Pregnancy-health center there to help

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I have been searching for a topic on which to write an article in the Brunswickan. A brief column in a recent issue has provided me with the subject and the impetus. I was disappointed, Sheenagh Murphy. The caption was inappropriate, and your article did not effectively publicize the new peer health information service on campus. Also, your report of a short interview with myself was misleading, inaccurate, and "cold".

The most important work we do at the Health Center is with approximately 30 students who become pregnant unexpectedly each year. Most of these young women need help in sorting out their feelings, and they need information. We do not attempt to influence the decision concerning continuation of pregnancy versus abortion. We aim to help create the best possible frame of mind in which to make this important decision. Once the decision is made, we arrange for the appropriate medical management. We strive for confidentiality, and we promote boyfriend and/or parental participation whenever possible.

Who gets pregnant unexpectedly? My first impression was that the finest, most charming, most intelligent young women were most at risk. As I thought further about this question, I soon realized it can happen to anyone; and the reason I found these students so likeable was because I got to know them better.

Why do unwanted pregnancies occur? It is not because of stupidity, carelessness, nor some other negative reason; but because of trust, need, love, or some other powerful and positive element of human communication.

I came to UNB-STU, 3 1/2 years ago, full of idealism about certain areas. My goal was to eliminate the unexpected pregnancy, through effective patient education techniques. I am a bit more realistic now, mostly because of communication with approximately 100 young women who have had to face the experience.

My feeling is that mass advertising campaigns and patient education techniques have reached their full potential in our society. If we expect to make further progress in "prevention", we must take a look at our current concepts of sex education.

On the whole, the topic "sexuality" is avoided in the home. In junior high school, a few technical and anatomical details may or may not be taught in the "health" course. Everyone, including the educators, admit that the effort to provide sex education in schools is inadequate.

Years ago, it seems that the problem was handled by "protecting" the girls from information and men until they were old enough to marry. Today, however, with the onslaught of mass communication (T.V., books, magazines, etc.), the topic can no longer be swept under the carpet by the family, nor by the schools.

Where we fall down is that we emphasize the anatomical and technical aspects of human sexuality, but we ignore the "feelings" involved. We as parents must deal with our own attitudes toward sexuality, become "at ease" with our feelings, and discuss the subject appropriately and freely in our homes. The school system must place "health education" on a much higher priority level, and train education specialists who are comfortable in certain specific areas including "sex education". We must begin early in the school system; we must begin even earlier at home. Again we must stress the "feeling" aspect of human sexuality.

In summary, unexpected pregnancies are here to stay. If handled well (by the patient and all others with whom she shares her situation), it need not be a negative event in one's life. Mass advertising campaigns concerning birth control methods are effective up to a point. Only by emphasizing good communication within the family, and by supplementing this with an effective sex education program in the schools, can we improve our present attempts at prevention. (Sex lives might improve too).

But we must not interfere with the spontaneity of the human sexual response; nor with the instinctive and creative aspects of human sexual activity. Otherwise, let's leave the topic alone, accept our present level of unexpected pregnancies, and handle them well.

The world is white/the world is black and never the twain shall meet

The country of South Africa inforces 2 completely different systems. For whites, school is compulsory and free with first class facilities whereas for blacks, schooling is a privilege. Over 60 percent of the native black population who start school will have dropped out by grade 4 and will be left functionally illiterate.

White schools are financed by the state while blacks must pay for theirs. Even if there was compulsory education for blacks the available education resources would be swamped by the intake.

The few blacks who make it to university must attend universities on tribal lines. Unless they are lucky enough to obtain government permission, blacks cannot go to white universities inside or outside of the country.

A notable discrepancy in university education between whites and blacks lies in enrollments in medical schools. After overcoming enormously high odds, in entering medical school and later against qualifying, high odds, in entering medical school and later against qualifying, black doctors are forced to work under professional conditions which are very different from those of their white counterparts.

Of the 6 new medical schools in Africa, blacks are excluded from 5 of them by an Act of Parliment. Each year the individual must apply to the Minister of the Interior for a permit to study which is issued and re-issued at the direction of the minister.

Whites are admitted to the other 5 universities solely on the basis of academic qualifications. The permit system which the whites are not subject to, effectively prevents the voicing of any grievances by blacks.

In their years of clinical study, white students are permitted to examine the patients in all wards of the hospital, both black and white. The black students are allowed only to examine the patients in the black wards.

In 1975, 3,838 white medical students were matriculating with 580 graduates. The black figures were 220 and 16. Doctor population figures in 1974 also supports the ambiguities of the medical profession in South Atrica. The doctor patient ratios for the whites is superior to that of Canada at 1:400. The blacks are subjected to a ratio of 1:44,000.

As well, the allocation of the Health resources can be seen to be extremely biased in favour of the whites. The results of such discrimination is indicated by infant mortalities /1000 of 16 for whites in contrast to 63 for blacks and T.B. incidents /1000 of 18 for whites opposed to 312 for blacks.

In the terms of patient care, black wards are more crowded than the white wards, black patients are, on the average, discharged earlier from the hospital than white patients and queues in the outpatients section of the hospital are longer.

The next to nil opportunity for black students to matriculate is very evident in South Africa. Of the total number of whites in school in 1970, 4.2 percent matriculated representing 36,433 students. The blacks had a 0.1 percent of their total student population in universities, which amounts to 2,938 individuals.

These figures are representative of a country with a population total of 25 million, 71.5 percent being black natives.

This system of education is supported by the white republican government of South Africa which bases its idealologies on apartheid; not legalized.