Sociology for Physiotherapists

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SYLLABUS
(For Bachelor of Physiotherapy)

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FOREWORD

The present textbook entitled *Sociology for Physiotherapists* covers a comprehensive course in sociology for the benefit of the students pursuing studies for Bachelors Degree in Physiotherapy. Today, the concept of disease, treatment and rehabilitation of the patient has undergone a sea change. It has been increasingly recognized that disease and its treatment aspects are deeply rooted in the socio-cultural spectrum of a society. Also, the way of life led by the people at large influences these. Thus, a complete understanding of a disease and its cure warrants a systematic insight of the socio-cultural and economic milieu from which patient comes. Moreover, the doctors and paramedical personnel also emerge from a similar set of milieu. Their values, perceptions and preferences shape their approach towards the disease, patient and treatment. It is in this context that a systematic understanding of social factors has a special place of study for health care professionals.

Dr Dibyendunarayan Bid has done a commendable job in bringing out this book. It has been written in a lucid style. The contents of the book succinctly cover a systematic meaning of sociology, its relations with other social sciences and elaboration of basic sociological concepts relevant to the health care professionals. It also explains the significance of social institutions, besides elementary methods and research techniques used in sociology. Dr Bid has also covered the idea of social welfare, social work and welfare state; explanation of contemporary major social problems has also received adequate space in the book.

I am happy to say that this is a welcome addition to the literature on sociology for the benefit of not only the students of physiotherapy but also for all other health care professionals and medical social workers.

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PREFACE

The need of an introductory book in sociology to be used by physiotherapy students was sincerely felt. The present work is done to meet this demand. Since sociology is a subject dealing with society, social relationships, social institutions, social change, social organization, social problems as well as social reconstruction; I kept these in view while writing this book.

Special efforts have been made to present the various topics in relation to the society and health in India. This book specifically meets the requirements of syllabus of various universities in this subject for physiotherapy students. Though the book is primarily to serve the physiotherapy students; the doctors, nurses, administrators, social workers, paramedical and health personnel, can also use it as a handy book of sociology.

Dibyendunarayan Bid

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Chapter 1

Introduction to Sociology

1. MEANING, DEFINITION AND SCOPE OF SOCIOLOGY

Auguste Comte, a French Philosopher, coined the term sociology in 1839. The word 'sociology' is derived from the Latin word '*societus*' meaning society and the Greek word '*logos*' meaning study or science. The etymological meaning of sociology is thus the 'science of society.'

Sociology is the study of man's behavior in groups or of the interaction among human beings, of social relationships and of the processes by which human group activity takes place.

Definition of Sociology

Here are some definitions given by some important sociologists.

A. Sociology is the science of society or of social phenomena— LF Ward.
B. Sociology is the study of human interaction and inter-relation, their conditions and consequences—M Ginsberg.
C. Sociology is the study of the relationships between man, and his human environment—HP Fairchild.
D. "The chief interest of sociology is the people, the ideas, the customs, the other distinctively human phenomenon which surrounds man and influence him, and which are,

therefore, part of his environment. Sociology also devotes some attention to certain aspects of the geographical environment and to some natural as contrasted with human phenomena, but this interest is secondary to its pre-occupation with human beings and the products of human life in association. Our general field of study is man as he is related to other men and to the creation of other men which surround him"—ME Jones.

E. "Sociology seeks to discover the principles of cohesion and of order within the social structure, the way in which it roots and grows within an environment, the moving equilibrium of changing structure and changing environment, the main trends of the incessant change, the forces which determine its direction at any time, the harmonies and conflicts, the adjustments and maladjustments within the structure as they are revealed in the light of human desires, and thus the practical application of means to end in the creative activities of social man"—McIver.

The various definitions of sociology can be summarized as:

a. Sociology is a science of society.
b. Sociology is the science of social relationships.
c. Sociology is the study of social life.
d. Sociology is the study of human behavior in groups.
e. Sociology is the study of social actions.
f. Sociology is the study of forms of social relationships.
g. Sociology is the study of social groups or social systems.

Scope of Sociology

In the broadest sense, sociology is the study of human interactions and inter-relations; their conditions and consequences. Thus, ideally sociology has for its field the whole life of man in society, all the activities whereby man maintained themselves in the struggle for existence, the rules

and regulations which define their relations to each other, the systems of knowledge and belief, art and morals and any other capacities and habits acquired and developed in the course of their activities as members of society. But this is too wide a scope for any science to deal with properly. An attempt has therefore, been made to limit and demarcate the field of sociology.

The scope of sociology is very wide. It is a general science but it is also a special science. As a matter of fact, the subject matter of all social sciences is society. What distinguishes them from one another is their viewpoint. Thus economics studies society from an economic viewpoint; political sciences studies it form political viewpoint while history is a study of society from a historical view. Sociology alone studies social relationships and society itself.

McIver correctly remarks—"What distinguishes each from each is the selective interest."

Green also remarks—"The focus of attention upon relationships makes sociology a distinctive field, however closely allied to certain others it may be."

Sociology studies all the various aspects of society such as social traditions, social processes, social morphology, social control, social pathology, effect of extra-social elements upon social relationships etc. Actually, it is neither possible nor essential to delimit the scope of sociology because, this would be, as Sprott put it—"A brave attempt to confine an enormous mass of slippery material into a relatively simple system of pigeon holes."

2. SOCIOLOGY AND ANTHROPOLOGY

Sociology and anthropology lie so close together that they often appear as two names for the same field of enquiry. Anthropology is derived from two Greek words '*anthropos*' meaning man and '*logos*' meaning study. Thus, according to its etymological meaning, anthropology is the study of man

as such, that is a study of the development of human race. Anthropology has thus a very wide field of study. Anthropology has been divided into three divisions: (i) Physical anthropology which deals with bodily characteristics of early man and our primitive contemporaries, (ii) Cultural anthropology which investigates the cultural remains of early man and of the living cultures of some of the primitive contemporaries, (iii) Social anthropology which deals with the institutions and human relationships of primitive, of the past and present.

Anthropology thus devotes its attention entirely to the study of man and his culture as they developed in times long past. Sociology, on the other hand, studies the same phenomena, as they exist at present. According to Kluckhohn, "The sociological attitude has tended towards the practical and present, the anthropological towards pure understanding and the past".

Sociology depends very much on the material supplied by anthropology. In fact the historical part of sociology is identical with cultural anthropology. Anthropology has contributed substantially to the study of sociology. Sociology has to depend upon anthropology to understand the present day social phenomena from our knowledge of the past. Sociology has borrowed cultural area, cultural traits, interdependent traits, cultural lag and other conceptions from social anthropology on whole basis cultural sociology has developed. The discoveries of Linton and Kardiner have influenced sociology in no small degree. From their researches it is evident that each society has its own culture and the personality of its members is molded according to it in their fancy. Likewise the research done by Malinowski has proved valuable to sociology. He has given a functional viewpoint to the study of culture. The researches of Franz Boas and Otto Kineberg have proved that there is no co-relation between anatomical characteristics and mental superiority. The concept of racial superiority has been disproved by anthropology.

According to Hoebel, " Sociology and social anthropology are, in their broadest sense, one and the same." A.L Karoeber has called sociology and anthropology twin sisters. Evans Pritchard considers social anthropology to be a branch of sociology.

In the same way, some of the conclusions drawn by sociologists have also helped the anthropologists. For example, anthropologists like Morgan and his followers have come to the conclusion regarding the existence of primitive communism from the conception of private property in our modern society. Robert Redfield writes, "Viewing the whole United States, one sees that the social relations between sociology and anthropology are closer than those between anthropology and political science".

In spite of the interdependence of these two sciences the field of the study of each is quite distinct. Keesing writes "but the two academic disciplines have grown up independently, and handle quite different types of problems, using markedly different research methods". Firstly, anthropology is the study of the whole society. It studies its political and legal problems, family organization, religion, art industries and occupations, etc. Sociology studies only its particular aspects. The focus of sociologist is social interaction. Secondly, anthropology studies cultures, which are small and static while sociology studies civilizations, which are vast and dynamic. That is why anthropology has developed faster and better than sociology. Thirdly, anthropology and sociology are separate sciences as the former is the study of man and his cultures as they developed in times long past; while the latter studies the same phenomena as they are at present. According to Kluckhohn, "The sociological attitude has tended towards the practical and present, the anthropological towards pure understanding and the past". Lastly, sociology is concerned with both social philosophy and social planning whereas anthropology is not

concerned with social planning. It does not make any suggestions for the future.

3. SOCIOLOGY AND SOCIAL PSYCHOLOGY

Social psychology deals with mental processes of man considered as a social being. It studies particularly the influence of group life on the mental development of individual, the effect of the individual mind on the group, and the development of the mental life of the groups within themselves and in their relations with one another. Sociology, on the other hand, studies the various kinds of groups, which compose the society.

Social psychology has to depend on sociology to understand properly human nature and behavior as it is sociology which provides the necessary material regarding the structure, organization and culture of societies to which individuals belong. According to Kimball young, " we might say that while our major emphasis is on the individual in interaction with others, such interaction can only be understood within the social life and cultural matrix in which it occurs." The sociologists in their turn also have to draw up social psychology. They recognize the importance among other things of psychological factors in understanding the changes in social structure. Lapiere and Fransworth wrote, "Social psychology is a link between psychology and sociology." As a result of the close relation between the two Karl Pearson has not accepted the two as separate sciences. In other words of MacIver, "Sociology in special gives aid to psychology, just as psychology gives special aid to sociology." It is now generally assumed that a scientific study of social phenomenon must have a psychological basis; and the psychological facts regarding human nature should not be assumed but should be explored by direct observation as well as experimentally. The improved understanding of human behavior will make the science of sociology more objective and realistic.

Mac Dougall and Freud were of the view that whole of the social life could be reduced finally to psychological forces. In that case sociology would be reduced to a mere branch of psychology. But this view cannot be accepted as the causes affecting social behavior are other than psychological also like the economic, geographical, political, etc. Social life cannot, therefore, be studied exclusively with the methods of the psychologists. The fact of mutual dependence of social psychology and sociology should not be interpreted to mean that one is either identical with or the branch of the other. As a matter of fact there are important points of distinction between these two related fields of investigation.

i. *Difference of subject matter*: Firstly, sociology is a study of the society as a whole while social psychology is merely the study of individuals in interaction as members of groups and of the effect of that interaction on them. Sociology has been aptly compared to the science of mechanics which considers masses of matter and properties of matter in mass, and social psychology to molecular physics which deals with molecules and their invocation in view of the fact that sociology studies the organization of social groups, their central values and the various forms of institutional behavior arising on account of them and social psychology is concerned with the individuals as members of the group. The individual is the unit of analysis in social psychology. As remarked by Klineberg, "The primary concern of the sociologist is group behavior, and that of the social psychologist is the behavior of the individual in the group situation." Bogardus writes "As psychology analyses mental processes so sociology analyses social processes."

ii. *Difference of attitudes*: Further, sociology and social psychology deal with social life from different angles. The former studies society from the viewpoint of the community element while the latter from the viewpoint of psychological factors involved.

4. SOCIOLOGY AND PSYCHOLOGY

Psychology is the science, which studies the internal mechanisms of human behavior. It is but clear that in order to study human behavior fully, the study of internal aspects is absolutely essential. Almost all our actions are the overt expression of our motives, desires, instincts, impulses, and emotions. At the same time, our actions are also regulated or modified through external conditions and stimuli. Sociologists study these external conditions and this knowledge is helpful to psychologists in their analysis of human behavior. To get knowledge about the changing aspects of social life, which affect our thinking, attitudes, and values, psychologists have to depend upon sociologists. Sociology is a social science, which deals with group life, whereas psychology deals with human being only as an individual. Sociology is mainly concerned with the external aspects of behavior, while psychology deals with the internal aspects. The methodology of two sciences is different—psychology uses experimental method and testing, whereas sociologists use survey and statistical method in general.

5. METHODS AND TECHNIQUES OF SOCIOLOGY

The term "method" means an apt way of doing something. As we know, sociology is also a science, so it uses certain methods by which sociological facts could be collected, analyzed and put into proper form and certain conclusions drawn from them. To claim sociology as a science depends upon the use of an appropriate methodology which can eliminate the possibility of personal bias from influencing our comprehension and evaluation of social facts.

Sociology is still in its infancy. So, it does not have its own method for its researches. However, it has met with appreciable success in analyzing the social phenomenon by using the methods of other social sciences.

Sociology, like every other science is an objective study of natural systems and since the social systems, like all systems, evolves in course of time; it must be investigated in the very process of its evolution through methods used in such branches of study. As the social phenomenon is very complex and the data to be collected are very large, it is difficult to suggest which particular method sociologists should employ. There are many methods in sociology, namely, historical method, observation method, laboratory or experimental method, common sense method, statistical method, anthropological or comparative method, survey method, detective method, philosophical method, etc.

The most common methods of sociology are discussed here.

Case Study

A case study is defined as, "An investigation of an individual or group in which the variables which are measured and whose empirical relations explored are characteristics of the individuals or group and not a sub-unit of it." It is a form of qualitative analysis involving a very careful and complete observation of a person, a situation or an institution.

This method is usually employed for the study of professional criminal and other social deviants and involves an investigation and analysis of all factors entering into the case and its examination from as many points of view as possible. Some of the techniques used in this method are interviews, questionnaires, life histories, documents of all kinds having a bearing on the subject and all such materials, which may enable the sociologists to have a deep insight into the problem. Thoroughness is the keystone of this method.

Casework is based on the principles of acceptance, self-determination and confidentiality. The principle of acceptance refers to the attitude of the worker, his respect for the client as an individual which gives him a sense of security and encourages him to speak about his problems frankly, the

principle of self determination allows the client to decide for himself rather than deciding for him; and the principle of confidentiality implies that the relationship between the case worker and the client is one of the trust and whatever is revealed to the worker is to be kept confidential and is not to be shared with anyone except in the interest of the client with his permission.

Case work is used in a variety of settings such as child care and child guidance institutions, schools, colleges, medical and psychiatric settings, family welfare, marriage counseling centers, institutions for the old and infirm as well as handicapped and also with people who suffer from addiction, character disorders, emotional disturbances and the like.

Questionnaire and Interview Method

The questionnaire is a list of important and pertinent questions concerning to a problem. It is sent to persons and associations concerned, requesting them to answer to the questions to the best of their knowledge and ability. The object is to obtain knowledge about facts known to the informant but not to the investigator. From answers received to certain questions predictions are made about social behavior. It is necessary that proper care should be taken in formulating questions; they should not be ambiguous, too many or too personal, nor too difficult to be answered by a man of average intelligence and common understanding.

The interview method consists in having direct personal contact with persons or groups concerned who are, in any way, connected with the problem under study. Discussion of the problem with the person interviewed at personal level goes a long way out in clearly understanding his problems and remedying them accordingly.

This method has been employed in bringing out some outstanding works such as "A medical study of sex

adjustments" by Dr Dickinson and Dr Beam; "The sexual behavior in the human male and female" by Dr AC Kinsey etc.

Many kinds of information can be obtained either by interview or by questionnaire. The questionnaire has the great advantage of anonymity, making for more truthful answers. It also serves to cut out uncontrolled personal influences, and there is less likelihood of bias in the coding of replies. The interview is in general more flexible. Since the same questions can have different meanings to different people, the interviewer can remove such misunderstanding. He can probe for true replies and make ratings based on the whole of the subjects' behavior. He can change the order of questions and prevent the subject looking over the whole list before answering.

The Public Opinion Poll Method

This method is used to seek and gauge the beliefs, sentiments and attitudes of the public on any given proposition. "Public poll" is very popular in America. Where data regarding public opinion about various social, economic and political situations are collected through this instrument very frequently. The public gives its view by answering 'Yes', 'No' or 'Do not know' to the proposition. The results of the public poll help the authorities concerned in modifying their policies accordingly.

The Social Survey Method

The social survey method consists in the collection of data concerned in the living and working conditions of the people in a given area with a view to formulating practical social measures for their betterment and welfare.

Thus social survey is concerned with collection of data relating to some problems of social importance with a view to

formulating a constructive program for its solution. It is conducted within a fixed geographical limit. Social surveys are of various types. These are:

i. General or specialized surveys;
ii. Direct or indirect surveys;
iii. Census surveys or sample surveys;
iv. Primary or secondary surveys;
v. Official, semi-official or private surveys;
vi. Postal or personal surveys; etc.

It involves the following steps:

1. Definition of the purpose or objects;
2. Definition of the problem to be studied;
3. The analysis of this problem in a schedule;
4. The delimitation of the area or scope;
5. Examination of all documentary sources;
6. Field work;
7. Arrangement, tabulation and statistical analysis of the data;
8. The interpretation of the results;
9. Deduction;
10. Graphic expression.

These surveys are useful as they do not only provide detailed accounts of the social and economic facts but also bring home various social evils prevalent among the people of the area concerned and thereby draw the attention of the government to eradicate these evils by passing appropriate legislation. America and England have been making use of social surveys, both general and specialized, since long on a very large scale to solve some of their social problems. India and other underdeveloped countries are also now benefiting from social surveys both in the urban and rural areas, which they are conducting either on their own or with the co-operation, and help of other advanced countries.

6. IMPORTANCE OF STUDY OF SOCIOLOGY WITH SPECIAL REFERENCE TO HEALTH CARE PROFESSIONALS

Sociology is a very useful science especially for the physiotherapy professionals as discussed below:

1. Sociology will help the physiotherapists and doctors to know the culture and social life of the patients. In a country like India, where people have their affiliation with different religions, castes, tribes ad communities, it is essential to know the culture of these groups. The customs, traditions, folkways, mores and values of the patients must be known before treating them, so as to make the medical and physiotherapy services more effective. For this, sociology is necessary.
2. Treatment of diseases, mental or physical, is a co-operative venture in which a united effort of various medical, para-medical and even non-medical personnel is required. Knowledge of sociology helps physio-therapist to maintain congenial relationships between different personnel at different levels.
3. The most important person who can help in the recovery is the patient himself. Unless he desires to be healed and co-operates in the process, treatment and physiotherapy care become very difficult indeed. Hence, it is of paramount importance that the physiotherapist must be able to gain full confidence of the patient. In this process, her knowledge of the social system and social relation-ships is very vital.
4. To meet the needs of her patient adequately, it is essential that the physiotherapist develop self-understanding. She must strive constantly to become emotionally, mentally, morally and socially mature. The study of sociology along with psychological training is very useful in this process.

5. Today physiotherapy is not simply an effort to cure illness. Preventive services and promotion of health are also equally important aspects of physiotherapy. To be an effective agent of health promotion, knowledge of the community and facilities and resources available therein are essential. Sociology, which is called the science of human society, can play an important role in the understanding and improvement of community life.
6. A large number of physiotherapists are working outside the hospital nowadays. In programmes like public health, industrial health, school health and so on, the physiotherapist has to work in very close proximity with different sections of the society. The knowledge she has about society is extremely useful.
7. Technological progress has successfully eliminated many diseases, but it has brought new problems and challenges to the physiotherapists. The problems of the aged, patient suffering from AIDS or persons suffering from permanent disabilities due to industrial or various other types of accidents are all examples. Deep understanding of human behavior, relationships and psychology can be very useful in handling such situations.

Chapter 2

Social Factors in Health and Disease

1. MEDICAL SOCIOLOGY AND THE SOCIOLOGY OF HEALTH AND ILLNESS

Sociological approaches to health and health care have a long history. Many of the current preoccupations within the field of study of what for many years has been known as 'medical sociology', but now which has increasingly been redesignated as 'the sociology of health and illness'. These concerns relate on the one hand to the extent to which social and economic structures determine people's life chances and possibilities, including their possibilities of health. On the other hand they relate to the extent to which people through individual or collective actions may have some control over their lives, including in relation to their health. There continues to be a debate within medical sociology about the extent to which *structures* determine health, compared to the degree to which people have the capacity to control (to use their *agency* over) their health.

Currently there is considerable research in medical sociology on the precise effects of a range of inequalities—economic, class, gender, age and ethnicity for example, on specific patterns of ill health and disease. Further there is complementary research on the degree to which the remedy to the differential distribution of health and illness should be

addressed mainly at a structural level (particularly by lessening economic inequalities in populations), or at an individual level—through an individual's own lifestyle decisions and actions.

Another burgeoning area of sociological research in relation to health and illness has been that focusing on the meanings, effects and practices associated with health and illness at the level of social interactions between people—in small groups, amongst families and friends, between doctors and patients, and in other social interactions focused on health.

There is considerable interest by sociologists in how disease categories may change as the role of medicine changes, and in the ways in which 'new diseases' such as post-traumatic stress disorder (PTSD), and chronic fatigue syndrome (CFS) become incorporated into medical practice.

2. SOCIAL FACTORS INFLUENCING HEALTH STATUS

The health status of an individual depends upon the interaction of a large number of factors.

Social and economic factors which include housing, occupation, financial and social status, climate, geography, nutrition, norms and roles of the society in which the individual lives and personal characteristics of the individual which include the age, sex, genetic make up, intellect and personality, personal habits, behavioral characteristics and medical history.

As a result of the interaction of the above factors, the individual either maintains or fails to maintain equilibrium. Break down in this equilibrium results in ill health.

A United Nations Expert Committee listed 12 factors, which need to be improved if levels of living were to be raised. They are:

1. Health including demographic condition;
2. Food and nutrition;
3. Education including literacy and skills;
4. Conditions of work,

5. Employment situations;
6. Aggregate consumption including savings,
7. Transportation;
8. Housing;
9. Clothing;
10. Recreation and entertainment;
11. Social security and
12. Human freedom.

The state of health is not absolute, one can always be healthier than at a particular time, relatively. This is known as positive health. In the state of positive health, all the organs of the body function at the best physiological level and the body as a whole attains the full biological potential and balance in the total environment. A little disregard to the rules of health may at times not affect adversely the very stable balance once acquired. This is because of the development of strong non-specific immunity or resistance against the harmful microbes.

Health cannot be distributed or given, it has to be consciously acquired and won. One can promote one's health only by understanding what it is, on what it depends, and applying this knowledge meticulously in everyday life. In fact care of the body regarding food, clean water and air, cleanliness, exercise, rest, sleep, measures for protection against diseases etc are essential for the growth and maintenance of health.

It is the prime duty of everyone to take care of his or her body and maintain good health. This is a duty he owes to himself, to his family, to his neighbors, to his community, to his country and to his nation and above all to his Creator.

Medical care facilities play an important role in improving the health status of individuals and community by providing curative, preventive and promotive services. A humanist approach is required to provide for a system of health care, which is technically adequate and socially acceptable so that

the vicious circle of poverty, malnutrition, high morality and morbidity, high fertility leading to more poverty is broken. Providing effective, efficient and good quality medical care within the reach of people, would promote the health status of the individuals and their families.

Provision of merely assets like safe and potable water supply, sanitary latrines and facilities for maintaining environmental cleanliness etc do not in itself secure freedom from water and fecal-borne diseases. People must recognize good drinking water and sanitary disposal of human excreta and wastes, as 'felt' health need to give up their old, unhygienic habits of polluting water supplies and fouling their surroundings by indiscriminate disposal of faeces and garbage.

In the present world there is a denial of the basic right (health) to millions of people, specially in the underdeveloped countries, who are caught in the vicious circle of socio-economic exploitation and ill health, and who are also chained by out of date customs and traditions and superstitious beliefs leading to an unhealthy life-style.

Providing good and efficient medical care, good environmental conditions like safe drinking water, sanitary latrines, good houses, nutritious food, environmental cleanliness, will not by itself promote health or prevent ill health; they have only potential to good health. Individuals must take up the responsibility of managing and utilizing the resources effectively and efficiently and adopt healthy ways of living.

3. HEALTH AND ILLNESS

Definitions of health and illness are very complex, in that there are cultural differences in how societies classify what are health and illness, the causes and the treatment. However, because disease occurs in patterns it is thought that the conditions that determine health chances are social conditions. The way we think about health and illness is socially constructed as we are used to accepting the views of the medical profession.

In modern medicine our bodies are seen as machines and doctors as mechanics, however studies by sociologists show that there is a range of environmental, political and behavioral factors that contribute to the construction of health and illness. In societies what appears to be abnormal or unacceptable is often labeled as disease, conflicts arise because what accounts for illness differs from place to place and from time to time. Numerous studies also show that a person's social class strongly affects health and longevity, and that poverty and social class are the most important factors determining health. The lower ones social rank the more prone one is to early death.

There was a pattern to the wealth and health experienced by the different social classes, based on occupation the report showed health inequality and suggested that professionals fare better than managers, managers fare better than skilled workers and so on down the line.

The social selection explanation theorizes that it is not social class that affects heath but health that affects social class, people who suffer from poor health stay at the bottom of the occupational scale because they are not healthy enough to make any progress, and that it is not the lower class which actually causes their poor health but rather people who are ill tend to take time off school and work so their chances of succeeding are less likely than someone who is healthy and is rarely absent from school or work.

The health and illness that affect the social classes are often influenced by their environment for instance the child mortality rate of the lower classes can be caused by living in poverty, damp housing, low income, inadequate diet, through unemployment, all the issues which contribute to stress and depression as the lower class is caught in an never-ending circle where each problem contributes to another and so lifestyles tend to stay the same. This diminishes hope and limits choices causing a threat to health. The lower classes also have the worst facilities of health care.

Our ideas in society tend to construct gender differences in health problems, there appears to be some evidence that men take more risks than women such as dangerous sports and violent activities and hazardous occupations, also women tend to consult doctors more often but yet statistics suggest women have more ill health, but this could be because women in their socially produced gender roles are seen as more acceptable to show weakness and seek medical help. Women's lives are more often medicalised than men, in childbirth, reproduction and mental health women are more likely to be given prescriptions for anti-depressants or tranquilizers, men however are more likely to have alcohol related problems, a more socially acceptable response to stress than it is for women.

A woman's role is often looking after everyone in the family and because she tends to carry an added burden of stress with an attitude of having to soldier on with her responsibilities she may be prone to physical and mental disorders. As victims of social and economic circumstances women tend to suffer from what is known as "*housewife syndrome*." The isolation and constant decision-making involved in housework are very stressful as is the responsibilities of looking after young children.

There is substantial evidence that illness is socially constructed through the medical professions interventation in creation of iatrogenic diseases, in many cases the treatment causes more damage than the illness ever would for example the thalidomide drug, where the effects on the unborn children greatly outweighed the advantages to the pregnant women. People suffering from depression are often given tranquilizers, this in turn can cause addiction. There is also much evidence to suggest that there are many unpleasant side effects to the contraceptive pill as it can cause cancer or thrombosis and intrauterine devices can cause all sorts of infections.

Health and illness are socially constructed by the environment, technological changes over time have brought

improvements in sanitary systems ending the risks of major epidemics, however this industrialized engineering has also brought about high levels of dangerous chemicals with the result that the major killers in modern industrial societies are heart diseases and cancers.

The large drug companies which are the most profitable in the world help shape the pattern of medicine, drugs are made to produce profit, therefore there is a relationship between doctors and drug companies designed to maximize the sale of drugs.

The elderly in society are also often diagnosed as sick because they are most vulnerable to illness; a large number of the elderly are in hospitals not because they are sick but because there is no one to look after them at home and also because health and welfare services fail to provide enough care in the community.

The social construction of health and illness is a complex interaction of gender, class, age and other social characteristics, still vast social divisions of health outcomes, social class divisions in mortality and morbidity are probably the result of material factors, what is defined as disease often occurs in patterns which are best understood sociologically. The improvement in life expectancy over the years is because epidemic diseases were reduced with improved sanitary conditions, looked at in this perspective, modern medicine has been less important than changes in environments.

Chapter 3

Socialization

1. MEANING AND NATURE OF SOCIALIZATION

According to McIver, "Socialization is the process by which social-beings establish wider and profounder relationships with one another, in which they become more bound up with, and more perceptive of the personality of themselves and of others, and build up the complex structure of nearer and wider association."

Gillin and Gillin write, "By the term socialization, we mean the process by which individual develops into a functioning member of the group according to its standards, conforming to its modes, observing its traditions and adjusting himself to the social situations."

HT Majumdar defines socialization as, "The process whereby original nature is transformed into human nature and the individual into person." Every man tries to adjust himself to the condition and environment predominantly determined by the society of which he is a member. If he fails to do so, he becomes a social deviant and is brought back into line by the efforts of the group of which he is a member. This process of adjustment may be termed socialization. It is the opposite of individualization. It is a process of the extension of the self. It develops in him the community feeling.

Socialization is a learning process whereby a person acquire the patterns of social action and culture of a society is transmitted to new generation through the process of socialization.

2. GOALS OF SOCIALIZATION

1. The teaching of basic discipline through controls and rewards.
2. The instilling of fundamental values, goals and aspiration into the individual.
3. The transmission of skills.
4. The ability to play social roles.

3. TYPES OF SOCIALIZATION PROCESS

a. Primary socialization: Learning in primary groups—family, peer group, neighborhood, etc.
b. Secondary socialization: Learning in secondary groups like schools, organizations, club, associations, books, mass media, etc.
c. Anticipatory socialization: Learning in anticipation of future positions.

a. Primary socialization: The process of socialization that occurs in the family ever since the birth of a child is known as primary socialization. Whatever one learns in the family from the formative period of one's personality continue to affect throughout the life the way one feels and acts. Primary socialization is usually carried out through tender care, emotional support and rewards in informal ways.

Similarly, the peer group and neighborhood are also equally significant agencies of primary socialization. Cooley an American Sociologist called the primary groups 'The nurseries of human nature'.

b. *Secondary socialization*: The process of secondary socialization starts at a later stage than the process of

primary socialization. An adolescent is also exposed to school, mass media, organization, club etc. These are also agents of socialization. What one learns in these secondary groups is known as secondary socialization. This process of learning is ' task-oriented' and not 'emotional' one as it happens in the case of family, peer group or a neighborhood. The process of secondary organization is geared through secondary agencies more on formal basis.

c. *Anticipatory socialization*: This means socialization prior to actually entering a position. One learns many roles by playing the roles as play. For example, one takes over imaginatively the status of a doctor or a judge. The educational process provides much of the anticipatory socialization. Similarly, anticipatory socialization takes place through imitation.

In this case the person copy the attitudes and behavior pattern of his or her role model anticipating to appear like role model. Anticipatory socialization thus, relates within the learning of future positions and roles.

4. STAGES OF SOCIALIZATION

i. *The oral stage*: During this stage child depends upon oral signals for pressing needs. The child is a 'possession' in the family. Freud called this stage as a stage of 'primary identification'.

ii. *The anal stage*: It continues from first year to three years of age. During this stage, the child internalizes two roles—his own and that of his mother, now clearly separate.

The child not only receives care, he also receives love, and gives love in return. The child, during this stage, is encouraged for correct performances and punished or discouraged for incorrect behavior.

iii. *The third stage*: This stage extends from fourth year to puberty, i.e. up to roughly twelve or thirteen years. A

child learns to get along without the immediate guidance and support of his family.

The child experiences 'oedipus complex' or 'electra complex'. In oedipus complex boy is attracted towards 'mother' and in electra complex girl is attracted towards 'father' in the family. During this stage many social pressures are brought to bear on the child to identify with the appropriate sex. Accordingly, the socializing agent grants rewards. Boys tend to play with boys and girls tend to play with girls. Thus, 'identification' with 'sex-roles' takes place. Mother plays 'expressive roles' whereas father plays 'instrumental roles' towards the child.

iv. *The adolescence stage*: This stage begins after puberty or the age of 12 years. At this stage young boy or girl tend to move away from the control of parents. There is greater demand for independence in the behavior of the boy or girl. A phase of psychological pressure starts at this stage. A child tends to put a good deal of his sentiments into a play group or gang of boys or girls of his or her own age. The adolescent stage finally culminates into adulthood.

5. AGENCIES OF SOCIALIZATION

The process of socialization is operative not only in childhood but also throughout life. It is a process, which begins at birth and continues unceasingly until the death of the individual. It is an incessant process.

Since socialization is an important matter for society, it is but desirable that child's socialization should not be left to mere accidents, but should be controlled through institutional channels. What a child is going to be is more important than what he is. It is socialization, which turns the child into a useful member of the society and gives him social maturity. Therefore, it is of paramount importance to know as to who

socializes the child. There are two sources of child socialization. The first includes those who have authority over him; the second are those who are equal in authority to him. The first category may include parents, teachers, elderly persons, and the state. The second one includes the playmates, the friends and the fellows in the club. His training varies in content and significance according as it is acquired from one or the other source. In one category is the relationship of the constraint; in the other it is that of co-operation. The relationship of constraint is based on unilateral respect for persons in authority, while the relationship of co-operation is based on mutual understanding between equals. The rules of behavior, under the first category are felt as superior, absolute and external, but rules in the second category have no superiority or absoluteness in themselves but simply are the working principles of association. Persons having authority over the child are generally older than he, while persons sharing equality with him are apt to be of similar age.

The chief agencies of socialization are mentioned here:

1. *The family:* The parents or family are the first to socialize the child. They are not only closely related to the child but physically also they are nearer to him than others. From the parents he learns his speech and language. He is taught societal morality. He learns respect for persons in authority. In the family, he learns a number of civic virtues. The family is rightly called the cradle of social virtues. The child gets his first lessons in co-operation, tolerance, self-sacrifice, love and affection in the family. The environment of a family influences the growth of a child. The psychologists have shown that a person is what he becomes in a family. In a bad family child learns bad habits, where as in a good family he acquires good habits. An important cause of juvenile delinquency is bad family environment. At the time of mate choice, the parents also try to find out the family history of the boy and girl in

order to know their good and bad points. The relationships between the parents and the child are one of constraint. The parents are older than he and have the power to command obedience. In case the child does not follow the rules, he may be coerced. Of the parents it is the mother, who first begins the process of socialization. The family continues to exercise its influence throughout life.

2. *The school:* The school is the second agency of socialization. In the school the child gets his education, which molds his ideas and attitudes. A good education makes the child a good citizen, while a bad education can turn him into a criminal. Education is of great importance in socialization. A well-planned system of education can produce civilized persons.
3. *The playmates or friends:* The playmates and friends also are an important agency of socialization. The relation between child and his playmates is one of equality. It is based on co-operation and mutual understanding. They are mostly of similar age. As told above, the child acquires something from his friends and playmates, which he cannot acquire from parents. From them he acquires cooperative morality and some of the important aspects of culture like fashions, fads, crazes, modes of gratification and forbidden knowledge. The knowledge of such things is necessary from social point of view. To take an example, the knowledge of sex relations is considered in our society undesirable for a youth till he gets married. If such knowledge is banned strictly until marriage, the performance of numerous functions of sex life may be difficult after marriage. This knowledge child acquires from his friends and playmates.
4. *The Temple/Church/Mosques, etc:* Religion has been an important factor in society. In the early society religion provided a bond of unity. Though in modern society the

importance of religion has diminished, yet it continues to mold our beliefs and ways of life. In every family some or the other religious practices are observed on one or the other occasion. The child sees his parents going to the temple and performing religious ceremonies. He listens to the religious sermons, which may determine his course of life and shape his ideas.

5. *The state:* The state is an authoritarian agency. It makes laws for the people and lays down the modes of conduct expected of them. The people have compulsorily to obey these laws. If they fail to adjust their behavior in accordance with the laws of the state, they may be punished for such failure. Thus the state also molds our behavior.

One of the reasons for the increasing crime in society is the failure of the socializing agencies to properly and adequately socializes the child. The modern family faces a crisis today and suffers from parental maladjustments, which adversely affects the process of socialization. The educational system is full of drawbacks. The school is no longer a temple of education. It is a place where boys and girls learn more of drugs and alcohol and less of cultural heritage. The onslaught of urbanization has abolished the neighborhood system and snatched playmates from the child who now plays with electronic games than with neighborhood children. Similarly, religion has a lesser hold in an urban society and the state authority is more disobeyed than obeyed.

It need not be said that in order to have socialized beings these agencies should function in an efficient manner. The modern society has to solve several problems of socialization and for that purpose it has to make these agencies more active and effective.

Chapter 4

Social Security

1. MEANING OF SOCIAL SECURITY

The idea of social security has arisen out of the deep and eternal need of a man for some measure of security for his immediate future. A man has to face a number of contingencies or risks right from his birth. These contingencies include employment injuries, industrial diseases, invalidity or disablement, ill-health, maternity or childbirth, old age, widowhood, orphanhood and unemployment. During these contingencies, it becomes difficult for the person concerned either to work or obtain work. This difficulty of work and earn is particularly felt, when the need for means of subsistence is more acute.

The International Labor Office defines this, "Social security is the security that society furnishes, through appropriate organization, against certain risks to which its members are exposed. These are essentially contingencies against which the individual of small means can not effectively provide by his own ability or foresight alone or even in private combination with his fellows."

Prof. Friedlander stated, "Social security is a program of protection provided by society against those contingencies of modern life— sickness, unemployment, old age dependency, industrial accidents, and invalidism against which the individual cannot be expected to protect himself and his family by his own ability or foresight."

Social security may be provided through three main forms, namely,

a. Social insurance.
b. Public assistance.
c. Public service.

Social insurance is used in cases of those contingencies, where the incidence of which is predictable, namely, old age, death, sickness, maternity, work injury, and unemployment. Contributions are made by the insured persons, and sometimes by their employers and the government also. The government on the basis of actual existence of need provides public assistance. No previous contributions have to be paid.

The term public service is used for those benefits and services which may be provided by government on a general basis to all the members of a group based on age, sex or other considerations for example, children's allowances and national health service.

2. SOCIAL ASSISTANCE AND THE HANDICAPPED

Generally speaking, the physically handicapped includes all persons who have either completely lost the use of or can make only a restricted use of one or more of their physical organs. A physically handicapped person is a perfectly normal being except for the handicap from which he suffers. For example, it is possible for a blind person to perform any job for which the use of eyesight is not essential.

The physically handicapped people can be divided into three broad categories:

1. The blind, the deaf and the dumb.
2. The orthopaedically handicapped and crippled.
3. The other type of physical impairments such as cardiac, tubercular, diabetics, leprosy, etc.

To solve the problems of physically handicapped people, following things should be provided to them:

a. Proper and cheap treatment.
b. Social grants and other aids.
c. Employment facilities.
d. More institutions for their care, and
e. Special training and other facilities.

We may discuss the problem of physically handicapped persons under five heads:

a. Services for the blind.
b. Services for the deaf and dumb.
c. Services for the crippled.
d. Services for lepers, and
e. Services for other persons.

Services for the blind: Among the blind are included those persons whose vision is of no practical value to them for the purpose of education or in general business of living. In India, a blind is defined as, "A person is blind who cannot count the fingers of the outstretched hand and held at a yard's distance." The chief causes of blindness are:

1. Inflammatory diseases of conjunctiva and cornea.
2. Cataract and glaucoma.
3. Malnutrition.
4. Venereal diseases.
5. Small-pox.
6. Quacks.
7. Ill effects of bad posture, glare, bad-lighting and badly-printed books.

Rehabilitation of the blind: The primary aim of blind welfare is to equip the blind with such training as would enable them to have gainful employment. Our existing institutions provide this training, but do not procure employment for them. It would therefore, be necessary to procure suitable employment after they have been given the requisite training to rehabilitate themselves in the real sense. The blind can be absorbed in professions like music, in cottage industries like weaving, chair

canning, basket making, knitting, paper bag making, card board box making and also in factories where they can perform repetitive operations very successfully.

It would also be necessary to have separate training centers for the adults, who become blind after twenty, as the education and training required for them would be of different nature according to the profession followed by them in the past.

Services for the deaf and dumb: "The deaf are those in whom the sense of hearing is non-functional for the ordinary purposes of life." The loss of hearing is measured by a pure tone audiometer and is expressed in decibels. Persons with a loss of over 60 decibels are generally regarded as deaf.

The handicap of deafness gives rise to two problems, first, the acquisition of the power of speech, as speech is an acquired faculty and second, the adoption of a suitable means of understanding the spoken language. It is by a complicated process that the deaf is taught an isolated sound, including vowels, consonants and diphthong and he is made to understand the spoken language by means of a process known as lip reading. The acquisition of speech by lip reading takes a long time, as a deaf child generally takes more than double the time than a normal child to acquire a particular standard. Besides, there is a large number of children who retain a certain degree of hearing, which can be made use of with the help of modern hearing aids.

The main causes of deafness are—otitis media, acute infectious diseases, septic tonsils, adenoids, malnutrition, eruptive fever, small pox, malaria, mumps, etc.

Rehabilitation: A deaf person can perform any job not specifically requiring the use of the hearing sense. Thus they can take up many kinds of normal occupations after necessary training. Many deaf persons work as tailors, printers, weavers, etc.

Services for persons with defective speech: Clinics in big cities promote the sociability of the patients by individual exercises,

group games, etc. The psychiatrist deals with the sub-conscious mind and the speech therapist with the conscious mind.

Services for the crippled: " The crippled child in the orthopedic sense is a child that has a defect which causes a deformity or an interference with a normal functioning of the bones, muscles or joints. The condition may be congenital or it can be due to disease or accident".

The two great crippling diseases are: 1) poliomyelitis, and 2) tuberculosis of the bones and joints.

Rehabilitation: For the rehabilitation of crippled a four pronged program is required:

1. Prevention, i.e. early discovery.
2. Treatment.
3. Education.
4. After-care, i.e. suitable employment.

A cripple must seek out early and seen through. This requires highly specialized team work, consisting of orthopedic surgeons, physiotherapists, psychotherapists, speech therapists, occupational therapists, nurses, prosthetic and orthotic engineers, special teachers for imparting education and experts in vocational training and guidance.

3. OTHER PHYSICALLY HANDICAPPED PERSONS

Among them are included cardiac, epileptics, rachitic, spastics, TB, the diabetics, etc. Persons suffering from such diseases cannot work like normal men; need long time treatment and special type of vocation after their recovery.

If such persons are to be rehabilitated in the real sense, they should be given sufficient monetary assistance for medical treatment and provided employment after recovery from disease. If some of them cannot recover and become permanently invalid, they should be provided with invalidity pension.

4. PROBLEMS OF SOCIALLY HANDICAPPED

Among the socially handicapped may be included the old and the infirm, invalids due to some accidents, widows, orphans, deserted women etc. A majority of them have no organic defects or do not suffer from chronic diseases, but they are incapable of doing work because of their age, loss of limbs or certain social difficulties.

5. SERVICES FOR THE AGED AND THE INFIRM

The family either provided for the aged and the infirm in the past or in case the family was not able to support them they depended upon private charity. In some cases, homes were opened for the aged and the infirm by welfare agencies. The concept of providing assistance to such persons through private charity or charitable institutions, which is a degrading one, has changed in the modern age. Provisions through social security measures has now to be made for such persons who have no other source of income. One way of providing assistance to such persons is through fund schemes, old age and invalidity pensions, whether contributory or non-contributory, to the workers employed in the factories.

Chapter 5

Social Problems

1. POPULATION EXPLOSION AND POPULATION CONTROL

By population explosion, we mean very rapid and unprecedented growth of population, which creates a lot of problems in the country. By population control we mean the control of population growth by family planning or birth control.

Population explosion is a major problem faced by developing counties of the world today. When we look at the figures of Indian census from time to time, we observe that there is an enormous growth of our population from 1931 onwards. This is shown in the Table 5.1.

Table 5.1: Growth rate of population in India

Census year	*Total population in crores*	*Annual growth rate (%)*
1901	23.84	–
1911	25.21	0.56
1921	25.13	0.01
1931	27.9	1.01
1941	31.56	1.33
1951	36.11	1.25
1961	43.92	1.94
1971	54.64	2.22
1981	63.38	1.21
1991	84.93	2.01
2001	102.3	–
Source of information		*Census of India*

Any population, which grows at an annual rate of 2 percent, can double in 35 years. It has happened in Indian population. By 2045, it is expected, that we will be the most populous country in the world. Peoples of the Republic of China may be pushed to the second position, because, the rate of population in their country has come down with enforcement of one child family. This sudden outburst of our population is mainly due to the sudden fall in our death rates. With the use of antibiotics, wider immunization programmes and overall medical facilities, death rate fell sharply whereas there is no corresponding decrease in the birth rate. This led to situation of population explosion, and, almost all other problems our country is facing today have their roots in this. If we look at the fertility and mortality figures, this will be very clear. The following Table 5.2 shows the same.

Table 5.2: Birth and death rates in India

Year	*Birth rate*	*Death rate*	*Growth rate*
1901-11	48.1	41.9	6.2
1911-21	48.2	48.6	0.04
1921-31	46.4	36.3	10.1
1931-41	45.2	31.2	14
1941-51	39.9	27.4	12.5
1951-61	41.7	21.8	19.9
1961-71	41.2	17.2	24
1971-81	37.2	15.00	22.2
1981-86	33.2	12.2	21.0
1986-91	29.5	10.00	–
1991-96	27.4	–	–

The ill effect of such sudden explosion of population is devastating on the national economy. All our planning and efforts become futile under these unfavorable demographic conditions. Our national leaders have correctly said that planning in the present situation is like constructing a house on a flooded river.

Impact of Population Growth

As a result of high fertility and comparatively high mortality, developing countries like India have an extremely large young population. The total population of India is almost three times that of America. The number of people above 65 years in both the countries is the same, but 0-4 age group is six times more in India than that of America.

Because of the huge young population, dependency rate is very high. Any population with large percentage of dependents and small percent of working people, will be economically backward.

The young population incurs huge national expenditure in many other ways. Large sum of money is required for the upbringing of children. The need primary and secondary schools which in turn requires lot of money. The medical and other needs of the growing population are pretty larger. Due to the high infant and child mortality rate, the rate of national waste is also high, because, expenses on the children go waste in the event of their death.

Whenever this percentage of young population is high, the population will be on the increase because all these children will be growing into adults and producing more children. Hence, even with wide acceptance of family planning methods, the population growth cannot come down.

Further, with large dependent population, the per capita income and the standard of life cannot improve. Even with remarkable increase in the national income, the per capita income of Indians is still very poor. Large population is mainly responsible for this.

Capital formation of the country is also greatly hampered with such a large population. Lion share of the national income is spent on our un-productive items like food, shelter, clothing, education, health facilities, etc. These day-to-day needs are to be met before we can think of spending capital more on major works.

In the absence of capital, large-scale development projects cannot be implemented. Industrialization process becomes slow, and this, in turn, affects the economic growth of the country, and the standard of life of the people.

With adequate economic development and industrialization new employment opportunities become limited. On the other hand, a very large number of people are entering the labor market as job seekers every year. This gives rise to the situation of acute unemployment, which our country is facing at present.

Overpopulation results in food problem as well. The cultivable land of any country cannot increase to any remarkable extent. Therefore, food supply to the increased population may be a major problem. Fifteen percent of the world population lives in India whereas we have only 2 percent of the cultivable land. Macmara has estimated that at least 100 million people of the world are severely malnourished. In India women and children suffer from malnutrition. Pregnant and lactating mothers also suffer from malnutrition, and poor health. Deficiency diseases like blindness, beriberi, rickets, and scurvy are extremely common.

With tremendous growth of population, not only economic but several other types of problems have come up. Housing is a major problem especially in cities and in the absence of cheap and hygienic facilities, the number of slum dwellers is shooting up. Inflation is increasing day-by-day, due to limited resources and increased demands. Communalism, regionalism, crime, violence, all have their roots in poverty and economic discontentment.

The pressure of population on the land is increasing. Though additional land is being made available through land reclamation means, the per capita land is decreasing due to population increase. With lack of additional employment facilities, more and more people are turning to cultivation.

The availability of cheap labor inhibits development of technology, and labor saving devices. In the long run, this is

going to affect the cost of production. The scope for improvement of skill and productivity is limited. Natural resources are not completely utilized due to slow rate of industrial and technological development.

All these factors result in country's standing in the world market. In a highly competitive world market, we are not able to compete and enter due to poor standards of our production technology. Thus, our international trade is greatly affected.

All the above-mentioned factors together result in slow economic development and poor standard of life. If we have to improve our standard of living, the first and foremost necessity is to control our population. The idea of small family should be spread far and wide. Today, with improved communication techniques like television, information is widely disseminated. What remains is to study the rate of attitude change, and the extent of adoption of family planning techniques.

An awareness regarding our population should be created in the young generation, and also in the general public. We have already included population education as a part of curriculum in schools. It should be effectively taught with the help of audiovisual aids and children should be made aware of the extent of the problem and their own responsibility in coping with the problem in future. Similarly, the general public especially the less educated and less privileged class should be made aware of the problem. All measures should be taken to check infant mortality and birth rate. When the survival rate of children improves, the number of birth also gradually comes down.

All village level workers should be trained and motivated to contact all eligible couples in their own areas and persuade them to accept family planning techniques. It is essential that these workers have correct knowledge of each technique. Primary health centers should also be properly equipped. It should be added that while family planning, and birth control

devices have been accepted and followed by educated urban people of India, it is not so in rural areas. Illiteracy and ignorance are a set back. So, special attention is to be paid to our villages in respect of population control.

2. POVERTY

Poverty is relative to richness. It is only when people feel resentment at their lot as compared with that of others that they feel the sting of poverty. They fail to achieve more than what they have and the awareness of this failure causes resentment of poverty among them. People are poor not because of an increase in misery but because of the attitude of resentment what they do not possess and what others possess. They regard themselves as poor when they feel deprived of what others possess and enjoy. It is then that poverty becomes a social problem.

Poverty is the most important problem of the rural people in India. Vast majority of our villagers live below poverty line. Rural sociologists like Sorokin and Zimmermann have held that about 30 percent of rural people all over the world are poverty stricken. In India it is much more.

Concept of Poverty

1. Gillin and Gillin—"Poverty is that condition in which a person, either because of inadequate income or unwise expenditure, does not maintain a scale of living high enough to provide for his physical and mental efficiency, and to enable him and his natural dependents to function usually according to the standards of the society of which he is a member."
2. TG Goddard—"Poverty is insufficient supply of those things which are requisite for an individual to maintain himself and those dependents upon him in health and vigor."

Somebody else has defined poverty as a condition of chronic insufficiency. Further it is a condition in which a person is not able to lead a life according to the desirable standard of society.

There are two types of poverty, namely, (i) abject poverty and (ii) relative poverty. Abject poverty is a condition in which a person has nothing to eat, to put on or no proper housing. Relative poverty means that compared with others in a particular society, a person is lacking certain things. For example, poverty in the United States (as different from India) may mean that a person is not having many cars or TV sets as others in that society are having.

Causes of Poverty

Some of the important causes are mentioned here:

A. *Landlessness:* Land is the chief means of production for a rural man. A good percentage of ruralites in India does not possess any land; they are called landless agriculturalists. They work as agricultural labour and are engaged in some other non-agricultural occupations. They are very poor. The wages they receive are also very low.

B. *Sickness*: Chronic ailments like malaria, tuberculosis, and other diseases make the villages weak and physically incapable of working. No proper medical treatment is available in most of the villages.

C. *Illiteracy and ignorance*: Illiteracy and ignorance make the rural people to lead a life of superstitions and inefficiency. Others can exploit any illiterate and uneducated person easily; including the moneylenders, government officials, and traders.

D. *Extravagancy*: These are non-essential items of expenses. Much money is spent on account of sradhs, festivals, marriage, and pilgrimages.

E. *Unhealthy habits*: Bad habits like drinking and smoking also make the villagers poor.

F. *Natural calamities*: Natural calamities like famine, pestilences, floods and earthquakes destroy life and property of rural people. These make them very poor and destitute.

G. *Unemployment and underemployment*: Non-agricultural people in the villages face unemployment very often. Farmers are underemployed. Agriculture is a seasonal occupation and most of the time of a year is wasted. There is no work between the time of sowing and harvesting.

H. *Exploitation by the elite groups*: The moneylenders, rich farmers, middlemen, or even government officials like patwaris or tehsildars often exploit a poor villager.

I. *Over-population*: Birth control methods are not yet fully used in our villages. While most of the educated urban people take to family planning, most of the rural people do not, with the result that the rural population is fast increasing. There is over-crowding in the villages. Subdivision and fragmenting of land make the holding of land uneconomical.

J. *Lack of supporting industries*, lack of facilities for transportation, poor marketing system, and defective social organization is the cause of poverty.

The Gillins listed three factors as primarily responsible for poverty:

i. Incapacity of the individual, which may be due to a faulty heredity or to the environment;

ii. Unfavorable physical conditions, such as poor natural resources, bad climate and weather, and epidemics, and

iii. Misdistribution of wealth and of income and the imperfect functioning of our economic institutions. Of these three factors the last two factors are principally responsible for poverty in India. Ours is a country rich in natural resources, but we have not yet adequately exploited them.

REMEDIAL MEASURES FOR ERADICATION OF POVERTY

Some of the remedial measures for poverty eradication in rural India are given below:

A. *Agricultural development:* Better farming, redistribution of land, development of animal husbandry, poultry, and small cottage industries suiting the rural environment are needed.

B. *Development of supporting occupations:* Facilities for supplementary employment such as handicrafts, weaving, pottery, may be helpful.

C. *Spread of education:* Education should be made compulsory at least up to high school standard. This will broaden the total outlook of the rural people, and adopt better ways of life.

D. *Family welfare programs:* These should be intensified at the village level, so that all unwanted births are avoided and the burden of over-population is reduced.

E. *Fixing minimum wages:* Just as in the factory, minimum wages should be fixed for the agricultural labor also, and it should be actually implemented.

F. *Better marketing facilities:* A farmer should get proper price for his produce. Co-operative societies can be very useful in this regard.

G. *Prohibition* should be introduced all over the country, and so the rural people also should be prevented from drinking.

I. *Redistribution of land:* The unequal distribution of land should be changed, so that some justice is done with regard to land ownership and use. The land already in the ownership of people should be in their real possession and use too. All exploitation in this regard should be stopped.

J. *Rural electrification:* Even now, there are villages, which are not electrified. Electricity is needed for irrigation and house lighting.

K. *Others* like social security schemes, implementation of all legislation and rules and regulations concerning rural people. Social security schemes like unemployment allowances, old age pension, and sickness assistance may be difficult in a country like India, where majority of the people live in villages, yet some measures have to be introduced like compulsory insurance of human beings, animals and crops, and assistance in sickness as well as old age.

The lot of poor people cannot improve except through economic development. There is imperative need for drastic economic reforms. The progress we have made has fallen short of our plan targets. The maladies are many. The over-bureaucratization, excessive control over industrial sector and undue importance given to public sector without ensuring its profitability and now lack of firm political leadership due to a fractured mandate have pushed the country back compared to many emerging nations.

3. UNEMPLOYMENT AND UNDEREMPLOYMENT

Unemployment and underemployment are serious problems of the villagers in India. Millions of rural people in India are unemployed, as well as underemployed.

These have several causes and effects. It is necessary that we control and prevent much unemployment in our villages, though complete success in this regard may be a utopia.

Concept of Unemployment

I. "Unemployment is a condition of the labor market in which the supply of labor is greater than the number of available openings."
II. "Unemployment is a state of affairs when in a country there are large number of able bodied persons of working age who are willing to work, but cannot find work at the current wage levels."

Thus, we find that unemployment is a particular condition in a society where there are people able and willing to work, but they cannot find jobs. It is a negative aspect of the economic process; it is enforced or involuntary separation from remunerative work.

Underemployment is a condition of not being fully employed, that is the time and capacity of the worker are not fully utilized. For instance, in Indian villages, the farmers have work only for 100-200 days; the other days, they are idle. There is no supplementary employment. Similarly in the urban areas, we find that educated men and women are employed in jobs much below their qualification or ability. For example, a graduate or postgraduate is working as a menial worker, or a small office assistant.

Types of Unemployment

There are mainly three types of unemployment:

1. *Seasonal:* This is caused by seasonal changes in production, e.g. in the case of agriculture, or work in a dockyard.
2. *Cyclical:* Caused by economic ups and downs. When there is economic depression, there is much unemployment.
3. *Normal:* This type of unemployment is the inevitably concomitant or any economic system based upon a free labor market, as we find in England, or America or in India too. Thus, a minimum amount of unemployment is inevitable.

Causes of Unemployment

Some of the main causes of unemployment in Indian villages are:

1. *Population explosion:* The excessive increase in population is the main factoring unemployment.
2. *Division and fragmentation of agricultural land:* Due to population increase, the size of land holding becomes too small.

3. Seasonal nature of agriculture.
4. Vagaries of climate.
5. Lack of literacy, education and technical training.
6. Too many festivals, pilgrimages and other traditional religious and cultural activities. These hinder the villagers from working.
7. *Chronic diseases:* Chronic ailments make the farmers unfit for work; inadequate medical facilities keep the villagers sick for a longer period.

Remedies of Unemployment

To prevent unemployment or underemployment in Indian villages is not easy, looking at the magnitude of the problem, aggravated by population increase, poverty and illiteracy. Yet, we may suggest following remedies:

1. *Land reclamation, conservation and improvement*: Though country is overpopulated, a lot of land still remains unused, as they need reclamation and improvement. If all wasteland is put to use, then, there will be more land for cultivation, which in turn, will create more employment.
2. *Improvement in the agricultural system:* Better seeds, manure, pesticides and modern techniques can improve agriculture. This may create more employment avenues.
3. Development of cottage industries, animal husbandry, poultry farming, food preservation, and fisheries.
4. Population control.
5. *Assessment of the problem:* The problem of rural unemployment has not yet been studied scientifically. Therefore, there is great need of scientific assessment of the problem of rural unemployment, particularly, the type of unemployment, extent of the problem, age group involved, causes and then suggest ways and means to control and prevent the problem of rural unemployment. Mere guesswork would not be sufficient. The question of

starting employment exchanges in rural areas may also be explored in this connection.

6. *Organization of rural labor:* While there are several associations and unions to safeguard the interests of urban labor, there is not much in rural India. So, there should be rural labor organizations to promote the welfare of the rural labor.
7. *Development of rural areas as a whole:* The development of our villages needs construction of roads, irrigation canals and projects, dams, working of different types of co-operatives, and revival of cottage industries. When such developments take place, underemployment also will be solved to a great extent.

CONCLUSION

There are millions of people unemployed in India—both urban and rural. Urban unemployed are educated, while those of the rural are illiterate, or semi-literate. At the end of second five year plan, it was estimated that there were about 20 millions unemployed in rural India. This may have doubled now. The evil consequences like poverty, frustration, revolution result in crimes and social disorganization. Therefore, it is necessary that all efforts be made to have maximum employment facilities. The Government of India has already announced that the question of payment of unemployment allowance cannot be considered in India.

4. BEGGARY

Beggary means, "The state or condition of a habitual beggar." A beggar is one who begs, one who lives by asking alms. Beggars were found from ancient times. Beggary was a profession or way of life has come into being in modern times. India is a country where a very large number of beggars are found. According to one estimate, there are at least 15 millions beggars in India. These beggars roam about all over the

country, and are especially located at railway stations, bus stands, and place of pilgrimage, temples and mosques. In fact, beggary has become a big nuisance in the Indian cities. Anti-beggary legislation is passed by different states, and the union government is also contemplating to have all India legislation. But then, whatever legislation or rules and regulations are there, they must be enforced. For example, the Indian railways have prohibited beggars in their premises, but then we find that the maximum numbers of beggars are found at railway stations, and even inside the railway compartments. It sometimes makes the railway travel very inconvenient.

There are several causes of beggary in India. Beggary has serious ill-effects too. Further, the incidence of beggary is steadily on the increase. Therefore all steps are ought to be taken to control and remedy the situation.

Definition of Beggar

The *Bombay Beggars Act* defines beggar as, "A person without subsistence wandering about or found in public places or allowing himself to be used as an exhibit for the purpose of begging."

Types of Beggars

There are various types of beggars, some of which are as described below:

1. *Child beggars*: There are vagrant children engaged in begging. They may be poor at home, or may have stopped school education as dropouts, or may have run away from home, or they may be doing odd jobs and then begging too. Most of these children are between the ages of 10 and 16.
2. *Physically handicapped*: They are blind, lame, deaf and people who have lost their arms or feet owing to accidents or diseases.

3. *Mentally sick beggars*: They are lunatics, and mentally deficient people, men and women, who seldom live in their homes.
4. *Able-bodied beggars*: They are physically and mentally fit to work, but then they have taken begging as profession. They do not want to get rid of their habit.
5. *Tribal beggars*: This category includes those who have migrated from the rural and tribal areas.
6. *Religious mendicants*: Religions like Buddhism and Hinduism have somehow or other encouraged beggary.
7. *Small trade beggars*: Some such people are engaged in small trades, but occasionally resort to begging too.
8. *Temporarily unemployed beggars*: Unemployment paves the way to poverty. So, when people are rendered unemployed they take to begging.
9. *Permanently unemployed*: These are those who fail to secure employment for their livelihood. They find it difficult to have proper jobs, although they are physically and mentally all right.
10. *Orphans and destitute*: In country like India, there are thousands of orphans and destitute. They are helpless. The state does not provide social security facilities to them. Therefore, they take to begging.

Causes of Beggary

There is relationship between the types of beggars and the causes of beggary. Some important causes of beggary, especially in India are the following:

1. *Poverty*: There are millions of people who live in chronic poverty in India. They are found in tribal, rural and urban centers. There is no exaggeration in saying that at least fifty percent of our population is poor, or have a poor standard of living. There are many who are in abject poverty, that is, there is nothing to eat, wear or live in. Some of them take to begging.

2. *Loss of agricultural employment in villages*: Due to over-population, and fragmentation of land, the ruralites have serious economic problem. There are million of landless agriculturists in our villages.
3. *Physical defects and diseases*: Physical deformities like blindness, deformed legs and hands, hunch-back, deafness, and several other conditions make a person unable to do any work. Similarly, people afflicted with chronic debilitating diseases like TB and malaria, also lose their ability to work regularly.
4. *Mental disorders*: In a poor country like ours, family members are unable to support abnormal persons at home.
5. *Leprosy*: This deserves a special mention as a cause of beggary, because a very large bulk of beggars is formed of lepers. Severe stigma is attached to leprosy and anyone afflicted with it simply thrownout on the streets to beg. In India it is estimated that there are not less than four million leprosy patients.
6. *Children uncared for*: Marriage is a universal phenomenon in India. Everybody is ought to marry. But nobody worries about the number of children and the means to bring them up well. So, poor children go out of the home and take to beggary.
7. *Desertion* or death of the family is also a cause of beggary.
8. *Natural calamities*: Natural calamities like famines, floods, pestilences, and earthquakes turn many as orphans and destitute. There are institutions run by the government and non-governmental agencies to take care of them to some extent, but then all cannot be looked after.
9. *Laziness and indifference*: There are people who do not want to work. They are indifferent to work. They start begging and then it becomes a habit. Thus they become habitual beggar.

10. *The desire to give alms*: Human nature all over the world is to give alms to thqe poor and the beggars. Many a time, it is not realized that by giving alms, we are encouraging beggary. There are religious, moral and humanitarian motives behind this. All religions teach that its followers should be kind, loving, hospitable, and helping the needy. According to Dr Clifford, there are six reasons why people give alms, religious, custom, personal, fear, pity and carelessness.

MANAGEMENT OF THE PROBLEM

Most of the civilized countries have long ago prohibited begging and declared it as an offence. In India also, various states have made legislations against beggary. Bombay, Bengal, Madras, Cochin, Mysore and Travancore, have passed Acts against beggary even before independence. Legislations are also passed in MP, Punjab, UP, and some other places. Police Acts of Bombay, Calcutta and Madras cities also provide measures against beggary. These laws follows more or less uniform pattern as shown below:

1. They prohibit and penalize begging in public places.
2. Some classification is made on the basis of age, and physical condition of the beggar. Juveniles are taken care of under the provisions of the *Children Act*.
3. Most of them are operative in areas notified by the government.
4. All the legislations penalize escape or violation of discipline with imprisonment, fine or both.

There are institutions in the states for custody, care and assistance to beggars and their rehabilitation. The inmates of these institutions are provided with food, clothing, sanitation, education and vocational training. These home also try to provide religious and moral instructions and facilities for physical well being of beggars. Employment facilities are provided so that all able-bodied beggars may learn to work and support themselves.

Suggestions for the Eradication of Beggary

Legal measures are often inadequate to solve a social problem. Though several acts are passed against beggary, we still find that there are hordes of beggars in streets, bus stands, railway stations, religious places or any other public place where public are likely to gather. Hence in order to prevent the problem, society has to look for other measures. In this connection, some suggestions are given below:

1. The law concerning beggary should be made more stringent and uniform for the entire India. Any beggar found in the public should be arrested immediately. The beggars should not be allowed to move from place to place.
2. More orphanages, shelter homes and beggar homes should be established so that orphans, destitute and the disabled may be given proper care and protection.
3. Old age homes should be established so that the aged citizens may be looked after well. This is especially so in cases where the children do not care for their old parents.
4. Any able-bodied persons found begging should be severely dealt with. The names of such persons should be registered and listed. Further, they must be made to work.
5. Any person found begging should be fined heavily. He should be sent to beggars' home and made to work.
6. Try to educate beggars' and develop a sense of self-respect and dignity of labor in their life.
7. The general public should be educated not to give alms indiscriminately. By giving alms we are not helping the persons, but are encouraging him to become a parasite. If people are really interested to donate for the welfare of the beggars, they should do so for the establishment and management of beggars' homes.
8. More organized community efforts should be made to eradicate the problem.

9. All efforts should be made to create social awareness in the public about the problem of beggary, so that collective efforts be made to solve it. The existing legislations against beggary also should be made known to the public.

5. JUVENILE DELINQUENCY

Juvenile delinquency (JD) is anti-social behavior committed by young people. Delinquency has many causes and consequences. Juvenile delinquents must be treated properly and reformed.

Concept of Juvenile Delinquency

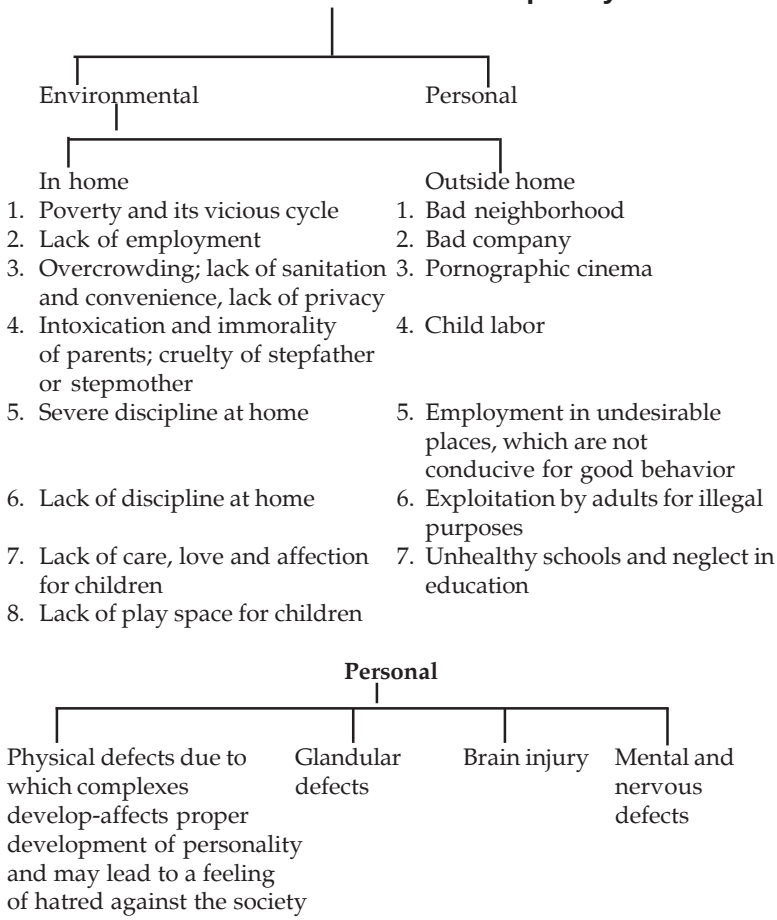
According to Sethna, "*Juvenile delinquency involves wrong doing by a child or young person who is under an age specified by the law of the place concerned.*" According to Robinson, juvenile delinquency is, "*Any behavior which a given community at a given time considers in conflict with its best interest, whether or not the offender has been brought to court.*" Thus, JD is any act of a child which is against the norms and values of a society and which violates the law of the state.

All children, somehow, do something, which is in violation of the norms of the society or the provisions of the law. This is due to their ignorance. It is not with any intent. But sometimes the acts of certain children become so grave that some action is to be taken against them by the state. For example, there are children who are in the habit of stealing, fighting and indulging in violent activities.

Prevention of Juvenile Delinquency

1. Programs for reducing delinquency:
   – Organizing the constructive forces of the community to guide children into desirable patterns of behavior, channelizing their energy and enthusiasm for the benefit of the community and the nation.

Causes of Juvenile Delinquency



- Discovering potentially delinquent children and referring them to appropriate agencies competent to help.
- Wise handling of cases in which children are involved by the police, courts, and correctional institutions.

2. Poverty, slums and leisure time activities:
   - Elimination of slums and poverty may go a long way in improving the conditions of juveniles. Leisure time

activities; development of talents and status-giving activities are essential.

3. Dealing with psychological factors:
   - We must recognize the need for early psychological, psychiatric and sociological diagnosis of children who show sign of serious maladjustments.
4. Giving moral and religious education:
   - A malady of our times is that there is no fear of God and fear of authority. If children are taught in early childhood to fear God and authority, we can prevent much of delinquency among our children. The juvenile delinquents of today are the criminals of tomorrow. So, we should try our best to control and prevent JD so that we can also prevent crimes.

6. PROSTITUTION

Prostitution is considered as one of the oldest profession. It has existed in all communities in some form or the other. There is mention of prostitution in our ancient texts like the Vedas, though as an institution, it was developed probably in the post-vedic period. The institution has grown with civilization; so it can be understood as a necessary evil of civilized life.

Definition

A prostitute may be defined as "An individual (male or female) who for some kind of reward (monetary or otherwise) or for some other form of personal satisfaction and as a part or full time profession, engages in normal or abnormal sexual intercourse with various persons who may be of the same sex or the opposite sex to the prostitute." From this definition, it is clear that prostitute need not be a woman as commonly understood. Anyone who indulges in sexual relations in return for monetary benefits may be termed as prostitute.

Thus, three important constituents of prostitution are:

a. Promiscuous sexual relationship

b. Mercenary basis, whether in cash or in kind, and
c. Lack of affection or personal interest.

CAUSES OF PROSTITUTION

There are many causes that are responsible for the occurrence and perpetuation of the problem of prostitution.

Poverty: 'The foundation of prostitution is hunger'. Several studies have shown that 80 percent of the prostitutes enter into this profession out of sheer economic necessity. It is the tragedy of women who are illiterate, unfortunate and poor.

Religious factor: In several places of India, young girls are dedicated to temples as ***devdasis***. They sing and dance during daytime, but are used as prostitutes and concubines by the influential class of the people.

Child widows: In our country, widow remarriage was strictly prohibited. In states like Bengal, Bihar and Orissa, child marriage was widely practiced and child widow were abundant in number. Once widowed, they were neglected, ill treated or even abandoned. Most of these young widows often become prostitutes.

Broken home and neglect of girls: In many broken homes, father or mother abandons children. Without proper care and guidance many of them turn to prostitution.

Desire for luxury: Many young women are turned towards prostitution today just to lead a life of affluence. The meager salary or income of their parents or husbands cannot by the luxuries they desire and often take up prostitution as a part time activity. Call girls associated with modern hotels are good example of this.

Excessive sexual drive: Some women are hypersexual and crave to fulfill their sexual desire by indulging in prostitution.

Laziness: Prostitution is taken as an easy way to earn money. Women who are lazy by nature may think this as an excellent opportunity to earn.

Growth of modern cities: Modern industrial and urban centers facilitate prostitution in many ways. All the cities have large number of unattached men. Even married men are forced to leave behind their wives because of the problem of housing in cities. This bulk of unattached men are the customers who patronize prostitutes. The anonymity existing in cities facilitate the prostitutes to operate in an unobtrusive way.

Unsatisfactory home and marital life: The unsatisfactory conditions existing in the home often drive women to prostitution. Dissatisfaction in sex life may especially be one reason, which pushes women into prostitution.

Mental deficiency: Certain studies have shown that a large number of sex offenders and prostitutes have poor intelligence. Women of poor intelligence may be easily exploited and misled.

Enticement by antisocial elements: Since prostitution is a lucrative trade, many middlemen may be engaged in luring young women into prostitution. In several cities, brothels employ pimps who bring not only customers but also more women into the profession.

Demand for prostitution: Probably the most important reason for prostitution is its demand itself. Various types of men patronize prostitutes. The unmarried men, old bachelors, widowers, those who are dissatisfied in their marital relations, those who desire for variety, men with excessive and perverted sex urge, all go to prostitutes. If there is no demand for prostitution from men, this profession cannot continue. In other words, men and their demand are mainly responsible for the perpetuation of this trade.

Types of Prostitutes

Prostitutes can be classified into two major groups:

1. The overt group, and
2. The clandestine group.

The overt group includes those who live in brothels. The clandestine prostitutes include a wide variety of women who enter into sex relationships foe mercenary considerations. They may be women employed in several occupations, students, or even married women, who use sex to procure monetary benefits. They usually have a restricted clientele. Modern facilities like posh hotels and telephone network help their operations.

Prevention and Control of Prostitution

The measures to be adopted to fight this vice may be grouped into four:

1. Preventive
2. Prohibitory
3. Prophylaxis
4. Legislation.

1. Preventive Measures

- Facilities for vocational and moral training for women of lower economic stratum should be provided.
- As far as possible, women workers should not be retrenched from jobs.
- Rescue homes, shelter home and other facilities should be provided for the poor and destitute women. Girls who are in moral danger should be put in reformatories or institutions where they can be kept safe from the clutches of anti-social elements. In these institutions facilities for vocational training should be provided, so that girls will be economically independent.
- Males should be taught to respect women folk and not to exploit them sexually.

- Unhealthy social customs like devdasis should be abolished completely.
- There should be sex education at school and college levels. Girls should be taught in their curriculum, the danger of sex exploitation by males.
- Social education and propaganda also are important measures to fight this evil. A healthy public opinion should be created against illicit sex relations.
- Pornographic literature and obscene films should be completely banned.
- The existing legislation against prostitution should be adequately and realistically implemented.

2. Prohibitory Measures

Medical examination of all prostitutes should be conducted frequently. Any woman who is found to be infected, should be segregated immediately, and should not be allowed to receive customers till she is cured. Licensing system of prostitutes will be helpful if the law permits it. This will facilitate to help constant check over them. Medical personnel dealing with prostitutes should be specially trained. Sympathetic, efficient and free care should be provided to the prostitutes, because many of them are very poor and helpless.

Many of the brothels are situated near the market places or industrial area. No prostitution should be allowed in or near the working men's residences, or educational institutions. Employment of women in hotels and similar institutions should be under close supervision.

3. Prophylactic Measures

The prophylactic measures include prevention of communicable diseases and improvement of hygienic conditions. Many of the brothels are dirty and overcrowded. The prostitutes and the customers should be instructed to use protective measures. Males may use condoms and females can use chemical

disinfectives after the exposure. These will prevent the communication of venereal diseases. Young men should be educated to practice celibacy and develop healthy habits of recreation.

4. Legislative Measures

There is a good deal of difference of opinion about the efficacy of legislation in combating a vice like prostitution. Legislation alone may not be effective. Industrialization, growth of unhealthy slums, excess of male population in urban centers, employment of female labor in the factories and workshops in unhealthy social environments, poverty, alcoholism all demand proper attention to prevent the problem of prostitution. The development of a single standard of ethics for men and women, education and economic freedom of movement, widow remarriage, establishment of rescue and destitute homes are all measures to be considered for preventing moral danger to women.

According to law, prostitution as such is not an offence, where both parties to the act are adults and no fraud or force has been used. It is regarded as personal affair beyond laws cognizance. The Indian law concerns itself with prostitution when it offends public decency or its practice amounts to public nuisance.

Rehabilitation of Prostitutes

A very important aspect of prostitution is the rehabilitation of those prostitutes who want to leave their profession. Unless and until society welcomes them back and gives them shelter, security and assurance, we cannot expect these unfortunate women to leave their ways. There should be adequate provision to train them in some other work, educate them and settle especially the younger women. The older women should be assisted through social security schemes and free medical assistance. If prostitutes have children, they should

be cared for by the state; especially female children should be protected, lest they should follow the footsteps of their fallen mothers.

7. ALCOHOLISM

Alcoholism is not only a moral issue or a form of deviant behavior. In fact it is also a deadly and costly disease. The victim of alcoholism needs a systematic treatment from specialist such as psychiatrists, doctors, social workers and family members. These are the people who will help the victim to reconstruct his personality.

A physiotherapist should consider an alcoholic person as a patient who needs treatment and rehabilitation.

What is Alcoholism?

Alcoholism is a condition in which the individual has lost control over his/her intake of alcohol and he/she is unable to refrain from drinking once he/she begins.

Drinkers may be broadly classified into two groups: (i) Moderate drinkers, who consume alcohol moderately, and their drinking habit does not cause much problem; (ii) Problem drinkers.

According to Durfee, "A problem drinker is one if, as a result of drinking, his health is endangered, his peace of mind affected, his home life made unhappy, his business jeopardized and his reputation clouded and drinking has become his routine."

Richard Waskim says, "An alcoholic is a compulsive drinker". Further, "An alcoholic is an excessive drinker whose dependence upon alcohol has reached such a degree that it results in a noticeable mental disturbance or an interference with his bodily and mental health, his interpersonal relations and his smooth social and economic or one who shows the early signs of such developments." Thus, an alcoholic is a different person from an "occasional" or "social" drinker.

Characteristics of Alcoholism

Broadly speaking, following four characteristics are identified:

1. Excessive intake of alcoholic beverages.
2. Individuals increasing worry over his drinking
3. Loss of drinker's control over his own drinking, and
4. The disturbance in his functioning, in his social world.

The Process of Becoming Alcoholic

A drinker or an alcoholic person is not born. It is one's socio-cultural milieu, which led one to initiate the act of drinking. It is a process that has following stages:

a. *Pre-alcoholic symptomatic phase*: In this phase an individual starts drinking to reduce tension and solve his personal problem.

b. *Prodigal phase*: In this phase along with the increase in the frequency of drinking, there is increase in the quantity of drink too. However, there is a 'guilt feeling'.

c. *Crucial phase*: In this phase drinker' s habit of drinking becomes conspicuous. He, however, develops rationalization to face social pressure and to assure him that he has not lost control over himself. Nevertheless, his physical and social deterioration becomes obvious to every one.

d. *Chronic phase*: During this phase the alcoholic starts drinking even in the morning. He faces prolonged intoxication, impaired thinking, indefinable fears, tremors and loss of skills. He always thinks of drinking and feels restless without alcohol.

Causes of Alcoholism

One thing should be clear that all those, who drink, 90 percent are not alcoholic. Some become alcoholic because of any one or cluster of following reasons:

1. Environmental pressures—Social, cultural, etc.

2. Peer pressure
3. Authoritarianism
4. A dominant sub-culture
5. Over-rejection—Emotional pressure
6. Success workship

The current approach to handle the problem of alcoholism is to understand the problem in terms of character and motivation. An alcoholic is seen as a sick person. His/her personality is a victim of self-destruction. Hence he/she needs proper treatment rather than condemnation and blame.

Suggestions for Controlling and Eradicating the Problem

1. Alcoholism is generally found more among the industrial workers, agricultural laborers, and also among those who are employed in strenuous manual occupations. This is more so in India. The working conditions are to be improved, if the problem is to be eradicated.
2. Mass education through various means of communication about the evils of drinking. Public lectures, film show, songs, radios, television, all methods should be adopted to convince the people.
3. Recreational facilities should be provided. Healthy recreation will divert the minds of people and keep them away from the habits of drinking.
4. Brothels should be away from the residence of industrial workers. It is said that wine and women usually go together.
5. Housing facilities be provided for the workers, either by the management or by the government, so that workers can bring their families to the cities where men work. Family living might be helpful to keep people away from evil habits.
6. High officials in administration should not indulge in drinking. Anyone in responsible position if found drunk, should be seriously dealt with, because, the senior

responsible people should set an example before others. Here, it may be mentioned that a study abroad showed that "the higher the education one has, the stronger the possibility of one's being a habitual drinker or consumer of more alcoholic beverages than the one with lower education."

7. The practice of serving drinks in parties should be banned.
8. Women should undertake anti-drinking movements, because, women are the worst sufferers if the men-folk drink and behave irresponsibly.
9. Early detection and treatment of addicts: In several cities, now de-addiction services are available. Parents, spouses or other close relatives should take the addict to such places and help to get treatment. It is their responsibility to rehabilitate the addict and help him to get re-adjusted in life. Without family support, this cannot be achieved.
10. The central and state government, as well as local self-government together with private agencies should see that stopping the production, sale and consumption of alcohol in any form imposes complete prohibition. The economic loss caused by this due to the loss of revenue should be gained through some other means. It will be a vicious circle if we say that we cannot impose prohibition, as we will lose revenue through excise duty or license fees. The constitutional provision of implementing prohibition throughout India should be put into real effect.

Chapter 6

Social Change

By social change we mean the change in the size, composition and organization of society and the resultant change in the inter-relationships between individuals and groups.

Two aspects of social change are: (a) change in the social structure itself, bringing about changes in the pattern of social relationships and (b) changes in the attitudes or motivation or changes in the value themselves. Social changes may be understood as the changes in social relationships. Social relationships include social interaction, social patterns and social processes.

FACTORS OF SOCIAL CHANGE

Robert Bierstendt has listed the following factors of social change:

- Geographical
- Demographical
- Biological
- Technological
- Economical
- Ideological
- Political and military
- The role of great men

Education, social movements, social legislations, psychological factors, cultural factors, also brings about social change. Fear is also perhaps one of the important factors of social change.

GEOGRAPHICAL OR PHYSICAL FACTORS

Geographical factors comprise all the inorganic (non-living) phenomena that exert an influence on human life. Natural events like floods, drought, earthquake, climate changes, exhaustion of natural resources, changes in the course of rivers, excessive soil erosion, etc. lead to demographic changes and changes in trade routes.

BIOLOGICAL FACTORS

The plants and animals in an area constitute the biological factors that influence the lives of human beings in that area. Man utilizes the available flora and fauna, in ways determined by his culture and keeps off from poisonous plants, bacteria, insects, pests and dangerous creatures.

Biological processes determine the number, the compositions, the selection and the hereditary qualities of succeeding generations. Social attitudes and interests may themselves influence these processes, as the latter control sex relations, inter-racial, inter-religious and intercaste marriages, the size of the family, etc. Social behavior of various kinds induces biological changes. Some social conventions such as taboos on intercaste or religious marriages, child marriages, etc. tend to adversely affect the quality of offspring. Race is an important biological factor.

DEMOGRAPHICAL FACTORS

The size of a population is an important factor. Very small societies seldom rise to positions of historical imminence. Very large ones exert influences not only upon their neighbors but

also upon the course of history. An expanding population in any country brings many changes in the nation's economy and a contracting population has contrary effects. In short we can say that the demographical variables—fertility, mortality and migration affect the social order and the social order in turn affects the demographic variables. The effectiveness of medical care has improved through out the world and this has shown an impact on demography. Better surgical procedures and potent drugs have lowered the mortality rates around the world.

POLITICAL AND MILITARY FACTORS

The ushering in of democracy, communism or socialism, brings about innumerable changes in the society. For example, democracy establishes political, economic and social equality. In a democracy every individual has the right to express his thoughts, form associations and indulge in all constitutionally permissible activities. It creates a government *for the people, by the people, and of the people.* Democracy aims at providing equal opportunities for all.

TECHNOLOGICAL FACTORS

The process of industrialization alters the structure of society and the behavior patterns of its members. Specializations, mass production and integrated organization govern both industry and business. Modern technology in instituting large-scale industries has accelerated the process of urbanization and has already changed, and is also changing the whole socio-cultural life of human beings. Capitalism has brought about changes in the property system and in the division of labor and has given rise to new social strata and classes. Technology has also brought about unemployment due to displacement of labor. Ogburn mentions that the introduction of self-starter in the class has revolutionized the lives of many women.

ECONOMIC FACTORS

In economic interpretation of social changes, the name of Karl Mary is associated. Karl Marks asserted that economic conditions and economically-oriented actions constituted the base of the social structure and profoundly influenced all other aspects of human society. It is the relations of production, which constitute the economic structure of society and the real foundations for the legal and political superstructures. Marx stressed that the economic conditions and techniques of production, have a great influence on all human activities and social institutions. The accumulation of capital by organization of labor, labor relations, etc. have brought about socialistic measures to alleviate hardships of labor and sharing of benefits of enterprise in various forms.

IDEOLOGICAL FACTORS

Ideologies are ideas that people in a given society value and respect. Thus ideologies are powerful motivational forces in social change. What people think, what they do and what they want etc are concerned with prevailing ideologies. For example, the capitalist or communist ideology may initiate corresponding social changes, among their adherents.

THE ROLE OF GREAT MEN

The great social reformers of India worked hard to bring about a new social order. Mahatma Gandhi, Raja Ram Mohan Roy, Iswarchandra Vidyasagar, Swami Dayanand Saraswati and host of other social reformers have brought about changes in our society, such as removal of untouchability, equal rights for women, removal of sati custom, etc.

EDUCATION AND LEARNING AS SOURCES OF CHANGE

Education is perhaps one of the most important factors in bringing about social change. Through education knowledge

is gained and awareness is created. Studies on community development help to change the community and realize the potentials of community organizations with technical knowledge of how it may be brought about, such as, through childcare, nutrition, and health education, etc. Nutrition, health, population, family life, sex, and extension studies could bring about the desired social changes among people.

SOCIAL LEGISLATIONS AND SOCIAL CHANGE

The law or social legislation brings about social change by creating norms and sanctions. For example, the Sati Prohibitions Act, the Widow Remarriage Act, the Untouchability Offences Act. Acts allowing intercaste and inter-religious marriages, divorce, adoption, equal share for women in property, etc. were instrumental in bringing about social change.

SOCIAL MOVEMENTS AND SOCIAL CHANGE

Social movements have occurred throughout history, but the significant and far reaching changes in the social order of the world have taken place during the eighteenth, nineteenth and twentieth centuries, as products of social movements. The French Revolution, the Russian Revolution and American Revolution transformed the then prevailing social orders.

Women's movements, student's movements, peasant and tribal movements, labor movements, nationalist movements, social reform movements and a wide variety of resistance or counter-resistance movements are the order of the day. And these movements have directly or indirectly affected the social order and the life of the people.

Likewise professional organizations have started functioning as pressure groups and thereby bring about changes in many aspects of our lives. Medical and paramedical associations have also gained a lot as a result of their organized professional movements.

FEAR AS A CAUSE OF CHANGE

It is possible that the fear of a nuclear war caused leading world powers to come together and co-operate in the control of these weapons and the use of atomic power for peaceful purposes. The danger arising from the uncontrolled use of drugs and narcotics have forced world powers to make concentrated efforts to control them.

The fear of dire consequences of unprecedented population explosion has compelled many countries to adopt family planning as a state policy and take steps to control population growth.

OBSTACLES TO SOCIAL CHANGE

Anderson and Parker state that the social change does not come in a society without resistance. There are many forces tending to block the acceptance. Those obstacles are:

- Inertia
- Habit
- Suspicion
- Tradition
- Vested interests
- Lack of knowledge

These factors opposing social change are all closely inter-related. Inertia may grow out of habits, while traditions are found on habits and lack of knowledge supports inertia. Vested interests also support these. In some cases each of these forces may be the major obstacle to social change. In most cases, they combine to form a complex of opposition, which multiplies the effects of the each separate force.

PLANNED SOCIAL CHANGE

In the second half of the twentieth century, especially after the Second World War, many countries in Asia, Africa and Latin America achieved political independence. The main

concern of these independent states was to achieve the welfare of their citizens. Government resorted to various types of planning for development. Planning is a conscious attempt to achieve a given goal. Planning implies that society at large is not satisfied with status quo and desires for improvement in quality of life for all. At the national level, the government taking into consideration of its resources fixes its priorities and allocates funds accordingly. Thus, planning means a consciously designed advancement towards a new social and economic order.

To supplement national planning, regional planning and planning at the grass root level and family level, is also encouraged through family welfare schemes, rural development, village and cottage industries schemes, etc.

Chapter 7

Social Work

MEANING OF SOCIAL WORK

Social work is a term used to describe a variety of organized methods of helping people in some need, which they cannot meet unaided.

In the 19th century it was developed as an organized method in UK and USA to help the poor people for their material and spiritual welfare. Later it was extended to the promotion of health as well as mental and emotional well being. These days social work has become a professionalized activity. Since the later part of the 20th century, there are several universities offering specialized advanced courses in social work.

METHODS OF SOCIAL WORK

Social work methods fall into three main categories:

1. Social casework: Which is concerned with individuals and their families.
2. Social group work: In which associations with others is the primary therapeutic agent, and
3. Community work: In which the focus is on the development and utilization of neighborhood and community resources.

ROLE OF A MEDICAL SOCIAL WORKER

The role a medical social worker (MSW) has been increasingly receiving significant attention in medical profession in India since last three decades. In most of the large cities, MSWs are being appointed in hospitals, public health centers etc. They are also engaged in community health programs. Recently, some of the industrial firms have also started creating positions of social workers in their establishments.

Although most of the MSWs are employed in the hospitals run by state government, central government and municipal corporations. But psychiatrists and physicians also employ some MSWs.

Following are the major areas of role of a MSW:

1. *Securing material help for patient:* MSW in hospitals help patient and his or her family in procuring expensive medicines and treatment facilities. To the hospital this turn out to be the most useful service as it ensured money and other material help necessary for proper treatment.
2. *Casework service:* Usually people display certain social and emotional reactions to their disease. Some are able to cope with it unaided, but there are others who need help and guidance in meeting their social and emotional difficulties. MSW provides this service considering the each case separately. MSWs establish professional relationships with the patient and help the patient at the time of diagnosis and treatment.
3. *Discharge of patients:* The MSW follows up the case even after discharge and helps patient by catering to physical, emotional and economic needs. With the rise of modern complex society-based on industrial urban set up such a role of MSW is becoming increasingly significant. This is happening due to the fact that traditional support systems such as joint family, caste, etc. are fast declining in this respect.

4. *Group work service:* The MSW serves the patients by conducting recreational, educational and therapeutic group activities in the wards and hospitals. At time they take up such activities for physically or mentally handicapped persons also.
5. *Community planning for health and happiness:* The MSW's role is equally significant in planning for community health in urban and rural areas both.

   They also work as motivators in community health programs such as vaccination drive, family planning programs, creating awareness about health and hygiene, etc.

Thus, the MSW's role is intrinsically integrated with the prevention, diagnosis, treatment and rehabilitation aspects of health care of patients. MSW's immediate task is to help patients and families through casework, group work and consultation. To keep pace with new knowledge in medical science, medical social worker must also gain new knowledge to meet the needs of people.

To sum up, the role of medical social worker includes following:

a. To stimulate socialization: Among patients through casework and group work, etc.
b. To provide emotional support encouragement to the patients through sharing of experience with them as to help the later in managing their disease or disability.
c. To motivate patients to follow medical recommendations and their exercise program.
d. To participate in education, training and orientation program of the hospital.
e. To participate in community planning as related to the interests of the hospital.
f. To participate in planning and development of services within the hospital.

Chapter 8

Culture and Health

CONCEPT OF CULTURE

In simple words culture is that part of human environment which has been created by men in the process of living together. E.B. Taylor says, " Culture is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society."

Ogburn classifies cultural items into two categories:

1. Material aspects of culture such as tools, equipment, arms etc.
2. Non-material aspects such as values, beliefs, customs, norms and law etc.

Characteristic of Culture

1. Men create it, it is not genetically transmitted.
2. Culture can be learnt through the processes of socialization and education.
3. Culture is explicit and implicit design of living.
4. It sets standards of behavior carrying legitimacy.
5. It goes on advancing from simpler form to complex form.
6. Culture shapes human behavior and molds personality.
7. Material aspects of culture changes with a faster pace than the non-material aspects.

Culture and Behavior

Cultural elements are so pervasive in human society that no human behavior is free from its influence. What we are, in terms of our acting, thinking and feeling, we are product of our culture.

It regulates our behavior by prescribing standards through the values and norms. Thus culture

i. prescribes certain patterns of behavior,
ii. prohibits certain other patterns of behavior, and
iii. sets standards of permissiveness or tolerance.

Men gets potentialities through heredity, but these potentialities in real sense grow only in appropriate cultural milieu.

Our biological needs are also regulated and served through the prescriptions provided by the culture.

Sheer biological explanation shall hardly serve any purpose in understanding human behavior. Human behavior can be explained only with the help of its cultural context. The culture has so profound influence on human behavior that even societies and nations are characterized by the culture(s), which they have inherited from their predecessors.

Cultural Meaning of Sickness

In every society sickness is explained in the context of shared understanding. In the primitive societies and even in modern complex industrial societies disease, sickness and all other human sufferings are ultimately tried to be understood in the context of supernatural power and evil spirits, etc. Thus, in every society we find traditional healers including the modern industrial and high tech societies.

Culturally, a sick person is one who is unfit to carry out the roles which are assigned as per the cultural values and social norm. The recognition in this sense relieves him from normal expectations by others as long as one is sick. Moreover,

the person is looked after by the social support system such as family, neighborhood, health care institutions, community, and state, etc.

As the fact of birth and death is explained in cultural context, so is about the sickness in every society. With the advancement of science and technology the concept of disease, sickness and measures of treatment are also fast changing. The evolution of medicine and surgical treatment has passed through the phases of growth of scientific knowledge.

Now, there is increasing awareness about empirical causes of sickness rather than supernatural ones due to change in cultural perception of sickness.

Culture and Health Disorders

The WHO defines health as follows: "Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity."

1. The well being of a member of any society is also culturally determined. Those members who are relegated to lower rung of society often live under the conditions of total subjugation and deprivation. Their health problems are hardly given the attention that they deserve. As a result thereof, the poorer people are forced to live amidst sufferings and health disorders.
2. The belief in supernatural power and evil spirit work as cultural impediment in motivating people to adopt healthy practices and life-style. Such a situation aggravates the problem of health disorders.
3. Cultural practices relating to maternity and childcare often ignore the requirement of cleanliness, nutrition and standards of health, etc. As a consequence of such practices, the problem of infant mortality becomes acute due to higher vulnerability of infants to the ailment such as diarrhea, malnutrition, etc. The mothers are also

subjected to several such elements, especially among the socio-economically poor classes.

4. Rapid social change leads to the problems of maladjustment causing mental stress and cardiac ailments. The societies that are highly-urbanized also suffer from health disorders of these types.
5. Environmental pollution due to heavy industrialization and technological advancements has led to acute degradation of human conditions of a decent living. This has given birth to several health hazards that adversely affecting the community health as well as the health of individuals. In a recent WHO report it has been pointed out that due to the environmental degradation during the last 20 years more than 30 new diseases have surfaced.
6. Cultural stigma towards certain communicable diseases such as leprosy, sexually transmitted diseases such as AIDS and tuberculosis etc provides for perpetuation of health disorders. This is true in the case of mental illness as well. The fear of social rejection by one's own people often result into refusal to go for proper treatment and care.

The cultural environment works as factors fostering health disorders under specific circumstances. These can be made ineffective only through effective education, community awareness and adequate institutional arrangements involving people's participation and health care programs.

Chapter 9

Social Groups

Social groups are universal. All societies in the world have some type of groups. Men and women are born and brought up in groups and they spend their life in them. Man can fulfill his biological, physical and emotional needs only by being in groups.

DEFINITION OF GROUP

According to McIver and Page, group is, "Any collection of social beings who enter into distinctive social relationships with one another."

According to Ogburn and Nimkoff, "Whenever two or more individuals come together and influence, they may said to constitute a social group."

CHARACTERISTICS OF SOCIAL GROUPS

Important characteristics of social groups are:

1. *Identifiability*: Every group is different from every other group, or we may say that there are certain distinguishing features of all groups. A family is different from a club or trade union.
2. *Social structure*: Groups has definite social structure. Structure means pattern of relationships. The inter-

personal relationship inside a group is well-fixed. The family has husband-wife, parent-child, and brother-sister relationships.

3. *Individual roles*: In every group, every member is assigned some role to play. In a family, father has to play a definite role, and mother has to some other role. There is close relationship between role and status of members.
4. *Reciprocity*: Reciprocal relationships are important in groups. There is give and take relationship between members.
5. *Norms of behavior*: Every group has certain norms or expected behavior pattern for every individual member. Members know what is expected of them for the good of all members and the group as a whole.
6. *Common interests and values*: Because of common living or close interaction between members, they develop some common values. Many groups are formed due to common interests.
7. *Goal or goals*: All groups have certain goals, aims and purposes. The family has certain basic purposes such as love and affection, sex, procreation and upbringing of children.
8. *Relative permanancy*: Most of social groups last at least for sometime. Many groups are more or less permanent and may continue even when the members constituting them die and vanish. Of course, some groups are permanent (e.g., family) and some other temporary (e.g., an audience).

Social groups are formed when the following conditions are fulfilled:

1. Two or more individuals get together at a place.
2. Interactions develop among these people.
3. These individuals come to certain understanding among themselves due to common goals and interests.
4. There is mutual awareness among members.

5. Because of interactions, a definite structure of the group is formed.

Why Groups are Formed?

One who lives in a group feels that he is a part of something larger than himself, and that he is involved in a whole, which often acts quite independently of the individual's private wishes. Yet, we cannot forget the fact that individuals form groups. Neither the individual nor the group alone is an adequate exhibit of all aspects of social life. In the process of socialization, the individuals are taught the values of group living. The customs, traditions, habits, beliefs, folkways, mores and ideals of the group are oriented and aim at maintaining and improving group life. Right in the family group, individual is taught the basic lessons of group living, mutual co-operation and co-ordination. Later, the individual becomes member of many other groups.

Essential Conditions for the Formation of Social Groups

There are several conditions that are essential for the formation of social groups. Some of them are mentioned below:

1. *Social relations:* Without people establishing contacts and relationships with each other, social groups cannot be formed. Social interaction is thus essential for a group.
2. *Common aims:* There should be similarity of aims for the formation of a group.
3. *Ability to influence each other:* This comes as a result of interaction of inter-relationship. Interaction or inter-relationship involves mutual influence. As soon as a teacher enters the class, the students stand up, and as he starts teaching, the students open their notebooks and start writing.
4. *Physical presence:* In order to form a social group, people should be present physically.

FUNCTIONS OF A SOCIAL GROUP

While there are communities and societies that are relatively of large size, small groups are formed by people in order to fulfill certain basic social needs. They may be summarized as follows:

1. To ensure the continuity of society. The family group is actually entrusted with this essential function.
2. To maintain and perpetuate culture—one group of people maintains culture and transmits it to the coming generation.
3. Groups enhance the progress of culture and civilization.
4. Groups promote 'we' feeling.
5. Groups function as important units of human social system.

PRIMARY AND SECONDARY GROUPS

Charles H Cooley, classified groups into two, namely;

1. Primary group.
2. Secondary group.

Primary Group

Cooley defined primary group as: " By primary group, I mean those characterized by intimate face to face association and co-operation. They are primary in several senses, but chiefly in that they are fundamental in forming the social nature and ideals of individual."

According to Lundberg and others, primary group means—"Two or more persons behaving in relation to each other in a way that is intimate, cohesive and personal."

Examples of primary groups:

1. The family.
2. Play group of children.
3. Neighborhood.
4. Small village community.
5. Work team.

Characteristics of Primary Groups

The characteristics may be classified into two:

1. Physical conditions, and
2. Internal characteristics

Physical Conditions

The physical conditions of primary group are:

1. *Physical proximity*: The members of a primary group should be found in close proximity. This is required in order to develop intimate relationships.
2. *Small size of the group*: A primary group has to be a small one, say 50 to 60 people at the most. Intimate interaction is possible only when the group is small.
3. *Durable relationship*: The relationship in the primary group has to exist for a long time. For example, family relationship is life long.

Internal Characteristics

They are:

1. *Identity of ends*: In a primary group, the aims, objectives and ambitions of the members are identical to a great extent. Every one is interested in the intimate well-being of others in the group.
2. *The relationship is an end in itself*. The relationship is not for attaining any particular end but it is only for the sake of relationship. If the relationship is established to achieve certain personal purposes, it cannot be termed as a primary relationship. For example, if a person marries in order to get a huge dowry, the marital relationship cannot be termed as primary.
3. *The relationship is personal*. For example, the parent-child relationship, the husband-wife relationship, etc are quite personal. All others know the ideals, desires, ambitions, likes and dislikes, weaknesses, and strong points of a member.

4. *Primary group relationship is spontaneous*. Such relationship is not made but it develops spontaneously without effort from the side of the any person. A person enters into a primary group relationship out of his own free will and according to his innermost wishes.
5. *Relationship possesses power to control the individual*. The control in the primary group is not due to external pressure but it is voluntary. A person may be willing to please another or even undergo hardship and adverse conditions out of free will. A mother or father may sacrifice her/his comforts and interests for the sake of the child. In extreme cases, a person is even willing to sacrifice his life for the sake of others in the primary group.

Functions of Primary Groups

Primary groups fulfill very vital functions for the members of the society. Some of these functions are given below:

1. Individuals are born and brought up in primary groups.
2. Socialization of the individual takes place in the primary group.
3. Primary groups are responsible for maintaining social order. In fact, social organization depends upon the members of the primary groups.
4. All-important functions of the society such as reproduction, sex satisfaction, emotional security, and social control are fulfilled in primary groups.
5. Primary groups teach individuals high ideals like freedom, loyalty, love, sacrifice, patriotism and justice, etc.

SECONDARY GROUP

Definition

According to Lundberg and others, secondary group means—"Two or more persons behaving toward each other in a way

that is impersonal, concerned with specialized interests and guided by consideration of efficiency."

Most of the social groups we see in contemporary world are secondary groups, e.g., trade unions, political parties, clubs, occupational associations, etc.

Characteristics of Secondary Groups

1. *Large size:* Most of the secondary groups are large in size. The membership of some of the secondary groups might be in lakhs or even crores.
2. *Spatial distance:* Members of the secondary group are dispersed and may not even meet each other personally.
3. *Duration of relationship may be short:* Secondary group relationship may not be long lasting. Some of the secondary groups like audience or crowd may last only for a short while, whereas some others like a nation or an association may last longer than the individual.
4. *Disparity in ends:* In secondary groups, members have different types of goals. Because of lack of close inter-personal relationship, the goals of one person may not be even known to others.
5. *Extrinsic valuation of relations:* The relationship is valued only for the gain out of it. When there is no utility out of a relationship, it is unusually discontinued.
6. *Extrinsic valuation of other persons:* The other persons are evaluated not as individual person but in relation to the function he is performing. For example, a teacher is evaluated as to how well he can teach. All his other personal qualities are often forgotten.
7. *Specialized and limited knowledge regarding the other persons:* In secondary groups, people have very limited knowledge regarding the other persons. Usually, a person is known only as a functionary, e.g. shopkeeper, driver, newspaper vendor and vegetable dealer, etc. Even the name of the other person may not be known.

8. *Secondary groups are usually formed for certain definite purposes:* The group may even get dissolved once the purpose is served.
9. *The relationship is formal and superficial*. There is no depth in secondary group relationship.
10. *The control in secondary group is formal,* and through external forces. Rules, regulations, byelaws, legislation, constitution, etc. form the courts of behavior in secondary group.

In short, we may say that the secondary groups are just the opposite of the primary groups. They are increasing in number day-by-day because of the increased means of transportation and communication, urbanization and increase in population. The modern man prefers superficial contacts of give and take nature. Persons and relationships are often discarded as soon as their purposes are served.

IN-GROUPS AND OUT-GROUPS

Sumner has classified groups as, in-groups and out-groups. An in-group is any group or social category to which a person feels he or she belongs—family, people of the same age group, students of a class, workers in a factory, etc. Out-group is any group or social category to which a person feels he or she does not belong—other families, people of the other castes, people of other religions. Out-groups include both people an individual rejects or ignores and those who reject or ignore that individual.

People feel comfortable and secure with member of their in-groups because they know they certain experiences and beliefs. 'We go to church every sunday.' 'My school is the best in the city.' Those statements denote the feeling of being a member of an in-group.

Often people are hostile towards out-groups. Lack of contact with other group can lead to misunderstanding and suspicion. Hence members of an in-group assume that they would feel uncomfortable with members of out-groups.

Strangeness and ignorance of other people's ways set the stage for the prejudice, avoidance, hostility, and out right aggression. Negative impressions harden into stereotypes; the in-group is glorified, the out-group, dehumanized. Intense competition and frustration also promote hostility toward out-groups and the formation of negative stereotypes. The same forces that create solidarity within a group create hostilities between groups.

The relation of comradeship and peace in the we-group and that of hostility and war toward other-groups are corelative to each other. Loyalty to the group, sacrifice for it, hatred and contempt for outsiders, brotherhood within, war likeness without all grow together, products of the same situation.

According to Federico, " What sumner meant is that when an individual develops the sense of belonging with one group of people, he automatically begins to feel he does not belong with others. There is no "we" without a corresponding "they", in-groups and out-groups are two sides of the same coin."

Chapter 10

Rural Community

Human society has mainly two communities, namely, rural community and urban community. Rural community or the village pre-existed the urban community or the city. The first collective life was in the village, with a sense of *'we'* feeling, and co-operation. Agriculture is said to be the starting point of the human civilization, as it helped man to have a settled life, in a village. Prior to that, man had nomadic life, as people engaged in hunting or food gathering and tending to the sheep and cattle (pastoral life). Thus village life is the first significant stage in the life of man to have group life.

DEFINITION OF VILLAGE

According to Merril and Elridge, " The rural community comprises of the constellation of institutions and persons grouped about a small center and sharing common primary interest."

According to AR Desai, " The village is unit of rural society. It is the theatre wherein the quantum of rural life unfolds itself and function."

From these definitions, it is clear that village is an agricultural settlement, and it comprises of the institutions and interactions of the rural people.

FEATURES OF THE RURAL COMMUNITY

The following are the important features of the rural community:

1. *Agricultural occupation*: The main occupation of the rural community is agriculture, and allied activities like animal husbandry, poultry, and small enterprises like bee keeping, and fishing.
2. *Natural environment*: All the villages have natural set up. Animals, birds, river, ponds, and all other natural things are found in the village. There is a saying that village is made by God or Nature. This natural atmosphere enables the rural people to have simple and natural life-style too.
3. *Small size of the community*: The village communities are small in size. There may be a few households or small number of people. Of course, in Indian villages, we have hundreds or thousands of families.
4. *Low-density of people*: As the villages have large areas of land for cultivation, the number of inhabitants is surely small. However, in our Indian village, the particular habitat has overcrowding, while land around is spacious. Therefore, if one considers the density of the real habitat of the village, it is high; many families live huddled up; in fact, there is no road even to have convenient transportation.
5. *Homogeneity*: The village life has much homogeneity. People of a village have a common occupation, and common life-style. For example, if a person goes to the village to meet someone, he should go early morning or in the evening, as the villagers will be in the field during the day. The people of a village share the same customs, traditions, and values. However, it must be understood that in an Indian village of different castes and tribes, there may be some variation in the style of life of the people. Complete similarity is not possible.

6. *Low-mobility*: Mobility means movement or transition of people from one place to another, or from one social status to another. That is, there are physical as well as social mobility. Both are limited in the villages, especially in the Indian villages. This is so, because, means of transportation and communication are limited in villages, and due to this, there is isolation of village communities. Social status cannot be changed easily because of the caste system, according to which status is hereditary. Economic class mobility is also not much in rural communities, especially of Indian type.
7. *Less social differentiation and stratification*: Universally, this is true, but due to stratification based on caste system, in our Indian villages, there is much differentiation.
8. *Primary group relation*: The rural communities, especially of smaller types, have primary group relationship. The village is like a large family. Every one is known personally and the members of the community have family or family like relations.

HEALTH HAZARDS OF RURALTIES

The high rate of morbidity and death rates in rural India result on account of following reasons:

1. Lack of awareness about cleanliness and hygienic conditions including lack of clean potable water.
2. Ignorance and illiteracy.
3. Traditional and customary practices.
4. Belief in supernatural power and evil spirits.
5. Poverty and lack of proper nutrition.
6. Lack of modern medical facilities.
7. Widespread apathy towards proper treatment.

Chapter 11

Urban Community

The city or the urban community came into being after the development of villages. There were cities in ancient times also, but most of them were of importance due to religion (pilgrimage), political (capital), or trade and commerce. Thus there were cities in ancient Egypt, Rome, Greece, India and Mexico. But the modern cities are mostly of industrial importance that is why; the growth of modern cities is due to industrialization.

DEFINITION OF CITY

According to WB Munro, "A city is a large body of people possessing striking characteristics, massed in a small area, chartered as municipal corporation, having its own local government, carrying on various economic enterprises and busily engaged in trying to solve the multifarious problems which its own crowded life puts on it."

According to Howard Woolston, "A city is a limited geographical area, inhabited by a large and closely settled population, having many common interests, and institutions, under a local government, authorized by the state."

A city is a permanent settlement of relatively large, dense and heterogeneous individuals. Thus, we find that city or

urban community has a limited area, a local government, and certain striking traits quite different from the rural community.

According to Census of India a town or urban settlement is one that has:

1. a population of not less than 5000 persons;
2. density of not less than 1000 persons per square mile or 400 persons per square kilometer;
3. at least three-fourth of male workers are in pursuit of jobs outside agriculture and
4. possessions of few pronounced urban characteristics and amenities;
5. all such areas which have municipalities, cantonments, notified areas and other places enjoying recognition from the state administration as town or city.

FEATURES OF URBAN COMMUNITY

Following are the important characteristics of urban community:

1. *Non-agricultural occupations*: The urban man is engaged in a large number of diverse occupations such as industry, trade, commerce, transportation and communication, education, government and recreation. There are hundreds and thousands of occupations for the city dwellers.
2. *Artificial environment*: The city and its environment is made by man, and so, it is quite artificial. The factories, shops, modern roads, railways, buildings, and many other things are created by men.
3. *Large community*: Cities are very large communities, and their population may be in lakhs, or crores. In a small area, very large number of people reside.
4. *High density of population*: The density of population is really very high. There is much overcrowding and congestion. Therefore, slums are also created. Due to

such a situation, the health of urbanites is also not satisfactory.

5. *Heterogeneity of population*: There is no similarity in the life of urban people. There is diversity in the fields of occupation, language, religion, and the total culture.
6. *High social differences and stratification*: The diversity in various aspects of life, and variation in the status of individuals and groups in the city community are striking. For example, while majority of the people in an Indian metropolis may be poor, there are many of the middle class and few of the upper class. Similarly, there are illiterates, semi-educated and highly-educated people in an Indian city. The life-style of the people also varies according to religion, occupation, and other socioeconomic status.
7. *Much social mobility*: The city is a place where social mobility is very easy and quick. People achieve their status and status is not ascribed to them. The urban man can rise or lower his status to a remarkable degree during his lifetime and the competition for status becomes a perpetual pre-occupation. City is a place where social climbing is more prevalent. The exercise of talent, the achievement of education, the accumulation and display of wealth—these are avenues to a high position in all the different spheres of urban life. The freedom and availability of opportunities in the city facilitate social mobility especially of the people of lower strata.
8. *Impersonal interactions*: The city is a place of secondary relations. By virtue its size, the city cannot be a primary group. It must instead be a secondary group; people must associate constantly and at close quarters with strangers. Even friends and acquaintances are likely to be known only in a particular context, in a particular segment of life. It is parts of person's not whole persons that are known.

HEALTH HAZARDS OF URBANITES

1. Congested living and unhygienic housing.
2. Industrial, transport and environmental pollution.
3. Slums surrounded by dirt, filth and poor sanitation.
4. High cost of medical facilities.
5. Alcoholism, prostitution and drug addiction, etc.
6. Stress related mental problems such as depression, anxiety neurosis, etc.
7. Lack of physical activities and hence, constipation and obesity usually develops.
8. Loneliness for aged people because of other family members are working or studying and hence elderly people become more prone to sickness.

Chapter 12

The Family

Family is a known as a primary group, social institution, and basic unit of the society; and a key association of the human society. There is no society in the world where family is not found—primitive society, rural society and the urban society. The family fulfills basic needs of the society. Family is the cradle of socialization of the child. It is here where the child learns the health habits.

DEFINITION OF THE FAMILY

According to ME Jones, "Family is the social institution based on the fact of sex which has for its function, the production and nurture of children."

McIver and Page have defined family as "A group defined by a sex relationship sufficiently precise and enduring to provide for the procreation and upbringing of children." Sex satisfaction, procreation and upbringing of children are the important functions of family as a primary group.

CHARACTERISTICS OF THE FAMILY

Some important characteristics are:

1. There is mating relationship between the husband and wife in a family, which results in procreation of children.

2. There is a form of marriage in the family such as monogamy, polygyny and polyandry.
3. There is also a system of nomenclature in the family, such as father, mother, brother, sister, uncle, aunt, etc. The system of nomenclature in the family involves also a mode of reckoning descent. The children take the family name of either father or mother, and usually, the transfer of property also follows the pattern of nomenclature.
4. In the family there is economic provision too, so that the economic needs of the family members such as food, clothing and housing are met.
5. A common home or household is also a characteristic of the family.
6. There is close interaction between members of the family. Interpersonal relationship is the keynote of the any family.
7. The maintenance of a culture is also a characteristic of the family. The merging of cultural patterns transmitted from the two sides of the family in interaction with outside cultural influence creates the distinctive cultural patterns of every new family.
8. Family has certain important functions as well as status. Functions relating to sex, procreation and upbringing of children are very important. Family is one of the status-giving agents of the society.

In a family in India certain striking features are noted below:

a. There are different types and forms of family and marriage in India such as nuclear family, joint family, monogamy, polygyny, polyandry etc. While majority of the society has monogamous family, there is prevalence of polygyny among some tribes like Bhils and Nagas. It is also found among some Muslims and Hindus. There is polyandry among some people of the Himalayan hilly areas and the Todas of Nilgiris. While majority of the families is nuclear, there are joint families in villages and even in cities.

b. The traditional family in India especially the joint family is changing its structure as well as functions.
c. Rules of endogamy and exogamy are practiced. Yet, intercaste, inter-religious and inter-community unions are taking place in India facilitated by certain factors such as education, urban life, social legislation and government programs.
d. Family planning and family welfare measures are being adopted by Indian families are more and more, especially among the educated people.
e. Marriage still has its religious significance to most people in India, e.g., Hindus, Christians and Jains.
f. Child marriage are still prevalent in villages, especially in North and Central parts like Madhya Pradesh, Uttar Pradesh, Rajasthan, Bihar and Orissa.
g. Status of women in India is still poor. Yet, women's status is steadily improving facilitated by education, employment outside the home, and economic independence.
h. Child rearing practices are still traditional in India.
i. Most of the marriages are still arranged by parents and elders.
j. Dowry and bride price are still practiced.

TYPES OF THE FAMILY

- Family can be divided into:
- Family of orientation—the family into which one is born.
- Family of procreation—the family one enters into as an adult.
- Matrilocal arrangement—a married couple live near or with the bride's parents.
- Patrilocal arrangement—a married couple live near or with the groom's parents.

Changes in Family Patterns

Changes in family patterns are generated by such factors as the development of a centralized government, the expansion of towns and cities, and employment within organizations outside family influence.

These changes are producing a worldwide movement toward nuclear-family systems, eroding extended-family forms and other types of kinship groups.

The most important changes occurring worldwide are the following:

- Clans and other kin groups are declining in influence.
- There is a general trend toward the free choice of a spouse.
- The rights of women are becoming more widely recognized, with respect to both initiating marriage and making decisions within the family.
- Kin marriages are becoming less common.
- Higher levels of sexual freedom are developing in societies that were very restrictive.
- There is a general trend toward the extension of children's rights.

SOCIOLOGICAL SIGNIFICANCE OF THE FAMILY

Stressing the sociological significance of the family, McIver and Page have written that " of all the organizations large or

small, which society unfolds, none transcends the family in the intensity of its sociological significance. It influences the whole life of society in innumerable ways and its changes, as we shall see, reverberate through the whole social structure."

There are eight distinctive features of family, which suggests its sociological significance:

a. *Universality*: Family is found in all societies, primitive and modern, rural and urban, and everywhere. Family is found even among animals.
b. *Emotional basis*: The love, affection, sense of belonging, and intimate relationship and concern show the emotional basis of the family. Everybody is fond of the home, and there is an eagerness to return home.
c. *Formative influence*: The family molds the character and personality of the individual by the impression both of the organic and mental habits. It is the most important agency of socialization of the child. The family is first and the best school.
d. *Limited size*: Family is a small group. Smallness of the group affords intimate and intensive relationships. It is smallest of all the organizations that make up the social structure. It is the most significant primary group.
e. *Nuclear position in the social structure*: Family has a nuclear, central position in the total social structure. It is the nucleus of other social organization. The whole social structure is built of family units. Even the basis of all classes, castes and communities is the family. In fact, community itself is a union of families.
f. *Responsibility of the members*: The sense of responsibility between the members of the family is unique. In times of crises, men may work and fight and even die for their country, but they toil for their families, all their lives. The first responsibility of a person is towards his family, and thereafter only his responsibility towards his community and nation. The loyalty, co-operation and sacrifice of members of the family are very striking.

g. *Social regulation*: Family is a very important agency of social control. Socialization and personality development take place right in the family. The discipline that is learnt and followed in the family is the foundation of control.
h. *Permanent and temporary nature*: The family is both permanent and changing. As an institution, family has been in existence ever since the creation of human society, but then the form of family, the pattern of interpersonal relationship, and the functions of the family have been changing from time to time. For example, family had different forms like polyandrous, polygynous, and finally monogamous. Likewise, the size of the family was large previously, but now, it has become small. Small family is the norm now.

FUNCTIONS OF THE FAMILY

The family is most vital social institution as it fulfills very important functions such as: affection, sex, procreation, and upbringing of the children, religion, socialization.

In order to meet these functions, the family should have several facilities. A healthy family requires the following:

a. Healthy parents
b. Healthy children
c. Good house
d. Employment of parents
e. Education of children
f. Healthy neighborhood
g. Good recreation and
h. Good standard of life.

The nutrition, the environment, the interpersonal relations, are all necessary for a good family. Family welfare needs family planning, and family education.

The family should meet the needs of children, adolescents, youth, the adults and the aged. This was so in the traditional joint family of India.

If we divide the needs of a family, two major types of needs may be pointed out, namely, (i) the physical needs and (ii) the socio-cultural psychological needs. In the physical needs is included health; food, house and household amenities. In the socio-cultural psychological needs may be included education, socialization, recreation, as well as moral and spiritual needs.

The family must be called the 'sweet home' where all members should be eager to go, and spend their life. This is called centripetal tendency. On the contrary, if the family is not meeting important needs, there will be centrifugal tendency, that is members would be eager to go out. With regard to juvenile delinquency, it is told that absence of meaningful relations inside the family is very much responsible for it.

The functions of the family may be broadly classified into two, that is, *essential functions* and *non-essential functions.*

Essential Functions

- Stable satisfaction of sex urge.
- Procreation and upbringing of children
- Affection function.

Non-essential Functions

- Economic function
- Educational function
- Religious function
- Recreational function
- Medical function
- Protective function
- Governmental function
- Status giving function
- Transmission of culture.

As the name indicates, the essential functions of family are

the most basic functions, which no other agency/institution can perform. Though extra-marital and pre-marital sex relations might occur, stable and socially-approved satisfaction of sex urge is possible only within the family. Similarly, the children born in the wedlock only receive social and even legal recognition. Human childhood extends for many years and the presence of both the parents is essential for the full physical, mental, and emotional development of the children. Love, affection, and concern exist between the family members and the same cannot be found in other group. Family is considered as a center of emotional and psychological tension release in family a person can share all his problems and worries and expect full sympathy and understanding.

The non-essential functions are those functions that the family used to perform in the past, but they are now transferred to other institutions. Economic function was and is still an important function of the family. The family has the responsibility of providing for its member, especially the children, and the aged. Educating and training the children was done earlier within the family. The mothers trained the girls and the fathers trained the boys. Even formal education was offered within the home with the help of private tuition. Now, the role of the family in educating children has become very insignificant, as we have specialized institutions right from nursery schools to highly developed technical institutes. Religious education and training was an important part of training in traditional; societies. With the decline of the impact of religion, this part is loosing its significance in many societies. Recreational facilities were very limited in earlier times and people had look for whatever entertainment possible within the family. With the advent of mass media, especially movies and television, commercial recreation has taken over above all earlier simple forms. Unlike the traditional joint family, the modern nuclear family has no role in providing recreation to its members. However, it may be mentioned that the radio and the TV provide recreation in the family. Elder members

of the family with the help of household remedies and indigenous herbs did looking after the sick and ailing. Childbirth also took place within the family with the assistance of older women or a local maid. With the development in the medical science and with specialized medical and paramedical personnel, hospitals, nursing homes, clinics and so many other facilities; families have hardly any role in taking care of the sick.

The role of family in controlling its members is limited to childhood years. In areas of control and administering justice, secondary agencies like the state, laws, regulations and legislations, police, court, etc. are the main agencies. A person's status very much depended on the family to which he belonged.

This was doubly so in India due to caste system. But in modern times, education, occupation, economic condition, possessions, political affiliation and several other matters determine person's social status. Transmission of culture was an essential function of any family group. In our country, care was taken to teach all the elaborate norms of one's own caste. But the modern youth is more influenced by the ideals that they see on the screen or television and also by the peer group culture.

Thus, we find that the functions of the family have undergone drastic changes. With industrialization, urbanization, modernization and the spread of education as well as science and technology, more and more family functions are transferred to other institution and agencies. Even the very essential functions of the family like sex and reproduction are being fulfilled outside the family. With such changes, the very existence of family is threatened. Unless we revert to some of our old values and patterns, family is truly in danger of becoming obsolete.

From the foregoing discussions, we may conclude that family is still the most important institution of human society. Emotional support a person receives from the family is

particularly significant at the time of sickness. Bodily recovery depends, to a great extent, upon the state of mind. A physiotherapist should understand the role of family members in providing emotional support to the patient, even when they are unable to provide physical care. Similarly, family members will be anxious and concerned about the condition of the patient. Sympathetic understanding of them is essential, and wherever possible, they should be reassured and comforted. Healthy rapport between the physiotherapist, patient, and family results in better care and speedy recovery.

INFLUENCE OF THE FAMILY ON HEALTH AND ILLNESS

Chronic illness refers to a chronic, progressive, and degenerative disease. It is found that treatment of chronically-ill related affective disorders is the most neglected area of research, in spite of both the seriousness and the prevalence of emotional disturbances among patients and their families with chronic illness.

Rodgers and Calder (1990) highlighted the importance of marital adjustment as a critical factor influencing emotional adjustment to couple relating when there is a chronically-ill member. Minden and Moes (1990) suggest that referral of chronically-ill patients and their families to psychiatrists, psychologists, social workers, marriage and family therapists, or psychiatric nurses "can be helpful to patients with adjustment difficulties and marital and family dysfunction".

Meaning of the Illness

Chronic illness is not simply an individual subjective experience; it is interpersonal and social. The definition or meaning an individual gives to an illness is profoundly influenced by current and influences that person's social world. The social culture and the social networks shape and are shaped by the individual's experiences. The meaning of the illness is

shared and negotiated in everyday interactions and it is deeply embedded in the social world. As such it is inseparable from the structure and processes that constituted social world.

Unexpected, health-related life events raise many questions for therapists and other health service providers.

What are the factors that determine the onset of serious, chronic and degenerative diseases and how does the progression of an illness affect families?

To what extent does gender, the life-cycle stage of the players at the onset of the illness (childhood/adulthood), roles, couple relationships, social support systems, and finances contribute to the way families cope?

Can family systems be strengthened rather than or weakened in the face of health problems?

How do marital and family dynamics, belief systems, rules and boundaries determine the physical well being of its members and their ability to adapt to physical health problems?

A Biopsychosocial Perspective

Until recently, disease was thought to be a function of the breakdown of biophysiological processes. This bio-medical model of disease assumed that there were distinct separations between the mind and the body. Within this framework, health was an exclusive function of a person's physical state. While there are some changes emerging, the medical system in this country is still primarily a product of this model, and within this belief system, interventions consist almost entirely of medical technologies. The medical system concerns itself with the treatment of the biology of an illness in an individual. Little clinical attention is paid to the person's mental health and even less attention is paid to his or her family.

The *biopsychosocial model* suggests that an interaction of the biological, psychological, and social aspects of a person's life are the determinants of his or her health, the onset of illness, and often the prognosis. Even the immune system, which was

thought to be a strictly biological response, is now thought to be influenced by emotional factors, and even the course of chronic illness is now considered largely determined by lifestyle behaviors. Now, it is believed that psychological factors, such as cognition, emotion, and motivation for behavior and mental processes contribute to a person's proneness for illness and also to the person's speed of recovery (i.e., positive attitudes decrease recovery time, negative attitudes extend recovery time).

Family Life Cycle Considerations

Biopsychosocial factors change systematically in response to developmental stages. For example, the biological functioning of older people is challenged by many more chronic diseases than middle-aged people or children, just by virtue of more lengthy normal wear and tear on their bodies.

Rolland (1989) proposed a model, which emphasizes the intertwining of evolutionary threads: the illness and the individual family life cycles. He proposes a typology that conceptualizes distinctions of (1) onset, (2) course, (3) outcome, and (4) degree of incapacitation. By combining the kinds of onset (acute versus chronic), course (progressive versus constant versus relapsing/episodic), outcome (fatal versus shortened lifespan versus nonfatal) and incapacitation (present versus absent) into a grid format, Rolland generates a typology of 32 potential psychosocial types of illness.

In addition to the core themes, he also utilizes the context of three major disease phases: (1) crisis, (2) chronic, and (3) terminal, in order to follow the history of the disease process. This facilitates an appreciation and understanding for the ever-changing needs and requirements of the patient, the couple, and the family system over the course of the family life cycle. In addition, he incorporates the concepts of centrifugal (forces that push members apart) versus centripetal (forces that push members together) family styles and phases

in the family life cycle as a means of integrating family, individual, and illness development. It is particularly useful to bear in mind the significant centripetal pull which chronic disease exerts on a multigenerational family system, and its potential impact on the couple's boundaries and the established hierarchy within the family. For example, if the couple has children, the therapist's interest in their adjustment process may prompt a sharing of the parents' concerns and a discussion of problem-solving options. This may also have the effect of strengthening the parental hierarchy. For couples who wish to have children, there may be concerns regarding genetic factors relating to the chronic illness and the potential risks of pregnancy.

Illness as a Life Event

Becoming chronically-ill is a life event. A life event may be broadly described as an array of experiences that require significant changes in the ongoing life pattern of the individual. Life events may be categorized in three ways: *normative age graded events*, such as marriage, childbirth, or menopause; normative history graded events, such as wars, economic depressions, etc; and *non-normative events*, such as illness, disability or job loss. Chronic illness falls into the last category and as such necessitates a redefinition process by all family members. This redefinition process involves the incorporation of the idea that a family member is ill. It primarily involves a construction of a reality centered on the concepts of sickness and disease, often involving isolation and control. The "sick" family member becomes more isolated as those who are healthy take on more controlling attributes.

Life events may be understood broadly as experiences that require "significant change in the ongoing life pattern of the individual." Hultsch and Deutsch (1981) classified events in three categories:

The first, *normative age-graded events*, are determined largely by biological capacity or social norms; and accordingly, their timing and duration are similar for many people. Representative examples include marriage, childbirth, menopause, and retirement.

The second category, *normative history-graded events*, are experienced by most members of a cohort. Representative samples are wars, political shifts, economic depressions, and mass immigrations.

The third category consists of *non-normative events*. These are weakly correlated with life stage or historical time, which are idiosyncratic in occurrence, and limited to a small proportion of the population. Examples include illness, disability, and job loss.

The sociological impact of family or cultural membership affects belief systems, family rituals, and the different ways people use the healthcare system at different times during the life cycle. The response to a child's illness, the role sick family members play, the respect for or willingness to use health professionals all have roots in family of origin dynamics. Hence, interventions that increase people's ability to delay the onset of or cope with serious illness must include an understanding of disease entities, expected physical prognoses, and psychosocial implications, especially interpersonal relationships, coping styles, and present and past family dynamics. When the onset of chronic illness coincides with transitional points in the individual or family life cycle, there is perhaps an even greater risk of problems. "The added centripetal pull exerted by a progressive disease increases the risk of reversing normal family disengagement (i.e., child going away to college) freezing a family into a permanent state of fusion." An important aspect of therapy with couples in the reversal of such centripetal over-reactions involves frank discussions of what they see as realistic alternatives and options.

Reactions to a Diagnosis of a Serious Illness

A diagnosis of a serious illness provides medical practitioners with a label and frame of reference with which to approach patients. While the diagnosis speaks to biophysiological factor, it does not begin to suggest the psychosocial demands that the diagnosed individual, couple and family may face.

The label of the disease itself often addresses the beliefs and past experiences of the people involved with the illness. When a person is diagnosed with cancer, for example, several expectations may be made. If there is the belief that cancer is not "treatable" or "beatable," and is physiologically devastating, then, compensations often begin even before any severe symptoms manifest themselves. The person may develop a "sick" role by virtue of the diagnosis alone. Here, people tend to surrender their responsibilities to others. This can result in a shift in the family power and further encourages the diagnosed person to define him or herself as no longer capable. This sick role may have some advantages, for example, in a disease that runs a particular course it may give the diagnosed person an opportunity to rest and recover with a respite from the usual responsibilities. On the other hand, it may discourage the person from maximizing their coping abilities.

Even in the case where the disease requires the ill person's constant self monitoring, people who have taken on the sick role tend to relinquish their decision-making rights and care taking to health providers or significant others. On the other hand, some people may believe that cancer is not a death sentence, but an opportunity to deepen their lives, to bring new meanings to their relationships, to increase their religious affiliations or to take control and "be strong," perhaps for the first time in their lives. As a result, these responses can result in many positive changes in family systems.

Shontz (l975) outlines a common sequence of reactions people tend to have when they are diagnosed with a serious illness.

The first reaction, shock, is characterized by bewilderment. The person behaves in an automatic fashion, exhibiting feelings of detachment from the immediate situation. These avoidance reactions are a means of getting distance from the overwhelming feelings.

In the second phase a person may exhibit disorganized thinking, and feelings of loss, grief and despair. This is more typical when a diagnosis comes without warning to a seemingly healthy person.

The third phase is characterized by a denial of the circumstances, along with an acknowledgment of the existence of the health problem.

However, in most cases, the reality of the situation returns slowly as the person's ability to cope increases. If avoidance and denial are maintained over too long a period of time, a person may become immobilized, especially in his or her ability to gather information about the problem. This can prohibit them from making timely decisions about their treatment or care needs. This could also result in another family member taking over the decision-making role, evaluating treatment options and providing daily care. It is in this situation that power shifts, role reversals and conflicting triangulations occur. Or, as the family surrounds the ill-member, it can result in bonding more closely, strengthening each member into a support system. These increases in family bonding and support also may increase healing and promote coping.

While shock is a fairly consistent initial response, some persons who become ill do not become disorganized or evidence avoidance behaviors. They seem much more in control and accepting of the illness and begin to structure their lives around the necessary accommodations. Peoples' beliefs about the identity of an illness, the cause, the duration, and the consequences of their conditions are important predictors of their ability to adjust.

Locus of Control

Rotter (1966) developed the original scales for measuring internal and external locus of control. People with an "internal locus of control" believe that they are in control of their own successes and failures. Hence, people with a powerful internal locus of control believe that something they do or do not do determines their health status. These individuals are also more likely to think that their ability to overcome a serious illness is determined by themselves and their behaviors. They verbalize things like, "If I give in to this, I will get sicker," or "I will decide what is best for me!" They also tend to make their own informed decisions about their care and adhere to regimens that they believe will work.

People with an external "powerful other" locus of control are more likely to believe that professionals or others outside themselves determine their illness successes or failures. These individuals believe that the outcome of their illness is determined by their doctor or surgeon and generally leave their care in the hands of a medical professional, basically doing only what they are told.

Chance locus of control is exhibited by people who believe that luck, fate, or God determines their successes and failures. Persons with a chance locus of control will say things like, " If I am lucky, I will get over this" or "If my time is up, it is up, and nothing I can do can change that."

As people move from middle to older age, their notions of chance or powerful other locus of control tends to increase and they are more likely to turn to medical professionals to make their health related decisions. People who optimize their health by living healthy lifestyles believe that they can determine their own health status. People who exhibit less stress and those who tend to cope with serious illnesses tend to have stronger internal loci of control.

Externality or internality of control also influences the way people use the healthcare system. Individuals who hold belief

systems that incorporate notions like "the doctor knows best" and turn their care over to the practitioner are less likely to seek second medical opinions and medical procedures unless their primary physician suggests it. Few questions are asked about the treatment process, treatment expectations, or the protocol and they tend to perform as the "good patient." On the other hand, believing in fate or God often causes people not to seek treatment or can limit the treatment they seek because they do not believe, that it will make any difference in the outcome.

Implications for the Family

Individuals and their families deal with a wide range of issues when a chronic illness enters the family. Issues can range from existing issues prior to the illness, to fear of abandonment, fear of death, spiritual beliefs, and exhaustion from care taking and interaction with the medical community. Although a serious illness manifests itself in one member of the family, it is perceived as an intruder by other family members. Eventually the illness itself becomes an independent functioning member of the system, with its own separate identity. It is demanding in that it requires readjustment of schedules, roles, finances, etc. It elicits anger in that it is often uncontrollable and causes pain and fear. It is selfish in that it must be attended to whenever it demands, despite other activities or interests. It is isolating in that it often changes intimacy and friendship patterns.

While the family's task is to meet the ill person's medical and other caregiving needs, the emotional well-being of the entire system is challenged. This may lead to couple or family discord that continues to decrease health status which in turn negatively affects family dynamics. Family scripts and experiences with illness have implications to the functioning of the system and its ability to adapt. If, for example, the family has a definitional system which includes ideas that the

illness could have been prevented or that it was caused by themselves or another family member, then a place for blame is sought, i.e., the family diet was not healthy because it was not a priority of the meal preparer, or the ill person worked too many hours on his/her job, or the children caused "too much stress". These types of thought process attempt to explain or offer some level of control over what feels like an uncontrollable situation. Hostility, low self-esteem, and other negative patterns may develop as the family system is threatened.

These patterns tend to create distance from the problem or create distance between family members, often closing down communication and leaving little room for accommodation to the new situation. In some cases, blame is sought outside the family system. Here, it is usually directed toward the medical profession, i.e., the doctor incorrectly diagnosed the ailment or took too long to recognize it. In these cases there is a loss in faith in the medical system, which may result in the delay of necessary treatment. The demands of an illness often deplete energy, dissolve optimism, and create depression. If the chronically-ill person experiences depression, it may lead to other family members having increased risk for depression.

When an illness compromises the diagnosed member's physical capabilities and personality characteristics, there is a constant struggle on the part of the person to maintain equilibrium. In some cases, this struggle creates growth, development, new closeness and trust in the primary or family relationships as needed shifts in roles, power and responsibilities emerge.

However, in other cases, as the person's self-care capabilities decrease, resentment, jealousy, and/or feelings of overburdenedness may occur as the family relationships deteriorate. The task of maintaining the family support and intimacy is ongoing for all members. In order to effectively

accommodate and regain equilibrium, it is helpful for family members challenged by serious illness to receive information about the expected patterns of the particular disorder or illness and the resultant practical and emotional demands these patterns may create for them over time.

Open communication for all family members is crucial. Living with secrets can encourage fear and guilt. Since all family members may be anticipating loss, it is helpful to discuss the issues of health care, living wills, powers of attorney and finances in the present. This may help the family to keep their affairs in order at a time when they are under tremendous stress. The onset of an illness, whether an acute attack or a gradual development of symptoms, has implications for how families will function, as does the nature of the expected progression of a particular disease (progressive, constant or relapsing) and the expected outcome for survival. Can a course of events be outlined for an individual upon diagnosis, including the degree of disability and pain that is likely to occur or is the future vague and uncertain? What medical interventions are available and how can people access them?

Enmeshment/Disengagement

Disengagement may occur among family members who cannot cope or are unable to care give in ways that are acceptable to themselves or the system. Others may become so enmeshed in the symptoms and disease entity that it becomes difficult to distinguish between the sick member and the others who are well. While the ill person is still able to maintain his or her past roles or tasks with some modifications, the enmeshed family might usurp that ability and elicit a lack of competence. When the sick role becomes assigned to an individual with a previously dependent spouse, that spouse when encouraged may become stronger and better functioning. But, as they do so, there is an obvious shift in the power in the relationship away from the ill spouse.

The Roller Coaster

Chronic illnesses like cancer can have periods of remission between bouts of serious debilitation, which can create a roller coaster type of effect. During remission, there is a slow "lulling" away from the immediacy of loss, fear, and suffering. During the re-occurrence periods, impending loss, helplessness, feelings of anger, confusion and fear are likely to return.

Here the individual's short-range goals and future plans are severely disrupted and life seems to take on an unpredictable dimension. Finances in situations where an ill spouse holds a primary role like providing for the family's income or childcare, there may be fear of the future. In addition, sometimes guilt arises. An ill spouse may have to make decisions that demand acknowledging the outcomes of his or her illness. Here the challenge for the family is to verbalize the emotions and assist the ill person to maintain as much independence as possible while releasing responsibilities.

Life Cycle Issues

The life cycle of the sick person and the developmental stages of the other family members have implications for the family's ability to adapt. The impact of disabilities on the expectations and skill mastery at one stage may differ considerably from another but no matter what the stage of life, illness and disability has a profound effect on family systems. For example, if chronic illness enters the family in a child who has not achieved independent living skills, it has a different impact than if it occurred later in the child's life. If a certain level of success is achieved at a career that requires skills that cannot be maintained, it may have a different effect on the individual and the family than if it occurred at the end of the career or before that particular career had been selected.

Rolland (1993) suggests that families need support in establishing "beliefs that sustain hope and empower, instead of those that foster blame, shame, or guilt". Independence

and an ability to maintain optimal functioning within the parameters of the illness needs to be fostered.

Furthermore, to avoid hostile imbalances in power and control, he identifies the need for families to see health problems as couple or family problems. Serious chronic illness can create a reconstruction of the past to find meaning for the future. People who have remission from serious illness can achieve a much greater meaning for each life event. From this powerful experience of vulnerability can be opportunity for the strengthening of marital bonds, emotional intimacy, deep expressions of caring and commitment, opening communications and increasing trust.

Chronic Illness and Children

Bronchial asthma, juvenile diabetes, leukemia and other cancers are among the more serious chronic and debilitating diseases that affect children and young adults. While once fatal, as a result of medical technology and effective pharmacology, children often live with these illnesses and their related problems for the whole of their lives. The pre-conceived notion about a chronic illness has implications for a family's ability to cope and adjust.

In early childhood, the parent child relationship can be interfered with by long in-patient separations where the doctors or nurses meet the child's needs. These have implications in the maintenance of the family hierarchy where there are physical disabilities that may interfere with attempts at independence, children's self confidence may be compromised.

Over-compensating parents may inhibit their child's developmental task mastery or the child can become rebellious in an attempt to push out the boundaries. The peer system in later childhood and early adolescence provides a yardstick by which children measure themselves and develop their self-image. If a child has a chronic illness at this life cycle stage,

peer relationships may become problematic. Peers can be cruel and may make it more difficult for the child to develop a social network, especially if the disabilities are severely restricting. When this happens, the family may overcompensate and become strongly protective of the child, meeting more of the child's needs than are necessary.

This is a particularly crucial and difficult time for families, as children with chronic illness attempt to negotiate adolescence through close friendships and personal values that are different from their families. Sometimes the withdrawal and loneliness experienced by an ill child results in anger and self-recrimination. If the family has been vested in maintaining the adolescent's health without encouraging their maximum input, adolescent rebellion may be expressed in refusal of treatment or medication. When the day-to-day activities of a family are adjusted by an ill child's needs, other family members especially other siblings may become angry and resentful at the same time as they experience guilt for any attention they do receive.

Siblings in a family with an ill child adapted best when schedules, visits, and vacations, were adjusted to the total family's needs wherever possible rather than entirely to the diagnosed child's. When sibling's identities and importance in the family are supported and appreciated, less resentment and anger was felt. Where a family's encouragement in maintaining an ill child's involvement in his or her own care and decision making (where developmentally appropriate), the child's confidence and coping ability are maximized.

The interactional patterns, communication and feelings of the entire family unit are important therapeutic material. The resources external to the family system (i.e., financial, childcare, etc.) can support or weaken the stability of the family and its ability to accommodate to the illness. Helping families with the multitude of support services they might need to survive a serious childhood illness requires a multi-systemic intervention.

Less explored in the literature are the problems young children faces when a parent is seriously ill. The separation and the fragility of the diagnosed parent may result in feelings of insecurity in the child. The protective environment of the family seems compromised when attention is placed on the ill parent. Temporary caregivers may not set appropriate boundaries so that children may feel particularly vulnerable. Children may feel excluded from the family interactions especially when they are given little or no explanation for the changes in the system or about their parent's health status. There is more than one case where the parent of a young child was taken to the hospital where she/he died and the child was given no explanation whatsoever, other than "Mommy/Daddy went to heaven." Later in therapy sessions, the adult explores the anger the child may have experienced from feelings of abandonment.

As children reach adolescence, they may be expected to become the caregivers of their ill parents or siblings even during acute phases of the illness. Their care giving may inhibit their opportunities for social development and peer relationships. Children, like adults, may feel angry with their ill parent, or ill sibling, sometimes secretly wishing them dead.

Chronic Illness in Adults

When serious chronic illness emerges in adulthood, it can occur in the primary family or in elderly parents. When it occurs in early adulthood it may interfere with people's ability to marry, have children, or become successful in their careers. In middle adulthood, illness can be perceived as disrupting the family and work systems. Mid-life is the time when major financial and other responsibilities for young children are completed. People are established in their roles and couples are often readying themselves for their retirement in good health. Plans that were put off for some time in the future seem close at hand, if not in place.

Couples in mid-life are always aware of the potential for illness but their life scripts have its occurrence put off for older age. With recent sophisticated medical technology, a first acute attack of an illness (cancer, heart attack) rarely ends in death. A couple will often have an opportunity to live for several, if not many, years with some quality of life. The quality of life is sometimes associated with their ability to change their definition of themselves to accommodate for the changes in their physical ability. Their quality of life is to some extent also dependent upon how their finances cover their medical and care giving needs.

Changing from an intimate couple relationship to a care giving and care-receiving one is a difficult task for couples. If the spousal relationship is compromised by some loss of ability to do basic hygiene tasks, it may upset sexual and social boundaries. For example, in the case of sexuality, spouse caregivers of partners with dementia or Alzheimer's disease have reported finding particular distress with partners who make sexual overtures to them yet do not remember who they are or that they have participated at all.

When the sexual intimacy of a relationship is changed by an illness, the couple or the caregiver may have to redefine their relationship from lovers to companions. Care giving may also change family's roles. For example, when there is a loss of control over body functions and the care giving partner is responsible for diaper changing and dressing responsibilities, the marital relationship may be perceived as being replaced by a parent-child dynamic. The ill person becomes ashamed of his or her inabilities, may withdraw or react angrily and/or may become despondent. Finding new meanings for accommodations to the relationship must be made in the context of communication between the partners. While dependency in physical needs may occur, the therapist can assist the partners to elicit maximum participation from the sick partner in family decisions and in any other ways that are possible. Encouraging participation of the ill spouse to the

fullest extent throughout the course of the illness maximizes the quality of the relationship.

Gender factors have been known to play important parts in how care is given. Because of differing socialization, women tend to accept care-giving roles more readily than do men. Studies on post cardiac incidents indicate that women are better able to provide environments for their husbands to rest and recover because they have generally been responsible for the family chores. On the other hand, men tend to seek care giving or housekeeping assistance from others when their wives are recuperating from acute illnesses.

In less acute cases like Alzheimer's disease, the care giving responsibilities tend to be transferred over time. The caregivers most frequently sought are adult daughters although the healthcare system does provide some nursing and home health aide assistance, most often by women. Care giving tends to isolate people and increases the caregivers' own risk for illness. The status of a mid-life couple's social system in terms of other experiences with illness can affect their quality of life, if and when one member becomes chronically ill. If others in their peer group have had similar experiences, adjustment and support systems may be available. If adult children are close by, they may provide a replacement social support network. The least overall disruption in social activities or family gatherings, the easier the adaptation. Families can be encouraged to include the ill member in social situations wherever possible and discouraged from taking over all of the sick person's responsibilities.

In the case where these family and friend support networks are not available, medically based peer groups (Heart clubs, Partners of People with Parkinson's Disease, etc.) offer a setting for families to re-establish themselves. These groups often provide a forum for the establishing of new friendships for both partners. By providing psycho-education about these support groups, a physiotherapist or physician can assist the family to minimize their loneliness and isolation.

Chronic Illness in the Elderly

Chronic illness has often been defined as the illness of old age. It is also believed that if one lives long enough, one is expected to encounter a chronic illness, thus, leading individuals to assume that they will someday be ill.

The life situation, experiences with loss, socio-economics and support systems of older people is often directly related to their stage of old age (65-75; 75-85; 85+) and their ability to cope with illness. Belief systems about aging often affect the way families and the healthcare system responds to chronic illness in this later stage of life. If illness is defined as an anticipated, expected component of advancing age and elderly people are not expected to be able to care for themselves, then their care may be taken over by family members or the health system. If they themselves share this notion, they may relinquish themselves to the care-giving situation. Comments like "I'm old" are often synonymous with "I'm feeble" or "unable". These self-determinations may result in self-fulfilling prophecies that are often encouraged by well-meaning health care providers or children who become parents to their elderly parents.

Furthermore, if it is acceptable for elderly persons to be unable to care for themselves and regain positions of health after a serious illness, then they may not be encouraged to do so. Yet, many older people do not succumb to these definitions and fight hard to maintain their independence and self-sufficiency. They recover and refuse care, sometimes to their families distress. The family's definition of itself as caregiver of its elderly members determines its willingness to give care, the style of care giving and the ensuing effect. A spouse, siblings or children, may provide the care giving needs of the elderly. In long-term relationships, spouses usually have a vision about caring for one another in old age and are most comfortable when they can carry these out. Their scripts incorporate "till death do us part". Oftentimes, children

interfere with these efforts in fear that the well parent's health is being irrevocably compromised. This interference may disrupt the lifetime promise and the well spouse caregiver responds to family pressure by giving up the role or keeping the family at a distance.

Older spouses who give up responsibilities often feel that they have deserted their ill spouse and may become depressed and withdrawn. Other times, the well spouse caregiver continues the care, even though it may compromise their own health. In some cases, spousal relationships were first entered into during this later life period and the role of caregiver and the expectations of families may already be imbalanced as their life scripts differ. Boundaries between the "new" well spouse and the birth of children or other relatives of the ill spouse often need to be established when serious illness occurs. Who makes the decisions, who does the care giving and where it will occur are problems that need to be resolved. Reconstituted families can become engaged in inevitable power struggles as they protect "their own." Environments that support older persons belief systems and independent decision-making wherever possible should be encouraged. Often a couple has never expressed their feelings or their fears to one another about who will die first, or who will care for whom has never been expressed. These are difficult times for couples.

General Caregiving Issues

Historically, care of the infirmed people was the responsibility of the family, and where no family existed, the religious institutions took care of them. In families, men were responsible for the money to pay for the health needs of their ill and women for the hands on care. Caregiving has several meanings; love and intimacy, forgiveness, proving one's maturity; fulfilling obligations, and many others. Caregivers experience enormous frustration and sometimes "irrational anger, ambivalence, death wishes or escape fantasies". These

intense feelings can result in distancing and guilt by the caregiver. Directing the caregiver's intense, explosive frustrations at the illness rather than at the ill partner can diminish the guilt and bring the family closer together.

Chapter 13

Problems of Employment and Health of Women

INTRODUCTION

The role of women in the workforce varies according to the structure, needs, customs, and attitudes of the societies in which they live. In prehistoric times, women and men participated almost equally in hunting and gathering activities to obtain food. With the development of agricultural communities, women's work revolved more around the home. They prepared food, made clothing, and cared for children, while also helping to plow fields, harvest crops, and tend animals. As cities developed, some women sold or traded goods in the marketplace.

Some major changes are now occurring in industrial nations, including the steadily increasing proportion of women in the labor force; decreasing family responsibilities (due to both smaller family size and technological innovation in the home); higher levels of education for women; and more middle and upper income women working for pay.

WORKING WOMEN IN THIRD WORLD NATIONS

Despite the fact that women constitute more than one-third of the world's labor force, in general they remain concentrated in a limited number of traditional occupations, many of which

do not require highly technical qualifications and most of which are low paid. According to data from the International Labor Organization, however, as countries become industrialized, more women obtain jobs in more occupations.

Much of Africa, Asia, the Middle East, and Latin America remain primarily poor agricultural economies. Most women work in the fields and marketplaces, but their economic contributions are generally unrecognized. As men migrate to the cities in search of increasingly important cash incomes, many rural women are left to support families alone.

Illiteracy is higher among women than among men. Even in countries where some equality has been achieved, problems such as high unemployment rates affect women adversely. In India, some progress is being made in widening women's work opportunities. These women still do not have equal access to education and training programs, however, especially in skills necessary to a nation-building economy.

EFFECTS OF WORK ON WOMEN'S HEALTH

Very little is known about the effects of work on women's health and safety specifically. This is despite the fact that about half of the workforce in India is made up of women. There are many sectors where women are the predominant workers. Women workers are more likely to work in part-time or casual work, often working more than one job at a time. Women find themselves in insecure employment, and this has consequences with relation to reporting of accidents and injuries and claiming for, much less receiving, compensation.

It is important to look at the question of women's health for a number of reasons:

- Much less is known about the risks that women face;
- Women are concentrated in certain occupations and industries, and therefore certain specific risks apply;
- Legislation makes no distinction between women's and men's jobs, and many norms and standards have been developed by men for men;

- There are physical differences between men and women, that have an impact in the workplace; and
- It is still the case that most women have the major responsibility for unpaid work in the home, in addition to the paid shift in the workplace.

Women in traditionally male-dominated high-risk occupations were exposed to much higher risks of impairment than their male colleagues. Many women suffer from musculoskeletal disorders. They are probably the most common work-related problem among women workers. These disorders are generally associated with heavy lifting, awkward postures, monotonous or repetitive tasks and inadequate systems of work. Health care and home care workers, cleaners, catering and other hospitality staff, and many office workers, who are usually women, often work in such conditions. Yet gender is not an issue that is often considered during risk assessments.

In many sectors, such as cleaning, women are exposed to harmful chemicals, including solvents. These substances may affect fertility and pregnancy, and can lead to miscarriages or premature births. The effect on women going through menopause is totally unknown. Such substances may also increase the risk of other diseases, such as dermatitis, allergies, and even cancer.

Older women work longer hours than younger women, have lower status jobs and have a higher chance of developing bad backs and broken bones.

Where women experience gynecological or reproductive problems and other possible work-related concerns, apart from very few cases, a link is rarely made with their work. Even today women's doctors do not ask them about their work or work patterns.

WHAT SHOULD BE DONE?

Urgent action is required to improve the jobs and health of women:

- *Employers:* There is a whole range of health and safety issues for women that are not being effectively addressed by employers. It is important that employers consider their women workers when developing any health and safety initiatives, such as carrying out risk assessments, planning new systems of work, work equipment or personal protective equipment.
- *Standards:* The general view that the health and safety problems and needs of women workers are identical to those of men is clearly not true, yet in general, the same standards apply to both and women in the workplace. Government agencies must ensure that legal standards take full account of the occupational health and safety issues facing working women.
- *Compliance:* Government agencies must take legal action against employers reluctant to comply with their duties under the Occupational Health and Safety Act and regulations.
- The government agencies and NGOs must continue to campaign on the prevention of ill-health to workers, and ensure that the health and safety of women workers is effectively addressed in the workplace.

Chapter 14

Sociology of Nutrition

In any society where people are hungry or where many children are malnourished, food ought to be the major concern for people. Poor nutrition due to lack of food leads to bodily weakness which in turn leads to greater susceptibility to illness and death. Thus poor nutrition, as caused by hunger and poverty, is probably the major crippler of poor peoples and probably the major cause of death today in young children.

It appears to be a paradox that we have more malnourished children today than ever before in human history—this is despite so much technological progress, rapid communications, the Green Revolution, the public distribution system, national and international bodies constantly discussing how to grow more food. The real reasons for hunger and poor nutrition are not however difficult to seek. Poor people have low food availability because of the unequal distribution of land, resources and political and socio-economic power. Yet it is surprising that most national and international programmes that claim to attack malnutrition or for that matter, most educational programmes claiming to teach nutrition, do not examine the causes of hunger and poverty and the reasons for unequal distribution of resources.

Under-nutrition and malnutrition are not technical problems but social problems. It exists not so much because of

shortage of land, food or wealth, but because these are very unequally distributed. "The number of hungry children in a country or a community may be one of the most accurate measures of social justice and human rights."

Agricultural Practices and their Connection to Hunger:

MYTHS

1. People are hungry because of scarcity.
2. Hunger results from over-population.
3. To solve the problem of hunger, the top priority is on growing more food.
4. Increased food production can only come at the expense of the ecological integrity of our food producing resources. Pesticide use will have to be stepped up and farming pushed on to marginal lands at the risk of irreparable erosion.
5. Hunger is a contest between the Rich World and the Poor World.
6. Export agriculture is the enemy.
7. The need to produce food, conflicts with the goal of greater justice; redistributing control over resources would undercut production.
8. Societies that have done so only by denying people's rights, there appear to be a trade-off between freedom and ending hunger.
9. To help the hungry, we should improve and increase First World foreign aid programmes.
10. Peasants are so underfed, so, ignorant of the real forces oppressing them and conditioned into a state of passivity that they are beyond the point of being able to mobilize themselves.

Truths

1. There is more than enough food to feed everyone. China has merely half the cultivated acreage for each person

that India has. Yet in only 20 years the Chinese people have succeeded in eliminating visible hunger while so many Indians still go hungry.

2. Brazil has more cultivated land per person than the USA, yet in recent years the percent of people undernourished has increased from 45 to 72 percent. Hunger is rather from the needless under use and misuse of food producing resources— with land, and marketing systems controlled by a few, out of the control of the landless farmers. The real barriers to greater production are not physical but political and economic. The wealth of any country is people and the economic security of a nation depends not so much on rich natural resources but on how effectively its people can be motivated and their labour utilized.
3. On the whole the food production per person in under developed countries is above the level of 20 years ago. Yet there is more hunger. It is due to:
   - Unlimited private control of resources.
   - Inequalities in control over resources.
   - In 83 countries approximately 3 percent of all landlords have come to control almost 80 percent of the land.
   - Inequality of access to credit—moneylenders lend at very high rates as high as 200 percent.
   - New agricultural machinery that displaces poor people and robs them of employment.
   - The percentage of rural work force that is landless has doubled in India.
   - The issue is technology at whose interest it is working. Even the smallest scale appropriate technology can undermine the position of the poor if the society is structured against them.
4. The alternatives to chemical pesticides—crop rotation, mixed cropping, hand weeding, hoeing, collection of pest eggs, manipulation of natural predators and so on; are

numerous and proven effective. The first step is spraying only in response to a specific outbreak rather than the blind, scheduled spraying recommended by pesticide manufactures.

- In Haiti, the rich valley lands are in the control of the elites (and their First World partners) whose concern is not food but cash to pay for an improved life-style. These fertile lands produce largely low nutrition and feed crops (sugar, coffee, Alfalfa for cattle) exclusively for export.
- The Amazon is rapidly being deforested to protect large estates controlling 43 percent of Brazil's farm land. MNCs get massive government subsidies to bull doze hundreds of millions of acres of forest to produce beef, rice, and wood for upper income domestic and foreign markets.
- The environment is destroyed by land owners that export nonfood and luxury crops forcing the rural population to marginal lands; by colonial patterns of cash cropping that are reinforced by elites today and a system that promotes utilization of food producing resources simply according to profit-seeking criteria.
- Cutting the world's population in half tomorrow, would not stop any of these forces.

5. The reality of stratified societies is visible in all countries as poverty and hunger in all the lower rungs of peoples.
   - Hunger is the result of social process.
   - Many of the food corporations are now shifting production to under developed countries where land and labor cost is as little as 10 percent of those in developed countries.
   - These multinational agribusiness firms are busily creating a Global Farm to serve a Global Supermarket with food auctioned off to highest bidder. This has led to bands of women (forced by hungry children at

home) raiding the supermarkets at night to feed their children.

6. Unless the poor have control over their country's food-producing resources, hunger and poverty will continue. Export agriculture does cause commodity prices to go up, tenants and self-provisioning farmers are threatened with loss of their land as big landholders expand their holding; also overall inflation leads to less real income for the poor. Export-oriented agricultural operations invariably import capital-intensive technologies and whatever is produced is exported to pay the import bill; a vicious circle of dependency. This lead to exploitation of labor, especially women and children. Owners and export-oriented governments will stop at nothing to crush workers efforts to organize themselves. Basic food needs should be met locally. Basic self-reliance to prevent famine is a must.
7. This antidemocratic food system where a few are in control under uses and misuses food-producing resources; it leads to waste. Throughout the world larger landholders consistently produce less per acre than the small producers. When a few control the land, credit and marketing system as much as 1/2 to 3/4 of the value of agricultural production is not returned to the development of the area's agricultural resources, but squandered on luxury consumer items or "invested" in urban areas. Inequality in control over productive resources thwarts people's motivation to develop these resources. It also thwarts the co-operation among people that is essential to development.
8. We must distinguish between theoretical and effective freedoms. In India or Mexico people have the freedom to organize and to vote. But more people are losing control of their land; find it hard to get jobs, and experience increasing levels or poverty and hunger. The elite quickly squash efforts to bring justice. The goal must

be to achieve a society where the individual's legitimate self interest and the community's needs are more and more complementary. Participation and collective leadership will increase production as seen in Chinese collectives. The need is for community-based but society wide planning.

9. Aid is not answer.
   - First World must stop military sales and assistance programmes to Third World countries.
   - To repay loans is impossible and they help only infrastructure projects, especially highways, dams, electrification. Mainly, loans go to governments with strategic military location and "open door" policies for MNCs.
   - The main reason for poverty is lack of economic and political bargaining power and no Aid Program can give that. The only hope for poor rural people is to organize themselves and press for change.
   - Financial aid, food aid and food-for-work projects do nothing to change the ownership and power structures that produce unemployment in the first place. No governments will be willing to give 'aid' for changing big landlord-tenant structure.
10. In every country in the world the poor are turning their energies into eradicating hunger, building the basis of genuine food security.

Action to Counter the Myths

1. Every country in the world has the resources necessary for people to free themselves from hunger. Teach people this truth.
2. Address the root cause of hunger and high birth rates: The insecurity and poverty of the majority results from control over basic national resources by a few. Organize people to confront this and take back their power.

3. Hunger is only made worse when approached as a technical problem. Work with people to transform the social structures so that they can directly participate in building a democratic economic system.
   - Teach and use collective leadership—work at participation and shared responsibility through value education sessions.
   - Help people internalize values of co-operation, participation, compassion for others, and justice and peace.
4. Work with people to care for their environment, organic gardening, local seed varieties, local breeds of animals, protecting the forests, cleaning up rivers and waste ways, etc. Use herbal pesticides, and natural remedies.
   - Work with people for equitable share of wetland ownership.
   - Work to stop deforestation and toward building up forest cover, conserve water reservoirs to preserve rainwater.
   - Grow staple diet locally. Work so all people get a fair share of land.
5. The hungry are allies not enemies.
   - Join people all around the globe to increase power to the poor to gain food production control.
   - Boycott packaged food products and MNCs products. Refuse to work for MNCs at low wages. Start locally needed food production units.
   - Educate yourself and others on the World Hunger truths and what action to take. Locally grown and eaten fresh food is best; live by this dictum.
6. Export only after local staple food security is ensured.
   - Do not let more land get into the hands of large landowners. Work for redistribution of land to the poor.
   - Use only simple appropriate technology that is labor intensive.

- Be sure that women receive equal pay and privileges. Work so all children can study and need not work.
- Work for strength by unions and other collectives so the poor control, the productive resources to insure food security.

7. Justice and production are to be controlled by the many, not a few elites; work for this.
8. Work for and educate people to participate in decision-making.
   - The elite will have to limit their style of life so there is enough for all; work for this.
   - Educated people not only to stand for their rights, but also to safeguard the rights of others.
   - Work to remove the obstacles in the way of people's efforts for self-determination.
9. Work to halt military and counter insurgency assistance; as it is used against those working for the changes necessary for abolishing hunger.
   - Work to end all support for agribusiness and penetration into food economies; from abroad and multilateral lending agencies and through tax incentives.
   - End foreign assistance to governments working against the food security of their people.
   - Work to build a democratically-controlled food, self-reliant economy in Asian countries.
   - Support unionization of farm workers and worker-managed production units, i.e. family farms and co-operatives.
10. People have the resources of solve the problems once they are aware of it.
    - Bring awareness, consciousness and hope; they will do the rest by participation and collective leadership.

DISTRIBUTION OF MALNUTRITION IN INDIA

Various data reveal briefly the following features about nutrition.

1. Taking average nutritional status of households, severe malnutrition is more prevalent in the eastern states, and in UP, MP and Kerala.
2. The nutritional status of scheduled castes and tribes was substantially lower than the recommended minimum in most states. In particular, the intakes of scheduled castes in Kerala, Maharashtra, Tamil Nadu, MP, UP, Bihar, Gujarat and West Bengal were alarmingly low.
3. The incidence of acute malnutrition is definitely high among children, especially in the age group of 0-3 years in almost all states, it being higher in tribal tracts. In a number of states, the percentage of children with adequate caloric protein intakes were much lower than the corresponding percentage for households. Children of scheduled castes and tribes in all cases where data was available, suffer from a high incidence of malnutrition.
4. There is field experience of several activists to suggest that there is gender discrimination in food intake against very young girls, not only in North India but elsewhere too. There is general gender discrimination with respect to providing quality of life to all women, either it be health care when sick or education or sharing of drudgery.

Nutritional Problems in India

The major nutritional problem in India is protein calorie malnutrition (PCM), especially among most vulnerable groups like children, pregnant women, lower income groups and population living in tribal tracts. The other major nutritional deficiency diseases are vitamin A deficiency, goiter and iron deficiency anemia. In certain parts of India fluorosis is also a problem due to the presence of excessive amounts of fluoride

in drinking water. Pellagra, caused due to niacin or nicotinic acid deficiency is prevalent in populations whose staple diet is maize. Pellagra has also been reported in jowar eaters, although there is no niacin deficiency in this millet.

Lathyrism is especially prevalent in MP, Bihar, UP, etc. among landless laborers and poor farm workers, who are usually the victims and who often get Khesari Dal as a form of wages. The pulse itself is rich in protein. Harmful effects of this pulse are produced if a diet in 2 to 4 months contains more than 40 percent of Khesari Dal. The disease manifests itself in the form of paraplegia with most victims become crippled for the rest of their lives. Khesari is often used for adulteration of other pulses, which is one more vested interest to ensure its cultivation. Soaking of Khesari in hot water to detoxify it is not feasible because of fuel shortage. The only solution seems to be banning its cultivation.

Also in India there are a host of other mineral and vitamin deficiency diseases, other deficiency anemias, like folic acid, vitamin B_{12} and B_6 deficiency anemias, and problems caused by food toxicants like epidemic dropsy (adulteration of mustard oil with argemone seed oil), alfatoxicosis (due to consumption of groundnut flour contaminated by toxic fungal growth in groundnut seeds). Guinea worm infestation of water is also a major problem caused by unclean drinking water, chief of which are diarrhea and intestinal parasitic infestation (including hookworms) that promote chronic blood loss and in turn aggravate iron deficiency.

Dietary Patterns of the Affluent

As Indian populations, move up in social scale, important changes that appear to take place are:

1. Substitution of 'coarse' grains like millets for more 'prestigious' cereals like wheat and rice. There is also a progressive increase in use of polished varieties of rice. The total substitution of millet by rice or wheat would decrease fiber content in diet by about 50 percent.

2. Increase in intake of vegetable oils and ghee with vanaspati (hydrogenated fat) replacing, vegetable oils.
3. Increase in intake of sugar.
4. General increase in calorie intake, which is not required for sedentary nature of occupations.
5. Increased intake of pulses, vegetables and milk.
6. More consumption of processed and commercialized foods, some of which include junk foods high in calories, fats, salt and sugar—all conducive to heart disease and strokes.

The affluent group of Indians has had prevalence of coronary heart disease (CHD) comparable to the affluent in the First World, with prevalence of type II diabetes, that is five times that of similar groups in west. Indian who become affluent appear to be particularly genetically prone to diabetes and CHD, especially when devoid of dietary discipline Fat intake (in the form of ghee, vanaspati, edible oils) in Indians is particularly bizarre with the 5 percent of population consuming 40 percent of the available fat.

Practically, every Indian diet consists of some fat, as 'invisible fat.' Using more recent information available on total lipids in food materials, especially, along with rice, wheat and other cereals, the intake of invisible fat was shown to be 20 to 50 gms a day, averaging 29 gms. Large coconut intakes in Kerala and Tamil Nadu led to high levels of invisible fat in these states.

The outcome of these findings is that even poor Indian diets are reasonably adequate in fat. For the affluent sections, intakes of edible fat of the order observed are wholly unnecessary if not dangerous.

A related point to be noted is that the fashion among the affluent to go in for safflower oil and sunflower oil, based on their reported superiority due to high content of polyunsaturated fatty acids (PUFA), instead of traditional vegetable oils like groundnut, may actually be misplaced. These oils contain 70 percent of linoleic acid (an essential fatty acid)

as compared to 30 percent linoleic acid for groundnut and sesame oils. Excess linoleic acid could lower blood cholesterol—a feature desirable for coronary heart disease prone populations. Excess linoleic acid is also suspected to lead to certain types of tumors and suppression of immune response.

Dietary Guidelines for the Affluent

If dietary guidelines for the affluent be thought of as an irrelevance, one should remember that even at 5 percent (let us assume only 5 percent have affluent characteristics described above) of the total population of India, they constitute about 40 million, which is a big number of people at nutritional risk, not to speak of the economic costs of keeping this 5 percent healthy.

Dietary guidelines are merely guidelines for nutritional discipline. They may not solve all health problems of the affluent but could certainly help minimize the nutritionally related risk factors in, for instance CHD or diabetes. These guidelines should form part of school curricula in especially upper class schools.

1. Overall energy intake should be restricted to levels commensurate to the sedentary occupations of the affluent, so that obesity is avoided.
2. Highly refined and polished cereals should be avoided in preference to under-milled cereals.
3. Green leafy vegetables (a source not only of β–carotene but also of linoleic acid derivatives) should be included at least in levels recommended.
4. Edible fat intake need not exceed 40 gms and total fat intake should be limited to levels at which fat will provide no more than 20 percent of total energy. The use of ghee, clarified butter, a prized item in the Indian culinary system should be restricted for occasions and should not be a regular daily feature.

5. The intake of sugar and sweets should be restricted.
6. High salt intake should be avoided. In households in some parts of the country, diets contain unnecessarily high levels of salt, spices and condiments. High salt intake certain certainly serves no useful nutritional purpose and is generally best avoided, and especially by those prone to hypertension.

Dietary Guidelines for the Poor

The Indian Council for Medical Research (ICMR) makes periodic recommendations on desirable diets for Indian populations. Considering the fact that at least one-third of the households in India are not able to afford even the minimum nutritional requirements (these households spend 80% of their income on food), the ICMR felt that its Recommended Diet Intake (RDI) should also have practical suggestions as to how the recommended nutrient allowance could be procured from low-cost diets. In recommending diets for poor Indian Groups, the ICMR has been guided by the following considerations:

1. Diets recommended should be less expensive and conform to traditional and cultural practices as closely as possible.
2. Energy derived from cereals need not exceed 75 percent of the total energy requirement.
3. Pulse (legume) intake should be such that the ratio of cereal to pulse protein does not exceed 5:1. This would imply that pulse intake should be at least around 9 to 10 percent of the cereal intake. The diet should provide for a minimal milk intake of 150 ml. These recommendations regarding intake of pulses and milk were designed to improve the protein quality of the predominantly cereal-based diet, usually devoid of animal protein to minimal acceptable levels.
4. About 150 g of vegetables (leafy and other vegetables) should be provided. These were considered as levels,

which will not unduly increase the bulk of the cooked food—a major consideration in all diets that are heavily cereal-based.

5. Energy derived from fat and oil need not exceed 15 percent of total calories. This takes into consideration the fact that cereal diets already provide invisible fats at levels of about 10 percent of total energy.
6. Energy derived from refined carbohydrates (sugar or jaggery) need not exceed 5 percent of total calories.

Additional messages that need to be got across with respect to children are:

1. Breast-feed as long as possible.
2. Introduce semi-solids from 6 months.
3. Feed young children 3 to 6 times a day.
4. Do not reduce food in illness.
5. Use available health services; immunize your child. Keep the family and surroundings clean. Ensure that you drink clean water.
6. Do not ignore mother's health and dietary needs during pregnancy and lactation. Most mothers in India being anemic require appropriate iron and folic acid supplements.

Guidelines for other Major Nutritional Problems

1. *Iron-deficiency anemia:* Usually responds well by iron salts like ferrous sulphate tablets. These are very low cost, much cheaper than iron tonics and vitamin preparations. Iron is found in green leafy vegetables (Palak, amaranth, drum stick leaves, coriander, etc.), ragi and dried fruits. The average Indian diet provides as high as 30 gm iron daily. However, the simultaneous presence of phytate and tannins inhibit iron absorption. There is also low level of calcium and ascorbic acid (vitamin C)—a factor that could reduce net bioavailability of iron. Mass strategies that have been suggested are prophylactic administration of iron and folic acid to women and

children in poor communities as part of routine PHC services.

2. *Vitamin A deficiency:* Vitamin such as, retinol is mostly derived from beta-carotene. Absorption of beta-carotene from carrots and papayas has been shown to be good when diets have even low fat content. Intake of green leafy vegetables are recommended by ICMR in its model less costly balanced diets for adults would provide 600 mg of retinol daily and 300 mg daily for the pre-school children (about 40 gms of green leafy vegetables). Usually many of the foods rich in iron are also rich in retinol. Thus intake of greens will help in both vitamin A and iron deficiency. It is an irony that green leafy vegetables, though comparatively inexpensive, are not considered 'prestige food'; as people go up the social scale. The colostrum, usually not given to the child by many mothers on accounts of certain beliefs, is rich in vitamin A. Other strategies for combating vitamin A deficiency, especially in cases of repeated infections prophylactic administration of massive doses of vitamin A for children less than 3 years age is recommended.
3. *Goiter/Iodine deficiency:* Studies need to be made as to how new goiter-endemic areas emerge. It has been suggested that the Green Revolution type technology could have induced iodine deficiency in soils and foods that are grown in such soils. But for the present, strategies to combat goiter seem to be universal iodination of common salt and banning of unfortified salt. There are of course many logistical problems about universal iodination of salt.
4. *Fluorosis:* Simple technologies for defluoridation of drinking water with the upper limit for fluoride set at 1 ppm. Strategies for lowering fluoride content found to the extent of 10 mg/kg in staple food items like rice, corn, wheat, cabbage, potatoes, etc. are yet to be clearly thought about.

5. *Lathyrism:* No other alternative, but banning of cultivation of Khesari Dal is the most appropriate and just policy.

There are dietary guidelines that have been formulated for a host of other deficiency problems but the above to be the major one. Particular guidelines will have to be worked out considering location specific conditions.

Bibliography

1. Adam Kuper and Jessica Kuper (eds). The Social Science Encyclopedia. Rutledge, London, 1989.
2. Abraham CM. Sociology for Nurses. BI Publications Pvt. Ltd, Chennai, 1999.
3. Dorian Apple. "Sociology and Anthropology" Bibliographies on Nursing.
4. Harold A Philips. Contemporary Social Problems (3rd ed) Prentice Hall, inc, New York 1947.
5. John J Macionis and Ken Plummer. Sociology: A Global Introduction, Prentice Hall. Europe, New York, 1998.
6. KN Rao. Philosophy of Medicine. Current Technical Hit. Co, Bombay 1967.
7. LG Brown. Social Pathology. FS Crofts and Co, New York, 1942
8. Madan GR. Indian Social Problems; Volume I and II, 5th Edition, Allied Publishers Private Limited, Mumbai, 2002.
9. Pothen KP, Pothen S. Sociology for Nurses. 2nd Edition, NR Brothers, Indore, 2002.
10. Stuart Chase. The Proper Study of Mankind. Harper and Bros, New York, 1956
11. VidyaBhusan, Sachdeva DR. An Introduction to Sociology. 36th Edition, Kitab Mahal, Allahabad, 2003.
12. William M Dobriner. Social Structures and Systems. Santa Monica, California, Goodyear 1969.

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