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Population and Development Challenges in Some Asian Countries: A Knowledge Sharing Experience

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The Centre for Policy Dialogue (CPD)*, established in 1993, is an innovative initiative to promote an ongoing process of dialogue between the principal partners in the decision-making and implementing process. The dialogues are designed to address important policy issues and to seek constructive solutions to these problems. The Centre has already organised a series of such major dialogues at local, regional and national levels. These dialogues have brought together ministers, opposition frontbenchers, MPs, business leaders, NGOs, donors, professionals and other functional groups in civil society within a non-confrontational environment to promote focused discussions. The expectation of the CPD is to create a national policy consciousness where members of civil society will be made aware of critical policy issues affecting their lives and will come together in support of particular policy agendas which they feel are conducive to the well being of the country. The CPD has also organised a number of South Asian bilateral and regional dialogues as well as some international dialogues.*

In support of the dialogue process the Centre is engaged in research programmes which are both serviced by and are intended to serve as inputs for particular dialogues organised by the Centre throughout the year. Some of the major research programmes of CPD include The Independent Review of Bangladesh's Development (IRBD), Governance and Development, Population and Sustainable Development, Trade Policy Analysis and Multilateral Trading System, Corporate Responsibility, Governance, Regional Cooperation for Infrastructure Development and Leadership Programme for the Youth. The CPD also carries out periodic public perception surveys on policy issues and developmental concerns.

As part of CPD's publication activities, a CPD Dialogue Report series is brought out in order to widely disseminate the summary of the discussions organised by the Centre. The present report contains the highlights of a symposium on the theme of ***Population and Development Challenges in Some Asian Countries: A Knowledge Sharing Exercise*** *held at* ***Hotel Sheraton, Dhaka*** *on* ***September 22-23, 2002*** *organised by the Ministry of Health and Family Welfare, Government of Bangladesh in collaboration with UNFPA, Dhaka to which CPD provided the technical support.*

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Population and Development Challenges in Some Asian Countries: A Knowledge Sharing Experience

THE SYMPOSIUM

The Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh and the United Nations Population Fund (UNFPA) jointly sponsored the two-day symposium on the theme *Population and Development Challenges in Some Asian Countries: A Knowledge Sharing Experience* with technical assistance from the Centre for Policy Dialogue (CPD). Intended to be a knowledge-sharing experience, the symposium was held at the *Dhaka Sheraton Hotel* from *September 22-23, 2002*. The host country apart, it marked the constellation of a good number of participants from Sri Lanka, Nepal, India, Pakistan, Indonesia and Iran. The participants represented a wide range of professionals including demographic experts, researchers, population policy planners, members of the academia, medical professionals, donor representatives, NGO officials, politicians, bureaucrats and members of the civil society.

Mr M Fazlur Rahman, Secretary, MOHFW presided over the inaugural session of the symposium, while *Dr Khandakar Mosharraf Hossain*, Minister for Health and Family Welfare was the Chief Guest. *Dr Wasim Zaman*, Director UNFPA CST Nepal, *Dr Kamal Uddin Siddiqui*, Principal Secretary to the Prime Minister and *Mr Amanullah Aman*, State Minister for Health attended the inauguration as Special Guests. While UNFPA Representative *Ms Suneeta Mukherjee* made the welcome speech, *Mr Md Lutfor Rahman Chowdhury*, Additional Secretary of the MOHFW delivered the vote of thanks.

PURPOSE OF THE SYMPOSIUM

In the face of demographic transition, most developing countries have now to rethink their respective population policies. This need to 'rethink' is stimulated by a growing concern that the central issue of poverty alleviation in the developmental strategy is becoming increasingly enmeshed with how countries address their population-related issues and concerns. This has become especially important in the current context in view of the preparation of the Poverty Reduction Strategy Paper (PRSP) in many of the developing countries. The PRSP exercise has emerged as a critically important element of the development policies for a number of South Asian countries in the recent times. From the perspective of meaningful reduction in poverty, the PRSP exercise could be made effective if population related concerns are adequately incorporated in the poverty reduction strategies of these countries. Success of such an exercise depends largely on understanding of the relationships between population variables and economic development in terms of potential impact on poverty reduction.

As most South Asian countries are presently passing through a demographic transition with consequent implications for development prospect of these countries, the centrality of this has been re-emphasised in the context of current plateauing of the fertility rate experienced by South

Asian countries, such as, Bangladesh. Although attainment of a replacement level fertility remains a major challenge, issues such as, sex ratio, aging and built-in population momentum despite the fall in fertility rate, also need to be taken into consideration. However, it is felt that the efforts to bring down fertility beyond a certain limit will be successful only if issues such as poverty, education and health for the poor are adequately addressed through population and other development policies.

An in-depth discussion and debate that addresses the issues of demographic transition, population stabilisation, and poverty reduction in the South Asian countries and their implications for development strategies, would, therefore, come in extremely handy in the current context. Exchange of regional experience in these fields, is expected to throw useful insights in terms of taking the population discourse forward, moving away from the demographic agenda and broadening the discourse on population policy making. Sharing the experience of the non-South Asian countries could also be as much rewarding because many such countries have had to tackle similar issues at a stage of economic development, which their South Asian counterparts are now passing through.

It is also expected that this symposium will provide much needed opportunity to the policy-makers from different countries in the South Asian region for sharing their experiences in the context of integration of population and development strategies in poverty reduction efforts. Besides, the participation of experts from other regions and international agencies is also expected to substantially enrich the discussion as this will provide an opportunity to interface South Asian experience with that of other countries and regions.

FORMAT OF THE SYMPOSIUM

The symposium was divided into three sessions: *Challenges of Demographic Transition*, was chaired by *Dr JVR Prasada Rao*, Secretary, Family Planning, Government of India. *Dr Vasantha Kandhia* presented an overview of the demographic transition of selected countries of South and East Asia. *Professor Ataharul Islam* from Bangladesh and *Mr M Mosleh-Uddin* from Iran made presentations of their respective countries. The second session: *Rethinking Population Policies* was chaired by *Dr Wasim Zaman*, Director, UNFPA CST/SAWA, Nepal. *Dr Ubaidur Rob* and *Ms Simeen Mahmud* presented papers on Bangladesh Population policies. Representatives from Iran, Indonesia and India also made presentations of their respective countries during the session. The third session: *Integrating Population Concerns in the Poverty Reduction Strategy Paper (PRSP)* was chaired by *Mr Badiur Rahman*, Secretary, Planning Division of the Government of Bangladesh. *Dr Barkat-e-Khuda* and *Professor Shushil Ranjan Howlader* made a joint presentation. This session also included presentations from Sri Lanka by *Professor Tudor Silva*, by *Mr Amanullah Khan* from Pakistan and by *Mr Imam Haryadi* from Indonesia. In all three sessions there were discussions from the floor. Chaired once again by *Dr Wasim Zaman*, *Ms Janet Jackson* of UNFPA summed up the discussion, while *Ms Suneeta Mukherjee* of the UNFPA concluded the two-day long proceedings with the vote of thanks.

I. INAUGURAL SESSION

1.1 Welcome Speech by Ms Suneeta Mukharjee, Representative, UNFPA

While setting the ball rolling, UNFPA Representative *Ms Suneeta Mukherjee*, captured the mood of the symposium in her welcome speech, saying that many of the developing countries are facing similar population challenges, especially in the areas of adolescent health, plateauing of the total fertility level (TFR), aging, threat of HIV/AIDS etc. She also pointed out that close linkages between reproductive health and poverty reduction have been found in the newly emerged area of PRSP. Increased number of poor maternal health, morbidity and gender inequality leads to a greater pressure on resources and limits economic development. Hence, reproductive health status is a critical dimension of poverty, and thus an important measure of poverty reduction strategy.

Being hopeful that the discussions – both formal and informal – during the course of the symposium will prove to be enlightening and fruitful to each other, she thanked the participants. She was also optimistic that the participants representing very senior levels of the Government of Bangladesh, CST UNFPA, the Islamic Republic of Iran, India, Pakistan, Sri Lanka and Indonesia would take on the issues effectively across the table and help policy makers devise meaningful population policies.

Ms Mukherjee particularly thanked CPD for its valuable technical inputs to the Symposium. She thanked *Dr Debapriya Bhattacharya*, Executive Director, CPD and his colleagues for their support towards successful holding of the Symposium.

Ms Mukherjee thanked the guest speaker from UN Statistics Division *Ms Vasantha Kandhia*, Health Minister of Bangladesh, State Minister for Health, Health Secretary, and the Secretary to the Hon'ble Prime Minister for taking keen interests in the dialogue and sharing their knowledge on population policies.

As for Bangladesh, she said the country's government and the civil society must be commended for having achieved remarkable success in the Family Planning Programme in the 1980s. Also lauding the government for taking notable steps in the fields of girls' education and environment this year, she simultaneously hailed the efforts of the NGOs, the civil society and the development partners who have contributed enormously in the areas of health and family planning. But now, she said, the country is faced with greater challenges. These mostly relate to keeping the country a low prevalence one in HIV/AIDS and breaking the plateaued TFR, she added.

"In UNFPA, we believe that dreams come true and whatever we work for can be achieved," she said noting that this regional population symposium is a reiteration of that truth.

1.2 Speech by the Special Guests

Linkage and Follow-up are Must

Dr Wasim Zaman, Director, UNFPA CST/SAWA, Nepal started by thanking the Government of Bangladesh for thinking about the issue and lauding the country for the open-book approach regarding health, fertility, and population policies. He also greatly appreciated the resilience of the Bangladeshi people in dealing with problems of immense magnitude and their capacity to win those over. He, however, pointed out that poverty and inequality are a much greater threats in South Asia than the threat of N-power and this makes the region a dangerous place to live in. Illiteracy, environment and poverty linkages must be made while addressing the population problem and be squarely dealt with.

Pointing out the need for constant follow up and monitoring of policy implications, he stressed on significant follow up on International Conference on Population and Development (ICPD) held in Cairo in 1994 and the International Conference on Women in Beijing. *Dr Zaman* noted with optimism that there has been significant progress since the last 10 years after the Cairo Conference. However, evaluating the report card on Beijing, he felt that a lot more remains to be done on female empowerment and their access to general and reproductive health.

South Asia, he informed, is still riddled with multi-dimensional handicaps in the areas of poverty, equity, governance, empowerment, women and reproductive health, HIV/AIDS, adolescent reproductive rights, urbanisation and environment. Referring to a recent study, he mentioned that violence against women may start at home on the first day of marriage since the partners know very little about their own bodies. To address these problems, the countries in the region would also need significant resources in addition to an enabling policy regime as rights cannot be translated without resources. Implementing rights of health choices is much harder than establishing the rights of franchise, he reminded, adding that quality of life of the population became the central theme in the World Development Summit recently concluded in Johannesburg, South Africa. This greatly concerns health also.

While pointing out the need to attain the national population objectives evenly, he underscored the urgency to address the regional variations within a national boundary in a sensitive way. In this connection, he said a lot needs to be done in the under-belly of India, namely Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa. Bangladesh, he added, has a lot of successes but that should leave no room for complacence, while Pakistan still needs a lot of catching up to do. Meanwhile, Iran has made great strides in the last 15 years, while Sri Lanka and Maldives have also made good progress with their demographic challenges, he noted. *Dr Zaman* hoped that through this knowledge-sharing exercise, the participating countries could truly go beyond national shores to assess the progresses and address the stagnation.

Need to Break the TFR Barrier

Developing countries are currently passing through a demographic transition with consequent implications for development prospects, *Dr Kamal Uddin Siddiqui*, Principal Secretary to the Prime Minister said. In Bangladesh, the centrality of this transition is highlighted by the current plateauing of fertility rate at 3.3 although contraceptive prevalence rate continues to increase, he

critically observed. The most pertinent point is finding out the ways and means to overcome the plateauing trend and achieve further success in the field of family planning (FP) in Bangladesh and other South Asian countries.

Tracing the genesis of the FP programme in Bangladesh, he said it started on an experimental basis in 1951 but it was only in 1965 that a countrywide FP programme was launched. However, it was in the mid-1970s that FP received a serious thrust. Political will combined with the commitment of the government servants, NGOs and civil society were responsible for making the FP programme in Bangladesh a success story, he pointed out. Besides, the government along with the development partners planned in 1998 another major initiative – Health and Population Sector Programme (HPSP), which is expected to continue till 2003. However, the HPSP is currently undergoing review. There is now a proposal for integrating nutrition with FP, he informed the symposium, adding that after the restructuring, the Health and Nutrition Programme (HNP) is likely start to start next July.

Besides, there is also an attempt to take population related variables in formulating the poverty alleviation strategy. The present government's firm commitment to education for girls is a major step towards that direction, he assured. *Dr Siddiqui* also urged the participants of the symposium to be down to earth in its deliberations and come out with a clear plan of action.

Sharing Experiences to Attain Net Replacement Rate

Hon'ble State Minister for Health *Mr Amanullah Aman* said every country has some unique experiences though most countries of the region are engulfed with the same sort of population problems. He said except for Sri Lanka, all other countries, namely, Bangladesh, India, Indonesia, Iran and Pakistan are yet to achieve Net Replacement Rate (NRR) = 1. Stating that to attain this target is no mean task, *Mr Aman* said, it requires certain reform at the local level as well as sharing of experience with other countries.

The current symposium, he felt, has provided a unique opportunity to share both the programme and policy related experiences of different countries. He believed that with participation of leading population experts from some Asian countries, it would provide an excellent opportunity to hone in into the issues and problems at hand for Bangladesh and other South Asian countries.

1.3 Speech by the Chief Guest

Hon'ble Minister for Health and Family Welfare *Dr Khandakar Mosharraf Hossain* categorically stressed that since poverty reduction is a common goal in South Asian countries, this symposium should aim at helping policymakers attain a better understanding of the underlying constraints of implementing different strategies. In this context, he said, there is a need to move away from the demographic agenda and broaden the discourse on population policy-making. The opportunity to have an informed discourse on experiences of Asian countries is expected to help South Asian policymakers to get critical and useful insights into concrete measures to address relevant concerns under diverse circumstances, the minister added.

Dr Hossain said Asian countries have made considerable progress in reducing their population growth rate and achieving socio-economic development through enormous strides in population control. But he regretted that much of that gain has been significantly neutralised by tremendous increase of population, especially in some low-income countries like Bangladesh, where search for evolving appropriate strategies to rein in population growth and enhance socio-economic development is still on.

Other than Sri Lanka, the TFR is in the range of 2.1 to 4.0 in all. In respect of economic growth measured by GNP per capita, Iran tops the list, followed by Indonesia and Sri Lanka. Other countries like Pakistan, India and Bangladesh are lagging behind, he noted. The size of the poor population in absolute number in all these countries continues to grow with the increase in population. As life expectancy is gaining, the size of the old age population (60 years +) is also increasing to the extent of more than 10-12 percent of the population in the next ten years, which will generate huge demand for healthcare services, the minister reminded, adding that urban population is also expanding almost paralysing the urban capacity to cope. The people of this region are engaged in combating the problems arising from population growth on the one hand, and massive threat of poverty owing to lack of income opportunities on the other. Except for Sri Lanka, other countries are struggling hard to achieve their respective demographic goals of replacement level fertility, while a strategic plan for poverty reduction of the millions in all these countries still remain an unfinished task, he added.

Zeroing in on Bangladesh, the minister said, in the mid-1970s Bangladesh's population was 75 million and growing at a rate of 3.0 percent per annum. The CPR was 15 percent and TFR was 6.3 during the period. In 1994, comparable figures were 44 and 3.4 respectively. Since then, family planning programme effort has been continuing and the contraceptive prevalence rate (CPR) could be raised up to 54 percent in 2000. But the TFR has not declined to a desired level as a result of the population growth momentum. Even if it succeeds in achieving NRR=1 by the year 2010, Bangladesh is destined to add 2.0 million people annually on an average in the next twenty years and thus, raising the present population between 172 to 174 million by the year 2020, he said signalling an ominous turn of events.

Worse still, cautioned the minister, since 1994 TFR has remained unchanged. This premature plateauing of TFR is going to have a serious impact on the society since the population size will continue to increase and is likely to cross the "carrying capacity level" of the economy in the near future. If the size of the population continues to expand, the efforts of the government will not yield the minimum expected outcomes in the sphere of economic development, poverty reduction and improving the health status, he cautioned.

"The experiences in Bangladesh and elsewhere suggest that family planning alone cannot be the surrogate for reducing fertility to the level of NRR=1. The beneficial impact of development in other sectors of the economy must come into play to reduce both individual and societal fertility

levels. Hence, integration of population factors in development planning in South Asian countries is crucial to ensure demographic development balance," he categorically said.

But for assessing the impact of population pressure on development and poverty reduction, minister asked the participants to indulge in some soul-searching in the course of the symposium to find out answers to some relevant questions. These include how the increasing population pressure adversely affect the pace of development and poverty reduction, what interventions are needed to break the plateaued TFR, how much resources are required to reduce the TFR to the desired level, what strategies Bangladesh should evolve in order to achieve the GDP growth rate of seven percent per annum against the backdrop of average annual increase of 2.0 million people in the next two decades, which is a target set in the national poverty reduction strategy document.

The minister agreed that the symposium could not have been more timely for Bangladesh because it is taking place at a time when heads have been put together at the policy level to finalise the Population Policy and Interim Poverty Reduction Strategy paper (I-PRSP) of the Health, Nutrition and Population (HNP) sector. He said the six participating Asian countries, comprising almost one-fourth of the global population, had unique demographic and development experiences, which are illuminating and may hold lessons for the mutual benefit of the participating countries as well as developing future course of actions.

1.4 Concluding Words of the Chair

In his brief concluding remark, the chairperson of the session *Mr M Fazlur Rahman*, Secretary, MOHFW, said since it is the opinion of the demographic researchers that there is a varying degree of TFR in different parts of Bangladesh, a balanced TFR rate should be aimed at for effectively breaking the current plateauing trend of fertility.

Mr Rahman also reminded the participants that time is fast running out for devising some effective population policies to avert the catastrophic impacts of population pressure on the given resources. He said due to population pressure, the man-land ratio in Bangladesh is getting worse each passing day, while the cultivable land is shrinking, environment becoming polluted and forest covers being depleted. Such consequences of population pressure, he argued, are further limiting economic and physical health of the people.

To overcome these limitations on growth imposed by population pressure, he implored the participants to find out the vital linkages between population, poverty reduction and development initiatives and help policymakers to address the population problems effectively. Asking them to find out the doable, he hoped that the symposium will work out effective solutions to demographic challenges and help facilitate better population management to optimise their participation and contribution in the country's development process.

II. SESSION-I

Challenges of Demographic Transition – Chaired by *Dr JVR Prasada Rao*, Secretary, Family Planning, Government of India.

2.1 An Overview of Demographic Transition in Selected Countries of South and Southeast Asia

In providing an overview of demographic transition in some selected countries of South and Southeast Asia *Dr Vasantha Kandhia* of the UN Population Division, discussed the demographic transition of nine countries – India, Bangladesh, Pakistan, Sri Lanka, Bhutan, Maldives, Nepal, the Islamic Republic of Iran and Indonesia in her paper.

Describing Asia as a region of great diversity, she said, it is home to 13 countries that are classified as least developed and three countries that are considered to be part of the developed world. The diversity is also visible in the fertility levels. In 1995-2000, East and Northeast Asia had a TFR of 1.8 births per woman but in the South and Southwest Asia, the TFR was twice as high with 3.6 births per woman.

The transition in these countries can be characterised by five stages that include the pre-transitional stage when the TFR is five children per woman and holds very little sign of decline; the incipient or early stage, when fertility has started to decline from a maximum level recorded but is still above five children per woman; the core stage that encompasses fertility levels of three to five children per woman; the advanced stage corresponding to fertility lower than three children per woman but still at or above replacement level; and below replacement level fertility that is typical of the post-transitional stage, she elaborated.

According to UN Population Division estimates for 1995-2000, Pakistan, Bhutan and Maldives have fertility rates between 5.8 and 5.5 births per woman. But the evidence of decline put these countries in the incipient stage of fertility transition. India, Bangladesh and Nepal that have TFRs ranging from 4.8 births per woman in Nepal to 3.3 in India, are in the core stages of transition, while Indonesia and Iran are in the advanced stages. Both the countries have TFR of 2.6 births per woman. Sri Lanka is the only country in this group to have attained replacement level fertility.

Pakistan: Signs of Fertility Transition

Having an estimated population of 141 million in 2000, Pakistan's population is expected to double in 30 years. Analyses of data derived from demographic surveys in Pakistan suggest that the decline recorded from a peak TFR of 6.3 births per woman to the current 5.5 is indeed real and signals the onset of fertility transition. The latest estimates of CPR for the country was 24 percent in 1996-97, more than double the prevalence just 10 years back when it was 9.1 percent. Prevalence is expected to continue to increase if all the unmet demand for family planning could be met. Another important factor in Pakistan's incipient fertility decline is the rising age at marriage. In 1961, just one-quarter of females aged 15-19 were unmarried, but in 1998, the situation was completely reversed in that just one-fifth of females in that age group were

married, informed *Dr Kandhia*, adding that little information is available on Maldives and Bhutan. But the UN Population Division estimates for 1995-2000 show a small decline in TFR in the 1990s.

Bangladesh: Fertility Plateaued Despite Rise in CPR

There has been much interest in the case of Bangladesh because fertility declined despite the absence of improvements in socio-economic conditions thus raising the questions about socio-economic pre-conditions for the onset of fertility transition, she explained. In Bangladesh, the government's commitment of the FP programme is thought to have played a part in bringing about changes in behaviour and attitude towards family size and contraceptive use. But the fertility decline appears to have stalled in the 1990s although contraceptive prevalence continues to grow. Several reasons have been cited for the stall but it is likely that the stall is temporary and fertility will continue its declining trend, she said optimistically, adding that a number of other countries including Sri Lanka, had experienced similar trends in the late 1970s.

India: Trapped in its Diversity?

With a population of one billion in 2000 and TFR of 3.3 births per woman, India is another of the three countries at the core stage of the fertility transition in addition to Bangladesh and Nepal, *Dr Kandhia* pointed out. In 1952, India became the first country to launch a family planning programme aimed at reducing population growth and since then has provided direct support to family planning activities. Since the onset of fertility decline in the early-1970s, the TFR has come down from 5.4 birth per woman in 1970-75 to 3.3 in 1995-2000. However, there appears to be a clear divide between the northern states in India and the states in the south, *Dr Kandhia* pointed out. The northern states generally have much higher fertility than those in south. Some southern states like Kerala and Tamil Nadu already have TFRs that are below the replacement level, whereas, Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh have TFRs of above four children per woman. This diversity could be one reason why India's overall level of fertility is declining at a relatively slow pace, she explained.

Nepal: Steady Progress

Nepal's fertility hovered around 5.8-6.1 births per woman between 1950 and 1955, and was not until 1980-85 that a sustained decline was recorded and it was since the early-1980s, that fertility declined by one child per woman.

Indonesia and Iran: Fast-movers

Indonesia and Iran are at the advanced stage of the transition with TFR of 2.6 children per woman at the turn of the century, informed *Dr Kandhia*. In Indonesia, fertility has been declining since the early-1970s, while Iran was a relatively latecomer to the transition. Indonesian fertility rates were above five children per woman until 1970-75, but declined rapidly to half the level to 2.6 at the end of the 1990s. Socio-economic development has created a favourable climate for changes in reproductive behaviour, but the government's commitment to a policy to reduce fertility level was a strong factor, explained the author of the paper.

The Islamic Republic of Iran has seen a precipitous decline in fertility from a level of 6.5 births per woman in 1980-85 to just 2.6 in 1995-2000. A large increase in CPR of up to 72.9 percent of currently married couples using a method of contraception accounts for most of the decline, she argues. That increase is due in part to the strong FP programme supported by the government. The government's policies, such as, promoting education for women, the establishment of health network systems and the increasing access to electricity, safe water, transport and communication in remote areas of the country have all played large parts in reducing fertility, *Dr Kandhia* added.

Sri Lanka: The Achiever

Sri Lanka is the only one of the nine countries with fertility at replacement level. Fertility fell from a high of 6.0 births per woman in 1955-60 to 2.1 in 1995-2000. This sharp decline was stalled briefly in the 1970s but continued in the 1980s. The reason for the stall has been attributed to changing marriage and child-bearing patterns, she believed.

Quality of Leadership Matters

In many high fertility countries, the quality of leadership can play important roles in curbing population growth, she argued. By 1999, Bhutan, Maldives and Pakistan all had policies aimed at fertility reduction. But policies and programmes can be upset by lack of firm commitment to implement them, she argued.

Need to Facilitate Transition

Countries that have entered transition period more recently, did so at levels of development those were lower than those countries that entered the transition earlier. This is the case for Bangladesh and Pakistan, argued *Dr Kandhia*. She explained that fertility decline generally starts among urban educated women and spreads quickly to other parts of the society, establishing new attitudes towards family size and the use of family planning. Strong programmes and good communications networks facilitate the process. Thus, once fertility starts to decline, the process is fairly rapid as women with unmet need for family planning have access and the means to achieve their desired family size.

Although the onset of transition begun at lower levels of transition for those countries starting the transition more recently, high levels of human development have to be achieved to reach the advanced stages of the transition. This conclusion is especially pertinent to Bangladesh where the fertility transition appears to have stalled. While the FP programme in Bangladesh has been very effective in meeting the demand for contraception, the programme needs to focus also on quality and accessibility issues in order to further increase prevalence. Fertility in Bangladesh may not continue to decline unless more attention is paid to the demand factors that lead men and women to aspire for smaller families and have the means and the willingness to act on those aspirations, she argued. In this process of facilitation, issues of cardinal importance are education of women

and men, improving the status of women and child survival, reducing the level of poverty, in other words, advancing human development, concluded *Dr Kandhia*.

2.2 Demographic Transition and Policy Challenges in Bangladesh

This paper by *Professor Ataharul Islam* of the Department of Statistics, University of Dhaka, examines the status of demographic transition and the factors attributable to such transition as well as potential barriers, their impact and relevant policy options.

Population Growth Profile

The population of Bangladesh was estimated at around 14.5 million in 1801. It took about 100 years for the population size to double in 1901 with a modest growth rate of 0.7 during that 100 - year. However, the same size of population increase was observed in almost the next 50 years. Since then, the population increase was very rapid. During 1951-74 period, the population increased by about 29 million, in a period of 23 years. However, it was more rapid during the next 27 years with an increase of another 60 million during 1974-2001, *Professor Islam* pointed out.

Projected Population Growth

The population size of Bangladesh of 1991 will be doubled in 2039 as obtained by high-fertility variant (HFV). However, if the level of effective CPR is increased and the proportion of *never married* is assumed to have increased during the period, as evident from surveys, then the population will be doubled in 2051, assumed the author. The total population will remain below 200 million (192.3 million) in 2051, according to low-fertility variant (LFV). The population will be 243.9 million in 2051 as per HFV. So, an increased level of effective CPR will reduce the size of population by 51.6 million. The population will grow at a rate of 1.3 percent per year for HFV and 0.91 percent for LFV projections.

Age Composition of the Future Population

The HFV projection shows that the young age population will initially decline but will increase to 56 million in 2051. Depending on the fertility variant, the size of the young age population may vary to an extent of approximately 20 million by 2051. However, it is more likely that the population growth will follow HFV projections, cautioned *Professor Islam*.

There is also likely to be remarkable increase of the women in reproductive ages during 1991-2051, he informed. The number of women will increase by 129 percent during the referenced period if HFV projection is considered, while the increase according to LFV projection will be three-fourth.

The working age population of Bangladesh in 2051 will be around 158 million as compared to that of 57 millions in 1991. The increase in the number of working age people will be more than 100 million in 2051, according to HFV estimates, while the LFV projection puts the number at 70 million. This increase in working age population in such large numbers can be transformed

into productive force in order to accelerate growth of the economy at a much faster rate, he said, reminding that for that time-befitting policies would be needed so that gainful employment could be created for the additional population joining the productive age.

Besides, the process of aging will pose a formidable difficulty for the country in the near future, irrespective of high or low fertility variant projections. The number of elderly people will increase from 3.7 millions in 1991 to 29.9 millions in 2051, increasing at a rate of 3.5 percent annually. This is likely to have serious policy implications because with such a speedy change in the age composition, the policy-makers need to focus on the increasingly growing elderly population, Prof. Islam categorically pointed out, reminding that although Sri Lanka has attained replacement level fertility, the growing old age population continues to cast a negative impact to its development.

A country with high proportion of children is expected to devote a high proportion of resources to their care, which tends to depress the pace of economic growth. On the other hand, an increased population in the working ages could accelerate economic growth with their productivity, assuming that policies are in place to take advantage of this. In fact, the combined effect of large working age population and health, family, labour, financial and human capital, policies could create virtuous cycles of wealth creation. Meanwhile, if a large proportion of a nation's population consists of the elderly, the effects can be similar to those of a very young population.

Challenges Ahead

Bangladesh has experienced a large population growth in the past, but due to the success of family planning programmes, the level of TFR has declined rapidly. However, the increased level of CPR did not have the expected outcome during the recent past. Instead, the level of fertility has remained unchanged. Therefore, attainment of replacement level fertility remains a formidable challenge to the policy makers. Human capital accumulation factors have been emerging as very important determinants in shaping both the future growths of population and development. Moreover, once the process of population momentum is initiated, the population will keep on increasing very rapidly during the next 40-50 years until it is eventually stabilised. The overall economic growth will be severely affected due to the population momentum and without integrated policy measures, *Professor Islam* reckoned that it will be difficult to face the emerging challenges.

In Bangladesh, the onset of fertility decline was evident from the mid-70s. It occurred at a rapid pace during 1975 to 1993-94. The TFR was 6.3 in 1975 and decreased to 3.4 in 1993-94. However, since then the level of total fertility appears to be stagnant at a level of 3.3. From 1993-94 to 1999-2000, the CPR has increased substantially from 44.6 percent to 53.8 percent. The unchanged fertility level despite rapid increases in the CPR has left the fertility level well above the replacement level. This has made policy measures to complete the demographic transition all the more pertinent.

In attaining replacement level fertility both child survival and mean ideal number of children play important roles in determining TFR. When under 5 mortality rate is high, it is almost impossible to attain replacement unless women desire for even a lower mean number of ideal children. To attain replacement level fertility, the mean number of ideal children should be around 2.1 to 2.2 with an accompanying push in the behavioural and cultural context of a society, the author pointed out. In Bangladesh, the mean ideal number of children is lowest in Khulna with 2.3. The highest mean ideal number of children is observed in Chittagong with 2.8. There is no change in the mean ideal number of children during 1996-97 to 1999-2000, showing that it does not depend on the increase of CPR. Instead, CPR may be considered to have an upper limit determined by the mean ideal number of children.

Even after reaching the replacement level fertility, it may take quite a long time to attain zero growth rate due to the young age structure of a population. The population will continue to increase even after reaching the replacement level as a relatively larger population of girls will enter into the child-bearing age groups until the age structure stabilises, *Professor Islam* explained.

For a country like Bangladesh, which is just getting ready to initiate the process of population momentum and experiencing an overwhelming increase in the population size, initially at very young ages, then at working age groups and finally at the elderly age groups, has the opportunity to capitalise on the brighter side of demographic transition. “But this demographic benefit or bonus is not however automatic,” said the author. He said it could only be possible given the right kind of policy environment. Critical policy areas, according to him, include: public health, family planning, education, economic policies that promote labour market flexibility, openness to trade and savings. Policymakers have the opportunity to consider the means to maximise and capture this benefit by accelerating demographic transition and allowing extra labour to be absorbed productively in the market. They should also plan for the healthcare and quality education of the children as an investment and future healthcare and pension income needs as security of this ‘baby boom generation’ when it ages.

Capital Role of Quality Education

The role of education, particularly the quality of basic education, was instrumental behind the success of the East Asian countries. It is argued that the demographic transition contributed to the realisation of the East Asian Miracle due to the very important role of education, said *Dr Islam*.

The effect of population momentum can be reduced and level of fertility declined substantially also by delaying age at marriage as well as by widening the space between consecutive births, which was noticed in the Sri Lankan case. But in this respect also education played a pivotal role.

Besides, in attaining the replacement level fertility the factors that play catalyst roles are the universal quality of education beyond the primary level, with especial emphasis on generating

technical skills among the students in a bid to involve them in income generating activities for pacing up economic development. The utilisation of a large population in their working ages for productive purposes can play the most vital role in increasing the average per capita income as well as accelerating the fertility downtrend. This was instrumental in the case of East Asian Miracle, the author pointed out.

Illustrating the importance of education, he informed that the mean ideal number of children is the highest for women with no schooling (2.7) in 1999-2000 and lowest for women with secondary or higher level of education (2.3) in Bangladesh. There was no substantial variation in the mean number of children in 1996-97 and 1999-2000 periods.

Similar observation can be made for TFR by education of women, he argued, saying that the TFR level is already close to replacement level for women with secondary and higher education. On the basis of regional variations, the estimates for wanted fertility indicates that replacement level fertility is favoured in Khulna, Rajshahi, Barisal and Dhaka. By contrast, the wanted fertility in Chittagong and Sylhet are still very high with 2.6 and 2.9 respectively. In other words, except for Chittagong and Sylhet, a rapid decline in under-5 mortality may have accelerated the attainment of replacement level fertility.

Moreover, education of women can pave the way for attainment of replacement level fertility for the reason that under-5 mortality is negatively associated with the level of mother's education. For mothers with primary no schooling, the under-5 mortality remains at a very high level of 100 or more deaths per thousand live births. By contrast, for mothers having secondary or higher level of education, the under-5 mortality is significantly lower at 68 per thousand live births, according 1999-2000 survey, as compared to 130 per thousand live births for mother with no education and 100 for those with primary level education.

Therefore, *Dr Islam* argued that universal and higher level of education is directly linked with the process of demographic transition. As a result of a decline of under-5 mortality, the TFR will also decrease and the rate of decline will be faster if the mean years of schooling can be upgraded to secondary or higher level. "The pace of attaining the replacement level fertility depends on the pace at which the changes in the necessary inputs such as education and under-5 mortality are implemented through targeted policies" he explained.

Shaping Policies to Reap Riches from Demographic Transition

Any economy with a very timely economic policy and its proper implementation can utilise the benefits of demographic transition to the extent that the depressing effect of the future can also be minimised during the transition to aging, said *Dr Islam*. This process begins and ends in such a diversified manner in a period of 50 years or so those policies need proper adaptation during several stages. These include: investment during first phase to develop human resources for the economic growth, creation of jobs and economic activities for increasingly large populations entering the job market every year, and investment for the increasingly large elderly population every year during the third stage in order to provide social security and healthcare.

This implies that the economic policies for the demographic transition need to take note of the long-term strategies with short-term modifications at each stage. In other words, the economic policies need to consider the dynamic process in economic policies so those long-term goals can be achieved through short-term modifications.

Demographic transition produces an increasingly large population in the working ages and reduces the dependency ratio. However, the benefit of demographic transition is not obvious because it requires careful plan and implementation in order to improve the quality and level of human capital.

Benefits of decreasing dependency ratio can be transformed into economic growth, and thus, increasing allocation for healthcare and social security for the elderly can be materialised. Without a long-term plan with provision short-term adjustments, it would be difficult to achieve the targets of integrating a rapidly growing working age population into the economic activities for a sustained economic growth at a great pace within a short time-span.

However, *Professor Islam* reckoned that for turning the demographic benefit to our favour and preparing the growing working age population for economic activities, improved and higher level of education with scopes for skill development through vocational and technical education was the single most important factor. Currently, Bangladesh spends about 2 percent of the GDP on education, which is grossly inadequate to face the challenges of the ongoing demographic transition, he concluded.

2.3 Demographic Transitions in the Islamic Republic of Iran

In his presentation *Mr Mosleh-Uddin*, Country Representative, UNFPA, Iran, said the Islamic Republic is considered a model for its rapid transition from a high fertility country in the mid-1980s to below replacement level in the 1990s and beyond. Listing the major achievements of Iran, he said the TFR was 6.6 in 1966, 5.5 in 1976, again rose to 6.3 in 1986 and then made an impressive decline at 2.6 in 1996 in spite of the fact that the total population of Iran almost doubled between 1976 and 1996. This decline in TFR was also marked by a sharp fall in the number of its adolescent population, bringing the age-composition of the population much to its favour, he informed, adding that the initial decline was in the urban areas. But the rural areas soon caught up.

However, there are still significant variations in population growth and fertility trends between the urban and the rural areas, *Mr Mosleh-Uddin* pointed out. During 1973-76 period, when TFR was recorded at 6.6, the fertility rate in the urban areas was 4.50, while in the rural areas it was 8.10. Meanwhile, in the year 2000 when the TFR for the country stood at 2.00, it was 1.79 for the urban and 2.39 for the rural areas, he said quoting statistics.

It is expected that through extensive interventions that are currently being undertaken in the rural areas through setting up village health houses and centres the rural-urban gap could be bridged. Besides, the compulsory system of pre-marriage counseling with regard to family planning and

reproductive needs of the to-be-weds also went a great length to help the cause of population control and making informed reproductive choices, he informed the symposium.

With a population growth rate of 1.47 percent and TFR of 2.0 as of 2000, the CPR in Iran is 72.6 percent. Some 87.6 percent of the births take place in hospitals and health centres with 89.6 percent births being attended by trained health professionals. Meanwhile, an overwhelming 95 percent of its population had access to basic health services. The age at first marriage for female was 20.3 years in 2000, while the proportion of by mothers under 20 years to total birth is 25.5 percent and the percentage of unmet contraception is 6.6.

Behind Iran's remarkable success in population management, argued *Mr Mosleh-Uddin*, the biggest factor at work was its innovative primary education programme. A quantum leap in the overall literacy level, in fact, helped Iran to a demographic turnaround. While the pre-revolution literacy figures were 35-40 percent for the males and 30 percent for the female, the post-revolution figures skyrocketed to 86 percent and 76 percent respectively in 2000 for males and females respectively, he said.

2.4 Discussion

Rise in CPR could help only up to a Certain Point

Meanwhile, a discussant of the session *Dr Hossein Malek-Afzali*, who is the President of FPA of Iran and a Deputy Minister in the Ministry of Health and Medical Education of the Iranian Government, said rise of CPR could help in reducing fertility trends only up to certain point. Referring to the plateuing of TFR level in Bangladesh despite significant rise of CPR, *Dr Afzali* argued that FP and CPR could have an effect on TFR up to 3.2-3.3 births per woman. But for achievement beyond that the social and developmental factors have to be brought in into the demographic paradigm.

Citing examples of Iran, he said political commitment, integration of religious leaders, expansion of primary and female education made the demographic turnaround possible in Iran. Providing electricity and other infrastructure also helped. It was not only FP, but all other social sectors combined that orchestrated the demographic turnaround, he categorically pointed out.

He said the TFR in Iran has dropped from 5.4 in 1998 to below 2.0 percent now, while CPR rose from 27 percent in 1998 to 56 percent now. But reminded that a painstaking process of policy initiatives and developmental linkages had to be ensured to achieve the success.

Dr Afzali said in the ten years after the Islamic Revolution from 1978-88 a few important events took place in Iran. These were the imposed war that took place with Iraq, which caused around 500,000 deaths and USD 1000,000 million worth financial drainage. The second was the misinterpretation of Islam in the period immediately after the revolution, which encouraged people to have increased number of children in the following 10 years. The children of that generation are now aged around 15-25 years and comprise 25 percent of the Iranian population with 16 million people. However, the challenge now is now to guide the huge number of younger

population in the face of threats of HIV/AIDS, STDs and unemployment, he said. But the post-revolution expansion of primary education resulted in decrease of maternal and infant mortality. Population control in that period was targeted at ensuring quality of life, he assured.

Quantity and Quality of Services should Receive Greater Attention

The second discussant of the session Mr. G. Giridhar, Adviser, UNFPA CST, Nepal, agreed with the concerns raised in Prof. Islam's paper about premature plateauing of the TFR in Bangladesh. However, the regional variations in fertility raise the question whether such a generalized conclusion should be a matter of serious concern. Bangladesh experience is perhaps not very unique in South Asia, where there were other instances of regional variations as well as plateauing of fertility.

However, what demand serious attention are factors that contribute to slow or no decline in fertility despite increasing CPR. One such factor relates to RH-FP service delivery system, in terms of inadequate quantity and quality of services provided. There is an urgent need to focus on supply related issues, because the ability of the supply system to effectively respond to increased demand is very limited. As pointed out by Prof. Islam and others, increased CPR is composed of shift towards more "ineffective" methods, as well as discontinuation rates. We should recognize a good supply system creates greater and newer demand; not just IEC/BCC inputs. In fact, without good supply system to back up, these inputs can even be counter-productive.

Mr Giridhar agreed with the finding that reducing under-5 mortality and enhancement of education, particularly female education, is essential for reaching a replacement level fertility. But such longer term development issues take more time, but meanwhile focus on services is essential to create a conducive environment. Poor implementation of projects and programmes can significantly impede demographic progress. Hence improved policies and enhanced capacity of programme managers in implementing such policies should receive lot more attention in such symposia, he argued.

We need to explore ways in which programme managers and management specialists can have a meaningful dialogue and sharing of knowledge, not just as a one time training programme, but more on a continuing basis. Helping the doers to do their jobs more effectively should be the spirit of such exchange, he said.

2.5 Open Floor

Initiating the open floor discussion, *TV Antony*, Chief Secretary of State of Tamil Nadu, India asked Bangladesh not to become too obsessed with the plateauing of the TFR. Such preponderance, he argued, would only create psychological barriers. Instead, he stressed on concentrating on the service delivery aspects to make sure that the services available in areas where they are needed the most. He said in Tamil Nadu had reached the so-called plateau twice

from 1970-71 to 1976-77, which it overcame after that taking up vigorous programmes to ensure better service delivery.

Explaining the fertility trends among the rich and the poor in Bangladesh, *Dr Barkat-e-Khuda* said the TFR was 2.2 for the richest and 3.8 for the poorest in Bangladesh. He felt that FP had played a very critical role in lowering the fertility. Speaking in agreement with *Mr Giridhar* of Nepal about the importance of ensuring effective service delivery mechanisms with greater emphasis on the supply side, *Dr Morshed Chowdhury* of Gonoshastthya Kendra, Bangladesh, said the main reason for failure in service delivery was due to weak management, not technical weakness. For improving the service delivery and supply mechanisms, he stressed on putting in greater efforts in assessing the actual need of the people and developing a practice of listening to those remaining unheard. *Dr M Alauddin* of Bangladesh said the level of management and implementation should be properly assessed to understand the regional variations on TFR. Meanwhile, *Professor K Tudor Silva* from Sri Lanka said the population discourse and discussion on service provision should go beyond nation-state interventions. Because in the globalised market, demand and supply is different and keeps on changing with time. Imam Haryadi from Indonesia felt that resource, strong role of the government and community participation are the basic preconditions for effective population control and management.

Mr Mosleh-Uddin of UNFPA, Iran raised questions on the impact of population research. Are we really doing research for research's sake, he asked. Stating that since it is common knowledge that the TFR has plateaued in Bangladesh, researches should find out practical and effective ways to dismantle the TFR barrier. Being critical of the current research initiatives, he said, researchers should better utilise the donor money as 70 percent of the donor fund remains unaccounted for. Reacting strongly to his observations, *Ms Simeen Mahmud* of Bangladesh, said researchers would definitely conduct research for generating knowledge. But it is up to others to use the knowledge and put it into proper use for the betterment of the people, she argued. Also chipping in with his remarks, *Dr Hossein Malek-Afzali* of Iran said qualitative and interventionary research for the community should be improved.

2.6 Concluding Words of the Chair

The chairperson of the session, *Dr JVR Prasada Rao*, in his concluding remarks said there exists a wealth of data on various population management interventions. He asked the researchers, participants, programme implementers and field level managers to make best use of these data to bolster the implementation process. Pointing out timely strategies and increased programme implementation skills as key factors for further success, *Dr Rao* said the journey ahead becomes increasingly harder as nations come down to a fertility rate of 3.00 births per woman.

III. Session-II

Rethinking Population Policies – Chaired by *Dr Wasim Zaman*.

3.1 Bangladesh's Population Policy: Emerging Issues and Future Agenda

From 1973 to the present time, Bangladesh's population policy has evolved in two distinct phases. The first phase lasted till 1996 and it was guided by the objectives and strategies presented in the 1976 Population Policy. The objectives, strategies and programmes in the subsequent First through Fourth Five Year Plans (FYPs) were based on and developed from the 1976 policy. This period was marked by implementation of a target-driven family planning programme. The second phase of the population policy development started in 1997 and continues till the present. This stage was strongly influenced by the 1994 ICPD in Cairo and it has been characterised by a transition from a target-driven to a client-centered approach, which is reflected in the Fifth FYP that started in 1997, the Health and Population Sector Programme (HPSP) that began in 1998 and the draft of the New Population Policy (NPP) that's currently being finalised.

The paper by *Dr Ubaidur Rob* and *Dr Noah Sprafkin* described several of the major population and development issues in Bangladesh, examined how Bangladesh's existing and proposed population policies and programmes deal with these concerns, identified where the gaps are and discussed how the policies and the programmes can be improved to address the emerging issues. These issues, as highlighted in the paper, stressed on six areas including unmet contraceptive needs, adolescent population growth, high maternal mortality and morbidity, HIV/AIDS and Sexually Transmitted Disease (STD) concerns, lack of female empowerment, and increasing urbanisation.

Unmet Contraceptive Needs

The 1999-2000 Bangladesh Demographic and Health Survey (BDHS) shows that the country has 16 percent unmet contraceptive needs. While every eligible couple knew about modern contraceptive methods, only 54 percent eligible women currently used any contraceptive method and half of the contraceptive users discontinued the chosen methods within one year after initiation. The highest rate of discontinuation was for condoms (67 percent) and the lowest was for IUDs (34 percent), the authors pointed out.

As for policy interventions, they said, several policies in the Fifth FYP tried to address the unmet need for contraceptives in Bangladesh. One policy supported providing quality services, using information, education and communication (IEC) campaigns, and involving the NGOs to deal with FP issues in almost all thanas of the country. Two other policies promoted the use of clinical contraceptive methods and advocated the production and social marketing of contraceptives through the private sector. The HPSP also stressed that the CPR of modern methods should be increased. Meanwhile, the draft NPP states that contraceptive security is a 'cornerstone' of the population policy, but it does not give details about programmes or activities for the provision of these essential contraceptives. Although the draft NPP does highlight the important role of the NGOs and the private sector in population activities, it does not specify tasks for these groups.

Although the Fifth FYP, HPSP and the proposed NPP have several initiatives to address unmet contraception needs, two areas have not been adequately dealt with. These are reducing contraceptive discontinuation rates and another is the procurement and distribution of different contraceptive methods. One strategy for addressing the gap could be through developing BCC materials and outreach activity targeted at groups with highest contraceptive discontinuation rates like condom users, said the authors. Another strategy could be to ensure better follow up mechanisms in place so that field workers and other staff providing contraceptive methods can reinforce the importance of method use, they argued. As for the supply of contraception materials, a long-term plan could be evolved that projects a realistic contraceptive method mix and coordinate with NGOs on the distribution issues, they recommended.

Adolescent Population Growth

Adolescent population (aged between 10 and 19) comprised one-fourth of the total population in 1999-2000 with 14 percent aged 10-14 and 11 percent aged 15-19. The adolescents mostly belonged to the school-going, working and reproductive health practicing population. For 10-19 year-olds, approximately half of the males and only 11 percent of the females were engaged in gainful employment. Among the currently married women, adolescents aged 15-19 had the highest rate of current pregnancy with 16 percent. Only 38 percent of the married women aged 15-19 are currently using any contraceptive method.

The Fifth FYP did not deal directly with the RH and development needs of the growing adolescent population, but some of its programmes did. Adolescent health was included as an important component of the provision of RH through the Essential Services Package (ESP). The activities of several line ministries of the government were also directed toward specifically dealing with the adolescent needs, the authors informed. The HPSP also attempted to address youth needs through the adolescent care area of the RH component of the ESP. It said that BCC messages would be used to reach adolescents. Meanwhile, the draft NPP includes several policies and programmes for addressing the RH and development needs of the adolescents. It promotes RH counselling and services through involving NGOs to delay marriage, prevent underage marriages, postpone first birth by at least two years and have adequate spacing between births. It supports developing employment opportunities for young men and women through setting up credit facilities and vocational training for young people and encourages adolescents to focus on developing skills in information technology (IT).

However, while addressing some of the pertinent issues, those did not deal sufficiently with two areas, the authors argued. Among those, one was involving the adolescents in the development programmes to deal with their needs. For dealing with this unmet need an initiative could be taken to establish elected adolescent community advisory boards in community and the national level, they proposed. Another are not well touched upon was the need for legal measures to protect adolescents. An apparent strategy to deal with the issue and give adolescents protection

against child marriage, harassment, physical abuse, sexual violence and incest is to enforce comprehensive legislation, argued *Dr Ubaidur Rob*.

Maternal Mortality and Morbidity

Although maternal mortality rate (MMR) has decreased considerably from 514 in 1986-90 to 400 in 1998-00, it is still one of the highest in the world. In 2001, approximately half of the mothers did not receive antenatal care and two-thirds of the currently pregnant women did not intend to have assistance during delivery. The data indicate that 60 percent of women have complications during pregnancy, at pregnancy or after delivery. In terms of assistance, 39 percent of women did not seek help for life-threatening complications, while 58 percent did not get help for non-life-threatening concerns.

In terms of policy intervention, the Fifth FYP said that the RH component of the ESP would deal with maternal mortality and morbidity issues including safe pregnancy and abortion. These services would be provided through integrated Family Welfare Centres (FWCs). The HPSP dealt with maternal mortality and morbidity in the RH component of the ESP through supporting safe motherhood, improving maternal nutrition, addressing MR and unsafe abortions. It also discussed setting up some women-friendly hospitals and BCC materials to promote safe motherhood themes and initiated the Bangladesh Integrated Nutrition Project. Meanwhile, the NPP makes the reduction of the MMR a priority policy objective. It indicates that MMR will be decreased by providing quality antenatal delivery and post-natal services, emergency obstetrics care and managing complications arising from unsafe abortions mainly through the RH component of the ESP.

The existing and proposed policies and programmes do not deal adequately with the issue of male cooperation in reducing maternal mortality and morbidity, noted *Dr Rob*, proposing to conduct BCC outreach activities to men in the community and to provide incentives for couples to participate together in safe motherhood activities. Although the HPSP and the draft NPP make prevention of unsafe MR and abortion priorities, these do not emphasise on post-MR or abortion services. This problem could be overcome by training the service providers to provide FP and RH health information or to refer these women to an appropriate facility.

HIV/AIDS and STDs

The reported prevalence rates of HIV/AIDS and STDs in Bangladesh are currently low. But several factors indicate that these could become emerging problems. Data from the third round of national HIV surveillance completed in 2001 reveal that the HIV rate was extremely low among high-risk groups with less than 1.0 percent among sex workers and 1.7 percent among intravenous drug users (IDUs) in the central part of the country. However, Only half of the currently married men and one-third of the currently married women had ever heard of HIV/AIDS, and 89 percent of the ever-married women and 81 percent of the currently married men knew nothing about sexually transmitted infections (STIs). Such ignorance could bring ominous results for Bangladesh, the authors felt.

As for policy supports, the population section of the Fifth FYP did not specifically address HIV/AIDS and STDs, but it was one of the areas covered under the provision of RH services of the ESP. The activities of some of the government ministries addressed HIV/AIDS and STDs more directly. The Ministry of Information planned to broadcast television and radio messages on HIV/AIDS and STDs. The Ministry of Labour and Manpower planned to establish HIV/AIDS surveillance system for individuals returning from overseas workplaces. The HPSP included the prevention and control of HIV/AIDS and STDs as areas within the RH and communicable disease control components of the ESP. It emphasised that women aged 15-49 would be targeted for HIV/AIDS and STDs, but that men would not be. Though there is no mention specifically in the NPP, the policy indicates that services for the prevention of HIV/AIDS, STDs and RTIs will be provided. However, it does reveal that counselling on preventing HIV/AIDS and STDs will be provided to the adolescents through the involvement of the NGOs.

Although a national strategy is being developed to deal with HIV/AIDS and STD, there are several elements missing in the existing and proposed policies, informed the authors. The issue of government and NGO coordination is missing. This concern could, however, be addressed by setting up a national committee to coordinate the GO-NGO programmes to minimise overlapping of services and maximise coverage. Another issue that requires policy attention is the involvement of the male population in the prevention of the diseases. Promoting and introducing RH services and counselling for men at government facilities could ensure this, said *Dr Rob*, adding that a legal measure to protect people with HIV/AIDS or STD against social prejudice is an important concern that needs addressing. One strategy to avoid these problems could be to develop laws that prohibits such discrimination, he argued.

Empowerment of Women

Educational status, employment situation, and women's role in household decision-making are three indicators for assessing the empowerment of women. Among the currently married women in 1999-2000, 46 percent had no education, while only 10 percent had completed primary school. In terms of working status, 77 percent of the ever-married women were not employed and 18 percent worked at full-time jobs. Among the currently employed women, 71 percent earned cash only, while 3.8 percent were not paid. With regard to household decision making, 87 percent of the currently married women made the final judgment on what food to cook, but only 60 percent of these women made the final decision on large or serious household decisions.

The Fifth FYP did not directly address the female empowerment issue in its policies, but several of its multi-sectoral collaborations deal with this important population and development issue. The Ministry of Health and Family Welfare intended to provide health education, vocational training and micro-credit opportunities for women's programmes. Besides, ministries of Social Welfare, Women and Children Affairs and Youth, Sport and Cultural Affairs were going to continue several women's development programmes. The HPSP did not include female empowerment as part of the ESP though it categorised it as a cross-cutting issue. The plan also

revealed that the objectives of the National Policy and Action Plan on women would be used as the basis for monitoring the gender equity interventions. However, the draft NPP makes female empowerment through the creation of income generating opportunities and childcare support systems at workplaces, more male involvement and sharing of responsibility one of its core objectives. It proposes to extend micro-credit and vocational education for women's income generation, set up childcare centres at workplaces for child care support, improve women's institution and focus on eliminating all forms of discrimination, violence and sexual exploitation against women through various ministries of the government.

Despite being addressed in almost all the existing and proposed policies, there are still some significant gaps, argued the authors. For instance, the NPP supports vocational education for creating gainful employment, but it does not deal with developing the general education levels of women. One strategy to redress this could be through establishing night schools for working women, the authors recommended. Another gap is in the area of legal measures for protecting women against child marriage and sexual violence. Here, the authors proposed an anti-discrimination law for women as they become increasingly empowered.

Increasing Urbanisation

In 1974, 8.2 percent of Bangladesh's population (6.27 million) lived in urban areas, and by 2001, it had skyrocketed to 23.4 percent with 21 million individuals. The urban population is projected to grow to 36 percent by 2027, which will be equivalent to approximately 61 million, making this a major policy concern.

The FFYP policies and programmes recommended developing regional cities, but did not provide details about how they should be improved. It also suggested improving employment opportunities to decrease rural-urban migration. The HPSP did not address the urbanisation issue whatsoever. However, the NPP identifies reducing rural-urban migration as one of its key objectives. It aims to decrease urban population explosion through coordination with rural development, industrial location, employment, urban improvement plans, developing rural infrastructure to support the growth of new areas and trying to move influential organisations to emerging areas.

Although some of the discussed policies refer to a multi-sectoral approach for decreasing the trend of urbanisation, the issue of community involvement was left out from those, especially from the NPP. This could be overcome by establishing community advisory committees. Another issue missing in the policies is the provision to offer incentives like decreased land taxes, subsidised loans to start a business locally etc. to those deciding to stay back in their communities. This could also lure people not to opt for rural-urban migration, said the authors.

3.2 Re-thinking Population Policy in Bangladesh

The recently stagnating fertility levels have very succinctly brought to light several challenges facing population policy in particular. This has considerable human and development

consequences, argued *Ms Simeen Mahmud* of Bangladesh Institute of Development Studies (BIDS). In her paper on the above mentioned topic, *Ms Mahmud* noted that the base of the population pyramid has begun to make a welcoming shrink as a result of the rapid decline in the birth rate. But the proportion of persons above 60 years of age is on the rise and the mean age is increasing with the gradual increase in life expectancy. Therefore, addressing the health needs of the elderly poses a formidable policy challenge since the existing programme is almost exclusively geared towards married women of reproductive age.

Macro and Micro Inertia

The more direct concern for population policy is in the fact that the proportion of women in the childbearing ages remains large (women aged 15-44 years was 45 percent in 1995). Thus, even with a growth rate of less than two percent, the size of the population grew by one-third between 1981 and 1995. This built-in growth momentum, termed by an economist as *macro inertia* of population is aggravated by the existing pattern of family building, namely, a very early start at childbearing and relatively short spacing between births, resulting in a very small generation gap. The motivation for changing family building patterns is also constrained by the fact that women, who are the prime users of contraceptive, have little say both in reproductive decision making within the household and in the choice of birth control methods within the programme. Besides, service provision is unresponsive to the needs of women and poor couples. These relate to the *micro inertia* of population. Both these macro and micro inertia lead to weak motivation for further fertility decline and inadequate motivation on the part of poor couples. So, there is an urgent need to reassess the population policy of Bangladesh, argued *Ms Mahmud*.

Besides, women's fertility preferences are mediated by the fact that they are unable to reap the full benefits of the halving of their reproductive burden because they are denied choice and decision making power as regards fertility, health and family planning needs. Therefore, their motivation for further reducing family size depends upon changes in the underlying conditions that determine their relative decision-making power, argued *Ms Mahmud*, adding that requisite changes in the socio-economic environment rather than programme interventions are more important in creating motivation for further decline in family size, both for the couples and the women. Removal of both supply and demand side constrains, extreme contraceptive bias and female bias was seen as a salvaging factor by the author.

Policy Initiatives

In the First Five Year Plan (1973-78), lowering the birth rate was seen as the goal of population policy and contraceptive service delivery through a national family planning programme was seen as the primary means of achieving that goal. Its exclusive thrust was to increase use of modern birth control methods by married women in their childbearing ages through a doorstep delivery service because controlling the population growth was the overriding concern of the government at the time, *Ms Mahmud* informed.

She pointed out that successive FYPs have set narrow time-bound targets to achieve replacement level fertility through progressively higher levels of contraceptive prevalence. The assumption that increasing contraceptive prevalence was the aim of the policy has also caused a contraceptive bias in service provision, even to the extent of marginalising health services required to deal with health needs of contraceptive users.

However, the only genuine attempt to broaden the programme came after the ICPD in 1994 to better reflect the goals of ensuring health and expanding choice in family planning. The process of internalising a broader mandate by the government culminated in 1998 in the Health and Population Sector Programme (HPSP), which incorporated a conceptual shift in approach to service delivery from pure contraceptive delivery to comprehensive reproductive health (RH). Although the stated objectives of the HPSP reflect the government's development goals of poverty alleviation and human development, its performance, argued the author, has been undermined by the inability to reorganise service delivery, which is a broader governance challenge faced by Bangladesh.

The target of attaining replacement level fertility, which implies a CPR of 70-75 percent of eligible couples, can also lead to violation of human rights if poor couples, for whom there are still no adequate institutional support or market substitute for children's old age security and risk insurance value, are under pressure to comply. The over-emphasis on raising the CPR level has allowed the programme to abuse women's liberties through the absence of choice in methods, he noted.

Policy Challenges: Removing Female and Contraceptive Bias

The ultimate goal of any policy is to contribute to the achievement of the broad development objectives. These include: expanding women's choice and decision-making power with respect to both fertility decisions and decisions about their health and family planning needs; being responsive to differential client needs for health and contraceptive services according to age and sex; and mitigating or minimising the costs of reduction in family size preferences and alteration of family building patterns, especially for women and poor households.

Another important implication for policy is that of financial and programme sustainability in a context where further reductions in the birth rate through contraceptive prevalence will be increasingly difficult and more costly to attain, as already evident from the plateauing fertility levels, she maintained. Under the circumstances, the issue of cost reduction through minimising duplication and wastage, and cost-sharing through innovative social insurance schemes must be considered seriously, especially in view of the squeeze on donor funds for population and health.

Attaining the above policy goals, however, require broadening of the programme mandate. Some of the central concerns in these strategies must be to remove the extreme contraceptive delivery bias and inclusion of safeguards to prevent abuse of policy leading to violation of people's right, especially women's liberties. Strategies should also aim at raising the age of marriage, delay the

initiation of childbearing and increase the intervals between births so that gap between generations can be increased significantly, she argued.

In improving the women's status, influencing fertility decisions and societal norms, the programme should therefore link up with other development or market interventions that have proven impact on creating gainful employment for women.

Besides, service provision and motivation will have to focus on how to convert users into efficient users in terms of better birth spacing, fewer unwanted pregnancies and less health problems and on how to elicit a positive role for men in changing family building patterns, *Ms Mahmud* said. Service provision has to make a quantum shift from a monolithic approach exclusively geared to married women of childbearing ages to one that's more fine-tuned to differential health and contraceptive needs according to age and sex. It must be re-organised for guaranteed provision of high quality contraceptive and reproductive health services to an increasingly demanding and differentiated clientele, concluded the author.

3.3 Islamic Republic of Iran's Success Story: Challenges Ahead

There has been phenomenal improvement in the demographic profile of Iran in the recent decades, claimed *Dr Hossein Malek-Afzali*, President, FPA of Iran and Deputy Minister Ministry of Health and Medical Education, Islamic republic of Iran in his presentation.

He said a stark difference is visible in the population statistics of Iran between the pre-revolution and the post-revolution periods. In the 10 years prior to the Islamic revolution (1966-76) in Iran population growth rate was averaged at 2.7 percent with the crude birth rate (CBR) being 39 per 1000 and the crude death rate (CDR) being 12 per 1000. However, said *Dr Afzali*, the demographic profile of the country dipped in the first 10 years following the revolution between 1997 and 1988 due to misinterpretation of Islam by the Islamic clerics. During this period, the average population growth rate touched 3.9 percent with the CBR being 42 and DBR being seven per 1000. But within the next one decade (1989-1996) the country made a remarkable comeback averaging population growth rate at 1.2 percent with a corresponding birth rate of 18 and death rate of six per 1000.

During this phase, Iran crossed the ICPD thresholds in all respects. While ICPD indicators recommended that at least 60 percent deliveries should be attended by trained health personnel, in Iran it is 89.6 percent. The ICPD threshold for CPR is 55 percent, while in Iran it is 73.8 percent. It was recommended that at least 60 per cent of people should have access to basic health services whereas Iran has ensured 90 percent. In case of infant and maternal mortality rates, the ICPD thresholds were 50 per 1000 live births and 100 per 100,000 live births respectively. On both these counts, the figures for Iran are 28 and 37.4 respectively. Meanwhile, the gross female enrolment rate at the primary school level and adult female literacy rates in the ICPD thresholds were 75 percent and 50 percent respectively. In Iran enrolment of female at the primary level is 107.8 percent and for adult female literacy, it is 75.9, said *Dr Afzali* while listing his country's achievements.

He also informed the gathering that medical education in Iran is integrated with service delivery through the Ministry of Health and Medical Education and students have to serve in the rural areas at least twice in the academic career for being certified, which cast positive impacts on Iran's population programmes.

Besides, the essential policy and strategy for development of family planning was approved in 1988, he informed, adding that it emphasised on general education and face-to-face education and placed population planning and FP concerns into development programmes. It also integrated the FP into the primary healthcare system, paid special attention to high-risk couples, used all potential resources from the community and private sector for research to promote management, accessibility and quality of services.

Approval of population control programme in 1988 for the next 20 years till 2008 has already resulted in reining in the population growth rate from 3.2 to 1.2 as of 2001, reduced TFR from 5.4 to 2.0, increased use of modern contraceptive from 27 percent to 44 percent, he claimed, pointing out that all mentioned goals were achieved faster than it was perceived. In 2001, seven years prior to 2008, the CPR in Iran was 73.7 percent and life expectancy for male was 67.8 years and for females it was 70.6 years.

Dr Afzali attributed several reasons for this dramatic success. These included: increasingly flexible role of the religious leaders, government commitment manifest through funding and enacting laws, increased literacy of women, development of the PHC system, integrating FP into MCH programme, assuming FP as a key way to provide mother and child health, compulsory pre-marriage counselling and blood testing for thalesemia, using research methodology to assess programmes, role of women health volunteers, provisioning of free services, training of rural midwives, collaboration with international organisations, etc.

However, he admitted of some lingering problems. There are still some religious and political leaders who are opposed to family planning and deem it a US-doctrined programme. But fortunately, they are small in number and not in power, said *Dr Afzali*. High rate of unwanted pregnancies (25 percent), poor level of service quality, insignificant male participation, demographic impacts vs. health effects (tubectomy of older women) also pose as problems. Besides, national laws are sometimes against ICPD recommendations, media limitation exists in some aspects of RH publicity, poor NGO involvement in RH and FP programmes, no significant participation of the private sector, still-high rate of 15-24 year population, anxiety over increasing STIs and AIDS are some concerns that need to be addressed. Pointing out mobilising the adolescent population and containing violence against women as major challenges, he said, the official number of AIDS patients in Iran is 4,000, but the unofficial estimate would be no less than 20,000.

Iran at the ICPD and ICPD+5 said 'yes' to family planning and 'no' to abortions, informed *Dr Afzali*, mentioning that a recent 'fatwa' or injunction proclaims that 'safe abortions' could be

allowed on special circumstances. But for effectively taking on all the mentioned challenges he stressed on greater advocacy for the clerics to increase social mobilisation geared towards realisation of suitable changes in the policy regime regarding population, development and poverty reduction.

3.4 New Dimensions of the Population and Family Planning Policy in Indonesia

The paper by *Mr Soedibyo Alimoso,* Indonesia presented the population policy under the BKKBN, which is the National Family Planning Coordinating Board of the country. Its activities are supported by its 34,562 field-workers, thousands of volunteers, cadres, community institutions like Village Family Planning Association and acceptor groups. Besides, it also depends on national family data that can be used for family planning and other development programme planning, availability of IEC and advocacy networking to support community participation, successful integration of NGOs, private sector and international support organisations.

The fact that the national family planning programme in Indonesia has been successfully implemented in the last 30 years is well understood from the acceptance of the Small Family Norms by the community, he claimed. Listing the Indonesian success, *Mr Alimoso* said the TFR has declined from 5.6 in 1970 to 2.78 in 1997. In 2000, the TFR has been estimated at 2.4; the CPR has risen from 26 percent of all married couple to 54.7 percent; the infant mortality rate (IMR) declined from 71 per 1000 live births in 1990 to 51 in 1997; maternal mortality rate (MMR) declined from 450 per 100,000 live births to 334 per 100,000 live births in 1997; and annual population growth rate decreased from 1.97 in 1980-90 to 1.49 in 1990-2000.

Briefing on the policy and strategic initiatives, he said, the 1999 National Development Guidelines stated that the National Family Planning Programme as one of the national programmes to improve the quality of the population through birth control, postponement of first marriage and improving family resilience and family welfare.

Besides, the Public Law on Population and Development of Happy and Prosperous Family in 1992 and a government regulation (1994) stressed the implementation of the National Family Planning Programme based on the existing laws, principles of equity, openness, democracy, accountability, shifting paradigm and strategy. Another public law (1999) on regional autonomy provided greater administrative authority to the regions in the use of local resources for development, community participation and equity, paving the way for devolution of power and flexibility in decision-making, he informed.

Moreover, the National Development Programme 2000-04 outlined four main programmes of the BKKBN. These include family empowerment, family planning and reproductive health, adolescent reproductive health, family planning network and institutional development. It was mandated with planning the FP programme, formulating policies on birth control and reducing the IMR, U5MR and MMR, implementing the information system and family welfare through creating a guideline on the development of quality family. The BKKBN, hopes to transfer these

family planning and welfare tasks to the regional government by the end of 2003, informed *Mr Alisomo*.

He, however, acknowledged that the country is still to tame the big population growing at a high rate, persisting high level of IMR and MMR, relatively high level of fertility, low educational level with an unmet demand for human rights, democracy, equity, welfare improvement, inadequate male participation in family planning, low reproductive health knowledge among youth, weak synergic capability among related sectors, diversity of priorities etc.

Integration of services; further decentralisation; development of staff, community workers and managers, partnership among central, regional and international bodies, target segmentation as regards priority attention to poor and marginalised family segments and gender equity are some key strategic challenges ahead of Indonesia, he surmised.

In targeting Quality Families by 2015, the country needs to improve community empowerment, build partnership for self-reliant communities and resilient families, improve FP/RH services, increase promotion and protection for fulfilling reproductive rights, improving female empowerment for ensuring gender equity through FP programme and develop quality human resources, he added, hinting at medium and long term objectives.

3.5 Population Policies and Programmes in India

A nation with significant variation and diversity, India houses 16.87 percent of the global population. This variation is also reflected in her population and demographic trends, said *Dr JVR Prasada Rao*, Secretary, Ministry of Family Welfare, India while making his presentation on the above mentioned topic.

These diversities are explicit as regards the TFR, acceptance of modern contraceptive methods, acceptance of sterilisation, safe delivery, IMR, underage marriage and female education, he pointed out citing statistics.

Within 2.1 TFR range, there are two states with more than 20 million population, while the number of other states and union territories with a population of less than 20 million is six. Within the TFR range of 2.2 to 3.0, there are seven states with more than 20 million population while the number with a population size of less than 20 million is six. With TFR between 3.1 and 4.0, there are four states with more than 20 million population, while those with less than 20 million population is three. Within TFR between 4.1 to 4.6 there are four states with more than 20 million population, while number of states with a population of less than 20 million is one.

As far as contraceptive prevalence by modern methods is concerned Bihar and Uttar Pradesh were the worst performers with 23.3 percent and 21.6 percent respectively, while the high performers were Andhra Pradesh with 58.7 percent, Karnataka with 57.9 percent, Maharashrta with 58.3 percent and Tamil Nadu with 49.9 percent as of 1998-99 statistics.

As regards acceptance of sterilisation by couples exposed to higher order (between three and above births) Bihar was again the worst performer with a total of 14,752 eligible couples, among whom 11,639 are unsterilised. On the contrary, Tamil Nadu was the best performer with 10,807 eligible couples and the rate of sterilisation per 10,000 couples with higher order of birth being 2,882.

Percentage of safe delivery was worst again in Bihar followed by Madhya Pradesh, Orissa and Uttar Pradesh with 19.0 percent, 27.5 percent and 32.7 percent and 20.8 percent respectively. The same were much higher in Tamil Nadu, Maharashtra and Karnataka with 82.4 percent, 61.2 percent and 59.9 percent respectively, according to 1998-99 statistics.

In taming infant mortality, however, Orissa, Madhya Pradesh and Chandigarh were the poor performers with 96, 94 and 89 per 1000 live births respectively in 1997, while the same was 71 in Bihar, 53 in Tamil Nadu and Karnataka and 47 in Maharashtra, informed *Dr Rao*.

As for percentage of marriages below the age of 18, Bihar again was the worst performer with 58.2 percent, closely followed by Rajasthan with 57.1 percent, Karnataka with 35.3 percent and Maharashtra with 30.9 percent. On this count, Uttaranchal and Tamilnadu performed well with 12.4 percent and 19.1 percent. Meanwhile, Orissa had a low percentage of marriage below 18 with 32.2 percent in 1998-99.

In female education for which the Indian standard was 54.16 percent, according to 2001 census, the high performers were Kerala with 87.86 percent, Delhi with 75 percent, Himachal Pradesh with 68.08 percent, Tamilnadu with 64.55 percent, Punjab with 63.55 percent and West Bengal with 60.22 percent. Meanwhile, it was lowest in Bihar with 33.57 percent, Uttar Pradesh with 42.98 percent and Rajasthan with 44.34 percent.

Dr Rao informed that to bridge these yawning gaps and make an effective dent on population management, the Population Policy 2000 has set a number of immediate, medium and long term goals in consistency with the requirement of sustained economic growth, sectoral development and environmental protection. Its immediate objectives include addressing the unmet needs for contraception, healthcare infrastructure, health personnel and aims at providing integrated service delivery for basic reproductive and child health care. Its medium term aim is to achieve a TFR of 2.1 by 2010 through vigorous implementation of inter-sectoral operational strategy, while its long-term objective eyes on achieving population stabilisation by 2045.

Meanwhile, the national socio-demographic goals for 2010 and the goals set for Family Welfare Department aims at addressing the unmet needs for basic reproductive and child health services, supplies and infrastructure. Other goals include: reducing IMR to below 30 per 1000 live births; reducing the MMR to below 100 per 100,000 live births; achieving universal immunisation of children against all vaccine-preventable diseases, attaining 80 percent institutional deliveries by trained personnel; achieving counselling and services for fertility regulation and contraception; integrating Indian System of Medicine (ISM) in the provision of reproductive and child health

services and in reaching out to the households and vigorously promoting the small family norm to achieve replacement levels of fertility.

Besides, goals set for other departments include making school education up to age 14 free and compulsory and reduce dropouts at primary and secondary school levels to below 20 percent for both boys and girls; promoting delayed marriage for girls, *Dr Rao* said.

Issues involving inter-sectoral coordination relates to achieving 100 percent registration of births, deaths, marriage and pregnancy; containing the spread of AIDS RTI and STI through the National AIDS Control Organisation; preventing and controlling communicable diseases; and bringing about convergence in implementation of related social sector programmes so that family welfare becomes a people-centred programme.

Meanwhile, for providing greater regional autonomy, letters addressed to all the states have been sent advising that State Population Policies may be formulated in line with the National Population Policy 2000. Madhya Pradesh, Rajasthan, Uttar Pradesh, Andhra Pradesh, Gujarat, Maharashtra and Tamilnadu have already announced their population policies, while the same is under formulation in Uttaranchal, Orissa, Bihar, Jharkhand, Chattisgarh and Karnataka, he informed.

Dr Rao further informed that India had spent Rs. 18221.6 million (with 4512.4 million on RCH) on Family Welfare Programme in 1997-98 and Rs. 35966.3 million (with 9452.0 million in RCH) in 2001-02.

3.6 New Dimensions in India's Population Policy

In 1951, India's first ever five year plan advocated a reduction in birth rate in order to stabilise population at a level consistent with the needs of the economy. The goal of lowering the birth rate and the measures proposed in the early 1960s to achieve this continued to be the major thrust of population policy in India well into the 1980s, said *Dr Leela Visaria*, population policy specialist from India during her presentation.

However, by the early 1990s, the Indian government recognised that the FP goals were unrealistic. Besides, the target-setting exercise tended to stifle innovation and flexibility at the grassroots level, made problem identification in service delivery difficult and encouraged service providers to inflate or report the use of reversible methods of contraceptives. As a result, service statistics based contraceptive use rate was inconsistent with the observed fertility level.

The 1994 Cairo Conference on Population and Development and the 1995 Beijing Conference on Women, generated additional pressure for changes in the approach of the Indian FP programme. As a signatory of the plan of action of the ICPD, the Ministry of Health and Family Welfare recognised the need for a paradigm shift from the narrow FP oriented focus to meet the entire reproductive and other health needs of women and men, *Dr Visaria* informed.

Less than two years after Cairo, in April 1996, it took a bold step of removing centrally determined contraceptive targets. Instead, local health workers were to be trained and encouraged in assessing the health and contraception needs of the community members and setting their own goals. A manual on community needs assessment was prepared and the health workers were trained to follow the new decentralised approach. However, a few years following the announcement of target-free approach, said *Dr Visaria*, a great deal of scepticism was aired and the new approach was equated with reversing the gains made from increased contraceptive use.

In October 1997, the Indian government, with World Bank and other funding agencies, launched the Reproductive and Child Health (RCH) programme, that entailed not only a change in policy but in the management and implementation as well. The goals of the RCH included removal of all contraceptive targets, phasing out incentive payments to both acceptors and providers of FP, increasing utilisation of existing facilities rather than creating new structures, and tapping the non-governmental sectors to increase access to services. It also emphasised on district-level planning and monitoring to make programmes more responsive to the local needs.

Meanwhile, the NPP-2000 aims at striking a balance between the ultimate goal of stabilising population growth and making reproductive healthcare accessible and affordable to all through empowering women, she informed. It distinguished between immediate, medium and long-term policy objectives. Apart from focusing on the stated objectives of the RCH, it also focused on responsibility of men in family limitation.

She pointed out that the National Population Policy (NPP) 2000 offers health insurance to couples below the poverty line provided they marry after legal age at marriage and accept permanent method of contraception after two children. The goal of population stabilisation is viewed as a long-term one and is linked to socio-economic development such as empowering women with education and employment. Besides, it reiterates the need for state-specific population policies in order to address issues pertinent to a region.

However, people's participation and the need for consulting the community for assessing its FP, RH and other health and development needs are yet to be fully realised, *Dr Visaria* complained. She held the traditional top-down, centrally determined, target-oriented programme implementation responsible for this and proposed that the health workers must be trained in the participatory approach.

The concept of built-in growth momentum is also not fully comprehended by many responsible for family planning programme implementation, she said, adding that the recent history of high fertility in most Indian states has resulted in an uneven young age population distribution. As these young people enter reproductive ages in the coming decades, the absolute number of birth is bound to remain high even if all the couples choose to restrict their fertility to replacement level, she argued.

Besides, the Indian FP programme has paid much more attention to physical infrastructure, personnel and equipment rather than standards of care, *Dr Visaria* alleged, saying that health infrastructure, personnel, integration of service delivery issues can hardly be addressed in the short run. She, however, recommended to continue the debate on incentives and disincentives in the overarching framework of human rights, constitutional rights and access to healthcare services.

3.7 India's Population Explosion – Can it be Regulated?

India's population touched 1 billion in July 2000. Many people share the pessimism that with the population of India steadily growing at around 17 to 18 million annually, there is no apparent solution to it. But few are aware about the fast changing population growth patterns in Kerala, Tamil Nadu, Andhra and Karnataka in the last decade, said *Mr TV Antony*, Member Tamil Nadu State Planning Commission, with optimism while presenting his case.

Pointing out that the success of the mentioned states were worth emulating, he said the NFHS-II report claims that in the six years between the two reports, the number of births per woman has come down to about half a child, which, in national terms, means about four million children less per annum.

The long-term goal that India has set itself to in 1983, was to reach replacement level of fertility by the turn of the century with a CBR of 21/1000 and a CDR of 9/1000. This goal was reached in Kerala in 1988 and Tamil Nadu in 1993. Andhra and West Bengal may be the next states to reach this level, followed by Karnataka, Himachal and Punjab, he informed.

Mr Antony added that with a total population of 200 million, all the southern states, have either reached or are well on their way to reaching the goal of 21/1000. On the other hand, there are states like Bihar, Madhya Pradesh, UP and Rajasthan with CBR uniformly above 30/1000 and a TFR in excess of four. A demographic turnaround is possible and the goal of population stabilisation by 2010 seems very much on the cards through understanding the reasons for the transformation in the southern states, he argued.

Moreover, the convening of a National Commission on Population under the chairmanship of the Prime Minister recently holds much hope for the future of population programmes in India. The committee is to review, monitor and give directions on the implementation of NPP by forging synergy between demographic, educational, environmental and developmental programmes through inter-sectoral coordination. Tackling population problem should concern everybody. All government departments and voluntary organisations combined should launch an attack through a multi-pronged approach led by the top-most political authority of the land, he argued. The examples of China, Tamil Nadu and Andhra are pointers to the fact that when commitment comes from the top, success follows naturally, he added.

In the 1960s and 70s, Tamil Nadu's family planning programmes primarily aimed at persuading more and more people to adopt some forms of contraception and sterilisation in particular.

Voluntary organisations helped in making people aware of the 'small family norm'. Non-official leadership at the Panchayet level often took an active role. The high level of publicity, care and attention resulted in about 22,000 persons getting sterilised in just 40 days, informed *Mr Antony*, adding that the figure for sterilisation shot up from 5,000 in 1970-71 to about 30,000 in 1971-72 through camp technique.

Relating Tamil Nadu's success, he said sterilisation, particularly tubectomy, continues to be the mainstay of its contraceptive programme. One important factor about its contraceptive programme was that while tremendous pressure was exerted on the staff of various departments to achieve 'contraceptive targets', the targets were achieved through a high level of Information Education and Communication (IEC), good service and prompt attention. At least in the 1980s, it can be asserted that there was no direct pressure on people to get sterilised to achieve the 'targets', he claimed.

However, when there was a lot of criticism during 1977-82 about the contraceptive programme all over the country, the sterilisation figures of the state declined to about 150,000 to 200,000 and the CBR which had so far declined, remained level at around 28/1000. When again the sterilisation figures moved to about 500,000 in the mid-1980s and Intra Uterine Device (IUD) figures also reached about 500,000, the CBR fell steeply from 28/1000 to around 21/1000 by the end of the decade. The TFR also fell from 3.3 to 2.2, he said pointing to the state's dependence on permanent contraception.

Another major factor responsible its success in reducing fertility, was its effective and the all-pervasive IEC program, he said, adding that today there is hardly any family that desires to have one or more children, while the third ones are an accident. The main success of the IEC programme was that it was the joint effort not only of the comparatively weak Health Department, but all departments of the government, many voluntary organisations, educational institutes and industrial entities.

Among the real achievements in Tamil Nadu was a rapid fall of the IMR from about 113/1000 to 57/1000 between 1971 and 1991. This was mainly due to intensive training programme for the health staff, a very effective universal immunisation programme and well-monitored field visits to the grassroots.

The almost universal support for the contraceptive acceptance programme and the IEC program deteriorated considerably in the latter half of the 1990s after the advent of 'free target approach'. In 1995-96 contraceptive targets were removed from Tamil Nadu, Kerala and all other states of India. This has been replaced by a system in which many aspects of childcare, nutrition, RTI/STD, AIDS and also contraception were to be addressed. While this programme was intended to improve the quality of health services, what happened in Tamil Nadu was that the FP programme was removed from the centre stage of attention. Ever since 1993-94, the CBR which had till then been on a steady decline, has remained stationery at around 19/1000, with the TFR remaining at around 2.0.

Presently, a lot of attention is again being given to reduce higher order of birth. However, in the last 10 years, children of parity 3 has remained at around the same level. If the parents of these children received the same level of information and services as in the past, unplanned third children could have been halved, argued *Mr Antony*, informing that the IEC wing of the family welfare department of Tamil Nadu has now taken up an active campaign in this regard.

3.7 Discussion

Thinking of Population Growth in Respect of Economic Growth

The designated discussant of the session *Professor Kalinga Tudor Silva* from Sri Lanka started off by thanking the participants for seven interesting presentations from four countries, having both commonality and differences. The commonality is that all are fairly big countries, while the difference is in their varying degrees of demographic and economic transitions. Stating that measures should be taken for solving the regional inequalities, he, however contended that it cannot be achieved under a command policy regime.

These four countries represent different stages of demographic transition with Bangladesh and India in the third phase and Iran and Indonesia in the post-transition phase, he pointed out. The inequality is also reflected in apportioning funds, he said, adding that Indonesia spends five percent of its GDP on health, which may not be possible by many countries.

Bangladesh is a country with rapid economic growth but not an all-too-impressive population control rate. So, we should think about the role of population growth in respect of economic growth, he categorically stressed, laying importance on creating linkages between demographic, social, economic and poverty reduction initiatives.

Also describing the gender issues and youth constituencies, as major areas of challenge, he said managing the adolescent population has become a major policy concern in Iran, especially in light of the growing unemployment, AIDS and other STDs despite strict religious sanctions. In South Asia pre-marital sex is not encouraged but it happens nevertheless, he noted, adding Sri Lanka is also heaving under the pressure of a large adolescent population. Political commitment from the highest level is a must for managing the increasing youth constituency and turning them into productive assets, he concluded.

3.8 Open Floor

Sharing *Professor Silva's* concerns on the future of the youth constituency, *Dr Md A Mahboob* from Bangladesh, said the size of adolescent population is becoming increasingly larger in Bangladesh. Targeted investments should be made for infants, adolescents, curbing maternal mortality and doorstep delivery of services should once again be initiated instead of one-stop delivery, he argued. He also proposed that traditional birth attendants (TBAs) should be placed in every village of Bangladesh as targeted in India. Besides, there are regional variations in population trends in many countries within their own geographical bounds. How we deal with

this variation is an important issue, he said, adding that reaching the hard-to-reach areas with effective programme would be the key to balancing these inequalities.

Professor Mizan, Additional Director General of Health Service, Bangladesh hurled a number of questions at the Iranian minister *Dr Afzali*. He asked since medical services are included in the health education of Iran, how do the medical students contribute to the FP programme and how much time do they devote for advocacy in the rural areas. He also wanted to know whether or not abortions stemming from illicit relationships were illegal in Iran. *Dr Morshed Chowdhury* of Ganoshastthya Kendra, Bangladesh also asked about the qualifications of the TBAs who conduct some 90 percent deliveries in Iran.

Meanwhile, *Professor Ataharul Islam* from Bangladesh, said short, medium and long term plans should be undertaken by creating linkages between demographic and economic transitions for facing future challenges effectively. Stressing the need for political commitment and support as referred to by a number of participants, *Dr Rao* from India agreed that political sensitisation is an absolute necessity. Unless there's political support, no population policy will see the light of success. Andhra Pradesh has been able to see success because of a dynamic and committed Chief Minister, he pointed out.

Answering some of the queries targeted at him, *Dr Afzali*, pointed out that Iran has problems relating to the youth. The adolescents and youths are usually not talked with about matters directly relating to sex and reproductive behaviour mainly due to the prevailing social and religious inhibitions. What clicks in Western societies, does not always go along with the Iranian culture, he said, adding that people aged 14-19 are only given FP counselling under parental guidance. But there is still some resistance, he admitted, saying that there's a need to open up to save the youth and adolescent population from AIDS/HIV pandemics and STDs. He also informed that the medical schools of his country are under the ministry of health and medical students are sent twice in their academic life to the rural areas as managers of the rural health centres and also to conduct research. As for abortions, he said, around 80,000 abortions take place in Iran annually although it is illegal. It happens in the underground, he divulged, saying that efforts are already underway to convince the country's leaders to make it more legal in case of special physical needs. On the issue of safe deliveries and services, *Dr Afzali* said the transportation is good and hospital are available in many areas. As for the qualification of the TBAs, he said rural midwives (over 25 years of age) are trained and educated for six months.

Meanwhile, *Ms Suneeta Mukherjee* of UNFPA, Bangladesh, asked *Dr Rao* from India on the incentives and disincentives in the population policy, claming that though there are some incentives in the population policy of Bangladesh, there are no disincentives as such. She also asked him whether or not there was any distinction between skilled birth attendants and TBAs in India. Besides, *Mr Faruk* from Bangladesh asked *Dr Rao* about the mechanism of handing over programmes to the NGOs. *Dr Vasant Kandhia* also chipped in saying, Indian programme focuses

more on sterilisation. But the youth/adolescent reproductive health is still a big problem. This does not seem to fit in, she insisted.

Also pointing to the participant from Indonesia, she asked how maternal mortality in Indonesia was still so high despite a low TFR level. Reacting to this, *Mr Alimoeso* from Indonesia admitted that it was true that the country has a high MMR. But he informed that to minimise the trend advocacy is now being carried out at the family level and the readiness of the community is also being hyped up to prevent avoidable maternal deaths.

Commenting on the presentation by *Mr TV Antony* of India, *Dr Morshed Chowdhury* of Bangladesh, insisted that political leadership is a greater booster of population programme than medical intervention. To this, *Mr Antony* said he also stated in his presentation that population programme could not be addressed without political will and leadership. It has to be a total package, he reiterated.

Meanwhile, answering the queries aimed at him, *Dr Rao* said there are no disincentives in the National Population Policy of India. There are, however, some disincentives in Rajasthan, Madhya Pradesh and Uttar Pradesh. But these states have asked to remove those. On the issue of TBAs, he said as it is not possible to provide trained nurses in all the villages, his country has opted for TBAs or SBAs in every village, who basically have the same kind of training and expertise. Reacting to another query about the volume of foreign assistance in population management, *Dr Rao* the actual quantum of external funding is increasing, but it is decreasing in proportion to other components. Answering to another concern raised by *Dr Kandhia*, he said sterilisation takes place only by choice and emergency contraceptive pills have now become available to women in India.

3.9 Concluding Words of the Chair

In his brief concluding remarks, *Dr Wasim Zaman* congratulated all for their brilliant papers and inputs. He said an urgency to look at things very closely was visible among the participants in this session. However, he implored them to come down to a micro level in order to deal effectively with the emerging demographic challenges.

Dr Zaman said there are both short term and long term elements of population challenges and concerns. In the short run, he said, while it is a welcome attitude to be concerned about the steep demographic targets and challenges ahead of us, it is important that we do not panic about those. He said the regional exchange through the symposium has laid the framework for sharing the lessons learnt, which would help all the participating countries put the population puzzle together.

IV. SESSION-III

Integrating Population Concerns in the Poverty Reduction Strategy Paper (PRSP) – Chaired by *Mr Badiur Rahman*, Secretary, Planning Division, Government of Bangladesh.

4.1 Containing Population Pressure for Accelerating Poverty Reduction in Bangladesh

The premature plateauing of the TFR in Bangladesh since 1994 will have serious impact on the society as the size of population will continue to increase and is likely to cross the "carrying capacity level" of the economy in the near future. If the size of population continues to expand, the economic, poverty reduction and health delivery efforts of the government will not yield the expected minimum outcomes. This apprehension was aired by *Dr Barkat-e-Khuda*, Associate Director, Policy and Planning, ICDDB; and *Professor Shushil Ranjan Howlader*, Director, Institute of Health Economics, University of Dhaka in their paper on the above mentioned theme.

Besides, the increasing pressure of population seems to be a major reason for the growth rate of the economy remaining low and the absolute poverty remaining considerably high over a long period of time despite huge interventions, the authors observed.

The Government of Bangladesh is currently preparing the PRSP to be incorporated in the next five-year plan. The PRSP should highlight and make provisions to find out the mechanisms through which population pressure adversely affect the pace of development and poverty reduction, needful interventions to break the plateaued TFR, and the extent of resources needed to reduce the TFR to the desired level, they argued.

Successes Overwhelmed by Challenges

Between 1975 and 2000, the CPR increased by about seven times, rising from 7.7 percent in 1975 to 53.8 percent in 2000. Besides, the current average fertility level is three children per woman. Between 1971-75 and 1999-2000, fertility almost halved. Despite some noticeable success over the years in lowering infant mortality, increasing female education and employment, enhancing the CPR and consequently forcing the TFR to decline, the society is riddled by a number of challenges, the authors felt. These mostly relate to the size of the population, the plateauing of TFR at 3.3 despite the steady increase in CPR, the demographic momentum and inequity in CPR between the accessible and the remote areas and also between the poor and non-poor households. Besides, another major FP concern is in the rate of contraceptive dropouts. Some 15-16 percent of the married women have unmet contraceptive needs, they informed.

Alongside population stabilisation interventions, the government has adopted huge measures to rapidly improve the health status of the population and has achieved considerable success in establishing a well-knit infrastructure of health services, declining both infant and maternal mortality, reining in incidence of communicable diseases, improving sanitation and nutritional levels. However, The GOB lacks the means to address all the health needs of its citizens, particularly the poor. Seven diseases account for 75 percent of total DALYs. Communicable diseases now account for about 38 percent of DALYs, while non-communicable diseases are also major causes of death in the country, *Dr Khuda* said. Besides, with demographic transition taking place, diseases patterns of the past are changing. Child nutritional situation has been improving since the mid-1980s, but maternal malnutrition is still quite high in Bangladesh.

On the economic front several positive changes are also visible. Adoption of modern technology in agriculture has increased agro-production and employment, off-farm activities have increased, export of non-traditional items is on the rise, infrastructure developed resulting in a rise in per capita income and economic growth. The per capita income is USD 370. Employment has witnessed noticeable changes with poverty-driven female employment. But there is still high inequality in income distribution as 40 percent of the rural population lives below the poverty line. There are numerous other hurdles the economy has to overcome before effectively taking off towards a self-sustained growth. The increased growth so far noticed was mainly triggered by agricultural and service sector growths. But agriculture depends on the vagaries of nature and undue expansion of the service sector also causes inflation, distortion and inequity. So, industrial expansion should contribute more to economic growth, employment and export if economic development is to be rapid and sustainable.

As for reining in poverty, the adoption of modern technology in agriculture and implementation of micro-credit and other income generating schemes, extreme poverty has declined significantly and absolute poverty has also fallen, but no to a degree that frees the country from a still-high poverty status. Due to regional inequity, some areas and villages have not received the benefits of development and remain disadvantaged. Poverty of the poor households is intensified by the fact that their households have less access to education, health and modern amenities, the authors pointed out. They added that increasing population pressure accentuates poverty mainly in two broad ways: directly, via its effects on per capita income and per capita consumption, and indirectly, by reducing the positive effects of development interventions.

PRSP of Bangladesh: Linking Population Concerns to Poverty Reduction

The PRSP indicates that the government is seriously committed to rapid reduction of poverty. The strategic elements of anti-poverty policies and institutions cover five broad sets of policies like accelerating and expanding the scope for pro-poor economic growth; fostering human development of the poor through education, health, nutrition and social interventions; supporting women advancement and closing of gender gaps in development and influence participatory governance, *Dr Khuda* observed. He added that poverty has to be operationally and uniformly defined in the PRSP. An appropriate mechanism of identification of the poor and the disadvantaged people also need to be devised as increasing population pressure dampens poverty reduction efforts in a resource-constrained economy.

Besides, the section on human development recognises that development of human capital has strong poverty reducing effects in Bangladesh; addressing the pro-poor concerns in health remains an unfinished task; developing a pro-poor agenda within the rubric of a sector-wide approach is the main challenge to the health and population sector. While the section on human development has covered a number of relevant issues, areas such as reproductive health, child health and population pressures have not received due emphasis, maintained the authors.

In breaking the stagnated TFR, increase in the effectiveness of contraception is required through greater use of more effective or longer acting methods. Increased use of effective methods and effective use of all methods, in turn, require increased efficiency of the programme, enhanced quality of care, proper management of side effects. For further increase of CPR through FP programme should be made more extensive, intensified and dynamic through linking it with development and poverty reductions interventions. Above everything, said the authors, the inertia that prevails in the programme at the field level and the lack of sufficient motivation of the field workers must end if the FP programme has to be rejuvenated.

Besides, for effectively combating the onslaught of demographic momentum the age at marriage and first birth should be further increased, FP programme should increasingly attach emphasis on delivering messages about the adverse effects of early marriage and early first birth. Efforts should be made to make aware the adolescents about FP and health issues. Decline in TFR will also further reduce the effect of demographic momentum.

4.2 Population Dynamics, Poverty Trends and Proposed Poverty Reduction Strategy for Sri Lanka

While examining the linkages between poverty and population dynamics in Sri Lanka and assessing its impacts for proposed PRS for Sri Lanka, *Professor Kalinga Tudor Silva*, in his presentation, said as far as demographic and social indicators go Sri Lanka can be considered as a role model for the South Asian countries. However, stating that there is also a downslide to demographic transition when not accompanied by rapid economic growth, he regretted that the country's success in economic growth and poverty reduction is limited and it has so far been unable to cash in on the demographic bonuses.

The Demographic Bonuses

Elaborating on the country's success, he said TFR reduced from 5.0 in 1963 to 2.2 in 2000. MMR declined from 165 per 10,000 live births in 1945 to 2.3 in 1996, while the IMR declined from 140 per 1000 live births in 1945 to 16.3 in 1997 and population growth fell from 2.8 in 1953 to 1.1 in 2001. Such successes were triggered by factors like the central role of welfare state, universal free education and especially increased literacy of women, rising age at marriage, universal free healthcare, high contraceptive prevalence, immunisation coverage, *Professor Silva* explained.

The rate of male literacy rose from 70.1 percent in 1946 to 92.5 percent in 1996, while female literacy which was 43.8 percent in 1946, increased to 87.8 percent in 1996. The rate of life expectancy for males has also risen to 70.7 years in 1996 from 43.9 years in 1946, while that of female life expectancy which was recorded at 41.6 years in 1946, had increased to 75.4 years in 1996. Such gains have created demographic bonuses for the country by attaining replacement level fertility, reduced child dependency ratio and increased share of working age population, he maintained.

Bulging Challenges

However, among the demographic challenges that the island state still have to face, are: raising the population quality, meeting the rising expectations of the bulging youth population, addressing their RH needs and containing political radicalism, increase in the number of the elderly population, addressing war-related complications, dealing with high abortion rates and poverty related issues.

However, describing the war-related predicaments as a major hurdle, he said it has given rise to IDPs, increase in female headed households, injury, disability, loss of property and assets, low school enrolment and possible reversal of some other positive social indicators.

As far as Sri Lanka's economic growth is concerned, the policy environment was state-led from the 1940s. Economic liberalisation started since 1977. But the Sri Lankan economy has been afflicted by slow and inconsistent growth, he further noted.

Vital Policy Linkages

Professor Silva stressed an obvious need for creating a re-linkage between demographic transition (DT) and economic transition (ET) because Sri Lanka has attained DT but not poverty reduction. DT may not necessarily lead to poverty reduction as policies necessary for economic growth may be different from those needed for achieving DT. Meanwhile, the welfare state in a developing country setting can help achieve DT, it can also inhibit growth if pursued without necessary economic reforms, he argued.

Therefore, he informed, poverty reduction strategy in Sri Lanka has been developed through a consultative process since 1999 and it is expected to be finalised in 2002. Though in most parts it is donor-driven, there is considerable local participation. Four key strategies of the PRS are pro-poor growth, reforming social safety nets, empowering the poor and improving governance.

Among the population and RH issues and challenges, some have been addressed and some haven't. But there is no clear effort to integrate demographic transition with economic development, he critically observed.

However, among the issues that have been addressed includes encouraging urbanisation, reducing conflict-related poverty, malnutrition, dual morbidity profile, reining in infectious and non-communicable diseases.

The issues that are still left unaddressed, include poverty of the growing elderly population, finding ways to take advantage of the demographic bonuses, high prevalence of abortions in poor families, creating links between pockets of poverty and pockets of high fertility and implications of the health sector reform, he pointed out.

Pakistan's Policy Paper

With a population of 145 million and adding three million people annually, Pakistan faces formidable challenges in poverty reduction, economic development and growth. This additional

stock of population, especially in the backdrop of low socio-economic indicators is not only an impediment to the development process but it adversely impacts the utilisation of limited resources, said *Mr Amanullah Khan*, Chief of Planning and Development Division, Government of Pakistan.

The government is fully cognisant of the population pressure and realises that sustainable development would make it possible to adjust to the consequences of unacceptable population growth and facilitate demographic transition, he said, adding that it has taken initiatives to create linkages between demographic factors and sustainable development.

In fact, the agreement reached at the ICPD in Cairo in 1994, stressed that early stabilisation of the population would make crucial contributions to the achievement of sustainable development. Nevertheless, widespread poverty, unemployment, malnutrition, illiteracy, low status of women, exposure to environmental risks and limited access to social and health services including FP remains major development challenges for the country, he said.

"There is a vicious cycle at work involving high infant and maternal mortality with high fertility rates among women. As a result, the dependent age structure is very high. Some 42 percent of the population in Pakistan is aged below 15. This increased dependency has led to high unemployment rates," he informed, arguing that there is a need for reducing fertility and infant and maternal mortality to create a positive impact on employment.

Pakistan embarked on a Population Welfare Programme, realising the above inter-linkages between poverty and population, *Mr Khan* observed. The programme is an ongoing social development endeavour designed to serve the twin objectives of creating awareness and behavioural change and overcoming limitations in services. Though it has been able to stem the tide of rapid population growth, its growth continues to be high at 2.1 percent and TFR at 4.6, he noted critically.

Besides, the Pakistan Interim Poverty Reduction Programme (IPRSP), November, 2001 has given due emphasis to population planning in addition to education, health, nutrition etc. under which TFR and growth rate will be monitored every year as poverty reduction strategy.

Briefing on the service delivery infrastructure, he said, the population programme operates through 1,688 Family Welfare Centres, 131 Mobile Service Units and 106 RH Centres both in the urban and rural areas of the country. The 12,000 VBFPWs of the Ministry of Population Welfare and 58,000 Lady Health Workers (LHWs) of the Ministry of Health have been unified as one cadre of 70,000 Family Health Workers (FHWs) and will be made technically at par with each other for the provision PHC/RH services at the grassroots level through a multi-pronged approach, he added.

Besides, focus will be given on creating demand for FP services through inter-personal communication (IPC) and advocacy, informed *Mr Khan*. Frontline workers will be trained in communication and counselling skills with especial reference to IPC. Religious leaders and

traditional healers will also be sensitised through advocacy campaigns for meeting the 38 percent unmet FP needs.

In fact, the Population Policy of Pakistan 2002 has been framed for building a national consensus towards striking a balance between population growth and development. It emphasises on sustained political commitment and mobilisation of broad-based support from various stakeholders for the population issue. The policy sets out a broad framework and provides futuristic vision to achieve the ultimate aim of reducing poverty and raising the quality of life of the common man. As far as population issues are concerned it hopes to create conditions for achieving replacement level fertility followed by population stabilisation. Besides, the seriousness of the Pakistan government is also reflected in its commitment to funds, he pointed out, saying that a total of Rs 49.5 billion has been earmarked for the next 19 years for achieving fertility replacement perceived under the Population Policy by the year 2020.

Its main targets include improvement in the quality of services, expansion of coverage, better management and further strengthening of FP and RH components of the programme through creating greater linkages between population activities and health services as a whole.

4.3 Population and Poverty Alleviation

The pattern of 'demographic transition' that has taken place in Indonesia is not too different from the developed countries. However, the speed was much too faster. Some of the provinces in Indonesia have achieved replacement level fertility in 25 years. This has been possible mainly through transitions in the mortality profiles, health status, the birth rates and the rate of population growth, informed *Mr Imam Haryadi*, Deputy Chairperson, BKKBN, Indonesia, while presenting his country-specific case. The Indonesian population growth rate declined from nearly 2.32 percent during 1971-1980 to around 1.98 percent during 1980-90. It dropped further to 1.35 during 1990-2000 due to rapid fall in the average number of children per mother, he observed, adding that the TFR also declined rapidly and steadily since 1967-70 from 5.605 children per woman to 2.856 in 1994 and 2.788 in 1997.

Meanwhile, the government policy on development is aimed at improving the people's welfare by ensuring availability of adequate food, clothing and housing. Besides, the population and other social development concerns have also been effectively integrated into the policy regime, observed *Mr Haryadi*.

In addition to vigorous FP and health programmes, the improvement in educational status has also contributed greatly to the demographic changes in Indonesia. Better access to education have brought about changes to the labour participation rate over the last two decades, particularly among women, and changes in the age structure of the population.

Besides, the National Family Planning Coordinating Board (BKKBN) works to ensure family empowerment, family planning, reproductive health, creation of FP network and attaining institutional development. The poverty profile of Indonesia shows that poverty has declined from

45 million or 40 percent in 1970 to 37.1 million or 19 percent in 2001. The BKKBN has divided families according to their prosperity status in a bid to create effective links between population and poverty and raise the quality of life of the masses, he said, adding that family segments have been classified as pre-prosperous, prosperous family (stage-I), prosperous family (stage-II) and prosperous family (stage-III) etc.

Moreover, the National Policy on Poverty Alleviation also targets at developing labour intensive industries, increasing access of the poor to public services like health, FP, education, micro-credit and infrastructure. Enabling the poor to voice their needs, strengthening the role of women in decision making, encouraging capital accumulation and investment with local communities, integration with other development programmes, evolving special programmes to address poverty in remote and resource-poor regions, decentralisation, providing social-economic security against shocks like economic downturns, ethnic conflicts and natural disasters are its other aims.

For entrepreneurship development geared towards poverty reduction and provisioning of micro-savings and micro-credits, two very innovative interventions – TAKESRA (savings programme) and KUKESRA (credit programme) – have been instrumental. Besides, KPKU (credit for partnership programme) have also played pivotal role in integrating economic activities with population concerns, informed *Mr Haryadi*.

TAKESRA, which is a group savings scheme with memberships from pre-prosperous families and stage-I prosperous families, had a total balance of Rp. 214.5 billion (around USD 25.2 million) with the involvement of some 11.5 million families as of March, 2002. Meanwhile, KUKESRA, is also a prosperous family loan, which was launched in 1995 aiming at a similar audience. As of March 2002 Rp. 1.7 trillion (around USD 2.2 billion) was disbursed under the project.

4.4 Discussion

All Aspects of Population should Feed into Poverty Reduction

Reproductive health and poverty reduction is a dynamic interaction. Population is very dynamic and all its aspects should feed into poverty reduction, observed *Ms Suneeta Mukherjee*, UNFPA Representative, Bangladesh.

Describing the IPRSP as a search for convergence between the WB-sponsored structural adjustment facility and the IMF-sponsored interventions on macro balance, fiscal monitoring and exchange rate policy, she congratulated Bangladesh for owning the PRSP as it is government-driven with stakeholder participation.

Stating that the UN has always tried to keep the interest of the poor foremost in its agenda, she said, it took the initiative to articulate and adopt globally the Millennium Goals to address the problem of poverty reduction in the context of sustainable development.

Bangladesh's economic history and a number of remarkable success stories provide interesting insights to dealing with some of the income and particularly non-income aspects of poverty, she said, adding that though not publicised or articulated as PRSP, many of its policies and expenditures were directed towards such goals.

Commending the Bangladesh government for drafting an IPRSP with its own resources, she said it is a well-researched evolving document, which has identified seven major targets for tackling poverty.

These include: reducing the number of population below the poverty line by 50 percent, universal primary education for all, eliminating gender disparity in primary and secondary education, reducing infant and under-5 mortality rates by 65 percent and eliminating gender disparity in child mortality, reducing the proportion of malnourished children under-5 by 50 percent and eliminating gender disparity in child malnutrition, reducing maternal mortality rate by 75 percent, and ensuring availability of reproductive services to all women.

"All these targets of the PRSP are common to the millennium goals. The GOB might consider including environmental sustainability as an additional goal of the PRSP," she proposed, articulating the need for greater agreement on desegregated targets and indicators that should be the core of the strategy and guide implementation. Issues like clinical facilities, communication systems, urban poor, attitude of service providers are also important factors to be considered, she observed.

Besides, she argued that RH should be included as a development objective, which has critical linkages with other poverty reduction programmes such as education, micro credit, development of infrastructure etc. These aspects and gender equity issues are integral part of any comprehensive poverty reduction strategy, she said, noting that gender inequality takes place from birth.

However, the greatest challenge is to keep Bangladesh a low-prevalence HIV/AIDS country. Population education programmes have to reach adolescents and youths to contain unwanted pregnancies and rising trends of STD/RTI infections, she stressed, warning that now was the time to act. Because if attainment of replacement fertility is delayed to 2015, the population of Bangladesh will reach 250 million, she added.

New Policies Must for Balancing Population and Poverty Dynamics

Population and poverty concerns are closely interrelated. The nature of rapidly changing population dynamics per se demands new population policies. Meanwhile, the changing demographics under rapid globalisation and the changing face of human deprivation demands serious rethinking about the poverty reduction-related strategies, argued *Professor Abul Barkat* of the Department of Economics, University of Dhaka.

In his discussion, he said, all the three papers presented in this session by participants from Bangladesh, Sri Lanka and Pakistan were of much interest and would be of high utility in designing policies to integrate population in the poverty reduction endeavour.

He said the Bangladesh lesson depicts that accelerated decline in TFR and demographic transition is possible in a low income and relatively low literacy country through vigorous efforts and sustained commitment. He, however, agreed with the authors that the PRSP lack empirical analysis of population and health outcomes. Emphasis on RH, child health and population pressure is inadequate in the draft PRSP and a transition from the PRSP is needed towards preparation of the poverty reduction plan (PRP). But, he added that the proposed PRP should take into full consideration the conceptual linkages between population pressure, poverty and the determinants of poverty as indicated in the paper.

The Sri Lankan achievement, he pointed out, shows that both poverty reduction and demographic transition is possible with sustained efforts directed towards socio-cultural development and women's empowerment through relatively high investment in social sectors like education and health. However, sustaining such achievements is impossible without peace or protracted ethnic unrest, he observed in reference to the war-implications in the country.

As regards the Pakistani experience, he said ups and downs in the investment patterns in population and health might be less productive or even counter-productive at times. The momentum gained through the population programme should be retained and more efforts are required to expedite the process of achieving the replacement level fertility by 2010 instead of the projected 2020 to orchestrate a significant impact on poverty reduction, argued *Professor Barkat*. In this case, Pakistan can profitably use the experiences of Bangladesh and Sri Lanka, he added.

4.6 Open Floor

As soon as the floor was opened for discussion, Professor *Silva* faced a volley of questions from the participants. Deeming the Sri Lankan experience important for Bangladesh, *Professor Ataharul Islam* asked what really contributed to the GDP growth of Sri Lanka during 1990-2000 period. Referring to the East Asian Miracles, he questioned to what extent the Sri Lankan education was flexible to this kind of demographic reality. *Dr M A Masud* from Bangladesh asked whether or not it was an absolute necessity to have an economy in which the GDP growth is three times larger than population growth to sustain economic growth. He also proposed that redesigning respective programmes – strategy-wise as well as coverage-wise – could be the common take off point of the symposium. *Professor Kabir* from Bangladesh also asked if the welfare health system of Sri Lanka could be replicated in Bangladesh.

On the issue of PRSP being donor-driven as raised by *Professor Silva*, *Dr Wasim Zaman* said unless we desegregate and establish the various needful linkages ourselves and address issues like governance and corruption, it will continue to be donor-driven. In respect to the growth

prospects of the region, he said India, Bangladesh, Pakistan and Indonesia is likely to account for 70 percent of the growth in the region. However, stating that numbers are often over-burdening, he said, without dwelling on these hopeful statistics, we should get down to action to manage quality of services imparted to the poor. Quality of life, he said, has to be brought into the equation to curb inequality in population and development initiatives.

Meanwhile, *Mr G Giridhar* from Nepal focused on increased access of the poor to social services. But he noted that separate ministries of the government in respective countries provide these services. Therefore, the achievements are usually disjointed, he said stressing the need for greater synergy. On the options of making a departure from the centralised system of governance and service delivery, he said we should rather decentralise. But at present, we are increasingly depending on non-existent services in the name of decentralisation, he observed.

Dr Vasantha Kandiah stressed that fertility trends among the rural poor women needs to be monitored before coming up with effective strategies. Besides, it also needs to be seen whether or not men and women under the new strategies change their family behaviour.

In another question, *Mr T V Antony* asked *Dr Khuda* what kind of contraception is used in Bangladesh in a bid to break the current plateauing of the TFR. *Ms Priti Dev Sen* from India, said *Dr Barkat-e-Khuda* showed the importance of getting beneath the averages. The paper dealt with the socio-economic context of population policies. However, she strongly felt that in the face of plateauing TFR, the lower income groups must be addressed more vigorously.

Meanwhile, reacting to some questions and observations, *Professor K Tudor Silva* said he was not particularly opposed to donor-driven PRSP. It creates an opportunity to compare experiences, he said, admitting that at times it however tends to be standardised, which is negative. Reacting to another query, he insisted that the Sri Lankan situation was beset with opportunities and challenges. In the post-transition stage, Sri Lanka is still riddled with many economic challenges as the growth of the young population is rising, he said. *Professor Silva* also clarified that he never presented Sri Lanka as a model to be replicated elsewhere. As for the GDP growth trends in the 1990s, he said during that time it was inconsistent with regard to the components of growth. The main component was the service sector, he said.

In response to a question from *Dr Leela Visaria*, *Mr Amanullah Khan* from Pakistan informed that Pakistan has taken a number of steps integrating populations concerns in poverty reduction, gender and development. About women's rights and development, he said, a women's nutritional package has been launched recently among girls over 15 years. The help of the micro-financial institutes, said *Mr Khan*, also addresses gender and poverty issues.

Meanwhile, replying to a query, *Dr Barkat-e-Khuda* said the most plausible way to integrate poverty in population growth was through discussing the supply and demand issues. In another reply, he said the contraceptive method mix has been very inconsistent in Bangladesh.

4.7 Concluding Words of the Chair

In his concluding remarks, the chairperson of the session *Mr Badiur Rahman* said for far too long we have been dealing with strategies. He surmised that development strategies are still inadequate to take care of the entire population and development dynamics. He attributed the policy failures to the often unhealthy and unwelcome penchant for looking at people as "objects" rather than "subjects" of development initiatives. Lack of mass participation is the major inadequacy of our development strategy so far, he critically observed.

Strategies, projects, programmes and agencies without mass participation cannot salvage us from the from the problems we're in, he insisted, recommending to initiative a search for a convergence, where all the strategic aspects of the population and development paradigm would be dealt with holistically.

In this connection, he said the government is now reviewing the HPSP as it is not a cultured element and its project designs were wrong. Also coming down heavily on the donor agencies, he said it is understandable that the disjointed manners in which we have so far steered our development plans and projects have yielded little results. If the government is perennially foot-dragging, slow and inadequate in its efforts, what has happened to our development partners in filling up the missing link, he asked. They also failed in capturing this inadequacy, he insisted, adding that unless this missing link is filled up, it will take one five-year plan after another to attain a convergence as far policies and their practicality of implementation are concerned.

He said a good deal of lessons were learnt during the session. Though sharing of experience helps in ways more than one, in the long run, he said, we have to evolve our own country-specific programmes through indigenous ways and assessing indigenous needs.

V. SESSION-IV

Wrap-up session: Chaired by *Dr Wasim Zaman* and co-chaired by *Ms Suneeta Mukherjee*.

5.1 Outcome of the Symposium and Discussions: Networking and Follow up

Wrapping up the entire discourse of the symposium, *Ms Janet E Jackson*, Deputy Representative, UNFPA, Bangladesh, reminded at the very outset that it would be very easy to over-simplify a lot of the detail and the complex issues that have been presented. Nevertheless for the purpose of policy dialogue, main challenges emerging from the two days may be summarised as below.

Learning from East, West and South Asia

As far as policies are concerned, it is now time to decide whether we dispense with targeting or whether we redefine targeting in a different way. More importantly, the discussion in the last two days has helped us to begin to think in terms of the macro and micro relationships. Often one goes on without necessarily being linked to the other. It would help to bear in mind the interrelationships between the two. Besides, much could be learnt in respect of institutional,

operational, management development and delivery mechanisms through exchanges and comparing notes.

The symposium has also given valuable insights into how the demographic bonus could be optimised at the national and the individual levels. On the macro-micro interface of policy, macro trends conceal large number of specificities and regional variations that need to be addressed. Therefore, it is important to take into account issues related to rural-urban differences, geographical differences, income distribution in respect of equity and rights, presence of infrastructure and how developed different areas are.

Addressing Specificity

One of the big areas where more discussions should follow is in local government involvement, including also the local involvement of the people, the extent to which the poor people of a country are the 'subjects' of the I-PRSP and to what extent they are 'objects', as had been poignantly pointed by speakers of Bangladesh and elsewhere. The local involvement of people in terms of macro and micro level planning is very pertinent to this discussion.

However, decentralisation and devolution have different implications in different countries. For instance in Indonesia, there is a centralised policy, but this can basically be abrogated through a devolution process. On the other hand, in India, there is an over-arching central policy that is often interpreted, revised at the local level rather than being substituted. Added to this, better governance, through efficient management and control over resources, curbing corruption, and improving accountability, would go a long way to achieving the policy objectives.

Increasing autonomy in adapting policy to local needs, controlling budgets and resources for local needs within the context of a national policy vision and commitment is of paramount importance. This is the point where targeting would come in, and make links to contributing at the national or even the global level, for example through the millennium development goals. However, nationally agreed targets would have to be interpreted at the local level. This would not necessarily be in numerical and quantitative terms, but in terms of looking at special needs among special groups and in terms of the ways in which the local level was going to make a contribution to the achievement of the national level targets.

Avoidable Problems

Over the last two days, the warning was given that countries should not run into avoidable problems. For example, the deliberation from Iran clearly pointed out that, had there been a lot more discussion and forward thinking, the country could have avoided or been better able to address the pressure of a higher than projected population and the consequence this has had in certain areas, for example, unemployment.

Further, careful review of budgetary expenditures in the education and other social sectors in addition to health in the PRSP is also needed. Iran was able to achieve tremendous progress in a very short period largely because it made a significant contributions (5.0 percent) to heath itself.

In Bangladesh it is less than 1.0 percent of GDP. This is expected over the next five years to go marginally above 1.0 percent, while in education and health combined it is barely over 2.0 percent and will increase by about 0.5% in the medium term.

It was pointed out how improper allocations can also lead a country into problems. The need was highlighted, for example, for greater allocation to education if the quality of literacy was to be achieved in countries like Bangladesh. For this to happen, a substantial allocation to education would be needed and reflected more strongly in an I-PRSP. But it is doubtful if the increase as it stands would be sufficient for what is envisaged in the stated timeframe, especially in making any substantial dent in improving the quality of education at both the primary and secondary levels. However, when the budgetary allocations on education and literacy in the I-PRSP are finally set, there needs to be emphasis on monitoring how these get distributed within the sector. A forum like this therefore helps remind us of the need to bring in a lot more disciplines around the table to discuss and look at the problems in their entirety and across sectors. This helps in seeing how the allocations that are made nationally are being apportioned locally for greater social impact. It also helps to consider where shifts need to be made. This approach would help to better address collectively social issues that are of national concern, for example the challenges of contraceptive mix and choices, high and leveling TFR, as well as and other social development issues that have direct relevance to population growth and sustainable development.

Besides management, issues such as inappropriate approaches and the inability to give the local level the required flexibility, need to be addressed also, especially if we are to meet the specific needs of different groups in the population. The service accessibility problems posed by an infrastructure that is inadequate to meet the needs of those in the hard-to-reach areas, need to be overcome. Insufficient institutional capacity has often been cited as another nagging problem that lands many countries into avoidable situations. In most countries under discussion, much of the system weakness lies in a general lack of the specialised skills and disciplines that are needed for overall institutional efficiency.

Exploiting Demographic Bonuses

There is an urgent need to examine to what extent the demographic bonus in the South Asian context can be used for accelerating economic growth and national wealth at both the national and the individual levels. In order for this to happen, there needs again to be more dialogue between planning, financing, labour, employment and other development sectors. The problem cannot be viewed only from context of health and education. In Sri Lanka, the reduction of population growth hasn't necessarily been commensurate with the level of economic growth. But then again, the planning timeframe of 3-5 year was a short one. Meanwhile, Pakistan, which has been witnessing an increasing level of poverty has set a 10-year timeframe. In Indonesia, there was a 15-20 year timeframe. A longer time and planning framework is necessary to engage meaningfully with other relevant sectors to achieve defined national goals.

Lowering dependency via employment creation in the medium term is one way of averting the long-term costs of unemployment and capitalising on the demographic bonuses. But in building

human capital via education, it should not be just education *per se*, the emphasis should also be on the quality of education, and preparing and equipping the young generation to meet the nation's future challenges. While, as has been emphasised from the Bangladesh experience, primary education is crucial, the quality secondary education also must be stressed more. Not only will this affect future career opportunities, it is also critical to reversing the trend of early marriage, thereby delaying the first birth and reducing teenage parenthood.

On the social development side, large adolescent populations need access to programmes tailored to their realities. And this must happen in culturally sensitive ways, which address RH, sexual health and HIV prevention. This group of the population is about to step into employment age. This potential should be harnessed to help create lasting wealth for the nation's future prosperity and security, as has been experienced in some of the East Asian countries.

Beyond Policy Commitment

The biggest irony is that people want smaller families, and we are also promoting smaller families - we want the same thing, but it's not happening. National objectives are not therefore in contradiction with the wishes of the individual. Somehow, there seems to be a mismatch in the way we are all going about it, and this probably needs to be thought out carefully at the planning level as far as medium and long-term initiatives are concerned.

Policies therefore need to be effective at both the macro/national level and at the micro/local level. India's experience has shown that the challenge is actually to take these on. Policies should lead to programmes that cater for the special or specific needs of different local communities.

The Delivery System

Essentially there are strong delivery infrastructures in most countries under discussion, and these are largely accessible, though not sufficiently used. So, there's a need to change the way in which the system works, rather than changing the delivery system itself. It needs to be more effective, getting the right balance between the demand and the supply sides of service delivery. The challenge of sequencing and balancing the supply and demand and the role of private sector, NGOs has to be met. Bangladesh, at the moment, wants to find ways in which this can be achieved. In India, some Indian states are sub-contracting services by involving the private sector, as part of an effort to better manage health care. Managing resources has to be on the basis of allocative efficiency. This has to be done being mindful also of the socio-cultural dimensions. Iran is a positive example of how this can be done, taking account of the socio-economic aspects, women's status, demand creation, communication, advocacy and the role of religious leaders. Also, within the context of FP and RH, the whole question of contraceptive mix must be addressed on the basis of free and informed choice of the individual.

More than Health

Demographic transition must be linked to economic transition and be integrated into the different streams of policy and strategic discussions and the programmes for different key sectors. Individual countries, as well as the region, also benefit from a forum that can bring together the

different streams of discussion on the various issues on population challenges. This can be preferable to holding parallel discussions, where the linkages between the sectors are less likely to be established. Ultimately challenges like the plateauing of TFR, will best be met through multi-sectoral and co-ordinated responses.

Bridging Knowledge and Communication Gaps

Stressing the need for continuing dialogues, it has been emphasised how learning must take root rather than planted only. These types of dialogues need also bring together policy makers, researchers, programme managers, using downstream actors for creating new knowledge and demonstrating how this can be used. This then would benefit both upstream and downstream players.

Thinking Globally and Acting Locally

Subscribing to national targets can happen through local level initiatives and the targeting of particular groups (e.g. the pregnant women, the young, the elderly) and geographical populations like the aged and the young are important. Balancing top-down with bottom-up approaches is therefore necessary. Besides, long-term plans must be supported by middle course corrections and short-term interventions, that are flexible and innovative. It was also reiterated that changing policies does not mean a change in the system set up. But, for better impact, it may mean a change in how implementation is done and in how programmes are managed.

Conclusion

In conclusion, there has been an emphasis on expressing the immediate urgency to maximise the potential opportunities of demographic bonuses in the region. The integration of population factors into sectoral planning is an unfinished, and in some cases not even begun, agenda. Meanwhile, decentralisation and devolution have proved to be preconditions for effective planning and implementation, as well as the ability to tackle regional variations and address special population needs. Finally, dialogue on population challenges needs to come at all levels (international, South Asia, national, district and grassroots levels).

However, the case of Sri Lanka rings a resounding warning bell in as much as the demographic change should not be considered irreversible. It can only be sustained with the right kind of socio-economic policies and multi-sectoral commitment being in place – A focus on economic growth alone will not necessarily achieve this.

4.6 Concluding Words of the Chair

Chairperson of the session *Dr Wasim Zaman* said since the symposium is a learning experience for all the participants, it does not necessarily aim at coming up with a very big blueprint on the future courses of action. Rather, he said, it is expected that from now on these countries will think together in facing the population and development challenges. As for Bangladesh, he assured that it has always been an open society, which is quite receptive of foreign ideas and experiences.

However, Dr Zaman categorically pointed out that there's an awful lot of complexities in trying to deal with the entire gamut of population and development in the 21st century. Therefore, he suggested that the participating countries should try and take advantages from the linkages through finding out commonality and differences among them. We should take advantage of working together. Bangladesh would always welcome sharing of experiences in removing these complexities, he reiterated.

Referring to the invitation of the Iranian Deputy Minister *Dr Afzali* for holding this symposium in Iran, *Dr Zaman* said such invitations are welcome, but before that the agenda for the current year should be progressed.

We need a more concrete framework for bringing these demographic and development connections together and also ensuring connections amongst ourselves, he observed, noting that there is absence of significant connections in order to reap the cumulative effects of the various policy making and thinking exercises for ensuring population and demographic goals.

Thanking all for their presence and sharing of valuable experiences, he pleaded that nothing mechanical or rhetorical should come up from this exercise. Only the connections and linkages that add value to addressing the population and development concerns and actions should feature here. He also urged the participants to use the UNFPA as a platform for achieving this.

He also thanked *Ms Janet Jackson* and *Ms Suneeta Mukherjee* for their contribution to the symposium. He thanked *Dr Debapriya Bhattacharya* of the Centre for Policy Dialogue (CPD) for providing the technical inputs of the symposium and commended both local and foreign participants for enlivening the symposium with their lively presentations and thoughtful insights.

List of Participants
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3.	*Dr Jahir Uddin Ahmed*	Director (MCH Services) & Line Director (ESP-RH), GOB
4.	*Mr Md Akhtaruzzaman*	Director (Admn) Directorate of Family Planning, GOB
5.	*Mr Ahsanul Alam*	NIPORT
6.	*Mr Tofayel Ahmed*	Programme Manager, UMIS
7.	*Dr M Alauddin*	Country Representative, Pathfinder International
8.	*Mr Faruque Ahmed*	Director, HNP, BRAC
9.	*Mr Jalaluddin Ahmed*	Director, South-South Centre Bangladesh
10.	*Mr Iftekhar Ahmed*	Research Associate, CPD
11.	*Mr M Syeed Ahamed*	Research Associate, CPD
12.	*Mr Soedibyo Alimoeso*	Director, Bureau of Organisation, Law and Work Procedure, Indonesia
13.	*Mr T V Antony*	Former Chief Secretary Tamil Nadu, India
14.	*Dr Hossein Malek Afzali*	President, Association of Iran and Deputy Minister for Research & Technology, Iran
15.	*Dr Suniti Acharya*	Representative, WHO, Dhaka
16.	*Ms Tahera Ahmed*	Assistant Representative UNFPA, Dhaka
17.	*Ms Halima Begum*	Research Associate, CPD
18.	*Mr Md Abu Sayed Badal*	Chairman, Damodor

		Union Parishad, Khulna
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22.	*Professor Abul Barakat*	Director, HDRC
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24.	*Dr Morshed Chowdhury*	Director, Gonoshasthya Kendra
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30.	*Professor Sushil Ranjan Howlader*	Director, Institute of Health Economics
31.	*Mr Imam Haryadi*	Deputy Chairperson BKKBN, Indonesia
32.	*Dr M Akram Hussain*	CIDA, Canadian High Commission Dhaka
33.	*Professor M Ataharul Islam*	Statistics Department, University of Dhaka
34.	*Professor M Mazharul Islam*	Department of Statistics University of Dhaka
35.	*Ms Janet E Jackson*	Deputy Representative UNFPA

36.	*Mr A R Khan*	Director General NIPORT
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67.	*Mr Neil Squires*	Senior Health Adviser, DFID British High Commission
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69.	*Ms Leela Vlsaria*	India
70.	*Professor Nashid Kamal Waiz*	Head, Population-Environment, Independent University, Dhaka
71.	*Mr Wahiduzzaman*	Joint Secretary, Ministry of Health and Family Welfare, GOB
72.	*Dr Wasim Zaman*	Director, UNFPA, CST Nepal

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1.	*Mr Nurul Alam*	Staff Reporter, The Daily Inqilab
2.	*Mr Enamul A Chowdhury*	Correspondent, The Reuters
3.	*Mr Mujtahid Faruqui*	The Daily Jugantor
4.	*Mr Sarder Zobayar Hossain*	The Daily Ittefaq
5.	*Mr Md Aish Uddin Hossain*	Assistant Editor, The Daily Somachar
6.	*Mr Sadrul Hasan*	Staff Reporter, The Daily News Today
7.	*Mr Naimul Huq*	Senior Reporter, The Daily Star
8.	*Mr M Zohurul Islam*	Senior Staff Reporter, The Observer House
9.	*Mr Golam Kibria*	Staff Reporter, The Prothom Alo
10.	*Mr Hamim Ul Kabir*	Staff Reporter, The Daily Shangram
11.	*Mr M Shafiqul Karim*	BSS
12.	*Mr Ali Masood*	The Daily Dinkal
13.	*Mr Mosaddeq Al Mahmood*	Special Correspondent, The ATN Bangla
14.	*Mr Alam Raihan*	The Banglabazar Patrika
15.	*Mr Abdur Rahman*	The Daily Independent
16.	*Ms Sharmeen Rumey*	Channel I
17.	*Mr S M Selim Reja*	The Ain Pakkha
18.	*Mr Sohel Rahman*	Staff Reporter, The Dainik Arthaneeti
19.	*Mr Shahed Siddiquee*	The Daily Bhorer Kagoj
20.	*Mr S Sarker*	The Daily Ajker Prottasha
21.	*Mr Mukul Talukder*	The Daily Manobjamin