Journal of Social Work Education and Practice 5(2) 72-79 www.jswep.in
ISSN: 2456-2068 *April 1, 2020*

Secrecy, natural learning, and gendering in reproductive health: Indian Context

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ABSTRACT: Reproductive Health remains an unmet need for millions of populations in India. Knowledge, attitude, and practice on reproductive health are hugely interconnected to the social fabrics of Indian society. And most of the Social factors are not favouring a better reproductive health care behaviour among the general public. This paper conceptualizes three social factors that have a strong negative impact on reaching out to reproductive health service in India, i.e., Secret *Subject*, *Natural Learning*, and *Gendering*. These social factors play a crucial negative role in three levels, Individual, Community and the Public Health Care Delivery of reproductive health. In this scenario, this paper poses *a top to bottom approach* model in addition to the existing *bottom to top approach* model to resolve these issues to an extent.

Keywords: reproductive health, social factors, secret subject, natural learning, gendering, top to bottom approach, bottom to top approach

Introduction

Reproductive health is a state of complete physical, mental and social wellbeing 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 can have a satisfying and safe sex life and that they can reproduce and the freedom to decide if, when and how often to do so (WHO, 2018). This definition proclaims the human right aspects of reproductive health. The sustainable development Goal three- (SDG-3- Ensure healthy lives and promote

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wellbeing for all at all ages, Target -7) aims to ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030 (United Nations in India, 2020). Though India has introduced several reproductive health programs, the planned goals of each program were not attained as intended.

After the inception of the Family Welfare Program in 1951, India experienced significant growth in the service delivery of reproductive and child health services and quality of care. Nevertheless, some areas frightened the success of the program – *the significant number of unintended pregnancies and the unmet need for contraception* (Sebastian, Khan, & Sebastian, 2013). The absence of women's autonomy in reproductive decision-making, compounded by poor male involvement in sexual and reproductive health matters, are fundamental issues yet to be addressed in India (Pachauri, 2014). Social factors, such as gender relations, sexual identities, and social inequalities, play a primary role in determining an individual's ability to achieve good sexual and reproductive health (World Health Organisation, Integrating Poverty and Gender into Health Programmes: A Sourcebook for Health Professionals, 2008). There is no regular source of data to indicate the reproductive health status of women in India (Park, 2017). However, the most common problems are malnutrition, anemia, either unwanted or mistimed pregnancies, complicated labour, unsafe abortions and infections and unmet need for family planning. Contraception is female-oriented and male participation in sharing responsibility for contraception is low. Male sterilization was accepted by only 1% of currently married couples. High maternal mortality, sexually transmitted infections/reproductive tract infections and unequipped public health systems are increasing the gravity of the problem (Ministry of Health & Family Welfare, 2013).

Social view on reproductive health in India

As compared to other health domains, reproductive health is much mediated through the social-cultural fabrics of India. Indian society has rigorous social control over sexuality and reproduction through religion and culture (Mahajan, Pimple, Palsetia, Dave, & De Sousa, 2013). Sex and sexuality have always been put aside from normal social affairs of the society based on morality and custom. Society always considers sex organs as the most loutish part of the human body, and reproduction is a secret and hot topic. Though India has an ironic heritage of literature

(*Kamasutra*1) on sex and sexuality, reproduction and sexuality remain as a moral subject rather than biological subject.

In India, reproductive health knowledge is being exchanged mainly through informal exchange and peer group interactions. It created the phenomenon of *hiding and talk*, in which sex and reproductive health-related topics are barred from the mainstream social affairs. But when they get a hidden opportunity, people are ready to exchange their knowledge. Usually, the exchanged knowledge might be sexual fallacies capable of giving sexual pleasure than helpful information to have good reproductive health behaviour in the future. Finally, it negatively affects an individual's knowledge, attitude and practice on reproductive health. In Indian social perception, reproductive health is mediated through three broad areas a) *Secret subject* b) *Natural learning* and c) *Gendering.* These three factors have a significant influence on determining one's knowledge, attitude and practice on reproductive health.

Secret subject: Indian society always tried to hide reproductive health from general social matters. Hence, it has been declared informally as *forbidden matter for discourse* in an open social context. It has been considered as an immoral and tabooed topic. The secrecy of reproductive health and sexuality spreads mainly through peer interactions.

So, the matter of reproduction and sexuality are being hidden throughout the life courses of an individual. It ultimately makes the general public to receive the most misinterpreted information on reproductive health for lifelong. It acerbates the unmet need for contraception, reproductive hygienic, availing proper knowledge and health care services, delaying proper reproductive health services, the spread of illness and fear to speak up. Moreover, it generates biased and prejudiced views on reproductive health to the general public. And finally becoming a social hindrance to health care providers to invest more time due to the fear of being victimized.

Natural learning: The basic aim of reproductive health promotion is to make sure that everyone should know safe sex, avoiding fear associated with reproduction and preserving a healthy generation ahead (World Health Organisation,2018). A proper awareness on reproductive health is therefore needed to achieve the aim. But Indian society has been promoting the attitude of *natural learning* for reproductive health either directly or indirectly. It comes from the social practice of the *secret subject*.

Natural learning stems from the view that reproduction occurs naturally (biological) rather than learned. Here, the common questions arise like this, why do we need sex education or

[1] *Indian Sanskrit text on sexuality, eroticism and emotional fulfillment in life, written between 400 BCE and 300 CE.*

reproductive health education since our ancestors had not received any formal knowledge such as that kind? This attitude opens a plethora of challenges to both the general public and health care providers in many-faceted ways. It propagates the secrecy of sex and reproductive health to the next-generation indirectly. Moreover, it makes a barrier among common people to accept the new knowledge on reproductive health. The main victim of this social attitude would be adolescents and youth. They may get wired information on reproductive health. It may never change with scientific knowledge due to the secreting nature of reproductive health, leading to experiment with it and risks their health and life. The natural learning is the current vehicle for the spread of venereal disease and negligence towards treating it due to social shyness to open it up to a physician.

Gendering: Gendering is the process of assigning social roles over individuals based on their sex. It includes ascribing characteristics of masculinity or femininity, femaleness or maleness to a phenomenon (i.e., a role, position, concept, person, object, organization, or artifact), usually resulting in power and privilege, voice and neglect, or advantage and disadvantage (Dye, 2010). It aims to control all gender by providing socially sanctioned roles and responsibilities. Gender disparity occurs in the form of socially constructed, predefined gender roles firmly fastened in India's socio-cultural fabric that has deep cultural and historical roots in India (Batra & Reio, 2016).

Reproductive health has an annoying history of gender disparity in India. Since reproductive health is a secret and natural learning subject, common men and women are unaware of their respective sex organs' anatomy and physiology. This may end up in early marriage, early motherhood, maternal mortality, malnutrition, poverty, emotional disturbance, exploitation, etc.

Gender inequality and inequity cover gender-based violence as well as gender discrimination, which cuts across the life cycle of the woman, attitudes, religious and cultural practices of various nations, and issues related to employment, economy, politics, and development (Adinma & Adinma, 2011). Prenatal tests are used to determine the sex of the fetus and abort if it is found female (Forum for Women's Health, 1994). The menstrual cycle is the most disastrous period for women in India. During menstruation, women face partial ostracism from mainstream familial and social activities and stamping as impure. It can be seen as the most visible form of gender inequality. Indian women and men suffer a lifelong burden of reproductive health unmet needs mainly due to taboo attached to reproductive health. The decision making on

reproductive health mostly done still univocally by the men dominated families in India. It prevents women from safeguarding their reproductive health rights and thereby risking their entire life course on reproductive health matters.

How to overcome?

The present approach of Indian reproductive health care has been focusing on *the bottom-up approach*, wherein reproductive health education is given to at the bottom level of the society. That is focusing the adolescent and youth levels through schools and colleges. But the approach has failed to receive attention not only from the bottom but also from the top. Sex education at school level has attracted strong protests and apprehension from all walks of society, including parents, teachers, and politicians. And it banned in six states, which include Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Chhattisgarh, and Karnataka. It shows the gravity of the problem inflicted on society by a noble initiative (Ismail, Shajahan, Rao, & Wylie, 2015). Therefore, India needs to adopt the *top to bottom approach*, along with the *bottom-up approach* on an experimental basis to tackle social hindrance on reproductive health issues.

In the *top to bottom approach,* the focus is given to impart reproductive health knowledge to the upper social power structure of the society such as politicians, religious leaders, community leaders, parents, and teachers. Educating these top power structures of the society on the importance of reproductive health education could yield approaching confidently to the bottom level (children, adolescent, youth and eligible couple) of the society. This will reduce the knowledge gap between the upper and bottom regarding reproductive health and will yield a volatile environment for the dissemination of knowledge. Moreover, health education is to be given as a mandatory subject to the general public. In that reproductive health education should be a part. Thereby the use of the phrase *"sex education"* can be ended in all social health education contexts to avoid inviting unnecessary troubles from the social society.

Discussion

Reproductive health is the most vital human right. However, negative social factors hinder its way from angles along with other factors, such as poverty, lack of adequate public health care system and health insurance. This is why reproductive health in India is still not capturing its beneficiaries. India started its first reproductive health care initiative through the Reproductive Health Program (RCH –I and RCH-II program in 1997, 2005, respectively). Before that, India embarked on family planning in the year 1952. But India still accounted for 19% of all global maternal deaths (Ministry of Health & Family Welfare, 2013). This mainly due to the inability of

health care intervention to break the negative social factors on reproductive health.

The *secret nature* of reproductive health is the main barrier that separates health care facilitators and people. That is why reproductive health programs did not yield what it was intended. This should be addressed first to dilute the secrecy based communication gap among the health care providers and the beneficiaries.

The *natural learning* is the main pillar in which all negative social factors are built up. A layperson would be thinking, *why should I study reproductive health and sexuality through books or from external as it is biological? All things will come naturally at the right time*. This kind of argument could be visible among even from the highly educated social class. It indicates how much society rejects the effort of public health care initiative even without seeing its merit.

Reproductive health has a significant relationship with gender. Girls have little understanding of pubertal changes, menstrual hygiene, reproductive tract infections (RTIs), contraception and sex itself (Thirunavukarasu & Simkiss, 2013). In India, poor sexual health exists across all socioeconomic groups and in both rural and urban settings, even though women might suffer more compared to male counterparts. It underlines the social phenomena of gendering, in which the recent trend demonstrates the steady decline of HIV from a peak of 0.38% in 2001-03 through 0.34% in 2007, 0.28% in 2012 and 0.26% in 2015 to 0.22% in 2017. The reduction of social rejection towards people who have AIDS is showing the positive social changes that happened in society (NACO, 2018). It indicates a positive outcome of efforts being made by the health system combating all odds.

The Indian society requires a combined top to bottom approach by putting all stakeholders under an umbrella to impart better reproductive health care service. Non-Government Organizations (NGOs) and Neighborhood Associations, Community Based Organizations (CBOs) are to be effectively used for this purpose. Utilizing the multi-disciplinary team approach (Psychologists, Social Workers, Psychiatrists, Obstetricians and Gynecologists, and Genito-Urinary Physicians) is to be considered to impart a holistic intervention in reproductive health in India.

Conclusion

India has achieved several milestones in health. But inadequate data on STI2s, STDs3, UTI4s and other reproductive health issues and its social etiology are not yet fully determined. The Social factors articulated in this paper have significance as the most severe un-favouring social

[2] Sexually transmitted infections
[3] Sexually Transmitted Diseases
[4] Urinary Tract Infections

factors on reproductive health in Indian. Therefore, the Indian health care system needs to look at more on the social etiology of reproductive health, focusing on the positive and negative social factors bound on reproductive health while planning policies and programs. Research on social and behavioural research on reproductive health is to be carried out to develop culturally specific evidence-based health education programs for a diverse Indian population.

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