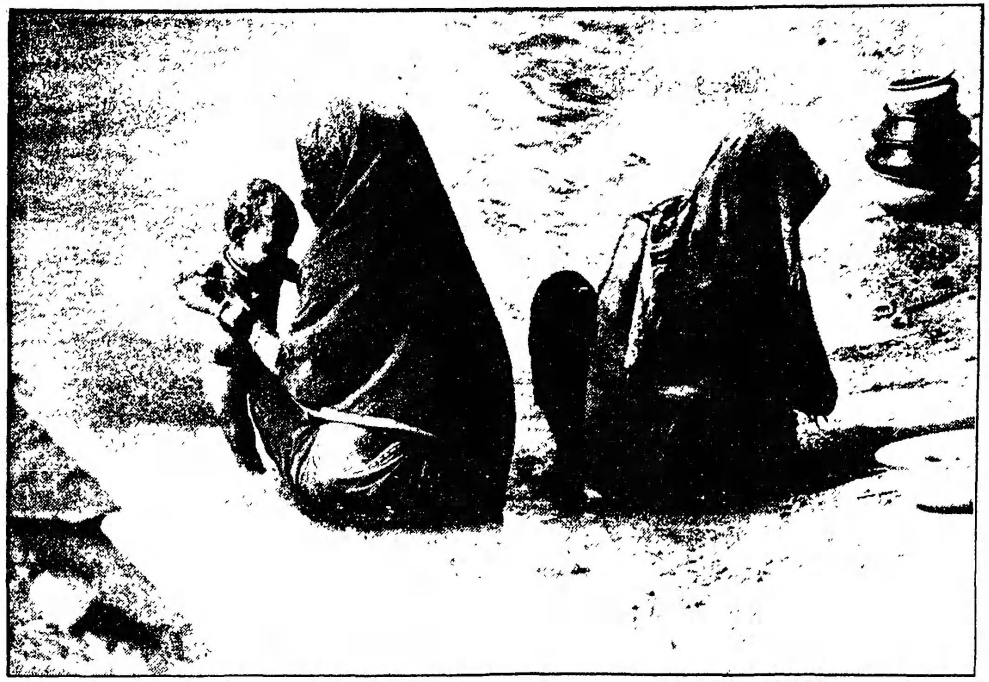
John Cunningham reports on how the Family Planning Ministry is getting its message across to a largely illiterate population far removed from major towns and cities, and on the success of sterilisation projects

100 million reasons why family life must change



THE PRESSURE is on the people of Bangladesh to reduce the birthrate. The Malthusian nightmare could be in sight before the end of the century if the present total of 82 millions continues to grow at the present rate of 2.8 per cent per year. If that continued, a country no bigger than England and Wales would have to support 160 millions by the end of the century.

It is a prospect which for some time has horrified foreign governments and international agencies, both of which are massively pouring aid into Bangladesh, to make up deficiencies in the economy. But it is a projection which is worrying President Zia Rahman who has set a maximum population target of 100 millions by the year 2000.

That is a slogan. Demographers know that even if all couples decided on a two child family as a maximum and adhered to it from this moment, the 100 million figure would still be passed. The biggest problem in the birth control programme is motivation — 90 per cent of the populaton are in agriculture, the majority with tiny landholdings, or else have no land at all.

The traditional Asian notion that a lot of sons represent free labour and security in old age persists. The reality is that Bengali women on average have nine pregnancies, knowing that three will end in abortion or the death of a baby before its first birthday is reached. Yet they go on producing children, knowing that their lot never really improves. Parents working till death — which occurs in what the West regards as middle age — forsthere is no word for retirement in Bengali: there is only the word paralysis.

Ironically, it is the most hopeless who are the source of most hope for the family planning teams. Some 40 millions have an income of between £15 and £20 a year. They are the most wretched in a country where fine shades of grey differentiate the disadvantaged. These people are too poor to own land, and as such, they behave differently in their family aspirations from the landed peasants.

"If they have a prospect of improving their lot, they will take it," says Dr M. A. Sattar who heads the Family Planning Ministry. "For survival, they will accept injectables, abortions and sterilisations. But in their homes, there is very little privacy: they don't like caps and pills and IUDs — coils induce bleeding in Bengali women, who are prone to anemia anyway."

The Government's campaign is a war waged on many fronts. Last year, there was an intensive drive on sterilisation. It was an experiment to see what could be achieved. In six weeks in 50 thanas (administrative districts with populations of around 250,000), 76,000 men and women had the operation — 96 per cent of them were from the lowest economic group.

For women, the operation involved a three day stay in hospital where food was provided (usually families feed their relatives in hospitals in the sub-continent; they received a new sari and transport back to their homes. Twice as many men as women volunteered. The outcome is that officials believe as many as 400,000 sterilisations a year could be performed in Bangladesh.

The other main experiment involves injections which can prevent conception for three months. "Women like this better than other methods. It can cause menstrual irregularities. But these mostly don't require drugs. In only 0.5 per cent of cases is bleeding profuse. It is very much a question of counselling women about the effects," says Dr Sattar.

The Family Planning Ministry is infiltrating its message to a rural, largely illiterate population. Sometimes areas feel neglected by central government in Dacca. Where there is a local bureaucracy sometimes provided by another government department, family planning staff will use it, for it provides a direct contact with the people. Thus many areas are served by agricultural extension workers who advise farmers how to control pests, raise poultry, increase crop yields and so on. In all, they explain 25 methods to increase agricultural production. Now they also explain how to stop human fertility to farmers and their wives: the agricultural extension workers attend training programmes on family planning techniques.

Dr Sattar's method involves a distribution and counselling network for a branch of preventive medicine which does not need a large number of highly trained medical personnel. It is a system which is quite different from that which Bangladesh, as the former East wing of Pakistan, inherited from its colonial days — a curative, hospital-based medical system. Now it is realised that a lot of work can be done by those who have not had, and do not need, long years of training.

Particularly successful has been the barefoot doctor schemes. These have been pioneered by Dr Zafrullah Chowdhury. The "practitioners" are village women, mostly of fairly limited education, who are trained for six months are able to perform tubectomies on village women whose confidence they have gained because they speak the same rural dialects. This para-medical training has been available for about seven years, and there are two main clinics now in Bangladesh.

In a developing country, most methods of contraception will be non-medical. In fact, 85 per cent of the people never see a qualified practitioner and less than five per cent of babies are delivered in maternity hospitals. The Ministry has more than a hand in improving child health. About one quarter of children die before they are five — this high infant and child mortality is one reason for the high average number of pregnancies which mothers have. Dr Sattar says: "If we can convince mothers that their children have more than an even chance of survival, they are likely to be more receptive to contraception." A greater survival rate means, in part, concentration on a nutrition programme for a population of which two-thirds suffers from vitamin and protein deficiency.

There have been some isolated successes. There are, among the thousands of villages, 700 where the birth rate is one per cent or lower. And there are nine villages where, after the intensive attentions of paramedical staff for three years, zero growth has been maintained. Dr Sattar is convinced that the overall rate will drop. He points out that the worst effect of the population expansion is that it is neutralising the effect of international aid which is being pumped in and which merely maintains a stagnant economy. Ideally, aid should promote development.

Economic improvement will bring wide acceptance of smaller families. Dr Sattar quotes his own case: "My income group behaves as I do. Delayed marriage — in my case 29, and only two children." Most of the present acceptors are in the income bracket £200-£300. "That gives me 12 to 15 per cent of fertile couples in the population who are likely acceptors." It is a question for millions of breaking through the income ceiling: smaller family size comes with an enhanced standard of living. That is an improvement which will come only very slowly. But meanwhile, the emphasis is on an energetic approach to persuade as many as possible to limit the number of children.