

CHAPTER ONE

Introduction

Bangladesh has adopted the ICPD (International Conference on Population and Development) global policy. The country has modified its approach to fertility reduction not only through family planning but also through inclusion of a broad based reproductive health approach. Efforts are increasingly being made to incorporate important reproductive rights and women's empowerment in the Population Policy, which is under review, to improve the quality of life of the people of the country. The proposed policy is based on the principles of the ICPD, which mainly deal with improvement of quality of life through improved health care, equity and empowerment of women, human rights and cultural interest.

Background

The state of reproductive health in Bangladesh is gradually improving. The country has been able to achieve considerable progress in fertility regulation and in increasing contraceptive prevalence rate (CPR). By the early nineties the total fertility rate (TFR) had come down to 3.3 from the level of 6.3 in the mid seventies. During the same period CPR increased to 54 percent from the level of 8.5 percent while life expectancy at birth had increased to 61 years by the late nineties from the level of 48 years in the mid-seventies. During the same period, development of physical infrastructure, institutional facilities and health and family planning services was also remarkable (MOHFW, May 2003).



Photo: Amin/JSI Bangladesh

The International Conference on Population and Development (ICPD)

The International Conference on Population and Development (ICPD), held in Cairo from the 5th to 13th September 1994, established a close link between population policies and reproductive health including women's rights. The ICPD advocated that there is a need to expand the horizon of a country's population policy beyond the confines of achieving stabilization of population through reduction in its fertility. Stabilization of population is to be achieved by providing the opportunity and option to decide, not by coercion and control. The major objectives and goals of the ICPD Program of Action are:

- sustained economic growth in the context of sustainable development;
- education, especially for girls;
- gender equity and equality; and
- infant, child and maternal mortality reduction and provision of universal access to reproductive health services, including family planning and sexual health.

ICPD has recommended a rights-based approach for sexual and reproductive health. This approach was reaffirmed and extended at the Fourth World Conference on Women (FWCW) in Beijing in 1995 and again at the ICPD+5 review in 1999.

Even before the ICPD was held Bangladesh had been trying to implement the proposals and actions relevant to those in the ICPD document. During the three decades preceding the conference, the Government of Bangladesh (GoB) had launched countless interventions for socio-economic development for the alleviation of poverty, spatial and income equity of the population and improvement in family planning and maternal and child health care services. Prior to the ICPD, the Bangladesh family planning program was revamped with emphasis on quality and access to health services and sustainability of the health system. Women's empowerment had already become a national issue of concern and attention.

The ICPD was held at a time when Bangladesh had already begun making some fundamental changes in its health system, and therefore the event has reinforced its commitment to continue with the changed process. The ICPD has helped to create a strong integration of the existing programs and has facilitated a holistic approach for women's development. Involvement in the ICPD of NGOs, advocacy groups and technical assistance agencies as well as the GoB has facilitated the process of program redefinition.

The Bangladesh Population Policy, which is on the anvil, advocates for the stabilization of a population that is sensitive to national tradition and culture, while upholding human rights and adhering to commitments made at various international conferences on issues such as education (Jomtien, 1993), population and development (Cairo, 1994), women and children (Beijing, 1995), and other relevant international fora, as well as adhering to the agreements reached at the Millennium Summit (New York, 2001).

The outline of the first Population Policy was prepared in 1976, to comply with the articles 15-18 in Part 11 of the Bangladesh Constitution, which states "the State has the responsibility to ensure to its citizens certain basic needs such as health, education, food and security". In the Population Policy Outline, high population growth rate was identified as the nation's "number one problem." This policy has been reflected in all successive plans and programs.

The National Population Policy of Bangladesh, which is under review, "aims at improving the overall standard of living of the people of Bangladesh through improved reproductive health status and contributing to a more desirable balance between population and development".

The major policy objectives of the proposed policy are:

- Provide quality reproductive health and family welfare services to people at all levels of the society, and especially the under-served rural and urban population.
- Support and provide quality antenatal delivery and post-natal services, emergency obstetrics care; manage complications arising from unsafe abortions; ensure delivery by skilled staff.
- Ensure universal child immunization, supply of vitamin 'A' and other micronutrients; ensure prevention of malnutrition among children and pregnant women.
- Ensure coordination among relevant Ministries
- Ensure adequate availability and access to sexual and reproductive health counseling and services to adolescents
- Develop the human resource capacity of planners, managers and service providers
- Ensure gender equity and empowerment of women
- Increase social security for the elderly and food security and shelter for the destitute
- Reduce rural to urban migration
- Ensure a conducive environment for improved quality of life and better living conditions
- Adopt poverty alleviation strategies and ensure shelter for all.

Post-ICPD developments in Bangladesh

The Ministry of Health and Family Welfare seeks to create conditions for the people of Bangladesh to have the opportunity to reach and maintain the highest attainable level of health. It is a vision that recognizes health as a fundamental human right and, therefore, the need to promote health and to alleviate ill health and suffering in the spirit of social justice. This vision derives from a framework that is based on the core values of access, equity, gender equality and ethical conduct (MOHFW, May 2003).

Following the ICPD, many activities have been undertaken and many relevant formal bodies have been set up in Bangladesh (Barkat A and U Rob, 1999). A National Plan of Action was developed, disseminated and approved by the GoB. The plan covered the themes of poverty reduction, women's equity, equality and empowerment, reproductive rights and reproductive health.

Some of the major events that have taken place after the ICPD are:

- Formation of a National Committee for the Implementation of the Program of Action (PoA) of ICPD
- Development of a National Plan of Action
- Preparation of document entitled "Strategic Directions for the Bangladesh National Family Planning Program: 1995-2005"
- Development of a Health and Population Sector Strategy (HPSS) and Health and Population Sector Program (HPSP)
- Development of a National Integrated Population and Health Program (NIPHP)
- Development of a National Policy on HIV/AIDS and STD related issues
- Establishment of a National Council for Women's Development
- Formation of a National Population Council
- Formation of a National Population Policy Committee
- Formation of a National Health Policy Committee
- Formation of a High Level Committee
- Formulation and approval of a National Food and Nutrition Policy
- Formulation of a National Reproductive Health Strategy
- Formation of a government-NGO Consultative Council
- Formulation of a National Women Development Policy.
- Establishment of Partners in Population and Development, and the South-South Centre.

Post-ICPD global developments

According to an assessment by UNFPA of the ICPD's impact on population policies and program around the world, many countries have taken steps to broaden existing family planning and related policies and programs (maternal and child health, birth spacing, safe motherhood, etc.) to include other reproductive health information and services. They are giving increased attention to the quality of care in reproductive health and family planning programs. Several governments have taken steps to decentralize the management of public health programs to promote community participation in reproductive health care. Several countries have reported that most aspects of the reproductive health concept were available for middle and higher income groups in urban areas and were unavailable or inadequately available to most of the rural and urban poor. Initiatives have been undertaken in many countries to address the reproductive health and rights of adolescents and to put their needs on the political agenda. Gender issues have been incorporated in the design and implementation of reproductive health programs and women are now involved in decision-making positions to advance efforts to meet their reproductive health needs. Many countries now recognize the need to involve men in reproductive health programs and some have taken up innovative programs. Following the ICPD, steps have been taken to increase the collaboration of governments with NGOs and the private sector in delivering reproductive health information and services.

In 1998, the sector wide approach (SWAp) i.e. the program approach was adopted in the health and population sector. When the idea of the sector wide approach was shared with the government, its operational advantages appeared to be attractive. The GoB developed the Health and Population Sector Strategy (HPSS) on the basis of consensus between and development partners. Subsequently, the Health and Population Sector Program (HPSP) was formulated based on HPSS (MOHFW, May 2003).

Implementation Plan (PIP) of HPSP was also put in place from July 1998. The major component-wise outcomes of the program were:

- Essential Service Package defined, funded, promoted and implemented
- Services delivery mechanism unified, restructured and decentralized
- Integrated support systems strengthened
- Hospital-level services focused and improved
- Policy and regulatory framework strengthened
- Other important public health services strengthened

The Fifth Five Year Plan (FFYP) (1997-2002) of the GoB was formulated in 1998 to create a greater degree of public awareness of the population problem through a social movement in order to reach the replacement level of fertility by the year 2005. The focus of the FFYP was on a reproductive health subprogram which aims at extending the coverage of reproductive health services, including efforts to improve safe motherhood, quality obstetric care, clinical methods of contraception and the management of RTIs and STIs. Issues of gender equity and equality and reproductive rights were introduced in the programs of education, law enforcement, religious affairs, the garments and tea plantation industries and other sectors. The FFYP also completed a phased program to upgrade a network of 64 Maternal and Child Welfare Centers (MCWCs) with proper equipment and training of staff in EmOC so that these can offer a package of comprehensive maternal health services.

Present situation

The HPSP came to an end on 30th June 2003. In order to encompass all the activities of the health sector, the GoB has revised the HPSP and formulated the new "Health, Nutrition and Population Sector Program (HNPSPP) (2003-2006). The vision and targets outlined in the Interim Poverty Reduction Strategy Paper (i-PRSP) of the GoB have been taken as an overarching long-term policy framework and political commitment of the Government upon which the

The broad strategies of the HNPSPP are:

- Reduction of morbidity, mortality, fertility and malnutrition;
- Increasing access (to the poor) and improved service delivery by providing essential services through close-to-client facility, public health services, as well as secondary and tertiary hospitals, and access to essential drugs and indigenous & traditional medicine by improving quality laboratory services and through improved Management Information System;
- Disease prevention, control and reduction;
- Health promotion and behavior changes;
- Addressing health of specific target groups such as the urban poor, school children, adolescents and young people;
- Ensuring adequate human resources for health needs through updating HRD and management strategies, ensuring high quality medical education, training of nurses, laboratory technicians and pharmacists, continuing education and developing a National Center of Excellence;
- Health Sector reform such as autonomy to institutions, decentralization or unification, promoting partnership with private and NGO sectors and involving community and stakeholders in planning, implementation and monitoring;
- Organization and management of health services through sector wide management & procurement of goods and services.

Note:

The strategy for the provision of ESP is to provide health and family planning services and nutrition interventions through a mix service structure at the peripheral level coupled with appropriate domiciliary services and a functional referral system. Services will be near and user-centered, culturally sensitive, need-based, effective, efficient and well utilized and will be planned and managed with active community involvement.

The vision is outlined in IPRSP as:

“With the constitutional obligation of developing and sustaining a society in which the basic needs of all people are met and every person can prosper in freedom and cherish the ideas and values of a free society, the vision of Bangladesh’s poverty reduction strategy is to substantially reduce poverty within the next generation”.

HNPSP will be developed and will contribute to poverty reduction in the country.

The goal of the HNPSP is sustainable improvement of health, nutrition and family welfare status of the country’s population, especially the vulnerable, e.g., the poor, the women, the children and the elderly.



Photo: Amin/JSI Bangladesh

The purpose will be to increase the availability and utilization of user-centered, effective, efficient, equitable, affordable and accessible quality services for a defined Essential Services Package plus other selected services.

The priority objectives are to achieve the targets set in the Millennium Development Goals. These are (1) reducing maternal mortality ratio (MMR); (2) reducing total fertility rate (TFR); (3) reducing malnutrition; (4) reducing infant and under-five mortality; (5) reducing the burden of TB; (6) ensuring essential services through close-to-client (CTC) facilities; (7) improving access to and quality of care of secondary and tertiary hospitals; (8) control of communicable diseases including kala-azar, dengue, leprosy, STD and HIV/AIDS; (9) control of non-communicable disease like cancer, cardiovascular diseases, diabetes, thyroid disorder etc; (10) control and prevention of public health issues like arsenicosis, environmental and occupation hazards and food safety; (11)

National Plan of Action

Areas of Action

- **Poverty Alleviation and Sustainable Development**
 - Rural poverty alleviation in order to minimize the problem at source
 - Agriculture
 - Industrialization
 - Urbanization, migration and environment
- **Health and family Planning**
 - Health Goals
 - Safe Motherhood
 - Family Planning
 - Male Involvement
 - Adolescent and Child Welfare
 - RTI/STD/HIV/AIDS, Infertility and other Reproductive Health Services
 - Child/Infants/Neonate
- **Research, Training and Information**
 - Generation, analyze, dissemination of newer information through research
- **Education**
 - Education is for sustainable development and the improvement in the quality of life
- Greater public knowledge, understanding and commitment necessary to respond positively to population concerns

preventing injuries due to violence (especially against women and children) and accidents and injuries (MOHFW, May 2003).

HNPSP will continue to focus on areas of reproductive health and population such as safe motherhood, reduction in total fertility and advocacy for vulnerable groups. Efforts in detecting, preventing and treating RTIs/STDs/HIV/AIDS will also continue.

Strengths and challenges

Bangladesh has been successful in reducing the population growth rate from 3% in the mid-seventies to 1.4% by the year 2000. Over the past three decades, the country has achieved impressive reductions in fertility and infant and child mortality. The 1994 Cairo Conference hailed Bangladesh as a family planning success story. In spite of this achievement, population growth has been a continuous impediment to the government's efforts to improve the standard of living of the people. High population density (2,403 persons per square mile, one of the highest in the world), deforestation and reduction of cultivable land, air and water pollution, scarcity of drinking water, inadequate shelter, unemployment, malnutrition and slow pace of progress in health and education sectors are some of the problems faced by the country today.

Continued emphasis on reproductive health services is required to attain replacement level fertility. The quality of basic health services must also be improved simultaneously.

The Millennium Development Goals (MDG) and targets set in the i-PRSP imply achieving the following targets for IMR, U5MR, MMR, life expectancy, population growth and underweight children by the end of the HNPSP period:

Table 1.1

Indicators in light of MDGs:	Major Goal Post Poverty Targets				
	Current (2000)	2004	2006	2010	2015
Income-Poverty (percent)	50	45	43	35	25
Infant Mortality Rate (/1,000 live births)	66	56	48	37	22
Under-Five Mortality Rate (/1,000 LB)	94	80	70	52	31
Maternal Mortality Ratio (MMR/1,000 LB)	32	29.5	27.5	24	14.7
Life Expectancy (Years)	61	64	66	69	73
Population Growth (percent p.a)	1.6	1.5	1.5	1.4	1.3
Percent Child under Five Underweight	51	48	42	34	26

Source: I-PRSP, ERD, 25 March 2003 (www.erdbd.org/iprsp)

A new set of benchmarks adopted at the ICPD+5 Review

(a) The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary school enrolment ratio for children of both sexes should be at least 90 per cent;

(b) By 2005, sixty per cent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection; 80% of facilities should offer such services by 2010, and all should do so by 2015;

(c) At least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should be 50% and 85%, respectively, by 2010; and 60% 90% by 2015;

(d) The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75% by 2010, and by 100% by 2015.

Recruitment targets or quotas should not be used in attempting to reach this goal;

(e) To reduce vulnerability to HIV/AIDS infection, at least 90% of young men and women between ages 15-24, should have access by 2005 to preventive methods – such as female and male condoms, voluntary testing, counselling, and follow up, and at least 95% by 2010. HIV infection rates in persons 15-24 years of age should be reduced by 25% in the most affected countries by 2005 and by 25% globally by 2010.

The Ministry of Health and Family Welfare will contribute to achieving the long-term vision and the targets set in the i-PRSP programs and activities in a phased way. Each individual program will have its own strategic vision (for the program period) to realize part of the targets set in the i-PRSP in a manner which will enable all targets to be achieved in full by the end of 2015. Investment in health will contribute to improvement in health outcomes and will enable to achieve sustainable human development and poverty eradication goals (MOHFW, May 2003).

It is estimated that by 2025, almost a half of the population of Bangladesh will be urban. Inhospitable urban environment, lack of employment opportunities, congestion and the high rate of the growth of urbanization are contributing to increased poverty. With the majority of the population being under 25 years of age, combined with large-scale internal and external migration and the serious threat of HIV/AIDS spreading rapidly in the region, the need to address adolescent reproductive health issues has also acquired significant urgency.

The relatively young age structure of the population indicates continued rapid population growth in the future. According to the 2002 World Population Data Sheet of the Population Reference Bureau (PRB), 40% of the population is under 15 years of age and 3% are of the age 65 or above. This young age structure constitutes a built-in “population momentum” which will continue to generate population increases well into the future, even in the face of rapid fertility decline. An additional two million people gets added to the population each year. With this trend, the population is likely to grow to 172 million by 2020 and might stabilize at or below 210 million by the year 2060 even if replacement level fertility (i.e., $NRR=1$) is achieved by the year 2010. However, if it is delayed by another 10 years i.e., until 2020, the population will stabilize 25 years later (i.e., 2085) at 250 million. This will inevitably put a tremendous constraint on national resources and will negatively affect all efforts to improve the quality of life and living standards of the people.

Multi-disciplinary and multi-sectoral efforts are needed for influencing population stabilization efforts. This involves active participation of ministries and sector corporations like that of Health, Education, Labour, Employment, Social Welfare, Women and Children’s Affairs, Youths, Sports and Cultural Affairs, Rural Development and Cooperatives, and Planning and Information.

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(c) At least 40% of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80% globally by 2005; these figures should be 50 and 85%, respectively, by 2010; and 60 and 90% by 2015;

(d) The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75% by 2010, and by 100% by 2015. Recruitment targets or quotas should not be used in attempting to reach this goal;

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