



## **UNFPA - ICOMP REGIONAL CONSULTATION**

### **Family Planning in Asia and the Pacific Addressing the Challenges**

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### **The Bangladesh Family Planning Programme: Achievements, Gaps and the Way Forward**

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## **Executive Summary**

### **1. Background**

Like many developing countries, Bangladesh had an official family planning (FP) programme beginning in 1960. The programme went through different phases. It achieved commendable success until mid-1990s; however, the pace of success slowed down thereafter due to erosion in political will and commitment to the programme. This, in turn, has affected the commitment of concerned officials in programme implementation.

In 1994, the United Nations organized the International Conference on Population and Development (ICPD) in Cairo. It came up with a Plan of Action (POA), which recommended, among others, that governments should meet the FP needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to full range of safe and reliable FP services. However, the ICPD failed to clearly operationalize how FP was to be made an integral part of the reproductive health (RH) programme, especially in countries like Bangladesh, which has two separate directorates offering RH services independently of each other.

The purpose of the Bangladesh Case Study is to review the status of the FP programme. The study discusses programme achievements, highlights various programmatic gaps, and identifies Bangladesh-specific strategies for renewed focus and increased investment in FP.

A review of all relevant documents and data from the BDHSs and earlier surveys and in-depth interviews with relevant stakeholders was undertaken to obtain an in-depth understanding of the FP Programme of Bangladesh.

### **2. Country Setting**

#### **2.1 Demographic Challenges**

Bangladesh is the seventh most populous country in the world and the fifth largest in Asia with a population of around 160 million people. The annual rate of population growth is around 1.4 percent, i.e. about two million new faces are added to the population annually.

During the 1960s, fertility was quite high, with the total fertility rate (TFR) of over 7. It declined to 6.3 in 1975, and remained above 6 until 1981. Between 1989 and 1993-94, fertility declined sharply from 5.1 to 3.4. However, the decline was much slower thereafter, and stalled at around 3.3 during the 1994-2000 period. Then, it declined slowly to 3 in 2001-03 and 2.7 in 2007. There are pronounced fertility differentials by characteristics of the women. Also, adolescent fertility is quite high.

Bangladesh is facing a serious demographic crisis in terms of growing population size and density, proportion of the population under 15 years of age, increasing number of married women in reproductive ages, stalling and/or near stagnation in fertility, extremely high level of adolescent fertility, sharp differentials in fertility by socio-economic characteristics of the women, low female age at marriage, early childbearing, and high neonatal and maternal mortality. Such demographic challenges place enormous burden on the limited resources of the country insofar as poverty reduction and efforts to tackle environmental and climate change are concerned. Also, these are seen as hindering efforts to achieve other reproductive goals, including reduction in maternal mortality.

## **2.2. Socio-economic Condition**

Major socio-economic changes have taken place in Bangladesh over the past two decades, both on the positive and negative sides, affecting fertility norms and behaviour. Changes in the positive direction include increase in female education, employment, women's empowerment and access to mass media; while changes in the negative direction include increasing landlessness, shrinking employment opportunities in the agricultural sector, high incidence of poverty and growing urbanization.

## **3. Family Planning Programme**

### **3.1 Evolution and Development of the Programme**

The FP activities in Bangladesh have been carried out in three distinct phases. Phase I activities were largely voluntary, beginning in the early-1950s. Phase II activities began in 1960, with the government taking some broader steps to check the population growth rate. Population control was made the official policy in the First Five-Year Plan of Pakistan (1960-65). Phase III activities were initiated in 1973 with the launching of the First Five-Year Plan of Bangladesh. The Plan attached equal priority to population control and food production. It marked the beginning of a multi-sectoral and broad-based population control and FP programme in the country.

### **3.2. Programme after ICPD**

Following the ICPD, the Government of Bangladesh (GOB) formed a National Committee and developed a National Plan of Action for implementation of the goals set in the ICPD POA. Under the integrated approach of population and development, national policies on Population, Maternal Health, HIV/AIDS and STD were formulated; and strategies were developed for Reproductive Health, Population, Health and Nutrition. Major changes had already begun in the FP and RH programmes in Bangladesh even before the ICPD. Following the ICPD POA, however, integration of FP within the RH programme was further strengthened under the subsequent health, population and nutrition sector programmes in the country.

### **3.3 Achievements**

Knowledge of FP method is almost universal among Bangladeshi couples. In the context of favourable political and religious environment, the FP programme in Bangladesh achieved commendable success until the mid-1990s, but since then the pace of success has slowed down. The achievements can be attributed to strong political will and commitment until the mid-1990s, increase in the demand for FP services, provision of such services by the FP programme, and socio-economic development.

### **3.4 Gaps**

The overall political environment is far less supportive of a broad-based approach to containing the population growth rate in the country. Indeed, since the mid-1990s, there has been erosion in political will and commitment of successive governments to tackle the problem. This is clearly the major gap, because all other gaps are due to lack of political will and commitment, which, in turn, has adversely affected programme implementation at different levels. The other gaps include: slowing down in the rate of increase in the CPR; inadequate coverage, low quality and inappropriate method-mix (inadequate and inefficient service delivery, low CPR among young married women, regional variations in contraceptive use, declining share of longer-acting and permanent methods (LAPM), and high discontinuation rate); rising unmet need for contraception and high future intention to use FP in future; gaps in contraceptive security; lack of adequate support for BCC; and limited funding and actual expenditure.

## **4. The Way Forward**

Given the major gaps faced by the programme, there is need to adopt and effectively implement the following strategies to reverse the slowing down in the rate of increase in the CPR and the consequent stalling and/or near stagnation in fertility decline. These include the need to: (i) develop a supportive and proactive policy environment; (ii) adopt a client-segmented approach to both BCC and service delivery; (iii) improve access to, and quality of, FP services; (iv) strengthen service delivery; (v) improve commodity security; and (vi) improve programme efficiency.

## **5. Conclusion**

The Bangladesh Family Planning Programme was initiated by the government to reduce the rate of population growth. The Programme made great progress until the mid-1990s, but, due to erosion in political will and commitment and certain systemic issues, the programme has since then been lagging behind.

To achieve the desired increase in the CPR and fertility decline, the GOB should undertake a number of measures. First and foremost, there should be a renewed commitment on the part of the political leadership to contain the population growth rate. Second, the systemic problems affecting the programme should be addressed on an urgent basis. Third, there is a need to re-think the role of the Directorate General of Family Planning (DGFP) in providing quality FP-related services rather than being involved in various non-FP activities, thereby enabling the DGFP to achieve its primary goal of increasing the CPR and use of LAPM in bringing about the desired fertility reduction. Fourth, both access to, and quality of, FP services should be improved. Fifth, service delivery and programme efficiency need to be enhanced. Sixth, effective public-private partnerships should be established to maximize use of existing resources, personnel and networks. Seventh, efforts should be made to further improve child survival rates and the overall status of women. Eighth, female education should be made a national priority, thereby empowering women to have only their desired number of children and offer them attractive alternatives to childbearing. Ninth, issues relating to better governance and accountability should receive high priority. Finally, the government should reposition the FP and RH programme as part of its overall development agenda; otherwise, its development objectives will not be fully achieved to the detriment of the country as a whole.

## **1. Background**

Like many developing countries, Bangladesh had an official family planning (FP) programme beginning in 1960, though voluntary FP programme efforts started in the early-1950s. The programme went through different phases. It achieved commendable success until mid-1990s; however, the pace of success slowed down thereafter due to erosion in political will and commitment to the programme. Not surprisingly, therefore, the pace of success has slowed down, resulting in a stalling and/or near stagnation in fertility decline in Bangladesh. Although there has been no change in official policy regarding the need to contain the rate of population growth, the commitment of political leadership has weakened considerably. This, in turn, has affected the commitment of the concerned officials in programme implementation.

In 1994, the United Nations organized the International Conference on Population and Development (ICPD) in Cairo. It came up with a Plan of Action (POA), which recommended, among others, that governments should meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to full range of safe and reliable family planning services (see e.g. UNFPA 1995). The ICPD accorded due importance to women's health and rights, and accordingly, made FP part of the overall reproductive health (RH) agenda. However, the ICPD failed to clearly operationalize how FP was to be made an integral part of the RH programme, especially in countries like Bangladesh, which has two separate directorates-- Directorate General of Health Services (DGHS) and Directorate General Family Planning (DGFP)—offering RH services independently of each other, without any effective coordination and cooperation between the two directorates.

The purpose of the Bangladesh Case Study is to review the status of the FP programme, including the knowledge and practice of contraception and the service delivery system. The study: (i) identifies achievements of the Bangladesh FP Programme; (ii) highlights various gaps faced by the programme; and (iii) identifies Bangladesh-specific strategies for renewed focus and increased investment in FP.

A review of all: (i) relevant documents, strategies and assessment reports (all such documents have been referenced in the paper), and (ii) the 2007 Bangladesh Demographic and Health Survey (BDHS) and the earlier BDHSs and its predecessor surveys for the period 1975-2007 was undertaken to obtain an in-depth understanding of the Bangladesh FP Programme. In addition, interviews were held with relevant stakeholders such as officials from the Ministry of Health and Family Welfare (MOHFW), the Directorate General of Family Planning (DGFP), international donor/bilateral agencies, NGOs and the private sector. The list of persons interviewed is given in Annexure 1.

## **2. Country Setting**

### **2.1. Demographic Challenges**

Bangladesh is the seventh most populous country in the world and the fifth largest in Asia with a population of around 160 million people. The annual rate of population growth is around 1.4 percent, i.e. about two million new faces are added to the population annually. According to the Government of Bangladesh (GOB) estimates, the population of Bangladesh under varying assumptions will range from about 170 million to 184 million by 2020, and from 218 million to 294 million by 2050 (GOB, 2006). According to an UN estimate, the population of Bangladesh is projected (under medium variant) to increase to 185.6 million by 2020 and further to 222.5 million by 2050 (UN, 2010).

Bangladesh is the most densely populated country in the world, with the exception of some island states. Its population density of around 1,000 persons per square km. is projected to increase (under medium variant) to 1,289 persons per square km. by 2020 and further to 1,545 persons per square km. by 2050 (UN, 2010).

About one-third of the total population is below 15 years of age, and the elderly population (60 years and above) accounts for around 6 percent of the total population, indicating a high dependency ratio. The elderly population is projected to rise to 8.2 percent and 21.2 percent respectively in 2020 and 2050. Women in the reproductive age group is projected to increase from 55.8 percent in 2010 to 56.7 percent in 2020, and then, decline to 45.9 percent in 2050 (UN, 2010).

According to the 1974 census, only 9 percent of the population lived in urban areas, which rose to 18 percent by 1988. Currently, around 30 percent of the total population lives in urban areas. By 2025, the urban population is projected to increase to 40 percent; by 2031, it will exceed the rural population; and by 2051, urban population will be 64 percent of the country's total population (GOB, 2006).

Dhaka, the capital of Bangladesh, is today one of the world's largest metropolis. From a population of around 14 million people now, Dhaka is expected to be the 4th largest city in the world with a population of 23 million by 2015 (Brockhoff, 2000). Also, other smaller towns have grown in size. While the annual growth rate of rural population is around one percent, it is about 5 percent for urban population (United Nations Population Division, 1998).

During the 1960s, fertility was quite high, with the total fertility rate (TFR) of over 7. It declined to 6.3 in 1975, and remained above 6 until 1981 (Cleland et al, 1994). Between 1989 and 1993-94, fertility declined sharply from 5.1 to 3.4. However, the decline was much slower thereafter, and

stalled at around 3.3 during the 1994-2000 period. Then, it declined slowly to 3 in 2001-03 and 2.7 in 2007 (Figure 1 and Table 1).

There is extremely high level of adolescent fertility since the mid-1990s, with adolescent fertility in Bangladesh being one of the highest in the world. One-third of adolescent married women aged 15-19 years have begun childbearing. Childbearing among adolescents is higher in rural than urban areas; higher among those with no education than those with education; and higher among those in the lowest wealth quintile than those in the higher wealth quintiles (NIPORT, Mitra and Associates and Macro International, 1994, 2005 and 2009).

There are sharp differentials in fertility levels. Fertility is lower in urban than rural areas by about half a child; lower in Khulna and Rajshahi divisions (where replacement or near replacement level fertility has been reached) than in Sylhet and Chittagong divisions (with TFR ranging between 3.2 and 3.7); lower among educated women (women with secondary complete or higher education have reached near replacement level fertility of TFR of 2.3) compared to a TFR of 3 among women with no education); lower among women in the highest wealth quintile (who have reached replacement level fertility) than those in the lowest wealth quintile (TFR of 3.2) (NIPORT, Mitra and Associates and Macro International, 2009). Also, fertility is lower among limiters and spacers, those with access to mass media than those without, ever-users of FP methods, working women, women belonging to landed households, and those belonging to households with electricity connection, an indicator of not only economic condition of the household but also its level of monetization (Khuda, 2004; Neaz et al 2004).

There has been a slow but steady rise over the past 25 years in the age at which Bangladeshi women marry, from a median age at marriage of 14.1 years for women in their late forties to 16.4 years for women in their early twenties<sup>1</sup>. The median age at marriage is about two years lower than the legal minimum age at marriage for females. The median age at marriage is positively associated with level of education and wealth status (NIPORT, Mitra and Associates and Macro International, 2009).

Bangladeshi women begin early childbearing. Women, on average, have about one-quarter of their children before reaching 20 years, more than half of their children during their twenties, and one-fifth during their thirties. The median age at first birth is only about 18 years. It is one year higher in urban (19 years) than rural areas (18 years), about four years higher among educated women (21 years) than those with no education (17 years), and two years higher among women in the highest wealth quintile

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<sup>1</sup> About 50 percent of the females under 20 years of age are married in Bangladesh compared to 33 percent in India, 25 percent in Pakistan, and much less in other developing countries (GOB, 2004).

(19 years) than those in the lowest wealth quintile (NIPORT, Mitra and Associates and Macro International, 2009).

Birth intervals are generally long in Bangladesh, with a median interval of about 44 months; however, it is only 25 months among adolescent mothers (NIPORT, Mitra and Associates and Macro International, 2009).

Under-five mortality, child mortality and post-neonatal mortality have shown considerable decline; however, neonatal mortality continues to be high, with around 71 percent of infant deaths occurring during the first 28 days of birth. Maternal mortality, which has shown some decline, continues to be unacceptably high, given that only 15 percent of births take place in a health facility and only 18 percent of babies are delivered by medically trained providers. Half of pregnant women received antenatal coverage (ANC) from a skilled provider. Sixty percent of women received at least two doses of tetanus toxoid (TT) for their most recent birth, 23 percent received only one TT injection, and 17 percent received none. The percentage of women receiving no ANC is especially high in Sylhet (46%) and Barisal (48%) divisions (NIPORT, Mitra and Associates and Macro International, 2009).

Knowledge of HIV/AIDS among ever-married women increased from 19 percent in 1996-97 to 67 percent in 2007. The corresponding figures for currently married men were 34 and 87 percent. However, based on an indicator of comprehensive knowledge of HIV/AIDS (which includes that knowing the HIV can be prevented by using condoms and having just one, uninfected partner; knowing that a healthy-looking person can have HIV; and rejecting the two most common misconceptions about HIV/AIDS--that HIV can be transmitted by mosquito bites, and that a person can become infected by sharing food with someone who has HIV), only 6 percent of ever-married women and 14 percent of ever-married men have comprehensive knowledge of HIV/AIDS (NIPORT, Mitra and Associates and Macro International, 2009).

It is clear that Bangladesh is facing a serious demographic crisis in terms of growing population size and density, proportion of the population under 15 years of age, increasing number of married women in reproductive ages, stalling and/or near stagnation in fertility, extremely high level of adolescent fertility, sharp differentials in fertility by socio-economic characteristics of the women, low female age at marriage, early childbearing, and high neonatal and maternal mortality. Such demographic challenges place enormous burden on the limited resources of the country insofar as poverty reduction and efforts to tackle environmental and climate change are concerned. Also, these are seen as hindering efforts to achieve other reproductive goals, including reduction in maternal mortality.

## **2.2 Socio-economic Changes**

Major socio-economic changes have taken place in Bangladesh over the past two decades, both on the positive and negative sides, affecting fertility norms and behaviour. Changes in the positive direction include increase in female education, employment, women's empowerment and access to mass media; while changes in the negative direction include increasing landlessness, shrinking employment opportunities in the agricultural sector, high incidence of poverty and growing urbanization.

The education sector has witnessed considerable improvements. The literacy rate of adult population aged 15 years and above increased from 45 percent in 1995 to 51 percent in 2006, with the rate being higher among males (59%) than females (49%), and higher in urban (67%) than rural areas (49%). Between 1985 and 2005, primary school enrollment increased by about two times (from 10 million to 16 million) and secondary school enrollment increased almost three-fold from 2.6 million to 7.4 million (GOB, 2009).

The per capita income is only around US\$700, with sharp inequity in income distribution. Forty percent of the population lives below the poverty line, mostly in rural areas and urban slums. The present government has placed elimination of poverty and inequity at the forefront of its development strategy. In the FY2010-11 budget, the government allocated 14.8 percent of the total development and non-development budget and 2.5 percent of the total GDP for social security and social empowerment (GOB, 2010 a). The aim is to bring down the poverty rate from 40 percent in 2008 to 15 percent by 2021. The social safety net measures also partly address the needs of the elderly population by providing monthly allowance of Tk. 300 to select number of beneficiaries (Khuda, 2010 a).

There has been a considerable rise in the Human Development Index (HDI). According to Bongaarts and Watkins (1996), the HDI for Bangladesh rose by 45.5 percent between 1960 and 1980. Between 1980 and 2007, the HDI for Bangladesh increased by 1.86 percent per annum from 0.328 to 0.543, giving the country a rank of 146<sup>th</sup> out of 182 countries (UNDP, 2009).

Because of rising population size, the land-man ratio continues to worsen. The average farm size is smaller now than before, with increasing landlessness and rise in the number of marginal farmers. This has reduced the demand for household labour on the farm. As a result, there has been increasing rural-urban migration, especially to Dhaka city (Alam and Khuda, 2010).

The male labor force participation rate (LFPR) remained almost unchanged at around 56 percent from 1974. However, the female LFPR, which was quite negligible until 1985-86, increased to 29 percent in 2005-06 (Khuda, 2010 b). Part of the increase in female LFPR is due to changes in definitions used

in the different censuses and labor force surveys, while part of the increase is real reflecting their increased participation in labour force. In 2006, the garment industry provided jobs to 4.5 million people in urban areas, 80 percent of whom were females, mostly young and unmarried (ADB, 2006). The number has increased since 2006, because of further expansion in the garment sector. There is evidence of poverty-driven female employment, resulting from poor household economic condition and high rates of female headship (Rahman, 1986; Safilias-Roth-Schild and Mahmood, 1989; BIDS, 1990; Rahman and Hossain, 1991).

Notwithstanding that women in Bangladesh are a disadvantaged group, their status has improved. In general, they now have greater freedom of movement, enhanced role in household decision making, relative freedom from more patriarchal structures than before, and increased contraceptive use (see, for example, Khuda et al 1990a and b, and 1993b; Schuler and Hashemi, 1994; Islam et al 2000; and NIPORT, Mitra and Associates and Macro International, 2009).

There has been a considerable increase in access to mass media, both print and electronic. Ideational changes resulting from increased access to the media have fostered modern outlooks and attitudes in general and those relating to FP and RH in particular. The influence of modernization helped to change the high fertility norms, even among the poor, who, themselves have experienced increase in contraceptive use and decline in fertility over time, though much less than the relatively well-off. Among the poor, two forces operate to depress fertility norms. On the one hand, it is poverty-led because of the inability to maintain a large family; while on the other hand, it is aspiration-driven being imbued by modern ideas and attitudes (see also Caldwell et al 1999 and Khuda et al. 2001).

### **3. Family Planning Programme**

#### **3.1 Evolution and Development**

The FP activities in Bangladesh have been carried out in three distinct phases. Phase I activities were largely voluntary, with the setting up of the Family Planning Association in 1953 by a group of dedicated social workers, who realized the adverse consequences of population growth on the development efforts of the country. Subsequently, the voluntary activities received some limited support from the government.

Phase II activities began in 1960, with the government taking some broader steps to check the population growth rate. Population control was made the official policy in the First Five-Year Plan of Pakistan (1960-65). A sizable cadre of FP personnel was recruited; a number of clinics were set up; a training-cum-research institute was established; and information, education and communication (IEC)

activities emphasized clinic-based counseling and dissemination of knowledge about contraceptives by physicians and paramedics.

Phase III activities were initiated in 1973 with the launching of the First Five-Year Plan of Bangladesh. The Plan attached equal priority to population control and food production. It marked the beginning of a multi-sectoral and broad-based population control and FP programme in the country. At a meeting of the National Population Council in June 1976, population was declared as the number one problem for the country. The GOB emphasized the urgent need to make the FP programme an integral part of the development process. The base of the programme was broadened by integrating maternal and child health (MCH) activities. Other positive developments included recruitment and training of field workers; introduction and subsequent availability of menstrual regulation (MR) services; setting up of mobile sterilization teams; setting up of upazila (sub-district) MCH clinics; strengthening of IEC activities; involvement of multi-sectoral ministries; and involvement of NGOs and the private sector. The programme was further strengthened in the subsequent plans<sup>2</sup>.

### **3.2. Programme after ICPD**

Following the ICPD, the GOB formed a National Committee and developed a National Plan of Action for implementation of the goals set in the ICPD POA. Under the integrated approach of population and development, national policies on Population, Health, Women, Maternal Health, HIV/AIDS and STD, Children, Environment, Food and Nutrition were formulated; and strategies were developed for Economic Growth, Poverty Reduction and Social Development, Reproductive Health, Population, Health and Nutrition (UNFPA/GOB/MOHFW, 2005).

Major changes had been taking place in the FP and RH programme in Bangladesh even before the ICPD. Following the ICPD POA, however, integration of FP within the RH programme was further strengthened. In 1996, the MOHFW prepared “Strategic Directions for the Bangladesh National Family Planning Program: 1995-2005”, which focused on a client-oriented approach to expand quality FP services and achieve replacement level fertility by 2010 (GOB, 1996). The 2004 Population Policy recognized that the high rate of population growth and the resultant increase in population size adversely affect the pace of development, and emphasized the need for involvement of other concerned ministries in population-related activities. The 2004 Population Policy is being revised in line with the GOB’s intention to implement a broad-based response to the population crisis faced by the country. The goals of the draft revised 2010 population policy are to focus on improving

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<sup>2</sup> For a more elaborate discussion on the evolution and development of the FP programme in Bangladesh, see, Khuda, 1981 and 1984; Khuda et al., 1992, 1993a and 1994 a; Khuda and Anwar 2004; Khuda and Barkat 2010; Cleland et al 1994.

the status of FP and maternal and child health, including RH services, and to improve the living standard of the people.

The MOHFW is primarily responsible for providing health, population and nutrition services to the people of Bangladesh through its two directorates—DGHS and DGFP and one project, the National Nutrition Project (NNP). The MOHFW's activities are supplemented by many NGOs and the private sector, including the Social Marketing Company (SMC). The DGFP provides the following types of services through its field-based network and facility-based service delivery points, the Maternal and Child Welfare Centres (MCWCs): FP, antenatal care (ANC), postnatal care (PNC), normal vaginal deliveries, C-section deliveries, EPI, behavior change communication (BCC), adolescent RH services, menstrual regulation (MR), sexually-transmitted infections (STI) screening and treatment, and STI prevention through provision of condoms. The DGHS provides preventive and curative health care services, including managing the HIV/AIDS programme under funding from the Global Fund for AIDS, TB and Malaria (GFATM), with no involvement of the DGFP in the latter programme under which it imports condoms separately and distributes those free of charge, unlike in the FP programme where it is sold at Tk.1.20 per dozen of condoms. The NNP manages the nutrition programme.

The Health and Population Sector Programme (HPSP) was formulated as part of the Fifth Five-Year Plan (1998-2003), keeping in view the principles of the Health and Population Sector Strategy (HPSS), which called for a single and integrated sector for both health and population (GOB, 1998). The main objective of the HPSP was to ensure universal access to essential health care services of acceptable quality and to further slow down the population growth rate. The Essential Services Package (ESP) delivered through different levels of the primary health care system (community, union, upazilla and district levels) included RH services, including FP; child health and immunization; control of selected communicable diseases; limited curative care and BCC. The HPSP targets were not achieved (Streatfield et. al. 2003). The Health, Nutrition and Population Sector Programme (HNPSPP) was launched in 2003 (GOB, 2004). Adolescent health became a major part of the ESP under the HNPSPP. The HNPSPP targets are to: (i) increase the CPR from 54 percent in 2003 to 72 percent by 2011; (ii) reduce discontinuation rate of contraceptives from 44.5 percent in 2007 to 20 percent by 2011; and (iii) increase the uptake of LAPM—VSC:17,50,000, IUD:23,00,000 and Implant: 10,50,000 (GOB, 2008 a). However, the targets are quite over-ambitious, and hence, are not likely to be achieved. With one year left into the HNPSPP, the MOHFW has begun the process of designing its next 5-year health, population and nutrition programme. The Health, Population and Nutrition Sector Strategic Plan (HPNSSP) has identified the key interventions required to accelerate the pace of the health, population and nutrition sector, so that it becomes more responsive to clients' needs, more efficient in the delivery of services and more effective in providing key services for poor

people. It proposes to revitalize various FP interventions to achieve replacement level fertility by 2016 by giving priority for: (i) efforts to delay age at marriage and age of childbearing; and (ii) increase in use of long-term and permanent methods (LAPM) (GOB, 2010 b).

Recognizing the threats of HIV/AIDS, the GOB developed a comprehensive policy on HIV/AIDS and STD related issues in 1997 to provide necessary guidance and support to address the issue. The MOHFW has the overall responsibility for HIV/AIDS programmes, and other related ministries support its activities. There is a STD/AIDS network consisting of more than 135 NGOs and private organizations, which is working actively to coordinate and strengthen HIV/AIDS related activities.

The HIV/AIDS and STD Surveillance was set up in 1998 to monitor trends of HIV infection and risk behaviours for HIV transmission among the most vulnerable population groups (IDUs, CSWs and MSM) and among the bridging population (transport workers). Targeted interventions are being implemented with high-risk and bridging population groups (UNFPA/GOB/MOHFW, 2005).

### **3.3 Achievements**

The Bangladesh Family Planning Programme has become a social movement. It received the highest political commitment until the mid-1990s. The programme has the support of the elite, including journalists (Khuda et.al. 1994 a). Also, the role of religious leaders is, by and large, positive (Khuda 2004).

Knowledge of FP method is almost universal among Bangladeshi couples. In the context of favourable political and religious environment, the FP programme in Bangladesh achieved commendable success until the mid-1990s. From about 4 percent of married couples using FP in the 1960s (Sirageldin et. al., 1975; Stoeckel and Chowdhury, 1973; Azhar and Hardee, 1977), the contraceptive prevalence rate (CPR) slowly increased during the 1970s (Kingdom of Netherlands, 1978; Mia et.al., 1978; Bhuiyan, 1980; Khan et.al., 1977; Khan, 1981; Khuda, 1981). In 1993-94, the CPR increased to 44.6 percent, i.e. almost six-fold increase compared to 1975. Thereafter, the rate of increase slowed down, and in fact declined from 58 percent in 2004 to 56 percent in 2007 (Figure 2 and Table 1).

The achievements until the mid-1990s can be attributed to strong political will and commitment since the launching of the First Five-Year Plan of Bangladesh until the mid-1990s, increase in the demand for FP services, provision of such services by the FP programme, and socio-economic development (see, e.g. Cleland et.al 1994; Caldwell et.al 1999; Khuda et.al 2001; and UNFPA 2010) .

### **3.4 Programmatic Gaps**

#### **3.4.1 Policy Environment**

The overall political environment in the country is far less supportive of a broad-based approach to containing the rate of population growth in the country (see also Alauddin et. al. 2010). Indeed, since the mid-1990s, there has been erosion in political will and commitment of successive governments to tackle the problem (Khuda and Barkat, 2010). This is clearly the major gap, because all other gaps discussed below are due to lack of political will and commitment, which, in turn, has adversely affected programme implementation at different levels. Based on the family planning programme effort studies conducted in several countries, including Bangladesh, in 1999, 2004 and 2009, the overall Policy score has declined in Bangladesh between 1999 and 2009 (Appendix Table 1).

#### **3.4.2 Slowing down in the rate of increase in the CPR**

Between 1975 and 1989, the CPR increased from about 8 percent to 31 percent, i.e.1.6 percent increase per year. Between 1989 and 1991, there was a sharp increase in the CPR from 31 percent to 40 percent, i.e. 4.5 percent increase per year. Thereafter, the rate of increase in the CPR slowed down. Between 1993-94 and 2004, the CPR increased from 45 percent to 58 percent, i.e.1.3 percent increase per year. Worse still, the CPR declined from 58 percent in 2004 to 56 percent in 2007. A similar pattern emerges, if we look at the trend in the use of modern methods, which remained almost unchanged between 2004 and 2007 (Figure 2 and Table 1). Data from the ICDDR, B Matlab area, which had considerably higher CPR than the national rate over the past years, also show a declining trend in CPR from over 70 percent in 2004-05 to 56.6 percent in 2007 and further down to 54.4 percent in 2008 (ICDDR, B, 2010). The slowing down in the rate of increase in the CPR is a matter of concern, given the need to accelerate the rate of increase in the CPR to achieve the desired reduction in fertility.

The decline in the rate of increase in the CPR and the decline in the CPR between 2004 and 2007 is due to the following gaps in the programme: (i) erosion in political will and commitment, (ii) failure on the part of the 1994 ICPD to clearly operationalise how FP was to be made an integral part of the RH programme, (iii) various organizational weaknesses of the programme, (iv) variations in contraceptive use by region and place of residence, (v) low contraceptive use among young married women, (vi) low fieldworker visitations, (vii) declining trend in the relative share of LAPM, (viii) high discontinuation rate, and (ix) rising unmet need for contraception and high future intention to use FP.

### **3.4.3 Inadequate Coverage, Low Quality, and Inappropriate Method Mix**

**(i) Inadequate and Inefficient Service Delivery:** The FP service delivery suffers from various constraints. These include, for example, inadequate funding by the GOB; inadequate staffing; lack of a regular, reliable and uninterrupted supply of contraceptives; scarce and inconsistent BCC messages; lack of strong technical and managerial leadership; and limited role of the NGOs and the private sector, with the exception of the Social Marketing Company SMC). All these result in a general lack of access to quality FP services, especially in the low-performing areas.

Field workers are a critical part of the FP programme. Their role is advocacy, motivation and supplying/resupplying FP methods. They visit women at their homes to motivate them about using FP, teach them about FP practices, provide women with contraceptives, help re-stock them on a regular basis, and make referrals for LAPM. However, only 21 percent of the married women in the 2007 BDHS reported having been visited by a FP fieldworker (84% of them by GOB field workers and only 16% by NGO field workers), which declined sharply from 43 percent in 1993-94 (Table 1). More than 85 percent of the young (15-19 years) and old women (45-49 years) did not receive any field worker visit. Chittagong had the lowest fieldworker home visitation rate (14%), followed by Sylhet (18%) compared to Rajshahi (26%) and Khulna (24%). It was lowest among women with no living children (7%). Also, it was lowest among pill users (36%), followed by IUD and injectable users (29%) and condom users (24%).

The public sector programme is faced with the problem of shortage of field workers, the Family Welfare Assistants (FWAs). Over the past several years, their number has declined, because fresh recruitment has been on hold. The majority of the field workers, recruited two to three decades ago, will be retiring in the next 2/3 years. The problem is further compounded by the fact that the FWAs, who were originally recruited to serve an average of 600 households, are now responsible for almost double that number. In addition, they are now responsible for a broader array of health information and services (such as supply of ORS, Vitamin A capsules, and health education on ANC and PNC, newborn, nutrition, and adolescent health), thereby diverting their time away from FP service delivery activities.

Most of the FWAs who were recruited two to three decades ago have not received adequate follow-up training, and hence, are unable to effectively counsel clients on side effects of different FP methods and successfully match clients to different methods, based on their reproductive life-cycle needs. It is, therefore, not surprising that a sizeable proportion of older, high-parity women continue to use the

pills rather than switch to LAPM. Further, the very high and rising rates of discontinuation among the users indicates poor quality of services.

The public sector is the predominant source of supply of FP methods, providing contraceptives to half of all users, although its contribution to FP provision has declined by seven percentage points in 2007 compared to 2004. The public sector is the predominant source for female and male sterilization, injectables and implants, while the private sector is the predominant source of oral pills and condoms. Forty-five percent of pill users in 2007 used SMC brands compared to 52 percent who used the government-supplied brand. Condoms sold by the SMC account for over 60 percent of the total market share, with the public sector accounting for 17 percent, and the rest by private sources and others (NIPORT, Mitra and Associates and Macro International, 2009). The overall Services score has declined in Bangladesh between 2004 and 2009 (Appendix Table 1).

**(ii) Low Contraceptive Use among Young Married Women:** Women less than 20 years of age—adolescents-- accounted for 13 percent of the married women interviewed in the 2007 BDHS, less than 42 percent of whom used contraception and only 38 percent used modern methods. Of those using modern methods, 78 percent were on the pill. Compared to the national rates, the CPR and the use of modern methods among adolescent women were lower-- 25 percent and 21 percent respectively. Given the disproportionately high share of such women in the total fertility rate (23%), low contraceptive use among young married women is a major gap in the programme.

**(iii) Regional Variations in Contraceptive Use:** There are pronounced regional variations in contraceptive use in Bangladesh. The CPR and use of modern methods are more than twice as high in Rajshahi division (66% and 57% respectively) compared to Sylhet division (32% and 25% respectively).

The CPR varies by place of residence. It is higher in urban (62%) than rural areas (54%), although the urban-rural gap has been narrowing down since 1996-97. The urban-rural gap is primarily due to higher use of condoms in urban areas (9.5%) than in rural ones (3%). Within urban areas, the CPR is lower in slums than in non-slum areas (NIPORT, MEASURE, ICDDR, B and ACPR, 2008).

The variations in contraceptive use by region and by place of residence indicate limited access to, and availability of, FP services across different regions of the country. Also, this is due to lack of adequate and effective BCC campaigns in the under-served areas of the country.

**(iv) Declining Share of LAPM:** Over time, the relative share of modern methods has increased, although the relative use of LAPM has declined. Global experience shows that the most successful FP programmes include considerably high use of LAPM (see, e.g. UNFPA, 2010). Modern methods account for over 85 percent of overall contraceptive use. The pill continues to be the most popular FP method, used by 28.5 percent of currently married women, followed by injectables (7%), sterilization (5.7%), and condoms (4.5%) (NIPORT, Mitra and Associates and Macro International, 2009).

With the increase in use of short-term methods, especially the pill, the contraceptive method mix has changed over time. For example, the pill now accounts for 60 percent of modern method use compared to 48 percent in 1994. Similarly, injectables now account for 15 percent of modern method use compared to 12 percent in 1994. In sharp contrast, the relative share of LAPM declined from 32 percent of modern method use in 1994 to only 14 percent in 2007. As already noted, Bangladeshi women begin early childbearing, and have more than half of their children during their twenties and one-fifth during their thirties. The median age of sterilized women was quite high (27 years) in 2007, which has remained unchanged since 1993 (NIPORT, Mitra and Associates and Macro International Inc. 2009). High median age for sterilization and early pregnancies pose major problems in maintaining small and healthy families.

The change in the contraceptive method mix has implications for the FP programme in respect of reliance on fieldworkers, especially among the poor, rural women, for re-stocks of modern temporary methods as well as on the overall programme sustainability. Also, the extremely low fieldworker home visitation, especially in areas with low CPR, among women with one or no living child and among condom and pill users, adds a new dimension to the problem. In addition, the change in method mix has implications for the women themselves. About one-fifth of married women aged 35 years and above and over one-quarter of those with three or more surviving children relies on the pill. Relying on the pill rather than accepting LAPM poses a major problem for the efficiency of the programme.

Under the Mayer Hashi Project, funded by USAID, the goal is to achieve 5 million voluntary sterilization (VS) clients over the 4-year project period (May 2009 to September 2013). The target is unlikely to be achieved because of lack of prerequisite conditions such as shortage of trained providers. The LAMP achievements are below the targets (GOB, 2008 a), and this has been further confirmed by the concerned DGFP officials. The Mayer Hashi Project is implemented by EngenderHealth in collaboration with DGFP.

Figure 3 shows the trend in LAMP performance in the national programme. The total number of VS cases increased from around 70,000 during October 2002-September 2003 to about 300,000 during October 2009-September 2010; however, the numbers declined during October 2005-September 2006 and during October 2001-September 2008. The number of IUD acceptors increased from less than 200,000 during October 2002-September 2003 to around 350,000 during October 2008-September 2009, but then declined to around 200,000 during October 2009-September 2010. The number of Implant acceptors increased from over 50,000 during October 2002-September 2003 to over 200,000 during October 2008-September 2009, but then declined to 50,000 from October 2008. The decline in the use of the different LAMPs between October 2002 and September 2010 is largely on account of stock-out of such methods; and shortage of trained providers, equipment, infrastructure and finance. Further, the demand for LAMP is affected by the poor quality of services in the public sector and lack of promotional efforts. Overall, the quality of health and FP services continues to be low, and this disproportionately hurts the poor (The World Bank, 2010).

**(v) High Discontinuation Rate:** A key concern for FP programmes over-dependent on temporary modern methods is the rate of discontinuation and clients' reasons for discontinuation. Over half (56.5%) of the users stopped using a method within 12 months of starting its use in 2007, up from 48 percent in 1993-94 (Table 1). Discontinuation rate was highest among condom users (76%), followed by those practicing withdrawal (67%), pill (54%), injectables (53%) and IUD (33%). Most users drop out because of method failure, side effects, health reasons, or because they want to become pregnant. Dropping out on account of side effects and method failure indicates low quality of FP services. Such high drop-out rate indicates huge system loss for the programme.

#### **3.4.4 Rising Unmet Need and High Future Intention to use FP**

**Rising Unmet need for contraception:** Unmet need for contraception increased from 11 percent in 2004 to 17 percent in 2007 (Table 1). Further, if those using traditional methods of FP (8% in 2007) are considered, unmet need for effective methods of contraception was 25 percent in 2007. Unmet need has increased across all age groups, all educational groups, in both rural and urban areas, and in all geographic regions of the country. Unmet need is highest in Sylhet division (26%), and it is lowest in Khulna and Rajshahi divisions (12%). Unmet need is higher among limiters (11%) than spacers (7%). The increase in unmet need reflect problems with fieldworker home visitations, the supply of FP methods and services, and/or an actual increase in the demand for FP.

**High Future Intention to Use:** Seventy percent of the non-users in the 2007 BDHS reported that they want to use FP in future (Table 1). The high proportion of non-users who intend to practice FP in

future creates both a challenge as well as an opportunity for the programme to be able to provide them with access to quality FP services.

### **3.4.5 Gaps in Contraceptive Security**

The term “commodity security” is used to describe a situation where every person willing to practice FP is able to choose, obtain and use quality FP methods at the right time and in the right place. “The Six rights” principles are: right commodities, right quantities, right conditions, right place, right time, and right prices (GOB, 2010 c). Contraceptive security exists, when the following four conditions are met by the programme: (i) its ability to accurately estimate its contraceptive requirements; (ii) it has or coordinated the necessary funding to procure contraceptives; (iii) it has the technical capacity to procure contraceptives on a timely basis; and (iv) it is able to ensure reliable delivery and availability of contraceptives to the end-users for the medium- to long-term future. Of the four essential conditions for achieving contraceptive security, the ability to procure commodities has been the most difficult for Bangladesh (GOB, 2004 b).

The contraceptive requirements of Bangladesh are met by the public sector, the SMC, private sector and NGOs. Except for the private sector, the public sector, with grant from development partners and loan from the World Bank/IDA, is procuring contraceptives for the public sector and NGOs. The SMC currently receives commodities directly from donors and procures some products with the sale proceeds of donated contraceptives.

Before 1998, most contraceptives were supplied by the donors (DFID, KfW, CIDA, UNFPA and USAID) to the Bangladesh FP Programme. Under the HPSP with a budget of approximately US\$ 3 billion provided by the GOB and the World Bank, a pool of development partners, about half of the funds were allocated for procurement of goods and services. Procurement was to be carried out in line with IDA and World Bank procurement guidelines. Due to lack of experience within the MOHFW with these procurement guidelines, the Development Credit Agreement called for the MOHFW to contract a private procurement agency, which, however, did not work out. Subsequently, the responsibility of procurement was assigned to the two directorates, DGFP and DGHS. However, due to lack of prior experience of DGFP and DGHS with procurement and lack of familiarity with the IDA and World Bank procurement guidelines, the procurement process was ineffective, leading to considerable delays in processing orders as well as delivery of commodities. To address this problem, USAID’s DELIVER project provided technical assistance to train procurement staff of DGFP and DGHS (USAID/DELIVER Project, 2008).

The procurement and supply of goods under IDA guidelines, World Bank procedures and the Government of Bangladesh Public Procurement Regulations is a complex process. Ideally, it takes between a year and a year and a half. The DGFP contraceptives procurement process funded during the contingency period (2003-05) was initiated in late 2005/early 2006. The delay in contingency plan funding was accompanied by delays encountered throughout the procurement process, resulting in delayed commodity deliveries and eventual stock-outs of condoms, IUDs, injectables and implant contraceptives. There was a shortfall of 247 million pieces of condoms between February and March, 2008; 614,000 IUDs between May and June, 2007; and 20 million injectables between November and December 2006 (USAID/DELIVER, 2008). Such shortfalls led to high discontinuation among users; and the method-mix being dominated by temporary methods, resulted in high incidence of unintended and unwanted pregnancies. According to the 2007 BDHS, three in ten births in Bangladesh are either unwanted or mistimed and wanted later, with no change from 2004 (NIPORT, Mitra and Associates and Macro International, 2009). The overall Availability score has declined in Bangladesh between 2004 and 2009 (Appendix Table 1).

Other constraints on availability of contraceptive methods include: (i) considerable shortage of trained providers hampering provision of tubal ligation, no-scalpel vasectomy, and IUDs; (ii) non-availability of emergency contraceptive pill (ECP), therefore leaving menstrual regulation (MR) and abortion as the only back-up method for method and/or user failure; (iii) non-availability of progestin-only pill (POP); (iv) stock-out of injectables; and (v) stock-out of Implants.

With technical assistance from donors, Bangladesh has developed large, successful supply chains for both the MOHFW and NGOs, and separately for SMC. However, about half of the Upazilas still do not have proper storage facilities, and generally keep their supplies in a small room of the Upazila Health Complex (UHC) or at the Upazila Parisad building (Upazila administrative complex), where it is not possible to follow basic storage principles. Further, the increase in contraceptive requirement could result in the warehousing system experiencing shortage of spaces.

The Government of Bangladesh undertook a number of measures to simplify and modernize the public procurement policy and procedures to minimize delays. Despite such efforts, delays continue to hamper the procurement process. Delays arise largely due to: (i) limited technical capacity of the DGFP and MOHFW officials and Tender Evaluation Committee (TEC) members; (ii) high staff turnover at DGFP and at MOHFW; (iii) considerable time involvement for MOHFW and World Bank Review Process; and (iv) lengthy time for decision making by MOHFW and World Bank officials.

The high turnover of trained procurement staff and senior management staff creates a knowledge and experience gap, limiting the capacity of the MOHFW/DGFP to carry out timely and effective procurement. Also, the TEC members do not have requisite knowledge for preparing acceptable bid evaluation reports.

### **3.4.6 Lack of adequate support for BCC**

Communication is an integral part of the FP programme facilitating exchange of information and ideas to promote and sustain behavioural changes among different population groups towards small family size norm and promote use of contraception.

The Information, Education and Motivation (IEM) Unit of the DGFP prepares various types of communication materials such as posters, handbills, billboards, short TV serials, dramas, radio jingles and advertisements; however, most such materials are out-dated and not tailored to meet the specific needs of different client groups. Also, there is no separate cadre of officials at the district level for BCC activities.

The major BCC objectives under the HNPSP include: (i) encouraging users not to discontinue FP use without valid reasons and continue with option to use other FP methods; (ii) developing positive attitude among the people about LAPM and promote male participation; (iii) extending BCC activities to hard-to-reach areas, urban slum dwellers and disadvantaged population groups; and (iv) increasing BCC knowledge among service providers for better counseling and quality care services. The key strategies include: (a) strengthening BCC interventions at service centres, (b) improving interpersonal communication (IPC) skill of service providers, (c) developing and disseminating appropriate messages using media mix, (d) advocacy programmes for policy makers and other stakeholders, and (e) promoting LAPM (GOB, 2008 a). To achieve the goals and objectives outlined in the HNPSP, the GOB developed the Adolescent Reproductive Health Strategy (GOB, 2006 b) and the National Communication Strategy for Family Planning and Reproductive Health (GOB, 2008 b). Although such strategy documents (as well as the previous strategy documents, see, for example, Khuda et. al. 1993 a) are quite comprehensive, their implementation has hardly begun. According to the concerned DGFP officials, the major constraints to implementation of such strategies include: (i) lack of adequate support from the higher level decision-makers, (ii) inadequate funding, (iii) lack of adequate number of trained staff, and (iv) limited capacity of the DGFP's printing press to print different types of BCC materials. As a result, both FP users and service providers have not been able to get access to relevant information from a coherent national BCC programme, which promotes small family size norms, counters clients' misinformation and misconceptions, provides clients with information regarding where services are available, and informs couples of their FP options. Consequently, basic

knowledge of FP methods is low; and provider knowledge is relatively low resulting in poor quality of service, which, in turn, leads to ineffective use of FP methods, unwanted pregnancies and increased use of MR and abortion (see also Alauddin et. al. 2010).

### **3.4.7 Limited Funding and Actual Expenditure**

The Total Health Expenditure (THE) was estimated at Tk. 159.91 billion (US\$2.32 billion) in 2007, up from Tk. 73.8 billion (US\$1.4 billion) in 2001 and Tk. 48.47 billion (US\$1.1 billion) in 1997. THE as percent of GDP was 2.7% during 1997-2000, which increased to 3.4% in 2007. Per capita spending on health increased from Tk. 391 (US\$9) in 1997 to Tk. 1,111 (\$16) in 2007, one of the lowest in the world. Bangladesh's public expenditure constitutes 26% of THE, similar to that of India (25%). Private expenditure as percent of THE account for 74 percent in Bangladesh, 83 percent in Pakistan and 52 percent in Sri Lanka.

Households pay for major share of the health expenditure in Bangladesh, whose relative share has increased from 57% of THE in 1997 to 65% in 2007. The GOB is the second largest financing agent accounting for 26% of THE in 2007, with its share declining from 36% in 1997.

For public sector financing, MOHFW serves as the primary financial intermediary of the GOB receiving funds from the Ministry of Finance (MOF). Of the total amount of public sector health financing, MOHFW's share was Taka 40.1 billion (\$581 million) which is 97% of the total public financing in 2007. MOHFW uses these funds primarily by disbursing them to its healthcare providing units. In addition to its own providers, through transfers and grant-in-aids to NGOs, MOHFW supports the health, FP and maternal and child health activities of NGOs (GOB, 2010 d).

The estimated budget for the HNPSP (2003-11) is Taka 3,738,411.05 lacs, of which Tk. 2,081,764.52 lacs (56%) is from the GOB Revenue Budget, Tk. 629,911.82 lacs (17%) from the GOB Development Budget, and Tk.1026734.71 lacs (27%) from Project Aid. For the development budget, the share of GOB is 38 percent and that of Development Partners is 62 percent. Out of the development budget of Tk. 1,656,647, the share of the FP and maternal, child and RH programme is Tk. 357,129 (22%) of the total development budget--- Tk. 98,662 lacs (16%) from GOB Development Budget and Tk. 258,467 (25%) from Project Aid. Of the total amount allocated to the FP and maternal, child and RH programme, FP Service Delivery accounts for 56 percent, while it accounts for only 12 percent of the total development budget to the health, population and nutrition sector (GOB, 2008 a).

During 2003/04 and 2009/10, actual expenditure from the Revenue Budget was over 90 percent in most years, except 2005/06 and 2008/09. However, expenditure from the Development Budget did not follow any clear pattern, ranging between 62 percent in 2008/09 to 89 percent in 2004/05 (Table 2). Thus, not only is allocation to the FP and maternal, child and RH programme inadequate, it is also unable to spend the funds allocated to it, thereby not being able to achieve the desired programme objectives. Inefficiencies in public spending remain the health sector's most immediate challenge. Widespread system inefficiencies, weak planning capacity and overly centralized approval process lead to under spending of available funds. Further, weak accountability, limited implementation capacity and weak governance inevitably lead to underperformance in the delivery of public services (The World Bank, 2010).

#### **4. The Way Forward**

Given the major gaps faced by the Bangladesh Family Planning Programme discussed in the preceding section of the paper<sup>3</sup> and identification of the HPNSSP's major interventions, there is need to adopt and effectively implement the following strategies to reverse the slowing down in the rate of increase in the CPR and the consequent stalling and/or near stagnation in fertility decline.

##### **4.1 Need to develop a supportive and proactive policy environment**

There is no doubt the Bangladesh Family Planning Programme has lost much of the focus and priority it had received until the mid-1990s. To fully achieve its development objectives and bring about the desired reduction in poverty levels, the GOB should give high priority to the FP and RH programme and make it an integral part of its overall development agenda; otherwise, the demographic challenges it faces will impede its overall development goals and objectives. Hence, there is clearly a need to develop a supportive and proactive policy environment by sensitizing the political leadership and other stakeholders of the country about the grave dangers of the continued relatively high population growth rate in the country. Also, there is a need for a more inclusive strategy, involving greater involvement and participation of all other concerned ministries, the NGOs, the private sector and professional groups. The political leadership should renew its commitment to containing the rate of population growth, as it had until the mid-1990s, instead of putting it in the backburner.

The HNPSP will end in June 2011, and the government is currently involved in designing its next five-year Health, Population and Nutrition Sector Strategic Plan (HPNSSP) (2011-2016). The Plan recognizes the demographic challenges faced by the country. The overall objective is to achieve replacement level fertility by 2016. The Plan aims at raising the CPR to 75 percent from 56 percent in

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<sup>3</sup> See also Khuda et. al. 1994 a and b; Khuda et. al. 1997; Khuda and Anwar 2004; Khuda and Barkat 2010; and UNFPA 2010.

2007 (GOB, 2010 e). The target appears ambitious, implying 2 percent increase in the CPR annually. However, given considerable unmet need for contraception, the target can be achieved, though with major modifications and overhauling of the programme. The HPNSSP has identified a number of interventions and modifications to the FP programme aimed at facilitating a further decline in fertility. These include the need to: (i) promote increased use of FP before the first birth; (ii) provide better counseling on side effects; (iii) hire additional field workers in low-performing regions; (iv) hire, train and update programme personnel; (v) improve delivery of FP as part of post-abortion care; (vi) use different service delivery approaches for different geographic regions; (vii) segment target population by specific characteristics; (viii) promote use of LAPM; (ix) strengthen BCC; and (x) improve commodity security.

#### **4.2 Need to adopt a client-segmented approach to both BCC and FP service delivery**

It is clear that the “one-size-fit” approach has not been working. Hence, there is need to develop a client-segmented approach to both BCC and FP service delivery to be able to motivate non-users to use FP; promote increased contraceptive use among married adolescents to delay their first birth; promote contraceptive use in under-served areas, including urban slums; increase use of LAPM; and motivate and provide methods of choice to those with unmet need and those who intend to practice FP in future.

Over two-fifths of eligible couples in Bangladesh are not practicing contraception. The priority target groups include married adolescents; women aged 35 years and above; those in Sylhet and Chittagong divisions; those in urban slums; those with unmet need for contraception, including those using traditional methods; non-users who intend to practice FP in the future; and those who could be motivated to adopt LAPM. It is, therefore, critical that the programme undertakes appropriate measures to motivate the priority target groups to start using FP by adopting a client-segmented approach to both BCC and FP service delivery. There should be a differential or segmented approach to both BCC and service delivery. Priority should be given to ensuring that trained providers are available to offer quality FP services. Efforts should be made to motivate men to practice male methods as well as support their wives to practice contraception by developing appropriate BCC messages and campaigns to remove misconceptions about male method; orienting and training staff on male involvement in RH and FP services; and providing services for males at the health centers, including mobile satellite clinics (see, e.g., Ashraf et.al.1999). Major emphasis should be given to implement the 2006 Adolescent Reproductive Health Strategy and the 2008 National Communication Strategy for Family Planning and Reproductive Health developed, with due emphasis given to: (i) sensitizing the policy makers and the population as a whole to the dangers of growing population and the need for smaller family size; (ii) addressing and reducing high-risk pregnancies; (iii) conducting

intensive BCC campaigns in low-performing areas, including urban slums; (iv) motivating traditional method users to switch to more effective methods of contraception; and (v) motivating temporary method users to use more effective methods of contraception, especially LAPM among older clients (see also Alauddin et. al. 2010).

#### **4.3 Need to improve Access to, and Quality of, FP Services**

Given the high discontinuation rate of contraceptive use, it is essential to improve the access to, and quality of, FP services. By providing good quality services, the programme can take advantage of satisfied clients in addition to field workers to advocate for FP methods to non-users. It is also imperative that couples have access to quality FP services. Efforts should be made to: (i) ensure that trained providers are available to offer quality FP services; (ii) increase the number of follow-up visits to improve continuation and effectiveness rates of commodity-based methods; (iii) provide better counseling on side effects; (iv) provide an appropriate mix of methods for spacing and limiting births; (v) improve delivery of FP as part of post-abortion care; and (vi) ensure that there is no stock-out of FP methods. Public-private partnerships should be strengthened to take advantage of the existing private-sector networks in the distribution/sales of contraceptives, successful supply-chain systems, and well-trained providers.

#### **4.4 Need to strengthen Service Delivery**

Currently, there is an underutilization of existing health care facilities, lack of adequately trained personnel, and negligence towards priority segments of the population. To improve the current FP programme and achieve the desired CPR, it is critical that the service delivery is adequately strengthened.

Efforts should be made to: (i) maximize the use of existing trained personnel, health care facilities, equipment and services for promotion of FP methods, including LAPM; (ii) give adequate emphasis to various priority segments of the population; (iii) remove internal conflicts between the medical and non-medical personnel within the DGFP; and (iv) ensure better coordination and linkages between the DGFP and the DGHS. The latter two measures are critical for reversing the declining trend in the relative share of LAPM as well as raising the overall CPR in the country. Also, the MOHFW should work in close collaboration with the Ministry of Local Government, the Urban Primary Health Care Project (UPHCP), BRAC and SMC in extending service delivery in urban slums.

Effective public-private partnerships should also be strengthened to assist the GOB in its efforts to improve the current FP programme. The private sector (for-profit) can play an important role in providing quality and accessible FP services at affordable prices, as is evident from the role played by

the SMC. Other private sector organizations can also be encouraged to sell contraceptives at affordable prices, and thereby contribute to the public sector efforts. If necessary, the government and/or donors should provide financial and commodity support to those private sector organizations as in the case of the SMC. At present, the role of the commercial sector is largely limited to oral pills and condoms; however, it is time to encourage the private sector hospitals and clinics to provide temporary as well as LAPM to the middle and higher income bracket populations. If service providers from the private health care facilities are provided with the necessary training on the standard service delivery protocols on LAPM, it will help the public sector efforts in increasing the use of LAPM among the upper and middle income groups. The role of NGOs, which played a pioneering and laudable role in the past, needs to be redefined. With only 16 percent of the women being visited by NGO field workers and NGOs accounting for only 4-6 percent of the CPR, there is need to reposition NGOs to serve different functions which the public sector is not adequately equipped to deal with such as serving under-served areas and providing specialized tasks such as training and BCC.

#### **4.5 Need to improve Commodity Security**

It is critical that the FP programme ensures consistent and uninterrupted supply of a broad range of FP methods as well as product varieties within methods. As already noted, the DGFP's procurement capacity is not yet up to the desired level. Therefore, there is a need to further enhance technical procurement capacity in the MOHFW/DGFP. Also, there is need to develop a chain of accountability within the DGFP for timely procurement of FP methods. The HPNSSP Pre-appraisal mission recommended that there is need, among other things, to identify the most efficient arrangement for managing the procurement functions across the seven procuring entities, and develop a procurement processing plan to ensure timely submission of the Operational Plans (OPs) and procurement plans each year (GOB 2010 f).

Being dependant on development partners (DPs) support, coordination among concerned stakeholders is needed to achieve contraceptive security in Bangladesh. Therefore, there is need to develop coordination mechanism among DPs for the purpose of jointly advocating GOB leadership in developing and implementing policies, practices and procedures relating to timely procurement and supply of contraceptives. The DGFP has established the Logistics Coordination Forum, which is supposed to meet quarterly to review consumption, stock, pipeline and procurement status; however, this forum has not met on a regular basis in the past. Hence, it should be ensured that this forum meets regularly to take existing stock of the situation and provide necessary remedial measures.

Based on the current consumption trends and projected requirements of contraceptives for the period 2011-2015, estimated cost of contraceptives for Bangladesh is about US\$ 55.6 million (Tk. 3,836.4

million) in 2011, which is projected to increase to US\$ 62.6 million (Tk. 4,319.4 million) in 2015 (GOB, 2010 c). To reduce the financial burden on the public sector and on the DPs, the costs of contraceptives should be shared by all the implementing partners in the programme, including NGOs, the SMC, the private sector and the end users, especially those belonging to the middle and upper income groups.

Emphasis should also be given to local production of contraceptives. At present, there are two condom manufacturers in Bangladesh: one in the private sector (the Bangla-German Latex Company Limited - BGLCL) and the other in the public sector run and managed by Essential Drugs Company Limited (EDCL). A pharmaceutical company “Organon Bangladesh” is producing Oral Pill in limited quantities, which are sold in the market at a higher price compared to the products offered by SMC. Preference for local manufacturers during public sector procurement will encourage growth of the private sector in the country in manufacturing contraceptives.

With the contraceptive requirement increasing, the warehousing system is likely to experience shortage of spaces. It is, therefore, imperative that an assessment be made of the storage needs for all tiers of the supply chain at least for next decade.

#### **4.6 Need to improve Programme Efficiency**

The current FP programme is inefficient due to a number of factors. These include low staff morale, absence of career planning, staff vacancies, inadequate training, staff over-burdened with various non-FP activities, poor monitoring and supervision, lack of leadership and management, limited funding, weak implementation capacity, and non-involvement of other concerned ministries. All these result in considerable system loss.

Efforts are, therefore, needed to: (i) address various human resource (HR) issues by giving top priority for recruitment of additional workforce both to fill in the existing vacant posts and to recruit additional staff, especially in the low-performing areas, to meet the needs of the increasing number of eligible couples; (ii) re-think the role of the DGFP in providing quality FP-related activities, like until the early-1990s, rather than being involved in various non-FP activities, thereby enabling the DGFP to achieve its primary goal of increasing the CPR and use of LAPM in bringing about the desired reduction in fertility; (iii) enhance training capacity (NIPORT is primarily responsible for training of fieldworkers and paramedics and undertake programmatic research, both of which, and especially the former, has remained largely under-utilized) to provide necessary training to programme personnel; (iv) improve staff morale through better job security, career planning and compensation packages; (v)

promote task-shifting among health care workers; (vi) train supervisors and managers who can provide guidance to other staff; and (vii) stop frequent transfer of programme personnel.

The GOB has decided to recruit 10,000 additional FWAs, 655 additional FWVs and 400 additional doctors; however, the recruitment process could take over a year to be completed at the earliest. After they are recruited, they need to go through training before they can begin their work. Regarding FWVs, the initial training period is of 18-month duration, followed by 6 months of midwifery training. Training of other staff is also needed to build and enhance their capacity, especially those dealing with BCC and procurement. The programme should address the issue of its inadequate training capacity by training its existing trainers; hire new, skilled trainers; update its training curriculum, protocols and manuals; and fully utilize its training infrastructure and facilities. Also, it should be ensured that the trained staff are not transferred to do other jobs, thereby not only reducing wastage of time and resources spent on training but also improving programme implementation.

Actions should also be taken to ensure active participation of concerned Ministries mandated to carry out various population-related activities, and encourage greater participation of the communities, NGOs and the private sector in providing and /or sharing the cost of FP supplies and services.

As already noted, the overall health expenditure is only around 3 percent of the GDP, with relatively smaller portion going to the FP and RH programme. Hence, there is need for increasing the budgetary allocation to the overall health sector, with a higher share earmarked for the FP and RH programme. However, the financial performance of the sector shows that while on the one hand it has not been able to fully utilize its funds from the GOB and DPs because of its weak implementation capacity, on the other hand the services it provides are under-funded, and hence, there is need for additional funding. This calls for a re-examination of the programme strategies along two lines: (i) how to more efficiently utilize the funds allocated to it by the GOB and the DPs; and (ii) how to increase the financial resource base for the programme. Hence, there is a need to enhance the programme implementation capacity to ensure more efficient use of available resources and avoid leakages in the system, and thereby, improve programme efficiency (also see GOB 2010 f). Regarding increasing the financial resource base for the overall health programme, three sets of budget estimates have been prepared for the HPNSSP (2011-2016): (i) Tk. 41,187,52 crore (US\$ 5,969.20 million), which is 2.5 times higher than the estimated cost of HNPSP (2003-11); (ii) Tk. 31,848,54 crore (US\$ 4,615.73 million), almost double the size of the development budget of HNPSP; and (iii) Tk. 26,030,00 crore (US\$ 3,772.46 million), over 60 percent higher than the development budget of HNPSP (GOB 2010 e). The FP and RH programme is projected to receive an allocation of only 16 percent, 21.6 percent and 22.2 percent respectively under the high, medium and low scenarios. In addition to GOB, the

HNP sector is currently being supported by 16 DPs in the form of both pooled and non-pooled parallel funding. The three estimated HNPSSP budgets depict a picture of the total development budget outlay. The GOB is projected to share the burden of 35 percent of the resource requirement, and expects the DPs to contribute the rest 65 percent of the development budget requirement for implementation of the HNPSSP (GOB, 2010 e). The DP support will be aligned with the sector programme and its components. DPs will finance part of the overall MOHFW's programme and budget, including technical assistance. The Pre-appraisal mission has identified, among others, the following next steps in relation to the next programme's budget: (i) MOHFW's total budget requirement for the Programme (2011-16) should include both the Revenue and Development Budgets; (ii) MOHFW will scrutinize the OP wise budget submitted by the Line Directors (LDs) in line with the goals, objectives, priorities and reform areas of the Programme, and rationalize the total development budget requirements, based on realistic increases in resource envelopes and funding gap; and (iii) based on the rationalized budget and availability of funds indicated by the DPs, MOHFW will suggest options for mitigating the funding gap, if any (GOB 2010 f).

## **5. Conclusion**

The Bangladesh Family Planning Programme was initiated by the government to reduce the rate of population growth. The Programme made great progress until the mid-1990s, but, due to erosion in political will and commitment and certain systemic issues, the programme has since then been lagging behind. The rate of increase in the CPR among married couples has considerably slowed down since then, and indeed, declined between 2004 and 2007. Among those using FP, most are opting for short-term methods rather than LAPM. The current programme is inefficient and ineffective. There is inadequate number of trained providers and lack of effective measures to improve job satisfaction. Also, there has been problem of stock-out of FP methods. Furthermore, there is limited funding available for the programme; and worse still, the funds are not fully utilized due to weak implementation capacity.

To achieve the desired increase in the CPR and fertility decline, the GOB should undertake a number of measures. First and foremost, there should be a renewed commitment on the part of the political leadership to contain the population growth rate in the country. Second, the systemic problems affecting the programme should be addressed on an urgent basis. Third, there is a need to re-think the role of the DGFP in providing quality FP-related services, like until the early-1990s, rather than being involved in various non-FP activities, thereby enabling the DGFP to achieve its primary goal of increasing the CPR and use of LAPM in bringing about the desired reduction in fertility. Fourth, both access to, and quality of, FP services should be improved by training workers, increasing field worker visitations, enhancing worker morale and job satisfaction, and ensuring that there is no stock-out.

Fifth, service delivery and programme efficiency should be enhanced by making better use of existing infrastructures, resources and personnel of both the DGFP and the DGHS to reach out to the underserved population groups. Sixth, effective public-private partnerships should be established to maximize use of existing resources, personnel and networks. Seventh, greater emphasis should be given to further improving child survival rate and the overall status of women, and thereby promote FP use among non-users. Eighth, female education should be made a national priority to empower women which will deter them from having more than the desired number of children and offer them attractive alternatives to childbearing. Finally, issues relating to better governance and accountability should receive high priority.

The GOB should re-evaluate its existing FP Programme, and adopt and effectively implement the strategies proposed above to make the programme more efficient and sustainable. This will help accelerate the rate of increase in the CPR and ultimately achieve population stabilization within the shortest possible time. Provision of quality FP services can save lives of mothers and children. FP could prevent as many as one in every three maternal deaths by enabling women to delay childbearing, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size. Thus, provision of quality FP services can help Bangladesh achieve its MDG-5 target, one of the most off-track MDGs. Moreover, FP use can help reduce poverty and promote economic growth by improving family well-being, raising female productivity, and lowering fertility (see, e.g. UNFPA 2010). Finally, the government should reposition the FP and RH programme as part of its overall development agenda; otherwise, its development objectives will not be fully achieved to the detriment of the country as a whole.

**Figure 1**  
**Trends in TFR in Bangladesh: 1975-2007**

Sources: Source: NIPORT, Mitra and Associates and Macro International Inc. (2009)

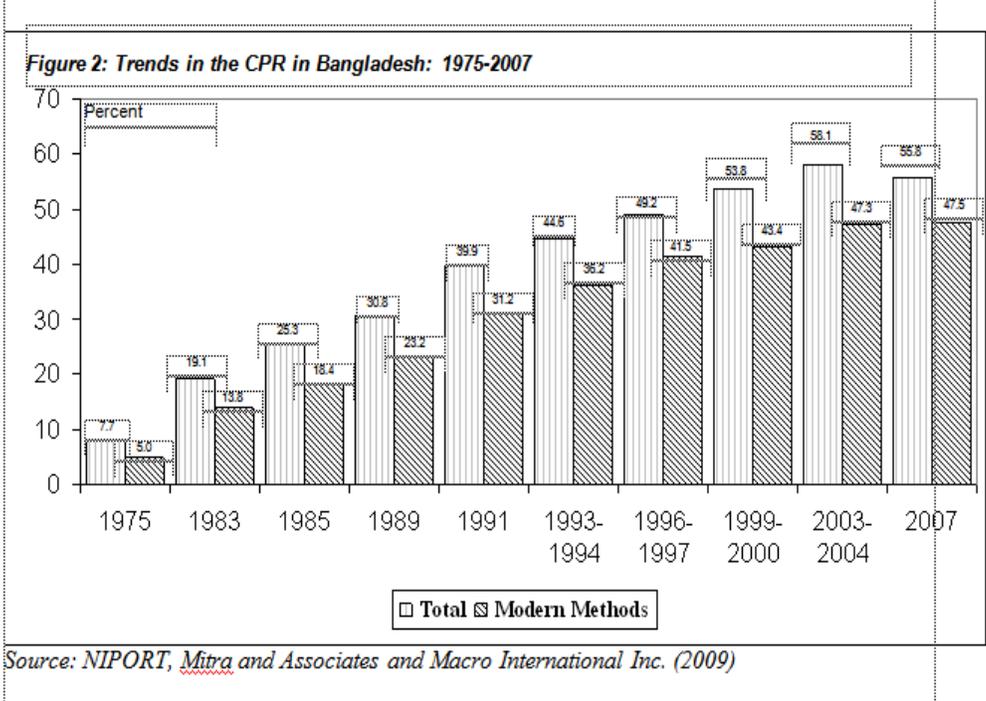
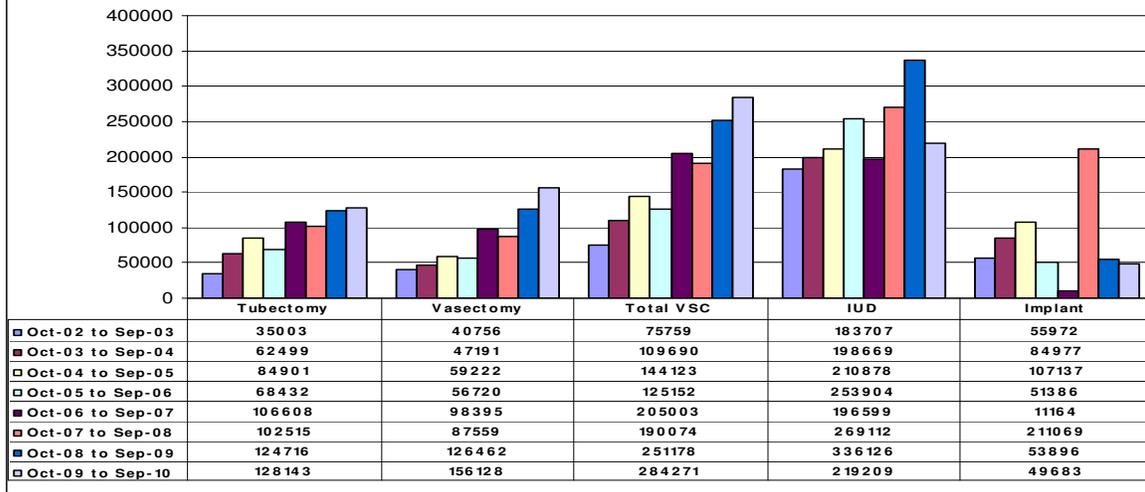


Figure 3

**Trend of National LA/PM Performance  
(October 2002 - September 2010)**



Source: Directorate General of Family Planning.

**Table 1: Data on Selected FP and Fertility Variables, Bangladesh: 1975-2007**

Variables	1975	1989 BFS	1991 CPS	1993-94	1996-97	1999 -	2004	2007 BDH
<b>1. Contraceptive Prevalence Rate (CRP) (%)</b>	<b>7.7</b>	<b>30.8</b>	<b>39.9</b>	<b>44.6</b>	<b>49.2</b>	<b>53.8</b>	<b>58.1</b>	<b>55.8</b>
1.1. Any Modern Method (MM) (%)	5.0	23.2	31.2	36.2	41.5	43.4	47.3	47.5
MM as % of CPR	64.9	75.3	78.2	81.2	84.3	80.7	81.4	85.1
1.2. Longer-acting methods (LAM)	1.6	11.1	12.1	11.4	10.5	8.4	6.4	6.6
LAM as (%) of CPR	20.8	36.0	30.3	25.6	21.3	15.6	11.0	11.8
LAM as % of MM	32.0	47.8	38.8	31.5	25.3	19.4	13.5	13.9
2. Field worker home visit (%)	N/A	41.0	N/A	43.0	35.2	21.2	18.2	21.0
3. Discontinuation of a FP method within 12 months after beginning use (%)	N/A	N/A	N/A	47.8	46.9	48.6	49.4	56.5
4. Unmet Need for Family Planning (%)	N/A	31.0	N/A	19.4	15.8	15.3	11.1	17.1
5. Future Intention to use family planning (%)	N/A	N/A	N/A	66.0	66.5	71.3	73.2	70.1
6. Percentage of currently married women wanting no more children in future, plus those sterilized	N/A	55.0	N/A	60.0	57.8	59.9	53.5	56.7
<b>7. Total Fertility Rate (TFR)</b>	<b>6.3</b>	<b>5.1</b>	<b>4.3</b>	<b>3.4</b>	<b>3.3</b>	<b>3.3</b>	<b>3.0</b>	<b>2.7</b>
8. Wanted Fertility						2.2	2.0	1.9

N/A= Not Available

**Sources:** Government of Bangladesh, Ministry of Health and Population Control (MOHPC), 1978. Bangladesh Fertility Survey, 1975-76: First Country Report, Dhaka; Mitra, S.N., C. Lerman, and S. Islam, 1993. Bangladesh Contraceptive Prevalence Survey-1991:Final Report, Mitra and Associates, Dhaka; Huq, M.N. and Cleland, J. 1990. Bangladesh Fertility Survey 1989: Main Report, National Institute of Population Research and Training (NIPORT), Dhaka; NIPORT, Mitra and Associates and Macro International Inc. 1994. Bangladesh Demographic and Health Survey 1993-1994, Dhaka; NIPORT, Mitra and Associates and Macro International, 1997. Bangladesh Demographic and Health Survey 1996-1997, Dhaka; NIPORT, Mitra and Associates and ORC International, 2001. Bangladesh Demographic and Health Survey, 1999-2000; NIPORT, Mitra and Associates and ORC Macro, 2005. Bangladesh Demographic and Health Survey 2004, Dhaka; NIPORT, Mitra and Associates and Macro International, 2009. Bangladesh Demographic and Health Survey 2007, Dhaka.

**Table 2: Budgeted Amount and Actual Expenditure under the FP and RH Programme:  
2003/04-2010/11  
(In Lac Taka)**

**Development Budget:**

FY	Budget			Expenditure			
FY	GOB	DPA (Project aid)	Total	GOB	DPA (Project)	Total	Expenditure as % of Budget
2003-04	13984	31733	45717	13090	21572	34662	75.82
2004-05	8400	29778	38178	6779	27123	33902	88.79
2005-06	7767	35888	43655	6952	23825	30777	70.50
2006-07	7844	48797	56641	6441	41589	48030	84.79
2007-08	9724	23175	32899	8453	19107	27560	83.77
2008-09	12557	38400	50957	11054	20306	31360	61.54
2009-10	13225	42995	56220	12590	34086	46676	83.02
2010-11	19906	33175	53081	19906	33175	53081	

**Revenue Budget:**

FY	Revised Budget	Actual Expenditure	Expenditure as % of Revised Budget
2003-04	30539.05	30263.14	99.09
2004-05	42557.80	39075.46	91.81
2005-06	51484.29	46239.95	89.81
2006-07	62629.01	59602.34	95.16
2007-08	62840.71	61566.17	97.97
2008-09	73694.66	63364.74	85.98
2009-10	79397.59	78691.18	99.11
2010-11	97829.32	-----	-----

Source: Directorate General of Family Planning

## Appendix Table 1: Family Planning Programme Effort Scores: 1999, 2004 and 2009

### 1999 Scores:

Country	Total	Policy	Services	Evaluation	Availability
Bangladesh	56.9	70.2	48.8	55.0	57.6
Cambodia	48.5	46.2	49.6	62.2	42.2
China	77.2	87.4	70.9	73.2	79.1
India	49.7	62.2	38.9	46.8	58.0
Indonesia	69.3	77.7	68.3	77.7	56.0
Iran	62.2	57.2	58.5	72.2	71.7
Laos	40.5	46.5	38.9	35.2	38.9
Malaysia	65.6	72.2	59.1	75.9	65.7
Nepal	51.8	61.2	46.3	53.7	50.1
Pakistan	46.1	49.9	42.0	49.6	48.1
Philippines	49.7	52.5	45.0	54.7	53.9
Sri Lanka	47.4	55.5	46.1	33.3	46.3
Thailand	71.2	72.2	66.2	74.0	79.6
Vietnam	66.7	83.0	56.9	54.7	72.2

### 2004 Scores:

Country	Total	Policy	Services	Evaluation	Availability
<b>Bangladesh</b>	<b>64.4</b>	<b>66.8</b>	<b>62.4</b>	<b>59.9</b>	<b>67.5</b>
Cambodia	46.0	48.2	46.0	41.4	45.4
China	71.3	81.9	71.1	66.1	61.8
India	48.7	65.1	41.4	39.7	47.4
Indonesia	56.4	63.4	56.5	57.5	47.8
Malaysia	62.9	62.5	61.5	68.3	63.4
Myanmar	31.8	29.7	31.0	36.6	33.8
Nepal	57.4	62.3	53.8	59.5	57.5
Pakistan	55.2	63.8	54.4	48.1	49.8
Philippines	46.9	48.2	43.8	59.5	45.5
Thailand	66.8	61.8	65.7	65.8	74.8
Viet Nam	72.5	82.3	66.8	63.5	75.9

### 2009 scores

Country	Total	Policy	Services	Evaluation	Availability
Afghanistan	50.7	56.0	51.6	53.4	41.8
<b>Bangladesh</b>	<b>56.4</b>	<b>61.1</b>	<b>53.1</b>	<b>49.5</b>	<b>60.2</b>
Cambodia	55.8	59.9	58.5	51.1	48.2
China	72.9	83.0	74.8	75.4	56.7
India	53.5	59.0	51.0	55.8	50.7
Indonesia	59.9	68.6	56.9	67.3	52.3
Malaysia	62.2	61.9	58.8	74.1	63.8
Myanmar	28.1	22.3	26.1	33.7	35.9
Nepal	56.8	58.4	55.0	48.3	62.0
Pakistan	45.7	59.6	42.5	45.3	35.9
Philippines	29.8	35.7	28.8	34.5	23.1
Sri Lanka	55.4	55.0	55.2	62.7	53.0
Viet Nam	71.1	77.8	67.4	63.3	73.8

Sources: Ross, John, and Ellen Smith. 2010. The Family Planning Effort Index: 1999, 2004, and 2009. Washington, DC. Futures Group, Health Policy Initiative, Task Order 1.

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## **Annexure 1: List of persons interviewed**

1. Mr.Md. Humayun Kabir, Secretary, Ministry of Health and Family Welfare (MOHFW), Government of Bangladesh
2. Mr. Abu Taher, Joint Secretary, MOHFW
3. Mr. Md. Abdul Mannan, Joint Chief, Planning, MOHFW
4. Mr. Md. Helal Uddin, Deputy Chief, Planning, MOHFW
5. Begum Dilruba, Additional Secretary and Director General, Directorate General of Family Planning (DGFP)
6. Mr. Faikuzzaman Chowdhury, Director, (Finance) and Line Director (Field Services Delivery Programme), DGFP
7. Mr. Ganesh Chandra Sarker, Director (IEM) and Line Director (IEC), DGFP
8. Dr. A.K.M. Mahbubur Rahman, Line Director, Clinical Contraception Services Delivery Program and Line Director (MCH Services), DGFP
9. Mr. Md. Humayun Kabir, Assistant Chief, Planning, DGFP
10. Mr. Dhiraj Kumar Nath, former Secretary and former Adviser, Government of Bangladesh, and currently Urban Health Expert, Asian Development Bank, Bangladesh Resident Mission, Dhaka
11. Mr. Arthur Erken, UNFPA Representative, Bangladesh, Dhaka
12. Dr. Bushra Alam, Senior Health Adviser, The World Bank, Bangladesh Country Office, Dhaka
13. Dr. Marcos Arevalo, Senior Family Planning Advisor, USAID, Dhaka
14. Dr. Shehlina Ahmed, Health and Population Adviser, DFID, Bangladesh, Dhaka
15. Dr. Momena Khatun, Health Advisor and Reproductive Health Specialist, Program Support Unit, CIDA, Dhaka
16. Mr. Juan Carlos Negrette, Chief of Party, Smiling Sun Franchise Program, Dhaka
17. Dr. M.A. Shahid Khan, Managing Director, Chief of Party, Smiling Sun Franchise Program, Dhaka
18. Dr. A.J. Faisel, Country Director, EngenderHealth, Bangladesh, Dhaka
19. Mr. Toslim Uddin Khan, Head, Research and MIS, Social Marketing Company, Dhaka
20. Dr. Jahir Uddin Ahmed, former Director General, Family Planning Association of Bangladesh (FPAB), Dhaka (retired in September, 2010)
21. Ms. Misti McDowell, Country Director, Family Health International, Bangladesh Country Office, Dhaka

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