

IUSSP DEBATE: 21 September 2026

**Since Cairo 1994, too little attention has been
paid to rapid population growth?**

YES or NO?

Yes

Mohammad Mainul Islam
University of Dhaka, Bangladesh

ARGUMENT 1:

The demographic-development community has not given sufficient policy attention to the continuing consequences of rapid population growth in high-fertility countries, especially in Sub-Saharan Africa and parts of Western Asia.

- **Socioeconomic Strain:** In parts of Sub-Saharan Africa and Western Asia, rapid population growth continues to outpace infrastructure, public education, job creation, and healthcare capacity, trapping communities in poverty cycles.

- **The issue is not: “The International Conference on Population and Development (ICPD) in Cairo, 1994 ignored population growth.”**

- ☐ Rather, **our argument is: “After Cairo, the international development discourse have underweighted the macro-level consequences of persistent rapid population growth in high-fertility countries.”** Population growth itself sometimes received less political and policy attention than other dimensions of the Cairo agenda.

- ☐ Our debate statement can be interpreted as **“too little attention relative to the magnitude and consequences of the problem”, not that population growth was completely neglected.**

Top 10 Countries of Population in the World

Rank	1994	2026	2050
1	China (1209)	India (1476.6)	India (1679.6)
2	India (941.2)	China (1412.9)	China (1260.3)
3	United States of America (265.5)	United States of America (349.0)	United States of America (380.8)
4	Indonesia (196.6)	Indonesia (287.9)	Pakistan (371.9)
5	Brazil (159.3)	Pakistan (259.3)	Nigeria (359.2)
6	Russia (148.2)	Nigeria (242.4)	Indonesia (320.7)
7	Pakistan (130.7)	Brazil (213.6)	Ethiopia (225.0)
8	Japan (125.3)	Bangladesh (177.8)	Democratic Republic of the Congo (218.2)
9	Bangladesh (120.3)	Russia (143.4)	Brazil (217.5)
10	Nigeria (107.9)	Ethiopia (138.9)	Bangladesh (214.7)

ARGUMENT 2 :

Paradigm shift & less priority on family planning at different stakeholder levels, although the ICPD PoA argues in favor of Family Planning for their respective country settings!



- ICPD 1994= *Paradigm shift in population and development interrelationships*
- Investing in **individual human rights, capabilities and dignity**-across multiple sectors and through life course-is the foundation of **SUSTAINABLE DEVELOPMENT**

Chapter

- I. Preamble
- II. Principles
- III. Interrelationships between Population, Sustained Economic Growth, Sustainable Development and Environment
- IV. Gender Equality, Equity and Empowerment of Women
- V. Family, It's Roles, Rights, Composition and Structure
- VI. **Population Growth and Structure**
- VII. Reproductive Rights and Reproductive Health
- VIII. Health, Morbidity and Mortality
- IX. Population Distribution, Urbanization and Migration
- X. International Migration
- XI. Population, Development and Education
- XII. Technology, Development and Research
- XIII. National Action
- XIV. International Cooperation
- XV. Partnership with Non-government Sector
- XVI. Follow-Up to the Conference

Actions

6.4. Countries should give greater attention to the importance of population trends for development. Countries that have not completed their demographic transition should take effective steps in this regard within the context of their social and economic development and with full respect of human rights. Countries that have concluded the demographic transition should take necessary steps to optimize their demographic trends within the context of their social and economic development. These steps include economic development and poverty alleviation, especially in rural areas, improvement of women's status, ensuring of universal access to

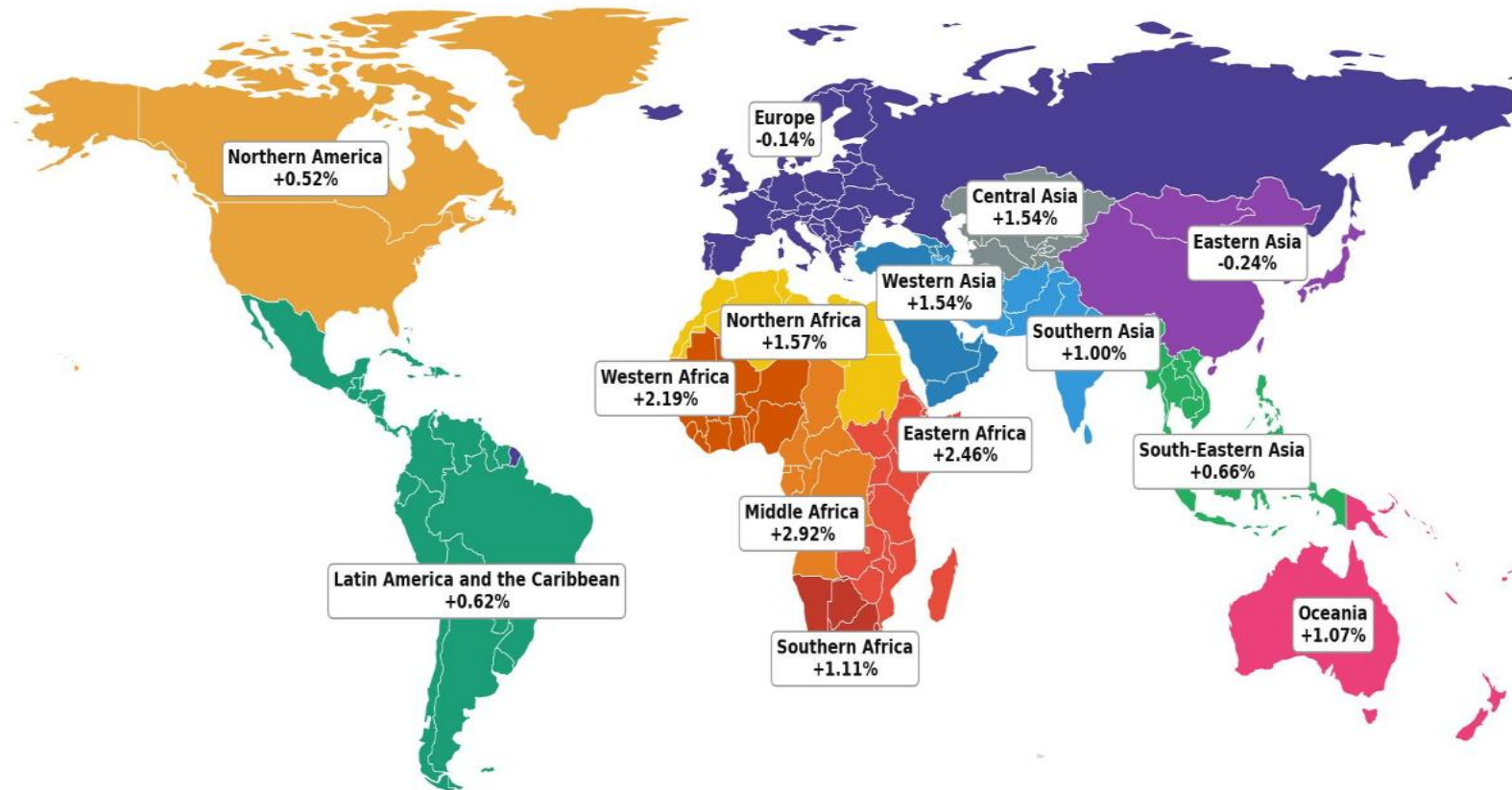
quality primary education and primary health care, including reproductive health and family-planning services, and educational strategies regarding responsible parenthood and sexual education. Countries should mobilize all sectors of society in these efforts, including non-governmental organizations, local community groups and the private sector.

6.5. In attempting to address population growth concerns, countries should recognize the interrelationships between fertility and mortality levels and aim to reduce high levels of infant, child and maternal mortality so as to lessen the need for high fertility and reduce the occurrence of high-risk births.

- African regions consistently concentrated the highest growth rates where Middle Africa peaked near at 4.5% in 1994 and stays above 2% in 2050.

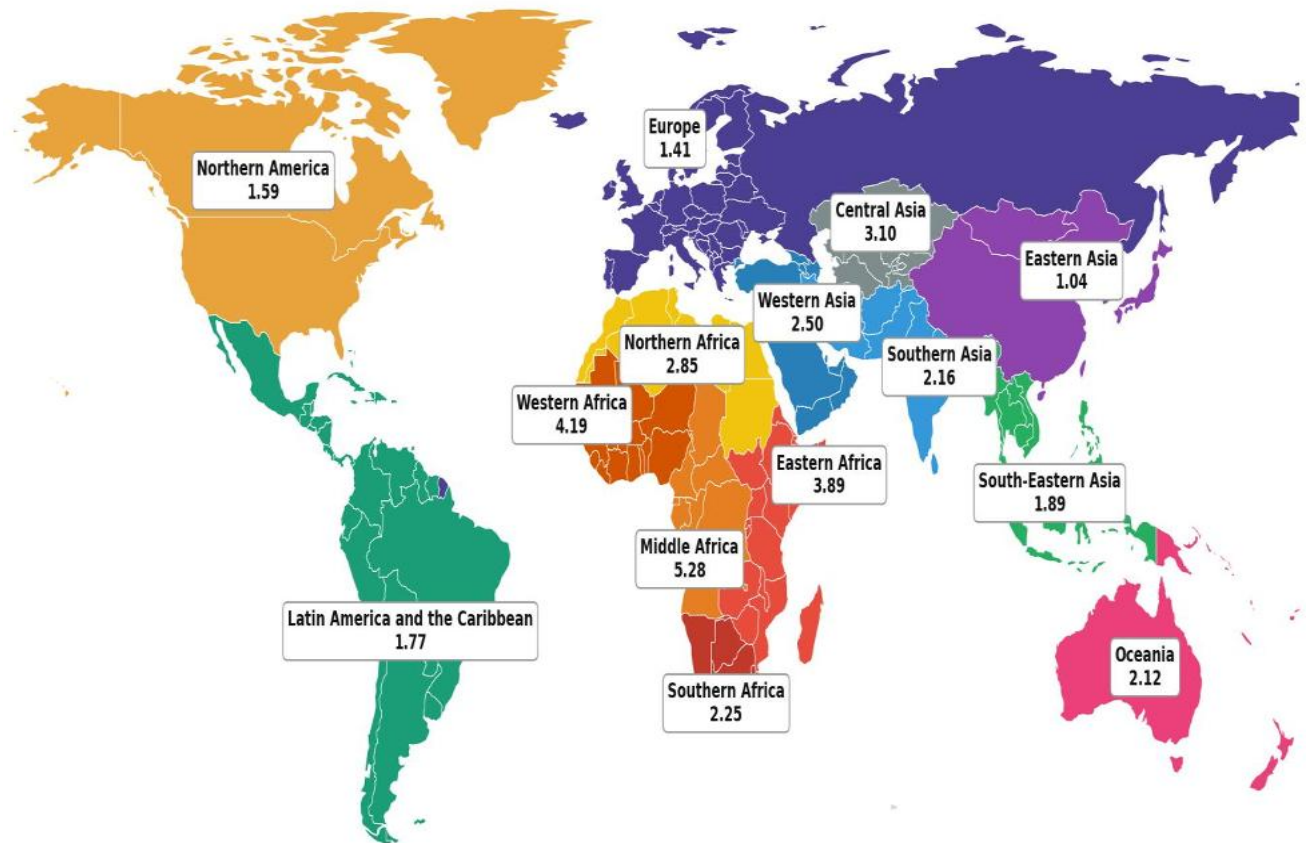
- Even if growth rates fall everywhere (demographic transition), African regions and Western Asia remain slowing growth than other regions.

World Population Growth Rate by Region, 2026



Sources: World Population Prospects 2024

World Total Fertility Rate by Region, 2026



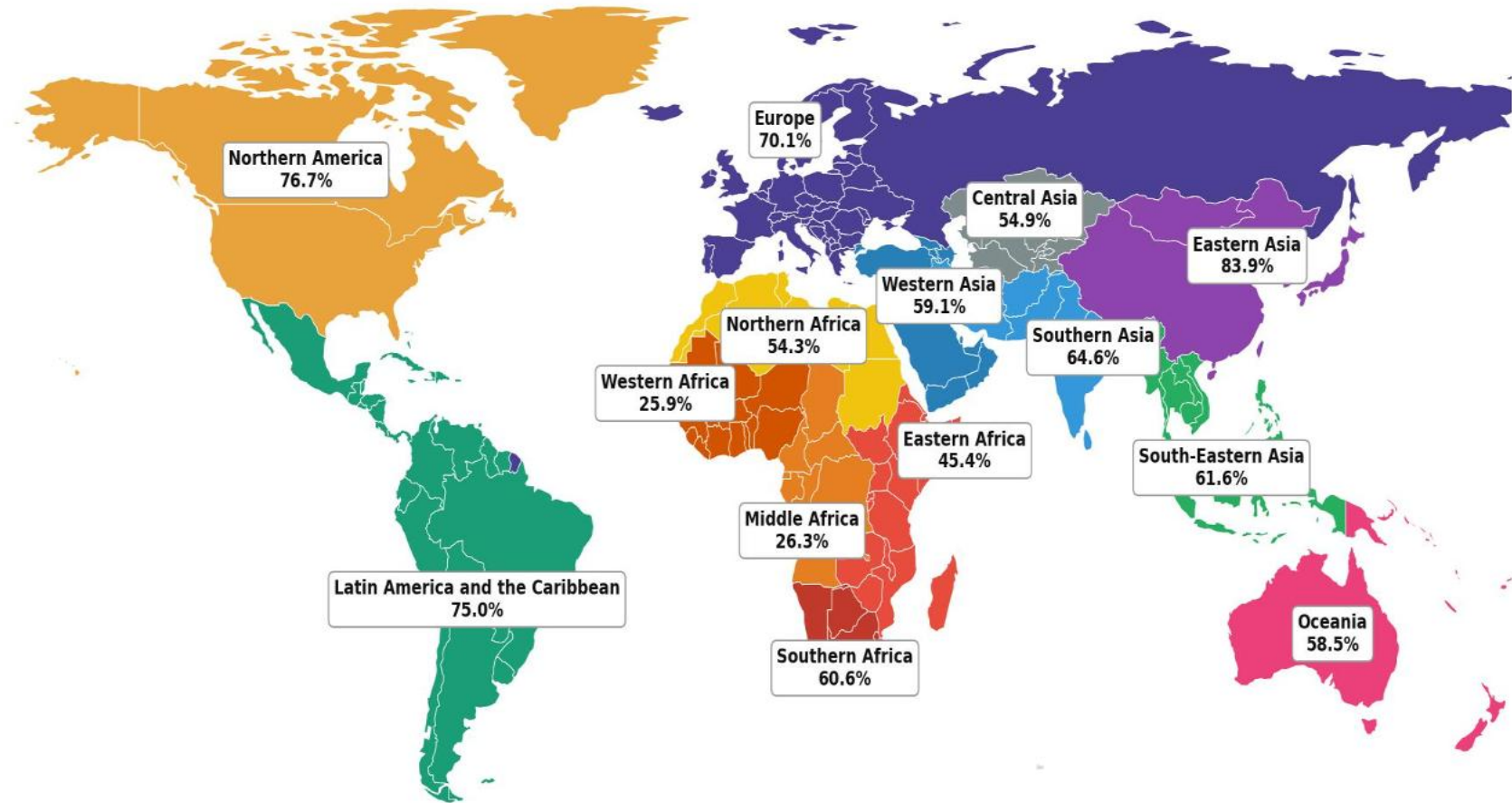
Sources: World Population Prospects 2024

Top 10 Countries of Total Fertility Rate (TFR) in the World

Rank	1994	2026	2050
1	Yemen (7.80)	Chad (5.84)	Chad (3.85)
2	Niger (7.79)	Somalia (5.80)	Democratic Republic of the Congo (3.66)
3	Afghanistan (7.77)	Democratic Republic of the Congo (5.80)	Somalia (3.60)
4	Somalia (7.54)	Niger (5.64)	Mali (3.37)
5	South Sudan (7.35)	Mali (5.33)	Central African Republic (3.36)
6	Chad (7.31)	Angola (4.89)	Angola (3.24)
7	Burundi (7.23)	Burundi (4.57)	Tanzania (3.23)
8	Mali (7.12)	Afghanistan (4.56)	Niger (3.22)
9	Ethiopia (7.05)	Mozambique (4.54)	Mauritania (3.14)
10	Angola (6.99)	Mauritania (4.48)	Afghanistan (3.09)

World Contraceptive Prevalence Rate by Region, 2026

Contraceptive access has improved everywhere but lower in African regions, especially in Western Africa and Middle Africa CPR was just 9.9% and 14% in 1994, reaching at 25.9% and 26.3% by 2026.



Top 10 Countries With Highest Unmet Need for Family Planning (%)

Rank	1994	2026	2030
1	Haiti (44.4)	Angola (33.9)	Angola (32.5)
2	Yemen (39.0)	Haiti (31.4)	Equatorial Guinea (29.6)
3	Rwanda (37.8)	Equatorial Guinea (30.4)	Haiti (29.3)
4	Ghana (37.5)	Mauritania (29.9)	Mauritania (28.9)
5	Togo (36.7)	Liberia (29.8)	South Sudan (28.9)
6	Ethiopia (36.1)	South Sudan (29.1)	Liberia (27.7)
7	Angola (35.1)	Benin (28.7)	Eritrea (27.4)
8	Malawi (35.1)	Togo (28.4)	Benin (27.3)
9	Eswatini (34.9)	Gabon (28.1)	Gabon (27.0)
10	Lesotho (34.5)	Eritrea (28.0)	Togo (26.8)

Top 10 Countries of Lowest Contraceptive Prevalence Rate (CPR) in the World (%)

Rank	1994	2026	2030
1	Angola	Chad (9.1)	Chad (10.3)
2	Comoros	South Sudan (9.2)	South Sudan (10.9)
3	Equatorial Guinea	Somalia (11.0)	Somalia (12.8)
4	Haiti	Niger (15.4)	Niger (17.5)
5	Mauritania	Eritrea (15.6)	Eritrea (18.3)
6	South Sudan	Guinea (15.9)	Guinea (18.7)
7	Liberia	Mauritania (17.2)	Mauritania (19.8)
8	Eritrea	Comoros (17.7)	Comoros (20.1)
9	Benin	Sudan (18.4)	Sudan (20.8)
10	Gabon	Angola (19.3)	Angola (21.4)

Top 10 Countries of Highest Child Marriage in the World

Rank	1994	2025
1	Bangladesh (88) 1994*	Niger (76) 2012
2	Niger (80) 1992	Central African Republic (61) 2019
3	Chad (70) 1994	Chad (61) 2019
4	Guinea (62) 1993	South Sudan (52) 2010
5	Central African Republic (54) 1994	Burkina Faso (51) 2015
6	Mali (54) 1999	Mali (49) 2024
7	Somalia (50) 1991	Mozambique (48) 2023
8	Mozambique (48) 1999	Bangladesh (47) 2025
9	Burkina Faso (46) 1995	Guinea (47) 2018
10	South Sudan (39) 1995	Somalia (45) 2006

Sources: UNFPA Database 2025

* BDHS 1993-94

Top 10 Countries of Highest Adolescents Fertility Rate in the World

Rank	1994	2024
1	Niger (204.4)	Central African Republic (161.3)
2	Chad (193.3)	Equatorial Guinea (152.9)
3	Equatorial Guinea (188.7)	Mozambique (151.9)
4	Uganda (181.6)	Niger (141.6)
5	Mali (174.2)	Angola (139.4)
6	Sierra Leone (163.3)	Mali (135.9)
7	Bangladesh (163.3)	Chad (132.1)
8	Ethiopia (162.0)	Madagascar (128.7)
9	Mozambique (159.4)	Liberia (124.7)
10	South Sudan (159.0)	Guinea (116.8)

Sources: World Development Indicators 2025

To reduce adolescent fertility, focus on women education, rural areas and addressing poverty as well as strengthening family planning are needed.



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Data Availability Statement: Data are available from the <https://dhsprogram.com/data> Institutional Data Access. From this website we downloaded datasets for Standard DHS type (SPSS file format) of Bangladesh for the survey years 2004, 2007, 2010, 2014.

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RESEARCH ARTICLE

Adolescent motherhood in Bangladesh: Trends and determinants

Mohammad Mainul Islam^{*}, Md. Kamrul Islam, Mohammad Sazzad Hasan, Mohammad Bellal Hossain

Department of Population Sciences, University of Dhaka, Dhaka, Bangladesh

^{*} mainul@du.ac.bd

Abstract

Background

While studies on fertility and contraceptives issues are available, until recently adolescent motherhood has not received enough attention among policy makers in understanding adolescent motherhood in Bangladesh. We aimed to examine the trends and determinants of adolescent motherhood among women aged 15–49 years.

Methods

For trend analysis we used all the 7 waves of Bangladesh Demographic and Health Survey (BDHS, 1993–2014) data but for multivariate analysis 4 waves of BDHS (2004–2014). Two separate analyses were carried out on ever married women aged 15–49: (1) teenage girls aged 15–19 and (2) adult women aged 20 and above.

Results

The prevalence of adolescent motherhood had declined to a slower pace from 1993 to 2014 (from 33.0% to 30.8%). Lower spousal age gap and higher education were found to be associated with lower likelihood of adolescent motherhood both among teenage girls [OR 0.447 (0.374–0.533)] and adult women [OR 0.451 (0.420–0.484)]. Teenage girls in the poorest wealth quintile [OR 1.712 (1.350–2.173)] were more likely to experience adolescent motherhood than the richest wealth quintile. Teenage girls who had no education were found to have 2.76 times higher odds of adolescent motherhood than their counterparts who had higher than secondary education. Concerning the time effect, the odds of adolescent motherhood among adult women was found to decline overtime.

Conclusions

Despite substantial decrease in total fertility rate in Bangladesh adolescent motherhood is still highly prevalent though declining from 1993 to 2014. Social policies including those addressing poverty, ensuring greater emphasis on education for women; and adolescent mothers in rural areas are needed.

Argument 3: Emphasis on Family Planning Can Bring Success

(Examples from Bangladesh and Pakistan)

Comparison the Demographic Trends of Bangladesh and Pakistan from 1971 to 2050

Year									
 Bangladesh					 Pakistan				
	Population (in million)	Growth rate (%)	TFR	CPR (%)		Population (in million)	Growth rate (%)	TFR	CPR
1971	70.28	1.70 ¹	6.83	6.0		61.85	2.63	6.80	4.8
1974	75.84	2.68	6.78	7.9		67.41	2.96	6.81	4.5
1993	118.13	1.82	3.83	42.9		127.02	2.97	6.11	13.6
2026	177.82	1.19	2.4*	58.2*		259.30	1.59	3.44	42.3

- Bangladesh and Pakistan started nearly similar total population, growth rate, TFR and CPR in 1970s. Although Bangladesh had high population in starting, but between 1993 to 2026 which shifted and Pakistan Population becomes double (**From 127.02 to 259.30 millions**) .
- The TFR of Bangladesh decreased after the 1970s due to family planning program, but Pakistan TFR reduction between 1971 to 1993 appeared no improvement. Pakistan Slower demographic transition indicates the gap of attention on family planning and population growth despite both countries started almost same conditions.

Sources: World Population Prospects 2024
* MICS 2025
¹ World Development Indicators data, 1971

**Argument 4: When the Program on Family
Planning Become Weak- the Demographic
Outcomes Raise Concerns**
(Example from Bangladesh)

AN OUTLINE



GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH
POPULATION CONTROL & FAMILY PLANNING DIVISION
JUNE, 1976



বাংলাদেশ জনসংখ্যা নীতি-২০১২

স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়
গণপ্রজাতন্ত্রী বাংলাদেশ সরকার

II. BASIC STRATEGY

Population Control and Family Planning is needed not only to reduce the growth rate and stabilize population size consistent with available resources of the country, but also to:

- (ii) regulate family size to ensure better health for women and children, higher standard of living and welfare of the family, and
- (b) reduce the burden of larger families and thereby release time and energies of women and youth for increased production and greater strength of the nation rather than diverting all their efforts into only building larger families.

From this point of view population control and family planning programme is an integral component of total social mobilization and national development efforts.

Historically, demographic transition leading to stable rate of population growth has taken place almost in no society without a high level of socio-economic development, such as per capita income of \$500-700, substantial urbanization, literacy and modernization. Therefore, with the present socio-economic condition, below subsistence level of average income, scanty urbanization, low level of literacy and traditional way of life, Bangladesh will have to follow a deliberate policy of population control with supportive legal, administrative and economic measures combined with the policy of close involvement of the community in order to bring rate for reaching the demographic goal.

The counselling efforts in a few communities such as the Swamian villages of Hutan Dugang and Kajang in Rungtun and integrated Family Planning project in Rongka (Chittagong) and Salla (Sybel) resulted in reduced population growth rates in the range of zero to 1.5 per cent within a period of about 2 years. This was made possible through community mobilization for socio-economic development, sanction for smaller family and intensive service delivery with particular emphasis on non-clinical (pills and condoms) and traditional (herb, *ashab*, breast-feeding and late marriage) methods. This model of population control development, as our society, by its own people is similar to the experiences in rural China. The above experiences possibly show as the guidelines for formulating an appropriate strategy for population control in Bangladesh.

3

Under the above approach of integrated socio-economic development and family planning with close involvement of local community, the Zero Population Growth project in 20 unions in 5 districts and intensive Family Planning Programme in 325 selected Samwari villages have recently been launched.

The approach to family planning programme in Bangladesh has so far been largely clinic-oriented (intra-uterine device control) programme. With limited clinical facilities and medical manpower the programme could not make much headway. There is now an urgent need for total reorientation of the strategy making population control and family planning programme an integral part of social mobilization and national development efforts with emphasis both on clinical methods, such as sterilization, IUD, M.R. injectables and non-clinical and traditional methods, such as pills, condoms, AZL, rhythm, breast-feeding, late marriage and abstinence.

III. POLICY MEASURES

In fact, past the Family Planning Programme suffered from many weaknesses. The presence of a unimpressive population policy, lack of a national policy on population, inadequate supervision, training and full time village level workers, inadequate incentives, training and financial incentives to workers, isolation of Family Planning Programme from, and little coordination with other development agencies, non involvement of the community and absence of a legal and institutional framework. Some of these problems have been partially resolved. Still there are many problems blocking the way for efficient implementation of the programme. Some of these are part of the general difficulties common to all sectors, while others are due to the rather complex nature of the problem itself. Now that the Government's commitment to the Family Planning Programme and the population and systems set up and a population policy framework work has been worked out, various problems should be resolved systematically in the course of programme implementation.

The targets of 2.51% growth rate in 1978, 2% in 1980 and replacement level by 1985 may sound too ambitious but they are within the realm of possibility. It will require an appropriate strategy, massive organisational, financial, technical and community support as well as a legal framework for the realisation of the rather optimistic programme objectives.

A. Organization

Discussion

The organisation with a separate Division and a Directorate with its field offices and village-level full time workers is well conceived.

- ୭ । କୃପକଣ୍ଠ:

বাংলাদেশের জনসংখ্যাকে পরিকল্পিতভাবে উন্নয়ন ও নিয়ন্ত্রণের মাধ্যমে সুস্থ, সুখী ও সমৃদ্ধশালী
বাংলাদেশ গড়ে তেলে।

- 8। উদ্দেশ্যসমূহ:

- ৪.১। পরিবার পরিকল্পনা পদ্ধতির ব্যবহার ৭২%-এ উন্নীত করে মোট প্রজনন হার (TFR) ২.১-এ হ্রাস করা এবং ২০১৫ সালের মধ্যে নীট প্রজনন হার ১ (NRR=1) অর্জন করা;

- ৪.২। পরিবার পরিকল্পনাসহ প্রজনন স্বাস্থ্যসেবা সহজলভ্য করে সকল দম্পতীর কাছে পদ্ধতি প্রাপ্য নিশ্চিত করা এবং দরিদ্র ও বিশেষ-কিশোরীদের মধ্যে পরিবার পরিকল্পনা, প্রজনন স্বাস্থ্য, প্রজননসহায়ক সক্রমণ ও এইচআইভ/এইডস বিষয়ে সচেতনতা বৃদ্ধি এবং কাউন্সেলিং সেবাকে প্রাধান্য দেয়া;

- ৪.৩। মাতৃমৃত্যু ও শিশুমৃত্যুর হার হ্রাস করা এবং নিরাপদ মাতৃত্ব নিশ্চিত করে মা ও শিশুসহ
টানত করার পদক্ষেপ গ্রহণ করা;

১৮৮ ২৭৭৭

পরিবার কল্যাণ সহায়না সনদপত্র
 স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
 স্বাস্থ্য ও পরিবার কল্যাণ সহায়না
 জনসংখ্যা অধিশাখা

নথি নং-৫৯.০০.০০০০.১১৫.০২৯.০০৪.২০১৮/ ১৮৮

তারিখ: ১৪/০৭/২০১৮খ্রি

বিষয়: "হেলে হোক, ঘরে হোক, দু'টি সন্তানই যথেষ্ট" প্রোগ্রাম কার্যবাহারের প্রস্তাবনা।

সূত্র: পপস/জাইডএম/প্রোগ্রাম পরিবর্তন/২০১৮/২০১৯/২০১৮ তারিখ: ১৮/০৭/২০১৮খ্রি।

উপর্যুক্ত বিষয় ও সূত্রে স্বাক্ষরকার পরিস্থিতিতে জানানো যাচ্ছে যে, জাতীয় জনসংখ্যা পরিষদের নির্ধারিত কমিটিসহ সবার কার্যবিবরণীর সিদ্ধান্ত ৪.২ অনুযায়ী বর্তমান প্রোগ্রাম "দু'টি সন্তানই যথেষ্ট" বোঝা একটি হলে ভাল হয়। এর পরিবর্তন করে প্রোগ্রাম অর্থাৎ "হেলে হোক, ঘরে হোক, দু'টি সন্তানই যথেষ্ট" কার্যবাহার করার জন্য নির্দেশনামতে অনুমোদন করা হলো।

সহপরিচালক
 পরিবার পরিচালনা অধিদপ্তর
 ৬, কাকডাঙ্গা বাজার, ঢাকা
 (দু'টি আকর্ষণ-প্রতিপাদক, আই ইউ এম ইউনিট)।

অনুলিপি

- ১। মাননীয় সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মহালয়।
- ২। মাননীয় প্রতিমন্ত্রী মহোদয়ের একান্ত সচিব, স্বাস্থ্য ও পরিবার কল্যাণ মহালয়।
- ৩। সচিব মহোদয়ের একান্ত সচিব, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মহালয়।
- ৪। অতিরিক্ত সচিব (প্রশাসন) মহোদয়ের ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মহালয়।
- ৫। অতিরিক্ত সচিব (জনসংখ্যা, পরিবার কল্যাণ ও আইডি) মহোদয়ের ব্যক্তিগত কর্মকর্তা, স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ, স্বাস্থ্য ও পরিবার কল্যাণ মহালয়।

BANGLADESH POPULATION POLICY

MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF THE PEOPLE'S REPUBLIC
OF BANGLADESH, DHAKA



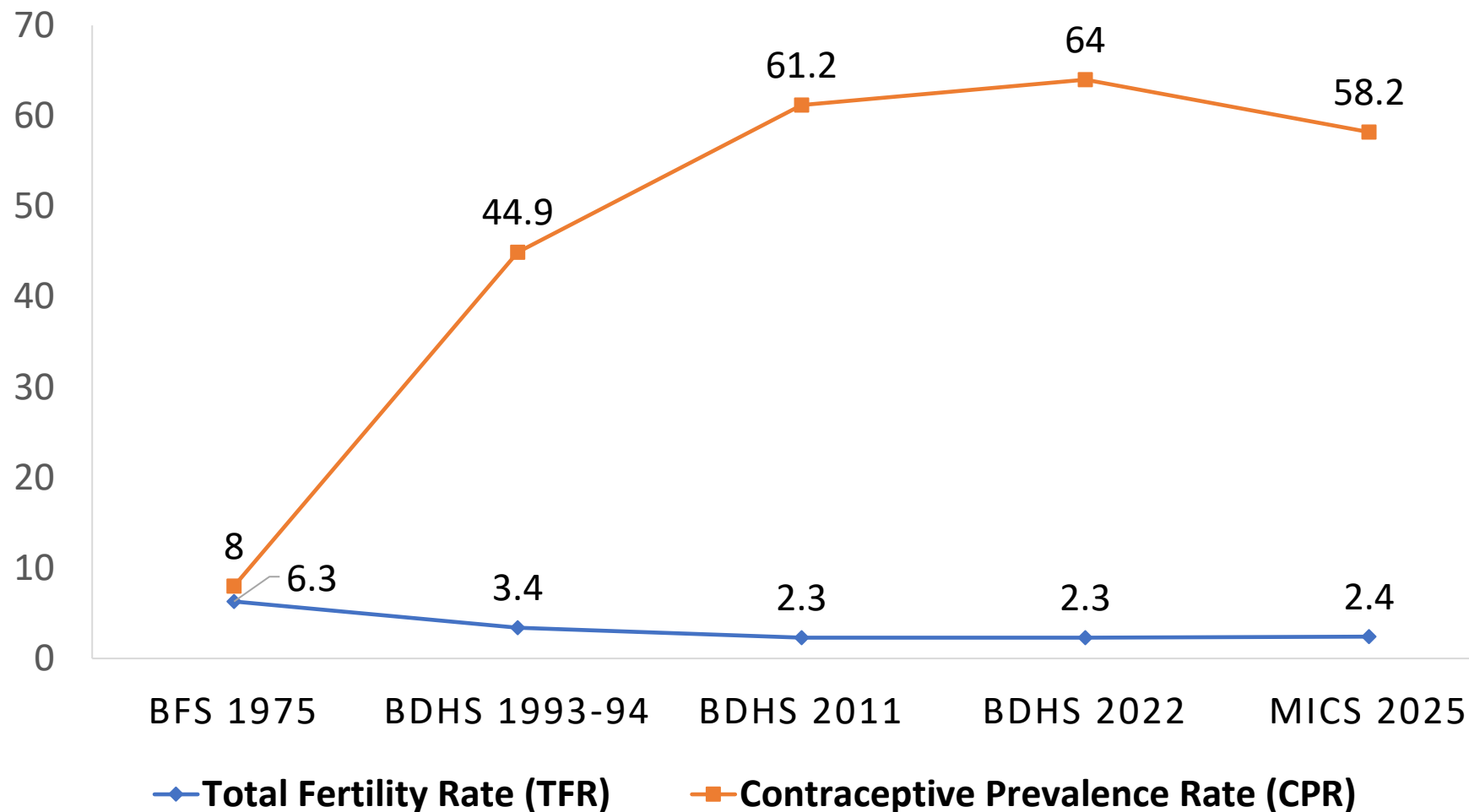
OCTOBER 2004

বাংলাদেশ জনসংখ্যা নীতি ২০২৫

गुणिमत्र

১. কৃষিকান
 ২. বাংলাদেশ জনসংখ্যা নিতি সুযোগসম্পন্নী করার ঐকিকতা
 ৩. বাংলাদেশ জনসংখ্যা নিতি ২০২৫ এর মৌলিক দ্বিত্তি
 ৪. বাংলাদেশ জনসংখ্যা নিতি ২০২৫ এর তৃপকক
 ৫. বাংলাদেশ জনসংখ্যা নিতি ২০২৫ এর উদ্দেশ্য এবং সুখ্য কৌশল
 ৬. উদ্দেশ্য-১: সকল জনগোষ্ঠীর জন্য মানসম্মত ও সহকরকর স্বাস্থ্য ও পুষ্টি সেব্য, ঐতিহাসিকক মানসম্মত শিক্ষা ও সামাজিক নিরাপত্তা নিশ্চিত করার মাধ্যমে লক্ষ মানসম্মত সুখসুপ্তির ককর জনমিতিক লক্ষ্যে অর্জন করা
 - ৬.২ উদ্দেশ্য-১ অর্জনের লক্ষ্যে কৌশল:
 - ৬.২.১ জনমিতিক লক্ষ্যে অর্জনের লক্ষ্যে মানসম্মত উন্নয়ন
 - ৬.২.২ নিরাপদ আন্তর্জাতিক শ্রম অধিবাস
 - ৬.২.৩ প্রাথমী জনগোষ্ঠীর কল্যাণ
 - ৬.২.৪ অনুগ্রসর জনগোষ্ঠীর জন্য বিশেষ কর্মসূচি গ্রহণ
 - ৬.৩ উদ্দেশ্য- ২: পরিবার পলিকরনা শঙ্করির অধুণী বাধিব, প্রতিরোধযোগ্য মাতৃমৃত্যু, নবজাতক ও শিশুমৃত্যু এবং বাল্যবিবাহের সকল কতিকর আচরণের দ্বার হ্রাস করা
 - ৬.৩ উদ্দেশ্য- ২ অর্জনের লক্ষ্যে কৌশল:
 - ৬.৩.১ অধিকারকিকক লাবন্যবীন সৌন ও প্রলমন স্বাস্থ্যসেব্য
 - ৬.৩.২ কিশোর-কিশোরী কল্যাণ কাব্যক্রম
 - ৬.৩ উদ্দেশ্য- ৩: তৃপ্ত ও পক্ষম শিশুবিসেব্যের সুবিধা অর্জন এবং লক্ষ্যে বাংলাদেশ পটসের লক্ষ্যে প্রস্তুতির প্রসার ও ব্যবস্থাপনার জন্য স্বাস্থ্য, মধ্য ও বীজসেব্যের পরিকল্পনা গ্রহণ করা
 - ৬.৩ উদ্দেশ্য- ৩ অর্জনের লক্ষ্যে কৌশল:
 - ৬.৩.১ সুস্থ ও বৈষম্যবীন বাংলাদেশ পটসে প্রস্তুতির প্রসার
 - ৬.৩ উদ্দেশ্য- ৪: অঞ্চলকিকক উন্নয়ন পরিকল্পনা এবং কর্মসংস্থানের সুযোগ সুবিধা সকল নাগরিক সুবিধা নিশ্চিত করার মাধ্যমে শহর ও গ্রামীয় অঞ্চলের সমান সুযোগ সুবিধা নিশ্চিত করা
 - ৬.৩ উদ্দেশ্য- ৪ অর্জনের লক্ষ্যে কৌশল:
 - ৬.৩.১ অঞ্চলকিকক পরিকল্পিত উন্নয়ন ও কর্মসংস্থান
 - ৬.৩.২ নগর ও গ্রামীয় স্বাস্থ্যসেব্য
 - ৬.৩ উদ্দেশ্য- ৫: নারীর অর্থনৈতিক, সামাজিক ও রাজনৈতিক ক্ষমতায়নের মাধ্যমে জেলার সমতা নিশ্চিত করা এবং জেলার লক্ষ্যে অর্থনৈতিক
 - ৬.৩ উদ্দেশ্য- ৫ অর্জনের লক্ষ্যে কৌশল:

Trends of TFR and CPR in Bangladesh, 1975-2025



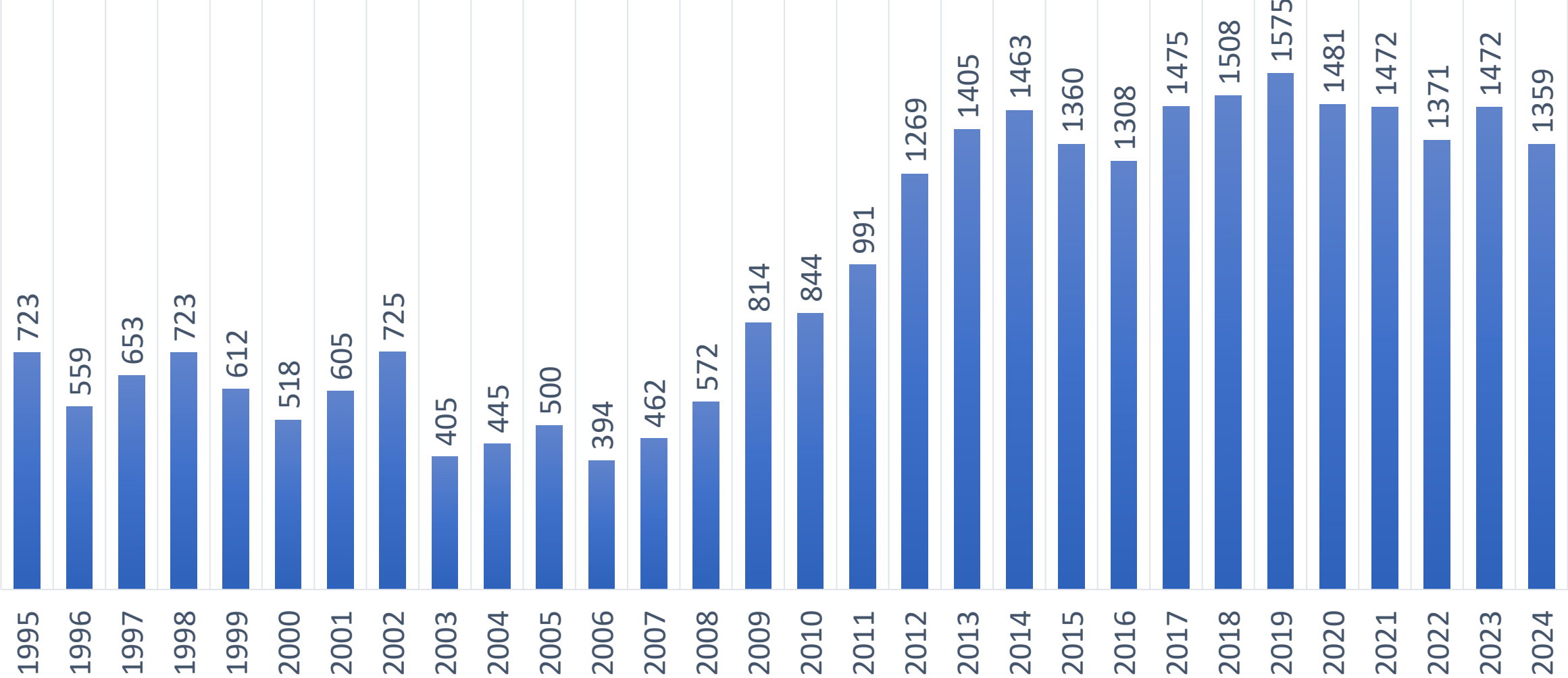
A recent unpublished BBS projection (2026) indicates- Bangladesh may gain about 67 million people between 2022 and 2072 (237.01) under the medium scenario (TFR 2.15) but for high scenario (2.35) about 108 million (278.27).

Sources: Bangladesh Fertility Survey (BFS) 1975, BDHS 1993-94 to 2022, MICS 2025

ARGUMENT 5

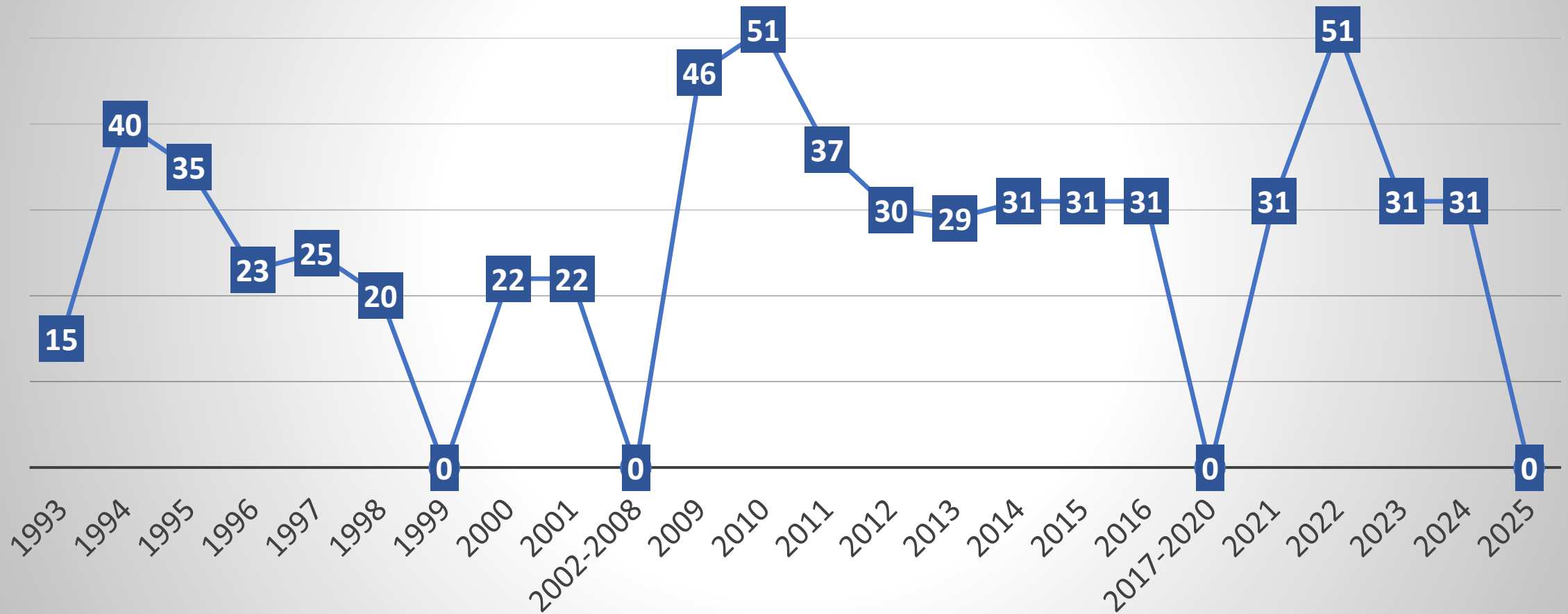
- **GLOBAL FUNDING FOR FAMILY PLANNING** is decreasing from the 1994 despite the expected cost is more than double.
- **FUNDING DIVERGENCE:** Resources shifted toward broader health frameworks, leaving dedicated voluntary family planning programs underfunded relative to the surging demand in high-growth nations.

Expenditures for Family Planning from 1995-2024
(in million US Dollars)



Sources: UNFPA and OECD CRS database; Financing the ICPD Program of Action 1995 to 2024

USA Funding for UNFPA from FY 1993-2025 (in million dollars)



Sources: KFF Analysis data from the Office of Management and Budget U.S. Foreign Assistance Dashboard, 1993-2025

ARGUMENT 6: Urban Family Planning is becoming more critical to address the vulnerabilities!

- The world has become increasingly urban; more people live in cities today than in towns or rural areas
- More people live in small and medium-sized cities than in megacities; many of these smaller settlements are among the fastest growing, especially in Africa and Asia.
- Growth of the world's city population between now and 2050 will be concentrated in seven countries- **India, Nigeria, Pakistan, the Democratic Republic of the Congo, Egypt, Bangladesh, and Ethiopia**

- *World Urbanization Prospects 2025*

■ **Urbanization and migration are becoming essential phenomenon and Urban Family Planning needs more attention:** Rapid urbanization, mobility, displacement (*Example from Bangladesh*)

■ **Appropriate institutional and policy measures are required to address: Disaster Caused Displaced Population.** Among others, policies and strategies are to be implemented in climate hotspots and urban slums. In Bangladesh, **7 per cent of all migration in urban places is caused by environmental damage in city slums.**

■ **Urban Population Growth, Marginalized sub-groups of group of population and Family Planning is in less attention in policy matters in resource poor settings**

Islam and Gagnon *BMC Women's Health* (2016) 16:15
DOI 10.1186/s12905-016-0296-4

BMC Women's Health

RESEARCH ARTICLE

Open Access

Use of reproductive health care services among urban migrant women in Bangladesh

Mohammad Mahnul Islam^{1*} and Anita J. Gagnon^{2,3}

Abstract

Background: Recent internal migration flows from rural to urban areas pose challenges to women using reproductive health care services in their migratory destinations. No studies were found which examined the relationship between migration, migration-associated indicators and reproductive health care services in Bangladesh.

Methods: We analyzed the 2006 Bangladesh Urban Health Survey (data made publicly available in June 2013) of 14,191 ever-married women aged 10–59 years. Crude tabulations and logistic regression were conducted.

Results: Migrants and nonmigrants did not differ significantly in their use of modern contraceptives and treatment for STI but were less likely to receive ANC even after controlling for a range of variables. Compared to nonmigrants, more migrants had home births, did not take vitamin A after delivery, and had no medical exam post-birth. Migrant women being village-born (rather than urban-born) were associated with risk of diminished use of ANC; treatment for STI; medical exam post-birth; vitamin A post-birth. Migrating for work or education (rather than other reasons) was associated with risk of diminished use of ANC; use of modern facilities for birth; and medical exam post-birth. Each additional year lived in urban areas was associated with a greater likelihood of receiving ANC.

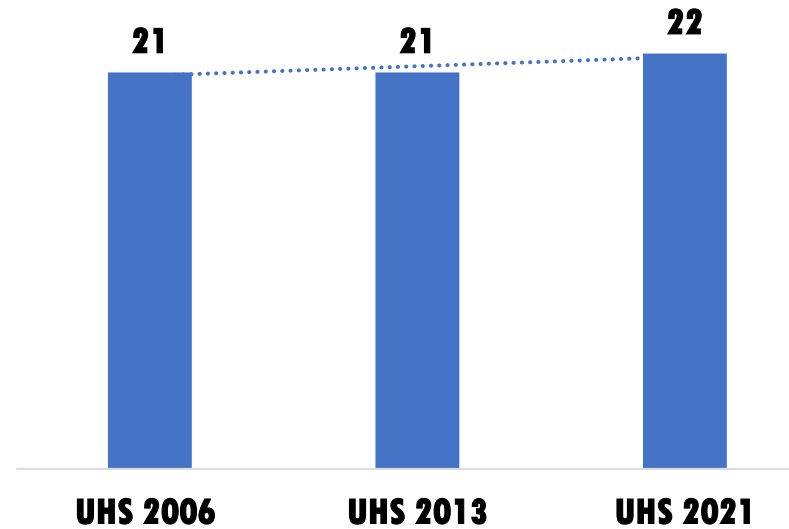
Conclusions: Women who migrated to urban areas in Bangladesh were significantly less likely than nonmigrants to use reproductive health care services related to pregnancy care. Proactively identifying migrant women, especially those who originated from villages or migrated for work or education may be warranted to ensure optimal use of pregnancy-related services.

Keywords: Reproductive health, Care services, Urban, Migrant women, Bangladesh

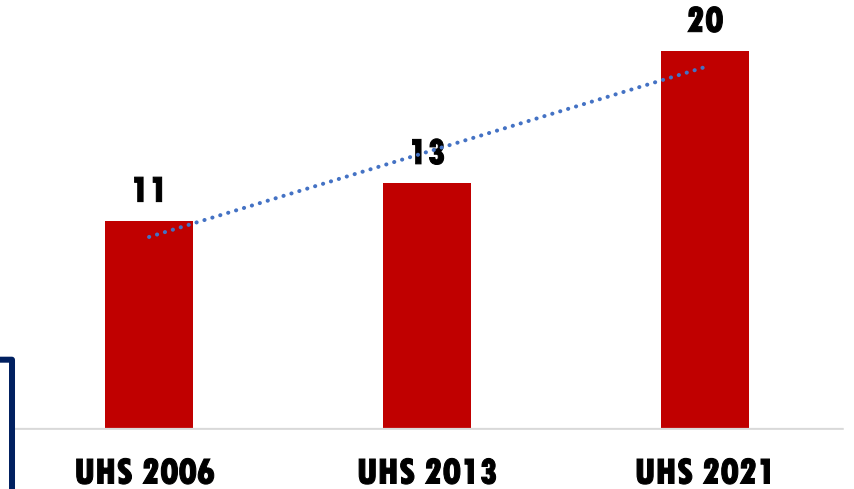
Trends in Teenage Pregnancy, UHS 2006, 2013 & 2021

(% of women aged 15-19 starting childbearing)

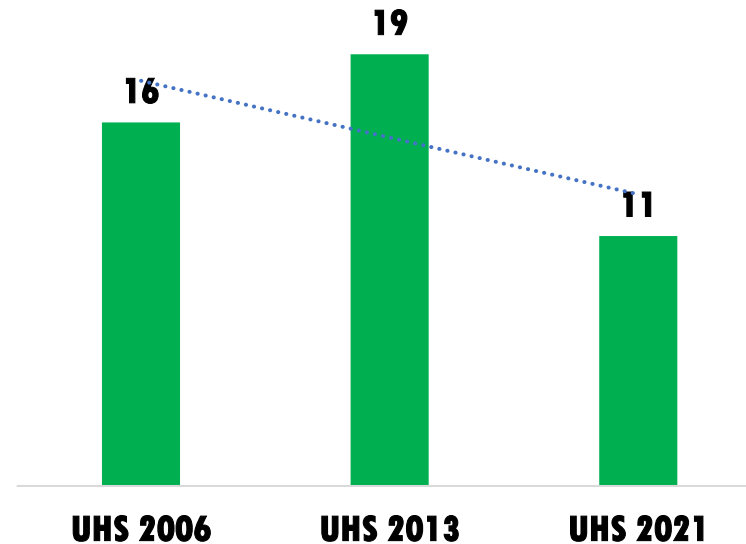
City Corporation Slum



City Corporation Non-Slum



Rest Urban



Source: UHS=Bangladesh Urban Health Survey (2006,2013,2021)

❑ **Conflict Caused Displaced Population and Humanitarian Effort: Appropriate institutional and policy measures on family planning are required to address human displacement and climate migration.**

Evidence showed- ‘The practice and use of contraception among the Rohingya refugees in the camps are low, and the birth rate is high, which needs more critical attention’.



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Comment

Why is the use of contraception so low among the Rohingya displaced population in Bangladesh?

Mohammad Mainul Islam, Ph.D, Md. Anwer Hossain, MSS, MD Yeasir Yunus, MSS

University of Dhaka, Department of Population Sciences, Arts Building (3rd Floor), Faculty of Social Sciences, Dhaka 1000, Bangladesh, Phone: +8801720109438, Fax: +88029667222

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A recent article published in the Lancet Regional Health – Western Pacific refers to the factors affecting child marriage and contraceptive use among the adolescent Rohingya girls (10–19 years) who married before 18¹. Though this study provides valuable insights into the factors that influence and determine the widespread prevalence of child marriage and the low use of contraceptives among the married Rohingya adolescents, some fundamental limitations exist. This study did not adopt a probability sampling technique, and also the sample size was relatively small. Another demographic profiling and needs assessment study found that 86.7%

their family members in the decision-making role⁴. Also, the fear of side effects of using contraceptives restricts Rohingya couples from family planning methods uptake^{2,4}. Along with, misperceptions about contraceptive methods may cause infertility and even death; some other causes need to be considered for adolescents and entire reproductive-aged (15–49) women. A literature review also shows that the long history of domination, oppression, and persecution of the minority Rohingya in Myanmar act them not to receive family planning services, grounded on the religious-political motivations of suppressing the Rohingya community to

ARGUMENT 7: Geographical concentration of fertility indicates to address on geographical needs of family planning services and socio-cultural barriers

Geographic disparities and determinants of fertility outcomes in Bangladesh

S.M. Mostafa Kamal^a, Efehan Ulas^b, Yesim Senayli^{c,*}

^a Department of Mathematics, Islamic University, Kushtia 7003, Bangladesh

^b Department of Biostatistics and Medical Informatics, Kırklareli University, Kırklareli, Turkey

^c Department of Anesthesiology and Reanimation, Kırklareli University, Kırklareli, Turkey

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Keywords:

Fertility

Spatial analysis

Multilevel analysis

Regression analysis

Bangladesh

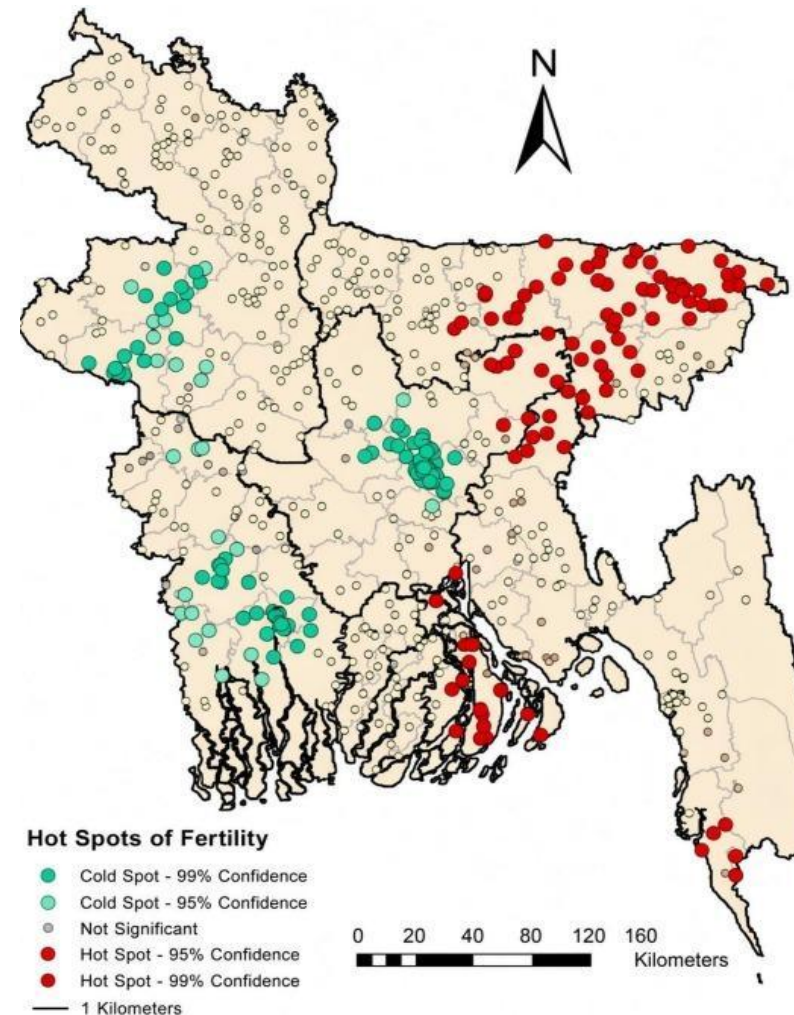
ABSTRACT

Objectives: Regional disparities in maternal and reproductive health persist in developing countries. This study investigates geographical differences and hierarchical factors influencing fertility in Bangladesh.

Methods: Using 2017–18 Bangladesh Demographic and Health Survey data, this study models the cumulative fertility of ever-married women aged 15–49. It applies a two-level hierarchical multilevel Poisson regression to separate individual socioeconomic factors from community context. Additionally, global Moran's I and local Getis-Ord (Gi*) analyses identify geographical hot and cold spots of childbearing across communities.

Results: Significant geographic clustering of fertility in Bangladesh, with hot spots in Sylhet and Chittagong and cold spots in the northwest and southwest. Regression indicated that individual factors like child marriage and low maternal education increased parity. Community factors such as socioeconomic disadvantage and high fertility norms also independently influenced reproductive outcomes.

Conclusions: Fertility behaviors in Bangladesh are shaped by both individual traits and the normative characteristics of shared spaces. National family planning campaigns are no longer enough; interventions must focus on community-level, geographically segregated strategies that address local infrastructural and sociocultural barriers within high-fertility hot spots.



- Hot spot analysis identified the North-East and South-East as areas of significantly higher fertility
- North-West and South-West (and parts of the Central region) were cold spots

Sources: (Kamal et al., 2026)

Argument 8: The youth bulge is both an opportunity and a risk

- A rapidly growing working-age population can generate a **demographic dividend**, but only when countries invest sufficiently in education, health- family planning, skills, women's empowerment and productive employment.
- Otherwise, a large young population can increase unemployment, inequality and social pressure.

Unemployment and Inequality lead to Political Instability: Some cases



**July 2024 Revolution in Bangladesh
Started against quota system**



**Sri Lanka 's Aragalaya movement
started against corruption in 2022**



**Nepal's Gen Z Revolution started from social media
prohibitions and corruption in 2025**



**India's Protest of Cockroach Janta Party (CJP)
started from unemployment issues in 2026**



Kenya's Gen Z anti-tax revolutionaries in 2024



Nigeria's "End Bad Governance" protests in 2024



Gen Z Madagascar started for electricity and water shortages in 2025



Morocco Gen Z 212 Protest for social inequality and corruption in 2025

CONCLUDING REMARKS

- The debate is not “population control versus rights”.
- Our **YES** argument is **not** a return to coercive population-control policies. Rather, it is that governments and the international community- respective stakeholders should give greater attention to **voluntary, rights-based fertility reduction**, universal access to contraception, girls' education, delayed marriage, women's empowerment and reproductive autonomy.
- **While rapid population growth in high-fertility countries must once again become a central development priority. The challenge is not to control people—it is to expand people's choices.”**

Thank you for your attention!

