### Modernisation of Land Administration

# The On-going TAP Project of Land Ministry

ownership and configuration of lands.

OMEONE once said: 'Landreform is like hot soup it should be taken slowly. Nothing could be said more aptly than this in qualifying efforts relating to so-called reforms or modernisation of land management. And this applies particularly to countries with predominantly

agricultural economy. The land system in undivided Bengal was absolutely foreign to the British people. when the East India Company initially secured the official grant of Dewani of Bengal, Bihar and Orissa from Emperor Shah Alam, the then paramount Moghul ruler at Delhi Court, on 12th August. 1765. Todar Mall's system of land assessment was in force when the British assumed control of the revenues of Bengal. They applied their mind and tried to understand the inherent settlement problems. which, of course, they sought to solve in their own way to suit the imperial interest, starting from Lord Cornwallis in 1793. That the Company's British officials gradually mastered the land revenue administration thoroughly is evident from the fact that from 1888 onwards. the entire Province of Bengal was covered in completing a thorough survey and settlement operation in each district, under the provisions of Bengal Tenancy Act, 1885, by he year 1940. The Settlement officers who carried through the job were by and large British members of the Indian Civil Service. They included eminent persons like CGH Allen, J G Cumming, N D Beatson Bell, FD Ascoli, FA Sachse, WH Nelson and L R Fawcus, besides others. Some of them proved themselves as experts on Bengal's land revenue system and rose to the position

of Member, Board of Revenue

HE vision of Health For

in 1978. In May this year, the

51st Session of the World

Health Assembly adopted a new

Global Policy on Health For All

in the Twenty-First Century,

which is a continuation of the

HFA process and which sets a

few targets by the Year 2020 in

an important issue not only for

Bangladesh, but also for each

and every country, has not been

given due attention and impor-

tance it merits, by the succes-

Bangladesh. This has rather

been a neglected issue. The pri-

mary reason of this neglect was.

however, resource constraints.

The other reason was that

health development was viewed

as an isolated issue. But the fact

that it is not at all an issue of

that kind. It is very much an is-

sue that is inextricably linked

with other social issues like

poverty, population dynamics,

environment, education, wom-

en's development etc. A coordi-

nated intersectoral action is

required for health develop-

August 1996, I pursued a Ph. D

course in Jawaharlal Nehru

University, New Delhi. The title

of my Ph. D topic was Imple-

mentation of the Health For All

Strategy in Bangladesh: Role of

Between August 1994 and

ment.

Health development though

achieving its goals.

All (HFA) by the Year 2000

was launched at Alma-Ata

(the highest revenue authority). The cadastral survey and settlement conducted by the above mentioned Settlement oflicers in different districts of Bengal were regarded as highly authentic and are considered even today as most dependable land surveys and land records originally undertaken in Bengal. All of them produced their final reports (known as Settlement Reports) which are of high statical value and contained a detracted contemporary almanac of geographical, histori-cal and economic accounts of

the districts. The land system then prevailing in Bengal was complex involving interests of Zamindars. Talukdars, Howladers, rim-howholders and similar other rent-receivers existing over raiyats, underraiyats, etc. who actually tilled the land. However, by a single stroke

of pen, the entire chain of rentreceiving interests was abolished in 1956 and, at the same time, a ceiling of land holding per family was fixed. As the result. Government stepped into the shoes of landlords and all kinds of rent-receivers and the actual titters of soil, who had some interest in land as raivat or under-raivat, came to be recorded as tenants (now called maliks) directly under the government. The amount of rentals, which each of these ground tenants was actually paying to his immediate superior rent-receiver, was recorded as rents payable to the government.

The Government has now the responsibility of collecting these individual rents from the ground tenants all throughout the country. Although rents payable upto 25 bighas (roughly, 8.25 acres) have been remitted by successive governments after Independence

The present system of having periodical survey and settlement operation has to continue. This country has limited land resources, while the population is fast increasing. On the otherhand, this is a riverine deltaic region which undergoes constant changes . . . All these have their inevitable impacts on the pattern and extent of land (1971) in pursuance of their political decisions, land development tax is always being realized from all such tenants at the stipulated rate. The amount of land development tax plus rent

(where payable), classification of plots of land in each holding. share of each tenant (in case of joint holdings) and also various other incidents e.g. right of public easement (if recorded as pathway) common pasturage or not (if recorded as pasturage), etc. find place in the ROR (Khatian) issued for each individual holding. In fact, a single Khatian (holding) now depicts, inter alia, the whole socio-economic picture of the family, emerging from one or more

> in the name of the family. These holdings originated from the time of Zamindars or proprietors or other rent-receivers, based on pattas, or kabuliyats or dakhilas created of the time of settlement of the land covered in favour of the tenant family. They have now found place, as they-covered originally, in the records of tahsildars working under Asstt. Commissioners (Land) in each district. In case of any future decision

plots of land recorded therein.

towards rationalization of rent the structure of the present Khatian will provide the basic data needed for such an exercise. Moreover, to give certain rights to the bargadars (share-croppers) most of whom are landless, as has been done in West Bengal (India) in course of land reforms there and also provided in our present land laws (of Land Reforms Act, 1984), we need to retain the existing Jama-based Khatians Uama meaning rental). This is surely a dependable instrument to collect rents (where payable) and land developing tax, totalling crores of Taka, forming a big chunk of revenue going to

the government coffer. In modernizing the land administration, the idea of making it plot-based in place of the present Khatian-based system will be futile. This will create problems rather than solving them. The consultants' objective is to issue an authoritative 'certificate of land ownership' for each plot, which would be exclusive and conclusive proof of ownership. The meaning of the word 'authoritative' is not clear. Apparently, it indicates that the 'certificate' will be issued under the signature and seal of a competent authority. I presume, the level of this authority is meant to be Asstt. Commissioner (Land). This officer works at thana level and is supposed to be a very junior officer, having at the most a confle of years' total experience. which may or may not include the usual settlement training. The competence of such a junior officer to sign and seal a 'certificate of land ownership' which is meant to be 'exclusive' and conclusive prof of ownership, is open to serious doubt. This is a sort of a guarantee about the conclusive proof of land ownership, ensuring 100

per cent accuracy. Even a court

of judiciary cannot give such a guarantee and this is why, law provides for appeal against a court's decision. The whole concept of issuing a certificate of land ownership, which will be considered as 'conclusive' seems to be fallacious.

In land administration setup, the civil court does not come into the picture. It is the Sub-Register, Asstt. Settlement Officer and Asstt. Commissioner (Land), who will be involved in the entire process of issuing a 'certificate of ownership'. None of them are judicial officers. Yet, under the new system, the Sub-Register will adjudicate on the title of the land proposed to be transferred. On his report, the AC (Land) will act and in case of partial transfer of a plot of land, the ASO's intervention will come. Here three agencies are concerned and it is assumed that all of them will perform their task efficiently and honestly. This will obviously be asking for the moon, so today. Human failings are there and then, motivated action cannot be ruled out. The new system does not provide for redress at any higher level in the form of filing an objection or appeal. Assuming that scope for asking for such redress will be provided, delay in disposal of a transfer case by way of gift, sale mortgage or otherwise is inevitable. Moreover, in the absence of any of these three agencies being given the powers of adjudication (which is most unlikely) the end-result cannot

have the character of being

'conclusive'. If the whole process is termed administrative. the action of any of these agencies can never have the validity of being called conclusive or authoritative.

In the present system of preparation of ROR (which means map plus record), the basic structure is initiated by the Kistwar Amin and Sardar Amin. The former does the map correction on the basis of a plane table survey, while the latter started preparing the record. The map and record is then attested by a Kanungo. If there is any objection, the Asstt. Settlement Officer (with the powers of a Revenue Officer) gives a hearing and then gives a decision. The Settlement Officer sits on appeal with necessary powers of a Superior Revenue Officer (not judicial powers). The ROR so prepared is kept open in final publication for one month and then certified. Yet, the law gives the ROR so prepared a presumptive value of being correct until and unless rebutted in a court of law. This is the modern system of judicature. In such perspective, how can the question of issuing on authoritative certificate of ownership by A C (Land) arises? How can such a certificate be called conclusive, having unquestioned acceptability and validity?

administration may be limited to the following issues: (i) using the modern tech-

The modernisation of land

nology in land survey, preparation and printing of maps:

(ii) printing of record of right by computerisation; (iii) introducing a Land Informates System, (LIS) for storage and retaining of information relating to land ownership

and map, and (iv) introducing a computer application programme known as Land Administration and Management System (LAMS).

The present system of having periodical survey and settlement operation has to continue. This country has limited land resources, while the population is fast increasing. On the otherhand, this is a riverine deltaic region which undergoes constant changes, because of floods, erosion and silting of river beds and shifting of river courses. All these have their inevitable impacts on the pattern and extent of land ownership and configuration of lands. The situation is accentuated by fast development activities and continuous fragmentation of land due to inheritance, transfers, etc., which necessarily affects the character and use of land on a considerable scale all throughout the country, particularly in urban areas. In view of this perspective, survey and settlement operation has to be carried out from time to time to incorporate extensive changes which take place in the classification and use of land and recording of new accretions in big river basins. In addition, annual diara surveys have to be undertaken in char land, where hundreds of acres of land are wasted away or thrown up from the bed of the river every year.

I had an opportunity to attend a workshop held recently to test the results of a TAP programme funded by the ADB. which are being conducted phase by phase, in pilot project areas. These pilot projects were recommended by another

FAO/UNDP Project taken up in 1988 and conducted by a team consisting of an international consultant (a British expert) and myself as one of the two national consultants.

The present study, undertaken by an Australian Consultant Team, has brought out new ideas, the main thrust of which is the introduction of a plotbased land registration system. starting with a one time SRS to provide for issuing authoritative certificate of land ownership' for each plot, which will be the exclusive and conclusive proof of land ownership. While attending the workshop, I expressed my views rather piecemeal for shortage of time. But as the subject is very important and in view of extra ordinary recommendation professed by the consultant purporting to change the existing land administration system, lock, stock and barrel, I decided to write a comprehensive paper giving my reaction to the new ideas advocated.

In conclusion, I must observe that a consultative committee be set up to study the phase II recommendations of the Australian consultants more closely and submit their report to the Land Ministry within a specified time. The consultative committee should include not only experts on survey and settlement and land administration, but also representatives of Law Ministry Bangladesh Institute of Development Studies (BIDS) and others concerned.

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play a crucial role in mobiliz-

## Implementing Health for All Strategy in Bangladesh by Khalilur Rahman

In order to ensure HFA or at least to improve the health status of the population, overall social development is

needed. There is an urgent need for intersectoral action for this purpose.

sive Governments in

The basic objectives of the study were to define the concept of health in broader perspective; to establish linkages between health and other social issues; assess the roles of WHO and other Government and Non-Government Actors in implementing the HFA Strategy; and to develop a Systemic

Bangladesh. The study was based on the

WHO. Based on the findings of my study, I developed a Thematic Model on possible Implementation of the HFA Strategy in Bangladesh. Following confirmation of my Ph. D Degree, many of my well-wishers advised me to publish my work. They were of the view that this Model might attract attention of the policy makers in the Government. Mainly due to lack of interest. I have not so far done

Since last April, I have been writing for the DS basically on development issues of interest to our country. Considering the wide readership of the DS, I have finally decided to disseminate the findings of my study among its readers through publishing a sort of excerpt of the study, which is furnished be-

hypotheses that a re-organised and decentralised health system could be more effective, responsive and service oriented;

Model on Implementation of the HFA Strategy in

private practice of the Government doctors was an obstacle to effective delivery of health care services in Government health institutions; an educated society could reduce population growth, incidence of poverty and environmental degradation and could improve overall health status of the population; and WHO's role in the implementation of the HFA Strategy was that of a catalyst, collaborator, facilitator and supervisor and the organisation had been trying to bring health-related issues within the purview

calling for intersectoral action for health development. The study identified a close linkage among population, poverty and environment and revealed that Bangladesh was caught in a "vicious cycle" comprising these three elements. It also confirmed that this linkage had tremendous negative impacts on overall health status of the population. Poverty. in particular, was identified in the study as the root-cause of ill health and diseases in It was also Bangladesh. observed in the study that edu-

cation status of the people in

of broader health concept and

Bangladesh was very low, particularly among young girls. women and the poor. The study identified that education to women could reduce population growth rate and provide better health care and nutrition. The study came to a conclusion that the more one was educated and financially solvent, the more improved his health status could be. In other words, a direct relationship among education level, income and health status was established:

The study recognised NGOs' contributions in social development including in health sector development in Bangladesh It, however, recommended their enhanced accountability, transparency and formal organisational structure, which were not adequately observed in the field surveys done for the study.

The study identified a number of actors whose concerted efforts are needed for health sector development in the country. Based on the findings of the study, a Conceptual Systematic Model on Implementation of the HFA Strategy in Bangladesh was developed.

The study recommended that

due focus should be placed on such strategic priorities as breaking the vicious evele of "poverty-population-environment" (PPE) in order to reduce its perilous consequences on health, ensuring equity of access to, utilization and outcome of health system with special measures for the poor, women and children, integrating health policy within the overall development framework and arranging for adequate sustained financing and newly-ac-

quired technology for health. Political commitment and accountability for health, not only by the health care providers, but also at the political level, effective reorganization and decentralization of the present health care services, reorientation of health personnel and managers, prohibition of private practice by the Government doctors compensating with enhanced salary and better promotion prospect, reallocation and substantial increase in financial resources for health, are urgently required for the improvement of health sector in Bangladesh.

In order for arranging required financial resources for

health, the study recommended that the Government initiated viable measures for alternative limancing for health care services. Social Insurance Schemes, introduction of Health Tax leaving the poor and setting up of a National Health Fund were recommended as possible ways for this purpose. Considering the necessity for a "National Health Policy", it was strongly recommended that the same should be introduced in consultation with all concerned without further delay.

For global intervention in the health system of the country, the study advocated for placing priority to areas like creating propitious conditions for diffusion of technology defining ethics of promoting family planning taking cognizance of Bangladesh's religious and socio-economic real-

It was emphasised that in order for breaking the vicious cycle of "PPE", substantial progress should be made in education, employment generation, nutrition and family planning. With a view to raising educational level of the population, it was recommended that

centrality of primary education be recognised and be placed at the top of the national list of priority in order to ensure primary education for all at the shortest possible time. Emphasis should be laid on community mobilisation and participation in ensuring effective delivery of education facilities. It was strongly recom-

mended to make special provi-

sions for education to girls and women. Given the nefarious effects of poverty on health, the study suggested that efforts be made for poverty alleviation with special emphasis on women and children, since they are the usual victims of this phenomenon. Considering the process of urbanization as intrinsic to economic and social development, it was advocated that the objective of urbanization should target facilitation of a balanced distribution of population by promoting sustainable development.

The study identified resource constraints as the most important obstacle to health development in Bangladesh. It suggested that as the world leader in health and in view of the changing socio-economic world polity, WHO should also play a role in mobilising the most required "resources" for the poor and densely populated countries like Bangladesh.

It was argued that WHO could

ing necessary funds not only for the health sector, but also for other health-related social sectors. It was also argued that WHO should strive to convince the donor community for the fulfillment of the target of 0.7% of GNP for overall ODA as outlined in the International Conference on Population and Development at Cairo in 1994 and 0.15% of GNP for ODA for the LDCs as agreed in the Second UN Conference for the LDCs for the 1990s. It might also make sincere efforts to persuade the Government to undertake the 20:20 Human Development Compact, which aims at fulfilling the basic human development needs.

It was suggested that in order to ensure HFA or at least to improve the health status of the population, overall social development is needed. There is an urgent need for intersectoral action for this purpose. It was also suggested that the efforts and programmes of the development agencies in the country should be coordinated to avoid duplication of works in order to save precious funds for development activities. The Government has to play an important role in this coordination

the Bangladesh Permanent Mission, Geneva

The writer is Counsellor in

## Public-Private Health Sector: Time for

Public health care, by definition, are those services delivered by the state while private health care is provided by individuals and institutions that are outside the state (public) sector. With the rise of private health care in recent years, interest in how the private and public sectors work and cooperation between the two has increased. But the government health planners are not taking a total systemic view and are still confining their plans almost entirely to plans in the public sector institutions and

services. In many countries, including the poor countries, private expenditure on health care exceeds, often by far, expenditure in the public sector. I strongly urge that it is time the planners take a systemic (total health sector) view. It is rational and most likely to harness avail-

ciently. When central planning

was the rule in command

economies, the private sector

might have been of little or no

reigning and public health care

is under-funded, within-sector

partnership with private ser-

vice providers has become in-

vate sector grew independently

from the public health sector.

The private sector usually views

with suspicion any form of reg-

ulation or evaluation. Aversion

to any form of interference pre-

vails. Nonetheless, a comple-

mentary partnership within

the total health system is essen-

tial to avoid wasteful duplica-

True, historically the pri-

But as market economy is

significance.

dispensable.

# a Fresh Look

by Dr M Zakir Husain must operate on a public or so-

Good public-private partnership in health is based on clear role and mutual trust under a regulatory regime

that protects public interest and promotes social responsibility.

able health resources more effi- of various denominations. What is really relevant to strengths and advantages of

cial rationale. Before we contemplate a complementary partnership.

let us explore a little further the ground situation and how best to define public and private health care. I am of the view that things have changed sufficiently to merit a fresh look. Obviously, institutions funded by public (state) money and which are owned by the state are "public". On the other hand, the private sector is a mixture of different types of providers including private practitioners. private clinics and hospitals of multiple descriptions, non-governmental organisations, other private voluntary associations and agencies, charitable bodies

These are not owned or

funded by the state. But the pic-

ture is not that simple in real-

ity. Many public facilities for

example government general

and specialised hospitals are

often used by practising staff

for private income. It is the case

when physicians employed in

state institutions engage in pri-

vate practice using public facili-

ties. On the other hand, some

private charitable and NGO

clinics and hospitals may run

without profit and are func-

tionally with a public sector

mission. In this confusion and

array of overlapping borders.

the worst scenario is when gov-

ernments end up subsidising lu-

crative private income in the

public and private sector alike

often without any regulation or

the public facilities out of reach

of the public they are supposed

to serve. It is not uncommon for

the governments to subsidise

the public sector while refusing

subsidies to private providers

This effectively puts some of

quality control.

including those who may indeed be operating as non-profit bodies. On the other hand, some of the NGO providers may also engage in earning profit while others run without profit. I am not suggesting government subsidies to profit-making private providers. Yet there is need to rationalise the financing and relationship between the two on the basis of actual operating realities.

A new definition should therefore use different criteria based not on ownership identity but on purpose or mission and access to the services. Mere administrative control or label does not tell us about the nature of service or access to it by the

national health planners is the

type, quality and cost of the

health care, and a measure of

the output and beneficiaries. In

other words, who gets what for

how much? The product of the

facilities can then be matched

with the stated intent. A public

facility fails in its intent and

output if it does not give service

of good quality to those who

need it irrespective of capacity

to pay. A private or NGO facility

may provide service without

profit when its stated intent is

not to make profit. Private

profit-making facility should

be evaluated on whether it ad-

heres to quality standards and

its prices are fair and competi-

public money must have an

overriding social purpose — to

improve human well-ness. It

cannot discriminate on the ba-

sis of payment for service; those

who cannot pay must not be

given a poor quality of care. It

should adopt a population per-

spective and not individual per-

A public facility run with

spective: operate with popular involvement and with social accountability.

The public institution should reflect the government policy in its operations. It may not make a profit but it does not mean that it will deny the staf good and rewarding working conditions. It has no excuse to run inefficiently and incur losses. If income or profit is made such as in a district hospital giving good care and recovering some costs from those who can and will pay, such income should be retained and used to improve the facility and

When planners are taking a systemic approach and incorporate public and private services of different shades and outcomes, there is a solid basis for a workable partnership. Such partnership is likely to be realistic and build upon the

public and private sectors. It is

then conceivable that the pre-

sent isolation or mistrust will

be replaced by trust and coop-

eration. Public facilities may be

accessed by private providers

and vice versa. The ultimate

beneficiary will be the con-

sumer public and social control

will establish social and public

will be to complete a compre-

hensive sector analysis with

periodic updating. The planner

has to move beyond merely

planning the government

health services. The planner

has to undertake policy analy-

sis and suggest policy options

that will involve the private

ship in health is based on clear

role and mutual trust under a

regulatory regime that protects

public interest and promotes

social responsibility. That is

primarily a policy and plan-

ning function supported by in-

formed public choice.

Good public-private partner-

For the planner, a first step

good rationale.

sector.

T'S a bizarre demand supply equation, India gets a total supply of 800 million sy-

ringes a year but uses 3,700 million! The shortfall, which is more than three times the actual production, is met through recycled syringes that flies in the face of all safety standards, says environmentalist Iqbal Malik.

In a report titled the "Plight of hospital waste handlers". Malik says that in Delhi alone more than 7,000 people starting from ragpickers to a well-organised mafia are involved in the process of collecting hazardous hospital waste and then segregating, cleaning and repackaging it.

Worse still, this gory venture is only a small part of a much larger malaise. Piles of medical waste, in-

cluding used syringes, blood vials, bandages and plasters, are a common sight anywhere in India. In the absence of any law governing the management of this deadly litter, things have only gone progressively worse. particularly with the proliferation of private clinics all over the country.

The situation may yet change. The Union Law Ministry is studying a draft on Biomedical Waste Management and Handling Rules which, once cleared, will be the first all-India regulation of its kind. The law won't come a day too soon. Out of the 5,000 tonnes of

municipal waste Delhi generates every day, only 60 tonnes is medical waste, says Ravi Agarwal of the non-governmental organisation (NGO) Shrishti, which has worked extensively on the subject. Of the 60 tonnes, only 10-12 tonnes is infectious.

If the waste is not managed properly and segregated at source, a relatively small amount ends up contaminating the entire 5,000 tonnes of municipal waste, Agarwal points

He says there are three basic rules to hospital waste management: segregate, segregate and segregate. Agarwal's insistence on this formula stems from another big problem - of

## Amit Kumar, writes from New Delhi

indiscriminate incineration. Though one kills the pathogen. one comes up with new toxins.

he says. When PVC (polyvinyl chloride) is burnt, for instance, one gets dioxins, a family of 73 compounds which are the most toxic substances known to man. Dioxins cause serious endocrine disruption -- hormonal imbalances.

Picking up a jar of incinerator ash taken from the capital's prestigious All India Institute of Medical Sciences (AIIMS). Agarwal points to the pieces of unburnt plastic and foil. The chilling verdict - the AIIMS incinerator has to be producing dioxins.

Yet, the confusion over incinerators continues. While in the U.S. 93 per cent of all onsite medical waste incinerators have been ordered to shut down. informs Agarwal. Uttar Praclesh has just placed an order for 51 incinerators worth Rs. 510 million. "The only people it will make happy are those selling it," he says.

Only 15 per cent of all hospital waste, including anatomical waste, needs to be incinerated, he says. In other words, the current number of incinerators are more than enough, if they are used in a centralised way.

The bulk of the medical waste -- comprising sharp objects like needles and scalpels, bandages, liquid waste and lab cultures -- can be treated in various non-burn techniques like autoclaving, microwaving and chemical disinfection. To avoid reuse, plastics and sharps must also be mutilated.

Till that happens, the deadly trade in recycling of medical waste will continue to flourish -- at the cost of everyone involved, the suppliers as well as the users.

Those who come in primary

GARFIELD ...

Lethal Medical Waste Up For Grabs contact with the waste, including ragpickers and persons employed by contractors to segregate, face immediate and maximum danger. "None of them uses gloves or protecting cloth-ing while handling used sy-

ringes, bottles, blood-soaked

bandages or body parts." Describing the procedure, Malik says either hospitals and clinics simply throw out all the waste for the ragpickers to collect, or there's a nexus between parameuical staff and the mafia. Once the waste is collected in a central place, barehanded workers sift through that toxic garbage. At the end of the day, there are the massive mounds of syringes, bottles,

bandages and cotton. While the syringes and bottles are sent out in truckloads to cleaning and repackaging centres in Madhya Pradesh, Uttar Pradesh and Bihar, much of the cotton is bundled off to states

like Haryana - India Abroad News Service

## Carfield ®



IAN FLEMING'S

DRAWING BY HORAK

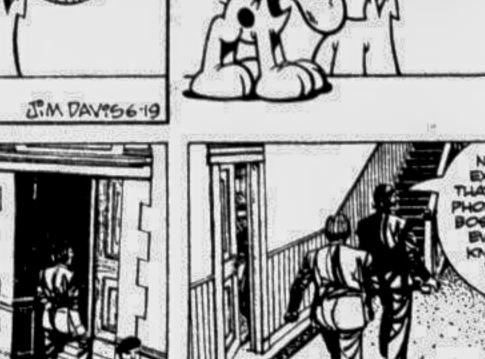
YOU THINK

DREUX AND HER ENGLISH

BOYFRIEND

EXPECTING US?

James Bond









### tion and promote useful cooperation. For each sector, the goal and mission statements should be clear and the operating rules and parameters should be well understood and complied with. It should be also understood that the entire health system