

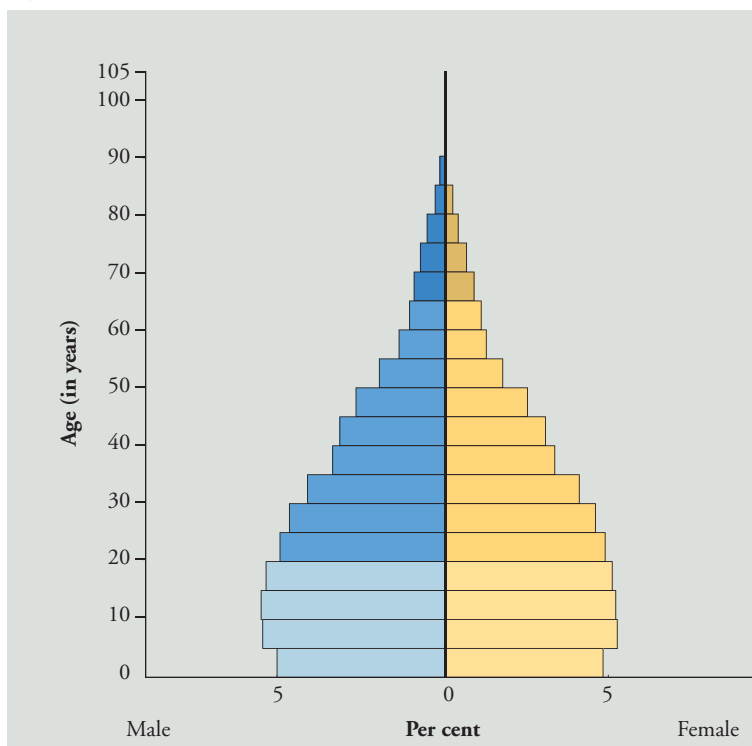
Bangladesh and Family Planning: An overview



Background

The 2011 census pegs the population of Bangladesh at 150.6 million, reflecting an increase of more than 20 percent over the 2001 census population levels. This decadal growth rate is higher than the 17 percent growth in population seen from 1991 to 2001. With an area of just 147,570 sq. kms., this population load translates into an average population density of 1015 persons per sq.km which is one of the highest in the world. In face of the relatively poor economic status of the country, the large population size puts an excessive strain on the countries resources and is a major impediment to its economic development.

Figure 1: Population pyramid, 2010



Source: UN Population Projections 2010

now stands at 2.3 according to the Bangladesh Demographic and Health Survey 2011, which is still some distance away from replacement fertility levels. According to a an analysis done by the Population Reference Bureau in 2003, even if Bangladesh reached replacement level fertility by 2010, population stabilization would take another 15 years, the growth being fuelled by the large proportion of youth in the country.

Situation Analysis

The rapid growth in Bangladesh's population can largely be attributed to the age distribution of its people. As can be seen from the population pyramid (Figure 1), 56% of the women in Bangladesh are in the reproductive age group of 15–49 years. Another 31% of the population is below the age of 15 years and will soon be entering the reproductive life span and contributing to the increasing numbers.

Total fertility rate

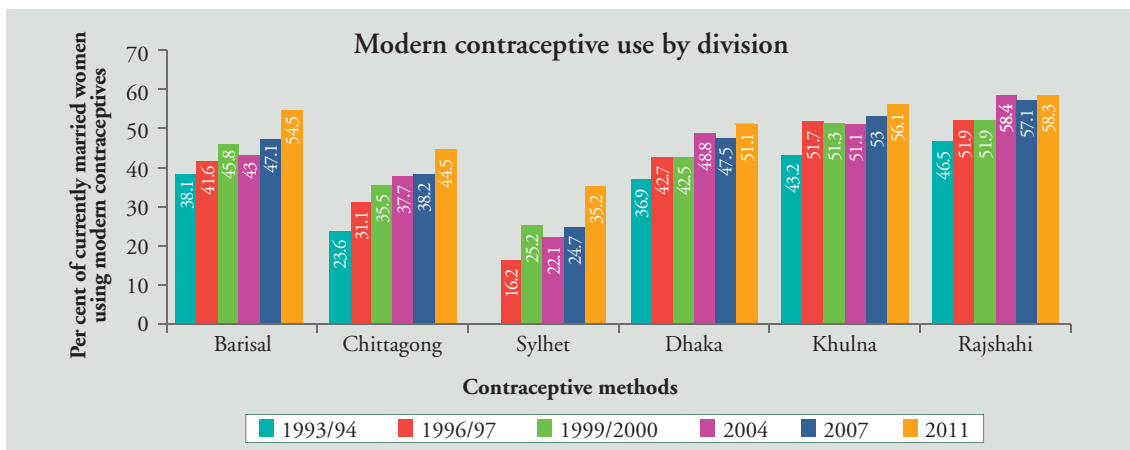
Owing to intense efforts in the country to control the population growth, the total fertility rate (TFR) has been steadily reducing over the past almost four decades. From extremely high levels of 6.3 in 1975, to 3.3 in the year 2000, the TFR



Contraceptive prevalence rate (CPR)

A large proportion of this reduction in TFR can be attributed to the growing availability and use of contraceptives by Bangladeshi couples. According to the Bangladesh Demographic & Health Survey 2011, contraceptive use among currently married women has been increasing steadily from 1993–94, when it was 44.6% (not shown in graph) to 53.8% in the year 1999–2000, and reached 58.1% in 2004. Then with a slight dip in contraceptive use at 55.8% as per DHS 2007, it now pegs at 61.2% as per latest DHS 2011.

There exists an urban-rural divide in the use of contraception with 52% of the urban women using a modern method of contraception compared to only 46% of the rural women. However, more alarmingly, these averages mask the geographic (inter-division) differentials in contraceptive use. For example, Sylhet division of Bangladesh has the lowest modern method CPR of only 25%, while it is more than double in Rajshahi division, where modern method CPR is 57%. The DHS found no significant difference in contraceptive use between married women belonging to different wealth quintiles, thus showing that poverty is not a factor that restricts access of women and couples to contraceptive products and services.



Source: BDHS, 2011

As the TFR continues to show a steady decline despite the fluctuations in CPR, it can be inferred that increase in contraceptive use is not the sole factor responsible for decrease in fertility levels. One of the other reasons that may be contributing to this reduction is the improvement in access to maternal health services, including safe abortion services (including menstrual regulation), which has helped reduce the number of unplanned and unwanted births. It must be noted that the Bangladesh government does not promote abortion as a family planning method, but provides facilities for the same as an integral part of maternal health services, and in concordance with the international treaties on women's rights.

Contraceptive method mix

Of the 56% of married women who are using a contraceptive method, 8% are using traditional methods such as withdrawal and periodic abstinence, and only 48% are using a modern method of contraception. The pill continues to be the most preferred method with 29% of the married women relying on the same to prevent conception. Another hormonal method, injectables, comes a distant second in the list with 7% of the women using the same. Five percent of the women in the survey had relied on tubal ligation as the method of choice. Condoms were the only male centric method that found any substantive proportion of acceptors (5%).



Comparing to the DHS 1999–2000 figures of contraceptive method mix, there is a reduction of more than 2 percentage points in the proportion of non-users of contraception as well as in the users of traditional methods. Similarly, female sterilization rates also show a decline of 1.7% percentage points. The reduction in all these areas is reflected in the increase in pill use from 23% in 2000 to 29% in 2007. The rate of injectable use peaked to about 10% in 2004, but has again dropped down to 7% in 2007, which is almost similar to the uptake levels in 2000. Other modern methods of contraception such as IUDs, implants, vasectomy etc. continue to find very few takers.

Unmet need for family planning

The Bangladesh Demographic Health Survey 2007 reveals that 17% of all married women have an unmet need for family planning. This has increased significantly from 11% in 2004. The reduction in contraceptive use from 58% to 56% in the corresponding time frame, can only partially explain the increase in unmet need, and is probably due a reduction in availability and/or utilization of family planning services. The larger reason would be an increase in the felt need for family planning among married women, which, when coupled with stagnant or reducing service accessibility, led to the rise in unmet need.

Of the 17% unmet need, 7% is for spacing and 11% for limiting births. There is a very wide inter-division variation in unmet need. It is highest among those living in Sylhet (26%) and Chittagong (23%) divisions and lowest in Khulna and Rajshahi (12% each). This corresponds very well with the CPR levels in these districts.

The overall situation is shown by the relevant indicators in the following table.

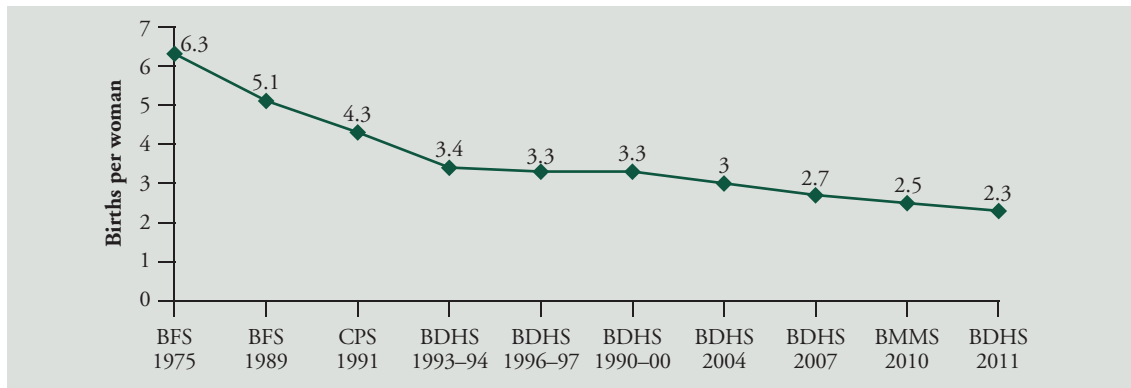
Table 1: Key indicators

Total Population, (in million), 2011 (Census)	150.6
Population Growth Rate, Census 2011	1.37%
Population Density, (people per square km), 2011	1021
Urban Population, 2011	39.8%
Population <15 years of age (percent), 2010	31.3%
Total Fertility Rate (TFR), 2011	2.3
Contraceptive Prevalence Rate (CPR), 2011	61%
- Pill	27.2
- Injectable	11.2
- Female sterilization	5.0
- Other modern methods	3.2
- Condom	5.5
- Periodic abstinence	6.9
- Withdrawal	1.9
- Other traditional methods	0.4
Unmet Need, 2011	14%
Average (median age) at first marriage, 2011	15.5
Median age at first birth, 2011	18
Crude Birth Rate (CBR) (per 1,000 population), 2011	19.2
Maternal Mortality Ratio (MMR), per 100,000 live births, 2011	209
Infant Mortality Rate, 2011	35
HIV adult prevalence (age 15–49), 2012	<0.1%

Source: UN Population Projections 2010; BDHS, 2011

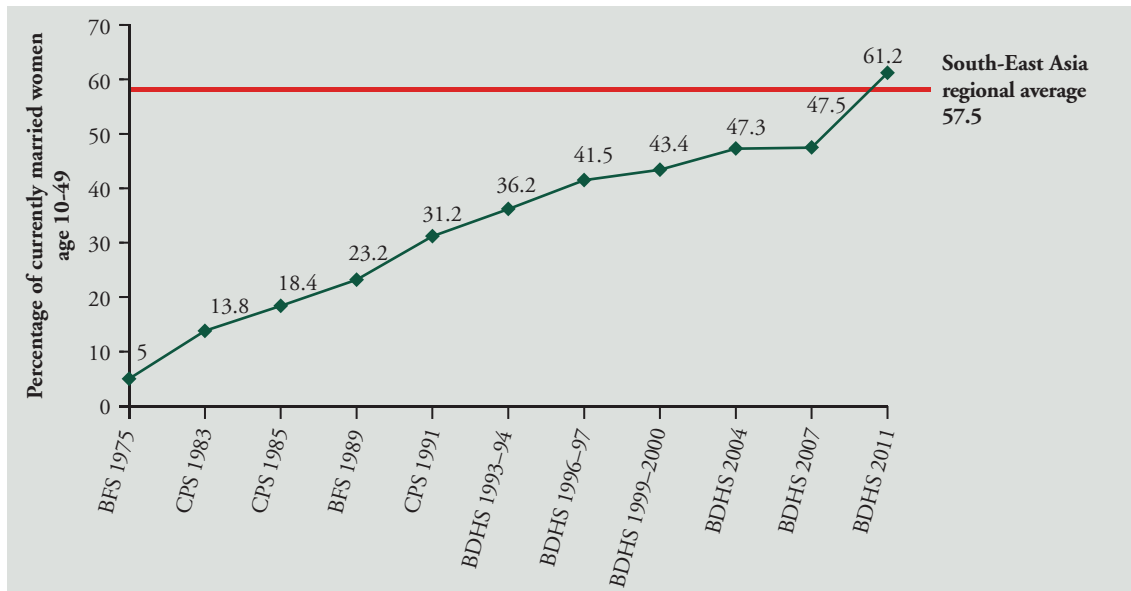


Figure 2: Trends in total fertility rates, 1975–2011



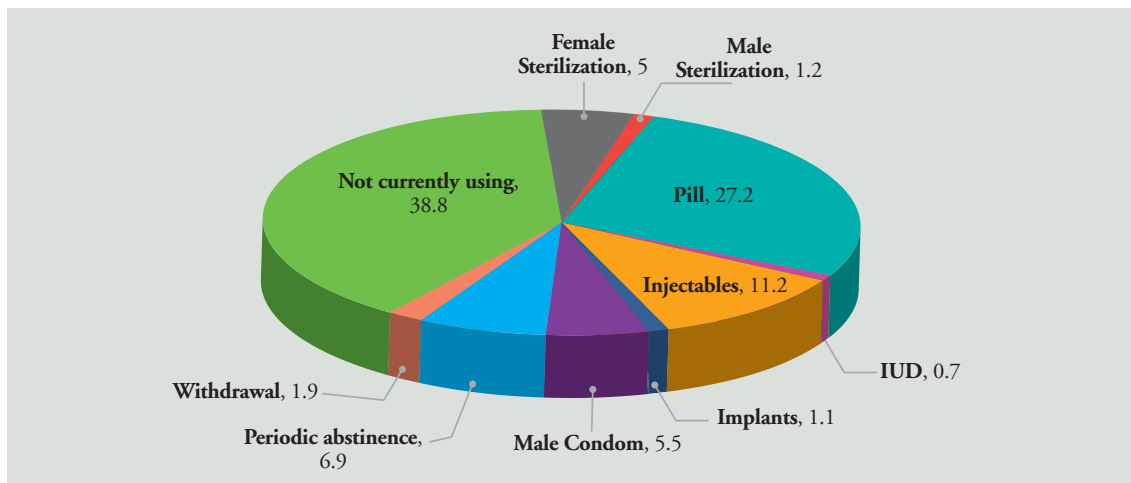
Source: Bangladesh DHS 2011

Figure 3: Trend in contraceptive prevalence rates (%), 2005–2011



Source: Bangladesh DHS 2011

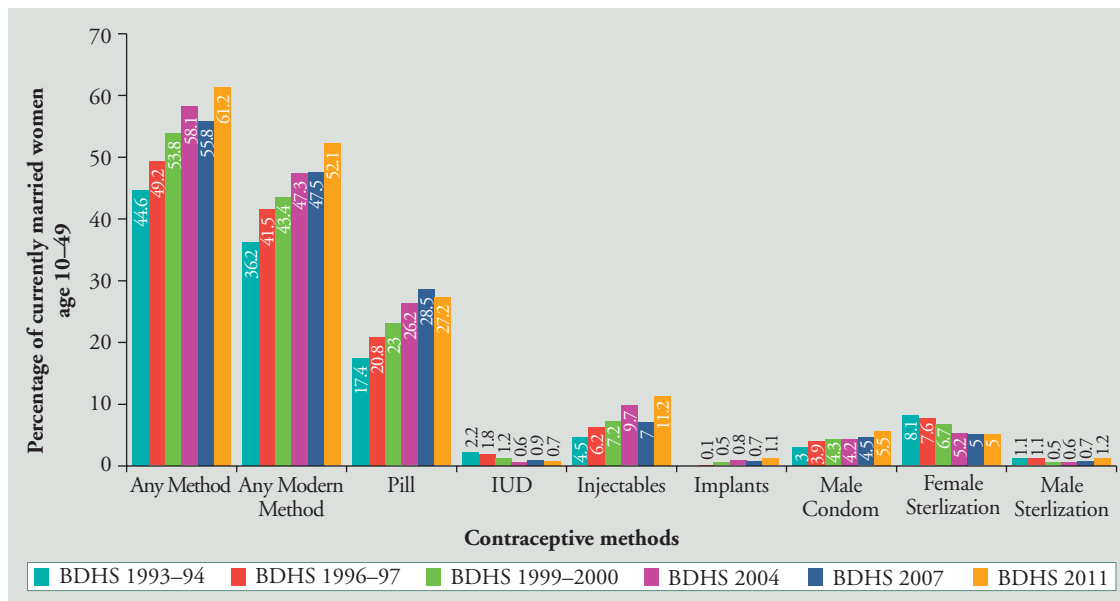
Figure 4: Contraceptive method use by married women in Bangladesh, 2011



Source: Bangladesh DHS 2011



Figure 5: Trends in modern contraceptive use in Bangladesh



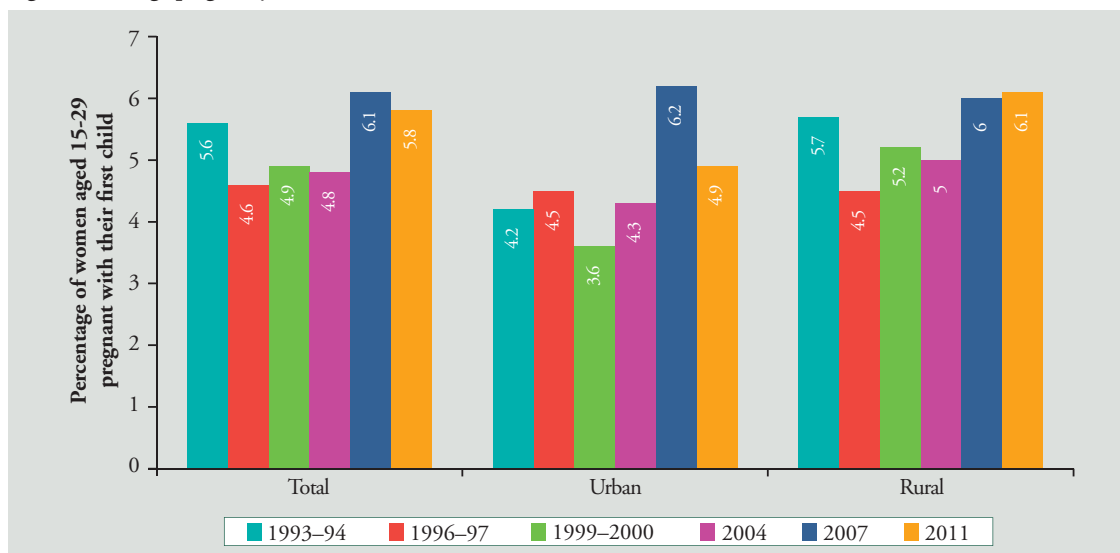
Sources: Bangladesh DHS 2011

Adolescent fertility

Bangladesh is a country where the adolescent fertility rate is relatively high. Most of these teenage pregnancies occur within the confines of marriage due to the cultural practice of early marriage. It is about 73 per 1,000 girls aged 15–19 years.

In Bangladesh, the legal minimum age of marriage is 18 for girls and 21 for boys. However, despite the law governing the age of marriage, early teenage marriages are common and the average age for a girl at first marriage has reduced from 16 years in 2003 to 15 in 2007. About 11% of girls aged 10–14 and 46% of 15–19 years olds are married (Adolescent Health Fact Sheet, WHO, January 2007). Moreover, during the 2007 survey, 6% of the girls aged 15–19 years were reported to be pregnant with their first child.

Figure 6: Teenage pregnancy

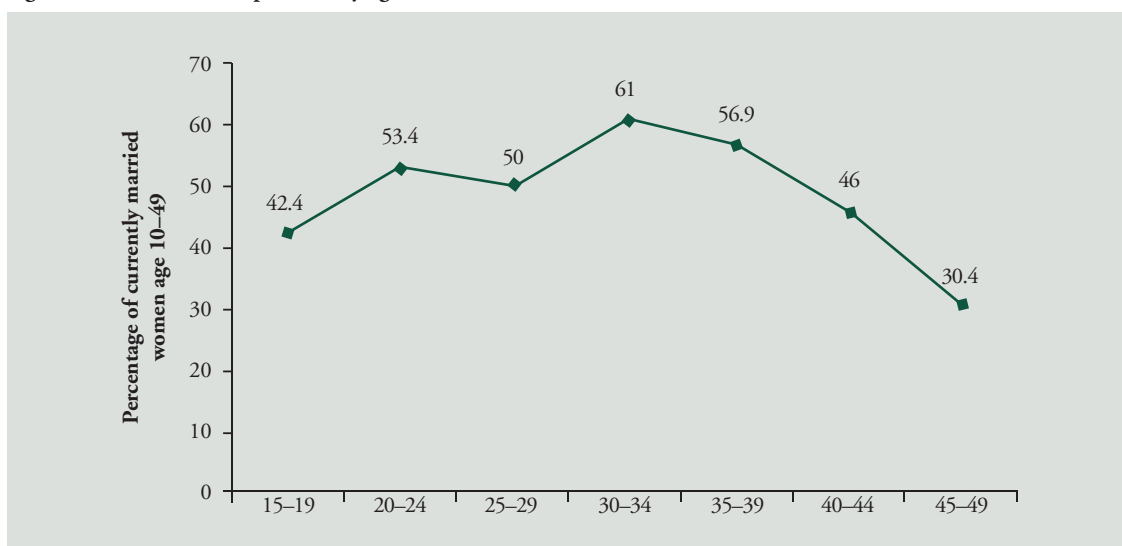




Over one-fifth of births to adolescents are unplanned. In all the age groups, adolescents have the highest unmet need for family planning. While awareness about family planning methods is high among Bangladeshi couples (99%) irrespective of their age, the use of contraceptives by adolescents aged 15–19 years is much lower than by older married women. According to the 2007 DHS, while about 56% of married women aged 25–34 years were using a modern method of contraception, only two thirds of that percentage, i.e. about 38% of married teenage girls were using a family planning method. Though relatively low, current usage levels reflect a gradual improvement over the situation in 1992–93 when only 25% of the married adolescent girls (15–19 years) were using a contraceptive to prevent pregnancy.

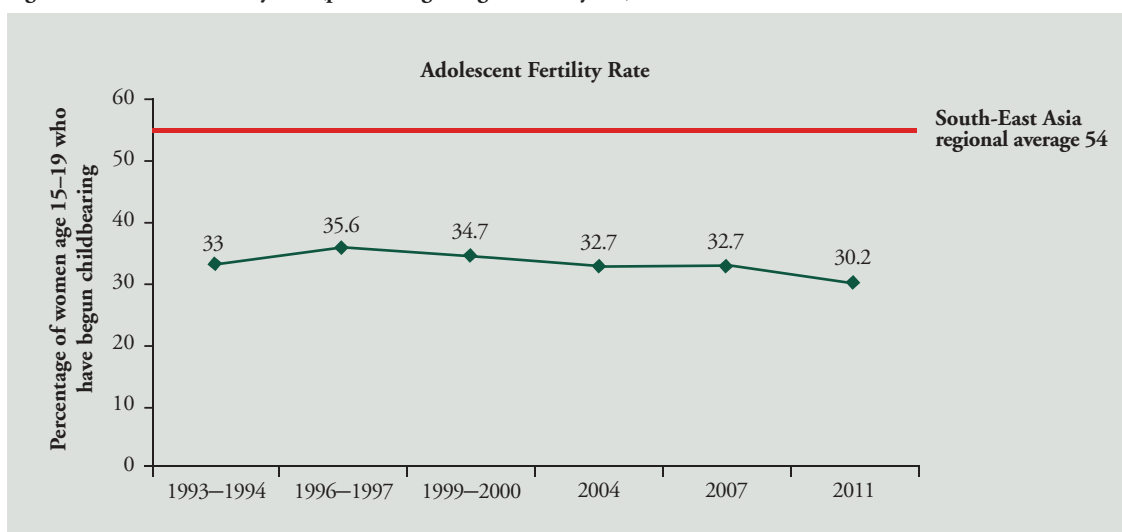
Given the age, the contraceptive method mix used by adolescents reflects a reliance on reversible methods. In line with the overall pattern in Bangladesh, pills and injectables are the most preferred methods of contraception. Use of condoms is relatively low.

Figure 7: Modern contraceptive use by age, 2011



Source: Bangladesh DHS 2011

Figure 8: Adolescent fertility rate (per 1,000 girls aged 15–19 years)



Sources: Bangladesh DHS 2011



Access to family planning information and services

In the 2007 DHS, 38% of women and 59% of men acknowledged that they had read, seen or heard family planning messages through mass media. Television was the most common source of family planning messages for both men and women. Men also named mid-level media such as posters, billboards, and leaflets etc. as vehicles for family planning related information.

About 75% of the married women reported that a satellite clinic had been arranged in their community in the three months preceding the survey. One in five women in the reproductive age group also mentioned visits to their home by a peripheral health worker in the past six months. Given the preference for reversible family methods especially pills and injectables, such outreach sessions coupled with home visits serve as the platform for counseling to ensure continuation of method use and replenishment of contraceptive supplies with the clients.

Various multilateral agencies such as UNFPA, UNDP, and UNICEF, along with NGOs such as FPAB, BCCP, SMC, NDSP, PSTC, BRAC, Engender Health, Marie Stopes Clinic Society as working with the government of Bangladesh for expanding communication outreach of family messages as well as increasing access to needed services.

Current Family Planning Efforts

The Bangladesh government is now running a comprehensive health programme called the Health Population and Nutrition Sector Development Program (HPNSDP) which aims to not only reduce the population growth rate but also reduce morbidity and mortality levels in the country along with and improvement in the nutritional status of the population, especially the women and children. HPNSDP, which began in July 2011 and is planned for five years till June 2016, is the third sector-wide program in Bangladesh, following in the wake of HPSP (1998–2003 and HNPS (2003–2011).

HPNSDP strategises strengthening of FP services to reach replacement fertility levels. A new operational plan has been drawn up for delivery of maternal, neonatal, child and adolescent health services. The program will make special efforts to reach out to disadvantaged communities and hard to reach areas with the needed services. Areas with high unmet need will receive additional inputs through area based targeted interventions. While continuing with the community-based distribution of contraceptive supplies, HPNSDP will attempt to expand the current method mix, and reach out to a greater number of eligible couples, the program plans to lay special emphasis on provision of long acting permanent methods of contraception such as sterilization. Counseling of eligible couples, especially adolescents for using family planning methods will be an important intervention area of the program.

The Bangladesh Family Planning Program has made remarkable progress over the last thirty years due to continuous political commitment, innovative program approach, government and non-government collaboration, strong IEC program, method-mix cafeteria approach and commitment of the field-level functionaries.

Challenges and Opportunities

1. **Continuing population expansion:** The population growth of the country is fuelled by a) large base population, b) population momentum due to a large proportion of youths, and c) a stagnating CPR.

While not much can be done about the first two factors, a stagnating CPR is a cause for concern. Despite the efforts by the government and the development partners, CPR in Bangladesh is not seeing an increase. On the contrary, there has been a 2 percentage point reduction in the same between 2004 and 2007. However, the silver lining in this decline is



the minimal increase in the modern-method CPR from 47.3% to 48%. This indicates the possibility of converting non-users and/or users of traditional methods to modern methods of contraception. While the government through its new HPNSDP plans to expand the contraceptive mix by specially promoting permanent methods, it should also think of fertility awareness based methods, such as SDM and LAM, which mimic traditional methods and may be more acceptable to users of traditional methods.

The other window of opportunity is the increasing levels of unmet need in the country. This reflects that communication efforts for promoting family planning are working. Thus the government, with help from its non-governmental partners, should continue with its family planning messaging and counseling services and try and match the demand thus generated by ensuring availability of family planning services and supplies. It is hoped that the program's special efforts to reach out to disadvantaged areas and communities will reduce the regional divide in the availability of services and result in a concomitant and balanced increase in CPR in all the divisions.

2. **High adolescent fertility:** Bangladesh has a high adolescent fertility rate, one of the highest amongst the SEAR nations. Early initiation of child bearing leads to rapid increases in population by not only lengthening the productive period in the woman's life, but also by shortening the inter-generational span. As most of the adolescent child bearing occurs within the realm of marriage, it means that the law governing the age at marriage needs a much stricter reinforcement. It is heartening that through HPNSDP the government plans to make special efforts to reach out to adolescents with family planning messages and individual and community level counseling services. Convincing the adolescents to delay the first pregnancy and child birth beyond the adolescent age frame will go a long way in bring TFR down to replacement levels.
3. **Family Planning Service provision:** The human resources issues such as insufficient training for health providers, inappropriate placement and personnel and inadequate supervision and the infrastructure in health sector are the keys challenges that government is facing to improve the health and family planning services. HPNSDP plans to not only increase the number of trained service providers both at the community and facility levels, but also ensure their skill and capacity development through continuing in-service education and training. It also plans to improve coordination between public, private and NGO sectors, and thus hoping to increase coverage levels for various health services, including family planning services.

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