

Bangladesh's Population Policy: Emerging Issues and Future Agenda

1. Introduction

The well being of people can be affected by the policies regarding population growth. Policies can have devastating or constructive effects. Sometimes it is the absence of population policy that causes negative results, but other times it is the continuation of restrictive policies that directly influence health outcomes. Progressive national policies like those that delay age at first marriage, can save the young bride from death in early childbirth. Similarly, policies that ensure safe and voluntary family planning programmes can greatly enhance a woman's opportunity to regulate her fertility. Conversely, policies that limit the availability of pregnancy termination consign women to unnecessary mortality and morbidity as they either bear children they cannot care for or resort to the unhealthy practices of illegal abortions.

The International Conference on Population and Development (ICPD) had a strong impact on the development of population policies in many countries throughout the world including Bangladesh. The Programme of Action (PoA) had an important influence on the population section of Bangladesh's Fifth Five Year Plan (FYP) that started in 1997, the Health and Population Sector Programme (HPSP) that began in 1998, and the draft of the New Population Policy (NPP) that is currently being finalised. Each policy document incorporated some important components from the ICPD document but also excluded others (UN,1995; Mabud and Akhter, 2000).

The primary objectives of this paper are to describe several of the major population and development issues in Bangladesh, examine how Bangladesh's existing and proposed population policies and programmes deal with these concerns, identify where there are gaps between the issues and the policies and programmes, and discuss how the policies and programmes can be improved to address these issues more effectively.

2. Major Population and Development Issues

Bangladesh currently faces many significant population and development problems. This section will describe six important issues including unmet contraceptive needs, adolescent population growth, high maternal mortality and morbidity, HIV/AIDS and Sexually Transmitted Disease (STD) concerns, lack of female empowerment, and increasing urbanisation.

Unmet Contraceptive Needs

Data from the 1999-2000 Bangladesh Demographic and Health Survey (BDHS) show that the country continues to have considerable unmet contraceptive needs. Although every eligible couple knew about modern contraceptive methods, only 54 percent of eligible women currently used any contraceptive method. Currently married women reported using modern contraceptive methods four times as much as traditional methods, and they indicated that pills, injectables, and female sterilisation were the most frequently used modern methods. The 1999-2000 BDHS also indicates that approximately half of the contraceptive users discontinued the chosen contraceptive method within one year after they started. The highest

discontinuation rate was for condoms (67 percent), and the lowest rate was for IUDs (34 percent). Additionally, 71 percent of currently married women and 62 percent of currently married men who were not currently using contraceptives said that they intended to use them in the future (NIPORT, 2001). Addressing unmet contraceptive needs is a major issue, because contraceptive use is one of the most important methods for reducing fertility and for preventing the spread of HIV/AIDS and STDs.

Adolescent Population Growth

The data indicate that male and female adolescents, age 10-19, comprised an important portion of the total, school going, working, and reproductive health practicing populations of Bangladesh in 1999-2000. They represented one-fourth of the total population with 14 percent of age 10-14 and 11 percent of age 15-19. In 1999-2000, two-thirds of adolescents of age 11-15 and one-third of those ages 16-20 were attending school. For 10-19 year olds, approximately half of males and only 11 percent of females were engaged in gainful employment. Among currently married women, adolescents age 15-19 had the highest percentage of current pregnancy (16 percent). Only 38 percent of married women age 15-19 were currently using any contraceptive method. For mothers less than 20 years of age, the neonatal mortality rate of 72, the infant mortality rate of 103, and the under-five mortality rate of 130 were the highest figures reported (NIPORT, 2001). These figures illustrate that male and female adolescents currently have important unmet population and developments needs, and the data suggest that substantial additional resources will be required as these individuals grow older and enter their most productive employment and reproductive years.

Maternal Mortality and Morbidity

The recent 2001 Bangladesh Maternal Health Services and Maternal Mortality Survey indicates that there are substantial maternal mortality and morbidity problems in the country. Although the Maternal Mortality Rate (MMR) has decreased considerably from 514 in 1986-1990 to 400 in 1998-2000, it is still one of the highest in the world. In 2001, approximately half of mothers did not receive antenatal care, and two-thirds of currently pregnant women did not intend to have assistance during delivery. The data indicate that 60 percent of women reported have complications during pregnancy, at pregnancy, or after delivery. Among these women who experienced complications, half had headache, blurry vision, high blood pressure, edema, or pre-eclampsia, while 24 percent had breech deliveries, prolonged labor, torn uterus, or obstructed labor. In terms of assistance, 39 percent of women did not seek help for life-threatening complications, while 58 percent did not get help for non-life threatening concerns. Importantly, 34 percent of women with life threatening and 20 percent with non-life threatening complications did not seek assistance from a facility or a doctor. For women who went to a facility for treatment, 48 percent received care from a government facility, while the remainder were treated by NGOs, private health facilities, private doctors, traditional doctors, or other (NIPORT, 2002). There is very limited information about abortion in Bangladesh, but approximately 5 percent of currently married woman have used menstrual regulation (Rob 2002a). Dealing with maternal mortality and morbidity is crucial, because mothers play in integral role in raising their children.

HIV/AIDS and STDs

Although the reported prevalence rates of HIV/AIDS and STDs in Bangladesh are currently low, several factors indicate that these diseases are important emerging problems. Data from the third round of national HIV surveillance completed in 2001 reveal that the HIV rate was extremely low among high-risk groups with less than 1 percent of sex workers and 1.7 percent of Intravenous Drug Users (IDUs) in the central part of the country infected. However, between 32 percent and 43 percent of sex workers and 18 percent of IDUs in this area had syphilis. Among these sex workers, 98 percent of brothel based sex workers and 100 percent of street based sex workers reported having sex without condoms during the previous week. Among these IDUs, 93 percent said that they had shared injecting equipment in the last week (GOB, 2001). In the general population, only half of currently married men and one-third of currently married women had ever heard of HIV/AIDS, and 89 percent of ever-married women and 81 percent of currently married men indicated that they had no knowledge of sexually transmitted infections (STIs). Among currently married women, the most frequently reported STD related health problems were abdominal pain, urinating problem, itching or irritation during menstruation, and pain during intercourse. Among currently married men, five percent had a STD, while 5.2 percent had a sore or ulcer on the penis (NIPORT, 2001). These data suggest that there is strong potential for HIV/AIDS and STDs to become serious problems in Bangladesh.

Empowerment of Women

Educational status, employment situation, and women's role in household decision making are three indicators for assessing the empowerment of women. Among currently married women in 1999-2000, 46 percent had no education, and only 10 percent had completed primary school. Women of age 30-49 had the highest percentage of no education and the lowest percentage of secondary and above schooling, while the reverse was true for females of age 10-29 with them having the lowest percentages of no education and the highest levels of secondary and above schooling. In terms of working status, 77 percent of ever-married women were not employed in 1999-2000, and 18 percent worked at full-time jobs. Among currently employed women, 71 percent earned cash only, and just 3.8 percent were not paid. With regard to household decision making, 87 percent of currently married women made the final judgement about what food to cook, but only 60 percent of these women made the final decision on major household decisions. Approximately 54 percent of the women had the final say about their own health care, and 61 percent made the final determination about the health care of their children. Additionally, only 27 percent of currently married women were allowed to go to a health center or hospital by themselves (NIPORT, 2001). The data indicate that the empowerment of women as measured by educational, employment, and decision making status is still a major concern in Bangladesh.

Increasing Urbanisation

Increasing urbanisation is a significant population and development concern in Bangladesh. In 1974, 8.2 percent of Bangladesh's population, 6.27 million people, lived in urban areas, and by 2001, it had increased to 23.4 percent which equaled 21 million individuals. The urban population is projected to grow to 36 percent by 2027 which will be equivalent to

approximately 61 million. In 2001, Dhaka, Chittagong, Khulna, and Rajshahi were the four largest cities, and they accounted for 52 percent of the urban population. The population of each of these cities increased substantially from the year 1974 to 2001, and Dhaka's population growth from 2.07 to 9.91 million and that of Chittagong's growth from 0.81 to 3.2 million during this time period were two notable examples. In several smaller regional cities including Dinajpur, Comilla, Jessore, and Mymensingh, considerable increases in population also occurred. From 1974-2001, the population of Dinajpur increased from 62 to 157 thousand individuals, while the number of people in Comilla rose from 86 to 168 thousand. During the same time period, Jessore's population increased from 76 to 178 thousand people, and Mymensingh's size grew from 76 to 226 thousand individuals. (Rob, Kabir, and Mutahara, 2002) These data show the rapid urbanisation that has occurred in Bangladesh and such trend is projected to continue. This information raises an important question about how the needs of the increasing number of people in the urban areas will be met.

3. Existing and Proposed Population Policies and Programmes

This section will provide a brief history of Bangladesh's population policies and programmes from the country's inception to the present, and it will then examine how Bangladesh's existing and proposed population policies and programmes address the issues described in the previous section.

History of Population Policies and Programmes

From 1973 to the present, Bangladesh's population policy has evolved in two distinct phases. The first phase lasted upto 1996, and it was guided by the objectives and strategies presented in the 1976 Population Policy. The objectives, strategies, and programmes in the subsequent First through Fourth FYPs were based on and developed from the 1976 policy (GOB,1973; GOB,1976; GOB,1978). This period was marked by the implementation of a target driven family planning programme focused on reducing population growth. During this time, developing an MCH-based service delivery system, deploying field workers to provide services at clients' homes, expanding contraceptive availability and usage, promoting multi-sectoral collaboration, and motivating people to use family planning services were emphasised (GOB, 1980; GOB, 1985; GOB,1990)

The second phase in Bangladesh's population policy development started in 1997 and has continued to the present. This stage was strongly influenced by the 1994 ICPD in Cairo, and it has been characterised by a transition from a target driven to a client-centered approach which is reflected in the Fifth FYP, the HPSP, and the draft NPP (Islam, 2000). Under the Fifth FYP (1997-2002) the emphasis of the population policy was to deal with a broader range of reproductive health issues targeted at a larger number of population groups rather than addressing family planning needs alone. The HPSP (1998-2003) emphasised the concept of integrating health and family planning facilities and personnel to provide an Essential Services Package (ESP) of which reproductive health was one of its core components. In addition, there has been a move away from the delivery of family planning services directly to clients at their homes to providing the ESP at one-stop clinics. The draft NPP builds on the approaches described in the HPSP and the Fifth FYP, and it provides a list of objectives and

strategies for providing comprehensive reproductive health and family planning services to a wider segment of the population.

Unmet Contraceptive Needs

Several policies in the Fifth FYP tried to address the unmet need for contraceptives in Bangladesh. One policy supported providing quality services, using information, education, and communication (IEC) campaigns, and involving Non-Governmental Organisations (NGOs) to deal with family planning issue. Two other policies promoted the use of clinical contraceptive methods and advocated the production of contraceptives in Bangladesh. (GOB, 1997)

The plan indicated that contraceptives would be provided through the reproductive health component of the Essential Services Package (ESP) and that there would be a focus on surgical contraception. However, unlike previous FYPs, it did not discuss the contraceptive method mix. The Fifth FYP did indicate that the Ministry of Information would broadcast television and radio messages. It also revealed that NGOs would play an important role in recruiting new contraceptive users and that the Government of Bangladesh “wanted to ensure their presence in almost all the thanas.” (GOB, 1997) In addition, the plan encouraged private sector to get involved in the social marketing and production of contraceptives. (GOB, 1997)

The HPSP described several policies for dealing with the unmet need for contraceptives. The plan said that the Contraceptive Prevalence Rate (CPR) for modern methods should be increased. It also indicated that contraceptive discontinuation should be decreased. Additionally, the plan supported the use of more permanent contraceptive methods. The HPSP revealed that these policies would be pursued through behavior change communication (BCC) activities, counseling, and treating contraceptive side effects. It also said that male involvement would be emphasised through promoting condom use and non-scalpel vasectomy (NSV) sterilisation. In addition, the programme specified that the GOB and NGOs would continue to collaborate on providing contraceptives services in both urban and rural areas. (GOB, 1998)

The draft of the NPP states that, “contraceptive security is a cornerstone of the population policy” (GOB, 2002), but it does not give details about programmes or activities for the provision of these essential contraceptives. The policy does indicate that there will be a choice of contraceptive methods and that there will be an adequate supply of them. Although the draft of the NPP does highlight the important role of NGOs and the private sector in population activities, it does not describe specific tasks for these groups for addressing unmet contraceptive needs like the Fifth FYP did. (GOB, 2002)

Adolescent Population Growth

The Fifth FYP’s policies did not directly deal with the reproductive health and development needs of the growing number of adolescents, but some of its programmes did. Adolescent health was included as an important component of the provision of reproductive health care through the ESP. The activities of several government ministries were also directed toward specifically dealing with the needs of adolescents. The Ministry of Education was planning to “update curricula on population education in their formal school system from four to twelfth

grades.” (GOB, 1997) Furthermore, the Ministries of Social Welfare, Women and Children Affairs, Youth, Sports and Cultural Affairs were developing programmes for enhancing the skills and reproductive health knowledge of adolescents. (GOB, 1997)

The HPSP attempted to address youth needs through the adolescent care area of the reproductive health component of the ESP. The main policy of the plan was to provide adolescents with information about “proper nutrition and hygienic practice, puberty, safer sexual behaviour, and how to avoid health risks including STDs/HIV/AIDS.” (GOB, 1998) It said that BCC messages would be used to reach adolescents (GOB, 1998).

The draft of the NPP includes several policies and programmes for addressing the reproductive health and development needs of adolescents. It promotes the provision of reproductive health counseling and services “to delay marriage, postpone birth for, at least, two years and have adequate spacing between births.” (GOB, 2002) The policy also supports developing employment opportunities for young men and women (GOB, 2002).

The draft NPP indicates that programmes will be established to provide reproductive health counseling and services to adolescents, but it does not give details about where they will be delivered or who will provide them. The policy also supports setting up credit facilities and vocational training for young people, and it emphasises encouraging adolescents to focus on developing skills in information technology. Education will be provided to “both in-school and out-of-school adolescent boys and girls.” (GOB, 2002) The plan says that parents, teachers, and other individuals who interact with adolescents will be given training on reproductive health issues. The policy will involve NGOs to promote the delay of marriage and first birth, and it will pursue legal measures to ensure that underage marriages do not occur. In addition, similar to the Fifth FYP, the Ministries of Education, Social Welfare, Women and Children Affairs, Youth, Sports, and Cultural Affairs will also play an important role in dealing with adolescent needs. In this policy, the Ministry of Information is committed to broadcasting messages about reproductive health targeted to young people (GOB, 2002).

Maternal Mortality and Morbidity

The Fifth FYP dealt with maternal mortality and morbidity primarily through the policy of delivering comprehensive reproductive health care services. In fact, a major emphasis of the reproductive health care programmes in the plan was the provision of maternal care. It said that the reproductive health component of the ESP would deal with maternal mortality and morbidity issues including safe pregnancy and abortion and that services would be provided through integrated Health and Family Welfare Centers (HFWCs). The Safe Motherhood Initiative and Essential Obstetric Care (EOC) programmes proposed in the Fifth FYP had not been fully operationalised. The Ministry of Information was responsible for broadcasting messages about Maternal and Child Health (MCH), while the Ministries of Local Government, Rural Development and Co-Operatives, Social Welfare of Women and Children Affairs; Youth, Sports and Cultural Affairs were planning to incorporate MCH into their programmes (GOB, 1997).

The HPSP dealt with maternal mortality and morbidity in the reproductive health component of the ESP through supporting safe motherhood, improving maternal nutrition, and

addressing MR and unsafe abortions. To promote safe motherhood, the programme focused on providing EOC through Family Welfare Assistants (FWAs) and female Health Assistants (HAs). It said that “antenatal care safe birth practices, postnatal care will also be emphasised.” (GOB, 1998) The plan also discussed setting up women friendly hospitals and using BCC materials to promote safe motherhood themes. To support better maternal nutrition vitamins and other supplements were distributed through the Bangladesh Integrated Nutrition Project (BINP). To address the problems of MR and unsafe abortion, the programme planned to ensure that staff were trained appropriately and that adequate supplies were available for providing these services safely. (GOB, 1998)

The draft of the NPP makes the reduction of maternal mortality and morbidity a priority objective of its policy. It indicates that maternal mortality and morbidity will be decreased by “providing quality antenatal delivery and post-natal services, emergency obstetrics care and managing complications arising from unsafe abortions.” (GOB, 2002) The policy reveals that these services will be delivered mainly through the reproductive health component of the ESP. The draft NPP also says that providing services to adolescents will decrease maternal mortality. (GOB, 2002)

HIV/AIDS and STDs

The population section of the Fifth FYP, did not address the issues such as HIV/AIDS and STDs, but it was one of the areas covered under the provision of reproductive health services. However, the Fifth FYP did indicate that a National Policy on HIV/AIDS and STD related issues had been approved and that it focused on reducing the transmission, the risk behaviors, and the impact of these diseases. One of the main programmes for managing HIV/AIDS and STDs was through the reproductive health component of the ESP, although the plan did not specify how these problems would be dealt with. The activities of some of the government ministries addressed HIV/AIDS and STDs more directly. The Ministry of Information planned to broadcast television and radio messages on HIV/AIDS and STDs. The Ministry of Labour and Manpower also intended to establish an HIV/AIDS surveillance system among individuals returning from working abroad (GOB, 1997).

The HPSP included the prevention and control of HIV/AIDS and STDs as areas within the reproductive health and communicable disease control components of the ESP. In the reproductive health area, programmes promoted prevention through BCC interventions and through condom use. It also said that syndromic management would be provided but would be implemented gradually. The HPSP emphasised that women of age 15-49 would be targeted under the reproductive health component for HIV/AIDS and STDs but not men. In the communicable disease control area, the programme said that a national plan was going to be implemented. The plan was supposed to “include capacity building with surveillance and diagnostic facilities, BCC, legal reforms and treatment and counseling services and introduction of syndromic management at peripheral facilities.” (GOB, 1998)

Although HIV/AIDS and STDs are not mentioned specifically in the objectives of the draft of the NPP, there are several sections which address these emerging issues. The policy indicates that services for the prevention of HIV/AIDS, STDs, and Reproductive Tract Infections (RTIs) will be provided, but it does not describe what services will be delivered. However,

the draft NPP does reveal that counseling on preventing HIV/AIDS and STDs will be provided to adolescents. It also says that NGOs will be involved in awareness raising activities for these diseases. In the draft NPP, several government ministries are responsible for dealing with HIV/AIDS and STDs. The Ministry of Information will broadcast messages on HIV/AIDS and STDs, and the Ministry of Labour and Manpower, Expatriate's Welfare and Overseas Employment will continue developing an HIV/AIDS and STD surveillance system for overseas workers. The Ministry of Religious Affairs will train religious leaders about the prevention of HIV/AIDS and STDs. (GOB, 2002)

Empowerment of Women

The Fifth FYP did not directly address the empowerment of women in its policies, but several of its multi-sectoral collaborations deal with this important population and development issue. The Ministry of Health and Family Welfare (MOHFW) intended to provide reproductive health education, vocational training, and micro-credit opportunities for women's programmes under the supervision of the Bangladesh Rural Development Board, Social Welfare Directorate, and Women's Affairs Department respectively. The Ministry of Education planned to "support scholarship programmes to retain girls in school beyond the secondary level (GOB, 1997)," and the Ministries of Social Welfare, Women and Children Affairs, Youth and Sports, and Cultural Affairs were going to continue several women's development programmes. (GOB, 1997)

The HPSP did not include the empowerment of women as part of the ESP, but it categorised it as a cross-cutting issue. The HPSP stated that "social and institutional interventions will be taken to empower women, raised their self-esteem, and reduce discrimination and violence against women (GOB, 1998)." Initially, it indicated that gender issues would be incorporated into the ESP training curriculum and the training programme for high-level officials. The plan also revealed that the objectives of the National Policy and Action Plan on Women would be used as the basis for monitoring the gender equity interventions. (GOB, 1998)

Unlike the Fifth FYP and the HPSP, the draft of the NPP makes the empowerment of women through "the creation of income generating opportunities and child care support systems at work places as more active male involvement and responsibilities" (GOB, 2002) one of its main objectives. The programme will increase women's income generating capabilities through micro-credit and vocational education programmes. To promote child care support, the government will try to set up child care centres at work place. The policy also supports improving women's institutions and "eliminating all forms of violence and sexual exploitation." (GOB, 2002). Although the draft NPP reiterates that men should take on more responsibilities in the home, it does not describe what roles they should assume or what activities they should do. The plan also indicates that female empowerment will be handled through some of the government ministries. The Ministry of Local Government, Co-Operatives and Rural Development will promote the empowerment of women through the development of "functional literacy, adult education, and training programmes." (GOB, 2002) The Ministries of Social Welfare, Women and Children Affairs, Youth, Sports, and Cultural Affairs will continue ongoing programmes to help women develop vocation skills, have access to micro-credit opportunities, and be aware of their rights (GOB, 2002).

Ongoing Urbanisation

The Fifth FYP's policies and programmes dealt with the issue of urbanisation. It indicated that "appropriate regional distribution of population to prevent influx of population to the major cities in Bangladesh" should be supported. The plan recommended developing regional cities but did not provide details about how they should be developed. The Fifth FYP also suggested increasing employment opportunities to decrease urban migration. (GOB, 1997)

The HPSP's policies and programmes did not address the issue of ongoing urbanisation. Even among cross-cutting issues, it was not mentioned.

The draft of the NPP identifies reducing rural to urban migration as one of its key objectives. It recommends decreasing urbanisation through "coordination with rural development, industrial location, employment, and urban development policies and plans." (GOB, 2002) Some of the policy's specific programme suggestions include developing agricultural based rural employment opportunities, developing rural infrastructure to support the growth of new areas, and trying to move influential organisations to emerging areas to encourage people to stay. The policy also supports making it easier for people to work overseas and increasing the skills of the men and women who remain in Bangladesh. Additionally, the policy seeks to discourage urban migration by blocking the development of slums in the cities which have traditionally provided homes for many migrants. (GOB, 2002)

4. Gaps Between the Issues and Policies and Programmes/Strategies to Address Them

This section will first describe the gaps between some of Bangladesh's population and development issues and the existing and proposed policies and programmes. It will then make suggestions for improving the proposed policies and programmes to better address these issues.

Unmet Contraceptive Needs

Under the existing Fifth FYP, HPSP and the proposed draft NPP have several initiatives that attempt to address unmet contraceptive needs, but none of these two areas are dealt with adequately. Although the HPSP mentions reducing contraceptive discontinuation, it does not describe any programmes to address this issue, and it is not discussed in the draft NPP. Decreasing contraceptive discontinuation rates is an important priority, because even if substantial progress is made in increasing the CPR and ensuring adequate supplies of contraceptives, these advances will have limited impact unless the discontinuation levels also drop. One strategy for addressing this gap in unmet contraceptive needs could be developing BCC materials and outreach activities specifically targeted at groups with the highest contraceptive discontinuation rates like condom users. Another strategy could be to have better follow up mechanisms in place so that field workers and other staff providing contraceptive methods can reinforce the importance of method use.

Ensuring the procurement and distribution of different contraceptive methods is another area of unmet contraceptive need that is not addressed fully by the existing and proposed population policies and programmes. Although the Fifth FYP, HPSP, and draft NPP all indicate that sufficient quantities of contraceptive methods will be provided by the government and NGOs, it does not describe how many contraceptives will be realistically

needed on an ongoing basis and how they will be supplied. One strategy for dealing with this concern could be to develop a long term plan that projects realistic contraceptive method mix and coordinate with NGOs on the distribution issues.

Adolescent Population Growth

The existing and proposed population policies and programmes addressed some of the issues associated with adolescent population growth, but it did not sufficiently deal with two important concerns. One important issue not incorporated by the Fifth FYP, HPSP, and draft NPP is involving adolescents in the development of programmes to deal with their needs. One strategy for dealing with this unmet need is to establish elected adolescent community advisory boards in communities and at the national level that will help government policymakers create and implement programmes that successfully meet the population and development needs of adolescents.

Another concern that is not dealt with fully by the current and proposed population policies and programmes are legal measures to protect adolescents. Although the Legal and Social Measures section of the Fifth FYP emphasises preventing child marriage, it does not pursue laws for dealing with sexual violence including such areas as harassment, physical abuse, and incest. One apparent strategy for dealing with these issues would be to promote the adoption of appropriate and comprehensive legislation.

Maternal Mortality and Morbidity

The existing and proposed population documents do not deal adequately with two issues pertaining to maternal mortality and morbidity. Although men can play an important role in decreasing maternal mortality and morbidity, the Fifth FYP, HPSP, and the draft NPP do not address the participation of men in this area. A strategy for involving this underutilised resource could be to conduct BCC outreach activities to men in the community to make them aware of how valuable they can be in helping to ensure the safety of their wives before, during, and after childbirth. Another strategy could be to provide incentives for couples to participate together in safe motherhood activities. Some incentives could include receiving useful products for their children like blankets or getting a savings bond for the education of their children.

Although the HPSP and the draft of the NPP make preventing unsafe MR and abortion priorities, they do not emphasise providing post MR or abortion services. After MR or induced abortion has occurred, there is a valuable opportunity to reach women with family planning and reproductive health information to help decrease the need to use these services in the future. One strategy for introducing post MR or abortion services could be to train the service providers to provide family planning and reproductive health information or to refer these women to an appropriate facility.

HIV/AIDS and STDs

Although there is a national strategy being developed to deal with HIV/AIDS and STDs in Bangladesh which incorporates several elements into the existing and proposed population policies and programmes, there are also some issues that are not addressed. Although the draft NPP indicates that NGOs will help raise awareness about HIV/AIDS and STDs, it does

not discuss how to effectively coordinate government and NGO efforts to deal with these diseases. One strategy to address this concern could be to set up a national committee to coordinate government and NGO programmes related to HIV/AIDS and STDs to minimise the overlapping of activities and to maximise the populations reached by initiatives.

Another area overlooked by the current and proposed policies is emphasising male involvement in the prevention of HIV/AIDS and STDs. Since males play an important role in determining contraceptive use in their marriages and since they are more likely to engage in extramarital sexual relationships, it is important to develop HIV/AIDS and STD programmes targeted to them. One strategy could be to promote and introduce reproductive health services and counseling for men at government facilities.

A legal measure to protect people with HIV/AIDS or STDs is an important future concern that needs to be addressed. In countries where HIV/AIDS and STDs are more prevalent, individuals suffering from these diseases particularly HIV/AIDS have been refused treatment, dismissed from jobs, and ostracised from their communities. To minimise the possibility of these problems occurring in Bangladesh, another strategy could be to develop laws that would prohibit discrimination against people with HIV/AIDS and STDs.

Empowerment of Women

Although current and proposed population policies and programmes have started addressing the empowerment of women, there are still some important gaps. The draft NPP emphasises empowering women through creating income-generating opportunities, eliminating violence, and promoting male involvement. The policy supports vocational education, but it does not deal with developing the general educational levels of women which is an important means of empowerment. One strategy for providing more comprehensive education to women could be to establish night schools for working women.

Another important gap between existing and proposed policies and programmes and the issue of the empowerment of women is the lack of legal measures for protecting women's rights. As mentioned previously, draft NPP emphasises pursuing legal measures to prevent child marriage but does not promote legislation to guard women against sexual violence. The policy also does not address preventing discrimination in the workplace or in education institutions. One strategy could be to introduce anti-discrimination law to protect women as they become increasingly empowered.

Increasing Urbanisation

Increasing urbanisation is another area in which the existing and proposed population policies and programmes do not fully address the emerging issue. Although the draft NPP indicates that a multi-sectoral approach should be utilised for decreasing urbanisation, it does not promote community involvement which is an important means for developing new areas. To ensure that the development initiatives being considered will motivate people not to move, one strategy could be to establish community advisory committees composed of a representative sample of community members to provide feedback and to make suggestions on proposed changes.

Another issue not considered sufficiently in the current and proposed policies and programmes for addressing increasing urbanisation is to offer direct incentives to people to stay in their communities. Some incentives could include decreased land taxes for property owners who agree to remain a certain number of years or subsidised loans for people who plan to start businesses in their communities. In addition to the motivation provided by development efforts this would encourage people to stay and invest in their communities.

5. Conclusion

This paper examined how Bangladesh's existing and proposed population policies and programmes have dealt with some of the country's important population and development issues including unmet contraceptive needs, adolescent population growth, high maternal mortality and morbidity, HIV/AIDS and STD concerns, and increasing urbanisation. The analysis revealed that these issues have been addressed to some extent but there were some important gaps. Based on the principles of the 1994 ICPD, recommendations have been proposed to fill these gaps and better address this population and development issues in future population policies and programmes.

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