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RECENT SHIFT IN BANGLADESH'S POPULATION POLICY AND PROGRAMME STRATEGIES: PROSPECTS AND RISKS

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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 ***Recent Shift in Bangladesh's Population Policy and Programme Strategies: Prospects and Risks*** has been prepared by Dr. Mohammed A. Mabud, Former Division Chief, Planning Commission, Government of Bangladesh and Ms. Rifat Akhter, Assistant Professor, Population and Environment Department, Independent University, Dhaka.

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Acronyms

HPSP = Health and Population Sector Programme
NPC = National Population Council
MOHFW = Ministry of Health and Family Welfare
TFR = Total Fertility Rate
CBR = Crude Birth Rate
CDR = Crude Death Rate
ECNEC = Executive Committee of the National Economic Council
NIPORT = National Institute of Population Research and Training
NIPSOM = National Institute of Preventive and Social Medicine
FWC = Family Welfare Center
NRR = Net Productive Rate
STD = Sexually Transmitted Disease
ADP = Annual Development Programme
LGRD = Local Government and Rural Development
FWA = Family Welfare Assistant
EOC = Essential Obstretics Services
AOP = Annual Operational Plan
MCWC = Maternal and Child Welfare Center
ESP = Essential Service Package
IEC = Information Education and Communication
MCH = Maternal and Child Health
FWV = Family Welfare Visitor
CPR = Contraceptive Prevalence Rate
IUD = Intra Uterine Device
FWVTI = Family Welfare Visitors' Training Institute
HFWC = Health and Family Welfare Center
BCC = Behaviour Change Communication
MIS = Management Information System

Table of Contents

		Page
1.	**Introduction**	**1**
2.	**Policy and Programme Review in Retrospect**	**2**
3.	**Multi-sectoral Strategies and Progress**	**8**
4.	**Debate on Policy and Programme Strategies**	**12**
	(a) Revisionist School of Thoughts	12
	(b) Reformist School and Thoughts	13
5.	**Introduction of Health and Population Programme Strategy (HPSP) and its Scope**	**14**
6.	**Essential Service Package (ESP)**	**14**
	6.1 Reproductive Health Care	16
	6.2 Child Health Care	20
	6.3 Communicable Disease Control	21
	6.4 Limited Curative Care	21
	6.5 Behaviour Change Communication (BCC)	22
7.	**Common Grounds and Differences between Revisionists and Reformists**	**23**
8.	**Some Critical Lapses in HPSP**	**25**
	8.1 Lack of Multi and Inter Sectoral Approach	25
	8.2 Demographic Momentum	27
	8.3 Women's Development in Population Context	28
9.	**Policy Instrument**	**29**
10.	**Prospects and Risks**	**29**
	10.1Risks	29
	10.2 Prospects	31
11.	**Concluding Remarks**	**31**
References		**34**

Recent Shift in Bangladesh's Population Policy and Program Strategies: Prospects and Risks

1. Introduction

Since Bangladesh came into being in 1971, all successive Governments demonstrated two things in common in respect of population policy planning, namely, their serious concern about the rapid proliferation of human number and political commitment to solve the problems arisen out of that. In a war ravaged country fraught with poverty and massive illiteracy, the first such concern and commitment were shown by the Government of Banghabandhu Sheikh Mujibur Rahman in 1973 which declared that the population control and family planning activities were of national priority and that as a policy response, most of the development ministries had to undertake appropriate population activities in one form or the other befitting their scope and stride. The population policy goal was set to reduce growth rate from 3.0 to 2.8 percent by the end of the First Five Year Plan period (1973-78) and it was achieved. Multi-sectoral policy strategies were also clearly laid out. Besides, true to its spirit and commitment, Government had created a separate sector for "Population Planning" for effective coordination, resource management and activity planning. It created a Population Planning Division in the MOHFW to give an undivided attention to population issues and intensify service delivery all over the country. It also laid an emphasis on human resource and institutional development. The Government's serious concern for fertility control was revealed in the following statement .

> "No civilized measures will be too drastic to keep the population of Bangladesh on the smaller side of 150 million for sheer ecological viability and the nation has to be mobilized and early. The more this mobilization is delayed, the more will be the possibility of attaining the above objective by currently acceptable means recede. The first requisite is the realisation of the gravity of the population problem at all levels of political leadership and total commitment to its solution." (First FY Plan, P.538).

The above thrust and emphasis on population activities continued until the introduction of Health and Population Sector Programme (HPSP) in 1998. This change resulted into several shifts in emphasis on population activities from the point of view of strategic approach to the population problem. The central purpose of this paper is to discuss those shifts and their prospects as well as risks. Keeping in view this purpose, the paper is structured as follows: First in order is the review of the population policy and programme in retrospect to highlight the success and failure followed by a discussion on the debate that has emerged for introducing new policy and programme strategies through HPSP. This is followed by some discussion on the major highlights of the HPSP with a view to showing the shifts that differ from the previous policy strategies. Some common ground between the old and new policy strategies are also identified and discussed. Based on the analyses of the implementation experience of various stakeholders, some risks and prospects are presented. Finally, the author makes some recommendations as to how risks can be minimized in the current policy strategies.

2. Policy and Programme Review in Retrospect

The First Five Year Plan was the first population policy document which envisaged the integration of Family Planning and Health Services which were parallel programme activities as a legacy of the erstwhile Pakistani period and continued in an augmented form until 1997. The Government adopted one population policy guideline in 1976 which was followed until 1980. In fact, the population plans contained in the subsequent Five Year Plans were the only population policy documents which guided the population activities in Bangladesh. In pursuance of the First FY Plan policy strategy, the Government tried to integrate Health and Family Planning Programme in 1974 but with little success. During 1973-75, a good number of measures were taken such as: introduction oral pill in the programme and registration of couples. Health facilities were utilized to popularize sterilization and IUD programmes. In late 1975, erstwhile East Pakistan Family Planning Board was converted into a Directorate of Family Planning and put under the direct control of the Ministry of Health. The maternal and child health (MCH) programme was also transferred to the newly created Directorate of Family Planning. Since then, MCH-based family planning became the keystone of the service

delivery package and all logistics, infrastructure and supplies were geared towards this end. The National Population Council (NPC) headed by the Head of the Government was, for the first time, established; and the first Bangladesh Fertility Survey (BFS, 1975) was conducted. Three important findings of this survey were: TFR was 6.3; CPR was 8.5 percent; and female age at first marriage was estimated to be 14.9 years.

The successor Government of Ziaur Rahman (1976-82) not only maintained the policy, but also went one step ahead by declaring that the population problem was the nation's number ONE PROBLEM. It put emphasis on service delivery and follow up care at the doorstep. For this purpose, it deployed 13,500 matriculate female workers and 4500 whole time union level supervisors by replacing 30,000 part time village Dais with back-up service by the technical staff like doctors and hundreds of paramedics all over the country. Zia's Government bifurcated the Ministry of Health into Population and Health Divisions and put one Minister exclusively in charge of Population Division to address population issues with full attention. In 1976, the government approved a National Population Policy guidelines involving various ministries and NGOs. The policy contained both family planning and non-family planning measures such as (i) tax benefits to unmarried and families with fewer children; (ii) preferential treatment in allotment of housing, and giving medical benefits to individual with fewer children; (iii) credit and economic benefits to the mothers' club, women's cooperatives and other organized groups; (iv) liberalization of law relating to abortion, to cite a few. The central purpose was to hasten the achievement of demographic goal of NRR=1 set for the year 1990, much ahead of social changes, especially in respect of education, health, and women's status simply by pursuing two strategies namely (i) accelerated service delivery at the doorstep, and (ii) multi-sectoral approach to poise the society through intensive campaign and services through organized sectors. The Government's in its desperate bid, experimented a "5 Year Zero Population Growth" at Dhamrai - a suburb of Dhaka. Despite four times larger per capita investment, the results of this experiment were far from expectation and the project was abandoned in 1982. In fact, this new policy of 1976, in spirit and many of its components, was the resonance of the previous policy and its demographic goal of NRR=1 set for 1990 was no longer pursued as it was found to be

unachievable within this stipulated time. But efforts for service delivery were heavily intensified through field workers and motivational campaign with all conceivable means.

Since 1976, family planning turned increasingly to be an MCH-based, multi-sectoral and community-based-integrated programme. In order to provide MCH care and family planning services from institutional set-up in rural areas, it was decided to establish Family Welfare Centers (FWC) at the union level, and accordingly, as many as 79 (out of 80) FWCs were set up in pilot areas of five districts -Dhaka, Chittagong, Jessore, Rangpur and Tangail during 1978-80. In addition, involvement of voluntary organizations, social groups and religious leaders including youth and women was increased to broaden the horizon of contraceptive practice through a social movement. The integrated MCH and Family Planning Organization was extended from the national level to all districts, Sub-divisions, Upazilas, Unions, Wards and Villages. Besides, a supervisory tier was established at Divisional level with a view to decentralizing the process of decision-making and follow up action.

In brief, a Director at the Divisional level; a Deputy Director and two Assistant Directors at the District and a Family Planning Officer at the Upazila level were created. Besides, a Medical Officer (MCH-FP) at the Upazila level was also created for technical supervision. A Family Planning Assistant at the Union level (FPA) and a Family Welfare Assistant (FWA) at the Ward level were appointed on full time basis. Besides, several institutions were also established for manpower development. These were: (i) a college of nursing, (ii) 12 family welfare visitors' training institutes and, (iii) eight Medical Assistants' Training Institutions (MATIs).

During the tenure of Hussain Mohammed Ershad (1982-90), the population policy strategies remained more or less the same as the previous governments. Ershad used to hold National Population Council almost every month to monitor the progress of implementation of population activities and gave necessary direction to the MOHFW and other ministries involved in population activities. In fact, the programme during the 80's entered into the 2nd phase. In early 1983, it confronted the most controversial issues viz

integration of health and family planning, and later on, "functional integration" was rationalized to appease the rival groups in the programme. In the beginning, it may be noted that "integration" was understood to mean basically integrating family planning services with health and MCH with a view to making it more acceptable and more effective by using a common delivery system. But those who opposed such integration held the view that emphasis on population control and family planning would be lost, if it is integrated with health service delivery system which was already weak and that required priority would no longer remain. The underlying reasons for not being able to integrate family planning with health was that the FP structure was a new one. It had generated a built-in resistance to major changes and that despite various problems, this separate arrangement was making progress. The "functional integration" as it was used to be called was meant separating health and family planning into two separate structures, but placing the two structures under one Minister and one Secretary as the head of administration. In substance, two vertical wings namely, Health and Family Planning joined at the top at the office of the Secretary of the Ministry and at the bottom by multi-purpose village-based workers, but bifurcated at the Directorate, district and upazila level.

A significant policy decision taken during the Second Five Year Plan (1980-85) was regarding the fixing of the demographic goal to achieve a replacement level fertility in 1990. By implications, it means to reduce the crude birth rate from 43 per 1000 in 1980 to 32 per 1000 by 1985 implying a concomitant increase in contraceptive use rate from 14 percent to 38 percent during the plan period. While this demographic goal was too ambitious, the decision to adopt such a high goal was governed by the consideration that a ten years' delay in achievement of NRR=1 by 1990 would result in an increase of about 12 million population by the turn of the century. An additional 2.1 million tons of food grain would need to maintain the current meager average per capita consumption of 16 ounces per day; and additional work force of 3.1 million, and increase in the number of school going children by about 8 million. The social and economic costs of absorbing this additional population will be enormous. Recognizing these realities, the Government felt that the population policy strategy must aim at achieving a considerable decline in

fertility without any further delay. The implementation strategy to achieve the objectives included strengthening health and family planning/MCH service delivery at upazila level and below.

The third Five Year Plan (1985-90) was launched in the country with wide range of policy, programmatic, social and motivational initiatives undertaken by both the GOB and the NGOs with a view to achieving the demographic goals and programme targets. The goals and targets of the plan were to reduce population growth rate from approximately 2.4 percent in 1985 to 1.8 percent by 1990; to bring down infant mortality rate from the prevailing rate of 125 per 1000 live births and to reduce maternal mortality rate from 6 to 4 per 1000 live births. The contraceptive practice rate was planned to increase from 25 percent to 40 percent by 1990. In order to achieve this goal, the following strategic approaches were made:

a. Family Welfare Assistant registers were introduced for proper record-keeping of acceptors, and monitoring the programme performance. This register is expected to help improve local level planning and priorities for the different segments of eligible couples for different services. A country wide couple registration system was introduced to generate couples related data base.
b. Satellite clinics, twice a week, are being organized by FWVs from each Union Health and Family Welfare Center to provide family planning and MCH services to the door-step of the people. similarly, Medical Assistants (MAs) organized Satellite Clinics for health education and other services.
c. On average, two sterilization camps from each of the 345 Upazila Health Complexes were organized every month to take the service facilities nearer to the people.
d. Community level depo-holders for contraceptive distribution was organized from amongst the female members of the Village Defence Parties (VDP) in the rural areas. In addition 20 female VDP members belonging to one selected upazila of each district (64) initially are being attached to each FWA.
e. Logistic Monitoring Teams identified problems relating to supply, storage and distribution of contraceptives and other commodities. They also provided guidance for proper maintenance of stores at central, regional and district level.

f. it was decided that in order to strengthen the IEC programme through Television, 25 minutes-attractive-programmes were telecast daily besides, Journalists were encouraged to publish population related articles, stories etc. to create awareness of small family norm.
g. Branch of National Population Council was set-up in each district under the chairmanship of the District Coordinator. In this committee like the National Population Control Council, people from all walks of life especially MPs, teachers, doctors, political leaders, administrative heads of all government organizations etc. were made members. But their functioning was moderate to low owing to lack of leadership/initiative at the district.
h. Three Women's programmes were strengthened. In addition to project level regular evaluations, three important studies were conducted namely, contraceptive prevalence surveys in 1981, 83, 86 and 1989 (USAID), Bangladesh fertility Survey, 1989 (NIPORT), and Family Planning impact Survey at the District level by the PDEU, 1990 which provided a significant data base for the programmes.

During Begum Zia's tenure (1991-96), resource utilization was full and population programmes made a considerable progress. At the beginning of the Fourth Five Year Plan (1990-95) the population was estimated to be 114.2 million with a growth rate of about 2.16 percent, a crude birth rate (CBR) of 35.2 and crude death rate (CDR) of 13.6 per 1000 population. Total fertility rate (TFR) was estimated at 4.6. The 4th Plan document stated: "if the present rate of population growth continues to be unchecked, Bangladesh is expected to double its population by 2022 AD." At present, one out of every three eligible couples is using contraceptives in comparison to one out of four during the Second Plan. The Planning Commission observed that "in the MCH-based Family Planning Programme where MCH component is vital for overall programme thrust, the desired progress is slow". The Commission has further observed that NRR=1 could not be achieved by the year 2000. It shifted this demographic goal upto 2005 (Ref: Chapter-XII on Population Control and Family Planning in the Fourth Year Plan, 1990-95).

The core components of the National Family Planning Programme were:

a. Organization and Management

b. Logistics and Supplies;

c. Information, education and motivation;

d. Service Delivery including MCH; and

e. Management Information System.

These five components were brought together under the overall umbrella of the Directorate of Family Planning headed by the Director General who was assisted by six Directors and a Superintendent of the MCH Institute. The Directorate of Family Planning is a permanent set-up operating through officers at 6 Divisions, 64 Districts and 464 Upazilas and they are borne out of the revenue budget of the Government. The Director General, Family Planning (DGFP) as the Chief Programme-Manager administers the programme through six Directors, each responsible for six field of activities, namely, Service Delivery, Administration, MIS, Logistics and Supplies, Finance, Information, Education and Motivation (IEM).

3. Multi-sectoral Strategies and Progress

During 1975-96, both political support and donors' assistance continued to remain strong. The MCH-based family planning was the key essential service package. Multi-sectoral strategies to combat the adverse effects of population growth and to poise the society for small family norm were further strengthened. Several thousand rural family welfare centers were established; and field works were intensified. Besides, quality of care received utmost attention and population activities through other ministries were further expanded and intensified. Much of the complications arisen out of clinical contraception (e.g. IUD and Sterilization) was reduced to the international level of acceptance. Human resource development at various level and research efforts were considerable. What is to be acknowledged is that population policy measures adopted in mid-seventies remained in force until 1997 when the present Government introduced new policy and programme strategy under the rubric of "Health and Population Sector Programme (HPSP)." The result of the previous population policy measures is a success story, as one can see the

marked improvement in several key demographic and programme indicators in the table below:

Table 1: Progress of Population Programme from 1973-1996 by Few Selected Indicators

No.	Indicators	1975	1985	1989-90	1996-97
1.	Population (in million)	80.0	99.9	108.0	122
2.	Population Growth Rate (%)	2.8	2.30	2.15	1.8
3.	Crude Birth Rate (CBR) per 1000 population	46	36.0	33.5	27
4.	Crude Death Rate (CDR) per 1000 population	18.0	13.0	12.0	9.0
5.	Total Fertility Rate (TFR)	6.3	5.5	4.9	3.3
6.	Infant Mortality Rate (IMR) per 1000 live birth	140	112	94	77
7.	Maternal Mortality Rate (MMR) per 1000 live birth	7.0	6.3	6.0	4.5
8.	Life Expectancy at birth (in years)	47	55	56.1	58
9.	Contraceptive Prevalence Rate (CPR) (%)	8.5	25.0	39.0	48
10.	EPI Coverage Rate of Children under 1 yr. (%)	-	-	50.0	77

Sources: i) Adapted from the Fifth Five Year Plan (1997-2002)
ii) Contraceptive Prevalence Survey, 1985
iii) Bangladesh Fertility Survey, NIPORT; Ministry of Health and Family Welfare, 1991.

In fact, during 1973-96 i.e. for long twenty three years, the population policy involving various sectors of economy, initiated by the first Government remained as the key guiding force. In 1973, there was only one programme viz family planning programme which had several components, namely (i) an establishment of several hundred officers, doctors and a large fleet of field workers including 30000 DAIS at the village level; (ii) logistics; (iii) supplies and services; (iv) information, education and communication (IEC); (v) training and (vi) research. But some of these components were turned to be

rudimentary when the size of the acceptors started increasing year after year. Some strategic approaches had to be clearly laid out in the successive Five Year Plans with clear-cut policy objectives and an ambitious demographic goal. As a result, each of the above components was turned to be a big programme supported or reinforced by a number of technical projects. The number of projects/programmes ranged from 32-40 during 1975-80 to 50-65 during 1980-85. In 1995-96, the number of projects came down to 42 in the Population Sector. Almost two-third of the projects/programmes were implemented by the Ministry of Health and Family Welfare, while one-third by other Ministries such as (i) Ministries of Education, (ii) Information, (iii) Local Government, Cooperatives and Rural Development, (iv) Agriculture, (v) Labour and Employment, (vi) Social Welfare, (vii) Women Affairs, (viii) Religious Affairs, (ix) Youth and Sports and (x) Ministry of Planning/Planning Commission. The nature of participation of these ministries was in the form of (i) training and orientation of their own personnel in population activities, (ii) utilizing their trained personnel for motivation of their target population, and (iii) integration of population and MCH components into their activities and training curricula. In fact, skill training, credit facilities and MCH-based population education, use of mass media, population census and programme evaluation were the main features of multi-sectoral population programmes. About one-fifth of the total investment used to be spent for multi-sectoral population activities. While four-fifth was spent for population projects/programmes under the Ministry of Health and Family Welfare.

An examination of the data in Table I shows that investment in population sector during 1985-1997 gave promising results and brought hope to various stakeholders. Initial progress was slow, but steady. There was linear increase in achievement in ever indicators. Entire investment was, as if, directed towards social mobilization, human resource and infrastructure development. When the society was poised and a reasonable ground was prepared through the concerted efforts of the stakeholders, civil society, large number of field workers and use of mass media, including Radio and TV, faster decline in fertility[1] and moderate decline in mortality[2] started especially infant mortality and

[1] Total fertility rate was reduced from 1990 level of 4.9 to 3.3 in 1996-97.

improvement in contraceptive prevalence rate (CPR) and life expectancy at birth from 1985 onward. Notwithstanding low socio-economic development, massive illiteracy and wide-spread poverty, progress in terms of fertility decline and increase in CPR was spectacular during 1990-97 (see Table-1). Although policy was prepared in the country, policy-ideas, sometimes, came from the donors who were also the participants in policy planning and implementation. Apart from the Government, donors especially the World Bank has been a major player in the population field since 1973 till to-date. In fact, their financial and technical assistance played a great role for the success of Bangladesh's population policy and programmes during the entire period of 1973-97.

In brief, the population policy during 1973-97 was characterized by (i) multisectoral approach involving many agencies/sectors, (ii) a separate "Population Planning" sector of the economy for better resource management and activities planning, (iii) deployment of a large fleet of matriculate female field workers for door step service delivery, (iv) establishment of 3200 family welfare centers at the Union, 12 FWVTI's and a National Institute of Population Research and Training (NIPORT) and (v) implementation of a mix of programme and projects approach, (vi) integration of population/MCH component with women activities of the BRDB, Rural Social Service Programme (RSS) of Social Welfare Directorate and Vocational Training Programme of the Women Affairs Department and (vii) effective use of mass media especially Radio and TV, and (viii) Regular undertaking of demographic surveys, programme evaluation and three decinnial censuses (1972, 1981 and 1991). Though Bangladesh was extremely in low profile on development scale, it has, however, earned a great reputation for its remarkable achievement made through credible implementation of its population policy and programmes especially after 1985. It was expected that this policy would continue up to 2005-the year set for achieving the NRR-1 as the performance trends clearly showed that the demographic goal would be achievable by then, if the policy could remain uninterrupted. Coinciding with the end of the GOB's Fourth Five Year Plan (1991-95), the World Bank-led 4th Population and Health Project also ended. Later on, tenure of both the GOB's Fourth Plan and World Bank's 4th Population and Health Project was extended

[2] CDR was reduced from 1990 level of l2 to 9 per 1000 population in 1998-97.

for two years (1995-97). This intervening period gave a window of opportunity to review the then-policies and programmes which generated many new thoughts and holistic ideas deliberated in many workshops and seminars. This lag period saw the emergence of two schools of thoughts -"Revisionist" and "Reformist".

4. Debate on Policy and Programme Strategies

(a) The Revisionist School of thought held the view that the population policy already stood the test of time and that any abrupt change without testing the new policy strategies might paralyze the system that gave expected results in terms of reduction in fertility and infant mortality as well as raising contraceptive prevalence rate and improvement in quality of service. It also strongly advocated for maintaining .the doorstep service and integrating population, reproductive health, nutrition, HIV/AIDS into the programmes and policies of other sectors of the economy. It argued that support of other sectors, though cannot be measured in demographic terms, would be extremely helpful in creating an enabling environment for achieving the demographic goals and social objectives of Health and Population Plan as well as for reaching the millions of residual population who always remain outside the purview of the MOHFW owing to their occupational belonging and vocational variations. It also argued for reducing the number of projects and retaining the objective-oriented programmes only for better efficiency and accountability within the framework of Annual Development Programme (ADB). It argued integration of Health and Family Planning services at thana level and below and strengthening existing service delivery units at all level as well as strengthening the existing multi-sectoral population programmes including the three women's programmes, namely, (i) use of women's vocational training for population activities, (ii) use of Mothers' centers for population activities of the Department of Social Welfare; and (iii) Use of Women's Cooperatives for population activities for the Bangladesh Rural Development Board (BRDB) adding in those programmes components like HIV/AIDS, and STD, and Nutrition. The revisionist school wanted to extend the activities to the other sectors which were hitherto remained non-participant in population and health activities and introduce reforms in hospital management and cost sharing in health services at the hospitals and established institutions. They suggested that HPSP should be implemented

in phases and not in the whole country in a single go as it might create problem for the providers and beneficiaries. They also urge that population policy must be redesigned to take into account the adverse effects of several emerging problems, such as; (a) increasing malnutrition; (b) peoples' health hazard owing to arsenic contamination; (c) rapid increase in adolescent girls and their high fertility; and (d) environmental degradation affecting people; (e) imbalance in the spatial distribution of population; and (f) growing size of labour force and unemployed population. The Population Policy should be responsive in the sense that it must seek to ameliorate the adverse effects of these emerging problems.

(b) The Reformist School of Thought represents the MOHFW and some development partners, especially the World Bank. They argued for a sector-wide approach in which it is assumed that resources available through revenue and development budget be taken into consideration for the entire gamut of health and population activities. According to them, earlier progress was slow and could not reduce substantially the maternal and infant death which is largely owing to lack of health orientation of the policy itself and that time had come to shift the policy strategies towards sector-programme approach rather than the multiple project approach. All health and population activities are brought under one mega-programme called Health and Population Sector Programme (HPSP). Only this programme is included in the ADP, but its various components such as logistics, IEM, service delivery etc. will not be reflected there. There will be an Annual Operational Plan (AOP) showing implementable activities and budget. The AOP will be prepared by the line-directors who will submit it to the MOHFW for clearance by two inter-ministerial Steering Committees -one is headed by the Secretary and the other by the Minister of Health and Family Welfare. The former steering committee is a recommending body; and while the latter holds the approving authority. The advantage of this approach is that different line-directors need not have to run to the Ministry of Finance and Planning Commission for release of fund or approval of the new project(s) or revised unapproved project(s). In their view, sector-wide management is a time-saving device, efficient and cost-effective. This School of thoughts proposed several reform measures such as:

(i) Privatization of hospital services;
(ii) Pricing the service-cost at certain level;
(iii) Decentralization of service delivery;
(iv) Service Delivery under one unified command at the level of Thana and below; and
(v) There should be one stop service system in stead of door -step service delivery.
(vi) Introduction of a broad package of services which, to use their own term is called "Essential Package of Services (ESP)" .The service delivery should be through integrated approach, particularly at the Thana level and below.

5. Introduction of HPSP and its Scope

For the sake of clarity, a working definition has been provided in the HPSP (p. 15). In the context of Bangladesh, the health and population sector is taken to include those activities relating to the promotion and restoration of health to the population, including activities to promote family planning and reproductive health. In true sector approach, this includes all activities which fall under the remit of the Ministry of Health and Family Welfare (MOHFW), as well as health services provided by other agencies such as Ministry of Social Welfare, Local authorities, urban councils, communities, Non Government Organizations (NGOs) and the private sector. It excludes, however, aspects which are handled by different branches of Government other than MOHFW and are quite different in scope, such as population censuses, female education or migration policy. Similarly, it excludes other activities which impinge on health status such as provision of safe water. But for the sake of HPSP, the sector includes all activities that are provided by the MOHFW and the NGOs. This definition reflects the sector boundaries, which are implicit in the Health and Population Sector Programme (HPSP) Strategy. Thus it is referred to as the "health and population sector", while recognizing that certain activities which have an impact on health and population are not covered.

6. Essential Service Package (ESP)

One of the key features of new health and population policy is the introduction of Essential Service Package (ESP) which aims at maximizing health benefits relative to per capita expenditure, meet felt needs of the clients, strengthen service delivery, and

improve system management. The Government currently provides many elements of the Essential Service Package through the Directorates of Health and Family Planning. However, with the increasing cost of health care, the Government has to focus on the ESP which consists of the following five major areas:

- Reproductive Health Care;
- Child health Care;
- Communicable Disease Control;
- Limited Curative Care; and
- Behaviour Change Communication.

Due to resource constraints intended increases in the coverage, quality and accessibility of the ESP will not be immediately feasible. A prioritization exercise was done to identify the potential interventions and those that need to be included in the first year. The "Reformist" argued that for efficient delivery of ESP, reforms in service structure at three tiers would be necessary. First, actual restructuring of the central level (Secretariat and the Directorates) is to be completed by year 2000. Second, restructuring at the thana level and below where the ESP delivery will be through an unified structure comprising health and family planning workers under a single manager who will be responsible for the overall management and administration of all activities including:

(a) writing the Annual Confidential Reports (ACR) of the officers and the staffs at the thana level, and

(b) as drawing/disbursing officer

The third restructuring will be at the community level where the services will be provided from a fixed Centre, namely 'community clinic'. This is a significant shift from the existing domiciliary-based service delivery system. The main principle in establishing these community clinics is to make these as centers with community involvement through their initiation in maintaining and providing the requisite security. The need for one-stop service delivery and follow up visits for dropouts and/or special target group have been

taken consideration. The following discussion will illustrate various components of ESP as mentioned above.

6.1 Reproductive Health Care

These are the services that aim at safe pregnancy and delivery, including fertility regulation and treatment of abortions, avoiding unwanted pregnancies and postpone births. It also includes reproductive morbidity and mortality, including STD/HIV, and other aspects of sexual and reproductive health among adults and adolescents. To date there has been insufficient attention given to maternal care and although the physical infrastructure is in place, the concepts of the Safe Motherhood Initiative and the provision of Essential Obstetric Care (EOC) have only been implemented on a limited scale. The Essential Services Package will provide increasingly sophisticated services at each level of the system, with a capacity to perform cesarean sections at specified Thana Health Complexes (THCs), MCWCs and all district hospitals. During FPHP period (1991-1997), under different projects, namely, MCH Strengthening Services (FP Directorate), EOC (UNICEF assisted and OBGN Society implemented), TFIPP and Maternal and Neonatal Health Care Pilot, 86 thanas and 47 MCWCs were strengthened to provide Comprehensive Obstetric Care (with provision for Cesarean Section). However, the strengthening was not uniform in all thanas. During the first year of HPSP, in addition to further strengthening in these thanas, 35 more thanas and 18 MCWCs will be functionally equipped to provide Comprehensive EOC. In the meanwhile, the rest of thanas will be strengthened to provide the Basic EOC.

Interventions aimed at fertility reduction will continue but strategically focus on delaying the age of first birth, improving continuation rates and improving quality of surgical contraception. This will require complementary actions in other sectors to attain, e.g. female education, employment generation and empowerment of women. The broad categories of reproductive health care are:

- Safe Motherhood
- Family planning
- Prevention and control of RTI/STD/AIDS
- Maternal nutrition
- Unsafe Abortion
- Adolescent care
- Infertility
- Neo-natal care

(a) Safe Motherhood will focus on creating, in the health facilities as well as the community, the necessary conditions for preventing maternal death and disability. The focus will be on increasing utilization of EOC services. For this purpose, EOC will be decentralized together with mobilizing communities. Antenatal care, safe birth practices and postnatal care will also be emphasized. This component has the provision for FP services, particularly for preventing unsafe abortions and the resulting death and disability. Health facilities will be improved to make them women friendly and provide services related to violence against women (both curative and counseling) along with emergency transportation.

While at the thana and below the overall services will be provided under a single management. As a transitional process, technical back-up management will be provided by the directorates. The overall functions of safe motherhood have been divided between the Health and Family Planning Directorates. At the community level, till to date the TBAs are the only linkage to assure safe delivery, but existing evaluation suggests that this has not improved the situation significantly. There are suggestions for the need for a cadre of community midwives to ensure safe birth practices and prompt referral of obstetric emergencies. However, it is planned to train the FWA and female HAs for 24 weeks on basic EOC and through the community clinic they will be able to provide the obstetric first aid with normal delivery care closest to the community.

(b) Family Planning Service is an important means to achieve the country's goal of NRR=2 by year 2005. The attainment of this goal will require introducing some strategic changes. The most important strategy is to consider the FP activities as integral part of Reproductive Health Care and accordingly, implement this re-conceptualizing process. While the basic strategy will be to increase overall CPR of modern methods; other strategies would be to reduce discontinuation rate of different contraceptives and to encourage gradual transition of acceptors to long acting and permanent methods. A third strategy will be to improve family planning services, for which improved management skills will be ensured at all levels particularly in low performing areas and for under - served groups. A fourth set of strategies will focus to increase skill manpower, improved logistic supply, appropriate follow-up with supportive supervision and monitoring, and improved management of side effects and complications.

(c) For Prevention and Control of RTI/STD/AIDS, the main focus will be on BCC and condom promotion. In addition, the Government has identified syndromic management for men and women with appropriate referral services as a strategy. The component of prevention and control of RTI/STD/AIDS under the reproductive health care reflect those intervention targeted for women within the 15-49 years age groups.

(d) Menstrual Regulation (MR) and Unsafe Abortion: Existing information suggests that each year about 2.8% of all pregnancies undergo MR and about 1.5% undergoes induced abortion. A significant amount of these are conducted in the public facilities, but under unsafe conditions. Although significant number of doctors and paramedics (about 12,000) received formal training in MR, and rate of complications and side effects have been reduced over time, still unsafe termination of pregnancies mostly occurs due to inadequate trained personnel and logistic support. In addition, many women do not know of a provider or are not aware of time limits and access to legal MR services, especially in rural areas. These also contributed to the factors related to unsafe abortion and MR causing avoidable morbidity and mortality.

(e) Adolescent Care: Adolescents in Bangladesh, both male and female, constitute about a quarter of the total population. Son preference and low status of women are affecting girl adolescents' nutrition, education and access to health care. Early marriage and early matrimony affect their overall health status. Only when they are married, the adolescent girls get maternal care or family planning services; unmarried adolescents may not have access to health care of any kind. Specific BCC messages will be addressed to adolescents for:

- Proper nutrition and hygienic practices
- Information about puberty, safer sexual behaviour and how to avoid health risks including STD/HIV/AIDS.

(f) Infertility: Infertility is considered to be a considerable reproductive health problem. Infertility, primary or secondary is generally a medical problem requiring medical investigation and treatment. RTIs in general and STDs in particular are the major causes of preventable infertility. Sexually transmitted infection is now considered to be the most common STD, causing pelvic inflammation leading to infertility. Interventions proposed to improve the current status are:

(a) to educate both husbands and wives about the factors contributing to infertility ; and

(b) to prevent secondary infertility, through (i) Prevention and treatment of STDs/RTls; (ii) Safe abortion services; and (iii) Safe delivery and post natal care

(g) Neo-natal Care: The services that will be mainly at domiciliary and union levels include the following education, motivational and health care:

- Health education for mothers on cleanliness.
- Umbilical cord care
- Breast-feeding
- Thermal control
- Management of birth asphyxia
- Routine eye prophylactics
- Special care of pre-term and low birth weight babies

6.2 Child Health Care

(a) Child Health Care encompasses basic preventative and curative care for infants and children. The GOB has implemented control programmes for Acute Respiratory Infection (ARI), Diarrhoeal Diseases, Vaccine-Preventable Diseases *EPI) and Prevention of Vitamin A Deficiency disorders. While there have been decline in child mortality from all causes in Bangladesh, many children still do not have access to preventive and curative services delivered by trained health workers.

These situations, therefore, indicate a need for an integrated approach to managing sick children and for child health programmes that go beyond single diseases in order to address the overall health of a child. Integrated Management of Childhood Illness (IMCI) is a child survival strategy directed at improving prevention and case management of the five major diseases measles, malaria, malnutrition, diarrhoea and bacterial pneumonia which are responsible for about 70% of all mortality in children under 5 years of age.

(b) Immunization: Hepatitis B immunization of infants and Td (Tetanus-diphtheria) immunization of school age children will be considered for inclusion in EPI programme. Existing estimates show that HB immunization can potentially save 22,000 lives annually at a cost of US $ 25 per year of life saved. The immunization of school age children would protect children against tetanus and diphtheria and would advance future mothers towards completion of a 5-doses TT schedule to confer life-long immunity against tetanus.

(c) Malnutrition: It is the major factor that has been referred to as key compounding factor for infant and child mortality. Nutritional status of children and adolescents not only affects the present generation but also the future one. Chronic energy deficiency, protein energy malnutrition, low birth weight, micronutrient deficiency are all serious health problems in Bangladesh. Improper breast-feeding and weaning practices are aggravated by the current situation of poverty, gender discrimination and inadequate food security.

(d) School Health Services: School health services include training of school teachers for providing first aid to the school students and provision of a First Aid Box in every school. At least one school teacher will be trained for this purpose. The Medical Officer in THC responsible for disease control will visit schools to conduct health check-up of school children. Trained teachers may also identify students who need to be referred for examination and treatment for any major illness or infirmity in THC/District hospitals. Teachers will provide Health Education to the students mainly on hygienic practices, communicable disease control and on life skills to prepare for adulthood. This will include information on reproductive health including family planning and raising awareness of STD/HIV/AIDS, and also identification of illness among students and referral.

6.3 Communicable Disease Control

(a) Major interventions will include prevention and effective management of communicable diseases with a severe health impact, e.g. TB, Leprosy, malaria, filaria, kala-zar, intestinal parasites, STDs/RTIs, including HIV/AIDS and other emerging and re-emerging diseases. The estimated incidence of pulmonary sputum smear positive tuberculosis is about 111/100,000 population and the estimated incidence of total TB cases (inclusive of sputum negative and extra-pulmonary cases) is about double the sputum positive cases.

(b) For vector-bone diseases, particularly malaria and kala-azar the accepted Strategy for Early Diagnosis & Prompt Treatment (EDPT) will be strengthened. For control of filariasis, WHO recommends annual chemotherapy along with deforming for intestinal infestations of parasites. A pilot study will be conducted to determine the most effective regimen under this strategy.

6.4 Limited Curative Care

Care for common conditions and injuries must be provided because an Essential Service Package has to meet the public expectations for these services. Government resources are needed to provide basic first aid, treatment of medical emergencies, pain relief and

advice. Such services are especially important for the poor. The resources available will limit the amount of service provided. However, economic evaluation of limited curative care would be incorporated into overall cost-effectiveness prioritization of ESP components in the future years of the HPSP. For the first year, provision of funds has been made for basic first aid, management of medical and surgical emergencies at the community, HFWC and THC levels. The most common disease like -asthma, skin diseases, eye, dental, and ear diseases of infectious nature are also included. The first year operational plan is given in Annex 8.1.4 along with the child health component.

6.5 Behaviour Change Communication (BCC)

BCC is a cross cutting intervention conceptualized to capitalize on the opportunities of the rapidly expanding communication networks in Bangladesh. The emphasis is on multi-media, multi-channel, inter-sectoral approaches based on systematic planning process to produce innovative communication and creative strategies.

The primary aim of the BCC component is to shift health and family planning service provision from a sectoral and provider-based system to an inter-sectoral, client-oriented, demand-based system emphasizing community and women's empowerment with a focus on social and gender issues, elderly and the poor. Target client will understand their need for, and entitlement to, the Essential Service Package and demand them. The BCC component aims at:

- Changing attitudes and behaviour of people to improve their health status;
- Building effective community support for health seeking behaviour;
- Changing attitudes and behaviour of service providers to provide client centered services;
- Promoting men's respect for the special situation of the women and the girl child in the society.

The six promotional strategies implicit in the BCC component are:

- Social Change -to address the issue of familial support to women and children especially the girl child;

- Social Ownership -to trigger positive and practical approaches to ownership of service delivery networks by the society;
- Provider Relations -to shift provider attitudes and practices towards a client oriented and inter-sectoral approach to service delivery;
- Advocacy -to gain concurrence and support from the community at large, including the social and political system, community and religious leaders, and the mass media. Advocacy will be carried out to ensure partnership of the non-health sectors, particularly the Ministries of Information, Education, Religious Affairs, LGRD(DPHE), NGOs and corporate entities.
- ESP Intervention promotions -the promotion of the Essential Services Package with an emphasis on demand generation and addressing the social and gender issues that Impede the take-up of practices by women, mothers and adolescents.
- Social Marketing will integrate the social, gender and behavioural-change messages into existing programmes in order to sensitize men for those aspects.

7. Common Ground and Differences

(a) Both "Revisionist" and "Reformist" Schools of thoughts have many things in common. First, both the schools of thought agree that decentralization of authority all the way down is a sine qua non for overcoming the bottlenecks that impede the process of decision making by the functionaries who are close to the people, transparency and good governance. The size of the Ministry, according to them, should be reduced and much of its functions should be delegated to the Directorates and the Directorates, in turn, delegate some of its functions to the district and so on. The MOHFW should devote itself in (i) policy planning, (ii) regulatory functions and (iii) research, monitoring and evaluation. Secondly, both agree to reduce the number of projects to several thematic programmes for efficient management; Thirdly, both the schools agree to have integrated health and family planning services at the thana level and below under one unified command for economy of scale; and Lastly, both strongly believe in decentralized practices, and community participation in health and population activities.

(b) Notwithstanding the common ground, both have many subtle and strong differences. First, Revisionist School feels that integration of Health and Family Planning should be experimented in one or two districts and based on experimental results, it could be expanded in phases throughout Bangladesh over a period of five years. The Reformist School holds the view that integration should proceed with a single go and that experimentation is unnecessary as it will delay the process of integration. Secondly, "Revisionist School" feels that all thematic programmes, about 14 to 16, could be included in the Annual Development Programme (ADP) for better accountability and monitoring the programme activities, goal(s) and resource allocation. On the country, the Reformist School holds the view that all components of the Health and Population Sector should be brought into one mega programme, under the rubric of Health and Population Sector Programme (HPSP) and that only this will be included in the ADP for better intra-components-resource-management and overcoming the delays in meeting the complex process of approval. It also argues that both health and population sectors should be converted into a single sector which is contrary to the notion of the Revisionists that such a conversion is uncalled for and undermine the importance attached to the "Population Planning and priority", it has been enjoying since 1973. Thirdly, the Revisionist School holds the view that inter-sectoral programmes should be broadened to include health issues, HIV/AIDS, nutrition, arsenic and remain as an important part of sector financing. Some of the inter -sectoral programmes now exist are too thin both from the point of view of investment and coverage of population. Both the GOB and other donors should also directly participation in inter -sectoral activities. The Reformist School excludes it altogether and holds the view that HPSP would confine itself within the MOHFW, although it admits that outcome of the programmes of other sectors of the economy may affect the outcome of the HPSP. Lastly, the Reformists converse both revenue and development into a single budgetary system for programming the activities -a new system in which revisionist finds no real benefits.

Arguably, Revisionists stand for cautious move as they believe that social change should not precede any scientific experimentation and that any good and sustained results can be achieved by initiating changes, modifications or even some reforms within the system as

long as it is appreciated and understood by all stakeholders and also, it should be designed to yield greater goods for the greater number of people in the Society; Reformists, on the other hand, stand for quick fix and see that socalled revisions and modifications of the on-going system will never bring about the desired results without reforms; and hence, there is an element of urgency, especially in Bangladesh where things move too slow. The debate on policy issues officially was settled, when the HPSP was approved by the Government in May, 1998. But the question still looms large whether such abrupt action was right! The Reformists ideas appear to be too attractive for consideration. Many reform proposals contained in the HPSP are welfare oriented and its service delivery package is much more substantial than the preceding one. There, however, still remains serious apprehension regarding the implementation of various components of HPSP, because those who are appointed to implement them at various tiers were neither fully familiar with its contents nor the skills and necessary training - things which are prerequisites for any new programme.

8. Some Critical Lapses in HPSP

Notwithstanding the enchantment of reform appeals, the HPSP has committed quite a few lapses for which creation of enabling environment for achieving its various objectives is rendered difficult. These lapses are: (i) HPSP does not provide for other sectors' participation in Population, Health, HIV/AIDS and Nutrition etc.; (ii) it underestimates or excludes measures for minimizing population momentum effect; and (iii) role of three women's programmes of BRDB, Social Welfare and Women Affairs Departments in Population, Health, HIV/AIDS etc. was excluded. The discussion that follows illustrate these three basic lapses which, according to the Revisionist Schools will impede the prospects of achieving the objectives of HPSP and the 5th plan's objectives for Health and Population Sector.

8.1 Lack of Multi and Inter Sectoral Approach

In the Health and Population Sector, demographic momentum, deteriorating health status and ever increasing size of severely malnourished population are, among others, major problems having the gravest consequences on society and economy. The-sources of these

problems are, by and large, outside the MOHFW, but disease burden and adverse outcome of these problems squarely lie on it. This is why it is important that other sectors of the economy must be allowed, especially when they are so willing, to play their due role befitting the scope and stride, in reducing the adverse consequences of deteriorating health, population growth momentum) nutrition status and other emerging problems like HJV/AIDS and STD and arsenism.

Realizing the importance of other sectors' participation in population activities, the Fifth Five Year Plan assigned appropriate roles to various ministries such as: Education, Information, Social Welfare, Women Affairs, Local Government, Rural Development and Cooperative, Agriculture, Youth and Sports, Planning etc. (PP 481-82). The introduction of HPSP provided great opportunity to extend such role to those ministries for health, nutrition, HIV/AIDS and STD, and arsenism. This strategic lapse has disturbed the culture of participation which was already developed through conscious effort and deliberate policy planning. The hietas created by the narrowly defined boundary of HPSP is difficult to fill in, unless immediate steps are taken to extend opportunity to other Ministries for participating in population and related activities. For the Success of HPSP itself, two kind of inter-and-multisectoral approaches are needed - one is direct and the other is indirect. Direct inter-sectoral participation is one which is conceived within the framework of HPSP and its operational definition. This will provide an obligation for other ministries to prepare their own project or operation plan envisaging objectives-based-specific activities, method of participation, result of such participation to the Health and Population Sector and budget from the pool fund or from a bilateral donor. Indirect participation is the one which is designed primarily to achieve objectives of the sector-ministry and secondly, to contribute to the achievement of Health and Population Sector objectives. In fact, given the seriousness of Health and Population Sector problems, HPSP needs both direct and indirect inter-sectoral participation. Due to narrowly defined boundary of HPSP, the MOHFW has alienated itself from other Ministries and their agencies and thus, turned itself as a lone custodian of Health and Population activities.

8.2 Demographic Momentum

Bangladesh's population is presently estimated to be 130.0 million, whereas it was only 76.0 million in 1975, an increase of 54.0 million in a span of .25 years. Such a phenomenal increase in human number in such a short time has put tremendous pressure on its limited resources. Though population growth rate declined from 3.0 percent in mid-seventies to 1.5 percent mostly due to vigorous F.P programme efforts, future growth potentials built into the age-structure is still very high as population below 15 years of age represents 43.0 percent of the total population and women in 15-49 years of age are 44.0 percent of the total female population. These two features of Bangladesh's population bespeak the demographic momentum. Even if Bangladesh achieves the net reproductive rate (NRR) of 1 by 2005, population will still grow upto 170-172 million by the year 2020. This means that there shall be a net addition of 2.0 million population on average per annum in the next two decades. The population projection of the Bangladesh, Planning Commission (Mabud, 1995) based on the assumption of achieving NRR=1 by the year 2005, shows that working age population (15-59 years) will increase upto 110 million in 2020 from the present size of 72.0 million and that women of child bearing age (15-49) will go upto 46.13 million from the current level of 31.0 million. These demographic developments are unavoidable, notwithstanding the projected accelerated service delivery efforts within the ambit of HPSP and GO-NGO collaboration and increase in contraceptive prevalence rate upto 68-70 percent from 2005 onward and reduction in rate of population growth from current level of 1.5 percent to around 1.0 percent during 2005-2020. Primary school (6-10 yrs.) and secondary school (11-15 yrs.) aged population will gradually decline from current level of 16.22 and 18.38 million to 14.5 and 12.63 million in 2020 respectively, but size of adolescent and old age population will increase. At present, adolescent population aged 10-19 years represent one-fifth of the total population and it will go upto 22.0 percent in the next decade. Elderly population of 60 years and above will increase from current level of 6.5 percent to 9.2 percent in 2010. It will be close to 10.0 million in 2000 and 15.0 million in 2010.

As stated above, under the optimistic assumption of NRR=1 by the year 20051 population will grow upto 170-172 million in 2020, but under the less optimistic

assumption, it may increase upto 180 million or more by then. At any rate, Bangladesh is destined to add up 40-42 million or more population in the next two decades. Already, the present population is too large and addition of 40-42 million population or more in the next two decades is frightful to visualize and sure to have terrible strains on its resources, land space, and worsen further the man-land ratio, per capita food availability, population density, nutritional status, per capita educational and health expenditure. In fact, it will affect all branches of the economy. The situation demands an all-out inter/multi-sectoral approaches at all levels -national, district, thana and union as well as all sectors of the economy to offset the adverse effects of population momentum. The sense of urgency which the situation demands is not addressed in the HPSP .

8.3 Women's Development in Population Context

Reduction in fertility and improvement in mortality have been made possible in societies where women have access to work-opportunities and education. Actuated by this concern, Government in mid-seventies undertook three women's programmes under the Health and Population Sector and implemented through the (i) Women's Cooperatives of the Bangladesh Rural Development Board (BRDB), (ii) Mothers' Centers of the Social Services Department, and (iii) Vocational Training Programme of the Women's Affairs Directorate. All these programmes were designed to achieve three main objectives, namely, (a) Functional education and skill training, (b) provision of credit facilities and (c) MCH-Population, education. Since mid-seventies thru mid 1990'5, these three programmes have been expanded to the extent that BRDB's Women's Cooperative had 500,000 women's members; Social Service Department had 450,000 members at its 15000 rural mothers' centers and more than 20000 trained women of the Women's Vocational Training Programme. The area where these programmes were operated, total fertility rate had come down, to near replacement level. Despite this achievement, these programmes were not retained as sectoral programmes. As a result, the opportunities which were created during the preceding decades were just lost and the support which is more needed for the success of HPSP is lost altogether. Thus, women's issue in stead of moving forward moves backward as far as the HPSP is concerned, no matter what is being envisaged or pronounced therein.

9. Policy Instrument

Although a comprehensive Population Policy of the sort that Bangladesh should have, is not in place at present, even whatever policy measures are envisaged in the 5th Five Year Plan are also not implemented in real sense of the term for sheer dysfunctionability of the Policy Instrument which is, in this case, the National Population Council (NPC), headed by the Head of the Government. The National Population Council is the highest policy making body. During the last four years only two meetings were held. The MOHFW is the Secretariat of the NPC which has been rendered ineffective by the Ministry itself. The NPC does not even know the various roles and responsibilities of different ministries in respect of population, nor perhaps is it aware of the emerging problems like population momentum, deteriorating nutrition problem, problem of high adolescent fertility, population environment linkage etc. The MOHFW is fully preoccupied with the implementation of the HPSP which is a service delivery related-operational policy strategy confined to itself. The dysfunctionality of the NPC is a major deterrent to the Population Plan/Policy implementation.

10. Prospects and Risks

10.1 Risks

The HPSP has superseded many aspects of the 5th five year Health and Population Plan (1997-2002). For example, the 5th Five Year Health and Population Plan (p. 479) envisages implementation of HPSP in unions where there are FWCs with doctors and also, in phases. Based on implementation experience, it should be gradually expanded to other places in congruence with the progress in human resource development through training in new programme strategy. This basic approach was undermined. The Government has rushed into implementing the programme without creating a core of well motivated trained people to implement the package of services envisaged in the HPSP. Contrary to previous practices, the MOHFW designated 30 (thirty) senior officers as the line Directors who are vested with both financial and administrative power to execute thirty different components of HPSP. These line-Directors themselves were not reportedly fully conversant or oriented with the programme approach. Such inadequate preparation has created some confusion at the national level and further down. Thus, it

has affected service delivery programme. It has been observed that some established institutions like NIPSOM and NIPORT which used to draw their annual allocation from the Ministry of Finance is now made subservient to the Line Director (training) who cannot provide them the resources they need unless he gets approval of the Ministry of Health and FW and Ministry of Finance. Consequently, it has not only limited the institutional freedom, but also affected their training programme. Same is the case with research activities which are also subject to similar limitation. The sector-boundary is defined within the narrow confine of the MOHFW barring the participation of other Ministries (P. 19). This has extremely limited prospects of other Ministries' contribution towards achievement of the objectives of Health and Population Sector. The MOHFW's shift from "doorstep" to "one stop" service involves risk as the society is not yet poised and accultured towards visit to clinic or hospital to take F.P. services. Female literacy rate is still not high enough to ignite such strong motivation as may be needed for one stop service. It is not the public demand that workers should not visit them at home, for motivation, follow up and supplies. In fact, all these problems have created a great risk for the success of population/family planning service delivery. Some analysts even doubt that the 'demographic and social objectives of the Health and Population Sector as envisaged in the 51h Five Year Plan may not be achieved under the changed circumstances. Instead whatever progress has been achieved so far is most likely to be neutralized owing to lack of direction and operational stagnation at the grass root level. Various reform measures such as (I) hospital autonomy, (ii) cost sharing in public hospitals etc. are yet not taken. As mentioned earlier inter-sectoral support for HPSP[*] was not visualized as essential and thus, other ministries' ability to contribute towards the success of the HPSP is thwarted. The measures to counter the effect of demographic momentum are not built-in the HPSP itself, because in other sectors' direct involvement in population and health activities is excluded. Such an important issue, is highly marginalised. This is indeed a serious risk.

[*] We are referring to HPSP, because Population/FP activities are taken as an integral part of it.

10.2 Prospects

Prospects of the HPSP is not, however, totally bleak. The HPSP is a new paradigm which postulates a relationship between rapid improvement in health care and adoption of new reform measures through sector-wide management. Here sector has one programme with many components and necessary resources will be injected for each component from both development and revenue budget. It has abridged the multiple planning processes. Once the programme is approved, It needs not have to come to the Planning Commission or ECNEC. Different desk masters can resolve their problems through the intra-sectoral arrangement. It is also a time saving device in the sense that each component of the HPSP has to have an annual operational plan with budget breakdown for each sub-component and so on. The designated Line Directors are the key holders of the HPSP. The Secretary of the MOHFW is the principal task Manager and responsible for overall implementation of the programme. The HPSP is supposed to ensure economy of scale at various level, especially at the MOHFW, but in reality it remains as large as before and the Line Directors, despite their delegated authority, are still dependent on the Ministry even for tasks which they can do. For example, the service matters of the non-gazetted staff of the Directorate of the Health services are still attended by the MOHFW which as a matter of fact, no other Ministries deal with such matters. If the risk factors are taken into account from now onward and addressed properly, the HPSP may yield expected result. But it will take some more time than one might have vitualised. If risk factors are undermined or ignored, the HPSP may have disastrous consequences. The part of its success also lies on the trained manpower at all level of Health and Family Planning programme which is currently lacking.

11. Concluding Remarks

Our review of the population policies and programmes in retrospect reveal that despite substantial progress in term of fertility decline, increase in contraceptive prevalence rate and life expectancy at birth, accured through cumulative efforts of all successive Governments since 1973, a new policy and programme strategy was put in place in mid 1998 replacing the earlier ones which resulted into several shifts in respect of population policy strategies. These are: (i) from door step service to one stop service, (ii) from multi-

sectoral to sectoral, (iii) from a mix of projects and programme approach to single mega-programme approach; (iv) from sectoral status to sub-sectoral status; and (v) from 40/50 project/programme directors to 28/30 Line Directors, to cite a few. The Population and Health Plan as contained in the 5th Five Year Plan envisages the implementation of the HPSP in phases (FYP. 479) rather than in single-go to avoid risks that may endanger the outcomes of earlier policies and programmes. Thus far the 5th Plan guidelines were not adhered to fully nor are the other policy strategies such as the issues relating to spatial distribution of population, support to three population related women's programmes, and adequate support to inter-sectoral population programmes of other ministries, problem of adolescent population, environmental degradation and its impact on population, peoples' health problem owing to arsenic contamination etc. There appears to be some lack of appreciation of such policy measures resulting into some lag impeding the progress. Besides, lack of meaningful understanding of the HPSP strategy by the large number of stakeholders at various levels has slowed down the pace of progress. Hence, it is widely believed that in stead of making progress, sector may have some backward trend in respect of decline in fertility and mortality as well as raising contraceptive prevalence rate.

Thus, in a variety of ways, HPSP appears to be in risk. Having such a scenario, one can foresee that prospect of the HPSP strategies may not be as rosy as predicted. It is important that Government should initiate a mid term review to find out the extent to which (i) different ESP elements are in place as envisaged in HPSP; (ii) Whether CPR has increased and fertility rate has decreased further; and (iii) the extent of GOB's efforts in initiating the various reforms measures. In order to provide inputs in the review exercise, one quick survey with the stakeholders and another one with the general beneficiaries should be concerned to see the status of various health and population indicators. The sooner these surveys are taken, the better for the country. Based on results, the HPSP can be modified, retained or strengthened. In the meantime, in appreciation of the other Ministries' expressed desire to participate in population activities, some more broad-based multi and inter-sectoral programmes can be taken up. Some inter -sectoral programme/project which are currently underway with the support

of the UNFPA are the remnants of the past and can hardly cover the large target population. These need to be broad based.

The purpose of this paper is not, however, to say 'right' or 'wrong' with the HPSP per se, but to see whether the on-going population programme strategies, apart from family planning/reproductive health activities, can attenuate the adverse consequences of some of the emerging population problems like demographic momentum, arsenic problem, HIV/AIDS, deteriorating nutrition status of growing population, increasing slums, environmental degradation and massive flux of rural population to the urban areas and so on. The HPSP has made the MOHFW as the single custodian of population activities, although sources of population problem largely remain outside the scope of this Ministry. It is important that the problems-ongoing and emerging ones that threat the existence of population should be inter and multi sectoralized. It is also important that the population policy instrument which is, in this case, the National Population Council (NPC) that has been highly dysfunctional for long should be activated to allocate population-business to other Ministries and regularly monitor the progress of implementation. Unless these tasks are taken seriously now, this poor nation will pay time-penalty which will be too high to bear with.

A public policy, to be regarded as population policy, must be both population responsive and population influencing[*]. It must have a long term vision to have a particular size of population with clearly stated means to achieve that population. Viewed in this sense, we don't have a population policy. To have such a population policy is, therefore, our national priority.

[*] Population responsive policy ameliorates or overcomes the effects of unpreceded increase in population size and density, high birth rate, death rate and growth rate; and population influencing policies will bring about a reduction in fertility, mortality, and in growth rate and will beneficially influence internal migration. Policies for employment, food supply, urbanisation and resource development are in the first category. Family Planning Programme/programme to reduce fertility, health and nutrition programme, to reduce mortality, and transportation and industrial planning to influence internal migration are in the second.

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