THE BANGLADESH FAMILY PLANNING PROGRAMME: ACHIEVEMENTS, GAPS AND THE WAY FORWARD*

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1. Background

The purpose of the Bangladesh Case Study was to:

- Identify achievements thus far of the existing Family Planning (FP) Programme
- Highlight various programmatic gaps
- Identify Bangladesh-specific strategies for renewed focus and increased investment in FP.

A review of all relevant documents, data and interviews was undertaken for the purpose of this study.
2. Country Setting

2.1 Demographic Challenges:

- Growing population size and density
- Proportion of population under age 15 years
- Low female age at marriage
- Early childbearing
- High neonatal and maternal mortality
- Extremely high adolescent fertility
- Stalling and/or near stagnation in fertility

Such demographic challenges place enormous burden on the already limited resources of the country.
Figure 1: Trend in Total Fertility Rates (TFR) in Bangladesh, 1960-2007

Sources: Cleland et.al., 1994; and NIPORT, Mitra and Associates and Macro International Inc. 2009
2. Country Setting cont’d.

2.2 Socio-economic Changes

Major socio-economic changes have taken place over the past two decades, both positive and negative, affecting fertility norms and behaviour.

Positive changes include:
- Female education
- Female employment
- Women’s empowerment
- Access to mass media

Negative changes include:
- Increasing landlessness
- Shrinking employment opportunities in the agricultural sector
- High incidence of poverty
- Growing urbanization
3. Family Planning Programme

3.1 Evolution and Development

FP activities have been carried out in three distinct phases.

• Phase 1 activities were largely voluntary.

• Phase II activities began in 1960, with population control being made the official policy.

• Phase III activities were initiated in 1973, with population control and food production receiving equal priority under the First Five-Year Plan. It marked the beginning of a multi-sectoral and broad-based population control and FP programme.

The Government of Bangladesh (GOB) emphasized the urgent need to make the FP programme an integral part of the development process.
3. Family Planning Programme cont’d.

3.2. The Programme after ICPD

- Following the ICPD, the GOB formed a National Committee and developed a National Plan of Action for implementation of the ICPD goals.


- The MOHFW has begun the process of designing its next 5-year HPN programme (2011-16), which proposes to revitalize the FP programme to achieve replacement level fertility by 2016.

- The Directorate General of Family Planning (DGFP) provides the following types of services: FP, ANC, PNC, normal vaginal deliveries, C-section deliveries, EPI, BCC, adolescent RH services, MR, STI screening and treatment, and STI prevention through provision of condoms.
3. Family Planning Programme cont’d.

3.3 Achievements

- The Bangladesh FP Programme has become a social movement.
- It received highest political commitment until mid-1990s.
- It has the support of opinion leaders.
- Knowledge of FP method is universal.

- The FP programme achieved commendable success until mid-90s. In 1993-94, the CPR increased almost six-fold (45%) from 8% in 1975.
- Achievements until mid-90s can be attributed to strong political will and commitment, increase in demand for FP services, provision of such services by the programme, and socio-economic development.
Figure 2: Trends in the CPR in Bangladesh: 1960-2007

3.4 Gaps

3.4.1 Policy Environment - Since the mid-90s, there has been erosion in political will and commitment to address the problem of growing population.

3.4.2 Slowing down in the rate of increase in CPR - The annual rate of increase in CPR was 1.6% during 1975-1989, 4.5% during 1989-91, and 1.3% during 1994-2007. Worse still, the CPR declined from 58% in 2004 to 56% in 2007.

3.4.3 Inadequate Coverage, Low Quality, and Inappropriate Method Mix, resulting in general lack of access to quality FP services, especially in low-performing areas and under-served populations.

3.4.4 Rising Unmet Need - Unmet need increased from 11% in 2004 to 17% in 2007. It increased among all population groups.

3.4.5 Gaps in Contraceptive Security and Logistics System: limited technical procurement capacity; complex and time-consuming process of procurement and supply of goods; high turnover of trained staff; lack of proper storage facilities in half of the upazilas (sub-districts); shortage of trained providers for LAPM; non-availability of ECP and POP; and stock-out of IUDs and Implants.
3.4 Gaps cont’d.

3.4.6 Lack of adequate support for BCC

- Most BCC materials are out-dated and aren’t tailored to meet specific needs of different client groups.
- There is no separate cadre of BCC officials at the district level.
- The GOB developed the ARH Strategy and the National Communication Strategy for FP and RH. However, their implementation has hardly begun.

3.4.7 Limited Funding and Actual Expenditure

- 44% of the HNPSP budget come from Development Budget.
- The share of FP and maternal, child and RH programme is only 22% of the development budget.
- During 2003/04-2009/10, expenditure from Development Budget ranged from 62% to 89%.
- Thus, allocation is inadequate, and there is also under-spending.
4. Next Steps

Given the major gaps faced by the Bangladesh Family Planning Programme, there is a need to adopt and effectively implement the following strategies.

- 4.1 Enhance political and policy commitments - Sensitize the policy makers and the general population about dangers of growing population and need for smaller family size

- 4.2 Improve access to, and quality of, FP services

Develop a client-oriented approach to both BCC and FP service delivery to motivate various priority groups to use FP:
  - non-users
  - married adolescents
  - those living in low-performing areas, including urban slums
  - those with unmet need
  - those who intend to practice FP in future
  - those in need of LAPM
4. Next Steps cont’d.

4.3 Strengthen and Expand Service Delivery

- Maximize use of existing trained personnel, infrastructure and equipment
- Remove internal conflicts between medical and non-medical personnel
- Ensure better coordination and linkages between DGFP and DGHS
- Ensure close collaboration between MOHFW and the Ministry of Local Government, the Urban Primary Health Care Project, BRAC and SMC in extending service delivery in urban slums
- Encourage the private sector (for-profit) to play an important role in providing quality FP services at affordable prices
- Redefine the role of NGOs to serve different functions
4. Next Steps cont’d.

4.4 Improve Commodity Security and Logistics System

• Further enhance technical procurement capacity
• Develop a chain of accountability for timely procurement of FP methods
• Strengthen coordination among concerned stakeholders to achieve contraceptive security
• Emphasize local production of contraceptives
• Ensure proper storage needs for all tiers of the supply chain

thereby ensuring no stock-outs.
4. Next Steps cont’d.

4.5 Improve Programme Efficiency

- Address various HR issues
- Re-think the role of DGFP in providing quality FP-related services
- Enhance training capacity
- Promote task-shifting among health care workers
- Train supervisors/ managers to provide guidance to other staff
- Ensure active participation of all concerned in providing and /or sharing cost of FP supplies and services
- Enhance budgetary allocation
- Improve implementation capacity
5. Conclusion

The Bangladesh Family Planning Programme made great progress until mid-90s, but, due to erosion in political will and commitment and certain systemic issues, the programme has since then been lagging behind.

Therefore, the GOB should reposition the Family Planning and Reproductive Health 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.
Conclusion cont’d

To achieve the desired increase in CPR and fertility decline, the GOB should more specifically:

• Renew its political and policy commitments, as until the mid-1990s
• Address systemic problems affecting the programme
• Re-think the role of DGFP
• Improve access to, and quality of, FP and RH services
• Strengthen and expand service delivery
• Improve commodity security and logistics system
• Improve programme efficiency
• Give greater emphasis to further improve child survival rate
• Make female education a national priority
• Create adequate productive employment, especially for females
• Address issues relating to better governance and accountability.
Thank you!