The World Bank and the Bangladesh Population Program

Bangladesh is a demographic anomaly. Since 1970, the total fertility rate has fallen from more than 7 to about 5 and contraceptive prevalence has risen from 3 to 32 percent (1988). Yet the economic progress and social change usually thought to be needed for substantial reductions in fertility have not occurred.

Working as a donor, as a program leader and coordinator, and as a direct provider of technical assistance, the Bank has played a vital role in Bangladesh’s population program since its inception in 1971.

An OED review of the program and the Bank’s involvement* finds that the basic thrust of the Bank’s strategy in Bangladesh—to support the provision of convenient contraceptive care to the rural poor—has been sound. The program has clearly contributed substantially to the increase in family planning. Its experience shows that a supply-oriented approach can increase contraceptive practice and decrease fertility significantly even in highly unfavorable social, economic, and institutional circumstances.

Country characteristics

Bangladesh is among the poorest Asian countries. GNP per capita, now at $170, has grown very little since 1970 and is still among the lowest in the world (see box). Rural people—90 percent of the population—have seen increasing landlessness and economic dislocation. Underemployment remains high. The overall literacy rate is 30 percent; for women, it is only 22 percent. The social status of the vast majority of women, bound by the restrictions of a patriarchal, traditional society, has changed little since Independence.

Neither Bangladesh’s social and environmental conditions nor the structure of its public bureaucracy encourage the efficient implementation of programs for social and economic improvement requiring highly decentralized mechanisms.

Power in this largely rural society is very diffuse and often shifting. The physical environment makes implementation of all rural programs very difficult. Few of the country’s 66,000 villages are accessible by all-weather roads. Seasonal flooding of vast areas greatly complicates logistics and communications. And natural disasters call for periodic shifts in priority away from longer-term programs such as education or family planning.

The civil service is highly centralized and rigid, and staffed by poorly-paid and often poorly-motivated employees for whom it provides only a partial source of income.

The population program reflects these conditions in many ways. Begun in an atmosphere of impending demographic crisis, it is large, complex, multi-faceted, and centrally planned. Now staffed by tens of thousands, the program emphasizes the intensive provision of information through many channels at once; the use of outreach workers; and the widespread, ready availability of contraceptive devices and services at low cost.

What has been achieved?

Studies show that in Bangladesh the greatly expanded use of contraception has been the single largest contributor to the decline in fertility rates. Though the decline cannot be ascribed to the population program beyond a doubt, it does seem plausible that the program crystallized a latent demand for contraception.

* "The World Bank and Bangladesh’s Population Program," Report No. 9751, June 28, 1991. OED reports are available from the Internal Documents Unit and from Regional Information Services Centers.
Bangladesh: Socioeconomic and fertility indicators, 1965 and 1988

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<thead>
<tr>
<th></th>
<th>1965</th>
<th>1988</th>
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<tbody>
<tr>
<td>Infant mortality (per 1000 live births)</td>
<td>145</td>
<td>118</td>
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<tr>
<td>Life expectancy at birth:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Males</td>
<td>45</td>
<td>49 - 51</td>
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<tr>
<td>Females</td>
<td>44</td>
<td>52 - 54</td>
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<tr>
<td>GNP per capita ($US)</td>
<td>110 (1976)</td>
<td>170</td>
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<tr>
<td>Percentage of school-age population enrolled in secondary school:</td>
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<tr>
<td>Total</td>
<td>13</td>
<td>18 (1987)</td>
</tr>
<tr>
<td>Females</td>
<td>3</td>
<td>11 (1987)</td>
</tr>
<tr>
<td>Crude birth rate (per 1000 population)</td>
<td>47</td>
<td>40</td>
</tr>
<tr>
<td>Contraceptive use prevalence (%)</td>
<td>3 (1970)</td>
<td>32</td>
</tr>
<tr>
<td>Total fertility rate</td>
<td>7.2 (1970)</td>
<td>5.0</td>
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Sources: World Development Report, 1990
World Development Report, 1978
The World Bank and Bangladesh's Population Program, 1991

Key achievements of the program:

Basic clinic infrastructure: Small rural health and family planning clinics now blanket the country, serving as primary care facilities for clinical family planning, side-effect treatment, and basic health care, including basic maternal and child health services.

Outreach: About 19,500 female workers have been hired, trained, and equipped to deliver family planning services to couples in their homes. About 40 percent of all women of childbearing age are being visited by female village workers at least once quarterly.

Communication and information: A large mass media campaign, along with the information activities of the clinics and outreach workers, has made knowledge of contraception virtually universal in this largely illiterate society. By 1983, 99 percent of women knew about at least one method of contraception. Most women know about several modern methods, where to obtain them, and their costs.

Wide availability of contraceptive supplies, at low cost, from nonclinical sources: by 1989, almost 40 percent of couples practicing contraception were using supplies from commercial outlets, through a very successful social marketing project.

Sterilization services, offered free of charge in each of the 350 small subdistrict hospitals and every district hospital.

Involvement of NGOs, which provide an increasing proportion of contraceptive commodities and ancillary services. By 1990, 120 NGOs were collaborating with the government program in providing contraceptive services, reaching about 20 percent of users.

Ancillary health services, including the wide extension of child immunization (by 1991, more than 60 percent of children were immunized) and other health outreach services provided by paramedics.

How, in this setting?

Critical factors seem to be:

Government's determination: GOB proceeded publicly and rapidly, despite the political risks involved. It allocated a sizeable share of its budget and managerial talent to the program, supplemented by foreign assistance and advice. Since 1974/75, almost 6 percent of the government's development budget and 5 percent of its budget revenues have been devoted to family planning and health programs.

Size, extent, of foreign aid: About two-thirds of the necessary funds—much of it supplied as grants—has come from foreign assistance (see box). Considerable waste must have been involved in

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**Funding**

Bangladesh Population Projects: Funding Sources, 1975-1994

(US$ millions)

- **IDA Loans**
- **Cofinancers**
- **GOB**

(a) Budget at pre-appraisal

The Bank contributed through three projects, approved in 1975, 1979, and 1986. The first of these projects cost almost $46 million, of which IDA and cofinancers supplied more than $40 million. Each of the next two projects doubled in size. A fourth project, scheduled to start in 1992, may cost as much as $600 million, almost three fourths of which would be supplied by IDA and cofinancers.

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*June 1991*
trying to move as fast as the growth of funding implies. But the result was to force a pace of progress that otherwise would have been impossible, given the state of the economy and the size of the government budget. The aid community found a variety of ways to expand the government’s initially very limited capacity for population work. Within this community the Bank played a leading and catalytic role. Had it not done so, the confusion, inefficiency, and bottlenecks involved would have resulted in far fewer funds mobilized for the sector and substantially less progress.

**Matlab Pilot Project**

Before the favorable national trends in Bangladesh were established, a pilot project in the Matlab area showed that the significant latent demand measured there was real and that a high-quality service program adapted to local cultural characteristics could have significant effects. This was a carefully designed and monitored project mainly supported by USAID with technical support from the Population Council. It brought contraceptive prevalence up from very low levels to more than 50 percent in an area not much better off than the rest of Bangladesh in social, economic, or health terms.

It had two very important effects. By showing that such success was possible, it greatly strengthened the morale and commitment of Bangladeshis and donors alike. Second, it provided lessons for the national program, for example on the necessary density of field staff.

**Program structure, management**

Operationally, the program is still quite inefficient. The quality of services is often poor. Administratively, lines of authority within the program remain confused, supervision is weak, and morale among workers at many levels is low. The program management is overly centralized and decision making tends to be autocratic. Major changes in focus, content, and structure are promulgated without field trial or phased implementation and there is a preoccupation with rigid demographic goals, targets, administrative orders, and operational rules, irrespective of local conditions.

The focus of program staff is shifting to developing strategies to improve program efficiency and operational effectiveness. Ways have been established to encourage innovation and help solve problems. In addition, much needs to be done to improve the quality of care available through the network of clinics and via the ancillary health services.

The program’s comprehensive, multisectoral approach has often threatened to overwhelm the managerial, administrative, and coordinating capacities of the various government ministries that share responsibility for it. Though in principle the program has been multisectoral, in fact the bulk of its resources is allocated to the Ministry of Health and Family Welfare, and a truly effective interministerial coordinating body has yet to be established. Ministries and agencies outside the health sector have therefore not been effectively mobilized. Even within the Ministry of Health, there has been a failure to truly integrate the family planning agency with the Ministry’s primary health care delivery and other, related, functions. The program is remarkable for the relative success it has achieved in spite of these and many other inherent problems.

**Recommendations**

The following hold promise for projects and programs in settings with similar economic, social, and institutional constraints:

- Move in parallel, on both a national and a small scale, thereby building flexibility into the national approach (see box). In the Bangladesh program, fundamental structural problems arose as a result of implementing a complex, multi-faceted project from the beginning on a national scale. This

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led to institutionalized organizational problems which had to be addressed in subsequent projects.

- Rely heavily on proactive donors in settings where demand is fragile, administrative capacity is limited, and the absorptive capacity of government is limited as well. To work, this approach must be applied right from the start of program design and implementation, and it must have whole-hearted support from the government. In these circumstances, consider forming a donor consortium even before lending begins.

- Recognize that if the borrower's administrative structure is weak, intensive, close, day-to-day involvement by donor organizations may be needed for project success. In Bangladesh, Bank staff found innovative ways to get things done and work them through the system. To its credit, the Bank eventually accommodated itself to such different procedures.

- Provided there is sufficient latent demand, introduce a supply-oriented approach to initiate increased contraceptive practice, even in exceptionally unfavorable social, economic, and institutional circumstances. A key element seems to be trained and well-supervised workers who visit rural households on a regular basis and offer a range of reliable family planning services. Whether a strictly supply-side approach can sustain fertility decline to the replacement level is another question. It is likely that other programs that attempt to fundamentally alter demand for children—through education for women and greatly decreased infant mortality, for example—will eventually be required to complement this approach.

- Recognize that new projects based on supply-side principles are likely to take longer to prepare. They may involve pilot projects, and will certainly need more intensive staff and technical assistance inputs than the Bank usually provides.

The Bank's traditional approach to lending involves large projects and loans, standardized procedures, arms-length involvement in preparation, and intermittent supervision. Ways were found around these conventional modes, in part by using the flexibility provided by other donors. A sufficient number of well-qualified personnel concentrating on the country program, both in Washington and in the field, seems essential. If the Bank cannot use such approaches, it should consider allowing or encouraging other donors with grant funds and flexible procedures to take the lead in the early phases of program development, coming in with its own large, traditional projects only once the program begins to take shape.