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MAE-005

POPULATION AND DEVELOPMENT EDUCATION

HOW TO CONTROL?

Per	Population Addition	
	World	India
Minute	250	60
Hour	15000	3600
Day	360000	86400
Month	10800000	2592000
Year	131400000	31536000 (One and a half Australia)
Decade	1314000000 (One India)	315360000 (15 Australias)

THINK OF IT!

**FAMILY LIFE EDUCATION
AND QUALITY OF LIFE**

2

Block

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January, 2013

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ISBN : 978-81-266-6308-8

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Further information on the Indira Gandhi National Open University courses may be obtained from the University's office at Maidan Garhi, New Delhi.

Printed and published on behalf of the Indira Gandhi National Open University, New Delhi by the Registrar, MPDD, IGNOU, New Delhi.

Laser Typeset by Tessa Media & Computers, C-206, A.F.E.-II, Okhla, New Delhi.

Printed at : Hi-Tech Graphics, D-8/2, Basement, Okhla Industrial Area, Ph-II, New Delhi-20

COURSE MAE-005: POPULATION AND DEVELOPMENT EDUCATION

Block 1 Population and Development Education: An Overview

- Unit 1 Population Education: Concept and Development
 - Unit 2 Demographic Concepts
 - Unit 3 Determinants of Population Change
 - Unit 4 Consequences of Population Change
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-

Block 2 Family Life Education and Quality of Life

- Unit 6 Family Life
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 - Unit 9 Family Welfare: Gender Equality and Equity
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Block 3 Population Control Measures: Individual, National and International

- Unit 10 Individual Measures of Population Control
 - Unit 11 National Measures of Population Control
 - Unit 12 International Measures of Population Control
-

BLOCK 2 FAMILY LIFE EDUCATION AND QUALITY OF LIFE

Introduction to the Block

This Block deals with family life education and quality of life. It covers various aspects of family life, adolescence education and sex education and their significance in improving the quality of life of the individuals and the families. It highlights the importance of reproductive rights and reproductive health in the context of mother and child care. It discusses different aspects of family welfare with focus on nutrition, health and family planning and on the need for promotion of gender equity and equality. This Block consists of 4 units.

Unit 6 “*Family Life*” explains the significance of family as an important part of our life compared to (m)any other part(s) of our life, since it gives an individual not only the basic strength that a person requires but also exerts significant influence on his/her life as a whole. It discusses different aspects of family life with emphasis on family structure, roles, needs, shared rights and responsibilities, the role of parents in promoting gender equality, in caring the children and the aged, and in controlling the family size for better quality of life of the family as a whole. It also highlights the significance of responsible parenthood and the small family norm in the context of overall quality of life of the family, society, nation and the world.

Unit 7 is about “*Adolescence Education*”. It covers the nature, magnitude and range of changes that take place during adolescence stage including varying nature of problems that the adolescent confronts, with focus on individual differences in this regard. It also highlights the complexity of these changes in adolescents vis-à-vis challenges, responsibilities, adjustment problems and consequences thereof before they become adults. It is intended to serve as a guide to the adolescent members of the families, their parents and society for ensuring their smooth transition into mature adults.

Unit 8 titled “*Sex Education*” deals with different aspects of male and female reproductive systems including their functioning and the process of reproduction. It highlights the importance of reproductive health and hygiene in the context of sexual and reproductive rights. It dwells, at length, on how reproductive health and hygiene gets affected with RTIs, STIs/STDs including HIV/AIDS with focus on causes, methods of transmission, effects and prevention. It also lays special emphasis on the care to be taken by the individuals regarding their sexual and reproductive aspects of life for their healthy living as individuals and as members of the family and society.

Unit 9 “*Family Welfare: Gender Equality and Equity*” explains the concept of gender and its significance in social development and human welfare in general, and in family welfare in particular. It discusses different aspects of family welfare with focus on nutrition, health and family planning. It highlights the significance of reproductive rights and reproductive health in the context of mother and child care along with priority areas in the field of reproductive health. Further, it lays due emphasis on the need for promotion of gender equity and equality in the matters of reproductive health vis-à-vis family planning/welfare.

UNIT 6 FAMILY LIFE

Structure

- 6.0 Introduction
- 6.1 Objectives
- 6.2 Concept, Characteristics and Types of Family
 - 6.2.1 Concept of Family
 - 6.2.2 General Characteristics of Family
 - 6.2.3 Distinctive Features of Family
 - 6.2.4 Structure and Types of Family
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- 6.4 Responsible Parenthood: Gender Equality, Care of the Children and the Aged
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6.0 INTRODUCTION

In Unit-5, you have learnt about the concepts such as demography, population dynamics, population studies, population education, family life education, sex education, family planning (education) and their interrelationship. Now, in Unit-6, we will focus our discussion on family life touching upon the concept, types, roles, needs, shared rights and responsibilities of family in general, and the role of parents in promoting gender equity and equality in caring the children and the aged, and in deciding the family size for better quality of life in particular.

6.1 OBJECTIVES

After going through the Unit, you should be able to:

- Explain the concept of family, its structure, types and roles;
- Recognise the importance of basic needs, shared rights and responsibilities of family;

- Appreciate the significance of responsible parenthood, gender equality, caring the children and the aged in family; and
- Analyse interrelationship between the small family norm and the quality of life.

6.2 CONCEPT, CHARACTERISTICS AND TYPES OF FAMILY

As an adult, you must be having your own concepts and meaning of “Family” and “Family Life”. But, your concept of family will be clearer to you after going through this unit. To begin with, we all know that human beings are social animals and wish to live in groups and family is one such group in our society. We all need family for lot many reasons – mutual love, care, support and warmth and also to procreate and continue the human species/race. A family is the unit, which builds up a person’s personality. The way we behave, what we become in life, etc depend very much on our family life and also the influence of the neighbourhood families on our family and vice-versa, among many other things. A child learns the most first from his or her family (life). Family is an important part of our life compared to (m)any other part(s) of our life, as it gives us not only basic strength that a person requires but also exert significant influence on our life as a whole.

6.2.1 Concept of Family

Family is the unit of a society. Family is the simplest and the most elementary form of any society. It is a universal social institution and an inevitable and inseparable part of the human life. Of all the social groups, family touches the life of the individuals most intimately. Starting from birth to death, the family exerts a constant influence on the individuals. It is the first group in which we find ourselves comfortable as it provides for the most enduring relationship in one form or the other. Every individual grows up in a family and every one of us is a member of one family or the other. Family can be defined in general as a group of individuals united by blood ties, marriage or adoption, and residing together. Families form the society, though the form of the family varies widely across the world.

The word ‘Family’ is taken from Latin word ‘Famulus’ which means a servant. In Roman law, the word ‘family’ denotes a group of producers, slaves and other servants as well as members connected by common descent or marriage. Thus, family, to begin with, consists of at least a man (husband) and a woman (wife) leaving with physical/sexual relationship, either with or without a child or children. Historically, the concept of family has undergone several changes, from a hard and fast social structure or institution to a flexible human relationship. Thus, family, to put in its simplest definition, is a more or less durable association of husband and wife, with or without children and/or other dependents.

Different scholars have defined family in different ways.

- The family is a group of persons united by ties of marriage, blood or adoption constituting a single household interacting with each other in their respective social role of husband and wife, mother and father, brother and sister, creating a common culture” (Burgess and Lock, 1950).

- Family is a social group characterized by a common residence, economic cooperation and reproduction. It includes adults of both sexes at least two of whom maintain a socially approved sexual relationship and one or more children of the sexually co-habiting adults or adopted by them (Murdock, 1949).
- Family is a group defined by sex-relationships sufficiently precise and enduring to provide for the procreation and upbringing of children (MacIver and Page, 1959).
- Family is a group of persons whose relations to one another are based upon consanguinity and who are therefore kin to one another (Kingsley Davis, 1960).
- Family is the institution within which the cultural traditions of a society are handed over to a newer generation. This indispensable function could not be fulfilled unless there are relations between parents and children; the relations reciprocally of authority and respect (Malinowski, 1927).

From the above definitions, it becomes easy to sum up the meaning, or offer general definition of the family. In simple words, family is a system of relationships existing between parents and their own or adopted children. It is a biological and social unit composed of husband and wife, if smallest, and added to by child(ren).

With this understanding of the concept of family, let us identify its characteristics.

6.2.2 General Characteristics of Family

We can identify the following features/characteristics of family, as they can be inferred from the kind of relationships that we can easily imagine to exist between its members in general.

- i) **A Mating Relationship:** A family comes into existence when a man and a woman establish mating relationship between them. When there is no marital relationship, the possibilities for its break down are more.
- ii) **A Form of Marriage:** Mating relationship is established through the institution of marriage. In marriage, parents or elders may select partners for their sons/daughters or the choice may be entirely left to the individuals concerned.
- iii) **A system of Nomenclature:** Every family is known by a name and has its own system of reckoning descent, be it through the male lineage or the female lineage.
- iv) **An Economic Provision:** Every family needs income and other material support to satisfy the economic needs, usually carried out by the head of the family.
- v) **A Common habitation:** A family requires a home or household for its living. This becomes inevitable for bearing and rearing of children.
- vi) **Universal institution:** Family is a universal institution found in every age and in every society.

Thus, a family is primarily characterized by biological relationships implying institutionalized relationship between the husband and the wife, and other members. All societies — ancient or modern, primitive or civilized – consist of one form of family or the other.

6.2.3 Distinctive Features of Family

Family has the greatest sociological significance. It occupies the central position in social structure and functions. The family, unlike other institutions, enjoys a unique position in every society because of its distinctive features, which are as follows.

- i) **Universality:** There is no human society in which some form of the family or the other does not exist. According to Malinowski (1927), the typical family is a group consisting of mother, father and their progeny which is found in all communities. The irresistible sex needs, the urge for reproduction and the common economic needs have contributed to this universal existence of family.
- ii) **Emotional basis:** Family is built upon the sentiments of mutual love, affection, sympathy, cooperation, relationship and friendship. It is based on emotions, procreation, maternal devotion, fraternal love, parental care and sentiments of the members.
- iii) **Limited size:** The family is the smallest social unit and is smaller in size as compared to the other social groups.
- iv) **Formative influence:** The family is the earliest social environment with which the child comes into contact. It is the most important agency for socialization of children. It shapes the personality by molding the character of its members, and emotionally conditions the children.
- v) **Nuclear positions in the social structure:** The family, being the nucleus of all other social organizations, occupies the central position in the social structure. The entire social structure is made up of family units, which in turn influence the life of society.
- vi) **Responsibility of members:** The members of the family have certain responsibilities, duties and obligations. The smooth running of the family depends on how best the members discharge their responsibilities in mutual co-operation and co-ordination with the other members of the family.
- vii) **Social regulation:** The family is guarded by certain social and legal regulations. The society takes precaution to safeguard family from any possible break down – by divorce, desertion or separation.

6.2.4 Structure and Types of Family

Family structure is conceptualized as the configuration of role, power, status and relationships in the family. Family structure has implications for family unity and stability and development of individuals. The functions that the family as an institution performs are divided among family members in the form of roles. *Roles* are culturally defined and are passed on to generations. The family structure can be explained as follows.

- **Filial Relation:** Parent-child relation.
- **Fraternal Relation:** Relation between siblings.
- **Conjugal Relations:** Relation between husband and wife.
- **In-law Relation:** Relation between family members related through marriage and not by blood.

Reflection

With the understanding of “family” you just think of as to how you can distinguish between family and other social groups on the basis of: a) Universality; b) Emotional Basis; c) Limited Size; and d) Formative Influence. Assess for yourself, whether the concept and meaning of family you had just before reading the above sub-sections had changed now or not?

Based on the structure of the family we can classify it into different types or forms. We will discuss these types or forms below.

Types of Family: On the basis of different considerations families can be classified into various types as follows.

- 1) **Types based on marriage:** On the basis of marriage family can be classified into three major types, viz. the following.
 - i) **Monogamous family:** It is a form of family in which an individual has only one spouse at any one time. The most widespread form of marriage is monogamous, which is preferred in most parts of the world. Monogamy appears in two forms. *Serial monogamy* in which the individual may remarry after the death or divorce of a spouse, and *straight-life monogamy* in which remarriage is not permitted.
 - ii) **Polygamous family:** It is a general term that covers any form of marriage of three or more persons. Polygamy may appear in two forms:
 - **Polygynous family:** The family in which a man has several wives at the same time.
 - **Polyandrous family:** The family in which a woman has more than one husband simultaneously.
- 2) **Types based on the nature of authority:** On this basis, family can be classified into the following two main types.
 - i) **Matriarchal family:** The matriarchal family is also known as the mother-centered or mother-dominated family. Here, the mother or the woman is the head of the family and she exercises her authority. All the members of the family are subordinate to her. In this system, women reign supreme and hold full possession of all legal rights and family power. In India, it is found in small pockets in south and the northeast India. For example, the Nairs and Mappillas in Kerala, the tribal groups of Minicoy Island of Lakshadweep and the Khasis and the Garos of Meghalaya have the matriarchal family system.

Characteristics of matriarchal family: These include the following.

- a) *Descent, inheritance and succession:* Here the descent is traced through the mother. Daughters inherit the property of the mother. They succeed their mother. The status the children is mostly decided by the status of mother.
- b) *Matrilocal residence:* Matriarchal family is matrilocal in residence. After the marriage, wife stays back in her mother's house. The husband pays occasional visits to the wife's house.
- c) *Exercise of Power:* In theory, the mother exercises authority and power in the matriarchal family. She is the head of the family and her decisions are final.

- ii) *Patriarchal Family:* The patriarchal family is also known as father-centered or the father-dominated family. Patriarchy is a social system in which the role of the male as the primary authority is central to social organization, and where fathers hold authority over women, children, and property. In a patriarchal family, the father or the eldest male member is the head of the family and he exercises authority. In most patriarchal societies, the male spouse makes the major decisions, but his power is based on cultural norms rather than legal traditions.

Characteristics of patriarchal family: These include the following.

- a) *Descent, inheritance and succession:* Patriarchal families are patrilineal in nature, that is, the descent is traced through the male lineage. Only the male child inherits the property of the father. In some instances, the eldest male child enjoys some special rights and normally succeeds the father.
- b) *Residence:* Patriarchal family is patriarchal in residence. Sons continue to stay with the father in his own house after their marriages and the wives come and join them. Children are brought up in their father's family.
- c) *Authority:* The father or the eldest male member of the patriarchal family is the dominant person. He takes all major decisions pertaining to the family affairs and he is the owner and manager of the family property.

3) Types based on size or structure and the depth of generations: On the basis of size, structure and depth of generations, the family can be classified into the following types.

- i) *Nuclear family:* The nuclear family comprises couples and their unmarried children and is generally financially independent of other families. A nuclear family is an autonomous unit free from the control of the elders. Since the newly-weds create a separate residence, the physical distance between parents and married child or between parents and grandparents minimizes their interdependence. The nuclear family is the characteristic of all the modern industrial societies. The nuclear family is the basic building-block of most kinship systems. It is the most important unit in terms of the social functions of the family in

contemporary western civilization. The nuclear family fits the needs of industrial societies more adequately than extended family structures. The nuclear family is ideal and almost universal.

The structure of the nuclear family: The structure of the nuclear family is not same everywhere. T. B. Bottomore (1962) makes a distinction between the two kinds of nuclear family systems: a) the family systems in which the nuclear family is relatively independent, b) the family systems in which the nuclear family is incorporated in, or subordinated to a relatively larger group, that is to the extended family.

The independent family, which is a common feature in the modern industrial society, has emerged mainly due to the growth of society, social mobility and individualism. The modern nuclear family is mainly found in the advanced societies of the west and is becoming gradually common in the developing countries also.

- ii) *Joint or the Extended Family:* The joint family is also called as the undivided family or the extended family. In an extended family, three or more generations are included in a single, functional family consisting of grand-parents, parents, grand-children, brothers, sisters and their spouse and children. Joint family can be defined as “a group of individuals who generally live under one roof, who eat food cooked at one hearth, who hold property in common, who participate in common family worship and are related to each other as some particular type of kindred” (Karve, 1965). It normally consists of members who at least belong to three generations: husband and wife, their married and unmarried children and their married and unmarried grandchildren. The joint family system constitutes the basic social institution in many traditional societies, particularly in India.

Characteristics of joint family: These include the following.

- a) *Large size:* The joint family is large consisting of people of three or more generations including at least grandparents, parents and children, and other near-relatives.
- b) *Common Residence:* The members of the joint family usually live under the same roof. They may also live in separate houses in close proximity to each other.
- c) *Common Kitchen:* Members eat the food prepared jointly at the common kitchen.
- d) *Common Property:* The members hold a common property. The total earning of the members are pooled into a family treasury and the family expenses are met out of that.
- e) *Common Religion:* Generally, the members of the joint family believe in the same religion and worship similar deities. They perform jointly the religious rites and duties.
- f) *Exercise of Authority:* In the patriarchal joint family, usually the eldest male member exercises authority and other members are subordinate to him. In contrast to this, in the matriarchal joint family, the eldest female member exercises the supreme authority.

Merits of the joint family system: These include the following.

- *Ensures economic progress:* The joint family meets the basic needs of its members -- food, clothing and shelter.
- *Advantage of division of labour:* Every member in the family is given the advantage of division of labour.
- *Social insurance:* The joint family acts as a social insurance for the old, sick and incapable.
- *Helps social control:* The joint family acts as an agent of social control by exercising control over the behaviour of its members. The individuals are taught to subordinate their individual interests to family interests.
- *Promotes psychological security:* The joint family, through creating a harmonious atmosphere in the family, contributes to the development of social solidarity. It provides psychological security to its members and prevents the growth of excessive individuation inside the family.

Demerits of joint family: These include the following.

- *Retards the development of personality:* The joint family system does not provide enough opportunity to its members to develop the qualities of adventure, self-determination, industriousness, etc. The elders take up most of the responsibilities and the younger ones are over protected.
- *Un-controlled procreation:* In the joint family, the responsibility for bringing up and educating the children is shared. The offspring of one member is treated on the same footage as others.
- *Promotes idleness:* The joint family is said to be the home of idlers. Since all members of the family are assured of the basic necessities of life, no one takes much interest in productive activities.
- *Undermines the status of women:* In patriarchal joint families, women have only secondary roles and are not given sufficient freedom to express and to develop their personality. Women in such families can hardly resist their elders because obedience is enforced upon them.

Gradual disintegration of joint family in India: The joint family system is most suited to agricultural societies. With the trend towards urbanization and industrialization, the joint family living arrangement becomes irrelevant. Modern education brought about a change in the attitudes, beliefs, values and ideologies of people. Educational attainment and economic independence results in individualism among men and women. As the level of education rises, the proportion of people supporting the joint family system gradually decreases. The large-scale migration of people from rural areas also affected the existence of joint families. Cities provide opportunities for men and women for gainful employment. When people start earning, they also seek freedom. Change in age at marriage, freedom in mate selection, changing attitudes towards marriage has affected the traditional joint family set-up. In addition to these, the increasing influence of western values and cultures also undermine the authority of elders and questions the relevance of joint family arrangements. Many scholars argue that joint family system in India is not only changing, but also tending towards disintegration.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

1) Explain in brief the general characteristics of family.

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2) Describe the effect of urbanization on disintegration of joint family in India.

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6.3 BASIC NEEDS, SHARED RIGHTS AND RESPONSIBILITIES OF FAMILY

Basic needs of the family are of different types: biological, physical, social, psychological / emotional, economic, educational and religious, among others. The family has to meet these needs, and the members of the family have different rights and responsibilities in this regard. These rights and responsibilities are integral part of the functions of the family.

In this section, the focus of our discussion will, therefore, be on the functions of the family, and shared rights and responsibilities of its members. Further, we will also touch upon the social changes affecting the Indian family system and the alternative family systems emerging in India.

6.3.1 Functions of Family

The family as a social institution performs several functions. Opinions, however, differ regarding the functions of the family. Kingsley Davis (1960) has categorized the main functions of the family into four divisions: i) Reproduction, ii) Maintenance, iii) Placement, and iv) Socialization of the young.

Lundberg (1956) has listed four basic functions of the family:

- i) The regulation of sexual behaviour and reproduction.
- ii) Care and training of children.
- iii) Co-operation and division of labour.
- iv) Primary group-satisfaction.

Ogburn and Nimkoff (1940) have divided family functions into six main categories: i) Affectional, ii) Economic, iii) Recreational, iv) Protective, v) Religious, and vi) Educational.

After combined reading of and a comprehensive look at the categories of functions mentioned above, we can divide the functions of the family into two broad categories: i) essential functions, and ii) non-essential functions.

i) *Essential functions of the family:* These include the following:

- *Stable satisfaction of sex-needs:* The sexual behaviour of men and women is regulated through family and, thus, it provides for the satisfaction of sex-needs.
- *Reproduction or procreation:* The process of reproduction is institutionalized in the family. The family introduces legitimacy to the act of reproduction.
- *Production and rearing of children:* It is one of the most essential functions of the family and is also called as the maintenance function of the family. Family is the best institution for production and rearing of children and no other institution can bring up children as efficiently as a family can.
- *Provision of home:* Family provides the home for its members and the entire family is dependent on it for comfort, protection, space and peace.
- *Family as an agent of socialization and cultural transformation:* The family guarantees not only the biological continuity of the human race but also the cultural continuity of the society of which it is a part. Along with the cultural transformation, the family also indoctrinates the child with the values, morals, beliefs and ideals of the society. Family acts as a mechanism to discipline the individuals.
- *Function of status ascription:* The family is the source of our social identification. Our families confer upon us the nationality and the ethnic, religious, residential, educational and/or class status.

ii) *Non-essential functions of the family*: These include the following.

- *Economic functions*: The fulfillment of the economic functions of the society has been the traditional function, but one of the most important functions of the family.
- *Educational functions*: The family provides the basis for the child's formal learning. In spite of changes occurring in society, the family still provides the child the basic training in social attitudes and habits important to participation in social life.
- *Religious functions*: The family is a centre for the religious training of the children. The family not only meets the spiritual needs of its members but also passes on the religious inheritance to the next generation.

6.3.2 Shared Rights and Responsibilities within the Family

Family relationship consists of natural, humane and caring qualities which are strengthened by promoting and protecting every individual's rights for status, equality, freedom of choice, social security, and physical security from abuse and violence. Each individual member of the family is expected to behave rationally and perform certain functions. These functions cast certain roles and responsibilities upon each member and are to be performed by each member accordingly. These are influenced by social norms and practices. If these roles and responsibilities are not performed by each of them as expected, then disharmony prevails in the family, and at times, in the neighbourhood and society as well. Thus, each member of the family has certain rights and responsibilities. The healthy growth and development of the family can be ensured when both the parents share the responsibility of looking after the children, and other members of the family as the case may be. When male members join female members in performing household responsibilities including child-rearing, it leads to the improvement of the quality of life in the family. The elderly (aged) members of the family and the children need special care and emotional security. If there are some handicapped members in the family, they also need extra support from others. All the family members are supposed to take care of such members and respect their individuality. They are as valued members of the family as others.

The major rights and responsibilities that are shared among the members of the family are listed below.

- i) Every member has the right to equal allocation of family resources, and equal responsibility towards household work.
- ii) Both the married partners have the rights to gender equality in their conjugal and other related affairs.
- iii) Every member has the right to freedom and choices in family life.
- iv) Every member has the right to life and security of person.
- v) Every member has the right to care and support from other family members in crisis events such as disability, illness and old-age.
- vi) Individuals are free to seek legal protection of the State for their rights within the family.

- vii) It is the responsibility of every family member to register birth, marriage and death of every family member.
- viii) It is the responsibility of every family member to promote sensitivity and responsiveness, democratic decision-making, and peaceful and non-violent approaches to solving conflicts in their family interactions and affairs.

6.3.3 Social Changes Affecting Indian Family System

Family as a social institution continues to be one of the most important elements in the fabric of Indian society with deep-rooted values. If we look at the general and distinctive characteristics/features of family discussed elsewhere above with special reference to the context of Indian family, both historically and currently, it is an undisputed fact that the family in India has contributed to the stability of Indian society and culture. Today, the Indian family is subject to the effects of changes that have been taking place in the economic, political and cultural spheres of our society. The process of industrialization, urbanization and migration along with the changes in the socio-economic, political and cultural milieu of our society have led to changes in the structure, functions, roles, relationships and values of the family. Due to increased urbanization and migration, the concept of joint or extended family in India is gradually fading away and resulting in the formation of more and more number of nuclear families.

A major aspect of the family that has been affected or influenced most is the *traditional role allocated on the basis of sex, age or kinship*. Due to increasing employment of women, their traditional role has changed and similarly the roles of the father, mother and elders in the family has also changed. The cherished Indian values such as respect for the aged, concern for the weak, devotion to one's duty and co-operation are also undergoing changes.

The concepts of freedom, individuality and rights have had their impacts on the relationships in the family too. Today's family is slowly moving towards materialism, individualism and liberalism. The function of setting moral standards for the children and adolescents has been taken over to a great extent by peer-groups, mass-media, etc. In other words, the influence of family on socialization and personality development of individuals is gradually declining.

The consequences of these changes are visible in the form of problems such as child-neglect, behavioural problems in children, indiscipline among the youth, alcoholism, neglect of the elderly, elderly abuse, desertion, divorces, etc. Therefore, there is a need for the families to cope with the pressures and challenges of their life situations, which are affected by the interacting forces in the economic, political and cultural spheres, among others. In the process of the families adjusting to the changing circumstances, there is inevitable emergence of alternative family patterns in India.

6.3.3.1 Alternative Family Patterns Emerging in India

In Indian society, many variations are occurring in the family life due to personal or socio-economic circumstances. India is experiencing the most striking feature of the presence of a range of family variations, from the traditional extended families with strict gender-based (and gender-biased) sex roles to the modern dual-career families (wife and husband employed) based on liberal sex roles such as adults cohabiting without marriage. Of course, there are experimental or

chosen lifestyles, like living without marrying and being childless voluntarily, which are restricted to an extremely small group of people. Thus, most commonly observed family variations or patterns of emerging families in India are:

- i) Single-parent families,
- ii) Female-headed households,
- iii) Dual earners or dual-career families,
- iv) Single-child families, and
- v) Childless families.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

3) What are the essential functions of a family?

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4) What are the major changes taking place in the Indian family system?

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6.4 RESPONSIBLE PARENTHOOD: GENDER EQUALITY, CARE OF THE CHILDREN AND THE AGED

As we have discussed elsewhere above, the family is the first and the most important institution that the child comes into contact with and it shapes the life and personality of the individual. Parents play an important role in the upbringing of the children. Responsible parenting is essential for proper growth and development of the children and also other dependent members of the family,

including the aged. In this section, we would be discussing these aspects of responsible parenting with an emphasis on gender equality, care of the children and the aged.

6.4.1 Responsible Parenting

A marriage relationship undergoes transition from simple husband and wife relationship into parenthood with addition of any child(ren) to the family. The transition to parenthood is quite different from the other transitions in life. At times, it may create crisis in the life of married couple as it forces them to take on an important and demanding responsibility. In fact, the task of parenting leaves the couple little time to devote for each other.

Parenting is the process of raising and educating a child from birth until adulthood. Parenting is the process by which parents or other significant caregivers rear children in their heritage and for life in their society. Parenting is used interchangeably with words such as “bringing up” or “child-rearing”. The constant overseeing of small children and infants is necessary for their survival. Parenting is the process by which the children learn the basic skills necessary or essentially required in life; they develop self-identity and learn to be autonomous (Shashi, 2007).

Responsible parenthood refers to the will, ability and commitment of parents to respond to the needs and aspirations of children and the entire family, particularly through family planning. Responsible parenthood means effective sharing of the responsibilities of parents. One of the basic purposes of entering into marriage and founding the family is that of procreation. Parents bear and rear children and it is a joint responsibility of both the parents to plan child-birth and spacing and make every provision for their future. Parental responsibilities relate to pregnancy, antenatal care, childbirth, post-natal care, child-rearing, growth and development of the child.

Methods and aspects of parenting: Parenting usually utilizes rewards, praise and punishment as tools of behavioural control of child. The different aspects of parenting are as follows:

- i) *Physical care:* It includes the provision of shelter, physical safety, nourishment, education and medical care.
- ii) *Social development and emotional support:* It includes the following.
 - a) Love and play.
 - b) Social skills and etiquette.
 - c) Ethics and value systems.
 - d) Moral and spiritual development.
 - e) Norms and contribution to the child's religion and ethnic customs.
- iii) *Financial support:* This aspect of parenting includes the provision of financial support to the children for carrying out various activities such as education, medical care and other basic requirements (Shashi, 2007).

Aspects of responsible parenthood: The different aspects of responsible parenthood are as follows.

- Responsible parenthood means the knowing and respecting the parental functions.
- To deliberate and take generous decision to raise a family with due respect for the morale and law either to avoid for the time being or even for an indeterminate period, a new birth.
- Husband and wife should recognize fully their own duties towards themselves, towards the family and towards the society, in a correct hierarchy of values.

6.4.2 Gender Equity and Equality

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men, and often requires women-specific projects and programs to end existing inequalities. The United Nations Population Fund (UNFPA) has declared that women have a right to equality (UNFPA, 2006). United Nations Children's Emergency Fund (UNICEF) defines gender equality as "Leveling the playing fields for girls and women by ensuring that all children have equal opportunity to develop their talents" (UNICEF, 2008). Gender equity is an important aspect of the Millennium Development Goals (MDGs) to end world poverty by 2015. "Every single goal is related to women's rights, and societies where women are not afforded equal rights as men can never achieve development in a sustainable manner" (UNFPA, 2006).

Gender equality is the first and the foremost of the human rights. Women are entitled to live with dignity and freedom from wants and fears. Empowering women is an indispensable tool for advancing development and reducing poverty. Empowered women contribute to the health and productivity of the whole family and community at large along with improving the prospects for the future generations. The importance of gender equality is underscored by its inclusion as one of the eight Millennium Development Goals (MDGs), and gender equality is considered to be a key in achieving the other seven goals. In spite of all these, discrimination against women and girls -- including gender-based violence, economic discrimination, reproductive health inequalities and harmful traditional practices -- remain the most pervasive and persistent forms of inequality (UNFPA, 2006).

Responsible parenthood plays a major role in gender equality. It is the parents especially the mother, who can ensure that the girls are treated on equal-footing as that of the boys in the family. Parents should ensure that there is no gender discrimination with respect to the basic facilities such as proper food, medical care, educational facilities, etc.

Our world is characterized by deeply unequal sharing of the burden of adversities between the two sexes. Gender inequality is present in most parts of the world and this inequality can take various forms. In fact, gender inequality is not a homogenous phenomenon but is rather a collection of disparate and interlinked problems. According to Amartya Sen (2001), the *seven types of gender inequality* are as follows.

- Mortality inequality:** In some regions in the world, gender inequality involves the matters of life and death, and takes the brutal form of unusually high mortality rates for women and consequently the preponderance of men in

total population, as compared to the preponderance of women found in societies with little or no gender bias in health care and nutrition. Mortality inequality is observed extensively in North Africa and in Asia, including China and South Asia.

- ii) **Natality inequality:** Son preference, which is common feature in most of the male-dominated societies, can manifest itself in the form of the parents wanting the child to be a boy, instead of a girl. With the availability of new technologies to determine the gender of the foetus, sex-selective abortions have become common in many countries. This is particularly prevalent in China, South Korea and India. This *high-tech sexism* is also emerging as a statistically significant phenomenon in India and South Asia (Sekher and Hatti, 2010).
- iii) **Basic facility inequality:** Women also face inequality in the basic facilities such as education. In countries such as Afghanistan, India and also in the countries of Latin America and Africa, girls have far less opportunity of schooling than boys do. Besides education, the inequalities in other basic facilities available to women including the encouragement to nurture their talents, the participation in rewarding social functions of the community, etc., continue at large.
- iv) **Inequality in special opportunities:** Even when little difference is present with respect to the basic facility including schooling, the opportunities of higher education may be fewer for young women as compared to the men. Indeed, gender bias in higher education and professional training can be observed even in some of the richest countries of the world, like Europe and North America.
- v) **Professional inequality:** Though lesser in degree, gender inequality does exist in employment and promotion in work and occupation. Women are likely to face higher handicap than men in certain areas.
- vi) **Ownership inequality:** In many societies, the ownership of property is very unequal and even basic assets such as homes and lands are shared unequally. This type of inequality has existed in most parts of the world, though there are local variations. In India, even though traditional property rights have favoured men in bulk, the Nairs in Kerala are an exception with the matrilineal family system.
- vii) **Household inequality:** Gender inequalities exist in different forms such as son preference, anti-female bias in survival, sharing the burden of household work and childcare. In many societies, the concept of men working outside the home is accepted but for women work outside home should be combined with various inescapable and unequally shared household duties. This inequality includes unequal relations not only within the family but also in employment and recognition in the outside world (Amartya Sen, 2001).

There are, thus, several dimensions of gender inequality existing in all societies including India. Therefore, responsible parenthood would ensure that these gender inequalities are absent in upbringing of their children.

6.4.3 Care of the Children

Care of children includes physical care of the young children and provision of educational and other facilities to them as they grow. Bringing a child into the world means making a commitment for its proper upbringing. Therefore, parents have to decide how many children they wish to have and when. The decision has to be taken by both the spouses together, in the interest of the health of the mother and the growth and development of the child(ren). Parents have to provide opportunities for the child to grow and develop into a useful and responsible member of the society. Every child has a right to get proper love and care of the parents. Without discrimination based on gender, the parents have to take care of the health, nutritional, educational and other needs of the children. One of the most important tasks of the parents is to get the child immunized strictly according to the immunization schedule. Each child has a right to get education to become a productive and enlightened citizen. It is essential that the parents give equal treatment to the girl-child in every respect on par with their son.

Healthy growth of the child – boy or girl – to a great extent depends on the health of the mother. When the size of the family is small with adequate spacing between child-births, there is scope for better health of the children and, the mother is most likely to be in a good state of physical, mental and social health and also would be in better position to socialize them more effectively.

Role of the family in socialization of the child: Every family and society prescribes its own ways and means of giving social training to its newborn members, so that they may develop their own personality. This social training is called “socialization”. Socialization is a process by which persons learn the ways of living in a given society. Children are, therefore, taught the values of their society through contact with already socialized individuals.

Family is the first agency that acts in the socialization process of children. Family is the most important agent in socialization of the children as it maintains contacts with the children for longer period of time as compared to the other groups or agencies of the society and through close emotional association it is also able to exert maximum influence on their life at home and in the society. Both adults and other siblings act as role models in providing examples for children in development of their personality by bringing in attitudinal and behavioral changes in them. The process of socialization begins, for everyone, in the family. The parental, particularly the maternal, influence on the child is very great in its socialization process.

6.4.4 Ageing and Family: The Indian Context

In India, the family is the most important institution for supporting aged persons in their advanced age. The Indian family, like most families in oriental culture, is considered strong, well knit, resilient and enduring. However, heterogeneity and diversity are the characteristics of Indian families. There are regional and cultural variations in the family structure and functioning. The norms and values of family-life vary according to religion, caste, social class and residential patterns (Dhruvaranjan, 1989). In traditional Indian society, elder people lived within multi-generational extended families including one or more adults, children, grand children and other kin. The aged in these societies received unparalleled sense of honour in decision-making responsibilities in the economic and social activities

of the family. Traditionally, family has been the institution that provided care and support to the individuals at different stages of life. The elderly in the family enjoyed unquestionable power and authority and were treated as knowledge banks and resource persons for the younger ones. In the last few decades, industrialization coupled with urbanization has brought significant changes in the family structure in India. As a result of such changes, the extended families in India have gradually changed to nuclear ones which have in turn affected the position of the elderly in the family as well as the family's capacity to take care of them. The break-up of the extended family system is facilitated by the changes in terms of education, aspirations, values and availability of resources. As a result of all these, the family is unable to meet the financial, social, psychological, medical, recreational and welfare needs of the aged, thereby creating a need to look for other support sources.

Further, the inter-generational relationship and role of women in the family started changing, thus, impacting upon the care of the aged in the family. The most prominent feature of disintegration of the joint-family system is the erosion of authority commanded by elder members, as they cease to be the economic head of the family. Thus, modernization has profoundly influenced the values like interdependence, cooperation and self-sacrifice giving way to changes in the structure and functioning of the family system. Although, at present the inter-generational families are fewer, the interaction between the generations is mostly based on affection and characterized by unconditional mutual respect. However, in India as compared to the other western countries, the older people are still cared for by the younger relations. In India, keeping parents in old-age homes draws criticism from social networks and community at large as living in old-age home is not popular in India. The strong cultural pressure makes the families to take care of the elderly.

Living arrangements of the elderly are determined by various factors such as marital status, health status, financial dependency, kinship patterns as well as cultural traditions including social support, etc available to the aged. All these are important factors of overall well-being of the elderly and give an indication of the extent of support available to the elderly from the family and kin. Thus, the living arrangements available to the elderly enable us to understand the status of the elderly and the aged, particularly in the absence of public institutions and social security schemes meant for them in a country like India.

In India, still a higher proportion of elderly or the aged are living with their families. There are changes both in composition and quality of interactions among the members. The generational gap is widening due to the fast-changing lifestyles, globalization, migration of young and influence of diverse ideologies. There are evidences that inter-generational relations are undergoing transitions due to social and cultural changes. Especially, the teenagers perceive their grandparents in a different way (Gayatri Devi, 2004).

India's National Policy for Older Persons assures elderly that their concerns are national concerns and they will not be ignored, marginalized or left unprotected. The policy aims to strengthen their legitimate place in society and help older persons to live their last phase of life with purpose, dignity and peace.

Women and Ageing: Women take care of everyone in the family. Aged in the family gets special attention from the women, particularly the daughter-in-law. Today's women, due to their higher education and work outside the home,

sometimes come in conflict with their care-giving role, especially for the old family members. As a result, it becomes necessary at times for the women to leave her job to take care of the elderly. This dilemma is going to increase in future as the family structure becomes more and more vertical in shape with problems getting multiplied, particularly when there are elderly persons in the home requiring constant care and support.

Life expectancy of women is longer than men and its implications are many. Larger proportions of elderly women are likely to become widows and are less likely to remarry as compared to men due to low social acceptance of widow-remarriage in India. Widowhood brings about both subjective and objective consequences. The subjective consequence can be almost the same for widows and widowers, but the objective consequences differ due to the distinctively different roles of men and women. The major role of man is that of provider and that of women as homemaker. When death strikes the spouse (woman), a man loses a homemaker, and if it is contrary (i.e. male spouse dies), a woman loses a provider. Hence, widow faces much more serious situation than the widower does. Since women live longer, they are likely to suffer more from chronic illness and disabilities. In India, widows suffer from social exclusion and they are dependent on their sons for their survival.

Extended families are declining in many parts of the developing world, as young people move to the cities and establish nuclear families. Even where extended families are still the norm, they are showing the strains of longer life expectancy and greater care-burdens. As a result, many elderly are living alone, in all parts of the world. Older people can be subjected to abuse and violence. Such abuse can take many forms, including physical, emotional and financial abuse and neglect. Most often, the perpetrators of abuse are family members and primary care-givers (Sebastine and Sekher, 2010).

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

5) What are the different aspects of responsible parenthood?

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6) Describe the role of family in socialization of children.

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6.5 SMALL FAMILY NORM AND QUALITY OF LIFE

The size of the family is a matter of concern not only for the individual family members but also for welfare of the community and the nation as a whole. India has adopted the goal of universalizing the two-child family norm, the achievement of which has important consequences at micro and macro levels.

6.5.1 Significance of Small Family

In spite of significant progress that India made in various sectors since independence, the fruits of these developments have not yet reached the poor, who constitute the major chunk of the population. Due to rapid increase in population during the past few decades, it has been a difficult task to bring in radical improvement in the quality of life of millions of people. It calls for universal adoption of small family norm in India.

Small Family and Quality of Life: The size of the family affects the quality of life of human beings. The quality of life is determined mostly by the social status, economic standards and size of the family, among others. The family size has its impact on the following aspects of the family and the nation:

- i) Fulfillment of basic human needs;
- ii) Income and growth of the economy and savings;
- iii) Food and nutrition-quality and quantity;
- iv) Health, especially that of the mother and the child; and
- v) Education, particularly of the children.

Here, we attempt to say little more about how these aspects of family affect the quality of life.

- **Larger the family, lower the share of basic needs:** In any society, the larger the size of the family the relatively smaller will be the per capita share of basic needs. In other words, the smaller the family or the fewer its members the larger will be the per capita share for existence and development.
- **Income, savings and resources:** Smaller family would lead to less expenditure and as a result, large part of the income adds up to the savings.
- **Family size, food and nutrition:** Increase in family size results in decrease in per capita food and nutrition availability and this slows down the nutritional and general health standards of the members. This results in decrease in productivity of labour affecting the overall economic development.
- **Family size and fragmentation of land:** Preference for a large family size eventually leads to fragmentation of land-holding, especially in rural areas leading to decrease in per capita productivity. Decrease in the per capita productivity leads to migration to urban areas, which in turn, exerts pressure on urban public systems, leading to poor social and economic development.
- **Family size and health:** Large family size would lower the amount of money available for spending on health care, which in turn leads to higher morbidity and mortality.
- **Family size and education:** Small family leads to lower expenditure and higher savings, which can be spent or invested on education of the children, especially their higher education.

All these emphasise the need for adoption of small family for improvement in the quality of life of not only family but also the nation as a whole.

6.5.1.1 Advantages of Small Family

The specific advantages of small family norm are as follows.

- Health of the mothers:** Adoption of small family with reasonable gap between the two children provides mothers sufficient time to replenish her body nutrients depleted due to earlier pregnancy.
- Better care of the children:** In small family, due to less number of children, mother has sufficient time to provide attention, affection and love towards her children.
- Participation of women in fruitful activities:** In small families, the mother has more time to participate in other fruitful activities like education and vocational training. The mothers can also contribute to the family income by engaging in gainful economic activities.
- Advantages for the children:** Small family provides conducive environment for physical and psychological growth of the children. The children in such families are able to get proper education, nutrition and healthcare along with parental care and love.
- Advantage for the community and the country:** Small family will lead to less depletion of natural resources. The basic facilities like schools and hospitals will be available for all. Small and planned families would bring happiness, peace, harmony and prosperity to the community in particular and the country at large.

6.5.1.2 Efforts to Spread Small Family Norm

The efforts to popularize small family norm among the people can be made in two ways. The first is, by providing necessary information and services to help people to adopt small family norm. Second, by bringing in changes in the associated factors such as increasing the female literacy rate, raising the age at marriage, and improving the general socio-economic conditions.

Small family norm or the two-child family norm helps in improving the quality of life not only of the individuals but also of the community and the nation at large. In spite of its well-known benefits, the small family norm is yet to be widely accepted in India. The various religious, cultural and socio-economic factors have major deterrent effect on adoption of the small family norm in India (Sekher, 2011). For making the small family norm popular in India, concerted efforts should be made to provide education and information to the people, especially those residing in the rural areas and urban slums to motivate them to accept the two-child family norm. It is imperative for everyone to advocate and adopt the two-child family norm and contribute towards improving the quality of life of the individuals, the family, the community and the nation.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

7) Explain the merits or advantages of small family norm.

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6.6 LET US SUM UP

This unit has discussed the concept of family, its structure and roles, shared rights and responsibilities within a family; types of family and the alternative family patterns emerging in India. It has highlighted the responsible parenthood, gender equality, care of the aged and the children, and the small family norm. We hope that you are very clear about all these aspects that we have discussed in this unit and also about what is expected of you as an adult educator.

6.7 ANSWERS TO “CHECK YOUR PROGRESS” QUESTIONS

- 1) Family is the simplest and the most elementary form of any society. A family is a unit of the society implying institutionalized physical, biological and social relationship between the husband and the wife. Family is a universal institution found in every age and in every society. All societies — ancient or modern, primitive or civilized — belong to one or the other form of family. The *general characteristics of the family* can be listed as follows:
 - i) A family comes into existence when a man and a woman establish *mating relationship* between them. This mating relationship is established through the *institution of marriage*. When there is no marital relationship, the family breaks down.
 - ii) Every family has its own *system of nomenclature* and is known by a name and has its own *system of reckoning descent*, be it through the male lineage or the female lineage.
 - iii) An *economic provision* is an essential part of every family, as family needs income and support to satisfy the economic needs, usually carried out by the head of the family.
 - iv) A *common habitation* is an important characteristic of a family and a family requires a home or household for its living. This becomes inevitable for bearing and rearing of children.
- 2) The *joint family* is also called as the *undivided Hindu family* or the *extended family*. Three or more generations are included in a single, functional joint family consisting of grandparents, parents, grand children, brothers, sisters and their spouse and children. The joint family system is an integral part of the Indian society, but gradually changing and getting disintegrated due to increasing urbanization and migration of its members. Modern education has brought about a change in their attitudes, beliefs, values, ideologies and practices. Educational attainment and economic independence results in individualism among men and women. As the level of education rises, the proportion of people supporting the joint family system gradually decreases. The large-scale migration of people from rural areas also affected the existence of joint families. Cities provide opportunities for men and women for gainful employment. When people start earning, they also seek freedom. Change in age at marriage, freedom in mate selection, changing attitudes towards marriage, etc., have affected the traditional joint family set-up. Along with these, the increasing influence of western values and cultures also undermines the authority of elders and questions the relevance of joint family arrangements. Many scholars argue that joint family system in India is not only changing but also tending towards disintegration.
- 3) The family as a social institution performs various functions. The functions of the family can be broadly divided into *essential* and *non-essential functions*. The essential functions of the family are as follows:
 - i) The satisfaction of the sex-needs by regulating the sexual behaviour of men and women.
 - ii) Procreation is another essential function of the family. The process of reproduction is institutionalized in the family.

- iii) Production and rearing of children which is also called the maintenance function.
 - iv) Family provides the home for its members and the entire family is dependent on it for comfort, protection and peace.
 - v) Family acts as an agent of cultural transformation, besides being an agent of socialization. Family guarantees not only the biological continuity of the human race but also the cultural continuity of the society. The family also indoctrinates the child with the values, morals, beliefs and ideals of the society and acts as a mechanism to discipline the individuals.
 - vi) The family is the source of our social identification and confers upon us the nationality and the ethnic, religious, residential, educational and class status.
- 4) Joint family has been the most important element in the fabric of Indian society. But, today due to changes in the socio-economic, political and cultural milieu of our society the changes are taking place in its structure, functions, roles, relationships and values. Due to increased urbanization and migration, joint families in India are gradually fading away and resulting in formation of nuclear families.

Along with the disintegration of the joint families, the increasing employment of women has led to the change in the traditional role of the women. Similarly, the roles of the father, mother and elders in the family have also changed. The cherished Indian values such as respect for the aged, concern for the weak, devotion to one's duty and co-operation are undergoing changes. Today's family is slowly moving towards materialism, individualism and liberalism. The function of setting moral standards for the children and adolescents has been taken over to a great extent by peer-groups, mass-media, etc. The influence of family on socialization and personality development of individuals is gradually declining. The major consequences of these changes are problems such as child-neglect, behavioural problems in children, indiscipline among the youth, alcoholism, neglect of the elderly, elderly-abuse, desertion, divorces, etc. Therefore, there is a need for the families to cope up with the pressures and challenges of their life situations, which are affected by the interacting forces in the economic, political and cultural spheres.

- 5) *Responsible parenthood* refers to the will, ability and commitment of parents to respond to the needs and aspirations of the children and other members of the family. The different aspects of responsible parenthood are as follows:
- Responsible parenthood means the knowing and respecting the parental functions.
 - To deliberate and take generous decisions to raise a family with due respect for the morals and law and with a view to avoid for the time being or even for an indeterminate period a new birth.
 - Husband and wife should recognize fully their own duties towards themselves, the family members and the society, in a correct hierarchy of values.

- 6) Socialization is a process by which children learn the ways of living in a given society. The process of socialization begins for everyone in the family. The parental, particularly the maternal influence on the child is very great for the process of socialization. Children are taught the values of their society through contact with already socialized individuals. Family is the first and the most important agent that acts in the socialization process of children, as it maintains contacts with the children for longer period of time compared to any other groups. Through close emotional association it is able to exert maximum influence on their lives. Both adults and other siblings act as role models in providing examples for children in development of their personality, attitudes and behavior.
- 7) Small family norm helps in improvement of the quality of life not only of the individuals but also of the community and the nation at large. The merits of small family norm are as follows.
 - i) *Health of the mothers:* Adoption of small family with reasonable gap between the two children provides mothers sufficient time to replenish her body nutrients depleted due to earlier pregnancy.
 - ii) *Better care of the children:* In small family, due to less number of children, mother has sufficient time to provide attention, affection and love towards her children.
 - iii) *Participation of women in fruitful activities:* In small families, the mother has more time to participate in other fruitful activities like education and vocational training. The mothers can also contribute to the family income by engaging in gainful economic activities.
 - iv) *Advantages for the children:* Small family provides conducive environment for physical and psychological growth of the children. The children in such families are able to get proper education, nutrition and healthcare along with parental care and love.
 - v) *Advantage for the community and the country:* Small family will lead to less depletion of natural resources. The basic facilities like schools and hospitals will be available for all. Small and planned families would bring happiness, peace, harmony and prosperity to the community in particular and the country at large.

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Suggested Readings

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UNIT 7 ADOLESCENCE EDUCATION

Structure

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7.0 INTRODUCTION

More often than not adolescence is referred to as a challenge. Why is it so? Here, it is relevant to quote Anne Frank (1952), from *The diary of a young girl*: "I think what is happening to me is so wonderful, and not only what can be seen on my body, but all that is taking place inside". Though Anne Frank wrote it on a cold wintry in January 1944 in a diary, it was published in 1952 and gifted to her on her 13th birthday. Anne was a young Jewish girl who went into hiding to escape the Nazis during the Second World War. Due to the harsh realities of her life and an untimely death, Anne could not but celebrate the charms of adolescence.

Let us try, in the discourse below, to discover the hidden nuances of adolescence that help us educate ourselves about adolescence and draw-up some conclusions of our own.

7.1 OBJECTIVES

After studying this Unit, you should be able to:

- Explain the process of growing-up and the significance of adolescence stage;
- Describe different aspects and changes characteristic of adolescence stage;
- Explain the interrelationship between physical, psychological, social and other aspects of adolescence stage;
- Analyse the problems associated with gender and sexuality of adolescents; and

- Discuss the individual, familial and social responsibilities of adolescents and the problems and consequences of maladjustment in fulfilling such responsibilities;

7.2 PROCESS OF GROWING-UP: ADOLESCENCE STAGE

We all know that the process of growth of an individual from infancy to childhood to adolescence to adulthood to senility are marked by the biological, physical, psychological, social and other changes which are characteristic of these stages of life. In this section, we will, however, focus our discussion on adolescence stage.

Just as infancy evokes a feeling of love and warmth, puberty has always managed to bring out mixed feelings of awe and dismay, excitement and fear, happiness and sadness all rolled into one. Both the adolescent and the parents ride this roller-coaster of emotions sometimes together but often alone. Coming of age is a common term 'adolescence' used for the 'stage of transition of an individual from childhood to adulthood'. This period is often marked with rituals and ceremonies the world-over. The young people of Anne Frank's religion welcome 13 year-olds to adulthood by celebrating Bar Mitzvah for boys and Bas Mitzvah for girls. You would be wondering about the relevance of such celebrations. Before the twentieth century, a child took on all adult responsibilities immediately after puberty and there was no concept of adolescence as a recognized developmental stage. But, recently it has been considered as very important phenomena where not only does puberty arrive earlier but also requires a long period of education and training before an individual is ready to take on adult responsibilities.

Activity 7.1: Recall and write your own experience

Had you ever participated in any age-ritual related to puberty and adolescence in your area? Or, was such ritual performed for you as well? Write about it in 150 words sharing your feelings of such a ceremony conducted for others in which you participated or your experiences when it was conducted for you.

7.2.1 Meaning and Significance of Adolescence

The term 'adolescence' has Latin origin. It is derived from the verb *adolescere*, which means "to grow into adulthood" or "to achieve maturity". Today, the term 'adolescence' has a much broader meaning and includes mental, emotional and social maturity along with physical maturity. Britannica Concise Encyclopedia (www.britannica.com) defines adolescence as 'a period of life from puberty to adulthood characterized by marked physiological changes, development of sexual feelings, efforts toward the construction of identity, and a progression from concrete to abstract thought'. Developmental psychologists consider the passage from childhood into and through adolescence as composed of a set of transitions that unfold gradually touching upon many aspects of the individual's behavior, development and relationships. These transitions are biological, cognitive, social and emotional.

Although many psychologists have carried out research on adolescence, it is G. Stanley Hall (1904) who is credited to have formalized the concept of adolescence and turning it into an area of scientific research. He also coined the term “storm and stress” reflecting the turbulence an individual goes through during this period. Piaget (1972) has defined adolescence from a psychological view point. According to him “Psychologically, adolescence is the age when the individual becomes integrated into the society of adults, the age when the child no longer feels that he is below the level of his elders but equal, at least in rights”. It is actually Bigner (1983) who finally defined adolescence as a stage in the life cycle between 13 and 18 years of age characterized by increasing independence from adult controls, rapidly occurring physical and psychological changes, exploration of social issues and concerns, increased focus on activities with a peer group and establishment of a basic self-identity.

7.2.2 Biological Changes Characteristic of Adolescence

Adolescence usually begins between 11 and 13 years of age with the appearance of secondary sexual characteristics. It spans the teenage years, terminating at around 18 to 20 years of age with the completion of the development of the adult form. The biological changes that take place during this period are characteristic of adolescence.

The progression from pubescence to puberty is not an overnight change, but is a result of maturation process. *Pubescence* is the stage during which the reproductive organs start maturing. Almost all the changes that occur can be attributed to hormonal secretions from different glands in the body. These hormonal secretions vary from individual to individual. Many factors affect the hormonal secretions and can vary from genetic background to the emotional make-up of an individual, from the nutritional status to deficiency diseases, from unrealized desires to personal ambitions, etc. The main biological changes that herald adolescence and end childhood include the following:

- i) physical changes, which are clearly visible; and
- ii) physiological growth, which is rapid.

7.2.2.1 Physical Changes during Adolescence

Concern about the physical appearance amongst young people is shared by adolescents across borders, cultures, gender and class. Although all the changes are revolutionary, the physical changes are the most visible ones. There is a rapid gain of height and weight accompanied with development of reproductive organs. Quick changes in bodily proportions, budding of breasts in girls and growth of mustaches and cracking of voice in boys are early visible signs of physical changes. However, these changes do not happen overnight. They emerge out of the process of maturation from pubescence to puberty.

Primary sex organs enlarge and secondary sexual characteristics appear along with rapid gain in height and weight. It takes about two years for this process to complete into puberty. Puberty is the stage when a girl or a boy reaches full sexual maturity and is physically able to reproduce. The onset of puberty may be different for different individuals but the only certainty is that puberty happens. It is also a fact that the age of onset of puberty is getting shorter / younger over the years.

- **Pubescence and puberty:** Pubescence is accompanied with a rapid growth of height and weight, enlargement of primary sex organs and appearance of secondary sex organs. This stage normally lasts for about two years and ends at puberty. Appearance of secondary sexual characteristics at puberty is a very individual matter and varies from one child to another. If you notice the students of class eighth or ninth they will present a picture of contrast. Flat-chested girls will be sitting next to a full bosomed young girl just as a short skinny boy would be sitting next to a broad shouldered mustachioed young man. This individual variability is very normal and should not be a cause of concern. There is about a six to seven years of range in both boys and girls to eventually reach puberty.

Table 7.1: Secondary Sexual Characteristics in Girls and Boys

Girls	Boys
• Breasts • Pubic hair • Axillary hair (Underarm) • Widening of pelvis • Changes in voice • Changes in skin	• Pubic hair • Axillary hair (Underarm) • Facial hair • Changes in voice • Changes in skin • Broadening of shoulders

The average age of beginning of pubescence for girls is at about 10 years with puberty following at 12. Some girls may show the first signs as early as 7 or as late as 14. The average age for boys is 12 followed by puberty at 14. However, the normal range could vary from 11 to 16 with puberty from 11 to 18 years (Chumlea, 2003). However, the boys are roughly two years behind the girls in terms of puberty. The age of puberty has been getting lower since past many years. Look us at the Box 7.1 below which presents the case of eleven-year-old Ruma.

Box 7.1: Puberty: A Case of Eleven-year-old Ruma

Ruma came from a sheltered middle-class home with traditional upbringing. She was a bright and an intelligent girl. Her teacher noticed that lately she had become withdrawn and quiet. Her school work and her interest in the school activities had deteriorated. On being asked she confided in her teacher that she was probably suffering from cancer. She had interpreted her first period as a sign of cancer. Since her aunt had just died from it she did not want her parents to go through the same pain again and hence was suffering silently.

It has been recorded that, over the last seventy years, the age at menstruation has come down by about four years. Exact reasons for the same have still not been identified but a healthier diet and better health care do play an important part in it. Early puberty not only results in a girl's ability to bear children at an age when they are not emotionally mature to handle, but also overwhelms them if they have not been prepared for it. Hence, it becomes very important they are explained the process of growing-up. They also need to be empowered to protect themselves from embarrassment, discomfort and abuse.

7.2.2.2 Physiological Changes during Adolescence

The physiological changes that occur during adolescence are very difficult to describe and explain. But, we attempt to make these changes clear by discussing a few cases, as given in Box 7.2 below.

Box 7.2: Physiological Changes Occurring during Adolescence

- i) **Adolescent Growth Spurt:** Vinitha and Ananth are just two years apart. Fourteen years old Vinitha has always been the care-giver and leader of her younger brother, Ananth. Lately, she has been realizing that Ananth is becoming taller and stronger than her. He is no longer willing to follow everything she says but puts his own point of view forward too. Vinitha, who has led the role of an elder sister, is very hurt and upset. She is finding it very difficult to cope with this changed scenario.

What do you think has happened here? Both the kids are undergoing adolescence. They are typically going through a phase of sudden growth. This is referred to as the *Adolescent Growth Spurt* — a rapid increase in height and weight. Vinitha reached it earlier as the girls experience it, two years earlier than the boys. For girls it generally begins between the ages of 9-14, whereas in boys it takes place between the ages 10-16. From the age of 11 to 13, girls are taller, heavier and stronger. Vinitha continued with her leadership role. Before the growth spurt, boys are about 2 percent shorter than girls. During the growth spurt, boys make-up for this and by the end of it they are about 8 percent taller, heavier and stronger than girls. As the boys reach the growth spurt two years later than the girls they also get an extended period of pre-pubertal growth, which is faster than the rate of growth during puberty. On average they are 12-13 cm taller than females mainly because of the 2-year delay in bone closure as compared to girls. This accounts for about a 10-cm difference between the two sexes; in addition, males also have 2-3 cm more of growth during their growth spurt. Before puberty, boys are only slightly stronger than girls of their age. However, this changes dramatically after the growth spurt. The larger muscle-mass, heart and lungs and a greater capacity to carry oxygen to lungs makes the boys noticeably stronger.

- ii) **Asynchronous Growth:** Srihari is a typical Indian adolescent. Lately, he is constantly bumping against furniture and keeps on tripping. His parents took him to an ophthalmologist for an eye test. He has been diagnosed as myopic. His parents are not able to accept this as his eye test the previous year was 6/6. What do you think has happened? The adolescent growth spurt actually affects the entire skeletal and muscular frame. Different parts of the body grow at different rate and at different time. Hence, often you observe that part of adolescent body may be out of proportion resulting in typical teenage gawkiness and awkwardness. This may also result in tripping and bumping against furniture as the teenager is not fully familiar with his growing body. Even the eyes grow rapidly during this period. This may result in myopia, as was the case in Srihari. This is because the eyeball becomes so elongated that it is unable to focus the images on the retina.

Other familiar changes are that the jaw becomes thicker and elongated, the nose gets projected and the incisors of both jaws become more upright. These changes are greater in boys than in girls. Hence, they go through a more pronounced and a longer period of gawkiness. This is referred to as *Asynchronous Growth*. It is described as dissimilarity in the growth rates of different parts of the body. It is not really known what triggers the process of maturation and why it happens but the emergence of puberty is more or less sequential.

From the above cases, it is clear that not only is the rate of growth different in boys and girls, even the type of growth differs. The boys become larger overall. Their shoulders and chest widen. In relation to their trunk, their legs are longer. Similarly, the forearms are longer relative to both their upper arms and height. On the other hand, the girls develop breasts and their pelvis widens. Both these developments are connected to childbearing. Layers of fat get deposited just under the skin giving a rounded appearance to the body.

An increase in physical size is a universally recognized event of puberty. During puberty height increases drastically and reaches peaks during the adolescent growth spurt. The weight also increases and reaches peaks during the adolescent growth spurt. Do you know that pubertal weight gain accounts for about 50% of an individual's ideal adult body weight? The actual timing or even their order may vary a little. Table 7.2 and 7.3 below show the sequence of physiological changes that take place in girls and boys during adolescence period.

Table 7.2: Sequence of Physiological Changes in Girls during Adolescence

Physiological Changes during Adolescence	Age of Appearance
Growth of breasts	8-13
Growth of pubic hair	8-14
Menarche	9-14+ (Mean age 12)
Axillary hair	About 2 years after pubic hair
Increased activity of oil and sweat glands	About the same time as appearance of axillary hair

Table 7.3: Sequence of Physiological Changes in Boys during Adolescence

Physiological Changes during Adolescence	Age of Appearance
Growth of testes, scrotal sac	10-13+
Growth of pubic hair	10-15
Body growth	10-16 (peak at 12)
Growth of penis, prostate gland, seminal vesicles	11-14+ (peak 12+)
Change in voice	About the same time as growth of penis
First ejaculation of semen	About 1 year after the beginning of growth of penis
Facial hair and axillary hair	About 2 years after pubic hair
Increased activity of oil and sweat glands	About the same time as appearance of axillary hair

The timing and sequence of changes is influenced by an individual's genes, health, nutrition and environment. The pituitary glands send a message to the gonads or sex glands. In case of girls, the ovaries start producing estrogen, and in the case of boys testes start producing androgens, particularly testosterone. These hormones in turn stimulate sexual maturation. Although many hormones influence growth the key hormone remains Gonadotropic Hormone (GH). The increase in its secretion is most marked during mid and late puberty. The maturation of bones is influenced by thyroid hormones, adrenal androgens, and gonadal sex steroids, mainly estrogen. At puberty, both sex steroids and growth hormone participate in the pubertal growth spurt. The ending of the growth spurt is due to the action of the sex steroids. Pubertal growth accounts for about 20% of final adult height and an average growth spurt lasts 24-36 months. According to a recently concluded longitudinal study by Mills, Shiono, Shapiro, Crawford and Rhoads (1986) body size in infancy may correlate with the timing of puberty. The study was conducted on 76 boys. It was seen that the boys who were heavier and more muscular at the age of six months were more advanced in sexual development.

From the above presentation and discussion, adolescence can be seen in 3 stages – early, middle and late adolescence – and each stage has a different manifestation on girls and boys. These can otherwise be called pubescence, puberty and late adolescence stages. But, it is difficult to categorise them into watertight, compartmentalised distinct stages with exact age-demarcation for these stages and changes.

Given below are the significant and broad characteristic changes that occur during adolescence period.

Table 7.4: Characteristic Changes that Occur during Adolescence Period

Between ages 8 to 12	• No visible signs of physical development. But, the ovaries are enlarging and hormone production is beginning.	May begin as early as age 9 and continue until 14	• No sign of physical development but hormone production is beginning.
May begin anywhere from ages 8 to 14.	• Height and weight increase rapidly. • Fine hair growth begins close to the pubic area and underarms. • Breast buds appear; nipples become raised and this area may be tender. • Sweat and oil glands become more active which can result in acne.	May begin anywhere from ages 11 to 13.	• Height and weight increase rapidly. • Testicles become larger and scrotum hangs lower. • Scrotum becomes darker in color. • Fine hair growth begins at the base of the penis. • Hair growth may begin on the legs and underarms.
May begin anywhere from ages 9 to 15.	• Breasts become rounder and fuller. • Hips may start to widen in relation to waist.	May begin anywhere from ages 12 to 14.	• The penis, scrotum, and testicles grow. • Pubic hair becomes darker, thicker, and curlier.

	• Vagina begins secreting a clear or whitish fluid. • Pubic hair becomes darker, thicker, and curlier. • Height and weight continue to increase. • For some girls, ovulation and menstruation (periods) begin, but may be irregular.		• Muscles become larger and shoulders become broader. • Sweat and oil glands become more active, which can result in acne. • Sperm production may begin. • Temporary swelling and tenderness may occur around nipples. • Height and weight continue to increase. • Hair growth on the legs and underarms continues.
May begin anywhere from ages 10 to 16.	• Underarm hair becomes darker. • Pubic hair starts to form a triangular patch in front and around sides of genital area. • The nipple and the dark area around the breast (areola) may stick out from the rest of the breast. • For many girls, ovulation and menstruation (periods) begin, but may be irregular.	May begin anywhere from ages 13 to 16.	• Sperm production has usually begun. • The larynx (Adam's apple) increases in size. Vocal chords become longer and thicker, and the voice begins to break or crack, then becomes low. • Height and weight continue to increase. • Penis and testicles continue to grow. • Pubic hair increases in amount and becomes darker, coarser, and curly.
May begin anywhere from ages 12 to 19.	• Adult height is probably reached. • Breast development is complete. • Pubic hair forms a thick, curly, triangular patch. • Ovulation and menstruation (periods) usually occur regularly. • Overall look is that of a young adult woman.	May begin anywhere from ages 14 to 18.	• Growth of facial hair begins. • Chest hair growth may begin (not all males get much chest hair). • Adult height is reached. • Penis and testicles have reached full adult size. • Pubic, underarm, and leg hair are adult color, texture, and distribution. • Overall look is that of a young adult man.

Source: James W. Vander Zanden. 1978. *Human Development*. McGraw-Hill, Inc. (Adapted)

A child undergoes a number of changes while attaining adulthood; the changes that signal the end of childhood largely pertain to the physical, sociological and psychological maturation.

7.3 LATE ADOLESCENCE: TOWARDS MATURITY

As the growth continues, the adolescent gradually becomes more and more mature physically, sociologically and psychologically. We will discuss these aspects below.

7.3.1 Physical Maturity

With the onset of puberty the adolescent continues to grow further and becomes physically more mature. Once the adolescent stage is almost complete the person becomes an adult. It means, the person is capable of performing all the physical activities involving the body of the person. Sexual maturity or sexual maturation is one of the important aspects of maturity of adolescent culminating the adolescence stage and beginning of adulthood.

Sexual Maturation: All the physiological changes herald sexual maturation. The complete transition of reproductive organs to reproductive maturity is called sexual maturation. All such characteristics that are related to reproduction, specifically the sex organs are called the *Primary Sexual Characteristics*. In fact, these happen to be the only external sign of whether a newborn baby is a boy or a girl. Although male and female sex organs are similar in origin and structure because they develop from the same embryonic cell (mass), they are, however, very different in appearance. The difference comes about only gradually during the fetal stage. The sex organs do not become fully functional until after puberty when, under the influence of certain hormones, they finally complete their growth. Even the skin of both boys and girls become coarser and oilier. The increased activity of sebaceous glands often leads to pimples and blackheads.

- a) **Sexual maturation in girls:** The first visible sign of sexual maturation in girls is the budding of breasts. It begins around ten years of age. This is due to rapid creation of glandular cells along with fatty and connective tissues. Nipples become projected and areola, the pigmented area around it, becomes elevated. Around the same time, pubic and auxiliary hair start appearing. The hips start becoming rounded due to the deposition of fatty and supportive tissue. Side by side, the uterus and vagina starts maturing. Menarche, the first menstrual period, starts towards later part of puberty. The menstrual period in the early stage tends to be irregular. It is only after ten to eighteen months after the first menstruation that ovulation (release of mature ovum) takes place. The girls remain sterile during this period.
- b) **Sexual maturation in boys:** The first visible sign of puberty in boys is increase in size of the testes and scrotum. This is followed by a growth of fine hair at the base of penis. It happens around twelve years of age. The growth continues till about sixteen years of age. By the end of it the penis also lengthens and thickens. The larynx enlarges and the vocal folds double in length. This is responsible for the change in voice. Much to the embarrassment of adolescent boys, some of them experience temporary breast enlargement. This is quite normal and lasts for about twelve to eighteen months. As the boys turn around fourteen years of age, their prostate glands are producing a fluid that can be ejaculated during orgasm. However, mature sperms are ejaculated only after about a year later. Presence of sperms in urine is considered as the principal sign of sexual maturation in boys. At

about fourteen to fifteen years, the boys begin to have nocturnal emissions or wet-dreams. This is perfectly normal and may or may not be accompanied with an erotic dream. Axillary and facial hair generally appears about two years after the appearance of pubic hair. The facial hair begins from the corners of the upper lips and then spread to complete the mustache. The side burns, chin and lower lips sprout in that order. The facial hair are soft downy at first and become coarser by late adolescence. Chest hair appear either during late adolescence or in early twenties.

Both early and late maturation impacts the psychological development.

Check Your Progress

- Notes:** a) Space given below the question is for writing your answer.
b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 1) Differentiate between pubescence and puberty.
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- 2) Explain the process whereby boys become taller and stronger than girls.
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- 3) What do you think would happen if the sex steroids did not end the growth spurt? Explain by justifying the role of sex steroids.
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7.3.2 Psychological Maturity

The dramatic physical and hormonal changes lead to a deep psychological impact on the adolescent. This is also a period when the young adult is forming his/her own identity. As Logan P. Smith (1865-1946, see http://www.quotationspage.com/quotes/Logan_Pearsall_Smith/) has very aptly summed up: 'Don't laugh at a youth for his affectations; he is only trying on one face after another to find a face of his own.' If you look back at your own growing-up phase you would remember that it was probably the most embarrassing period in one's life. One was acutely self-conscious and felt that everyone was watching every move. There was a conscious attempt to appear mature and resentment against parental control. Company of friends was becoming more and more important and sexual attraction had started to unfold itself. The major developmental task during adolescence is to prepare for adult life. During the early adolescence one is learning to be independent of adult guidance and control. It is during the later adolescence that one learns the specific skills needed for adult life. This is the time when an adolescent is undergoing the formation of:

- i) Identity and personality,
- ii) Self-concept and self-esteem, and
- iii) Gender roles.

These are briefly discussed below.

- i) **Identity and personality:** Have you ever observed a trapeze artist in a circus? There is that fraction of a second when the artist is hanging in the air with no support. Erickson (1956) has described an adolescent like this trapeze artist who has let go of the safe-hold on childhood and midair reaches out to take a firm grip on adulthood. As per the developmental sequence of psychosocial stages described by Erickson, the fifth stage which covers the period of adolescence focuses on the search for identity. The main task of adolescence is to build and confirm a reasonably stable identity. Simply stated, identity consists of the answers an individual gives to questions such as 'Who am I?' and 'Who am I to be?' Identity is how an individual places oneself within the world in the larger context of life. People's interaction with one another is based not as much on who they actually are but on who they think they are. If an individual perceives herself/himself as a reasonable, well-mannered human being, then her/his conduct will reflect the same. Identities are not fixed but continually changing throughout life.

For example, at the age of fifteen years, Simran has a body of a woman. She is now capable of adult sexual behavior. She also has complex decision-making ability and understands that she is responsible for her own life. What decision should she take? Will she be able to live by the choices she makes? There are no easy answers. All these choices are often accompanied by a lot of emotional turmoils. The challenge of becoming a person, unlike any other that has ever lived or will ever live, is immense. Adolescents simultaneously grapple with both, searching for their own identities and confronting future adult tasks and roles. The way in which they deal with issues like occupational choices, decision to continue with further studies, making and maintaining relationships beyond immediate family, individual moral value system as well as freedom from adult authority also determines who the individual finally becomes.

This period between childhood and adulthood allows adolescents to try out different roles and ideologies. That is why they go through this period of following various fashions and ideologies. They can safely explore until they finally feel comfortable with themselves and choose their own life style. During this period of experimentation, before forming a stable self-concept, many adolescents are faced with blurred self-image. Referred to as 'Identity' or 'Role 'Confusion', Erickson (1956) describes it as a state of confusion regarding who one is, what one belongs to, and where is one going. This accounts for the volatile nature of the adolescent behavior. It can also lead to an individual taking a very long time to reach adulthood. However, he feels that it is important for young people to go through this 'try-out' period. Forming an identity too soon often results in foreclosing many of life's potentialities and options.

Psychologist Marcia (1966) defines identity as 'an internal, self-constructed, dynamic organization of drives, abilities, beliefs and individual history.' He has identified *four identity states* correlating them to important aspects of personality e.g. self-esteem, anxiety, moral reasoning, etc. These states are not progressive and may or may not be permanent. An individual's identity status keeps changing as he or she continues to develop (Marcia, 1966). Marcia's *four states of identity* are based on the presence or absence of two important elements – *crisis* and *commitment* – which Ericson found crucial to identity formation. Crisis refers to period of conscious decision-making, and commitment is personal occupation or a system of beliefs or ideology. These states are:

- **Identity achievement:** It is essentially crisis leading to commitment state. The people who have carefully thought about important issues in their lives earlier now stand committed to the crucial decisions they have made. Such people are usually thoughtful but not so much that they cannot make a decision. They are open to new ideas, possess a sense of humour, perform under stress and are capable of nurturing intimate relationships.
- **Foreclosure:** This refers to commitment without going through the period of crises. In this state, people often make a commitment based on other people's plans for their life. They themselves do not take any decisions after considering various options. A good example is the arranged marriages in India or parents deciding the future occupation of their children. Such people are usually happy, self-satisfied with a strong commitment to family ties but become dogmatic when their beliefs are threatened. The recent resurgence of khap panchyats when the traditional marriage system was threatened is an example of this.
- **Identity diffusion:** This state refers to a period of no commitment. Such people are either carefree, who have actively avoided making a commitment or are drifters. They often tend to be superficial, unhappy and lonely as they find it difficult to establish intimate relationships.
- **Moratorium:** Moratorium is the period of crisis. Such people are in the middle of weighing their options before making a commitment and finally achieving an identity. They appear to be in conflict but are lively and talkative. Closer to the parent of opposite sex, they are competitive. They understand what an intimate relationship entails and want to be in one.

Every adolescent requires a lot of support from parents, peers, family and society. According to Ericson (1956) every adolescent courts the danger of failing to form a stable identity. Such adolescents may experience *Identity Diffusion*, which means lack of ability to commit even in late adolescence. Another danger could be the formation of *Negative Identity* where they might form debased self-images and social roles or they may form *Deviant Identity* which means that they take on behaviors or life-styles that are not approved by the social norms. Many developmental psychologists have carried out researches in finding the differences in the paths of male and female in their quest for identity. It was concluded that girls lay less stress on their identity as an individual but more in terms of the kind of relationships they build and their ability to care for others and themselves. The path of identity formation taken by boys was mostly through *competitive striving* and for girls it was through *cooperative effort*. This variation could be attributed to different child-rearing practices or dissimilarity in the way parents treated both the sexes.

- ii) **Self-concept and self-esteem:** All boys want to be tall and broad shouldered and girls slim and curvaceous. Anything other than that makes them feel despondent and dejected. Reflecting the media's culture of emphasizing on women's physical attributes it's the girls than boys who are more likely to feel unhappy about their looks. This feeling of inadequacy about the looks during adolescence has a far reaching consequence as our identity is largely affected by what we think about ourselves. Every individual evaluates himself/herself either positively or negatively. The self-assessment could be in one particular dimension, e.g. 'I am a good dancer'. Or it could be global, e.g. 'I am an honest human being'. The term 'self-esteem' comes from a Greek word *kenodoxia* which means 'admiration of self'. The 'self' refers to our beliefs, attitudes and values, while 'esteem' is the worth that we give ourselves. Nathaniel Brandon (1995) defines self-esteem as the disposition to experience oneself as being competent to cope with the basic challenges of life and of being worthy of happiness. In other words, a person with positive self-esteem has the ability to learn, makes appropriate choices and effectively responds to any change in life, whether positive or negative.

Developing a sense of self and self-worth is one of the developmental tasks. Self-esteem essentially grows out of self-concept. Psychologist William James (1890, mentioned in Damon and Hart, 1982) divides self into two components, the 'me' and the 'I'. According to him the 'me' is composed of all that an individual can call his own. This includes an individual's abilities, personality, characteristics and his material possessions. The 'I' is the reflective part of the self. It is 'self as a knower' where this part of self 'continually organizes and interprets experiences, people, objects and events in a purely subjective manner'.

Self-concept in early childhood is based on concrete observable physical attributes like height, colour of eyes, etc. During middle childhood, one is able to assess oneself in more abstract terms and a distinction between mind and body can be clearly seen. The children become concerned about their competencies, especially in comparison to others, e.g. I can play football better than my friend and I don't cheat while playing. By the time they reach adolescence this elementary understanding of self gradually develops into

an elaborate and fairly stable network of self-perceptions and feelings. Now, they begin to evaluate themselves and assign positive or negative values to their own attributes. Based on the fact as to how they have rated their own abilities they have a positive or a negative self-esteem. Self-esteem is not linear but it is multi-dimensional. This means that self-esteem will vary for each domain of behavior, i.e. cognitive, social and physical skills. Children rate themselves differently for different areas. It is interesting to note that early-developing girls have less positive self-esteem in comparison to boys where early development leads to a positive self-esteem. During this period self-esteem is primarily linked to appearance and peer acceptance. On occasions when young people are excluded from a group or friends, it results in their feeling ugly and unworthy. Adolescents are preoccupied with thoughts about body-image and media plays an important role by projecting an unreal image of what they should be. Both boys and girls end up setting unreal goals for themselves and feel a failure when they cannot achieve those goals.

Let us now look at the characteristics of self-esteem and factors affecting self-esteem.

- ***Characteristics of high self-esteem:*** People who enjoy a positive self-esteem consider that they are equal in dignity and feel secure within their relationships. They demonstrate self-respect, self-confidence, and self-acceptance. In touch with their own strengths and weaknesses, they maintain a balance between extremes of thought, feeling and behavior. They usually believe in certain values and principles but are, however, secure enough to modify them in the light of the experience gained. They are confident about their ability to solve problems. They have the ability not only to make the best choices in the given circumstances but also to stand by their decision without feeling guilty. They appreciate differences in individuals and are sensitive to the feelings and needs of other people. They resist being manipulated and do not indulge in actions to prosper at someone else's expense. They learn from the past and plan for the future, but live in the present. They have the courage to forgive self and others. Choosing continuous self-improvement they exhibit the ability of taking positive risks. The survival value of high self-esteem is obvious, so is the danger when it is missing.
- ***Characteristics of negative self-esteem:*** Young people suffering from low self-esteem believe themselves to be inadequate, unlovable, unworthy and/or incompetent. They tend to assume that other people see them in the same negative way as they see themselves. They may anticipate rejection, expect to be ignored or mistreated and convince themselves that they deserve it. Overly self-critical, they find it difficult to accept compliments; instead believe that other person is making fun of them. They lack assertiveness and have poor communication and social skills. They are unable to discern who and when to trust. Hence, there is a danger of them being manipulated or taken advantage of by others. Lacking self-confidence they believe that they cannot succeed in life. Desperate to prove themselves, some of them may become over-achievers while others remain under-achievers. However, even over-achievers often do not believe in their success, considering themselves as merely "lucky". They usually remain in relationships that are unsatisfying and/or abusive,

remain in jobs where the pay is poor and the benefits are non-existent. They often 'test' their loved ones giving out cues about what they need and rate them as 'not caring' or 'not caring enough'. They have a fear of change, loneliness and their own ability to make right decisions. Fearful of failing they become overly critical of themselves and others, and can sometimes be seen as arrogant. This is because they are so focused on the negative aspects that they look for, rather only the negative traits. In case of a disagreement they exhibit extreme reactions of anger, petulance, sarcasm, accusation or despondency. They imagine that others are deliberately trying to slight them because they are unworthy. They are rigid in their beliefs and thinking and are judgmental of others who think, feel, or act differently as they have not developed the ability to critically analyze issues and consider the varying merits before choosing a side. Assailed by self-doubt regarding their own ability to make good choices they blindly follow an authoritarian figure.

Poor self-esteem often leads to serious consequences such as obsessive, compulsive or addictive behaviors. With a firm desire to feel better about themselves, people with low self-esteem may over-spend, over-eat, use alcohol or drugs and indulge in perfectionism or sexual promiscuity. These behaviors often evolve into addictions. In extreme cases, one can observe depression, suicide, anorexia, nervosa, bulimia, self-mutilation, etc.

- **Factors that affect self-esteem:** Having a positive support system at home with a warm, caring and loving environment can have very enabling effect on building of high self-esteem. Parents can focus on the areas where children appear especially competent and build self-esteem in those areas. As you would recollect it was discussed earlier that children may show excellence in one domain, e.g. they may excel in sports but may not be academically inclined or vice versa. It may also be noticed that positive self evaluation in one domain may not carry it over into another, e.g. a person may possess high self-esteem in academic activities but may have poor social skills resulting in low self-esteem. It helps if young people cultivate a hobby which they enjoy and in which they can excel. This helps in positive validation of their self-concept. Care, however, must be taken that they do not set unrealistic goals for themselves. Parents must also be cautioned against putting too much pressure as this can lead to negative self-esteem if the children fail to live up to the high standards that parents expect. The hobbies should be selected in consultation with the children keeping their interests in mind. This would also help build close friendships with like-minded children.

It is unfortunate that physical features over which we have no control exert so much influence on our self-esteem and identity-formation. Most people credit physically attractive people with all sorts of desirable personality traits (Dion, Bercheid and Hatfield, 1972). This compounds the feeling of inadequacy and unhappiness amongst many young people with low self-esteem. It is not until middle forties that these feelings disappear (Bercheid, Walster and Bohrnstedt, 1973).

- iii) **Gender Roles:** Self-concept includes both individual attributes as well as the identity-based culturally acceptable social role. One of the most basic

but important social roles is based on gender. What is the first question that comes to your mind when a birth is announced? — ‘Is it a girl or a boy?’ In most of the cultures gender determines a large part of an individual’s personality. Our likes and dislikes, interests, hobbies, games and personality attributes are often clubbed or categorised either as ‘feminine’ or ‘masculine.’ Children at a very young age gauge the difference and start imitating the gender appropriate behavior. All of us go through a process of sex-typing. Sex-typing is the way in which biological gender and its cultural associations are incorporated into a child’s self-perception and behavior. The following table illustrates the various components of gender role and its impact on sex-typing.

Table 7.5: Components of Gender Role and its Impact on Sex-typing

Components	Gender / Sex Role Identity (How one perceives oneself)	Concepts (Gender and social stereotypes)	Sex-Role Preference	Behaviour Adopted
Biological Gender	Gender identity Sex-role identity	Gender constancy	Desire to be a male or female	Clothing, hair style, etc.
Interests / activities	Awareness about one’s own interests	Sex-typing of toys / interests / games / activities	Exhibition of preference for games, toys, etc	Spending time on the preferred activities
Personality attributes / social behaviour	Perception of one’s own personality	Concept about gender-specific behaviour, e.g., aggressive, kind, etc.	Assimilation of the values/ behaviours one prefers	Exhibit behaviour according to the values preferred
Gender-based Social Relationships	Awareness about the pattern of friendship, sexual-orientation	Concepts about norms for same sex and heterosexual friendship, lovers, etc.	Preference for male / female friends, lovers, etc.	Selection of friends / lover on the basis of gender

Source: Wishwa Prakashan, Mussen, B., Conger, J. J., Kagan, J., and Huston, A. C. 1990. *Child Development and Personality*. New York: Harper & Row.

As we can observe in the table above, there are four distinct features of sex-typing.

- a) *Gender Identity*: It is acceptance of our biological nature of either being a male or a female. Based on our biological identity, each one of us has a sense of being either feminine or masculine. Our behaviour conforms to how we define femininity and masculinity. Children develop a rudimentary gender identity between the ages of 18 months and 3 years. Around this time they start labeling themselves as a girl or boy. However, their understanding of gender is very limited.
- b) *Gender Constancy*: The second aspect of sex-typing pertains to the concept about how society defines femininity and masculinity. *Gender constancy* is

the understanding that gender does not change. It is a three-step process. After acquiring the gender identity by the age of three they learn that gender does not change around four years of age. Around five to six years of age they start comprehending that gender remains the same even if you wear the clothes usually worn by opposite sex or by playing games popular with opposite sex. They also have quite significant information regarding social expectations from both the sexes. Around the same age they also start learning about stereotype personality and social behaviour. They also start associating loud, aggressive, independent behaviour to boys and quite, obedient and emotional behaviour to girls. By middle childhood they become less rigid in their views. They can now appreciate that people can show both feminine as well as masculine behaviours. However, all of us invariably end up adopting more or less the same stereotype behaviour pattern accepted by our society even though we may not agree with it.

- c) *Sex Role Preference*: This facet essentially refers to the choices an individual makes in the given culture. It is about what is a child's personal definition of self.
- d) *Overt Behaviour*: The fourth and the last facet deals with *acting on the choices one makes* or the *overt behaviour one displays*. Children learn about the gender roles by observing others and through direct reinforcements. They process this information integrating it with knowledge acquired through other media and experiential learning. This helps them to construct concepts of gender appropriateness in their given situation. They also consider social values and reinforcement of ideas received from people as important and go a long way in forming their own concept of gender, which is displayed in their overt behaviour.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 4) Self-concept is non-judgmental where as self-esteem is. Explain the statement.

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7.3.3 Sociological Maturity

By and large the period of adolescence is the healthiest period in life. However, when body and mind undergo such rapid changes there is bound to be some areas of concern. The adolescents have to perform as an individual adolescent, as a member of the family and as a member of the society. In their attempt to perform their diverse and emerging roles characteristic of adolescence, they are bound to face problems of adjustment. Those who fail to adjust may resort to some unacceptable behaviours harmful to themselves and to the family and the society. So, in this sub-section our discussion will focus on all these aspects. Let us try and find out what exactly ails our younger generation, what are the risk factors and the consequent deviation in behaviours.

7.3.3.1 Maladjustments: Causes and Consequences

Some of the major maladjustments of the adolescents, their causes and consequences are as follows.

- **Smoking and alcoholism:** Sneaking a cigarette or trying a puff with friends has always been narrated as funny incidents from youth. With the awareness about health hazards and identification of cigarettes as a gateway-drug, what was once viewed with indulgence has become a reason of major concern. Children who smoke often take their first puff between 10-12 years. Those who continue to smoke, even though they do not enjoy it first, become dependent by around the age of fifteen. National Family Health Survey (NHFS-3) conducted in 2005-06 states that, among youth, 40 percent of men and 5 percent of women use tobacco and one-fifth of young men and 1 percent of young women in the age group of 15-24 consume alcohol. In fact, the study confirms that tobacco use in any form, smoking, and consumption of alcohol among men increases sharply from age 15 to 24 years.

It has been observed that adolescents who mature late often smoke to appear grown-up. They tend to be more rebellious, poor performers in school and are less interested in sports than the peers who do not smoke. Both smoking and alcohol are considered gateway-drugs. Cigarettes and alcohol are considered as dangerous because these are inexpensive, easily available and socially acceptable. They are not only as addictive as drugs but also lead to the risk of an adolescent experimenting with harder drugs. Elders smoking at home, peer pressure and media exposure induce young people to smoke and drink. As a result, they become addicted to the same leading them to suffer from the consequences thereof.

- **Drug-abuse:** One of the important tasks is learning to cope with stress, conflict and frustration. Those who suffer from insecurity, stress, low self-esteem, feelings of rejection repeatedly turn to drugs. Such young people fail to reach the required proficiency in cognitive, social and vocational domains. Failure to meet these tasks leaves them ill-prepared to take on the additional demands of responsible adulthood.

It is, however, important to note that although far too many adolescents become serious drug users, majority do not. A significant number of those who begin under peer-pressure think that they are doing it for 'fun' or are 'experimenting' later become dependent. The indiscriminate use of drugs

and the resultant addiction invariably exposes young people to indulge in high risk sexual behaviour.

- **High risk sexual behaviour:** The age at marriage for one group of young people in India is presently delayed while another group is getting married too early. NHFS-3 concluded that a much higher proportion of female youth than male youth have ever had sexual intercourse: 51% vs. 27%. Given the very low mean age at marriage among women, it is not a surprising data. It was found out that among youth, one-tenth of women and 2 percent of men had sexual intercourse before they had reached age 15. Further, among those who have ever had sexual intercourse, men had, on average, 1.8 partners, whereas, women had slightly more than one partner. Among youth who have ever had sexual intercourse, less than 1 percent of women, but 26 percent of men (or 7% of all male youth), reported having had higher-risk sexual intercourse in the past 12 months.

Poor genital hygiene and reproductive tract infections (RTI) coupled with high-risk sexual activity has been found to be positively associated with the risk of sexually transmitted infections such as HIV. It is important for young people to maintain good genital hygiene and know the symptoms of STIs and STDs. Consult a doctor immediately if they have a symptom of RTI. Young people must observe the ABC rule of abstinence, being faithful and condom use. Parents need to play a very supportive role during this period. Keeping channels of communication open through adolescence and maintaining a healthy relationship with children plays a big role in keeping them safe.

- **Generation-gap:** The term 'generation-gap' has often been used to describe the growing alienation between parents and children. It is actually the tendency for grown-ups to view young people as rebellious, disrespectful and lacking any clear goals. Similarly, the younger generations tends to view the elders as controlling, dull and old-fashioned. Parents fear the growing influence of friends on their children and react by becoming more protective especially towards the girl-child, and the young-adult resents it.

In reality, the generation-gap just might not be such a big problem as is being depicted by media and social critics. It has been found out that both the family as well as peer group are important stabilizing factor in the lives of young people. Both help in anchoring the teenager. The extent of differences between the young people and adults varies from issue to issue. As per a study conducted by Conger in 1977, generation-gap is not as pervasive as is implied. When the issue involved is on fashion, entertainment, cheating in exams or experimenting with smoking or drinking, teenagers tend to look at what their peers prefer. But, when the issue involves core values, future life goals, etc they tend to look towards their parents or other adults for guidance (Kandel and Lesser, 1972).

As the adolescents' ties with their parents become progressively looser, their dependence on peer relations increases. Consequently, the parent-adolescent relationship is charged with conflicting emotions of love and hostility. Clearly, the most critical and difficult adjustment both for parents and the adolescents revolves around their developing sexuality. However, healthy interpersonal

relationships with mutual trust and respect can go a long way in developing a strong bond between the parents and young adults. It is also important to keep the channel of communication open between both the parties.

- **Nutrition:** It remains a principal area of concern for Indian adolescents. Both boys and girls require balanced nutrition during growing period. Where boys require 2800 calories per day, the girls need 2200 calories. Apart from calcium, the most common deficiency amongst adolescents in India is iron. As per the survey conducted by National Family Health Survey (NHFS-3) conducted in 2005-06, 44 percent of females in the age of 15 to 24 are abnormally thin and 4 percent are overweight or obese; only about half have a BMI (Body Mass Index) in the normal range. Compared with female youth, male youth are slightly more likely to be abnormally thin, but slightly less likely to be overweight or obese. The BMI is defined as weight in kilograms divided by height in metres squared (kg/m^2). The survey also found out that 56 percent of Indian women and 25 percent of men in the age group of 15-24 are anaemic. Iron deficiency anaemia is one of the most common forms of malnutrition in the world; characterized by a low level of haemoglobin in the blood it can have detrimental effects on an individual's health. Anaemia is of particular concern for female youth since it can become an underlying cause for maternal and perinatal mortality and is associated with an increased risk of premature delivery and low birth-weight for children. The prevalence of anaemia is higher for youth in rural areas than in urban areas. It was also found that the prevalence of anaemia among both women and men decreases with education and wealth quintile. Lack of information, poor eating choices, body image issues and gender discrimination contribute to the poor nutritional status of Indian adolescents.
- **School dropout:** Young people who fail to acquire the reading, writing and mathematical skills put themselves at a serious disadvantage in the job market. Education is perhaps the single most important factor that can positively influence overall development. The positive correlation between women's education and lower fertility, child mortality and other social development indicators is well established. Moreover, society tends to stigmatize the dropouts. India is grappling with the serious dropout phenomenon especially amongst the urban and rural poor, particularly the disadvantaged including girls.

In the upper primary level, 45% boys and 39% girls dropped out of school, while at the secondary level the dropout rates are 56% for both boys and girls. While 12% of girls in the age group 10-14 have completed 8-9 years of education, only 18% of girls in the age group of 15-19 manage to complete 10-11 years of education. The statistics of boys' education look slightly better. Among 10-14 year-old boys 12% completed 8-9 years of education, while among 15-19 year-old boys, 22% completed 10-11 years of education (Statistics of School Education, 2008-2009). This seriously compromises their ability to get and hold employment. It also makes them vulnerable to the perils of early marriage, parenthood and child-labour.

7.3.3.2 Individual and Familial Responsibilities

With so much attention given to the negative aspects of a few deviant adolescents, we sometimes fail to recognize the positive side. Adolescence is the most exciting phase in an individual's life. This is a time when a young person engages with

self and sculpts his/her own personality, thus writing his/her own future. They are on the threshold of participating in the adult life and in finding a vocation and a partner as well as of contributing as responsible citizens of their country. This is a period when every thing appears to be possible and yet only a few adolescents recognize and value their strengths.

Adolescents need to be responsible to maintain good health and have the energy and vitality to achieve goals. Not only do they need to be responsible towards their nutrition but also need to protect themselves from risky activities like smoking, drinking, drug-abuse and sexual experimentation. They have an ability to make friends outside their family, give and receive affection and love from others as well as have the capacity for empathy. It is hence their responsibility to experiment with various communication skills to develop and maintain cordial relationships with people of both sexes. However, it is important that they develop the ability to withstand negative peer-pressure and practice negotiation skills. Developing closeness and loyalty to family has long-term gains, so they need to find time and get along with their siblings and parents. One of the primary responsibilities of young people is to develop dependability. Being able to keep a promise or an appointment, sticking to time-schedules and persevering to bring the task at hand to a logical conclusion play an important role in their being trusted by others. This also has a positive impact on their self-esteem and helps in shaping their personality.

The critical developmental task which confronts adolescents is to arrive at vocational decision. They are faced with the fact that their future depends on their ability to find and keep a job. This has a direct impact on their status and level of acceptance amongst peers, standard of living and finding the right partner. To achieve this, it is their responsibility to educate themselves, acquire vocational skills, make long-term and short-term goals, and develop critical and creative abilities. Participating in clubs or organizations, developing hobbies, etc., help them connect with their inner strengths and hence is an important way of exploring the kind of vocation they would be comfortable with.

The parents and society have to play a very important role in providing a safe space and support to the young adult to experiment and evolve as a responsible human being. Constant dialogue, opportunities to explore, open communication, commitment of support and a chance of redemption after failure are the critical factors for an all-round healthy development of an adolescent.

7.3.3.3 Social Responsibilities

Adolescence is marked with qualities like idealism and real concern for the future of their country and the world. Due to the heightened sensory awareness and perceptibility they often question contemporary values, philosophies and institutions. They often think deeply and seriously about issues. Since they possess a strong sense of fairness and risk-taking ability, it often makes them courageous and, hence, they are ready to fight for a cause that they think is just, even if it does not concern them. They usually have an optimistic and positive outlook and are honest, frank and open. This quality ensures that they are flexible and ready to change if properly counseled. However, the same qualities are often exploited by vested interests that push them towards detrimental ideologies.

To make an effective use of all these qualities it is important for parents and society to provide the adolescents a chance to make a positive contribution both in society and at home. However, care needs to be taken to gently steer the adolescent towards sports, hobbies and spiritual or institution-building activities. The environment at home must be open to discussions rather than autocratic which forbids questioning of societal norms so that the young adult is not pushed towards people who can exploit his innate strengths.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 5) Cigarettes and alcohol are often referred to as gateway-drugs. Explain the statement.

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7.4 LET US SUM UP

Adolescence stage is the most crucial stage in the individual's life. It is the stage that makes or mars the life if it is not understood well and not moulded properly. The range of changes that take place during this stage and the diversity of problems that the adolescent confronts vary from individual to individual. Though many common characteristics can be understood by the adult members of the society, since they have already crossed this stage, some changes are unique to some adolescents and difficult to understand, describe or explain without paying serious attention to such changes.

We have, therefore, presented to you the diversity of changes that occur, the range of responsibilities they have to shoulder, the challenges they face as adolescents and (mal)adjustment problems that they are likely to suffer from along with the possible causes and consequences during the adolescence period. We hope this unit will be useful to you in your attempt to educate adolescents as well as the adults about adolescence period so as to enable them to guide the adolescent members of their families and of the society for their smooth transition into mature adults.

7.5 ANSWERS TO 'CHECK YOUR PROGRESS' QUESTIONS

1) *Pubescence* is the stage during which the reproductive organs start maturing. Primary sex organs enlarge and secondary sexual characteristics appear along with rapid gain in height and weight. It takes about two years for this process to complete into puberty. *Puberty* is the stage when a girl or a boy reaches full sexual maturity and is physically able to reproduce.

2) The process whereby boys become taller and stronger than girls is as follows.

The boys reach the growth spurt two years later than the girls and they also get an extended period of pre-pubertal growth, which is faster than the rate of growth during puberty. On an average they are 12-13 cm taller than females mainly because of the 2-year delay in bone closure as compared to girls. This accounts for about a 10 cm difference in height between the two sexes; in addition, males also have 2-3 cm more of growth during their growth spurt.

3) If the sex steroids do not end the growth spurt, people will keep on gaining height throughout their life. Sex steroids play the role of agents of bone closure.

4) *Self-concept* is non-judgmental because it is based on personal attributes. *Self-esteem* is judgmental because it judges and evaluates the personal attributes and assigns them positive or negative values.

5) Both smoking and alcohol are considered gateway-drugs. Cigarettes and alcohol are considered as dangerous because these are inexpensive, easily available and socially acceptable. They are not only as addictive as drugs but also lead to the risk of an adolescent experimenting with harder drugs.

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UNIT 8 SEX EDUCATION

Structure

- 8.0 Introduction
- 8.1 Objectives
- 8.2 Sexual and Reproductive Health: Concept, Rights and Aspects
 - 8.2.1 Concept of Sexual and Reproductive Health
 - 8.2.2 Aspects of Sexual and Reproductive Rights
- 8.3 Reproductive Growth, Health and Hygiene during Adolescence Period: An Overview
 - 8.3.1 Physical and Emotional Changes in Adolescents
 - 8.3.2 Sexual Health and Hygiene
 - 8.3.2.1 Puberty
 - 8.3.2.2 Care to be taken by Parents, Family Physician and Adolescent Individuals
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- 8.4 Human Reproductive Systems and Processes
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- 8.6 RTIs, STIs / STDs and AIDS/HIV
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 - 8.6.2.1 The STI – HIV Relationship
 - 8.6.3 AIDS / HIV
 - 8.6.3.1 What does HIV do in the human body? Signs and Symptoms of HIV/AIDS
 - 8.6.3.2 Incurability of AIDS
 - 8.6.3.3 Transmission of HIV: Facts and Myths
 - 8.6.3.4 HIV/AIDS and Women
 - 8.6.3.5 Prevention of Spread of HIV/AIDS
 - 8.6.3.6 Ten Key Points on AIDS
- 8.7 Tips for Good Sexual Health
- 8.8 Let Us Sum Up
- 8.9 Answers to 'Check Your Progress' Questions
- 8.10 References

8.0 INTRODUCTION

In Unit-7, we have discussed the process of growing-up with special emphasis on the physical and emotional changes that take place during adolescence period which poses serious challenges to adolescents in maintaining their interpersonal, social and other relationships with others. As they grow into adults – males or females – their physical changes become more visible and clear in them.

Therefore, in Unit-8, we will deal with sex education with special reference to the male and female reproductive systems, their functioning, the process of reproduction, the importance of reproductive health and hygiene in the context of right to reproductive health and how it gets affected with RTIs, STIs/STDs including HIV/AIDS, if proper care is not taken by adults regarding their sexual and reproductive aspects of life.

8.1 OBJECTIVES

After going through this Unit, we expect you to be able to:

- Describe the structure and functioning of male and female reproductive systems;
- Appreciate the significance of reproductive health and hygiene in the life of an individual;
- Explain the process of reproduction and factors affecting it;
- Discuss the causes and consequences of RTIs, STIs/STDs including HIV/AIDS; and
- Analyse the effects of unhealthy sexual practices/relationships on the sexual, reproductive and general health of human beings.

8.2 SEXUAL AND REPRODUCTIVE HEALTH: CONCEPT, RIGHTS AND ASPECTS

We are all aware that the sexual and reproductive health plays an important role in the life of every adult. Sexual and reproductive health is a general state of physical, mental, social and emotional well-being, and not the mere absence of illness, in all aspects related to sexuality and the reproductive system. Sexual and reproductive health is oriented towards developing a positive life and personal relationships and not merely attending to reproductive processes and sexually transmitted diseases.

8.2.1 Concept of Sexual and Reproductive Health

In recent decades, it is understood that the personal and cultural experiences of sexuality are intimately linked to the biological health of the reproductive system; these are two inseparable dimensions of what is experienced as a single phenomenon in human life. Reproductive and sexual health develops interdependently during the life cycle, and affects each person in multiple ways and levels (Bassu, 1997). It means, certain sexual practices and choices can make individuals vulnerable to diseases that cause harm, and even infertility in the reproductive system.

In 1974, a committee of experts from WHO defined sexual health as the integration of physical, emotional and intellectual elements in ways that positively enrich and strengthen personal identity, communication and love. The comprehensive vision expressed here surpasses reproductive and pathological aspects to encompass affection, pleasure and communication which are important in people's lives (Cerruti Basso, 1993) and contribute to improved life and interpersonal relationships (ICPD, 1994; and Alcalá, 1995). Different definitions and interpretations of sexual and reproductive health coexist. Medical scientists tend to express them in biological terms, while some NGOs and international organizations tend to emphasize rights of men and women or the provision of information and services (WHO, 1997).

The International Conference on Population and Development (ICPD) held in Cairo in 1994 established a new vision of reproductive health that explicitly incorporates sexual health. Reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in these conditions are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant (ICPD, Programme of Action, Paragraph 7.2, 1994).

With this understanding of sexual and reproductive health, we will now look at sexual and reproductive rights.

8.2.2 Aspects of Sexual and Reproductive Rights

Sexual and reproductive rights are inalienable human rights, inseparable from other basic rights such as the right to food, housing, health, security, education and political participation. Sexual and reproductive rights can be defined in terms of power and resources: the power to make informed decisions over one's own fertility, procreation and child care, gynecological health and sexual activity, as well as the resources to carry out those decisions safely and effectively (Correa and Petchesky, 1994). These rights include but are not limited to the following {**Note:** This list of rights below is compiled from: i) *IPPF's Declaration of Sexual and Reproductive Rights* (1996), ii) Mari Ladi Londoño's book, *Sexual and Reproductive Rights* (1996), and from iii). *Open Forum for Sexual and Reproductive Rights in Chile* (1996)}.

- The exercise of sexual independence as well as the right to enjoy it according to one's own preferences, and the right to legal protection.
- Pleasurable and recreational sexuality, independent of reproduction.
- Adequate information and knowledge about sexuality and reproduction.
- Love, sensuality and eroticism in sexual relations.
- Sexual education that is appropriate, comprehensive, secular, scientific and gender-sensitive.
- Refusal to engage in sexual activity.

- Freedom from fear, shame, guilt and other imposed beliefs that inhibit a person's sexuality and diminish his or her sexual relations.
- Choice of sexual partners, to exercise sexuality without coercion or violence.
- Nutrition necessary for adequate growth and balanced development of one's body and future reproductive potential from childhood.
- Voluntary motherhood, to decide and live motherhood for one's own choice and not by obligation.
- Complete information concerning the benefits, risks and relative effects of all contraceptive methods.
- Free or inexpensive contraceptives with current information, follow-up and responsibility on the part of those who prescribe it.
- Marriage and family or the choice not to have either.
- Parenthood and the right to decide when to have children.
- Good quality services for prenatal care, birth, and postpartum care, guaranteed by appropriate legislation.
- Equal participation by women and men in child care, creatively constructing children's identities beyond traditional gender roles.
- Effective legal protection against sexual violence.
- Adoption and right to comprehensive, accessible treatment for infertility.
- Prevention and treatment of illnesses of the reproductive tract, and the right to make informed decisions about related interventions.

By asserting on these rights, among others, and by following certain practices the individuals will be in a better position to maintain their sexual health and hygiene, which assumes greater relevance since the beginning of reproductive growth till the end of active reproductive and sexual life.

8.3 REPRODUCTIVE GROWTH, HEALTH AND HYGIENE DURING ADOLESCENCE PERIOD: AN OVERVIEW

In Unit-7 on "Adolescence Education" you have already learnt that the reproductive growth starts in adolescence period and the reproductive capacity continues throughout adulthood. In this context, it is relevant for us to have an overview of physical and emotional changes that take place in adolescents.

8.3.1 Physical and Emotional Changes in Adolescents

You are already aware that adolescence is the transitory phase between childhood and adulthood. This is the time when a child changes from a boy to a man and a girl to a woman. Adolescence is from 10-19 years. During adolescence, the girl or boy undergoes various physical, psycho-social, and emotional changes which make her/him feel different from others. These changes usually start between 9 to 12 years and continue until 16 or 19 years, and are due to sudden

change in the hormonal pattern of boys and girls at this stage. However, the most significant change is the maturation of the reproductive organs so that the adolescent girl/boy becomes capable of reproducing sexually. This maturation is called *puberty* (girls usually attain puberty a year or two before boys).

Some of the changes occurring during adolescence are visible while some are invisible happening within. These changes which occur in all girls and boys are quite natural.

Physical Changes in Girls: These include the following.

- Growth spurt occurs
- Skin becomes oily
- All permanent teeth are in
- Underarm hair appears
- Breasts develop
- Waistline narrows
- Hips widen
- Long bone growth stops
- Pubic hair appears
- External genitals enlarge
- Ovulation occurs
- Menstruation begins
- Uterus and ovaries enlarge

Physical Changes in Boys: These are as follows.

- Growth spurt occurs
- Skin becomes oily
- All permanent teeth are in
- Underarm and chest hair appears
- Larynx (voice box) enlarges, voice deepens
- Facial hair appears
- Shoulders broaden
- Long bone growth stops
- Muscles develop
- Pubic hair appears
- Penis and testes enlarge
- Sperm production begins
- Ejaculation occurs

Emotional Changes in both Boys and Girls: These include the following.

- Increased production of hormones prompts sexual thoughts, daydreams and fantasies in most young people.
- There is increased awareness of sexual attraction to the opposite sex.
- Frequent shift of moods.

8.3.2 Sexual Health and Hygiene

Sexual hygiene is part of the daily cleaning “ritual” and is considered to be just as important as overall hygiene. The sex organs are more sensitive than other parts of the body, which is why they should be as clean as possible, if not cleaner. Keeping in view the specific physical aspects of males and females, in addition to this routine cleaning, there is a need for special care to be taken by the parents, family physician and the adolescents themselves.

8.3.2.1 Puberty

Puberty is the time when a girl develops into a woman and a boy develops into a man; they become physically capable of reproducing children. The ovum or female egg begins to be released once a month from either of the ovaries of the adolescent girl and sperms are constantly produced in the testes of the adolescent boy. The adolescent girls or boys are still not adults and hence are not ready to shoulder the responsibilities of parenthood, even if their eggs and sperms are mature and

capable of reproducing sexually. As you are aware, signs of puberty are different in males and females.

- **Semen Production:** There are the two round glands lying in the scrotum hanging behind penis which are called testes. These produce and store sperms from puberty onwards. They also produce the male sex hormone responsible for male characteristics and sexual performance. Two sac-like structures called seminal vesicles lying behind the urinary bladder and a gland located in the male pelvis which surrounds the lower part of the bladder and the upper urethra also secrete a thick milky fluid that forms most part of the semen. In response to thoughts, fantasies, temperature, touch or sexual stimulation, the penis gets filled with blood and becomes hard and erect for sexual intercourse. As a result of such sexual excitement semen is released from the penis — the process which is called *ejaculation*. This may occur at night during dream in adolescents which is commonly called a ‘wet dream’, or due to sexual excitement caused for any reason or during the process of intercourse. We will discuss many other aspects and changes in detail in the male reproductive system under Section 8.4.1.
- **Menstruation:** A major change that occurs in girls during puberty is the start of “menstruation”, bloody discharge from vagina, which happens periodically. This cyclic process is called ‘*periods*’ or ‘*menstrual cycles*’ because they occur every month and mark the onset of sexual maturity in girls. This cycle is repeated every month, if she does not become pregnant. If pregnancy occurs, then the periods stop till the delivery takes place. Menstrual cycles may occur within a range of 24 to 35 days and each menstruation may lasts for about 3 to 7 days. Menstruation begins at puberty and continues until menopause, i.e. stoppage of menstruation, which occurs around age 45 to 50 years; it stops forever because the ovarian function stops at that stage. Any bleeding from vagina, after menopause could be a sign of dangerous disease like cancer or tumor of uterus and should not be ignored. We will discuss, in detail, many other aspects and changes in the female reproductive system under Section 8.4.2.

Adolescent needs to keep in mind these changes occurring in him/her to maintain cleanliness and to take special care of his/her reproductive health from this stage onwards. Here, we touch upon the care to be taken by parents, family physician and individuals themselves.

8.3.2.2 Care to be taken by Parents, Family Physician and Adolescent Individuals

As mentioned elsewhere above, the sex organs are more sensitive than other parts of the body which is why they should be as clean as possible. Hygiene is a cornerstone of modern civilization and daily cleaning “ritual” is considered to be just as important as overall hygiene.

It is important that sexual education be given to boys/girls about to enter college or a business career, for it is at this period of life that their sexual temptations become greatest.

- At the age of ten or twelve, the family physician or parent should give instruction to boys/girls as to the harm which results to them from unnaturally

exciting their sexual nature by handling and stimulating the sexual organs and also warn them against filthy literature and improper companions.

- At the age of puberty the girls/boys should be warned against the moral and physical dangers of sexual intercourse with lewd men/women. The physical dangers refer to the great possibility of infection with common diseases such as syphilis, gonorrhea, etc., which are acquired by sexual contact with one suffering from these terrible disorders.
- Idleness is also another influential factor in indirectly causing sexual desires; hard physical and mental works are powerful correctives of these passions.
- Alcohol is the most dangerous foe next to bad companions; association with persuasive friends, and weakened by its influence they may forget or ignore the advice and warning they may have received.
- It is also desirable for the parent or the family physician to inform the young man or woman about: a) consequences of having close and frequent personal contact with the opposite sex, and b) sexual and reproductive health in general, and especially if either is about to enter into a marriage engagement. It is only when the sexual functions are properly understood and normally exercised in adult life, as in sexual intercourse, that sexual excitement is not harmful.
- Young women about to marry should receive special instruction from their mothers as to the sexual relations which will exist after marriage. Most girls are allowed to grow up ignorant of such matters and in consequence may become greatly shocked and even disgusted by the sexual relations in marriage fancying that there must be something unnatural and wrong about them because the subject was avoided by those responsible for their welfare.

Therefore, in conclusion, it may be said that parents must take upon themselves the burden of instructing their children in sexual hygiene or request the family physician, who can undertake it with much less mental perturbation and with more intelligence. Otherwise, they subject their offspring to the possibility of incalculable suffering, disease, and even death largely through their own inexcusable neglect.

8.3.2.3 Special Personal Care by Women during Menstruation

Menstruation is a normal physiological process in the life of woman. However, in our society, it is often viewed as something 'dirty'. Vagina is not only the main organ of sexual contact in woman but also the outlet of menstrual flow. Poor hygiene can lead to reproductive tract infections. The blood that comes out during menstruation can become the medium for growth of many germs, if the sanitary napkins are not changed frequently. It is thus very important for women to observe menstrual hygiene. It includes the following.

- Bathe daily during menstruation.
- Use clean napkins and change them frequently.
- Wear clean underwear, change pads or cloth frequently.

- Do not use dirty cloth. Wash menstrual cloth with soap and dry in the sunshine. If cloth is washed without soap and dried in dark damp conditions, bacteria can grow in it and can cause infections.
- If pads or cloth are not available, identify other local alternatives that are clean and replaceable.
- Eat healthy food, get adequate rest, and continue normal activities.
- Some girls are little uncomfortable during their periods. They may experience cramping pains or pains in their lower abdomen or back. There are several things a girl can do if she experiences cramps: take a warm bath; take a walk; rub the abdomen; lie on the back with knees up — move the knees in small circle.
- Exercise speeds up circulation and helps ease tension.
- The body may retain more water at this time. Cutting down on salty food will help to prevent water retention.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 1) Explain the concept of sexual and reproductive health according to ICPD.

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- 2) What are sexual and reproductive rights?

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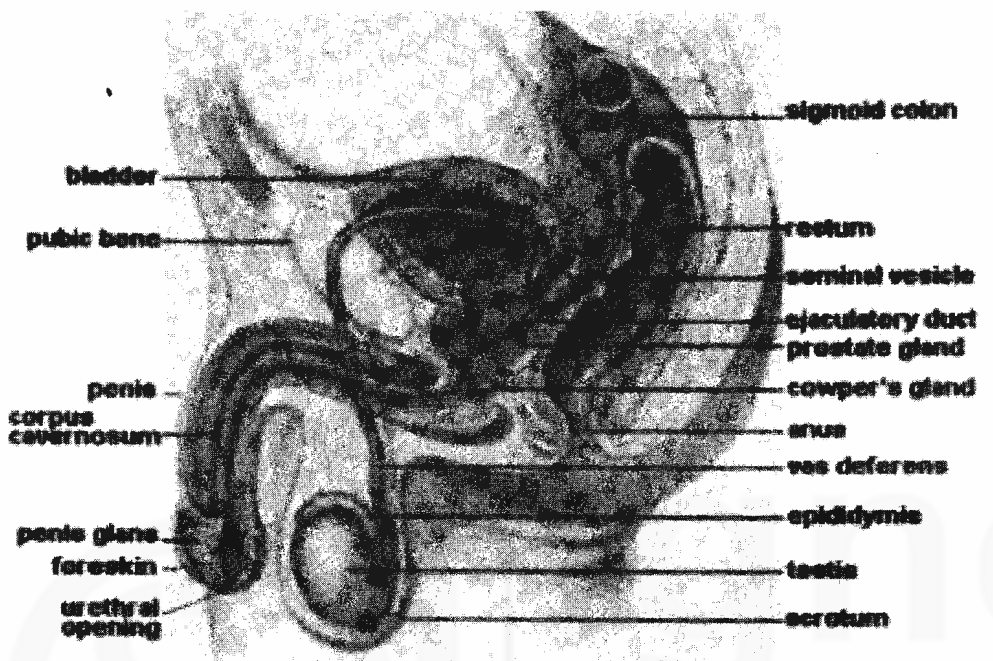
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8.4 HUMAN REPRODUCTIVE SYSTEMS AND PROCESSES

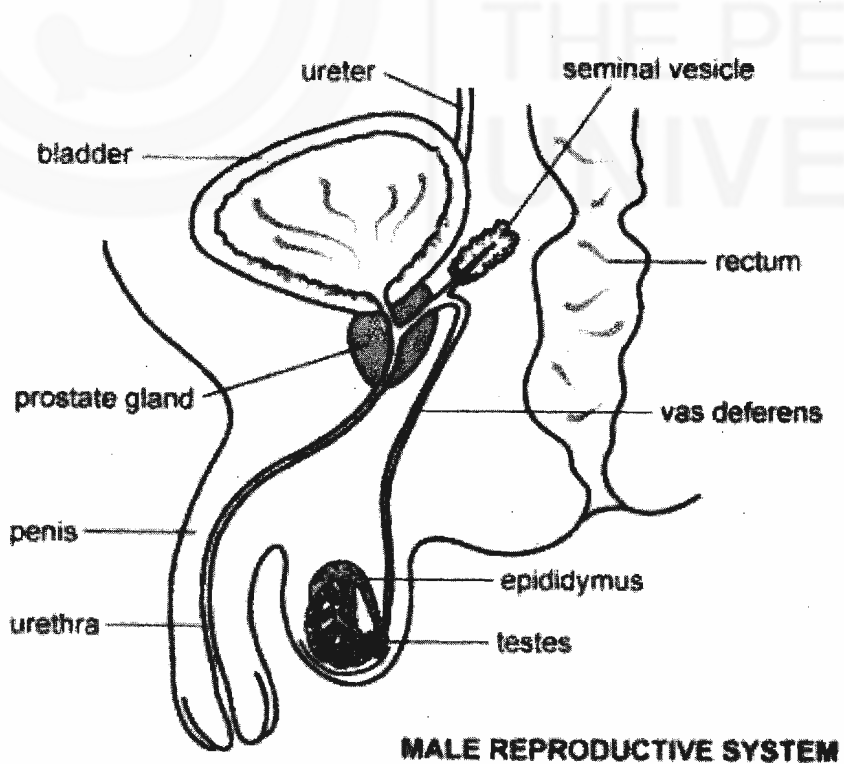
In this section, we will present you an overview of human reproductive systems and process with a view to enable you to understand the aspects of sexual and reproductive life for maintaining your sexual and reproductive health. This would also be helpful to you in having better understanding of how various methods and techniques of family planning will be useful in family welfare based on equity and equality as well as in controlling the population change by regulating the process of human reproduction.

8.4.1 Male Reproductive System: Organs, Functions and Processes

In this sub-section, the focus of our discussion will be on different organs, functions and processes involved in male reproductive system. Given below are the organs involved in the male reproductive system along with a brief note on their functions and processes.



Source: http://en.wikibooks.org/wiki/Human_Physiology/The_female_reproductive_system



MALE REPRODUCTIVE SYSTEM

Source: <http://www.patient.co.uk/diagram/Male-Reproductive-system.htm>

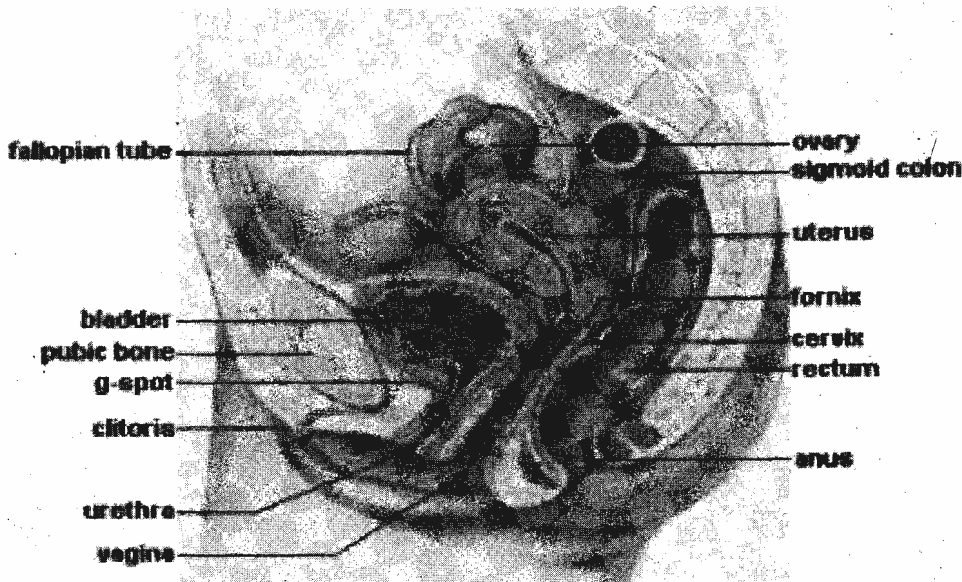
Figure 8.1: Male Reproductive System

- **Penis:** It is the male organ for sexual intercourse. It acts as the means to deposit sperms and semen into the female body through urethra, a thin, long tube passing through penis.
- **Scrotum:** It is the pouch located behind the penis, which contains two testes, provides protection to the testes, and controls temperature necessary for sperm production and survival.
- **Two Testes:** These are the two round glands lying in the scrotum, which produce and store sperms from puberty onwards. They also produce the male sex hormone responsible for male characteristics and sexual performance.
- **Two Vas Deferens:** From each testis, a thin and long tube arises which is called vas deferens. Sperms are carried from each testis to the urethra by vas deferens.
- **Two Seminal Vesicles:** These are two sac-like structures lying behind the urinary bladder which secrete a thick milky fluid that forms part of the semen.
- **Prostrate Gland:** A gland located in the male pelvis which surrounds the lower part of the bladder and the upper urethra. It also secretes a thick milky fluid that forms most part of the semen.
- **Erection of Penis:** In response to thoughts, fantasies, temperature, touch or sexual stimulation the penis gets filled with blood and becomes hard and erect for sexual intercourse.
- **Cowper's Glands:** These are two glands located near the prostrate gland. They produce a small amount of clear, sticky fluid which is released into the urethra prior to ejaculation. This fluid changes the environment of the urethra to enable sperms to remain alive as they pass through it.
- **Ejaculation:** The release of semen from the penis after sexual excitement or during the process of intercourse is called ejaculation. Ejaculation may also occur at night or even day during dream which is commonly called a 'wet dream', or due to sexual excitement caused for any reason.

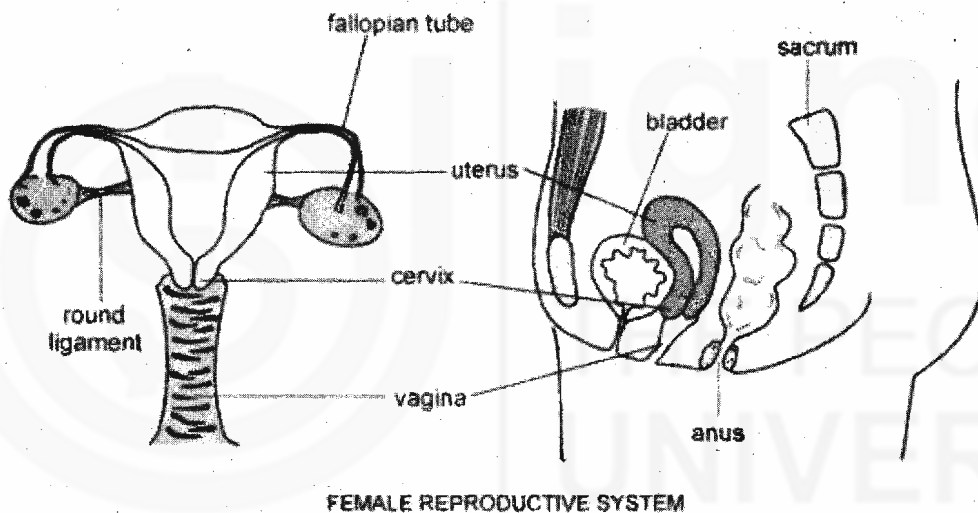
Sperms produced by testes are of *two types*. So, out of millions of sperms produced, half of them are of one type called *sperms carrying X-chromosome*, while the other half are of the other type called *sperms carrying Y-chromosome*. Any type of sperm can fertilize the egg. We will discuss more details about these sperms cells/male gametes in Sub-section 8.4.2.2.

8.4.2 Female Reproductive System: Organs, Functions and Processes

In this sub-section, we will present, in brief, about different organs, functions and processes involved in female reproductive system. The organs of female reproductive system along with their functions are briefly described below.



Source: http://en.wikibooks.org/wiki/Human_Physiology/The_female_reproductive_system



Source: <http://www.patient.co.uk/diagram/Female-Reproductive-System.htm>

Figure 8.2: Female Reproductive System

External Organs: These include the following.

- **Vaginal opening:** It is located between the urethral opening and the anus. It is usually covered by a thin membrane called hymen. It is the outlet for the menstrual flow and childbirth and also the opening for penetration of penis during intercourse.
- **Hymen:** It is a thin fold of mucous membrane partially covering the opening of the vagina.
- **Labia Majora and Labia Minora:** These are two sets of folds on either side of the vaginal opening which provide protection to the clitoris and the urethral and vaginal openings.
- **Clitoris:** A small round and fleshy structure located above the urethral opening at the point where the labia meet. It is the focal point of sexual stimulation for the female hormones, i.e., estrogen and progesterone which begin maturation and release of eggs from puberty onwards.

Internal Organs: These are as follows.

- **Vagina:** It is the passageway extending from the outside of the body to the uterus. It is also the passageway for the menstrual flow to the outside; a canal or the place where intercourse occurs and also serves as passage through which baby comes out during delivery. It is capable of expanding during intercourse and childbirth. It also lubricates during sexual arousal.
- **Cervix:** It is the narrow lower portion of uterus (with opening into the uterine cavity) that protrudes into the uppermost part of the vagina.
- **Uterus:** It is a pear-shaped muscular organ located in the pelvic region. Beginning at puberty its internal lining sheds periodically (usually monthly) during menstruation. The baby develops within it during pregnancy.
- **Fallopian tubes:** These are two thin tubular structures arising from the upper part of the uterus and having funnel-shaped free ends. Each tube is the passageway for the egg from the respective ovary (left or right) to the uterus, a place where fertilization occurs.
- **Ovaries:** These are two oval-shaped structures located in the female pelvic region. They contain many immature egg cells at birth; produce female hormones i.e. estrogen and progesterone. After puberty maturation of these cells begins and eggs are released.

8.4.2.1 Ovulation and Menstruation

A girl has thousands of egg cells or ova in each of her two ovaries (see the oval shaped structures in Fig.8.3). Each month, one cell ripens into egg and leaves the ovaries. This process is called ovulation. In other words, *ovulation* is the release of a ripe egg from one of the ovaries once in a month. Each egg is of the size of a minute grain of sand. The egg is picked up by the broad end of the Fallopian tube and it starts moving towards the uterus, the "V" shaped area. It is during this time that the egg is fertilized by a sperm. Fertilised egg is called *zygote*.

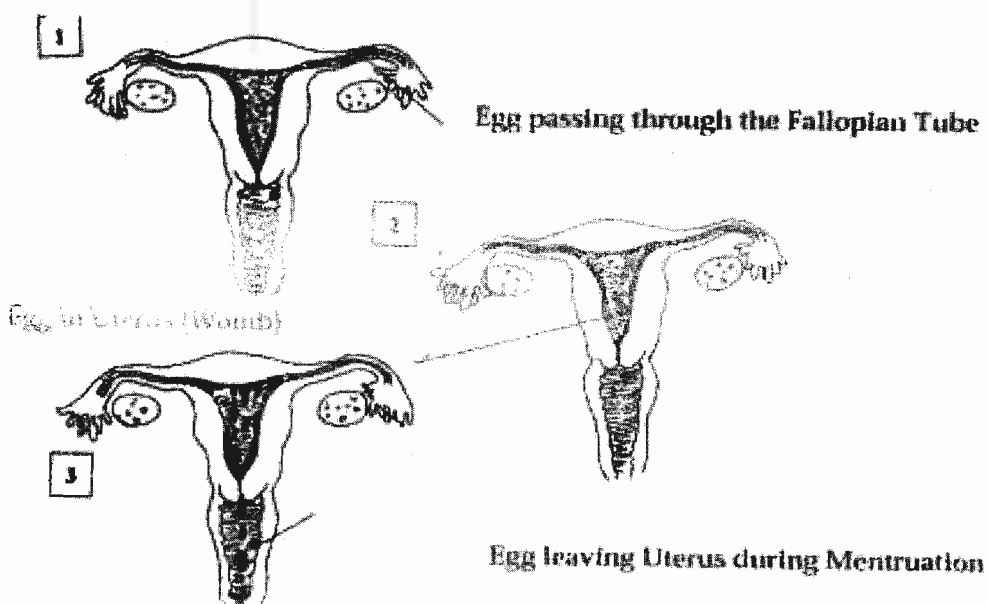


Figure 8.3: Menstruation Cycle

Every month, when one egg ripens in the ovary of the woman the inner lining of the uterine cavity starts becoming thick and spongy (due to increased blood supply) as it prepares to implant the “fertilized egg” i.e. zygote. However, after ovulation, if the egg does not get fertilized, it dies and the uterus also sheds its inner lining, which come out of the woman’s body as broken tissue along with blood through vagina as menstrual flow. Menstruation occurs approximately 14 days after ovulation, if the egg is not fertilized. Menstrual periods may last 2-7 days; the average menstrual period lasts 4-5 days. As mentioned above, if the egg is not fertilized by a sperm, menstruation will occur and egg is released in each such successive cycle. These menstrual cycles continue to occur about every month until a woman goes through ‘menopause’ when the menstruation stops for ever i.e. the rest of her life. This is the end of reproductive stage in a woman, which may happen around age 45-50.

On the other hand, if the egg is fertilised by a sperm there will not be any menstrual flow. A woman is said to have become pregnant or conceived only when the egg is fertilized. Let look at the process of conception below.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

3) Explain the difference between ovulation and menstruation.

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4) What is the care to be taken by women during menstruation?

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8.4.2.2 Process of Conception: Sex Determination

The process of conception occurs as a result of the following.

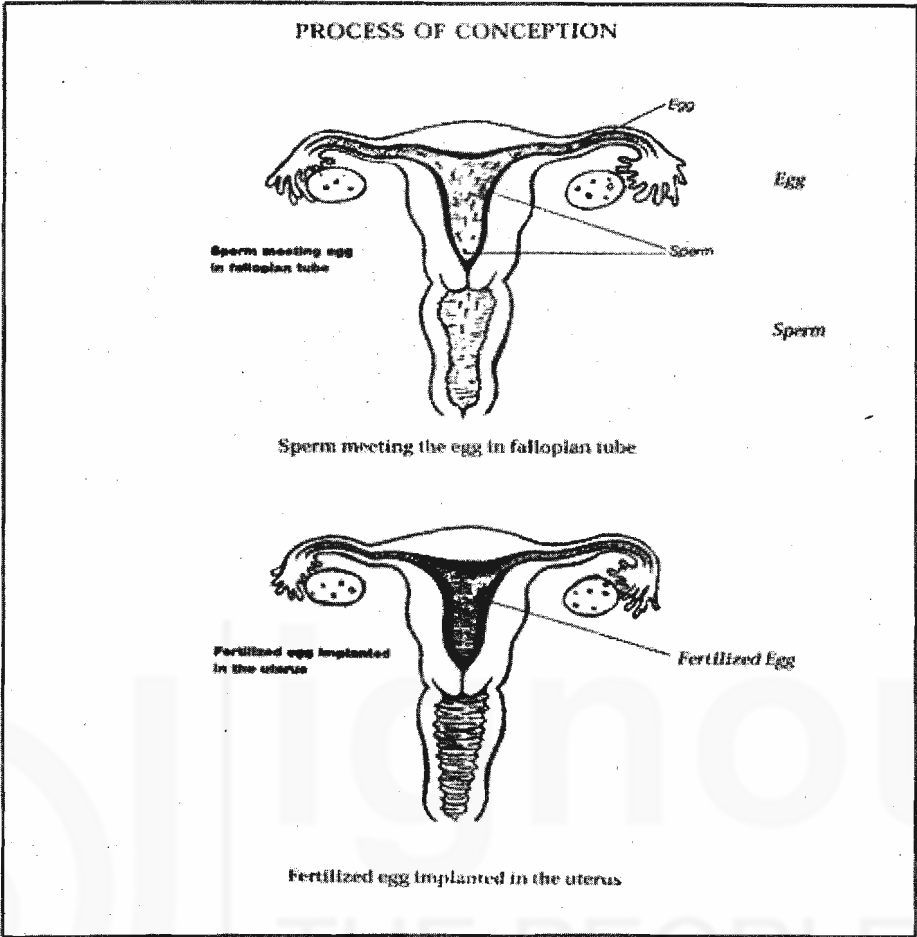


Figure 8.4: Process of Conception

- Sexual intercourse takes place between male and female i.e. insertion of the penis into the vagina. During intercourse, millions of sperms are ejaculated from the penis into the vagina. Here, it is important to note that these sperms are of two types (one type carrying X-chromosome and the other type carrying Y-chromosome), and any type of sperm can fertilize the egg. The ejaculated sperms swim up through the vagina into the uterus and through the fallopian tubes seeking an egg. If a mature egg is present, the sperms of both the types surround the egg and any one and only one sperm will fertilize the egg. Thus, although millions of sperms may be present, only one sperm fertilizes the egg i.e. egg and sperm join together into one called 'zygote'. This is what is called *conception*. Once the zygote is formed, the cycle of menstruation stops till the delivery of the baby. Though it stops during pregnancy, it starts again after the baby is born.
- A woman has the chances of becoming pregnant at every sexual intercourse including the first time. Formation of zygote is technically called 'conception', which is the beginning of pregnancy. The fertilized egg (zygote) moves through the Fallopian Tube in the uterus where it attaches to the thick lining of the uterus (implants itself) and grows into foetus. This lining nourishes and supports the baby until its birth.

- Usually only one egg is released during ovulation either from left or right ovary. Sometimes, two eggs are released at the same time. If this happens and if both the eggs are fertilized, non-identical twins will be born. Or, sometimes, if the single fertilized egg (i.e. zygote) divides into two and each develops into a baby, accordingly the identical twins (either both males or both females) are born.

Sex Determination — Need to avoid any kind of biased treatment towards the sex of the baby: Regarding how the sex of the baby is determined, you need to remember the following so as to avoid any kind of biased treatment towards the sex of the baby.

- i) In the human reproductive process, two kinds of sex cells, i.e. gametes (sperms and eggs) are involved. The male gamete or sperm, and the female gamete or the egg or ovum meet in the female's reproductive system to form a zygote, which develops into a baby, a new individual. Both the male and female reproductive systems are essential for reproduction.
- ii) Humans, like other organisms, pass on certain characteristics of themselves to the next generation through their genes, the special carriers of human traits. The genes of parents that pass on to their offspring make kids similar to others in their family, but they also make each child unique. These genes come from the father's sperm and the mother's egg, which are produced by the male and female reproductive systems. However, *the gender of the baby is determined by the sex chromosomes of the male.*
- iii) **Sex-Chromosomes, X-Y:** The male gametes or sperm cells in humans and other mammals are heterogametic and each gamete (sperm) contains one of the two types of sex-chromosomes – X or Y. Thus, these male gametes are of two distinct types – one type of sperms carrying X chromosome and the other type carrying Y chromosome. The female gamete (egg), however, contains only the X chromosome and, thus, eggs are homogametic. In fact, it is the sperm cell that determines the sex of the baby as follows:
 - a) If a sperm cell containing an X chromosome fertilizes an egg, the resulting zygote will be XX or female baby;
 - b) If the sperm cell containing Y chromosome fertilizes the egg, then the resulting zygote will be XY or male baby.

Gender is, thus, determined by the male gametes (the male's sperms) at the stage of conception – dictating whether the baby will be a boy (XY zygote) or a girl (XX zygote).

Box 8.1: Who Determines the Sex of the Baby?

It is the man who is responsible for the sex of the baby and not the woman.

Prior to conception, the unfertilized egg (woman) carries an X chromosome while the sperm (man) can carry either an X or a Y chromosome. The gender of the baby comes down to one simple event:

- *If the sperm carrying an X chromosome fertilizes the egg, a **girl** is conceived.*
- *If the sperm carrying a Y chromosome fertilizes the egg, a **boy** is conceived.*
- *It is the man who is responsible for the sex of the baby.*
- *Women are not to be blamed or condemned for giving birth to daughters.*

Then, why to blame the woman for baby's sex?

8.4.2.3 Risks Involved in Pregnancy: Danger of Adolescent Pregnancy

As mentioned above, fertilization takes place when a male gamete or sperm cell meets and merges with the female egg i.e. when zygote is formed. This is called conception by a woman. The fertilized egg moves from the Fallopian tube into the uterus (womb) where it will grow into foetus. Implantation occurs when the fertilized egg lining is not shed throughout pregnancy, so menstruation stops. This fertilized egg (zygote) continues to grow in the uterus for nine months and becomes a baby. It then comes out of the mother's body by the process of childbirth through vagina.

Risks Involved in Adolescent Pregnancy: Following are the risks involved in adolescent pregnancy.

- Once the male and female attain puberty, they become capable of reproducing children, but the reproductive maturity is reached only when adolescents are physically fully developed. Therefore, if pregnancy and motherhood occur before the reproductive maturity is attained, it exposes adolescents to serious health risks and other problems. Early marriage continues to be the norm in several regions of India in spite of laws stipulating legal age of marriage as 18 years for girls and 21 years for boys. The early marriage and the pressures on young married women to prove their fertility result in high rates of adolescent pregnancy and associated problems.
- Whether within or outside marriage, adolescent pregnancy leads to serious health risks and problems such as the following.
 - ✓ Adolescent pregnant mother is more likely to suffer from anemia.
 - ✓ Greater likelihood of prolonged labour multiplies the hazards to the mother and her child.
 - ✓ Pregnancy at an early age can result in severe damage to the reproductive tract.
 - ✓ Adolescents who begin child-bearing in their early reproductive years increase their available period for child-bearing. On an average they can have higher number of births than those who begin child-bearing late.
 - ✓ Adolescent pregnancy increases the risk of maternal and child mortality.
 - ✓ The adolescent mother is not mentally prepared to play the role of a mother.
 - ✓ Adolescent pregnancy severely curtails educational and employment opportunities and is likely to have long-term adverse impact on the quality of life of the family.

Means to reduce the risks: Conscious use of different methods of family planning by couples in their reproductive ages in order to avoid or space pregnancies and achieve the desired family size is termed as *Fertility Regulation* or *Family Planning* or *Fertility Management*. It is a means of enhancing the quality of families, which includes regulating and spacing child-birth, helping sub-fertile couples to beget children and providing counseling for parents and would be parents. It is in other words, a way of promoting the welfare of the family. It ensures that every child is a wanted child and protects the health of the mother, children and the entire family.

The methods used to prevent pregnancy are termed as *Contraceptive Methods*. They include permanent and temporary methods. There are various methods. However, one method which is suitable for one, may not be so for the other. One may choose a method according to one's needs, wishes, culture or situation. Each method has its own advantages and disadvantages. We will discuss the details of these methods and techniques in Unit-10 "Individual Measures" of Block-3 of MAE-005.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 5) What is conception? Explain how sex of the baby is determined at the stage of conception itself. Is it wise to blame a woman for the sex of the baby?

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8.5 REPRODUCTIVE HEALTH AND HYGIENE DURING ADULT AND MARRIED LIFE: SOME IMPORTANT ASPECTS

Normal functioning of the male and female reproductive systems depends on complex hormonal communication signals between the endocrine system and the sexual organs (ovaries in women and the testes in men). Knowledge of the natural processes involved in the maturation of an egg in the woman and the production of sperm in a man helps to improve the understanding of the causes of (in)fertility and the role current infertility treatment plays in aiding conception (or contraception). Reproduction means procreation, having offspring or babies. Both man and woman are responsible for reproduction and they have specific reproductive organs in their bodies which are functionally influenced by hormones to carry out this important function (reproduction) as follows.

- Man and woman have sexual intercourse.
- Conception may occur and lead to various stages of pregnancy.
- Delivery of a baby.

8.5.1 Hormones and Fertility

Hormones play vital role in growth and development of individuals throughout the life in general, and more so in sexual development and reproductive process. Like most of the body's systems, hormones (hormonal system) direct the intricate processes involved in male and female fertility. There are *three key hormones* responsible for controlling the reproductive systems in both sexes.

The first is *gonadotropin-releasing hormone (GnRH)*, originally called luteinising hormone-releasing hormone (LHRH), secreted by the hypothalamus, (an endocrine gland located in brain). This hormone stimulates the secretion of two gonadotropin hormones — *luteinising hormone (LH)* and *follicle stimulating hormone (FSH)* — from the pituitary gland. These two gonadotropins of pituitary gland are the key driving forces behind the development of sperm in a man and the maturation and release of a fertile egg (ovulation) in a woman.

The body must produce these hormones in the right amounts, in the proper sequence and at precisely the right times for ovulation and sperm production to occur. Imbalances due to insufficient amounts or the wrong timing reduces the chances of conception.

8.5.2 Sperm Production

LH is responsible for the production of the male hormone — *testosterone*, which along with FSH is responsible for stimulating sperm production in the testicles (or testes). The process of producing sperm, i.e. spermatogenesis, is a continuous process which takes about 72 to 74 days for a male 'germ' cell to develop into an active sperm. Several hundred million sperms are produced on a daily basis from a starting point of about eight times as many germ cells. Spermatogenesis is most efficient at a temperature of 34°C, but is vulnerable to a number of factors. A high environmental temperature or a prolonged fever, for example, can be seen to affect the quality of the matured sperm two to three months later. From the millions of sperms available each day, only a small proportion of them have full fertilising potential.

Sperm consist of two main parts: i) the head which has the crucial role of attaching to an egg and penetrating the outer membrane taking with it its genetic information, and ii) the tail, which enables it to 'swim' the length of the female reproductive tract to reach an egg. Problems with any of these components will affect the fertilising power of the sperm.

8.5.3 Menstrual Cycle and Fertility

There are three phases/stages in a woman's 'monthly' cycle or menstrual cycle — *the first*, during which the mucus in the cervix becomes 'sperm-friendly'; *the second*, the lining of the uterus prepares for pregnancy; and *the third*, an egg in one of the ovaries matures within a follicle (fluid-filled sac) before being released to be ready for fertilisation.

- **Stage one:** The first stage of the cycle is called the *follicular phase* and lasts for about two weeks. During this stage, the secretion of *FSH* rises, stimulating the development of an egg-containing follicle and the maturation of the egg within it. The growing follicle secretes increasing amounts of the female hormone, *estrogen*, which triggers changes in endometrium (i.e. the inner

lining) of uterus and cervical mucus. The cervical mucus thins to allow sperm to pass through, and the endometrium thickens making it ideal for the implantation of a fertilised egg.

- **Stage two:** About 32 hours before an egg is ready to be released, the amount of estrogen produced by the follicle peaks, causing the pituitary to secrete a spike of luteinising hormone. This surge in LH production causes *ovulation*, when the matured egg bursts out of the follicle and travels down the fallopian tube.
- **Stage three:** The remains of the follicle become a corpus luteum, which secretes a second female hormone, *progesterone*. This helps maintain the best conditions for pregnancy should the egg be fertilised, and is known as the *luteal phase*. If the egg is not fertilised within about 72 hours the corpus luteum eventually degenerates, and the egg is expelled from the uterus along with its lining as part of menstruation around two weeks later.

8.5.3.1 Fertilisation, Pregnancy and Delivery

Unlike men, women are born with about 400,000 immature eggs already in their ovaries. Each month between puberty and the menopause one egg, usually, fully matures and starts its journey down the fallopian tubes in anticipation of fertilisation.

Humans are, comparatively, one of the least fertile creatures on Earth, with only a 25 percent chance of conception each month. This is due to the relatively short time within each cycle when a woman's egg can be fertilised. The best time for fertilisation and pregnancy is around the middle of the menstrual cycle just before ovulation occurs. This fertile period may range from 10-14 days. Sperm can only live for around 48-72 hours in the female reproductive tract, and the egg needs to be fertilised within 72 hours following ovulation. Under normal circumstances only a few hundred of about 14 million sperms naturally deposited into the vagina during intercourse are able to reach the end of the fallopian tube where the egg can be fertilised.

After one sperm has successfully fertilised an egg, the fused cells become a zygote, cell division begins and an embryo forms. About a week following ovulation, the embryo finds itself in the uterus and implants itself into the endometrium. Successful implantation prevents the corpus luteum and endometrium from breaking down. From here, a third gonadotropin, human chorionic gonadotropin (HCG), produced by the placenta that develops at the point of implantation, plays an important role in maintaining the pregnancy by stimulating the corpus luteum to continue to produce high levels of estrogen and progesterone. The embryo gradually grows into foetus/baby leading to its delivery.

8.6 RTIs, STIs / STDs AND AIDS/HIV

In this section, the focus of our discussion will be on RTIs and STIs/STDs including AIDS/HIV.

8.6.1 Reproductive Tract Infections (RTIs)

Reproductive tract infections are the infections of the ducts, passages, canals or tubes of reproductive organs. There are many types of infections and inflammations of the reproductive tracts exhibiting different symptoms in men

and women. They are caused by different organisms/germs that can enter the reproductive tract. They can also be caused by several organisms, which normally live in the reproductive tract, when these expand in numbers.

The reproductive tract infections occur due to the following:

- Poor general health due to poor diet, lack of sleep, and life stresses which lowers the body's resistance to infection.
- Poor genital hygiene promotes infections e.g. unclean underwear, failure to change or remove pads, wiping from rear to front after passing stools.
- Use of some soaps, perfumes and deodorants which irritate tender skin.
- Some medicines (antibiotics) that kill normal bacteria that protect the vagina's health.
- Sexual intercourse with an infected person.
- Trauma (e.g. from delivery, sexual intercourse or use of chemicals, etc.)
- Unhygienic practices of health-care providers. e.g. unhygienic delivery or abortion practices, insertion of contaminated intra-uterine device (IUD).

RTIs in Women: RTIs are more common in women because of their body structure and functions (like menstruation, pregnancy and childbirth). They are much more vulnerable to entry and growth of disease-causing germs.

- Foul-smelling, unusual vaginal discharge.
- Pain in the pelvic area between the navel and sex organs, i.e., pain in lower abdomen.
- Genital sores or blisters, with or without pain.
- Swollen and painful lymph glands in the groin.
- Pain or bleeding during intercourse.
- Painful or itchy genitals.
- Changes in menstrual bleeding, e.g. very little bleeding or heavy bleeding.
- Delayed or early menstruation.

RTIs in Men: These are generally of the following type or nature.

- Genital rashes and redness
- Discharge from the penis
- Painful urination, difficulty in urinating
- Sores or ulcers on the penis
- Swollen and painful lymph glands in the groin
- Pain during intercourse.

8.6.2 Sexually Transmitted Infections/Diseases (STIs/STDs)

STIs spread if a person has unprotected sexual intercourse with an infected partner. The sexual act can be vaginal, anal or oral. The vagina, penis, rectum and mouth provide the ideal environment from which the STI germs can invade the body.

STIs can be prevented though there is no vaccine or immunity against these diseases. Following are the measures that can help reduce the chance of infection.

- Abstain from having sex (the only guaranteed protection).

- Have one faithful sexual partner.
- Treatment of STIs in both sexual partners.
- Use of condoms.
- Avoid sexual intercourse if any signs of infection are present.
- Do routine genital self-examination to detect signs of infection.

Sexually Transmitted Diseases (STDs): These are very common in people who resort to unhealthy / unprotected sexual intercourse particularly in the circumstances when protection is a must.

There is strong evidence that Sexually Transmitted Diseases (STDs) put a person at a greater risk of getting and transmitting HIV. This may occur because of sores and breaks in the skin or mucous membranes that often occur with STDs. There are various types of sexually transmitted diseases of which AIDS is only one most dangerous disease. Knowledge of other common sexually transmitted diseases discussed below is also important for understanding AIDS.

- **Syphilis:** It is transmitted by a microscopic organism called *Treponema Pallidum*. It spreads by skin contact where the skin is broken. The symptoms occur in three stages. *First stage* – reddish ulcers at the site of infections; *Second stage* – rash, enlarged lymph nodes, fever, sore throat; *Third stage* – ulcers, joint pains, loss of sensations, damage to heart, blood vessels, spinal cord and brain. The complications that occur are: i) Damage to heart and major blood vessels resulting in heart failure and death, ii) Brain and spinal cord damage causing paralysis, insanity and death, and iii) Intra-uterine growth retardation, premature birth, still-births and congenital infection of the infant.
- **Genital herpes:** This disease is caused by the *herpes simplex*, a virus, which produces painful genital ulcers that heal spontaneously but recur, the initial outbreak being the longest and most intense. Herpes is most infectious when sores are open, but the disease can also be spread to sexual partners by individuals who are not aware of any symptoms. Although child-birth during an active outbreak of a mother's primary infection is rare, 20-25 per cent of the babies born under these circumstances will be infected at sites such as the eyes, skin, mouth, central nervous system and lungs. The majority of infants with infections extending beyond the skin, eyes and mouth will suffer permanent neurological damage or death.
- **Chancroid:** It is caused by the bacterium *H. Ducreyi*. This disease usually causes a painful ulcer in men, while it may occur without symptoms in women. As with other genital lesions, chancroid increases the risk of HIV transmission.
- **Genital warts:** These warts are small painless growths caused by the *Human Papilloma Virus* (HPV). The precise prevalence of HPV infections is unknown, because most HPV infections are asymptomatic. These infections are difficult to treat and recurrent infections are common. Several of the over 50 types of HPV are associated with increased risk of cervical cancer.
- **Bacterial Vaginosis (BV):** It is the most common of all vaginal infections. It can occur without symptoms, or be accompanied by excessive vaginal discharge with an unpleasant odor. The organisms causing BV are normally found in low numbers in the vagina. BV results from their rapid multiplication

due to a variety of factors that upset the normal balance of bacteria in the vagina. BV may cause upper tract infections. In pregnant women, this may lead to premature child birth; in non-pregnant women, infertility or tubal pregnancy may result.

- **Candidacies:** It results from overgrowth of normal vaginal flora. Symptoms include vaginal discharge, burning during urination, bad odor or occasionally lower abdominal pain. It is associated with increased risk of HIV transmission.
- **Trichomoniasis:** It is sometimes referred to as “trich”. It is a common cause of vaginitis. It is asexually transmitted disease, and is caused by the single-celled protozoan parasite *Trichomonas vaginalis* producing mechanical stress on host cells and then ingesting cell-fragments after cell death. Trichomoniasis is primarily an infection of the urino-genital tract; the most common site of infection is the urethra and the vagina in women. Typically, only women experience symptoms associated with *Trichomonas* infection. Symptoms include inflammation of the cervix (cervicitis), urethra (urethritis), and vagina (vaginitis) which produce an itching or burning sensation. Discomfort may increase during intercourse and urination. There may also be a yellow-green, itchy, frothy foul-smelling (“fishy” smell) vaginal discharge. In rare cases, lower abdominal pain can occur. Symptoms usually appear in women within 5 to 28 days of exposure. In many cases, men may hold the parasite for some years without any signs (dormant). Some sexual health specialists have stated that the condition can probably be carried in the vagina for years, despite standard tests being negative. While symptoms are most common in women, some men may temporarily exhibit symptoms such as an irritation inside the penis, mild discharge, or slight burning after urination or ejaculation (<http://en.wikipedia.org/wiki/Trichomoniasis>).
- **Chlamydia:** It is a particularly difficult infection to control for three reasons. *First*, majority of women with Chlamydial cervicitis have no symptoms, so they rarely seek care. *Second*, accurate tests for Chlamydia are technically demanding and expensive. *Finally*, at least a week of therapy is required to eradicate lower tract chlamydial infection, in contrast to the single dose regimens available for many other bacterial STDs. Chlamydia can lead to extremely serious complications and infections in the upper tract frequently causing infertility. During pregnancy, Chlamydia may cause still-birth, premature-birth, and congenital infections such as pneumonia or eye infections. It is also associated with an increased risk of HIV transmission.
- **Gonorrhea:** It is caused by the bacteria *Neisseria Gonorrhea*. It is the most common preventable cause of Pelvic Inflammatory Disease and tubal infertility worldwide. It spreads easily: a man’s risk of acquiring this disease in a single heterosexual encounter with an infected partner is approximately 20-25 per cent, while a women’s risk is higher because infected secretions from the male are retained in the vagina following intercourse. In women, symptoms of cervical infection include abnormal vaginal discharge, burning during urination; upper tract infection with lower abdominal pain and abnormal menstruation. Blood-borne phase of infection may be manifested by rash and painful joints. Gonorrhea can produce spontaneous abortion, premature births, and potentially blinding eye infections in newborns.

Need for prevention/early treatment of RTIs and STDs: Untreated RTIs and STIs can cause serious complications such as the following.

- Infertility in men and women.
- Eight to ten times increased risk of getting HIV/AIDS, if exposed.
- Increased risk of cervical cancer.
- Risky pregnancy e.g. miscarriage, still-births or infants born with birth-defects, including brain damage.
- During birth, the newborn can get severe eye infection from mother's birth-canal and can become blind.

8.6.2.1 The STI – HIV Relationship

Sexually transmitted infections increase the likelihood of HIV (the virus that causes AIDS) transmission from one sexual partner to another. In turn, the presence of HIV increases vulnerability to STIs and prolongs the duration of infectivity. Prevention and management of STIs, therefore, have become a critical strategy for minimizing the impact of the HIV/AIDS pandemic.

It is now well-established that the presence of other sexually transmitted infections greatly facilitates the transmission and acquisition of HIV between sexual partners. STIs which cause genital ulcers significantly increase the chances of HIV acquisition per sexual act the most. Other RTIs, however, can also increase the risk of HIV transfer between sexual partners, particularly if they result in inflammation in the genital tract. The ways in which HIV transmission and acquisition are facilitated by the presence of infection are summarized below:

Types of RTI	Increased risk of HIV transmission	Way in which HIV transmission is facilitated
Ulcerative STI • Syphilis • Chancroid	3-9 times	Because HIV is transmitted and acquired through direct contact of bodily fluids; the presence of open sores and blisters / ulcers allows for greater such contact and access to the bloodstream for the virus.
Herpes Simplex Virus	2 times	
Inflammation-causing STIs • Gonorrhea • Chlamydia • Trichomoniasis	3-5 times	These infections increase genital shedding of HIV infected cells. In addition, urethral and endocervical infections that cause inflammation allow for more efficient exchange of infectious particles.
Bacterial vaginosis	1.5 – 2 times	

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 6) Explain the difference between RTIs and STIs. What are the symptoms of RTIs / STIs in women and men?

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- 7) How can a person protect himself/herself against RTIs / STIs?

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8.6.3 AIDS / HIV

AIDS is caused by HIV. Do you know what HIV and AIDS mean? They are the popularly used acronyms which are explained below.

HIV stands for:

- Human (Human beings).
- Immune deficiency (weakness of natural strength of the body to fight with disease).
- Virus (disease causing virus).

AIDS stands for:

- Acquired (not present in body but one gets it from someone).
- Immune (natural strength of body to fight with diseases).
- Deficiency (shortage of immunity).

- Syndrome (a group of diseases or their symptoms and not one disease or its symptoms).

While AIDS is the disease, HIV is the virus that causes AIDS.

8.6.3.1 What does HIV do in the Human Body? Signs and Symptoms of HIV/AIDS

HIV destroys the immune system of the body and the affected person loses resistance or immunity to diseases. The destruction of the immune system by the virus means that infectious organisms can invade the body unchallenged and multiply to cause disease. So far, there is no real cure for this disease.

Signs and Symptoms of HIV/AIDS: People who are affected with HIV show no symptoms of the disease for many years. These people may remain completely healthy and free from symptoms of a disease but they have the virus in their blood and are at the risk of developing AIDS at any time in future. Once a person is infected with HIV, he/she can transmit the virus to other people even though he/she may appear perfectly healthy and may not know that he/she has been infected with HIV. There is no way of knowing whether a person is infected with HIV except by having a blood test.

HIV/AIDS has no symptoms of its own.

- It becomes visible in the form of symptoms of common diseases like diarrhea, fever, oral and genital infections, TB, etc.
- Presence of symptoms of more than one common disease and their persistence for a long period indicates the presence of AIDS.

The length of time taken by the people with HIV to develop AIDS varies widely from person to person.

8.6.3.2 Incurability of AIDS

No Preventive Vaccine or Cure for AIDS: Although there is no preventive vaccine or cure for AIDS, there are various steps the people with HIV can take to safeguard their health. In order to maintain good health and delay the onset of the disease syndrome, it is important for people with HIV to:

- Seek early medical treatment for health problems such as oral infections and pneumonia;
- Eat a varied balanced diet;
- Have regular sleep and rest;
- Relax and enjoy leisure time;
- Take good physical care of the body;
- Practice good hygiene; and
- Maintain morale and a positive self-image.
- Avoid bites by insects, e.g. mosquitoes, bed bugs, etc.

Given below are some important practical steps that the individuals with HIV can take:

- Avoid further HIV infection through unprotected sex;

- Avoid smoking;
- Avoid becoming overtired;
- Reduce stress and worry; and
- Avoid other infections.

8.6.3.3 Transmission of HIV: Facts and Myths

It is essential for you to know the facts about transmission of HIV so that you can dispel all the myths about its transmission.

Facts about how HIV is transmitted: HIV is present in the blood and other body fluids of the infected person. HIV is known to be transmitted into the body of the uninfected person through the following *four main routes*.

- i) Sexual intercourse with an infected person.
- ii) Blood transfusion of HIV-infected blood.
- iii) Use of syringes, needles and other instruments infected with HIV (used by HIV-infected person).
- iv) Infected mother to her unborn child.

How HIV is not transmitted: Note that, one will not get HIV/AIDS through everyday social contact with a person infected with HIV. HIV is not at all transmitted in the following ways.

- Shaking hands.
- Kissing and hugging.
- Sharing cups, plates and other eating utensils.
- Sharing toilet and bathroom facilities.
- Through coughing or sneezing or through the air we breathe.
- Sitting in the same classroom or canteen.
- Sharing work instruments or machinery.
- Swimming together or playing together.
- Donating blood to the Blood Bank (with sterilized needles).

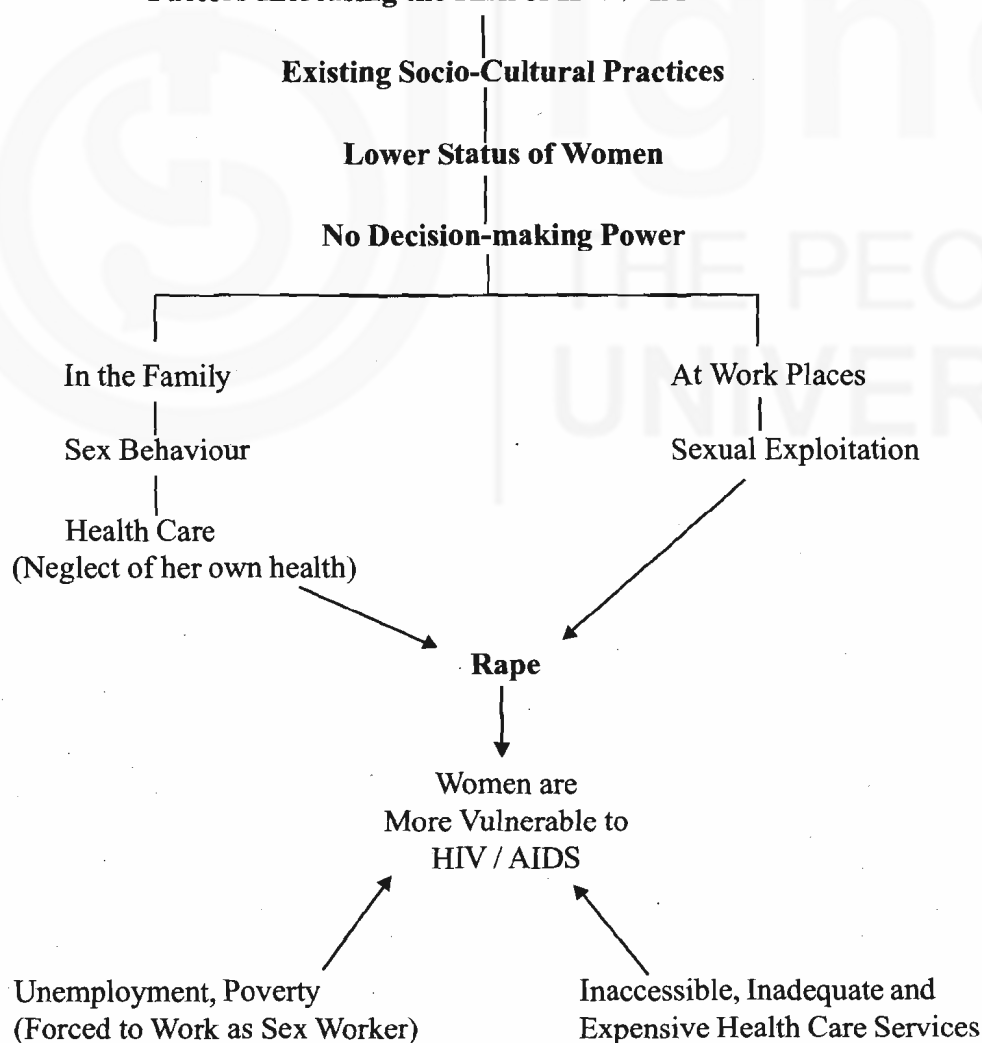
8.6.3.4 HIV/AIDS and Women

Women in the general are often vulnerable to the HIV infections, not so much because of their own sexual behavior but because of their partners.

- Male promiscuity – multiple partners and visits to commercial sex workers – is often the norm. Girls and women in such circumstance generally do not have power to determine whether, when, and with whom they should and should not have sex.
- Women may be subjected to reproductive tract trauma due to sexual violence or male sexual preferences, and they can rarely negotiate safer sex practices, especially condom use.
- Biologically too, women are more vulnerable than men because the transmission of HIV/AIDS and other STDs is more effective from men to women.

- The consequences for women are more serious than for men, and women who have infections often have no symptoms and, therefore, do not seek treatment.
- Women have little, if any, accurate information on the causes, consequences and treatment of RTI/STDs and endogenous infections. The view in many societies is that it is shameful to have a reproductive tract infection and, in many cases, it may even threaten the marriage even if it is the man who is its cause.
- Infected women have little or no access to services because attendance at STD clinics carries a stigma and STD services per se are rare. There is widespread misunderstanding that infections are not “natural” or minor, that STD services carry a stigma, that these services are too complicated and too expensive to treat.
- Women often feel most comfortable with traditional remedies, including some that may introduce or exacerbate infection. When women do seek public or private reproductive health services, they can be at a high risk of infection if procedures are improperly followed. Often, these services are poor in quality because of lack of resources, poor training or lack of supervision.

Factors Increasing the Risk of HIV / AIDS in Women



Source: Women Health and Development Resource Centre, Ahmadabad.

Vicious Circle of Infection — Vulnerability of Women to HIV/AIDS: The relationship between HIV and other STIs extends beyond the increased risk of HIV transmission. An individual with HIV eventually suffers damage to the immune system, making him or her more susceptible to contracting other infections, including RTIs. In an HIV-infected person, RTIs are more difficult to treat and cure. As a result of the presence of other untreated STIs and some endogenous RTIs, an HIV-infected person is more likely to transmit HIV in subsequent unprotected sexual contact.

Women are more vulnerable to HIV/AIDS for the following reasons.

- Rape by or an early marriage with an infected male exposes women to HIV/AIDS at an early age.
- Due to social and sexual subordination, women find it difficult to negotiate and prevent men from practicing unsafe sex at home and at workplace as well.
- Lack of control over sexuality, in addition to the culture-specific submissiveness, increases the chances of HIV infection in women.
- Poverty, unemployment and lack of education might force them to accept sex work, increasing chances of HIV infection through forced unsafe sexual practices.
- Inadequate information, lack of mobility and poor health services increase the chances of HIV infection by manifold.
- Inadequate laws aggravate her HIV status. For example, Rape law and PITA (Prevention of Immoral Traffic Act) are inadequate and more often the violator goes unpunished due to the lapses in the Act.
- Immature cervix in adolescents and less mucus production in the genital tract of post-menopausal women may cause injury during sexual intercourse increasing their susceptibility to HIV infection.
- Female birth passage is not visible to the naked eye, and any lesion that may occur is not easily recognized and treated.
- Since foetus can acquire HIV from the infected mother, infected women often have to deal either with a tremendous sense of guilt and grief about infecting their children or the loss of their child-bearing potential.

8.6.3.5 Prevention of Spread of HIV/AIDS

Use of condoms by men, on which women have little control, is the potential means of preventing spread of AIDS. HIV/AIDS can be prevented from spreading by taking certain precautionary measures such as the following:

- Having one sex partner.
- Using a condom.
- Using sterilized (properly boiled or disposable) needles and syringes for injections, not sharing razors and blades,
- Using only sterilized needles for tattooing and ear-nose piercing.
- Taking only HIV/AIDS-tested blood.

- If either partner (husband or wife) is infected, never have sex without condom.
- Avoid producing a child after getting infected (either partner).
- Avoid breast-feeding, if mother is infected.

i) **Management of STIs as HIV Prevention:** Management of STIs is the effective way of prevention of spread of HIV. To limit the morbidity and mortality associated with both STIs and HIV, prevention of spread of HIV is crucial. Primary strategies for preventing the transmission of STIs are the same as those for HIV/AIDS. However, once contracted, many of the other sexually transmitted infections are curable, whereas HIV is not. As a result, timely and appropriate management of other STIs can help curb the HIV pandemic.

There are *three stages of HIV prevention through STI management*. They apply to both individual behavior and health policy strategy. These are as follows:

	1. Reduce Exposure	2.Reduce Efficiency of Transmission	3. Shorten Duration of Infectivity
Individual Behavior	Restraining from frequent sex • Limit number of partners • Remain in a mutually monogamous relationship	Substitute safer sexual practices for risky sexual behavior • Use condoms	Seek immediate treatment for infectious symptoms • Abstain from sex during treatment • Refer partners • Adhere to recommended therapy
Health Policy	Work to limit population prevalence of STIs • Target risk groups • Promote awareness of self-protection methods	Promote safer sex through active, high-quality, gender-sensitive information campaigns • Make condoms easily available (e.g. through social marketing)	Provide accessible STI services (e.g. introduce syndromic management for symptomatic cases) • Encourage partner referral and treatment

ii) **When you deal with HIV/AIDS patients:** Perhaps because of the sensitive issue of sex and death are interwoven around AIDS, the negative reaction from the general public to AIDS patients has been unprecedented. Hence, when you deal with HIV/AIDS patients, be sure that HIV is not contagious; it is not transmitted through normal everyday contact. So:

- Do not give the HIV infected the feeling of neglect.
- Do not show any discrimination against them.
- Show sympathy and empathy to them.
- Do not deprive them of their present jobs, education and other facilities.
- Give them due care.
- Do not attach any stigma to them.
- Look upon them as any other normal person.

8.6.3.6 Ten Key Points on AIDS

Given below are Ten Key Points that increase your understanding of AIDS.

- 1) ***AIDS is a major health concern:*** Nationwide, the HIV prevalence rate for the population aged 15-49 is 0.28 percent i.e. 1.7 million HIV positive persons in India in April 2006, the midpoint of the NFHS-3 survey. The HIV prevalence rate is 0.22 percent for women and 0.36 percent for men aged 15-49. The prevalence rates for the six states are: Manipur (1.13 percent), Andhra Pradesh (0.97 percent), Karnataka (0.69 percent), Maharashtra (0.62 percent), Tamil Nadu (0.34 percent), and Uttar Pradesh (0.07 percent). The official estimate of HIV prevalence for India is 2.47 million which has spurred the Government of India to further intensify the efforts to control this pandemic.
- 2) ***AIDS is the end stage of infection with HIV:*** In adults, it takes an average of 10 years to develop aids after acquiring the HIV infection. A person infected with HIV may thus look and feel healthy for many years, but he or she remains a potential source of infection to others. HIV is transmitted through – unprotected sexual intercourse with an infected person / partner, through infected blood or blood products or fluids, and from an infected mother to her baby before, during or shortly after birth (pre-natal transmission).
- 3) ***Sexual transmission of HIV is preventable:*** Sexual transmission of HIV can occur from man to women and from woman to man (heterosexual) and also from man to man (homosexual). The most effective way to prevent transmission of the virus is to abstain from sexual intercourse or the two uninfected partners should be faithful to one another. The risk of spreading HIV through sexual intercourse can be significantly reduced by making proper usage of condoms.
- 4) ***Infection through blood is preventable:*** Blood for transfusion must be tested for HIV infection and discarded if found contaminated with HIV positive. Needles, syringes and other skin-piercing instruments must be properly sterilized or discarded after each use and should never be shared.
- 5) ***HIV is not transmitted by casual social contact:*** HIV virus does not survive easily outside the body. It is not spread by casual contact at work or school, by shaking hands, touching or hugging, it cannot spread through food, water or air, by sharing cups or glasses, by coughing or sneezing, in swimming pools or toilets. This means, there is no danger of its spread through causal social contact.
- 6) ***Isolation of cases is not the answer:*** Discrimination against people with HIV or AIDS, besides being a violation of human rights also endangers public health. First, it gives people outside the stigmatized group a sense of threat of infection and thus the need for more personal precautions. Second, it drives the AIDS problem underground, making all efforts at prevention and care much more difficult.
- 7) ***Information and education are vital:*** Changes in personal behaviour to prevent the spread of HIV are the best form of preventive tools. Information and education to promote public awareness are vital to fight against this deadly scourge. It should be remembered that prevention is the only form of cure for HIV / AIDS.

- 8) ***AIDS remains a global threat:*** AIDS recognizes no boundaries of race, sex, class or age. No one is immune to this deadly disease and no one will remain untouched in the next century or so, as AIDS has reached a pandemic proportion and threatens entire communities and changes the pattern of daily life for everyone.
- 9) ***Sharing the challenge of this global menace:*** AIDS has become an area of global health concern and can be stopped in our country if it is stopped in all countries. Working together – pooling efforts, resources and imagination – gives us the best chance of bringing the pandemic under control.
- 10) ***What can you do to stop this menace?:*** You can contribute to fight against this global threat by making sure that you understand the facts about AIDS and help others also to understand it. World AIDS Day is a special opportunity every year, to focus attention on this urgent problem, a life threatening challenge, that affects us all and join forces to fight against it.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

- 8) Explain the difference between HIV and AIDS.

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- 9) Explain the signs and symptoms of HIV/AIDS.

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8.7 TIPS FOR GOOD SEXUAL HEALTH

We have discussed in detail the aspects and issues related to reproductive process, RTIs, STIs/STDs and AIDS in the context of sexual and reproductive rights, and sexual health and hygiene. Based on the above, we can now identify the following as important tips for maintaining good sexual health.

- i) **What is sexual health?** Good health is considered to be a state of “complete physical, mental and social well-being and not merely the absence of diseases or infirmity”. Following principles help in determining the sexual health which is intricately linked with overall health of a person:
- “Physical well-being” means good health and hygiene for the genitals and related systems.
 - “Mental well-being” means feeling okay about sexual desires and needs and not guilty or depressed about them.
 - “Social well-being” means not facing social discrimination because of sexual desires and needs, or because of any problem that may result from unsafe sex.

A combination of all these factors makes for a sexually healthy PERSON!

- ii) **What are HIV and AIDS? Are they one and the same?** HIV stands for “Human Immunodeficiency Virus” and AIDS stands for “Acquired Immune Deficiency Syndrome”. In simple terms, HIV is a *virus* that makes the human body’s immune system weak or deficient, while AIDS is an *outcome of HIV infection*. However, being infected with HIV is not the same as having AIDS simultaneously from the moment of infection.

AIDS is actually a ‘late stage’ of HIV infection and comes about only when HIV has made the body’s immunity (defence system) too weak to fight off other infections. It may take several years for AIDS to develop after HIV infection. The healthier the body and better the care taken, the longer it will take for AIDS to develop.

- iii) **What do you understand by AIDS (Acquired Immune Deficiency Syndrome)?** The term “*acquired*” implies that AIDS is not hereditary or present in the body from birth. It comes from an external source through certain behaviours or situations.
- “*Immune Deficiency*” means AIDS is something that makes the body’s immunity deficient.
 - “*Syndrome*” implies that AIDS is a collection of diseases that attack the body when its immunity becomes weak. These diseases are often called opportunistic infections. An AIDS death is actually an outcome of these diseases. But, if treated properly and in time, they need not be fatal; which means that AIDS need not be fatal. Two of the commonest opportunistic infections in India are tuberculosis and diarrhoea.

- iv) **How does a person get infected with HIV?** A person gets infected with HIV if certain body fluids from an infected person’s body enter other person’s body. Body fluids mean blood, seminal fluids (semen) and vaginal fluids, which can host HIV and carry it from one person to another. In almost 80% of cases, HIV is passed on sexually. If one has unprotected penetrative sex – vaginal, anal or oral – with an infected person, body fluids from that person can enter the body. Different sexual acts have different risks. Unprotected vaginal sex and anal sex are considered to be more risky than unprotected oral sex. One can get infected with HIV if he/she receives blood or blood products or certain fluids from an infected person. HIV can enter the body if

syringes or other sharp injecting instruments used by/for an infected person are used for others, because these instruments can lead to exchange of blood from the infected person to the other person. HIV can also be transmitted from an infected mother to her child during pregnancy (through blood across the placenta), during delivery (through vaginal fluids or blood) or during breast-feeding (through milk). HIV has also been detected in other body fluids like saliva, tears and sweat, but the concentration of the virus in these fluids is too little for transmission of the virus to take place. Viral concentration is much higher in blood, vaginal fluids, seminal fluids and breast milk.

v) ***How can you avoid being infected with HIV through sex?*** By having a mutually faithful and monogamous sexual relationship with an uninfected partner, you can avoid possibilities of getting infected with HIV virus. If such a relationship is not possible or preferable, then by practise safer sex with every sexual partner by using condoms or other latex barriers (like dental dams and femmedoms) properly, and every time you do penetrative sexual acts, specifically vaginal sex, anal sex and/or oral sex. Condoms and other latex barriers prevent exchange of infected blood, vaginal fluids and seminal fluids during these sexual acts. A wide range of other sexual acts where chances of exchange of infected blood, vaginal fluids or seminal fluids are minimal, condoms or other latex barriers need not be used.

vi) ***What is proper condom usage?*** Proper condom usage involves the following:

- Checking the expiry date of the condom before use.
- Tearing one end of the condom pack and gently pressing the other end of the pack so that the condom slides out.
- Putting on the condom only when the penis becomes fully erect, and avoiding penetrating the penis into the partner's body before the condom is put on.
- Before putting on the condom make sure that the lubricated side of the condom remains on the outside.
- Pressing the tip of the condom with one hand while unrolling it on to the penis with another to make sure that no air remains trapped inside the condom.
- Unrolling the condom right down to the base of the penis before starting the penetration.
- After ejaculation, holding the condom at the base and gently withdrawing the penis to make sure that the condom does not remain inside the vagina, anus or mouth.
- Taking the condom off carefully and away from the partner's body to avoid spilling the semen outside the condom.
- Tying up the condom with a knot, wrapping it up in a piece of paper and disposing it off into a dustbin.
- Never re-use a condom. A fresh condom should be used for each sexual act.

- Using a water-based lubricant like K Y Jelly or saliva on the condom for extra lubrication during anal sex (to make the penetration easier and smoother).

vii) How can HIV be detected? A person infected with HIV may look and feel healthy for many years, but can still pass on the virus to others. You cannot tell whether a person is infected with HIV just by looking at the person. The only way to find out for sure is through a blood test. If HIV is detected through the test, the result is said to be “HIV positive”. If not, the result is “HIV negative”. There are several types of blood tests, like the following, for HIV, each with its own procedures and costs involved:

- *Enzyme Linked Immuno Sorbent Assay (ELISA) test:* It is the most common and cost-effective test. It detects the presence of anti-bodies to HIV in the body. But, it takes approximately 6-12 weeks from the time of the infection for the anti-bodies to show up in the body. So the ELISA test is effective only if it is conducted after this time period.
- *Western Blot test:* It is also an antibody-based test. It is more accurate than the ELISA test in detecting HIV, but is much more expensive than the ELISA test. Thus, in India it is often used only to confirm the results of ELISA tests.
- *Spot test:* It is another most commonly used HIV test in India with a high degree of accuracy. It also tests for antibodies to HIV.
- *Polymerase Chain Reaction (PCR) test:* It is a direct test that looks for viral particles rather than antibodies to the virus in the blood. This test is capable of detecting HIV in the blood even within a few hours since the time of infection. But, it is an expensive test and is available only in select pathology laboratories.

Attention: No test for HIV should be done without your informed consent. That is, HIV tests should be voluntary and not forced. If you agree to an HIV test, strict confidentiality should be maintained with regard to your identity and the test result. You should receive both pre-test and post-test counselling – the first to help you mentally prepare for the test and its result, and the second to guide you on what to do after the test result is available (irrespective of whether test result is positive or negative).

Remember: An “HIV positive” result need not be the end of the world. There is help at hand to help you deal with the situation. And an “HIV negative” result need not mean you can throw caution to the wind and take risks that could lead to infection in future. It is important to listen to what the counsellor has to tell you to play safe and stay safe!

viii) Is there a treatment for HIV or AIDS? A cure for HIV/AIDS has not yet been discovered and prevention remains a crucial weapon against HIV/AIDS. However, the days when AIDS was considered invariably fatal are on their way out. It is increasingly becoming possible to treat HIV/AIDS. In some cases, HIV-infected individuals, who went on to develop AIDS, when given proper treatment, recovered to the extent that the viral load (amount of HIV) in their body became negligible! This is why *AIDS is no longer called the “end stage”* of HIV infection. It is now referred to as a “*late stage*” of HIV

infection. In other words, it is possible to live with HIV/AIDS. Hence, an increasing use of the expression “people living with HIV/AIDS” or PLWHA.

HIV/AIDS treatment has broadly *two components*:

- Treatment for HIV infection through anti-retroviral (ARV) therapy. If started at the right time and taken regularly, ARV therapy can reduce the viral load in the body to negligible levels. However, ARV therapy needs to be life-long. If it is stopped, HIV can regain its strength in the infected person’s body.
- HIV/AIDS treatment should be taken only under the supervision of a certified doctor, after fully knowing potential side effects. The costs involved should also be clearly understood. Efforts are being made to reduce costs of medicines for ARV therapy and opportunistic infections, and associated diagnostics, but these still remain quite high for many people in India. Free or subsidized medicines and diagnostics are currently available only through select government hospitals.

ix) *Is medical treatment for PLWHA enough, or is something more needed?:*

What PLWHA need is not just treatment, but also self-care, care from their close ones and larger social support. A combination of care, support and treatment can remarkably improve the quality of life of PLWHA, something they deserve as much as people living/dealing with any other illness!

So what constitutes care, support and treatment for PLWHA? It includes treatment for HIV and being careful about the opportunistic infections associated with AIDS while treating and caring them and their families:

- Provision of emotional, social and economic support – not only to PLWHA but also to their families, particularly children.
- Maintenance of general health and well-being through nutritious food (that is in keeping with the person’s socio-economic background), exercise and rest, and stress reduction and management.
- Prevention of opportunistic infections through general hygiene, safe food and drinking water, and safeguarding against air-borne infections and diseases like malaria.
- Prevention of opportunistic infections is also possible by limiting the chances of HIV re-infection. For this, what is needed are safer sex practices, safer sharing of injecting equipment and safer exchange of blood and blood products.

It is not necessary that care, support and treatment can be provided to PLWHA only in a hospital or hospice. Home-based care is also possible, where PLWHA can learn to take care of themselves in many ways.

x) *What are sexually transmitted infections (STIs)? How can they be prevented?* STIs are infections that are transmitted through sexual contact.

Like HIV, many STIs are transmitted through unprotected penetrative sex (vaginal, anal or oral). Therefore, these STIs can also be prevented in the same way as HIV i.e. through mutually faithful and monogamous sexual relationship with an uninfected partner or practising safer sex with each and

every sexual partner. However, what is safer sex with regard to HIV may not prevent STIs. For instance, sexual acts like body rubbing and deep kissing may not be risky in terms of HIV, but can transmit certain STIs. Limiting the number of sexual partners and maintaining overall personal hygiene (including oral hygiene) are some of the ways to reduce possibility of transmission of these STIs.

- xi) *Can STIs be transmitted non-sexually?*** Yes, like HIV, many STIs can also be transmitted non-sexually. STIs like Hepatitis B and C, herpes simplex virus, syphilis, gonorrhoea and many others can be transmitted through sharing of infected injecting instruments and infected blood and blood products. Some of these can also be passed on by an infected pregnant woman to her child during pregnancy or delivery. Safer sharing of injecting instruments and blood or blood products, and early detection and complete treatment of infected pregnant women help in preventing non-sexual transmission of STIs.

STIs like pubic lice can be transmitted through sharing of towels and underwear. Not sharing clothes and maintaining personal hygiene prevents non-sexual transmission. Hepatitis A can be transmitted through contaminated food and water. Maintaining personal and general hygiene, and food and water safety prevents non-sexual transmission of Hepatitis-A.

- xii) *What are the symptoms of STIs?*** Some generic symptoms of common STIs *in men* include:

- Discharge or pus from the penis or anus.
- Sores, blisters, rashes or boils on the penis or testicles.
- Sores, blisters, rashes or boils in or around the anus or mouth.
- Lumps on or near the penis, testicles and anus.
- Swelling on the penis or testicles.
- Pain or burning during urination.
- Itching in and around the genital areas – penis, testicles, thighs and anus.

Some generic symptoms of common STIs *in women* include;

- Pain in the lower abdomen.
- Unusual and foul-smelling discharge from the vagina.
- Lumps on or near the vagina, thighs and anus.
- Pain or burning during penetrative sex (vaginal).
- Itching in and around the genital areas – vagina, thighs and anus.
- Sores, blisters, rashes or boils in or around vagina, anus or mouth.

- xiii) *Is there a link between STIs and HIV?*** The predominant mode of transmission of both HIV and STIs is sexual (in the sense, HIV is also an STI). The presence of certain STIs in a person is often considered as a marker for potential HIV infection as well. Many of the measures for preventing the sexual and non-sexual transmission of HIV and STIs are also the same.

In addition, many STIs cause ulcers, blisters, sores and boils, and most of these are located in / on / around the mouth, penis, vagina and/or anus. During unprotected penetrative sexual acts, HIV transmission can take place more easily through these openings in the skin or mucous membrane present in these organs. Early and complete treatment of STIs is, therefore, desirable not only to reduce or prevent the harmful effects of STIs themselves, but also to prevent HIV infection.

In people already infected with HIV, STIs tend to compromise the immunity further, making it easier for HIV infection to progress in the body.

- xiv) What should you do to treat STIs?** As soon as any *symptoms* that can be associated with STIs appear, or if you suspect that you may have been exposed to an STI, you should *immediately* consult a dermatologist (skin specialist). The doctor may prescribe some tests, which should be carried out at the earliest. It is also important to *complete* the entire course of medicines prescribed by the doctor and keep your follow-up appointments. If you don't complete the treatment, many STIs can recur – more painfully so can cause serious complications!

Remember: The key to dealing with STIs is early detection and complete treatment. It is also important to prevent re-infection with STIs. This will require prevention of both sexual transmission and non-sexual transmission.

- xv) What is male responsibility in the context of sexual health?** Men need to consider the fact that their sexual activities can have a very serious bearing on the health of their sexual partners – male or female. Men who have unprotected penetrative sex (with men or women) outside marriage dangerously increase the risk of their wives and through them their unborn or newborn children getting STIs or HIV infection. In the Indian context, women often have very little say in the matter of safer sex with their male sexual partners, including husbands. Men, often through authority or ignorance, take advantage of women's vulnerability. If men learn to be responsible in their sexual behaviours, they can protect their own lives as well as the lives of their sexual partners and other loved ones.

8.8 LET US SUM UP

We have discussed sex education touching upon the aspects of human reproductive systems, the process of reproduction, RTIs, STIs/STDs and AIDS with emphasis on their causes, methods of transmission and prevention. We have also focused on the sexual health and hygiene, sexual and reproductive rights, and the ways and means of protecting and promoting sexual and reproductive health and hygiene. We hope, your learning from this unit will enable you to contribute effectively to the sexual health and hygiene of the humanity at large.

8.9 ANSWERS TO 'CHECK YOUR PROGRESS' QUESTIONS

- 1) The International Conference on Population and Development (ICPD) held in Cairo in 1994 established proper vision of reproductive health that explicitly incorporates sexual health. Reproductive health implies that people

are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in these conditions are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

2) Sexual and reproductive rights can be defined in terms of power and resources. The power to make informed decisions over one's own sexual activity, fertility, procreation and child care, gynecological health; and the resources to carry out those decisions safely and effectively (Correa and Petchesky, 1994). These rights include but are not limited to the following:

- The exercise of sexual independence including the right to enjoy it according to one's own preferences, and the right to legal protection.
- Pleasurable and recreational sexuality, independent of reproduction.
- Adequate information and knowledge about sexuality and reproduction.
- Love, sensuality and eroticism in sexual relations.
- Sexual education that is appropriate, comprehensive, secular, scientific and gender-sensitive.
- Refusal to engage in sexual activity.
- Freedom from fear, shame, guilt and other imposed beliefs that inhibit a person's sexuality and diminish his/her sexual relations.
- Choice of sexual partners to exercise sexuality without coercion or violence.
- Nutrition necessary for adequate growth and balanced development of one's body and future reproductive potential from childhood.
- Voluntary motherhood, to decide and live motherhood for one's own choice and not by obligation.
- Complete information concerning the benefits, risks and relative effects of all contraceptive methods.
- Free or inexpensive contraceptives with current information, follow-up and responsibility on the part of those who prescribe it.
- Marriage and family, or the choice not to have either.
- Parenthood and the right to decide when to have or not to have children.
- Good quality services for prenatal care, birth and postpartum care, guaranteed by appropriate legislation.
- Equal participation by women and men in child care, creatively constructing children's identities beyond traditional gender roles.

- Effective legal protection against sexual violence.
- Adoption and right to comprehensive, accessible treatment for infertility.
- Prevention and treatment of illnesses of the reproductive tract, and the right to make informed decisions about related interventions.

- 3) *Ovulation*: A girl has thousands of egg cells or ova in each of her two ovaries. Each month, one cell ripens into egg and leaves the ovaries. This process is called ovulation. In simple terms, *ovulation* is the process of release of a ripe egg from one of the ovaries once in a month. After puberty in a girl, ovulation normally occurs in between 12-16 days after menstruation or any day in the middle period of about 4-5 days between two menstrual cycles.

Menstruation: Every month, when one egg ripens in the ovary of the woman, the inner lining of the uterine cavity starts becoming thick and spongy (due to increased blood supply) as it prepares to implant the “fertilized egg” i.e. zygote. However, after ovulation, if the egg does not get fertilized, it dies and the uterus also sheds its inner lining, which come out of the woman’s body along with blood through vagina as menstrual flow. Menstruation occurs approximately 14-16 days after ovulation, if the egg is not fertilised. In other words, if the egg is fertilised by a sperm there will not be any menstrual flow. A woman is said to have become pregnant or conceived only when the egg is fertilised. Menstrual periods may last 2-7 days; the average menstrual period lasts 4-5 days. As mentioned above, if the egg is not fertilized by a sperm, menstruation will occur and egg is released in each such successive cycle. These menstrual cycles continue to occur about every month until a woman goes through ‘menopause’ when the menstruation stops for ever i.e. in the rest of her life. This is the end of reproductive stage in a woman, which may happen around age 45-50.

- 4) There is need for special personal care by women during menstruation. Though menstruation is a normal physiological process in the life of woman it is often viewed by the society as something ‘dirty’. Vagina is not only the main organ of sexual contact in woman but also the outlet of menstrual flow. Poor hygiene can lead to reproductive tract infections. The blood that comes out during menstruation can become the medium for growth of many germs, if the sanitary napkins are not changed frequently. It is thus very important for women to observe menstrual hygiene. It includes the following.

- Bathe daily during menstruation.
- Use clean napkins, and change them frequently.
- Wear clean underwear, change pads or cloth frequently.
- Do not use dirty cloth. Wash menstrual cloth with soap and dry in the sunshine. If cloth is washed without soap and dried in dark damp conditions, bacteria can grow in it and can cause infections.
- If pads or cloth are not available, identify other local alternatives that are clean and replaceable.
- Eat healthy food, get adequate rest, and continue normal activities.

- If there are cramps during menstruation: take a warm bath; take a walk; rub the abdomen; lie on the back with knees up and move the knees in small circle.
 - Exercise speeds up circulation and helps ease tension.
 - Cutting down on salty food will help to prevent water retention.
- 5) Formation of zygote is technically called '*conception*'. Zygote is formed when a sperm fertilizes the egg. Although millions of sperms may be present, only one sperm fertilizes the egg i.e. egg and sperm join together, fuse into one cell called '*zygote*'. When woman conceives she is said to have become pregnant, which is the beginning of pregnancy. A woman has the chances of becoming pregnant at every sexual intercourse including the first time. Usually only one egg is released during ovulation either from left or right ovary. Sometimes, two eggs are released at the same time. If this happens and, if both the eggs are fertilised, non-identical twins will be born. Or, sometimes, if the single fertilized egg (i.e. zygote) divides into two, each develops into a baby, and accordingly the identical twins (either both males or both females) are born.

Sex Determination: During intercourse, millions of sperms are ejaculated from the penis into the vagina. These sperms are of two types (one type carrying X-chromosome and the other type carrying Y-chromosome). The male gametes or sperm cells in humans are thus heterogametic and each gamete (sperm) contains only one of the two types of sex-chromosomes — X or Y. Thus, these male gametes (sperms) are of two distinct types. The female gamete (i.e. egg), however, contains only the X chromosome and, thus, all eggs are homogametic. It is the sperm cell that actually determines the sex of the baby; it happens as follows: a) If a sperm cell containing an X chromosome fertilizes an egg, the resulting zygote will be XX or female baby; b) If the sperm cell containing Y chromosome fertilizes an egg, then the resulting zygote will be XY or male. Gender is thus determined at the stage of conception, by chromosomal characteristics or combination. Hence, *it is unwise to blame woman for the sex of the baby.*

- 6) *Reproductive tract infections (RTIs)* are the infections of the ducts, passages, canals or tubes of reproductive organs. There are many types of infections and inflammations of the reproductive tracts exhibiting different symptoms in men and women. They are caused by different organisms/germs that can enter the reproductive tract through different means. They can also be caused by several organisms, which normally live in the reproductive tract, when these multiply in numbers.

STIs spread if a person has unprotected sexual intercourse with an infected partner. The sexual act can be vaginal, anal, or oral. The vagina, penis, rectum and mouth provide the ideal environment from which the germs causing STI can invade the body.

Some major RTIs / STIs include the following.

- i) *In women*, the symptoms of RTIs / STIs are as follows.
 - Foul-smelling, unusual vaginal discharge.
 - Pain in the pelvic area between the navel and sex organs, i.e., pain in lower abdomen.

- Genital sores or blisters, with or without pain.
- Swollen and painful lymph glands in the groin.
- Pain or bleeding during intercourse.
- Painful or itchy genitals.
- Changes in menstrual bleeding e.g. very little bleeding or heavy bleeding.
- Delayed or early menstruation.

ii) *In men*, the symptoms of these infections are in the following forms.

- Genital rashes and redness.
- Sores or ulcers on the penis.
- Discharge from the penis.
- Swollen and painful lymph glands in the groin.
- Painful urination, difficulty in urinating.
- Pain during intercourse.

7) Since there is no vaccine or immunity against RTIs/STIs, a person can take the following measures that can help reduce the chance of their infection.

- Abstain from having sex (the only guaranteed protection).
- One faithful sexual partner.
- Treatment of STIs in both sexual partners.
- Use of condoms.
- Avoid sexual intercourse if any signs are present.
- Routine genital self-examination to detect signs of infection.

8) **HIV** stands for the following:

- **Human** (Human beings).
- **Immune deficiency** (weakness of natural strength of the body to fight with disease).
- **Virus** (disease causing virus).

AIDS stands for the following:

- **Acquired** (not present in body but one gets it from someone).
- **Immune** (natural strength of body to fight with diseases).
- **Deficiency** (shortage of immunity).
- **Syndrome** (a group of diseases or their symptoms and not one disease or its symptoms).

While AIDS is the disease, HIV is the virus that causes AIDS.

9) HIV destroys the immune system of the body and the affected person loses resistance or immunity to diseases. The destruction of the immune system by the virus means that infectious organisms can invade the body unchallenged and multiply to cause diseases. So far, there is no real cure for this disease.

Signs and Symptoms of HIV/AIDS: People who are affected with HIV show no symptoms of the disease for many years. These people may remain completely healthy and free from symptoms of a disease but they have the virus in their blood and are at the risk of developing AIDS at any time in future. Once a person is infected with HIV, he/she can transmit the virus to other people even through he/she may appear perfectly healthy and may not know that he/she has been infected with HIV. There is no way of knowing whether a person is infected with HIV except by having a blood test.

HIV/AIDS has no symptoms of its own.

- It becomes visible in the form of symptoms of common diseases like diarrhea, fever, oral and genital infections, TB, etc.
- Presence of symptoms of more than one common disease and their persistence for a long period indicates the presence of AIDS.

The length of time taken for people with HIV to develop AIDS varies widely from person to person.

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UNIT 9 FAMILY WELFARE: GENDER EQUALITY AND EQUITY

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9.0 INTRODUCTION

Nutrition, health, education, employment and happiness of family are the essential aspects of family welfare, which in turn forms the basis for social welfare and national development. Women are equal partners in family life and socio-economic and political development of the nation in general and in human development in particular. They need to have equal rights, role and status in the

context of family welfare that has its implications for social and national development. Gender inequality and inequity in many developing countries including India adversely affect family welfare. Without duly recognising women's status and promoting their interests in matters of their concern it is almost impossible to ensure family welfare with gender equity and equality. It is therefore important that these aspects of family welfare are adequately highlighted so as to make family life education not only comprehensive but also complete. Hence, in this Unit we will focus our discussion on different aspects family welfare.

9.1 OBJECTIVES

After going through this unit, we expect you to be able to:

- Explain the concept and significance of family welfare;
- Discuss the influencing factors and indicators of nutrition and health of individuals and family;
- Analyse the issues of gender inequality and inequity in the matters of health, nutrition, education and employment opportunity and their relevance to family welfare; and
- Describe the health situation and priorities in India in the context of family welfare.

9.2 SOCIETY AND WOMEN: NEED FOR GENDER EQUITY AND EQUALITY

Before we actually focus our discussion on family welfare it is pertinent to take stock of the women's status in the society and relevance of gender equity and equality to human welfare in general and family welfare in particular.

9.2.1 Social Status of Women: Some Concepts

Status of women in society denotes her position in terms of their rights and obligations in comparison with men. In discussions on women's status in any society, the general convention has been to assess their roles in relation to men. Two other dimensions have also been introduced to facilitate such assessment; *firstly*, the extent of actual control enjoyed by women over their own lives, and *secondly*, the extent to which they have access to decision-making processes in positions of power and authority.

The status of women refers to the position that women occupy in the family and in a society in comparison with men. It also refers to the position of women of one class/section of society in comparison with women of other classes/sections in a country or in other countries, or of other times. The United Nations and other organizations have compiled sourcebooks of indicators of the status of women such as literacy, education, employment, age at marriage, political representation, and legal rights. Like empowerment, status is multidimensional (for example, a woman may have high educational status but low economic status) and it applies to individuals and groups of women.

Sometimes, it is argued that women in India enjoy a very high status. In this context, constitutional and legal provisions are cited and distinguished women in public offices are mentioned. Educated urban employed women are also included in this category. On the other hand, it is maintained that the lot of Indian women is very strenuous; therefore arguments in favour of reservation for women are justified. Illiterate women from rural areas and urban slum dwellers can be identified in this category.

9.2.1.1 Meaning of Gender: Difference between Sex and Gender

Sex is the biological classification of a person as male or female. So, sex is a biological thing whereas gender is about a society's expectations of people of different sexes. Gender differences are not fixed but vary overtime, from place to place and in different traditions or religious beliefs.

Gender refers to the socio-cultural definition of man and woman; the way societies distinguish men and women and assign them social, economic and political roles. It is used as an analytical tool to understand social realities with regard to women and men. Thus, the term *gender* refers to the economic, social and cultural attributes and opportunities associated with being male or female. In most societies, being a man or a woman is not simply a matter of different biological and physical characteristics. Men and women face different expectations about how they should dress, behave or work. Relations between men and women, whether in the family, the workplace or the public sphere also reflect understandings of the talents, characteristics and behaviour appropriate to women and men. Thus, gender differs from sex in that the former is social and cultural in nature rather than biological. Gender attributes and characteristics encompassing, inter alia, the roles that men and women play and the expectations placed upon them vary widely among societies and change over time. But, the fact that gender attributes are socially constructed means that they are also amenable to change in ways that can make a society more just and equitable.

Every culture has its ways of valuing girls and boys and assigning them different roles, responses and attributes. All the social and cultural '*packaging*' that is done for girls and boys from birth onwards is "*gendering*." Each society slowly transforms a male or female into a man or a woman into masculine and feminine, with different qualities, behavioural patterns, roles, responsibilities, rights and expectations. Thus, unlike sex, which is biological, the gender identities of women and men are psychologically and socially determined.

According to Oakley (1974), who was among the first few feminist scholars to use this concept, "gender" refers to the social classification of men and women into 'masculine' and 'feminine'. The main differences between sex and gender are as follows:

- Sex is natural. Sex is biological. It refers to visible differences in genitalia and related differences in procreative function. Sex is constant; it remains the same everywhere and through out life; sex can't be changed.
- Gender is a socio-cultural concept and it is man-made. It refers to masculine and feminine qualities, behavioural patterns, roles, responsibilities, etc. Gender is variable; it changes from time to time, culture-to-culture, and even from family to family. Gender, thus, can vary or be changed depending upon the context.

Sex	Gender
• It is biological / natural. • People are born with it. • It cannot be changed even if you try or practice (without surgical intervention). • It is constant all over the world (e.g. physically a man would look the same everywhere).	• It is socially constructed (roles that people around us make for us). • It is learned (parents, siblings teach us these roles). • It can be changed, if you try or practice. • Gender roles vary in different societies, countries, cultures and historical periods.

9.2.1.2 Women's Autonomy: Significance of Gender Equity and Equality in Human Welfare

Women's autonomy refers to an individual woman's capacity to act independently of the authority of others. Since female status is multi-dimensional, a woman may have considerable autonomy in some spheres of activity but very little in others. Autonomy implies freedom such as the ability to leave the house without asking or seeking anyone's permission or to make personal decisions regarding contraceptive use. Although household decision-making is often used as a measure of autonomy (for example, having the final say over how much of the family budget is to be spent on food), it is not necessarily a measure of power because other household members may delegate such decisions to women.

Gender equity is the process of being fair to women and men. To ensure fairness, strategies and measures must often be available to compensate for women's historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. *Equity leads to equality.* Gender equality requires equal enjoyment by women and men of socially-valued goods, opportunities, resources and rewards. Where gender inequality exists, it is generally women who are excluded or disadvantaged in relation to decision-making and access to economic and social resources. Therefore, a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives. Gender equality does not mean that men and women become the same; only that access to opportunities and life changes is neither dependent on nor constrained by their sex. Achieving gender equality requires women's empowerment to ensure that decision-making at private and public levels and access to resources are no longer weighted in men's favour, so that both women and men can fully participate as equal partners in productive, reproductive and social life.

Significance of gender equity and equality: Gender equality is intrinsically linked to sustainable development and is vital to the realization of human rights for all. The overall objective of gender equality is creation of a society in which women and men have the same opportunities, rights and obligations in all spheres of life. Equality between men and women exists when both sexes are able to share equally in the distribution of power and influence; have equal opportunities for financial independence through work or through setting up businesses; enjoy equal access to education and the opportunity to develop personal ambitions,

interests and talents; and share responsibility for the home and children and are completely free from coercion, intimidation and gender-based violence either at home, at work or at any other place.

Within the context of population and development programmes, gender equality is critical because it will enable women and men to make decisions that impact more positively on their own sexual and reproductive health as well as that of their spouses and families. Decision-making with regard to such issues as age at marriage, timing of births, use of contraception and recourse to harmful practices (such as female genital cutting) stands to be improved with the achievement of gender equality. This would enable them to make decisions and take actions to achieve and maintain their own reproductive and sexual health that has more relevance to family welfare in particular and social and national welfare in general.

9.2.2 Empowerment of Women

Inequality between men and women is one of the most crucial disparities in many societies. It has raised grave concern over issues related to women and development (Hasnain, 2004). Women constitute nearly half of the total human population but their share in the fruit of development is abysmally low. This low status has raised the issue of what development ought to be. Development is not gender neutral which in turn emphasizes the need for empowerment of women.

9.2.2.1 Concept and Framework of Women's Empowerment

Broadly, the concept of empowerment signifies the structural change in the existing system of society; and particularly in the context of women, it advocates to alter the existing hierarchical gender relations in a society that establishes the male hegemony thus restricting the scope of women to move upward in the hierarchical strata. Empowerment is directly associated with giving the power or authority to someone to do something. You can easily sense the existing imbalance of power between men and women with a look around. Now pause for a moment and look around your community and family and think over the following issues.

- Who decides over the petty issues of households?
- Who has control over the household income?
- Who decides in which manner and where the income should be spent?
- Who decides which school and what course your younger siblings should opt for?
- Have you ever experienced that a girl either in your family or community was prohibited from doing something at the cost of a boy, for example like schooling, buying dresses, food sharing, employment opportunities, etc?
- Who decides to which candidate in the election a woman in the family is supposed to vote for?
- Who decides over the marriage allegiance in your family?
- Have you ever experienced that access to the public sphere is very restricted to women either in your family or community?

In almost all the issues raised above, you will notice a gender bias in society legitimizing the male decision as final say on these issues. Don't you feel that women are relatively at receiving end in society as compared to their male counterparts? If yes, does the answer (i.e. here the concept of empowerment), imply or intend to dismantle this decision-making power that is culturally determined and vested in the biologically stronger sex (men) since ages or not? Obviously, the final answer is also 'YES'.

Recently, the word "empowerment" has become a buzz word, but lacks clear definition of the concept across several disciplinary lines. Despite lack of consensus over its definition, a workable definition is a prerequisite for understanding its underpinnings. Page and Czuba (1999) offer such a definition: "Empowerment is a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities and in their society by acting on issues that they define as important". They argue that empowerment depends on two things. *First*, empowerment requires that power can change. If power cannot change, if it is inherent in positions or people, then empowerment is not possible, nor is empowerment conceivable in any meaningful way. In other words, if power can change, then empowerment is possible. *Second*, the concept of empowerment depends upon the idea that power can expand. They further explain that power is not exercised in isolation, rather it is exerted into a relationship where super ordinate rule subordinates. This asserts that power is not inherent in individual rather within the context of relationship that can be altered to. Similarly, by expansion of power they intended to explain the transfer of power between super-ordinate and sub-ordinates. This aspect means that gaining power actually strengthens the power of others rather than diminishing it, such as occurs with domination/power. If above mentioned is the case there is scope for empowerment.

Chambeline (1997) has given more workable definition of 'empowerment' by describing its qualities as:

- Having decision-making power.
- Having access to information and resources.
- Having a range of options from which to make choices (not just 'yes/no', 'either/or').
- Assertiveness.
- A feeling that the individual can make a difference (being hopeful).
- Learning to think critically; unlearning the conditioning; seeing things differently;
- Learning to redefine:
 - a) who we are (Speaking in our own voice);
 - b) what we can do;
 - c) our relationships to institutionalized power.
- Learning about and expressing anger.
- Not feeling alone; feeling part of a group.

- Understanding that people have rights.
- Effecting change in one's life and one's community.
- Learning skills (e.g. communication) that the individual defines as important.
- Changing others' perceptions of one's competency and capacity to act.
- Coming out of the closet.
- Growth and change that is never ending and self-initiated.
- Increasing one's positive self-image and overcoming stigma.

With this clarity on the concept of empowerment let us examine the framework for women's empowerment.

Framework of Women's Empowerment: Drawing from the above discussions, women empowerment would mean to alter the age-old existing asymmetric power balance between the gender stratification that has cultural sanctions ultimately resulting into discrimination against women as a class and restricting societal opportunities to them. It advocates equipping women to be economically independent, self-reliant and possessing a positive esteem to enable themselves to face any difficult situation and to participate in development activities. The empowered women should be able to participate in the process of decision-making. Mayoux (2000) defines empowerment as a process of change in power relations that is both multidimensional and interlinked. She has laid out a framework that is useful for developing strategies for women's empowerment.

Framework for Women's Empowerment in different Spheres of Life

- **Power Within:** Enabling women to articulate their own aspirations and strategies for change.
- **Power To:** Enabling women to develop the necessary skills and access the necessary resources to achieve their aspirations.
- **Power With:** Enabling women to examine and articulate their collective interests, to organize to achieve them and to link with other women's and men's organization for change.
- **Power Over:** Changing the underlying inequalities in power and resources that constrain women's aspirations and their ability to achieve them.

Source: UNFPA. 2007. *Women's Economic Empowerment: Meeting the Needs of Impoverished Women*. New York: UNFPA. Also See http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/women_economic.pdf.

Bhuyan (2006) states that women's empowerment is used in two broad senses, viz. i) general, and, ii) specific. In a general sense, it refers to empowering women to be self-dependent by providing them access to all the freedoms and opportunities, which they were denied in the past only because of their being women. In a specific sense, women empowerment refers to enhancing their position in the power structure of the society. The word women empowerment essentially means that the women have the power or capacity to regulate their day-to-day lives in the social, political and economic terms – a power which enables them to move from the periphery to the centre stage.

9.2.2.2 Main Drivers of Women's Empowerment

Education and employment are the two main facilitators of the process of women's empowerment. Education has also been described as the catalyst that moves individuals and communities out of poverty and ignorance, into an improved quality of life (Wright, 2000). It is a milestone of women-empowerment because it enables them to respond to the challenges, to confront their traditional role and change their life. Education is the process by which society deliberately transmits its accumulated knowledge, skills, and values from one generation to another. Education not only boosts self-confidence of women but also helps them in delaying marriage, enjoying better health, participating in family decisions, enhancing their position in family and society, and accelerating economic opportunities, returns and political participation (Grown et. al., 2005). They are better equipped to extract most of the benefits from existing services and opportunities and to generate alternative opportunities, roles and support structures for themselves. These empowering effects of women's education are manifested in a variety of ways, including increased income-earning potential, ability to bargain for resources within the household, decision-making autonomy, control over their own fertility, and participation in public life. Similarly, employment of women brings positive self-esteem among them, gives a sense of security and dignity, and improves their bargaining power within the households which subsequently accelerates the process of empowerment (Safa, 1995; and Kabeer, 1994). Moreover, Amin and Others (1995) stated that in settings where women's mobility is restricted, increased employment opportunities can release constraints on mobility and enable women to seek and access reproductive healthcare and family welfare. However, constitutional provisions, statutory and policy measures can play a major role in advancing the efforts in these matters.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

- 1) Explain the difference between the concepts 'sex' and 'gender'.

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- 2) Highlight the significance of women's autonomy in promoting gender equity and equality in the context of social development and human welfare.

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3) What do you understand by women's empowerment?

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9.3 FAMILY WELFARE

Family welfare assumes greater significance in promotion the quality of life of the individual, family, community and the nation. It involves adequate nutrition, health, education and employment that together determine the happiness of the family – the children, parents and other members including the dependents taken individually and collectively. Equality of reproductive rights and their equitable and effective exercise without gender discrimination plays crucial role in determining quality of reproductive health of the parents and consequential effects on children and indirect effects on other members of the family as well.

Health is a comprehensive concept which is the most important aspect of family life with which we all are concerned. It influences and reflects the quality of life of a family resulting from the status of its individual members and the family as a whole. Welfare of family is thus dependent on several factors — internal (familial) and external (social) — including gender equality and equity in different matters and more so in reproductive health. In view of the above, in this section, we attempt to provide you a brief overview of family welfare by touching upon different aspects related to it.

9.3.1 Nutrition: Concept and Indicators

Nutrition may be defined as the science of food and its relation with health. After oxygen and water, nutrition is the most important, basic and essential component of life. Adequate nutrition is critical for ideal physical growth and development and for enjoying good health. Nutrition depends upon the food that we eat. Thus, food, nutrition and health are closely related. Nutrition depends on the quality of food intake and has direct impact on health. Inadequate nutrition results into several consequences for human health and development. Malnutrition in men and women results in reduced productivity, slow recovery from illnesses, increased susceptibility to infections and other adverse outcomes.

To assess the nutritional status, *three standard indices* are used. Each index provides different information about growth and body composition. These indices are presented here as follows:

- Stunting (Height for age)
- Wasting (Weight for height)
- Underweight (Weight for age)

- i) **Stunting:** The *height for age index* represents the long-term effects of malnutrition on an individual and is an indicator of linear growth retardation and cumulative growth deficits. Stunting shows the sign of failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illnesses.
- ii) **Wasting:** The *weight for height index* measures body mass of an individual in relation to body length and describes the nutritional status. Wasting reflects the failure to receive adequate nutrition in the period immediately preceding the survey and may be the result of inadequate food intake or a recent episode of illness causing loss of weight and onset of malnutrition.
- iii) **Underweight:** The *weight for age* is a composite index of *height for age* and *weight for height* which considers both acute and chronic malnutrition.

Body-Mass Index (BMI): Other indicators to measure the nutritional status are *height and body mass index*. The height of a human being is an outcome of several factors including nutrition during childhood. Usually, the cut-off point for height is considered to be in the range of 140-150 centimetres for women and 150-160 for men. Below these cut-off points a man or woman can be identified as nutritionally fragile. A commonly used indicator of determining nutritional status is *Body-Mass Index (BMI)* which is defined as the weight in kilograms divided by height in meters squared (kg/m^2) and cut-off point BMI of 18.5 is used to define thinness or acute under nutrition and a BMI of 25 or above indicates overweight or obesity. It indicates that good nutrition is essential for maintaining a nutritional status that enables us to grow well and enjoy good health.

9.3.2 Health

In this sub-section, we will focus on the concept and definition of health, factors affecting health, its indicators and status in India which have great relevance for family welfare.

9.3.2.1 Concept and Definition of Health

In simplest terms, health is defined as “absence of diseases”. The World Health Organization (WHO) defines health in broader sense as, “*A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*” (WHO, 1946, p.100). Health, therefore, implies the general condition of a person characterized by physical fitness, ability to perform various social and community duties, ability to deal with physical, biological and social stress, a feeling of well-being and freedom from the risk of disease and untimely death. The maintenance and promotion of health is an ongoing process and is achieved through different combination of physical, mental and social well-being, together termed as “*Health Triangle*”.

In spite of efforts to define health status, it is generally measured in terms of disease, illness, disability, morbidity and death. All these terms indicate lack of good health conditions. *Disease* refers to the state of physical ill-health, whereas *illness* refers to the social experience of being sick. *Disability* encompasses both acute and chronic conditions that affect human’s ability to function and to carry out his/her daily activities. *Morbidity*, in its broad terms, comprises acute conditions that include acute illness and injuries and chronic conditions that include chronic illness and impairments.

9.3.2.2 Factors Determining Health: Health Indicators

There are several factors that eventually affect health of an individual in one way or another. The factors that determine health include the following: i) Environment, ii) Biology and genetics, iii) Nutrition, iv) Personal health practices and coping skills, v) Life style and social status, and vi) Health care services.

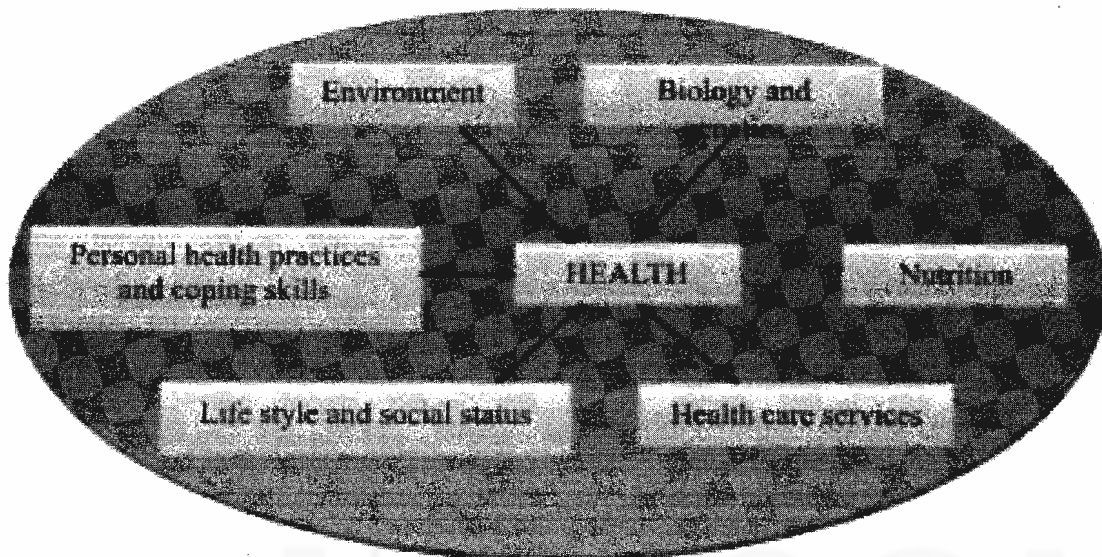


Figure 9.1: Factors affecting health

- The environmental factors effecting health include: the natural/physical surroundings of the individuals, his/her familial, social and economic environments. In addition, safe, accessible and adequate water supply, sanitary disposal of excreta and all wastes, healthy housing, good climate at home and working place, pollution free surroundings, etc are also crucial factors of environment.
- The physical and mental status of any human being is determined by his/her genetic constitution as well. There are well-defined genetic structures and metabolic abnormalities that affect health. Further, even in apparently normal person genetic constitution is an important factor determining reactions to stress and the ability to cope with it.
- Nutrition is one of the basic life supports which depend on adequate and proper food supply. Lack of adequate and proper food supply and even excess of food results in unhealthy status. Both under-nutrition and over-nutrition are injurious to health.
- Purposes of health (care) services are to improve the health status at individual, familial and community level. Availability of and accessibility to good quality health care services help people get relieved from unhealthy conditions. Risk of illness and death is connected with lack of water and sanitation facilities, personal hygiene, elementary human habits and customs, and availability of health care facilities.
- For majority of the people in any population, health status is determined by their life-style. Socio-economic status also reflects on the health conditions of an individual, family, community or population. There is strong association

between the health status and life-style of individuals. Economic progress is the major factor that reduces the morbidity and improves the life expectancy and quality of life. It is also an important factor in health-seeking practices which further assist in improving health. The life-style i.e. the way people live includes cultural, behavioural patterns and personal habits such as personal hygiene, smoking, alcoholism, tobacco, etc. Health requires promotion of healthy life-style including healthy personal habits.

Thus, in general, health of the family is both a consequence of life-styles and other factors discussed above. Improvement in health is achieved from the combined effects of many factors which can be broadly defined as socio-economic, bio-medical, environmental and behavioural factors. Based on all these factors we can easily understand the health indicators.

Health indicators: Health status of individuals, family and the community has always been an interesting phenomenon among researchers. For getting information regarding health status, several indicators are used. These indicators are used not only in measuring health status of a particular community but also in comparing the health statuses of different communities.

Health can be measured from either subjective or objective information on health conditions. Data on health can be obtained from censuses, vital statistics and administrative records, Sample Surveys and National Health surveys, epidemiological studies, clinical trials, etc. In the past few decades, the concept of health has extended beyond measures of mortality (e.g. death rates, infant mortality rate and life expectancy) to specific health measures such as incidence or prevalence of morbidity, summary measures of health such as healthy life expectancy and health related quality of life. All these indicators are briefly explained here.

- **Crude death rate (CDR):** It is defined as the number of deaths per 1000 population per year in a given population. This is the simplest and crude indicator of mortality which measures the rate at which people are dying.
- **Expectation of life:** Life expectancy at birth is defined as the average number of years a new-born would live if he/she is experiencing the prevailing mortality conditions. An increase in life expectancy can be regarded as an improvement in health conditions.
- **Infant mortality rate (IMR):** It is the ratio of deaths under 1 year of age in a given year to the total number of live births in the same year. It is not only one of the most accepted indicators of health status of infants but also for the whole population.
- **Disease-specific mortality rate:** This indicator is also used to measure health status of any population or community. This takes into account the deaths due to specific causes/particular diseases such as cardiovascular diseases, diabetes, accidents, etc.
- **Incidence and prevalence of morbidity:** Incidence of morbidity is the number of new cases of illness arising during a given period (reference period). Prevalence rate measures the frequency of illness during a specified period. It shows how common the disease is in a population.

Incidence rate = New cases and Prevalence rate = Old cases + new cases.

- **Healthy life expectancy (HLE):** This indicator provides information on the population's functional state and its quality of life. Healthy life expectancy can be measured through disability-free life expectancy or disability-adjusted life expectancy.
- **Health related quality of life:** It is the subjective component of well-being. According to WHO (1976), quality of life is "*the condition of life resulting from the combination of the effects of the complete range of factors such as those determining health, happiness (including comfort in the physical environment and a satisfying occupation), education, social and intellectual attainments, freedom of action, justice and freedom of expression*".

9.3.2.3 Health Status in India

As mentioned above, health status of a population can be determined through various indicators of mortality and morbidity. Thus, health status of India may also be studied with the help of these indicators.

Table 9.1: Estimates of Average Annual Death Rate, Life Expectancy at Birth and Infant Mortality Rate, India — 1970-2005

Year	Death Rate	Life Expectancy at Birth	IMR
1970-75	15.5	49.7	131.8
1976-80	13.8	52.3	124.0
1981-85	12.1	55.5	104.2
1986-90	10.6	57.7	91.2
1991-95	9.5	60.3	76.2
1996-00	8.8	61.9	70.6
2001-05	7.9	63.2	61.0

Source: Sample Registration System Reports — 1997-2003.

Table 9.1 shows notable improvement in the death rates, life expectancy at birth and infant mortality rate, and thus in overall health status of population in India. India has made impressive progress in reducing the deaths. From 1970-75 to 2001-05, the average annual Indian death rate has declined from 15.5 per thousand population to 7.9, a reduction of about 50 percent. The trends in infant mortality rate also show a continuous decline from 132 infant deaths per 1000 live births in 1970-75 (SRS) to 61 in 2001-05 per 1000 live births. Similarly, life expectancy at birth has also increased for total population in India. It has increased from 49.7 years in 1970-75 to 63.2 years in 2001-05. Specifically, it is 64.1 years for males and 65.8 years for females (2005). This has also revealed the decrease in death rate and the improvement in health conditions in India. However, there are inter-state, inter-district and rural-urban differences in life expectancy at birth in India due to low literacy, differential income levels and socio-economic conditions, among other things (WHO, 2005).

A World Health Report (WHO, 1999) gives the main causes of mortality in India as non-communicable diseases (48%), communicable diseases (42%), and injuries (10%). National Family Household Survey-3 i.e. NFHS-3, 2005-06 (International Institute for Population Sciences and Macro International, 2007)

conducted a study, among other things, on some major diseases prevailing in India, i.e. asthma, tuberculosis, jaundice, malaria, diabetes, etc. In India, number of persons who have asthma is over 1600 per 100,000 among both men and women. The prevalence of asthma is high in rural areas than in urban areas and is slightly higher among less educated persons. The overall prevalence of tuberculosis in India is 445 per 100,000 populations. It is again more in case of rural areas than in urban areas and more for male than females. It is more in males because males are in contact with more people who might have TB and smoking is more in men. Over 2 percent of women and men in age 35-49 have diabetes in India. All these diseases, however, vary or differ from State to State depending upon the climate and geographical locations of the areas.

Although the National Health Policy (NHP) in India was not framed until 1983, India has built-up a vast health infrastructure and initiated several national health programmes in government, voluntary and private sectors. The first National Health Policy, 1983 aimed to achieve the goal of 'Health for All' by 2000 AD through the provision of comprehensive primary healthcare services. The main objective of the revised National Health Policy, 2002 is to achieve an acceptable standard of good health among the general population of the country and has set goals to be achieved by the year 2015.

Reproductive and Child Health (RCH) programme, a flagship program under National Rural Health Mission (NRHM) has five components: i) Population stabilization, ii) Maternal Health, iii) Child Health, iv) Adolescent Health, and v) STIs & HIV/AIDS. The alarming increase in population has given rise to multiple problems in the society and hence there is a need to propagate 'small family norm' as a way of life among the eligible population. In this context, the role of the Directorate of Family Welfare is vital in achieving the set goals that have greater bearing on the family welfare in general (http://delhi.gov.in/wps/wcm/connect/doit_health/Health/Home/Family+Welfare/). The main objective of RCH is to provide quality Integrated and Sustainable Primary Health Care services to women in the reproductive age-group and young children and special focus on family planning and immunisation respectively.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under "Answers to 'Check Your Progress' Questions".

4) What are the indices of nutrition?

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5) What are the factors that determine health?
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6) List out the indicators of health.
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9.3.3 Reproductive Health: Mother and Child Health

Reproductive health of the couple also determines the health of their children. It is their collective health that finally determines the overall health of the family. In this section, we, therefore, focus our discussion on different aspects of reproductive health in general and the health of the mother and the child in particular including their status and significance in welfare of the family.

9.3.3.1 Concept of Reproductive Health: Association between Maternal and Child Health

Reproductive health encompasses a range of health concerns that emerged from the 1994 International Conference on Population and Development (ICPD) held at Cairo, Egypt. This Conference defined reproductive health as *'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes'* (United Nations, 1994). In short, a reproductive health orientation, drawn from this definition, includes:

- A satisfying and safe sex life free from the fear of disease, and free from coercion and violence;
- The capability to reproduce and the freedom to decide if, when and how often, to do so; that is, access to both infertility services on the one hand and contraceptive services on the other;
- Reproductive choice for women and men; that people have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice;
- Access to safe and affordable abortion facilities;
- Safe child-bearing; access to appropriate health-care services that will enable women to go safely through pregnancy and child-birth and provide for a healthy infant;

- Access to services for prevention and care of the reproductive health problems, both gynaecological and obstetric, in a culturally sensitive manner;
- Special attention to adolescents, whose reproductive health needs have been particularly overlooked.

It is clear that the reproductive rights as well as the ethical issues involved thereof have great relevance to family welfare.

Mother and Child Health: Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death (WHO, 2005). Mother's health has its impact on the child's health. Each year, millions of women, newborns, and children die from preventable causes. While the interventions that could save their lives are widely known, the same are often not available or accessible to those needing them most. A look at the statistics worldwide shows that each year:

- About 530,000 women die from pregnancy related complications, with some 68,000 of those deaths resulting from unsafe abortions (WHO, 2005).
- More than 60 million women deliver at home without skilled care (Knippenberg, *et al*, 2005).
- About 4 million babies die within the first month of life (the newborn period), and more than 3 million die as stillbirths (WHO, 2005).
- Over 10 million children under the age of 5 die each year (Black, 2003). Moreover, nearly all (99 percent) maternal, newborn, and child-deaths occur in low- and middle-income countries.

Association between maternal and child health: The health and well-being of women, newborns, and children are closely linked and should be managed in a unified way. This model calls for availability and access to essential health and reproductive services for:

- a) *women* from adolescence through pregnancy, delivery, and beyond; and
- b) *newborns into childhood, young adulthood and beyond*, because a healthy start can lead to a healthier and more productive life.

In developing countries, a mother's death in child-birth means that her newborn will almost certainly die and that her older children are more likely to suffer from disease. Moreover, when mothers are malnourished, ill or receive inadequate care, their newborns face a higher risk of disease and premature death (Tinker and Ransom, 2002). Almost one-quarter of newborns in developing countries are born with low birth weight, largely due to their mothers' poor health and nutritional status, which results in increased vulnerability to infection and a higher risk of developmental problems.

9.3.3.2 Maternal Mortality: Major Causes

In 1960s and 70s, maternal health services within the Maternal and Child Health (MCH) programme focused on antenatal care and the high-risk approach. It was believed that good antenatal care and using the high-risk approach would reduce maternal mortality. However, the level of maternal mortality remained high in

developing countries including India until the mid-1980s. Therefore, the causes of maternal death including the socio-medical factors contributing to maternal death were re-examined.

Research studies showed that for mothers who develop complications during delivery, emergency obstetric care was needed to reduce maternal mortality. Since it is not possible to predict which woman will develop complications, the high-risk approach could not really prevent maternal deaths. In fact, the high-risk approach resulted in many women being referred, several of whom eventually had normal deliveries. This discredited the referral process. On the other hand, since maternal death can occur within hours to days of developing complications, it is important to promptly transport women to institutions equipped to manage complications. If obstetric complications are handled effectively, mortality can be substantially reduced. Given these arguments, it was proposed that first referral units where emergency obstetric care can be provided should be established. Such first referral units were believed to be the most cost-effective way of reducing maternal mortality.

Major causes of maternal deaths: The major causes of maternal deaths include haemorrhage, obstructed labour, infection, hypersensitive disorders of pregnancy and septic abortions. Many of these causes are preventable, but it was found that millions of women around the world suffering from these morbidities continue to suffer silently because of various social, psychological and cultural factors that operate in a complex manner to leave women in an isolated state of silent suffering. Conditions constituting obstetric morbidity are presented in Table 9.2 below.

Table 9.2: Conditions Constituting Obstetric Morbidity

Sl.No.	During Pregnancy	During Delivery	After Delivery
1.	Haemorrhage	Haemorrhage	Haemorrhage
2.	Discharge	Episiotomy/tear	Discharge of inflammation
3.	Fever	Delivery by instrument	Fever
4.	Headache	Caesarean section	Depression
5.	Oedema in limbs	Mal presentation of the foetus	
6.	Burning with urination	Long labour	
7.	High blood pressure		
8.	Convulsions in third trimester		
9.	Natural pregnancy conditions		

9.3.3.3 Reproductive Health Situation in India: Factors Influencing Mother and Child Care

Despite the interest in women's reproductive health in India, information on the reproductive health situation continues to be incomplete and patchy (Jejeebhoy, 1995). As expected, the most comprehensive data are available on one aspect of

reproductive health, that is, contraceptive-use-patterns. In contrast, there is almost no information available on the prevalence of reproductive tract infections, abortion-related morbidity and infertility. The highlights of the reproductive health situation based on the available information include the following.

i) Inadequate health-care services to ensure safe motherhood: Safe motherhood is still a dream for much of India and particularly for its rural areas. Few women have access to antenatal care: the recent study based on National Family and Health Survey (NFHS) data shows that only half of all rural women were immunized against tetanus; only two in five had received an ante-natal check-up from a doctor or other health professional; and only 45 per cent received iron supplementation. As a result, high-risk cases go undetected, anaemia is widespread, and knowledge of health and nutrition needs during pregnancy and the post-natal period are poorly understood. Access to safe delivery is equally poor: three in four rural Indian women continue to be delivered by untrained attendants in unhygienic conditions (Kanitkar and Sinha, 1989). Within a global perspective, it is estimated that India accounted for 19 per cent of all live births worldwide, and as much as 27 per cent of all maternal deaths. Maternal deaths account for over 10 per cent of all deaths of women of reproductive age, which is even more among rural women. A large proportion of these deaths — up to two-thirds by some accounts — are preventable.

ii) Reproductive health care and gynaecological and obstetric problems: Reproductive morbidity and lack of care during pregnancy and childbirth, including both obstetric and gynaecological conditions such as reproductive tract infections, cervical cell changes and genital-prolapses are common among women. There are a few community-based studies, which have tried to fill this gap in respect of reproductive tract infections (RTIs) and other aspects of reproductive health. All of these studies, many thus far unpublished, observe high levels of morbidity, ranging from 50 per cent to over 90 per cent. For example, in an investigation of rural women in Gadchiroli district, Maharashtra (Bang et al, 1989), clinical examinations found that some 92 per cent had one or more gynaecological diseases particularly of the genital tract and pelvic inflammatory disease, vaginitis and cervicitis that contributed to half of this morbidity. Despite this high prevalence, only 8 per cent had undergone gynaecological examination and treatment in the past.

Health facilities at the community level are poorly equipped to deal with gynaecological and obstetric morbidities, since they have neither the diagnostic facilities nor the drugs to treat them. Moreover, service providers are not trained to detect such morbidities; nor to provide sensitive counselling. The prevention and treatment of common RTIs is not complicated and can be treated at the first level of care. What is needed at the primary health centre level are facilities for routine diagnosis of gynaecological conditions, improved obstetric care, sensitive counselling and sound referral services.

iii) Inadequate access to appropriate abortion services: Despite the fact that abortion has been legal for over 20 years, limited availability and poor quality services have kept safe abortion beyond the reach of most of the poor women. Roughly five million abortions continue to be performed annually; of these, only about 0.6 million abortions are performed under the health services

network, while another estimated six million occur illegally (Chhabra and Nuna, 1993). And, the growing tendency to misuse sophisticated prenatal diagnostic techniques to abort female foetuses suggest the disturbing possibility of increased abortions and repeat abortions. As a result, complications resulting from unsafe abortion exact a heavy toll, and constitute a major source of reproductive mortality and morbidity. Over 10 per cent of all maternal deaths are due to abortions. Safe abortion services are available only in urban areas since registered practitioners are rarely available in rural areas. Nor is information and counselling about legal termination services available to rural women; there is limited publicity about the law and there is a widely held perception that abortion is illegal. Further, the women who seek abortion are denied confidentiality or are coerced to accept an IUD or sterilization as a precondition for the abortion. And, finally, the quality of abortion services and care at approved centres can be impersonal and intimidating.

- iv) **Infertility problem:** Little is known about the levels, patterns, determinants or consequences of infertility in India. Evidence from the 1981 census (Ministry of Health and Family Welfare, 1990) and a village level study in Maharashtra (Bang, et al, 1989) suggest that infertility may be in the range of 6-7 per cent. Factors underlying infertility include, among others, women's poor health and nutrition status, which can lead to repeated miscarriages and foetal wastage, unhygienic obstetric and abortion procedures, STDs and even such debilitating diseases as tuberculosis. And, infertility can have serious consequences for female well-being in a culture, which prizes reproduction, exposing her to various kinds of emotional harassment or marital disharmony. The health services are rarely comprehensive enough to provide access to reliable information, sympathetic counselling and services to infertile couples. What is required is a sound referral system for infertile couples, along with primary health care, which can provide basic information and counselling.
- v) **A safe sex life free from RTI/STI and HIV/AIDS:** Information on levels and patterns of sexually transmitted diseases (STDs), which have severe implications for the reproductive health of both women and men, come predominantly from studies of patients of STD clinics and rarely from community-based investigations. The limited community-level evidence available suggests a relatively high prevalence of STDs: a village level investigation of 650 women in Maharashtra (Bang, et al, 1989) suggests that a disturbingly large proportion of women was suffering from syphilis (10.5 per cent) and gonorrhoea (0.3 per cent). Other estimates suggest that over a million men and women were suffering from HIV/AIDS with dangerous potential for its wider spread. While HIV prevention activities have focused on high-risk groups, an alarming increase in HIV infection has been observed among a thus far 'low-risk' group: monogamous women who have acquired the infection from their husbands and risk transmitting it to their unborn children. These women had little support either in caring for their own children or in seeking care when they themselves fell ill (Chinai, 1995).
- vi) **Special attention to adolescents, especially girls:** Adolescent girls, most of whom are out-of school, constitute a sizeable proportion of the female population. They are particularly vulnerable and neglected, coming under

the purview of government programmes only once they are pregnant, and the majority are out-of-school, and are neither serviced by educational or school health programmes nor by child health and nutrition services. At the family level too, girls are highly vulnerable: son preference is pervasive, resulting in gender disparities in health care, food intake, school attendance and child labour, from an early age. Moreover, marriage and child-bearing are typically early and universal. Early marriage leads to early onset of child-bearing: 10-15 per cent of all births annually occur to women in their teens (Mathai, 1989; Kapil, 1990), often before the female is physically fully developed. Complications of pregnancy, perinatal and neo-natal mortality, and low birth-weight are much higher among adolescent women than among older women. And, not only does early child-bearing further deplete the already malnourished adolescent, but it also can result in severe damage to her reproductive tract (Ramachandran, 1989).

A comprehensive focus on improving the nutritional levels, access to health services, information, vocational skill development, and increase in the age at marriage of girls, mostly out-of-school adolescents, would address their reproductive health needs at an early stage in their life cycle. Such measures are fundamental for enhancing the situation of adolescent girls, both within and outside the household and for enabling them to have a say in their own lives. Also, recognising the link of early marriage and child-bearing to both reproductive health and social development, and measures to delay marriage or enforce the law pertaining to minimum age at marriage need to be taken more seriously.

vii) Sexual behaviour and sexual health: Sexual activity of unmarried young people is rarely considered a concern in the Indian context and there is scant attention paid to the sexual information and contraceptive needs of young unmarried men and women (Jejeebhoy, 1995). Sex education for adolescents has, thus far, been vague and incomplete, inadequately addressing questions concerning their bodies, their physical developments or their curiosity about sexual activity. Boys, no less than girls, are ignorant of sexual matters, and yet there is evidence of growing high-risk sexual activity among adolescents and youth. Increasing sexual activity combined with ignorance about safe sex is particularly an alarming combination in the light of the HIV epidemic. Unwanted pregnancies and often unsafe abortions among urban adolescent girls in particular are not uncommon. Urgently required for youth, both female and male, are programmes which help deal with their own well-being, their health, their bodies and their sexual lives. It is time that sex education programmes become more realistic in terms of information needs of adolescents and youth, both in and out of school.

viii) Access to quality health care for prevention and care of reproductive health problems: Little systematic evidence exists in India about standards of care in the family welfare programme. More attention has been paid to physical infrastructure, personnel and equipment than on quality of care especially from the client's perspective. Quality care comprises several dimensions: a) availability of a wide range of contraceptives, MCH and other services; b) accessibility of complete and accurate information about contraceptive methods, including their health risks and benefits; c) safe and affordable services along with high quality supplies; d) well-trained service

providers with skills in interpersonal communication and counselling; e) appropriate follow-up care; and f) regular monitoring and evaluation of performance incorporating the perspectives of clients and beneficiaries. Thus far, these elements of quality of care have been largely missing.

The health delivery system has been largely insensitive to the reproductive health-care needs of women. Doorstep services are essential for secluded women and these are rarely undertaken, and where undertaken these are focused more on contraception than on reproductive health in general. Further, health workers themselves are poorly informed about reproductive morbidity (especially gynaecological conditions) and insensitive to probing and recognising symptoms and are thus preoccupied with meeting contraceptive targets rather than offering a range of reproductive health services. And, given women's lack of autonomy and decision-making authority it is unlikely that sick women will take the initiative in obtaining health care for themselves.

While poor quality of care can inhibit women from seeking health care, women's lack of autonomy in decision-making or movement is also an important constraint on women's health-seeking efforts. In particular, there is a tendency to endure obstetric and particularly gynaecological morbidity as a fact of life and a shyness to reveal these conditions to or acknowledge a gynaecological problem, unless it is very advanced or permit a pelvic examination (SEWA, Rural, 1994). For example, a large number of women experience white discharge but consider it as part of their lives and rarely seek medical care for such a problem. Lack of decision-making, freedom of movement and time can restrict visits to health centres, even where a health problem has been recognised. Even if a problem has been diagnosed, treatment is frequently not followed through because it is seen as an unnecessary expense or too demanding.

Unfortunately, service delivery strategies have remained oblivious to both the magnitude of women's reproductive morbidity and to the kinds of real constraints women face in acquiring good health care. The government programme remains focused on fertility reduction, with reproductive health and even safe motherhood remaining as matters of secondary concern. There are a few examples of client-centred service programmes in the NGO sector; however, these examples remain undocumented and offer a few clear-cut strategies for replication of such service programmes.

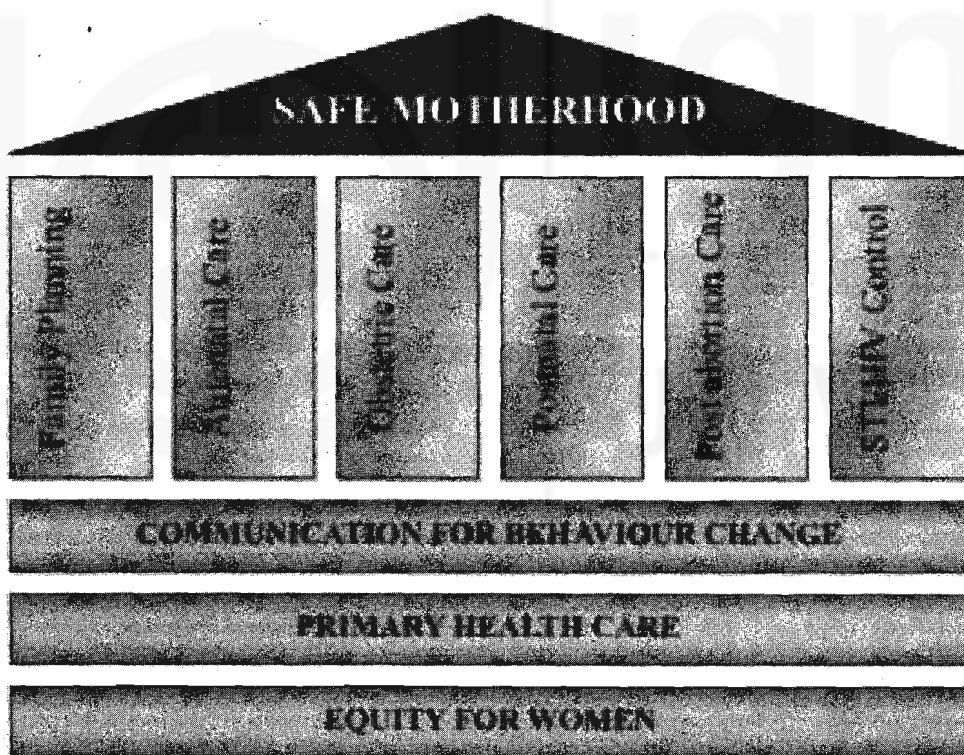
9.3.3.4 Prevention of Maternal Mortality: Child Survival and Safe Motherhood Programme

In the late 1970s, following the success in small pox eradication and the expanded programme of immunisation, UNICEF helped to launch the universal immunisation programme with the objective of reaching all children under 5 years of age and pregnant women with basic immunisations. By 1990, reported service statistics showed near 100 percent coverage of these groups. This was seen as a major achievement. The Government of India was encouraged to expand its focus from immunization to a broader and more comprehensive programme, which would include interventions for child survival and safe motherhood.

The goal of the safe motherhood component of the programme was to reduce maternal mortality from 4 per 1,000 births to 2 per 1,000 births by the year 2000.

The key strategy for reducing maternal mortality included establishment of first referral units for providing emergency obstetric care. These first referral units were to be established within existing community health centres to provide emergency obstetric services including caesarean section. Another strategy was to improve maternal care at the village level. The mother was expected to receive antenatal care and high-risk cases would be identified and referred. The MCH programme was started in India in the early 1960s. In 1987, the Safe Motherhood Conference organized by the World Health Organization and other donors in Nairobi focused attention on the high levels of maternal mortality in developing countries. Following this conference, the WHO initiated the safe motherhood programme to help lower maternal mortality in developing countries. Later, the International Conference on Population and Development (ICPD) 1994, emphasised safe motherhood as a priority in its Programme of Action (United Nations, 1994).

All events that make pregnancy unsafe, irrespective of the gestation or outcome, are part and parcel of safe motherhood. Subsequent work on Safe Motherhood by the Inter-Agency Group and others have outlined clear strategies and specified interventions for the reduction of maternal morbidity and mortality, often referred to as the Pillars of Safe Motherhood (See Figure 9.2).



Source: World Bank, at <http://go.worldbank.org/V5EPGZUL40>.

Figure 9.2: Pillars of Safe Motherhood

The Safe Motherhood Initiative is a worldwide effort that aims to increase attention to and reduce the devastating numbers of women who suffer from death or serious illness every year. Making motherhood safe for the world's women calls for national governments, funding agencies and non-governmental organizations (NGOs) to make maternal health an urgent health priority and ensure that the necessary political and financial support is dedicated to this effort.

Therefore, the Safe Motherhood programme had two major objectives: i) to reduce infant and child mortality; and ii) to reduce maternal mortality. It, therefore, included interventions for child survival as well as for safe motherhood. These interventions are given in Table 9.3.

Table 9.3: Key Interventions Included in the Child Survival and Safe Motherhood Programme

Sl. No	Child survival interventions	Safe motherhood interventions
1.	Essential new-born care (taking into consideration the life cycle approach and continuum of care)	Immunization for pregnant women Prevention and treatment of anaemia
2.	Infant and young-child feeding (including micronutrient supplementation and de-worming)	Antenatal care and early identification of maternal complications
3.	Immunization (childhood immunization and promotion of new vaccines)	Delivery by trained personnel
4.	Management of diarrhoea	Promotion of institutional delivery
5.	Management of acute respiratory infections	Management of obstetric emergencies
6.	Vitamin A prophylaxis	Birth spacing
7.	Prevention of mother-to-child transmission (PMTCT) of HIV	

Training of *Trained Birth Attendants* (TBAs) has been continued and they were provided with disposable delivery kits to perform hygienic deliveries. Sub-centres have been provided with equipment and drugs. *Auxiliary nurse midwives* provided maternal care at the sub-centre level. A monitoring system was developed to assess programme output and impact. In addition, information, education and communication activities have been undertaken to make people aware of this new programme and staff were trained to orient them to the new initiative and to upgrade their skills.

9.3.3.5 Reproductive Rights and Ethical Issues: Towards Meaningful Solutions

Reproductive health according to the WHO definition is 'a state of complete physical mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and its functions and processes'.

Reproductive health, therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, and when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility and the right of access to

appropriate health services that will enable women to have a safer pregnancy and childbirth.

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and the means to do so, and the right to attain the highest standard of sexual and reproductive life. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights by all people should be the fundamental basis for government and community supported policies and programmes in the area of reproductive health (United Nations, 1994).

Reproductive health and reproductive rights are thus relatively new concepts in the area of population policy. Reproductive rights may be viewed as certain rights that all persons possess which will allow them access to the full range of reproductive health care. They relate to areas of life that are most intimate and personal, such as sexuality, sexual relations and reproduction as well as to matters that are central to how the members of a family relate to one another and how they perceive themselves. At the same time, they are also linked with the status and empowerment of women.

Although the concept of reproductive rights is of relatively recent origin, there is ample support for these rights in existing international documents and human rights treaties. For example, the final documents adopted at all three international conferences on population and at the Fourth World Conference on Women, drawing upon the language originally formulated at the International Conference on Human Rights, held at Tehran in 1968, strongly support reproductive rights. Although the documents are not legally binding in terms of international law, they do bear great normative authority and have been endorsed by the vast majority of Governments.

Formal international treaties that are legally binding also support the concept of reproductive rights. For example, the International Covenant on Civil and Political Rights contains a number of provisions that are relevant to the right to make voluntary decisions about bearing children. Similarly, the International Covenant on Economic, Social and Cultural Rights recognizes the right of persons to enjoy the highest standards of health and calls for special attention to be given to women before and after childbirth and to the reduction of infant mortality. With the approval of the Convention on the Elimination of All Forms of Discrimination against Women in 1979, those reproductive rights are made explicit and strongly endorsed. National laws that support reproductive rights relating to maternal/child health care, access to various forms of family planning, sex education and treatment and prevention of sexually transmitted diseases are common in both developing and developed countries.

One of the cornerstones of the concept of reproductive rights is the right of access to methods of family planning. This idea has been fundamental to definitions of reproductive rights from the beginning, appearing repeatedly in

population and human rights documents as the right to have the “information and means” to decide freely and responsibly the number and spacing of children. Without such access, reproductive rights have, practically speaking, no real meaning.

Several key issues concerning the reproductive rights of adolescents pertain to marriage. In many parts of the world, women’s basic human rights are violated when they are given in marriage without their consent. Moreover, despite legislation designed to eliminate certain practices, girls in many countries marry shortly after puberty and are expected to start having children almost immediately, in part because of a lack of alternative opportunities. The adverse effects of early child-bearing are not only biomedical but also educational and economic, in the form of reduced opportunities for young mothers.

Many obstacles exist to the achievement of reproductive rights and reproductive health. Because of the sensitive and controversial character of the issues involved — in particular, sexuality, contraception, empowerment of women and family relations — there is resistance to the expansion of reproductive rights. Another major problem is conceptual in nature. In many countries, human and reproductive rights, as expressed in international documents, are not familiar to the general public and little information is disseminated on them. In addition, human and reproductive rights may seem abstract in their formulation or even foreign to local experiences, attitudes and traditions. The less educated are especially likely to lack knowledge about their rights. Also, more women than men are subject to restrictions on their personal status which prevent them from obtaining information on their rights. Thus, many women are not aware that they have reproductive rights and are, therefore, unlikely to exercise them.

Action to achieve reproductive rights and health is restricted in scope by such obstacles as mentioned above. However, one strategy to overcome such obstacles is to try to strengthen and make greater use of international monitoring mechanisms. Another is to increase the provision of information and education on reproductive rights and reproductive health. Efforts can be increased to reach the millions of persons throughout the world who have little knowledge or understanding of reproductive health. These efforts cover basic facts on health and the reproductive system and the connection between reproductive health and such matters as age at marriage, level of education, the status of women and harmful practices such as female genital mutilation. Greater publicity can also be given to the existence of the international level documents that countries have ratified which support rights on such matters, particularly the right to decide freely and responsibly the number and spacing of children. Moreover, to be effective, this information should be provided to medical personnel, religious leaders, government officials and non-governmental organizations.

The concept of reproductive rights must be presented in ways that are appropriate to the local level. One approach is to point to local laws that themselves support reproductive rights such as the constitutions, population policies and health laws of various countries. Another is to draw on local social movements and traditions that support reproductive rights. A third approach is to relate “rights” language to actual needs at the local level, for example, needs for basic health services, family planning and education. If reproductive rights and reproductive health

are to be secured at the local level, they need to be integrated into existing societal structures and, thus, become part of the fabric of society. Thus, reproductive rights to a large extent relate to areas of life that are most important and personal, such as sexuality, sexual relations and reproduction.

9.3.3.6 Gender Inequity and Inequality in Reproductive Health: Areas of Concern

The poor reproductive health situation in India and particularly that of Indian women outlined above argues convincingly for a broad reproductive health programme and a woman-centred orientation, with emphasis on voluntarism and informed choice. The task ahead is to reorganizing substantial training in the broader programme of reproductive health, and recognizing the need for increased allocation of resources for health services. Finally, strategies must recognize that underlying women's poor reproductive health is their lack of autonomy and egalitarian gender relations. Strategies and programmes to empower women in terms of control of economic resources, information and education, their rights, their self-confidence, and their ability to recognise, articulate and seek care for health problems are necessary conditions for enhancement of women's health and rights.

Priority areas in the field of reproductive health: The priority areas encompassing reproductive health today are: the special problem of the adolescents, sexuality and sexual conduct, safe motherhood and abortion, gynaecological morbidity including sexually transmitted infections, contraception, and quality of services. Many of these have already been enumerated in detail earlier. More specific research is required that probes men's experiences and perceptions of violence, their understanding and misconceptions about their own and women's bodies as well as about risk behaviours and danger signals that compromise reproductive health, their networking in peer groups, their perceptions and expectations of their roles as husbands and fathers, the role of inter-spousal communication, etc.

The above mentioned concerns can be addressed through the following.

- **Focus on missing services:** The singular focus of Indian Family Welfare Programme since the beginning has been on female sterilization thereby resulting in the neglect of many other important areas of women's reproductive health. An urgent need was felt to expand the focus of services, referral systems, Information Education and Communication (IEC) and research beyond Family Planning to include safe motherhood, abortion services, services for gynaecological and obstetric morbidity, infertility, sexual behaviour and STDs and even non-terminal methods of contraception.
- **Focus on quality of care:** Improvement in the quality of reproductive health care is an urgent need. Hence, at the service delivery level there is a need for a rigorous quality of care to be incorporated for interventions at the service provision level and future research.
- **Focus on adolescents:** Adolescent girls are the most neglected and underserved group. A focus on the health needs of the adolescent girls – their reproductive needs, their nutritional status, the risks of their early

marriage and child-bearing – is urgently required. Certain reproductive health risks for adolescents are unique in nature. Biologically, sexual relations before physical maturity may lead to pregnancy and hence they are more susceptible to HIV/AIDS. There is also a lack of appropriate and accessible services for the adolescents. Many are sexually active before physical maturity. Adolescent fertility within marriage is very high, hence needs serious attention.

- **Focus on filling the gaps in knowledge:** There is little social science research, which reflects the range of issues included under the rubric of reproductive health. There is, for instance, very little understanding of the socio-cultural context of reproductive health, of women's actual access to health care and of the constraints women face in acquiring good health.
- **Conveying message to rural women:** Considering the fact that rural women are less exposed to print or electronic media it is important that communication activities directed towards them should be more on the basis of traditional media and interpersonal door-to-door contacts.
- **Focus on sex education:** Finally, an urgent need is to focus on educational programmes related to HIV/AIDS, sex education both for adolescent girls and boys as well as for adults. Reproductive health approach recognizes the inter-linkages between events at younger ages and consequences at later ages. For instance, gender discrimination in intra-household allocation of food may lead to stunted and anaemic adolescent girls. Later, these women may experience obstructed labour due to contracted pelvises, increased infections or contraceptive contraindications due to anaemia leading to poor pregnancy outcomes.

9.3.4 Family Planning/Welfare Scenario: An Overview

Without family welfare it is not possible to realise the goal of population control/stabilisation and better quality of life. Family welfare is primarily dependent upon informed and choice-based family planning, among other things. Thus, family planning by the married couple is an essential component of family welfare. The couple should be able to plan their family by having access to safe, effective, affordable and acceptable methods of family planning of their choice. But, the choice-based planning is a rare thing happening in many families in India and many other developing countries.

Let us have a look at the brief history of family planning programmes in India first, and then various family planning methods and their current usage.

9.3.4.1 Brief History of Family Planning/Welfare in India

The Indian Government is the first in the world to formulate a national family planning programme in 1952, which was later expanded to encompass maternal and child health, family welfare, and nutrition. India is committed to promoting a small family norm and supporting population control and development programmes. In late 70s, family planning programme was termed as "Family welfare programme" and various strategies were formulated to improve overall demographic scenario which are presented in Box 9.1.

Box 9.1 Strategies of Family Welfare Programme

- *Integration with health services:* Family welfare programme (FWP) has been integrated with other health services, instead of being a separate service.
- *Integration with maternity and child health:* FWP has been integrated with maternity and child health (MCH). Public are motivated for use of contraceptives, abortion and post-delivery sterilization.
- *Concentration in rural areas:* FWP is concentrated more in rural areas at the level of sub-centres and primary health centres. This is in addition to hospitals at district, state and central levels.
- *Literacy:* There is a direct correlation between illiteracy and fertility. Fertility rate among educated females is low. So, stress and priority is given for girl's education.
- *Breast-feeding:* It is estimated that about 5 million births per annum can be prevented through breast-feeding; hence, it is encouraged.
- *Raising the age for marriage:* Under the Child Marriage Restraint Act, 1978 the age of marriage has been raised to 21 years for males and 18 years for females. This has had some impact on fertility.
- *Minimum needs programme:* It was launched in the Fifth Five Year Plan with an aim to raise the economic standards. Fertility is low in higher income groups. So, fertility rate can be lowered by increasing economic standards.
- *Incentives:* Monetary incentives have been given in family planning programmes, especially for poor classes; though these incentives have not been very effective.
- *Mass media:* Motivation through radio, television, cinemas, newspapers, puppet shows and folk dances is an important aspect of this programme.

Source: <http://www.preservearticles.com/201105247039/essay-on-family-planning-programmes-in-india.html>.

Other important initiatives of Government for family planning in India

- **In 1992**, the 72nd and 73rd Constitutional amendments and the Panchayati Raj and Nagar Palika Acts further decentralized the family planning programme to the Panchayati Raj Institutions.
- **In 1994**, legislation was passed in parliament to regulate and prevent the misuse of modern prenatal diagnostic techniques, largely for sex-selective abortion.
- **In 1997**, the Reproductive and Child Health (RCH) programme was launched, which espouses the principles of client-satisfaction in delivering comprehensive and integrated high-quality health services.
- **In 2000**, the National Population Policy advocated a holistic, multi-sectoral approach towards population stabilization, with no targets for specific contraceptive methods except for achieving a national average total fertility

rate (TFR) of 2.1 by the year 2010. This resulted in a shift in implementation from centrally-fixed targets to target-free dispensation through a decentralized, participatory approach. The target-free approach was recast as the community needs assessment approach.

Box 9.2: The Time-Line of Family Planning/Welfare Policy in India

A. Before independence - Factors behind general support for population control among the elite

- Lack of awareness among common people.
- Arguments in favour of population policy among the elite – politicians, intellectuals and others.
- Isolated efforts to establish clinics and inform people.
- Strong support for population control by Gandhi and Nehru despite difference in understanding of population dynamics and approaches to means of birth control.

B. After independence

➤ **1952 State-sponsored family planning — Gandhian approach**

- State-sponsored family planning programme started.
- Gandhian approach with abstinence and rhythm as the main methods.

➤ **1950-60 Clinical approach**

- Economic models suggesting a negative relationship between population growth and development.
- Estimation of demographic rates and ratios.
- Knowledge, attitude and practice (KAP) studies.
- Research in reproduction.
- Clinical approach.

➤ **1960-70 Extension approach and experimentations**

- Extension programme.
- IUCD programme.
- Target-orientation.
- Organizational changes.

➤ **1970-80 Camp approach**

- The concept of sustainable development.
- Mass vasectomy camps.
- National level studies in family planning.
- First population policy statement announced.
- Policy under Janata Govt. asserted voluntarism.

➤ **1980-90 Cafeteria approach**

- Cafeteria approach and emphasis on limitation of family size rather than on contraception.
- Planning in terms of NRR (with the goal of achieving NRR of unity by 1996).

➤ **1990-2000 Target-free approach**

- Collection of detailed national and regional level data on population, development and well-being.
- Abolition of targets.
- Shift from national to area-specific approach.

➤ **2000- National Population Policy 2000**

- National Population Policy
- Unmet-needs concept
- A rights-based approach
- HIV/AIDS
- Participatory approach

Source: http://nptel.iitm.ac.in/courses/109104044/lecture_pdf/Lecture%2033.pdf

9.3.4.2 Family Planning Methods and Practice: Unmet-need for Family Planning – Promotion of Gender Equality and Equity

The unmet-need for family planning can be discussed under two parts, viz. i) Awareness about family planning methods, and ii) Promotion of gender equity and equality in family planning.

- i) **Awareness about family planning methods:** Awareness of the couples about family planning methods plays a critical role in adopting family planning methods. Many a time, it happens that though the couples are just aware of these methods they may not have complete knowledge of the place where they are available, of using the particular method(s), of their effectiveness, and related side-effects.

Table 9.4 provides information on the awareness of both modern and traditional methods of contraception for ever married as well as currently married women, according to the District Level Household Survey - 3 (2007-08).

Table 9.4: Awareness of Contraceptive Methods in India by Rural-Urban Residence – 2007-08

Percentage of ever married and currently married women aged 15-49 years who are aware of specific contraceptive method						
Contraceptive Method	Ever married women			Currently married women		
	Total	Rural	Urban	Total	Rural	Urban
<i>Any method</i>	98.9	98.5	99.7	99.0	98.7	99.7
<i>Any modern method</i>	98.7	98.3	99.6	98.8	98.4	99.7
Female sterilisation	97.9	97.2	99.3	98.0	97.4	99.3
Male sterilisation	82.5	79.5	89.2	82.9	79.8	89.6

IUD	73.5	67.2	87.0	74.0	67.7	87.6
Pills	85.6	82.5	92.2	86.1	83.1	92.7
Emergency contraceptive pills	30.9	23.8	46.2	31.3	24.1	46.9
Injectables	52.2	47.1	63.0	52.8	47.7	63.8
Condom/Nirodh	74.2	68.5	86.6	75.0	69.2	87.4
Female condom	12.2	8.8	19.4	12.4	8.9	19.8
Rhythm method	52.5	49.1	60.0	53.3	49.8	60.9
Withdrawal	39.7	37.0	45.6	40.5	37.7	46.3
Other	2.0	2.1	1.9	2.1	2.2	1.9

Source: International Institute for Population Sciences (IIPS). 2010. *District Level Household and Facility Survey (DLHS-3), 2007-08: India. Bihar.* Mumbai: IIPS.

There was not much variation in the awareness of contraceptive methods between ever married and currently married women. 'Currently married women' refer to those who were married at the time of survey, while ever married women refer to those who were widowed, separated, and married but Gauna not performed among the currently married at the time of survey.

Almost all the couples are aware of some form of *modern contraception* as they desired to limit their family size or wanted to space between children according to their convenience. However, awareness of certain specific methods varied considerably. Around 83 percent women were aware of male sterilization as compared to 98 percent of female sterilization. Awareness about the spacing methods is important from the point of view of increasing birth-spacing. The pill was found as the most popular method among the temporary modern methods of family planning. About 86 percent of currently married women were aware of pills; and the percentage was higher in urban areas (92.7 percent). Almost three-fourth of total currently married women knew about the intra-uterine device (IUD) as a method of birth-spacing; a wide gap was seen between rural and urban percentages of women who are aware of IUD (67.7 percent in rural, and 87.6 percent in urban). The similar level of awareness was observed for the male Condom/Nirodh as well. On the contrary, only 12.4 percent of currently married women knew about the female condom. However, it is quite interesting to note that 31.3 percent of currently married women were aware of the emergency contraceptive pill that had recently been introduced in the national programme.

Among *traditional methods*, the rhythm method was the most popular method of family planning. Overall, 53.3 percent of currently married women were aware of the rhythm method comprising 49.8 percent from rural areas and 60.9 percent from urban areas. Around two-fifth (40.5 percent) of the total currently married women also knew that pregnancy can be avoided if the man practiced withdrawal method. The method was less known to rural currently married women as compared to their urban counterparts.

- ii) **Practice of Family Planning:** Table 9.5 gives us the level of family planning by ever use of specific methods of family planning. It provides us an idea about accessibility and acceptance of various contraceptive methods in different population sub-groups.

Table 9.5: Ever Use of Contraceptive Methods in India by Rural-Urban Residence – 2007-08

Percentage of currently married women aged 15-49 years who ever used specific contraceptive method			
Contraceptive Method	Total	Rural	Urban
<i>Any method</i>	<i>64.3</i>	<i>61.3</i>	<i>70.9</i>
<i>Any modern method</i>	<i>55.6</i>	<i>52.2</i>	<i>63.1</i>
Male sterilization	1.1	1.2	0.9
Female sterilization	35.8	35.6	36.3
IUD	5.7	3.9	9.4
Pills	11.0	10.4	12.1
Emergency contraceptive pills	0.6	0.5	0.8
Injectables	0.6	0.6	0.7
Condom/Nirodh	13.2	9.7	20.8
Female condom	0.2	0.1	0.2
Rhythm method	15.9	15.4	17.0
Withdrawal	9.2	8.9	10.0
Other	0.4	0.4	0.3

About 64.3 percent of women had used any method of family planning, 55.6 percent of women had ever used any modern method. By type of contraceptive method, female sterilisation was the most ever used method. On the contrary, male sterilisation was least used. This indicates dominance of female-oriented contraceptive methods. Among the temporary modern methods, IUD was ever used by only 5.7 percent of women at the national level. One out of ten (11 percent) women had used pills. Male condom/Nirodh was another spacing method, which had been ever used by almost 13 percent of husbands of the women. Injectables and female condoms had been used by less than one percent of women. In case of traditional method of family planning, rhythm had been ever used by almost 16 percent couples and 9 percent couples had ever used the withdrawal method.

Although more than two in five couples currently in the reproductive age used a method of contraception, there is little informed choice in the matter of contraception. Programme priorities promote female sterilization — and it is no surprise that two out of three couples using contraceptives are protected by female sterilization and almost nine out of ten by a female method (Kanitkar and Sinha, 1989).

iii) Promotion of gender equity and equality in family planning: The concept of unmet-need in women points to the gap between women's reproductive intentions and their contraceptive behaviour. Women with unmet-need in the family planning are those who are:

- fecund and sexually active but are not using any method of contraception, and
- report not wanting any more children or wanting to delay the birth of their next child.

The unmet-need for family planning is the number of women with unmet need for family planning expressed as a percentage of women of reproductive age who are married or in union. The indicator is useful for tracking progress towards the target of achieving universal access to reproductive health. Information on contraceptive prevalence complements the indicator of unmet-need for family planning. The sum of contraceptive prevalence and unmet-need provides the total demand for family planning.

This indicator provides a measure of the extent of unmet-need for family planning at a particular time. When unmet-need is measured in a comparable way at different dates, the trend indicates whether there has been progress towards meeting women's needs in this regard. It should be noted that, even when contraceptive prevalence is rising, unmet-need for family planning may sometimes fail to decline, or may even increase. This can happen because the demand for family planning increases due to declines in the desired number of children. Changes in the desired spacing of births or changes in the percentage of women who are at risk of pregnancy can also influence the trend in demand for family planning, independently of trends in contraceptive prevalence.

As a result of the emphasis on terminal contraception, young and low parity women remain unprotected from repeated and closely-spaced pregnancies: only 16 per cent of women below 30 practice any form of contraception, compared to 55 per cent of all women aged 30 to 44. The resulting repeated and closely spaced pregnancies at younger ages enhance chances of reproductive morbidity.

Many barriers to contraception remain even among women who are motivated to limit or space child-bearing. These barriers are rooted in the inadequacies of the programme on the one hand and by socio-cultural factors on the other. *First*, awareness and correct knowledge of non-terminal methods is generally poor. *Second*, though a cafeteria of methods is theoretically available most women and men do not have the wide choice as the list of theoretically available methods implies. For the most part, the prospective acceptor is informed only of methods considered appropriate by the service-provider and does not participate in the selection of the methods she will use. *Third*, services tend to be poor, impersonal, threatening or simply unavailable to women; domiciliary visits to secluded women or village level outlets for them have been, in practice, irregular and unresponsive to the needs of women. *Fourth*, male involvement is weak and needs to be more actively sought in terms of male method utilisation; even though vasectomy is simpler, cheaper and safer than tubectomy, it continues to be neglected by men, women and service-providers.

So, it is not surprising that there is considerable unmet-need for family planning given the range of methods available vis-à-vis lack of awareness and gender bias in practice. This can be addressed by developing comprehensive understanding of diverse methods and techniques of family planning for taking effective measures of controlling population change at the level of individuals or couples.

We will focus on the whole range of contraceptive methods and techniques in Unit-10 that follows in Block-3 of this course, i.e. MAE-005.

Check Your Progress

Notes: a) Space given below the question is for writing your answer.

b) Check your answer with the one given at the end of this unit under “Answers to ‘Check Your Progress’ Questions”.

7) What do you understand by reproductive health?

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8) What are the factors influencing the reproductive health of females as well as the mother and child care in India?

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9) What are the key interventions included in the Child Survival and Safe Motherhood Programme?

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10) What do you understand by ‘unmet-need in family planning’?

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9.4 LET US SUM UP

We have presented you the concept of gender and its significance in social development in general, and in human and family welfare in particular. We discussed different aspects family welfare with focus on nutrition, health and family planning. We have highlighted the significance of the reproductive rights and health in the context of mother and child care along with priority areas in the field of reproductive health. Further, we have laid due emphasis on the need for promotion of gender equity and equality in the matters of reproductive health vis-à-vis family planning/welfare.

9.5 ANSWERS TO ‘CHECK YOUR PROGRESS’ QUESTIONS

1) The *main differences between sex and gender* are as follows:

- Sex is natural. Sex is biological. It refers to visible differences in genitalia and related differences in procreative function. Sex is constant; it remains the same everywhere and throughout life; sex can't be changed.
- Gender is a socio-cultural concept and it is man-made. It refers to masculine and feminine qualities, behavioural patterns, roles, and responsibilities etc. It is variable; it changes from time to time, culture-to-culture, and even from family to family. Gender, thus, can be changed.

Unlike sex, which is biological, the gender identities of women and men are psychologically and socially determined. Every culture has its ways of valuing girls and boys and assigning them different roles, responses and attributes. All the social and cultural '*packaging*' that is done for girls and boys from birth onwards is "*gendering*." Each society slowly transforms a male or female into a man or a woman into masculine and feminine, with different qualities, behavioural patterns, roles, responsibilities, rights and expectations while the sex remains the same throughout their life.

2) *Women's autonomy* refers to women's capacity to act independently of the authority of others. Since female status is multidimensional, a woman may have considerable autonomy in some spheres of activity but very little in others. Autonomy implies freedom, such as the ability to leave the house without asking or seeking anyone's permission or to make personal decisions regarding contraceptive use. Although household decision-making is often used as a measure of autonomy (for example, having the final say over how much of the family budget is to be spent on food), it is not necessarily a measure of power because other household members may delegate such decisions to women.

Gender equity is the process of being fair to women and men. To ensure fairness, strategies and measures must often be available to compensate for women's historical and social disadvantages that prevent women and men from otherwise operating on a level-playing field. Equity leads to equality. *Gender equality* requires equal enjoyment by women and men of socially-valued goods, opportunities, resources and rewards. Where gender inequality exists, it is generally women who are excluded or disadvantaged in relation

to decision-making and access to economic and social resources. Therefore, a critical aspect of promoting gender equality is the empowerment of women, with a focus on identifying and redressing power imbalances and giving women more autonomy to manage their own lives for their development like the men do for their development. Achieving gender equality requires women's empowerment to ensure that decision-making at private and public levels and access to resources are no longer weighted in men's favour, so that both women and men can fully participate as equal partners in productive, reproductive and social life. The overall objective of gender equality is creation of a society in which women and men enjoy the same opportunities, rights and obligations in all spheres of life. Significance of gender equality lies in the fact that it is intrinsically linked to sustainable development and is vital to the realization of human rights for all for human welfare.

- 3) Broadly, the concept of empowerment signifies the structural change in the existing system of society. In the context of women, it advocates to alter the existing hierarchical gender relations in a society that establishes the male hegemony restricting the scope of women to move upward in the hierarchical strata. Empowerment is directly associated with giving the power or authority to someone to do something. Page and Czuba (1999) offer workable definition: "Empowerment is a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important". They argue that empowerment depends on two things. *First*, empowerment requires that power can change. If power cannot change, if it is inherent in positions or people, then empowerment is not possible, nor is empowerment conceivable in any meaningful way. In other words, if power can change, then empowerment is possible. *Second*, the concept of empowerment depends upon the idea that power can expand. They further explain that power is not exercised in isolation rather it is exerted into a relationship where super-ordinates rule sub-ordinates. This asserts that power is not inherent in individual rather within the context of relationship that can be altered to. Similarly, by expansion of power they intended to explain the transfer of power between super-ordinate and sub-ordinate. This aspect means that gaining power actually strengthens the power of others rather than diminishing it, such as occurs with domination/power.
- 4) Following are the indices of nutrition.
 - Stunting (height for age).
 - Wasting (weight for height).
 - Underweight (weight for age).

The *height for age index* represents the long-term effects of malnutrition in a population and is an *indicator of linear growth retardation* and cumulative growth deficits. Stunting, thus, shows the sign of failure to receive adequate nutrition over a long period of time and is also affected by recurrent and chronic illnesses. Next index i.e. *weight for height index* measures body-mass in relation to body-length and describes the nutritional status. *Wasting* reflects the failure to receive adequate nutrition in the period immediately preceding the survey and may be the result of inadequate food intake or a

recent episode of illness causing loss of weight and onset of malnutrition. *Weight for age is a composite index of height for age and weight for height* which considers both acute and chronic malnutrition.

- 5) Given below are the factors that determine health.
 - Environment
 - Biology and genetics
 - Nutrition
 - Personal health practices and coping skills
 - Life-style and social status
 - Health care services.
- 6) Following are the *indicators of health*
 - Crude death rates (CDR)
 - Expectation of life at birth
 - Infant mortality rate (IMR)
 - Disease-specific mortality rate
 - Incidence and prevalence of morbidity
 - Healthy life expectancy (HLE)
 - Health related quality of life.
- 7) Reproductive health includes the following.
 - A satisfying and safe sex life free from the fear of disease, and free from coercion and violence;
 - The capability to reproduce and the freedom to decide if, when and how often, to do so; that is, access to both infertility services on the one hand and contraceptive services on the other;
 - Reproductive choice for women and men; that people have the right to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice;
 - Access to safe and affordable abortion facilities;
 - Safe child-bearing; access to appropriate health-care services that will enable women to go safely through pregnancy and child-birth and provide for a healthy infant;
 - Access to services for prevention and care of reproductive health problems, both gynaecological and obstetric in a culturally sensitive manner;
 - Special attention to adolescents, whose reproductive health needs have been particularly overlooked.
- 8) Following are the factors influencing the reproductive health of females as well as the mother and child care in India.
 - Availability of appropriate health-care services to ensure safe motherhood.

- Reproductive health care facilities to address gynaecological and obstetric problems.
- Access to appropriate abortion services.
- Infertility services.
- A safe sex life free from RTI/STI and HIV/AIDS.
- Special attention to adolescents, especially girls.
- Sexual behaviour and sexual health.
- Access to quality health care for prevention and care of reproductive health problems.

9) Key interventions included in the Child Survival and Safe Motherhood Programme are as follows.

<i>Child survival interventions</i>	<i>Safe motherhood interventions</i>
• Essential newborn care (taking into consideration the life cycle approach and continuum of care)	• Immunization for pregnant women
• Infant and young-child feeding (including micronutrient supplementation and de-worming)	• Prevention and treatment of anaemia
• Immunization (childhood immunization and promotion of new vaccines)	• Antenatal care and early identification of maternal complications
• Management of diarrhoea	• Delivery by trained personnel
• Management of acute respiratory infections	• Promotion of institutional delivery
• Vitamin A prophylaxis	• Management of obstetric emergencies
• Prevention of mother-to-child transmission (PMTCT) of HIV	• Birth-spacing

10) The concept of unmet-need in women points to the gap between women's reproductive intentions and their contraceptive behaviour. Women with unmet-need are those who are: a) fecund and sexually active but are not using any method of contraception, and b) report not wanting any more children or wanting to delay the birth of their next child. The unmet-need for family planning is the number of women with unmet-need for family planning expressed as a percentage of women of reproductive age who are married or in union. The indicator is useful for tracking progress towards the target of achieving universal access to reproductive health. Information on contraceptive prevalence complements the indicator of unmet-need for family planning. The sum of contraceptive prevalence and unmet-need provides the total demand for family planning.

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