Re-thinking Population Policy in Bangladesh

1. Introduction

Population trends in Bangladesh, which can be traced from the beginning of this century due to the availability of population censuses conducted by the British, show that at present Bangladesh is well into the third phase of demographic transition, having shifted from a high mortality-high fertility regime to a low mortality-low fertility one. The transition in Bangladesh is quite unique because it departs from the classic pattern predicted by the theory in a number of important ways. First, significant change in demographic behaviour took place almost in the absence of concurrent improvement in income levels and standards of living. Second, the movement through the entire trajectory of the three phases was much more rapid than observed historically. The uniqueness of the demographic transition in Bangladesh is evident from the fact that while low income country populations world wide grew at the average annual (exponential) rate of 2.1 per cent between 1990 and 1997, the population of Bangladesh grew only at the rate of 1.6 per cent.

The rapidity of fertility decline has earned Bangladesh a 'demographic bonus', and as a result Bangladesh today can claim one of the highest growth rates in per capita income level among the low-income countries of the world. Moreover, containing the size of the population has meant that, even with limited domestic resources and dwindling foreign aid, fiscal adjustment as part of economic reforms did not compel government to squeeze the budgetary share of the social sectors, namely health, education and targeted food distribution. Thus, aggregate gains from reduced population growth are genuine enough, although continuing widespread poverty and poor living standards coupled with the low level of aggregate economic development has prevented the gains from the "demographic bonus" from being equitably distributed. Poor people particularly lose out since they are neither able to take full advantage of smaller completed families, because of inability to invest in children, nor able to compensate for the reduction in children's contributions to their present and future consumption because of the absence of well developed markets and institutions that provide security in old age and risk insurance against income erosion. This is, of course, a part of the general development challenges facing Bangladesh.

Recently stagnating fertility levels have very succinctly brought to light several challenges facing population policy in particular, but that have considerable human and development consequences as well. A direct consequence of demographic transition is the effect on the age composition of the population. The base of the population pyramid has begun to shrink as a result of the rapid decline in the birth rate, which is welcome, while the proportion of persons above age 60 is on the rise and the mean age is increasing with the gradual increase in life expectancy. To the extent that the health needs of the elderly should be addressed by population policy, this poses a challenge since existing programme is almost exclusively geared towards married women of reproductive age.

The more direct concern for population policy is the fact that the proportion of women in the childbearing ages remains large (the proportion of women aged 15 - 44 years was 45% in 1995), a legacy of high fertility levels in the recent past, ensuring a substantial annual incremental increase in population for a considerable number of years to come. Thus, even with a growth rate of less than 2 per cent the size of the population grew by one third between 1981 and 1995. This built in growth momentum, termed by an economist the "macro inertia" of population (Ray, 2000), is aggravated by the existing pattern of family building, namely a very early start to childbearing and relatively short spacing between subsequent births, which results in a very small generational gap. However, the motivation for changing family building patterns is constrained by the fact that women, who are the primary users of contraceptives, have very little say both in reproductive decision making within the household and in the choice of birth control method within the programme and by the fact that service provision is unresponsive to the differential needs of women.

The other challenges facing policy is a direct consequence of the inadequacy of policy and programme to address fertility preferences of women and couples that keep fertility levels from declining further, termed the "micro inertia" of population (Ray 2000). For couples family size desires are translated into demand for birth control subject to mediation by societal norms and perceptions about the changing economics of childbearing, or trade-offs between the costs and benefits of children to parents. Hence, the motivation of couples for further reducing family size is more and more contingent upon changes in the underlying socio-economic environment that generates the demand for children. Women's fertility preferences, on the other hand, 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 in fertility decisions and with respect to their health and family planning needs. Hence, their motivation for further reducing family size depends upon changes in the underlying conditions that determine their relative decision making power. In short, requisite changes in the socio-economic environment rather than programme interventions are more influential in mobilising motivation for further decline in family size, both from the perspective of poor couples and from the perspective of women.

If the goals of population policy are to contribute to achieving the broader development goals of government then it is time to re-assess population policy and programme strategy in the light of the above challenges. A useful starting point for this re-thinking exercise is to review past rationale for population policy making in Bangladesh.

2. The Rationale for Population Policy in the Past

Population Policy in Bangladesh was first articulated after the war of independence, when the economic imperative facing the government of containing population growth was paramount. In fact the First Five Year Plan (1973-78) declared that "no civilised measure would be too drastic to keep the population of Bangladesh on the smaller side of 15

crores for the sheer ecological viability of the nation" (Government of Bangladesh 1973, pp 538). 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. The exclusive thrust of the programme was to increase the use of modern birth control methods by married women in their childbearing ages through a doorstep delivery service. There was also a motivational campaign to promote the two-child norm and legitimise the use of modern methods of contraception.

When the Bangladesh population policy was first unveiled in 1973 demographers found the logic of the programme to be faulty and seriously questioned the likelihood of success in controlling population growth, the overriding concern of the government at the time (Demeny, 1975; Sirageldin et al 1975). Although it was conceded that a lowering of the price of birth control would elicit some new demand for birth control, the evidence supporting the existence of significant effective demand for modern contraceptive services was not believed to be sufficient to justify "building up a large-scale subsidised service-delivery system anticipating a yet to be proven demand" (Demeny 1975, pp 310). The very supply of service delivery and implementation of the programme, depending as it was on an unwieldy and centralised bureaucracy and an army of workers spread over the entire nation, was seen as a "Herculean" task. And the motivational efforts to generate demand were thought extremely unlikely to change fertility behaviour in a context where high fertility was the best response individual couples made in adjusting to their own environment. It was concluded that the "real bottleneck is the generation of demand" and that there would have to be "serious efforts that go beyond family planning" (Sirageldin et al 1975, pp 24). In short, the basic premise for the extreme skepticism was that change in fertility behaviour could only be induced through change in the socio-economic conditions which generated the demand for large families, or in other words, the belief that "Development was the best contraceptive".

Much to everyone's surprise and delight, fertility levels started to decline from 1975, slowly at first but with increased momentum after the mid 1980s. Fertility preferences also exhibited a concomitant trend towards smaller desired families, and at present the vast majority of currently married women want either to delay their births or limit childbearing completely, vouching for the huge present demand for birth control. Unfortunately, however, there appears to be a plateauing of the fertility level and further increase in contraceptive prevalence has not been translated into expected reductions in the birth rate.

In trying to understand the phenomenon of rapid increase in the demand for birth control demographers now presented a completely opposite explanation. The argument put forward was that the availability of family planning services in a fairly widespread manner from the mid1970s led to the rapid uptake of modern birth control techniques and caused the subsequent fertility decline because of the existence of a large "latent demand" for birth control. The thesis of the "sociology of supply" was invoked as the explanation for the entire decline in fertility levels, which viewed the supply of contraceptive services as the main factor responsible for creating the demand for modern birth control and the driving

force behind the change in reproductive behaviour, almost precluding any demand side explanations (Cleland et al 1994). An explanation which supported the viewpoint was that "Contraceptives were the best contraceptives".

Both of these views about the generation of effective demand for birth control in Bangladesh are only partial, and the most plausible explanation is that removal of both demand and supply side constraints has been important. There is no doubt that the programme, with its single-minded focus on contraceptive delivery, was able to legitimise the use of modern birth control methods and lower the average cost of contraception. Hence, it was able to satisfy the small unmet need for family planning that KAP surveys showed existed in Bangladesh even prior to the initiation of the family planning programme in 1975. However, the claim that there was a significant latent demand for birth control because of excess or "surplus" childbearing is not supported by evidence. During the late 1960s and early 1970s the total expected demand was certainly not large enough to lead to a CPR of 25 per cent of fertile couples by 1970, which was thought at the time to be necessary to reduce the birth rate from 50 per cent to 40 per cent. An analysis of future intentions to use birth control methods estimated that only 15 per cent of ever married women under 40 in rural areas (21% in urban areas) had any intention of using birth control (Sirageldin et al 1975). This can at best give an upper limit to aggregate unmet or "latent" demand, which was responsible for the slow increase in CPR up to the early 1980s but cannot suffice as an explanation for the rapid increase in CPR after the mid 1980s.

Indeed, there are convincing arguments supporting the view that a demand for smaller families was generated by change in the socio-economic environment, and this led to the emergence of differential motivations to limit family size according to socio-economic class (For a very comprehensive discussion see Kabeer, 1994). The significant role of children in household consumption and income earning at different stages of the household life-cycle showed that both children's costs to households and their security and risk insurance benefits, which are not restricted to old age alone, varied by socio-economic class (Kabeer 1994). Fertility levels (TFR) were higher among the poorest and the wealthiest households and lower in the middle class categories. Besides, the positive association between fertility preference (ideal family size) and contraceptive use, regardless of socio-economic status, supported the view that the demand for children plays an important role in generating demand for birth control and not vice versa.

As a response to this argument there was a half-hearted attempt at a multisectoral approach for demand generation, but not surprisingly this had negligible impact. In addition, since the mid 1980s maternal and child health services were included under the purview of family planning services, but this strategy was largely adopted to broaden the clientele for the delivery of contraceptive services by increasing mothers' incentives to attend clinics. The only genuine attempt to broaden programme strategy 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 government culminated in 1998 in the Health and Population Sector Programme, which incorporated a conceptual shift in

approach to service delivery from pure contraceptive delivery to comprehensive reproductive health.

However, the translation of this broader programme mandate at the ground level is yet to be realised and the programme has run into administrative and financial difficulties. The financing of the reproductive health agenda was not fully comprehended and the relatively greater shift in government expenditure to the health sector that a sector wide programme demanded has, quite predictably, not happened (Mahmud and Mahmud, 2000). Although the stated goals of the HPSP reflect the government's development goals of poverty alleviation and human development, its performance has been undermined by the inability to reorganise service delivery, a consequence no doubt of the broader governance challenge facing Bangladesh.

3. The Need to Distinguish between Ends and Means

The general understanding that emerges from the review of past policy rationale and the new challenges facing policy is that old ways of thinking and doing are neither valid nor even justified. The first step in this process of re-thinking is to distinguish between the ends and means of population policy in Bangladesh. If the ultimate intention of population policy has been to contribute to aggregate human development and enhancing people's well-being, this is hardly common knowledge remaining implicit within plan and policy documents, with the danger that eventually the means become ends. For example, successive five year plans have set narrow time-bound targets to achieve replacement-level fertility through progressively higher levels of contraceptive prevalence. Even when the broader goal of policy is articulated, such as in the health and population sector strategy which states that the programme will "provide adequate basic health care to the people and slow population growth" and that "health care services should be responsive to clients' needs, especially those of children and women and the poor, and achieve quality of care with adequate delivery capacity and financial sustainability" (Government of Bangladesh 1997), the belief remains strong that programme effectiveness (i.e. achieving a lower and lower CPR) is maximised if contraceptive delivery services are totally segregated from health services (Mahmud and Mahmud, 2000).

The inability of the programme to distinguish between ends and means has limited programme diversity and flexibility and has been extremely restrictive with regard to the structure of service delivery. It is not surprising that the structure believed to be most likely to succeed in contraceptive delivery to a vast population was the "centralised top-down bureaucracy for essentially transferring contraceptive technology" (Demeny 1975). The assumption that increasing contraceptive prevalence was the aim of 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. It has also created resistance against attempts to broaden programme mandate on the grounds that this would undermine the "success" attained in raising the CPR. Increasing access to contraceptives does, of course, reduce psychic costs of modern contraceptives for those with an existing unmet need for birth control, but is hardly likely to alter the motivation of the average couple.

The interpretation of means as ends lends itself more easily to errors of choice and abuse of policy, and even encourages violation of liberties and freedoms in the form of over ambitious targets, restrictions on choice of birth control method and unresponsiveness to the needs of contraceptive users, most of whom are women. For example, the target of attaining replacement level fertility, which implies a CPR of 70-75 per cent of eligible couples, can be a violation of human rights if poor couples, for whom there are still no adequate institutional or market substitutes for children's old age security and risk insurance value, are under pressure to comply. The overemphasis on raising the CPR has allowed the programme to abuse women's liberties through the absence of choice in methods, very low quality of care and non-responsive to health needs, and non-accountability of service providers (such as the refusal to remove an IUD or norplant when demanded) as these have no legal basis for correction. It has also produced a service structure that is gender biased, placing all the costs of using modern contraceptives disproportionately on women, but at the same time denying women's decision making power by restricting their choice of service. For example, women typically do not have any preference in choice of method and require husband's permission to obtain an MR. It is inevitable that a programme driven by the belief that attaining demographic targets is the goal of policy will also be unlikely to bring about any significant change in fertility preferences and family building behaviour.

4. Policy and Programme Implications

In view of the problematic rationale behind past population policy and the related confusion between ends and means, the first priority for population policy is the need for a clear and explicit declaration of policy goals, distinct from means or strategies. The ultimate goal of any policy, including population policy, is to contribute to the achievement of the broad development objectives of the country. But there are more immediate goals that also need to be explicated and justified by demonstrating their capacity to increase both aggregate and individual well-being of people, namely those of significantly altering the pattern of family building and generating demand for even smaller families. Moreover, policy must also articulate clearly the binding principles that must govern programme strategy. These are: 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 as far as possible the costs of reduction in family size preferences and alteration of family building patterns, especially for women and for poor households.

The second 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 of fertility levels. Moreover, the broadening of programme mandate that the above policy goals demand entail costs that cannot be avoided. Under the circumstances the issue of cost reduction through reduction of 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.

The above policy goals require a broadening of the programme mandate, which will have implications for specific means and strategies adopted. Of central concern in these strategies must be the removal of the exclusive contraceptive delivery bias and inclusion of safeguards to prevent abuse of policy leading to violation of peoples' rights and women's liberties and freedoms. Quite understandably programme strategy will include both service provision and motivational interventions.

With respect to the first policy goal, programme strategies will be to raise the age at marriage of girls, delay the initiation of childbearing and increase the intervals between births so as to significantly increase the gap between generations, strategies that have strong rationales with respect to increasing well-being. The strategy of increasing age at marriage has a very strong rationale on the ground of improving women's status but will require influencing fertility decisions and societal norms, which may not lend themselves readily to a service type intervention. The programme should therefore link up with other development or market interventions that have proven impact in this respect, the most promising of which are interventions that provide young women with gainful employment which increases the opportunity cost of their time. The strategy of delaying age at first birth will mean that service and motivational interventions have to be re-oriented to address the needs of newly married women without children. In this case the justification for programme strategy on the grounds of the health benefits to women and children is quite strong.

The strategy for increasing birth intervals, also strongly justified on health grounds and on the grounds of expanding women's opportunities, will mean that the focus of service provision and motivation will have to be on how to convert users into efficient users in terms of better spacing, fewer unwanted pregnancies and less health problems, and on how to elicit a positive role for men in changing family building patterns as this will require greater spousal cooperation. In addition, service provision must cater to the increasing need of birth control by women for protection against longer exposure to conception due to shorter periods of breastfeeding and longer marital durations. Thus, service provision has to make a quantum shift from a monolithic approach exclusively geared to married women of childbearing ages to one that is more fine-tuned to differential health and contraceptive needs according to age and sex. In short, service provision must be re-organised towards the provision of high quality contraceptive and reproductive health services to an increasingly demanding and differentiated clientele.

With respect to the second policy goal, the major programme strategy will consist of motivational interventions that will address the need to provide incentives and reduce costs of lowering family size preferences for women and poor households. Motivational and service interventions should be consolidated to provide maximum support to those women who are already strongly motivated, such as garment factory workers and users of micro-credit, and promote their role as innovators and trendsetters. Programme strategy must also

actively promote the role of men in generating desire for even smaller families, a neglected clientele so far, as a means for more effective family planning and of reducing costs borne by women.

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