Population Dynamics in Bangladesh

A case study on the causes and effects of demographic change in Bangladesh
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Preface

The topic of “Demography and development” is becoming increasingly important in our partner countries and, as a result, in international cooperation as well. While it is primarily a question of three central demographic processes – high population growth, ageing and migration – the issue of security also plays a major role. A glance at current scenarios and forecasts shows that the world population will grow by 2.5 billion in the next 40 years to a total of 9.2 billion, with most of this growth taking place in developing and emerging countries. At the same time, however, there will be an increasing number of old people.

Demographic changes pose a new challenge for ministries, public institutions, the private sector and civil society in our partner countries. As a result, GTZ faces the need to respond to these challenges in its current and future advisory and project work in the field, especially with regard to the question of sustainability and medium- and long-term policy making.

Given the growing importance of the topic, approval was recently given to a GTZ-financed “Zukunftsinnovation” (future innovation) with the title “Demography and development as a new GTZ theme and service package.” The aim of this measure is to develop a concrete range of GTZ services for various clients, in the form of practical approaches to dealing with demographic processes and their effects.

In an initial step, examples are selected from countries to better illustrate the topic of demographic change. This is the context in which the present study on “Population Dynamics in Bangladesh” was conducted. Examples, facts and figures are used to demonstrate the lasting change in the demographic structure and trends in this country in the past 40 years, and to highlight the resulting opportunities for the general population and economic development, but also the future challenges.

Why is Bangladesh such a particularly interesting country for the study of demographic changes?

On an international level, Bangladesh has a unique position in terms of demographic change:

- It is the **country with the highest population density worldwide**. The population pressure on the shrinking land due to climate change will become even greater in the coming decades.

- It is undergoing **very rapid urbanisation**, with Dhaka the fastest growing city in Asia. In some urban areas, the population density is already at 250,000/square km.

- Due to the family planning programs by the government and socio-economic changes, the total fertility rate (TFR) has **decreased drastically** on an the national level since the 1970s from 7 to 2.7 children per woman.

- Socio-economic improvements have resulted in **strong gains in life expectancy**. This, together with the sharp reduction in fertility, changes the shape of the demographic pyramid drastically, which has numerous repercussions on the society.
Given these drastic population challenges, Bangladesh poses a particularly interesting case for studying how these demographic changes affect society, as well as their implications for policy and technical cooperation.

The study was conducted jointly by the GTZ-offices in Dhaka and Eschborn. We should like to thank all those involved, in particular the experts in Bangladesh who provided us with the opportunity for interviews, the authors, Ms. Fleischer, Ms. Lutz and Mr. Schmidt, the co-authors, Dr. Rudolph and Ms. Köhler, and the Divisional Director, Dr. Petry, for supporting the process. We look forward to continuing the fruitful cooperation between the GTZ office in Bangladesh and GTZ headquarters within the framework of the future innovation project “Demography and Development”.

We hope that this study and other publications together with practical tools will convince people to take a greater interest in the topic of demography in technical cooperation projects at national and regional level, develop concrete services and modes of delivery for sectors and regions, and help to position GTZ successfully in the field of international cooperation.

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1. **Aim and methodology of the study**

This report provides an overview of the major trends in demographic changes in Bangladesh and the population challenges it currently faces. Fertility is a major catalyst for population growth (CPD 2003) which affects the overall health conditions of Bangladesh’s population, both directly and indirectly. For this reason, the change in Bangladesh’s total fertility rate (TFR) and the consequences for the country’s health system will be discussed in detail. The focus of this in-depth discussion lies on the impact of national family planning programmes and various socio-economic factors on the total fertility rate (TFR).

The study first addressed relevant scientific literature to explore the causes and rationales underlying demographic trends in Bangladesh. In addition, surveys such as the 2004 and 2007 Bangladesh Demographic and Health Surveys (BDHS) were used to identify the trends and factors which caused these demographic changes. National population policies were also consulted in order to understand the rationales for policy-making in relation to population dynamics.

Following this, 16 semi-structured interviews were conducted in Dhaka with representatives of national and international organisations, and with stakeholders working in the field of reproductive health and family planning. The key informants interviewed included government officials, representatives from local NGOs, local demographers, professors and scientific staff from the University of Dhaka, doctors and nurses from a community clinic and others (see the appendix for a list of interviewees). In sum, the study provides an overview of Bangladesh’s population in figures and highlights selected impressions and perspectives on population dynamics from experts in the field.
**Bangladesh: facts and figures**

<table>
<thead>
<tr>
<th>Area:</th>
<th>147,570 square kilometres</th>
</tr>
</thead>
<tbody>
<tr>
<td>Political independence:</td>
<td>26 March 1971</td>
</tr>
<tr>
<td>Divisions:</td>
<td>Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Sylhet</td>
</tr>
<tr>
<td>Languages:</td>
<td>Bengali (official), English</td>
</tr>
<tr>
<td>GDP total 2008:</td>
<td>US$ 79.0 billion</td>
</tr>
<tr>
<td>GDP per capita 2008:</td>
<td>US$ 494</td>
</tr>
<tr>
<td>GDP growth rate 2008:</td>
<td>6.2 percent</td>
</tr>
<tr>
<td>GNI total 2008:</td>
<td>US$ 85.3 billion</td>
</tr>
</tbody>
</table>

**GDP composition by production sectors (2008 estimate):**
- agriculture: 19.1 percent
- industry: 28.6 percent
- services: 52.3 percent

**Labour force by production sectors (2008 estimate):**
- agriculture: 63 percent
- industry: 11 percent
- services: 26 percent

**Population size:** approximately 150 millions

**Population density:** 920 per square kilometre

**Ethnic groups:** Muslims (90 percent), Hindus (9 percent), Others (1 percent)

**Terrain:** mostly low and flat alluvial plains; hilly in the Southeast; many rivers which are subject to frequent calamities, such as floods, cyclones, tidal bores and drought.

**Climate:** tropical, dominated by seasonal monsoons; hot, humid summer (March – June); hot, humid monsoon season (July – October); cool, dry winter (November – February).

*All data from CIA World Factbook (2009) and United Nations Statistics Division (2009).*
2. Background information on Bangladeshi demographics

Bangladesh has a population of about 150 million people with a corresponding population density of more than 920 persons per square kilometre. During the first half of the last century the population increased by 45 percent (BDHS 2007). Ever since independence in 1971, the government of Bangladesh has understood the need to address the issue of population growth. In 1970, the year before Bangladesh and Pakistan became two separate countries, East Pakistan (Bangladesh) had a population of approximately 69 million, and West Pakistan (Pakistan) of approximately 62 million. Both parts of the country shared a common family planning scheme and had identical fertility rates (6.85 children per woman)\(^1\).

Today, the situation is dramatically different. While Bangladesh has a population of approximately 164 million, Pakistan’s population is now over 184 million. (United Nations Population Division, 2008). The total fertility rate in 2007 was approximately 2.7 children per woman in Bangladesh (BDHS 2007) and 4.0 per woman in Pakistan. If present trends continue, Bangladesh will have 222.5 million people in the year 2050 compared to Pakistan with 335.2 million.

Although the overall total fertility rate (TFR) has declined, it should be noted that there are regional disparities in the TFR. In the Khulna Division in the southwest, for example, the TFR is estimated at two children per woman and has, therefore, already reached the designated replacement level of 2.2. In the Sylhet Division in the northeast, on the other hand, the TFR reached levels of up to 3.7 children per woman in 2006 (BDHS 2007). Given these regional disparities and the exceptionally high population density, further reductions in regional and national fertility rates are still high on the agenda of policy makers. Related to this goal are the following areas of concern:

- The number of Bangladeshi women who use contraception has stagnated in recent years. Since 2000, only 54 to 56 percent of currently married women use a method of contraception. Added to this, almost 60 percent of contraceptive users discontinue using their chosen method\(^2\) within the first 12 months of use (BDHS 2007).

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\(^1\) Unless otherwise indicated, all statistics are taken from the United Nations Population Division, 2008.

\(^2\) The following methods were considered in the BDHS 2007: Pill, IUD, injectable, male condom, periodic abstinence and withdrawal.
Bangladeshi women have a pattern of early marriage and early childbearing. According to current fertility data, on average, 22 percent of children are born to women under the age of 20 and 76 percent to women under the age of 30 (BDHS 2007).
In 2009, around 35 percent of the total population is under the age of 15. This figure means that despite a substantial decrease in the TFR, the population size will still increase considerably. This phenomenon of a large number of young people at reproductive age engendering a further increase in total population numbers is called population momentum.

Mortality rates declined in recent years. BDHS 2007 shows that the under-five mortality in the five years preceding the survey was 65 deaths per 1,000 live births. This means that one in fifteen children born in Bangladesh died before reaching their fifth birthday. The infant mortality rate was 52 deaths per 1,000 live births and the child mortality rate was 14 deaths per 1,000 children. The maternal mortality rate was 320 deaths per 100,000 live births (2001), a figure that has presumably decreased in the mean time.
At the same time, life expectancy has increased to 62 years for men and 64 years for women in 2008 (which is high compared to other South Asian countries) (BDHS 2007). The consequence of a simultaneous decline in mortality and increase in life expectancy is that a higher proportion of the large cohorts reach an older age. Hence, the number of elderly people is rapidly increasing in Bangladesh.

Currently there are 6.8 million people over the age of 60. This will increase to 65.3 million before the end of this century. The percentage of elderly people as a part of the total population will rise to 26 percent from its current share of three percent. This represents a radical change in the demographic pyramid and poses numerous challenges for, amongst other things, the health system, the labour force and the social security system.
3. Demographic challenges in Bangladesh

This chapter focuses on demographic phenomena and population challenges in Bangladesh. What specific demographic changes are occurring and why are these patterns intriguing?

3.1. Population growth

There are several projections for the population to grow beyond its current level of 150 million. The medium variant of the projections for 2025 stands at 195 million and for 2050 at 222 million. The rate of natural growth is 1.9 percent per annum (Population Division 2009). Due to the population momentum, Bangladesh’s population will increase even if the total fertility rate were already now at its designated replacement level of 2.07. The reason for this is the high TFR in the past, which means a huge proportion of people are now at a reproductive age. Approximately 35 percent of the current population is under 15 and half of the population is already in its reproductive phase (PRB 2009). To decrease the final population by 2050 the proposed replacement level of 2.07 is insufficient. Demographic experts are now coming to the conclusion that a TFR of 1.7 as necessary to decrease the population by around 25 million. This has to be achieved within the next 10 to 15 years (Streatfield, 2009).

To reduce the current TFR to below the replacement level, a general increase of the age at marriage – still very low in Bangladesh – is required. This must be accompanied by a reduction in unmet needs and an increase in the use of contraceptives, especially (permanent) long-term methods ([P]LTM).
3.2. Urbanisation

The rapid growth in the urban population ratio is also noteworthy. Urban areas are estimated to grow by around 3.5 percent yearly in the six metropolitan areas. At present, Bangladesh’s urban population numbers 34 million and it is possible that this number will increase to over 100 million this century (Streatfield, 2008). As a result of this rapid urban growth, Bangladesh’s urban areas have the fastest growing number of people living in slums. For example, the annual growth rate of slums in Dhaka is approximately 7 percent. Due to limited resources in rural areas, the lack of work and the decrease in land cultivation, many people seek better lives in urban areas, especially in Dhaka. This rural-urban migration means urban resources are also becoming more scarce. Overcrowding in urban areas – particularly in city slums – and the absence of sanitation and sewerage systems cause waterborne and airborne diseases to become prevalent (Bangladesh Urban Health Survey, 2006). The lack of job opportunities and the high risk of disease drive slum dwellers even further into poverty.

3.3. Ageing

Bangladesh has been experiencing a shift in the age structure of its population. The percentage of elderly people – those aged 60 years and over – will grow substantially within this century. Currently there are about 7 million elderly people in Bangladesh and this number will increase to up to 65 million by 2100 (26 percent of the whole population in Bangladesh). The growth rate of the elderly population is 2.2 percent per annum, whereas the working-age population growth rate is only 0.5 percent per annum (Streatfield 2008). The elderly population will therefore be increasingly prominent in Bangladesh’s overall age structure. The rapid growth of this older age group is linked to steep declines in total fertility rates in the 1970’s and 1990’s, as well as to improved medical practice resulting in increased life expectancy (Shrestha 2000). Life expectancy at birth is currently 64 years for women and 62 years for men (PRP 2009).

The ratio of elderly people to working-age people (the old-age dependency ratio) is increasing substantially in Bangladesh. The number of people aged 60 and over will increase six-fold by 2050, while the number of people of working age will not even double (Streatfield 2008). The shift in this ratio has significant economic, social and health consequences. For example, the demand for social pensions, care homes and health care is certain to increase.

An elderly man from Barisal, Bangladesh © GTZ
At this point the ‘demographic dividend’ needs to be considered. Due to the declines in fertility, the proportion of the working-age population in Bangladesh has increased in recent years. At present, the percentage of people of working age is remarkably higher than the percentage of economically dependent young people under the age of 15 and the elderly population over 60. The resulting ‘demographic bonus’ and ‘demographic window’ could be used for economic growth in Bangladesh but only while this age structure continues. This window of opportunity will soon close with renewed changes in the age structure (as mentioned above). Furthermore, it should be pointed out that to benefit from the current ‘demographic dividend’ in Bangladesh, the working-age population needs to be provided with increased job opportunities. Currently, almost 40 percent of the population is unemployed, with women mostly affected (Karsch & Muenz 2007).

3.4. Communicable and non-communicable diseases

The shift in age structure is the result of the demographic transition: crude birth rates and mortality rates are both low. Improved adult survival rates, prolonged life expectancy, lifestyle changes and the focus of national and international health programmes on infectious and parasitic diseases have led to increases in chronic and degenerative diseases. It is assumed that by 2010, non-communicable diseases will be responsible for 59 percent of all deaths compared to 40 percent in 1990. The percentage of communicable diseases will decrease from 51 percent to 30 percent within the same period (Streatfield 2008).

The Demographic Dividend:
The decline in fertility is followed by an increase in the proportion of working age population. Thus, there are currently more people who can potentially support proportionately less people (children and elderly). This results in a demographic window or bonus which can be used to further economic growth.

Demographic Window:
Before a country reaches the point where those over 40 constitute half of the population, it goes through a period labeled the „demographic window“. While the proportion of children and youth under 15 years falls below 30 per cent and the proportion of people 65 years and older is still below 15 per cent, the proportion of working age population is particularly prominent in a 30 - 40 year time period (UN Expert Meeting on world Population to 2300, 2004). This provides an opportunity for economic growth.
This epidemiological transition brings up two burdens of diseases. On the one hand the country still suffers from infectious and parasitic diseases but at the same time chronic and degenerative diseases are on the rise. Both types of diseases are more prevalent in poor households (ICDDR,B 2009).

The most common infectious and parasitic diseases in Bangladesh are cholera, dengue fever, malaria, tuberculosis, ARI, kala-azar and filariasis (Health Bulletin 2008, IEDCR 2009).

The three major non-communicable diseases identified by the Health, Nutrition and Population Programme (HNPSP) in Bangladesh are cancer, cardiovascular diseases and diabetes mellitus (WHO 2009). There is a marked difference in the prevalence of non-communicable diseases between rural and urban areas. For instance, rates of diabetes in urban areas are twice as high as in rural areas – 8 percent versus 4 percent in urban areas (Ghaffar et al. 2006).

These two burdens of diseases have immense cost implications for the health and social security systems. There is a growing demand for a broader health care system which considers infectious and parasitic diseases as well as chronic and degenerative diseases. Furthermore, the current medical school curriculum needs to take these changing demands into account (Streatfield 2008).

3.5. Age at marriage

In Bangladesh the legal age for women to marry is 18 years but a large number of women get married before that age. The median age at first marriage for women aged 20-49 is 16 years (BDHS 2007) and the trend for teenage marriage has not abated yet. In countries with declining fertility one usually notices an increase in the age at first marriage. Surprisingly, Bangladesh does not fit this pattern. Compared to the other four Divisions, for instance, the Khulna and Rajshahi Divisions have the lowest TFRs with 2.0 and 2.4. However, if we compare the age at marriage of each of these Divisions it is apparent that women in Khulna and Rajshahi have the lowest age at marriage – around 16 years. This regional difference shows that the age at marriage does not necessarily have an impact on the decline of fertility rates. In these regions the high spread of contraceptive use and, in particular, birth spacing methods are responsible for the reduction.

Furthermore, it is particularly interesting that the age at marriage has not changed in recent years, despite increasing primary and secondary education for girls. There is some evidence that the age at marriage is even lowering. This might be due to under-reporting of ages at marriage of girls and women. The Health and Demographic Surveillance System in Matlab – a programme of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) – found that 50 percent of respondents gave the wrong age at marriage (Streatfield 2009).
4. Bangladesh’s fertility decline

Between the early 1970’s and late 1980’s Bangladesh experienced an enormous decline in fertility (6.3 to 4.3, BDHS 2007). After this time period the TFR levelled off for almost a decade (1993 to 2000), remaining at approximately 3.3 children per woman. Since 2000 the TFR has been declining again and the current TFR is 2.7.

The decline occurred mostly in the older age group of 30 to 34 year-olds (BDHS 2007) and varied between the regions. Fertility is much higher in Eastern regions than in Western regions. Khulna and Rajshahi in the east have a TFR of 2.0 and 2.4 respectively compared to Sylhet and Chittagong in the west with TFRs of 3.7 and 3.2 respectively (BDHS 2007).

Developments in fertility in Bangladesh have attracted the interest of a large number of scholars, mainly from the field of demography. In discussions on the determinants of fertility decline in Bangladesh one can identify two distinct approaches, expressed in two different publications.

The first approach explains the fertility transition almost entirely in terms of the activities of the national family planning programme. Cleland et al.’s 1994 study for the World Bank ‘The Determinants of Reproductive Change in Bangladesh: Success in a Challenging Environment’ exemplifies this approach.

The second approach, set out in Caldwell et al.’s 1999 study ‘The Bangladesh Fertility Decline: An Interpretation’, considers the activities of the family planning programme as important, but sees socio-economic changes as equally significant, particularly in terms of the pace and persistence of the decline. In the next section there is an explanation of the perspectives of Cleland et al. (1994), followed by the approaches of Caldwell et al. (1999).
4.1 The role of family planning programmes

Cleland and his colleagues explain the rapid decline in fertility as primarily due to the impact of family planning programmes in Bangladesh (Cleland et al. 1994). After achieving nationhood in 1971, Bangladesh’s government affirmed a strong commitment to family planning services. The first president of the country, Sheik Mujibur Rahman, recognised population growth as a problem, especially in terms of national productivity. As a consequence, family planning became one of the government’s priorities and a number of national programmes were introduced.

All governments in power since the country’s independence in 1971 have placed a high priority on reducing the country’s high rate of population growth, which stood at three percent per annum during the 1970s. Since 1973, the government has received strong support from international donor agencies to intensify the efforts of family planning programmes. According to Cleland and others (1994), the Bangladesh family planning programme helped to change couples’ attitudes to the use of modern contraceptives. Khuda and Hossain (1996) explain changes in fertility behaviour and contraceptive use as follows:

“Bangladesh is the best example of a country with a strong family planning programme effort which has brought about a significant fertility decline, even when social and economic development is at a low level and not improving much. Bangladesh ranks low on almost every social and economic development indicator. Nevertheless, an intensive family planning programme has been followed by a substantial increase in the use of contraception and the consequent fertility decline (…) The Bangladesh case has, no doubt, strengthened the argument that a strong family planning programme can make a positive contribution to the process of demographic transition”

(Khuda & Hossain 1996:164).

In summary, according to scholars like Cleland, Bangladesh’s case challenges conventional demographic transition theory which generally links fertility decline to the impacts of socio-economic change. They posit that the country’s main achievements in decreasing fertility result from the national family planning programme.
4.2 Socio-economic changes

There is a debate on the influence of socio-economic factors on the fertility rate’s decline. Scholars like Caldwell et al. (1999) consider socio-economic factors as drivers for changes in fertility. They mainly attribute the decline of the TFR to socio-economic changes such as the increasing costs of sustaining a large family. Caldwell et al. (1999) show that there have been considerable social and economic changes in the country and argue that these transformations have influenced couples’ attitudes to family size, leading to a decline in fertility. According to Caldwell (1999), Rahman (2002) and others, these socio-economic changes included:

**Socio-economic changes:**

- **Education:** increasing access to primary and secondary education, particularly for girls;
- **Gender:** an overall improvement in the status and role of women;
- **Economic situation:** better economic conditions, following a rise in income-generating activities and employment opportunities, particularly for women (for example in garment factories);
- **Nutrition and housing:** The increasing cost of sustaining a large family, such as providing food, housing, clothing, school fees;
- **Public awareness:** improved access to the mass media.
Bangladesh's fertility decline

**Educational Attainment of Women (BDHS 1993/94)**

![chart](chart199394.png)

Fig.9: Data from BDHS 1993/94

**Educational Attainment of Women (BDHS 2007)**

![chart](chart2007.png)

Fig.10: Data from BDHS 2007

- Secondary complete or higher
- Secondary incomplete
- Primary complete
- Primary incomplete
- Primary incomplete
- No education
In summary, Caldwell’s approach identifies socio-economic factors such as female education and employment, women’s status in society, access to mass media and better health facilities as significant determinants of fertility decline.

### Employment Status of Women by Age-Group

![Employment Status of Women by Age-Group](image1.png)

- **Data from BDHS 1993/94 and 2007**

### Employment Status of Women (total)

![Employment Status of Women (total)](image2.png)

- **Data from BDHS 1993/94 and 2007**

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### Bangladesh’s Policy regarding NGOs:

In the mid 1980s, Bangladesh’s government amended policy in favour of NGO involvement in health and population activities. As a result, the number of NGOs involved increased significantly.
5. Interview findings

A total of 16 semi-structured interviews were held with representatives of national and international organisations and stakeholders working in the field of reproductive health and family planning (see full list in the appendix). These revealed a number of interesting results, which fall into two categories:

- 1. Arguments supporting the strong influence of national family planning programmes.

In the following section, we describe the key influences on fertility as expressed by the interviewees.

5.1 Family planning programmes

According to interviewees, the national family planning programme played a significant role in the substantial increase in the use of contraception and, therefore, in the reduction of fertility.

![A Family Welfare Assistant shares family planning information with villagers in the Trishad District of Bangladesh](© 1994 Cheryl Groff, Courtesy of Photoshare)

![Men participating in a “Jiggasha” family planning discussion group](© 1993 CCP, Courtesy of Photoshare)

Interviewees expressed the following to be key factors in the success of Bangladesh’s family planning programme:

- the deployment of female field workers,
- maternal and child health programs, and
- the involvement of the NGO sectors.

### Deployment of female field workers

By the mid 1970s, family planning programme managers in Bangladesh had come to realise that, for the programme to succeed in such a traditional society, it was necessary to reach women in their homes. Women, particularly in rural areas, are often illiterate, seldom work outside of their homes and have limited mobility. Hence, it is often difficult or even impossible for them to visit family planning service delivery points. For this reason, in the mid 1970s, the government introduced the ‘doorstep delivery system’. The idea was to ensure provision of services at the individual or household level. For this, fieldworkers called **Family Welfare Assistants (FWAs)** were employed to conduct routine home visits. So, instead of women or men coming to them, FWAs were tasked to conduct home visits once every two months, making family planning services accessible to a much larger part of the population.

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### Family Welfare Assistants (FWA):

Female Family Welfare Assistants (FWA) were employed to visit households once every two months to provide them with contraceptives and other family planning services. This is the so-called ‘door step delivery system’ by which family planning services became available to a larger number of people, especially in rural areas.
In the mid 1970s, the government deployed 23,500 female FWAs in the family planning programme, who provided family planning information to women in the home. This doorstep delivery system was quite effective in increasing the contraceptive prevalence rate, particularly in rural areas. Additionally, couples were financially rewarded for sterilisation.

According to the interviewees, the drop in the TFR that began in the late 1970s was in large part due to the work of these female field workers. Therefore, much of the national family planning programme’s success can be attributed to the deployment of FWAs.

**Integrated Maternal and Child Health (MCH) care services**

The Bangladeshi government considered maternal and child health (MCH) care services as another way to improve the acceptance of family planning methods introduced in the 1970s. They realised that the effective control of infant and child mortality is a pre-requisite for achieving a reduction in population growth. Studies have shown that fertility goals are influenced by the under-five mortality (CPD 2003, Streatfield 2008). The likelihood that children will survive to adulthood strongly influences how many children a couple desires. Hence, MCH care was integrated in family planning services. This shift brought about qualitative and structural changes in MCH activities and family planning programmes.

In order to provide comprehensive care for infants and children, an Expanded Programme on Immunisation (EPI) was established in the mid 1980s in the Health Directorate. According to the interviewees, this programme is still highly efficient and is one of the best known EPI programmes in Asia. The significant reduction in infant mortality rates over the last three decades is largely due to this programme, although other factors have also contributed, such as the increase in female education and better antenatal care. The EPI programme’s coverage of children under two years is nearly universal.

According to the interviewees, maternal and child health care services have been one of the key factors in the success of Bangladesh’s family planning programme.

The perceived probability that one’s children will survive to adulthood have a strong influence on the decision of the number of children a couple desires. The lower the infant and child mortality rates are, the less children a couple needs to have to ensure that the desired number of children will survive. Thus, an effective control of infant and child mortality is a prerequisite for the successful deceleration of the population growth rate.

**Expanded Program on Immunization (EPI):**

The Expanded Programme on Immunization was launched by the World Health Organization (WHO) in 1974. The goal of the programme is to provide all children with an access to vaccines to reduce child mortality.
NGO involvement and collaboration

Interviewees emphasised the fact that the government and NGOs have been collaborating for a long time in Bangladesh. In the field of family planning, NGOs have played a significant role in the government service delivery system. In the mid 1970s, NGOs in the health sector began to receive financial assistance from the government. In the mid 1980s, the government amended policy in favour of NGO involvement in health and population activities. And, since the late 1980s, NGOs have been allowed to play a complementary role to the government service delivery system in rural and urban areas. As a result of this change in policy, the number of NGOs engaged in health and family planning activities in Bangladesh has increased significantly. At present, nearly 300 NGOs are working in the health and family planning sector. Some of them are implementing large-scale, innovative programmes in rural, peri-urban and urban areas.

Several leading NGOs, such as the Bangladesh Rural Advancement Committee (BRAC), Gonoshasthaya Kendra and Grameen Kalyan play proactive roles in promoting health services, especially to poor, rural populations. However, the NGOs’ role is more about awareness-raising, leaving it to the Government to focus on service delivery, especially for the poor.

BRAC’s community health programme has become a sustainable model for the provision of comprehensive primary health care and family planning services through fixed facilities and doorstep services in rural areas. Both the Gonoshasthaya Kendra and Grameen Kalyan programmes are successful examples of private financing and cost recovery to support essential health and family planning services.

The interviews revealed that much of the success in increasing contraceptive use in Bangladesh is due not only to the Government’s activities, but also to the active role played by NGOs. Innovative approaches in service delivery, the introduction of new contraceptive methods and a policy of providing acceptors with a choice of methods are cited as key components of NGO programmes.
There are several particularly successful examples of NGO programmes that deserve mentioning. Grameen Bank and BRAC have received worldwide acclaim for their success in achieving effective results at the grassroots level in Bangladesh. Kamal et al. found that members of Grameen Bank have a higher likelihood of using contraception than non-members (Kamal et al. 1992). BRAC has also been successful in establishing income-generating activities in rural areas, and has successfully encouraged and developed measures to improve female literacy. Another successful NGO is Swanirvor Bangladesh. It recruits local female workers and distributes condoms and contraceptive pills in rural areas of the country. Another NGO, the Family Planning Association of Bangladesh (FPAB), is sponsored by the International Planned Parenthood Federation (IPPF) and has been in operation since 1953. It maintains 30 static clinics nationwide and provides family planning services alongside other FPAB social programmes that target women (Cleland et al. 1994).
5.2 Socio-economic factors

Interviewees also considered socio-economic factors as relevant to Bangladesh’s declining fertility. There was an agreement among respondents that the country has experienced significant social and economic changes over the last three decades. Concerning socio-economic factors, the interview partners placed special emphasis on:

- female education
- female employment
- improvement of women’s social status
- exposure to mass media.

The interviews revealed that there was no single deciding factor, but rather that family planning efforts combined with socio-economic factors, played a role in changing reproductive behaviour. Below, each of these major factors is briefly described in relation to fertility transition in Bangladesh, as reported by the interviewees.

Female education

Interview partners noted that Bangladesh has made huge efforts to raise the educational level of its people, putting a particularly high priority on girls’ education.

Primary education is mandatory and has always been free for boys and girls in Bangladesh. There is a steady fall in the percentage of both males and females in the younger age group who have never attended school. The proportion of women who have never attended school has decreased significantly, and the proportion of women attending secondary school or higher has noticeably increased (from 15 percent to 32 percent [BDHS 1993-1994; 2007]).

The increase in female education has narrowed the gap in education levels between male and female young people. Nevertheless, men are still more likely than women to have completed primary and secondary school.

The government introduced cash and food incentives as part of education programmes to encourage poor parents to send their children to school. Despite noteworthy achievements in female enrolment at the primary level, more effort is needed to ensure greater female enrolment in secondary and higher level education. To achieve this, the government has recently introduced a scholarship programme to take girls into secondary education.
Interviewees agreed that there is a **positive relationship between the level of educational attainment and the use of contraceptive methods**. Female education empowers women in decision-making at the household level, including in matters related to contraceptive use, reproductive behaviour, children’s schooling and healthcare. In particular, secondary and higher education increases female employment prospects. Consistently, interviewees stated that **female education is one of the most important variables affecting both contraceptive use and fertility regulation**.

**Female employment**

Traditionally, very few Bangladeshi women worked outside their homes. However, during the past three decades starting in the mid 1970s, a **number of employment opportunities for women outside their homes evolved**. Women in urban areas often work in textile factories (garment factories) and on construction sites. Some interviewees argued that the pressures of poverty were probably the main driver for women to go out and seek work.

The enormous increase in the number of women in the workforce – mainly due to the spread of garment factories in the country – may have affected contraceptive use and fertility. According to some interviewees, **working women might be more independent and autonomous** than non-working women and this may affect how they make decisions regarding the timing and spacing of births, as well as how many children they desire. **Female employment might also increase opportunity costs associated with childbearing**, and hence reduce the family size.
Women’s social status

The life of a Bangladeshi woman has been and is still to some degree dominated by the country’s patriarchal system. This system maintains a rigid division of labour that affects women’s mobility, roles and responsibilities, and sexuality. Traditionally, a woman in Bangladesh derives her status from her family. A woman’s status is usually defined by the number of children she bears, and household chores and childbearing are seen as her main duties.

Interviewees confirmed that an increase in female education and female employment might lead to an improvement in women’s social status. A higher social status for women might lead to more independent fertility decision-making, possibly leading to longer spacing between births and, as a result, less children. The enhancement of women’s status, especially through increased educational and employment opportunities, might further accelerate the process of fertility decline in the country. Interview partners considered the improvement in women’s status a critical determinant of fertility decline in Bangladesh and argued that it has contributed to increased contraceptive use.

Exposure to mass media

Radio, television and DVD-player ownership has increased significantly in Bangladesh over the past few years. Nowadays even large numbers of rural Bangladeshis and slum dwellers in Dhaka and other cities have access to mass media.

The interviews revealed that exposure to modern mass media, such as listening to the radio and watching television or DVDs, can affect people’s attitudes and ideas about desirable lifestyles and family planning methods. This is because radio and television offer information relating to health care, contraception needs and other related issues and, therefore, expose women and men to modern ideas and views. According to some interviewees, exposure to mass media is likely to result in increased contraceptive use and, consequently, reduce the fertility level.
5.3. Regional disparities

Some interview partners also emphasised the considerable variations in the total fertility rate among the six divisions of Bangladesh: “Health and family planning programme efforts lack uniformity throughout the country” (Al-Sabir 2008). The most notable difference exists between the two divisions of Sylhet and Chittagong with a particularly high TFR and the other four divisions with medium or relatively low TFRs.

The four major factors affecting regional variations in fertility levels that were mentioned by the interviewees are:

- The weakness of family planning programmes in Sylhet and Chittagong.
- The culture-driven “demand” for a larger number of children in Sylhet and Chittagong.
- Disparities in geographical location.
- Differences in the access to mass media.
Weaknesses in family planning programmes

“Lower contraceptive use in the regions of Sylhet and Chittagong is likely to be associated with family planning programme weakness. Lower fieldworker visitation is a clear indication of programme weakness”

(Al-Sabir 2008)

Further it is necessary to take into account that Sylhet is very conservative. Many family welfare assistants (FWAs) are Hindus and therefore are not accepted by the Muslim families.

The interviewees concluded that an inadequate supply of contraceptives in Sylhet and Chittagong is one of the major reasons for the lower level of contraceptive use and the higher total fertility rate in these regions. It seems to be a particular challenge for the Bangladeshi health system to increase the use of family planning services in these two low-performing regions. Ensuring availability of timely contraceptive services, and the delivery of good quality, continuous supplies are stated to be major problems in these regions. Low female field worker coverage combined with a lack of programme managers makes it difficult to ensure the delivery of quality contraception. Professional staff for counselling and logistical support are another hole in Sylhet and Chittagong’s provision.

The culture-driven „demand“ for children

The low use and prevalence rates for modern contraceptives and high total fertility rates in Sylhet and Chittagong are likely to be associated with higher demand for children in these Divisions. There are regional variations in people’s perception of the ideal number of children. People in Khulna are more likely than in other regions to favour a two-child family. In Sylhet and Chittagong a two-child family is particularly rare and is viewed as undesirable. Interviewees emphasised that cultural values play a crucial role for changing family size norms. Everyone agrees that Sylhet is a more conservative area than for example Khulna. Changes in social and cultural values and norms in Sylhet lag behind those in other regions of Bangladesh.
Geographical location

A crucial point mentioned in almost all interviews is the unfavourable geographical location of the regions Sylhet and Chittagong. Both districts are situated on undulating terrain, comprising hilly areas with steep gradients, flat plains and lowlands. Large parts of both regions are difficult to access throughout the year and floods are common in Sylhet. Given these geographical circumstances, it is assumed that residents have only limited access to information, counselling and family planning services.

Media access

Contraceptive knowledge, attitudes towards family planning methods, and the amount of exposure to media that advocates family planning, vary by region. Residents of Sylhet and Chittagong have limited access to mass media compared to other regions in the country. According to interviewees, women in these two Divisions have a comparatively lower knowledge of contraceptive methods – particularly modern methods – due to limited exposure to mass media.

There are also some regional variations in the perceived acceptability of the use of family planning methods. Women from Khulna division are most likely to have been exposed to family planning messages through radio, TV, newspapers and posters, while women from Sylhet are least likely to have been exposed to family planning messages through the mass media.

The exposure to mass media may have a strong positive impact on the use rate of family planning methods in Khulna. This Division shows the highest approval rate of family planning by women as well as their husbands, while Sylhet shows the lowest approval rate.
6. Conclusions from the interviews

In the first part of the interviews, the discussion focussed on factors influencing the reproductive behaviour in Bangladesh. In the second part, interviewees were asked for policy advice and suggestions regarding fertility decline in Bangladesh. Interviewees mentioned a number of policy requirements and possible courses of action that could help to design an effective family planning programme to enable Bangladesh to reach its target replacement level. The suggested policies illustrated below seek to promote contraceptive use as well as Bangladesh’s family planning programme. These policies might be transferable to other regions or countries. According to interviewees and based on the literature review, the following policy implications seem appropriate to positively impact fertility decline.

6.1 Policy requirements for further fertility decline

To promote further fertility decline, tailored approaches are needed for different groups and regions, including:

- Raising the age at marriage.
- Providing further family planning services.
- Strengthening the collaboration between the health and family planning directorates.
- Improving the procurement and distribution logistics of contraceptives.
- Increasing the use of (permanent) long-term contraceptive methods ((P)LTM), particularly in Sylhet and Chittagong.
- Generally improving women’s status, especially in rural areas.
- Improving the secondary school attendance rate further, especially for girls.
- Providing more employment opportunities, especially for women.
- Providing access to mass media to regions that are not yet covered.
- Designing and extending social protection systems
- Strengthening the collaboration between the government and NGOs.
Raising the age at marriage

In Bangladesh a high proportion of girls get married as teenagers. Early marriage correlates positively with early childbearing, which in turn correlates with a higher TFR (CPD 2003). Overall, raising the age at marriage should reduce the TFR but it has to be accompanied by the use of contraceptives – particularly (permanent) long-term methods ((P)LTM). However, it should be noted that an older age at marriage does not necessarily lead to a lower TFR, as illustrated by the regional differences mentioned above. The age at marriage on its own is not the cause for lower TFRs, but it can potentially contribute to a decline in fertility.

Several approaches exist for raising the age at marriage:
- Enrolment of girls in schools, particularly at secondary level.³
- Female employment and income-generating activities (Streatfield et al. 2007, APR 2009).
- Legally enforcing the legal age at marriage (female: 18 years, male: 21 years);
- Compulsory issuing of birth certificates (so people accurately know their own age).
- Enforcement of legal prohibitions against dowries (costs are lower for parents of younger girls) (Streatfield et al. 2007).

Providing further family planning services

Sylhet and Chittagong have the highest TFR’s at 3.7 and 3.2 respectively and it is fair to say that these are poor performing Divisions. Recruitment of fieldworkers to provide family planning information, advice, methods and referrals must be increased. For this reason, the geographic distribution of fieldworkers must be reanalysed (Streatfield et al. 2007). Proper incentives for fieldworkers and medical staff in rural and remote areas are needed to fill currently vacant posts. Paid volunteers who support fieldworkers during medical shortages might also be helpful (Streatfield et al. 2007).

In this context, it should be noted that the populations of some of Bangladesh’s regions are very conservative. This fact has to be kept in mind when recruiting fieldworkers. For instance, in Sylhet the majority of the population are Muslims and conservative. Most of the fieldworkers are Hindus which is why they are often not accepted by local families (Streatfield 2009). However, fieldworkers need to be accepted and trusted for their advice to be effective. In general, more skilled human resources are needed for family planning programmes.

³ In the west, because of widespread poverty, the focus lies more on efforts to enrol and retain girls in school. In the east, the focus lies not only on delaying marriage but most importantly on reducing fertility within the marriage (Streatfield et al. 2007).
Conclusions from the interviews

Strengthening the collaboration between the health and family planning directorates

In Bangladesh, the health and the family planning directorates work separately. Activities are merged in the Health, Nutrition, and Population Sector Programme (HNPSP). Some interviewees criticised this division into two directorates. According to them, it fosters duplication and poor coordination. The integration of health and family planning programmes should be pursued to prevent these problems. Examples of successful integration include:

- the Expanded Programme for Immunisation (EPI) which covers 82 percent of children under the age of five and considers family planning approaches;
- the medical curriculum of doctors and nurses who are now educated to be able to provide information on family planning and to advise clients regarding their specific family planning needs.

Improving the procurement and distribution logistics of contraceptives

The procurement of contraceptives and the logistics of their distribution still pose challenges in Bangladesh. The Ministry of Health and Family Welfare (MoHFW) does not currently monitor and coordinate the procurement process and neither is there a procurement configuration system in place (APR 2009). Consequently, stock-outs of family planning commodities occur, which explains why the unmet contraceptive needs of Bangladeshi women is still high (17 percent, BDHS 2007). Also, equipment in public hospitals is missing or often arrives late. For this reason, new evidence-based logistics approaches from abroad should be considered to ensure a constant supply of such commodities (Streatfield 2007). Furthermore, technical procurement agencies should be reinforced and Government procurement agents should continue to receive technical assistance and training. Last but not least, the length of the procurement process has to be shortened (APR 2009).

Increasing the use of (permanent) long-term contraceptive methods

Family planning programmes have to confront the high discontinuation rate of 56 percent (BDHS 2007). Men and women need to be convinced about the benefits of contraceptives and reduced family sizes. A possible solution is to update the Behaviour Change Communication (BCC) approach, which can help address misperceptions and misinformation especially about permanent long-term methods. To increase the use of (P)LTM, a more highly skilled workforce including doctors and nurses is also cited as necessary (APR 2009) to provide advice on family planning to clients. Although (P)LTM are the most cost-effective methods, poor women in particular might be discouraged by the initial costs of these methods. Family planning programmes should consider the instalment of payment structures or waiving fees for the poorest clients (PRB 2008).
Improving women’s status

Further improvement of women’s status can contribute to a continued decline in fertility. **Educated and working women are more likely to make important decisions**, such as the desired number of children and the temporal spacing of births. An improvement women’s status can be achieved by offering them more opportunities to achieve education, especially **secondary education and higher**. **The provision of employment opportunities can also contribute to an increased economic independence of women**, and thus to more freedom in their decision-making. Overall, socio-economic factors which play a role in women’s and men’s family planning decisions should be addressed by policies aiming to further reduce the total fertility rate.

Designing and extending social protection systems

The existence of a social protection system can also contribute to a further decrease of fertility. When poverty in old age is concerned, for example, various instruments exist that provide people with income security when they reach an old age: social pensions, contributory mandatory or voluntary pensions as well as private provisions such as microinsurances. In Bangladesh it is still common that children provide for their sick and aged parents, substituting for the lack of old-age protection as well as for the lack in social health protection, such as health care insurance for example. **By providing people in all regions with social protection, the necessity of having a large number of children can be reduced leading to a decrease in the fertility rate.** Various instruments pertaining to a social protection system will become increasingly important in the future of Bangladesh as the number of elderly within the population increases.

Strengthening the collaboration between the government and NGOs

Efficient collaboration between the government, NGOs and international development partners was a decisive factor for the success of the family planning programme, and hence, for Bangladesh’s rapid decline in fertility. In general, **NGO involvement supports the government and helps mass programmes succeed**.

Bangladesh is a unique example of government-NGO collaboration: In 1990 the government created the **NGO Affairs Bureau** which enables NGOs to obtain registration clearance, approval and permission through a single government agency. The aim of the Bureau is to promote high performance in the NGO sector and to ensure its accountability to the state. **The Government-NGO Consultative Council (GNCC) has now been formed with representatives from the Government, NGOs and civil society.** This aims to provide a regular forum for dialogue between the government and the NGOs to increase mutual understanding and cooperation. Added to this, the **Association of Development Agencies in Bangladesh (ADAB)** is an umbrella body of local, national and international NGOs which aims to play an effective role in facilitating greater unity and coordination of the NGO sector. **The strengthening of partnerships through NGO involvement could be promoted as a best practice example for replication.**
6.2 New areas for development cooperation

This report has highlighted the rapid and immense changes in Bangladeshi demography. Multi-sectoral approaches on national and regional levels are necessary to address resulting new challenges. Technical cooperation can support such approaches by treating demographic challenges as a cross-cutting issue.

Apart from family planning approaches, the following areas need closer consideration by future technical cooperation efforts:

- social protection for the ageing population, for example pension systems
- lifelong learning to keep the ageing population in the employment cycle
- health promotion in working environments
- health systems’ adaptation to needs of the changing demographic pattern
- promoting the rights and social status of women to give them more freedom of choice
- renovation and installation of water and sanitation systems, particularly in urban areas
- sustainable land use, particularly irrigation systems
- aversion of potential conflicts arising from resource scarcity
- protection of the environment and preparation for changes resulting from climate change
- effects of migration caused by climate change induced flooding

In order to be successful and achieve sustainable changes in these areas, technical cooperation needs to develop and offer policy advice which takes into account the population dynamics within a country and addresses issues resulting from demographic changes.
7. Summary and outlook

The most notable demographic change in Bangladesh has been the country’s unique and drastic decline in the total fertility rate since the 1970s. The TFR decline has resulted from strong governmental engagement and support in the fields of population, family planning, health, education, and employment. Its most salient causes were efficient family planning programs and important socio-economic changes, including an increase in female education and employment, and a wider-spread access to mass media.

As a result of high fertility rates in the past, however, a very high proportion of the population is currently at reproductive age which will lead to a further population increase (population momentum). The current population growth occurs primarily in urban areas resulting in an exacerbated urbanization trend.

Bangladesh also faces an ageing population as a result of a decrease in crude birth and mortality rates. The proportion of elderly within Bangladesh’s population is projected to increase to 26 percent in 2100. This shift towards an older population will be accompanied by an increase of chronic and degenerative diseases, posing a challenge to the health and social protection systems.

Overall, this case study of Bangladesh has shown that it is possible to shape a country’s demographic development and demonstrates the importance of strong governmental commitment accompanied by the engagement of civil society and international aid.

It needs to be taken into account that changes in attitudes and reproductive behavior do not pay off immediately, but lead to a slow shift in the population dynamics. Demographic change is an ‘inherently inert’ process. Therefore it is important to actively shape the population dynamics now and treat them with priority.

It should also be noted that the demographic changes do not only cause problems, but also create new potentials which technical cooperation can help to utilize. Due to the decline of fertility, Bangladesh is experiencing a “demographic dividend”. The country currently has one of the highest growth rates in per capita income level among the low-income countries of the world and shows a steady economic growth.
For further topics which should be included in such cross-sectoral approaches, see Chapter 6.2.

To offer qualified policy advice, it is necessary to invest in further research on the interrelations of demographic processes and topics such as rural development, social development, environmental change, economic development and employment.

This case study represents a first step towards a more systematic demographics-related technical assistance. Based on the findings of this study, implications for population policies and the potential for replication in other countries should be assessed. It should also be evaluated to what extend the experiences from Bangladesh can serve as “best practice” examples and how they can be integrated into the development of a concrete demographics-related policy advice service package. While expanding the approaches and experiences related to demography, it is important to take into account the specific demands and perspective of the partner countries.

These are some objectives of the GTZ-financed measure “Zukunftsinnovation Demographie und Entwicklung” (future innovation on the topic of demographics and development) which began in October 2009. In this context, the close and focused cooperation with “pilot” countries, such as the GTZ office in Bangladesh and the Health, Nutrition and Population Sector Programme will be continued and extended.
References


- Annual Performance Review (2009)


## Appendix

### Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ADAB</td>
<td>Association of Development Agencies in Bangladesh</td>
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<tr>
<td>APR</td>
<td>Annual Performance Review (of HNPSP)</td>
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<td>BDHS</td>
<td>Bangladesh Demographic and Health Survey</td>
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<td>BRAC</td>
<td>Bangladesh Rural Advancement Committee</td>
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<td>CPD</td>
<td>Center for Policy Dialogue</td>
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<td>EPI</td>
<td>Expanded Program on Immunization</td>
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<td>FPAB</td>
<td>Family Planning Association of Bangladesh</td>
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<td>FWAs</td>
<td>Family Welfare Assistants</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GNCC</td>
<td>Government-NGO Consultative Council</td>
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<td>GNI</td>
<td>Gross National Income</td>
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<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit</td>
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<td>HNPSP</td>
<td>Health, Nutrition and Population Sector Program (Bangladesh)</td>
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<td>HPSP</td>
<td>Health and Population Sector (Bangladesh)</td>
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<td>ICDDR,B</td>
<td>International Centre for Diarrhoeal Disease Research, Bangladesh</td>
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<td>IECDR</td>
<td>Institute of Epidemiology, Disease Control &amp; Research</td>
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<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>KfW</td>
<td>Kreditanstalt für Wiederaufbau – Entwicklungsbank</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>NGO</td>
<td>Non Government Organisation</td>
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<tr>
<td>(P)LTM</td>
<td>(Permanent) Long Term Contraceptive Methods</td>
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<td>PRP</td>
<td>Population Reference Bureau</td>
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<td>TC</td>
<td>Technical Cooperation</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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### List of interviewees

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