History

Bangladesh Family Planning Program evolved through a series of development phases that took place during the last 52 years. Family planning efforts in this country began in the early 1950s with voluntary efforts of a group of social and medical workers. Categorical FP program emerged during 1965-95 with the objective to control population growth as a strategy of economic development. The Family Planning Program in Bangladesh has undergone a number of transitional phases. The phases may be illustrated as follows:

**Phase I : 1953-59: Voluntary and semi-government efforts**

* Family Planning Association initiated family planning program in 1953 as a voluntary effort.
* The effort was limited to the small scale contraceptive distribution services in urban areas particularly through hospitals and clinics.

**Phase ll : 1960-64: Government sponsored clinic-based Family Planning Program**

* In 1960 the government sponsored clinic-based family planning activities under health services started.
* The Government set up a target of providing family planning services to 6.7 percent eligible couples and opened a family planning center in every hospital and Rural Dispensary.

**Phase lll : 1965-70: Field-based Government Family Planning Program**

* The family planning program was launched throughout the country as a priority program.
* A massive field oriented family planning program administered by a BOARD.
* Full time field staff and part-time village organizers known as dai (a female village mid-wife) were recruited and trained to provide motivation and service close to the door-steps of the rural people.
* Selected clinical and non-clinical methods offered.

*(The program came to a standstill during the Liberation war in 1971.)*

**Phase IV : 1972-74: Integrated Health & Family Planning Program**

* Administrative process for decision-making was shifted from the autonomous Family Planning Board and the Council to the Ministry of Health and Family Planning.
* Family planning services functionally integrated with health services at the field level.
* Oral pill was introduced in the family planning program as a method of contraception.
* The provision of part-time village level dais was abolished.

**Phase V : 1975-80: Maternal and Child Health (MCH)-based Multi-sectoral Program**

* In August 1975, a separate Directorate of Family Planning and an independent Division of Population Control and Family Planning in the Ministry of Health were created.
* A National Population Council - the highest policy making body - was constituted with the President of the People’s Republic of Bangladesh as the chairman and development-concerned ministries as members.
* A Central Co-ordination Committee was also formed with the Minister for Health and Family Planning as chairman and secretaries of concerned ministries as members to coordinate implementation and review progress of multi-sectoral population activities under different ministries.
* In January 1976, the Government declared the rapid growth of population as the number-1 problem of the country.
* In June 1976, the Government approved a National Population Policy outline.
* Full-time male and female field functionaries were recruited on regular basis to cause a thrust of the MCH-FP program in rural Bangladesh.

**Phase VI : 1980-85: Functionally Integrated Program**

* Delivery of MCH-FP services were functionally integrated with Health at Upazila level and below.
* MCH-FP became also a function of health officials.
* The National Population Council (NPC) was reconstituted into a high powered National Council for Population Control (NCPC) headed by the President of the Council of Ministers.
* An Executive Committee headed by the Minister for Health and Population was formed.
* An unified command had been established at the top by the merger of the two divisions of Health and Population Control under one Secretary of the Ministry of Health and Population Control.
* Upazila Family Planning Committee had been formed to be chaired by the Chairman of Upazila Parishad for facilitating implementation of the program at the local level.

**Phase VII: 1985-90: Intensive Family Planning Program**

* A broad-based multi-dimensional intensive MCH-based family planning program was launched.
* Improved family planning and MCH services were provided.
* Rapid FP- MCH infrastructural development by commissioning more service centers (Union Health & Family Welfare Centers---UH & FWC) in rural areas was initiated.
* Unit-wise FWA registers were introduced for record keeping family planning and demographic events of households.
* Satellite clinic - an outreach activity – was introduced to deliver MCH-FP services in remote & rural areas.
* Involvement of community leaders and NGOs was increased.
* Branch of National Council for Population Control was setup in each district under the chairmanship of District coordinator.
* FP-MCH program as “Social Movement” was launched.

**Phase VIII: 1990-95: Reduction of rapid growth of population through intensive service delivery and community participation**

* Expansion of MCH-FP service delivery with enhanced quality of care.
* Increased resource allocation for program implementation.
* Promoting family planning as an integral part of development activities through inter-sectoral collaboration.
* Mobilizing community support and participation.
* Increased involvement of NGOs and private sectors for supplementing and complementing government efforts.
* Enhancing women’s status through education and participation in social, economic and political life.

*(The Family Planning program had been implemented through an interim plan during 1995-97).*

**Phase IX: 1998-2003: Health and Population Sector Program (HPSP)**

* Health and Population Sector Program was introduced in 1998.
* However, the government upon review, decided in January 2003 to reestablish separate organizational structures and authority for health and family planning as they existed before July 1998.

**Phase X: 2003-2011: Health, Nutrition and Population Sector Program (HNPSP)**
To overcome the multidimensional problems and to meet the challenge according to the spirit of the International Conference on Population and Development (ICPD), the Government of Bangladesh launched the Health, Nutrition and Population Sector Program (HNPSP) in 2003. This aimed to reform the health and population sector. The program entails provision of a package of essential and quality health care services responsive to the needs of the people, especially those of children, women, elderly and the poor.

Within the HNPSP, the health and family planning structure is now functioning under separate management system. In the meantime, the FWA register and house visitation by the FWAs have been reintroduced in the program after 5 years. The MIS unit of the Family Planning Directorate has been functioning independently as before after 5 years and started publishing monthly reports on performance of RH, FP-MCH. The ultimate goal of the HNPSP is to achieve NRR-1 by the year 2011.

**The priority objectives of the HNPSP are:**

* To reduce Total Fertility Rate (TFR) from 3.3 to 2 by the year 2011.
* To increase Contraceptive Prevalence Rate (CPR) from 55.8 % to 72% by the year 2011.
* To reduce Maternal Mortality Rate (MMR) from 3 to 2.75 by the year 2011.
* To reduce Infant Mortality Rate (IMR) from 52 to 37 per 1000 live birth by the year 2011.
* To reduce Child Mortality Rate (Under 5) from 65 to 52 per 1000 live birth by the year 2011.
* To reduce burden of TB and other diseases and To reduce malnutrition.
* **(Source: HNPSP, PIP, June, 2003).** The Health, Nutrition and Population Sector Program has introduced Maternal Child & Reproductive Health Services Delivery Program, Clinical Contraception Services Delivery Program and Family Planning Field Services Delivery Program to ensure better services, addressing the needs of clients, strengthening service delivery and improving management system.

**References:**

1. Population Control Programme in Bangladesh: Past, Present & Future, By IEM Unit, June 1985, Directorate of Population Control.
2. Bangladesh’s Population Problem and Programme Dynamics, By Mohammed A. Mabud, January, 1992.

**Phase XI: 2011-2016: Health, Nutrition and Population Sector Development Program (HNPSDP)**
Bangladesh has achieved success in family planning programs against the backdrop of low literacy rate, low status of women, low income and so on. Despite this, one must note that due to past high fertility and falling mortality rates, Bangladesh’s population has a tremendous growth potential built into its age structure. So, population continues to remain as one of the most important nation’s problems as well as one of the major cause of poverty. Considering the fact, government has initiated to update the population policy 2004.Major successes in population sector programs were achieved in expanded access to family planning services with introduction of a broader range of modern and effective methods. Replacement level of fertility by 2016 at the earliest is the priority vision of the GOB.

In line with this vision present TFR of 2.3 children per woman (in 2011) needs to be reduced to 2.0 children per woman to attain net Reproductive Rate (NRR) =1 by 2016. To achieve replacement level of fertility by 2016, corresponding CPR has to be increased to 74% by mid-2016 from 61.2% (in 2011). Further efforts proposed to shift family planning use patterns towards more effective, longer lasting and lower-cost clinical and permanent methods covering low performing areas. But the major impact on fertility will be achieved by raising the age of marriage, which will push up age at first birth, and again trigger a tempo effect, to bring fertility down. Mother and Child Welfare Centers (70) under DGFP are considered as centers of excellence for emergency obstetric care services. Upgrading one third MNCH centers to provide adolescent friendly and reproductive health services and reducing adolescent pregnancies through BCC/IEC are the important activities under DGFP.

**Highlight of activities under Population Sub Sector of HPNSDP**

* Continuing and strengthening domiciliary services
* Strengthening IEC activities through multi-sectoral approach
* Introducing new approach; providing targeted HR, logistics and other management support; and strengthening monitoring and supervision at low performing and hard to reach area
* Ensuring commodity security and diversify local product
* Continuing Commodity Supply chain
* Ensuring community participation
* Institutionalization of Local Level Planning
* GO- NGO Collaboration and Public Private Partnership
* Increasing male participation
* Gender sensitization
* Ensuring quality of services
* Introducing new brand of contraceptives
* ICT and web based communication and monitoring
* Addressing infertility (3-5% of population.)
* Ensuring Human resources forecasting, management and development
* Introducing International Accounting Standard (IAS) from H.Q to field Offices / Ensuring Proper financial management from headquarter to field level
* Expanding FP services at urban areas (slum centered)/ special interventions at urban areas

**HPNSDP Priority Indicators with Benchmarks and Targets :**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Indicators | Base line (with Year and Data source), 2007 | Update 2013 | TARGET 2016 | On track? |
| Infant mortality rate (IMR), Per thousand life birth | 52, BDHS-2007 | 43, BDHS-   2011 | 31 | Likely |
| Under 5 mortality rate,  Per thousand life birth | 65, BDHS-2007 | 53, BDHS-   2011 | 48 | Yes |
| Neonatal mortality rate (NMR), Per thousand life birth | 37, BDHS-2007 | 32 BDHS-   2011 | 21 | Challenging |
| Maternal mortality rate (MMR),Per hundred thousand life birth | 194BMMS-2010 | 194 BMMS-2010 | 143 | Yes |
| Trends in Maternal Healtha)ANC at least 4 visitsb) Delivery attended by a medical trained providerc) PNC within 02 days of delivery | a) 22%b)  21%c) 20%BDHS-2007 | a) 25%b) 34.4%c) 27.6%UESD-2013 | 50% in  all 3 indicators | Challenging |
| Unmet Need for FP | 17.6%,BDHS-2007 | 13.5%, BDHS-2011 | 9% | Challenging |
| Contraceptive Drop- out rate | 49%,2004 | 35.7% BDHS-   2011 |   |   |
| Contraceptive Prevalence Rate (CPR) | 55.8%,BDHS-2007 | 62% UESD-2013 | 72% | Likely |
| Use of Modern Contraceptive in low performing Area | Syl:24.7%, Ctg:38.2%, BDHS-2007 | Syl:39.4%, Ctg:43.9%, UESD-2013 | Syl: & Ctg:50%, | Yes |
| Children with Stunting (height for age/ <5) | 43.0 percent(BDHS 2007) | 41.0 percent (BDHS 2011) | 38% | Yes |
| Children with Wasting (weight for height/ <5) | 17.0 percent (BDHS 2007) | 16.0 percent (BDHS 2011) |   | Yes |
| Children with Underweight (weight for age/ <5) | 41.0 percent(BDHS 2007) | 36.0 percent (BDHS 2011) | 38% | Yes |
| Total fertility rate (TFR) | 2.7,BDHS-2007 | 2.3 BDHS-2011 | 2.00 | Likely |
| Exclusive Breast Feeding(Children under 6 month) | 43%BDHS-2007 | 64% BDHS-2011 | 50% | Yes |
| Vitamin A supplementation (Children under 6-59 month) | 88.3%, BDHS-2007 | 74.8%, UESD-2013 | 90% |   |

**Implementation Strategy of Population and Family Planning**
The HPNSDP identifies service delivery priority focuses on the extension of family planning services, increased usage of family planning before and after the first birth and the introduction, and the promotion and usage of Long Acting and Permanent Methods (LAPM) of contraception. Implementation of this strategic priority is under the responsibility of two OPs within the DGFP: i) Clinical Contraception Service Delivery (CCSD); and ii) Family Planning Field Service Delivery (FPFSD). The other OPs within the DGFP provide support to these services namely Planning, Monitoring and Evaluation, Management Information Systems, Information Education and Communication, Procurement, Storage and Supply Management and NIPORT OP-TRD.

**Population and Family Planning: lead OPs are CCSD and FPFSD with strong supportive functions in OPs PME-FP, MIS, IEC, PSSM-FP and NIPORT.**

**Priority Interventions**

|  |  |
| --- | --- |
| (a) Population | (b) Family Planning Service |

* Promoting delay in marriage and childbearing, use of post partum FP, post abortion FP and FP for appropriate segments of the population.
* Strengthening FP awareness building efforts through mass communication and IEC activities and considering local specificities.
* Using different service delivery approaches for different geographical regions and segments of the population.
* Maintaining focus on commodity security and ensuring uninterrupted availability of quality FP services closer to the people (at the CC level).
* Registering eligible couples with particular emphasis on urban areas to establish effective communication and counseling.
* Compensating for lost wages (reimbursement for opportunity costs) for long acting and permanent method contraceptive performance.
* Strengthening FP services especially post partum and post abortion FP and demand generation through effective coordination of services with DGHS utilizing appropriate opportunities.

**References:**

1. Population Control Programme in Bangladesh: Past, Present & Future, By IEM Unit, June 1985, Directorate of Population Control.
2. Bangladesh’s Population Problem and Programme Dynamics, By Mohammed A. Mabud, January, 1992.
3. Program Implementation Plan, HNPSP, PIP, June, 2003
4. Program Implementation Plan, HNPSDP, July, 2011