Population & Society

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Lecture No. # 39

Population Issues in the Framework of MDGs

So, today we are going to discuss some population issues in the frame work of MDGs. In the last lecture, we were discussing about what MDGs are, MDG stands for Millennium Development Goal; and there are eight goals. Against each goal, we have certain indicators, these targets have been assigned to each indicator that by year 2015, we must be achieving these indicators. They include infant mortality, maternal mortality, child mortality, his school enrolment, gender disparity in education and so on. Today, we will see that in the light of these MDGs, what kind of new issues have emerged in the study of population. Now since these are two last lectures, today's and then one more, I thought that it will be good idea if we talk about, what are the new frontiers of the research? What are new issues? What kind of paradigmatic changes are taking place in the studies of population quantitative as well as qualitative?

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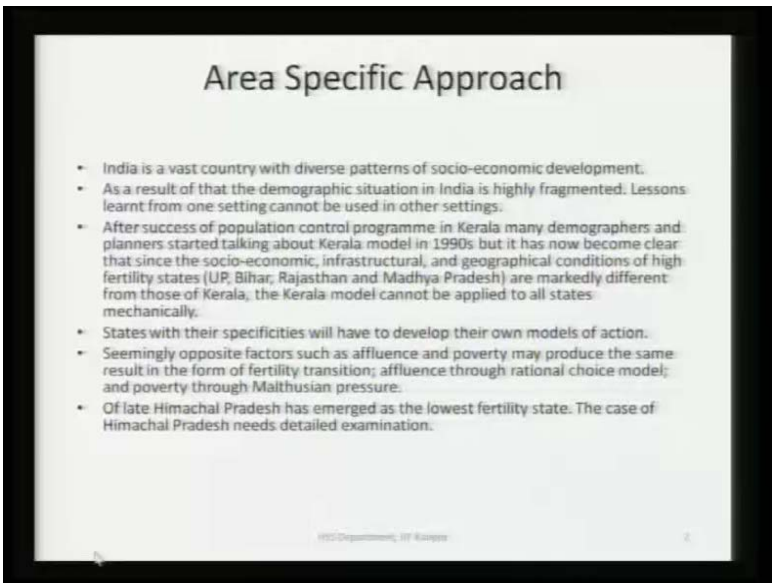

Now, one thing which emerges in the light of millennium development goals, national population policy 2000, is that to understand and solve problems of population in India, we require a disaggregated or area is specific approach. In your sociological language you can say, that we are moving towards hipper differentiation of demographic reality. And in a vast plural heterogeneous country of continental size, India the patterns of relationships are not same everywhere. So, what is true about some relationships, say relationship between education and fertility one state or in one district or one block may not be true in the other districts or blocks or villages.

Similarly, the issue of level of analysis what ids true art the micro level may be different from what is true at the macro level. So, from looked at from that is that perspective, we can say, that India is a vast country with diverse patterns of socio economic development. As a result of that, the demographic situation in India is highly fragmented. Lessons learnt from one setting therefore, cannot be used in a other settings. I remember for a long time, we used to talk about Kerala model of population policy or Kerala model of fertility transition.

Now, one has to understand in the light of this areas specific approach or national population policy 2000, that what is true for Kerala? Is not necessarily true for UP or Bihar or for the states of north east at (( )) level. As well as at the policy level, at the level of knowledge and also at the level of interventions, you have diversity of patterns and the reality is fragmented. After success of the population control program in Kerala, many demographers and planners started talking about Kerala model in 1990s. But it has now become clear that since the socioeconomic, infrastructural and geographical conditions of high fertility states UP, Bihar, Rajasthan and Madhya Pradesh are markedly different from those of Kerala. The Kerala model cannot be applied to all states mechanically.

Also states with their specificity, it will have to double up their own models of action. So, we can talk of Bihar model, you can talk of Jharkhand model, you can talk of Himachal model of demographic transition. Interestingly, seemingly opposite factors such as, affluence and poverty may produce the same result. So, in some situations, at some levels, in some areas, increasing affluence rationality and rational choice approach may explain, why fertility is declining, but at other places fertility may decline due to poverty.

I have seen several articles on Kerala, in which it was shown that in many parts of Kerala, fertility decline not because of education or social development, but more, because of perceived poverty. And people thought that, with growing poverty, there will be more Malthusian pressure on family resources, a large family might imply increasing poverty so, people became more careful. But at some other places it is urbanization industrialization social mobility, mobility aspirations are affluence, which affects fertility, in the same way, in which it affected fertility in the western countries.

Of late Himachal Pradesh has emerged as the lowest fertility state. The case of Himachal Pradesh needs detailed examination. We; this is one area, in which not much research is done and population foundation of India and several other donors are now interested in launching. They are looking for research organizations to take up the studies of demographic transition in Himachal Pradesh.

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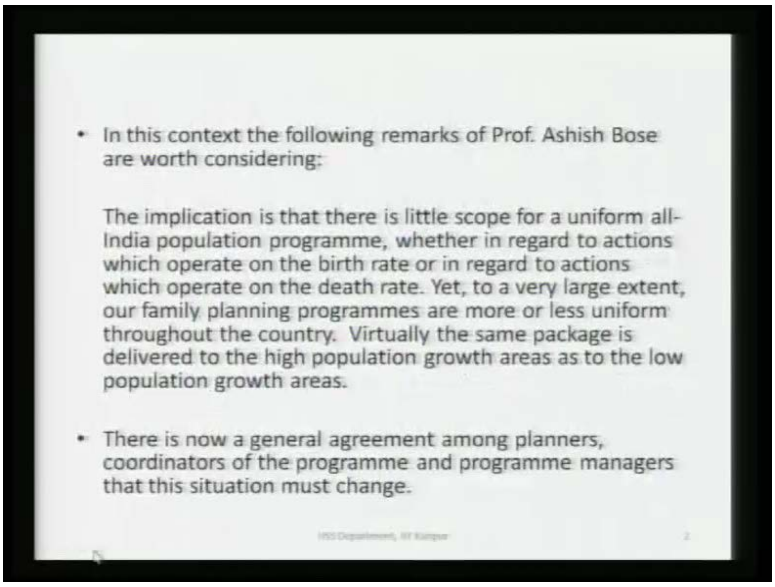

In this context, the following remarks of professor Ashish Bose are worth considering. The implication is that there is little scope for uniform all-India population program so, for, we ran a uniform all-India program. So, when we decide about incentive, disincentives communication strategies or conducting surveys, we decide about them uniformly that they will apply to all the states. If you fix some incentive after two children, you fix the same incentive for all the states in the country. While some states may not need them at all and some other states may need greater incentives.

So, to court Ashish Bose, the implication is that there is little scope for a uniform all India population program, whether in regard to actions which operate on the birth rate or in regard to actions which operate on the death rate. Yet to a very large extent our family planning program are more or less uniform throughout the country. Virtually the same package is delivered to the high population growth areas as, to the low population growth areas. In this context, I must say that yes in the eleventh five year plan, there has been an attempt to divide different states into different categories priority states, non priority states. And slightly different approaches are being adopted to control population growth in states belonging to different categories.

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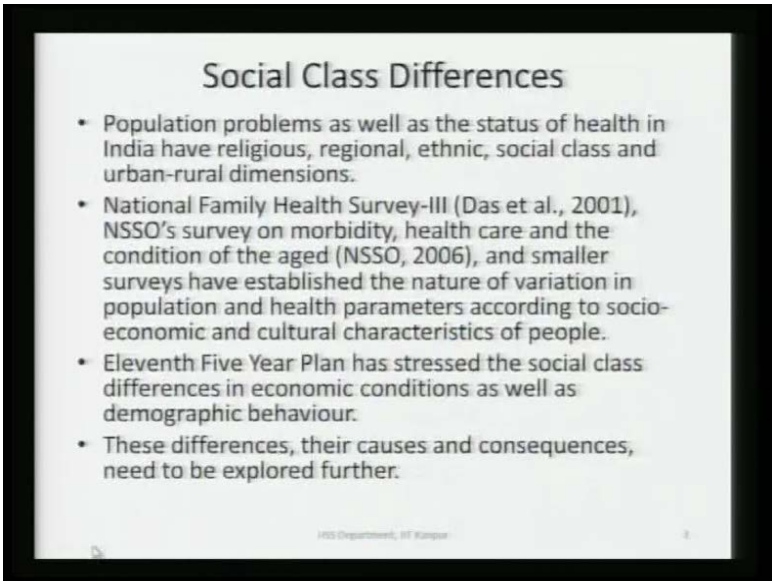

There is now a general agreement among planners, coordinators of the program donors, program managers that this situation must change and we must have separate policies. Or regionally differentiated policy, a frace which I found in literature on demographic diversity in Russia. In Russia at one time situation was very similar to that of India, that in the Asia part of Russia fertility was high and in the European part of Russia fertility had gone below the replacement level. So, the communist rulers of Russia were wondering, what to do? What is practical? And what is also consistent with the mars frame work? Finally, with lot of debate and controversy, it was decided that they will have different policies for European part and the Asia part.

Something like that may be required for India and not only, a real differences, there are also social class differences. Population problems as well as the status of health in India have religious, regional, ethnic, social class and urban rural dimensions. National family has survey third NSSO survey on morbidity health care and condition of the aged. One of the first and very important survey of health, all those students were interested in health must go through some pages of this health report NSSO 2006. And smaller surveys have established the nature of variation in population and health parameters according to socio economic and cultural characteristics of people urban, rural, tribal, non tribal, educated, uneducated, poor, rich, below poverty, above poverty line and so, on.

Eleventh five year plan has stressed the social class differences in economic conditions as well as demographic behavior. These differences, there causes and consequences need to be explode further, these are new issues.

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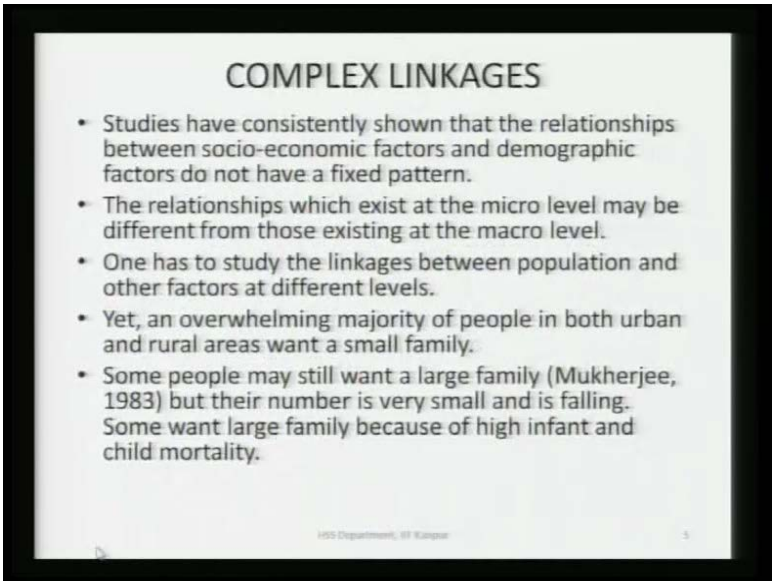

Now, studies have consistently shown that the relationships between socio economic factors. And demographic factors do not have a fixed pattern, what does that mean? Do not have a fixed pattern; that means that the strength of correlation the direction of relationship number and nature of mediating variables and moderate variables in different context are different. The relationships, which exists at the micro level, may be different from those existing at the macro level. What I mean to say, is that if you run a

regression analysis at the level of household, you may arrive at one set of results. If you run the same regression with the same variables at village level or community level or block level or a district or state levels, here results may be very different and often contradictory.

So, the level of analysis is also important, is somebody has done the study of correlation of fertility at the state level and as arrived at certain results, whether education affects fertility or not or what is the strength of correlation? What is the direction? That need not necessarily apply to relationship at the village or household level. So, you have to make a distinction between studies done in different context and studies done at the different levels. One has to be study the linkages between population and other factors at different levels. Yet an overwhelming majority of people in both urban and rural areas want a small family, this is also true.

Almost all surveys are showing that most people in India want a small family now. In a small family again there may be some differences, some people may want two childrens, some may want one child, some may not want any child at all. Some may want one son one daughter, some may want two sons, some want two children irrespective of sex, but everywhere now preference is for a small family.

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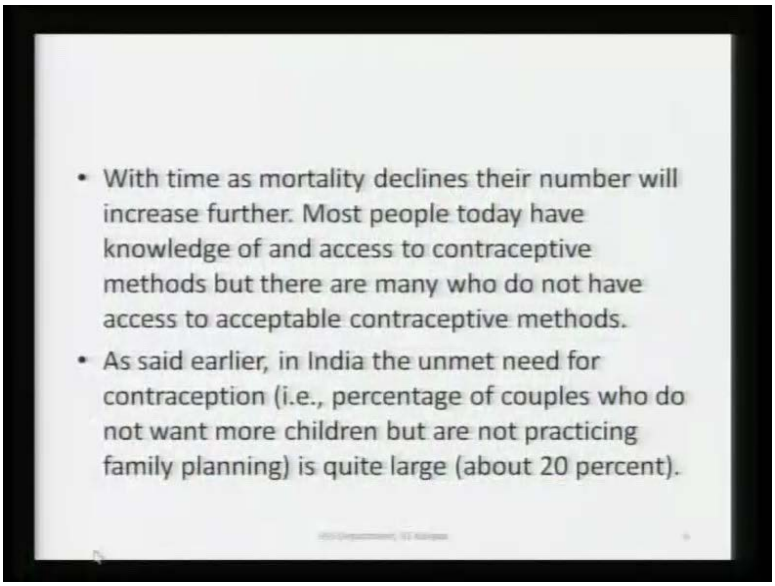

And wherever, some people want slightly more number of children, that is, because infant and child mortality are high. And with time as mortality declines their number, the

number of people who will want a small family will increase further. And number of people wanting more children due to high mortality will decline and the number of couples wanting a smaller family will increase. So, most people today have knowledge of and access to contraceptive method that is also true, but there are many who do not have access to acceptable contraceptive methods. As a result of that as said earlier also in India, the unmet need for contraception, that is percentage of couples who do not want more children, but are not practicing family planning is quilt large that is about 20 percent.

In one in tenth 5 year plan I was reading a in a chapter on population, they said that the three major causes of high population growth rate in India are age distribution, high mortality and unmet need. The age distribution, because even when total fertility rate has declined our birth rate continues to remain high due to young age structure and its contribution is as high as 60 percent. You will wonder, how age distribution alone is responsible for 60 percent variation in growth rate, high growth rate that 60 high growth rate is due to age structure that is true. That means, other factors remaining same when our age structure becomes older and older as the age structure of European countries is without any other change in fertility levels, our birth rate will decline by 60 percent.

In addition, there are some couples want more children, because of high mortality and their number was estimated to be around 20. And there is 20 percent unmet need, that there is; there are couples who do not want additional child, but because acceptable and effective modern contraceptive is not available to them. Either they do not know or they do not have access to it or there are side effects or rumors or misconceptions or side effects. So, they are not using them their percentage is about 20. Now various surveys are showing in some state, you find it to be 18 percent, in some state 17 percent number is declining or the hardly it is about 20 percent.

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Now demographic, another issue that in the past we always thought that population growth is bad. Now, there is controversy about that also in demographic sense is now seen both as having positive and negative implications for human resource development. While the continuing high growth rate of population may be disadvantageous in macroeconomic terms in terms of growth rate of income, in terms of per capital income, in terms of inequality, ginne coefficient, Lawrence curve and so on. The country has the advantage of opening of demography window finally, 20 years and there may be advantages of high fertility at the micro level or at house hold or at village levels.

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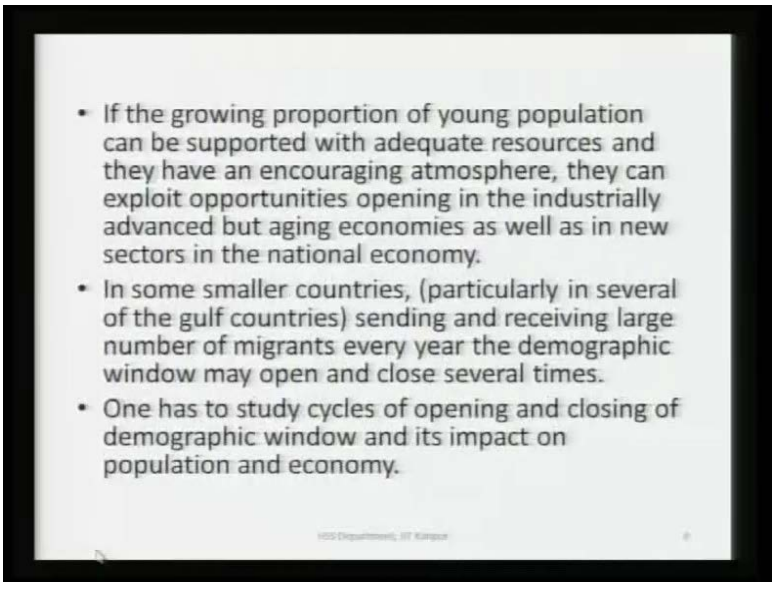

If the growing proportion of young population can be supported, that we have seen in one earlier lecture. That a if the growing proportion of young population can be supported with adequate resources and they have an encouraging atmosphere. They can exploit opportunities opening in the industrially advanced countries which are aging economies in the new sectors, in the national economy. In some smaller countries particularly in several of the gulf countries, interestingly standing and receiving large number of migrants every year the demographic window may open and close several times. Because in this period say people in younger age groups say 20 to 25 they migrate to other countries in search of employment.

So, proportion of adults in 20 to 25 declines. So, there is a closure of demographic window, but next time, there is more migration of say 35 plus or forty plus or 50 plus there is opening of demographic window. Depending on what kind of migrants live and what kind of migrants returned and went and also depending on trans in fertility and mortality, some researchers have shown that in some gulf countries. Demographic window has opened and closed several times and this makes an interesting question sociologists like you, who are interested in the study of population. One has to study cycles of opening and closing of demographic window and its impact on population and economy.

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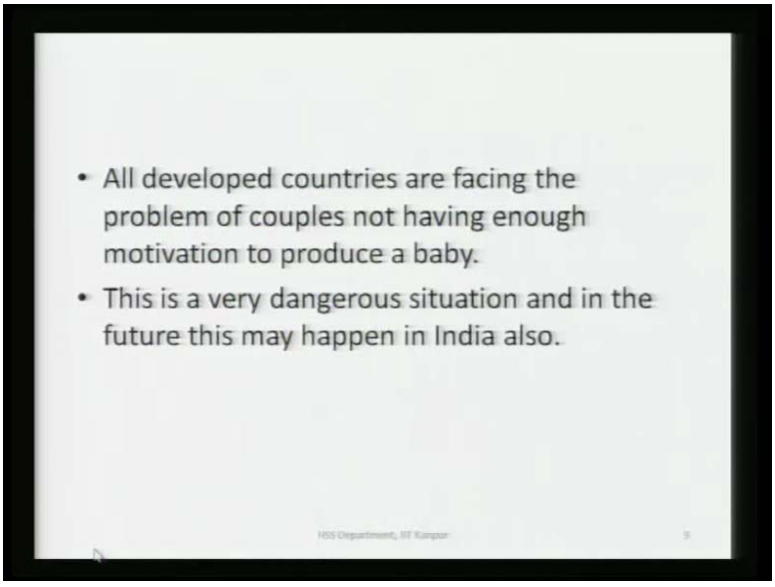

All developed countries are facing the problem of couples not having enough motivation to produce a baby. When we read articles and demography in population and development review and demographic articles and sociological journals, we find that in the context of developed countries. More articles now concentrate on third and forth demographic transition and the issue of fertility going to below replacement level. People, couples do not have enough motivation to produce a baby. There are changes in non, there are changes in family structures, there are changes in gender balance within family, because of that children are not wanted. This is a very dangerous situation from the perspective of developed countries, but should we also not start thinking in these terms.

We have always looked at a negative relationship between high fertility and economic development. Now, today when more and more of our states and a greater and greater proportion of our population, we will be experiencing this below replacement fertility. Or we also not going to have the same kinds of dangers which the developed countries have and should we not start talking about such dangers. I think time has come when along with or more talking in terms of negative consequences of high fertility. We should also start examining negative effects of declining fertility for economy, for culture kinship, religion, society, social structure, integration, unity and so on.

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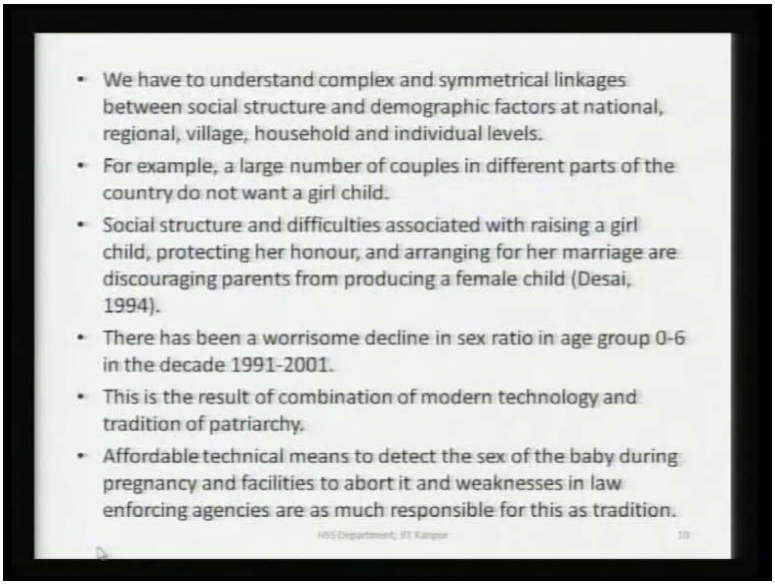

We; So, we have to understand complex and symmetrical linkages between social structure and demographic factors at national, regional, village, household and individual levels. I remember that in the very first lecture, I talked about social structure and demographic factors that, this course will be about social structure and demographic factors. But today I have added a phrase at national, regional, village, household and individual levels. That the relationship between social structure and demographic factors varies according to context and according to level of analysis.

So, for example, a large number of couples in different parts of the country do not want a girl child, these are some new issues. Social structure and difficulties associated with raising a girl child, protecting her honor and arranging for her marriage are discouraging parents from producing a female child. There may be a many other factors also. But two most important factors behind decline of guanine sex ratio are how to protect the honor of the girl child in a society in which violence is spreading increasing and how to arrange for marriage of a daughter in a situation of increasing amount of dowry.

There has been a worrisome decline in sex ration in age group 0 to 6 in the decade 91 to 2001. Let us see what happens in two 2011. Several religious organizations activists group, NGOS have been talking in terms of importance of girl child and that it is a hellions crime an illegal act to go for sex determination. And in case they find that, the child to be born is a girl to go for criticize. We do not know whether efforts of these NGOs, civil societies, actor religious groups and also efforts of the state will be (( )) or not, only 2001-2011 censes.

Next year, we will know what has happen there. Some people are saying that perhaps in this respect situation will be improved and some others are suspecting that. May be what has happened in Haryana, Himachal Pradesh, UP, Rajasthan, Delhi, the same thing is going to happen more and more to other states of India also. This is the result of combination of modern technology and tradition of patriarchy. And more and more populations have come under the access of patriarchy even tribal populations which had more of matrilineal, multifocal system, matriarchal system. Once they are converted to Christianity or Hinduism, all world religions are patriarchal and this has made a tribal populations increasingly patriarchal.

Affordable technical means, to detect the sex of the baby during pregnancy and facilities to abort it and weaknesses in law, enforcing agencies are as such responsible for this tradition or may be more than tradition. Traditionally, we do not have problem of low guanine sex ratio. It is not tradition, it is modernity, it is greed, it is fear, it is increasing violence alienation in society and it is improvement in technology and affluence.

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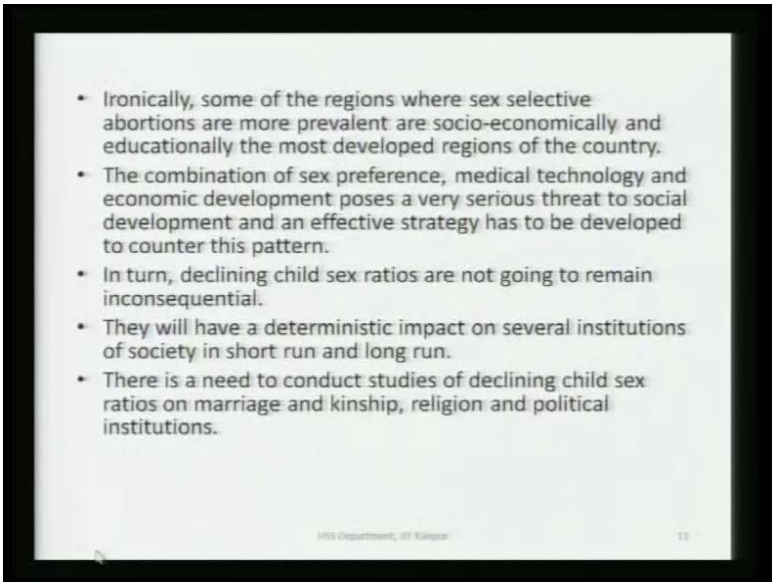

Ironically, some of the reasons where sex selective abortions are more prevalent are socio economically and educationally, the most developed regions of the country. The combination of sex preference, medical technology and economic development posses a very serious threat to social development and if and effective strategy has to be developed to counter this pattern. In turn, declining in child sex ratios are not going to remain in consequential. They will have a definite impact on several institutions of society in the short run and also in the long run. There is a need to conduct studies of declining child sex ratios on marriage and kinship, religion and political institutions, these are new issues.

So, one new issue is that the studies of relationship between social structure and demographic Trans must be done contractually in different state, different regions and in different levels. And another issue is the issue of declining child sex ratio that is very important issue.

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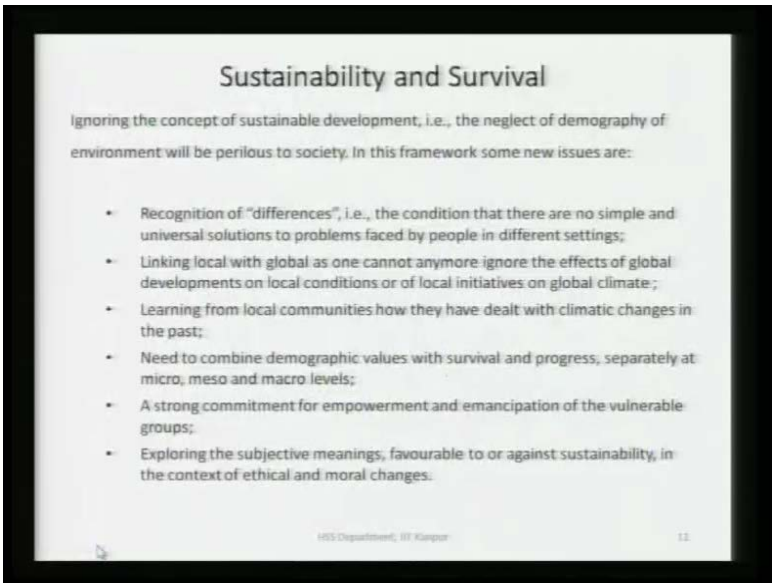

The third issue related to environment in the light of MDGs sustainable development, ignoring the concept of sustainable development that is, the neglect of demography of environment will be very less to society. In this frame work, some new issues are those of you who are computer have, you must have participated in perns P E R N seminars on population and environments several times, even the last month we had one. So, more people are taking interest in the relationship when population environment. Recognition of differences that the condition that there are no simple and universal solutions to problems faced by people in different settings.

There is no universal remedy to environmental problems or climate change problems. Again as in case of demography, you need area specific approaches. Linking local with global as one cannot any more ignored the effects of global developments and local conditions or of local initiatives on global climate. So, although you require contextually studies, micro studies, massive studies, but there is an increasing realization that local and global are connected. Suppose you can find global solution; global technological solution to the problem of ways from tanneries. Now, that global solution can be implemented in tanneries of Kanpur and you can improve the quality of water in the river gangers locally, that is, the relationship between global and local.

And if you can improve the quality of water in the river gangers in Kanpur, you also improve the quality of water in Allahabad in Varanasi in Patna. You know and you also

improve the quality of agriculture, quality of irrigation, quality of agriculture. And you also contribute to industrial and agricultural advancement of eastern UP, Bihar and west Bengal, that is, the connection between local and global. Once talking about environment I was telling that, they are several countries in Europe which are not. So, industrialized and which are primarily based on agricultural production and processing industry. But they are as much suffering from environmental problems of climate change as their industrial labour, because the problem of pollution climate change etcetera cannot remain confined to geographical or national boundaries.

So, there is a need to combine demographic values with survival and progress separately at micro meso and macro level. A strong commitment for empowerment and emancipation of the vulnerable groups which is part of sustainable development. Sustainable development is not only a condition of survival of mankind, but it is also a condition of survival or participation of the vulnerable sections of society. So, we have; if you want a sustainable development, we have to have a strong commitment for empowerment and emancipation of the vulnerable groups. SCs, STs, OBCs, women, old, children, state children, vagors, drug dependents, or drug misusers, families affected by rehabilitation, death of bed winner and so on.

Exploring the subjective meanings, favorable to are against sustainability in the context of ethical and moral changes in society is equally important. You ultimately for action, it is not the objective truths which are important, but the subjective meanings which ordinary people you or me. ordinary people attached to their action or environmental consciousness or environmental believes of ordinary people masses, that is important.

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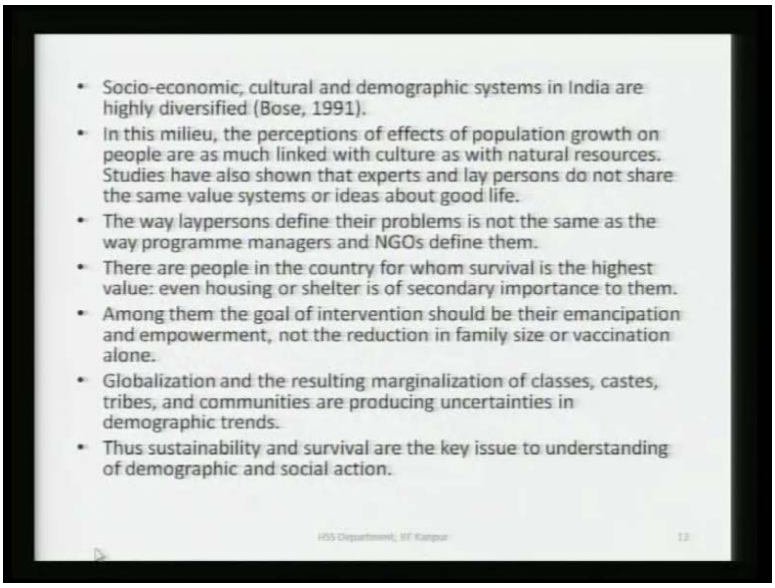

Socio economic cultural and demographic systems in India are highly diversified; this is only to repeat what I have said. In this milieu, the perceptions of effects of population growth on people are as much linked with culture as in natural resource. Say its studies have also shown that eperts and lay persons do not share, the same value systems arrive here that means there is also a need to shift attention from purely economic connections to cultural connections, psychological connections and cultural connections. Cultural connections, culture means values believes systems religiosity, psychology means drawing inference is not only about the objective reality on only, but also exploring experts believes, lay persons believes or social representations.

The way lay persons define their problems is not the same as the way program managers and NGOS define them. There are people in the country for whom, survival is the highest value even housing or shelter is of second importance to them. If we think that behind a people's action, it is their values and their believes. Then we must also see that these values and believes are not universal so, there is a need to explore values and believes. In one of our study, we use to think that, perhaps education or health or such things are of highest importance to people.

In one of our studies done by one of our PHD students in our department, we found that actually, it is household the value of a householder that is most important, not even health or not even economic status. People are ready to sacrifice their health, people are

ready to sacrifice their economic status. So that, they can effectively play the role of a householder, householders values being cultural is the most important value to then. So, we have to discover values. Among them, the goal of intervention should be their emancipation and empowerment. Among the things that we consider for intervention emancipation and empowerment must be give, due to important, not the reduction in family size or vaccination. These things have gone with first and second draft of population policy, Doctor Karn Sing and Jantha Policy.

Now, with national population policy 2000 and millennium development goals, there is greater emphasis on emancipation and empowerment, human rights, entitlements and so on. Globalization and the resulting marginalization of classes, cast, tribes and communities are producing un certainties in demographic trans. If these people become more vulnerable, we do no not know how will demographics behave? Thus sustainability and survival are the key issues to understanding demographic and social action.

This means, that some students of sociology interested in population issues, must also take interest in environmental issues, environmental believes, social representations, meanings of experts, meanings of lay persons, how lay persons define their values, how experts define lay persons values and how values affect their decisions and actions.

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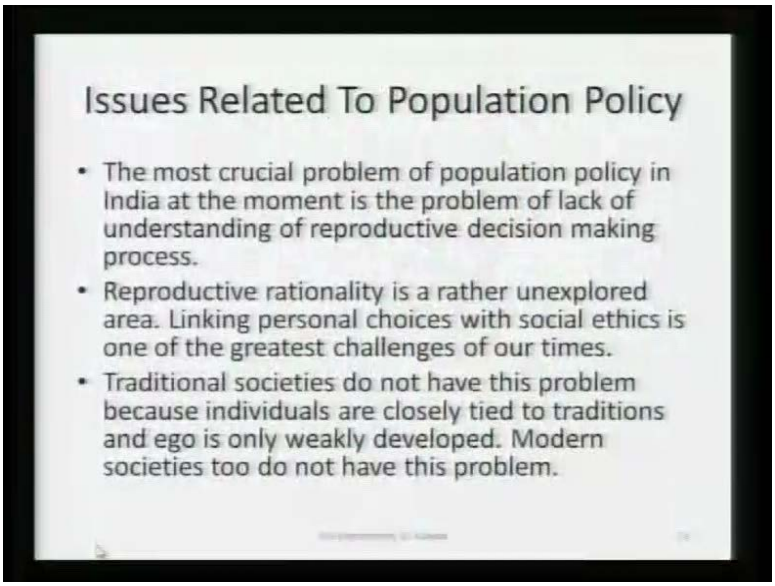

Now, some issue is related to population policy more directly. The most crucial problem of population policy in India at the moment is the problem of lack of understanding of

people at decision making process. We have done plenty of studies of relationship between demographic indicators, fertility, migration, urbanization and economic indicators. But we have not developed a good understanding of reproductive decision making, that is urgent may require. In the recent past during last 5 to 10 years, you find that more and more researchers are focusing on reproductive decision making rather than on fertility performance or family planning.

Reproductive rationality is rather; its rather unexplored area. Linking personal choices with social ethics, it is one of the greatest challenges of our times. How do people decide? How do individuals? How do couples? How do families decide? The sociologists cannot deny the fact that behind our reproductive decisions or our fertility preferences. There are social norms institutions and structures. But what is happening to relationship between individual and social structure with the process of increasing individualization with the process of post modernity of family with changes in marriages institution of kinship, marriage and family. So, that is something that we have to understand.

That if you are developing posts modern or differentiated forms of family. How will those differentiated families affect reproductive choices of individuals? Traditional societies do not have this problem, because individuals are closely tied to traditions and ego is only weakly developed. So, but modern societies too do not have this problem, because the modern society, there is perfect individuation and there are no social pressure, no traditional kinship, cast community presents to produce more number of children. But in between, in countries like India which are passing through a transitional phase, there is a conflict between individual rationality and norms of society.

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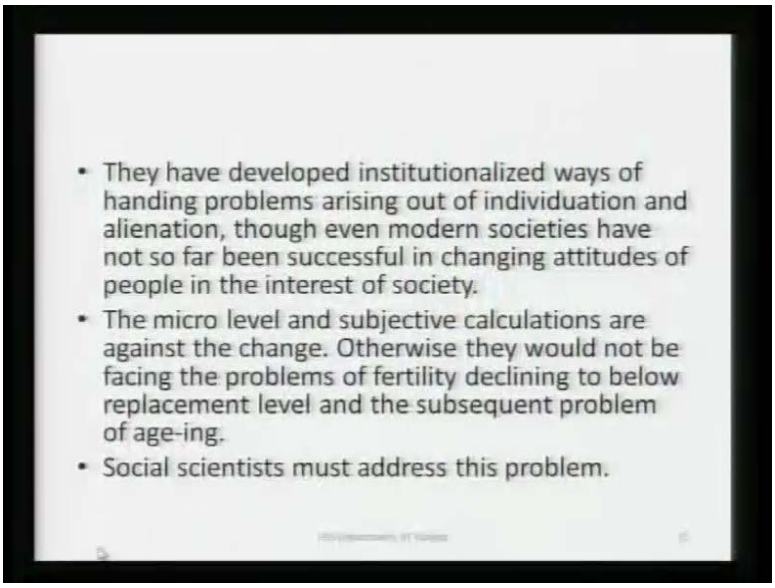

And how are different people, different families, different households responding to this conflict or this transition, that is, to be understood. Western societies have developed institutionalize ways of handling problems arising out of individuation and alienation. Though, even modern societies have not so far been successful in changing attitudes of people in the interest of society. We have seen that in Europe, they want pronetal policy and pronetal policy is developed countries are as much a failure as antenatal policies in the less developed countries.

So, there are problems, but in one respect our problems are more accurate and we require more studies of linkages between individuals and social structure. The micro level and subjective calculations are against the change, otherwise they would not be facing the problems of fertility decline. Decline into below replacement level and the subsequent problem of aging social scientist must adjust this problem.

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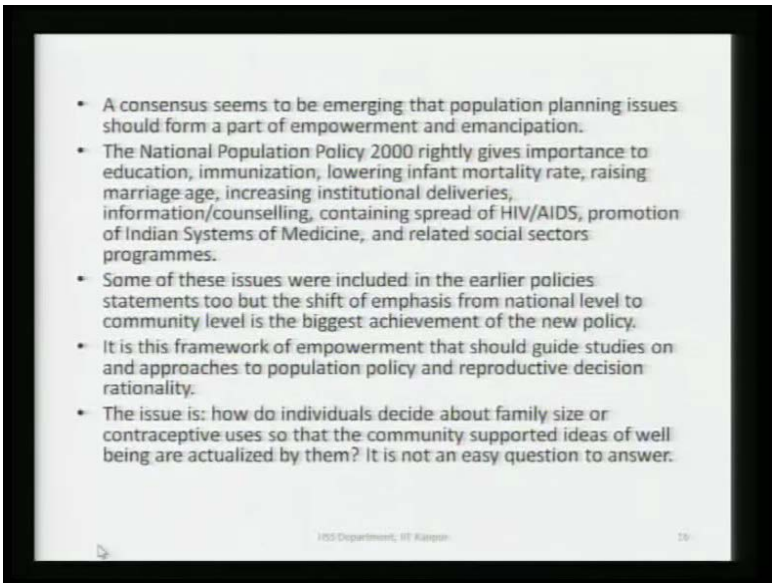

A consensus seems to be emerging that population planning issues, should form a part of empowerment and emancipation. National population policy 2000 rightly gives importants to education, immunization, lowering IMR, raising marriages, increasing institutional deliveries, information, counseling containing a spread of HIV aids, promotion of Indian systems of medicines and related social sector program, all directly or indirectly linked with empowerment and emancipation. Some of these issues were included in the earlier policy statements also, but the shift of emphasis from national level to community level. And shift of emphasis from targets to facilities is something to be celebrated and something which is new in new population policy.

It is this frame work of empowerment that should guide studies on and approaches to population policy and reproductive decisions.

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Let me also hurriedly say something about the history of empowerment and then if you have any question by then we can spend some time on that. You know that international conference for population and development which was held in 94 in Cairo. Maintained that size growth age structure and rural urban distribution of a country have critical impact on development process; prospects. And it called on countries to coat fully integrate population concerns into development strategies, planning, decision making and resource allocation at all levels.

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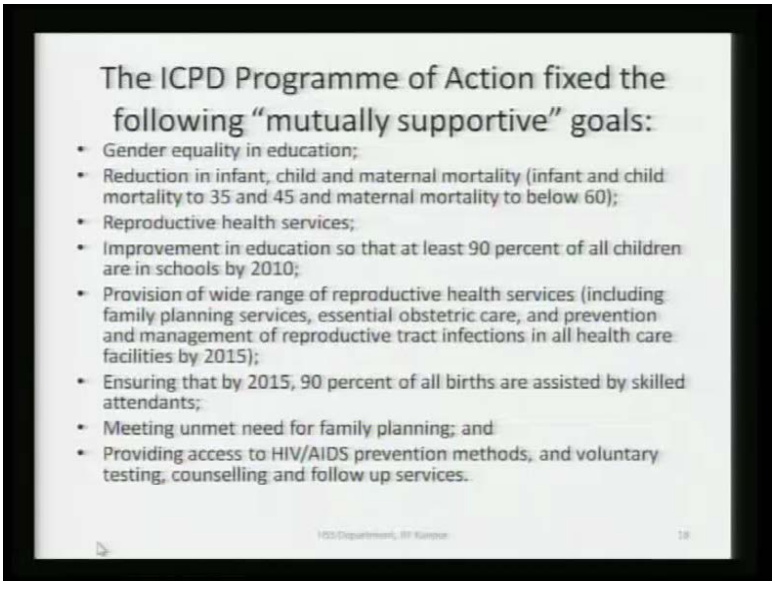

The conference, recognize that investing in people to burden their potential as human beings is the key to sustain economic growth and sustainable development. ICPD also fix the following, what they call? Mutually supportive goals gender equality, reduction in IMR, child mortality, maternal mortality. You say some of these targets were different from the targets fixed by millennium development goals. Like millennium development goals for IMR and child mortality are lower though for maternal mortality it is higher than 60, it is about 100 and 9. So, many of these points are very similar, improvement in education, reproductive health, institutional delivery, meeting, unmet needs.

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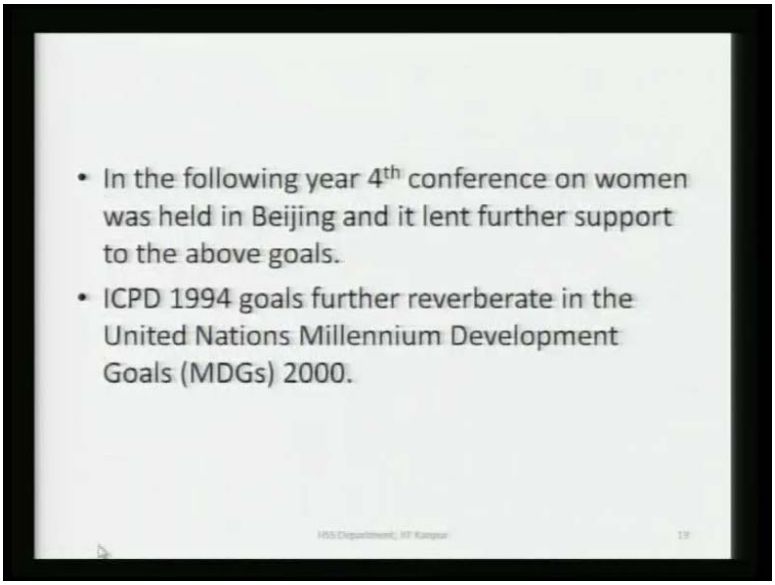

And in the following year 4 th conference on women was held in Beijing, it lent further support to the above goals. So, this is this; So, there is a long history of empowerment and participation. ICPD 1994 goals further reverberate in the united nations millennium development goals. One can say that there is nothing new in millennium development. Actually ICPD 1994 goals only are reverberate from 1994 in international conference on population and development, already paradigm had started.

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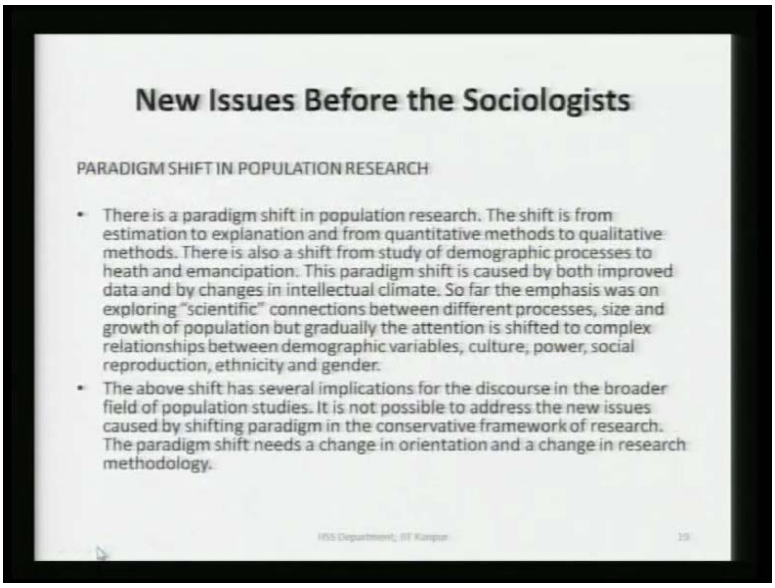

Now, considering all this, we can summarize that, there is a paradigm shift in sociology of population. This shift is from estimation to explanation, estimation of birth rate, estimation of death rate, estimation of birth intervals, open and closed birth intervals, parameters of chi squares, and mixtures of chi squares. Essentially from quantitative methods to qualitative methods, major shift from quantitative to qualitative, there is also a shift from study of demographic processes to health and emancipation. This paradigm shift is caused by both improved data partly, because there is more improved data, more reliable, more valid on demographic trans and partly in the intellectual climate, there is a change.

So, for the emphasis was on exploring scientific correlations between different processes, now, there is shift to complex relationships and social representations. The above shifts has several implications for that is course in the broader field of population study.

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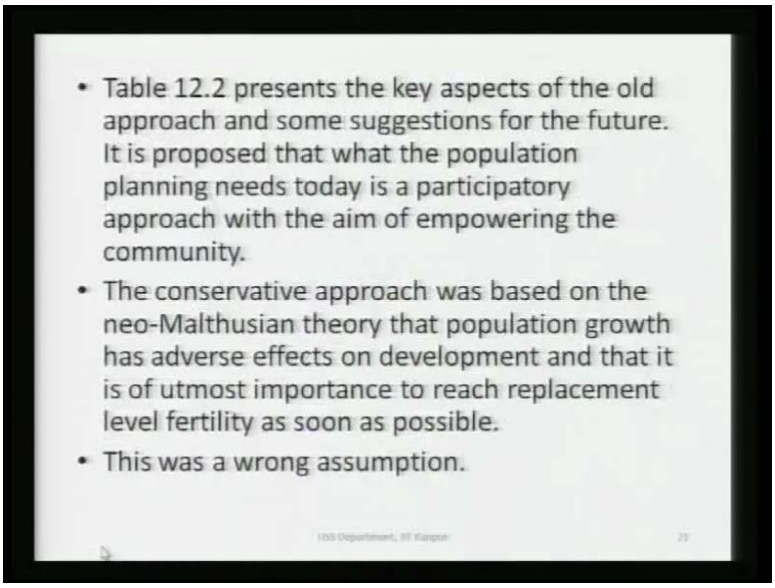

It is not possible to address new issues caused by shifting paradigm in the conservative frame work. There is a need for anthropologist sociologists to come together psychologists and anthropologists to come together psychologists and sociologist to come together. I have tried to summarize the key aspects of the old and new approach in the form of a table.

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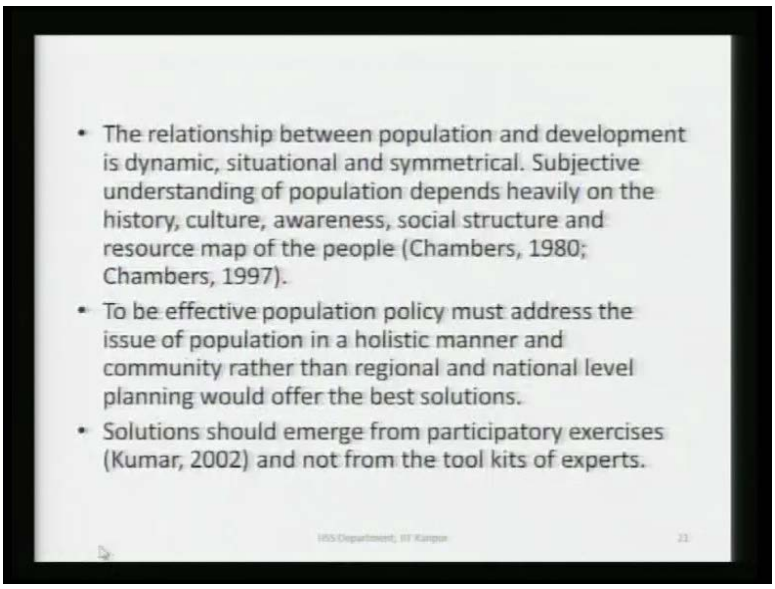

And I have tries to say that, the population policy must address the issue of population in a holistic manner, rather than analytical manner, rather than at the national or regional level.

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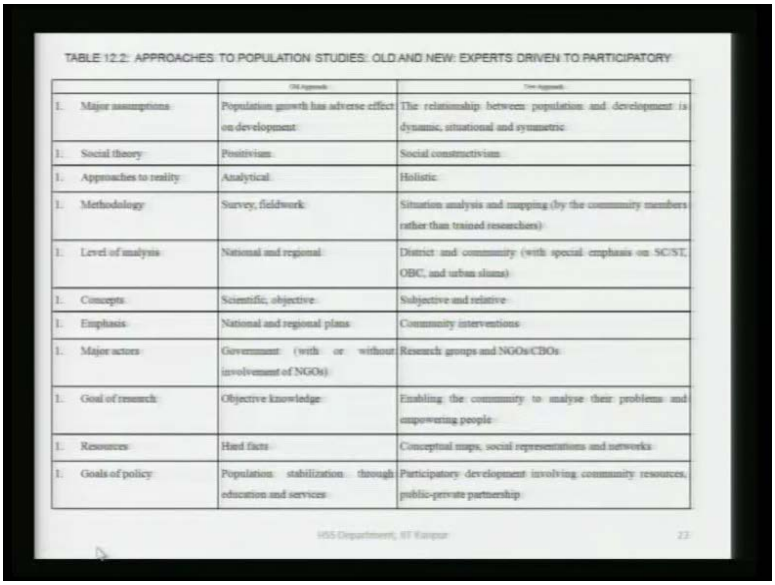

It has to go to micro level district block and village and household, ultimately household or individual level. You may not agree with all the points shown here, but broadly speaking you know the major assumptions of the old approach, where that population has adverse effect on development.

Now, the new approach will say that, the relationship is dynamic, situational and symmetric. Earlier we use positivism theory, now we are using more of a social constructivism knowingly or unknowingly. We have moved away from analytical approach to holistic approach in methodology, surveys and field work based studies are being substituted by qualitative studies, such as situation analysis and mapping. Earlier, the level of analysis was national and regional in the context of India region means; state. Now, there is a shift of attention to district and community with a special emphasis on SC, ST, OBC and urban slums.

The concepts, which were at one time scientific, now, they are more of subjective and relative emphasis in planning is at the community intervention, Panchayati Raj Institutions, rather than rational and regional plans. Major actors in the past were government, now, they are research groups NGOs and CBOs, CBO is emerging as a;

CBO means, community based organization. NGOs, NGOs work at a regional level, district level. CBOs work at the grass roots level community. So, there is a shift in attention from national level NGOs and state to NGOs working at lower levels and community based organizations.

The goal of a research is no more development of objective knowledge, it is the problem solving, enabling the community. Empowerment mans, enabling the community analyze their problems and empowering people. Resources, resources of researchers and planners and activists are not the hard facts so much, but conceptual maps social representations and network. The goal of policy which was earlier stabilization of population, now, it is more of participatory development involving community resources and public partner, public private partnership has become an important (( )) of emerging policy.

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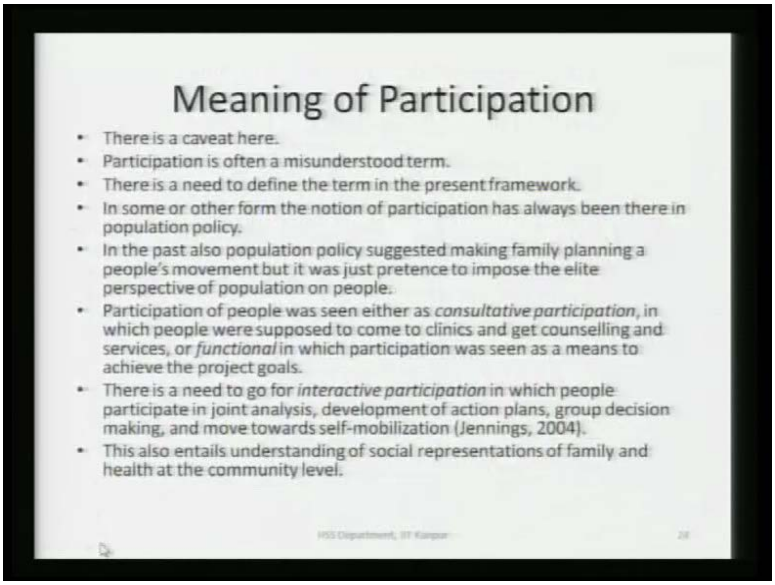

In this context, let me also spend two three minutes on the meaning of participation; participation is often a misunderstood term. There is a need to define the term, what do we mean by participation in the present; in the emerging frame work of empowerment and social representations. In some or other form the notion of participation has always been there in population policy. In the past also population policy suggested making family planning a people's movement. Doctor Kern Sing when he said that, when we make family planning, a people's movement certainly some kind of a notion of

participation was there. But it was just a pittance to impose the elide perspective of population of people.

Participation of people was seen either as consultative participation, in which people were suppose to come to clinics and get counseling and services or functional, in which participation was seen as a means to achieve the project goals. There is a need to go for interactive participation, in which people participate in joint analysis, you make people part of your analysis, planning, action, development of action plans, group decisions and movement towards self mobilization. In this respect participation is a new thing when doctor Kern Sing said that, let us make family planning, a peoples movement, the ideal was; obviously, one can say that the idea of family planning was doctor kern sings idea.

It was the states idea, it was intellectuals or experts or academicians idea and this idea was to be imposed or people were to be informed or convinced or motivated to accept this idea. Today the meaning of participation is that let us involve people not only in implementing family planning agenda, but in analyzing their situation through their own conceptual apparatuses. Help them in developing their own local action plan, district plan, block plans, panchyat plans, and let us have them in taking group decisions and let them help in make in moving towards self mobilization. Not mobilization by others, not by Health Minister any more, not by experts or academicians any more, but self mobilization of people.

Let the people analyze their situation, make plan for themselves, mobilize themselves to attain to achieve a better quality of life.

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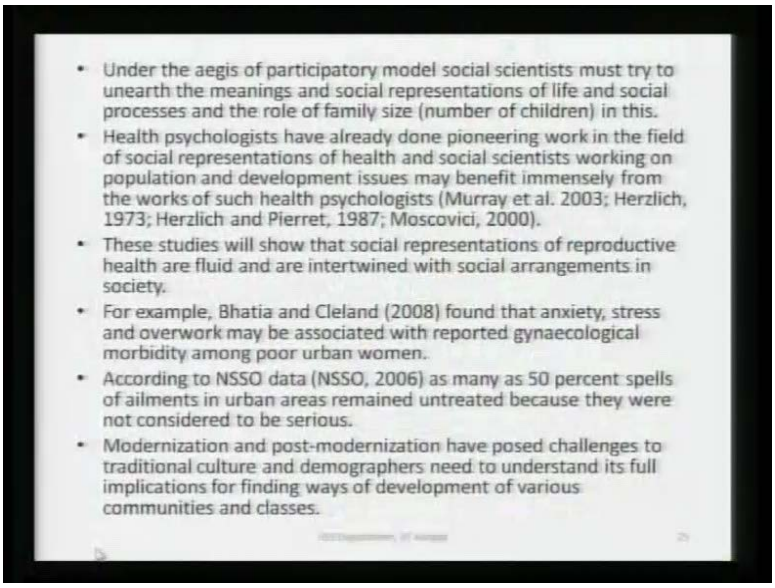

This also (( )) understanding of social representations of family and health at the community level. Under the aegis of participatory model, social scientists must try to unearth the meanings and social representations of life and social processes and the role of family size in this. Actually understanding of life and social processes is more important and understanding of role of family size must be seen only as a part of that. Health psychologists have already done pioneering work in the field of social representations of health and social scientists working on population and development issues may benefit immensely from the works of such health psychologists from the works of herzlich, moscovici.

Some of our PHD students in the field of health and population have already made use of social representation approach of herzlich and moscovici. These studies will show that social representations of reproductive health are fluid, they are changing, they are not same. They vary from one place to another and they change in the same space, same local, they change with changes in the environmental condition. They change with economic development political changes when the local cultures come in contact with the larger culture or when there is more interaction between micro and macro or little tradition or great tradition, there are changes, field view and textual view.

For example, Bhatia and Cleland found that anxiety stress and over work may be associated with reported gynecological morbidity among poor, urban, women. Now,

what the report about gynecological morbidity? May not be true for rural and rural women or rich urban women, here the reality has become so disaggregated. By the way, I must also tell that, another shift it attention in sociology of health is to shift from mortal; mortality to morbidity. Earlier we were studying more of mortality death rates, age specific death rates, life expectancy, conditional life expectancy, years of life lost due to different diseases. Now, there is greater safe towards morbidity or diseases.

Studies have shown that morbidity should be an issue in itself, even in those states like Kerala where mortality has declined and life expectancy has increased, morbidity rates have not necessarily declined. We must understand morbidity patterns, causes of morbidity patterns, relationship between economic condition and social structure on the one hand and morbidity patterns on the other. Develop ways through participatory methods to identify major morbidity patterns and to deal with them to mitigate the morbidity situation.

According to NSSO data as many as 50 percent spells of ailments in urban areas remained untreated, because they were not considered to be serious. Actually it is this point that relations to the point of social representations by herzlich and moscovici. If the people do not consider their diseases to be diseases, they will not come forward for their treatment or remedies. One such problem is the problem RTI, STI and RTI. Qualitative and quantitative studies show that in our country due to anemia mall nutrition, infection, poverty, ignorance in large percentage of women are suffering from STI RTI. But there is very little realization of this by women themselves.

And quite often, even when they suffer from pain or some consequences of RTI STI, they think that its natural, it is natural for women to have these kinds of problem. And since it is natural, no remedy is required. once they make RTI STI natural then nothing is to be done. So, there is a need to understand social representations of people and once we know that ignorance or you know these kinds of problems are there. Behind peoples lack of action to remedy the situations, we can help the people by creating interaction between lay persons an expert.

But first lay persons representations have to be understood modernization and post modernization have posed challenges to traditional culture. And demographers need to

understand its full implications for finding ways of development of various communities and class.

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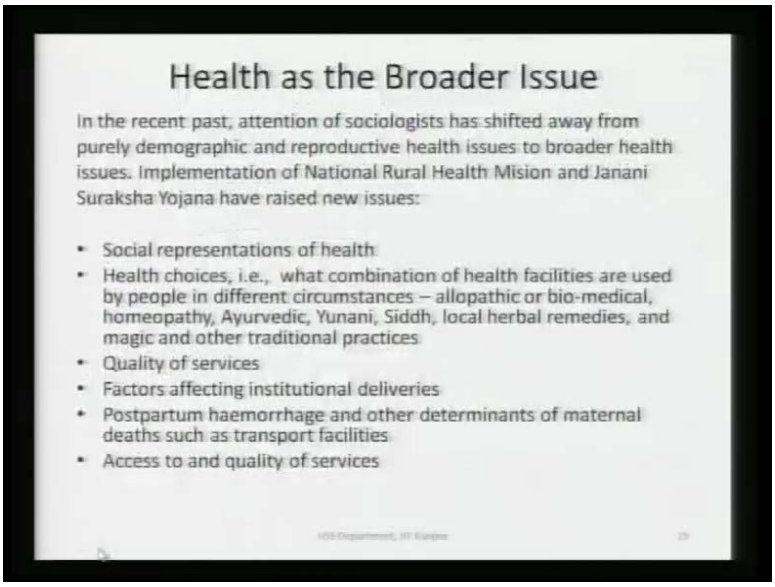

Health is a broad issue now and in a; So, for mortality to morbidity to health, with health we also have a new notion of positive health, health not merely an absence of diseases, but also as a positive concept of quality of life. We need to study some of you may be after doing your MA, when you go for MPhill and or when after doing your graduation in different professional subject, you go for higher level of studies. You may be take; taking up studies of social representations of health positive health, quality of life happiness and health choices.

What combination of health facilities are used by people in different circumstances? Allopathic, Biomedical, Homeopathic, Ayurvedic, Yunani, Siddh, local urban remedies, magic and other traditional practices. Researches show that, people do not think in either or terms and depending on their understanding and needs they may combinations of all of them. Then quality of services, then factors affecting institutional deliveries, postmortem haemorrhage and other determinants of maternal death, such as transport facilities access to and quality of services.

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This public private partnership has a new mechanic. We have not yet fully understood, the nature of its effectiveness, success of it and how can we promote a meaningful public private partnership in the field of health, population and development. Government of India has gone for public private partnership in health, in a big way. Public and private systems have their own strengths and weakness the idea was benefit from the strengths of both to escape the weakness of both. Its studies are needed to explore to what extent we have succeeded in doing so and what combinations of the two are good for society. And what ways of delivering as services need to be developed to have optimum benefit.

What should be the role of public sector, what should be the role of private sector, working in the field of health means having interventions and flows at several levels. Now, only generation recourses, institution building, communication services so, what should be the role of public sector? What should be the role of private sector? How to make an optimum combination of the two at various levels? What is optimum at village level may be different from? What is optimum at the district or state level and so on. So, these are some new issues. In the next lecture, we will wind up the whole discussion. I am sure that, there is at least one question.

Sir, while you talking about people making personal choices? Then how do they link? What is; what is the linkage between social ethics and personal choice? Are they compel to do so, or like is it out of choice?

Social ethics and personal choices, here social ethics may be seen in two ways. One in terms of what should happen and another social ethics as factors influencing peoples decision making through the process of socialization. Now, normally what is happening that, there was a time when our media, our books, our scientific literature and our elite, it started saying that traditional or endogenous. Knowledge system is mostly based on tradition, superstitions, ill understanding of health processes and we should do away with it and go for scientific understanding and scientific medicine.

But on the basis of their own experiences, people found that, there are many things in the tradition or in Ayurveda, in Siddh, in Yunani, in Homeopathy which are effective and useful. Or sometime in rural areas or tribal areas they are the only source, where western or modern medical system has not reached. So, the first choice of people is the ojas or the Herbal or traditional medicine or if there is an Ayurvedic practitioner, sometime ojas (( )) ayurvedic practitioners, all these roles are combined in one person. And they are very wide networks, that is, another thing that is an important issue for study by sociologists and anthropologists. We have studied some such network of ojas in the context of Udaipur Rajasthan.

So, but today, even the elite are saying that, there was some element of which, that we can combine the traditional system with modern system. Government of India is also supportive of Ayush, Ayurved, Yunani system of medicine and homeopathy. So, government is supporting, there have been the researches in centers of scientific research, All India Institute of Medical Sciences and Institute of Medical Sciences in BHU. You know, they are conducting researches on traditional medicine, Ayurveda Yoga. And now, the trend seems to be that, let the clients be empowered and on the basis of their experiences and on the basis of local resources services available to them, let them make the choice of what is optimum combination for them.

So, there is no ideological or scientific kind of threat to traditional or indigenous wisdom anymore, another problem with allopathic or scientific medicine that it had advanced to that level, that due to strong side effects. Doctors are not known in a moral position to say, what is right or what is wrong for the patients. So, they will only tell what are various choices, they should; they morally, they must upraise their clients all the positive and negative effects of all the choices and ultimately it is the patient or a client who take the decision.