

**Reproductive Health, Family Planning,
Population and Development Situation in Bangladesh:
Background document for the Common Country Assessment**

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The Right to Survival

In developing countries such as Bangladesh, there are a number of factors that impact people's health status. On the demand side are income, assets, and social practices resulting from ethnicity or religion and lifestyle; and on the supply side are the health care system, health expenditure and other related issues. Environment and gender inequality also influence health status. These include, among others i) poverty, food security, food pricing and malnutrition; ii) environmental pollution and degradation; iii) reproductive health problems; iv) social development, especially literacy rates; and v) public health care delivery system. The poor in particular are trapped in the vicious cycle of malnutrition, low birth weight babies, malnourished adolescents, and malnourished pregnant mothers. Survival rights are make up a central core of the millennium goals.

Population Growth and Fertility Rates

Bangladesh has made significant strides in lowering its population growth rates. The current population is estimated at around 140 million. Extensive campaigns promoting smaller families has helped to lower the population growth from an average of 2.7 per cent in the 1970s to around 1.54 per cent today.ⁱ This reduction in population growth rates is tied in part to a significant decrease in the total fertility rate (TFR) from 6.3 in 1975 to 3.3 in 1997-99 to 3.32 in 2000, which compares favorably with South Asia and other developing countries.ⁱⁱ Nonetheless, population pressures continue to be a serious obstacle to poverty alleviation efforts and at today's growth rates, the population is predicted to reach around 180 million by 2020 and is only expected to stabilize at 250 million by 2060.ⁱⁱⁱ

Table 6: Population projection of Bangladesh using three scenarios - Base (pessimistic scenario), Intender (likely trend), and Quality (optimistic scenario): 2003 – 2015

Year	Total fertility rate			Total population		
	Base (pessimistic)	Intender (likely trend)	Quality (optimistic)	Base (pessimistic)	Intender (likely trend)	Quality (optimistic)
2003	3.59	3.01	2.58	140736195	138546161	137144234
2004	3.61	2.95	2.44	143931187	141054771	139176002
2005	3.62	2.89	2.31	147258330	143591424	141139933
2006	3.64	2.84	2.20	150703141	146140899	143029119
2007	3.65	2.81	2.14	154207468	148670593	144836147
2008	3.66	2.80	2.09	157740726	151187215	146580072
2009	3.67	2.79	2.05	161299474	153699940	148276082
2010	3.68	2.80	2.05	164877518	156214803	149936797
2011	3.70	2.81	2.04	168487763	158748445	151582390
2012	3.71	2.82	2.03	172119942	161286763	153199866
2013	3.72	2.82	2.01	175760909	163813825	154774661
2014	3.72	2.81	1.99	179392881	166310184	156289335
2015	3.73	2.82	1.98	183016794	168776521	157747176

Source: Compiled by the authors based on MOHFW (1996). "Strategic Directions for the Bangladesh National Family Planning Program 1995-2005", pp. 17, 24, 33.

There exist many population projection exercises for Bangladesh. One such project exercise conducted for the government of Bangladesh in 1995^{iv} merits consideration for two major reasons: (1) the projected population size for 2004 almost coincides the actual 2004 size, and (2) the projection exercise took into account the various scenarios based on the improved situation in the national family planning and RH program. Three projections were done for upto the year 2015: Base Projection, Intender Projection, and Quality Projection. The "Base Projection" indicates that the population of Bangladesh will reach more than 180 million in year 2015. The population can be lowered down to 169 million with "Intender Projection", and to 158 million with "Quality Projection".

While total fertility rates have been in decline over the last twenty years, this decline appears to have plateaued though further research is required to identify the exact causes. Since 1996 a gradual increase in TFR among poorer households has been observed. A number of factors that could explain this increase include low educational levels, continued son preference, high infant mortality, lack of

gender rights and the lack of alternative economic opportunities. Moreover, contraceptive prevalence rates, which currently stand at around 55 per cent will have to increase significantly to between 67 and 68 percent in order to reach replacement levels by 2006.^v

Population projection of Bangladesh using three scenarios: 2003 - 2015

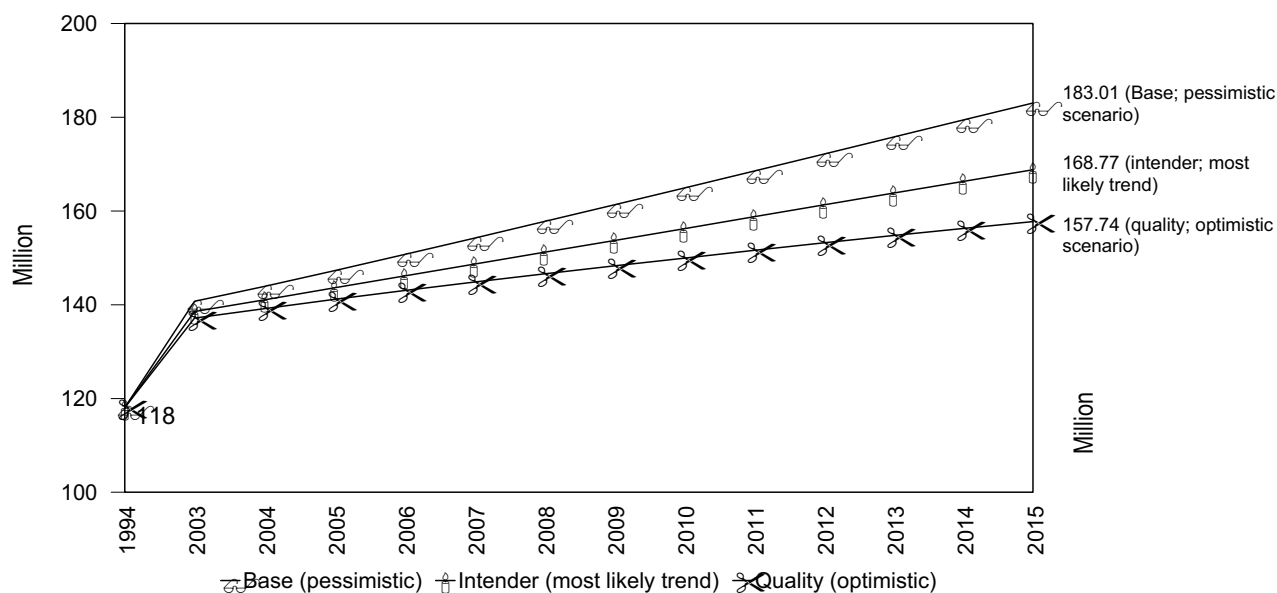


Table 7: Population size of Bangladesh under different assumption on NRR

Year	BBS		SMSHD Planning Commission		WB		UN Estimate	BANBEIS
	NRR by		NRR by		NRR by			
	2011	2016	2010	2015	2010	2010		
2000			129.2	129.2	132.4	129.1	129.3	132.7
2001	127.9	131.3						
2002								
2005			139.0	139.7	143.4	139.3	138.3	144.4
2006	136.0	141.1						
2007								
2010			147.23	149.6	153.4	149.8	145.1	156.1
2011	144.2	150.6						
2012								
2015			153.38	157.2	163.2	160.5	151.9	167.8

Source: BBS Analytical Report, 1994
M. Kabir et.al. Support for Monitoring Sustainable Human Development, January 1998
World Bank, World Population Projection, John Hopkins University Press, 1994-95

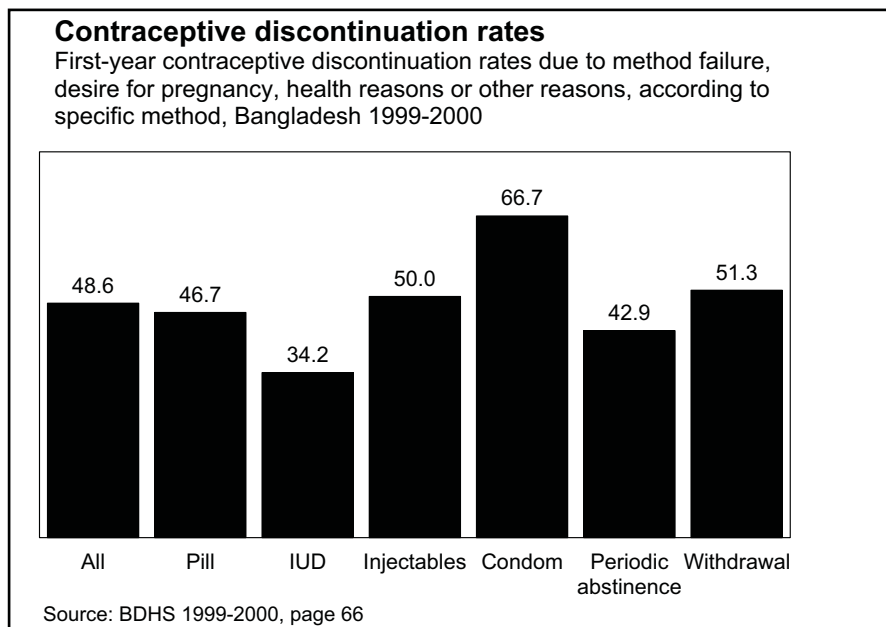
The TFR scenarios presented in Table 8 are adequately indicative of the population programme's impact on the population stabilization scenarios in Bangladesh.

Table 8: Total fertility rate scenarios to attain population stabilization by 2035, 2045, 2050

Time (Year)	1993	1996	1999	2002	2005	2008	2011	2015
Stable Pop by 2035	3.371	3.214	3.195	3.058	2.747	2.348	2.058	2.055
Stable Pop by 2045	3.371	3.214	3.195	3.131	3.039	2.947	2.852	2.723
Stable Pop by 2050	3.371	3.214	3.195	3.16	3.089	3.018	2.947	2.849

Despite the efforts of both the GOB and local NGOs, family planning services in Bangladesh remain inadequate. This in turn directly impacts on maternal mortality and morbidity rates, which are still very high. Some success has been achieved through the use of "doorstep" delivery methods to reach

uneducated and rural women, especially those from more conservative parts of the country. However, with a growing reliance on clinic-based services, it can be argued that the most marginalized members of society will be missed and method discontinuation (drop-out) rate will increase. Another important strategy to help reduce fertility rates over the medium and long term is to promote higher ages of first marriage for women and safe motherhood practices. Although the mean age of marriage for women is 18 (compared to 21 for men) many girls continue to be married at 15 years or less.



Rise of contraceptive prevalence rate (CPR) to 53.8 percent during 1999-2000 against 7.7 in 1975 is one of the greatest achievements of family planning since its inception. Although there has been a rise in modern methods, use of traditional methods has been reported to be high. Whereas 2.7 percent of the FP acceptors were using traditional methods in 1975, it rose to 10.3 percent in 2000. The use of modern methods was 43.4 percent in 2000, of which pill was the most popular method (23%), followed by injection (7.2%). There has been a fall in female sterilization (from 9.1% in 1991 to 6.7 % in 2000) including male sterilization (from 1.5 in 1985 to 0.5 in 2000). Increase in use of modern method appear to have slowed in the three years since 1996-1997 BDHS survey. Although overall contraceptive use has been increased by 9 percent between the last two BDHS surveys, it was largely due to the use of traditional methods, which increased by 34 percent (7.7 to 10.3 percent) among married women, and modern method increased by 4 percent (41.6 to 43.4 percent). The use of long-term methods are declining and short-term methods, especially the pill increasing, and the 'method mix' has changed over time. The pill now accounts for 43 percent of all contraceptive use, compared with 35 percent in 1991, and the share contributed by female sterilization has dropped from 23 percent in 1991 to 12 percent in 1999-2000.^{vi}

A wide range of difference has been observed among the administrative divisions regarding use of FP methods. While, it was highest in Khulna division (64 %), closely followed by Rajshahi and Dhaka Divisions, and only 34 percent in Barisal Division. Contraceptive use was higher in women having education. Younger cohorts of women show a tendency to use FP methods at an earlier age.^{vii}

One of the major concerns regarding the use FP methods is that, nearly 48.6 percent of the women who start using a contraceptive method discontinue within the first year. Contraceptive side-effects and health problems has been cited as the single major reason for discontinuation.

The most striking fact is that, in spite of the increasing trend of the Contraceptive Prevalence Rate during the last 10 years, the TFR is still stationary. Although the targeted TFR was 2.2, now it has been targeted to 2.8 by mid-2006 (HNPSP- PIP, March, 2004, MOHFW).

The major factors puzzle the phenomenon are:

1. Instead of a decline, there has been rather an increase in the TFR among the poorest: from 3.6 per women in 1996 to 4.2 in 2001 (Table 4). This increase in the TFR among the poorest is a major concern, at least for 2 reasons:
 - a) Poverty reduction itself is a national strategy for future development.
 - b) Other things remaining constant, the likelihood is high that the majority of the incremental population in Bangladesh will be poor.
2. Plateauing is evident in the face of substantial rise in CPR (and modern methods): CPR has increased to 54 percent in 1999-2000 from 40 percent in 1991.

A number of factors that could explain the plateauing in the TFR and increase of the same amount the poor segment include low educational levels, continued son preference, high infant mortality, lack of gender rights and the lack of alternative economic opportunities^{viii}.

Table 9 Trends in TFR by Economic Strata^{ix}

	Economic Quintiles				
	1 (Poor)	2	3	4	5 (Rich)
1993	3.8	3.6	3.6	3.3	2.9
1996	3.6	3.7	3.4	3.3	2.5
2000	4.1	3.5	3.3	2.9	2.5
2001	4.2	3.7	3.2	2.9	2.4

According to NIPORT Survey 2000, the limited participation of males in FP programme through use of condom is one of the causes behind this lack of success.^x The report suggests that in the intimate domain of a behavioral change it is very difficult to change behaviour regarding the number of children people should have, i.e. the gap between the desired and actual family size can be minimized through vigorous BCC efforts coupled with economic interventions.

Under the new Health, Nutrition and Population Sector Programme (HNPS, 2003-2006) government has taken a 3 years programme, where the health-FP workers are visiting home again for provision of FP, reproductive health and child health services. In this new programme the targeted TFR is 2.8 and CPR is 63 by the year 2006.^{xi}

Age Structure and Life Expectancy

The age structure of Bangladesh population (Figure 1) reflects the high levels of population growth mentioned earlier with 39 per cent or approximately 51 million citizens below the age of 15. About half of the population is young (10-24 years). In addition, there are approximately 32 million women in the childbearing age of 15-49 years, which suggests that in the absence of effective measures, population stabilization will be a too difficult objective to reach. There has, however, been a steady increase in life expectancy for both men and women. Until recently, the life expectancy rates for men were higher than for women (58.1:57.6 in 1996)^{xii}. However, for the first time, this has shifted marginally in favour of women 60.9:60.1, which brings Bangladesh into line with the vast majority of other countries. Nonetheless, due to a legacy of gender discrimination, the population still remains male biased with females making up just over 49.05 percent of the population.^{xiii} Overall, the male : female sex ratio in Bangladesh is 106.6, with 103.6 in rural areas and 117.2 in urban areas, which is in part due to male migration to urban areas in search of work. A large part of this migration is rural push migration due to entitlement contraction of the poor and marginalized peasantry in the rural areas.^{xiv} And this economic migration has resulted in an increase in the number of female-headed households (FHH) in rural Bangladesh currently estimated to be around 15 percent.

Table 10: Life Expectancy Rates

Time (Year)	1992	1995	1998	2001	2004	2007	2010	2015	Source
Urban Male	61.66	62.28	63.12	63.76	63.99	64.41	64.94	65.83	MDG
	61.66	62.28	64.34	69.91	70.03	70.27	70.55	71.04	BBS
Urban Female	60.79	61.35	62.12	62.70	62.90	63.28	63.75	64.56	MDG
	60.79	61.35	63.42	69.37	69.47	69.68	69.95	70.39	BBS
Rural Male	56.84	57.62	58.7	59.45	59.52	60.06	60.83	62.15	MDG
	56.84	57.62	60.23	67.41	67.44	67.75	68.18	68.92	BBS
Rural Female	55.57	56.33	57.39	58.10	58.24	58.77	59.53	60.82	MDG
	55.57	56.33	59.00	66.55	66.68	66.99	67.42	68.15	BBS

Source: Bangladesh MDG Report, UNDP 2004

Infant and Child Mortality

Infant and Child mortality are the two key indicators showing the level of care of mothers and children, health and nutrition status of children as well as the social, cultural, and economic progress of a country. The world governments have committed to reducing under-five mortality by two thirds by 2015 as part of the MDGs. Over the last decade Bangladesh has had one of the fastest rates of decrease in infant and child mortality in the developing world. Infant mortality has declined steadily from 92 per thousand live births in 1992 to 51 per thousand births in 2002. Similarly, under-five mortality rate (U5MR) has declined from 144 per thousand live births in 1990 to 77 in 2002.^{xv} There continue to be urban-rural differences in under-five mortality rates. In 2001, the rate in urban areas was 52 per thousand live births compared to 89 per thousand live births in rural areas. There is also a small difference in under-five mortality rates between boys and girls.

The majority of under-five deaths are due to three main causes: acute respiratory infections (21%), prenatal complications (29%), and diarrhea (8%). Neonatal mortality currently accounts for about two-thirds of infant deaths and almost half of under-five deaths and more than half of the neonatal deaths occur in the first week of life. Low birth weight, premature birth, and birth asphyxia make up two-thirds of all neo-natal deaths. Neonatal and perinatal causes contribute to 48 per cent of all U5MR in Bangladesh. Over 70 percent of all neonatal deaths are due to non-communicable diseases. A number of factors contribute to infant and child mortality, which include among others, the prevalence of early marriage, pressures to reproduce at an early age, high extent of maternal malnutrition. This is further aggravated by the limited access and use of medical facilities and trained medical practitioners during pregnancy and unhygienic living conditions, particularly in urban slums, that significantly increase the risk of water-borne and other diseases.

Although there was a steady decline in IMR and U5MR in general during last decades, a recent study had observed higher IMR and U5MR than the national average among poorest, second and middle economic quintiles.^{xvi}

Table 11: IMR and U5MR by Economic Strata

Indicator	Economic Quintiles					Average
	Poorest	Second	Middle	Fourth	Richest	
IMR	96.3	98.7	97.0	88.7	56.6	89.6
U5MR	141.1	146.9	135.2	122.3	76.0	127.8

Source: Gwathkin et.al., 2000.

In order for Bangladesh to continue to maintain its progress towards attaining the child and infant mortality goals set in the MDGs, a number of trends need to be sustained. This includes continuing to expand immunization coverage to reach marginalized population and consolidating and strengthening efforts to control diarrhoeal diseases and acute respiratory infections. Increased attention is also

required to further reduce neonatal mortality by ensuring that all pregnant mothers have access to antenatal care, skilled birth attendants, emergency obstetric care, and postnatal care.

Immunization Rates

Currently 63 per cent of children in Bangladesh aged 12 months and 74 percent between the ages of 12 and 23 months are fully immunized. Despite this improvement, it is estimated that approximately 1-1.5 million children remain unprotected with dropout rates of between 20 and 30 percent. In terms of the MDGs, measles immunization rates though increasing due to the concerted efforts to improve coverage, nonetheless remain low at just over 63 percent.

Immunization rates show disparities by sex and geographic location. Drop out rates for females in both rural and urban areas is on average five percentage points higher than for boys. Differences also exist between rural and urban dwellers with coverage rates for children under the age of one approaching 62 percent in rural areas compared to 72 percent in urban areas. A similar difference – 72 percent for rural areas compared to 83 percent for urban areas – also exist for those between the ages of 12 and 23 months. It should be noted, however, that coverage rates in urban slum, especially in Dhaka, is significantly lower than the city average. There are also significant geographical differences in coverage rates. In Sylhet, the rate is 57 percent compared to 68 percent for Khulna and Chittagong.

Table 12: Immunization Rates in Bangladesh

	Percentage of children immunized (under 12 months)				Percentage of children immunized (12-23 months)			
	BCG	OPV3 / DPT3	Measles	Fully Immunized	BCG	OPV3 / DPT3	Measles	Fully Immunized
1991	86	62	54	50	86	69	65	62
1992	86	62	60	53	89	74	68	65
1993	89	63	59	50	92	80	76	74
1994	95	74	71	62	96	88	86	84
1995	94	73	67	59	95	84	78	76
1997	88	66	59	51	90	77	69	67
1998	91	68	62	54	92	78	72	70
1999	94	66	61	52	95	82	73	72
2000	95	68	61	53	96	81	71	69
2001	94	66	64	52	94	83	76	75
2002	95	70	65	56	95	85	77	76
2003	95	72	69	63	95	83	75	74

This implies that there are significant access and outreach constraints to be addressed, which will require a concerted effort on the part of both the government and NGOs working to ensure that children from marginalized communities and in more remote areas are brought under immunization coverage. There exists direct correlation between immunization rates and proximity to health clinics: children who live more than 2 miles from a health facility are 30 percent less likely to be immunized.^{xvii} Similarly, children with mothers a secondary school education and above were 40 per cent more likely to be immunized.

Maternal Mortality and Morbidity

In contrast to the improvements in infant and child mortality rates, maternal mortality in Bangladesh remains very high. Maternal mortality in Bangladesh is often depicted as among the highest in the world. This view is based partly on estimates from various non-national, local area studies conducted during the 1970s and 1980-s, and partly on WHO estimate^{xviii} for Bangladesh in 1991, and WHO, UNICEF, UNFPA^{xix} estimate for 1995. These sources produced a range of estimates of maternal mortality ratio from 500 to 850 per 100,000 live births. The findings of the nationally representative Bangladesh Maternal Health Services and Maternal Mortality Survey (BMMS) show that maternal mortality ratio is still relatively high at 320 per 100,000 live births^{xx}

The high levels of maternal mortality reflect the fact that maternal health care in Bangladesh remains poor. Poor nutrition, poverty and a lack of access to health services contribute to some 15-20,000 maternal deaths each year.

According to the Bangladesh Maternal Mortality Survey 2001, only 20 per cent of mothers in the richest asset quintile have access to all three forms of maternal care - antenatal (ANC), delivery care (DC), and post-natal care (PNC)— while 70 per cent of the poorest asset-quintile do not have access to any maternal health care services at all.^{xxi}

The vast majority of deliveries (87.7%) take place at home and a skilled attendant is in attendance in less than 13 per cent of all cases.^{xxii} However, this masks the wide variations that exist among various groups. Thus while 40 percent of births in the highest income quintiles are attended by skilled health person, in the lowest quintiles the attendance is only four percent. This suggests the need to monitor indicators by different characteristics of poverty groups. Making motherhood safe requires action on three fronts simultaneously: (a) reducing the numbers of high-risk and unwanted pregnancies, (b) reducing the numbers of obstetric complications, (c) reducing fatality rates for women with complications.

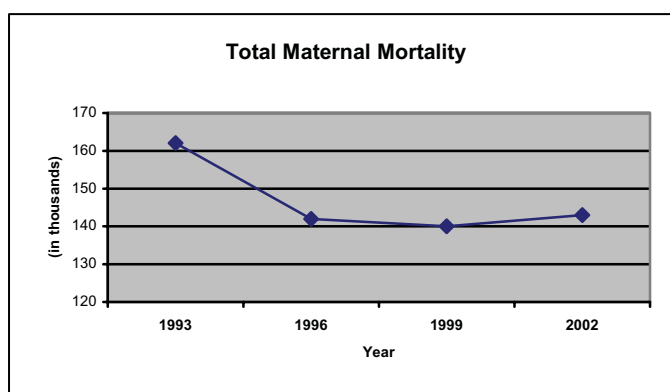
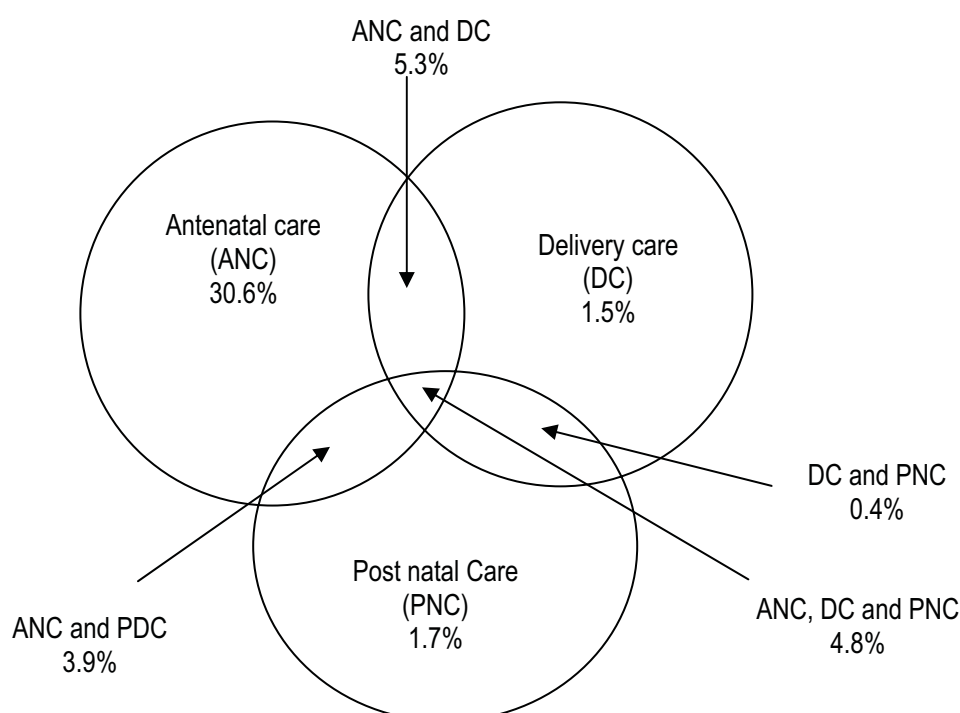


Figure 4: Situation of Maternal Care in Bangladesh¹³.



It is very important to note that, in case of 51.4 percent of births mothers received neither ANC nor DC nor PNC, and in only 4.8 percent cases they received all the cares (ANC, DC and PNC)¹³.

In Bangladesh, there are about 9 million women who have survived the regors of pregnancy and childbirth, but suffer from lasting complications such as fistula, uterine prolapse, inability to control urination and painful intercourse (source: WHO: Profile of RH in Bangladesh). These reproductive morbidities diminish women fertility, productivity and quality of life, as well as the health and survival of the next generation.

The global estimate is that, around 5 percent of the deliveries would be complicated to need a Cesarean Section. In Bangladesh, the proportion of births by Cesarean Section has been tripled from 0.7 percent in 1994 to 2.6 percent in 2001. Expenditures by women who sought facility – based care were substantially higher: 58 percent spent more than 1000 taka and 24 percent spent 5000 taka or more¹³. Although all the medical college hospitals, district hospitals, district level MCWCs, and a few of the Upzilla Health Complexes are providing Cesarean Section including other maternal health care services to meet 27 percent of the demand, it is expected that by the next five years it will be possible to meet 60 percent of the total demand of EOC^{xxiii}.

However, these measures might be insufficient to enable Bangladesh to meet the goal of reducing MMR to 140 by 2015 because of a number of demographic trends. A third of Bangladesh's population falls within the age group of 10-24 years. Nearly half the adolescent girls (15-19 years) are married, 57 percent become mothers before the age of 19, and half of all adolescent mothers are acutely malnourished. Thus MMR among adolescent mothers is 30-50 percent higher than the national rate. Absent concerted efforts to increase the age of marriage and changes in fertility and health seeking behaviour it is unlikely that MMR will decrease at the rates necessary to meet the MDG targets by 2015. Efforts to provide adolescent girls with greater access to higher education through scholarship and stipend programmes while proven to be effective, will nonetheless take several years to have a meaningful impact on fertility rates and by extension MMR rates.

Disease Prevalence

While there has been substantial progress in the prevention and control of communicable diseases, tuberculosis, malaria, childhood illness, complications associated with pregnancy and delivery and HIV/AIDS still pose considerable threats. The share of non-communicable diseases such as cancer, diabetes, cardiovascular diseases and injuries are expected to rise in the future from the present level of 40 per cent of the disease burden. In Bangladesh, major health problems include acute respiratory infections, TB and diarrhoea. The country has made steady progress in reducing mortality and morbidity rates for infectious diseases and Bangladesh aims to achieve a fifty per cent drop in incidence rates by 2015. It should also be noted that there has been an epidemiological transition of mortality patterns in Bangladesh. Due to the relative decline in deaths caused by infectious diseases, injuries and accidents are now becoming important causes of deaths: for example, 8 percent of all under-five deaths and 30 percent of total deaths among children aged 1-4 years have been found to be caused by injuries and accidents.

The malaria threat in Bangladesh is deepening in parts of the country although aggregate statistics suggest a progressive lowering of incidence rates over the last four years. While 13 of the 64 districts in the country are particularly affected, marginalized communities living in the remote hill tracts and adjacent districts of East and Northeast border of the country are most affected.^{xxiv} National mechanisms to combat malaria have been weakened due to insufficient resources, poor surveillance, rising drug resistance, prohibitive costs of insecticides, and poor community mobilization. Scaling up ITN program to provide coverage to 70 per cent of the high-risk population (14.7 million) particularly in the remote, poor and largely tribal families remains a big challenge. Additional investments will also be required to combat drug resistance problems and to institute Rapid Diagnostic Tests (RDT) and effective treatment strategies, as well as to increase the number of trained malaria experts in high-risk areas.

Bangladesh ranks four on the list of the 22 highest TB burden countries in the world. The estimated incidence of all cases and of new smear-positive cases is 233 and 105 per 100,000 respectively.^{xxv} About 70,000 patients are estimated to die of TB each year. Currently, only 30 to 50 per cent of those diagnosed with TB are adequately treated. Each uncured patient infects approximately 10 persons each year, increasing chances of infection. Without ensuring "directly observed treatment" (WHO Regional Office for South-East Asia 1999) and making services accessible for all patients, there is every reason to believe that the situation with regard to tuberculosis will in fact worsen with the emergence of multi-drug resistant TB and HIV/TB co-infection. Bangladesh is committed to achieve

the international targets of detection of 70 per cent of smear-positive patients and cure rates of 85 per cent by 2005. In order to gradually decrease TB incidence and prevalence these targets have to be maintained (or increased) after 2005.

Since 1997, the prevalence of night blindness, an early indicator of vitamin A deficiency, has been maintained below the one percent threshold that indicates a public health problem. This success has largely been due to the vitamin A supplementation programme, which increased coverage from 41 percent in 1993 to over 85 percent in the second half of the decade by linking the distribution of vitamin A capsules with the NIDs. Coverage of iodized salt increased from 19 percent in 1993 to 70 percent in 1999, and correspondingly, the prevalence of iodine deficiency fell from 69 percent to 43 percent. While these findings are encouraging, they mask the fact that infants and children continue to consume diets that are grossly inadequate in vitamin A, iron and other micro-nutrients.

In addition to these specific health challenges, the health system suffers from lack of funding and adequate management. Patients with access to health services in Bangladesh face many problems including doctor absenteeism, inadequate nursing services, lack of adequate diagnostic facilities, overcrowding, and lack of doctors' sensitivity to female patients.

HTD/HIV/AIDS

HIVAIDS rates are still low in Bangladesh but there is an emerging public health risk. The HIV rate among intravenous drug users (IDUs) in central Bangladesh is already four per cent and rising. Epidemiological data from other countries has shown that HIV rates of five per cent presage an emerging epidemic. In addition, research conducted by UNICEF reveals that all the conditions exist for HIV to spread from its concentration among IDUs. In particular, there are high incidences of risky sexual behaviour. Sex workers in Bangladesh have the highest number of partners in Asia. Consistent condom use is less than 2 per cent in Bangladesh with 90 per cent of hotel-based sex workers reporting that they do not use condoms. Lack of knowledge and information about HIV is also a major barrier to controlling the spread of the virus with 96 per cent of girls and 88 per cent of boys unable to name the basic means of transmission and protection. There are also other cultural barriers that preclude effective disease control including high incidences of men having sex with men.^{xxvi}

Till recently, 248 people (182 men and 35 women) have been found to be HIV positive. Most of these have contacted the disease from abroad. To date there are 48 cases of full-blown AIDS and 20 AIDS-related deaths.^{xxvii} In 1997, UNAIDS began to work with the government of Bangladesh to formulate a more coordinated surveillance plan.

HIV can easily spread to rest of the population if adequate preventive measures are not taken including use of condom during each sexual intercourse. Behavioral survey indicates that, the tradition of use of condom during sexual intercourse is almost absent in case of sex workers and thereby increases their risk of infection^{xxviii}.

Adolescent Reproductive Health (ARH)

In Bangladesh, according to the official statistics, adolescents are defined as those who fall in the age group 10-19 years. Bangladesh has a total adolescent population of about 31.5 million, who constitute 22.5 percent of the population (Population Census, 2001). The issues needing immediate attention, especially for the female adolescents are gender discrimination, education, employment, reproductive health, marriage and dowry, and nutrition. Gender discrimination in the form of discrimination against women has been identified as one of the prime issues of ARH in Bangladesh. This form of discrimination starts at birth and continues till death. The discrimination exists in the spheres of education, employment, marriage, dowry and even violence. Early marriage is customary for the female adolescents in Bangladesh. Almost all these marriages are arranged by their parents. Although the average age at first marriage is 18 years for the females and 21 years for the males, the divide is highly pronounced among adolescent girls in the rural areas. Dowry still remains at the core of marriage negotiations and a major cause of violence.^{xxix}

Adolescent mothers are more likely than women in their 20's to suffer pregnancy related complication and to die from childbirth. Mortality rates- neonatal, post neonatal, infant, child, under-five –all are higher for younger mothers. The infant mortality rate for children of mothers who are below 20 years is 103, whereas it is 79 for those with mothers age 30-39 years^{xiii,xxviii}.

Census 2001 reveals that 8.2 million boys and girls of primary school going age (49.69%) are enrolled in schools; of which 52.45% are boys. It further reveals that 49.56% of boys of the same age group are enrolled. The situation among the girls is slightly better (49.82% enrolled). A rural urban

differential in primary school enrollment among boys and girls has been observed (52.87% in urban and 48.49% in rural). In urban areas 52.63% of girls of primary school going age are enrolled, while in rural areas 49.16% are enrolled. Among boys 53.09% in urban and 48.75% in rural areas are enrolled in primary schools. It reveals that around 28.67% all of those who were enrolled during past five years had completed primary schools, of them 52.4% were girls. Of all who were enrolled in urban areas 30.07% had completed primary schools (47.35% girls), and 28.33 in rural areas (48.09% girls). It further shows that around 6.5 million boys and girls of secondary school going age have been enrolled, of whom 50.14% are girls. However 56.36% of girls and 61.69% boys of same age group remained out of secondary schools (Census 2001, National Report Provisional).

The Government of Bangladesh has identified adolescent health and education both as a priority and challenge, and in order to face the challenge, has incorporated this issue in the Health, Nutrition and Population Sector Program (HNPSPP).

Male Involvement in Family Planning

Although male involvement seem to be one of the cost-effective ways of promoting contraceptive level, it is still a neglected domain. Currently, a new non-scalpel method of vasectomy (NSV) makes it a very safe and easier procedure, but it could not be popularized due to lack of effective policy measures. Condom is now low cost, and the traditional methods– withdrawal and periodic abstinence are available without cost and side effects. However, for withdrawal, the first year failure rate is 18 percent among typical users, while periodic abstinence has a failure rate of 20 percent in the first year.^{xxx}

During the years of 1996 to 2000, the total CPR in Bangladesh rose from 49 to 54 percent. Interestingly, the increased use was more pronounced in case of male methods (19.3%), compared to female methods (6.2 %). Among the male methods, the traditional ones (withdrawal and periodic abstinence) shown an increase by 36.2 percent and condom increased only by 10 percent. On the other hand, vasectomy declined to a negligible figure^{vi}. Therefore, the promotion of the two modern male methods is highly significant from programme point of view.

Access to Health Services

Overall, Bangladesh spends approximately 1.2 per cent of GDP on health against a WHO target of 5 per cent; private expenditures make up around 2.6 per cent of GDP. Health expenditure per capita hovers around US \$47 and is barely adequate to meet expanding health demands in Bangladesh. Thus, despite the fact that the government spends about US \$5 on HNP services, patients still face private out-of-pocket expenditure to the tune of US\$7. This is in contrast to the WHO Commission on Macro Economics and Health (CMH) recommendation that least-developed countries spend on an average approximately US \$13 per person per year in total, with an optimum suggested expenditure of approximately US \$24 per capita per year, of which public sector outlays are US \$13. Overall 70 per cent of health expenditure in Bangladesh is out of pocket, with 50 per cent being spent on drugs and pharmaceuticals. Over the last three years, around 7 per cent of government spending goes to the health sector.

Ill health continues to be one of the most pervasive sources of vulnerability and distress among the poor in Bangladesh. A study conducted by the Bangladesh Institute of Development Studies (BIDS) in 2003 finds that the cost of treatment adversely affected other household consumption items: 68 per cent of those who sought in-patient treatment reported a direct impact on food consumption levels and 13 per cent experienced problems financing their children's education as a result of illness.^{xxxi} The study also shows that across all classes, 8.8 per cent of monthly household income was spent on illness treatment. Among the poorest households, health expenditures were disproportionately high with approximately 38 per cent of household income being spent on the treatment of illness compared to the richest households who spend only 3.4 per cent.

Table 12: Availability of Medical Facilities

Year	Hospitals			Hospital Beds			Doctors	Nurses	Midwives
	Govt.	Private	Total	Govt.	Private	Total			
1991	610	280	890	27,111	7,242	34,353	21,004	9,655	7,713
1996	645	288	933	29,502	8,025	37,527	27,425	13,830	11,200
2001	670	712	1,382	33,368	12,239	45,607	32,498	18,135	15,798

Source: BBS Statistical Pocketbook 2002 (2001 data) and Director-General of Health Services (Health Information Unit), Ministry of Health and Family Welfare.

The private sector provides the overwhelming majority of outpatient curative care especially among the poor, while the public sector serves the larger proportion of inpatient curative care, preventive and promotive care. To date there has been little effort to regulate or standardize the provision of private health services in an appropriate manner.

Data shows that most of the private hospital facilities are concentrated in urban areas and small in size in terms of hospital beds. However, private clinics show shorter stays and higher occupancy rates than public facilities of comparable size. This indicates a greater degree of resource efficiency in the private sector. Alternative Private Providers (APPs) continue to provide the majority of health care services in rural areas, but policy-makers have largely overlooked their role. There is, however, a lack of sensitivity to local needs in providing the correct service-mix. The majority of the APPs lack recognized formal education but their low fees make them an attractive alternative for the poor. The greater share of the income of APPs comes from selling medicines.

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- i This compared to growth rates of 1.8 for the whole of South Asia and 1.9 for developing countries
- ii Source: http://www.gobfinance.org/economic/chapter_12.pdf quoting BBS figures.
- iii It should be noted that this presumes that Bangladesh reaches the replacement level of fertility by 2010. A delay of ten years would see the population stabilize in 2085. Project Population Estimates, July 1995, Dhaka, Population Wing, Planning Commission quoted in background paper on Health, Ministry of Health and Family Welfare, April 2004.
- iv Strategic Directions for the Bangladesh National Family Planning Program 1995-2000, MOHFW (1996)
- v There is also evidence to suggest that contraceptive use tends to be highly irregular which further reduces its impact.
- vi Bangladesh Demographic and Health Survey 1999-2000.
- vii Ibid
- viii Population-Development-Fertility in Bangladesh: Little knowledge about a puzzle, A. Barkat, March, 2004.
- ix Ask UNFPA for source
- x Ibid
- xi PIP for HNPSP, March 2004, MOHFW, Government of Bangladesh.
- xii Bangladesh Human Development Report, BIDS, UNDP 1999.
- xiii WHO 2002.
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- xxi Cited in Sen and Hulme 2004
- xxii PRB 2001
- xxiii Cited in Sen and Hulme 2004
- xxiv Mahmood et al. 2000
- xxv WHO 2002
- xxvi The number of causes tested and found to be HIV/AIDS positive, are 248 people (182 men and 35 women) have been found to be HIV positive. The majority of these appear to have contracted the disease overseas but this pattern appears to be changing. To date there are 48 cases of full-blown AIDS and 20 AIDS-related deaths. Source: Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Bangladesh, UNAIDS-WHO-UNICEF, 2002 Update.
- xxvii Mahmood et al. 2000
- xxviii Barkat, Abul and Murtaza (2002). Position Paper on Health, Population and Family Planning, Planning Commission, GOB
- xxix Barkat A, SH Khan, M Majid, N Sabina (2000). Adolescent Sexual and Reproductive Health in Bangladesh: A Needs Assessment, Conducted for International Planned Parenthood Federation (IPPF) and Family Planning Association of Bangladesh (FPAB)
- xxx Citation for BIDS study
- xxxi Ibid.