Quality of Life and Birth Control

by Dr Syed Jahangeer Haider

WHICHEVER terminology — population control or family planning — we use, the fact remains that birth control is not the objective; it is the means to achieve the ultimate goal of improving the quality of life of the individual couple and their children in a family.

Recent citations of UNFPA confirm that "Family planning goes far beyond merely planning size (of population); size is only the beginning: after that comes nutrition, health, education, attention to all the children, but especially the girls". Acceptance of family planning practice reveals an attitude; a determination on the part of individual couple to change their life-style and improve the quality of life within a family. For an individual couple the guiding force to accept family planning practices is its concerns for improving the family's living conditions. The dilemma today is whether or not the population control/family planning programme is effectively addressing this issue.

Bangladesh with a limited land area of 143998 sq km is the most densely populated country in the world; it has a population of 115 million, which is expected to grow to 235 million by the year 2025. Population explosion in Bangladesh has been aggravating the already existing situations of abject poverty, rapid rural-urban migration, pervasive malnutrition and high illiteracy. Population explosion endangered by frequent natural calamities has already rendered more than one-third of the population landless; and about two thirds of its populations today suffer from malnutrition and poverty. Population control has been one of the priority programmes of the government for nearly two decades. Impressive results at national levels on population control have been achieved through efforts of the government and also due to the strong commitment of international donor agencies, like the World Bank, USAID, UNFPA and many other non-government organisations (NGOs). Today 10 million couples constituting about 40 per cent of the total eligible couples are contracepting. It has contributed to the decline of CBR (birth rate) from 43/1000 in the seventies to 33/1000 currently, which has also helped in the decline of the total fertility rate from seven (7) to about 4.6. It means that the family size has decline by about two persons over the years. Have these achievements resulted to the alleviating poverty of the population in Bangladesh? Are the individual couples aware of such declining effects of population growth and can relate to the fact that today they encounter reduced risks of infant mortality in their family life?

Mortality occupies an important position in the total processes of fertility decline. Substantial decline in the mortality rate universally preceded fertility decline in any society in the past. Bangladesh is no exception to such experience. Overall mortality has been declining, which intensified from mid eighties with the successful launching of some of the preventive health programmes, such as the EPI vaccines, sanitation, safe water availability and diarrhoea control. Although much remains to be achieved in many of these and other related health programmes, the reality is that some reduction in the infant mortality has been achieved. But the crux of the problem remains that the vast majority of the individual couples still do not realize that their new borns have today a greater chance of survival than what it was at least a decade before.

The life in rural Bangladesh is still predominated by early marriages, restricted mobility of the women, dependence on labour intensive agricultural undertakings with pre-modern technologies, where children are valued as extra hand in their labour, while ignoring the values of investing in their education. Consequently, the opportunity costs of raising an additional child is perceived marginal. On the contrary, available population literature always evidences the positive influences of female education on fertility decline. Especially girls' education above primary level significantly influences antifertility motives accelerating fertility decline in turn. Can the fertility motives be encouraged in the present cultural context of Bangladesh with predominant projection of family planning as a birth control endeavour? However one does not loose sight of the frequent advocacy of the Health and Family Planning Programmes to launch a social movement on family planning. Will a social movement be feasible with projection of birth control efforts as the primary area of emphasis at the clients'/beneficiaries' level?

The current policies although entail integration of family planning as a broad social movement for achieving overall socio-economic development, the programmes and the strategies at the grass root level of the current Family Welfare Directorate remain far short of inculcating the goals of welfare. Instead the programme, dynamics at the field continue to encourage only acceptance of birth control methods by the individual couples. The rural people, especially rural eligible couples, who are the targets of the current programme and whose life is engulfed by staggering poverty and malnutrition may not actively demand the contraceptive services until they rationalize the obvious linkages between population control and achievement of quality of life for them.

According to an estimate of the Ministry of Health and Family Welfare, the total number of women in the reproductive age currently at 22 million will increase to 31 million by the year 2005. The same estimate assumes that the population programme will have to recruit an additional 8.5 million eligible couples as acceptors to reach a total fertility rate of 2.2, which is the replacement level fertility for Bangladesh.

The national family planning programme was launched in 1965, which has succeeded in 1991-92 to recruit 10 million eligible couples as the current users of contraceptives. Assuming that the period between now and 2005 will experience accelerated rates of acceptance of contraception by the eligible couples, the target of recruiting an additional 8.5 million eligible couples is not realistic, if the programme continues to project birth control as the key image at the grass-root level. On analysis of the Contraceptive Prevalence Surveys of 1990 and 1991, it is observed that about 75 per cent of the couples below age 20, and 60 per cent of the couples below 25 are not currently contracepting (CPS 1991); while 92 per cent, 70 per cent and 58 per cent of the eligible couples with a parity of 0, 1, and 2 (child) respectively reported that they are not contracepting (CPS 1990). These findings evidence that the messages of the current population programme have been actively accepted by the couples, who are already at the ceiling or have crossed the ceiling of their desired size of family leaving the hardcore to be motivated. The hard core couples, who are predominantly young and who belong to the low-parity category will not accept contraception unless there are adequate rationalizations for meeting the basic needs of their life.

The Contraceptive Prevalence Survey of 1991 reported that 36 per cent of the women were visited by the field workers. Currently there are about 25000 fulltime employed government field workers deployed in the rural areas of Bangladesh to disseminate messages and render contraceptives services to the rural population. In addition, a large number of NGOs have also deployed field workers in the urban and in the rural inaccessible thanas. The field workers so far with messages of birth control have successfully covered the couples, who find strong rationalization to practice family planning after experiencing the burden of too many children and they desire to stop child birth. But the couples who are in the low-parity group, who may be convinced to improve their quality of life through spacing are not covered adequately. The field workers also tend to have contacted the women with higher education with ease.

The field workers are the crucial link between the population control programme and the millions of couples in the rural areas; their orientation to the goals of achieving quality of life through family planning practices is vital. Currently a very meager percentage of their time is devoted to the issues on quality life during their interactions with the couples. The essential components apart from achieving contraception by the couples are the issues of maternal and child health including the messages on EPI, oral rehydration therapy, nutrition and education of the female child. Although the field workers desired improved training on these issues, as have been observed in some of the studies of NIPORT, the apex training institute of Population Control Programme in the country, the actual performances during field workers contact with the rural couples do not reflect adequate coverage of these issues. Consequently, the studies conducted by NIPORT continue to report overwhelming religious and socio-cultural barriers to the acceptances of family planning methods by the rural couples, as perceived by the field workers. The other issues which may advent the achievement of both contraception and quality of life simultaneously are delayed marriages and exclusive breastfeeding, which remain largely ignored as effective strategies at the operational levels. The acceptance and pursuing of the quality of life in its operational manifestations along with the messages on contraception by the field workers may eventually accelerate demands for family planning.

Family Planning Programme was being evaluated in Bangladesh frequently through the indicator of prevalence of contraceptive acceptance by the individual couples. Integrating family planning with socio-economic development is a part of intersectoral population policies, which the government and the donor agencies are now considering as a strategy. Such a strategy will extend the responsibility of the field workers on the couples beyond mere acceptances of contraceptives allowing assessment of quality of life indicators.

At the current rate of growth of population (2.4 per cent), Bangladesh population will double in about 30 years. Bangladesh can not ensure minimum standard of life if population is 235 million in the year 2025. Socio-economic development and population control are inseparable, these operate sinergestically. Understanding this relationship is essential at the field workers' level, whose credibility and performances are key to the success of family planning and the achievement of the goals of quality of life in the near future.

The author was Director Family Planning, Government of Bangladesh; and served as Advisor, Primary Health Care both in the World Bank and USAID internationally.

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Why Vietnamese Children are Going Blind

by Peyton Johnson from Hanoi

EVERY year af least 4,000 Vietnamese children go blind because of the form of malnutrition known as Vitamin A Deficiency.

Said a Health Ministry official: "That is the number we can identify average year. But our communications and reporting systems are so inadequate, especially in the rural area, that this figure must be taken as minimum."

Photo: FAO

A Vietnamese mother and her sick infant in a Hanoi hospital. She has anemia and the child suffers from acute Vitamin A Deficiency.

Eighty per cent of Vietnam's 67 million citizens live in rural areas. Most are rice farmers who have known nothing, come war or peace, but grinding poverty. Malnutrition goes hand in hand with poverty with them come other afflictions: ignorance, stunted human growth, mental sluggishness and short life spans.

Vitamin A Deficiency, like malnutrition generally, is to a major minor degree endemic to all Vietnam's 48 provinces. The poorer the province the higher the incidence. Vietnam has one of the highest rates in Asia and the Pacific.

The deficiency leads to "exophthalmia," which in turn leads to night blindness, Bitot's spot, corneal xerosis and kerato-malacia, corneal scares and other sight disorders. In acute cases it causes total blindness.

"Once a child is blinded by Vitamin A Deficiency," the official explained, "there is no known way to restore its sight. Yet the deficiency is easy to prevent."

All it takes is a diet rich in Vitamin A, found in most green leafy vegetables, fresh fruit, liver, kidney and other meat products. All have been available in Vietnam for centuries, so why can they not be included in the rural household diet?

Simple ignorance is part of the explanation. Most villagers do not know what Vitamin A Deficiency is, much less what causes it and how to cure it.

The ancient monoculture of growing rice as the principal, and often sole, food is also to blame. Poorer villages lack the knowhow, the seeds, even the pitifully small investment needed to grow other crops.

Even the farmers who do grow some fruit and vegetable prefer to sell them for cash. They themselves, as did their father and grandfathers before them, make do with a montonous diet of rice and chilli.

Now, things are changing. A project of the UN Food and Agriculture Organisation (FAO) founded by Australia, operates in four rural areas of Vietnam.

FAO furnished the seeds and farm tools and teaches villagers to plant their own family gardens to grow the food needed to defeat Vitamin A Deficieney. The villagers trained as agricultural extension agents and nutritionists, both scarce throughout Vietnam.

In areas under the project the rate of Vitamin A Deficiency has dropped dramatically. The government wants to extend it to all over the country but cannot afford it. With a per capita income of just $200 a year, Vietnam is one of the poorest countries in the world.

Nor is Vitamin A Deficiency Vietnam's only malnutrition worry. The populations also suffers from other major forms of malnutrition -- protein energy malnutrition, anaemia and iodine deficiency disorders.

An official report says the average Vietnamese consumes just 1,932 calories a day, little of it from protein products, and 16 per cent below the minimum level required for normal health and energy. The report calls this "chronic starvation" level.

Chronic malnutrition, or "stunting," could lead to mental retardation, or "cretinism." Low birth weight in infants is also widespread, the mother being undernourished.

Anaemia takes a heavy toll. The National Institute of Nutrition reported that prevalence in pre-school children was 23 per cent in urban areas and 46 per cent in rural areas. The poor nutrition makes people easy prey to a variety of diseases easily enough shaken off by better fed peoples. A bad common cold may lead to penumonia and death.

The official asked: "How can you develop a nation when your people are so poorly fed that half are sick or too weak to work?"

The soaring birth rate, at 2.3 per cent one of Asia's highest, complicates the fight against malnutrition. In the Third World, for the majority the basic problem remains: too many people, 780 million according to FAO, simply do not get enough to eat to lead a healthy life. — GEMINI NEWS

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AIDS Taking a Heavy Toll on Asian Economies

by Mahesh Uniyal

BY the turn of the century, Asian economies may be in for an 'AIDS shock' that even the more buoyant among them will be unable to absorb.

Experts say the region is on the threshold of an HIV epidemic. Unless preventive steps are taken, it will have to pay a far heavier price in lost incomes and productivity than in providing medical care for those afflicted.

Worse still, the bulk of this loss will be borne by the poor who are most vulnerable to the AIDS virus, thereby worsening existing economic inequalities within regional countries.

These days, economists are joining medical and behavioural scientists studying the HIV virus as realisation grows that AIDS threatens even the economic health of nations.

"AIDS is a costly disease but the medical costs are monor compared to the loss of income from morbidity and mortality among the afflicted," says David Bloom, one of several experts present at the second International Congress on AIDS in Asia and the Pacific held here in November.

The economics department chairman of Columbia University in the United States, Bloom also says investment in efforts to keep the AIDS virus from spreading will yield a high economic return, in saving both medical costs and loss of economic output.

Earlier, the United Nations Development Programme (UNDP) released a study here called "AIDS and Asia: A Development Crisis". The study warns that an epidemic will have "potentially staggering economic consequences."

Blook and his colleagues at Columbia University have calculated the indirect economic costs of aids to be at least ten times the direct costs of medical care for each patient.

While the medical expense on each patient ranges from US$ 1,000 in India to US$2,000 in Malaysia, the corresponding estimate for loss of earnings for every AIDS case are US$10,000 and US$-85,000 respectively in these countries.

India is likely to have a million AIDS patients by the year 2000, and economists say this will mean a loss of US$11 billion to the national economy. Thailand is expected to have half that number of AIDS victims, but this translates into up to US$20 billion in lost incomes and productivity.

Asia's booming sex tourism, lax regulations and the continuous migration of people in and out of the region are being blamed as the main causes for the fast spread of AIDS.

But the sex trade rakes millions of dollars a year, and even the likes of the Thai government has been forced to admit its country's entire flesh industry is too big and ingrained in the national's culture to shut down.

Kanchit Limpakarnajanarat of the Thai Public Health Ministry says about 2.4 million Thai men, women and children will be infected by HIV, which causes AIDS, by the end of the century.

That cabinet member Mechai Viravaidya, the man who is known as "Mr Condom" for his efforts to get the government to recognise the threat Thailand faces from AIDS, estimates that 1,400 Thais become infested with HIV everyday.

"With one million pregnant women in Thailand, it means, 10,000 mothers-to-be are coming down with AIDS every year," adds Khanchit. "Statistically, one-third of them will pass the virus to the child. The number will increase as the percentage of HIV in pregnant women rise."

The situation is made worse as Thai sex shops employ more ad more young girls from neighbouring countries to service an ever-increasing number of customers.

Young girls from the isolated jungles and villages of Burma, Laos and southern China's Yunan province have been kidnapped or lured with false promises of well-paying factory jobs into Thailand where they end up as prostitutes.

The dissident Dawn News Bulletin in Burma reported recently on the large-scale trafficking of people from Burma, including young girls and boys, for prostitution in Thailand.

"Burmese girls are in demand because Thai customers perceive them at AIDS-free," the paper said. "In reality, they do not remain uninfected for long."

The Dawn also described Burma, as the "conduit of the AIDS Route, which carries the infection from Thailand into remote tribal areas of India and China." Within Burma, exposure to AIDS is heightened by the lack of screening of blood for transfusions and the practise of tattooing using unsterile brass roads.

Nearby Laos has been estimated to have only 11 HIV cases recorded so far. But the United Nations Development Programme (UNDP) warns: "Laos is threatened since it is a landlocked country with borders on southern China, Burma and Thailand, all of which have high rates of HIV infection."

Meanwhile, experts say Cambodia's infamous 'killing fields' could soon take on another meaning as HIV spreads into a country just emerging from the ravages of decades-old war. Prostitution is thriving, driven for the most part by the presence of thousands of United Nations peacekeeping troops.

Survey results show that most of those infected with the AIDS virus in Asia are between 20 and 50 years age — the most economically productive groups.

But according to Ajay Mahal of Columbia University, present estimates of the total loss to the economy may be modified as the process of calculations is complex.

"If you ignore ethical considerations, then the social costs cannot be derived by simply multiplying the total figures for people in their productive years by the economic costs per case," Mahal says.

"The costs could be very much less or more depending on the country and its labour markets," he adds. "One person's loss could be outweighed by another person's gain where there is surplus labour."

Experts are still refining methods to asses the economic impact of AIDS to provide for situations of unemployment and underemployment, common in Asia with its labour-intensive farm and industrial sectors.

The class of workers affected is also an important factor, Says Mahal: "In Asian countries, HIV infection is typically concentrated among lower skilled classes till now."

This is unlike Africa where most of those affected are skilled workers, as in Zambia where the cooper mining industry is badly hit. Mahal expects the economic cost of AIDS for India to come down and for Korea to go up from those presently estimated.

'AIDS economics' is a relatively nascent field and experts say more sector studies are needed as most surveys have been general in nature.

A study presented at the recent International AIDS meet here reports that HIV/AIDS will upset the "rhythm of farm life" in Laos with immediate effect.

Farming accounts for nearly 70 per cent of the total economic output of Laos. According to the study, AIDS can change cropping patterns, disturb intensive cultivation of land, speed up slash and burn farming, and eventually undermine the country's food security.

Prevalence of HIV among Asian workers is likely to exclude them from overseas markets.

Between 1960 to 1989, nearly 12 million Asians were hired as contract labour in the Middle East and in manpower-short countries like Singapore and Malaysia. In 1991, Thailand alone earned a billion dollars as remittances.

As HIV begins making its presence felt in the workplaces, employers will be under pressure to start compulsory screening.

But experts say workplace surveillance will only be counterproductive. They point out that those infected are capable of productive work for several years before the disease sets in. — IPS.

Female Smokers Threaten to Outnumber Men

by Ian Steele

TOBACCO-RELATED deaths among women are increasing rapidly and will more than double over the next three decades.

And women appear less willing or able than men to given up smoking and will be dying from lung cancer and other tobacco-related causes at the rate of one million a year by 2020.

This disturbing trend is the subject of a new publication — Women and Tobacco — by the World Health Organisation (WHO). The author is Dr Claire Chollat-Traquet, a scientist at WHO, who breaks new ground by addressing gender-specific factors which encourage women to smoke, and which impact on their health and that of their children. Dr Chollat-Traquet also proposes reasons why quitting might be more difficult for women than for men.

Surveys suggest that between 5 and 10 per cent of women in the developing world smoke, although in some areas, the rate is as high as 25 per cent.

While the number of men and women who smoke are converging in some countries, with men and women quitting at roughly the same-rate, indications are that more young women than men are taking up the habit. If this trend persists, female smokers will outnumber male smokers in the near future.

Dr Chollat-Traquet notes that until recently, in the absence of adequate data on smoking-related diseases among women, it was assumed that women were more resistant to lung and other damage than men. New data, she says, shows not only that women are as vulnerable as men, but that they face added risks as well. She notes that women who smoke are :

** Susceptible to infections of the reproductive tract and are more likely to suffer fertility disorders;

** More likely than non-smoking women to have menstrual disorders, and are likely to experience menopause two or three years earlier than non-smokers;

** Subject to premature wrinkling of the skin, gum disease, dental problems, hoarseness of voice and chronic coughing. Nicotine reduces blood circulation and oxygen intake with negative consequences for skin, hair and eyes.

More young women than men are taking up the smoking habit. If this trend persists, female smokers will outnumber male smokers in the near future

Smoking during pregnancy has been linked to premature delivery, spontaneous abortion, fetal or prenatal deaths, and the delivery of low birthweight infants. The children of mothers who smoke are also at increased risk of acute respiratory infections including pneumonia and laryngitis, and of contracting middle ear infections.

Dr Chollat-Traquet devotes a chapter of her book to gender differences in the physiology and social psychology of smoking. She notes that women tend to smoke to cope with stress, while men say they smoke for pleasure.

Women smokers report that smoking helps them cope with loneliness, sadness, grief, anger and frustration. As a result, women who give up smoking for long periods may relapse in negative emotional situations of conflict, stress or personal loss.

Men, on the other hand, tend to relapse in positive situations such as social events. Once women start smoking, the fear of gaining weight if they quit, may also make it more difficult for them to stop.

There is an urgent need, says WHO, for governments, policy-makers, health professionals and women's groups to develop national strategies aimed specifically at women. It says that programmes which encourage girls and women to avoid tobacco products are essential, as are programmes which are specifically designed to help women quit.

"Preventing girls from beginning the smoking habit is certainly the most efficient measure," says Dr Chollat-Traquet. "It requires a combination of improving their knowledge of the effects of tobacco, of developing personal and social skills which will enable them to resist social pressure to smoke, and of involving family, schools and other youth networks in promoting healthy lifestyles."

Many governments, however, remain reluctant to effectively address the clear relationships between tobacco consumption and poor health, premature deaths and increasing health care costs.

Tobacco sales are a rich source of government excise and tax revenues which short-sighted politicians can spend to shore up their popularity while ignoring long-term human suffering and budgetary impacts to a time when they will have retired from public life.