Introduction

At its independence in 1971, Bangladesh's population growth was high, threatening the country's development. The war of independence had impoverished and devastated the country. Faced with rampant poverty, the government concluded that if the population continued to increase at the same rate, it would outpace available resources. A dire famine in 1974 reinforced this conclusion. Public debates involving technical experts and policymakers were organized to focus attention on this issue and forge a broad consensus on the way forward. The government used compelling indicators of the country's socio-demographic crisis to highlight the growing concern about population issues: The country had 76 million inhabitants, high population growth (3 percent), high density (500 people per square kilometer in 1970), low food production, generalized poverty (73 percent in 1973), and food price inflation (Hasan and Reich, 2012; Levine and The What Works Working Group, 2004; World Development Indicators). From this difficult start, Bangladesh would make great strides in reducing its population growth. How it did so may hold important lessons for other countries that are confronted with a similar situation.

This delivery note attempts to explain how Bangladesh achieved a rapid decline in fertility despite severe economic constraints. Fertility reduction, in general, can be driven by different factors, particularly female education, female labor market participation, reductions in child mortality, overall economic development, and urbanization (Kabeer 2001; Mohanty et al. 2016). But in the case of Bangladesh, the clearest and strongest conclusion that can be drawn from the available evidence is that the rapid decline in fertility, especially between 1975 and 1990, was driven primarily by the national population program, although other contributory factors—economic growth, female education, female participation in an expanding ready-made garment industry, and related contextual factors—did reinforce the program’s impact at subsequent stages of Bangladesh’s development (Hasan and Reich 2012; Caldwell and Barkat-e-Khuda, 2000; Caldwell et al. 1999; Kabeer 2001). This finding in Bangladesh contrasts with the experience of other South Asian countries such as in India, where declines in fertility—although also impressive—were not only more gradual but also engendered more by the broader socioeconomic context.

The results of Bangladesh’s national population program demonstrated the efficacy of the “whole of government” approach that, according to the World Bank’s Human Capital Project, can overcome challenges countries face in developing their human capital. The three elements of this approach are: continuity (sustaining effort across political cycles), coordination (ensuring...
that sectoral programs and agencies work together), and evidence (expanding and using the evidence base to improve and update human capital strategies) (Human Capital Project 2019a).

This delivery note looks at Bangladesh’s success in coordinating the work of government and non-government actors and in developing partnerships to build a strong evidence base.

**Development Challenge**

The government wanted to reduce the fertility rate and curb population growth. In 1971, Bangladesh’s total fertility rate (TFR) was 6.9 births per woman, exceeding by far both the world average of 4.7 and the South Asian average of 5.7.¹

**Delivery Challenges**

Implementing the national population program was a massive undertaking that entailed fundamental changes in people’s behavior. Bangladesh had to overcome several difficult challenges over a sustained period to achieve this goal.

**Inter- and Intra-Governmental Coordination**

This program required the cooperation of many different units of government. Bangladesh needed to assign clear roles and responsibilities to ministries and agencies and provide them with clear policy goals to guide their work.

**Stakeholder Engagement**

High population growth was a problem the government could not fix on its own. Bangladesh needed a broad spectrum of stakeholders—including NGOs, the private sector, and the country’s religious leaders—to buy into the agenda and help implement it on the ground. The program had to reach out to these actors, effectively communicate to them the urgency and importance of the objective, and elicit their participation.

**Project Data and Monitoring**

Controlling population growth required a robust capacity for collecting useful data. Bangladesh had to track fertility rates around the country and evaluate which initiatives were effective in changing people’s behavior on the ground. The government would need to find ways to build this capacity.

**Addressing Delivery Challenges**

To implement the program, the government created a clear policy agenda, engaged key stakeholders, and developed partnerships to build a strong evidence base.

**Using National Development Plans to Coordinate Government Action**

Managing population growth became a priority in the national policy agenda and the Planning Commission included it in its First Five-Year Plan (1973–1978). The Planning Commission was made up of policymakers from different ministries, under the chairmanship of Bangladesh’s first prime minister, Sheikh Mujibur Rahman, a passionate proponent of sound population policy.

The five-year plan identified specific population activities for the Ministry of Health and Family Welfare and six other ministries, reflecting a whole-of-government approach. For example, the Ministry of Rural Development was tasked with promoting not only women’s employment but also functional and family planning literacy, through rural cooperatives. The Ministry of Agriculture introduced population and nutrition education in their extension programs. The Ministry of Education incorporated population education in academic curricula and created a Department of Population Sciences at Dhaka University, while the Ministry of Information disseminated information promoting fertility regulation through various mass media channels. These ministries developed projects to implement activities that supported family planning. Population Control Committees were formed at the national and sub-national levels to coordinate action across sectors under the broad ambit of a National Population Council, led by the prime minister.

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¹ Data from the World Bank, retrieved from https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=BD-1W-8S
Subsequent five-year plans maintained an unwavering focus on fertility control, with a national goal of reaching a replacement level of fertility (that is, a TFR of 2.1) by 1985. This had the express support of the highest levels of political leadership, most notably during the presidencies of Ziaur Rahman (1977–1981) and Hussain Mohammed Ershad (1983–1990).

The Fifth Five-Year Plan (1997–2002) embedded population goals within broader health goals for the provision of primary care services, essentially converting the multisectoral approach to population into a sectoral approach within the health sector. In addition to consistent support from the nation’s political leaders, a high level of cohesion within the broader policy community was a major factor in keeping population growth as a high priority on the government’s agenda (Hasan and Reich 2012).

**Partnering with Key Stakeholders**

Supported by the international donor community, the government created and maintained pluralism in implementing Bangladesh’s population policies. It brought in stakeholders from both the public and private sectors, including not only NGOs, the business sector, and international organizations but also bureaucrats, technocrats, government workers, religious leaders, and academic researchers.

Within the public sector, Bangladesh’s Family Planning Program (FPP) relied heavily on a massive deployment of married, salaried female outreach workers called Family Welfare Assistants (FWAs), who were recruited from the communities they served. Because FWAs were already embedded in their communities, they had the trust of the program’s beneficiaries, including rural women. At the peak of the program, it had 28,000 FWAs spread throughout the country, going door to door in villages to enhance women’s understanding of family planning and shift fertility preference to fewer children. FWAs also provided a range of contraceptive supplies and referred their clients to newly established clinics where the women could obtain long-term or permanent contraceptive methods. The high financial cost of the FPP (USD120 million in 1995) was shared by the government and donors (Hasan and Reich 2012).

Religious leaders, who held influential leadership roles at the village level in Bangladesh, were central to changing community-level norms about family size and increasing the acceptance of the FPP. The political leadership and the bureaucracy involved the religious establishment in population policy discussions and in program implementation. In addition to training that the Islamic Foundation (a government institution) provided to religious leaders, the government, with financial assistance from international organizations, supported exchange visits of Bangladeshi religious leaders to countries such as Egypt and Indonesia, where they were exposed to the progressive thinking of Islamic scholars on population issues. These leaders, upon return, used religious texts to explain to the population that Islam did not prohibit family planning (Hasan and Reich 2012). Overall, the political engagement, training, and international visits cemented the ownership of religious leadership of the population issue and helped to legitimize the FPP from a religious perspective.

The financial and technical assistance international organizations provided was also vital to the success of the population program, with organizations such as the World Bank, USAID (United States Agency for International Development), the Ford Foundation, the Population Council, and UNFPA (United Nations Population Fund) making substantial contributions. In addition, local NGOs such as the Bangladesh Association for Voluntary Sterilization (BAVS) and the Family Planning Association of Bangladesh (FPAB), although not major participants in the policy discussions, contributed to the FPP by providing family planning information and services (Chowdhury et al. 2013).

**Building the Capacity to Collect Data**

Bangladesh also invested significantly in population research, which was essential for program design, improvement, monitoring, and evaluation. Academic institutions and NGOs collaborated with the government to scale up innovative solutions and were highly involved in the research (Levine and The What Works Working Group 2004).

For example, in 1977 the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B) launched an experimental family planning and maternal and child health program in Matlab, a religiously conservative village in Bangladesh where various
methods to deliver reproductive and other health services were tested. The experimental program relied on community health workers (married and educated women from influential families in the village who were themselves using family planning methods) to make home visits about every two weeks and propose family planning methods to other married women. Several studies validated the success of this program (Phillips et al. 1988; Fauveau et al. 1991, Schultz and Joshi 2007). An evaluation of the program covering 149 villages (with 180,000 inhabitants), of which 70 were program villages, showed that by 1982 fertility had declined by about 15 percent in the program villages compared to the control villages, and that birth spacing between the second and third births had increased significantly (Schultz and Joshi 2007). The results of such research helped frame the design of the Bangladesh FPP.

Empowering Women to Accelerate and Sustain Fertility Reduction

Although not formally part of a plan to reduce fertility per se, women’s empowerment contributed to accelerating fertility reduction, particularly from the mid-1980s onwards. Population policy had dominated Bangladesh’s national agenda in the 1970s and early 1980s, but female education and microcredit programs gained priority in the 1980s and 1990s (Hasan and Reich 2012). In the 1990s and 2000s, the country achieved notable success in ensuring access to school for many girls and poor children. The success of this campaign was linked to an acknowledgement by the government that mass education was vital for national development. In particular, the government supported reforms that helped expand basic education and improved educational quality and academic standards through higher public expenditure. For instance, government expenditure on education rose from 0.9 percent of GDP in the early 1980s to 2 percent of GDP in the late 1990s (World Development Indicators). The Female Secondary School Stipend Program (FSSP), launched in 1982 and scaled up in 1994, provided free tuition and stipends to eligible girls from grades 6 through 10, conditional on their school attendance and test score achievement. This led to an increase in female secondary enrolment from 1.1 to 3.9 million girls between 1991 and 2005. This increased enrollment appeared to be negatively associated with TFR, and some studies established a causal relationship (see Kadir et al. 2003).

Additionally, certain other economic and development programs had the effect of empowering women and impacting fertility outcomes. First, the recruitment of women as FWAs for the FPP made the mobility and work of women more socially acceptable. This was partly facilitated by BRAC and other NGOs deciding to involve local religious leaders in discussions of contraception and the role of women outside the household. Second, the microfinance movement increased women’s bargaining power over resources and the use of family planning (Ahmed et al. 2013; Chowdhury et al. 2013). The majority of beneficiaries of these microfinance programs were women with no prior access to credit.

Third, the Multi-Fiber Trade Agreement led to the establishment of large, export-oriented garment factories that employed mostly women because sewing was traditionally women’s work in Bangladesh (Das 2008). It has been shown that the rise of the ready-made garment manufacturing sector over the 1985–2015 period was a major factor in explaining the sustained fertility decline, the rise in age at first marriage, and the rapid increase in girls’ educational attainment both in absolute and relative terms. This was because the garment industry rewarded cognitive skills and increased the returns to education (Heath and Mobarak 2015).

Altogether, the improved economic position of women, and the social acceptance of female mobility and employment, laid the groundwork for the long-term change in fertility preferences. These demand-side developments sustained the momentum of the supply-side effects seen in earlier periods.

Outcomes

Bangladesh’s marked fertility decline between 1975 and 1990 was particularly notable because the country was still grappling with debilitating economic and social issues. This declining trend extended through the 2000s. In 1960, the total fertility rate in Bangladesh was 6.7 births per woman, compared to a global TFR of 5.0. By 2007, Bangladesh’s rapid progress had brought its TFR below

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3 The program slowly expanded to include other services. These included the provision of measles immunizations to all children age 9 months to 5 years, training of traditional birth attendants, oral rehydration therapy for diarrhea, and antenatal care. An evaluation showed that women age 30–35 in program villages reported a greater likelihood (11 percentage points) of having some prenatal care in each of their pregnancies.
the world average of 2.6. By 2017, Bangladesh’s TFR in was 2.1, which was the replacement level of fertility, and significantly lower than the global rate of 2.4.

Most South Asian countries over time succeeded in reducing their TFRs to the replacement rate or just above it, but Bangladesh’s fertility reduction pace was significantly faster than any of its neighbors. In 2017, the South Asian average TFR was 2.4, higher than that of Bangladesh.4

Empowering Women Contributed to Sustained Positive Outcomes

Bangladesh implemented many policies that increased women’s human capital and access to economic opportunities. While not strictly part of the national fertility reduction program, these policies contributed greatly to changing women’s fertility preferences, sustaining the progress made in previous years and thereby contributing to even stronger outcomes.

Lessons Learned

National Policy Goals and Well-Defined Roles Enhanced Coordination

The Government of Bangladesh encouraged close coordination among ministries and agencies by including the population program in several consecutive five-year plans, which had the effect of guiding and maintaining development policies across successive administrations. These five-year plans assigned clear roles and responsibilities to the various government institutions involved in program implementation.

Engaging Local-Level Stakeholders Contributed to Behavioral Change

Because population growth policies set at the national level needed effective action at the local level to achieve results, the program focused on partnerships with actors who had a deep influence on people’s behavior. These actors included religious figures and frontline health workers who could directly communicate with people in their communities, and who had the trust of those they were trying to influence.

Partnerships to Collect Data and Test Interventions Provided a Robust Evidence Base

An ambitious, national-level population growth program required research and empirical data about which interventions were effective in reducing fertility rates. The government built the capacity to gather this evidence by partnering with academic institutions and NGOs.

4 Data from the World Bank, retrieved from https://data.worldbank.org/indicator/SP.DYN.TFRT.IN?locations=BD-1W-8S.
**Bibliography**


World Development Indicators (WDI), retrieved from https://datacatalog.worldbank.org/dataset/world-development-indicators

The Human Capital Project is a global effort to accelerate more and better investments in people for greater equity and economic growth. The Project is helping create the political space for national leaders to prioritize transformational investments in health, education, and social protection. The objective is rapid progress toward a world in which all children are wellnourished and ready to learn, can attain real learning in the classroom, and can enter the job market as healthy, skilled, and productive adults.

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