Lecture 42: New Issues before the Sociologists

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PARADIGM SHIFT IN POPULATION RESEARCH

There is a paradigm shift in population research. The shift is from estimation to explanation and from quantitative methods to qualitative methods. There is also a shift from study of demographic processes to heath and emancipation. This paradigm shift is caused by both improved data and by changes in intellectual climate. So far the emphasis was on exploring "scientific" connections between different processes, size and growth of population but gradually the attention is shifted to complex relationships between demographic variables, culture, power, social reproduction, ethnicity and gender.

The above shift has several implications for the discourse in the broader field of population studies. It is not possible to address the new issues caused by shifting paradigm in the conservative framework of research. The paradigm shift needs a change in orientation and a change in research methodology.

Table 12.2 presents the key aspects of the old approach and some suggestions for the future. It is proposed that what the population planning needs today is a participatory approach with the aim of empowering the community. The conservative approach was based on the neo-Malthusian theory that population growth has adverse effects on development and that it is of utmost importance to reach replacement level fertility as soon as possible. This was a wrong assumption. The relationship between population and development is dynamic, situational and symmetrical. Subjective understanding of population depends heavily on the history, culture, awareness, social structure and resource map of the people (Chambers, 1980; Chambers, 1997). To be effective population policy must address the issue of population in a holistic manner and community rather than regional and national level planning would offer the best solutions. Solutions should emerge from participatory exercises (Kumar, 2002) and not from the tool kits of experts.

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TABLE 12.2: APPROACHES TO POPULATION STUDIES: OLD AND NEW: EXPERTS DRIVEN TO PARTICIPATORY

	Old Approach	New Approach
1. Major assumptions	Population growth has adverse effect on development	The relationship between population and development is dynamic, situational and symmetric
2. Social theory	Positivism	Social constructivism
3. Approaches to reality	Analytical	Holistic
4. Methodology	Survey, fieldwork	Situation analysis and mapping (by the community members rather than trained researchers)
5. Level of analysis	National and regional	District and community (with special emphasis on SC/ST, OBC, and urban slums)
6. Concepts	Scientific, objective	Subjective and relative
7. Emphasis	National and regional plans	Community interventions
8. Major actors	Government (with or without involvement of NGOs)	Research groups and NGOs/CBOs
9. Goal of research	Objective knowledge	Enabling the community to analyse their problems and empowering people
10. Resources	Hard facts	Conceptual maps, social representations and networks
11. Goals of policy	Population stabilization through education and services	Participatory development involving community resources, public-private partnership

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MEANING OF PARTICIPATION

There is a caveat here. Participation is often a misunderstood term. There is a need to define the term in the present framework. 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 but it was just pretence to impose the elite perspective of population on people. Participation of people was seen either as *consultative participation*, in which people were supposed to come to clinics and get counselling 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, development of action plans, group decision making, and move towards self-mobilization (Jennings, 2004). This also entails 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 (number of children) in this. 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 (Murray et al. 2003; Herzlich, 1973; Herzlich and Pierret, 1987; Moscovici, 2000). These studies will show that social representations of reproductive health are fluid and are intertwined with social arrangements in society. For example, Bhatia and Cleland (2008) found that anxiety, stress and overwork may be associated with reported gynaecological morbidity among poor urban women. According to NSSO data (NSSO, 2006) as many as 50 percent spells of ailments in urban areas remained untreated because they were not considered to be serious. 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 classes.

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HEALTH AS THE BROADER ISSUE

In the recent past, attention of sociologists has shifted away from purely demographic and reproductive health issues to broader health issues. Implementation of National Rural Health Mision and Janani Suraksha Yojana have raised new issues:

- Social representations of health
- Health choices, i.e., what combination of health facilities are used by people in different circumstances – allopathic or bio-medical, homeopathy, Ayurvedic, Yunani, Siddh, local herbal remedies, and magic and other traditional practices
- Quality of services
- Factors affecting institutional deliveries
- Postpartum haemorrhage and other determinants of maternal deaths such as transport facilities
- Access to and quality of services

Government of India has gone for public-private-partnership in health in a big way. Public and private systems have their own strengths and weaknesses. Studies are needed to explore what combinations of the two are good for society and what ways of delivering health services need to be developed to have optimal benefits.

ISSUES BEYOND HEALTH AND REPRODUCTION

Starting with the issue of estimation of birth and death rates in the second half of twentieth century population studies is shifting towards issues of empowerment and emancipation, particularly in the context of studies of reproductive behaviour and RTI/STI. Yet, there are other major issues which need proper attention.

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HIV/AIDS AND SEXUALITY

HIV is a high-consequence risk (Giddens, 2003) about which there is no historical precedent to call on in preventing its spread and whose origin is least understood, whether it has cropped up “naturally” or has been caused by technological or environmental changes. To quote (NACO, 2006):

> Scientists have different theories about the origin of HIV, but none have been proven. The earliest known case of HIV was from a blood sample collected in 1959 from a man in Kinshasha, Democratic Republic of Congo. (How he became infected is not known.) Genetic analysis of this blood sample suggests that HIV-1 may have stemmed from a single virus in the late 1940s or early 1950s.

We do know that the virus has existed in the United States since at least the mid- to late 1970s. From 1979-1981 rare types of pneumonia, cancer, and other illnesses were being reported by doctors in Los Angeles and New York among a number of gay male patients. These were conditions not usually found in people with healthy immune systems. In 1982 public health officials began to use the term "acquired immunodeficiency syndrome," or AIDS, to describe the occurrences of opportunistic infections, Kaposi's sarcoma, and Pneumocystis carinii pneumonia in previously healthy men. Formal tracking (surveillance) of AIDS cases began that year in the United States.

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The cause of AIDS is believed to be a virus that scientists isolated in 1983. The virus was at first named HTLV-III/LAV (human T-cell lymphotropic virus-type III/lymphadenopathy-associated virus) by an international scientific committee. This name was later changed to HIV (human immunodeficiency virus). HIV is passed on from the infected person to another person through the contact of body fluids such as blood, semen, vaginal fluid, breast milk and other body fluids containing blood. In other words, the virus may be transmitted through blood to blood and sexual contact, and from pregnant women to baby during pregnancy, delivery or breast feeding. Among health workers it has also been acquired through contact of cerebrospinal fluid surrounding the brain and the spinal cord, synovial fluid surrounding bone joints, and amniotic fluid surrounding a fetus. The virus starts weakening the immune system of the body making it more and more susceptible to various types of infectious attacks. Since these infections can easily attack the body of the AIDS patient they are often called the “opportunistic” infections. The infected person ultimately succumbs to one or more of them and dies. Although, the relationship between HIV and AIDS is not fully understood, available evidence suggests that the HIV is the cause of AIDS: HIV may remain dormant for as many as 8-10 years and develop into AIDS after that.

HIV research has produced certain ideas: (a) transmission of HIV is complex and uncertain; (b) HIV risk is subjectively defined; (c) the focus has to be on risk behaviour rather than group; and (d) there is a need for a new sociological paradigm.

On the basis of various sources of data, Pandey et al. (2009) estimate:

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HIV prevalence among adults (15-49 yr) was 0.36 per cent (uncertainty bounds 0.29-0.46%) in 2006. Overall prevalence in the high prevalence States was 0.8 per cent and in low and moderate epidemic States was 0.2 per cent. Prevalence was highest in Manipur at 1.70 per cent followed by Nagaland at 1.41 per cent, and Andhra Pradesh at 1.04 per cent. The estimated number of PLHA in the population of all ages was 2.5 million (uncertainty bounds 2.0 - 3.1 million). The number of people living with HIV was highest in Andhra Pradesh at 525560 (range 420,448-651,694) followed by Maharashtra at 495,488 (range 396,390-614405), Karnataka at 276,129 (range 220,903-342,400) and Tamil Nadu at 246,473 (range 197,178-305,626).

HIV and AIDS epidemic has raised new issues in health research (Narain, 2004). Some of them are:

- Situation analysis of HIV/AIDS
- Knowledge and awareness of RTI/STI including HIV and AIDS
- Socio-psychological and other determinants of risk behaviour
- Sexuality

Thus HIV is a new risk without possibility of cure. In several countries youths and adults have a very high prevalence rate, say more than 20 percent. There it spread very fast. In other countries also if timely action is not taken it can spread equally fast or even faster. Improvement in transport and communication, globalization, geographic and social mobility, changing norms and vulnerability of certain sections of society are leading to spread of “HIV epidemic”. The biggest problem in fighting the HIV is that the positive people and the communities in which they are found are stigmatized for various things. Therefore, the people will not come out and go for testing and treatment. India is not free from the risk.

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UNICEF has sponsored situation analysis of HIV/AIDS in different parts of the country. The main purpose of these studies is to examine risk of HIV, map the vulnerable groups and develop and inventory of resources for HIV/AIDS action.

Sexuality research has opened many new areas for health researchers. Important among them are sexuality and sexual behaviour, brothels and their clients, men having sex with men and other high risk groups, non-marital sex, sex among adolescents and young adults, and determinant of condom use (Verma et al., 2004).

WHAT IS STIGMA?

The recognition that to fight HIV is to fight stigma against HIV positive people has led to studies of stigma. Sociologically speaking, stigma implies devaluation. Stigmatized persons are targets of prejudice (attitudes), stereotypes (i.e., cognition as beliefs, knowledge and expectations of social groups) and discrimination. According to Goffman (1963), persons who possess an attribute that risks their full acceptance from others are said to possess a stigma. As a consequence of the stigma, such persons are reduced in people's minds from whole and usual persons to the tainted, discounted ones. For Goffman stigma is relational in nature, i.e., it is an attribute that is deeply discrediting within a particular social interaction.

Thus a stigma involves the public's attitude toward a person or group of persons who possesses an attribute that falls short of societal expectations in a given social context. To quote:

> … we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances.

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Goffman further explained that stigma falls into three categories:

1. *Abominations of the body*—various physical deformities.
2. *Blemishes of individual character*—weak will, domineering or unnatural passions, treacherous and rigid beliefs, or dishonesty. Blemishes of character are inferred from, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, or radical political behavior.
3. *Tribal stigma of race, nation, and religion*—beliefs that are transmitted through lineages and equally contaminate all members of a family.

Stigmatising marks may be visible as physical disability or invisible as a social identity. Even membership of a vulnerable community or 'high risk group' is also stigmatised. For Goffman, race, ethnicity, religion, physical ability, appearance and gender are the common bases of stigma. Prostitutes, drug addicts, carnival workers, hobos, winos, show people, full time gamblers, beach dwellers, homosexuals and urban unrepentant poor were given as examples of stigmatized persons. Some terms used for stigmatized persons are cripple, bastard and moron. In case of HIV there is no visible mark. Yet, people have their own thinking of how a HIV infected person looks like.

In case of stigma against HIV too not only the HIV positive people but also the communities to which they perceivably belong are stigmatised. People lack comprehensive knowledge of transmission of HIV but a large majority of them think that HIV spreads through illegal sex. Then sex being central to morality, HIV positive people are most stigmatised; they suffer from **double stigma**, one from having HIV and another for violating the sexual mores of society. There is very little knowledge that HIV can spread through non-sexual routes also (blood transmission, unsafe medical procedures, and mother to child). The problem of identifying and controlling HIV is further complicated by the fact that a single test of HIV is not enough to confirm the positive status.

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CONSEQUENCES OF STIGMA

Goffman divides all the stigmatized persons into four groups: in-group deviants, social deviants, minority members and lower class persons. In all cases, stigma leads to damage to self-concept and self destruction. It may be stressed that people feel able to make guess about the characteristics of almost any defined social group on the basis of limited information at their disposal though the social scientist would consider that information inadequate.

Stigma against HIV may be divided into the following categories:

- Instrumental stigma—a reflection of the fear and apprehension that are likely to be associated with HIV and AIDS
- Symbolic stigma—the use of emic concepts to express attitudes toward the social groups or "lifestyles" perceived to be associated with HIV and AIDS
- *Courtesy HIV-related stigma*—stigmatization of people connected to the issue of HIV/AIDS or HIV- positive people

Among the above three types of stigmas the instrumental sigma seems to be of paramount importance. There is undoubtedly stigma against certain life styles such as homosexuals or drug users. In addition the fear that if they come in contact of HIV positive people they may catch a deadly and transmissible illness creates a great fear in people's mind. Stigma becomes more discriminatory when it occurs with domination, social discrimination and exploitation. Thus if a victim is also a member of socially disadvantaged groups, and is a woman, the HIV status has more negative implications.

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INTERNATIONAL MIGRATION

With increasing globalization and growth of world population growing migration has become an important issue. According to the assessments of The National Intelligence Council (2001) more than 140 million people live outside their countries of birth and migrants comprise more than 15 percent of the population in over 50 countries. It is estimated that their numbers will grow. Under certain conditions differences between migrants and natives are known to have produced stereotypes, discrimination and violent conflicts. Therefore, while migration ameliorates the labour force shortfalls at the place of destination it may evoke discrimination on the grounds of language, culture and religious practices. The most sufferers will be the less developed countries which receive a large number of illegal migrants.

INTERNAL MIGRATION

In case of India internal migration and its consequences are more important than international migration. As discussed earlier in Module 6 on India's population, there is a need to study social responses to demographically induced migration from one region to another within the country. Due to socio-economic and demographic diversity and a strong link between the two a significant shift is taking place in spatial distribution of population. Strong push factors of insecurity and unemployment are causing migration of people from states like Bihar to Maharashtra, Delhi, Gujarat, Punjab and Haryana where they can find employment in industry or agriculture. As the economic conditions are becoming harsher everywhere the local people are resenting. They want more jobs for the "sons of the soil." This leads to conflict. This also has implications for national integration. The major migration issues are:

- Volume and pattern of interdistrict and interstate migration
- Social causes and consequences of internal migration
- Vulnerability of migrants to various types of risks at the place of destination

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While lot of data are now available on volume and pattern of migration as well as the causes and consequences of migration there is less information of vulnerability of migrants at place of destination. For several countries, including India, internal migration, is a burning issue. In the future it would become a more important issue than fertility and mortality. If the regional inequalities – economic, political and social – increase further, as there seems to be the case, more people will be forced to migrate from one region to another. In several cases this will involve migration of a large number of people which would affect the composition of population at the place of destination. Usually when size of migrants is small the stream of migration is followed by absorption and assimilation but when a large number of people migrate they have a tendency to form a distinctive ethnic identity at the place of destination and that may result in ethnic conflicts caused by economic conflicts and increasing misery. There are already signs of such conflicts in several cities of India.

DISABLED POPUALTION

Apart from the regional, sex and social class differences there are special problems of the physically challenged people who have been made the part of horizontal reservation policy in the country. There is a need to estimate their population, understand the various problems they face, and how disability is intertwined with religion, sex, class and caste. Census 2001 provided data on disabled population. It revealed that over 21 million people in India are suffering from some or other disability. They constitute about 2.1% of the population of India. Sex wise break up shows that among the 21 million disabled people 12.6 million are males and 9.3 million are females. The disability rate (number of disabled per 100,000 populations) for the country as whole comes out to be 2130; 2,369 in the case of males and 1,874 in the case of females. Here one may ask: why the disability rate among females is lower than among males? Is it due to underreporting or due to higher death rates among the disabled females as compared to disabled males. We require elaborate data to have an understanding of this issue however. Further, the census data (Census of India, 2009) shows:

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Among the five types of disabilities on which data has been collected, disability In seeing at 48.5% emerges as the top category. Others in sequence are: In movement (27.9%), Mental (10.3%), In speech (7.5%), and In hearing (5.8%). The disabled by sex follow a similar pattern except for that the proportion of disabled females is higher in the category In seeing and In hearing.

Across the country, the highest number of disabled has been reported from the state of Uttar Pradesh (3.6 million). Significant numbers of disabled have also been reported from the state like Bihar (1.9 million), West Bengal (1.8million), Tamil Nadu and Maharashtra (1.6 million each). Tamil Nadu is the only state, which has a higher number of disabled females than males. Among the states, Arunachal Pradesh has the highest proportion of disabled males (66.6%) and lowest proportion of female disabled.

TABLE 6.6: NUMBER OF DISABLED POPULATION AND TYPE OF DISABILITY

	Population	Percentage
Total population	1,028,610,328	100.0
Total disabled population	21,906,769	2.1
Disability rate (per lakh population)	2,130	--
Type of disability		
(a) In seeing	10,634,881	1.0
(b) In speech	1,640,868	0.2
(c) In hearing	1,261,722	0.1
(d) In movement	6,105,477	0.6
(e) Mental	2,263,821	0.2

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CONCLUSION

To conclude, there is a need for micro and participatory studies of population linking the global imbalance between population and resources with the local solutions acceptable to people in different social milieus. Let us learn from the people how they decide what is best for them and how they evolve sustainable models of development in the value framework of their culture, keeping in view their limited resources. In these studies social scientists would act as facilitators, helpful to the communities and people, in arriving at more optimal solutions. Econometric and statistical models have certainly played a role in the past in estimating the unknowns and in suggesting macro level solutions but when it comes to developing effective intervention strategies they have been found to be of limited application: the abstractions on which they are based are far away from reality. Voluntary action groups, research NGOs, and those receptive to idea of multiplicity of perspectives are the most suited people to evolve the workable development plans in the fragmented society of India in our times. Time has come to learn about possible emancipatory strategies and empower communities and people to manage common and limited resources.

Questions and Exercises

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1. What are the major differences between old and new approaches to population policy in India? Critically examine the old approach and suggest how the new approach addresses the weaknesses of the old approach.
2. What are MDGs. Is there any link between MDGs and population policy?
3. Identify some major issues in population studies.
4. Write short notes on the following:
    a. area specific approach
    b. participatory approach
    c. relationship between gender gap and high fertility
5. What are the major pitfalls of the new approach to population?
6. Why is the study of internal migration important?
7. What is HIV? Which countries are affected by HIV epidemic most? What can be done to arrest spread of HIV?
8. What is the relationship between HIV and sexuality? Why is the issue of stigma so important in dealing with HIV?
9. Write a short note on the extent of disability in India?
10. Collect data on prevalence of HIV in different countries from the net? Which countries have high or low rates of HIV? What could be the reasons for high rate of HIV in the former?

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