 'Não doeu pra fazer, mas tá doendo pra nascer', né... E outras coisinhas mais" (Residente de medicina 2). "Eu vejo as pessoas gritarem com as pacientes, com as acompanhantes... Vejo um desrespeito verbal" (Residente de medicina 3).

> [...] é mais como forma de insulto realmente, a paciente pelo fato de... Hoje mesmo eu presenciei isso, hoje realmente como o PPP tava cheio de paciente, aí o profissional de saúde pegou e falou: 'isso é que dá, não quer parar de ter filho... Aí quer ficar sofrendo aqui, olha como a gente tá, tá lotado aqui, não tá dando pra dar assistência pra ninguém'. (Residente de enfermagem 1).

A partir do depoimento dos entrevistados, podemos observar a prática da violência verbal na atenção dispensada às mulheres, além da reprodução de um discurso moralista que estabelece um julgamento sobre a sexualidade feminina utilizando-se de jargões que menosprezam a mulher (HOTIMSKY*et al*., 2002). A clássica frase que retrata a violência obstétrica e foi aqui reproduzida por um dos entrevistados,"*não doeu pra fazer, mas tá doendo pra nascer*", foi observada em estudo sobre o tema (FUNDAÇÃO PERSEU ABRAMO, 2010) e revela a manutenção de um padrão de violência de gênero naturalizado na atenção ao parto. Como analisa Diniz (2009):

> Os abusos verbais voltados para a humilhaçãosexual do tipo "quando você fez você gostou"são uma constante nos estudos e fazem parte doaprendizado informal dos profissionais sobrecomo disciplinar as pacientes, desmoralizandoseu sofrimento e desautorizando eventuais pedidosde ajuda. (DINIZ, 2009, p. 320, grifos da autora).

O relato de violência verbal é observado nas análises sobre o tema como demonstrado na pesquisa de Sena (2016), na qual as entrevistadas mencionaram essa forma de violência como uma prática recorrente durante o trabalho de parto, principalmente quando as mesmas se recusavam ou agiam de maneira contrária ao que era imposto pelo profissional.

Aguiar, D'Oliveira e Schraiber (2013) apontam resultados semelhantes em sua pesquisa, na qual os entrevistados revelaram uso cotidiano de frases ofensivas,demonstrando a banalização dessas práticas. Porém, diferentemente dos entrevistados pelos autores, que consideraram o uso dessas agressividades verbais como "brincadeiras desrespeitosas", os profissionais deste estudo consideraram como uma forma de violência verbal.

A recomendação para assistência ao parto proposta pelo Ministério da Saúde disserta que o profissional deve respeitar a integralidade da parturiente e é sua responsabilidade manter um padrão de comunicação eficaz, e estar consciente do seu tom de

voz e das palavras utilizadas, bem como de suas atitudes, buscando manter uma relação de confiança entre ambos (BRASIL, 2017).

2. Abuso físico

Nesta categoria, 7 entrevistados (35%) reconheceram a ocorrência do abuso físico, o qual transcorre da seguinte forma: "Então uso de ocitocina, episiotomia sem o consentimento, eu já vi casos até de pessoas que não fazem anestésico pra fazer episio [...]. Eu já vi isso aqui, entendeu? [...] Kristeller também tem, eu já vi Kristeller" (Enfermeiro obstetra 1).

> O profissional não vê se uma conduta é necessária realmente naquele momento, mas ele faz aquela conduta pra adiantar um trabalho que ele poderia ter mais lá na frente. [...] Principalmente a questão de uso indiscriminado de ocitocina, amniotomia, o bebê tá alto, tá móvel, mas querem fazer amniotomia. Questões de tá fazendo a orquestra do períneo, ficar fazendo puxo dirigido, então tudo isso é muito observado aqui (Residente de enfermagem 3).

Os profissionais apontaram como formas de abuso a realização de procedimentos que são utilizados como rotina, tais quais as intervenções desnecessárias para acelerar o trabalho de parto, além da falta de orientação sobre procedimentos, ignorando a necessidade do consentimento da parturiente para realizá-los.

Desde 1996, a OMS afirma que a prática de episiotomia rotineira, o uso de ocitócitos indiscriminadamente e da manobra de Kristeller são consideradas práticas comprovadamente maléficas durante o trabalho de parto e que deveriam ser eliminadas. Somado a isso, também é apontado que a amniotomia precoce é considerada uma prática normalmente utilizada de maneira equivocada (BRASIL, 2001).

A episiotomia é o único procedimento cirúrgico realizado sem o consentimento da paciente e sem que lhe seja dada informações quanto aos riscos, benefícios ou às indicações, sendo uma forma de apropriação do corpo feminino, uma vez que é a única prática realizada em um indivíduo saudável, sem a sua autorização (DINIZ, 2001; PARTO DO PRINCÍPIO, 2012).

Tal procedimento provoca danos sexuais, dor, aumenta o risco de incontinência tanto fecal como urinária, além da possibilidade de complicações infecciosas. O uso dessa prática como rotina evidencia uma grave violação dos direitos reprodutivos e sexuais da mulher, além de violar sua integridade corporal (REDE FEMINISTA DE SAÚDE, 2002; PARTO DO PRINCÍPIO, 2012).

Qualquer intervenção realizada de rotina para simplesmente acelerar o trabalho de parto é maléfica, podendo aumentar o risco de morbimortalidade da mãe e do feto. A necessidade que os profissionais têm de acelerar o parto nos remete a uma linha de montagem, desconsiderando a fisiologia do nascimento e provocando uma série de intervenções e iatrogenias (PARTO DO PRINCÍPIO, 2012).

Quando o profissional desconsidera a necessidade de obter o consentimento da mulher para realizar uma intervenção no próprio corpo desta mulher, ele viola os direitos relacionados à condição de pessoa e faz com que a parturiente se torne apenas um corpo reprodutivo sob domínio da medicina (SENS, STAMM, 2019).

3. Falta de orientação sobre atendimento e procedimentos

A respeito da falta de orientação das parturientes, analisamos as seguintes falas:

> Os casos que eu vi foram de profissionais não-sensíveis tratando a paciente mal, de uma forma agressiva, não... Até mesmo o fato de você não explicar pro paciente o que tá acontecendo com ele, o que vai acontecer né, o estado dele, deixar ele sem informação já é uma forma de violência, principalmente a grávida. (Ginecologista obstetra 1).

> [...]vi muito Kristeller ser realizado aqui [...] procedimentos sendo feitos à força, sem o devido esclarecimento da paciente, uma episiotomia por exemplo[...]Às vezes o médico acaba ficando nervoso, acaba fazendo procedimento que não deveria...Deveria ter esclarecido antes. (Residente de medicina 2).

Vianna (2014) aponta em seu estudo que as parturientes receberam pouca ou nenhuma informação durante o trabalho de parto.Deslandes e Dias (2006) analisam em seu estudo que essa falta de orientação culmina na geração de insegurança tanto por parte da mulher quanto de seu acompanhante. A ausência de informações é comum em maternidades, pois legitima o poder médico, justificando a realização de condutas sem o devido esclarecimento, evidenciando, assim, a anulação do protagonismo feminino (BARBOZA; MOTA, 2016).

É importante ressaltar que a mulher, normalmente, desconhece a fisiologia do trabalho de parto, sendo fundamental uma orientação humanizada por parte dos profissionais que prestam o atendimento, como recomenda as diretrizes brasileiras de assistência ao parto. O documento orienta que a mulher deve ser atendida com tratamento respeitoso e fornecimento de informações baseadas em evidências científicas, para que possa ser inserida na tomada de decisões, estabelecendo uma relação de confiança entre profissional e parturiente e respeitando o protagonismo da mulher durante a parturição (BRASIL, 2017).

4. Exposição física

A prática de exposição da parturiente também foi sinalizada pelos profissionais, destacamos as falas mais relevantes: "às vezes vejo as pacientes sendo expostas fisicamente, porque deixam as portas abertas, que eu me lembre" (Residente de medicina 3).

> [...] diversos profissionais com diversos alunos desrespeitando aquele momento com a mulher, que acaba que lotam a sala do PPP e isso já é uma questão vista como violência, porque muitas delas nem querem a quantidade de pessoas que tem naquela sala, tem vergonha, porque tem homem, porque tem aluno homem, porque tem muitos alunos, e isso já por si já caracteriza. (Residente de enfermagem 4).

Com base nas entrevistas coletadas, foi possível observar a falta de privacidade das mulheres, pois os profissionais acabam expondo-as fisicamente ao deixarem as portas de seus quartos abertas após a avaliação, além disso, por se tratar de um hospital-escola, a instituição possui uma grande quantidade de alunos. Durante as avaliações ou partos propriamente ditos, os PPPs se encontram repletos de alunos, ávidos a aprender, sem o consentimento da mulher, expondo-a fisicamente para diversas pessoas.

Como apontam Wolff e Waldow(2008), os profissionais devem tratar a mulher com respeito, preservando sua privacidade, evitando, assim, causar constrangimentos ou inibição, pois isto pode afetar a evolução do trabalho de parto, dificultando-o. Os mesmos autores corroboram que durante a criação moralista de homens e mulheres, lhes foi ensinado que a genitália deve ser escondida e, portanto, quando a mulher é não somente exposta para um desconhecido, como para vários desconhecidos no momento íntimo do parto, é vergonhoso e intimidante, como foi demonstrado pelas puérperas entrevistadas no estudo.

5. Restrição da livre mobilidade

A restrição da mobilidade da parturiente foi percebidapelos profissionaisa partir das seguintes falas:“ainda tem muitos médicos, muitos profissionais que querem que a paciente tenha bebê naquela posição... Deitada ou semi-deitada, né.” (Residente de enfermagem 2).

> [...]falar que é pra ela parar de gritar, falar que ela tá gritando muito, que se ela continuar fazendo isso, ele vai embora, vai deixar ela sozinha lá pra ter o bebê, não vai mais ajudar ela, ela tá atrapalhando o bebê a nascer porque ela tá se movimentando, não quer ficar na cama[...]. (Residente de enfermagem 6).

Alguns profissionais ainda têm preferência pela posição litotômica, por ser a posição mais confortável para o profissional, mais fácil para a manipulação do períneo feminino. Dessa forma, muitos obrigam a mulher a ficar restrita ao leito, sem liberdade para movimentação e escolha da posição para o parto.

Para Niy*et al*. (2019), as limitações para a livre movimentação durante o trabalho de parto configuram uma forma de violência contra mulher. Neste sentido, as autoras afirmam:

> Nos países da América Latina, e no Brasil em especial, tem se construído o entendimento de que a restrição ao leito durante o trabalho de parto e a obrigatoriedade de dar à luz em posição supina podem configurar formas de violência institucional contra a mulher, uma vez que ferem a autonomia daparturiente, prejudicam o desenrolar fisiológico do parto e impedem que ela decida livremente sobre seu corpo. Essa apropriação do corpo das mulheres e de seus processos reprodutivos também tem sido denominada violência obstétrica, ou abuso, desrespeito e maus-tratos, e a cada dia crescem as evidências de que esse fenômeno está intimamente ligado à baixa qualidade da assistência e a piores desfechos, inclusive em serviços especializados. (NIY, *et al*., 2019, p.3).

As evidências científicas apontam que as posições verticalizadas durante o parto possuem mais vantagens, tais como: melhor padrão de contrações, processo de dilatação mais eficaz, diminuição da duração do primeiro e do segundo estágio do parto, menor incidência de sofrimento fetal devido ao maior fluxo sanguíneo que chega ao feto, e diminuição da dor por parte das parturientes (BALASKAS, 2015). Podemos ainda ressaltar aspectos psicológicos, como o aumento da sensação de controle e autonomia da mulher, fazendo com que a experiência da parturição seja mais satisfatória (NIY *et al*., 2019).

O Ministério da Saúderecomenda ainda que as mulheres devem ser encorajadas a adotar posições verticalizadas, se movimentar e buscar posições que considerem confortáveis e desencorajadas a adotarem posições horizontais (BRASIL, 2017).

Portanto, quando o profissional de saúde não permite que a mulher se movimente ou adote posições verticalizadas durante o trabalho de parto, este demonstra falta de conhecimento ou descrença nas evidências científicas, culminando no aumento de complicações que levam às intervenções e iatrogenias. Também podemos relacionar a preferência por posições horizontais como uma necessidade de manipular o períneo para utilização de outras práticas obsoletas no segundo estágio do parto, como a episiotomia.

IV. Conclusão

A assistência tradicional ao parto e nascimento, baseada no modelo tecnocrata e permeado por intervenções nocivas e sem respaldo científico, vem sendo questionada à medida que novas evidências surgem indicando melhores resultados perinatais. Porém, como foi observado pelo discurso dos profissionais, ainda existe um longo caminho para que práticas obsoletas, e consequentemente a violência obstétrica, deixem de fazer parte da assistência, uma vez que todos os atos mencionados pelos entrevistados, como o abuso verbal, o abuso físico, a falta de orientação e consentimento, a exposição física e a restrição da livre movimentação são criticados e desaconselhados de acordo com os estudos científicos atuais.

Como apontado na falas dos entrevistados, a assistência ao parto depende do profissional que a realiza e,aparentemente, não tem sido pautada nas orientações cedidas pelos documentos da OMS e do Ministéro da Saúde, uma vez que os entrevistados apontam episódios de objetificação das mulheres a partir de imposições e artifícios cruéis para lhes transformar em pessoas passivas e colaborativas com o trabalho de parto idealizado pelo profissional, centrado não na mulher e sim no obstetra (inclue-se aqui médicos e enfermeiros).

Podemos observar que ao longo dos anos o Ministério da Saúde vem implementando diversas ações para efetivar o uso de boas práticas durante o parto e nascimento, melhorando a assistência prestada à parturiente e ao recém-nascido e, consequentemente, visando também diminuir a incidência de maus tratos e violência contra essas mulheres, por meio de vários documentos, enfatizando a assistência humanizada, centrada no bem-estar da família e na autonomia da mulher, a partir de práticas com embasamento científico, com o propósito de obter um recém-nascido saudável e uma mãe satisfeita e não traumatizada.

Portanto, foi possível perceber que para a diminuição da prática de violência obstétrica é necessário que não só os profissionais e as instituições de saúde tomem conhecimento e apliquem todas as recomendações abordadas como boas práticas assistenciais para o manejo do parto, implementando intervençõesbaseadas em protocolos de assistência, pautados nas orientações do Ministério da Saúde e/ou evidências científicas atuais, além de oferecer cursos de educação continuada a fim de sensibilizar os profissionais que estão em atuação, para que se desestruture a cultura da violência durante o parto, bem como se faz necessário investir em métodos eficazes para fiscalização da qualidade da assistência oferecida nas instituições.

Compreendemos que parte do problema que envolve a violência obstétrica na atenção ao parto se relaciona à violência de gênero e ao desconhecimento dos direitos sexuais e reprodutivos das mulheres. Assim como a violência contra as mulheres se manifesta na sociedade de forma rotineira, essa cultura atravessa a atenção ao parto, em que pese as recomendações baseadas nas boas práticas.

Esperamos assim alcançar um modelo de atenção no qual o parto possa ser visto como um evento fisiológico, sem a necessidade de intervenções rotineiras ou uso de tecnologias intensivas, centrado na mulher e sua família, enfatizando o bem-estar do binômio mãe e filho e respeitando a individualidade de cada gestante e cada nascimento.

Para que tais práticas possam ser incorporadas em uma atenção humanizada é fundamental que a formação do profissional de saúde inclua as recomendações baseadas nas evidências científicas, bem como conheça os direitos sexuais e reprodutivos das mulheres,rompendo com uma cultura de violência de gênero que ainda é observada em muitas maternidades.

Contribuições das autoras

Todas as autoras participaram ativamente de todas as etapas de elaboração do manuscrito.

Abreviaturas

CPMI– Comissão Parlamentar Mista de Inquérito
PAISM– Programa de Atenção Integral à Saúde da Mulher
OMS– Organização Mundial de Saúde
SUS– Sistema Único de saúde
ANVISA– Agência Nacional de Vigilância Sanitária
PPP– Pré-parto, Parto e Puerpério

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Effect of Castor Oil on Induction of Labour in Tertiary Care Centre

By Dr. Rekha Aseri, Dr. Kalpana Mehta & Dr. Pankaj Kumar Solanki

Abstract- *Purpose:* Effect of Castor oil on induction of labour in tertiary care centre.

Materials and methods: 190 Patients admitted to labour ward of obg in mdm hospital jodhpur for induction of labour Castor oil was administered in 2 doses form in 18-24hrs interval and every given dose is 50 ml (47.75gm) in 200 ml of warm milk. Antiemetic drug was given 30 minutes prior to administered castor oil to minimize nausea and vomiting. Inclusion criteria was gestational age between >37 to 42 weeks plus intact membranes or amniotic fluid index >4 and regular fetal heart rate, normal fetal movements or reactive non stress test (NST), modified Bishop's score of ≤5 and estimated fetal weight 2.5 to 4kg.

Results: The frequency of labor initiation in the castor oil user was 57.8% and according to various authors in their studies frequency of labor initiation after castor oil administration. *and not induce labor was observed in* 42.10% and majority of women 84 (44.21%) delivered at our tertiary care centre belongs to age group 23 -27 yrs. in the castor oil user.

GJMR-E Classification: *NLMC Code: WP 660*

Strictly as per the compliance and regulations of:

Effect of Castor Oil on Induction of Labour in Tertiary Care Centre

Dr. Rekha Aseri [α], Dr. Kalpana Mehta [σ] & Dr. Pankaj Kumar Solanki [ρ]

Abstract- Purpose: Effect of Castor oil on induction of labour in tertiary care centre.

Materials and methods: 190 Patients admitted to labour ward of obg in mdm hospital jodhpur for induction of labour Castor oil was administered in 2 doses form in 18-24hrs interval and every given dose is 50 ml (47.75gm) in 200 ml of warm milk. Antiemetic drug was given 30 minutes prior to administered castor oil to minimize nausea and vomiting. Inclusion criteria was gestational age between >37 to 42 weeks plus intact membranes or amniotic fluid index >4 and regular fetal heart rate, normal fetal movements or reactive non stress test (NST), modified Bishop's score of ≤5 and estimated fetal weight 2.5 to 4kg.

Results: The frequency of labor initiation in the castor oil user was 57.8% and according to various authors in their studies frequency of labor initiation after castor oil administration. *and not induce labor was observed in* 42.10% and majority of women 84 (44.21%) delivered at our tertiary care centre belongs to age group 23 -27 yrs. in the castor oil user.

Conclusion: Castor oil are safe and effective for labour induction. Castor oil is cost-effective when compared to other inducind agents. Castor oil is stable at room temperature and does not need refrigeration.

I. Introduction

Castor oil can be considered a safe non-pharmacological method for labour induction. Labour is an inevitable consequence of Pregnancy. Only two events can prevent the onset of labour once pregnancy has become well established – the death of the undelivered mother or surgical removal of the fetus aim of successful induction is to achieve vaginal delivery when continuation of pregnancy presents a threat to the life or well being of the mother or her unborn child.

Castor oil is one of the most popular methods for labour induction Castor oil has long been used throughout history. In some countries, castor oil is used to terminate pregnancy if it is unwanted or unplanned. Its probable mechanism is to stimulate labour following the secretion of prostaglandins;[1,3,4] it may also lead to reflex stimulation of the uterus, and stimulation of the intestinal peristaltism.[1,2,4,5]

The aim of this study was to investigate the effect of castor oil in the induction of labour in term pregnant women.

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II. Aims and Objectives

To assess the effect of castor oil in induction of labour.

III. Induction of Labour

Ian Donald stated that induced labour is 'the one in which pregnancy is terminated artificially any time after the period of viability by a method which aims to secure delivery via naturalis.

IV. Material and Methods

Source of Data: 190 Patients admitted to labour ward of OBG Dept of MDM JANANA WING DR. S. N. MEDICAL COLLEGE JODHPUR and Hospital with an indication for induction of labour.

Indications for Induction in Our Study 1. Mild pre eclampsia 2. Severe pre eclampsia 3. Post dated pregnancy 4. polyhydramnios 5. oligohydramnios 6. Gestational Diabetes Mellitus 7. Chronic hypertension 8. Rh negative Pregnancy.

Inclusion Criteria: All pregnant patients admitted for delivery having: 1. Singleton fetus with cephalic presentation. 2. Over 37 weeks of gestation 3. Reactive fetal heart pattern 4. Unfavorable cervix Bishop score ≤ 5. No contraindication to vaginal delivery willing to participate in the study.

Exclusion Criteria: All pregnant patients admitted for delivery having following were excluded 1. Mal presentation 2. Abnormal fetal heart rate pattern 3. Meconium stained amniotic fluid 4. Contraindication to vaginal delivery 5. Patients not willing to participate in the study.

V. Sample Size

190 antenatal cases was taken who admitted in labour room for delivery. $N=4PQ/L^2$ P=Proportion of women at term who successfully induced with castor oil as a labour inducing agent, Q=100-P, L=Absolute allowable error.

VI. Data Analysis

To collect required information from eligible patients a pre-structured pre-tested Proforma was used. For data analysis Microsoft excel and statistical software SPSS was used and data were analyzed with the help of

frequencies, figures, proportions, measures of central tendency, appropriate statistical test

Method of Induction: This is a hospital based observational study which was conducted at Dr S N Medical College, Jodhpur, Rajasthan by evaluating the women who were admitted in our hospital (MDMH) for delivery. After informed consent had been obtained, the patients selected for the study were evaluated

Castor oil was administered in 2 doses form in 18-24hrs interval and every given dose is 50 ml (47.75gm) in 200 ml of warm milk. Antiemetic drug was given 30 minutes prior to administered castor oil to minimize nausea and vomiting. Inclusion criteria was gestational age between >37 to 42 weeks plus intact membranes or amniotic fluid index >4 and regular fetal heart rate, normal fetal movements or reactive non stress test (NST), modified Bishop's score of ≤5 and estimated fetal weight 2.5 to 4kg.

A detailed clinical history were recorded and a thorough physical examination was performed at the time of presentation. Investigations like complete blood count, liver function test, kidney function test, random blood sugar, viral markers, serum electrolytes, urine routine microscopy done.

After castor oil ingestation patients were monitored for signs of labour maternal vital signs, fetal heart rate and progress of labour. The fetal heart rate was monitored by either intermittent auscultation or continuous fetal heart rate monitoring. A partogram was strictly maintained in all patients induced.

Table 1: Distribution of women according age distribution

Age (in years)	Number	Percentage
18 – 22	64	33.68
23 – 27	84	44.21
28 – 32	35	18.42
33 – 38	06	3.16
>38	01	0.53
Total	**190**	**100%**
Mean ±SD	**24.64±3.92**	**Range – 18.00-40.00**
Median	**24.00**	

Table 2: Distribution of the women according to Labour initiation

Labour Initiation	Castor Oil Induction	Percentage
YES	110	57.8%
NO	80	42.10%

VII. Result

In table 1 shows that majority of women 84 (44.21%) delivered at our tertiary care centre belongs to age group 23-27 yrs.

In my study table no. 2 shows that the frequency of labor initiation in the castor oil user was 57.8% and according to various authors in their studies frequency of labor initiation after castor oil administration is as follow

Authors and year	Frequency of labour initiation
Davis et al (1984)[1]	75%
Garry et al (2000)[3]	57.7%
Azhari et al (2006)[6]	54.2%
Boel et al (2009)[7]	54.2%
Okoyo et al (2019)[8]	57.1%
Present study	57.8%

The frequency of labor initiation in the castor oil user in my study is coinciding with the studies of Garry et al (2000)[3], Azhari et al (2006)[6], Boel et al (2009)[7], and Okoyo et al (2019).[8]

Labour initiation in the castor oil user was 57.8% and the success of labour induction *and not to induce labor was observed in* 42.10%.

VIII. Conclusion

Castor oil are safe and effective for labour induction. Castor oil is cost-effective when compared to other inducind agents. Castor oil is stable at room temperature and does not need refrigeration.

In conclusion, we believe that Castor oil, is apparently safe, efficient and a cost-effective induction agent with no maternal and fetal side effects which may

become the drug of choice, for induction of labour in the coming years.

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Prevalence of Eclampsia and its Fetomaternal Consequences in Bangladeshi Women: A Cross-Sectional Study

By Dorothy Shahnaz Mukul Fatema, Abdul Khaleque & Salma Rouf

Abstract- *Background:* Eclampsia is a treatable and preventable cause of maternal illness and mortality, as well as a poor fetomaternal outcome, in developing countries. Despite advances in human resource health education and institutional obstetric care, delays in early detection of the problem and availability to appropriate professional care are important hurdles to lowering complications.

Objective: This study aims to determine the incidence of the fetomaternal outcome of eclampsia among Bangladeshi women.

Method: A cross-sectional study was carried out among 240 patients in the Gynaecology Department of Dhaka Medical College Hospital, Bangladesh, from January 2014 to December 2015. Details and data obtained from Medical Records Section were analyzed. All patients with eclampsia were included, and fetomaternal outcomes were measured in terms of complications.

Keywords: *fetomaternal outcomes, eclampsia, bangladeshi women.*

GJMR-E Classification: *NLMC Code: WA 310*

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Prevalence of Eclampsia and its Fetomaternal Consequences in Bangladeshi Women: A Cross-Sectional Study

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Results: Among 5073 deliveries, 240patients had eclampsia with the incidence of 47.3/1000 deliveries. Maximum (42.5%) patients were below 20 years of age, maximum (79%) patients had antepartum eclampsia, and the highest number of patients (71%) had cesarean section delivery. Maximum patients (51.2%) had primipara. Here, 5% patients had cerebral edema, 3.90% patients had renal failure, 4.1% patients had HELLP (Hemolysis, Elevated Liver enzymes, and Low Platelet count) syndrome, 2.8% patients had pulmonary edema, 3.2% patients had psychosis, and only 1% patients had anemia. Among perinatal complications, maximum babies (46.40%) were preterm babies and low birth weight babies (38.50%).

Conclusion: Eclampsia was prevalent in younger primigravida who did not have access to prenatal care. There is an urgent need for effective antenatal care, strict monitoring of individuals with eclampsia, and rapid hospitalization to improve maternal and fetal outcomes. Governments in low-resource countries must focus on developing and enabling women to be financially able to obtain health care to combat these figures on maternal, fetal, and neonatal health.

Keywords: fetomaternal outcomes, eclampsia, bangladeshi women.

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I. Introduction

Eclampsia is a potentially preventable disorder in underdeveloped nations that causes maternal sickness, mortality, and poor fetomaternal outcomes. [1] It is a life-threatening pregnancy condition that is connected to an elevated risk of morbidity and mortality for both the mother and the fetus. Eclampsia complicates roughly one out of every 2000 deliveries in developed countries, but it affects one out of every 100 to one out of every 1700 deliveries in poor countries. [2] Several studies have lately shown eclampsia as the primary cause of maternal death. Heart failure, pulmonary edema, aspiration pneumonia, cerebral hemorrhage, acute renal failure, cardiopulmonary arrest, adult respiratory distress syndrome, pulmonary embolism, postpartum shock, and puerperal sepsis are all suspected causes of maternal death in eclampsia. [1] While not all cases of eclampsia can be avoided, excellent antenatal care, early detection of eclampsia symptoms, prompt treatment, and timely termination of pregnancy can all assist to improve mother and fetal outcomes. Despite our country's relative progress in women's health education, human resource expertise, and institutional obstetric care, delays in early recognition of the problem, transportation to an appropriate health facility, and timely access to expert care continue to be significant roadblocks to reducing complications. Bangladesh has a high rate of eclampsia because it is a developing country. As a result, we chose to look into the occurrence of fetomaternal eclampsia outcomes in our research.

II. Objective

This study aims to determine the incidence of the fetomaternal outcome of eclampsia among Bangladeshi women.

III. Materials and Methods

Type of Study - A cross-sectional study

Place of Study - Gynaecology Department of Dhaka Medical College Hospital, Bangladesh

Period of study - January 2014 to December 2015

Sample size – 240 cases

Data collection: Data collected from the patients in a prescribed protocol.

Data analysis: After collection, all data were reviewed and edited during the analysis. Using window-based computer software built with Statistical Packages for Social Sciences (SPSS23), the data were then entered into the database, and statistical analysis of the results was obtained. The findings were presented in figures and tables.

IV. Results

The patient age distribution is shown in table 1. Among 240 women, maximum (42.5%) patients were below 20 years of age. Moreover, a minimum (1.7%) of patients were more than 35 years of age. The following Table 1 showed the age distribution of the patients:

Table 1: Age distribution of the patients

Age	Frequency	Percentage (%)
Less than 20years	102	42.5%
21 years- 25years	94	39.2%
26 years- 30years	27	11.2%
31 years- 35 years	13	5.4%
More than 35 years	4	1.7%
Total	240	100.0

Figure 1 shows the types of eclampsia found among the patients of this study. Here, maximum (79%) patients had antepartum eclampsia, 14% had intrapartum eclampsia, and a minimum (7%) of patients had postpartum eclampsia. See figure 1 below-

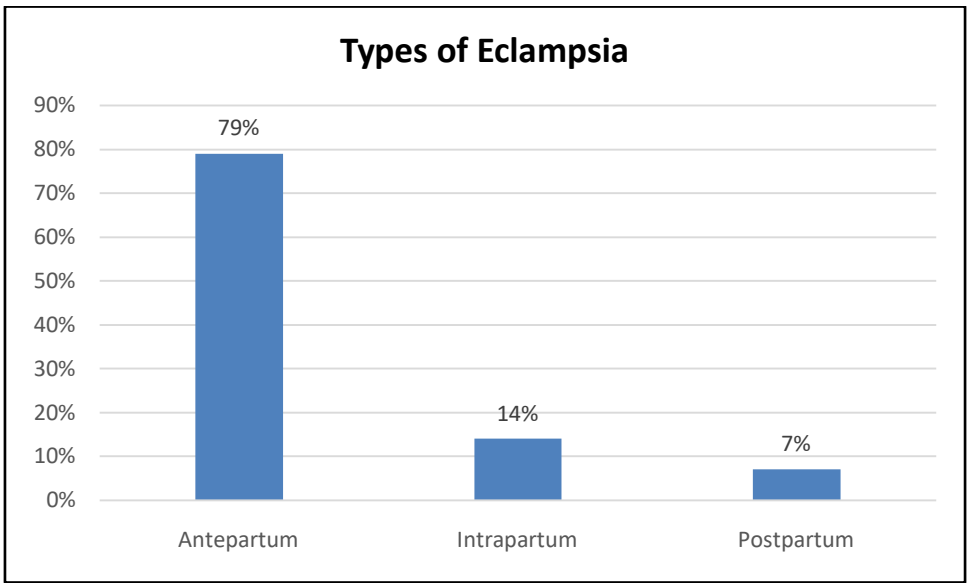

Figure 1: Types of eclampsia among the patients.

The mode of delivery of 240 women patients is shown in figure 2. Here, the highest number of patients (71%) had cesarean section delivery, 24% had a normal vaginal delivery, and only 5% had a delivery with vaccum/forceps. See below-

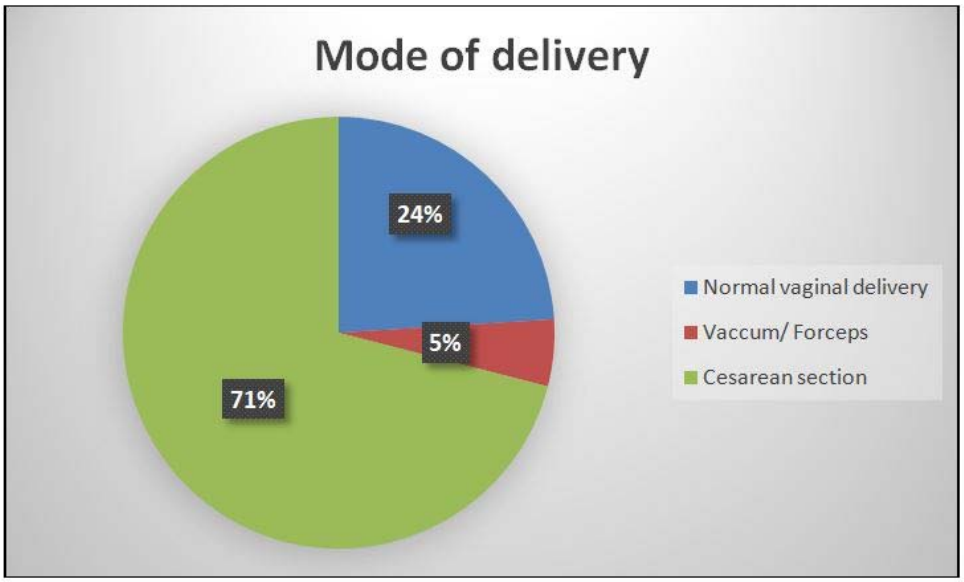

Figure 2: Mode of delivery of the patients

The distribution of parity among the 240 patients is shown in table 3. Here, maximum patients (51.2%) had primipara, while the minimum patients (2.5%) had grand multipara. See table 2 below-

Table 2: Parity distribution of the patients

Parity distribution	Frequency	Percentage (%)
Primipara	123	51.2%
Multipara	47	19.5%
Grand Multipara	6	2.5%
Antenatal care	4	1.6%
No antenatal care	98	40.8%

Figure 3 shows all the maternal complications of the patients in our study. Here, the maximum number of patients (69%) had no difficulties. However, 5% of patients had cerebral edema, 3.90% had renal failure, and 4.1% had HELLP syndrome. 2.8% of patients had pulmonary edema, 3.2% had psychosis, and only 1% had anemia. See figure 3 here-

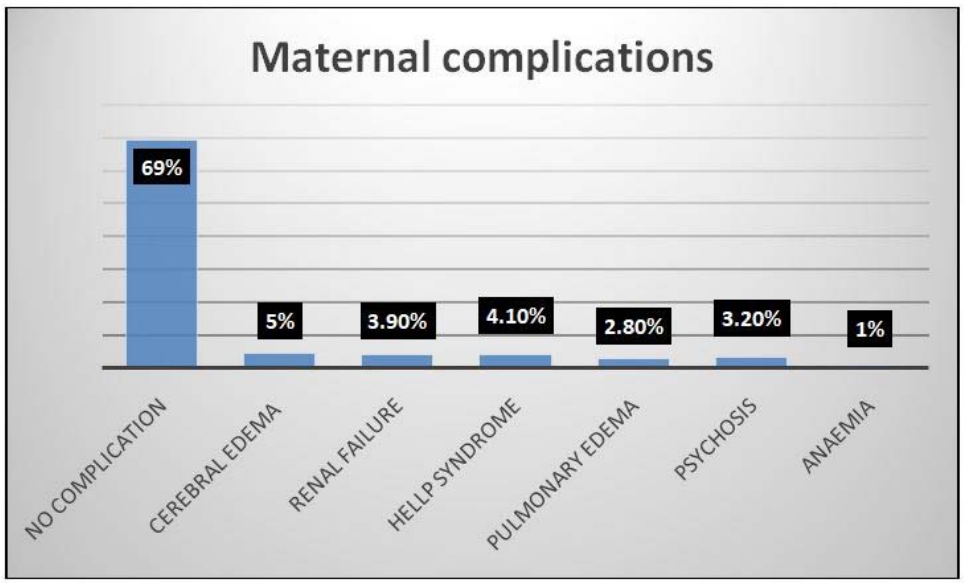

Figure 3: Maternal complications of the patients

Figure 4 shows the perinatal complications found in the babies. Here, maximum babies (46.40%) were preterm babies and low birth weight babies (38.50%). Moreover, 7.40% of babies were normal babies, 2.90% babies were macerated babies, and 4.80% were fresh still birth. See the chart (figure 4) below-

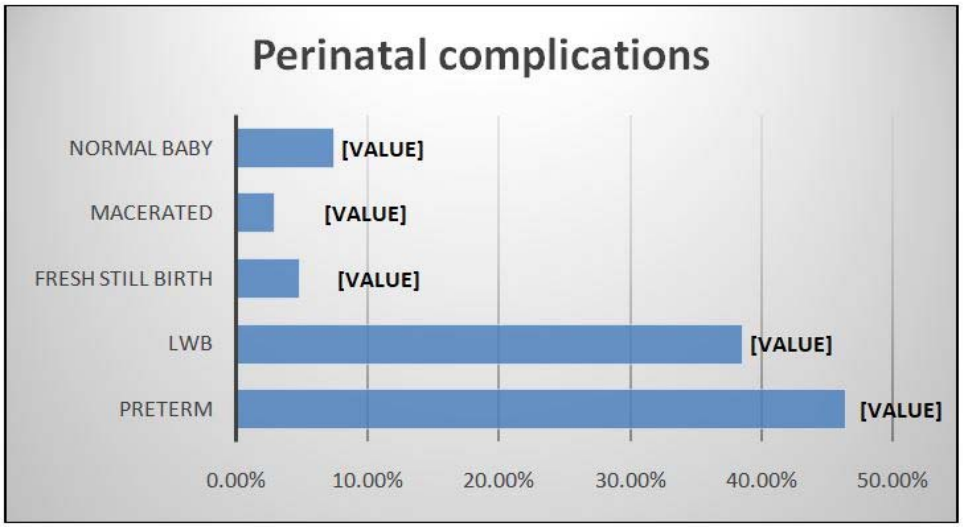

Figure 4: Perinatal complications observation.

The gestation period of the patients is shown in table 3. Maximum patients (56.25%) had 34-37 weeks of gestation, and minimum patients (3.75%) had less than 34 weeks of gestation. See all patients' gestation periods in table 3 below-

Table 3: Period of gestation of the patients

Period of gestation	Frequency	Percentage (%)
Less than 34 weeks	9	3.75%
34-37 weeks	63	26.25%
37-40 weeks	135	56.25%
Post-dated	33	13.75%

V. Discussion

Eclampsia affected 240 of the 5073 deliveries made in a year (January 2019 to December 2020), with a rate of 47.3/1000 deliveries and 4.73 percent. Eclampsia has been estimated to occur at a rate of 1.0 in the United States, 3.20 in India, and 0.05 in the United Kingdom. [4-6] Our investigation discovered a higher figure because the incidence of eclampsia is dependent on several factors. Temporal factors, socioeconomic development, age at marriage, maturation and modernization of the health facility, concentration of cases in a single location, particularly from the Safe Motherhood Program, no-risk policy, and referral of severe eclamptic patients to medical colleges all have an impact on the incidence. Geographic and racial factors may also play a role in the high prevalence, but more research is needed. The majority of the time, counting the factors that come into play directly or indirectly becomes extremely difficult; the only factors that must be considered when creating plans and policies are the prominent and adjustable factors. Our center is located in a developing country (Bangladesh), where early marriage is common, people live in poverty, and the vast majority of women do not receive antenatal care.

Due to improvements in socioeconomic status and the maturity of healthcare facilities, the prevalence in our country is decreasing over time. As a result, societal progress is becoming increasingly important in reducing the prevalence of eclampsia and its complications. In our study, eclampsia was found to be more common in young women (42.5%) and primigravidas (51.2%), which is similar to Sunita TH et al. and Kaur P et al. [7,8] In our study, 98 patients did not receive antenatal care from our center, and the amount of treatment and documentation provided to the remaining patients fell short of the standard of care. Patient and healthcare provider awareness appears to be insufficient for prompt referral and quality care. Gautam SK et al. reported that 98.4 percent of their patients received antenatal care, and the incidence of eclampsia was low in their study. [9] A study conducted by Manandhar BL found that prenatal care did not reduce the risk of severe preeclampsia/eclampsia. [10] Antepartum eclampsia, which usually occurs during a full-term pregnancy, affects the vast majority of our

patients (79 percent). Jha R et al. and Kaur P.'s findings were compared to ours. [8,11] Only 10.9 percent of patients gave birth within 6 hours of the convulsion, which is lower than Sunita TH et al (29 percent). [7] An early pregnancy termination would have been preferable, but due to logistical and other obstacles, including transportation, the time from home to the hospital was considerable. Our patients were delivered by cesarean section in the vast majority (71%) of cases, which is higher than Chaudhary P et alearlier.'s studies (55.31%) but lower than Gautam SK et alstudy,.'s which had all eclamptic patients delivered by cesarean section. [9,12]

Pneumoedema, cerebral edema, renal failure, and HELLP syndrome were the most common side effects in our investigation, which matched findings from an Indian study. [7] 69 percent of participants in our study, on the other hand, had no complications. This scenario demonstrates how these patients require a high level of expertise as well as a significant financial investment. Preterm birth, low birth weight, and stillbirth are all common perinatal complications among newborns. Perinatal problems can be avoided with early intervention and well newborn care services, which are common in developed countries. Finally, we conclude that eclampsia continues to be the most common cause of maternal and neonatal complications. According to the findings, a lack of adequate antenatal care, a low socioeconomic status, and a lack of community awareness of early detection, referral, and treatment of eclampsia are all important factors. Eclamptic patients should seek appropriate medical attention as a result of proper health education and public awareness, which should be promoted at all levels of the community.

VI. Conclusion

According to the findings, eclampsia is still one of the leading causes of maternal and neonatal problems. Eclampsia was common among younger primigravida who lacked access to prenatal care. There is an urgent need for good antenatal care, strict monitoring of patients with eclampsia, and immediate hospitalization to improve maternal and fetal outcomes. Governments in low-resource countries must focus on developing and enabling women to be financially able to obtain health care to combat these figures on maternal, fetal, and neonatal health. This would help avoid unnecessary problems and deaths. Global initiatives must include development assistance and debt reduction for developing nations so that funding can be directed toward women's and neonatal health issues.

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Management Strategies Adopted by Women in Menopausal Transition in a Selected Panchayath of Kozhikode District, Kerala, India

By Dr. Vijayasree K V

Background- The menopausal progress is a complicated period in a lady's life, reflecting ovarian maturing and hormonal changes, notwithstanding friendly and metabolic changes. These changes, thusly, impact the signs and issues normal to this period. Indications which are impacted by the hormonal variances happening during the menopausal progress incorporate vasomotor manifestations and vaginal dryness; others are bosom delicacy, rest issues and pre-feminine dysphoria. Hormonal treatment has been demonstrated to be first-line treatment for a significant number of these manifestations. Different sorts of pharmacotherapies might be useful, including specific serotonergic take-up inhibitors for vasomotor side effects. Trademark indications of the menopausal change incorporate unusual uterine bleeding, best made do with hormonal pharmacotherapy; lessening bone mineral thickness, which might warrant analytic intercession, and may profit from dietary and way of life adjustments; and expanded weight list and deteriorating lipid profile, which additionally may profit from dietary and way of life alterations.

GJMR-E Classification: NLMC Code: DDC Code: 618.175 LCC Code: RG186

MANAGEMENTSTRATEGIESADOPTEDBYWOMENINMENOPAUSALTRANSITIONINASELECTEDPANCHAYATHOFKOZHIKODEDISTRICTKERALAINDIA

Strictly as per the compliance and regulations of:

Management Strategies Adopted by Women in Menopausal Transition in a Selected Panchayath of Kozhikode District, Kerala, India

Dr. Vijayasree K V

I. Background

The menopausal progress is a complicated period in a lady's life, reflecting ovarian maturing and hormonal changes, notwithstanding friendly and metabolic changes. These changes, thusly, impact the signs and issues normal to this period. Indications which are impacted by the hormonal variances happening during the menopausal progress incorporate vasomotor manifestations and vaginal dryness; others are bosom delicacy, rest issues and pre-feminine dysphoria. Hormonal treatment has been demonstrated to be first-line treatment for a significant number of these manifestations. Different sorts of pharmacotherapies might be useful, including specific serotonergic take-up inhibitors for vasomotor side effects. Trademark indications of the menopausal change incorporate unusual uterine bleeding, best made do with hormonal pharmacotherapy; lessening bone mineral thickness, which might warrant analytic intercession, and may profit from dietary and way of life adjustments; and expanded weight list and deteriorating lipid profile, which additionally may profit from dietary and way of life alterations.

II. Need and Significance

The hormonal milieu of the menopausal progress encourages annoying vasomotor manifestations, state of mind interruption, brief intellectual brokenness, genitourinary side effects, and other sickness measures that decrease the personal satisfaction of influenced ladies. The endocrine tumult of the menopause progress likewise uncovered racial and financial differences in the beginning, seriousness, and recurrence of indications. Hormonal treatment (HT) can be powerful for perimenopausal indications yet its utilization has been hindered by worries about wellbeing hazards saw in postmenopausal HT clients who are more established than 60 and additionally ladies who have been postmenopausal for more than 10 years.

The menopause progress is a problematic cycle that can keep going for longer than 10 years and causes issues in a greater part of ladies. Clinicians should perceive early signs and symptoms of the progress and be ready to offer treatment to alleviate these manifestations.

III. Objectives

1. To find out the management strategies adopted by women in menopausal transition.
2. To find out the association between management strategies adopted by women in menopausal transition with marital status, education, occupation and menopausal transition stage.
3. To find out the adjusted effects of variables on the management strategies adopted by women in menopausal transition.
4. Find out the Correlation of knowledge on menopausal transition, health challenges of menopausal transition, health related quality of life and management strategies adopted.

IV. Methodology

Non experimental approach with a cross sectional survey design was adopted. 420 women of 40-55 years from Randomly Selected seven wards of (wards 3, 5,14,18,20,21,24) a selected panchayath of Kunnamangalam block of Kozhikode district, Kerala were included using a cluster sampling technique. After getting IEC permission from Govt. college of Nursing, data were collected using a semi structured interview schedule having three part. Section A with socio personal variable, Section B to assess the reproductive, marital and clinical data. Section C to assess the Knowledge on menopausal transition. This section consists of 24 items, which are categorized as 8 items on the meaning and causes of menopausal transition,7 items under signs and symptoms and problems associated with menopausal transition and 9 items under diet, exercise and management strategies adopted.

The collected data were analyzed using both descriptive and inferential statistics using SPSS soft ware 18 version.

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V. Results

a) Socio personal characteristics of the participants

The present study showed nearly one fifth of the population belongs to the age group less than or equal to 44 (25.7%), nearly one third in the age group of 45-49 years (35.5%) and the remaining one third belonged to the age group of greater than 50 years (38.8%). As far as religion is concerned nearly three forth (74.8%) were hindus, 20.7% were Islam and 4.3% were Christians and 0.2%were others. Out of the total sample more than half were home makers (68.8%) and 4.8%were private employees. only 7.6% were doing private employment and the rest 18.8% were working in the Govt. sector. Educational status showed 20% with non formal education, 30.2% with primary education, 17.6% completed secondary, 18.3% had higher secondary education and 8% were degree holders and 7.9% had post graduation. Regarding income, more than half had an income below Rs 5000/. Out of the subjects, 11% had an income of Rs >200001. Nearly cent percent are having a nuclear family (96.2%), only 2.4% had joint family and 1.4% had separated family. Nearly half of the sample had more than three members in the family (48.3%), 0.7% is having a single member in the family. Nearly hundred percent are following a mixed dietary pattern (97.9%) and only 2.1% are vegetarians.75.7% were following a sedentary life style and 24.3% doing hard work.

b) Menstrual, marital and clinical history

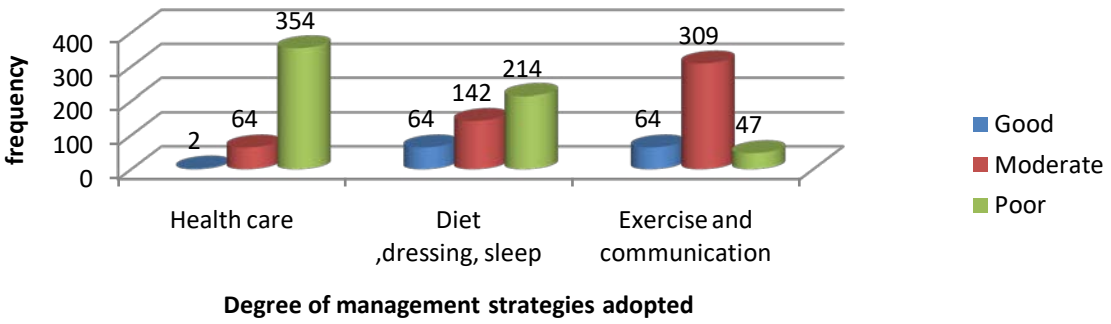
The mean age of attainment of menarche was 14.12years, with a SD of 1.21and nearly 90% attained menarche between 11 and 15 years. But 11% attained after the age of 16.Out of the total sample, 38.1% attained menopause. Out of the rest 38.6% had irregular menstruation and the rest with regular menstruation. Out of the sample with irregular menstruation, 23.8% had cycle duration less than 25 days and 13.6% had a longer cycle, ie, within 35-65 days and 1.2% had other type of irregularity. Women with menstruation 36.7% had a flow less than 5 days,18.6% with 5-7 days of flow and 6.7% had >7 days flow. Out of the samples 92.9% were married, 1.2% were single, 4.5% widows and 1.4% living separated. Regarding age at marriage more than half married after 20 years (55.2%), 13.3% got married before 18 years and 1.2% were not married. The average age of attainment of menopause was 47.83 years. As far as other illnesses are concerned, 47.4% had the history of illnesses. Diabetes mellitus, Thyroid disorders and hypertension were seen more in this study group. Out of the sample with history of illness, 5.7% had Diabetes mellitus and 12.4% had Hypertension. 6.7% with thyroid disorders and 6% with rheumatoid arthritis and 4.5% had the history of allergy. DM and hypertension were seen along with almost all other illness in this group.

c) Peri- menopausal status of the participants

Among the participants one fifth belonged to pre menopausal (23.3%), 38.6% menopausal and 38.1% post menopausal stage as per STRAW criteria. Out of the post menopausal group 35.5% had natural menopause and 2.6% had surgical menopause (attained menopause after hysterectomy).The mean age of menopause was found to be 47.83years.As far as number of pregnancy are concerned, more than 50% had less than two (57.1%), and 6% never became pregnant and not having children. Out of the sample, 10.7% of the women have One child, 50% with two children and 31.9% having more than two children. Regarding history of abortion 30.7% had and the rest don't.

d) Health seeking behavior of peri menopausal women

Nearly one third (22.1%) of the sample underwent ca cervix screening and the rest do not. Regarding mammogram 5.5% only underwent mammographic screening. More than three fourth (65%) of the sample used oral contraceptive pill in their life for different reasons. Nearly ninety percent completed their last child birth before 35 years, More than forty percent breast fed their baby for one year and 35.71% breast fed for more than 2 years.



Graph 1: Distribution of participants based on degree of management strategies adopted.

The management strategies were classified and assessed under health care, Diet, Dressing and sleep, exercise and communication. Based on the total score in the various domains, the total management strategies were classified as good, moderate and poor. Out of the total sample, 26.9% has got good, 56.42% has got moderate and 14.28% has got poor adoption of management strategies based on total score. The management under health care was seen poor than healthy life style and exercise and communication among these samples. 73.6% of the sample has adopted a moderate practice of exercise and communication as a management strategy to deal with the particular stage of menopausal transition they belonged.

Table 1: Distribution of participants based on level of management strategies adopted. (n=420)

		Total management strategies adopted	
		f	%
	Poor	60	14.28
	Moderate	237	56.42
	Good	113	26.9
	Very good	10	2.4

The data from the above table and graph is the division of the aggregate score of the total management strategy score of the participants. This data tell us nearly 15% of the women of menopausal transition age were having a poor total management score and only 2.4% had a very good score. It is good to say that the women of this study, who are mostly house wives, were using moderate level of management strategies to get acquainted with the inevitable stage of their life, the menopausal transition. Nearly thirty percent had (26.9%) good management.

Table 2: Descriptive association between management strategies adopted by women in menopausal transition and marital status. (n=420)

Marital status	N	Mean	Std. Deviation	df	F	p
Single	5	5.60	2.30	3	10.741	.000***
Married	390	10.14	4.52	416		
Widow	19	5.95	2.22			
Living separate	6	16.00	4.73			

The descriptive analysis between management strategy adopted by women of different menopausal transition group with their marital status showed statistically significant difference between women who were single and who were living separate as determined by One Way Anova (F (3,416) =10.741, p=.000). A Tukey HSD post hoc test revealed that the management strategy score was statistically significantly lower among women who are single with others like married and living separate. Women who were widow also had a less mean score compared to other groups. Marriage and family support really improves the health seeking of women.

Table 3: Descriptive association between management strategies of women in menopausal transition and occupation. (n=420)

Occupation	N	Mean	Std. Deviation	df	F	P
House wife	289	9.52	4.16	3	3.205	.000***
Private employee/coolie	20	10.95	5.59			
Temporary	32	11.16	5.18			
Govt. job	79	10.95	5.29			

The descriptive analysis between management strategy adopted by women of different menopausal transition group with their occupation showed statistically significant difference between women who were home makers and who were engaged with other jobs like private employment, temporary work/coolie and with government jobs as determined by One Way Anova(F(3,416)=3.205, p=.000). A Tukey HSD post hoc test revealed that the management strategy score was statistically significantly lower among women who are home makers than with others like doing private employment, temporary work or Government jobs. Women engaged in temporary work showed a high statistically significant mean score than women with private/coolie work or government job. The findings may be due to the individual differences.

Table 4: Descriptive association between management strategy adopted by women in menopausal transition and education

Education	N	Mean	Std. Deviation	df	F	P
Non formal education	84	9.90	3.89	5 414	17.832	.000***
Primary	127	8.42	4.05			
Secondary	74	10.66	4.82			
Higher secondary	77	8.77	3.78			
Degree and above	58	14.20	4.55			

The descriptive analysis between management strategy adopted by women of different menopausal transition group with their education level showed, a statistically significant difference between women who were primary educated and who were underwent higher education as determined by One Way Anova ($F(5,414)=17.832$, $p=.000$). A Tukey HSD post hoc test revealed that the management strategy score was statistically significantly lower among women who are having higher secondary education, non formal education, primary, secondary than with degree and above. The findings may be due to the individual characteristics of the sample.

Table 5: Descriptive association between management strategy adopted by women and menopausal transition stage

Menopausal transition stage	N	Mean	Std. Deviation	df	F	p
Pre menopausal	98	11.73	4.71	2 417	14.959	.000***
Menopausal	162	10.22	4.09			
Post menopausal	160	8.66	4.60			

The descriptive analysis between management strategy adopted by women of different menopausal transition group showed statistically significant difference between women who are post menopausal than who are pre menopausal as determined by One Way Anova ($F(2,417)=14.959$, $p=.000$). A levenes post hoc test revealed that the management strategy score was statistically significantly lower among women who are post menopausal than pre menopausal. The women of menopausal group also had a lower statistically significant mean score compared to the pre menopausal group. Adoption of management strategy depends on the need, availability, and individual knowledge.

Table 6: Adjusted effects of variables on the management strategies adopted by women in menopausal transition. (n=420)

Variable	Beta Co-efficient	t	Sig.
Income	.74	4.8	.000***
Dietary pattern	-.25	-.34	.734
Life style	.42	.822	.412
Number of pregnancy	.67	1.78	.076
Menstrual status	-.77	-2.96	.003**
Breast feeding duration of last child	-1.50	-3.34	.001**

'P' value based on ANOVA=<0.05, Adjusted R square=12.3%.

From the above table, a linear regression established that income, menstrual status, breast feeding duration of last child could statistically significantly associated with the health challenges of menopausal transition. $P<.001$, Adjusted R square 12.3% of the explained variability in the health challenges. Dietary pattern, life style and number of pregnancy were not statistically significantly associated with the management strategies adopted during menopausal transition among women in menopausal transition.

Table 7: Correlation analysis of knowledge on menopausal transition, health challenges of menopausal transition, health related quality of life and management strategies adopted. (n=420)

Knowledge on MT	Knowledge on MT	Health challenges	HRQOL	Management strategies
	1			
Health challenges	.275**	1		
	.000			
HRQOL	.286**	.628**	1	
	.000	.000		
Management strategies	.288**	.301**	.311**	1
	.000	.000	.000	

*** Correlation is significant at the 0.01 level (2-tailed).*

Significant positive correlation was noted between knowledge on menopausal transition and health challenges,(r= .275,p<.01), Health related quality of life and knowledge on menopausal transition(r =.286,p<.01),HRQOL and health challenges showed a high positive correlation(r=.628,p<.01)management strategies adopted with knowledge on menopausal transition(r= .288),with health challenges(r= .301) and with HRQOL (r= .311) p<.01. These all findings point out the importance of having knowledge regarding the menopause and menopausal transition.

VI. Discussion

Menopause in human is an in evitable and age related phenomenon, having associated with general health problems and problems specific to menopausal change too. So the principle of caring should consider the both. Drugs should be used with utmost care. Health care of aging women should approach with knowledge, optimism and compassion. Steps should be taken to provide effective and safe treatment for the most distressing menopausal symptoms of woman by taking in to consideration the good and bad effects of treatment.

Studies report that HRT to be used with most care, considering the general bone mineral density loss in both genders after 50 years, more among the female. A sensible approach, nutrition, exercise and ERT have found effective in MT symptom management. Helping woman to have a careful selection of HRT for the rest of her life is essential at a very early age of recognition of the first menopausal transition related symptom. Studies recognized the good effect of ERT in preserving and enhancing the cognitive function in post menopausal women. Exercise, stress reduction, and dietary changes may improve the QOL as they age.

Studies emphasized the greater advantage of a self help group for menopausal women at their community level to share their thoughts and up to date information, clarify their doubts and to empower them to take decisions too. These groups will have a therapeutic impact in the life of woman. Many herbal and homeopathic products with limited clinical trials were found to be effective in managing menopause related health issues, if taken as per direction. HRT use was more seen among smokers, with surgical menopause, with better socio economic status, higher education, and living in urban area. Single, divorced and widowed used HRT more than married. The more symptomatic women who were regularly consulting were the regular use of HRT. HRT has got a very positive role on the psychological well being among the post menopausal women. Studies in the USA revealed many women during MT, seek health care variably. VMS were considered as the most common symptom reported by all races/ ethnics. HRT, complementary and alternative medicine were used variably by these participants. Studies reported the beneficial effects of HRT, once started immediately after the menopause, but adverse effects also were reported. Studies reported the positive effects of exercise, yoga on menopausal symptoms. Studies also highlighted the importance of having greater awareness while handling the menopausal population from different ethnicities. Non leisure time physical activity seemed to be associated with a favourable sleep quality. Domestic guide lines on urinary incontinence and problems are found to be of great help among this group. Symptom management model to be practiced among this population to alleviate anxiety and to enhance the menopausal experience of women. Health and life style of the middle aged women need to be taken care of well. One Japanese study highlighted the effect of a ten minute stretching just before sleep in reducing the menopausal symptoms of Japanese women. Acupuncture showed good effect on VMS. Group education also found beneficial among this group. Soy isoflavones found to be good for managing the somatic and mental symptoms among the peri and post menopausal ladies.

VII. Conclusion

Need for empowering the women to actively participate in the management of MT symptoms including self care strategies provide a sense of worth and well being to them. This will have positive role in the general improvement of menopausal symptoms and overall health.

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Perceptions of Early Marriage among Young People in Kyrgyzstan

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Abstract- Despite legislation outlawing child marriage in Kyrgyzstan in 2017, the practice continues today. Early marriage is driven by social norms around religion, honor, financial stability, and restrictive gender roles. Participatory research activities were implemented with 12 adolescents in Kyrgyzstan Osh and the rural town of Chuy. Activities explored the perceptions of male and female youth around early marriage, gender norms, the consequences and benefits of marriage, and their autonomy in deciding who and when to wed. Responses from adolescents in the study were analyzed for themes by gender to reveal patterns in social norms around early marriage in Kyrgyzstan. Data showed that adolescents overwhelmingly did not support early marriage and expressed anxiety, shame, or concern about this topic. Interventions to prevent early marriage in Kyrgyzstan should advocate for girls' education and career opportunities and raise family and community awareness about the harms of child marriage.

Keywords: *adolescence, culture/ethnic practices, gender, global/international issues, qualitative methods.*

GJMR-E Classification: *DDC Code: 822.33 LCC Code: PR2827.A2*

Strictly as per the compliance and regulations of:

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Abigail Knouse [α], Sarah Milligan, MPH, MS [σ] & Suruchi Sood, PhD [ρ]

Abstract- Despite legislation outlawing child marriage in Kyrgyzstan in 2017, the practice continues today. Early marriage is driven by social norms around religion, honor, financial stability, and restrictive gender roles. Participatory research activities were implemented with 12 adolescents in Kyrgyzstan Osh and the rural town of Chuy. Activities explored the perceptions of male and female youth around early marriage, gender norms, the consequences and benefits of marriage, and their autonomy in deciding who and when to wed. Responses from adolescents in the study were analyzed for themes by gender to reveal patterns in social norms around early marriage in Kyrgyzstan. Data showed that adolescents overwhelmingly did not support early marriage and expressed anxiety, shame, or concern about this topic. Interventions to prevent early marriage in Kyrgyzstan should advocate for girls' education and career opportunities and raise family and community awareness about the harms of child marriage.

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I. Introduction

In the Republic of Kyrgyzstan, young women and girls experience pressure to follow traditional gender roles around marriage and childbirth. These pressures to conform to societal norms reduce investment in adolescent girls' educational and career goals. Despite negative attitudes and beliefs around child marriage and legislation that states the minimum age of marriage is 18, child marriage persists in Kyrgyzstan.

Early marriage often prevents young women from finishing their education and often results in adverse short and long-term health outcomes among adolescent girls (Reisel and Creighton, 2015). Due to early pregnancy and childbirth, in conjunction with lower access to healthcare, girls marrying as minors are at substantially significant risk for maternal morbidity and mortality, which increases the risk for neonatal death and stillbirth, premature and low birth weight infants, and infant and child morbidity and mortality. Further, even into adulthood, those married as minors are more likely to have significantly more children and experience low birth spacing between children. In addition to these maternal and child health concerns, there is also documentation of the mental health impact of child marriage. Research from Africa and South Asia has found that girls engaged or married as minors are at increased risk for depression and suicidality, linked with varying forms of gender-based violence. Additionally, there is some small but growing evidence that child marriage may increase the female risk for HIV and other *sexually transmitted infections* (STIs) (Raj, 2010).

Furthermore, normative pressure persists for girls to marry young due to the fear that they may be 'left behind' otherwise or not marry. Young men are pressured to marry around the age of 22-25 because of gendered norms that they must first secure a job and assets such as a house or car to provide for their family before marrying (National Statistical Committee of the Kyrgyz Republic & UNICEF, 2019). Parents wish to ensure financial stability for their daughters and strengthen their social networks through marriage.

This qualitative research was developed and implemented to add to the body of knowledge around the knowledge, attitudes, and experiences of youth in Kyrgyzstan with early marriage. Insights about adolescent knowledge, attitudes, and behaviors regarding early marriage can be leveraged by local non-governmental organizations to develop programs that empower and protect greater access to education and career opportunities for young women.

II. Literature Review

There are an estimated 650 million child brides (UNFPA, UNICEF & Global Women's Institute, 2019). The causes and drivers of child marriage include lack of economic or educational opportunities, adolescent pregnancy, events causing displacements such as natural disasters or conflict, lack of implementation of laws and policies to prevent early marriage, inaccessibility of sexual and reproductive health services, and gender inequity (UNICEF Regional Office for Europe and Central Asia, 2015). Religious beliefs are also cited as a driving factor for child marriage. It is believed that protecting the "honor" of adolescent girls by ensuring they are virgins upon marriage is culturally important (Kosheleva et al., n.d.). In Kyrgyzstan, traditional and religious practices such as bride kidnapping, bride price, and polygamy occur with

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limited social protection for young women who become subservient members of their husband's family members (Childress, 2017). Forced early marriage and cohabitation is a crime that carries a prison sentence of up to five years; however, these policies are often not enforced (UNICEF Regional Office for Europe and Central Asia, 2015). The lack of enforcement perpetuates the practice of child marriage and bride kidnapping.

A survey of adolescent girls in 2014 revealed that 10.4% had begun childbearing between the ages of 15 and 19, which correlates with the 13.9% prevalence of early marriage in girls aged 15 to 19 (Oxfam Novib, 2014). Another recent survey of adolescent girls in Kyrgyzstan showed that married girls face pressure to start having children as soon as they get married and continue until they give birth to a son, and only 7% of girls between the ages of 15-19 use one or more methods of contraception (UNICEF, 2018). In a qualitative study by UNFPA, nine out of 11 married girls experienced complications during pregnancy, childbirth, or post-partum (Kosheleva et al., n.d.). Despite these health concerns, they were still expected to continue physical labor and household chores and were not provided adequate access to medical care by their in-laws.

According to 2018 data from United Nations International Children's Emergency Fund (UNICEF), in Kyrgyzstan, 12.7% of women ages 20-49 got married before 18, and 13.8% of women aged under 24 married through some form of coercion (Childress, 2017). The United Nations also estimates that around 12,000 girls and women are abducted for marriage each year (Doolbekova, 2018).

Parents and caregivers arrange early marriages for their girls due to religious views and honor, a desire for financial stability, and the influence of restrictive gender roles (Bouman et al., 2017) (Doolbekova, 2018). Women in Kyrgyzstan have fewer employment opportunities than men due to the restrictive gender norms that uphold early marriage and encourage them to leave school to marry and start a family (Mayoux, 2017). In some rare cases, early pregnancy is a driver of marriage before 18 due to societal norms and expectations (National Statistical Committee of the Kyrgyz Republic & UNICEF, 2019).

Despite the legal protections for adolescent girls from early and forced marriage, there are still many barriers to its elimination. Since many early marriages are not registered, girls have few enforceable rights to financial support or property in the case of divorce or abandonment (UNICEF, 2018). In addition, it can be challenging for girls to leave a marriage if they experience abuse because they will be left vulnerable and do not have sufficient education or experience to find work. Another barrier to eliminating early marriage in Kyrgyzstan is early marriage is viewed as a "private matter" by society, making people unwilling to interfere or report suspected cases to law enforcement (UNICEF, 2018).

Proposed solutions to end child marriage include the empowerment of girls through formal schooling, information, skills, and social support, mobilization of parents and community members, economic incentives for girls and their families, and enabling a legal framework that prevents early marriage (Malhotra et al., 2011).

III. Theoretical Framework

This study explores the adolescent's perceptions in Kyrgyzstan about early marriage, gender norms within marriage, and their hopes for changes in the current social paradigm. According to Eco-social Theory (Krieger, 2012), effective public health practice should address and explore the lived realities of individuals facing exploitative practices in their communities. A clear understanding of individual and social factors driving harmful practices like child marriage is essential to developing evidence-based interventions that are relevant across an individual's life; and their historical context.

Social norms reflect a complex set of issues that comprise "unwritten rules" that emerge at the nexus of beliefs, perceptions, and behaviors. Harmful practices like child marriage exist due to an intersection of factors. First, it is essential to determine individual values and beliefs. Social norms theory describes three related domains. To be considered normative, a behavior needs to also align with the perceptions about what others do, also known as descriptive norms or normative expectations. If I think child marriage is a common practice, I might support it for fear of being socially ostracized. This perception of prevalence is not enough; norms prosper not just if others do something but also perceptions that I am expected to follow the norms, injunctive norms (empirical expectations). So not only do I think child marriage is a common practice, but I also believe that there is external pressure on me to comply. These two conditions are insufficient; people's behavior is based on their outcome expectations. This third domain of social norms is critical. I may think everyone is engaged in a practice and feels unspoken pressure to follow the norm. It is my expectations of adverse social outcomes for bucking the norm or positive social effects for following the norm that ultimately predicts my behavior.

The practice of asking elicitation questions about early marriage directly to adolescents (regarding experiential/instrumental attitudes, injunctive/descriptive norms, perceived control, and self-efficacy) allows us to hear from them directly. Better understanding, the specific social, cultural, and normative experiences of adolescents around child marriage can help develop a

critical understanding of this practice from the adolescent's perspective (Glanz et al., 2015).

Several factors play a significant role in predicting behavior change among adolescents (Krieger, 2012). These factors are typically categorized by personal, social, or environmental factors influencing behavioral change. Personal factors, or individual factors, include beliefs, knowledge, attitudes, or skills, whereas social factors involve interactions with friends, family, or community. Additionally, environmental factors consist of the physical and emotional environment that affect behavior change (Krieger, 2012). These factors often intersect and impact an individual's confidence to perform a new behavior (self-efficacy), their intention to perform a new behavior, or an individual's perceived behavioral control over performing a new behavior (Krieger, 2012). In situations such as child marriage, where structural inequities are at play, individuals, especially adolescent girls, perceived behavioral control significantly impacts their intentions and behaviors around marriage (Krieger, 2012).

Similarly, personal, social, and environmental factors can impact the health outcomes of adolescents. For example, social relationships can positively or negatively affect adolescent health outcomes (Umberson & Montez, 2010). Social relationships that are supportive and come from family, friends, or teachers can reduce stress, improve mental health, and enhance feelings of personal control (Umberson & Montez, 2010). While females have rarely reaped the rewards of social relationships, including marriage, this has not been the case for married, heterosexual men worldwide. Historically, this population has gained more health benefits as they experience fewer costs from child-rearing and are provided the opportunity to balance work and personal demands (Umberson & Montez, 2010).

Health recommendations provided by family, health care professionals, or a teacher can help lead to individual behavior change and improved health outcomes (Glanz et al., 2015). At the same time, social support and networks can greatly influence adolescents' behavior change and health outcomes by triggering the decision-making process within this population.

IV. Study Design, Tools, and Methods

This study was conceptualized as a rapid needs assessment of social norms perpetuating child marriage in Kyrgyzstan to support future social and behavior change interventions addressing social norms around this practice. Due to the limitations resulting from the COVID-19 pandemic, this needs assessment was unable to be conducted face-to-face. The research team had to be flexible and gather data by creating a digital diary with a series of prompts for adolescent boys and girls. Because of school closures, the research team collaborated with local NGO partners to identify adolescents between the ages of 14 and 17 to participate in the needs assessment. The sample included six adolescent males and six adolescent females between the ages of 14and 17. Half of the respondents were from Osh, the second-largest city in Kyrgyzstan, in the country's southern area. The other half of the respondents were from Chuy, a rural region located on the northern border with Kazakhstan.

Participants recorded their thoughts and feelings about early marriage over ten days using specific prompts in the diary. These diaries were then uploaded over the Internet, consolidated by local NGO representatives, and shared with the research team. The digital diaries consisted of five core activities, inquiring about their interests and demographic information, personal characteristics, dreams for the future, ideal future partner, life before and after marriage, social support network, and social norms around child marriage in their community. These activities allowed adolescents to share their thoughts freely about norms surrounding marriage and gender in their community while providing crucial data to inform program planning, implementation, and evaluation.

Table 1: Description of Tools

Name of Tool	Description
Famous Me	Participants provided Demographic information including age, gender, residence, level of education, as well as psychographic information such as favorite tv show, favorite film personality, and favorite ice cream flavor. • Participants were also asked to describe themselves using "I am" statements. **Research Question:** What are the demographic characteristics of a typical adolescent in Kyrgyzstan?
Dream Tool	Participants drew and then described Their dreams for the future and then explained their drawing describing observations about family, education, profession, hobbies, and their future spouse. • Follow-up questions about the age at which they would like to start a family and how many children they would like to have were included in this tool. **Research Question:** What hopes do young people in Kyrgyzstan have for their futures?

Perfect Life Companion Tool	Participants described: • How and where they will meet their future spouse. • The qualities and characteristics of their ideal partner. • How they would like to be treated by their spouse. • The type of housework their partner will contribute. • How they would like to spend time with their spouse. **Research Question:** How do ideal perceptions of marriage differ between adolescent boys and adolescent girls in Kyrgyzstan?
Life Before and After Marriage Tool	Participants described: • The typical lives of women in their village before and after marriage in terms of how she should behave, what she will do around the house, and what she should be doing. • Why a woman would want to get married and why a woman would not want to get married. • The benefits and consequences of getting married along with the benefits and consequences of not getting married. **Research Question:** What are the outcome expectations that adolescents hold around the social benefits and negative consequences of child marriage?
Know, Feel, Do	Participants described: • Their opinions about what they know, how they feel, and what they can do about early marriage. • Their perceptions about what others in their village know, how they feel, and what they can do about early marriage. **Research Question:** What are the current social norms around early marriage in Kyrgyzstan?

V. Data Coding Procedure and Analysis

Data from the Famous Me, Dream Tool, Ideal Partner, Life Before and After Marriage, and Know, Feel, Do activities were analyzed using a grounded theory approach involving thematic analysis to reveal social norms around child marriage in Kyrgyzstan. These codes were designed to uncover ideas, assumptions, and conceptualizations of early marriage shared by adolescents. The information was organized by theme in matrices and annotated with memos. Exemplar quotes were selected to represent major qualitative themes (such as dreams for the future, gender expectations in marriage, the role of parents/caregivers in early marriage, and fears/anxieties regarding early marriage). The analysis was disaggregated by gender to highlight differences between adolescent boys and girls in their feelings about early marriage in their communities.

VI. Results

Famous Me is an activity designed to allow participants to share information about themselves and develop rapport with the interviewers. This tool collected basic demographic data about participants such as age, gender, residence, level of education, and psychographic information such as favorite tv shows, favorite film personality, and favorite ice cream flavor. The favorite ice cream flavor prompt was used to engage adolescents. This tool also asked them to use "I am" statements to describe themselves. The most common adjectives used by male respondents to describe themselves were sporty, sociable, brave, responsible, studious, smart, honest, calm, funny, and shy. Female respondents used adjectives such as obedient, responsible, diligent, positive, sociable, inquisitive, industrious, smart, good, kind, and a good student.

The Dream tool is a visual and narrative activity that asks participants to draw their dreams for the future and then explain their drawings describing observations about family, education, profession, hobbies, and their future spouse. A follow-up question inquired about at what age they would like to start a family and how many children they would like to have. An analysis of the dream tool revealed that 83% of participants discussed future career aspirations, 58.3% spoke about their family, 50% mentioned their educational goals, 41.7% discussed their hobbies, 41.7% mentioned travel aspirations, and just 33.3% talked about marriage in describing their dreams for the future. Male participants described additional goals for the future, such as building their dream home, living with their parents or grandparents, owning a car, being a musician, having money, winning an Olympic gold medal, competing in tennis and football tournaments, playing chess, attending university, and having an attentive and obedient wife who will do household chores. One boy said he hopes to "win an Olympic gold medal in Greco-Roman wrestling, visit and tour the U.S., become a surgeon, go to the final football championship, play in chess competitions and a concert, play tennis, and have happiness."On average, both boys and girls identified their ideal age of marriage to be between 24-25 years and their perfect number of children to be between three and four. This same boy went on to say, "I would like to start a family at 26 and have two children, one son, and one daughter."Both male and female participants identified a slight preference for sons over daughters. One girl said, "I would like to start a family around 26-27

years of age and have five children: three sons and two daughters." Boys identified preferred occupations such as a businessman, pilot, chef, surgeon, doctor, and farmer. Girls, on the other hand, identified dream professions as becoming lawyers, pediatricians, or journalists. Additional dreams that female participants described include defending girls' rights, owning a car, playing basketball, blogging, making video content for social media, having money, making their parents and husband proud, owning a dog, attending university, and having happiness and protection. While male participants wanted to go to the United States and Moscow, Russia, the female participants dreamt of traveling to Korea, Mecca, the United Arab Emirates, and Paris.

Table 2: Dream Tool

Dream Tool	
Gender	Quote
Male	*"I hope to win an Olympic gold medal in Greco-Roman wrestling, visit and tour the U.S., become a surgeon, go to the final football championship, play in chess competitions and in a concert, play tennis, and have happiness."*
Male	*"I would like to start a family at 26 and have two children, one son and one daughter."*
Female	*"I would like to start a family around 26-27 years of age and have five children, three sons and two daughters."*

The Perfect Life Companion tool asked participants to discuss how and where they will meet their future spouse, the qualities and characteristics of their ideal partner, how they would like to be treated by their spouse, the type of housework their partner will contribute, and how they would like to spend time together. All female participants said they would like to meet their future spouse themselves either at work, university, or by chance. One girl said, "I told my mother that if they decided to marry me off, I would run away from home."On the other hand, half of the male respondents said their parents would find a wife for them. Girls hoped their future partner would be purposeful, humble, attentive, neat, patient, courageous, educated, respectful, honest, caring, generous, and kind.

In contrast, boys hoped their spouse would be smart, well-mannered, faithful, loving, beautiful, approved by their parents, kind, faithful, sincere, educated, obedient, honest, quiet, friendly, and calm. Female participants identified the household expectations of their future partner to include sharing advice, discussing issues, helping raise children, making money, working, offering advice, and repairing household items/appliances. One female participant said, "I want him to treat me with care and not forbid me to go for a walk in the park or a movie with girlfriends. He does not forbid me from making my dreams come true."

Male participants said they expect their future partners to do household chores, clean, entertain guests, cook, wash, raise children, tend to the garden, and milk cows. One male participant said, "She has to respect me, obey me, know her limits. She must understand and know that I want my own family to be like the family of my parents, with the same rules and order. I want her to stay at home raising her children. If she wants to work, then I will allow her to do that after, once the children have grown up." Boys said they would like to spend leisure time with their spouse by traveling, resting, going on a walk in the park or the capital, going to the zoo, watching movies at the cinema, spending time with their parents and children, going to a café, the theater, and the ballet. Girls said they would like to cook and eat delicious food with their spouse, discuss home renovations together, attend the same university, work together, listen to music, spend time in nature, go for walks, travel, watch movies and television and eat in restaurants.

Table 3: Perfect Life Companion Tool

Perfect Life Companion Tool	
Gender	Quote
Female	*"I told my mother that if they decided to marry me off, I would run away from home."*
Female	*"I want him to treat me with care and not forbid me to go for a walk in the park or a movie with girlfriends. He does not forbid me from making my dreams come true."*

The Life Before and After Marriage tool asked participants to describe the typical lives of women in their communities before and after marriage regarding how thye should behave, what they will do around the house, and what they should be doing before marriage. The tool then asked participants to describe why a woman would want to get married and why a woman would not want to get married. Finally, it asked them to

describe the benefits and consequences of getting married and the benefits and consequences of not getting married.

Adolescent boys and girls shared similar responses about how girls should behave, what girls should do around the house, and what they should be doing before marriage. Both groups primarily responded that girls should take on antiquated gender roles and perform activities such as cooking, cleaning, and obeying their family members before marriage. For example, one boy said, "Girls should be modestly obeying her parents, help her mother with household chores, clean around the house, cook and read books conducive to the development and enrichment of worldviews." Likewise, one girl responded, "Girls should do household chores, babysit children, not get an education." Adolescent girls responded with more comprehensive answers relating to how a girl should be and what they should be doing. For instance, one girl mentioned, "Girls should be modest and fun and thinking about their future work."

Adolescent boys and girls also responded with similar answers about how girls should behave, what girls should do around the house and what they should be doing after marriage. Responses from adolescent boys touched upon areas relating to household chores, taking care of and respecting their husbands and other family members, child-rearing, faithfulness, and obedience. One boy said, "A girl after marriage should be obedient, respect her husband's relatives, do "women chores" around the house, and love their children."Adolescent girls shared similar responses while adding that girls after marriage should be polite, non-emotional, well-groomed, support their family, and be silent and humble. For example, one girl mentioned, "After marriage, a girl should speak politely to the husband's parents and relatives."

Additionally, the Life Before and After Marriage tool asked participants to elaborate on why a woman would or would not want to get married. When asked why women want to get married, boys responded with answers relating to bearing children, pleasing their parents and relatives, financial senses, feelings of loneliness and independence, subjective norms, and media portrayals. One boy said, "Women want to get married so that they have independence and the money of the husband. Also, it is written on the Internet and on TV, and in all families, they think so. They see it in the village."Girls replied with identical answers; however, some girls mentioned that girls are expected to marry to have children. One girl said, "Loneliness is only good for Allah and no one else," while another girl responded with, "Women and girls were hammered into the head that they should continue their birth, they should have children and bring them up."

The participants were then asked explain why women would not want to get married. Boys responded with answers such as the ability to work, freedom and independence, study and attend university, inability to find their ideal life partner, financial reasons, and control and abuse of women. One boy said, "They want to get an education. To be independent. Perhaps they were once offended by men, or they saw men behaving as husbands, beating their wives, behaving dishonestly." Girls replied with answers relating to having the opportunity to work and study, inability to find an ideal life partner, a lack of desire to perform household chores, feelings of being afraid, dislike of children, the work that goes into being married and being a wife, restrictions that come with marriage, and the betrayal that can result from marriage. One girl responded that when you are married, "There are a lot of prohibitions, you can't speak. Children take a lot of time, the husband controls, and giving birth is hard and painful. There will be no freedom. All relatives and communities will control your actions."In addition, another girl said, "Some are afraid to get married because some families treat their daughters-in-law as slaves. They do not give freedom and do not consider her opinion."

Adolescents also reflected on the benefits and consequences of marriage for women. Boys identified the benefits of marriage for women, including having children, building a family, having a life partner, becoming a mother, and gaining respect in society. For instance, one boy responded by saying, "The benefits to marriage for women is that they get to create a family, become a mother, and build a family life." Likewise, boys identified the consequences of marriage for women as societal repercussions in the case of divorce, dislike of the husband or his relatives, abuse from a spouse, and the expectation that hobbies will end. One boy said, "The consequences of marriage for women are that they could endure screaming and beatings from their husband."

Additionally, male participants identified the benefits of not getting married for women as having the freedom to pursue work and university, autonomy, spending time with relatives, economic freedom, and having options for potential spouses. One boy said, "The benefits of not getting married for women are that they get to have a profession and more time to spend with their parents." In contrast, they identified the consequences of not getting married for women as childlessness, financial difficulties, societal repercussions, and loneliness. In particular, one boy replied, "The consequences of not getting married for women is that they will be alone."

Girls identified the benefits of marriage for women as happiness, spouse support, having a family and a home, becoming a mother, and having love. A participant responded, "The benefits of marriage for women is that they get to learn to appreciate their husband and have a home. They get to learn to raise children, and everyone will know she is married."They

identified the consequences of marriage for women as family quarrels, child-rearing, issues with the husband and his relatives, inability to pursue work or studies, and potential divorce. One girl said, "If a woman is divorced, her children are taken away. If a woman returns home after divorce, she is married a second time as a second wife. Or she is married to a man much older than her without even asking her consent." Female participants said the benefits of not getting married for women are freedom, the ability to study and live for themselves, the ability to pursue a career, fulfill dreams, and the ability to help their parents. One respondent said, "The benefit of not getting married for women is that her dreams will come true."Participants said the consequences of not getting married for women are living with their parents, being childless, and not having someone to take care of them in old age. One respondent said if she does not get married, her "parents can scold, constantly reminding her that she made the wrong decision at the time, that she did not listen to them." Another girl said, "Even if she is financially independent, she will still be told that she was not married because she has flaws. If she refuses to marry, she will be left alone, and people will condemn her."

Table 4: Life Before and After Marriage Tool

<table>
<tr><th colspan="4">Life Before Marriage and After Marriage Tool</th></tr>
<tr><th colspan="4">Life Before Marriage</th></tr>
<tr><td colspan="4">How Should A Women Behave, What A Women should Do, What Should A Women Be Doing</td></tr>
<tr><th colspan="2">Male Adolescents</th><th colspan="2">Female Adolescents</th></tr>
<tr><td colspan="2" rowspan="2">"Girls should be modestly obeying her parents, help her mother on household chores, clean around the house, cook and read books conducive to the development and enrichment of worldviews."</td><td colspan="2">"Girls should do household chores, babysit children, not get an education."</td></tr>
<tr><td colspan="2">"Girls should be modest and fun and thinking about the future."</td></tr>
<tr><th colspan="4">Life After Marriage</th></tr>
<tr><td colspan="4">How Should A Women Behave, What A Women should Do, What Should A Women Be Doing</td></tr>
<tr><th colspan="2">Male Adolescents</th><th colspan="2">Female Adolescents</th></tr>
<tr><td colspan="2">"A girl after marriage should be obedient, respect her husband's relatives, do "women chores" around the house, and love their children."</td><td colspan="2">"After marriage, a girl should speak politely by the husband's parents and relatives."</td></tr>
<tr><th colspan="4">Life Before and After Marriage</th></tr>
<tr><td colspan="4">Why A Women Would Want To Get Married</td></tr>
<tr><th colspan="2">Males</th><th colspan="2">Females</th></tr>
<tr><th>Reason</th><th>Quote</th><th>Reason</th><th>Quote</th></tr>
<tr><td rowspan="2">Independence and Financial Reasons</td><td rowspan="2">"Women want to get married because so that they have independence and the money of the husband. Also, it is written on the Internet and on TV and in all families they think so. They see it in the village."</td><td>Loneliness</td><td>"Loneliness is only good for Allah and no one else"</td></tr>
<tr><td>Child Baring and Expectations</td><td>"Women and girls were hammered into the head that they should continue their birth, they should have children and bring them up."</td></tr>
<tr><td colspan="4">Why A Women Would Not Want To Get Married</td></tr>
<tr><th colspan="2">Males</th><th colspan="2">Females</th></tr>
<tr><th>Reason</th><th>Quote</th><th>Reason</th><th>Quote</th></tr>
<tr><td rowspan="2">Ability to Attend University/Control and Abuse of Women</td><td rowspan="2">"They want to get an education. To be independent. Perhaps they were once offended by men or they saw men behaving as husbands, beating their wives, behaving dishonestly."</td><td>Restrictions, Lack of Freedom, Control over Women, and Feelings of being Afraid</td><td>"There are a lot of prohibitions, you can't speak. Children take a lot of time, the husband controls, and giving birth is hard and painful. There will be no freedom. All relatives and communities will control your actions."</td></tr>
<tr><td>Lack of Desire to Perform Household Chores, Lack of</td><td>"Some are afraid to get married because some families treat their</td></tr>
</table>

		Freedom, and Feelings of being Afraid	*daughters-in-law as slaves. They do not give freedom and do not consider her opinion."*
Benefits of Getting Married			
Females		**Males**	
"The benefits of marriage for women is that they ge to learn to appreciate their husband and have a home. They get to learn to raise children and everyone will know she is married."		*"The benefits to marriage for women is that they get to create a family, become a mother, and build a family life."*	
Consequences of Getting Married			
Females		**Males**	
"If a woman is divorced, her children are taken away. If a woman returns home after divorce, she is married a second time as a second wife. Or she is married to a man much older than her without even asking her consent."		*"The consequences of marriage for women are that they could endure screaming and beatings from their husband."*	
Benefits of Not Getting Married			
Females		**Males**	
"The benefits of not getting married for women is that her dreams will come true."		*"The benefits of not getting married for women are that they get to have a profession and more time to spend with their parents."*	
Consequences of Not Getting Married			
Females		**Males**	
"parents can scold, constantly reminding her that she made the wrong decision at the time, that she did not listen to them."		*"The consequences of not marrying for women is that they will be alone."*	

The Know, Feel, Do tool asked participants to describe the social norms surrounding child marriage by having them give their opinions about what they know, how they feel, what they can do about early marriage, and their perceptions about what others in their community know, how they feel, and what they can do about early marriage. The male respondents said they know that there are early marriages, that parents give their daughters to rich grooms, that the law prohibits early marriage, early marriage causes high mortality, a girl is not ready to become a wife and mother at 15-16 years old, and that girls will not be able to provide for the upbringing of their children without an education. Girls said they know that early marriage breaks people's lives, the consequences are harmful, they will become a mom early, it is harmful to health, girls can die during childbirth, they are not yet formed as a person, their interest in life will be lost, and that there are laws against early marriage with administrative fines. One girl responded, "Many regret that girls are married early."

In response to the social norms around child marriage, boys said, "That everyone knows and sees it. Many do not know the laws or understand the negative consequences of early marriage or early marriage is not the norm in their village". They responded, "That others feel a sense of pity and have different opinions that they cannot answer on their behalf. People don't talk about their feelings regarding child marriage because they often feel indifferent." Boys went on to say that people would not meddle or say anything if they disagreed with an early marriage and have seen parents or others arranging an early marriage for their daughter, who was a minor. One boy said, "The community should intervene if they see a mistake. Early marriage is a mistake."

Girls said that others know about early marriage, some pretend they are indifferent, and others know the law prohibits early marriage. However, they still create families at an early age. For example, low-income families form early marriages for religious purposes. One girl said, "My mom does not know, but I know she got married early. Then she married my father. All teenagers think marriage is bad and the consequences are negative. Girls think about it more. Boys don't even think about the future; they are not being stolen or married." Female participants said, "That other people don't feel anything, they don't care about early marriage, that their mom says to take your time with marriage, that people are indifferent or don't react, that others view it as a normal phenomenon and feel regret." Girls said that some people are taking legal action, that teachers say it is forbidden to get married early and girls should be educated first, and that there are no early marriages in their village, so no one pays attention to it. One respondent said, "Our neighbor got married last year; she was 15 years old. Everyone was happy." Another girl said, "At 18 years old, girls are looking for a partner. If they cannot find one after 25 years, they are left alone."

Table 5: Know, Feel Do Tool

Know, Feel Do Tool	
Gender	Quote
Female	*"Many regret that girls are married early."*
Male	*"The community should intervene if they see a mistake. Early marriage is a mistake."*
Female	*"My mom does not know, but I know she got married early. Then she married my father. All teenagers think marriage is bad and the consequences are negative. Girls think about it more. Boys don't even think about the future, they are not being stolen or married."*
Female	*"Our neighbor got married last year, she was 15 years old. Everyone was happy."*
Female	*"At 18 years old, girls are looking for a partner. If they cannot find one after 25 years, they are left alone."*

VII. Discussion

Data collected from the digital diaries revealed several significant themes, including lack of autonomy in decision-making, desire for freedom; future fears and hopes; gender inequities, social norms supportive of child marriage, and different expectations for married women compared to married men. Findings from the Know, Feel, Do tool concluded that parents and guardians were perceived as the decision-makers in early marriage, leaving both young women and men with limited autonomy in selecting both when they would marry and who their spouse would be. One boy said, "No one listens to me when there are adults involved." Another boy said, "If my parents had chosen my wife of 15 or 16 years and her parents would not mind, then I would have been silent and would live with it. Our parents decide everything."The dream tool disclosed the strong desires of adolescents for achieving their personal, professional, and academic goals. It conceded that early marriage remains a barrier for young women to achieve these goals. Both boys and girls expressed pity and concern for adolescents undergoing early marriage. One girl said, "I feel sorry for the girls. I think it's wild. It's not a deliberate act. I don't condone it. If the girls are firm and if they have a purpose, it's very difficult to get them married." The Life Before and After Marriage tool uncovered the difference in domestic roles and expectations of marriage between men and women. Young women are expected to bear children, perform household duties, and respect and obey their husbands and relatives. In contrast, young men are expected to find work, lead a marriage, and follow his aspirations. Furthermore, the characteristics of a future spouse and their household responsibilities revealed in the Perfect Life Companion tool demonstrated gendered viewpoints of the roles of men and women that are highly consistent with social norms and societal expectations in Kyrgyzstan, with more boys than girls reporting their appreciation of the status quo, related to gender and social norms. Information from this study has implications for future theory, program development, implementation, and monitoring and evaluating the effectiveness.

a) Implications for Theory

The collected information provided insights into the determinants of child marriage by using elements of eco-social theory and exploring the lived realities of individuals that could potentially face harmful practices in their communities. Overall the results show that child marriage exists within a complex web of individual and social factors. Self and normative expectations of gender roles were evident, with boys and girls tacitly agreeing with gender discriminatory norms, indicating that adolescents know about the harmful impacts of child marriage and generally hold opposing views on the subject. When asked questions in the context of their own lives, adolescents provided answers that suggest that theories of social norms can be applied to interventions designed to end child marriage.

b) Implications for Program Implementation

Although further validation is needed, these results have implications for developing and implementing future prevention programs. While recognizing family and community dynamics at play, traditional gendered attitudes about the other sex among boys and girls need to be challenged. School-based interventions designed to focus on social and emotional learning skills would help in influencing the next generation of adults in Kyrgyzstan. In addition, adolescents know the negative impacts of child marriage and express opposition to the practice. However, the data shows a lack of critical thinking and negational skills to communicate these attitudes and values properly. As a result, future interventions should teach adolescents how to talk and what to say to their parents while empowering young women and men to express their voices and challenge social norms that continue to uphold gender inequity. Young men who appeared to be more conservative than girls in their gender role attitudes should be involved in these interventions to shift their perceptions of gender roles and support them in developing healthy behaviors in relationships.

Furthermore, the results showcased the need for improving parent-child communication. It is possible to hypothesize that parents have similar reservations about talking with their children. The lack of communication between parents and children needs to be addressed by creating interventions designed for parents and adolescents to foster honest and open communication between parents and their children. Interventions that spark a dialogue about the causes, drivers, harms, and solutions for child marriage in Kyrgyzstan will help families, as well as communities, to explore social norms that perpetuate gender inequality. These conversations should include key stakeholders such as adolescent girls and boys, parents, religious leaders, policymakers, health care workers, and teachers.

c) Implications for Research and Evaluation

The present needs assessment data by no means replaces a theory-defined and evidence-based situation and causal assessment. Instead, this research delves deep into adolescents' knowledge, attitudes, and behaviors around child marriage norms using an innovative diary prompt. Lasting change requires addressing structural determinants like support for girls' access to education and career development. Hence addressing child marriage in Kyrgyzstan requires concerted action at all levels of the social-ecological model. We can further recommend that different diary-based activities can be used to study and compare youth populations and regularly monitor to what extent a given intervention is proving successful to plan for scale-up and which intervention approaches need to be reviewed, revised, and adapted to local contexts.

VIII. Limitations

The small sample makes it impossible to draw generalizations from the data. Threats to validity in this study include potential mistranslations or misinterpretations based on the Russian to English translation of the data. The translated data may have lost some of the cultural nuances in translation. Additionally, the need to change the data collection processes due to travel restrictions during the COVID-19 pandemic resulted in inadequate training for NGO staff explaining the activity to the adolescents. The long-distance nature of this project also limits the understanding of the cultural context of the researchers. It is also possible that the participant's responses were influenced by response bias due to the sensitive nature of the questions regarding gender and marriage. Despite these limitations, this small needs assessment does provide rich data to help design and implement future multilevel interventions to address the issue of child marriage by tackling social and gender norms.

Acknowledgments

Thank you to our colleagues from UNICEF Kyrgyzstan and to all the young people who shared their thoughts, dreams, and experiences with us through participating in this study.

List of Abbreviations

C4D: Communication for Development
UNFPA: United Nation's Fund for Population Activities
UNICEF: United Nation's International Children's Emergency Fund

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Fellows/Associates of Medical Research Council

FMRC/AMRC Memberships

Introduction

FMRC/AMRC is the most prestigious membership of Global Journals accredited by Open Association of Research Society, U.S.A (OARS). The credentials of Fellow and Associate designations signify that the researcher has gained the knowledge of the fundamental and high-level concepts, and is a subject matter expert, proficient in an expertise course covering the professional code of conduct, and follows recognized standards of practice. The credentials are designated only to the researchers, scientists, and professionals that have been selected by a rigorous process by our Editorial Board and Management Board.

Associates of FMRC/AMRC are scientists and researchers from around the world are working on projects/researches that have huge potentials. Members support Global Journals' mission to advance technology for humanity and the profession.

FMRC

Fellow of Medical Research Council

FELLOW OF MEDICAL RESEARCH COUNCIL is the most prestigious membership of Global Journals. It is an award and membership granted to individuals that the Open Association of Research Society judges to have made a 'substantial contribution to the improvement of computer science, technology, and electronics engineering.

The primary objective is to recognize the leaders in research and scientific fields of the current era with a global perspective and to create a channel between them and other researchers for better exposure and knowledge sharing. Members are most eminent scientists, engineers, and technologists from all across the world. Fellows are elected for life through a peer review process on the basis of excellence in the respective domain. There is no limit on the number of new nominations made in any year. Each year, the Open Association of Research Society elect up to 12 new Fellow Members.

To the institution

Get letter of appreciation

Global Journals sends a letter of appreciation of author to the Dean or CEO of the University or Company of which author is a part, signed by editor in chief or chief author.

Exclusive Network

Get access to a closed network

A FMRC member gets access to a closed network of Tier 1 researchers and scientists with direct communication channel through our website. Fellows can reach out to other members or researchers directly. They should also be open to reaching out by other.

Career | Credibility | Exclusive | Reputation

Certificate

Certificate, LoR and Laser-Momento

Fellows receive a printed copy of a certificate signed by our Chief Author that may be used for academic purposes and a personal recommendation letter to the dean of member's university.

Career | Credibility | Exclusive | Reputation

Designation

Get honored title of membership

Fellows can use the honored title of membership. The “FMRC” is an honored title which is accorded to a person’s name viz. Dr. John E. Hall, Ph.D., FMRC or William Walldroff, M.S., FMRC.

Career | Credibility | Exclusive | Reputation

Recognition on the Platform

Better visibility and citation

All the Fellow members of FMRC get a badge of "Leading Member of Global Journals" on the Research Community that distinguishes them from others. Additionally, the profile is also partially maintained by our team for better visibility and citation. All fellows get a dedicated page on the website with their biography.

Career | Credibility | Reputation

Future Work

Get discounts on the future publications

Fellows receive discounts on the future publications with Global Journals up to 60%. Through our recommendation programs, members also receive discounts on publications made with OARS affiliated organizations.

Career | Financial

GJ Internal Account

Unlimited forward of Emails

Fellows get secure and fast GJ work emails with unlimited storage of emails that they may use them as their primary email. For example,
john [AT] globaljournals [DOT] org.

Career | Credibility | Reputation

Premium Tools

Access to all the premium tools

To take future researches to the zenith, fellows receive access to all the premium tools that Global Journals have to offer along with the partnership with some of the best marketing leading tools out there.

Financial

Conferences & Events

Organize seminar/conference

Fellows are authorized to organize symposium/seminar/conference on behalf of Global Journal Incorporation (USA). They can also participate in the same organized by another institution as representative of Global Journal. In both the cases, it is mandatory for him to discuss with us and obtain our consent. Additionally, they get free research conferences (and others) alerts.

Career | Credibility | Financial

Early Invitations

Early invitations to all the symposiums, seminars, conferences

All fellows receive the early invitations to all the symposiums, seminars, conferences and webinars hosted by Global Journals in their subject.

Exclusive

Publishing Articles & Books

Earn 60% of sales proceeds

Fellows can publish articles (limited) without any fees. Also, they can earn up to 70% of sales proceeds from the sale of reference/review books/literature/publishing of research paper. The FMRC member can decide its price and we can help in making the right decision.

Exclusive | Financial

Reviewers

Get a remuneration of 15% of author fees

Fellow members are eligible to join as a paid peer reviewer at Global Journals Incorporation (USA) and can get a remuneration of 15% of author fees, taken from the author of a respective paper.

Financial

Access to Editorial Board

Become a member of the Editorial Board

Fellows and Associates may join as a member of the Editorial Board of Global Journals Incorporation (USA) after successful completion of three years as Fellow and as Peer Reviewer.

Career | Credibility | Exclusive | Reputation

And Much More

Get access to scientific museums and observatories across the globe

All members get access to 5 selected scientific museums and observatories across the globe. All researches published with Global Journals will be kept under deep archival facilities across regions for future protections and disaster recovery. They get 10 GB free secure cloud access for storing research files.

ASSOCIATE OF MEDICAL RESEARCH COUNCIL

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The primary objective is to recognize the leaders in research and scientific fields of the current era with a global perspective and to create a channel between them and other researchers for better exposure and knowledge sharing. Members are most eminent scientists, engineers, and technologists from all across the world. Associate membership can later be promoted to Fellow Membership. Associates are elected for life through a peer review process on the basis of excellence in the respective domain. There is no limit on the number of new nominations made in any year. Each year, the Open Association of Research Society elect up to 12 new Associate Members.

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Associates can publish articles (limited) without any fees. Also, they can earn up to 30-40% of sales proceeds from the sale of reference/review books/literature/publishing of research paper

Exclusive | Financial

Reviewers

Get a remuneration of 15% of author fees

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Financial

And Much More

Get access to scientific museums and observatories across the globe

All members get access to 2 selected scientific museums and observatories across the globe. All researches published with Global Journals will be kept under deep archival facilities across regions for future protections and disaster recovery. They get 5 GB free secure cloud access for storing research files.

Associate	Fellow	Research Group	Basic
$4800 **lifetime designation**	$6800 **lifetime designation**	$12500.00 **organizational**	APC **per article**
Certificate, LoR and Momento **2** discounted publishing/year **Gradation** of Research **10** research contacts/day **1 GB** Cloud Storage **GJ** Community Access	**Certificate,** LoR and Momento **Unlimited** discounted publishing/year **Gradation** of Research **Unlimited** research contacts/day **5 GB** Cloud Storage **Online Presense** Assistance **GJ** Community Access	**Certificates,** LoRs and Momentos **Unlimited** free publishing/year **Gradation** of Research **Unlimited** research contacts/day **Unlimited** Cloud Storage **Online Presense** Assistance **GJ** Community Access	**GJ** Community Access

Preferred Author Guidelines

We accept the manuscript submissions in any standard (generic) format.

We typeset manuscripts using advanced typesetting tools like Adobe In Design, CorelDraw, TeXnicCenter, and TeXStudio. We usually recommend authors submit their research using any standard format they are comfortable with, and let Global Journals do the rest.

Alternatively, you can download our basic template from https://globaljournals.org/Template

Authors should submit their complete paper/article, including text illustrations, graphics, conclusions, artwork, and tables. Authors who are not able to submit manuscript using the form above can email the manuscript department at submit@globaljournals.org or get in touch with chiefeditor@globaljournals.org if they wish to send the abstract before submission.

Before and during Submission

Authors must ensure the information provided during the submission of a paper is authentic. Please go through the following checklist before submitting:

1. Authors must go through the complete author guideline and understand and *agree to Global Journals' ethics and code of conduct,* along with author responsibilities.
2. Authors must accept the privacy policy, terms, and conditions of Global Journals.
3. Ensure corresponding author's email address and postal address are accurate and reachable.
4. Manuscript to be submitted must include keywords, an abstract, a paper title, co-author(s') names and details (email address, name, phone number, and institution), figures and illustrations in vector format including appropriate captions, tables, including titles and footnotes, a conclusion, results, acknowledgments and references.
5. Authors should submit paper in a ZIP archive if any supplementary files are required along with the paper.
6. Proper permissions must be acquired for the use of any copyrighted material.
7. Manuscript submitted *must not have been submitted or published elsewhere* and all authors must be aware of the submission.

Declaration of Conflicts of Interest

It is required for authors to declare all financial, institutional, and personal relationships with other individuals and organizations that could influence (bias) their research.

Policy on Plagiarism

Plagiarism is not acceptable in Global Journals submissions at all.

Plagiarized content will not be considered for publication. We reserve the right to inform authors' institutions about plagiarism detected either before or after publication. If plagiarism is identified, we will follow COPE guidelines:

Authors are solely responsible for all the plagiarism that is found. The author must not fabricate, falsify or plagiarize existing research data. The following, if copied, will be considered plagiarism:

- Words (language)
- Ideas
- Findings
- Writings
- Diagrams
- Graphs
- Illustrations
- Lectures

- Printed material
- Graphic representations
- Computer programs
- Electronic material
- Any other original work

Authorship Policies

Global Journals follows the definition of authorship set up by the Open Association of Research Society, USA. According to its guidelines, authorship criteria must be based on:

1. Substantial contributions to the conception and acquisition of data, analysis, and interpretation of findings.
2. Drafting the paper and revising it critically regarding important academic content.
3. Final approval of the version of the paper to be published.

Changes in Authorship

The corresponding author should mention the name and complete details of all co-authors during submission and in manuscript. We support addition, rearrangement, manipulation, and deletions in authors list till the early view publication of the journal. We expect that corresponding author will notify all co-authors of submission. We follow COPE guidelines for changes in authorship.

Copyright

During submission of the manuscript, the author is confirming an exclusive license agreement with Global Journals which gives Global Journals the authority to reproduce, reuse, and republish authors' research. We also believe in flexible copyright terms where copyright may remain with authors/employers/institutions as well. Contact your editor after acceptance to choose your copyright policy. You may follow this form for copyright transfers.

Appealing Decisions

Unless specified in the notification, the Editorial Board's decision on publication of the paper is final and cannot be appealed before making the major change in the manuscript.

Acknowledgments

Contributors to the research other than authors credited should be mentioned in Acknowledgments. The source of funding for the research can be included. Suppliers of resources may be mentioned along with their addresses.

Declaration of funding sources

Global Journals is in partnership with various universities, laboratories, and other institutions worldwide in the research domain. Authors are requested to disclose their source of funding during every stage of their research, such as making analysis, performing laboratory operations, computing data, and using institutional resources, from writing an article to its submission. This will also help authors to get reimbursements by requesting an open access publication letter from Global Journals and submitting to the respective funding source.

Preparing your Manuscript

Authors can submit papers and articles in an acceptable file format: MS Word (doc, docx), LaTeX (.tex, .zip or .rar including all of your files), Adobe PDF (.pdf), rich text format (.rtf), simple text document (.txt), Open Document Text (.odt), and Apple Pages (.pages). Our professional layout editors will format the entire paper according to our official guidelines. This is one of the highlights of publishing with Global Journals—authors should not be concerned about the formatting of their paper. Global Journals accepts articles and manuscripts in every major language, be it Spanish, Chinese, Japanese, Portuguese, Russian, French, German, Dutch, Italian, Greek, or any other national language, but the title, subtitle, and abstract should be in English. This will facilitate indexing and the pre-peer review process.

The following is the official style and template developed for publication of a research paper. Authors are not required to follow this style during the submission of the paper. It is just for reference purposes.

Manuscript Style Instruction (Optional)

- Microsoft Word Document Setting Instructions.
- Font type of all text should be Swis721 Lt BT.
- Page size: 8.27" x 11'", left margin: 0.65, right margin: 0.65, bottom margin: 0.75.
- Paper title should be in one column of font size 24.
- Author name in font size of 11 in one column.
- Abstract: font size 9 with the word "Abstract" in bold italics.
- Main text: font size 10 with two justified columns.
- Two columns with equal column width of 3.38 and spacing of 0.2.
- First character must be three lines drop-capped.
- The paragraph before spacing of 1 pt and after of 0 pt.
- Line spacing of 1 pt.
- Large images must be in one column.
- The names of first main headings (Heading 1) must be in Roman font, capital letters, and font size of 10.
- The names of second main headings (Heading 2) must not include numbers and must be in italics with a font size of 10.

Structure and Format of Manuscript

The recommended size of an original research paper is under 15,000 words and review papers under 7,000 words. Research articles should be less than 10,000 words. Research papers are usually longer than review papers. Review papers are reports of significant research (typically less than 7,000 words, including tables, figures, and references)

A research paper must include:

a) A title which should be relevant to the theme of the paper.
b) A summary, known as an abstract (less than 150 words), containing the major results and conclusions.
c) Up to 10 keywords that precisely identify the paper's subject, purpose, and focus.
d) An introduction, giving fundamental background objectives.
e) Resources and techniques with sufficient complete experimental details (wherever possible by reference) to permit repetition, sources of information must be given, and numerical methods must be specified by reference.
f) Results which should be presented concisely by well-designed tables and figures.
g) Suitable statistical data should also be given.
h) All data must have been gathered with attention to numerical detail in the planning stage.

Design has been recognized to be essential to experiments for a considerable time, and the editor has decided that any paper that appears not to have adequate numerical treatments of the data will be returned unrefereed.

i) Discussion should cover implications and consequences and not just recapitulate the results; conclusions should also be summarized.
j) There should be brief acknowledgments.
k) There ought to be references in the conventional format. Global Journals recommends APA format.

Authors should carefully consider the preparation of papers to ensure that they communicate effectively. Papers are much more likely to be accepted if they are carefully designed and laid out, contain few or no errors, are summarizing, and follow instructions. They will also be published with much fewer delays than those that require much technical and editorial correction.

The Editorial Board reserves the right to make literary corrections and suggestions to improve brevity.

Format Structure

It is necessary that authors take care in submitting a manuscript that is written in simple language and adheres to published guidelines.

All manuscripts submitted to Global Journals should include:

Title

The title page must carry an informative title that reflects the content, a running title (less than 45 characters together with spaces), names of the authors and co-authors, and the place(s) where the work was carried out.

Author details

The full postal address of any related author(s) must be specified.

Abstract

The abstract is the foundation of the research paper. It should be clear and concise and must contain the objective of the paper and inferences drawn. It is advised to not include big mathematical equations or complicated jargon.

Many researchers searching for information online will use search engines such as Google, Yahoo or others. By optimizing your paper for search engines, you will amplify the chance of someone finding it. In turn, this will make it more likely to be viewed and cited in further works. Global Journals has compiled these guidelines to facilitate you to maximize the web-friendliness of the most public part of your paper.

Keywords

A major lynchpin of research work for the writing of research papers is the keyword search, which one will employ to find both library and internet resources. Up to eleven keywords or very brief phrases have to be given to help data retrieval, mining, and indexing.

One must be persistent and creative in using keywords. An effective keyword search requires a strategy: planning of a list of possible keywords and phrases to try.

Choice of the main keywords is the first tool of writing a research paper. Research paper writing is an art. Keyword search should be as strategic as possible.

One should start brainstorming lists of potential keywords before even beginning searching. Think about the most important concepts related to research work. Ask, “What words would a source have to include to be truly valuable in a research paper?” Then consider synonyms for the important words.

It may take the discovery of only one important paper to steer in the right keyword direction because, in most databases, the keywords under which a research paper is abstracted are listed with the paper.

Numerical Methods

Numerical methods used should be transparent and, where appropriate, supported by references.

Abbreviations

Authors must list all the abbreviations used in the paper at the end of the paper or in a separate table before using them.

Formulas and equations

Authors are advised to submit any mathematical equation using either MathJax, KaTeX, or LaTeX, or in a very high-quality image.

Tables, Figures, and Figure Legends

Tables: Tables should be cautiously designed, uncrowned, and include only essential data. Each must have an Arabic number, e.g., Table 4, a self-explanatory caption, and be on a separate sheet. Authors must submit tables in an editable format and not as images. References to these tables (if any) must be mentioned accurately.

Figures

Figures are supposed to be submitted as separate files. Always include a citation in the text for each figure using Arabic numbers, e.g., Fig. 4. Artwork must be submitted online in vector electronic form or by emailing it.

Preparation of Eletronic Figures for Publication

Although low-quality images are sufficient for review purposes, print publication requires high-quality images to prevent the final product being blurred or fuzzy. Submit (possibly by e-mail) EPS (line art) or TIFF (halftone/ photographs) files only. MS PowerPoint and Word Graphics are unsuitable for printed pictures. Avoid using pixel-oriented software. Scans (TIFF only) should have a resolution of at least 350 dpi (halftone) or 700 to 1100 dpi (line drawings). Please give the data for figures in black and white or submit a Color Work Agreement form. EPS files must be saved with fonts embedded (and with a TIFF preview, if possible).

For scanned images, the scanning resolution at final image size ought to be as follows to ensure good reproduction: line art: >650 dpi; halftones (including gel photographs): >350 dpi; figures containing both halftone and line images: >650 dpi.

Color charges: Authors are advised to pay the full cost for the reproduction of their color artwork. Hence, please note that if there is color artwork in your manuscript when it is accepted for publication, we would require you to complete and return a Color Work Agreement form before your paper can be published. Also, you can email your editor to remove the color fee after acceptance of the paper.

Tips for writing a good quality Medical Research Paper

1. Choosing the topic: In most cases, the topic is selected by the interests of the author, but it can also be suggested by the guides. You can have several topics, and then judge which you are most comfortable with. This may be done by asking several questions of yourself, like "Will I be able to carry out a search in this area? Will I find all necessary resources to accomplish the search? Will I be able to find all information in this field area?" If the answer to this type of question is "yes," then you ought to choose that topic. In most cases, you may have to conduct surveys and visit several places. Also, you might have to do a lot of work to find all the rises and falls of the various data on that subject. Sometimes, detailed information plays a vital role, instead of short information. Evaluators are human: The first thing to remember is that evaluators are also human beings. They are not only meant for rejecting a paper. They are here to evaluate your paper. So present your best aspect.

2. Think like evaluators: If you are in confusion or getting demotivated because your paper may not be accepted by the evaluators, then think, and try to evaluate your paper like an evaluator. Try to understand what an evaluator wants in your research paper, and you will automatically have your answer. Make blueprints of paper: The outline is the plan or framework that will help you to arrange your thoughts. It will make your paper logical. But remember that all points of your outline must be related to the topic you have chosen.

3. Ask your guides: If you are having any difficulty with your research, then do not hesitate to share your difficulty with your guide (if you have one). They will surely help you out and resolve your doubts. If you can't clarify what exactly you require for your work, then ask your supervisor to help you with an alternative. He or she might also provide you with a list of essential readings.

4. Use of computer is recommended: As you are doing research in the field of medical research then this point is quite obvious. Use right software: Always use good quality software packages. If you are not capable of judging good software, then you can lose the quality of your paper unknowingly. There are various programs available to help you which you can get through the internet.

5. Use the internet for help: An excellent start for your paper is using Google. It is a wondrous search engine, where you can have your doubts resolved. You may also read some answers for the frequent question of how to write your research paper or find a model research paper. You can download books from the internet. If you have all the required books, place importance on reading, selecting, and analyzing the specified information. Then sketch out your research paper. Use big pictures: You may use encyclopedias like Wikipedia to get pictures with the best resolution. At Global Journals, you should strictly follow here.

6. Bookmarks are useful: When you read any book or magazine, you generally use bookmarks, right? It is a good habit which helps to not lose your continuity. You should always use bookmarks while searching on the internet also, which will make your search easier.

7. Revise what you wrote: When you write anything, always read it, summarize it, and then finalize it.

8. Make every effort: Make every effort to mention what you are going to write in your paper. That means always have a good start. Try to mention everything in the introduction—what is the need for a particular research paper. Polish your work with good writing skills and always give an evaluator what he wants. Make backups: When you are going to do any important thing like making a research paper, you should always have backup copies of it either on your computer or on paper. This protects you from losing any portion of your important data.

9. Produce good diagrams of your own: Always try to include good charts or diagrams in your paper to improve quality. Using several unnecessary diagrams will degrade the quality of your paper by creating a hodgepodge. So always try to include diagrams which were made by you to improve the readability of your paper. Use of direct quotes: When you do research relevant to literature, history, or current affairs, then use of quotes becomes essential, but if the study is relevant to science, use of quotes is not preferable.

10. Use proper verb tense: Use proper verb tenses in your paper. Use past tense to present those events that have happened. Use present tense to indicate events that are going on. Use future tense to indicate events that will happen in the future. Use of wrong tenses will confuse the evaluator. Avoid sentences that are incomplete.

11. Pick a good study spot: Always try to pick a spot for your research which is quiet. Not every spot is good for studying.

12. Know what you know: Always try to know what you know by making objectives, otherwise you will be confused and unable to achieve your target.

13. Use good grammar: Always use good grammar and words that will have a positive impact on the evaluator; use of good vocabulary does not mean using tough words which the evaluator has to find in a dictionary. Do not fragment sentences. Eliminate one-word sentences. Do not ever use a big word when a smaller one would suffice.

Verbs have to be in agreement with their subjects. In a research paper, do not start sentences with conjunctions or finish them with prepositions. When writing formally, it is advisable to never split an infinitive because someone will (wrongly) complain. Avoid clichés like a disease. Always shun irritating alliteration. Use language which is simple and straightforward. Put together a neat summary.

14. Arrangement of information: Each section of the main body should start with an opening sentence, and there should be a changeover at the end of the section. Give only valid and powerful arguments for your topic. You may also maintain your arguments with records.

15. Never start at the last minute: Always allow enough time for research work. Leaving everything to the last minute will degrade your paper and spoil your work.

16. Multitasking in research is not good: Doing several things at the same time is a bad habit in the case of research activity. Research is an area where everything has a particular time slot. Divide your research work into parts, and do a particular part in a particular time slot.

17. Never copy others' work: Never copy others' work and give it your name because if the evaluator has seen it anywhere, you will be in trouble. Take proper rest and food: No matter how many hours you spend on your research activity, if you are not taking care of your health, then all your efforts will have been in vain. For quality research, take proper rest and food.

18. Go to seminars: Attend seminars if the topic is relevant to your research area. Utilize all your resources.

19. Refresh your mind after intervals: Try to give your mind a rest by listening to soft music or sleeping in intervals. This will also improve your memory. Acquire colleagues: Always try to acquire colleagues. No matter how sharp you are, if you acquire colleagues, they can give you ideas which will be helpful to your research.

20. Think technically: Always think technically. If anything happens, search for its reasons, benefits, and demerits. Think and then print: When you go to print your paper, check that tables are not split, headings are not detached from their descriptions, and page sequence is maintained.

21. Adding unnecessary information: Do not add unnecessary information like "I have used MS Excel to draw graphs." Irrelevant and inappropriate material is superfluous. Foreign terminology and phrases are not apropos. One should never take a broad view. Analogy is like feathers on a snake. Use words properly, regardless of how others use them. Remove quotations. Puns are for kids, not grunt readers. Never oversimplify: When adding material to your research paper, never go for oversimplification; this will definitely irritate the evaluator. Be specific. Never use rhythmic redundancies. Contractions shouldn't be used in a research paper. Comparisons are as terrible as clichés. Give up ampersands, abbreviations, and so on. Remove commas that are not necessary. Parenthetical words should be between brackets or commas. Understatement is always the best way to put forward earth-shaking thoughts. Give a detailed literary review.

22. Report concluded results: Use concluded results. From raw data, filter the results, and then conclude your studies based on measurements and observations taken. An appropriate number of decimal places should be used. Parenthetical remarks are prohibited here. Proofread carefully at the final stage. At the end, give an outline to your arguments. Spot perspectives of further study of the subject. Justify your conclusion at the bottom sufficiently, which will probably include examples.

23. Upon conclusion: Once you have concluded your research, the next most important step is to present your findings. Presentation is extremely important as it is the definite medium though which your research is going to be in print for the rest of the crowd. Care should be taken to categorize your thoughts well and present them in a logical and neat manner. A good quality research paper format is essential because it serves to highlight your research paper and bring to light all necessary aspects of your research.

Informal Guidelines of Research Paper Writing

Key points to remember:

- Submit all work in its final form.
- Write your paper in the form which is presented in the guidelines using the template.
- Please note the criteria peer reviewers will use for grading the final paper.

Final points:

One purpose of organizing a research paper is to let people interpret your efforts selectively. The journal requires the following sections, submitted in the order listed, with each section starting on a new page:

The introduction: This will be compiled from reference matter and reflect the design processes or outline of basis that directed you to make a study. As you carry out the process of study, the method and process section will be constructed like that. The results segment will show related statistics in nearly sequential order and direct reviewers to similar intellectual paths throughout the data that you gathered to carry out your study.

The discussion section:

This will provide understanding of the data and projections as to the implications of the results. The use of good quality references throughout the paper will give the effort trustworthiness by representing an alertness to prior workings.

Writing a research paper is not an easy job, no matter how trouble-free the actual research or concept. Practice, excellent preparation, and controlled record-keeping are the only means to make straightforward progression.

General style:

Specific editorial column necessities for compliance of a manuscript will always take over from directions in these general guidelines.

To make a paper clear: Adhere to recommended page limits.

Mistakes to avoid:

- Insertion of a title at the foot of a page with subsequent text on the next page.
- Separating a table, chart, or figure—confine each to a single page.
- Submitting a manuscript with pages out of sequence.
- In every section of your document, use standard writing style, including articles ("a" and "the").
- Keep paying attention to the topic of the paper.
- Use paragraphs to split each significant point (excluding the abstract).
- Align the primary line of each section.
- Present your points in sound order.
- Use present tense to report well-accepted matters.
- Use past tense to describe specific results.
- Do not use familiar wording; don't address the reviewer directly. Don't use slang or superlatives.
- Avoid use of extra pictures—include only those figures essential to presenting results.

Title page:

Choose a revealing title. It should be short and include the name(s) and address(es) of all authors. It should not have acronyms or abbreviations or exceed two printed lines.

Abstract: This summary should be two hundred words or less. It should clearly and briefly explain the key findings reported in the manuscript and must have precise statistics. It should not have acronyms or abbreviations. It should be logical in itself. Do not cite references at this point.

An abstract is a brief, distinct paragraph summary of finished work or work in development. In a minute or less, a reviewer can be taught the foundation behind the study, common approaches to the problem, relevant results, and significant conclusions or new questions.

Write your summary when your paper is completed because how can you write the summary of anything which is not yet written? Wealth of terminology is very essential in abstract. Use comprehensive sentences, and do not sacrifice readability for brevity; you can maintain it succinctly by phrasing sentences so that they provide more than a lone rationale. The author can at this moment go straight to shortening the outcome. Sum up the study with the subsequent elements in any summary. Try to limit the initial two items to no more than one line each.

Reason for writing the article—theory, overall issue, purpose.

- Fundamental goal.
- To-the-point depiction of the research.
- Consequences, including definite statistics—if the consequences are quantitative in nature, account for this; results of any numerical analysis should be reported. Significant conclusions or questions that emerge from the research.

Approach:

- Single section and succinct.
- An outline of the job done is always written in past tense.
- Concentrate on shortening results—limit background information to a verdict or two.
- Exact spelling, clarity of sentences and phrases, and appropriate reporting of quantities (proper units, important statistics) are just as significant in an abstract as they are anywhere else.

Introduction:

The introduction should "introduce" the manuscript. The reviewer should be presented with sufficient background information to be capable of comprehending and calculating the purpose of your study without having to refer to other works. The basis for the study should be offered. Give the most important references, but avoid making a comprehensive appraisal of the topic. Describe the problem visibly. If the problem is not acknowledged in a logical, reasonable way, the reviewer will give no attention to your results. Speak in common terms about techniques used to explain the problem, if needed, but do not present any particulars about the protocols here.

The following approach can create a valuable beginning:

- Explain the value (significance) of the study.
- Defend the model—why did you employ this particular system or method? What is its compensation? Remark upon its appropriateness from an abstract point of view as well as pointing out sensible reasons for using it.
- Present a justification. State your particular theory(-ies) or aim(s), and describe the logic that led you to choose them.
- Briefly explain the study's tentative purpose and how it meets the declared objectives.

Approach:

Use past tense except for when referring to recognized facts. After all, the manuscript will be submitted after the entire job is done. Sort out your thoughts; manufacture one key point for every section. If you make the four points listed above, you will need at least four paragraphs. Present surrounding information only when it is necessary to support a situation. The reviewer does not desire to read everything you know about a topic. Shape the theory specifically—do not take a broad view.

As always, give awareness to spelling, simplicity, and correctness of sentences and phrases.

Procedures (methods and materials):

This part is supposed to be the easiest to carve if you have good skills. A soundly written procedures segment allows a capable scientist to replicate your results. Present precise information about your supplies. The suppliers and clarity of reagents can be helpful bits of information. Present methods in sequential order, but linked methodologies can be grouped as a segment. Be concise when relating the protocols. Attempt to give the least amount of information that would permit another capable scientist to replicate your outcome, but be cautious that vital information is integrated. The use of subheadings is suggested and ought to be synchronized with the results section.

When a technique is used that has been well-described in another section, mention the specific item describing the way, but draw the basic principle while stating the situation. The purpose is to show all particular resources and broad procedures so that another person may use some or all of the methods in one more study or referee the scientific value of your work. It is not to be a step-by-step report of the whole thing you did, nor is a methods section a set of orders.

Materials:

Materials may be reported in part of a section or else they may be recognized along with your measures.

Methods:

- Report the method and not the particulars of each process that engaged the same methodology.
- Describe the method entirely.
- To be succinct, present methods under headings dedicated to specific dealings or groups of measures.
- Simplify—detail how procedures were completed, not how they were performed on a particular day.
- If well-known procedures were used, account for the procedure by name, possibly with a reference, and that's all.

Approach:

It is embarrassing to use vigorous voice when documenting methods without using first person, which would focus the reviewer's interest on the researcher rather than the job. As a result, when writing up the methods, most authors use third person passive voice.

Use standard style in this and every other part of the paper—avoid familiar lists, and use full sentences.

What to keep away from:

- Resources and methods are not a set of information.
- Skip all descriptive information and surroundings—save it for the argument.
- Leave out information that is immaterial to a third party.

Results:

The principle of a results segment is to present and demonstrate your conclusion. Create this part as entirely objective details of the outcome, and save all understanding for the discussion.

The page length of this segment is set by the sum and types of data to be reported. Use statistics and tables, if suitable, to present consequences most efficiently.

You must clearly differentiate material which would usually be incorporated in a study editorial from any unprocessed data or additional appendix matter that would not be available. In fact, such matters should not be submitted at all except if requested by the instructor.

Content:

- Sum up your conclusions in text and demonstrate them, if suitable, with figures and tables.
- In the manuscript, explain each of your consequences, and point the reader to remarks that are most appropriate.
- Present a background, such as by describing the question that was addressed by creation of an exacting study.
- Explain results of control experiments and give remarks that are not accessible in a prescribed figure or table, if appropriate.
- Examine your data, then prepare the analyzed (transformed) data in the form of a figure (graph), table, or manuscript.

What to stay away from:

- Do not discuss or infer your outcome, report surrounding information, or try to explain anything.
- Do not include raw data or intermediate calculations in a research manuscript.
- Do not present similar data more than once.
- A manuscript should complement any figures or tables, not duplicate information.
- Never confuse figures with tables—there is a difference.

Approach:

As always, use past tense when you submit your results, and put the whole thing in a reasonable order.

Put figures and tables, appropriately numbered, in order at the end of the report.

If you desire, you may place your figures and tables properly within the text of your results section.

Figures and tables:

If you put figures and tables at the end of some details, make certain that they are visibly distinguished from any attached appendix materials, such as raw facts. Whatever the position, each table must be titled, numbered one after the other, and include a heading. All figures and tables must be divided from the text.

Discussion:

The discussion is expected to be the trickiest segment to write. A lot of papers submitted to the journal are discarded based on problems with the discussion. There is no rule for how long an argument should be.

Position your understanding of the outcome visibly to lead the reviewer through your conclusions, and then finish the paper with a summing up of the implications of the study. The purpose here is to offer an understanding of your results and support all of your conclusions, using facts from your research and generally accepted information, if suitable. The implication of results should be fully described.

Infer your data in the conversation in suitable depth. This means that when you clarify an observable fact, you must explain mechanisms that may account for the observation. If your results vary from your prospect, make clear why that may have happened. If your results agree, then explain the theory that the proof supported. It is never suitable to just state that the data approved the prospect, and let it drop at that. Make a decision as to whether each premise is supported or discarded or if you cannot make a conclusion with assurance. Do not just dismiss a study or part of a study as "uncertain."

Research papers are not acknowledged if the work is imperfect. Draw what conclusions you can based upon the results that you have, and take care of the study as a finished work.

- You may propose future guidelines, such as how an experiment might be personalized to accomplish a new idea.
- Give details of all of your remarks as much as possible, focusing on mechanisms.
- Make a decision as to whether the tentative design sufficiently addressed the theory and whether or not it was correctly restricted. Try to present substitute explanations if they are sensible alternatives.
- One piece of research will not counter an overall question, so maintain the large picture in mind. Where do you go next? The best studies unlock new avenues of study. What questions remain?
- Recommendations for detailed papers will offer supplementary suggestions.

Approach:

When you refer to information, differentiate data generated by your own studies from other available information. Present work done by specific persons (including you) in past tense.

Describe generally acknowledged facts and main beliefs in present tense.

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Topics	Grades		
	A-B	**C-D**	**E-F**
Abstract	Clear and concise with appropriate content, Correct format. 200 words or below	Unclear summary and no specific data, Incorrect form Above 200 words	No specific data with ambiguous information Above 250 words
Introduction	Containing all background details with clear goal and appropriate details, flow specification, no grammar and spelling mistake, well organized sentence and paragraph, reference cited	Unclear and confusing data, appropriate format, grammar and spelling errors with unorganized matter	Out of place depth and content, hazy format
Methods and Procedures	Clear and to the point with well arranged paragraph, precision and accuracy of facts and figures, well organized subheads	Difficult to comprehend with embarrassed text, too much explanation but completed	Incorrect and unorganized structure with hazy meaning
Result	Well organized, Clear and specific, Correct units with precision, correct data, well structuring of paragraph, no grammar and spelling mistake	Complete and embarrassed text, difficult to comprehend	Irregular format with wrong facts and figures
Discussion	Well organized, meaningful specification, sound conclusion, logical and concise explanation, highly structured paragraph reference cited	Wordy, unclear conclusion, spurious	Conclusion is not cited, unorganized, difficult to comprehend
References	Complete and correct format, well organized	Beside the point, Incomplete	Wrong format and structuring

INDEX

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