Population & Society

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Lecture No. # 38

Emerging Issues in Sociology of Population

Well friends and now this is our module 12, the last module of this course and lecture 38. These three lectures of module 12 will be devoted to Emerging Issues in Sociology of Population. The purpose is to sensitize the students to certain changes that are taking place in the policy of the country, and in the general intellectual climate at the international and national levels. General changes in (( )) about population issues and what kind of new questions are being asked by planners, demographers, sociologists, which are related to population dynamics. So, there will be three lectures on this, and today is the beginning of that module. Today specifically we will talk about two things, millennium development goals, the national population policy 2000.

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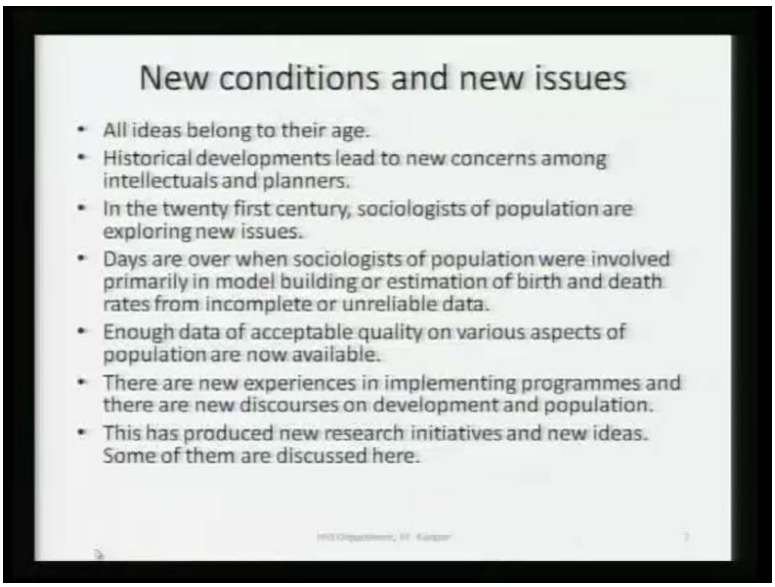

So, as one can see that all the ideas belong to their age and as time changes depending on socio economic, political, environment, culture, religious changes. Human beings have been posing different problems for solution, and that can be said to be happening in the

field of population also. The kind of problems with the demographers or sociologists of population are solving today are very different from the problems, which they did identify your this they solved, about say 30 year back or 50 years back or 100 years back, because historical developments lead to new concerns among intellectuals and planners. In the 21 st century sociologists of population are exploring, therefore, some new issues; days are over when sociologists of population were involved primarily in model building, for estimation of birth and death rates from incomplete or unreliable data.

About 35 years ago, when I entered this field of population as a student, I remember that the most of important issues is our population researches at that time were, estimation of birth and death rates at the national level. I still remember how (( )) method or UN methods were applied, to do these kinds of estimations for the country as a whole and later on for different states.

So, we learned about stable population methods, we learned about statistical methods of numerical analysis, graduation, forecasting, model building; and most of the first generation, population academicians in the country were, statistician's, mathematicians and some were economists. Today, the situation is completely changed, today this field of population is opened more for sociologists, because and to some extent psychologists also, because we are now ranging more of substantive issues rather than the issues of estimation.

All major things that we wanted to know by building statistical models or by using techniques of estimation from incomplete or unreliable data; they are not needed any more. You have plenty of data from census new questions have been added and refinements have been made in census questions, then you have NSS. So, you have national family health service, reproductive and child health service at the district level. And many other national sub national surveys conducted by research organizations such as ORG, Nelson population council; and now the issues are more regarding explaining the existing demographic turns rather than estimation of rates and ratios.

How they perform demography is the same (( )) where is demography, whether this is same population in sociology or some.

In the very first lecture perhaps on that day you are not present, I made a distinction between demography and population studies. Demography includes quantitative study of

demographic processes, fertility, mortality, migration, social mobility and marriage and it is methodology is largely mathematical and statistical.

Population studies focus more on relationship between population variables on the one hand and socio economic cultural and political variables on the other. So, this population studies part is closer to sociology than the demography. You like in demography, you are preparing the life table of India, what is exactly the life expectancy of birth in India today, based on statistical data opted from simple registration scheme or census.

But, a population sociologists is more interested in issues like, what is the relationship between say economic inequality and life expectancy, substantive issues; or will they improvement in gender equality, improve the life expectancy at birth in India or what are the causes of declining sex juvenile sex issue these are the substantive issues.

So, there are new experiences in implementing programs and policies and there are also new discourses on development and population. This has produce new research initiatives and new ideas and we will discuss them today.

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Among them one of the most important things is millennium development goals, I think today all sociologists, whether they are working in the field of population or not must familiarize themselves with the idea of millennium development goals. This is one major factor that has changed the discourse on population in this century this is a frame work of

development. And therefore, some attention has to be paid to this also because there is a close resemblance in the millennium development goals frame work and the national population policy 2000, one can see that NPP 2000 sharply reflects the millennium development goals.

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So, there are eight millennium development goals; millennium development goals are created by an international body of statesman, during the UN millennium summit in September 2000; 189 nations adopted millennium declaration. They committed themselves by signing that yes they are committed to achievement of millennium development goals. The declaration was signed by 147 heads of the states and governments.

The millennium development goals are drawn from the actions and targets contained in that declaration all these information is available on net, for history background which are these countries, what are the goals you can get information from UN sides.

So, these goals must be achieved by 2015, so a target was set that there are eight goals and these goals must be achieved by 2015; that respond towards main development challenges. These eight goals are further divided into 21 quantifiable targets that are natured by 60 indicators. So, when we talk of millennium development goals, we are referring to eight goals and in under these eight goals, we have 21 targets and 60 indicators.

In this 1 hour time, we because we have to talk a little bit about population policy or how MDGS are related to policy, I will not be able to talk about everything. But, I will just give you a glimpse of what these millennium development goals are, India is a signatory too millennium development goals.

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Goal 1 erradicate extreme poverty and hunger, goal 2 achieve universal primary education. Nobody will dispute the importance of poverty removal and raising educational enrolment rates. Now, 3 rd goal is quite important for sociologists like us, this says promote gender equality and empower women. One can also say that it is after declaration of MDGS that more and more social scientists including sociologists have started working on these issues.

Because, we are committed to them and not as one nation only a large number of nations are signatories to MDGS, which were accepted by a still larger group of countries of united nations.

The 4 th goal is reduce child mortality, 5 th goal is improve maternal health. So, these are goals but, what does health mean what are in indicators of health in what respect we fix target that you will see a little later.

Goal 6 deals with combat HIV aids, malaria and other diseases; obviously, because they are naming HIV aids and malaria. So, major focus of combating diseases is on HIV aids

and malaria. Here I should also say that these are not countries specific goals, these are the goals which all countries all those who are signatory to MDGS have committed to achieve these goals. That means if signatories to these countries and all those other countries, which support this achieve these goals, then we are going to achieve these goals at the world level global level.

Goal 7 ensure environmental sustainability, we have already spent nearly three lectures on environmental issues. And we have seen what kind of environmental problems are being created, today due to a faulty model of development, organization industrialization. Goal 8 is about develop a global partnership for development. So, there are some social goals and there are some goals regarding how to achieve those social goals.

First goal is mostly economic poverty; in sociology we are more concerned about a social goals of or goals of social development education, gender equity, child mortality, maternal health. And demographers would be particularly interested epidermologies, demographers they will be particularly interested in HIV aids, malaria and other diseases.

Then, there is something about environmental sustainability and then wage wage global partnership international bilateral collusion, public private partnership, United Nations organizations, multi lateral, international state organizations.

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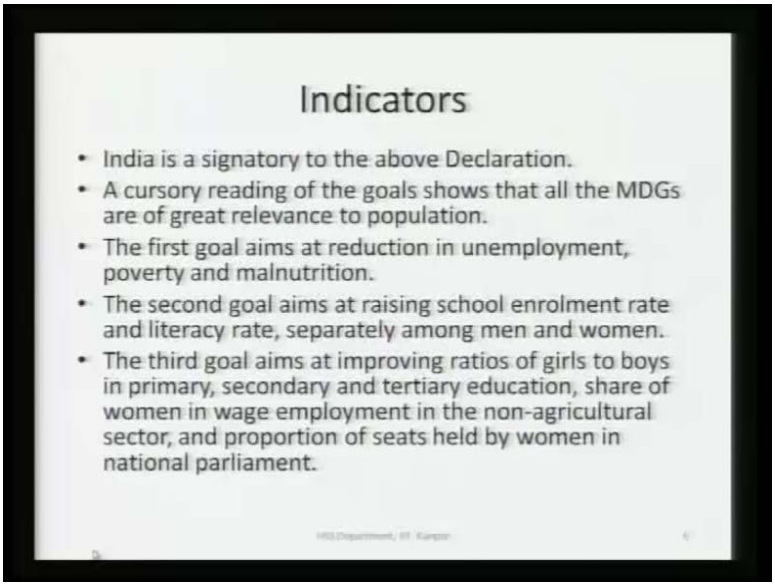

When it comes to indicators, a cursory reading of the goals shows that all the MDGS are of great relevance to population, first of all we was recognized this, I will also show you some figures regarding, what was the situation and what we want to aim at. The first goal aims at reduction in unemployment poverty and malnutrition. So, in terms of indicators for the first goal; first goal was removal of or reduction in poverty and hunger, this poverty and hunger goal contains indicators like reduction in unemployment, poverty means head count ratio of poverty or what we call level of poverty or extent of poverty or poverty ratio and malnutrition.

Since, a you will wonder why malnutrition with unemployment, this is because goal one is about poverty and removal of hunger. Now, hunger does not mean that only those, who are so, hungry that if they are not given food today they will die, hunger also includes malnutrition. Therefore, goal one has indicators of unemployment, poverty and malnutrition.

The second goal regarding education, aims at raising school enrolment rate and literacy rate, separately among men and women. Merely improvement in literacy at the aggregate level is not enough, you must raise school enrolment rate and literacy rates separately among men and women.

The third goal aims at regarding gender and empowerment of women, the third goal aims at improving ratios of girls to boys, in primary, secondary and tertiary education separately. Primary up to 8 th standard, secondary up to 12 th standard and tertiary graduation and above.

At all levels you want to improve ratios of girls to boys, then share of women in wage employment, which is very low. In the non agricultural sector and proportion of seats held by women in national parliament, you can see that connection between millennium development goals and the demand for reserving certain seats for women in the parliament.

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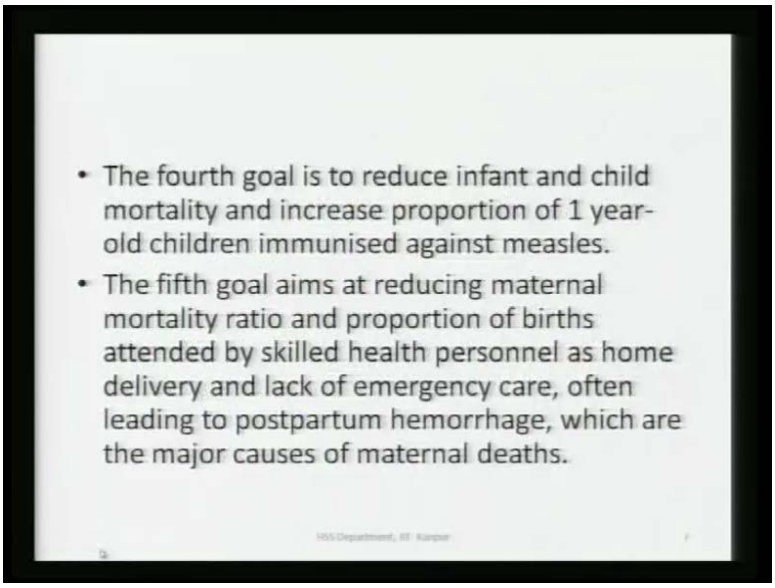

The fourth goal is to reduce, these are two indicators infant mortality child mortality, so the fourth goal is to reduce infant and child mortality. And increase proportion of 1 year old children immunized against measles. So, there is an element of immunizations.

First you want to reduce infant mortality, means mortality of children in the age group 0 to 1 year, child mortality 0 to 5 or 1 to 5, if we exclude infant mortality, then 1 to 5. And then immunization, this is that once children are immunized against measles, then they are also immunized against many other diseases for which vaccination exists, indicator includes measles.

The fifth goal aims at reducing maternal mortality ratio and proportion of births attended by skilled health personnel; because there is a close connection between them, in one of the lectures I was telling you that it is difficult to reduce maternal mortality ratio as compared to reducing infant and child mortality.

There are many countries, where infant mortality and child mortality ratios or rates have come down but, maternal mortality ratio is still remains high. India is one of those countries where maternal mortality ratio is high. you require special efforts to reduce maternal mortality ratio.

The facilities and developmental factors. which can reduce infant mortality and child mortality. which which are part of the fourth goal are not enough to reduce maternal

mortality ratio. Something has to be done especially to reduce maternal mortality ratio; and one of the factors being proportion of births, attended by trained nurse or midwives or safe delivery.

So, this fifth goal includes not only reducing maternal mortality ratio but, also proportion of births attended by skilled health personnel, as home delivery lack of emergency care. Often leading to postpartum hemorrhage, when there is lack of emergency care, the percentage may be small, percentage may be 2 percent, 3 percent but, in per 1000 terms it becomes 2 percent means 20 per 1000.

So, when there is a lack of emergency care, either because delivery does not take place in an institution or it takes place at home in absence of a trained nurse or midwives. And there is postpartum hemorrhage PPH and there is no knowledge or facility of transportation. No roads or no van, no car, no telephone numbers, no information or no motivation to take women to the nearest PHCS or CHCS, then this postpartum hemorrhage often leads to death of the mother.

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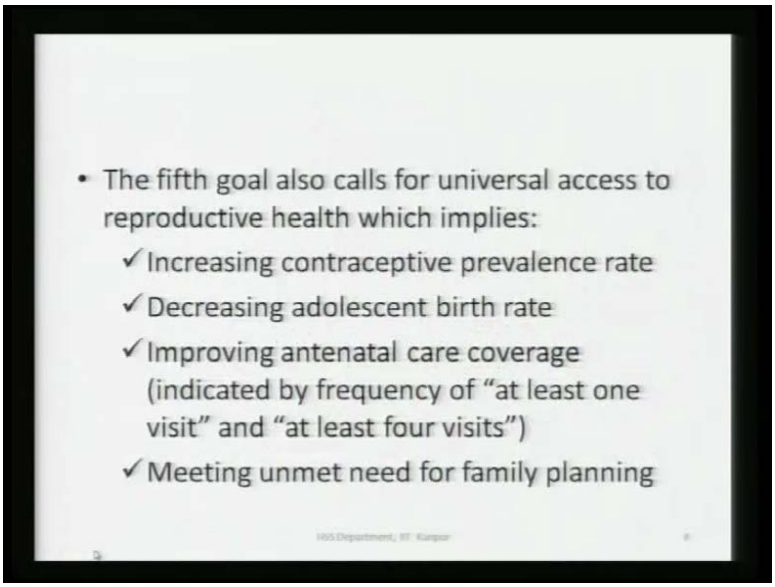

So, these are two major causes of maternal death and the fifth goal aims at reducing; the fifth goal also calls for universal access to reproductive health, which implies all these are actually interconnected, maternal health, institutional deliveries, safe delivery, reproductive health, reducing PPH women's empowerment they are all interrelated.

So, the fifth goal also calls for universal access to reproductive health, which implies increasing contraceptive prevalence rate. Decreasing adolescent birth rate, adolescent birth rate means teenage pregnancy and teenage fertility, teenagers are not biologically fit to produce a baby without any risk.

Generally, if you draw a graph of risk by age, then initially in teens and adolescent period chance of dying for a woman, due to factors related to child birth would be highest; then it declines and beyond the age of say 30 or 35 it again starts increasing.

So, if you want to reduce maternal mortality ratio, you have to decrease adolescent birth rate due to low age of marriage and due to heavy focus fertility. That immediately after marriage women have to produce a baby, they have to prove that they are fertile and there is stigma against women, who have not produced child. So, you have high adolescent birth rate and this must be reduced; if you want to reduce maternal mortality ratio, then adolescent birth rate has to be reduced.

Then improving antenatal care coverage indicated by antenatal care means, registration of pregnancy, home (()), referral distribution of iron and folic acid tablets, providing all knowledge regarding safe delivery. And in case there is any problem, hypertension or biological problem in carrying the conceptions and in delivery that has to be attended too all these are part of antenatal care.

So, antenatal care, delivery care and postnatal care, women's care, reproductive care is divided into three parts antenatal care, before child birth, delivery care during child birth and postnatal care after child birth, when PPH or such problems may arise.

And then meeting unmet need for family planning, this unmet need for family planning this I have already explained one day in connection with family planning program. That this means that there are several couples, who do not want any child but, they are still not practicing any family planning methods.

At one time their percentage was around 20, now it has declined to lower levels, this is the unmet need. So, we want to meet the unmet need, that those who do not want child, they should know and they should be in a position to use an effective modern contraceptive method.

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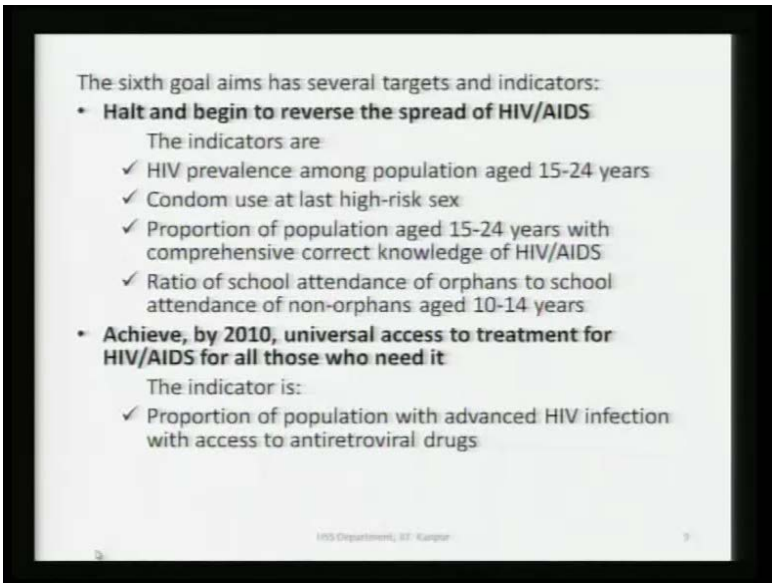

The sixth goal has several targets and indicators that also show the importance of the sixth goal halt and begin to reverse the spread of HIV aids. Halt in all those countries where HIV virus has been found, number of HIV cases is increasing. So, HIV must be halted and reverse the spread of HIV aids.

This means that the number of new infections should decline more and more people are protected against the risk of transmission of HIV from infected persons to uninfected persons. The indicators are HIV prevalence among population aged 15 to 24 years, it has been found that proportion of HIV prevalence in younger age groups 15 to 24 is increasing. This is the time when knowledge is less empowerment is less, they just desired to engage in adventurous or risky behavior facilities are less, access to conceptive methods is less because of all.

Even when NGOS or civil society act actors or volunteers go to rural areas, they have the tendency to focus more on married couples in age group 30 and above or 25 and above; at least 15 to 24 children teenagers, adolescents, young adults get ignored. So, HIV prevalence among them is increasing.

Then condom use at last high risk sex, this is another indicator what proportion of people use condom at last high risk sex, what is high risk sex, high risk sex is that in which chance of getting a HIV infection it is high. Which may be in multi partners sex or in sex with female sex workers or male sex workers or (( )) same behavior. So, those engaging

in high risk sex, multi partner or MSM or FSWS among them, percentage of uses of condoms must rise.

Then proportion of population aged 15 to 24 again young adults, with comprehensive correct knowledge of HIV aids. Right now the problem that we are facing in our country is that most people have heard about HIV aids. But there is lot of misconceptions people do not fully understand about four modes of transmission of HIV, they do not understand how they can save themselves from HIV aids and there are lots of misconceptions leading to various types of stigmas. So, there is a need to develop comprehensive and correct knowledge of HIV aids in the age group 15 to 24.

Then ratio of school attendance of orphans to school attendance of non orphans, aged 10 to 14 years lack of education lack of attendance of orphans has been a problem, it is recognize is a problem. So, they want to bring school attendance of orphans at par with the school attendance of non orphans.

Then achieve by 2010 universal access to treatment for HIV aids for all those who need it; that means, all those who are infected with HIV not all of them may need treatment there is test C D 4 count, who who have c d count less than 200 they need to go for ART Anti Retroviral Therapy. Some people who are not responding to ART any more, may require a more advance therapy hot. Now the indicator for this thing is proportion of population with advanced HIV infection, with access to antiretroviral drugs this is one indicator.

Then what proportion of HIV infected persons, you can say C D 4 count less than 200 have access to ART do they know, where ART is available, how far is that place from their residence. And how can they avail ART facility there, is the supply of ART regular or there difficulties in getting ART. Knowledge of ART sometime people do not take ART because of lack of knowledge and sometime because, they may have problem with supply we have seen both types of cases in our HIV service.

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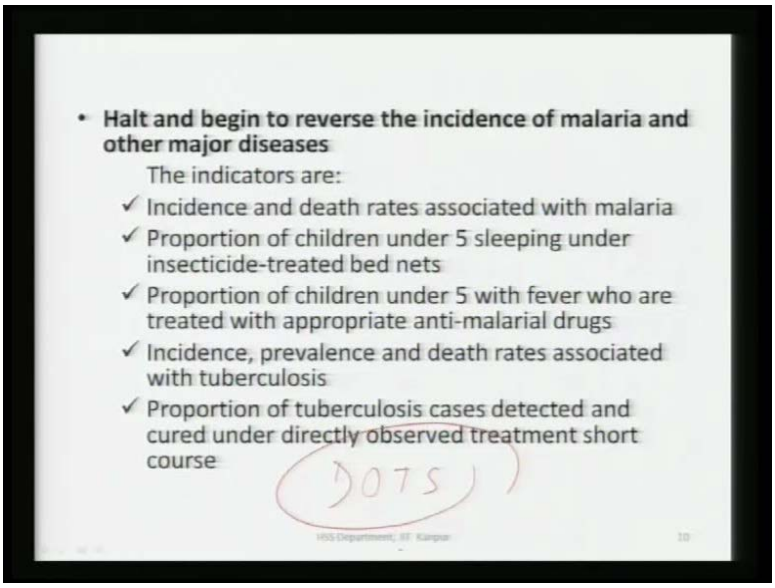

Then halt and begin to reverse the incidence of malaria and other major diseases. So, under this goal there were three things HIV, malaria and other major diseases, for malaria they say indicators are incidents and death rates associated in malaria.

Proportion of children under 5, sleeping under insecticide treated bed nets, proportion of children under 5 with fever, who are treated with appropriate anti malarial drugs. Then incidence prevalence and death rates, associated with tuberculosis among other diseases we have tuberculosis.

Tuberculosis is closely linked with HIV, according to one estimate nearly 60 percent of those infected with HIV are likely to develop tuberculosis later. When they have aids due to reduction in immunity system, if they come in contact of tuberculosis, bacteria they develop tuberculosis more easily, than those who are not suffering from HIV.

Proportion of tuberculosis cases detected and cured under directly observed treatment short course, DOTS program. Government of India now includes DOTS dots takes less time and DOTS is more effective and it has been found that in treatment of tuberculosis, DOTS is more effective than the traditional type of treatment.

So, another advantage of this directly observed treatment is that, patients are able to consult the doctors; and doctors can see the patients more regularly and prescribe them medicines according to their stage of development of tuberculosis.

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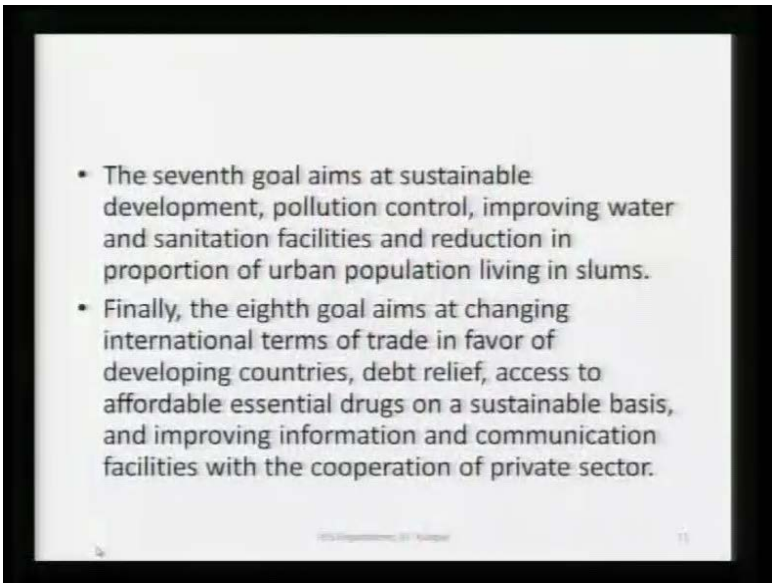

The seventh goal aims at sustainable development, this is about environmental issues climate change and this aims at sustainable development, pollution control, improving water and sanitation facilities and reduction in proportion of urban population living in slums, these are the indicators.

Indicators of sustainable development, pollution control, air, water, noise improving water and sanitation facilities and reduction in urban population living in slums. Now we have lot of data on urban population living in slums from Indian census.

Finally the eighth goal aims at changing international terms of trade, in favor of developing countries debt relief access to affordable essential drugs on a sustainable basis. And improving information and communication facilities with the cooperation of private sector. So, this talks of economic nature, this talks of regular supply, this talks of information and communication and with partnership of private sector.

That there are certain things with private sectors can do much better, private sector is more flexible, rigid rules which apply to government missionary do not apply to them the public private partnership.

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Now, MDG goals in India, we have made a table, which actually this table reproduce as table one of millennium development goals, India country report which was prepared in 2005. We could collect indicator wise more recent data but, this was one table where at one place I could find information on different indicators, so I am just reproducing that.

The report was prepared by ministry of statistics and program evaluation, central statistical organization government of India. And the table presents values and targets of sixteen indicator of different goals not one, different goals let us look at this table.

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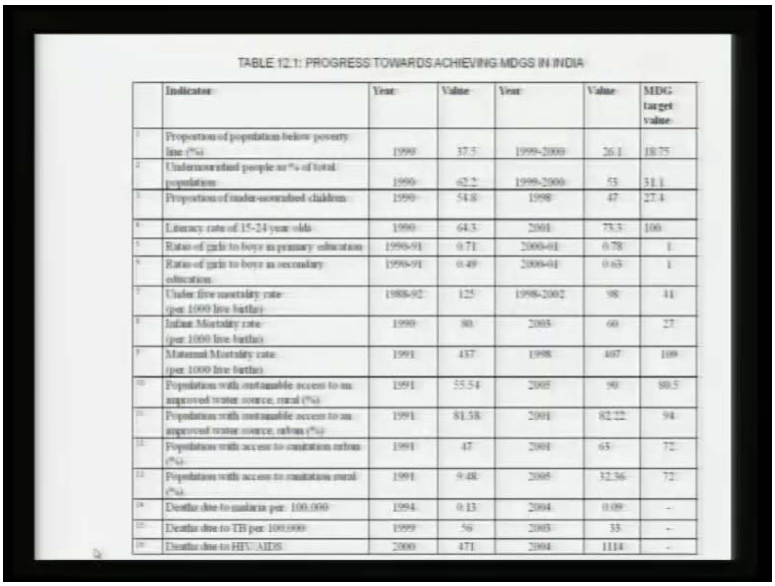
TABLE 12.1: PROGRESS TOWARDS ACHIEVING MDGS IN INDIA

	Indicator	Year	Value	Year	Value	MDG target value
1	Proportion of population below poverty line (%)	1990	37.5	1999-2000	26.1	18.75
2	Undernourished people as % of total population	1990	62.2	1999-2000	53	31.1
3	Proportion of under-nourished children	1990	54.8	1998	47	27.4
4	Literacy rate of 15-24 year olds	1990	64.3	2001	75.3	100
5	Ratio of girls to boys in primary education	1990-91	0.71	2000-01	0.78	1
6	Ratio of girls to boys in secondary education	1990-91	0.49	2000-01	0.63	1
7	Under five mortality rate (per 1000 live births)	1988-92	125	1998-2002	98	41
8	Infant Mortality rate (per 1000 live births)	1990	80	2005	60	27
9	Maternal Mortality rate (per 1000 live births)	1991	437	1998	407	109
10	Population with sustainable access to an improved water source, rural (%)	1991	55.54	2005	90	80.5
11	Population with sustainable access to an improved water source, urban (%)	1991	81.58	2001	82.22	94
12	Population with access to sanitation urban (%)	1991	47	2001	63	72
13	Population with access to sanitation rural (%)	1991	9.48	2005	32.36	72
14	Deaths due to malaria per 100,000	1994	0.13	2004	0.09	-
15	Deaths due to TB per 100,000	1999	56	2003	33	-
16	Deaths due to HIV/AIDS	2000	471	2004	1114	-

The first indicator proportion of population below poverty in 1990, roughly 37.5 percent population of India, while living below the poverty line in 1999, 2000 the percentage reduced to 26.1. So, there is a reduction of more than 11 points poverty ratio. The MDG value is that we have to bring it down to 18.75 percent. these are all ambitious goals under nourished people has percentage of total population, which was 62.2 percent in 90 reduced to 53 percent and we have to reduce it further to 31.1 percent.

Again a very ambitious target for reducing under nourishment, government policies are certainly important but, you also have to have a certain level of development and redistributing basis. Proportion of under nourished children, which was 54.8 percent in 1990 reduced to 47 percent in 1998, we have to reduce it further to 27.4 percent.

Literacy rate in 15 to 24 age group, which was 64.3 in 1990 has already come up to 73.3 percent in 2001. And this has to be raised to 100 percent, everybody should be everybody should be literate in 15 to 24 age group everybody should be literate. Perhaps it will be easier to attend this goal of 100 percent from 73.3 to 100 percent as compared to some other goals, which are of economic or morbidity related goals. And ratio of girls to boys in primary education 0.71 in 1991 means in primary education on every 100 boys you had only 71 girls.

This was raised to 78 in 2001 and this has to be raised to 100 percent by 2015, ratio of girls to boys in secondary, much more decimal it was only 0.49 in 1991 raised to 63. So, on every 100 boys you had 63 girls in secondary education this has to be raised to 1.

For all for 100 boys a secondary education, we want to see that there is also 100 girls equal number of girls. Under 5 mortality rate, under 5 mortality in 1988 to 1992 period was 1025 per 1000 labours, it reduced to 98 and we have to bring it down to 41. This would be these indicators would be somewhat difficult to achieve, infant mortality rate, we have to bring it down to 27.

The present level means level in 2003 was around 60 and it has to be brought down to 27. Our record in reducing maternal mortality rate is particularly frustrating, you see in 1991 maternal mortality ratio was 437. In 1998 it reduce a bit it came down to 407 and this has to be brought down to 109 most ambitious.

I do not exactly know what our level 2010 but, based on my reading of different papers on the matter, I can say that it is still hanging around 300. So, from 300 you have to bring it down to 109 in a very short duration; and this is something which require intervals at various levels, household level, village level, block level, district level. There are certain things, which the district health or (( )) have to do, there are certain things which families have to do there are certain things, which village health and sanitation communities have to do.

And when all of them households, communities, villages, blocks, districts and states work together, then only it is possible to reduce maternal mortality to 109. Then population with sustainable access to improve water source, we seem to be having good record of this in 2005, 1990 percent population had access to improve water source and the goal was on the 80.5. Then population with sustainable access to an improved water source in urban areas in 2001, 82.22 percent had access this has to be raised to 94.

Population with the access to sanitation, urban areas the figure has to be raised to 72 in rural areas also this has to be raised to 72. And here again a big challenge lies, ministry has initiated lots of studies of sanitation, why people are averse to the idea of individual household latrines and very interesting findings have come up.

So, this is a big issue how to encourage people to change their habits and there are poverty issues, cultural issues, village issues, gender issues, something has to be done drastically to achieve this.

Deaths to malaria we do not want to see any death occurring due to malaria and at the moment per 10,000 population 0.09 death are taking place due to malaria. TB deaths are more in number for every 10,000 population means 1,00,000 population, 33 people are dying due to tuberculosis and this has to be brought down to 0, with the help of DOTS program.

Deaths due to HIV aids in 2004, there were 1,114 it has to be brought down to as minimum theoretically 0 but, as low number as possible.

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Now, the impact of MDGS on population policy has been like this, focus attention of planners and development activists search for reliable data on these indicators at national state district and block levels. Targets set for evaluation of development programmes, seminars, conferences and research agenda; during last 10 years you find lots of universities and NGOS have organized conferences on MDGS, at the national level state level and some at the lower level.

If this is also given as a frame work for health and population policy, there is more stress on entitlements and human rights approach rather than course and incentives and disincentives, this has expanded role for private initiatives, influence on the perspective of 10th, 11th, 5 year plans that is another thing that we clearly see the impact of MDGS this has helped us in putting the development agenda on top of family planning program. And MDGS accord special importance to women, empowerment reproductive and child health and fighting HIV epidemic.

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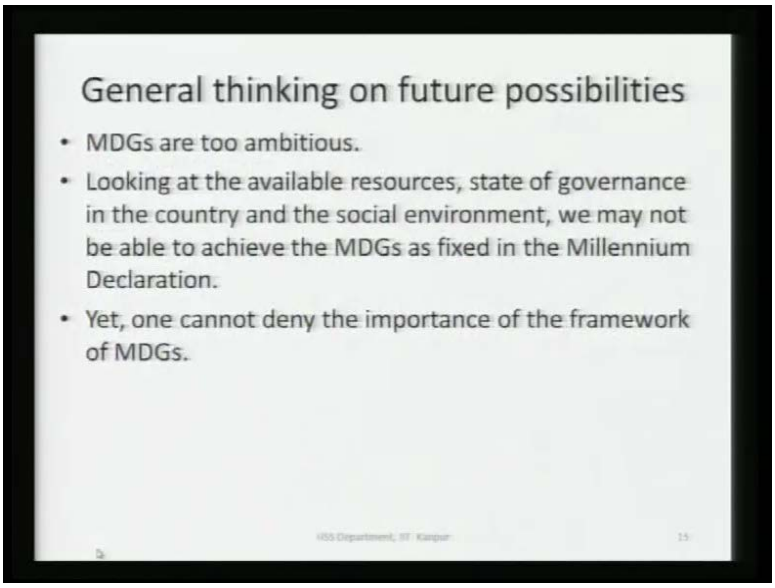

General thinking on future possibilities is that MDGS are too ambitious looking at the high level sources state of governance in the country and the social environment. We may not be able to achieve all the MDGS as fixed in the millennium declaration.

Some indicators will be fully achieved, some will be less achieved, records of achieving of different indicator targets will vary from indicator to indicator. But, one cannot deny the importance of the frame work of MDGS, whether you want to have population control or not MDG or goals in themselves goals of planning in themselves.

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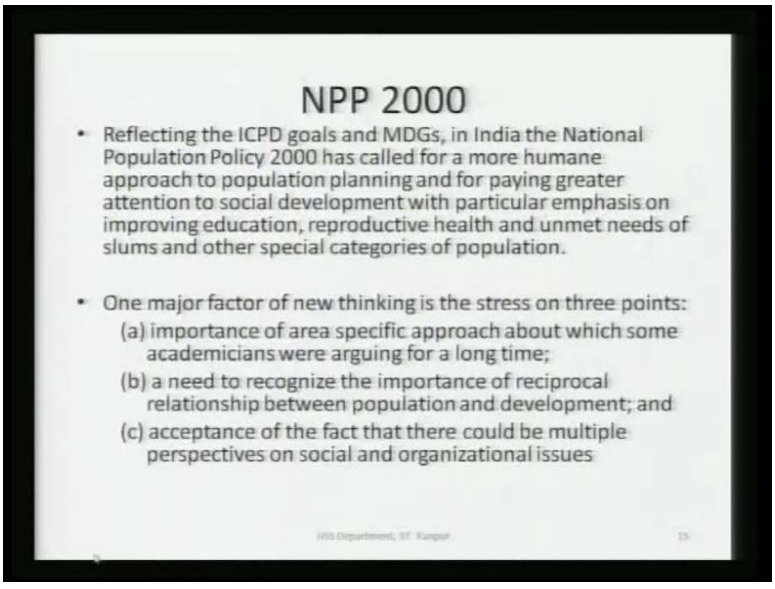

Now, compare this MDGS with NPP national population policy 2000 reflecting the international conference on population and development goals and MDGS in India. The national population policy 2000 has called for a more humane approach to population planning. And for paying greater attention to social development with particular emphasis on improving education, reproductive health and unmet needs of slums and other special categories of population.

One major factor of new thinking is the stress on three points, one importance of area specific approach, about which some academicians were arguing for a long time persons of the states of (( )) have been talking about this thing for a long time. A need to recognize the importance of reciprocal relationship between population and development and acceptance of the fact, that there could be multiple perspectives and social and organizational issues.

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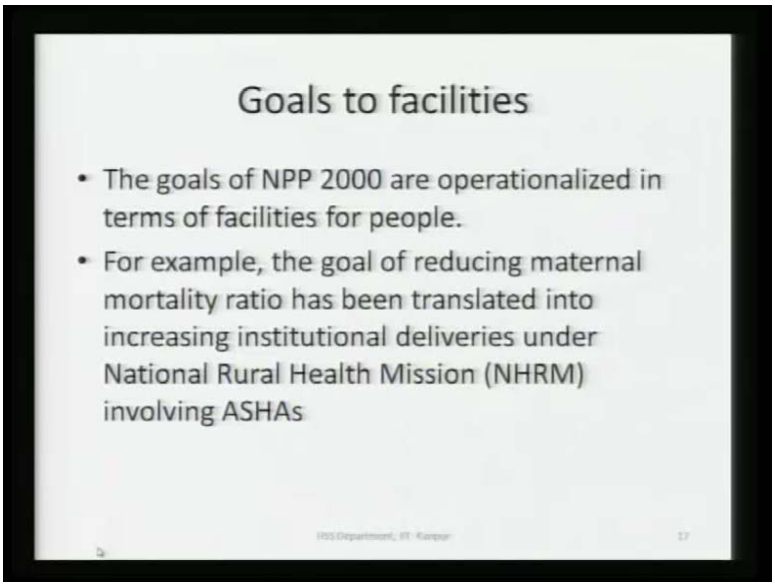

Goals for facilities under NPP, the goals of NPP 2000 are operationalize in terms of facilities for people. For example, the goals of reducing maternal mortality ratio has been translated into increasing institutional deliveries under National Rural Health Mission NHRM involving ASHAs.

So, earlier we have discussed the draft, population policy of Dr. Karan Singh and then janata draft, we have seen the emphasis was more on targets, on goals, visions need need to attain a high couple protection rate as soon as possible. But, now in NPP 2000

attention has been shifted more towards operationaliztion of goals in terms of facilities. Create more facilities, create more facilities for institutional deliveries, create more facilities for children.

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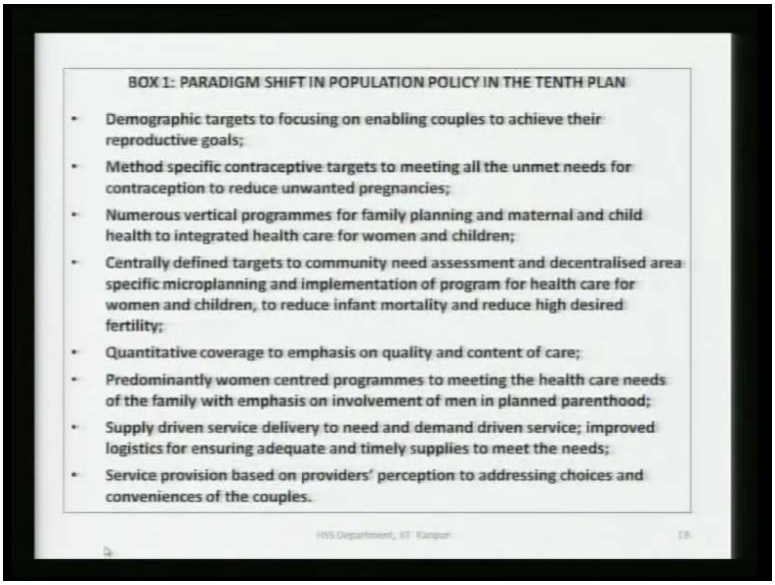

So, there is the paradigm shift in family planning, this box shows the paradigm shift in population policy in the tenth plan, demographic targets to focus on enabling couples to achieve their reproductive goals, their reproductive goals then method is specific contraceptive targets to meet the unmet needs for contraception to reduce unwanted pregnancies.

The nobody will dispute that unwanted pregnancies should be stopped Hindus have Muslims or (( )) around yes the pregnancy is unwanted issue it should be stopped, then couple should have all the facilities to reduce unwanted pregnancies. Because if they have unwanted pregnancy, then the consequences are more painful for them only, they will either produce babies or they will go for abortion; in both the cases they they will have to bear enormous cause of unwanted child birth.

Then numerous vertical programs for family planning and maternal and child health to integrated health care for women and children, family planning to health. Centrally defined targets to community need assessment and decentralized area is specific micro planning. And implementation of program for health care, for women and children to reduce infant mortality and high desired fertility; high desired fertility existed because,

infant mortality was high, child mortality was high and couples planned to produce more children, than they desired because, they thought that some of them might die.

Then quantitative coverage to emphasis on quality and content of care, there is a shift in NPP 2000, you find a shift from quantitative coverage to quality and content of care, satisfaction, quality quality of care satisfaction of clients. Predominantly women centered program, which the family planning program was initially to meet the health care needs. Now there is a shift to meet the health care needs of the family, with the emphasis on involvement of men in planned parenthood.

Then supply driven service delivery to need and demand driven service, improved the logistics transport information, mobility for ensuring adequate and timely supplies to meet the needs. And lastly service provision based on provider's perception to addressing choices and conveniences of the couples.

So, from supply to demand, supplies in the sense of facilities will be improve but, the program must cater more to needs and conveniences of the couples, rather than to philosophical, political and demographic ideas or the planners or providers, not providers the couples should decide, what should be done.

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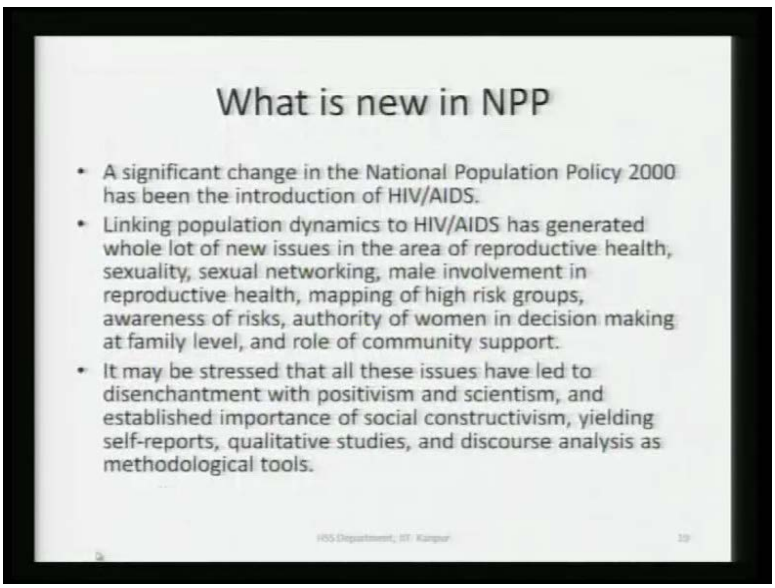

So, what is new in NPP, there are several new things in NPP 2000, a significant change in the national population policy 2000 has been the introduction of HIV aids, before this

NPP 2000 population policy did not talk about HIV aids. HIV aids did not exist the first case of virus in India was detected in 1986 somewhere in Chennai and after that there has been a gradual development.

After NPP 2000 HIV aids became an integrated part of population policy, then a linking population dynamics to HIV aids has generated, whole lot of new issues in the area of reproductive health like sexuality, earlier nobody was talking about sexuality. NPP 2000 made sexuality a new issue. So, our sociologists have lots of new issues now to examine, sexuality, sexual network, not that in sociology studies of sexuality were lacking in sociology, we talk of (( )) study of sexuality.

But in India nobody did the serious job of studying sexuality pattern, sexual networking. If you want to prevent HIV aids transmission from infected to an uninfected person through sexual routes, you have you must understand the sexual networking.

Then male involvement in reproductive health, without male involvement in (( )) (( )) family of India you cannot fight the aids epidemic. Then mapping of high risk group, who are high risk group, where are they living, what is their number, what is their mobility pattern. In high risk group usually we include FSWS, MSM and intervener drug users.

We want to know you must know their estimates at the national level, the state level district level tahsil level, taluk level and village level, where are they living what is their number, what is the mobility pattern, what are their practices, what are their needs. Then awareness of how aware they are of this, they as well as the general population, how aware people are of this.

Authority of women in decision making at family level and role of community support; it may be stress that all these issues have led to disenchantment with positivism and scientism. And established importance of social constructivism, yielding self reports, qualitative studies and discourse analysis as methodological tools.

So, in the beginning of this lecture I said when I entered population field as a student, then it was dominated why statisticians and mathematicians. Now because of all these factors millennium development goals NPP 2000, new issues, methodologically more sociologists would be using qualitative methods. Actually there is in research department

research institutions, there is much more demand for qualitative researchers today, than for quantitative research. Although you must know a little bit of quantitative methods, surveys, etcetera. What is surveys structured unstructured questionnaire, how to collect data how to analyze data using SAS or SPSS. But there is a growing demand for qualitative research.

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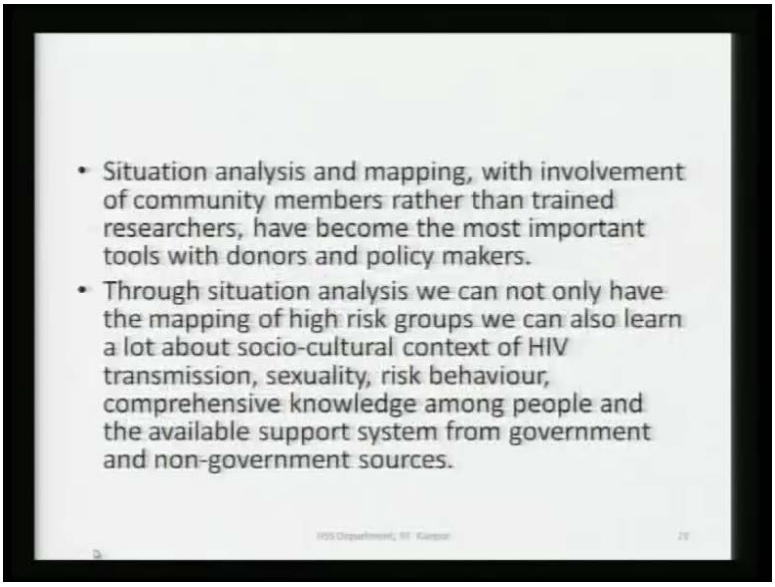

Situation analysis and mapping with involvement of community members, rather than trained researchers have become the most important tools with donors and policy makers. Participatory method; if mapping is to be done it has to be done using participatory methods, that is because the experts outsiders, experts, demographers, sociologists, field workers cannot arrive at quick and exact estimates of numbers of high risk groups; without involvement of the members of risk group themselves. So, participatory approach but it is not so, easy we have done yesterday for NACO - National Aids Control Organization and UNISEF in which we mapped high risk groups in Bihar all the districts, all the talukas using participatory approach very difficult; as qualitative approach participatory learning these are some new tools, which sociologists are using more and more in studying new issues related to population.

Then through situation analysis we can not only have the mapping of high risk groups, we can also learn a lot about socio cultural context of HIV transmission, sexuality, risk

behavior, comprehensive knowledge among people and the available support system from government and non-government sources.

So, this is all I wanted to talk about today, if you have one or two questions in mind please please.

Sir, it is whether (( )) Delhi development red clearance 2000. So, already actually (( )) already completed, so that the originate it around the sixty indicator but, in data it will be around sixteen. But, but after looking all the indicators, I think its not much after 10 years not much you grow men, but (( )) really said that the (( )) objective that it achieve in the universal (( )), because now around twenty 2000 it is I think 73. So, there is there is a chance, that we reach that 100 or 90, but except all the seven goals, so I think there should be how we can achieve this kind of, another point is that sir, sixth one that is accessibility of anti antiretroviral therapy over the drugs. For India as a (( )) I think in law I have heard, so many report that this kind of drugs accessibility of this which we say very, very much problem. Then (( )) said maternal mortality (( )), so how far, so all the (( )) to some extent it is national population policy or national rural mission government started some program to achieve this target. But it means that I think should be countries specific, sir you mentioned that it around 190 countries sir singed this (( )). So, this applicable to all the country, but country like India how far we will achieve already (( )). So, its good.

Actually we are talking about this in the context of population policy that millennium development goals have influenced, policy making in the field of population as far as achievement of indicators is concerned. Even if we did not have millennium development goals or we did not have population policy, there would be some improvement in them as you case on ministry. For example, is already working to promote literacy, school enrolment rate and general parent, ministry of rural development is already, was already working to reduce poverty ratio like this.

All these things were already part of development planning but, this millennium development goal have drawn attention towards certain specific goals of development that is one thing. And that has that also means that there is more attention of planners academicians, experts, journalists, civil society on these issues, energy of governments

civil society, the academicians is more channelized towards attainment of these specific goals.

Now, we may not be able to achieve all the goals 100 percent, some goals will be achieved may be more than 100 percent, some goals may be achieved 90 percent, some goals will be achieved 60 percent. But this clearly shows that there is a change in thinking, there is a paradigmatic change in thinking on population issues. In place of targets a birth rates, death rates, etcetera or couple protection rates, we are talking more in terms of creation of facilities, so that people can meet their needs.

So, the shift is from providers driven approach to client satisfaction, what the people what the couples want, what the clients want. So, in HIV also there is more focus on providing ART testing and counseling facilities. Now, as far as testing and counseling facilities are concerned, I think we have wide network of testing and counseling facilities and at the district level, even at the lower than district level, through rapid test it is possible to provide facility of this kind.

ART's ART is not available in all the districts here and certainly not at the block or PHC level or may be with improved funds, recognition of need more of these facilities will be created at lower levels. Certainly ART facility should be created at the district level and if possible if money permits, if ultimately to provide facilities at lower and lower levels you need funds, you need infrastructures.

Country like India combating HIV aids is should be (( )) but, at the same time may here the (( )) means HIV patient yeah.

So, it is stigma is another issue, which has been identified in the recent past and in the next lecture, we will talk about these things, thank you.