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Addressing the demographic imperative through health, empowerment, and rights: ICPD implementation in Bangladesh

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Since the Cairo conference, debate has flourished about whether or not the ICPD Programme of Action constitutes 'population policy.' The negative view is that the ICPD agreements contain no population projections, no demographic analyses, and no specific goals for contraceptive acceptance or fertility decline. Where, therefore, is the 'population policy'? The positive view is that the Cairo agenda does constitute population policy in the broadest sense. It supports reproductive freedom, and it promotes other policies to generate conditions conducive to smaller family size. Thus, in demographic terms, the Cairo agenda directly addresses the determinants of both wanted and unwanted fertility.

The divergence in views about Cairo may, in fact, have more to do with concern about allocation of conventional 'population' resources, both human and financial, than with the ICPD paradigm itself, or with demographic realities. The nay-sayers argue that Cairo's 'reproductive health approach' will be far more expensive and less efficient than vertical family planning programs. Rather, they say priority should be given to meeting the unmet need for contraception, as conventionally defined. They further argue that 'population' resources, small to begin with, certainly should not be stretched to cover the kind of 'social engineering'—that is, health, empowerment, and rights—mandated by the ICPD. If there is to be any 'social engineering', they say, it should take the form of incentives or other persuasive measures directly targeted on fertility and, in particular, contraceptive use.

Proponents of the Cairo agenda, on the other hand, argue that a reproductive health approach will be more cost-effective in meeting demographic goals in at least two ways: first by reducing contraceptive dropout and failure rates, and second by appealing to the younger individuals and couples who, in demographic terms, need to delay sexual initiation and marriage, and contracept earlier and longer. Proponents of ICPD also look to broad 'social engineering', rather than fertility-centred propaganda or incentives, to counter what Judith Blake called the 'coercive pronatalism' of everyday life. That is, we argue for creation of socio-economic conditions in which it makes sense for individuals to have two or fewer children, conditions that foster gender equity and poverty alleviation. The Cairo Programme of Action is clear: such social investments are to be made by broader development agencies and budgets, not from family planning budgets; nor would ministries of health and family planning be responsible for their implementation. Rather, the role of population professionals and agencies is to undertake necessary research and advocate for broader policy change. Let us examine the case of Bangladesh.

After some 20 years of an intensive, vertical family planning program, the contraceptive prevalence rate has risen to 45 per cent; the total fertility rate has dropped to 3.4.

From a family planning program perspective, Bangladesh is a 'success' story. But is the current, technology-centred 'population policy' the one to maintain in the next two decades? Consider the following facts. On a number of widely acknowledged counts, the quality of contraceptive services in Bangladesh is very poor, and discontinuation and failure rates, though improving, are high. Maternal mortality has hardly fallen and is among the world's

highest, estimated to be 4-5 per 1000, some say 6-8 per 1000; one-quarter to one-third of these deaths are due to botched abortions; the resort to unsafe abortion is due in large measure to inadequacies in the family planning program. Marriage at ages younger than 15 is still common, and half of adolescent girls aged 15-19 are already married. Only 15 per cent of projected future population growth can be addressed solely by contraceptive services to prevent unwanted pregnancy. Fully 85 per cent of the projected future growth will come from the very large cohorts of young people now entering their—potentially—sexually active years. We need to be concerned about their age at sexual initiation and marriage, the timing of their first and second births, and whether they are given access to sex education and reproductive health services, including but not limited to family planning, whether or not they are married. And finally, HIV/AIDS has arrived in Bangladesh and, along with conventional STDs, prevalence will explode, as is occurring in neighbouring countries, if a broader reproductive health approach is not taken.

On the basis of a commitment to health and justice, and to achievement of population stabilization, the Government of Bangladesh, together with all but two of the major donors and international agencies active in the sector, have framed the first Bangladesh national health and population sector strategy. The strategy takes the Cairo agenda as its starting point and refines it to suit Bangladesh conditions. I have just returned from the latest round of work to develop the details of a new five-year program and financial package to implement this national Health and Population Sector Strategy. Among the many lessons from our experience so far is that major shifts are required in the demographic, or more broadly, population, research agenda. Bangladesh surely has one of the largest bodies of demographic studies of any country; while helpful, that literature falls far short of what is needed to design and implement a sector strategy based on the ICPD agenda.

Central to the Cairo agenda is the concept of sexual and reproductive health and rights. This concept creates a new lens, filtered by sex and gender, through which to scrutinize the assumptions, research questions, program assessments and policy analyses of the population profession. Our experience in Bangladesh leads us to posit a new framework of analysis and a research agenda for a post-Cairo demography. That agenda would give higher prominence to the social context of sexual, marital, and reproductive behaviour across all three elements of John Bongaarts's framework: preventing unwanted pregnancy, reducing desired family size, and slowing demographic momentum. It includes those conditions that contribute to both the 'accidental' and the 'deliberate' fertility and health outcomes with which we are concerned: the currently 'wanted' aspects of sexual activity, relationships, marriage, and desired family size; and also the 'unwanted' aspects of sex, violence, forced early marriage and childbearing, problematic contraception, unsafe abortion, sexual and reproductive morbidity and mortality, and infant and child death and illness.

Our demographic survey tools are not up to the task: the DHS in Bangladesh as elsewhere, for example, does not survey the young and unmarried; nor have they analysed and published data on abortion, safe or unsafe. Such surveys do not assess the social context of decision-making yet they have been primary tools used for program planning. With some very important exceptions, such as Mead Cain's work on patriarchy, and recent analyses of the interaction between family planning and women's empowerment in Bangladesh by Ruth Simmons, and by Sidney Schuler et al., most demographic research in Bangladesh on fertility and family planning has been narrowly focused on contraceptive acceptance and use, and on fertility reduction.

At least five research areas require emphasis, not only in Bangladesh but worldwide, to support implementation of the Cairo agenda.

The first is the **situation of young people**, their life choices, including, but not limited to, their sexual and reproductive desires and behaviour. About 47 per cent of the population of

Bangladesh is currently less than 15 years old. By 2010, Bangladesh will have approximately 31 million people aged 10-19. This 'demographic imperative' requires a major shift in our understanding of the 'clients' to be served. Without neglecting traditional program clientele—married women of reproductive age—research is needed to inform action directed toward educating and influencing young people about sexuality, gender relations, mutual consent and respect in sexual activity and union formation, and the means to prevent both pregnancy and disease.

Second is the **significance of both sex and gender** which underlie reproductive and health-seeking behaviour. Neither of these has yet been explored in detail in Bangladesh: we have only the crudest understanding of the cultural meanings attached to sexuality, the power relations between women and men in sexual and marital relations, or the negotiation of fertility decisions.

Third is the **decision-making environment**. The Cairo agenda mandates social, economic and political initiatives at the national level to create an enabling environment for the exercise of sexual and reproductive health and rights, and for population stabilization. The health and population sector strategy work in Bangladesh recognizes that changes have occurred, for example, in the status of women in the last 20 years. Quantitative and also qualitative research, like that by Simmons, is needed to document these changes. Their multiple benefits, as well as their costs, need to be evaluated, along with additional means to improve girls' education, women's employment, their political participation, and their legal status.

Fourth is **applied demographic research** to estimate the costs and the benefits of reproductive health services, including family planning . We need better methods to assess the costs and the benefits of alternative modes of service delivery (village-based versus clinic-based workers, for example), based not simply on contraceptive acceptance, but on continuing contraceptive practice; not only on family planning performance, but on reproductive health outcomes; not only on fertility impact, but on health impacts. Similarly, extensive operations research is needed to develop and test the most appropriate clusters of services, and priorities among them, given both needs and resource constraints. Further, we need to develop and test effective IEC messages, beyond the simple family planning messages of the past, and modes of delivery to multiple audiences, including, especially, young people. Finally, we need new evaluation methods and program indicators beyond contraceptive acceptance, CYP and the TFR. The list is very long.

Fifth, and critically important, is engaging the population profession in **assessing and promoting changes in broader national development policies**. The shift from family planning to a wider reproductive health approach has been the central concern so far in the Bangladesh sector work, including some attention to adolescent sexual and reproductive health needs. More challenging even than this work is creation of broader 'population policy' for the nation. This requires involvement of ministries of planning, finance, women's affairs, education, labour and rural development and, ultimately, the cabinet, among others. In this regard, the Bangladesh Government, a leader in the Cairo negotiations, needs to redesign its overall development strategies and allocation of resources to emphasize gender equity and poverty alleviation. This is a tall order. The population profession, including researchers, technical agencies and donors, could, indeed must, assist by redesigning their own conceptual planning tools, by expanding data bases (on, for example, gender differentials in schooling and employment), and by assessing both the costs and the multiple benefits of increased investments in girls and women, as well as poverty alleviation.

The Cairo agenda, and specifically the research agenda proposed above, is based on consideration of three decades of family planning research and program experience. The Cairo agenda is a demographic agenda. It offers demographers, and all other population

professionals, unprecedented opportunities to expand our vision, to revitalize and strengthen our field, and to broaden the base of popular and political support for our work. The international population movement can and should do no less to meet the enormous demographic challenges that lie ahead.