Decision-making in the Family

Implications for the Family Planning Programme in Bangladesh

by Dr Syed Saad Andaleeb

THE family planning pro-gramme in Bangladesh has the unenviable task of curbing the serious consequences of population explosion. Through its various programmes, the government has attempted to achieve replacement levels of fertility. Apparently, that target has not been achieved yet in the country.

To achieve the desired targets, it is important to understand fertility behaviours. The literature indicates various factors that are associated with fertility behaviours and include demographics, socio-economic conditions, and programme parameters. Specially, these factors include breast-feeding, infant mortality, social class, female education, occupation, income, the desire to have sons, religious affiliation, and the perception that contraceptive methods are harmful and could affect the health of additional children couples planned to have in future.

One area of study that, perhaps, deserves greater attention is that of fertility decisions and how they are made in the family. Consequently, it is important to study the structure of power, influence, and motivation to adopt family planning practices in the husband-wife dyad. In this regard, in a study of marital power structure in India, a survey of 291 women led to categorizing 210 of the marriages as egalitarian and only 81 as husband dominated. This contention requires further corroboration, especially in the context of Bangladesh. In fact, because of their dependently status, women in Bangladesh may have little to say in family decisions. In another study in India, however, it was noted that a decline in the perceived value of women attenuated their status, power and influence in the family unit. These conditions may have serious implications for fertility control programmes because even if women are more motivated to regulate fertility, if their husbands have more influence over the fertility regulation decisions and are not inclined toward contraception, it could represent a major hurdle to increase contraceptive prevalence rates. It would also require creative intervention methods to overcome the hurdle. This article summarises the findings of a study and examines who, among target clients, are the most motivated to adopt contraception, and who, among the clients, have the greatest influence over the decision to adopt family planning practices. The article also derives several implications for the family planning programme in the country.

Past studies have relied on data obtained directly from the target population. This approach, using direct personal interviews, can be problematic because the researcher (or the data collection agents) and the respondents may have never met before. This could introduce errors because of the salience of the subject matter. Respondents are likely to provide a top-of-the head answer to be done quickly with the survey. Many of the respondents also may not respond to the questions truthfully because they are "expected" to provide socially desirable answers. These factors can introduce errors in the data generated by surveying clients and could attenuate the validity of the studies.

An alternative strategy that is likely to provide more reliable insights about clients is to interview FWs. As the most direct point of contact with clients and privy to insights that are not always apparent from client or administrative perspectives, they are likely to be best informed about decision-making in the family dyad. Consequently, their views were solicited. Respondents were assured of anonymity and the completed surveys were collected by the investigators. A total of 155 questionnaires were completed.

According to The World Fertility Survey, married women who were gainfully employed had fewer children compared to those who had never worked. Studies employing econometric estimation also show that female education dominated as a variable to explain both income and reduced population in the poorest countries.

Findings

There was near unanimous agreement among the FWs that female clients are more motivated to adopt the means of family planning that their male counterparts. Only one respondent indicated males as being more motivated. Such overwhelming agreement among the FWs, whether they were males or females themselves, whether they conducted field work in rural or urban areas, and whether or not they worked for government or non-government organizations, clearly suggests that women are more motivated than men to plan their family and limit their family size. Only 4.5 per cent of the respondents indicated that both members of the husband-wife dyad had about the same level of motivation.

However, it was also found that the group most motivated to adopt the means of family planning had the least influence over the decision to adopt the means of family planning. In other words, in the opinions of about 48 per cent of the FWs, males appeared to have the greatest influence over fertility decisions. In contrast, according to only 8 per cent of the FWs, the wife in the husband-wife dyad had greater influence over the decision to adopt contraceptives. What deserves attention is that about 40 per cent of the FWs felt that they had the most influence over a couple's decision to adopt family planning. This finding is consistent with studies reporting that FWs have established better communication and influence over their clients.

Discussion and Conclusions

From a programme management perspective, it is important to monitor the percentage figures reported above. If the trends demonstrate increasing motivation among men to adopt contraceptives, or a shift in the sphere of influence from men to joint influence or to women, these trends should have a positive impact on the goals of the family planning programme. If the trends are in the opposite direction, or do not show any appreciable change, it could have onerous implications.

More importantly, it is vital to the programme to adopt a proactive stance to shape power and motivation in the husband-wife dyad. For example, it is amply clear that means must be devised to empower women in Bangladesh. Two of the most effective ways to empower women that earlier research has concluded are to educate them and to find ways to enhance their earning power. For example, according to The World Fertility Survey, married women who were gainfully employed had fewer children compared to those who had never worked. Studies employing econometric estimation also show that female education dominated as a variable to explain both income and reduced population in the poorest countries. These views are supported by this study.

From a strategic standpoint, organized effort is needed to empower women. Efforts of grassroots organizations such as Grameen Bank, Bangladesh Rural Advancement Committee, and others are laudable in this regard. These organizations must be encouraged and supported by the government and other development agencies to strengthen programmes that help empower women. The development of women's organizations at the local level, supported by Bangladesh Mahila Samity, Concerned Women for Family Planning, Nijera Kori, etc. have also attempted to raise the status and influence of women by educating them and creating job opportunities for them. The real impact of these projects must be periodically assessed and strengthened.

Educational campaigns directed at men, must also be strengthened to "sell" to them the benefits of having a small family. Such focused programme efforts directed at men are not as prominent as programmes directed at women on the issue of fertility control. Consequently, programmes need to be strengthened and directed at educating and motivating men. Mechanisms also need to be devised to involve men to take greater responsibility for their families, especially children. In a culture where men seem to have relinquished the responsibility of bringing up children largely to their female counterparts, it makes it rather easy for them to moralise about contraception; it also makes them less motivated to adopt the means of birth control.

The finding that a significant number of FWs feel that they have the greatest influence over the contraception decision in the husband-wife dyad is encouraging, but needs further empirical investigation and substantiation. If FWs are able to exert influence over a family's contraception decision, this should be developed into a major thrust of the programme. At the same time, to motivate FWs to carry out their tasks even better, appropriate incentives should be introduced in the family planning programme. As the "salesforce" selling the family planning programme, FWs can make a substantial difference when equipped with proper persuasive skills and the right combination of incentives. Lessons from marketing and sales management literatures should provide rich dividends.

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Women and Children with Disabilities

by Parvez Babul

One of the main achievements of the decade has been the development of organizations of disabled persons and their empowerment leading to self determination in society. The rights of disabled people as complete citizens have been universally accepted . One of the realities which emerge is the redefinition of disabled people by themselves with greater emphasis on the barriers created by the social, ecological and environmental factors that limit their participation in society.

TODAY, economic disparity is greater than ever. Over one billion people (one-fifth of the world population) lack adequate food, clean water, elementary education and basic health care.

An estimated five hundred million people worldwide have visual, hearing, mobility or cognitive impairments. Typically, disabled people are among the poorest of the poor. Statistics show that they are most likely to have incomes below the poverty line, be less educated and participate less in society. And their employment opportunities are extremely limited.

The UN decade of Disabled Persons, so falling short of the high aims of prevention, rehabilitation, and equalization of opportunities, witnessed some notable advances. The decade witnessed the beginning of a revolutionary change in the world's ability to control causes of impairment which disabled massive populations in developing countries.

It recognizes that while many achievements have been made, the main objectives of the decade have not been fully attained. There are still in the world, devastating violations of human rights of persons with disabilities and many barriers to their full and active participation in society.

In many developing countries where 80 per cent of the disabled population have no access to the basic necessities of life and little or no access to medical services, rehabilitation education, training, employment and technical aids. Disabled people are still the poorest of poor and the incidence of disability is on the increase due to the aging of population, environmental factors, malnutrition, various diseases, wards civil strife and worsening economic and social conditions.

The consequences of disabling conditions are particularly damaging for the disabled women, children, elderly people, psychiatrically disabled and refugees.

Disabled women face a double disability as their women's normal role in society is greatly diminished.

For many children, the presence of an impairment leads to isolation. Disabled refugees find the door to resettlement shut in many countries. People with mental disabilities without access to communication and those with multiple disabilities experience particular discrimination.

The international context in which problems of persons with disability are being addressed are continuously changing. During the decade, there has been an increased democratization in communication which provides new opportunities to prevent impairment and control disabilities and to enhance participation of disabled people in society.

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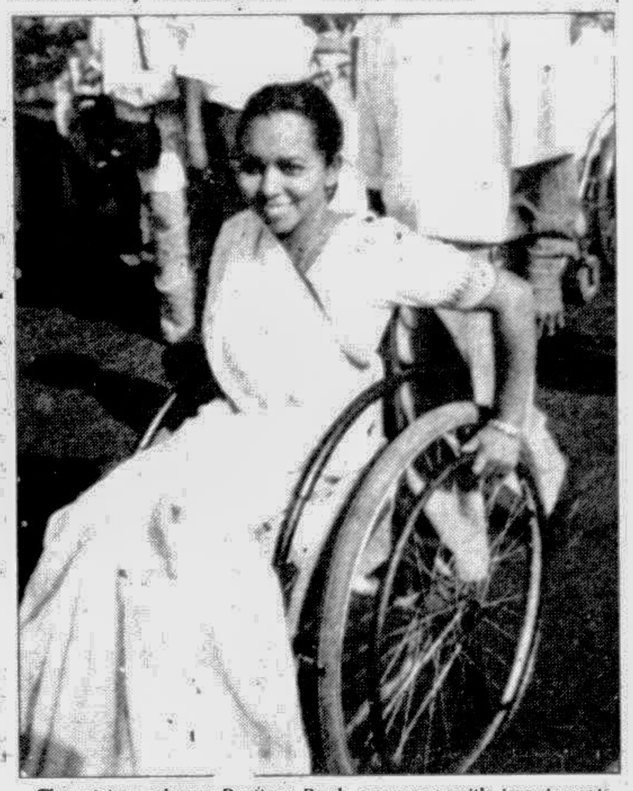
All those factors should be taken into consideration in the formulation of strategy aimed at promoting independence and human rights of disabled people. In this context there are new perspectives of partnership to plan, implement and monitor comprehensive policies for equalization of opportunities.

These new initiatives should be encompassed in the global strategies of the greater society such as under development and technical cooperation, human rights, illiteracy, pollution, environment, conflicts, and malnutrition. If it is in this context that the problems of disabled persons should be articulated and ultimately resolved.



The picture shows Pratima Paul, a person with impairment herself, who works for removing the distress of persons with disabilities.

The following priorities are of fundamental importance and should be addressed in the strategy:

a) Promotion and protection of human rights

b) Promotion of community based rehabilitation (CBR)

C) Development of independent living programmes

d) Enhancement of economic independence

e) Legislation, coordination and governing mechanisms as main instruments for improving the status of disabled persons.

Status of women and children with disabilities in Bangladesh

On February 15, 1993 the Government of Bangladesh passed a law that allows donor and non-profit agencies working for the welfare of the disabled, to import equipment free of import duties and taxes. On August 22, 1993, Bangladesh signed the proclamation for equal rights of the disabled people. These are great steps forward to ensuring a better way of life for them.

In Bangladesh about one per cent of the total population is blind. The rate of unemployment is high and there are only limited resources for welfare activities aimed at the disabled population.

Each year, more than 30,000 children go irreversibly blind due to vitamin A deficiency; half of them die within the first few months of the blinding. Now, is the time to give serious attention to remove this grave situation.

Very little has been done in Bangladesh when compared to the need for education and rehabilitation of the visually impaired. There is great demand for development, extension, production and supplies of educational aid for the blind women and children as well as the disabled. There is also a widely felt need for information and socio-economic rehabilitation. Because, physical obstacles and social barriers prevent citizens with disabilities from participating in community and national life.

The various impediments to participation and equality are especially formidable for *girls* and *women* with disabilities. With improved attitudes, increased awareness and much care, we can build social and physical environments. Above all, services should be offered so that they can live like a full member of the family and a full citizen of the country.

The writer is associated with Helen Keller International, Dhaka, Bangladesh.

India Claims to Have Discovered AIDS Cure

by Prakash Chandra and Jagan Nath

WHILE hundreds of millions of dollars are being spent by American medical research foundations in search of a wonder drug to cure AIDS, several researchers in India are claiming they have found the answer to this dreaded disease.

New Delhi's National Institute of Immunology (NII), run by the Ministry of Health claims that AIDS could be cured by using the ancient Ayurveda system of medicine wherein a combination of herbs are used to help strengthen the body's immune system.

The NII says the herbal mix can help eliminate viral infections. AIDS or acquired immune deficiency syndrome, which causes the body's immune system to break down making a person vulnerable to various diseases, is caused by the human immuno-deficiency virus (HIV).

Researchers say they are now testing seven plants growing in the wilds of the Himalayas which have been wisely used by Ayurveda practitioners. All the herbs are known for their anti-stress and immune-boosting properties. They are also free from side-effects.

According to Dr G P Talwar, former NII head and now professor at the institute, there are plants which activate the immune cells and which induce the protection of certain chemicals that kill unwanted bacteria.

Medical experts in the West have taken note of this development in India.

A paper published by Neil McKenna, editor of "World Aids" says: "Recent discoveries of plants from India and the Pacific Islands show potential for the treatment of AIDS, raising hopes for those affected by the disease."

But the World Health Organization (WHO) told Depthnews that no drug so far has proven effective against AIDS.

Even the centres in India where the Ayurveda drugs could be clinically evaluated showed no enthusiasm in conducting trials. Thus, the drugs were sent to Nigeria for tests.

The main herbs used by Dr S Rohatgi, in collaboration with the Centre for Scientific and Industrial Research Laboratories in Jammu, were "Har," "Jag Amla," "Bahera," "Gooch," and "Amla." All are excellent for cleaning toxins in the liver and help strengthen the body's natural defences.

Indian scientists have received encouraging feedback from the Nigeria tests. The Nigerians say that the administration of the drugs has resulted in the dramatic recovery of an AIDS patient from the infections he has acquired.

Germany and Uganda have also shown interest in these drugs. Preliminary trials in Germany have reportedly shown impressive results.

The Ayurvedic approach aims to increase the potential of the body's immune system and simultaneously stimulate the physiological functions which are impaired by AIDS .

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In addition to Dr Rohatgi, an herbalist, T A Majeed from Ernakulam, South India has also come up with a herbal preparation which he claims cures AIDS using likewise the Ayurvedic system. Mr Majeed's preparation has 20 ingredients — four to kill the AIDS-causing organism known as human immuno-deficiency virus (HIV), and the rest to improve the body's immune system.

It has been reported that representatives from various countries and the WHO are pouring into Mr Majeed's pharmacy in Kochi, Kerala state, South India. They allegedly confirmed that the Ayurvedic drug, called 'IMMUNO-or," can cure AIDS.

But the WHO Regional Office for the western Pacific which is based in Manila, Philippines said the United Nations technical organization has not yet recognized any anti-AIDS drug.

Mr Majeed tested his drug on two AIDS patients. One of the patients is 28-year-old Chitra. After taking the drug for 45 days, her blood test showed her negative for HIV infection.

The other patient was Baburaj, 40. After 10 weeks of treatment his weight increased by seven kilograms from only 32 kg. A blood test also showed he no longer had the AIDS-causing virus in his blood. Mr Majeed has made public the test results.

According to the National AIDS Control Organization (NACO), one of every 25 people in India is infected with a sexually-transmitted disease (STD) and a STD infected person runs a very high risk of acquiring the AIDS virus.

NACO says the number of AIDS cases in the country as of October 31, 1993 was 494. HIV infection cases confirmed were 13,448.

However, many cases of HIV infection and AIDS go unreported for lack of facilities to trace them, ignorance about the disease among the people, and the social stigma attached to it. Thus, actual figures for HIV infections and AIDS may be much higher.

A new social action programme has been started by the United Nations Development Programme (UNDP) in India to stimulate awareness of the upcoming social and economic consequences of the spread of HIV infection in Asia and the Pacific.

Bhaskar Bhattacharji, a senior UNDP official in New Delhi, says the impact of the HIV infection on people and society in Asia has so far been reckoned largely in terms of medical effects.

Little thought has been given to analyzing the impact of the disease on patients and their families, particularly their dependents, he explains.

According to a study by UNDP in the Asia and Pacific region, most of the costs of the epidemic will be borne by the affected individuals and their families.

The AIDS awareness programme in India is beginning to show positive results. For instance, fear of AIDS has led to prostitutes turning down foreign clients.

Over 75 sex workers from Bombay's red light district, called Kamathipura, met at the Stuttgart Hall of Max Mueller Bhavan, a place which is normally the hangout of the cultured. They talked about their firm resolve not to have sex without condoms.

Sex kitten Pooja Bedi has brought some sparkle to India's war against AIDS. She claims to be the first actress in the country to help create awareness about AIDS among the masses by appearing in an advertisement that promotes the use of condoms.

The Health Ministry has launched a major drive to make hospitals safe for patients from the threat of AIDS. Now, all blood from blood banks are screened for HIV.

Medical experts have warned that blood from many blood banks is highly suspect.

The WHO has recommended the supply of condoms to jails to prevent HIV infection through homosexual activity. Jail authorities were debating the issue because under the Indian Penal Code, homosexuality is a crime. Therefore, authorities felt that supplying condoms will be a tacit acceptance of the crime.

India my lose a US$10-million grant from the United States Agency for International Development (USAID) for the prevention of the disease in the southern state of Tamil Nadu because of bureaucratic wrangling between the ministries of health and finance.

Reports say that even the Health Minister has ignored the agreement between the donor agency and the government way back in September 1992 to start using the funds.

Finance Minister Manmohan Singh has warned the Health Ministry that the donor agency may pull out of the project unless they start using the AIDS funds.

Meanwhile, WHO experts are confident that effective prevention in developing countries could cut the number of new HIV infections by 9.5 million this decade.

This, WHO experts say, would mean four million fewer infections in both Africa and Asia, and one million less in Latin America.

They say that an annual US$42.5 billion price tag for HIV prevention in developing countries should be regarded as an investment for the future.

Investment of this amount by the year 2000 would lead to savings of nearly US$490 billion in direct and indirect costs from AIDS, they add.

— Depthnews Asia

New Health Policy Gets Rid of that 'Hospital Smell'

by Daniel Lubinga

All over the developing world, governments are experimenting with new ways of financing hard-pressed services such as health and education. Gemini News Service reports on the quick gains achieved by a new pay-for-treatment policy in Zambia's hospitals, but finds that there is a shortage of both drugs and patients.

TO help poor patients who cannot afford newly-introduced charges in Zambian hospitals, an experimental scheme allows them to pay for treatment with groundnuts, maize or other produce.

Deputy Heath Minister Dr Katele Kalumba says a pilot payment-in-kind project at a clinic in the Eastern province has proved so successful that the World Bank is considering introducing it in other countries.

Some of the government's attempts to improve health delivery, such as the creation of boards at major hospitals, have scored rapid and visible successes.

At three major hospitals in the cities of Ndola, Lusaka and Kitwe, for example, previously unkempt and run-down wards now have clean, regularly changed linen, beds have been repaired, the "hospital smell" has gone, fresh paint has spruced up the buildings, lawns have been cut and gardens brightened up.

But drug supply is still poor. Pharmacies have gaping gaps on their shelves. When drugs are available they are dispensed in scraps of paper. Patients frequently complain that tablets of similar colour and size get mixed up when the wrapping falls apart, making it difficult to take drugs in the right order and amounts.

George Sholoma, a village head-man from Kabwe, complains that after he paid 500 kwacha to a local clinic there were no drugs for his ailment :

"Instead they gave me panadol as a substitute. What kind of cheating is this? Even in colonial times we used to pay K500 once a year and the drugs were always available."

At the heart of the new policy is a voluntary K500 a month National Health Insurance Scheme. People above 65 and children below six, as well as "poor and disadvantaged", are exempted from the payment. Their fees are to be paid by the Ministry of Community Development and Social Welfare.

"Poor and disadvantaged" has not been defined, but Health Minister Michael Sata has advised those who cannot afford premiums to register with hospitals' social welfare departments, which in turn will forward their names to the Ministry.

The reforms have reduced the queues at hospital outpatients departments but only, it seems, because some ill people have been put off by the new fees.

The experience of 30-year-old Artwell Musongole is typical. He arrived at Ndola Central Hospital early in the morning.

At eight o'clock he and other prospective patients start shuffling slowly forwards. Musongole's names is registered and he moves to another queue, at the cashier's desk.

Finally, his name rings out. "Two hundred and fifty kwacha" calls the cashier routinely.

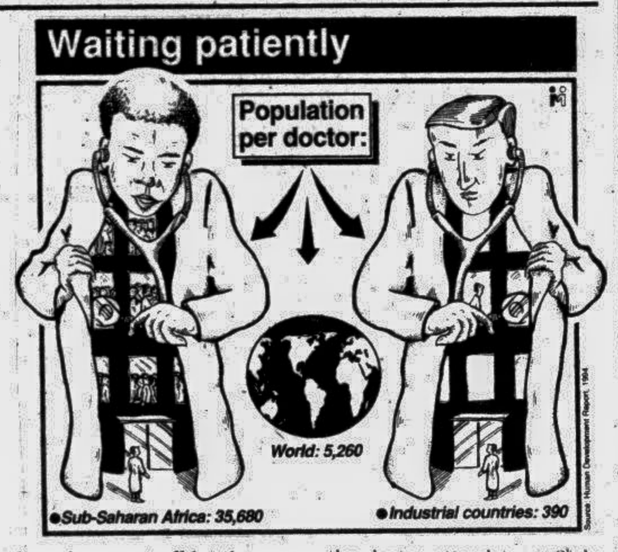
He fumbles in the pocket of his trousers, and says, "Sorry, madam I don't have enough money on me."

"Next", retorts the cashier dismissively, instantly losing interest in Musongole and turning her attention to the next patient.

Musongole lingers. "Can't the doctor attend to me?" he pleads. "I have absolutely nothing on me."

"I am afraid not", responds the cashier firmly, adding, "Look, even if I were to allow you to see the doctor, that is as far as you would get. Who would give you the medicine? The pharmacists will not issue medicine unless there is evidence that the cashier has been paid."

Government is conscious of the problems, and has increased expenditure on medicine and medical supplies. A week after Health Minister Sata launched the insurance scheme, a group of nine Western governments and United Nations agencies pledged $150 million towards it and to a four-year strategic plan.



World Congress on Penitentiary Health Care

Professor Anowar Ara Begum, Head of the Department of Forensic Medicine, Chittagong Medical College, Chittagong, attended the "1994 World Congress on Penitentiary Health Care and Treatment of Offenders" held in Tokyo, Japan from June 6 to June 9, 1994, as a special guest from Bangladesh.

Topics of the papers presented in the Congress were — Treatment of Illegal Drug Abusers, Women Offenders and Rights of Prison Doctors.