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Fertility and family planning in Bangladesh

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Background

Bangladesh, the eighth most populous nation in the world is also one of the poorest with a per capita income of less than US200. Although it enjoys a tropical monsoon climate, it is a country with unique geographic peculiarities, which distinguish it from the rest of the sub-continent. An alluvial land criss crossed by numerous rivers, the plains of Bangladesh are submerged in water for about half of the year, magnifying the effect of natural disasters such as floods. Its economy is primarily agricultural and it has traditionally depended on the export of agricultural products, especially jute and tea.

Bangladesh has a land area of 56,000 thousand square miles and is divided into 64 districts, which are the secondary units of administration. Districts are in turn, divided into upzilas, union, wards, and villages. A typical upzila has an area of about 80-120 square miles, a population of about 0 .25 to 0.30 million and is the primary administrative unit.

Population growth patterns

The 1991 Census reported a total population of approximately 115 million in Bangladesh. The population density of 2050 persons per square mile was among the highest in the world. The population has been growing at an alarming pace. Over the past three decades it has risen from 42 million in 1951 to 115 million in 1991. The annual growth rate was between 1.7 to 2.4 per cent in the intercensal period 1951-1991. During the period prior to 1900, it grew at a very slow pace, never exceeding an annual growth rate of less than one per cent, presumably due to recurring famines and epidemics which had kept mortality at very high levels [A] [B].

Ethnic and religious composition

The socio-cultural and political systems that have existed in Bangladesh have been described extensively [C] [D] [E] [F]. In describing social life, the authors have observed two characteristics which distinguish the Bengali population from the rest of the Indian subcontinent: first, the linguistic homogeneity and second,

Islamisation of the local culture and traditions. These distinctive features can be found in the socio-cultural institutions, mental outlook, way of life, food, dress, and manners and customs of the Bengali people.

The Muslim conquest of Bangladesh in the early 13th century changed its socio-cultural composition. The population of pre-Muslim Bangladesh was composed mainly of Hindus, Buddhists, aboriginal and Jains. Despite the significant number of Buddhists, Hindus were then the dominating group in political power, social position and also in economic affluence. During the entire Muslim period, a large section of the Buddhists, and a considerable number of Hindus, of both low and high castes, accepted Islam. The Muslim population of Bangladesh then consisted of two groups, migrant Muslims from Arab countries and converted Muslims from the local population. During the entire Muslim period and during half of the British period, Hindus were the majority group in Bengal. In 1991, 88 per cent of the total population was Muslim compared to 80 per cent in 1961.

Family structure

In Bangladesh, the family is extended, patrilineal and patrilocal. It generally consists of a senior couple; their married sons, wives and children; unmarried children and perhaps some widows or divorced sisters of the men. Kinship is primarily traced through men. The senior male is the head of the family and controls the family lands. As long as the father heads the family, household management rests with the mother. The married sons and daughters-in-law are expected to obey her. The extended family acts as a unit of economic production. Ones kinship relations determine one's loyalties, social status and political power. The extended family and family lineage's are very important in social structure. Early marriage for females is customary. In rural areas, many marry before the age of 16. Most marriages are arranged and brides are generally selected by the couple's parents. Following marriage the wife goes to live with the husband and his family.

Economy

Bangladesh is predominantly an agricultural country, and agricultural techniques are poorly developed. A small proportion of people are engaged in trade and commerce. In the rural agricultural environment, the village serves as an important social unit. Physically, the village is situated around paddy fields, near waterways or roads. Villages are contiguous and are identified by names. Their size varies significantly. Houses are built of mud or bamboo and are thatched; though one often sees a few made of brick and wood.

In rural areas, land is the basic source of income and production: ownership of land determines an individual's position and status within the village. The division of labor within a village is governed by a number of factors, which include social status, age, and sex. In general, villagers are classified into three groups based on their landholding. Landowners who own a significant amount of land are classified as upper class. In most cases, the upper class cultivates their land through share cropping or leasing out to landless farmers. The middle class consists of small landowners and tenant farmers. They are the majority in the village. The last group, the landless, either work as day laborers or cultivate the large landowners' lands as sharecroppers. Limited but expanding opportunities for young women are present in garment production in urban areas.

Education

The literacy rate in Bangladesh is below 30 per cent; males: 33 per cent, females: 19 per cent. In general, there are two types of education, religious and formal. Religious education can be divided into two categories; first there is education needed to perform prayers and other religious duties (particularly Muslim). A large proportion of Muslim children go to mosques to learn the Quran, which is written in Arabic and every Muslim has to memorize the required verses for daily prayers. The second kind of religious education combines both formal and religious education, and is known as madrasa education. In a madrasa, students learn how to read and write in Bengali, English and Arabic.

Status of women

The status of Bangladeshi women is lower than that of men. The low female literacy rate is a serious handicap. The religion of Islam also instructs women to observe purdah. Furthermore, in the Quran, it is specifically mentioned that women should not be seen by non-relative males in any circumstances. Where adhered to strictly, it virtually rules out any job for women where non-relative males are employed. Thus, it is dear that the social and cultural environment does not allow women to work outside the home. This is especially true in the rural areas, where women who work outside the household are of low status. Yet, due to recent economic changes several hundred thousand young women are employed in export-oriented garment factories in several large cities.

Fertility

Until recently, Bangladesh had been characterized by high fertility and comparatively high mortality. Despite many limitations in the vital registration system, there is now considerable documentation that the fertility pattern is changing. The higher fertility has been attributed to a combination of social,

cultural and economic factors such as the lack of employment opportunities for married women outside the home, the low level of urbanization, the low level of per capita income, the lack of educational opportunities for females in rural areas, an agriculture-based economy, and most importantly, societal attitudes toward reproduction [J] [K] [L] [M] [N].

Table 1 presents the crude birth rates (CBR) observed in Bangladesh for selected years. The rates presented in Table 1 are obtained from various sources, and are subject to varying sampling and non-sampling error, Nevertheless, the findings suggest that the CBR fluctuated around 50 per thousand population until the mid 1960s, and that in recent years there has been a rapid decline.

Table 1: Crude Birth rate, Bangladesh: 1962-1987

Year	Crude Birth Rate	Source
1962-65	53.0	Population Growth Estimates1962-63.]
1967-68	42.0	National Impact Survey 1966-68
1974	48.3	BRSFM, 1974
1976	47.0	Bangladesh Fertility Survey 1975
1979	47.0	ICDDR, B Matlab.
1980	45.5	ICDDR, B Matlab
1981	43.8	ICDDER, B Matlab
1981	43.0	Planning Commision
1982	44.6	ICDDR, B Matlab
1983	42.4	ICDDER, B Matlab
1984	37.3	ICCDR
1984	46.6	ICDDR, B Sirajgonj
1985	44.5	ICDDR, B Sirajgonj
1985	39.0	Planning Commision
1985	42.5	ICDDER, B Matlab
1986	40.0	ICDDR, B Matlab
1986	38.9	USAID, Dhaka
1986	39.6	ICDDR, B Sirajgonj
1986	38.0	National Family Planning and Fertility Survey
1987	40.6	ICDDR, B Siralgonj

The findings from national and sub-national surveys [G] [H] [I] [O] [P] [Q] [R] suggest that the total fertility rate (TFR) has remained at more than 4.5. TFR

estimates presented in Table 2 are from different sources and also are subject to methodology problems. In a strict scientific sense, they are not comparable. In addition, data from retrospective fertility surveys may suffer from various types of errors, which may bias demographic measures. The findings of the 1989 Bangladesh Fertility Survey (BFS) do suggest though, that between 1980 and 1987 fertility has declined by nearly 30 per cent.

Table 2: Total Fertility Rate, Bangladesh: 1963-1988

Year	TFR	Source
1963-65	7.1	Population Growth estimate, 1962-65
1967-68	6.0	National Impact Survey, 1966-68
1974	7.1	BRSFM, 1974
1975	6.4	Bangladesh Fertility Survey, 1975
1979	6.3	Contraceptive Prevalence Survey, 1979
1979	6.9	ICDDR, B Matlab
1981	6.3	ICDDR, B Matlab
1984	6.4	ICDDR, B Sirajgonj
1985	6.1	ICDDR, B Matlab Sirajgonj
1985	5.9	ICDDR, B Matlab Comparison Area
1986	5.5	ICDDR, B Matlab Comparison Area
1986	5.6	USAID, Dhaka
1986	5.4	ICDDR, D Sirajgonj
1986	5.6	National Family Planning and Fertility Survey.
1987	4.8	ICDDR, B Sirajgonj
1987	4.8	Bangladesh Fertility Survey, 1989
1988	4.6	Bangladesh Fertility Survey, 1989

The family planning program

Family planning activities primarily confined to urban areas were first started by voluntary organizations in the early 1950s. The national public sector family planning program was launched by the Ministry of Health and Population Welfare in 1965 with the deployment of part-time male and female workers to rural areas. Special attention was given to promote long-term contraceptive methods, that is, the IUD and sterilization. In 1969, the newly gathered momentum of family planning was halted due to political unrest. During 1972-75, the Government of Bangladesh was primarily engaged in reconstruction work after independence, and family planning services were not available in rural areas.

In 1975, a separate, directorate within the Ministry of Health and Population Welfare was established to provide family planning services. Several organizational steps were taken to co-ordinate family planning in conjunction with health service delivery. The reorganized program withdrew part-time male workers and deployed females in large numbers as front-line field workers of the program. In addition, health and family planning clinics were established in the rural areas to provide clinical contraceptive services. At present, the Government program extends throughout rural Bangladesh, and includes a community based component provided by a work force of 23,000 female field workers, as well as clinical services provided at 3,700 union-level Family Welfare Centers and 464 upzifla health complexes.

The Government of Bangladesh views rapid population growth as a serious and high priority problem, and the national population program is an integral component of Bangladeshis development plans. The President of the country provides direct and visible leadership. The Government recognizes that rapid population growth is one of the country's foremost problems mitigating against development efforts and undermining socioeconomic gains. Strategies to reduce fertility include the integration of health and family planning service delivery systems at the grassroots level, the provision of a wide range of contraceptive choices together with the expansion of quality sterilization services, and the intensive training and coverage of field workers. In the public sector, the population program is implemented by the Ministry of Health and Family Welfare in co-ordination with eight other development ministries.

In 1989, the Government formed the National Council for Population, a national level policy and coordinating body chaired by the President of the country, further affirming its commitment to population and family planning activities. The Governments broad demographic goal is to achieve a net reproduction rate of one by- 2010 AD, with a targeted reduction of the birth rate through a series of intermediate Five-Year Plans. The short-term objective has been to attain a contraceptive prevalence rate of 50 per cent by the end of the Fourth Five-Year Plan (1990-1995).

The Government stresses sterilization as one of the important methods of birth control. The program emphasis is reflected in introduction to clients, provider and referral incentives, launching of intensive campaigns and large-scale training of physicians. The national sterilization program was launched in 1966 initially with males. The performance on vasectomy reached its peak in 1969 with 389,500 sterilizations, and subsequently declined and continued at a low level till 1980. Since 1981, it has again started to rise and a level of over 100,000 procedures per year has been sustained to date.

During the last ten years, the Government has taken a series of policy and organizational decisions to promote the family planning program, particularly sterilization services in rural areas. Consequently, sterilization performance has increased substantially and reached its peak in 1984. The most important policy decision was the recruitment of full-time female family planning workers to cover rural areas. Another step was the integration of family planning services with the health care system at the local service level. Although the decision to integrate health and family planning services was taken several times, it was never implemented at the field level until 1983. The introduction of referral fees for IUD and sterilization clients and subsequent changes in the payment procedure also has affected program performance. Table 3 presents the family planning performance at the national level.

Table 3: National Family Planning Program Performance in Bangladesh, 1980-91

Year	Sterilization						
	Vasectomy	Tubectomy	Total	IUD	Injectable (Doses)	Oral Pill (Cycles)	Condom (Pieces)
1980	20,062	185,200	205,262	41,601	112,010	8,137,744	87,111,780
1981	42,750	202,441	245,191	83,663	81,065	7,751,352	93,230,412
1982	96,834	301,930	398,764	171,743	72,697	8,257,995	116,821,488
1983	115,591	290,766	406,357	181,933	104,700	8,870,693	127,784,886
1984	307,654	336,820	644,474	400,482	140,696	10,945,343	157,369,137
1985	168,562	144,282	312,844	403,413	189,030	11,796,166	127,332,364
1986	203,336	127,932	331,268	397,589	262,163	13,101,871	139,871,345
1987	129,944	115,499	245,443	395,181	350, 815	16,822,802	160,306,345
1988	101,278	119,987	221,265	389,020	468,570	22,060,990	168,068,974
1989	85,176	129,839	215,015	329,363	817,156	28,167,361	196,305,849
1990	67,367	122,793	190,160	351,014	1,604,227	38,987034	163,275,908
1991	74,523	95,606	170,129	267,094	1,910,835	45,903,08	143,271,185

From the very beginning, family planning activities in Bangladesh have been based on the strategy of providing information, education and motivation to couples to help them understand the value of a small family. The program facilitates the supply of, temporary methods and makes them easily available to couples. That the Government emphasis a cafeteria approach is evident from the extensive network established for temporary modern methods? dispensing of the pill without a medical prescription, free services, and a system of payment of transportation cost for IUD clients and referrers, and insertion fees to service providers. It should also be noted that under the present system, sterilization services are offered only to those with two living children where the last child is at least two years of age.

The contraceptive use rate rose from 12.7 per cent in 1979 to approximately 40 per cent in 1991 (Table 4). These findings suggest that during the period 1979-1991 women under age 40 have been increasingly adopting family planning. The proportion of currently married women in aged 15-49 who were using a contraceptive increased from 12 per cent to over 40 per cent over the twelve-year period.

Table 4: Per cent of Currently Married Women Aged 15-49 Practicing Contraception by age, 1979-1991

Age (Years)	1979	1981	1983	1985	1989	1991
<20	5.2	9.5	9.1	9.2	14.6	18.7
20-24	11.1	17.6	18.1	21.7	25.1	32.6
25-29	13.8	23.8	24.2	33.5	36.4	45.6
30-34	17.0	25.3	26.7	35.6	44.2	52.5
35-39	17.1	23.2	29.4	34.4	44.8	57.0
40-44	15.9	23.4	19.0	26.4	34.9	46.4
45-49	9.2	12.5	11.4	15.0	21.7	29.9
All	12.1	18.6	19.1	25.3	31.4	39.9

During 1979-1991, the total current usage of contraception increased five-fold. Much of the total increase in contraceptive use between 1979 and 1991 was due to the increased adoption of two methods-the oral pill and female sterilization (Table 5). Data from the 1991 Contraceptive Prevalence Survey (CPS) indicate that contraceptive prevalence rose from 31A in 1989 to 40 per cent, primarily due to an increase in the use of oral contraception.

Table 5: current Use of Contraception Among Currently Married Women Under 50 by Method in the 1975 BFS and 1979, 1981, 1985, 1989 and 1991 CPSs

Contraception Status	BFS 1975	CPS 1979	CPS 1981	CPS 1983	CPS 1985	CPS 1989	CPS 1991
Modern Methods (total)	5.0	8.9	10.9	13.8	18.4	24.4	31.2
Oral Pill	2.7	3.6	3.5	3.3	5.1	9.1	13.9
Condom	0.7	1.5	1.6	1.5	1.8	1.9	2.5
Vaginal Method	0.0	0.1	0.3	0.3	0.2	0.2	0.1
Injection	0.0	0.2	0.4	0.2	0.5	1.1	2.6
IUD	0.5	0.2	0.4	1.0	1.4	1.7	1.8
Tubectomy	0.6	2.4	4.0	6.2	7.9	9.0	9.1
Vasectomy	0.5	0.9	0.8	1.2	1.5	1.4	1.2

Traditional Methods (total)	2.7	3.8	7.7	5.4	6.9	7.0	8.7
Safe Period	2.2	3.9	2.4	3.8	3.8	4.7	-
Withdrawal	0.2	1.8	1.3	0.9	1.2	2.0	-
Abstinence	0.8	1.2	0.4	0.5	0.5	0.5	-
Other	0.6	0.7	1.4	1.7	1.7	1.5	-
Total Use Rate	7.7	12.7	18.6	19.1	25.3	31.4	39.9

It is dear that there have been considerable changes over time in the relative percentages of users relying on specific methods. The change in the proportion of users relying on female sterilization is particularly striking (Table 6). In 1975, only 8 per cent of currently married women were sterilized. This percentage rose to 22.8 in 1991. The use of the oral pill apparently decreased in 1983 and increased subsequently. Table 6 also shows an increase in the relative popularity of injectables. Although the increase between 1979 and 1985 was not significant, the use of injectables doubled between 1989 to 1991.

Table 6: Per Cent Distribution of Currently Married Women Aged 15-49 Practicing Contraception by Specific Method, 1975-1991

Method	**BFS 1975**	**CPS 1979**	**CPS 1981**	**CPS 1983**	**CPS 1985**	**CPS 1989**	**CPS 1991**
Modern method	64.9	70.1	58.6	71.7	72.7	77.7	78.2
Oral Pill	35.0	28.3	18.3	17.3	20.2	29.0	34.8
Condom	9.1	11.8	8.6	7.9	7.1	6.1	6.3
Vaginal Method	0.0	0.8	1.6	1.6	0.8	0.6	0.3
Injection	0.0	1.6	2.2	1.0	2.0	3.5	6.5
IUD	6.5	1.6	2.2	5.2	5.5	5.4	4.5
Tubectomy	7.8	18.9	21.4	32.4	31.2	28.7	22.8
Vasectomy	6.5	7.1	4.3	6.3	5.9	4.4	3.0
Traditional Method	35.1	29.9	41.4	28.3	27.3	22.3	21.8
Total	100	100	100	100	100	100	100

* Others include safe period, withdrawal, abstinence and kabiraji

NGO role in the family planning program

An important feature of the Government's policy has been to encourage the participation of non-governmental organizations in family planning service delivery. In Bangladesh, NG0s have played a valuable role in the development of

the family planning program. At present, over 400 NG0s operate in various areas of the country covering different aspects of MCH and family planning and related activities. To date, NGO activities have concentrated essentially on service delivery in urban areas. Most are involved in community distribution of contraceptives, while a few are engaged in clinical service.

The operational efficiency elements of NG0s can be identified with respect to a number of features: flexibility in operations, both managerial and financial; better quality input in personnel and logistics; possibility of closer supervision; better salary and incentive; and, most importantly, relatively easy hiring of competent and firing of incompetent workers.

Among the major NG0s are the Bangladesh Association for Voluntary Sterilization, the Family Planning Association of Bangladesh, the Social Marketing Project, the Pathfinder Fund, Concerned Women for Family Planning, the Asia Foundation, and the International Center for Diarrhoeal Disease Research. According to Government estimates, NG0s presently provide family planning services to approximately one-fifth of the total population, and account for about one-third of the total couple years of protection (CYPs) nationally. In the following sections, major successful NGO projects in Bangladesh are described.

Bangladesh Association of Voluntary Sterilization (BAVS)

BAVS is a non-governmental organization established in 1974 to offer quality sterilization services. The first clinic opened in 1975, and at present 25 clinics offer sterilization services throughout the country. The clinics are primarily located in urban areas and staffed by qualified surgeons and counselors. Until May 1987, BAVS recruited clients, through field agents, most of whom were non-literate. The field agents were classified as registered and unregistered and were paid a fixed amount of money per case referred. In addition, registered field agents received a monthly salary for referring a fixed number of clients every month. Unregistered field agents were eligible for registration if they referred a fixed number of clients for three consecutive months. Table 7 presents the number of sterilization's performed in BAVS clinics during 1975-86.

Although BAVS clinics are located in urban areas, over 80 per cent of the acceptors came from rural areas. This proportion of rural acceptors remained approximately the same over 1975*1986. The vast majority of the population is Muslim, and the findings indicate that over 80 per cent of the sterilized clients are Muslims; the remaining 20 per cent are primarily Hindus.

Table 7: Number of Sterilization Performed in BAVS Clinics, 1975-1986

Year	No. of Clinics	Vasectomy	Tubectomy	Total
1975	2	2781	1948	4729
1976	2	2063	5148	7211
1977	4	3739	7117	10856
1978	7	2634	15602	18236
1979	22	3048	22965	26013
1980	23	2821	31440	34261
1981	25	14509	36891	51400
1982	25	23970	43032	67002
1983	28	30401	37977	68378
1984	34	60760	41551	102311
1985	34	23022	14814	37836
1986	34	33732	16005	49737
Total		203244	274685	477970

The male-female sterilization ratio varies over the years. At the beginning of the BAVS program, female sterilization's predominated. The male-female sterilization ratio peaked in 1980, when 11 female sterilizations were performed against one male sterilization. However, it dropped to 2.5 in 1981 and declined gradually, beginning 1982. By the end of 1984, the number of male sterilization's performed in BAVS clinics exceeded the number of female sterilizations.

Since inception till 31 December 1986, BAVS performed 477,970 sterilizations, or approximately 16 per cent of the total sterilization's performed in the country. Furthermore, if we assume that on the average sterilization generates 10 CYPs and 3.5 CYPs are needed to prevent one birth, the BAVS program has prevented approximately 1.5 million births.

ICDDR, B Matlab Project

In 1977, ICDDR, B started an experimental family planning and MCH program in a rural sub-district of Bangladesh. Findings from the project demonstrated that family-planning program can be successful even under unfavorable socio-economic conditions. In 1990, three of every five eligible women residing in the project area were contraceptive acceptors and the total fertility rate was below four (Table 8).

Table 8: Per cent Currently Practicing Contraception by Method: Matlab Treatment Area and Comparison Area, 1990

Variables	Treatment Area		Comparison Area	
	Percent	(N)	percent	(N)
Current User	57.1	(2418)	27.2	(1009)
Modern Methods				
Oral Pills	21.1		29.9	
IUD	6.2		2.4	
Injectibles	49.9		4.1	
Condom	1.4		1.5	
Tubectomy	14.7		34.8	
Vasectomy	0.7		0.9	
Foam/jelly	0.2		0.4	
Sub-Total	94.2		74.0	
Traditional Methods				
Withdrawal	1.4		4.6	
Kabiraji	1.7		7.6	
Rhythm	2.6		13.5	
Other	0.0		0.3	
Sub-Total	5.7		26.0	
Current Non-Users	42.9	(1820)	72.8	(2699)
Total	100.0	(4238)	100.0	(3708)

The Matlab Project started as a comprehensive family planning program with only basic MCH services. Over a period of ten years, several other interventions such as tetanus and measles immunization, oral rehydration therapy, training of traditional birth attendants and the provision of safe delivery kits, limited nutrition education were added. The findings suggest a gradual rise in contraceptive use in the treatment area over the last 13 years starting from below 10 per cent it increased to 33 per cent in mid-1979 and to approximately 45 per cent in 1984.

An important component of the Matlab program is the presence of female community workers, most of whom are contraceptive users. In addition, there is a well developed support system of female paramedical and medical staff, and field supervision. Except sterilization, all other contraceptives are delivered at the household or community level. In addition, experiences from the project suggest that the introduction of an organizational culture based on qualification and performance with quality of care has succeeded in raising the performance to levels much higher than those of the Government program.

ICDDR, B Extension Project

The sharp increase in the contraceptive prevalence rate and its consequent impact on fertility in the Matlab project area raised question of its replicability in other areas of Bangladesh. In order to test the feasibility of incorporating the lessons learned from Matlab, ICDDR, B, in collaboration with the Government, started a project, called MCHFP Extension Project, in two other upzilas of Bangladesh.

The ICDDR,B interventions were designed to strengthen the knowledge and supervisory capabilities of mid-level Government officials to implement program activities at the field level. The primary objective was to train the Government field workers about the client-oriented motivational approach. Several four-week on-the-job training Programs were conducted at the field level to discuss family planning, oral rehydration, tetanus immunization, household visiting patterns, motivational techniques, community relations, referrals and record-keeping.

In the ICDDR, B Extension Project areas the contraceptive use rate is substantially higher than the national rate. The findings indicate that the program performance in the Government can be improved by introducing simple interventions. The findings of the ICDDR, B Extensive Project suggest that household visiting patterns, motivational techniques, community relations referral and record keeping are critical to success or failure in a large scale Government programs.

Bangladesh Women's Health Coalition (BWHC)

In 1980, the Bangladesh Women's Health Coalition (BWHC) was established to provide clinic-based contraceptive services in the urban slum areas. Over the years, its services expanded to include MCH care and BWHC established five urban clinics. At present, the BWHC clinics offer clinical contraceptives, menstrual regulation; treatment of diseases related to MCH and immunization. In addition, the Government Family Welfare Visitors are trained to perform menstrual regulation in the BWHC clinics. BVMC also provides one-week refresher training to the FWVS.

According to BWHC data, a clinic provides health; family planning and child care services to approximately 1,500 clients in a month. The findings suggest that there is a great unmet demand for menstrual regulation and family planing acceptance could be increased through personalized services, sustained contacts and motivation. The BWHC started its activities by providing menstrual regulation services, and then expanded to other areas related to MCH. In

Bangladesh, the BWHC clinics are considered as a model for provision of contraceptive services to the urban slum population.

Munshiganj MCH-FP Project

During 1979-87, the Ministry of Health and Family Welfare and the German Technical Assistance Agency jointly carried out an operations research project to strengthen the family planning services delivery capacity of Family Welfare Centers. The objective was to test various interventions and their impact on program performance. The project tested several simple interventions such as improved management information systems at different levels, training and supervision, monitoring and evaluation, and supply of contraceptives. The common features of these interventions were on-the-job training and monthly staff meeting to discuss field problems. The findings suggest that the performance of the Government family planning program can be substantially improved with simple interventions.

Several authors have identified the determinants of a successful NGO program and listed them as leadership, flexibility, training, management and supportive supervision, client-oriented approach, etc. Because of the special inputs involved in NGO program it is not reasonable to expect that models of successful program can be replicated in tact for application at the national level. However, several successful NGO demonstration projects have identified factors affecting program performance and suggest possible ways to improve this factor in more cost-effective ways.

Conclusion

In recent years the success of the Bangladesh family planning program has been impressive. Findings suggest that the contraceptive use rate has increased from less than 10 per cent in 1975 to over 40 per cent in 1991. During 1975-89 the Bangladesh family planning effort has been classified using an index of 30 program indicators as strong with a 70 per cent score, ranking as the, ninth strongest program in 98 developing countries in 1989 when adjusted, for "social setting" [S] Bangladesh has the strongest level of program effort among the "low" social setting countries. During 1975-1990, total fertility rates dropped from 6.4 to 4.6. Among countries classified as 'low social setting" Bangladesh's 22 per cent decline in total fertility rate among developing countries in 1975-1990 is the greatest. The involvement of NG0s in the family planning program played a key role in the success story.

Having an intensive rural village-based outreach system, continuous expansion of service delivery sites, learning from demonstration projects, strong national

political support, active assistance of NG0s, a strong IEC effort, a social marketing approach to contraceptive supply, all played a major part in the success of the to date. A sense of its achievement can be gained by seeing its contraceptive prevalence rate in the context of other South Asian countries many of, which share its difficult socioeconomic conditions (Figure 1). The program stiff has a long way to go to reach its goal of a contraceptive prevalence rate of 50 per cent by 1995 but prospects are hopeful.

Bangladesh 1991	40
India 1988-89	45
Nepal 1986	15
Pakistan 1990-91	12
Sri Lanka 1987	52

Figure 1: South Asian Countries: Estimated Contraceptive Prevalence as Per Cent of Married Women Aged 15-49

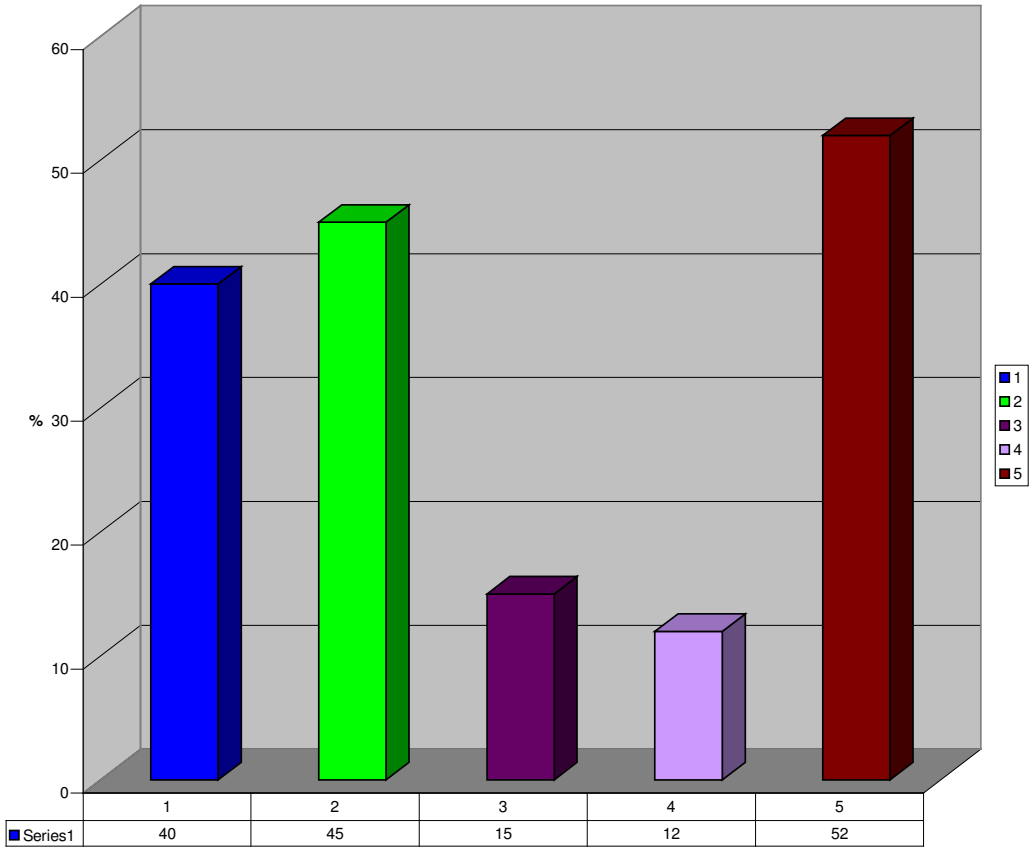
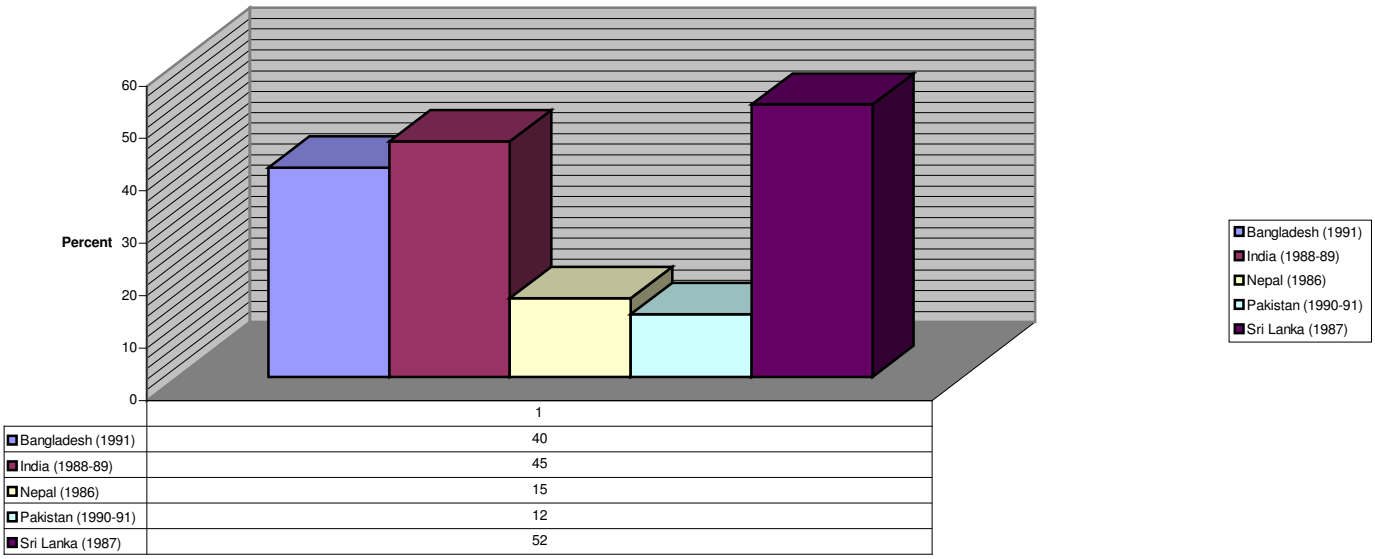


Figure 1: South Asian Countries: Estimated Contraceptive Prevalence as Per Cent of Married Women Aged 15-49



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