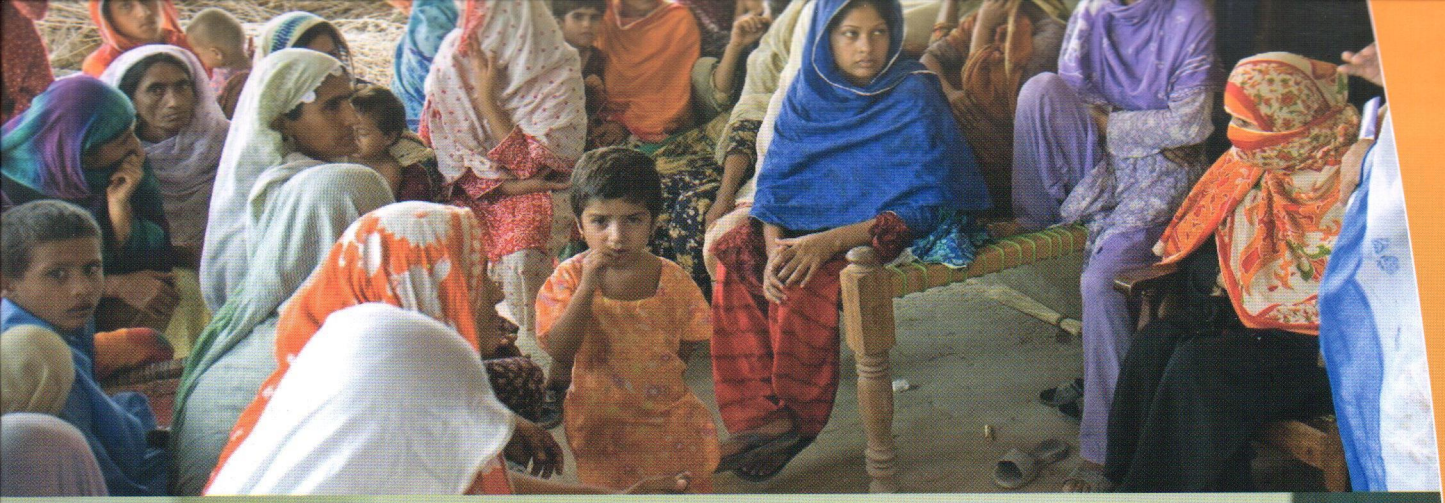


Policy Brief

SLOW PROGRESS OF FAMILY PLANNING IN PAKISTAN AND POSSIBLE LEARNINGS FROM THE SUCCESSFUL EXPERIENCES OF TURKEY, IRAN AND BANGLADESH

Government of Pakistan
National Institute of Population Studies
Ministry of National Health Services, Regulations & Coordination

NIPS

UNFPA

POLICY BRIEF

SLOW PROGRESS OF FAMILY PLANNING IN PAKISTAN AND POSSIBLE LEARNINGS FROM THE SUCCESSFUL EXPERIENCES OF IRAN, TURKEY AND BANGLADESH

1 BACKGROUND

Pakistan's population is estimated to be 220.9 million (mid 2020), growing at 2.1 percent per annum and with net annual addition of 4.3 million, it is projected to touch 263 million by 2030[1]. The rapid population increase has several implications for the socioeconomic development of the country. As one of the few pioneer countries, Pakistan visualized this situation in the 60s and took a policy decision to address population issue by introducing voluntary family planning services in the country. However, with five-decades of investment in family planning program, only 25 per cent of women reported using modern contraception in 2017-18, the lowest amongst the Asian and neighboring Muslim countries. With family planning programme in place, Pakistan aimed to achieve replacement level fertility (2.2 births per woman by 2030). Fertility declined steadily from 4.9 births per woman (1990-91 PDHS)[2] to 4.1 births (2006-07 PDHS) and to 3.6 births (2017-18 PDHS). Surveys reveal that fertility decline generally remained slow after 2006. Pakistan is falling behind to achieve its own goals set for lowering fertility relates to inadequate investment and attention to raise contraceptive use rate.

According to population Policy 2002 Pakistan envisioned to achieve replacement level fertility by 2020 and pledged at the London Summit on Family Planning in 2012 to achieve a mCPR level of 50 percent by 2020. But both the goals remained unattained. The existence of unmet need for contraception (17% of married women) and continued persistence of inequity among users reported by 2017-18 PDHS reflected in major difference of use of modern contraceptives between poor and rich segments of married women (13 point difference) point to weaknesses in the service delivery system. The non-use of contraception and high unmet need have resulted in high-risk births at times leading to unsafe abortions. A study undertaken by Population Council in 2012[3] estimated that 2.25 million induced abortions were performed directly affecting the highly sensitive health indicator of maternal mortality ratio (MMR). Though this has declined over the last decade (from 276 to 186 for 2006-07 and 2019), but still much higher than neighbouring Muslim countries.

The Third Meeting of the Federal Task Force (held on August 6, 2020), Chaired by H. E. Dr Arif Alvi, President of Pakistan who took note of the unusual slow pace and low uptake of family planning in Pakistan desired to know the reasons of this situation and how Pakistan can take benefit from successful experiences of three Muslim countries – Iran, Turkey and Bangladesh. This brief provides a comparison of major features of four nations to show where Pakistan stands, what best practices were implemented by these nations to address high growth rate, and how Pakistan can take advantage from their successful experiences.

POPULATION - PAKISTAN

MID 2020 (Estimated) **220.9 MILLION** → **2030** (Projected) **263**[1] **MILLION**

MODERN CONTRACEPTIVE METHODS

ONLY 25%

of women reported using modern contraception in 2017-18

FERTILITY RATE - PAKISTAN

PAKISTAN AIMED TO ACHIEVE REPLACEMENT LEVEL FERTILITY **2.2** births per women by 2030

- **1990-91** PDHS: **4.9** births per woman
- **2006-07** PDHS: **4.1** births per woman
- **2017-18** PDHS: **3.6** births per woman

[1] Elaboration of data by United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects: The 2019 Revision.

[2] Prior to the 1990s, average fertility in Pakistan was approximately six births

[3] "Induced Abortions and Unintended pregnancies in Pakistan, 2012" - Population Council

2 POPULATION AND FAMILY PLANNING PROGRAMMES OF TURKEY, IRAN AND BANGLADESH

INITIATION OF POPULATION AND FAMILY PLANNING PROGRAMMES

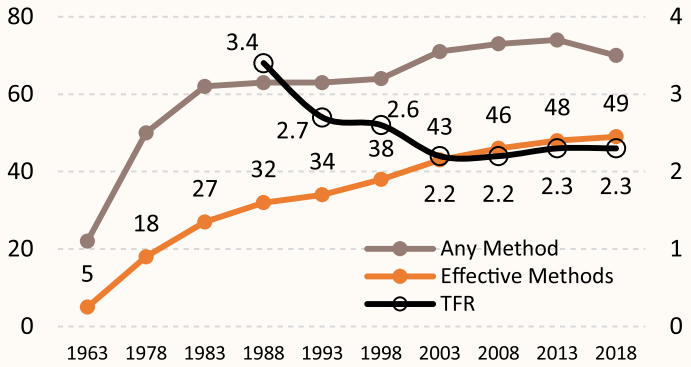
Pakistan	Turkey	Iran	Bangladesh
1965	1965	1989	1976

It is interesting to note that all three Muslim countries initiated their population and family planning programs almost at the same time or even later than Pakistan's policy declaration: Pakistan – 1965, Turkey – 1965, Iran – 1989, Bangladesh – 1976. The figures below present the trend of total fertility rate and contraceptive prevalence rate in each of these four countries. Turkey achieved 40 points increase in CPR in 2 decades (1963 – 83) but had high proportion of traditional method use complemented by abortion rate and by late 1980s already had achieved TFR of 3.4 births. Iran's progress has been most dramatic in the increase of modern CPR – doubled from 27 to 56 in just 12 years (1988 to 2000). Iran's fertility declined by more than half in ten years, from an average of 6.2 births per woman in 1986 to 2.5 births per woman in 2000 particularly impressive in rural areas[4]. Studies show that 61% of the reduction in fertility rate in Iran was attributable to family planning[5].

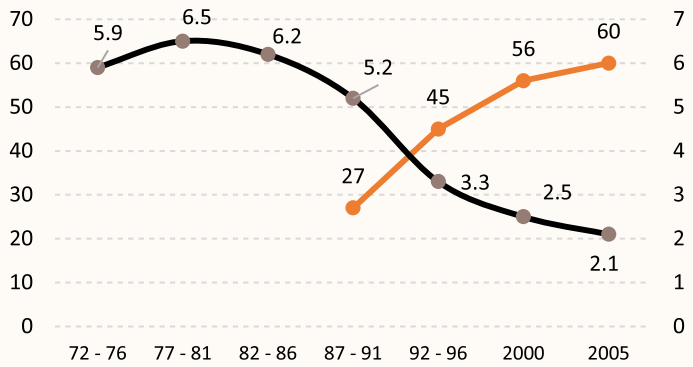
Bangladesh is a remarkable example of rapid increase in contraceptive use and fertility decline during mid-1970s to late 1990s when TFR declined from 6.3 to 3.3 births and modern CPR increased from 5 to 43 percent. The stalling of fertility in Bangladesh for a decade was taken as a challenge and addressed through series of programmatic modifications to achieve desired fertility level of 2.1.

TRENDS OF FERTILITY AND MODERN CONTRACEPTIVE USE IN TURKEY, IRAN, BANGLADESH, AND PAKISTAN

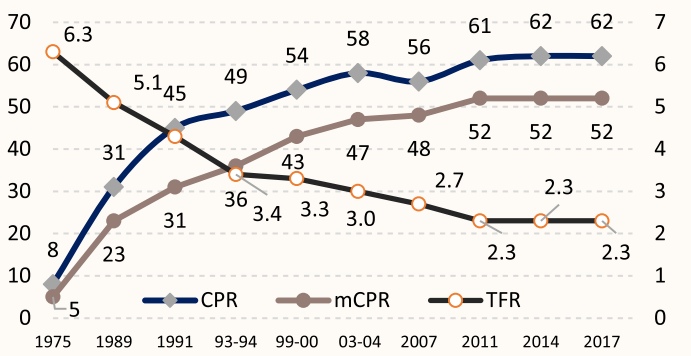
Trend of TFR and mCPR - Turkey



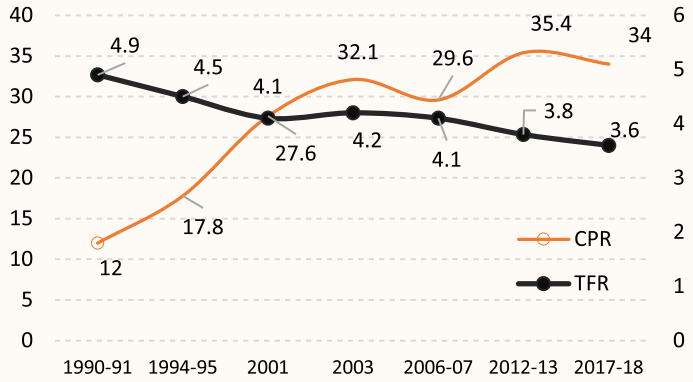
Trend of TFR and mCPR - Iran



Trend of TFR and CPR in Bangladesh



Trend of TFR and CPR - Pakistan



[4] Farzaneh Roudi, Pooya Azadi, and Mohsen Mesgaran. Iran's Population Dynamics and Demographic Window of Opportunity, Working Paper 4, Stanford Iran 2040 Project, Stanford University, October 2017

[5] Erfani A, McQuillan K. Rapid fertility decline in Iran: analysis of intermediate variables. J Biosoc Sciences 2008; 40:459–78.

3 ESSENTIAL ELEMENTS OF SUCCESS IN THREE MUSLIMS COUNTRIES

The critical features adopted by the three countries to achieve success are:

1 LEGISLATION AND PARLIAMENTARY SUPPORT TO REFLECT POLITICAL COMMITMENT

Passing of a Law by Parliament in Turkey (in 1965 and 1983) and Iran (in 1989) laid the foundation of Population Planning and Policy pursuit. Open discussion among members and Politicians built ownership especially in Iran when senior religious leadership issued Fatwa and began to give Friday sermons, which produced tremendous acceptance of the concept of small families and use of contraception. The Law provided legal framework for funding and to take measures for nationwide family planning program, with focus on reaching out at doorsteps with modern contraceptive methods. In Bangladesh, Population Policy was formulated in 1976 and approved by the Cabinet as integral part of development planning and social reforms. Firm political commitment upheld the establishment of long-term plans and to providing necessary funding to implement all aspects of the plans. Critical to their success was the 'open support and seriousness' expressed by the leadership towards the issue to convey determined message to program functionaries and people in general to pursue the goal. Leadership's unwavering support and clear understanding of population as a national cause on long term basis, and persistence with patience even with changes in political governments, were considered key factors for the results.

2 COMPREHENSIVE PLAN FOR UNIVERSAL COVERAGE AND AVAILABILITY OF SERVICES

Open political commitment, with firm and serious support of the leaders sustained over time was translated into a thorough Plan to ensure widespread availability of information and services along with a strong behavior change communications to educate and convince people. Commonalities among them also included: establishing a national program under the Ministry of Health responsible for implementing family planning initiatives; and all aiming at reaching women at their doorsteps: regional mobile teams in Turkey, community-based health workers and health houses in Iran; and family-welfare assistants in Bangladesh. The purpose in each case was to educate women regarding benefits of lower fertility, birth spacing, and giving them necessary information regarding modern contraceptives, and addressing their misgivings and fears. The uniqueness regarding Iran's motivation and Program was their three objectives: encourage birth spacing for 3-4 years; discourage pregnancies before age 18 and after age 35; and encourage families for three healthy children. Bangladesh specifically evolved communication program to address desire for large family size and son preference, campaign also contributed to the success of the program. Strict program monitoring, use of operations research and evaluation to address program weaknesses contributed significantly. Innovative initiatives especially in Bangladesh during a decade of status quo in fertility, enabled the country to go back on track to achieve a TFR of 2.1 in the next decade.

3 PROVISION OF MODERN METHODS AND INTEGRATING FP SERVICES TO BROADEN MATERNAL AND CHILD HEALTH SERVICES

Provision of a comprehensive package of modern methods remained fundamental to ensure proper birth spacing and minimizing unintended or untimely pregnancies. Promotion of IUCD (in Turkey); and IUCD and vasectomy (in Iran); and tubal ligation and injectables and emergency contraceptives (in Bangladesh) made real difference in reducing fertility. Furthermore, the role of 'state taking the driving force' was essential to determine the direction and to maintain momentum ensuring needed contraceptive method mix is attained and is aligned with the fertility lowering goals while still ensuring client's choice. Common to all three countries was the proactive use of public sector health personnel and facilities for the provision of FP services. Turkey used the 1965 Law on Population Planning to mandate and direct all health personnel of Ministry of Health to provide FP services and later in 1983 authorized trained non-physicians to provide IUCD that doubled IUCD use by 1988. Iran, besides expanding the network to reach out women also ensured primary health care setup to provide FP services. Bangladesh used maternal and child health framework post-approval of 2004 Policy whereby FP services were integrated with Primary Health Care for easy of accessibility to women.

4 PURSUIT OF FEMALE EDUCATION GOALS

Girls education works several ways to influence attitudes and behaviours especially when seen in context of female autonomy, social equity, understanding of family building and use of contraception for birth spacing. All three nations actively pursued girl's education as development objective over the years, which not only helped in increasing age at marriage, but also promoted desire for smaller family and minimized son preference as a factor for more fertility.

4 FACTORS CONTRIBUTED TO LOW UPTAKE OF FAMILY PLANNING IN PAKISTAN AND KEY LESSONS FROM THE THREE COUNTRIES:

Several major issues and missed opportunities may be noted for low uptake of family planning in Pakistan:

1. Rapid population growth though accepted as a barrier to developmental since 1960s but never openly discussed in the parliaments or legislation ever evolved. Furthermore, shyness of leadership towards open support and seriousness for sustained efforts with consistency and continuity marred all desired long-term gains. Absence of leadership's frontal public statements and guidance allowed conservative forces to establish confusions and fears among people, which were not allayed by direct contacts and education efforts.
2. High population growth was always seen as a competing priority against economic and development strides. Political leaders and programme managers lacked understanding and patience necessary to pursue the cause of population on sustained basis and wait for the result. Leadership and management also shied from progress review at the federal and provincial hierarchy reflecting lack of empathy.
3. Though service delivery and counseling at community level was given credence in mid 1990s but ever since year 2000 it is not taken with seriousness to be followed up for assurance and appreciation. Counseling women played a critical role in all three Muslims countries (Turkey, Iran & Bangladesh) to educate and encourage clients and address fears and myths of family planning and contraceptive technology. Unfortunately, it never received adequate attention by all stakeholders in Pakistan especially after dilution of the tasks of LHWs in year 2000 and beyond in support of other health programmes.
4. Provision of FP services within healthcare umbrella provided boost to service acceptability in all three countries. Unfortunately, delivery of FP services by the Population Welfare and Department of Health (solely and together) did not fully meet the needs of the people mainly because of silo approach and lack of coordination and collaboration. Merger of the two Ministries have been the agenda of several government's since year 2000 but it remained a difficult proposition because of differences in sources of funding, fund flows, hierarchical relationships, constitutional prerogatives and reluctance on part of functionaries[5]. Half-hearted response by all provincial Departments of Health never integrated or implemented FP services with MCH in real spirit of commitment.
5. Role of state towards 'policy review' and 'regulatory tasks' remained non-existent[6] at federal and provincial levels. Good understanding and developing improved assessment of progress and coordination with partners are critical for timely reaching the goal.
6. Contraceptive method mix of Pakistan is acknowledged for its least efficacy and effectiveness towards lowering fertility since 1990s. Focus on tubal ligation and condoms have contributed least towards this goal. Though about half of all women reach out to private sector for services due to their easy access and active role in promoting contraception but remained limited to least effective methods.
7. Quality of services monitoring, and beneficiary feedback remained secondary and lacked intensity.
8. Performance Evaluation and Research was a Programme pillar but not given adequate institutional support to address and analyze substantive field problems. Inadequate support to the pillar led to decay of research institutions in terms of research capacity and its contribution to the sector.
9. The devolution of functions in 2010 diluted the national cause and has not improved but contributed to further neglect of the importance in real terms. The spirit of devolution in terms of building capacity and authorizing districts for planning, action and accountability lacked seriousness.
10. Female education though considered a critical pillar to social change and a major factor in fertility decline yet was not given carefully attention and to enhance investment since year 2000.

5 WAY FORWARD

In view of existing barriers and to achieve the goal to further decrease fertility rates by 2030 (as pledged at ICPD 25 and Nairobi Conference Nov 2019) and based on the successful experiences of the three Muslim countries, following key measures are outlined:

1. Political Commitment and voice needed to be raised in Legislation with persistence and continuity. Sustained engagement of legislators for championing and holding the executive accountable.

2. Population should remain a national cause and provincial contribution evolved by consensus and funds made available by provincial and federal government with understanding of long term need and patience to wait for the results being critical due to crosscutting effect of the population variable on all socio-economic development sectors. We should sensitize and empower political leaders and the bureaucrats and follow up progress through a strong accountability mechanism.

3. All provincial Health Outlets must take on FP as integral service with full commitment. Strengthen LHWs and other CHW programme supplemented by other interventions such as male engagement, premarital counseling, encouraging female education and life skills based education for young people. Immediate high-level conversation and decision to come up with a more cost effective and expanded family planning programme by ensuring provision of family planning services as part of broader maternal and family health services by DoH.

4. Annual policy Review System must be established at national and provincial leadership levels. Implementation of CCI recommendations must be reviewed and steps taken to realize it.

5. Investment and promotion of birth spacing methods like IUCDs and implants is overdue and needs greater attention.

6. Equity must be a key strategy in future plans to enhance access to the poorest segment of population and promoting a method mix that builds birth spacing and minimizes unintended pregnancies

7. Counseling and services go as a package – but private sector remained focused on services and sales. A strong public private partnership model should be designed and integrated.

8. Research and Evaluation made essential part of policy revision. Implement strong M&E system supported by availability of reliable service coverage data and frequent representative surveys such as the Performance, Monitoring for Action (PMA).

[6] Sania Nishtar, Saba Amjad. 2009. Pakistan's health-population mantra J Pak Med Assoc. Vol. 59, No. 9 (Suppl. 3), September

ACKNOWLEDGMENTS

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FAMILY PLANNING AND FERTILITY TRANSITION IN TURKEY: PROCESS AND CHALLENGES

Turkey's population in 2019 was estimated at 83 million people rising from 28 million in 1960. Turkey's Population is projected to be around 87 million by 2022. Annual population growth rate was 2.85 percent in early 1960s which declined to 1.83 percent in 1990-2000. The total fertility rate (TFR) was 3.4 in 1988 and brought down to 2.2 in 2013 and currently estimated at 2.3 births per woman.

To address the high population growth Turkey's First Five-Year Development Program (1963 – 67) made the following recommendations.

1. Legalize the spread of information and materials related to contraceptives.
2. Legalization of the import and sale of contraceptives.
3. Personnel employed in health services (doctors, nurses, midwifes, health officers, nurse assistants) will be trained in population planning.
4. Health service personnel will be responsible for providing population planning education and materials free of charge
5. Contraceptives and pills will be provided at low prices and distributed to the poor free of charge

The Law on Population Planning was enacted in 1965, also known as the Population Planning Directory under the Ministry of Health[1]. The overwhelming influence of state policy reflects that family planning was not a grassroots movement - it was a top-down campaign. The Population Planning Law 1965 was intended to provide the legal framework for funding and implementing a nationwide family planning program[2]. The parliamentary debate on the bill revealed some of the underlying ideologies of the participants concerning population and showed their profound lack of information about population dynamics. The Ministry of Health had a demographic framework for understanding the development issues.

To strengthen the gains of the first Plan, the Second Five-Year Development Plan (1968 – 1972) created regional mobile teams. The mobile teams launched in mid 1960s was a key approach to inform the public about the FP services. The mobile teams worked in pairs, one providing education and information and the other providing contraceptives and medical services. The education team included female and male educators who visited the village first, then the medical team arrived to follow up with clinical services. Using this approach contraceptives, especially the IUD, were provided to villagers' doorsteps and to large squatter communities in the main cities. The mobile teams achieved remarkable successes in 1967 and 1968, finding an upsurge of interest among village women. Indeed, one of the early characteristics of family planning provision was the enthusiastic cooperation of village people whenever anyone visited to discuss or offer services.

Family planning education was given high priority than before and as such information was disseminated through radio and newspaper, and family planning education program was pursued in schools and in the military. To further consolidate the gains, the Third Five-Year Development Plan (1973 – 1977), resolved to integrate health services and family planning program and raise the mother and childcare services at the desired levels. This transformation widened the scope for family planning programs throughout the country.

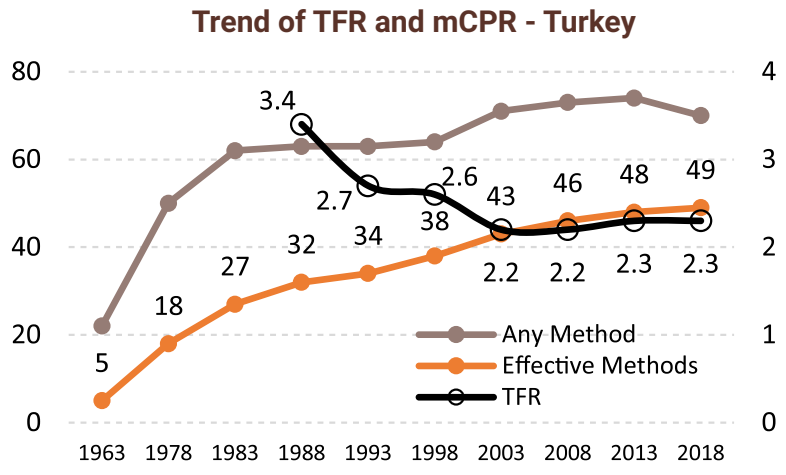
Over time it became clear that contraceptive practices would lag behind attitudes and knowledge[3]. By 1978, contraceptive use had risen to only 50 percent of couples, two thirds of whom relied on traditional methods with their high failure rates (Figure 1).

POPULATION - TURKEY

2019 (Estimated)	2022 (Projected)
83 MILLION	87 MILLION

TOTAL FERTILITY RATE - TURKEY

1988	3.4 births per woman
2013	2.2 births per woman
Currently estimated	2.3 births per woman



SCIENTIFIC APPROACH

Several local and national epidemiological investigations were conducted, as well as several operation research studies. Analyses of the national surveys, which were conducted every five years, established the unsatisfactory trends

[1]Belin Benezra: 2014. The Institutional History of Family Planning in Turkey. K. Kamp et al. (eds.), Contemporary Turkey at a Glance. DOI 10.1007/978-3-658-04916-4_5, © The Author(s) 2014

[2]Akin, Ayse 2007. Emergence of the Family Planning Program in Turkey. The Global Family Planning Revolution: Three Decades of Population Policies and Programs Warren C. Robinson and John A. Ross, Editors. The World Bank Publication, D.C. page 85-103

[3]Ibid: Akin, Ayse 2007.

in fertility regulation. The results of these studies were used for advocacy purposes and served as a basis for specific aspects of the new law. The results of the studies were well disseminated and publicized at several meetings organized by the Ministry of Health. At the parliamentary level, such dissemination workshops led to health care reform. Aiming to further strengthen service delivery program, a new Population Planning Law was passed in May 1983 authorizing trained nonphysicians to insert intrauterine devices (IUD), legalizing abortion up to 10 weeks on request, allowing trained general practitioners to terminate pregnancies, legalizing surgical sterilization for men and women on request, and establishing intersectoral collaboration to provide family planning services throughout the country. As a consequence of reforms, Turkey witnessed IUD prevalence doubled between 1983 and 1988 (see Table below).

Family planning started to be conceived in terms of human rights and health in 1990s with the goal to empower women to control their own fertility, while minimizing health problems. Male responsibility and participation in reproductive health was a key area raised by ICPD 1994 conference. The intention was to create greater parity between men and women in the family planning process. Furthermore, in 1993, for the first time, the prevalence of effective contraceptives exceeded the prevalence of traditional methods. By 2003, the total fertility rate was down to 2.2 births per woman and 71 percent of couples were using contraception (Figure 1). The public sector has always major role in dispensing FP, including government hospitals and family practice centers, currently provide modern contraceptive methods to 52% of current users, while the private medical sector provides methods to 36% of users[4].

Table: Trend of Method Mix of key contraceptives used in Turkey 1963 to 2018

	1963	1978	1983	1988	1993	1998	2003	2008	2013	2018
IUCDS	0	4	9	17	19	20	20	17	17	14
PILLS	1	8	9	8	5	4	5	5	5	5
CONDOMS	4	4	5	8	7	8	11	14	16	19
TUBAL LIGATION	0	0	0	2	3	4	6	8	9	10
WITHDRAWAL	10	22	31	31	26	24	26	24	26	20

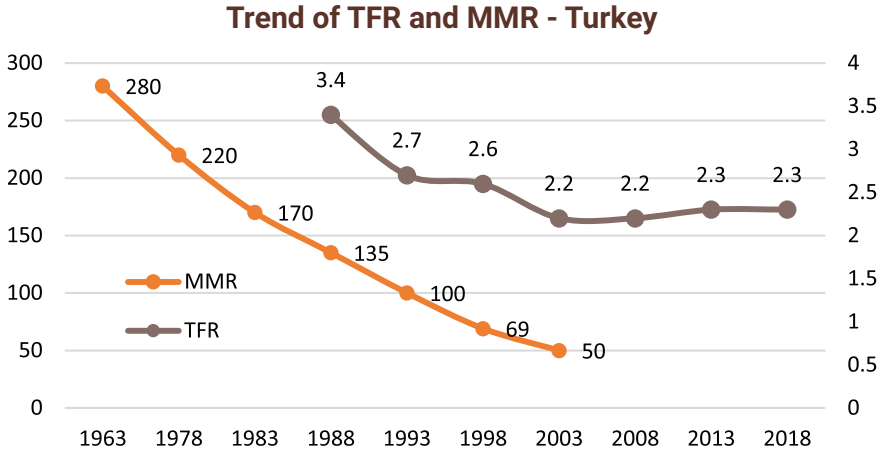
Source: Hacettepe University Institute of Population Studies. Turkey DHSs

LESSONS LEARNED AND CONCLUSIONS

Turkey's experience with changing its population policy, both the historic 1965 reversal and the 1980 modification, demonstrated the importance of the following effective ways to realize legal changes:

1. Vigorous planning and committed leadership
2. Support from scientific evidence based on empirical research
3. Advocacy through multiple channels (meetings, publications, and the media)
4. Intersectoral collaboration, both within the government and with the private sector
5. International collaboration and support.

Two trends were mutually supporting: a decline in the maternal mortality ratio, and greater use of modern contraceptive methods. Figure 2 shows the concurrent changes in the search for lowering fertility and maternal mortality. Evidence from national studies and from operations research helped in convincing the politicians and decision makers in legalization of abortion.



[4] Hacettepe University Institute of Population Studies. (2019). 2018 Turkey Demographic and Health Survey, Key Findings. Hacettepe University Institute of Population Studies.

IRAN'S FAMILY PLANNING PROMOTION AND FERTILITY TRANSITION

Iran's population increased from 22.0 million in 1960 to around 50 million by 1991, which according to the latest census was estimated at 82.1 million in 2019. The population is expected to touch 84.50 million by the end of 2020 and projected to be around 86.90 million in 2022. The average annual growth rate was 3.9 percent during 1971-91. The annual population growth rate has been brought down to 1.29 percent since 2011.

The Population Census results for 1997 showed a rapid decrease in the population growth rate due to fertility decline, which dropped from 6.2 births per woman to 2.5 births per woman, between 1986 and 1996. Iran experienced fertility decline starting in 1984-85 four years prior to the inauguration of the national family planning program by the government, counseling and services were provided to rural couples through the country's rural health networks. Iran's fertility decline has been particularly impressive in rural areas. The total fertility rate in rural areas dropped by three-quarters, from 8.1 births per woman in the mid-1970s to 2.1 births per woman in 2006. The current fertility rate in Iran is 1.8 births per woman which is below the replacement level of 2.1 births. Iran's fertility rate has been below the replacement level since 1997 and 2001, respectively and has remained below that level since. Iran stands out for lowering its fertility in a noticeably short time in only one generation, which in comparison, took European countries 300 years[5].

High population growth during 1970s and 1980s was voiced as major concern by Iran and sought government's shift in its population policies in the late 1980s. Religious leaders and political entities unanimously supported lowering fertility and use of modern contraception for the purpose. Ayatollah Khamenei the Supreme Leader and the than President discussed the value of the Family Planning Program during the Friday Prayer services in 1988. Imam Khomeini's endorsement and Fatwa was a significant step to launch family planning activities in Iran which was universally supported. In 1989, the Iranian parliament passed a development plan, which included a Family Planning Program. In May 1993, the Iran's parliament passed a national family planning law that effectively encouraged couples to have fewer children and restricted maternity leave benefits after three children; moreover, cleric bodies and the judicial system issued the authorization for family planning and supported the policy.

POPULATION - IRAN

2019 (Estimated)	2022 (Projected)
82.1 MILLION	86.9 MILLION

TOTAL FERTILITY RATE - IRAN

mid 1970s	8.1 births per woman
2006	2.1 births per woman
Current FR	1.8 births per woman below replacement level

REPLACEMENT LEVEL - TURKEY

replacement level	2.1 BIRTHS PER WOMEN

The National Family Planning Program launched in late 1989 had three main objectives:

1. Encourage birth spacing intervals of 3-4 years
2. Discourage pregnancy among women younger than 18 and older than 35
3. Limit family size to three children.

To achieve these objectives following main activities were carried out:

1 INCREASED ACCESS TO FREE CONTRACEPTIVES

Accessibility to FP/RH services through a nationwide network was enhanced through 17,000 health houses, 4500 urban and rural health centers, hundreds of village level health posts, 360 district health centers, and more than 100,000 health personnel forming a Primary Health Care network providing direct and indirect services to the client[6]. "Health houses" in rural area integrated family planning and health care service played a vital role in FP provision to rural women. The comprehensive health network that included mobile clinics and "health houses" provided family planning and health services to 80% of Iran's rural population. These easily accessible, low-cost or free community-based health houses with workers and thousands of trained volunteers having continuous personal contact with their clients have played a major role in the provision of family planning and other health services. Family planning remained and integrated with primary health care, couples have no stigma attached to access and use of modern contraceptives. The establishment of the separate Department of Population and Family Planning in the Ministry of Health provided tremendous boost to family planning services penetration to the remotest villages through creation of massive network of outlets. The progress of the program was carefully monitored and the impact periodically assessed.

[5] Patrícia Dérer: The Iranian miracle: The most effective family planning program in history? Overpopulation Research Project March 2019.

[6] Roudi-Fahimi F. Iran's family planning program: responding to a nation's needs. Washington DC: Population Reference Bureau, 2002.

2 PROVISION OF VARIETY OF QUALITY FAMILY PLANNING METHODS TO COUPLES

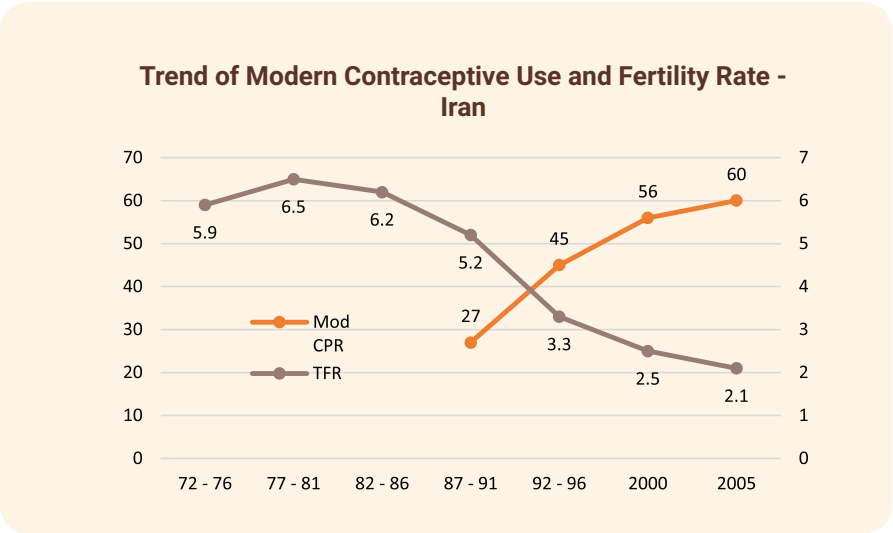
Male condoms and male and female sterilization were given priority for married couples. Two modern method received special attention: non-surgical vasectomy (NSV) and IUCD. Besides preparation of NSV standards for service delivery and training centers, service quality monitoring of 400 NSV centres throughout the country and organizing the quality control program for IUD service provision. Modern method mix recorded in 2005 included: tubal ligation (29%), IUCD (14%), NSV (5%), oral pills (32%), injectables (4%), and condoms (16%), etc. While vasectomies account for only 3% of contraception in overall CPR— compared with female sterilization of 29% — men nonetheless assumed more responsibility for family planning as more than 220,000 men have had a vasectomy during 1998 – 2002.

3 EDUCATIONAL PROGRAMS THROUGH SCHOOLS, COLLEGES AND MASS MEDIA REGARDING POPULATION ISSUES AND FAMILY PLANNING

Counseling was the most important component for the sustainability of programme. The main responsibility of service providers was client education esp in the selection of the method. The revamped public health system had a significant effect, especially on rural population fertility[7]. Moreover, family planning education became a mandatory component of the curriculum for 41 universities of medical sciences students, last year high school female students and soldiers; in addition, mandatory participating in contraceptive counseling and FP education programme to obtain a marriage certificate for all couples. As a part of the programme a huge media campaign was initiated to encourage women to space their pregnancies for 3–4 years, to limit the number of children to two, and to avoid pregnancy under the age of 18 and above 35. Religious leaders were actively involved with the dissemination activities and encouraging for smaller families, citing these as a social responsibility in their weekly sermons.

4 RESEARCH CONDUCTED ON VARIOUS ASPECTS OF FAMILY PLANNING DELIVERY AND POPULATION POLICY

Couples desire for smaller family size rose quite rapidly during mid 1980s which paved way for high level of social acceptance for the program. Other Programme activities included: Obligatory pre-marriage counselling of all couples; organizing a nation-wide phone-line to provide accurate FP/RH information; and updating the national FP guidelines to promote birth intervals. Contraceptive Security was given priority status by adopting national contraceptive policies; updating essential drug list by inclusion of contraceptive commodities; and transferring the contraceptive security capacity and skills of assessment to the provincial and district family planning managers.



As part of overall development plan, Iran gave high priority to education sector by giving special attention and increased investment on: Improvement of the literacy; Improvement of the higher education; and Improvement of university attendance. The programme used a broad approach and linking population policies with the improvements in overall social and economic indices. The planners associated fertility decline with increasing income and the standard of living in low-income groups, increasing women's workforce and education participation, and improving the health-care system in general. As a result of needed investment, the overall literacy increased significantly while male-female gaps in literacy and education attainment was minimized during 1986 and 2006. The literacy rate for adult males increased from 48% in 1970 to 84% in 2000. Female literacy climbed even faster, rising from less than 25% in 1970 to more than 70% in 2003. Meanwhile, school enrollment grew from 60 to 90% in the same period. Allowing opportunities for women empowerment, the average age at first marriage for females increased from 19.8 to 23.0 and for males increased from 23.6 to 27.4 during 1996-2017.

In all, the level and speed of the fertility decline went far beyond the government's original conservative targets. Studies show that Iran's family planning programme has been one of the most successful programmes in developing countries. The programme enabled families to choose the number of children they wanted to have, and space births as they desired them conveniently. During this period, 73.8% of married women over age 15 years were using contraceptives in 1997. The CPR was the highest rate of contraception use among developing and also Muslim countries[8].

[7] Modrek S, Ghobadi N. The expansion of health houses and fertility outcomes in rural Iran. Studies in Family Planning 2011; 42:137–46.

[8] Mehryar AH, Delavar B, Farjadi G., Hosseini-Chavoshi M, Tabibian M. Iranian Miracle : How to Raise Contraceptive Prevalence Rate to above 70 % and Cut TFR by Two-thirds in less than a Decade ? In: Presented at the 24th IUSSP Conference; 2001:1-45

The significant progress was noted in terms of closed the gap between women living in rural and urban area in the use of modern contraception. Furthermore, in 2004 over 60% of Iranian women did not want to have more than 2 children, underlining the significant role these policies played in empowering Iranian women.

As a result, , studies reveal that 61% of the reduction in fertility rate was attributable to family planning[9]; the rest was mainly caused by the increased age at marriage among Iranian women (mainly because of their pursuing higher education and changes in sociocultural norms) and desire not to have further children.

Other factors include urbanization, enhanced budget allocations and special emphasis on behavioural change communication to have supported changes in reproductive behavior towards fertility decline. Increased access to family planning services helped couples to achieve increased birth intervals even between the first birth and marriage.

A consequence of successes in family planning, Iran experienced two major improvements:

1. Rapid decline in estimated maternal mortality ratio from 140 (in 1985) to 24 (in 2005); and
2. The mortality rate for children aging 5 or younger, dropped from 188 to 17 deaths per 1,000 live births during 1966 and 2017.

Decline in child mortality further consolidated the desire to have smaller families. Iran's fertility transition as a result of universal access to health care and family planning, dramatic rise in female literacy, mandatory premarital contraceptive counseling for couples, men's participation in family planning programs — and strong support from religious leaders.

CURRENT SITUATION:

Development planners in Iran looking at the low fertility rates of several European countries realized that reduction in the fertility level resulted not only in a slower pace of population growth were alarmed at rapid growth of dependent older and aging population. The approach of the government toward family planning drastically changed in October 2006 with reversal of Iran's two-child policy, when President Ahmadinejad called the nation for larger families and to increase Iran's population to 120 million. Iran's family planning and contraceptive policy made sense 20 years ago, as quoted by Ayatollah Seyyed Ali Khamenei in July 2012 "but its continuation in later years was wrong … Scientific and experts studies show that we will face population aging and reduction (in population) if the birth-control policy continues." In 2014, Ayatollah Seyyed Ali Khamenei outlined broad policies of the country's population plans, stressing the need for making comprehensive plans to promote the country's economic, social and cultural situations based on the new population policies calling couples to procreate and have more children. Subsequently, in the same year, a bill to Increase Fertility Rates and Prevent Population Decline outlawed voluntary sterilization and blocked women's access to information about contraception, denying women the ability to make informed decisions about pregnancy. The budget for the population control program has been fully eliminated and policy of population control does not exist as it did previously and as such the free access to family planning services are restricted to a great extent.

[9] Erfani A, McQuillan K. Rapid fertility decline in Iran: analysis of intermediate variables. J Biosoc Sci 2008;40:459–78.

FAMILY PLANNING AND FERTILITY TRANSITION IN BANGLADESH: PROCESS AND CHALLENGES

BACKGROUND

Bangladesh population currently stands at around 165 million with an annual growth rate of 1 percent. Each year, the population is estimated to increase by 1.6 million. The country's population was 80 million in 1980, growing at a high rate of around 2.6 percent. The absolute size increased to 123 million by 2000, growing at 2.1 percent, but witnessed rapid decline in growth rate in later years – 1.72 in 2005 and 1.2 percent in 2010 with the size of 147.6 million. The population is expected to rise to 179 million by 2030 at the current growth rate.

Recognizing the importance of population with particular reference to development, the Government of Bangladesh paid special attention to the matter in 1976 and formulated a firm Population Policy whereby the rapid population growth was identified as number one national problem. It was considered as an obstacle to national socio-economic development. The policy document of the Ministry of Health and Family Welfare incorporated family planning program as an integral components of overall national development and social reformation programs. Focused programs and interventions were introduced to create opportunity and encourage acceptance of different methods of family planning by choice, strengthen mother and child health care activities, involve young and women groups, religious leaders, community leaders and voluntary organizations, initiate and sustain educational and awareness programs on family planning issues. The program was backed-up with research and massive training activities.

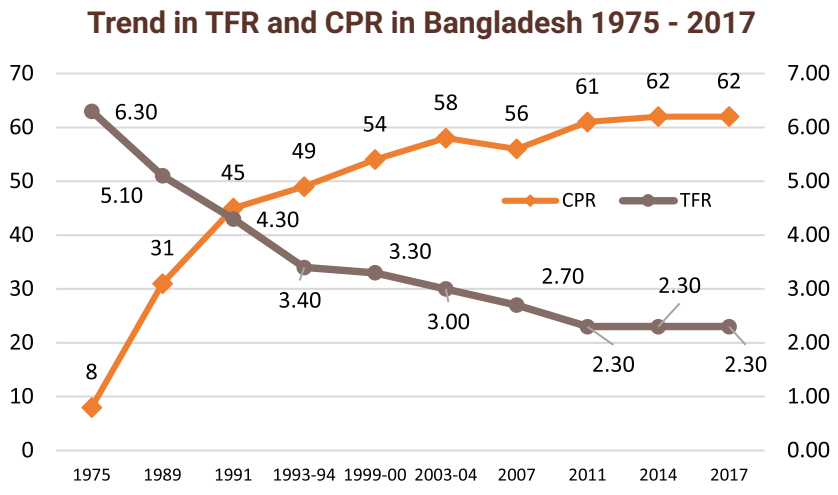
The focused attention accorded to the Family planning programs in Bangladesh was sustained and continued with determined efforts. It resulted in remarkable success in promoting contraceptive practice and lowering fertility over a period of about twenty years from mid-1970s to mid-1990s. The total fertility rate (TFR) declined from 6.3 in 1975 to 3.4 in 1993-94 with a simultaneous increase in contraceptive prevalence from 7.7 percent to 44.6 percent during the same time. This was a major achievement in population sector programs that contributed to enhance access to family planning services and introduction of a broader range of modern and effective methods. Two major steps may be noted in this regard. The government of Bangladesh in 1978 launched the delivery of family-planning services through family- welfare assistants at the grassroots level. The cadre was assigned the task of reaching out to the village women at their doorsteps. The health workers were sent out every two weeks to deliver messages about contraception, distribute contraceptives and motivate mothers to use them. The health workers addressed the women's fears and discussed the possible side effects of contraceptive use. The welfare assistants, paramedics and traditional midwifes not only provided awareness of new family-planning methods but also advised mothers about the benefits of having a small family for health and well-being of the family. Furthermore, a pilot Model Clinic was established in 1975, that offered a broad range of modern methods – including newer generation IUDs (such as Copper-T IUD 380A), long acting injectable contraceptives, menstrual regulation, female and male sterilization, oral pills, including low dose formulations and condoms. The model was replicated nationwide in 1979-80 and continued overtime program was supported by strong political will and sustained commitment; community-based distribution; cafeteria approach (choice of contraceptives); involvement of NGOs & private sector turned the program into a social movement; IEC efforts: IPC & mass media contributed to increase in demand for FP services. These measures resulted in a significant rise in new acceptance of contraceptives, especially that of more effective methods (Figure 1).

POPULATION - BANGLADESH

2010 (Estimated)	2030 (Projected)
147.6 MILLION	179 MILLION

TOTAL FERTILITY RATE - BANGLADESH

1975	6.3 births per woman
1993-94	3.4 births per woman



EMERGING PROBLEMS AND SOLUTIONS

The decline in fertility came to a stall in early 1990s with TFR remaining at around 3.3 in two subsequent inter-survey periods between 1993 and 2000. Several program trends provided consistent clues to the hypothesis: (i) a shift in contraceptive method mix toward less effective method, (ii) shrinking role of public sector in contraceptive service delivery, (iii) significant decline in new acceptance of effective methods, (iv) an increase in unmet needs, and (v) de-emphasis of outreach services.
Research and evidence gathering was given a priority to identify several aspects needing effective solutions. The analysis of BDHS revealed that declining trend in the lactational infecundability period offset the fertility reduction effect other factors[10].

Therefore, for any future reduction in fertility in Bangladesh[11] may be largely dependent on increased use of effective birth control methods. Moreover, for decline in fertility or to completing the demographic transition in Bangladesh improvement in socio-economic status of women particularly in education was given priority which would bring about a change in the desired family size along with a strong IEC services may indeed play a major role in both motivating people to have a small family and ending son preference. To expand family planning services and to improve the effectiveness of the method-mix, empirical evidence was gathered to evolve method-specific strategies[12] for evolving effective policy measures.

POPULATION POLICY REVISION

The national Population Policy was revised in 2004 to fully benefit from the evidence and resolved to attain growth rate equal to one by the year 2010 so as to stabilize population around 2060. The 2004 Policy approved a multi-sectoral approach to address population issue by ensuring coordination among relevant Ministries in strengthening population and development linkages and making their respective mandates and implementation strategies more population focused.
In order to address the problems of high fertility, the Policy was a comprehensive service-oriented response to provide family planning and maternal and child health needs that impact fertility. Besides increasing coverage and reaching out the clients at their doorsteps, improved quality of care and increased utilization of services were given more attention for reducing fertility, maternal mortality and morbidity, infant and child mortality. Addressing complications arising from unsafe abortions were also recognized as a significant matter to be part of strategies in Bangladesh.

Ensuring the availability of contraceptives and supplies remained as the cornerstones of the policy. Decentralization and community involvement were declared essential in order to ensure that women, children and other vulnerable groups have adequate access to services. Policy emphasized special attention to young, low parity and newly married couples for FP services and information; use of comprehensive client centered approach to provide maternal, child and reproductive health services; priority given to couples with one child for their adopting small family norm in the provisions of social services; establishment of Health and Family Welfare Centers at Union level; doctors to provide family planning services regularly along with maternal and child health services in all government and non-government health facilities; provide adolescent RH and life skills education as well as counseling regarding delay in first birth and birth spacing; etc. Role of private sector in service provision and NGOs in education and motivational areas was highly recommended.

Table: Trend of Contraceptive Method Mix in Bangladesh

	1983	1991	1999-00	2007	2017
ANY METHOD	19	40	54	56	62
MODERN METHODS	14	31	43	48	52
Methods					
PILLS	3	14	23	29	25
INJECTABLES	0	3	7	7	11
CONDOMS	2	3	4	4	7
TL	6	9	7	5	5
VASECTOMY	1	1	1	1	1
IUCD	1	2	1	1	1
IMPLANTS	0	0	1	1	2
TRADITIONAL	5	9	10	8	10

Source: Khan, Atiqur Rahman and Khan, Mufaweza. March 2010. Population Programs in Bangladesh: Problems, Prospects and Policy Issues. Dhaka; and NIPORT 2019. BDHS 2017-18

[10] M Mazharul Islam, M Ataharul Islam, Nitai Chakroborty. 2004. Fertility transition in Bangladesh: understanding the role of the proximate determinants. J Biosoc Sci. 2004 May; 36(3):351-69

[11] Radheshyam Bairagi and Ashish Kumar Datta. 2001. Demographic Transition in Bangladesh: What Happened in the Twentieth Century and What Will Happen Next? Asia-Pacific Population Journal, Vol. 16, No. 4

[12] Khan, Atiqur Rahman and Khan, Mufaweza. March 2010. Population Programs in Bangladesh: Problems, Prospects and Policy Issues. Dhaka.

Series of measures were initiated to address the emerging needs and included: enhancing community level services and out-reach, program recruited 13,500 married women with higher secondary education and computer literacy; improvement of quality of care through supportive supervision was prioritized to reduce method discontinuation, and promote effective use; strengthening technical capacity of the private sources was undertaken to meet growing use for contraceptive services; decentralization of services through devolution of power to the lower levels to ensure the people's participation in population, nutrition and health activities; integration of safe motherhood with FP services using innovative strategies gave tremendous boost to FP uptake; and prevention of unsafe abortion was recognized as an important and essential element of reproductive health. Educating women received high priority as the single most important social factor to remove misgivings and promote family planning in one hand and create aspirations and opportunities in life, on the other hand, to influence family size desire.

There has been a renewed commitment on the part of political leadership to contain population growth. Adopting various policy initiatives, Bangladesh made remarkable achievements in further reducing the total fertility rate per woman of reproductive age in post 2004 period. An important reason to succeed was the adoption of holistic approach to maternal and child health along with family planning. Contraceptive method mix improved towards more effective methods to realize small family adoption (Table 1). Doorstep services were boosted and as BDHS 2017-18 reflected that 20% of currently married women reported a visit by a fieldworker in the 6 months before the survey. Long acting or permanent methods such as sterilization, implants, and IUDs are usually obtained from a public sector facility, especially health complexes and union health and family welfare centers. However, the proportion of female sterilization in a private medical sector has been slowly increasing, from 21% in the 2011 BDHS, to 29% in the 2014 BDHS, and to 32% in the 2017-18 BDHS. The share of the private sector as a source of contraceptive supply has increased from 44% in 2007 to 47% in 2014 and 49% in 2017, surpassing the public sector as the dominant source of contraceptive supply.

FEMALE EDUCATION AS A FACTOR OF CHANGE

Investment and improvement in female education contributed fully towards bringing a change not only desired family size but also use of more effective methods. Bangladesh overall literacy reached 73 percent in 2017 while female literacy was 70 percent. Educational attainment among ever-married women age 15–49 continued to improve till 2017. Only less than 17 percent women did not attend a school, while 52 percent completed secondary or higher-level education[13]. Suitably designed population subjects were integrated in education curricula, including that for existing madrasah education system, and reviewed on a regular basis to ensure these are in conformity with correct interpretation of knowledge.

IMPORTANT FEATURES OF BANGLADESH'S EXPERIENCES

Bangladesh's dramatic birth-rate decline is attributed to following main elements[14]:

1. Political will and commitment critical for success and persistent program and systemic review
2. Strengthening coverage and access to services through doorstep availability and home visits to addressing women's fears and concerns about the side effects of contraceptives.
3. Improved Method Mix pursued for greater effect on fertility decline focused on promoting more effective methods (LAPM).
4. Gaps in Contraceptive Security and Logistics System seriously addressed. Districts capacity built for assessment and logistics, and inter-district commodity exchange authorized to address stock-out
5. Integration of FP with maternal and child health programmes, and adequate budget service quality
6. Evidence based policy formulation; management decision established. Decentralization in decision making strengthened accountability and performance.
7. Equity-based coverage formulated to give greater emphasis to poor areas to address unmet need
8. Improve Program Efficiency by addressing various HR issues and enhancing training capacity of related institutions
9. Women empowerment and education given due priority and investment to help reform social norms and counter son preference and large family demands.
10. Consensus emerged across Muslims scholars and clerics that use of contraception is not contradictory to Islamic teachings. Muslim clerics and reformers openly supported family planning in view of better health of mothers and children and quality of life of children

[13] National Institute of Population Research and Training (NIPORT), and ICF. 2019. Bangladesh Demographic and Health Survey 2017-18: Key Indicators. Dhaka, Bangladesh, and Rockville, Maryland, USA: NIPORT, and ICF.

[14] Barkat-e-Khuda: 2013. The Bangladesh Family Planning Program: Achievements and Challenges. Professor, Department of Economics, University of Dhaka, Bangladesh. Presentation at an Experience Sharing Seminar. Organized by Pathfinder International, Islamabad

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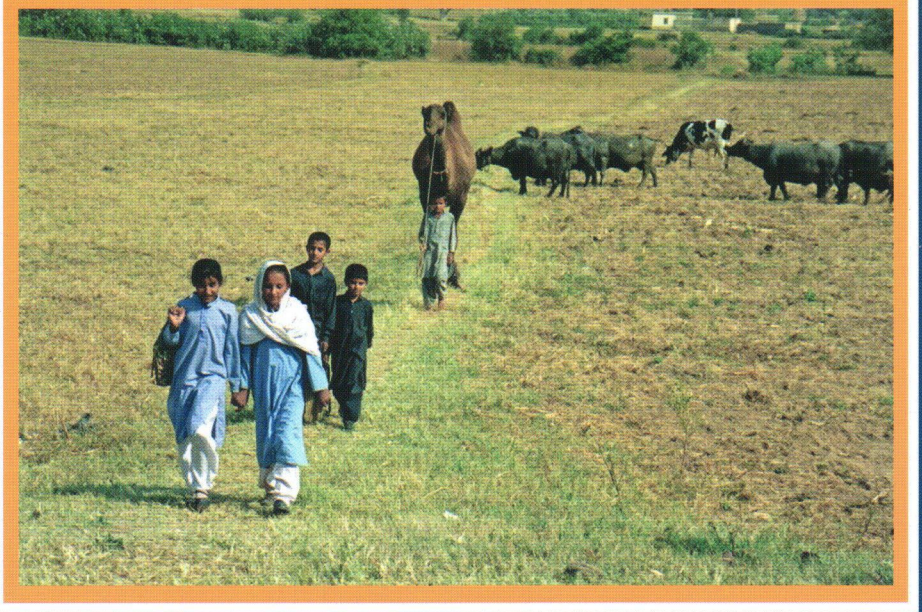

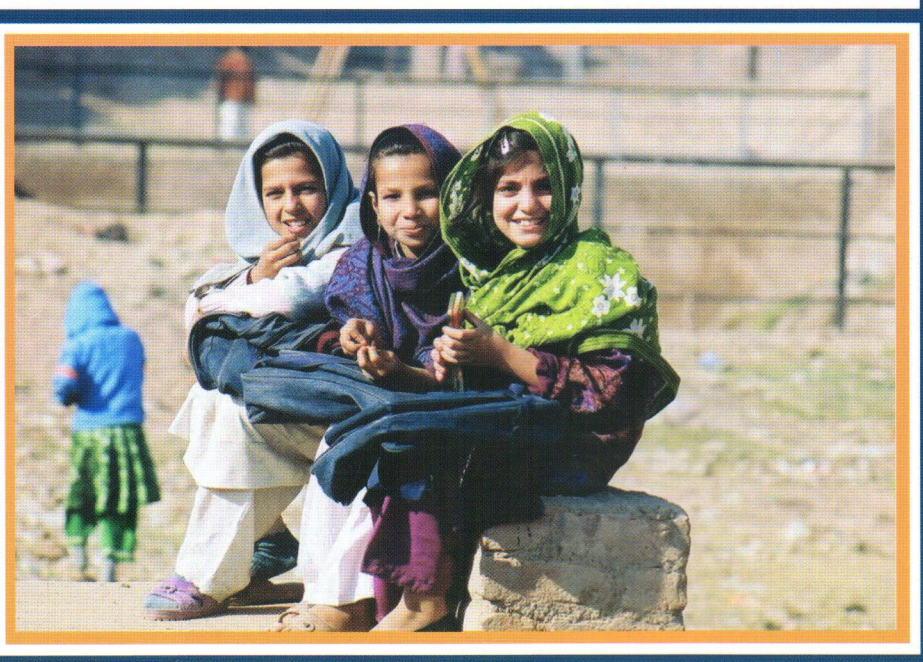

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Ministry of National Health Services, Regulations & Coordination