Family planning programs in South Asia: Developments and effectiveness

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ABSTRACT
This paper examines the development and effectiveness of Family planning programs (FPPs) in three South Asian countries – India, Pakistan, and Bangladesh – that were among the first to adopt such initiatives in response to rapid population growth. The analysis focuses on the evolution of program objectives, implementation strategies, contraceptive prevalence, and financial support, offering comparative insights into national contexts and outcomes. Despite shared goals – namely reducing fertility rates, expanding contraceptive access, and improving reproductive health – the trajectories of FPPs differ significantly across the three countries. India pioneered early implementation and initially emphasized demographic control, including controversial measures such as compulsory sterilization. Bangladesh focused on community-based approaches and benefited from strong donor support, while Pakistan faced persistent challenges due to political instability, religious opposition, and underfunding. The study finds that India and Bangladesh have reached contraceptive prevalence rates comparable to global averages, largely due to sustained investments, community outreach, and integration with public health systems. In contrast, Pakistan continues to lag behind, with limited progress and ongoing dependence on foreign aid. Financial commitment from national budgets has proven to be a key factor in the long-term success of FPPs, as demonstrated by India and Bangladesh. The comparison highlights that while structural design matters, program success ultimately depends on cultural sensitivity, gender equity, and adaptability to local conditions. Future policies should prioritize inclusive reproductive education, sustainable financing, and engagement of both women and men to strengthen the impact of family planning programs on population dynamics and socio-economic development.

KEYWORDS
family planning; India; Pakistan; Bangladesh; contraceptive prevalence

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1. Introduction

Rapid population growth has a high impact on the success of sustainable development in the world, and although many regions are experiencing a gradual reduction in population growth rates, concerns about global overpopulation persist (United Nations 2024). The world population is projected to reach 8.5 billion by 2030 and 9.7 billion by 2050 (World Bank 2018, United Nations 2024). The most populous regions of the world are East and South-East Asia, with both regions exceeding 2 billion inhabitants and representing the regions with the fastest population growth. The continuing population growth in these regions poses a threat to their economic, health and social growth. These are countries whose infrastructure and instability are unable to provide adequate living standards for their populations, widening the gap between the Western and Eastern worlds (United Nations 2022).

An effective mechanism for slowing population growth is to reduce fertility levels, which should be achieved through Family Planning programs (FPP). FPP are a structured public health initiative designed to provide individuals and couples with the information, services, and resources they need to make informed decisions about reproduction and childbearing. These programs typically include contraception education, reproductive health services, counseling, and access to contraceptive supplies (Donaldson and Tsui 2018). They aim to lower fertility, promote women's health, diversify contraceptive options, and strengthen reproductive health education (United Nations 2022).

Family Planning programs were created to reduce population growth and alleviate concerns about the unsustainable development of the world after World War II. The countries in South Asia, mainly India, Pakistan and Bangladesh, posed the greatest threat, which is why the programmes were first implemented in these countries (Robinson and Ross 2007).

While the programs slowed growth to some degree, their long-term effectiveness varied, and these countries remain among the fastest growing worldwide (United Nations 2024).

The paper examines the topic of family planning programmes in the countries concerned through several factors and sets two main objectives, namely:

1. Description and comparison of the Family Planning programs their development and main ideas focusing on their similarities and differences. This will show how the plans were gradually adapted or not adapted and what results this led to (Visaria and Ved 2016; Robinson 2023).
2. Comparing the Effectiveness of Family Planning Programs using an indicator of contraceptive prevalence and taking into account financing of FPP. Mapping program trajectories clarifies which approaches promoted or hindered progress, while contraceptive prevalence offers a comparable metric of success (FP2030, 2023). Given that financial resources influence service quality and method mix, we relate changes in contraceptive prevalence to funding levels and sources.

India, Pakistan, and Bangladesh launched their programs in similar periods and under global policy frameworks, analyzing differences in planning and implementation may explain variations in outcomes. The findings can contribute to understanding the impact of family planning policies on socioeconomic development and the effectiveness of government decisions.

2. Background

Family planning programs refer to organized efforts, typically led or supported by governments and international organizations, aimed at enabling individuals and couples to control the number and spacing of their children (Cleland et al. 2006). These programs provide access to contraceptive methods, reproductive health education, and related services, with the broader goal of improving health outcomes, empowering women, and supporting sustainable development.

The need to introduce family planning programs arose from the recognition that the extremely rapid population growth, which began to take place in the developing world since the mid-twentieth century, posed a serious threat – primarily due to its potential consequences for economic and social development. It has been presented as a possible brake on society that would cause a slowdown in the growth of living standards for most people in low-income countries (Seltzer 2002). World population conferences have played a crucial role in shaping family planning programs by fostering international dialogue, building political consensus, and redefining policy priorities (Sinding 2000). The 1974 Bucharest conference marked a shift by advocating for the integration of family planning into broader development efforts, challenging the Western emphasis on population control. In 1984, the Mexico City conference, influenced by Cold War geopolitics, promoted private sector involvement and reframed population growth as an obstacle to development. The most transformative was the 1994 Cairo conference, which redefined family planning as a matter of reproductive rights and individual autonomy, emphasizing women's empowerment, education, and access to voluntary contraception – principles that continue to guide global policy today.

Thus, the main objective was to reduce fertility levels, which would lead to a gradual population reduction, economic and social growth and consequently to an improvement in the standard of living of low-income populations (Seltzer 2002). These programmes target three basic premises – demographic,

health and human rights – that essentially imply family planning. The demographic rationale primarily addresses the consequences of the delayed onset of the demographic transition, particularly the persistence of high fertility and infant mortality rates. The health perspective reflects the inadequate level of health care with a strong focus on maternal and childcare, and the human rights perspective focuses on women's and men's rights in the context of family planning. If all these foundations are pursued in a balanced manner, they can contribute to the overall improvement of societal functioning and accelerate national development.

Over the decades, the rationale behind family planning programs has evolved (Bongaarts and Sinding 2011). While demographic and economic motivations were dominant in the early phases, later decades brought increased emphasis on women's rights, health equity, and individual reproductive autonomy. Today, family planning is widely recognized as a critical component of global health and development strategies.

The potential impact of family planning programs, which have been widely implemented across the developing world since the 1960s, has been a central topic of numerous studies (Bongaarts 2025; Bongaarts 2020; Günther and Harttgen 2016; Robinson and Ross 2007; Casterline and Sinding 2000; Cleland et al. 1994; Pritchett 1994). A World Bank review conducted in the early 1990s concluded that these programs had been successful as regards to address the unmet need for contraception in many countries and recommended their expansion (World Bank 1993).

Although some studies have questioned the significance of family planning programs, arguing that they played only a minor role in fertility decline (Pritchett 1994), other research suggests that their effect was indeed significant, though relatively modest (Günther and Harttgen 2016). In countries where high-quality programs were implemented, contraceptive use increased, and fertility rates declined (Robinson and Ross 2007). More recent evidence continues to emphasize that family planning programs have been among the most important determinants of fertility decline (Bongaarts 2020). However, current findings also highlight the importance of the broader context in which these programs operate and stress the need for alignment with national policies and local conditions (Finlay 2024).

Despite the scope of family planning programs has broadened over time in low- and middle-income countries, the primary focus has remained on the availability of contraception and the extent to which it meets the growing demand for birth control that has emerged over recent decades (Kantorová and Bongaarts 2024). Therefore, this paper focuses on trends in contraceptive use in relation to family planning initiatives. The analysis focuses on three countries in South Asia, as this region was among the first to implement such programs, allowing for an in-depth assessment of their long-term development and impact.

3. Methodology

For the purpose of comparison of the Family planning programmes in the surveyed countries, the method of literature review was used. A literature review is a systematic process of locating, collecting, evaluating and synthesizing expert sources (Snyder 2019). For it allows, based on available information and the results of previous empirical studies, a comprehensive assessment and comparison of historical developments in terms of political, economic and social context. In the search analysis, the objectives were first set and then used as a basis for the selection of relevant sources related to Family planning programs. Given the historical nature of the research, it was determined that the source had to have been published between the 1960's and the present. In addition, key terms were then identified based on which information was selected. The synthesis of information was based on the chronology of the programmes, for the purpose of comparing and finding differences and similarities in the different FPP's.

The comparison of similarities and differences between the programmes was based on the identification of thematic headings, which were answered for each country based on selected sources. The headings were:

1. Government policies – positions in the government system
2. Objectives – the objectives set by the programs
3. Focus – country specific requirements or objectives
4. Availability of services – health facilities, availability of contraception
5. Achievements – significant advances related to FPP
6. Challenges – limits that countries are addressing
7. Cultural and social factors – attitudes towards contraception and the influence of religion
8. Population – demographic characteristics of the population

On the basis of these headings, a table was drawn up comparing all the countries studied across all approved programmes from the 1960's onwards.

The success of Family planning programs was further compared focusing on the aspect of contraceptive prevalence rate (CPR) (United Nations 2024). Contraceptive prevalence rate is one of the key indicators of program success and is defined as the percentage of women aged 15–49 who are currently using, or whose sexual partner is using, at least one method of contraception, regardless of method being used (Kantorová and Bongaarts 2024) i.e:

$$\mathrm{CPR} = \left(\frac{\textit{Number of women aged } 15-49 \textit{ using contraception}}{\textit{Total number of women aged } 15-49 \textit{ who are married or in union}} \right) \times 100$$

Prevalence of contraception includes both modern and traditional methods of contraception. Modern ones include Female and male sterilization, Intrauterine devices (IUDs), Implants, Injectables, Oral contraceptive pills, Male and female condoms, Emergency contraception, Lactational amenorrhea method (LAM). Traditional methods are Rhythm (calendar-based) method and Withdrawal.

To illustrate the relationship between contraceptive prevalence and the share of government budget funding for family planning programs, data from the comparison of family planning funding in Chapter 4.7 (Tab. 2) was used. The share of FPP funding was divided into five categories: Exclusively donors, mainly donors (low share of the state budget), Combination of donors and state budget, mostly from state budget, mainly state budget. The category Mainly state budget was chosen as the reference value (100%) representing the highest level of government involvement. Other levels were scaled relative to this value – from 0% (for Exclusively donors) to 75% (e.g. Mostly from state budget), creating a quantitative axis of government involvement. The resulting graph was supplemented with contraceptive prevalence rates in selected countries and time periods.

Data for comparison of contraceptive prevalence were drawn from the World Bank database. The database guarantees the quality and integrity of the published data and continuously updates the available data. It works on the principle of collecting data from the statistical systems of member countries. Contraceptive prevalence is based on data from domestic surveys. It is precisely in data collection that the greatest limitations are found. The quality of data collection in the countries surveyed may not be entirely reliable. In the case of contraceptive prevalence, this most often involves discrepancies in respondents' understanding of questions relating to the definition of contraceptive use. It is therefore important to take these aspects into account when interpreting the data (World Bank 2023).

4. Results

4.1 Family planning programs in India

India was the first country in the world to officially launch a national family planning program in 1952 (Ledbetter 1984). Its creation was closely linked to concerns about a population explosion, which was seen as a major obstacle to economic and social development (Fárek 2012). The programs have changed several times over the decades, from an early behavioral approach to a client-centered model and massive campaigning to decentralized and participatory strategies that focused more on reproductive health and child survival. A critical assessment of these changes reveals tensions between technocratic, directive models and later efforts to respect individual rights and needs.

The first phase (the 1950's) was characterized by an emphasis on education and support for "responsible parenthood". In practice, this meant that the government assumed that behavior would change through information rather than through the actual availability of methods. Initially, the Ministry of Health and Family Welfare only approved the "rhythm method" because other forms of contraception were rejected for religious and cultural reasons (Connelly 2006; Ledbetter 1984). However, this approach failed because it did not take into account structural barriers, particularly low literacy among women and limited access to institutions. Critics point out that instead of changing behavior, it caused frustration and mistrust (Ram and Ram 2021).

In the 1960's, policy began to shift toward a client-centered approach, with the government expanding services in health facilities and gradually introducing intrauterine devices, sterilization, and other methods. Infrastructure was strengthened, and the program gained the support of international organizations, particularly the United Nations. This change had a positive impact on awareness of family planning, but fundamental problems remained: a shortage of trained personnel, irregular supplies of contraceptives, and unequal access to services, especially in rural areas (Robinson and Ross 2007). The program was criticized for focusing too much on the urban population and not taking social inequalities sufficiently into account.

A major turning point came in the 1970's with the so-called camp approach, i.e., mass sterilization campaigns. These had the direct support of Indira Gandhi's government, and especially during the period of emergency (1975–1977), compulsory sterilizations were introduced and quotas were set for individual states (Robinson and Ross 2007). These practices led to widespread human rights violations, including coercion of the poorest sections of the population (Kongawad and Boodeppa 2014). In the short term, there was a sharp increase in the number of sterilization procedures and an improvement in the population situation, but in the long term, this approach seriously undermined public confidence in state health programs and created a stigma associated with family planning (Pradhan and Dwivedi 2019).

Following this crisis, policy in the 1980's and 1990's gradually shifted toward voluntary programs and a broader context of overall family health. The goal was to link family planning to a broader concept of social care with a focus on maternal and child health (Kongawad and Boodeppa 2014). A significant change was the transition to the so-called community needs assessment approach in 1996, also known as the "no-target approach". This model aimed to decentralize decision-making, strengthen regional self-government, and take into account the specific needs of

communities (Pradhan and Dwivedi 2019). This was a step forward in terms of participation, but its implementation was uneven – particularly in poorer states of India, where access to quality services remained limited.

From the late 1990's, the program began to focus more on reproductive health and child survival, linking family planning to the goals of reducing maternal and infant mortality. This approach was in line with international development agendas (United Nations 1994, Millennium Development Goals United Nations 2000) and aimed to integrate family planning into the framework of human rights and development (Chaurasia 2014). At the same time, however, Indian programs continued to focus heavily on demographic indicators, i.e., reducing fertility and achieving replacement-level fertility, highlighting the continuing tension between declared humanistic goals and technocratic practice (United Nations Population Fund n.d.).

India's family planning program underwent several phases from the 1950's onwards, each revealing its own compromises and limitations. The early behavioral model based on information campaigns and the "rhythm method" proved ineffective in an environment of low literacy and limited access for women to institutions, widening the gap between policy intentions and actual behavioral change (Connelly 2006; Ledbetter 1984; Ram and Ram 2021). The client-centered approach of the 1960's expanded the range of methods available in health facilities, but it was hampered by staff shortages, irregular supplies, and an urban bias that excluded rural and poorer populations (Robinson and Ross 2007). The subsequent approach based on sterilization camps in the 1970's brought a short-term increase in performance, but at the same time seriously damaged the legitimacy of the program, stigmatized family planning, and undermined public confidence in the state (Kongawad and Boodeppa 2014; Pradhan and Dwivedi 2019). Decentralization through the community needs assessment model (the so-called target-free approach) after 1996 strengthened the influence of local residents and emphasized participation, but its results were uneven and limited by weak capacities in poorer regions (Pradhan and Dwivedi 2019). The later reproductive health and child survival framework attempted to link family planning with rights-based agendas, but monitoring remained tied to demographic targets. Gender imbalances persisted, as responsibility for contraception rested almost exclusively with women, while the proportion of male sterilizations remained minimal (Chaurasia 2014; Kongawad and Boodeppa 2014; United Nations Population Fund n.d.). Persistent institutional weaknesses, a lack of qualified personnel, poor service quality, and paternalistic management undermined the effectiveness of the programs over the long term.

These experiences show that a focus on quantitative targets and technocratic fertility control was insufficient. The key lesson is to prioritize service quality, diversification of contraceptive methods, and greater involvement of men over simply monitoring demographic quotas. Although the National Reproductive Health and Family Planning Strategy has emphasized girls' rights and education since 2015, India's approach remains largely technocratic and focused on birth control rather than comprehensive reproductive health (United Nations Population Fund n.d.; Pradhan and Dwivedi 2019).

An important achievement of India's family planning program has been the creation of a stable and relatively well-functioning institutional system. Despite numerous challenges, such as limited diversity of contraceptive methods and persistent inequalities between urban and rural areas, India has managed to maintain continuity of services and build one of the most extensive family planning infrastructures in the Global South (Chaurasia 2014; United Nations Population Fund n.d.). However, recent studies point out that the approach remains largely technocratic and overly focused on reducing fertility rather than comprehensively ensuring reproductive health (Pradhan and Dwivedi 2019).

Despite overall successes, the structure of contraceptive methods in India remains unbalanced. The long-term dominance of female sterilization and minimal use of male methods point to a persistent gender imbalance and the "technocratic" way in which family planning policy is implemented (Chaurasia 2014; Green 2018; UNFPA India n.d.). For the present, this implies a need to systematically promote voluntary and reversible methods, expand male contraceptive options, and strengthen the quality of counseling to reduce dependence on one-off performance targets (Pradhan and Dwivedi 2019).

4.2 Family Planning programs in Pakistan

Pakistan was one of the first countries in South Asia to recognize rapid population growth as one of the key challenges to development. Since the 1950's, the government has formulated explicit antinatalist policies, but by international standards and even compared to India and Bangladesh, the effectiveness of these programs has been relatively low (Sathar 2007). Although the country adopted a series of five-year plans that included population policy, the results were undermined by structural factors: political instability, insufficient funding, gender inequalities, and the strong influence of conservative religious norms (Wazir et al. 2013; Goujon et al. 2020).

The first generation of programs in the 1960's was based on the assumption that women would seek out family planning services on their own. The distribution of modern methods, particularly intrauterine devices, was supported by foreign donors (Bean and

Bhatti 1969). However, this approach proved ineffective. The main problem was rural areas. Women in these areas did not receive sufficient information about family planning program options and were not mobile enough to travel to services. As a result, access to services was minimal in practice (Hakim and Mahmood 2001).

In the 1970's, programs began to strengthen the community approach. The inspiration was the Alma-Ata Conference (1978), which emphasized the importance of primary health care. Community centers were established in villages, and the government invested in training health workers. Although this model was better suited to the needs of rural areas, its implementation was limited by a lack of resources and poor coordination. Critics point out that the state invested in tertiary care in cities, while primary services in rural areas remained underfunded (Wazir et al. 2013).

Unlike India, which experimented with sterilization in the 1970's, or Bangladesh, where cooperation with non-governmental organizations prevailed, Pakistan's family planning program suffered most from political instability. Changes in government led to frequent interruptions or suspensions of programs. Under the Zia-ul-Haq government, the family planning agenda was even almost abandoned (Hakim and Mahmood 2001). Weak political anchoring meant that long-term strategies were not implemented and the demographic dynamics of rapid population growth continued.

Change came in the 1990's, when Prime Minister Benazir Bhutto actively promoted reproductive health. Her participation in the Cairo Conference (1994) led to the adoption of programs emphasizing human rights and gender equality. A key step was the creation of the Lady Health Workers (LHW) program, which focused on home visits, contraceptive distribution, and basic maternal and child care. The LHW program not only improved contraceptive distribution and maternal health services, but also played a role in empowering women in their local communities. By providing direct services in households, the program increased awareness of reproductive health and strengthened women's decision-making abilities, although its coverage remains inadequate in some rural areas (Hafeez et al. 2011; Sathar 2007). The program continues to operate today and is considered the most effective reproductive health policy tool in the country (World Health Organization n.d.; Sathar 2007).

As in other countries in the region, Pakistan has gradually shifted its focus from antinatalist goals to a broader concept of reproductive health and child survival. This shift has led to the introduction of programs focused on prenatal and postnatal care, immunization, HIV/AIDS prevention, and combating gender-based violence (Sathar 2007). However, persistent barriers remained: low female literacy, early marriage, and limited economic opportunities for women, which significantly undermined the effectiveness of the programs (Goujon et al. 2020).

After 2000, the programs were decentralized and responsibility shifted from the federal to the provincial level. The aim was to tailor services to local needs. In practice, however, it became apparent that provincial capacities were uneven: for example, Punjab was able to provide relatively accessible services, while Balochistan lagged significantly behind (Sathar 2007). Decentralization thus exacerbated regional inequalities rather than reducing them.

The 2017 census confirmed high population growth. The government responded by creating federal and provincial working groups, approving a national action plan (2019), and launching the "Tawazun" campaign (2021). The national action plan had clearly defined goals: to increase contraceptive prevalence, reduce population growth to 1.1%, and reduce total fertility. The goal is to be achieved by 2030. The Tawazun campaign links family planning with sustainable development and human rights (Ministry of National Health Services, Regulations & Coordination 2021.). However, experts warn that without massive investment in girls' education and women's empowerment, these goals will remain largely declarative (Goujon et al. 2020).

Pakistan's original technocratic model, based on promoting intrauterine devices and centralized management, proved culturally and socially ineffective because it ignored local norms, relied on intermittent political support, and neglected primary care in rural areas (Hakim and Mahmood 2001; Wazir et al. 2013; Robinson and Ross 2007). Weak political anchoring and frequent discontinuity of individual initiatives further undermined the continuity necessary for demographic and health policy (Sathar and Zaidi 2010). In contrast, the community-based model of health workers visiting households has shown that direct services can increase women's awareness of and access to contraception and empower them, but its coverage remains inadequate and uneven across provinces (Hafeez et al. 2011; Nishtar 2010). The decentralization process has further fragmented administration, leading to significant regional disparities in the quality and availability of services. Deeper barriers include high rates of consanguineous and early marriage, low literacy, and limited participation of women in the labor market, which systematically undermine their autonomy in reproductive health (Zaidi et al. 2019; Sathar and Kazi 2000; Sathar and Royan 2013). These factors explain why, even when methods are available, there is no significant increase in their use, with demand further dampened in the long term by limited communication channels – mainly leaflets or radio spots – that do not meet the needs of the population (Population Services International Pakistan 2021; World Health Organization 2015).

4.3 Family planning programs in Bangladesh

Bangladesh is a unique case in South Asia. Despite extreme poverty and high population density, it has achieved a rapid decline in fertility since the 1970's, from more than six children per woman to approximately 2.1 today (United Nations Population Fund 2023). This success is linked to a combination of strong state involvement, active participation by non-governmental organizations, and a community-based approach (Cleland et al. 1994; Alam 2017).

After gaining independence in 1971, the government adopted its first five-year plan with the goal of significantly reducing the fertility rate. The goals were unrealistically ambitious (Amin et al. 1987), but they created a basic institutional framework. Of key importance was the MCH-FP Planned Parenthood project in Matlab, launched in 1977 by the ICDDR. The program combined intensive home visits, contraceptive distribution, and basic health care. Studies showed that this community-based approach could reduce fertility even without significant improvements in socioeconomic conditions (Phillips et al. 1982; Phillips et al. 1996).

Unlike Pakistan, Bangladesh soon opened its doors to nongovernmental organizations such as BRAC and Grameen. These organizations integrated health services with microcredit, education programs, and women's empowerment (Alam 2017). The model combining government and NGO funding allowed for more flexible implementation and wider acceptance in rural communities.

The Cairo Conference (1994) prompted Bangladesh to adopt the Health and Population Strategy Program (HPSP), which combined family planning with a broader concept of reproductive and sexual health (Jahan 2007; World Health Organization 2004). The Bangladeshi government's thinking on family planning thus shifted toward an emphasis on the reproductive rights of the population. A system was created that provided not only contraception but also prenatal care, safe abortions, infectious disease prevention, and nutrition for mothers. This change led to greater legitimacy for the programs and increased their long-term sustainability.

The decline in fertility in Bangladesh is often referred to as a "demographic paradox" because the country achieved a significant reduction in fertility despite its low level of development and political instability (Cleland et al. 1994). The institutionalization of a robust community platform, home visits, satellite clinics, and community workers played a key role in ensuring contact with even the poorest segments of the population. Long-term cooperation between the state and non-governmental organizations was also important, maintaining the availability of services even during periods of weaker state administration and bringing innovation to the integration of family planning with health and social care (Phillips et al. 1988; Phillips et al. 1996; Mercer et al. 2004). In addition, reforms under the HPSP/HNPSP linked contraception with maternal and newborn care, preventive services, and counseling, thereby increasing the legitimacy and continuity of the program (Jahan 2007; World Health Organization 2004). Improvements in human development also contributed to the success: increased school enrollment of girls, a decline in adolescent marriages, and greater participation of women in society strengthened their autonomy in decision-making and the demand for smaller families (Bairagi 2001; Shabuz et al. 2022; United Nations Population Fund 2023). In sharp contrast to Pakistan, where political instability, weak primary care, and the limited status of women have hindered progress, the combination of community work, the flexibility of non-governmental organizations, and improvements in human development in Bangladesh has created a "social space" that has outweighed religious conservatism in determining outcomes (Sathar and Kazi 2000; Hardee et al. 2014).

Among Bangladesh's most important achievements is the creation of a strong, functional network of community centers that ensures the availability and continuity of family planning services even in rural and economically disadvantaged regions (Phillips et al. 1988; Cleland et al. 1994). Another notable result is the decline in adolescent marriages, which has contributed to a slowdown in population growth and improved reproductive health indicators, in line with broader goals of women's empowerment and gender equality (Shabuz et al. 2022; UNFPA 2024).

Currently, family planning programs are based on sustainable development goals. The key framework is Family Planning 2030, which emphasizes universal access to reproductive services, support for young women, and prevention of gender-based violence (UNFPA 2024; Family Planning 2030). At the same time, the programs are integrated into the broader National Sustainable Development Strategy (NDS) until 2044, which links population policy with environmental and social goals.

Critical evaluation shows that although the ambitious goals of individual plans were essentially unrealistic, they created a framework in which new approaches and innovations could emerge (Cleland et al. 1994). Of particular significance was the Matlab experiment in Bangladesh, which clearly demonstrated the effectiveness of a community-based and personalized approach to family planning and became an internationally recognized model (Phillips et al. 1988). Non-governmental organizations also played a key role here, as without their active involvement, the state would not have been able to ensure sufficient coverage and availability of services (Mercer et al. 2004). The shift towards an emphasis on reproductive rights significantly increased the legitimacy of the programs and contributed to their gradual institutionalization (Hardee et al. 2014). Nevertheless,

certain limitations remain, including low service quality and persistent gender inequalities, which continue to undermine their long-term effectiveness despite the successes achieved so far (Sathar and Kazi 2000).

Bangladesh has succeeded despite political instability thanks to three factors: (i) a community-based door-to-doormodel (Matlab, FWA, satellite clinics) emphasizing continuous contact between households and providers (Phillips 1982; Phillips 1996; World Health Organization 2004; Jahan 2007), (ii) partnerships between the state and non-governmental organizations (BRAC, Grameen) linking family planning, microcredit, and women's education (Mercer et al. 2004; Alam 2017), and (iii) the gradual empowerment of women through girls' school attendance and later marriage (Bairagi 2001; United Nations Population Fund 2023). In contrast, in Pakistan, programs suffered from insufficient political support, inadequate primary care funding, and uneven coverage after decentralization; even the strong Lady Health Workers program was not sufficiently expanded (Sathar 2007; Hafeez et al. 2011; Wazir et al. 2013; Goujon et al. 2020).

4.4 Comparative analysis of Family planning programs

Family planning programs in India, Pakistan, and Bangladesh began operating in roughly the same period (second half of the 20th century) and given the considerable political and economic proximity of these countries, there are many commonalities in the programs (Tab. 1). All three countries have committed their Family planning programs to be part of the health system, leading to significant benefits. When the Family planning system and the health system function as a whole, it is easier to achieve the set goals and to change the settings of the different tools quite dynamically (Perera et al. 2024). At the same time, this brings more detailed mapping of the impact of Family planning programs on the health level of the population and consequently on changes in fertility and mortality (Robinson and Ross 2007).

Other common features are international aid and a community-based approach. In all countries, Family planning programs have been established with the support of major powers, as the World Health Organization (WHO) and the United Nations Population Fund (UNFPA). The community-based approach has emerged over the years in family planning programs in all three countries and has been a great success everywhere and has been considered the most effective tool for disseminating information (Sultan et al. 2002; Bhatia et al. 2024; Memon et al. 2024). India was the first to include the community approach in its programs, followed by Pakistan. Bangladesh introduced the community-based approach in its third programme, due to the continuity of effectiveness

Tab. 1 Common features and differences of Family planning programs in India, Pakistan and Bangladesh.

Common features	India	Pakistan	Bangladesh
1. Government commitments – all three countries have committed to Family planning programs as part of their health system 2. International aid and involvement NGO 3. Community approach 4. Linking health and care with Family planning programs in one sector			
Differences	**India**	**Pakistan**	**Bangladesh**
Government policies and priorities	Voluntariness in PPR, decentralized system	High government instability, decentralised system	Priorities within the socio-economic development, centralized system
Objectives	Slowing population growth, increased use of contraceptives, economic development	Slowing population growth, increased use of contraceptives	Slowdown in population growth, increase in contraceptive use, decrease in adolescent marriages
Focus	Emphasis on Family planning services (sterilization), initiatives for young families	Emphasis on sexual and reproductive health education and awareness	Emphasis on community engagement and women's empowerment
Availability of services	Extensive system, public and private sector involvement, strong promotion	Insufficient resources and very limited infrastructure	Actively expanding service distribution system, strong promotion
Achievements	Stable and quality system of functioning of Family planning Programs	Empowering women in the Lady Health Workers program	Strong functional network of community centres
Challenges	Low diversity of contraceptive methods	High illiteracy rates, especially among women	Women's educational attainment and lowlow socioeconomic status
Cultural and social factors (contraception)	Different cultural and social practices are reflected in attitudes to contraceptive use and family life issues		
Population	Different population sizes with different characteristics affect the overall dynamics of society		

Source: own processing.

in Pakistan, but its performance surpassed the quality of community-based functioning in Pakistan and became the most successful compared to the countries studied (Robinson and Ross 2007).

Despite these commonalities, the programs of each country differed in their outcomes and priorities. India faces limited diversification of contraceptive methods, as sterilization remains dominant despite relatively high prevalence (Chaurasia 2020). Pakistan faces persistent challenges in the form of female illiteracy and gender inequality (Ataullahjan 2018), while Bangladesh's main obstacle is the low socioeconomic status of women (Shabuz et al. 2022).

Government priorities have also differed. India has gradually emphasized voluntariness and sought to distance itself from the forced sterilization campaigns of the 1970's (Ministry of Health and Family Welfare n.d.). This shift has allowed couples to make more autonomous decisions, supported by a relatively extensive infrastructure. Bangladesh made women's empowerment and community participation central to its programs, based on the assumption that improvements in education and gender equality would stimulate socioeconomic development (World Health Organization 2018). Pakistan, on the other hand, is hampered by political instability and weak continuity. For decades, its programs relied mainly on leaflets and radio broadcasts, with broader media campaigns only emerging recently (Population Services International Pakistan 2021; World Health Organization 2015).

The availability of services shows several contrasts. India has built the largest network of clinics, health centers, and community centers, involving both the public and private sectors. Bangladesh, although less stable institutionally, is rapidly expanding its system through cooperation between the government and non-governmental organizations (Bates et al. 2003; World Health Organization 2015). Pakistan remains the weakest player, facing serious infrastructure shortages and insufficient resources (Robinson and Ross 2007).

4.5 Improvements in prevalence of contraception

The most rapid increase in contraceptive prevalence occurred in India and Bangladesh in the 1970s and 1980s. In India, the prevalence of contraception until the early 1970's was around 15%. At that time, only a very limited range of contraceptives was available, and the only officially recognized method from a religious point of view was the "rhythm" method. This method is not very effective on its own and requires regularity to work. For many women, it was therefore not an option they wanted to use (Ledbetter 1984). By 1980, the rate had risen to 35%. This means that in just 10 years, India managed to increase the prevalence of contraception by 20% points. The increase in the prevalence of contraception was mainly due to the introduction of compulsory sterilization under the Fourth Five-Year Plan (Kongawad and Boodeppa 2014, Robinson and Ross 2007). Between 1980 and 1990, there was a further increase of about 10 percentage points, reaching 45% in 1990. In this decade, the increase was slower. In the 1990s, there was a slight decline to 40% in India. At the beginning of the

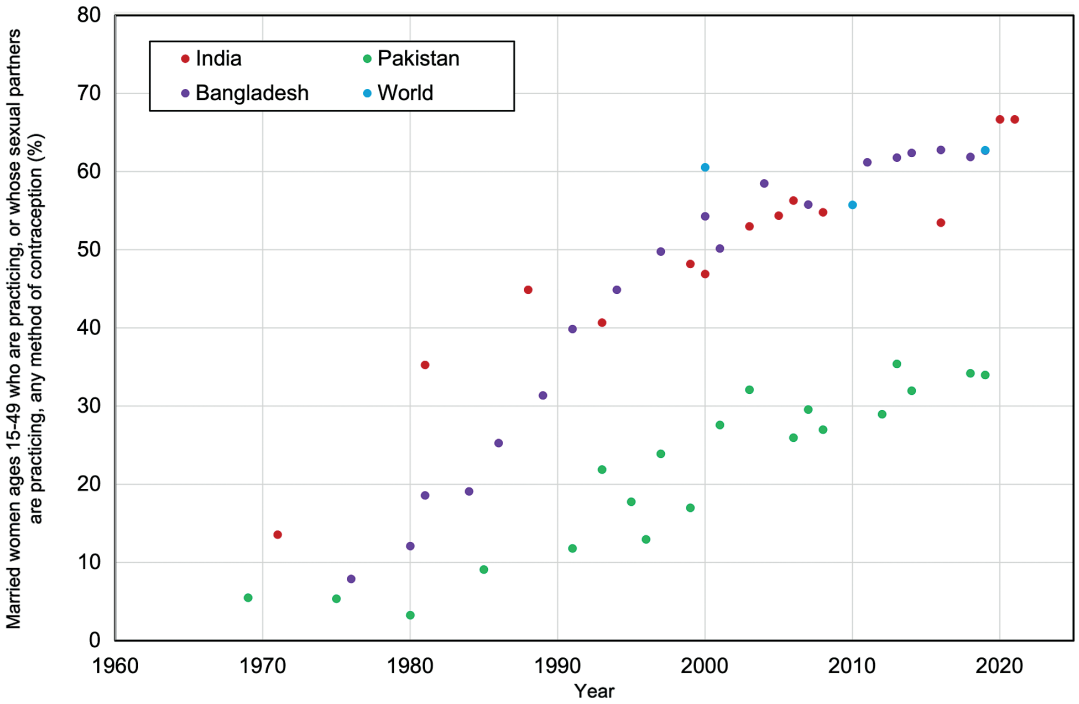

Fig. 1 Prevalence of Contraception, India, Pakistan, Bangladesh, 1960–2023.
Source: World Bank database, Prevalence of Contraception, India, Pakistan, Bangladesh, 1960–2023.

eighth Five-Year Plan, the focus shifted from expanding contraception to developing a community-based strategy. The decline was only temporary, and since the mid-1990s, contraceptive prevalence has been on the rise again. Currently, contraceptive prevalence in India is around 67%, and India's main goal is to continue increasing prevalence and, above all, to increase the diversification of modern contraceptive methods (United Nations Population Fund n.d.). Bangladesh has experienced a similar development to India. The highest increase occurred between 1970 and 1990. Bangladesh included access to contraception and the quality of its delivery in its first Five-Year Plan (Alam 2017). During this period, there was an increase from 8% in 1975 to 40% in 1991. Unlike India, however, Bangladesh also had a relatively successful period in the 1990s, when prevalence continued to rise. During this period, Bangladesh was implementing its sixth Five-Year Plan, which included the approval of a "reproductive health service package" that also focused on strengthening contraceptive use (Jahan 2007). A minor crisis did not occur until the beginning of the millennium, when there were minor fluctuations. Since 2010, the prevalence of contraception in Bangladesh has been stagnating at around 60%. In Pakistan, the increase was rather gradual at first and very inconsistent in later years, with high year-on-year fluctuations. The Pakistani government was very inconsistent in its first five-year plans, and there were significant disputes between the government and the Ministry of Health and Population Welfare. As a result, the achievement of contraceptive prevalence targets was neglected until the fourth five-year plan (Hakim and Mahmood 2001). Pakistani regulations were rather unstable, and contraceptive prevalence rose and fell regularly until the present day, which again points to strong government instability in Pakistan. A more significant increase began in 1990 after the introduction of the community system and the Lady Health Workers program in 1994. In 2019, the prevalence of contraception in Pakistan was 35%, while in Bangladesh it was around 61% and in India as high as 67%. Compared to the global prevalence of contraception, it can be seen that India and Bangladesh are approaching the global average, while Pakistan lags significantly behind (Fig 1).

4.6 Financing of Family planning programs

The success of Family planning programs is significantly influenced by the amount of money invested in their operation. All countries benefit from their own funding as well as support from foreign donors, NGO's or other countries (and later from the private sector) (Cole et al. 2019).

Funding for family planning programmes is in all the countries studied dependent on foreign aid and assistance from NGO's. However, in each of the countries studied, the pattern of funding and the extent of involvement of external funding sources varies (Tab. 2). In India, when the National Family Planning Program (was initiated 1952), most of the funding came from its own budget, with contributions from the UN and bilateral donors, of which the was the largest contributor USA. From the 1960's onwards, USAID joined in significantly and began funding most of the expenditure on technical assistance, equipment and education. However, the Government of India continued to contribute from its budget as well. In the period from 1975–1980, when forced sterilizations were taking place, many donors also withdrew, and the Government of India had to increase its share of investment again and thus more investment came from the government budget. Since the 1980's and the abolition of forced sterilizations, many donors have returned and there has been an increase in grants from USAID, UNFPA and the World Bank. However, India has steadily increased the amount of investment from its own budget, especially after the introduction of the National Rural Health Mission (2005) and the National Health Mission (2013). Today, it mostly funds Family planning programs from its own budget (United Nations Population Fund n.d.)

While India has invested significantly from its own budget, Pakistan has been the opposite. Due to significant opposition from conservatives, Family planning programs were not a priority (Guttmacher Institute 2019). Thus, until the 1990's, 80% was funded by foreign donors (USAID, UNFPA, World Bank), with Pakistan even announcing that it would establish a Population Welfare Program only if it was funded by foreign agencies. Its own participation in funding programs began to increase only after the formation of Lady Health Workers in 1993 (Oxford policy

Tab. 2 Comparison of Family planning programs funding, India, Pakistan, Bangladesh, 1950 – present day.

	1950–1980	1980–2000	2000 – present
India	Mainly donors (USAID, UN)	Combination of donors and state budget	Mainly state budget
Pakistan	Exclusively donors	Exclusively donors	Combination of donors and state budget (decentralization still key donors)
Bangladesh	Exclusively donors	Mainly donors (USAID, UN)	Mostly from state budget, donors as a complement

Source: own processing.

management 2019). Pakistan began to participate more financially and by 2010 donors were funding 60% of the programs. Currently, devolution is underway in Pakistan, an effort to shift responsibility for FPP to the provinces, which will change the overall funding system. However, foreign donors remain a necessary component of funding (UNFPA n.d.).

Bangladesh is somewhere between in terms of funding India and Pakistan. After independence in 1971, Family planning programs were entirely dependent on foreign donors. The government had invested in the infrastructure and overall functioning of the new state and there were no resources left for Family planning programs. Thus, as in Pakistan, more than 80% of the funding came from foreign donors (Cleland and Mauldin 1991). Unlike Pakistan, however, Bangladesh began to invest significantly in Family planning programs in the 1990's, particularly in the operation of services, training, and salaries of outreach workers. The share of funding from foreign donors has declined to about 50%. Today, Bangladesh is considered an ideal example of "transition financing", which consists of gradually reducing dependence on foreign donors. Today, Bangladesh finances about 70% of its costs from its own budget (UNFPA n.d.). UNFPA, USAID, NGOs and other donors then provide funding to specific projects rather than to the health system in general (Appleford and Ramarao 2019; UNFPA 2024; Cleland et al. 2006; United Nations 2011; United Nations 2016; United Nations 2005).

Fig. 2 illustrates the relationship between the share of state budget funding for FPP and contraceptive prevalence. The earlier and more extensively countries invested their own resources, the stronger their commitment to promoting contraceptive use, which is reflected in higher prevalence rates. India has financed FPP domestically since the 1960s and now covers most costs (UNFPA n.d), with steadily rising contraceptive prevalence. Bangladesh, initially dependent on foreign aid, began increasing contributions in the 1980s after the Matlab Project and the second five-year plan (Phillips et al. 1996), which was paralleled by a marked rise in contraceptive use. Since the 2000s, Bangladesh has further expanded domestic funding to achieve self-sufficiency. Pakistan, by contrast, invested little until 1994, when the Lady Health Workers program was launched by the Pakistani government; its funding increase was accompanied by growth in contraceptive prevalence (Hafeez et al. 2011). Overall, India leads in domestic funding and prevalence, Bangladesh has substantially caught up, while Pakistan still depends on foreign donors and shows lower prevalence levels.

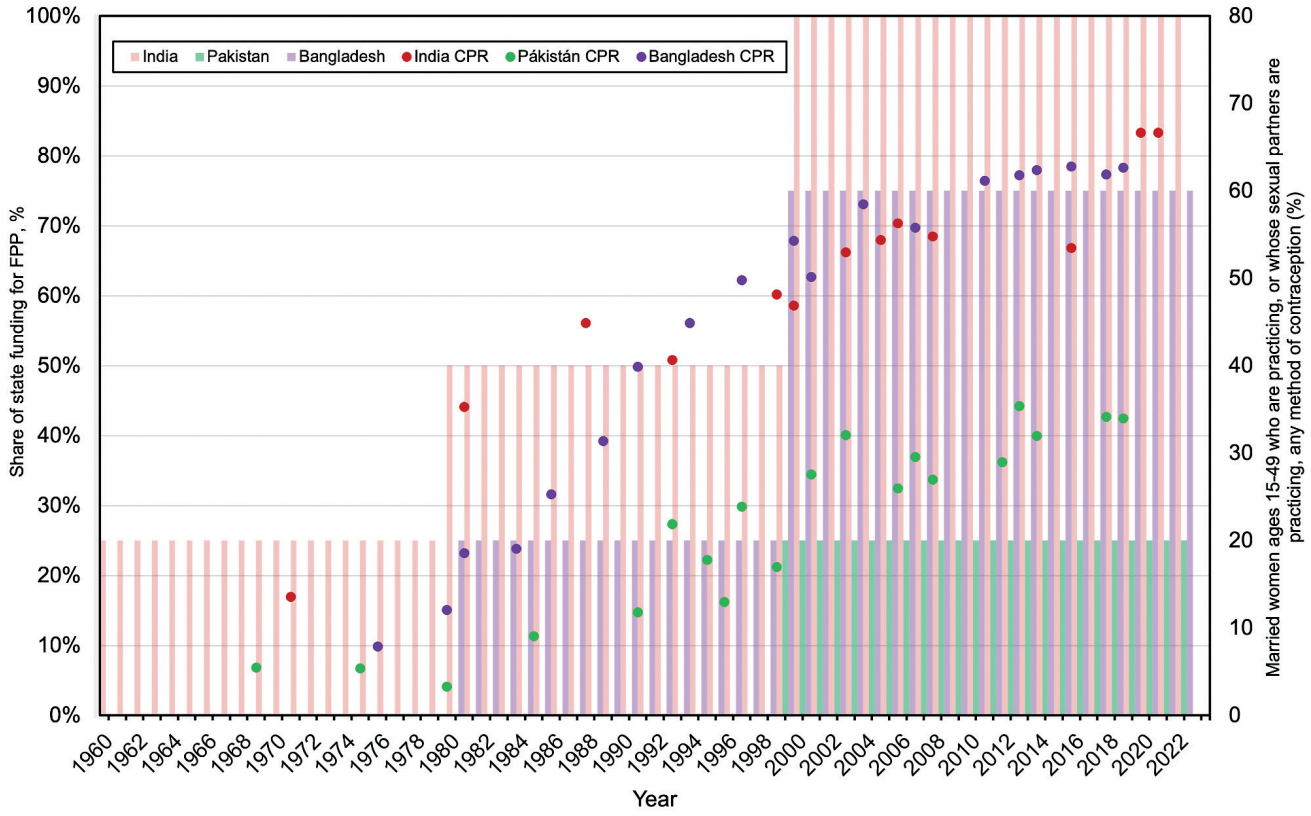

Fig. 2 Share of state funding for FPP, Prevalence of Contraception, India, Pakistan, Bangladesh, 1960–2023.
Source: World Bank database, Prevalence of Contraception, India, Pakistan, Bangladesh, 1960–2023, own processing.
Note: Share of state funding: Exclusively donors (0%), Mainly donors (25%), Combination of donors and state budget (50%), Mostly from state budget (75%), Mainly state budget (100%), Data based on Tab. 2.

5. Discussion

Comparison of Family Planning Programs in India, Bangladesh and Pakistan showed that the main objectives of FPP are the same in all three countries: slowing population growth by expanding contraceptive coverage, educating both sexes, supporting women's education, and implementing community-based systems. The main challenges are regional disparities and the influence of religion. India, Pakistan and Bangladesh all integrated FPP into health systems, relied on international aid, and used community-based approaches linking social and health care (Hay and Garcia 2007; Jha et al. 2023; Bonnifield et al. 2020).

India was the fastest in initial reforms and set the direction for Pakistan and Bangladesh. It also assumed financial responsibility early, covering most costs from its own budget (UNFPA n.d). However, the compulsory sterilization campaign of the 1970s, although it temporarily raised contraceptive prevalence, proved highly unethical and undermined public trust, leading to inconsistent trends in the 1990s after sterilizations became voluntary (Green 2018). Bangladesh, starting later due to independence, implemented FPP in the second five-year plan and, with large donor funding in the 1980s–1990s and a community-based system, achieved major increases in contraceptive prevalence (Phillips et al. 1996; Gray et al. 1997). Fluctuations in 2000–2010 were linked to political changes, health system reforms, and reduced donor subsidies (Jha et al. 2023). Persistent weaknesses are gender inequalities and lack of male involvement, which limit the broader impact of reproductive health education (Bhatia et al. 2024; Cleland and Mauldin 1991; Khan et al. 2020).

Pakistan invested little until 1994, when the Lady Health Workers program was introduced, largely financed by the government, and later reinforced by strong donor support (Hafeez et al. 2011; Phillips and Hossain 2003). Religious and cultural resistance to contraception (Azmat et al. 2015) explains its persistently low prevalence. Although community-based programs and foreign aid have helped, Pakistan still depends on external donors for more than half of FPP financing and lags behind both India and Bangladesh.

Differences are also evident in the promotion of modern contraceptive methods. India started early but narrowed its options in the 1970's and focused on sterilization (Green 2018). Pakistan faced religious resistance and did not make significant progress until the 1990's (Sathar et al. 2013). Bangladesh prioritized modern contraception from the outset and promoted it through community-based systems. As a result, it now has the highest rate of modern contraceptive use, followed by India, while Pakistan lags behind due to inconsistent policy priorities (Guttmacher Institute 2019; Azmat et al. 2015).

Overall, India and Bangladesh have now reached contraceptive prevalence close to the world average (Kantorová and Bongaarts 2024), while Pakistan remains far lower. The main differences reflect not only financing and policy commitment but also cultural and religious contexts, and societal barriers. In Pakistan, the high prevalence of consanguineous marriages, low female literacy, and early marriages have systematically reinforced the demand for larger families and limited the use of available methods (Zaidi et al. 2019; Sathar and Kazi 2000; Sathar and Royan 2013). In contrast, Bangladesh, despite political instability, has achieved a significant decline in fertility through a community-based door-to-door model (Matlab, FWA, satellite clinics), continuous contact between households and providers, and partnerships between the state and non-governmental organizations (e.g., BRAC, Grameen), which combined family planning with microcredit and women's education (Cleland et al. 1994; Phillips et al. 1988; Phillips et al. 1996; Mercer et al. 2004; World Health Organization 2004; Jahan 2007; Alam 2017). Gradual improvements in girls' school attendance, later marriages, and increasing female labor force participation further weakened traditional preferences for large families and correlated with long-term growth in the use of modern methods and a decline in TFR (Bairagi 2001; United Nations Population Fund 2023).

India presents a mixed picture: while Kerala achieved a rapid decline in fertility through education and health services, poorer states faced persistent difficulties, with programs long constrained by paternalistic and technocratic approaches that undermined women's influence (Jeffery and Jeffery 1997; Ram and Ram 2021; Robinson and Ross 2007). In Pakistan, on the other hand, stagnation in women's education and economic participation has been compounded by frequent program interruptions and weak political support, with the result that even the Lady Health Workers program has failed to achieve sufficient scale (Sathar and Zaidi 2010; Hakim and Mahmood 2001; Sathar 2007; Hafeez et al. 2011; Wazir et al. 2013; Goujon et al. 2020). Overall, these cases show that improvements in human development, education, and women's empowerment were more decisive factors for success than religious differences alone (Sathar and Royan 2013).

6. Conclusion

Despite sharing common goals and principles, family planning programs in India, Pakistan, and Bangladesh have developed along different trajectories shaped by cultural, social, economic, and political contexts. While all three countries integrated FPPs into their health systems and adopted community-based approaches with international support, India and Bangladesh have been more successful in increasing contraceptive use, particularly through early investments and policy innovations. India led in early

program implementation but later faced setbacks due to coercive practices, whereas Bangladesh benefited from donor funding and structured community outreach, despite persistent gender inequalities. Pakistan has consistently lagged, primarily due to religious resistance, weak policy commitment, and continued reliance on foreign aid. The effectiveness of FPPs thus depends not only on program design but also on how well they are adapted to local social structures and values. Future strategies must prioritize context-specific approaches to ensure more inclusive and sustainable progress in reproductive health.

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