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THE PROPOSED POPULATION POLICY OF BANGLADESH: SOME IMPORTANT ISSUES

Ataharul Islam

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CENTRE FOR POLICY DIALOGUE
House No 40/C, Road No 11, Dhanmondi R/A, GPO Box 2129, Dhaka-1205, Bangladesh
Tel: 8124770, 017521580; Fax: 8130951; E-mail: cpd@bdonline.com
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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 reduction 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. To address some of the related pertinent issues the Centre for Policy Dialogue has initiated a programme which aims at undertaking a series of studies covering the broad area of **Population and Sustainable Development.** The major objective of these studies is to enhance national capacity to formulate and implement population and development policies and programmes in Bangladesh, and through close interaction with the various stakeholder groups, to promote advocacy on critical related issues. The programme which is scheduled to be implemented by the CPD between 1999 and 2002 shall address, *inter alia,* such issues as population dynamics and population momentum and their implications for education and health services, the nexus between population correlates, poverty and environment, impacts of urbanisation and slummisation and migration, as well as human rights. The study has benefited from generous support provided by the United Nations Population Fund (UNFPA). The programme also envisages organisation of workshops and dialogues at divisional and national levels and also holding of international thematic conferences.

As part of the above mentioned CPD-UNFPA collaborative programme the CPD has planned to bring out a series of publications in order to facilitate wider dissemination of the findings of the various studies to be prepared under the aforementioned CPD-UNFPA programme. The present paper on the theme of ***The Proposed Population Policy of Bangladesh: Some Important Issues*** has been prepared by Dr. Ataharul Islam, Professor, Department of Statistics, University of Dhaka.

Assistant Editor: *Ms Ayesha Banu*, Coordinator (Dialogue & Communication), CPD
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I. Background

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. In the first FYP, the total population size for 2000 was projected to be 189 millions. It was assumed that the projected economic growth would not be able to cope with the size of the population and the minimum acceptable standard of living could not be maintained if such a growth of population persisted (GOB, 1976). At this backdrop, the first population policy was formulated in 1976 (GOB, 1976) and it was projected that the population of size 121 million in 2000 would be an acceptable size in context of economic growth of Bangladesh and strategies were proposed for family planning programs and specific targets were set in order to reduce the growth rate of population.

The population policy of Bangladesh as documented in the Five Year Plans (FYP) of Bangladesh mainly revolved around much emphasis to family planning programs in order to keep the size of the family small. The programs were marked as birth control programs as well. In other words, the population growth rate was intended to be reduced through controlling births through family planning methods. The strategies of the first population policy of Bangladesh were: (i) to regulate family size to ensure better health for women, and (ii) to reduce the burden of larger families and thereby release time and energy of women and youth for increased production. Population control and family planning were viewed as components of social mobilization and development efforts. Due to well planned vision presented in the first population policy, the country could eventually fulfil the target after a quarter century. Initially, longer acting methods were encouraged and

adequate government help as well as training and motivation were targeted towards clinical methods (Cleland et al., 1994).

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. Eventually these streams of measures for making attempts to reach the common people at the grass-roots levels resulted in a success story in a setting like Bangladesh. Unlike all other countries, the success of family planning program was not preceded by any remarkable socio-economic progress in Bangladesh. Interestingly, the progress at the grass-roots level was achieved within the framework of a very complex administrative mechanism which is essentially bifurcated with health and family planning as two separate and seemingly unrelated directorates. Attempts were made in the past to integrate the activities of health and family planning programs. However, at the lower level of the activities of family planning programs, some maternal and child health issues were integrated into the family planning programs.

The family planning programs were dependent mainly on donor-assistance and during the past decade the level of contraceptive prevalence has increased sharply. During this period, there was a shift in the method-mix from longer acting methods to short-term methods such as oral pills. The service delivery system had become increasingly costly due to shift in method-mix and the problem of quality of care emerged as a major constraint to the continuation of methods. It was projected that the costs of FP would be increased about 3 times during the period 1995-2015. The projected costs will be increased rapidly due to the population momentum, high rates of discontinuation of methods and higher use of modern reversible methods (Islam, 1997).

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. The draft national population policy 2000 is the outcome of the efforts to address the outstanding issues as well as to make the programs sustainable. The idea of cost-sharing, cost recovery and community participation were

taken into account with high priority. In this paper, the proposed population policy is examined critically with particular emphasis on the feasibility of the policy in the past, present and future contexts.

II. 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. Then the government programs were initiated on the basis of a modified approach and services were provided through government health clinics. In other words, government health clinics were providers of family planning methods. Another attempt to provide knowledge to the rural population through village aides was abandoned only after 18 months due to: lack of proper training and exclusion of health services. 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, independent of health, to emphasize the fast growth of the program. During this phase the impact of the program was very little but was successful in creating 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. The training program was also far from adequate. However, the staff who were involved in this program were eventually employed in a modified program started since the independence of Bangladesh. Hence, the failure of previous

stages contributed in terms of creating awareness among people as well as continued to train increased number of staff who could be involved at next phase.

Without much delay, since the independence of Bangladesh, the family planning programs were generously supported under a new population wing and the male outreach workers from the Pakistan era were included in the health wing. The number of workers were increased rapidly and instead of reforms, the old system, inherited from the Pakistan era, were adopted with a sense of urgency to slow down the growth of population. The separation of health and population wings created rivalries and conflicts. At the grassroots levels, health services were provided by male workers but family planning services were provided mainly by female workers. With a shift from family planning to maternal and child health and family planning, increased responsibility was shared by family planning workers due to their easy access to the female clients in Bangladesh. This process left the male health workers mostly redundant.

In the first FYP, the population problem was given a high priority and it was the beginning of an organized effort to reduce the population growth through expansion of family planning programs. Introduction of Family Welfare Assistants at the grassroots level was proved to be instrumental in bringing about the success of the family planning programs in subsequent years. A major breakthrough in the planning process was achieved through incorporating a multisectoral approach. However, the vision of multisectoral approach could not be realized meaningfully due to disjoint approach followed by different ministries. In other words, multisectoral approaches were visible in the budgetary allocations but integration of efforts under a broad framework with specific input-output relationships could not be established since the first FYP.

Since the independence of Bangladesh, a very weak family planning program eventually became a success story in the absence of concomitant change in the socio-economic status, due to various reasons as mentioned below:

(i) Emphasis was given in the first FYP in order to expand the family planning programs in Bangladesh with a sense of urgency,

(ii) Inclusion of maternal and child health issues,
(iii) Improvement in the service delivery systems through female FWAs,
(iv) Initiation of multisectoral approach,
(v) Demand generation activities through motivating potential clients since 1975,
(vi) Increased activities to communicate with the potential clients,
(vii) Neutralizing the conservative religious leaders,
(viii) Construction of Family Welfare Centres and employment of Family Welfare Visitors,
(ix) Implementation of Satellite Clinics, and
(x) Increasing role of NGOs in family planning programs.

These 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 programs in Bangladesh during mid-nineties (Islam, 1998). The underlying reasons for such priority setting were to: (a) address the problems stemming from shifts in the method-mix from longer duration methods to short-term modern methods, (b) improve quality of care, and (c) to introduce more cost-effective service delivery system.

Finally, the fifth FYP proposed policy shifts to cope with the problems faced by a system which has grown out of proportion without corresponding change in the organizational structure to cope with the new challenges. The major obstacle stemmed from the bifurcated leadership in the health and family planning sectors. The recent shifts at the grassroots level service delivery system could not deliver the optimum level of output mainly due to the increasingly heavy load on the FWAs and decreasing load on the HAs. It is worth mentioning that although the programs were improved through implementation of new strategies on the basis of findings from carefully designed studies, but no such effort was made to modify the existing complex organizational structure. The policy options remained wide open because without making the organizational structure cost-effective and capable of handling new challenges efficiently, new challenges to the family planning programs can not be achieved.

Some of the major shifts proposed in the fifth FYP (1997-2002) are:

(a) To decentralize authority for family planning, strategy formulation and resource mobilization and to encourage local level participation with ownership in program planning and implementation,

(b) To review and update population education and implementation of a comprehensive human resource development plan for the entire population sector,

(c) To use the Union Parishads and the Ward Committees as the nuclei for all population activities involving local community leaders and officials to provide for better horizontal interaction, coordination and people's participation,

(d) To design special programs for low income groups having large family size. Urban slum dwellers should also receive special attention in the provision of FP services.

These policy options are not adequately supported by clearly stated and specific strategies (Islam, 1998). Islam observed that decentralization process requires a well planned restructuring of the existing organizational set-up of the health and family welfare directorates through adequate pilot testing. In addition, local level participation and ownership is a utopian dream until the realistic modes of such process is tested at a small scale. The strategies for implementation of such transitions are not clear from the Fifth Five Year Plan Document.

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, © 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

III. Population and Development

The proposed national population policy of Bangladesh, 2000 was initiated after the International Conference on Population and Development held in Cairo in 1994. 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 can 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.

In 1997, as follow-up of ICPD 94, the population and development issues were reviewed in the context of Bangladesh. Islam (1997) observed that the interrelationship between population and development largely depend on the following characteristics of population:

(a) population growth, structure and distribution,
(b) human capital accumulation
(c) social and gender inequities, and
(d) poverty and distribution of income.

With a narrow perspective we can refer to measure of such integration in terms of the Human Development Index (HDI) where three selected indicators are employed, namely (UNDP, 2000):

(a) longevity, as measured by life expectancy at birth,
(b) educational attainment, as measured by a combination of the adult literacy rate and the combined gross primary, secondary and tertiary enrolment ratio, and
(c) standard of living, as measured by GDP per capita.

This is only a crude measure of the extent of integration of population and development. This measure does not take into account some of the major factors that are crucial in measuring the level of development in terms of interrelationships between population and

development such as: population growth, structure and distribution; social and gender inequities; and poverty and distribution of income. Human development encompasses three essential factors determining human capital accumulation that are required for explaining relationship between population and development: (a) long and healthy life, (b) education, and © decent standard of living. However, arguably this is the minimum set of variables that can be taken into account in order to integrate development strategies with dynamics of population.

IV. Feasibility of the Proposed Population Policy

The proposed national population policy of Bangladesh is formulated on the basis of principles stated in the ICPD 94 (GOB, 2000). There are certain new components in the proposed population policy if we compare this with that of the population policy as well as with the policies and strategies adopted and implemented during the Five Year Plans. Some of the components are included as a continuation from the previous policies. An attempt is made here to identify the major shifts in terms of: (i) targets, (ii) basic principles, and (iii) fundamental strategies.

4.1 Targets

Some of the targets and objectives of the proposed population policy are replicated from the previous policies namely, providing health and family welfare services to the people, evolving and implementing more effective family planning and reproductive health services, improving maternal and child health care services, ensuring quality of care, etc. However, a number of new objectives are included in the policy with greater emphasis:

(i) replacement level fertility is to be achieved by 2005 and the stable population by 2050, (ii) reduction of malnutrition among the children and females in particular , (iii) fifty percent reduction of IMR and MMR by 2005, (iv) awareness among health service providers in order to provide services for physical and mental violence against women, (v) finding appropriate system to provide emergency care, (vi) to make health and family planning services accountable and cost-effective, (vii) to consider the increasingly important problem of ageing, (viii) to ensure integrated and balanced population distribution to face the challenge of the rapid urbabization, etc.

4.2 Principles

The principles of the ICPD 94 have been undertaken as the stated principles of the proposed population policy with some major exceptions. The principles that are stated as the basis for the proposed population policy cover the following issues: (i) human rights, (ii) right to adequate standard of living, (iii) advancement of gender equality and equity, (iv) right to development in order to meet the needs of present and future generations, (v) improved quality of life, (vi) highest attainable physical and mental health, (vii) strengthening of family as the basic unit, and (viii) population and development needs of the indigenous population. All these principles deal with mainly improvement of quality of life through improved health care, equity and empowerment of women, human rights and cultural interests. However, the principles related to the linkage between population and development, which are given high priority in the ICPD 94, are not included in the proposed population policy. The excluded principles are mentioned below (UN 1996):

(i) Sustainable development as a means to ensure human well-being, equitably shared by all people today and in the future requires that the interrelationships between population, resources, the environment and development should be fully recognized, properly managed and brought into harmonious, dynamic balance,
(ii) All people shall cooperate in the essential task of eradicating poverty as an indispensable requirement for sustainable development,
(iii) Everyone has the right to education, which shall be directed to the full development of human resources, …with particular attention to women and the girl child,
(iv) The child has the right to standards of living adequate for its well-being and the right to the highest attainable standards of health, and the right to education,
(v) The developed countries acknowledge the responsibility that they bear in the international pursuit of sustainable development, and should continue to improve their efforts to promote sustained economic growth and to narrow imbalances in a manner that can benefit all countries, particularly developing countries.

It is worth noting that the main purpose of the ICPD 94 was to highlight the importance of integrating development and population strategies. Hence, the proposed population

policy fails to address the most essential component to cope with the emerging challenges.

4.3 Strategies

The strategies of the population policy are formulated in accordance with the Health and Population Sector Strategies. This is quite surprising because HPSS is a temporary and experimental project and strategies of a national population policy should not be guided by the strategies of a project. In addition, the targets and objectives of the population policy, which are primarily based on the principles of ICPD 94, have a much wider scope that are not addressed in the strategies of HPSS. This makes the scope of the proposed population policy very restricted and the vision underlying the broader perspective of the interrelationships between population and development has been deliberately ignored. In other words, the strategies of the proposed population policy deal mostly with a transition in the service delivery system from door-steps service of maternal and child health and family planning methods to a one-stop service of ESP instead of addressing the broader perspective of population dynamics as an integral part of the development process.

Now let us examine some of the important strategies that are being implemented. The client-centered approach of the HPSS is supposed to provide essential service package on: the following components: (i) reproductive health care, (ii) child health care, (iii) control of communicable diseases, (iv) limited curative care, and (v) behaviour change communication.

For an effective service delivery system for ESP, the necessary preconditions are:

(i) to integrate family welfare and health directorates at all levels,
(ii) to establish community clinics at a close proximity for about 6000 people,
(iii) to ensure rigorous training at all levels in accordance with the needs of the transformed system,
(iv) to ensure presence of trained personnel at the service centers,
(v) to ensure adequate supplies of family planning methods and drugs for communicable diseases and curative care,

(vi) to ensure participation of stakeholders and community leaders in the process of planning, management and financing of activities,

(vii) to ensure cost recovery through improved quality of care,

(viii) to evolve a new process of providing services to the poor people and for those who will not be able to utilize the one stop services,

(ix) to create willingness to avail the one stop services who were used to door-steps services in the past,

(x) to promote behavioral change communication through wide-spread use of modern facilities,

(xi) to evolve an effective evaluation and monitoring system through a unified management system in order to assess the weakness and strength of the program.

This is only a short list of preconditions which are to be satisfied prior to initiation of the ESP in Bangladesh. Each of these preconditions is complex enough to make one think how these preconditions will be materialized in reality. There is no evidence mentioned either in the HPSS document or in the proposed population policy document that can refer to any justifiable pre-testing on the basis of which these preconditions can be assumed to be realistic. Let us cite some examples of the underlying complexities of the above mentioned preconditions:

(i) Rivalry and conflict concerning integration of health and family planning wings of the Ministry of Health can be traced back since the early stage of organized effort of family planning programs (Cleland et al., 1994). There were several attempts in the past to integrate family planning and health services but without any success due to resistance from both the sides. What makes it certain at this stage that this will not only function smoothly but will be more efficient and effective? This seems to be a utopian scheme.

(ii) Establishment of community clinics is an excellent idea. But the problems stemming from community participation and ownership and cost recovery keep the potential functioning of the community clinics doubtful. These are not pre-tested in terms of personnel involved, sharing of responsibilities, supplies of logistics, cost sharing,

training of the personnel, reporting of activities, behaviour change communication and safety net programs.

(iii) Treatment of communicable diseases and limited curative care will depend on properly trained personnel and availability of essential drugs. An effective referral system for emergency care is crucial for the success of the program.

(iv) The family planning methods are available in the satellite clinics but in the past only negligible proportion obtained contraceptives from one stop centre (SCs) but SCs were popularly used for health purposes. Will there be any reversal under the current system? Is there any evidence in favour of such belief?

(v) The number of monitoring indicators will be increased greatly under the unified system, and some of the indicators will be difficult to report on a regular basis. Historically, there was over-reporting of achievements from the unit levels, making numbers difficult to believe. Is there any mechanism under the new system to check such fabrication of achievements?

These points were raised in a national dialogue held as early as October, 1997 and it was particularly emphasized that pilot testing on the proposed strategies were of utmost necessity before implementation of HPSS at national level in order to avoid ambiguities (Islam, 1998). In addition, the process of decentralization and participation by local government and local community can not be successful in the setting of Bangladesh without a strong political commitment irrespective of party affiliations.

V. Population Policy: Some Missing Links

It is clearly evident from our discussion that the proposed policy is 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 policy excludes 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. Recent estimates indicate that although the level of CPR has increased from 49.2 percent in 1996-97 to 53.8 percent in 1999-2000, the level of TFR remained constant at a level of

3.3. Similar experience is observed by Bairagi (2000) in the MCH-FP area where the level of CPR increased from 61 percent in 1991 to 69 percent in 1998 but the level of TFR has not declined from 3.0. Without taking into account population-development interrelationships, a further decline in the level of fertility will be difficult to achieve.

It has been mentioned in section 3 that the three components of human development are: health, education and standard of living. The proposed population policy deals with health only without making any realistic attempt to take account of other two components that can provide necessary inputs for population-development interrelationships. In other words, education and income generating activities of the population should be integral part of both the development strategies and population dynamics.

Malnutrition is identified as one of the major concerns of the population policy, but without addressing the issues of education and income generating activities, little can be achieved in reducing the level of malnutrition in Bangladesh. The positive association between education and economic growth, use of contraception, age at marriage, status of women, utilization of health care facilities, nutritional status and negative association with level of fertility, morbidity/mortality, family size, poverty, etc are well documented from various studies. In this case, education does not mean only general education, it may include basic education with different kinds of skills that can enable common people to be engaged in income generating activities. Non-farm activities need to be encouraged by the government. NGOs can be instrumental with active support from the government to decrease the level of poverty through well planned programs linking education and income generating activities (Islam, 1999). We have a number of such projects being operated by different NGOs from which the population dynamics can be linked with the development strategies. It is evident that access to non-agricultural income in rural areas can provide the means to reduce poverty among the landless and poor people (World Bank, 1997). The proposed population policy refers to multisectoral approach, but from our past experience it can be visualized that with a disjoint approach, the synergestic impact of the role of education and income generating activities can not be materialized. A joint approach operated under a community participation model (similar to the community clinic) at the smallest units can be effective in this respect. The government

can take lessons from some successful non-government examples before generalizing the concept at the national level.

There are serious concerns about the population growth and agricultural production in Bangladesh. It is likely that the dependence on agriculture will increase with rapid growth in the size of population due to population momentum. Bongaarts (1996) observed that Bangladesh has already reached its peak for using cultivable lands. The cropping intensity is already very high (Abdullah and Shahabuddin, 1997). Hence, if alternative sources of income generating activities are not explored, both the development and population sector strategies will be severely affected. As we mentioned earlier, the rural non-farm activities can provide such scope. For rural non-farm activities, basic education with appropriate skills can provide the necessary input. The population policy needs to address this issue with specific strategies. Hossain and Sen (1992) observed prominent role of education among those who are involved in non-farm activities.

VI. Population Policy and Population Momentum

In the proposed population policy, it is expected that the replacement level fertility will be attained by the year 2005 and the population will be stabilized in 2050. It is not clear though whether replacement level fertility can be achieved without remarkable improvement in the relationship between population and development. The most important links in this relationship can be established through education and income generating activities. The population will grow at a fast pace until the population size is stabilized, even if replacement level fertility is achieved in 2005, due to heavy young age composition, during this process of transition. This process is known as population momentum which is an echo effect of high level fertility. The impact of population momentum can be reduced to some extent if the level of fertility is reduced much lower than the replacement level within a short span of time (Islam, 2000).

The most visible impact of population momentum will be observed on the number of women in reproductive ages and on the number of elderly persons (Islam, 2000). The population policy could not suggest any specific strategies in order to face these

challenges. Without a very specific set of strategies, the purpose of the population policy will be greatly jeopardized.

The projected size of the total population is displayed in Table 6.1. Two different scenarios are employed. Scenario I projection assumes the contraceptive prevalence and age specific fertility rates obtained from BDHS 1996-97 (MOHFW, 1997) and it is assumed that that the rates will not be changed in subsequent years. Scenario II represents an increased level of CPR, decrease in age specific fertility rates and decline in infant mortality rate.

Table 6.1 Projected Size of the Total Population (in Millions), 1991-2051

Year	Scenario I	Scenario II
1991	111.5	111.5
2001	133.2	130.3
2021	185.2	157.9
2951	243.9	188.1

During the period from 2001 to 2021, an increase of 52 millions people is projected under scenario I as compared to that of 28 millions according to scenario II. Similarly, during the next 30 years, from 2021 to 2051, an additional 58 millions is projected under scenario I which will be about 30 millions under scenario II during the same period. Hence, if the population policies do not take into account alternative measures to address this issue then the strategies for reducing the growth of population will be seriously affected.

The increase in the number of females in the reproductive ages will pose the most formidable challenge to the new population policy. The extent of increase in the number of women in reproductive ages will occur so rapidly that the strategies, in terms of allocations, targets, supplies, logistics, providers, quality of care, number of one stop and mobile centres, will need to be updated at regular intervals. This issue has not been addressed in the proposed population policy adequately. Table 6.2 shows the projected number of women in reproductive ages for the period 1991-2051.

Table 6.2 Projected Number of Women in Reproductive Ages (Millions), 1991-2051

Year	Scenario I	Scenario II
1991	24.6	24.6
2001	35.6	35.6
2021	48.5	45.2
2051	56.3	41.8

Table 6.2 indicates that if the current age specific fertility rates continue to prevail in the future then the number of women in reproductive ages will be doubled during 1991-2021. If we consider a declining trend in the age specific fertility rates, still it will be nearly doubled during the same period due to the impact of the population momentum.

Another problem that will have increasingly important role during the next decades is attributable to the process of aging of population as the population will tend to stabilization. This issue is mentioned without referring to specific strategies to cope with rapidly increasing size of the elderly population. If this issue is not addressed properly and if adequate planning process is not initiated with special emphasis, then there will be increased social, economic and health problems in the country that will beyond control of any makeshift kind of solution. Table 6.3 displays the projected number of elderly population (60 years or older) for the period 1991-2051.

Table 6.3 Projected Number of Males and Females (Millions), 1991-2051

	Scenario I		**Scenario II**	
Year	Female	Male	Female	Male
1991	2.75	3.29	2.75	3.29
2001	3.39	3.83	3.39	3.83
2021	7.27	7.82	7.27	7.82
2051	22.29	22.66	22.29	22.66

During the period 1991-2021, the number of elderly people will increase 2.5 times while the size of elderly population will increase 7.4 times during the period 1991-2051. Without a very specific set of policy strategies concerning socio-economic and health services for such an increased number of elderly people, there will be serious imbalances in the society.

VII. Concluding Remarks

This paper examines the feasibility of the proposed population policy in the current as well as future contexts of Bangladesh. The family planning program in Bangladesh was considered as a success story due to its achievements in the absence of remarkable accompanying changes in the socio-economic conditions. Recently, the Government of Bangladesh has undertaken a very ambitious project called HPSS. A population policy is suggested based on the strategies of the Health and Population Sector Strategies.

The population policy mentions that the guiding principles of the population policy are based on the principles of the International Conference on Population and Development held in Cairo in 1994. However, we observe with utter surprise that the most important principles that constitute the major objectives of the conference have been excluded from the proposed population policy. 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. It is worth mentioning that the policy appears to be formulated in order to facilitate a short term experimental project funded by the stakeholders.

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 proposed population policy redundant.

This paper shows that the preconditions for the implementation of the strategies stated in the proposed population policy were not explicitly pre-tested. In that case, the uncertainties involved with the implementation of such strategies will make the process of transition extremely vulnerable and the targets set in the population policy will be unlikely to be achieved.

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