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POPULATION CONTROL IN BANGLADESH-REVIEW OF POLICY AND IMPLEMENTATION: RECOMMENDATIONS FOR THE FUTURE

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INTRODUCTION

Population is considered an asset or human resources of a country. The quality of human resources of a country depends on the status of its population like quality of life, society, the educational system, individual health level, nutrition and skill. So, certain level of population size with proper skills, knowledge and innovation is an important driving force of effective resource mobilization, sustainable economic growth and social development in any country. When a country cannot provide basic human necessaries like food, clothing, education, medicine and shelter or housing of its population then it causes problem .So, excessive size of population of a country brings hindrance and a big obstacle for any poor and developing country like Bangladesh.

Bangladesh is the most densely populated country in the world, excluding city-states such as Singapore, Bahrain and the Vatican[1]. Its population density is 1015 per square kilometer and growth rate is 1.37% [2]. If the situation remains unchanged, then it will be an unmanageable condition as Bangladesh has not enough recourses to accommodate the existing enormous population growth. So, the population growth should be controlled giving the highest priority.

Population Policies - From the past

The cornerstone of the Constitution of Bangladesh is to develop the socio-economic development of its all citizens. As per provision of Articles 15,16,17 and 18 the Government of Bangladesh is mandated to ensure the fulfillment of basic needs of its citizens such as health, education, food and security. In order to translate these constitutional goals into reality , the Government of Bangladesh had undertaken a wide array of public policies. Accordingly in the First Five Year Plan (1973-1978) the Population Problem was considered the top most national problem. In the continuation of that concept, realizing the importance of population and development, the Government prepared a population policy outline in 1976 and had identified population problem as the national problem. Under that circumstances a population policy was formulated and approved by the then Government in 2004.

The main objective of the Population Policy 2004 was to achieve Net Reproductive Rate (NRR) =1 by 2010 so that the population can be stable by 2060. To fulfill the objectives of 6th Five Year Plan, Millennium Development Goals (MDG's), International

1. BDHS-2011
2. BBS-2011

Conference on Population and Developemnt (ICPD) in 1994 and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) it has become a crying need to implement the family planning programmes through co-ordination with other policies of the Government. So, considering the above, the Government of Bangladesh formulated the Bangladesh Population Policy-2012 Bangla. The English Version *(Bangladesh Janashankha Niti-2012)* of which is yet to publish.

Vision of the Population Policy-2012

To make Bangladesh a happy and prosperous country through controlling and developing its population in a planned way is the main vision of population policy 2012. The major objectives of the Bangladesh Population Policy-2012 are as follows:

- Increase Contraceptive Prevalence Rate (CPR) to 72% and reduce Total Fertility Rate (TFR) to 2.1 and attain Net Reproductive Rate (NRR)=1 by 2015.
- Ensure adequate availability and access of family planning and reproductive health services to all including information regarding contamination and spread of AIDS/HIV, awareness building and give emphasis on counseling and services for adolescents.
- Improve maternal health with emphasis on reduction of maternal and child mortality.
- Ensure gender equity and women's empowerment and to expedite the programme on gender discrimination in maternal and child health care acitivities
- Initiatives for mid-term and long-term programmes with an aim to translate the population explosion to population implosion involving the concern Ministries.

Of the Population Policy 2012

With an aim to ensure services to door step and to make it complimentary or reciprocal, the following strategies have been proposed in the policy:

- Ensure the delivery of services through the existing centers at District, Upazila, Union and Community level including Satellite and Community Clinic.
- Ensure delivery of services to the users through NGO and private individual.
- Maintenance of existing door step services to reproductive couples and ensure referral arrangement from the field level. Moreover, introduce e-reproductive services.
- On priority basis newly married couples, adolescents and the couples having one or two child should be bought under the services.

- Identify the unmet demand regarding health and family planning and ensure services accordingly.
- Ensure delivery services through educated and skilled workers.
- Services regarding HIV/AIDS and other contaminated sexual diseases should be ensured for all with emphasis to the vulnerable section of people and area also.
- Encourage to produce fruits and vegetables in and around homestead to fulfill the demand of Vitamin-A and to build awareness amongst the people to prevent deficiency of protein of child and pregnant women.
- Involve all women and child in vaccination programmes.
- Ensure delivery of services from union health and family planning centre round the clock. Impart training to all workers at the centers including Doctors, Family Welfare Visitors, Sub-Asstt. Community Medical Officer, Pharmacists, MLSS and Aya and to make them midwife as per demand
- Ensure supply of necessary medicine and equipments and make easy availability of family planning goods and services to all Government and Non-Government service centers and also ensure security there.
- Encourage all reproductive couples towards informed choice and voluntarism through motivation and ensure specialized reproductive health services in case of disaster and emergency.

Other Provisions of the Policy

Besides the above major provisions, Bangladesh Population Policy-2012 includes a few measures/ programmes/ activities. There are: Steps in communicating behavioral change, welfare programme to adolescent, women empowerment and gender equity, human resource development, legal arrangements, social welfare programmes, housing, sanitation and other environmental activities, planned urbanization, use of information/data through co-ordination, decentralization of administrative and financial power, production and supply of family planning materials, co-ordination with other policy and programmes, role of other concern ministries, NGOs and private individuals, organizational arrangements for implementing the policy etc.

The National Population Policy includes several policies and programmes for addressing the reproductive health and development needs of adolescents. It promotes the provision of reproductive health counseling and services to delay marriage , postpone birth for, at least two years and have adequate spacing between births and developing employment opportunities for young men and women.

CONCEPT OF FAMILY PLANNING AND HISTORICAL PERSPECTIVE OF BANGLADESH FAMILY PLANNING PROGRAMME

Concept of Family Planning

Family planning refers to a programme to regulate the number and spacing of children in a family through the practice of contraception or other method of birth control[3]. As per medical definition of family planning , it is a planning intended to determine the number and spacing of one's children through effective method of birth control[4]. Family planning also refers to uses of measures designed to regulate the number and spacing of children within the family, largely to curb population growth and ensure each family access to limited resources. The first attempts to offer family planning services began with private group and often aroused strong opposition. Activists such as Margaret Sanger in the U.S, Marie Stopes in England and Dhanvathis Roma Rau in India eventually succeeded in establishing clinics for family planning and health care. Today many countries have established national policies and encourage the use of public family planning services.

Historical Perspective of Bangladesh Family Planning Programmes

In historical perspective Bangladesh family planning programme evolved through a series of development phases that took place during the last 54 years. Family planning efforts in this country began in early 1950s with voluntary efforts of a group of social and medical workers. Categorical FP programme emerged during 1965-95 with the objective to control population growth as a strategy of economic development. The family planning program in Bangladesh has undergone a number of transitional phases. The phases of development may be illustrated as follows:

Phase-I: 1953-65: Voluntary and Semi-government Efforts

Family Planning Association initiated national family planning information, education, and communication campaigns in Bangladesh in 1953 as a voluntary effort. The effort was limited to the small scale contraceptive distribution services in urban areas particularly through hospitals and clinics. In 1960 the government sponsored clinic-based family planning activities under health services started.

Phase-ll: 1965-71: Field-based Government Family Planning Programme

The Government set up a target for providing family planning services to 6.7 % eligible couples and opened a family planning center in every hospital and rural dispensary. A massive field oriented family planning program was launched throughout the country as a priority program. Full time field staff and part-time village organizers

3. www.thefreedictionary.com
4. www.marriam-webster.com

were recruited and trained to provide motivation and service close to the door-steps of the rural people. Selected clinical and non-clinical methods offered. A multi-media communication campaign was implemented to increase awareness and knowledge about family planning for couples in urban and rural areas, union council chairmen, teachers, and religious leaders.

Phase-III: 1972-74: Integrated Health and Family Planning Programme

Administrative process for decision-making was shifted from the autonomous Family Planning Board and the Council to the Ministry of Health and Family Planning. Family planning services are functionally integrated with health services at the field level. Health and family planning activities was shared by both Health and Family Planning personnels. Oral pill was introduced in the family planning program as a method of contraception.

Phase-IV : 1975-80: Maternal and Child Health (MCH)-based Multi-sectoral Programme

In August 1975, a separate Directorate of Family Planning and an independent Division of Population Control and Family Planning in the Ministry of Health were created. The IEM unit was established under the Directorate of Family Planning to promote the concept of small family size and to generate demand for family planning and maternal and child health services.

Outline of National Population Policy was formulated in 1976.In the same year, full-time male and female field functionaries were recruited on regular basis to cause a thrust of the MCH-FP program in rural Bangladesh. Rapid population growth was declared as number one problem of the country. National Population Council, as the highest policy advisory body, constituted. Women were selected from their communities, hired FWAs and FPAs and trained to provide family planning counseling and non-clinical contraceptive services to couples in their homes.

Phase-V: 1980-85: Functionally Integrated Program

Delivery of MCH-FP services were functionally integrated with health at Upazila level and below. Upazila Family Planning Committee had been formed to be chaired by the Chairman of Upazila Parishad for facilitating implementation of the program at the local level. The programme focused on improving awareness about family planning methods and adoption of contraceptive methods.

Phase-VI: 1985-90: Intensive Family Planning Program

A broad-based multi-dimensional intensive MCH-based family planning program was launched. Improved family planning and MCH services involvement of community leaders were provided. Rapid FP-MCH infrastructural development by commissioning more service centers (UH and FWC) in rural areas was initiated. Unit-wise FWA registers were introduced for record keeping family planning and demographic events of households. Satellite clinic - an outreach activity – was introduced to deliver MCH-FP services in remote and rural areas.

Phase -VII: 1990-98: Reduction of Rapid Growth of Population Through Intensive Service Delivery and Community Participation

Focus has been given on expansion of MCH-FP service delivery with enhanced quality of care, increased resource allocation for program implementation, promoting family planning as an integral part of development activities through inter-sectoral collaboration, mobilizing community support and private sectors for supplementing and complementing government efforts, enhancing women's status through education and participation in social, economic and political life. Involvement of Non-Government Organizations was increased.

Phase-VIII: 1998-2003: Health and Population Sector Program (HPSP)

Health and population sector program was introduced in 1998. Population education was introduced into the school curriculum during this period. This program emphasized reproductive health, a multisectoral approach to family planning demand generation, accessibility of reproductive health services through satellite clinics, and family planning outreach services.

Phase-IX: 2003-2010: Health, Nutrition and Population Sector Program (HNPSP)

To overcome the multidimensional problems and to meet the challenge, the HNPSP was launched in 2003. The program entails provision of a package of essential and quality health care services responsive to the needs of the people. The goal was to achieve NRR-1 by the year 2016.

Phase X: 2011-2016: Health, Nutrition and Population Sector Development Program

The HPNSDP has been initiated by the Ministry of Health and Family Welfare for a period of five years (2011-2016) to be implemented through 32 Operational Plans (OPs). After HPSP 1998-2003 and HNPSP (2003-2011), the HPNSDP is the third sector programme prepared following the SWAP for overall improvement of health, population

and nutrition sub-sectors. The priority of the programme is to stimulate demand and improve access to and utilization of HPN services in order to reduce morbidity and mortality, particularly among infants, children and women; reduce population growth rate and improve nutritional status, especially of women and children. The vision is to see the people healthier, happier, and economically productive to make Bangladesh a middle-income country by 2021.

Contributions of GO/ NGOs and other organizations

There are as many as 205 NGOs as shown in the Table below, and are enlisted with the Directorate of Family Planning who are also contributing to population control and delivery of general primary health services at the respective City Corporation, Division, District and Upazila level.

Performance of Government and NGOs for Contraceptive Services.

Table- 1: Contraceptive Performance for the year 2011-2012

Method	Performance			Share of Contribution in %age	
	Govt.	NGOs	Total	Government	NGOs
Permanent Method (Male, Cases)	118182	49080	167262	70.7	29.3
Permanent Method (Female Cases)	125289	14995	140284	89.3	10.7
Permanent Method (Total, Cases)	243471	64075	307546	79.2	20.8
IUD (Cases)	233654	27994	261648	89.3	10.7
Implant (Cases)	195858	19874	215732	90.8	9.2
Injectable (Doses)	11207148	2646029	13853177	80.9	19.1
Oral Pill (Cycles)	92897563	16754955	109652518	84.7	15.3
Condom (Pieces)	90433552	40235406	130668958	69.2	30.8

Source: Directorate of Family Planning, Dhaka.

Sources of Family Planning Methods

The sources of family planning methods are classified into four major categories such as: public-sector sources (including Government hospitals, Upazila health complexes, family welfare centers, satellite/EPI clinics, maternal and child welfare centers and government field workers), NGO-sector sources (including static clinics, satellite clinics, depot holders and field workers), private medical sources (including private hospitals and clinics, qualified or traditional doctors and pharmacies) and other private sources (including shops and friends or relatives).

Delivery of Services in Menstrual Regulation (MR)

The delivery of services in Menstrual Regulation (MR) of ever married woman age 15-19 in use of modern contraceptive methods. In this respect Government contributes 44 %, Private Sector 32 % where NGO 9 % and other 3 % (missing 10 % and don't know 2 %).

Source of Modern Contraceptive Method

The %age of current users of modern methods where public sector remains the predominant source by 52 % and 38 % of modern contraceptive users get their supplies from a private medical source, Non-government sectors supply contraceptives to 4 % and other source 5 % respectively.

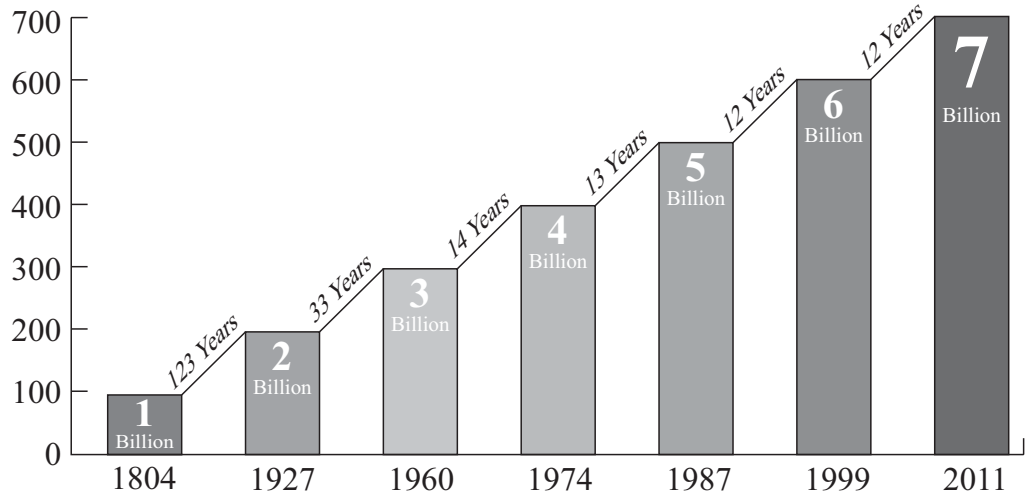
The 2011, BDHS says that there are differences by specific method in the source used. The public sector is the predominant source for sterilizations. IUDs, implants and injectables. The Upazila health complex accounts for the largest share of sterilizations and important for delivering injectables (now that they are authorized to dispense them). Their share in the provision of injectables increased from 8 % in 2007 to 24 % in 2011. Pharmacies are the predominant source for pills and condoms. The government fieldworker is also an important source for pills.

DEMOGRAPHIC SCENARIOS IN BANGLADESH COMPARE TO SOME RICH AND POOR COUNTRIES

Population Growth - World Context

The world's population grew from one billion to seven billion from 1804 to 2011, in slightly more than 200 years. Interestingly, at the beginning of the 20th century, the world had 1.6 billion people, whereas at the closing of it, the figure was just reversed to 6.1 billion. Currently, about 83 million people are being added to the planet annually, 1.2 % per year. According to median projection of the UN Population Division, the world population will reach 8 billion in 2025, 9 billion in 2043 and 10 billion in 2083.

Figure 1 : Trends in World Population Growth



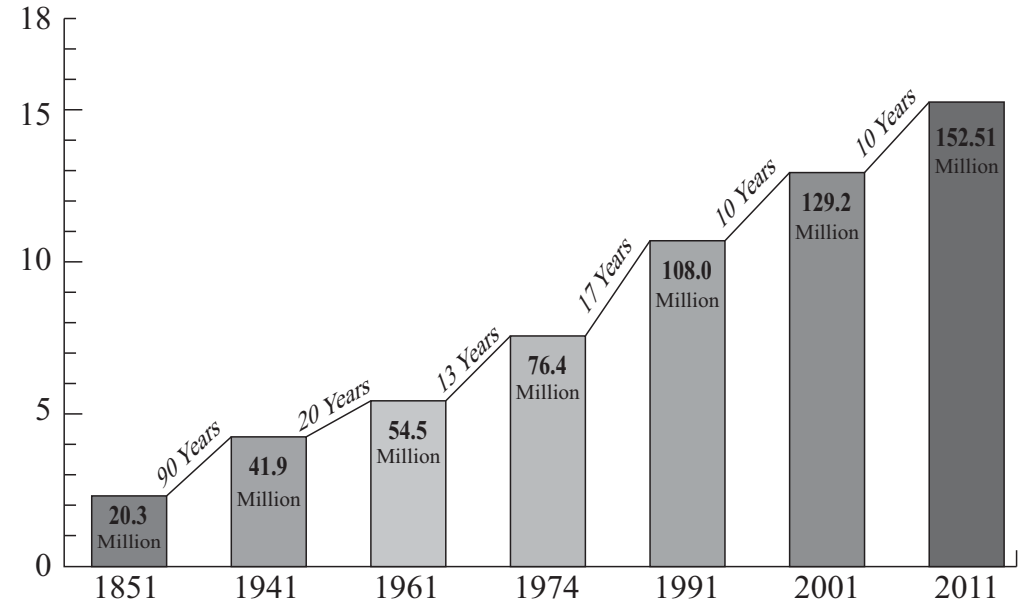
Source : The world-wide web virtual library: Demography & Population Studies, WPD Report-2011, UNFPA

Globally, people are living longer and healthier lives, and couples are choosing to have fewer children. But huge inequalities in health and demographic indicators persist and daunting challenges lie ahead. While many richer countries are concerned about low fertility and ageing, many poorer nations struggle to meet the needs of rapidly growing populations. And more people than ever before are vulnerable to food insecurity, water shortages and climate-related disasters. Whether we can live together on a healthy planet depends on the 'policy and funding decisions' we make now about 'family planning, maternal and child health care, girl's education and expanded opportunities for women and young people.'

Population Growth - Bangladesh Context

Bangladesh has experienced a high population growth from 1960 to 1990s, but due to the success of family planning programmes, the level of total fertility rate has declined rapidly. Current TFR is 2.3 and further decline is expected to reach replacement level fertility by 2015. Nevertheless, Bangladesh's population will grow by 60 million over the next 40 years which will eventually stabilize at around 230 million by 2050, a 50% increase of today's population.

Figure 2 : Population Growth- Bangladesh Context



Source : BBS 1994, 2003, 2009, *Bangladesh Population and Housing Census 2011 (Revised)

Trends in Overall Contraceptive Prevalence Rate-CPR (1975-2011)

The contraceptive prevalence rate for married women (10-49) in Bangladesh has increased from 7.7% in 1975 to 61.2% in 2011 irrespective of their socio-economic status. Use of modern methods also increased from 5.0% in 1975 to 52.1% in 2011, a ten times increase in last three decades.

Trends in Use of Method wise CPR

Table 1: Trend of Contraceptive Prevalence Rate (CPR) of Family Planning in Bangladesh

Name of Methods	1993-94 (BDHS)	1999-00 (BDHS)	2007 (BDHS)	2010 (UESD)	2011 (BDHS)
Any Method	44.6	53.8	55.8	61.7	61.2
Modern Method	36.2	43.4	47.5	54.1	52.1
Traditional Method	8.4	10.3	8.3	7.6	9.2
Modern Method:					
Oral Pill	17.4	23.0	28.5	29.7	27.2
Condom	3.0	4.3	4.5	4.4	5.5
Injectable	4.5	7.2	7.0	12.5	11.2
IUD	2.2	1.2	0.9	0.9	0.7
Implant	0	0.5	0.7	1.4	1.1
Tubectomy	8.1	6.7	5.0	4.6	5.0
NSV	1.1	0.5	0.7	0.6	1.2

Source: BDHS-1993-94, 99-00, 2007, 2010, 2011

The method-wise family planning performance has changed over the past two decades. The contraceptive prevalance rate increased to 61.2% in 2011 from 44.6% in 1994 while the permanent method users decreased to 6.2% in 2011 from 9.2% in 1994. During the last 18 years (1993/94-2011) the users of modern FP methods increased to 52.1% from 36.2% and the traditional method users also increased to 9.2% from 8.4% (BDHS-2011).

Trends in Total Fertility Rate- (1971-2011)

In Bangladesh, the decline in Total Fertility Rate (TFR) since 1975 has been sharp and consistent with a rise in contraceptive use. The CPR increased from 7.7% in 1975 to 61.2% in 2011 and TFR decreased from 6.3 in 1975 to 2.3 in 2011 in last three decades (BDHS 2011). There was a rapid decline by nearly two children per woman between mid 1980s and early 1990s, a plateau at around 3.3 births per woman for most of the 1990s, followed by another noteworthy decline during the current decade. TFR varies widely by administrative divisions. Four of seven administrative divisions including Rangpur have reached replacement level fertility or below. Sylhet division has the highest fertility (3.1) followed by Chittagong Division (2.8). As per BDHS 2011, the TFR for rural women is higher (2.5) than that of urban women (2.0).

Child Mortality

In Bangladesh, infant mortality rate has significantly declined from 150 (per 1000 LB) in 1975 to 43 in 2011 (BDHS 2011). One in 19 children born in Bangladesh dies before reaching the fifth birth day. During infancy, the risk of dying in the first month of life (32 per 1000 LB) is three times greater than in the subsequent 11 months (10 per 1000 LB). The Millennium Countdown Report-Countdown to 2015 (UNICEF 2008) places Bangladesh among only 16 countries in the world that are on track to achieve MDG 4 for under five mortality target of 48 (per 1000 LB) by 2015. One of the major challenges in achieving MDG 4 is the slow progress in preventing neonatal deaths which account for 60% of all under-5 deaths.

KEY CHALLENGES FOR CONTROLLING POPULATION GROWTH, MAJOR INTERVENTIONS TAKEN THE GOVT. AND MAJOR SUCCESS IN FP-MCH PROGRAMMES

Key Challenges for Controlling Population Growth

The key challenges are: Over population of 152.51 million (BPandH Census 2011-Revised), sharp regional variation of TFR (Sylhet-3.1, Khulna-1.9), unmet need still high (11.7%) for family planning services, high discontinuation rate (35.7) of contraceptive methods (condom-47%, pill-39%, injectables-36.1%, IUD-22.4%), low male participation in contraceptive use- 6.7% (NSV-1.2%; condom-5.5%), maternal mortality still high (1.94/1000 LB, BMMS 2010), childhood mortality is still high (neonatal-32; infant-43 and under five mortality 53 per 1000 LB), early marriage and early child bearing, reaching replacement level of fertility in Sylhet and Chittagong, high adolescent (15-19) fertility rate (118 per 1000 women), largest segment of population (19.9%) in reproductive age (15-24 yrs), (BDHS 2007), field worker and couple ratio is 1:1200-1500 or more reaching out population in hard to reach areas such as coastal belt, hilly, char (islet) and haor (fenland) areas, contraceptive insecurity due to lengthy and complex procurement process and dependency on foreign procurement, gender inequality and son preference (BDHS 2011).

Major Interventions Undertaken by the Directorate of Family Planning Under the Ministry of Health and Family Planning

The major interventions are: The National Communication Strategy for Family Planning and Reproductive Health, November, 2008 and Bangladesh Population Policy-2012 (Bangladesh Janasangkha Niti-2012) has been published in Bengali and the English version is under place as reported by DGFP officials, recruited more than 10,000 staff filling the vacant positions (FWAs, FWVs and other Staff), Favorable policies and strategies: a) National Population Policy (2012); b) National Communication

Strategy for FP-RH (2008); c) ARH Strategy (2006); d) Maternal Health Strategy (2006); e) Reproductive Health Commodity Security- RHCS Strategy (2010) are in place, introduced client-segmented service delivery, undertaken strategic IEC and BCC interventions nationwide targeting media-dark populations, adolescents, newly-wed couples, pregnant mothers, their husbands and in-laws including community gatekeepers, given special focus on LAPM (long acting and permanent methods), commenced six months 'midwifery training' for FWVs, providing FP-MCH services through satellite clinics (30,000 per month), providing primary health care services including FP-MCH services through more than 13,000 community clinics, providing FP-MCH services at door-step level by 23,500 FWAs (Family Welfare Assistants), Introduced 24 hours normal delivery services at 500 UHandFWCs (one for each Upazila) throughout the country, undertaken extensive IEC activities which include installation of billboards, advertisements in national dailies and private TV channels, production and airing of TV spots, drama serials, short-films, TV scrolling on private TV channels.

Major Success in FP-MCH Programmes

The major success in Fp-MCH programe are: Bangladesh received MDG award in 2010 for being on track to achieve MDG 4, population growth rate declined from 2.61% in 1974 to 1.37% in 2011 (BPandH Census 2011-Revised), CPR increased from 7.7% in 1975 (BDHS 2007) to 61.2% in 2011, TFR declined from 6.3 in 1971-75 (BDHS 2007) to 2.3 in 2011, contraceptives drop-out rate has been reduced from 49% in 2004 to 35.7% in 2011, unmet need for family planning services declined from 17.6 in 2007 to 11.7% in 2011, neonatal mortality rate (0-30 days) came down from 52 (per 1000 LB) in 1994 to 32 in 2011, infant mortality rate (0-1 yr.) came down from 87 (per 1000 LB) in 1994 to 43 in 2011, under-five mortality rate has declined from 133 (per 1000 LB) in 1994 to 53 (per 1000 LB) in 2011, maternal mortality rate also declined from 3.2 in 2001 to 1.94 in 2010 (BMMS 2010), life expectancy at birth increased from 56.1 in 1991 to 66.9 in 2009 (BBS 2010), delivery by trained providers increased from 16% in 2004 to 32% in 2011, facility deliveries increased from 12% in 2004 to 29% in 2011, complete maternity care (ANC, delivery care and PNC) increased from 5% in 2001 to 19% in 2010 (BMMS 2010), exclusive breast feeding increased from 46% in 1993-94 to 63.5% in 2011, EPI coverage increased from 81.9% in 2007 to 82.5% in 2011, The level of stunting (height-for-age/ <5 children) has declined from 51% in 2004 to 41% in 2011, The level of underweight (weight-for-age/ <5 children) has declined from 43% in 2004 to 36% in 2011 (BDHS 2011).

RECOMMENDATIONS

On the basis of the discussion made earlier, to reduce the population growth rate Bangladesh may adapt the following recommendations :

- The policy admits the necessity to build national consensus and synergy among public and private institutions, civil society and non-government organizations. So, involving all the sectors more realistic programmes and strategies should be chalked out and implemented accordingly to reduce the population growth from 1.37 to less than 1 by 2015.
- Some provisions of reward and punishment rules for the family planning workers and practitioners should be incorporated in the Population Policy-2012 to get more effective result in population control.
- Under the "Legal Arrangement" of the Policy, Government may introduce the provision for marriage license and mandatory training on birth control methods before getting marriage license to encourage late marriage, to have children later and keep sufficient gap between the birth of two children.
- Government may amend the present provision of age of marriage and increase the minimum age of marriage from 18 and 20 years to 21 and 23 years for the female and male respectively.
- As the largest reproductive segment of population (15-24) constitutes about 20 % of the total population and the adolescent (15-19) fertility rate in Bangladesh is 118 per 1000 women which has not decreased significantly for decades, the Directorate of Family Planning may take pragmatic steps to educate and impart proper training to this section of people with an aim to aware them more, the impact of population explosion.
- Directorate of Family Planning may improve efficiency of level of its filed workers by developing the standard of union health and family planning centers.
- Government may recruit appropriate number of family planning workers at the field level for extensive home visit to provide services at the grass root level.

CONCLUSION

It is depicted from the figures and data collected for the study that Bangladesh population growth has a serious socio-economic and environmental consequences which ultimately affect the governance in many forms and shades. Population growth is contributing to poverty and as such poverty, equity and GDP triangle must be synergistically designed with population, education and environment. The Government of Bangladesh , realizing the effects of overpopulation , undertaken several family planning programmes and other measures for population control. In spite of all those initiatives and measures total population of the country is increasing alarmingly each

year. Present size of population, age structure and characteristic of the adolescents are mostly responsible for this consequences. Under this circumstances, a desirable situation of demographic transition can reduce population growth more rapidly and minimize the future impact of population momentum in Bangladesh.

The government of Bangladesh has formulated Bangladesh Population Policy-2012 with a series of objectives to control population growth. But only any public policy through resource mobilization and allocation cannot do much in determining which way things should move unless the government plans to combat overpopulation though a sustainable population policy. Observing population day is a reminder to all the citizens thinking rationally at the level of awareness with the global policy community reaffirming its commitment to sustainable level of population growth. There can hardly be any argument with the fact that swelling population threatens to put at risk all implementation strategies of development in the substantive areas of public policy. Even a high budgetary allocation against any policy moves for a change can hardly be implemented in a country with a rising population. Family planning in Bangladesh needs to be strengthened as a movement involving Government, NGO, other related stakeholders, large number of rural and urban women as activists. A desirable situation of demographic transition may be created through educating the people, enhancing women empowerment, employment generation, poverty reduction and overall socio-economic development.

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