

POPULATION POLICY OF BANGLADESH: AN OVERVIEW OF SOME IMPORTANT ISSUES AND PRIORITIES

M. S. Islam*

Sociology Discipline, Social Science School, Khulna University, Khulna-9208, Bangladesh

KUS-03/51-161103

Manuscript Received: November 16, 2003; Accepted: May 18, 2004

Abstract: It is now widely recognised that there is a need to take the scope of the population policy in Bangladesh beyond the confines of achieving population stabilisation through reduction of fertility. Although in recent years the approach to reduce of fertility has changed from narrow family planning to a broad based reproductive health approach, it is being increasingly felt that Bangladesh's population policy should encompass other equally important issues which have wide implications for the development process and the quality of life of people of Bangladesh. In this paper, some important issues and priorities have been discussed to incorporate in population policy especially highlighting the International Conference on Population and Development (ICPD) recommendation.

Key Words: Population, FYPs, Development, Policy, Health, ICPD

Introduction

The concern about the growth of population was first recognized by a group of volunteers in the erstwhile East Pakistan in 1953. Since then different phases of experiments were conducted prior to the independence of Bangladesh, sometimes independently by non-government organizations and then with the sponsorship of the government organizations. However, the size of the population was considered as a real threat since the independence of Bangladesh. Population problem was given a high priority in the first Five-Year Plan (1973-78) of the Government of Bangladesh.

The history of the population policy of Bangladesh indicates that the program has developed and expanded on the basis of a trials and errors. The post-independence era of the policies on population basically stemmed from the pre-independence lessons with some modifications. The government of Bangladesh has formulated several policies to reduce the high population growth in the country. Since the main component of growth is fertility, primary focus was on the reduction of fertility through family planning programme (*Nabi, 2001*).

But the maximum policies are based upon theoretical perspectives, which are not practical and difficult to achieve in the present setting due to lack of clearly specified modes through which the targets can be realized. The proposed population policies exclude the main focus of the ICPD 94 and thus presents only a transition from one type of service delivery system to another extended type without referring to the need of integration of development strategies into population dynamics. In fact, to formulate any population policies, different demographic, economic, social, cultural and political factors should be included into population dynamics. Since the International Conference on Population and Development held in Cairo in 1994, the Government of Bangladesh initiated a process to develop a population policy to take account of the challenging issues.

Consequently, the scope of population policies has widened to a broader spectrum – from sheer population size, distribution, structure and changes composition, changes to poverty alleviation, gender equality, reproductive health, planning and management, human resource development, quality of life, good governance and civil society. In other words, population policy has become an element of the complex social development process. (*Hossain et al., 2003*). In this paper, the population policy is critically examined through incorporating a multidimensional paradigm with particular emphasis on the policy in the ICPD.

Population Policies in the Past

The first attempt to provide family planning methods was initiated by a private Family Planning Association in 1953 (*Cleland et al., 1994*). This effort was mainly made in order to provide clinical methods in cities at a limited scale with the help of government and donor agencies. Initially, both knowledge and utilization were very low. However, although this program had no visible impact on the demographic parameters of interest, the training programs organized during this period paved way for an improved system subsequently.

The government recognized the population problem during the first Five Year Plan (FYP) of Pakistan (1955-60), particularly after 1958, and made provision for financial support from the central government to help the promote family planning through voluntary efforts. Although it paved the way for the future development of population regulation of the country, the programme failed to achieve the target set forth in the plan (*Adil, 1969:16*). In the second FYP of Pakistan (1960-65), the government made a budgetary provision for family planning services in the country stressing the distribution of contraceptives through clinics and hospitals. But the programme achieved only 15 percent of its distribution target.

The first broad step to integrate clinical services, communication programs and expansion in outreach programs were made during 1965-70. A family planning board was established to emphasize the fast growth of the program. During this phase the impact of the program was very little but was successful in creating

*Corresponding author: Tel.: 88-041-720171-3, Ext. 281; Fax.: 88-041-731244; e-mail: regekuly@btbt.net.bd

awareness about population problem as well as about the methods of contraception. Dais were responsible to promote and recruit methods of contraception while male organizers used to recruit clients for vasectomy and condoms. Cleland et al. (1994) observed that the high level of commitments with large budgets but within a short span of time without pilot testing the optimum modes of delivering services resulted in the failure of the program. The program was heavily dependent on IUD, which was not popular among the women. The quality of services was very poor and misreporting of users of IUD made it difficult to measure the success of the program.

After independence in 1971, a large number of new policies were incorporated into the first and second FYPs (1973-78 and 1980-85, respectively). In June 1976, the government came out with concrete proposals on National Population Policy – the first comprehensive official statement on the issue. The main features of these two FYPs were: (i) the system of financial intensive was stopped; (ii) oral contraception was introduced for the first time; (iii) the abortion law was temporarily relaxed; (iv) family planning and health programmes were integrated; (v) maternity child health services and family planning were integrated under the population control division of the Ministry and Health Population; (vi) stress was laid on field workers (both males and females) at the grass root levels; (vii) a lot of importance was attached to the mass and local folk-media and the involvement of voluntary organizations and social groups of all kinds in promoting family planning in Bangladesh.

After the promulgation of Marital Law in March 1982, the government launched a two year Emergency Population Control Programme (*Population Control and family Planning Division, 1982*) aiming at 100 per cent achievement of the targets set in the second FYP period (1980-85). In this backdrop, different steps were materialized during the first, second, third, and fourth FYPs. However, several workshops were held in order to revise the priorities for the family planning programmes in Bangladesh during mid-nineties. But this goal was never attained due to several causes such as; inadequate contraception, fear and anxiety over contraception, lack of sufficient motivation for family planning, corruption, lack of commitment and dedication of the workers etc (*Hossain et al., 2003*).

Current Population Programmes

The most recent document on strategies to reduce the population growth is formulated by development partners and stakeholders, accepted by the Ministry of Health and Family Welfare (one of the stakeholders), is named as the Health and Population Sector Strategy (HPSS). The main objective of this strategy is to reform the health and population sector in order to provide an essential services package (ESP) to the population of Bangladesh (*GOB, 1998*). The main sectoral objectives of HPSS are: (a) maintenance of the momentum of efforts in Bangladesh to lower fertility and mortality, (b) reduction of maternal mortality and morbidity, and (c) reduction in the burden of communicable diseases.

The ESP comprises of four components: (a) basic reproductive and child health services, (b) control of selected communicable diseases, (c) limited curative care, and (d) behaviour change communication. It is expected that the ESP will be delivered through primary health care system at community, union, thana and district levels. The implementation strategies of HPSS include strengthening of support systems such as communications, logistics, human resource development and management information systems. These will heavily depend upon policy changes to make the system more cost-effective through restructuring of organization and management of service delivery and increased involvement of community in monitoring and evaluation. One of the major preconditions for an effective system of providing ESP is through a unified line management system, instead of the current bifurcated system. The major shift proposed in the HPSP is from door-steps service to a one-stop client-oriented service. This transition depends upon fulfillment of several preconditions. The preconditions are: (a) communities are to be involved in planning and management of services, (b) community participation in setting up of facilities, (c) maintenance of flexible mix of fixed site and mobile sites to ensure extended coverage, (d) change in the behaviour of women to receive services from static centres.

Population Planning and ICPD 94 Recommendations

The ICPD 94 was a follow-up of similar consensus oriented World Population Conferences held in Bucharest in 1974 and in Mexico City in 1984. The purpose of the 1994 ICPD was to examine and consider the newly emerged issues of population within the framework of a much broader perspective of interrelationships between population, development and environment. It was observed that none of these could be considered in isolation due to their close interconnectedness. There was consensus that population, poverty, patterns of production and consumption; education, economic status and empowerment of women and environment are interconnected. One of the objectives of ICPD 94 (*UN, 1996*) states that the population concerns are to be fully integrated into development strategies, planning, decision making and resource allocation at all levels and in all regions, with the goal of meeting the needs, and improving the quality of life, of present and future generations. Another objective of similar importance is that all aspects of development planning need to promote social justice and to eradicate poverty through sustained economic

growth in the context of sustainable development. The plan of action suggested in the ICPD 94 that international, national, and local level population issues should be integrated into the formulation, implementation, monitoring and evaluation of all policies and programs relating to sustainable development. There is a clear emphasis on the formulation of development strategies in order to reflect implications and consequences of population dynamics along with production and consumption.

Reproductive Health: A new paradigm

World Health organization (WHO) defines reproductive health as – “ A condition in which reproduction is accomplished a state of complete physical, mental and social well-being, and not merely the absence of diseases or disorders of the reproductive process” (WHO 1994).

The Programme of Action document of the ICPD 1994 has explained reproductive health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of family planning of their choice for regulation of fertility which are not the against the law, and the right of the access of appropriate health care – services, that will enable women to go safely through pregnancy and childbirth and provides couple with the best chance of having a health infant (UNFPA 1995). According to the broad definition, the basic elements of reproductive health covers a range of reproductive problems, including family planning, safe motherhood, safe abortion facilities, adolescent reproductive health, infertility, Reproductive Tract Infections (RTIs), and Sexually Transmitted Diseases (STDs), HIV/AIDS, concern of reproductive tract, and reproductive health needs of disables (Barkat et al., 1997). It may appear from the list of elements that the medicalisation of diseases and supply of service deliveries could be enough to take care of women's reproductive health. Medical science and technology play a very important role in protecting human health. But we also know that human health is the outcome of a combination of biological, genetic, environmental and socio-economic factor.

Population Policy: Some Missing Links and Concluding Remarks

It is clearly evident from our discussion that the most important principles that constitute the major objectives of the ICPD 94 have been excluded from the maximum number of proposed population policies. The interrelationships between population and development factors are ignored in the population policy, which will not only delay our economic growth but it will also delay the process of stabilization of our population to a great extent and it will eventually lead us to a vicious cycle of poverty.

The impact of population momentum on the number of women in reproductive ages as well as the problem of rapidly growing elderly population have not been addressed adequately in the HPSS or in the proposed strategies of the population policy. If these are not taken into account in our planning process with high priority then the socio-economic and health hazards will make the population policy redundant.

After reviewing the existing literature, researchers have summarised some of the major constraints of the existing GOB programmes and interventions. Technical competence like skills for communication, counselling, examination, screening and diagnosing RTI or other infections was found to be very inadequate. Service providers were found to have inadequate knowledge on PHC, nutrition, immunisation, and minor ailments (Mamud et al., 1990). Several studies found that records of follow-up visit, complications and management of complications of MR clients were deficient. Acute shortage of MR instruments was found in several studies. Information, Education, Communication (IEC) activities were found to be insufficient at the community level. IEC activities for prevention and promotion of treatments of STDs, RTIs and HIV/AIDS were found to be non-existent (Islam et al., 1994). Existing IEC activities do not address the growing need for reproductive health related care of the adolescents.

To achieve further success the implementation of the priorities recommended by the ICPD, the broader circumstances of women's lives that affect their ability to promote their own health and that of their families must be understood. Adequate knowledge in the circumstances under which women manage their health is a prerequisite to gain insights into the dynamics of the problem. Otherwise, right policies for the improvement of women's health could not be formulated. Human ecology and natural ecosystem also have important bearings on the way of life of a particular population. Certain demographic trends can also be a driving force that could determine health management pattern of a society. The elements that determine a population's health go beyond physiological factors to include gross national product, wealth distribution, access to employment, access to educational facilities, environment and physical infrastructure in rural and urban settings and political culture through which individuals and groups can influence distribution of resources that affect health and diseases of a society. Therefore, any understanding on reproductive health problems

must encompass not only diseases, disorders, and service delivery systems but also a way of life, behavior, socio-economic conditions, environment, ecosystems, and a system of cultural values, beliefs and practices of a society (Hossain et al., 2003).

So to formulate any population policies in conjunction with the ICPD programme of action the following issues could be prioritised for Bangladesh which may include population and sustainable development, poverty alleviation, human resource development, generation of employment opportunity, sustainable environmental protection, health and family welfare, unequal hierarchical land relations, elimination of gender discrimination, women education, reproductive rights, adolescents health and men's involvement, transparency and accountability, planning, management and reforms, advocacy and communication, good governance and civil society etc. These are the issues which needed to be addressed for a meaningful population control and for creating a relatively rich and healthy economy both social and economic terms.

References

- Bairagi, R. Development Versus Family Planning Argument for Fertility Decline in Bangladesh. Draft Paper. ICDDRDB, Dhaka.
- Barkat, Howlader.S.R. 1997. Population and Development Issues in Bangladesh. National Plan of Action Based on ICPD '94 Recommendations. *Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh*, pp. 115-150.
- Cleland, J., Phillips, J.F., Amin, S. and Kamal, G.M. 1994. The Determinants of Reproductive Change in Bangladesh- Success in a Challenging Environment. Washington, D.C.: The World Bank.
- GOB, 1976. Bangladesh National Population Policy: An Outline. *Population Control and Family Planning Division*, Dhaka.
- GOB, 1998. Health and Population Sector Programme 1998-2003, Programme Implementation Plan Part I, *Ministry of Health and Family Welfare*, GOB, Dhaka.
- GOB, 2000. Draft National Population Policy 2000. *Ministry of Health and Family Welfare*, GOB, Dhaka.
- Hossain,M. A.K.M.Nurun Nabi and I. Islam. 2003. *Bangladesh Development Agenda and Vision 2020 Rhetoric or Reality*. University Press Limited, Dhaka, pp. 23-38.
- Islam, M.A. 1997. *Interrelationship between Population and Economic Growth*. In Population and Development Issues in Bangladesh, 1997, Chapter 1, pp. 29-50. MOHFW, Dhaka.
- Islam, M. A. 1996. *Sustainable Population Policy: Emerging Issues*. In Growth or Stagnation?: A Review of Bangladesh's Development, 1996 (ed. Rehman Sobhan), Chapter 12, pp. 391-414. CPD and UPL, Dhaka.
- Islam, M. A. 1998. *Management of Population Programme*. In Crisis in Governance: A Review of Bangladesh's Development, 1997 (ed. Rehman Sobhan), Chapter 16, pp. 361-382. CPD and UPL, Dhaka.
- Islam, M.A. 1999. Population, Development and Environment: The Emerging Issues. Paper 2, CPD-UNFPA Programme on Population and Sustainable Development, CPD, Dhaka.
- Ministry of Health and Family Welfare, 2000. Bangladesh Demographic and Health Survey, 1999-2000. Dhaka: NIPORT.
- Nurun Nabi, A.K.M. 2001. Population of Bangladesh: Dynamics and Implications in the Twenty First. UN, 1996. Programme of Action Adopted at the ICPD 94. UNPFA, New York.