



Bangladesh and Family Planning: An Overview

Background

In 2003, Bangladesh was the seventh most populous country in the world, with an estimated population of 135 million. The country's population density, roughly 1,000 people per square kilometre, is also one of the highest in the world. As shown in Figure 1, about 40% of the total population is under the age of 15, and about 50% of the population is within reproductive age. The annual population growth rate is 1.48%.

Since gaining independence 33 years ago, health and education in Bangladesh have improved remarkably and poverty has declined. Still, there is limited access to health services, sanitation and safe water. With nearly half of its population living below the poverty line, Bangladesh has the highest incidence of poverty in South Asia and the third highest number of poor people living in a single country after India and China. Bangladesh cannot achieve sustainable development without continued efforts to curb population growth.

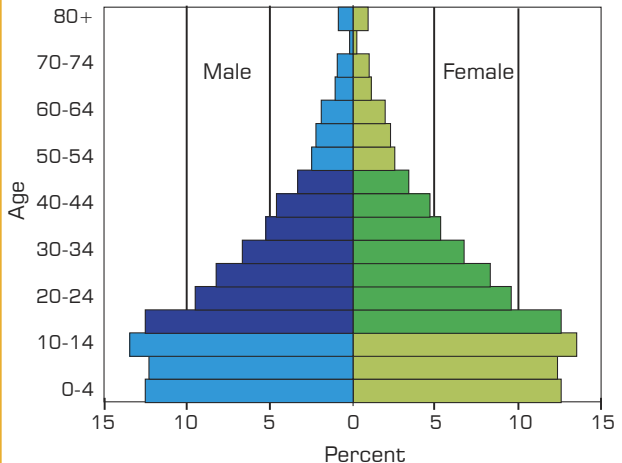
Situation Analysis

Over the past three decades, Bangladesh has made impressive gains in indicators related to population and family planning. The **total fertility rate (TFR) declined** from 6.3 births per woman in 1970-1975 to the current rate of 3.3, a decline of 48% in just 25 years. However, there is a discrepancy between rural and urban areas, with women in rural areas bearing one more child on average (3.5) than their counterparts in urban areas (2.5). The **contraceptive prevalence rate (CPR) has increased** six-fold, from 8% in the mid-1970s to 54% in 2000. Trends in contraceptive method use over the past decade are shown in Figure 2.

As shown in Figure 3, **54% of currently married women are using a contraceptive method;** 10.4% use traditional methods

Population pressure is creating additional demands on already scarce resources, making it difficult to support an increasing number of people.

Figure 1: **Population Pyramid Bangladesh, 1999-2000**

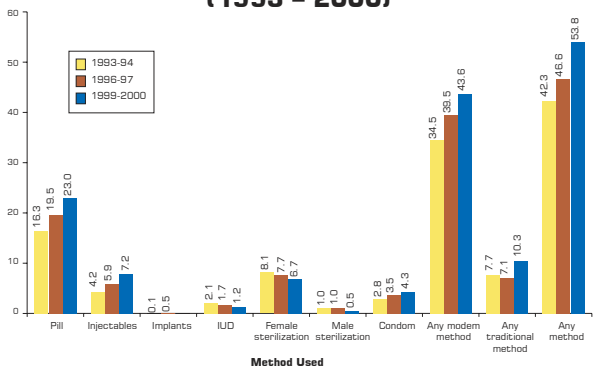


Source: Bangladesh DHS, 1999/2000

and 43.6% use modern methods. The pill continues to be the most popular method, with 23% of all currently married women choosing this contraceptive. Other commonly used methods are injectables (7.8%) and female sterilization (6.7%). Women who decide to undergo sterilization generally do so early in their reproductive life; more than one-third do so before age 25, and two-thirds do so before they reach the age of 30. Financial compensation for wage loss, food and transport costs are provided by the government for accepting long acting family planning methods.

The age at first marriage in Bangladesh is still young, although it is rising. The legal age of marriage for women has been increased from 14 to 18 years; the minimum for men is 21. In 2000, about 50% of women in Bangladesh were married by the time they were 15 years old, down from 60% just three years before. Still, 80% of Bangladeshi women marry during adolescence,

Figure 2: Trends in Contraceptive Method Use (1993 – 2000)



Source: Bangladesh DHS, 1993/1994; 1996/1997; 1999/2000

increasing the likelihood of having high-risk or ill-timed births, and more births over their reproductive life. Childbearing begins early and the majority (57%) of Bangladeshi women have a child by age 19.

Among ever-married women, 59% would prefer a two-child family and 22% consider a three-child family ideal. Overall, the mean ideal number of children is 2.5 among women, and 2.4 among men, indicating that men are not more pronatalist than women. Still **family planning is practised later in marriage**, and newly wed couples continue to have children roughly at the same rate as did their predecessors. Additionally, nearly half of users in Bangladesh discontinue their contraceptive method within 12 months of starting, with side effects or health concerns cited as the primary reasons. Nevertheless, birth intervals are generally long in Bangladesh; the median birth interval is 39 months.

A 1999-2000 survey which addressed **obstacles to accessing care** found that 80% of women felt that there was no adequate healthcare facility nearby; 50% mentioned a lack of confidence in the services and problems accessing the health centre; 70% could not meet the financial requirements for treatment; and about two-thirds said their lack of knowledge about where to go was the major obstacle to accessing care.

If the need for family planning could be met fully, the contraceptive prevalence rate would increase from 54% to 71%.

A high level of public **awareness and knowledge of family planning does not translate into an equivalent level of contraceptive use.** There is still a social preference for larger families and a male offspring. Abortion is illegal except to save a woman's life, and unsafe abortion is a major contributor to Bangladesh's high rate of maternal mortality. Menstrual regulation is practised for those who experience contraceptive method failure, among other reasons.

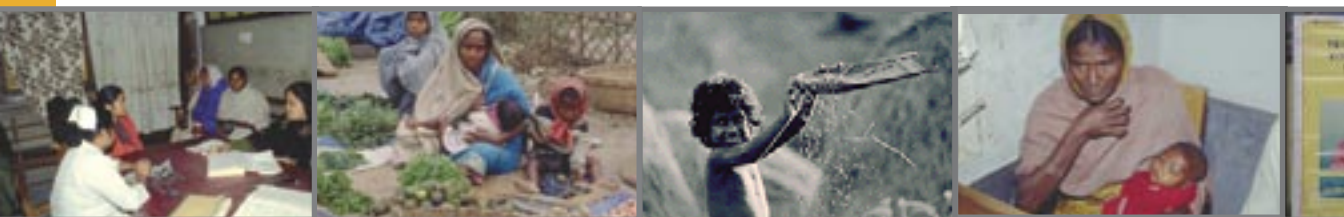
More than 15% of married women have an unmet need for family planning in Bangladesh, 8% for spacing and 7.3% for limiting births.

Current Family Planning Efforts

The Health Nutrition and Population Sector Programme (HNPS) began in July 2003, and forms the basis for relevant national level policy. The Government of Bangladesh is strongly committed to family planning, has prioritized **a national population programme to reduce population growth**, and a new population policy document is being prepared and likely to be approved in the near future.

Government field workers and satellite clinics are two crucial elements in the **provision of family planning services.** Efforts are being made to develop a package of essential services based on the priority needs of clients, to be delivered from 1,500 union Health and Family Welfare centres that have been upgraded. In January 2004, Family Welfare Assistants (FWA) started providing door-to-door visits again, and have registered 21,900,000 eligible couples thus far. This aids in the provision of a continuous supply of family planning methods, helping to reduce user dropout rates. Bangladesh's clinical contraception programme is currently being revitalized. This includes clinical training and curriculum development in the national health and family planning programme.

Actions considered to improve health and family planning services include the establishment of a national health academy, strengthening of existing National



Institutions of Population Research and Training (NIPORT), formulation of a human resource development plan, and enhancing the quality of medical education. As a long-term strategy the government plans to improve the quality of family planning services by increasing social awareness of family planning services, and improving access to clinical services by offering high quality services in major urban hospitals, district hospitals, and *upazilla* (sub-district) health centres.

The **public sector remains the primary source of family planning methods**. Sixty-four percent of current users of modern methods obtain their methods from a public-sector source; 36% do so from a public facility and 28% from a government field worker. In 2000, 64% of pill users relied on government supplied brands, which are provided free of charge.

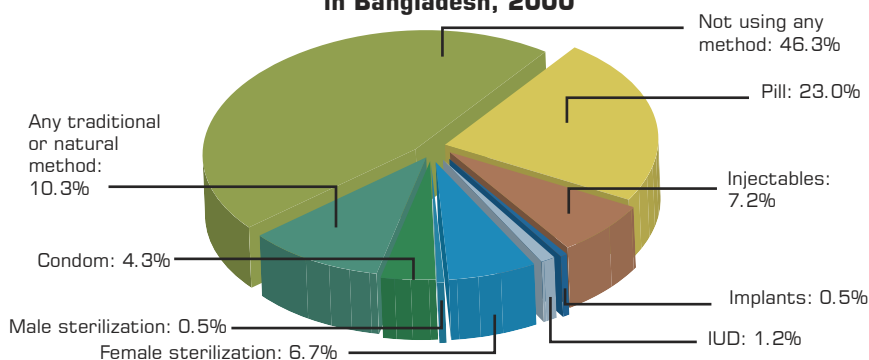
Additionally, **social marketing provides access to oral contraceptives and condoms** at thousands of non-clinical, commercial outlets across the country. In 2000, 29% of pill users were using social marketing brands, up from 19% in 1997, and seven out of ten condom users used a social marketing brand, up from 58%.

Bangladesh's NGOs are among the most active in the world. The government is currently encouraging NGOs to increase their level of family planning services provision. Experiences with **private-public partnerships** will be used

Key Indicators:

Total Population, 2003 (in millions)	135
Population Growth Rate, 2003	1.48%
Population Density, 2003 (people per square km)	1,019
Urban Population, 2003	27%
Population <15 years of age, 2003	40%
Total Fertility Rate (TFR), 2000-2005	3.3
Contraceptive Prevalence Rate (CPR), 2000	53.8%
- Pills	23.0
- Injectables	7.2
- Implants	0.5
- IUD	1.2
- Female Sterilization	6.7
- Male Sterilization	0.5
- Condom	4.3
- Traditional or Natural Methods	10.3
Unmet Need, 2003	15.3%
- For spacing births	8.0
- For limiting births	7.3
Average age at first marriage, 2003	16
Average age at first birth, 2003	18
Crude Birth Rate (CBR) (per 1,000 population), 1995-2000	19.9
Maternal Mortality Ratio (MMR), 2000	3.2
Infant Mortality Rate (IMR), 2000-2005	66
HIV adult prevalence, 2002	<0.1%

Figure 3: **Contraceptive Method Use by Married Women in Bangladesh, 2000**



Source: Bangladesh DHS, 1999/2000



in future planning processes by the Ministry of Health and Family Welfare.

Challenges and Opportunities

1. **Reaching replacement level fertility and stabilizing population growth.** After 2005, population momentum will cause population growth at an increasingly rapid pace. At the current growth rate, about two million additional people are added to Bangladesh's population each year, and every five-year delay in achieving replacement level fertility (RLF) results in a three percent larger final population size. According to the Population Reference Bureau, Bangladesh's population could exceed 250 million by 2050. As shown in Figure 4, however, if Bangladesh attains RLF by 2010 the population could stabilize at around 210 million by the year 2060. If RLF is delayed by another 10 years, and is attained in 2020, the population would stabilize in 2085 at around 250 million people. If RLF is only reached by 2025, Bangladesh's population will not stabilize until 2109 at 300 million people. Unfortunately, contraceptive prevalence has declined among the poorest in Bangladesh, and there is still a high discontinuation rate for family planning methods.

The government aims to achieve replacement level fertility by 2010.

2. **Reducing adolescent fertility.** It is estimated that 65% of the population growth

during 2000-2005 will be attributable to Bangladesh's current young age structure. Forty percent of the population, which is currently under the age of 15, will commence its reproductive years in the near future. To minimize the impact of population momentum it is crucial to increase the average age at first childbirth by increasing the age at first marriage and broadening the time period between marriage and first birth. Alarming, fertility among women 15-19 years old increased in the mid-1990s, at which point it began to decrease. While overall adolescent fertility has slightly decreased, it has increased among poor adolescents. It is hoped that the current provision of free education for female students through class 12 will contribute to increasing the age of marriage.

3. **Creating demand, and meeting existing met and unmet need for family planning.**

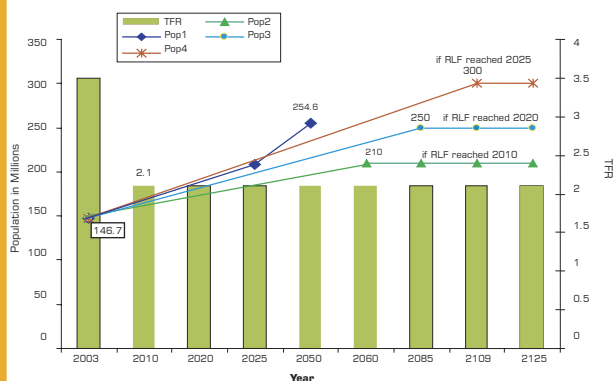
It is critical to continue to meet the needs of existing family planning users, address unmet need for family planning, and increase demand for family planning among non-users. These efforts include:

- Motivation of current non-users of family planning contraception to become users;
- Strengthening of the delivery system to provide quality services;
- Improving the quality of family planning services to meet the needs of increasing number of users, and to decrease the persistently high discontinuation rate among current users, by increasing outreach through home visits by FWA;
- Expanding the contraceptive method mix, especially through increased use of longer-term, cost-effective methods for those who want to limit their births;
- Developing appropriate services specifically for hard to reach coastal and urban slum areas, men and adolescents;
- Ensuring contraceptive supply by: maintaining sufficient stocks at all levels; fostering contraceptive manufacturing in the private sector; and through public-private joint ventures.

4. **Improving health and family planning services.**

Health and family planning personnel constraints include: inadequate attention paid to quality standards in basic and in-service training; inappropriate placement of personnel; lack of a good training institute for health workers, inadequate supervision; and poor accountability on the part of health

Figure 4: **Population Projections: Bangladesh**



Source: PRB, 2003; Bangladesh Reproductive Health Profile, WHO/SEARO. Unpublished, 2003.

personnel. Two key challenges currently faced by the government are maximizing the use of personnel, infrastructure and facilities of both Health and Family Planning

Departments; and community mobilization in order for the small family norm to be adopted nationwide.

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