# AGENDA-SETTING OF POPULATION IN BANGLADESH AND WEST BENGAL AND IMPACT ON FERTILITY

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Bangladesh's fertility decline occurred subsequent to the adoption of population policies in the 1970s-1980s. West Bengal's fertility decline occurred earlier and more gradually. Using a comparative qualitative case study method, we analyze how population got on the policy agenda, how agenda-setting influenced intent to implement, and the effect on fertility. We find that in Bangladesh, population got on the agenda in a top-down manner through internal decision-making, commitment of stakeholders and strong intent to implement. In West Bengal, the pro forma adoption of population policies was top-down from the national government, but the decision was external to the state's decision-making. Political priority within the state was economic empowerment of the poorest – not population – resulting in weak intent to implement population policies. We hypothesize that Bangladesh's fertility decline was driven mainly by family planning programs while West Bengal's resulted from improvements in contextual factors – not family planning programs.

# Table of Contents

# 1 INTRODUCTION

The total fertility rate (TFR) in Bangladesh has declined substantially from 6.8 children per woman in 1975 to 2.4 in 2007 (United Nations 2011). In the same period, the contraceptive prevalence rate (CPR) increased sharply from 6% to 48%. (Figure 1) Bangladesh has repeatedly been the focus of studies for its rapid fertility transition, and while numerous studies suggest family planning (FP) programs, female education or improvements in child mortality as the motivator of Bangladesh's fertility decline, the debate is ongoing (Joshi and Schultz 2007a; Schultz 2009; Hossain et al. 2007; Schultz 2007; Cleland et al. 1994; Joshi and Schultz 2007b). Results from the second chapter of the dissertation support the FP program body of literature, indicating that the use of FP in the community (a proxy for FP programs) was one of the most important – if not *the* most important – factors in the fertility decline in Bangladesh between 1975 and 2007. As illustrated in Figure 2, the increase in use of FP in the community explains nearly 70% of the total decline in births. While there were concomitant improvements in education and child mortality in the same period, they do not account for much of the decline in fertility. The fertility decline in Bangladesh took place subsequent to the adoption of population policies in the 1970s and 1980s. What remains unknown is how FP programs became such a motivating factor for fertility decline and how the policy process affected this. In this chapter, I explore three main questions: (i) how did population get onto the policy agenda? (ii) how did agenda-setting influence the intent to implement? and (iii) what were the effects of the policy process on fertility decline? In assessing the role of the policy process in the fertility decline in Bangladesh, I explore one component of the policy process for population and family planning policies: agenda-setting. For this analysis, I employ a comparative case study approach with the Indian state of West Bengal. Bangladesh and West Bengal have had comparable starting and ending points for fertility as well as historical, cultural, and linguistic similarities juxtaposed with important differences in fertility patterns and associated policies.

According to the framework proposed by Fox and Reich (Fox and Reich 2012), there are four main phases of the policy process: agenda-setting, policy formulation, policy adoption, and implementation. While recognizing that the policy process is non-linear, iterative and can have areas of overlap, I focus on the agenda-setting component of the policy process in this chapter. Differences in agenda-setting may have an impact on the formulation, adoption, and implementation of those policies. In the case of family planning, this may result in differential demand for contraception and the resulting fertility level. The role of the policy process in fertility decline has not previously been explored, and the research aims to contribute to the ongoing debate about fertility decline in Bangladesh within the demographic and policy

literature. I do this by reporting on in-depth interviews carried out with key informants to gain a qualitative understanding of how population got onto the policy agenda and how agenda-setting influenced the intent to implement in Bangladesh and West Bengal. Based on the results of the analysis, I generate some hypotheses that can help us understand more broadly the effects of policy on fertility decline.

**Figure 1. Total fertility rate (TFR) and contraceptive prevalence rate (CPR) in Bangladesh, 1960-2008**

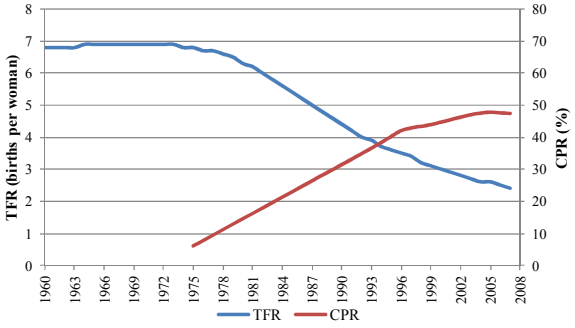
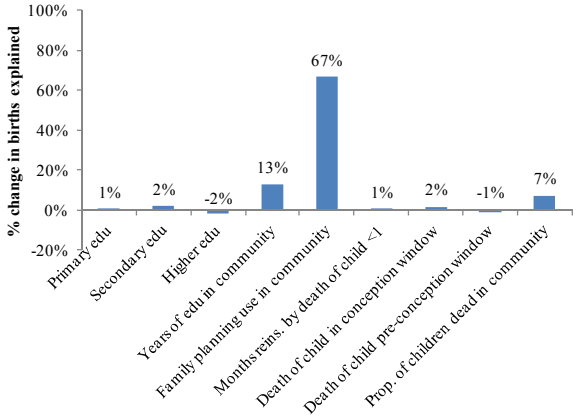



**Figure 2. Bangladesh: Percent of fertility decline explained by various socioeconomic factors, 1975-2007**




## 1.1 Comparing Bangladesh with West Bengal

### *1.1.1 Most similar cases*

One way to examine the role of the agenda-setting process in Bangladesh's fertility decline is through a comparison with West Bengal, based on a most similar cases rationale (Przeworski and Teune 1970). Przeworski and Teune state that a most similar cases approach includes assessment of economic, cultural, and political characteristics as categories of variables when determining cases for inclusion. The overall goal is to select cases in ways that maximize the number of common characteristics while minimizing the number of different characteristics for analysis. As discussed in the following paragraphs, the comparison of Bangladesh and West Bengal enables exploration of different political (and policy) characteristics of cases with similar economic and cultural characteristics.

The combined area of Bangladesh and West Bengal make up the Bengal region. (Figure 3) West Bengal and Bangladesh (formerly East Bengal) previously functioned as a unified province called Bengal within India. In 1947, India was partitioned along religious lines to create Pakistan and following partition, West Bengal became a state in India, and East Bengal became East Pakistan, a province of Pakistan. In 1971,

East Pakistan gained independence and became Bangladesh. Despite the political changes over this time period, West Bengal and Bangladesh continue to share the same language and culture, two of the main factors within diffusion theory of fertility decline. In addition, both have agriculture-based economies. Thus, language, culture and type of economy are key characteristics common to both Bangladesh and West Bengal.

**Figure 3. Map of the Bengal region: Bangladesh and West Bengal**


*Source:* Shmitra. http://en.wikipedia.org/wiki/Bengal

The important differences that make this comparison relevant are fertility and government policies. Although data show that West Bengal and East Bengal had comparable levels of fertility in 1931 – GFR around 100 (Porter 1933) – and that they are at comparable levels of fertility currently – TFR around 2 (Ministry of Health and Family Welfare 2009; United Nations 2011) – the fertility declines differed with respect to timing and perhaps also mechanism. Fertility began declining in West Bengal around 1960 and in Bangladesh around 1975. In addition, while previous studies and the results of Chapter 2 indicate that increase in FP in the community accounts for much of the fertility decline in Bangladesh, it has been posited that education and female labor force participation have been the primary determinants of fertility outcomes in West Bengal (Dreze and Murthi 2001; Basu and Amin 2000; Manna 1998). Furthermore, unlike Bangladesh and other states in India, it appears that West Bengal's government has not implemented targeted FP programs (Basu and Amin 2000). Thus, the mechanism of fertility change and government policies – the primary characteristics for analysis in this chapter – may have differed.

A potential challenge in this comparison may be religion. Bangladesh has a Muslim majority – according to the 2001 Census, Bangladesh is nearly 90% Muslim and 9% Hindu (Bangladesh Bureau of Statistics 2001). On the other hand, West Bengal has a Hindu majority with approximately 73% of its population Hindu and 25% Muslim (Office of the Registrar General and Census Commissioner 2001). However, the difference in religious profile is not anticipated to be a problem in this research for the following reasons. While Muslim women in India are less likely to use contraceptives than their Hindu counterparts, Muslim

women in West Bengal have higher contraceptive use than Muslim women in other parts of India (Basu and Amin 2000). Moreover, although conceptually religious affiliation may impact fertility, a study in India showed that after controlling for other factors, religious affiliation in and of itself does not affect fertility outcomes (Alagarajan 2003). Furthermore, the first chapter of this dissertation – a cross-country study of five countries in Asia – indicates that religion does not affect fertility after controlling for other socioeconomic factors. Because of both the literature on the role of religion in fertility as well as the nature of religion in Bengal, differences in religion between the two regions are not anticipated to be an obstacle in this study.

Thus, in general, the comparison of Bangladesh with West Bengal can be justified by a most similar cases argument. The fertility declines in Bangladesh and West Bengal occurred after the two regions of Bengal were under different political leadership such that the political variables differ over time while culture, language, and an agriculture-based economy have remained similar over the same time period. I choose this comparison because it may generate hypotheses about the relationship between policy processes (specifically agenda-setting) and fertility decline.

### *1.1.2 Comparing a nation state with a state within a nation*

It may be of concern to compare a nation state (Bangladesh) and a state within a nation (West Bengal) (Reich 1994). Such a comparison can raise the following questions: Can sub-national agenda-setting in West Bengal be compared to national agenda-setting in Bangladesh? How are India's national policies and priorities manifested at a sub-national level in West Bengal? I argue that comparing Bangladesh to West Bengal sub-nationally has fewer limitations than comparing it to India nationally because of (a) the level of decentralization in governance in India, (b) the diversity in language, culture, socioeconomic development, and health outcomes among states within India, and (c) the historical, cultural, and linguistic similarities between Bangladesh and West Bengal specifically.

With respect to decentralization, India is a federation of 28 states and seven union territories with a parliamentary government system that has become increasingly decentralized since its independence from Britain in 1947 (Wheare 1964; Echeverri-Gent 2002; Sinha 2004). Both national and state policies exist. In general, national policies are adopted centrally but implemented by the states with some share of funding from the national government. States can adopt additional policies which are then primarily funded by the state government. Thus, implementation of both national and state policies depends largely

on the specific priorities and capacities of each state. This implies that a national-level assessment alone would not accurately portray the state-level scenario and that a state-level assessment is necessary.

With respect to sub-national diversity, India has 22 recognized regional languages and a high degree of cultural pluralism (Baidyanath 2006). Language, cuisine, dress, music, dance, and literature vary from one state to the next. In addition, socioeconomic and health indicators vary by state as well. TFR is as low as 1.7 in Tamil Nadu and Kerala but 3.9 in Bihar (Ministry of Health and Family Welfare 2011). The literacy rate ranges from 91% in Kerala to 48% in Bihar (Government of Kerala ; Government of Bihar). Nearly 100% of births take place in health facilities in Kerala compared to only 18% in Jharkhand (International Institute for Population Sciences (IIPS) 2008). In 2005, fertility was as high as 4.0 children per woman in Bihar and as low as 1.8 in Andhra Pradesh, Goa and Tamil Nadu (International Institute for Population Sciences (IIPS) and Macro International 2007). This diversity suggests that assessing agenda-setting only at the national level can result in omission of variation at a disaggregated level and therefore is insufficient in generating hypotheses about the relationship between policy processes and policy outcomes.

Therefore, using a most similar cases approach, a comparison of Bangladesh and West Bengal – given similarities in their fertility levels, history, culture, language, and agricultural economy – is appropriate to explore the effects of policy variables on fertility. However, as discussed in the following sections, challenges also remain for this type of comparison.

# 2 BACKGROUND

## 2.1 History of Population and Family Planning in the Bengal Region

Bangladesh has followed a "planned development" course of action since its inception in 1971. A series of five-year development plans have guided the policies, priorities, resource allocation, and programs. FP policies – or population policies as they have been often called – have always been a component of the five-year plans. Bangladesh's five-year plans all included a population component with goals to reduce population growth. Over time, the implementation strategies for these policies have shifted away from incentive-based schemes narrowly focused on use of FP methods delivered directly to women's homes to a broader sector-wide integration of health and FP with service delivery at the community level. A review of the literature shows that population has consistently been a significant component in Bangladesh's development plans (Government of Bangladesh 1973, 1978, 1980, 1985, 1990).

Understanding the policy dimension in West Bengal is not as straightforward as assessing only the national level or only the state level policy process. What is necessary is an assessment of national population policies, state policies, and implementation of these policies at the state-level. Like Bangladesh, India has followed a series of five-year development plans which have all included population and FP policies. While each state in India is subject to the policies that are set at the national level, states do not simply "adopt" policies decided at the national level – rather, they have the opportunity to change and adapt them depending on state and local realities. Furthermore, while the national government provides financing for FP programs and policies, the state is responsible for implementation, implying that priority-setting, organizational capacity, organizational efficiency, and socioeconomic status of the state have much to do with the effectiveness and structure of the FP program (Srinivasan et al. 1991). Moreover, states also have the autonomy to adopt their own policies – a result of increasing decentralization in governance. To assess the impact of national-level policies on individuals, one needs to consider the degree to which national policies are translated into priorities and implementation at the state level. For example, surveys indicate that between 1972 and 1984, progress was achieved in the number of nurse-midwives, one of whose responsibilities included FP. However, this varied by state, and West Bengal was lagging behind other states with 56 nurse-midwives per million population in 1984 compared to 188 per million population in Karnataka (Srinivasan 1988). Thus, while national population policies are, in principle, adopted by states, the nature and extent of adoption – and subsequently implementation – varies from one state to the next and are affected by agenda-setting at the state level. Therefore, further work on agenda-setting can help assess the extent to which population was part of the state's policy agenda and how this affected implementation of policies and the subsequent fertility decline.

### *2.1.1 Population and Family Planning Policies in Bangladesh*

Bangladesh's First Five Year Plan (1973-1978) was launched after independence with the goals of alleviating extreme poverty and establishing a socialist economic structure. The government of Banghabandhu Sheikh Mujibur Rahman emphasized the national importance of population, and the plan included the specific goal to reduce the annual population growth rate from 3% to 2.8%. While most goals of this Five Year Plan failed, the population goal was successfully achieved. In 1975, two administrative bodies were formed: the Directorate of Family Planning and the National Population Council. The Directorate of Family Planning was put under the control of the Ministry of Health, and the maternal and child health program was transferred to the Directorate of Family Planning, making MCH-

based FP a cornerstone of service delivery (Mabud and Akhter 2000). In 1976, Ziaur Rahman's government came to power and reiterated that population was the number one problem for the country. The Bangladesh National Population Policy (NPP) of 1976 – which viewed FP as an integral component of development – was established and followed until 1980. The policy emphasized incentive schemes for both clients and field workers and emphasized doorstep service delivery (i.e. contraceptive supplies delivered directly to homes) (Mabud and Akhter 2000).

The Second Five Year Plan (1980-1985) focused on poverty, illiteracy, unemployment, and under-employment. The population component aimed to reduce population growth from 2.8% to 1.5% annually. Included in the Third Five Year Plan (1985-1990) was a goal to reduce population growth from 2.4% to 1.8%. More resources were allocated to population activities than to health activities, but the annual growth rate only reduced to 2.2% over the plan period. Other goals included reduction of maternal and infant mortality and increase in the contraceptive prevalence rate (CPR). The primary goal of the Fourth Five Year Plan (1990-1995) was economic development through population growth control, human resource development, poverty alleviation, increasing employment opportunities, and rural economic development. Once again, there was a goal to reduce population growth – from 2.2% to 1.9% – accompanied by greater allocation for FP than for health. There was full resource utilization and considerable progress for population programs in addition to a new focus on women following the 1994 International Conference on Population and Development, held in Cairo.

In the Fifth Five Year Plan (1997-2002), population goals were imbedded within health goals for the provision of primary health care services. Accompanying this shift from narrow population policies to broader health and population sector programs (HPSP) was a mandate for universal primary education. Strategies for incorporating the FP component into broader reproductive health services included increasing CPR, decreasing discontinuation of contraception, improving FP service management (particularly for underserved groups and low-performing areas), and increasing skilled human resources. The practical implications of these strategies were that doorstep service delivery changed to one-stop service delivery, the multi-sectoral approach to population became a sectoral approach within the health sector, a mix of projects and programs merged into a single mega-program, and population activities became a sub-sectoral component of health rather than having a sectoral focus (Mabud and Akhter 2000). During the implementation of the Fifth Five Year Plan, the NPP 2000 was formulated with a shift in strategy to deliver services. Overall, it would appear that integration of health and family planning services at the field-level under the HPSP hampered the functioning of the home distribution system of FP methods by the field workers at the household level (Hossain 2003).

### *2.1.2 Population and Family Planning Policies in India*

Similar to Bangladesh, India's five-year development plans have also included population components. However, the issue of population growth took root in India long before the inception of the Five Year Development Plans. In 1916, *The Population Problem of India* was published based on census data and highlighted the consequences of population growth. Then following the 1940 Bengal famine, the Bengal Famine Inquiry Committee was established to explore the famine and the potential link with rapid population growth (Harkavy and Roy 2007). The secretary of this committee went on to become the director of the 1951 census.

The First Five Year Plan (1951-1956) included the first national FP program in the world, focusing on limiting family size and controlling population (World Bank 1980). The goal was the provision of advice on FP for those who sought it through government hospitals and clinics. Program implementation was limited mostly to urban areas and resulted in people visiting the clinics less than anticipated with overall expenditures 20% of allocations. The Second Five Year Plan (1956-1961) retained the clinical approach and expanded the number of FP clinics, established FP boards, and created facilities for voluntary sterilizations. With expenditures reaching 44% of allocation, the number of total acceptors of FP practices increased, but outreach remained poor due to limited administrative capacity and poor management at the state and district levels. Under the Third Five Year Plan (1961-1966), 92% of allocation was spent, the Department of Family Planning was created within the Ministry of Health, and FP services were integrated with MCH services. During an "inter-plan period" (1966-1969), India embarked on an incentive system to encourage uptake of FP services and methods. Monetary incentives were given to acceptors of FP methods (primarily sterilization) as well as to FP workers who brought clients for sterilization. These incentives, however, were directed at the poorer segments of society. The goal of the population component of the Fourth Five Year Plan (1969-1974) was to increase sterilizations and IUDs while also promoting oral pills and injectables.

At the Bucharest conference in 1974, the head of the Indian delegation stated that "Development is the best contraceptive" (Sinding 2007), suggesting that emphasis ought to be on underlying causes of population growth such as poverty rather than family planning programs. Following the conference, the Fifth Five Year Plan (1974-1979) was launched. Included was the NPP of 1976 which promoted measures to encourage FP practices as well as action beyond FP measures to solve the population problem (Chaudhry 1989). The legal age of marriage was established at 21 for men and 18 for women, and incentives were set up for acceptors of FP. The Minister of Health stated that population was a

national priority and started an integrated health package (FP, health, nutrition) directed at women and children. However, following political and economic unrest, Prime Minister Gandhi declared a state of emergency in 1975 (referred to as "Emergency" hereafter), suspending elections and civil liberties for 21 months. During the Emergency, the government reversed its position at Bucharest and the broader approach of the Fifth Five Year Plan. Instead, it embarked on a serious population control agenda that included state-level targets for sterilizations and other forms of family planning. States largely had the responsibility to legislate compulsory sterilizations and meet nationally-determined targets. In response to the large number of deaths resulting from poor-quality sterilizations, fear and resistance set in, and people began fleeing official vehicles, avoided health centers and refused vaccinations for fear of sterilization. Partly as a result of backlash to the coercive family planning program, the ruling party lost the elections following the Emergency.

The Sixth and Seventh Five Year Plans (1980-1985, 1985-1990) maintained the priority on FP but emphasized the voluntary nature of the program and the focus shifted to the vulnerable sub-population of poor women. The government acknowledged the failure of the narrow FP program and stated that increases in CPR would be based on improvements in IMR, female literacy, and job opportunities for women (Chaudhry 1989). The NPP of 1986 promoted the two-child family with a focus on child mortality, health services, enforcement of the legal age of marriage, education on health and population, and women's educational and employment opportunities (Rao 1994). The Eighth Five Year Plan (1992-1997) had an overall focus on modernizing the industrial sector, increasing employment, poverty reduction, reliance on domestic resources, and slowing population growth. The Ninth Five Year Plan (1997-2002) also stated population growth as a problem but lacked any level of detail to address the population problem (Reddy 1998).

While information is available on India's national population policies, relatively little is available on policies in West Bengal – or to what extent population was on the state agenda or how the national policies were adapted, adopted, and implemented at the state level. A major goal of this research is to gain a better understanding of how population evolved on the state agenda in West Bengal as well as the relationship between the national and state agendas.

## 3 THEORETICAL FRAMEWORK

As noted earlier, the policy process can be considered in four phases: (1) agenda-setting, (2) policy formulation, (3) policy adoption and (4) implementation (Fox and Reich 2012). Agenda-setting refers to

the initial placement of the issue on the policy agenda. Policy formulation refers to the design of the policy or program, which includes both technical and political aspects. Legislative or executive passage of the policy is policy adoption, and implementation of the policy is the final phase. Each of these components is a complex process with a multitude of players and actions required. Even though there is evidence that population policies were adopted in both Bangladesh and India, it is unclear who pushed for these policies or what the motivations were behind the issue. While population policies were designed and legislative or executive actions were taken to adopt them, the process by which population policies came onto the agenda remains to be determined. Having a better understanding of this can elucidate where and who the ideas came from, how the issue became an agenda item, how much priority the issue received, how funds were allocated, and how implementation went. Thus, the focus of this chapter is the agenda-setting phase of the policy process.

Classic theories on agenda-setting include Cohen and colleagues' garbage can model and Kingdon's political streams (Cohen et al. 1972; Kingdon 1984). The garbage can model explains organizational decision-making as resulting from a combination of problems, solutions, and competing demands. Kingdon claims that the intersection of three factors make up the "policy window" which determines whether an issue makes it onto the agenda: problems, policy alternatives, and politics. Each component is mostly independent of the others but when they come together, the policy window for an issue is created. More recently, however, Kingdon's theory has been modified to be more appropriate for global health: Reich's five political streams, Shiffman's four conditions for an issue to gain national attention, and Shiffman's factors that influence the degree to which an issue appears on national policy agendas (Reich 1995; Shiffman 2003, 2007). Reich proposed five political streams to analyze the politics of agenda-setting: organization politics, scientific politics, symbolic politics, economics politics, and politician politics. Organizational politics refers to the use of power and position of organizations involved to control the issues gaining priority. Scientific politics refers to how funding of research can shift the agenda. Symbolic politics refers to the use of images and language to promote an issue onto the agenda. Economics politics refers to the use of economic power of for-profit organizations to control to agenda. And politician politics is the assessment of political feasibility, benefits, and costs to the politician with reference to supporting an issue for the agenda. Shiffman's four conditions for getting an issue on the national agenda are the presence of clear indicators, the existence of high-level political entrepreneurs to support the issue, attention-generating focusing events, and policy alternatives to address the issue. An additional framework proposed by Shiffman states that the intersection of three categories of factors determines the degree to which maternal mortality appears on the national policy agenda: (1)

transnational influences, (2) domestic advocacy, and (3) the national political environment (Shiffman 2007).

The goals of this policy analysis are to determine how population got onto the policy agenda in Bangladesh and West Bengal, and how agenda-setting influenced the intent to implement policies in these two entities. This analysis of population issues in Bangladesh and West Bengal adapts the Shiffman agenda-setting framework (2007) to elucidate the degree to which population had priority on the agenda. The categories of factors included in this framework are particularly pertinent since population issues have been affected by forces and conditions at multiple levels – international, national, and sub-national – and this framework can address these influences. The adapted framework is not only applicable to agenda-setting at the national-level but can also be extended to agenda-setting at the sub-national level. I consider three types of factors in the analysis: (1) political environment, (2) external influences, and (3) government advocacy (Table 1). To assess the political environment, I consider political transitions, competing priorities and political culture at the national level in Bangladesh and at the state level in West Bengal. I include external influences on norm promotion and resource provision. For Bangladesh, I take into account international influences – or forces outside of the country unit of observation. For West Bengal, I consider influences external to the state including both national and international influences. To assess government advocacy, I explore five factors – political entrepreneurship, policy community cohesion, credible indicators, focusing events, and clear policy alternatives – and consider each of these at the national level for Bangladesh and at the state level for West Bengal.

**Table 1. Factors Theoretically Influencing Agenda-Setting of Population Issues**

| Political Environment | External Influences | Government Advocacy |
|---|---|---|
| • Political transitions<br>• Competing priorities<br>• Political culture | • Norm promotion<br>• Resource provision | • Political entrepreneurship<br>• Policy community cohesion<br>• Credible indicators<br>• Focusing events (e.g. conferences)<br>• Clear policy alternative |

This framework can be used to assess whether agenda-setting occurred in a top-down or a bottom-up manner. A top-down approach would be implied by a dominance of external influences, political entrepreneurship, government advocacy by early adopters and policy experts, and focusing events organized by these same groups. A top-down approach would imply that agenda-setting – followed by policy design and adoption – "exogenously" induced demand for contraception and smaller families. On the other hand, a bottom-up approach would be implied by a dominance of advocacy motivated by

grassroots groups (acting on behalf of women and couples who have expressed the desire for contraception and fewer children) and focusing events organized by similar types of groups. A bottom-up approach would imply that demand for contraception and smaller families already existed in the population at large and that any agenda-setting – as well as policy design and adoption – occurred in response to this existing demand.

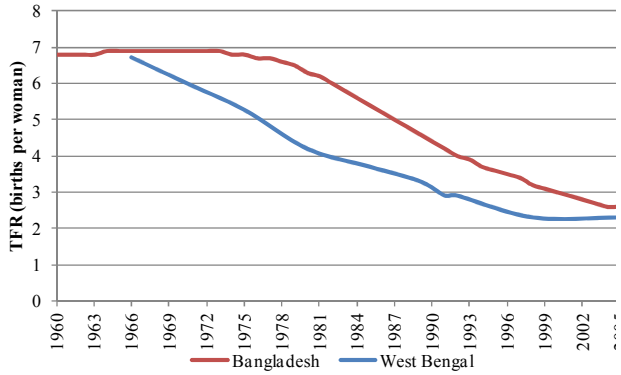
For this study, I hypothesize that in Bangladesh, population achieved national priority in a top-down command-driven manner – championed by a few powerful politicians, key political transition events, and resource provision by external donors. In contrast, in West Bengal population did not achieve political priority even though policies were adopted *pro forma* following the lead of the national government. These agenda-setting mechanisms would result in a strong intent to implement in Bangladesh but a weak intent to implement in West Bengal.

## 4 METHODOLOGY

I use process-tracing for this qualitative comparative case study. Process-tracing is a method used in qualitative political science research to assess causality by using multiple sources of information (Yin 1994). More recently, George and Bennett defined it as a "method [that] attempts to identify the intervening causal process – the causal chain and causal mechanism – between an independent variable (or variables) and the outcome of the dependent variable" (George and Bennett 2005). The focus of analysis is on the First through the Third Five Year development plan periods in Bangladesh (1973-1990) because changes in fertility and FP were most pronounced in these periods. The policy literature also indicates that most changes occurred during this time period. In West Bengal, the decline has been steadier and began in the 1960s (Figure 4). Therefore, the time horizon for analysis of West Bengal is broader (1960-1990).

The data for the study consist primarily of 30 key-informant interviews with policy experts (17 in Bangladesh, 13 in West Bengal) in the government sector, NGO sector, and academia using snowballing sampling procedure to identify potential interviewees. Prior to the interviews, each key informant was contacted and given a brief explanation of the project and its purposes. The in-person interviews were semi-structured and conformed to a basic questionnaire that was tailored to each key informant. The semi-structured nature of the interviews enabled comparability of data across settings and time (Maxwell 2005). The interviews were conducted primarily in Bengali, digitally recorded, transcribed, and

**Figure 4. Total fertility rate (TFR) in Bangladesh and West Bengal, 1960 to 2008**




*Data Sources:* WDI, DHS, Rele 1987, IRG 1996, NRC 1984

translated for deductive content analysis due to the fact that the structure of the analysis is based on existing theory and for comparisons across settings and time (Elo and Kyngäs 2008). The interview transcripts were deductively coded using NVivo software according to themes derived from the agenda-setting theoretical framework (Table 1) to explore how population got onto the policy agenda and how this affected the intent to implement population policies. All interviews, conducted in January and February of 2011 unless otherwise noted, are kept confidential but are referenced by interview number. IRB exemption was secured for administering the questionnaires. In addition to the interviews, published work and policy documents on the critical periods were also included in the analysis to assess the factors that shaped the agenda-setting process.

Triangulation – using a variety of data sources – was employed to minimize systematic bias from any one type of source (Fielding and Fielding 1986). My aim was to acquire first-hand information from participants in the process, with supplementation from other relevant documents. In Bangladesh, the focus was activity at the national level, and in West Bengal the focus was activity at the state level with some inclusion of activity at the national level as appropriate. Experiences of the actors involved and the perspectives of different sectors are critical to understanding the agenda-setting process.

Challenges of the policy analysis include the fact that the policy process is inherently political, making it difficult to acquire accurate, unbiased information from either individuals or documents. An additional limitation is the scope of the policy analysis. While it is not feasible to undertake all elements of a policy analysis (agenda-setting, policy formulation, policy adoption and implementation) in one paper, a more comprehensive explanation could result if all components were analyzed rather than focusing only on agenda-setting. Furthermore, an additional consideration may be the potential introduction of biases by interviewees due to the retrospective nature of the questionnaires. I have, however, tried to attenuate

these biases by supplementing the interview data with evidence from additional documents and publications. The parameters of this comparative case study make it difficult to draw causal inferences. Thus, this is a descriptive, hypothesis-generating exercise rather than a causal inference chapter. The aim, however, is to identify some factors related to mechanisms of fertility decline that will be relevant to the broader literature.

# 5 RESULTS

In this section, I present the findings for the two cases according to the factors in Table 1. The three categories of factors – political environment, external influences and government advocacy and mobilization – largely explain the extent to which population got onto the national agenda in Bangladesh and the state agenda in West Bengal. While in Bangladesh population was on the policy agenda, in West Bengal this does not appear to be the case. Table 2 summarizes the findings of the two cases:

**Table 2. Factors Influencing the Extent to which Population and Family Planning Appeared on the Policy Agenda in Bangladesh and West Bengal**

| | Bangladesh | West Bengal |
|---|---|---|
| **Political environment** | • Liberation War, independence, new government(s)<br>• Population was a top political priority<br>• Partisan politics not as strong | • 'Emergency' in India diluted emphasis on population at national and state levels<br>• Rise of Communist Party of India, Marxist (CPIM) in West Bengal elections<br>• CPIM priorities included land reform and education – not population |
| **External influences** | • Technical and financial assistance from international organizations<br>• Bucharest Population Conference | • Financial support and administrative direction from Central government for population |
| **Government advocacy and mobilization** | • Sustained support of high-level political champions<br>• Collaboration between technical experts, researchers, bureaucrats, religious leaders and politicians<br>• Indicators that highlighted the issue of population growth<br>• Famine and other events (i.e. workshops, seminars, etc.) that generated attention for population<br>• Clear and feasible policy alternatives formulated by a cohesive policy community and financially supported by external donors | • No political champions within the state<br>• Policy community at state level excluded from policy process<br>• Population density and population growth indicators insufficient in generating attention<br>• Lack of focusing events in the state |

## 5.1 Bangladesh

### *5.1.1 Political Environment*

#### *5.1.1.1 Political Transitions*

Literature from both developing and developed countries has shown that political changes (and reforms) have the ability to induce changes in priorities – they can open the window for new priorities, and they can also close the door on existing priorities (Cheema and Rondinelli 1983; Linz and Stepan 1996; Shiffman 2007). The analysis indicates that one of the main factors that influenced the national agenda in Bangladesh was independence from Pakistan in 1971. Following liberation, the new government assessed the future of their new country. Poverty was rampant, population growth was high, land ratio was low (population density high), unemployment was chronic, and the country was devastated by war. The leaders decided that if the population continued to grow at the current rate, population growth would outpace food production and resources – a very Malthusian viewpoint (Malthus 1798), but one that put population high on the policy agenda for political leaders of the country. Following liberation, there was a sense that the devastation from the war combined with an overall lack of resources would create great challenges of development that could be overcome only if population growth were curbed. Thus, government leaders gave a focus on population and family planning programs to reduce fertility and slow down population growth.

The liberation war also had an effect on the role of women that led them to have more decision-making power. Women were involved in the liberation movement in Bangladesh and were also the target of war atrocities. In addition, migration between Bangladesh and West Bengal during the war resulted in families being separated and reunited only afterward. With the male household heads off to war, women became the head of the households temporarily, which had lasting effects on women's autonomy after the war. Following independence, women displayed patriotism and publicly observed national days of remembrance through the colors of their clothing and attendance at national monuments. This brought them out of the home and into the public space more than prior to independence, thus contributing to women's empowerment. The social transformations associated with the liberation war and independence led to women having more control over the household economy, their mobility and eventually their fertility (I-1, I-7).

Another way in which the role of women was impacted by the liberation war was the legalization of menstrual regulation (as opposed to legalization of abortion). The legality of menstrual regulation depends on no legal establishment of pregnancy – no pregnancy test is done before the procedure and no

examination of uterine contents is conducted following the procedure (Piet-Pelon 1997). In Bangladesh, menstrual regulation is defined as "...an interim method of establishing non-pregnancy for a woman who is at risk of being pregnant, whether or not she is pregnant in fact" (Akhter 1986; Dixon-Muller 1988). Immediately following the war, the ban on abortion was temporarily lifted for women who were rape victims during the war. While these were abortions and not menstrual regulations, this may have reframed the debate on pregnancy termination and opened the door for legalization of menstrual regulation. The First Five Year Plan stated the following: "Legalization of abortion has been known as probably the best and most effective method for control of population growth. It should be seriously considered how this method can be adopted to control the population growth in Bangladesh" (Government of Bangladesh 1973). The government began its menstrual regulation program in 1973 primarily in urban clinics as a backup for contraceptive failure. While the rules were initially quite strict (within 12 weeks of conception with consent of husband or legal guardian) and services available primarily in urban areas, legalization of menstrual regulation expanded the conversation on family planning and influenced subsequent changes in social norms.

Thus, liberation as a political and social event helped place population as a top priority on the national policy agenda. The intersection of demographic and economic forces was recognized to a greater degree following independence. In addition, there was continuity in attention to population between independence and 1991, even with changes in government during this time period. Although the Pakistani government had been favorable to population and family planning – and in fact had implemented a family planning program, primarily in the urban areas – independence as an event reopened the issue in a major way in Bangladesh. Furthermore, liberation – and the ability to speak and write in Bengali – induced a psychological shift and enthusiasm that enabled people (both inside and outside government) to be more open to ideas and new approaches. This made the issue of population and family planning more easily accepted at the community level. One researcher explained the mentality following independence:

> "At that time of independence, it was a time when many things were changing. So this may have been related – people were willing to change their behaviors, accept new things."
> *I-10*

#### *5.1.1.2 Competing Priorities*

Issues compete for resources in all countries – but perhaps more intensely in resource-poor settings – so the priority an issue receives on the policy agenda largely determines the amount of funding that will be allocated to it; as such, the amount of resources allocated may be considered an indicator of priority. The

data show that population achieved top priority on the new national political agenda in Bangladesh and commanded attention of political leaders, bureaucrats, technocrats and donors. In 1972, a Planning Commission was formed and tasked with preparing short-, medium-, and long-term development plans (including the Five Year Plan); recommending and deliberating policies and institutional changes for the implementation of the Five Year Plan; and coordinating economic policies undertaken by various ministries (The Ministry of Planning 2004). The Planning Commission members agreed that the top priorities for economic development and poverty alleviation were population and food production. Population was considered a multi-sectoral issue and the government committed multiple ministries of government to participate in population activities. Furthermore, population was prioritized so highly that not only were resources allocated specifically to population activities, but when resources fell short, they were taken from other program areas and reallocated for population. One respondent commented:

> "[At] any meeting organized in government, population became number one because Planning Commission was saying so, government was saying so – then all famous economists were in the Planning Commission. In any political meeting the emphasis was that we had to control our population – this is the priority area."
> *I-1*

The famine of 1974 strengthened the Malthusian resource constraint viewpoint and increased attention given to population. Other sectors such as education – especially female education – gained priority later in the 1980s and 1990s. Similarly, microcredit programs (inspired by the famine of 1974) and the garment industry took off in the 1980s in Bangladesh and contributed to women's economic and social empowerment. From the start of the country, however, population was considered a top priority and remained high on the agenda for nearly 20 years through administrative transitions.

#### *5.1.1.3 Political Culture*

Today, partisan politics are so strong in the two-party system that when a party comes into power, many of the policies of the predecessor are reversed, which negatively impacts implementation. In contrast, the Bangladeshi political culture in the 1970s and 1980s was more cohesive and less partisan than the current period. (While there may have been strong competition between individuals and even a military coup, this did not result in strong competition among political parties.) At that time, government employees were not afraid to function in a committed manner for fear of their loyalties being assessed each time power changed hands. As a result, there was continuity in policies and priorities following changes in leadership, and implementation of the policies occurred in a sustained manner over a longer period of time. Furthermore, government legitimacy was important – the government showing support for family planning legitimized it for the people, making acceptance of new ideas and methods easier.

### *5.1.2 External Influences*

#### *5.1.2.1 Norm Promotion*

Ideational or diffusion theory suggests that the international political arena can have an impact on national policy agendas – ideas are exchanged between politicians at international meetings, international organizations are often involved with national governments in discussing and formulating policies, activists can exert pressure on international organizations as well as national leaders to further their causes, and research findings are disseminated to international academic communities (Rogers 1962; Finnemore 1996; Keck and Sikkink 1998; Shiffman 2007). The findings suggest that norm promotion by external influences was strong in Bangladesh. Following independence, Bangladesh was in a shambles and the international community was reaching out to provide technical guidance for policies and programs, which influenced the national political agenda. Ideas were flowing from international organizations and donors as well as top-level internal sources such as politicians and technocrats. The Malthusian fear of population growth had gained traction at the global level. The Third World Population Conference, which took place in Bucharest in 1974, and a series of international meetings leading up to it generated attention for population at the global level, influenced donor funding, and shaped international organizations' priorities (Finkle and Crane 1975). In addition, academics and technocrats from Bangladesh attended the Bucharest Conference and upon their return, workshops and conferences were held to discuss population and demographics. Although the Bucharest Conference had more of an effect on international partners than on politicians within Bangladesh, politicians as well as technocrats were able to use the Bucharest Conference to legitimize the issue domestically, as one member of the NGO community explained:

> "Outside, the [Bucharest] Conference was kind of a milestone. So at that time, the local leaders, technocrats and experts kept on talking about it, and they made references to the conference: 'Look, what we are saying here is also being said globally.'"
> *I-13*

The Ford Foundation and USAID helped train intellectuals on population. Financial support was provided to students in Bangladesh to go abroad and study population in the 1970s and 1980s. Some of these students, newly armed with demographic knowledge and skills, served on the Planning Commission and participated in other policy discussions when they returned to Bangladesh – thus ideas and norms established externally were flowing into Bangladesh during this time period. From a political perspective, supporters of both the Awami League and the Bangladesh National Party[1] were going abroad for this

[1] Bangladesh primarily has a two-party political system, though both parties have increasingly engaged in coalitions with smaller parties. The Awami League generally represents secular and liberal factions while the Bangladesh National Party (BNP) represents more conservative, right-of-center groups.

academic training, creating bipartisan support for population policy. Furthermore, external organizations (e.g. Ford Foundation, Population Council, USAID) provided technical support for design and evaluation of policies and programs. A current member of the academic community, and formerly an employee of an international organization, reflected:

> "[USAID] helped train the intellectuals on population. I was the USAID fellow and I got a full scholarship from USAID to go to Chicago. [Some others] went to Boston. All these intellectuals were part of the government but they are very good in their capacity in their respective fields. They were trained by USAID."
> *I-12*

Another influence was Indonesia, whose family planning program progressed from a private sector venture to a government one in 1970. The broad goals of Bangladesh's population program were similar to Indonesia's in the sense that they both aimed to reduce population growth for purposes of development (Herartri 2004). Although Indonesia had adopted a clinic-based approach, fieldworkers affiliated with the clinics disseminated information door-to-door (Hull et al. 1977). This door-to-door delivery of information was, in part, one of the models for Bangladesh's service delivery approach.

#### *5.1.2.2 Resource Provision*

The literature suggests that financial and technical support provided by international organizations can influence the policies and priorities that a national government decides to support (Stone 1999; Snow et al. 1986; Shiffman 2007; Reich 1995). Bangladesh was dependent on foreign aid following independence, and donors were keen to provide assistance to the new country. The data show that population and family planning was a priority for donors as well as for national political leaders and technocrats. Family planning was in the development budget, which was provided mostly by external sources. USAID was the largest bilateral providing aid to Bangladesh following independence, and since 1971, USAID has provided over $5 billion in development assistance. During the 1970s and 1980s, population and family planning was a priority for USAID not only in Bangladesh but other resource-poor countries as well. In Bangladesh, USAID was the first and for a while the largest donor for population assistance with sustained support for the first 20 years toward the provision of contraceptive commodities, technical assistance, and research associated with fertility and delivery of services (Shutt et al. 1991). From the USAID perspective, service delivery has been prioritized over the other interventions. USAID funds were channeled through both the Bangladesh government as well as the NGO and private sectors through organizations such as Pathfinder, Family Health International and Family Planning International Assistance (branch of Planned Parenthood Federation). The famine of 1974 brought donor support and also highlighted the growing population's food crisis. Partly because of USAID's substantial and

sustained financial project support for population and family planning, the issue remained a priority on the national political agenda for many years following independence. A respondent explained that the donor role was one of both financial and technical support (I-6).

In addition to USAID, organizations like the Ford Foundation, Population Council and UNFPA provided financial support for family planning activities. One example of this is training workshops for religious leaders. External financing contributed to dissemination of family planning information to community leaders, which resulted in broader support of – or at least reduced opposition to – population and family planning. Another example of external financing at the programmatic level is the provision of vehicles to bureaucrats for ease of transport. While people working in family planning had cars due to external funding, those working in other sectors did not have such benefits (I-7, I-10); this contributed to making population and family planning a more popular agenda item since they were personally benefiting from it.

External norm promotion by donors, academia/research, international conferences and attention to population in other developing countries promoted population as an important issue on the national policy agenda. Financial and technical support from donors and the international community helped raise the priority placed on population and family planning by national political leaders and influenced the level of priority it received at the national level.

### *5.1.3 Government Advocacy and Mobilization*

#### *5.1.3.1 Political Entrepreneurship*

Political leaders who promote a cause can bring significant attention to issues and influence the policy agenda (Kingdon 1984; Shiffman 2003, 2007). Population growth was considered the biggest problem by those at the highest levels of government in Bangladesh and received sustained attention from political entrepreneurs. In 1973, Prime Minister Sheikh Mujibur Rahman named population control and family planning as a national priority (Mabud and Akhter 2000). The Prime Minister also chaired the first Planning Commission, which was in charge of drafting the First Five Year Plan (1973-1978). Thus, the Planning Commission had full support of the Prime Minister, and this endorsement was crucial for the policy process. A former member of the government explained:

> "The head of the government – the Prime Minister – was the Chairman of the Planning Commission. So, Bangabandhu [Mujibur Rahman] himself was heading the Planning Commission. He said that something had to be done very seriously, and necessary priority had to be given, so they got his endorsement."
> *I-3*

The Five Year Plan specifically stated that "no civilised measure would be too drastic to keep the population of Bangladesh on the smaller side of [150 million] for the sheer ecological viability of the nation" (Government of Bangladesh 1973). The National Population Council was formed to specifically tackle the issue of population growth and family planning, and the Prime Minister headed this body as well (Mabud and Akhter 2000). In one often-cited speech, he declared, "People will have to eat people" if population growth were not curbed.

The successor government – led by Ziaur Rahman – continued to give prominent attention to population. In the aftermath of the 1974 famine, President Rahman identified population as the country's number one priority (Mabud and Akhter 2000). Under his leadership, the first National Population Policy was formulated in 1976 with aggressive goals on population growth and programmatic direction for family planning. This population policy was the foundation for subsequent policies and programs through the mid-1990s.

When Hussain Mohammed Ershad came to power in 1982 as the Chief Martial Law Administrator and later became President in 1983, he also emphasized the issue of population growth and continued to support the policies set by his predecessors. He used to hold National Population Council meetings every month to monitor progress on goals. Ershad's efforts on the issue of population and family planning were recognized internationally, and he was awarded the UN Population Award in 1987. Thus, starting with independence and through the 1980s when the bulk of the fertility decline occurred, support for population from political leaders was instrumental in placing and keeping population on the national policy agenda. A former member of the government explained the continuity of political support:

> "The emphasis was from any government that came – marshal law government, political government, democratic government – nobody had an objection to family planning. There was continuity."
> *I-11*

#### *5.1.3.2 Policy Community Cohesion*

The policy community includes individuals from the government, academia, NGOs, and donor agencies, among others. The extent of their authority in shaping the policy agenda is in part determined by the level of their cohesion (Shiffman 2007; Pelletier 2011). In addition to support from political leaders, cohesion within the broader policy community was a major factor in population's high priority on the agenda in Bangladesh. The Planning Commission was headed by the head of the government (prime minister or president) and included representation of multiple ministries. When population got onto the policy

agenda, it had a broad, multi-sectoral base of support. The Planning Commission was comprised of politicians, bureaucrats, academics and technical experts (primarily in economics and demography). Academics and technical experts received bureaucratic posts on the Commission, making them "technocrats." The technocrats, many of whom had international training, provided data and information to promote the issue of population, and the politicians generated public attention. The joint discussions between the politicians and technocrats enabled the exchange of ideas and cohesion of thought between technical and political stakeholders. In addition, this unity of the Planning Commission facilitated the transfer of the message to sub-national entities as well. Meetings organized by the government emphasized the issue of population and the importance of family planning in addressing it. Committees were formed at the district and union levels to give attention to population. Policies and programs were considered feasible and appropriate by those at the national and sub-national levels, partly due to the extensive discussions and substantial funding, resulting in ownership of the policies and programs and a commitment to implementation at various levels.

The Matlab Health and Demographic Surveillance System was a part of the policy community and contributed data and evidence to policy discussions. The villages of Matlab have been the site for large-scale operations research, including on family planning delivery options. One of these research projects had been comparing outreach services with fixed sites, and their findings contributed to a cohesive perspective on how to address the population issue.

The population policy discussion also involved the religious establishment. Religious leaders – who hold an important leadership role at the village level – were included in discussions by political leaders and technocrats. Workshops were held to illustrate to religious leaders how Islam does not prohibit family planning. Passages from religious texts were used to establish the acceptability of family planning in Islam. Religious leaders were also invited to participate in higher-level meetings with bureaucrats and technocrats. Honorariums were given to them on some occasions for their time and participation. There was a sense of honor and prestige to be a part of the national goals, and the Family Planning Association of Bangladesh and UNFPA worked with community leaders to help overcome the religious opposition. Involving religious leaders in the decision-making process gave them some ownership of the issue, and helped legitimize family planning from a religious perspective, which helped make it acceptable to their communities. Thus, while there had been some opposition from the religious establishment initially, this was eventually overcome through active steps taken.

Although they were not a major player in the policy community following independence, NGOs eventually contributed to population and family planning activities. The government gave direction to NGOs which began operating more widely in the 1980s and 1990s. Mothers' clubs and women's groups in the community were directed to include family planning information in their programs and additionally contributed to women's empowerment through other activities.

Thus, cohesion within the policy community and advocacy by various actors within the country – champions in the government, academics, religious leaders, and eventually NGOs – contributed to a unified and consistent message about population and family planning, enabling population to be placed high on the policy agenda.

#### *5.1.3.3 Credible Indicators*

In the literature, the existence of clear indicators can help get attention for an issue (Walker 1974; Kingdon 1984; Shiffman 2007). In Bangladesh, the large population numbers (76 million in 1972), high population growth figures (3%), high population density, low food production, widespread poverty (71% in 1973), and rising food prices persuaded not only the political entrepreneurs but also the general population of the need to address the growing population issue (Government of Bangladesh 1973; Mabud and Akhter 2000; Osmani et al. 2003). Replacement level fertility – or a net reproduction rate (NRR) of 1 – became a national goal. These indicators, provided by technocrats on the Planning Commission, made the issue of population more tangible and solidified the importance accorded to it. These indicators were also used to help mobilize religious and community leaders.

#### *5.1.3.4 Focusing Events*

In addition to indicators, focusing events can generate public attention to an issue. Focusing events can include disasters, conferences/seminars, accidents and discoveries (Kingdon 1995; Birkland 1997, 1998; Shiffman 2003, 2007). Devastation from the liberation war combined with food shortages resulting from the 1974 famine convinced people that the population was growing at a faster pace than food production. Furthermore, the World Population Conference in Bucharest in 1974 highlighted the issue of population growth to technocrats and politicians, and subsequently, seminars and workshops were held in Bangladesh. The World Fertility Survey was conducted in 1975, which resulted in a number of activities at the national and sub-national levels. In addition, meetings and seminars were organized at the local level to generate attention in communities rather than attention being limited to only the highest levels of government.

#### *5.1.3.5 Clear Policy Alternatives*

The public policy literature indicates that leaders are more likely to act on a problem if there are policy alternatives that can be feasibly implemented to overcome the challenges (Kingdon 1984; Sabatier 1998; Shiffman 2007). Leaders identified a number of challenges: lack of knowledge about family planning, preference for large families (both in Muslim and Hindu traditions), low women's status and mobility, and lack of access to family planning (Levine et al. 2004) To meet these challenges in Bangladesh, the policy community came together to design a family planning program that deployed a large number of married female outreach workers (known as family welfare assistants – FWAs) to deliver information and a range of contraceptive supplies door to door in their villages. This clear policy alternative increased knowledge about family planning and shifted preferences to smaller family size, averted the issue of women's mobility outside of their homes, and provided a wide range of contraceptive supplies directly to the homes of women by FWAs with whom they were already familiar. Since the FWAs were from the villages which they served, trust was achieved more quickly and easily. FWAs were the main link between women in rural villages and the government program (Levine et al. 2004). The door-step delivery service continued until 1997, and at the peak of the program, there were 28,000 FWAs working throughout the country (The World Bank 1989; Phillips and Hossain 2003).

In addition to the door-step delivery service, clinics were established for the provision of long-term or permanent methods (e.g. sterilization), and the FWAs could refer their clients as appropriate depending on the type of contraception desired. An accompanying mass media campaign (e.g. through television and radio dramas, movies, songs, plays, newspapers, and mobile vans) targeted both men and women in rural and urban settings in its social marketing efforts to reduce stigma, generate demand, disseminate information on availability of methods, and increase acceptability and uptake of family planning within households.

The policy alternative required a massive deployment of FWAs, infrastructure development, and logistical and supply chain development. The cost of this family planning program was high – in 1995, operating costs were about $120 million – but both the government and donors were willing to finance it (Levine et al. 2004). Donor financing enabled not only the supplies to be free to users but also covered operating costs. USAID was the major contributor from the beginning of the program, but other agencies (including the World Bank and UNDP) joined the financing efforts gradually. Furthermore, the creation of the Directorate of Family Planning and the National Population Council provided a forum for discussion of policy alternatives and brought various stakeholders together, contributing to cohesion within the policy community.

## 5.2 West Bengal

### *5.2.1 Political Environment*

#### *5.2.1.1 Political Transitions*

West Bengal's state policy agenda was affected by political transitions at both the national and state levels. With respect to the population issue, political transitions had a different role in West Bengal than in Bangladesh. In the late 1960s, India's national government introduced incentives – directed at poorer segments of society – to encourage uptake of family planning. In the 1970s, a target-oriented program was developed with individual states required to meet specific sterilization targets. The Government of India (GoI), led by Indira Gandhi's Congress Party, emphasized family planning. Her son, Sanjay Gandhi, pushed for sterilizations, and the coercive nature of the sterilizations during India's Emergency period (1975-1977) had a political backlash, in part leading to the fall of the ruling party. Raj Narain, who was anti-family planning, defeated Indira Gandhi in parliamentary elections in 1977 and went on to become the Minister of Health. In the aftermath of this major political event, emphasis on family planning was reduced across India and shifted to a broader health and family welfare approach.

While the Congress Party lost the 1977 elections at the national level, a similar backlash was occurring at the state level in West Bengal. The Communist Party of India, Marxist (CPIM) – one of a six-party United Left Front – had a landslide victory in 1977 over the Congress Party in state elections in West Bengal. Following the coercive sterilization and target-focused family planning program of the previous Congress government, there was a shift away from population and family planning at the state level as well. A former government official and researcher stated:

> "During emergency Sanjay Gandhi, prime minister's son, implemented sterilization, which in Hindi is called 'Nasbandi', in a horrible manner i.e. forcefully, by coercion method – which is still discussed – we call it 'Sanjay Effect' – many demographers and we are trying to find out that to what extent fertility has reduced due to 'Sanjay Effect'. But there was excessive misuse – people aged 60-65 years were sterilized forcefully. Target was met – but the target was not demographically effective – so there had been such type of misuses and as a result immediately after Sanjay Gandhi, Indian Family planning program was affected greatly - backlash. People seriously got scared."
> *I-21*

#### *5.2.1.2 Competing Priorities*

Under the new government of West Bengal (GoWB) in 1977, the Panchayat Raj system (PRI), a 3-tier decentralized system of rural governance within the state, flourished. The establishment of the PRI shifted decision-making power to the villages and away from the center. While the PRI system was established throughout India, West Bengal was the pioneer in implementing it (Webster 1992; Basu and

Amin 2000). With the Left Front in power and PRI operating, the state's agenda was focused on poverty alleviation through rural development and economic empowerment of the poorest. Land reforms had been promised during the campaign season, and after the 1977 election, the Left Front gradually implemented a program of land redistribution to landless farmers with an overall goal of equitable economic improvement. The results included change in economic status of poorer households, improved social status and empowerment. One government official explained:

> "Here, poverty alleviation has been a targeted program since 70's, and for us, this is not just about, as I said, controlling population because bringing in rural development will automatically make that happen."
> *I-15*

West Bengal has a long tradition of valuing science, literature and the arts that extends back to the 19th century when its capital Kolkata was the cultural center for all of India. In terms of legislation, the West Bengal Primary Education Act of 1973 had the goal of making primary education universal, free and mandatory. The GoWB took the lead in building new schools to ensure that the supply of schools was sufficient for the number of students. The Left Front government continued this historical trend and emphasized education reforms, including an attempt at switching from English-based schooling to Bengali-based schooling. The idea behind the shift in language was to benefit the poorer, less-educated households and enable them to excel in school. With respect to population, historical data suggest that the educated class in Kolkata led the fertility decline in India and that women who have completed high school in West Bengal are more modern in their fertility than their counterparts in other parts of India (Basu and Amin 2000). One respondent commented:

> "Education focus was there from before, but the focus on education that has existed is because of socioeconomic status. Female education and female literacy rate were low, comparatively low. It was higher than the national average, but it was still low. When land reform activities came, socioeconomic status increased and naturally acceptance of literacy became high."
> *I-18*

Overall, population did not appear as a priority at the state level in West Bengal. There is no evidence of legislation or policies related to population other than what was being adopted at the national level. Instead, the state's policy agenda was focused on economic empowerment (primarily through land reform) and education. Eventually in the mid-1980s and further in the 1990s, priority was placed on safe motherhood and child survival as well, but there was no policy attention to population and family planning.

> "With the political philosophy, it was mostly focused on helping the poor, so from that point of view after the redistribution of wealth, the economic status of the poorest went up and that was the main political item of their agenda. Besides that, population was not really taken care of so much, and on the education side, whatever was there before continued in that way except the English was switched over to Bengali."
> *I-20*

#### *5.2.1.3 Political Culture*

The socialist leanings of West Bengal in general – and especially the state's political leadership from the late 1970s onward – resulted in a pro-poor focus. The main political item on the agenda was improving the economic status of the poorest and redistribution of wealth through land reform. In the PRI system, efforts were also made to increase women's participation in government and a quota was established (Persson 2009). At the state level, the election manifesto – promises made to the voters by the candidates – included items like land reform, agrarian improvements, and education reform, but never included population growth. Perhaps in part because of state government efforts, poverty reduction made significant strides in West Bengal – the percentage of people living below the poverty line has decreased from about 73% in 1973 (the highest of all states in India) to 27% in 2005 (about average for India) (Rajakutty et al. 1999; Ministry of Health and Family Welfare (Government of India) 2008).

However, with respect to population and family planning, no party in West Bengal promoted it. Furthermore, the political culture in West Bengal tended to be more bottom-up rather than top-down, especially given the history of PRIs in the state. Thus many decisions were taken at the village level, where socioeconomic improvement was the priority due in part to political philosophy. A member of the government commented:

> "One general thing is that the philosophy is more pro-people. So, lower strata of the society could be reformed faster. Again it is not so much through targeted approach of family planning aimed at the poorer segments but more improving their contextual condition. For example, if they are earning more, if they have more, if they were given land, if they were given education, then the demand for the services will automatically grow."
> *I-23*

### *5.2.2 External Influences*

#### *5.2.2.1 Norm Promotion*

At the national level, population was a part of India's development plan since 1951 with a focus on limiting family size and population control. Population stayed on the agenda as a national priority

through 1977, with most headway made in the 1960s and 1970s. The strongest push for contraception came during the Emergency period of 1975-1977 (discussed above) which included coercive methods for sterilization. The GoI gave the mandate to the states to achieve targets for sterilization and acceptors of other family planning methods. The policy promoted an *extension education* approach initially (educate people toward small family norms which will induce them to come for family planning) but then transitioned to a *clinical* approach (expand clinics that offer family planning services, including provision of services postpartum). Political slogans were created and targets were set at the national level and passed down to the states. Sanjay Gandhi had a strong hand in this campaign and as a result suffered a political defeat. Family planning was primarily a centrally-sponsored concept that was promoted by the GoI and mandated to the states to implement. The GoI promoted norms regarding not only family size but also how to achieve that family size from a bureaucratic and logistical standpoint (staffing patterns in the GoWB and at the facility level). Incentives were given to service providers, administrators, as well as acceptors of family planning to motivate uptake of contraception. From a political perspective, the Congress Party was in power at the GoI and GoWB levels until 1977, so the state followed the national direction very closely. Thus, the state accepted the national policy and programmatic approach even without being involved in the process. One responded stated:

> "The central government has given the mandate and the mandate has been prepared by the political slogans or by the son of our ex-prime minister – late Sanjay Gandhi. You have to achieve the target. First, they made the program target-oriented, and then the target has been set by higher ups without taking into consideration the ground level scenario – the top-down approach is number one!"
> *I-16*

#### *5.2.2.2 Resource Provision*

Even more influential than the norms promoted by the GoI was the funding provided by the GoI. The family planning program was funded almost entirely by the GoI, which included not only supplies but also salaries for posts specific to family planning service provision. Staffing positions were created by GoI at the state level and these individuals were paid from GoI funds. Financial incentives were given to staff for meeting targets, but punishments were also given for not meeting them (e.g. staff did not get promoted). It is important to note that the financial resources that were allocated to the GoWB were time-bound and target-oriented with allocations, targets and timelines determined by the GoI with limited, if any, input from state-level stakeholders. Because there were targets with penalties for not reaching them, the numbers of family planning acceptors were often fabricated according to respondents; furthermore, men who were older than the target population (e.g. over 60 years of age) were sterilized to simply meet

the target for numbers of acceptors even though the acceptors were older than the policy called for (I-17, I-21, I-25).

> "Another important thing is that the feature that continues even today is that, it is 100% centrally sponsored. The state may chip in a little bit, but it is fully centrally sponsored. There was a criticism also about it being centrally sponsored – that it was too centrally-sponsored. What they do is that though they give the entire money, they even give the setup that this will be, normally there is no flexibility…you can add, but you cannot change anything, do you understand?"
> *I-25*

### *5.2.3 Government Advocacy and Mobilization*

#### *5.2.3.1 Political Entrepreneurship*

Unlike in Bangladesh, political entrepreneurship for population in West Bengal has essentially been nonexistent. While there were champions at the national level (Sanjay Gandhi), at the state level, no such figure was present. As noted above, population did not occur on the election manifesto in West Bengal elections, and public figures did not appear to be concerned about population, fertility, or family planning. Rather, they were speaking out about economic improvement, land redistribution, agricultural reform and education (I-25). A member of the research community commented:

> "At state level, there weren't any champions of the populations issue as there was at national level."
> *I-20*

#### *5.2.3.2 Policy Community Cohesion*

The policy community in West Bengal was left out of the policy process on population through the 1970s. Ideas were exchanged, policies adopted, and programs designed at the GoI level with limited input from state actors. Evidence below indicates that the *pro forma* adoption and implementation of population policies at the state level were mandated in a top-down manner from the GoI. While the state was the implementing agency, it was not involved in the policy process taking place at the national level where the policy and programmatic directions were being decided. Although some discussions occurred that included state level actors, very few modifications could be made to the GoI plan. While small modifications could be added on, nothing could be removed or modified substantially. According to interviews, the policy community at the state level felt excluded from the process and suggested that there was not enough involvement of the state. Thus, a gap arose between those who were setting the policy agenda in Delhi and those who were responsible for implementation in West Bengal. One respondent commented on the exclusion of the state in the process:

> "Now the main thing, implementation is done here…what is called state target is actually coming from the Centre and there is not enough involvement of the state. I thought they [the Centre] were giving too much to achieve. One main reason was that they had the purse."
> *I-25*

The lack of involvement of the West Bengal policy community in the national level policy dialogue resulted in the state agreeing to accept the policy but with no ownership of or commitment to it. As a result, implementation was weak and reports were falsely manufactured to meet the GoI's targets and avoid penalties (I-17, I-21, I-25).

#### *5.2.3.3 Credible Indicators*

Population growth received attention at the national level, and reducing the population growth rate was the main motivation for population getting onto the national policy agenda. Population density in West Bengal was seen to be an issue, especially after the influx of Bangladeshi refugees during the liberation war in 1971. However, these indicators failed to generate sufficient attention for population to get onto the state government's political agenda.

#### *5.2.3.4 Focusing Events*

Very little evidence was found suggesting that events took place in West Bengal to promote population. Unlike in Bangladesh, conferences, seminars, and meetings did not emphasize the population issue. The immense migration between Bangladesh and West Bengal during the 1947 partitioning of India and the influx of refugees from Bangladesh in 1971 had the potential to highlight population growth and density as a policy problem, but this population pressure was not felt or presented in a way that consolidated attention for population and family planning. On the other hand, the Emergency as a focusing event had the opposite effect, diluting the emphasis on population and family planning as discussed above.

#### *5.2.3.5 Clear Policy Alternatives*

In the 1950s, the GoI put forth modest family planning efforts – while hospitals and health facilities made family planning information available, no assertive measures were taken to motivate use of family planning or to promote a small-family norm (Heitzman et al. 1996). This policy trickled down to the states and was followed by West Bengal as well. In the 1960s, the GoI realized this relatively passive approach was insufficient to curb population growth and therefore established a number of postpartum units and family planning centers. In the 1970s, more aggressive policy measures were taken to increase use of family planning. As part of this effort, targets were set for numbers of sterilizations in each state as

well as numbers for other types of family planning. The GoI designed policies on how health facilities should be staffed to meet the family planning targets. Incentives were an important part of this policy – monetary and non-monetary incentives were put in place for family planning service providers, clients, and administrators. All of these policy directions, however, were devised at the national level and then given to the states to implement. In the late 1970s after the Congress Party was defeated following the Emergency, the family planning program was transformed into the "family welfare" program which integrated family planning with maternal and child health – in reaction to the political backlash from the coercive sterilizations during the Emergency.

# 6 CONCLUSIONS AND DISCUSSION

In the next few paragraphs I review directly the three questions raised in this chapter: (i) how did population get onto the policy agenda? (ii) how did agenda-setting influence the intent to implement? and (iii) what were the effects of the policy process on fertility decline? The results of the analysis above are summarized in Table 2 and indicate that in Bangladesh, agenda-setting mechanisms were strongly in favor of population, and as a result population got onto the national policy agenda in a top-down fashion. The liberation war of 1971 enabled changes in policies, priorities, and psychologies. One of the central findings of this research is that population was a central part of the development plans and achieved top priority on the national policy agenda. In the 1970s and 1980s, the political culture also facilitated continuity of population policies and programs despite changes in leadership. Thus, the overall political environment was not only favorable to population but also resulted in a strong intent to implement policies. External influences from the international community (including substantial financial and technical support provided by USAID) very strongly contributed to the government's intent to implement. Furthermore, within the country, government advocacy was strong and effective in mobilizing the policy community to become aligned in its ideas and take action to achieve agreed upon goals. Champions for population existed at the highest levels of government for nearly two decades. Population was a government priority, and donors also offered substantial financial and technical support. The policy community was highly cohesive with politicians, technical experts and community leaders aligned and working together toward a common goal. Credible indicators and focusing events helped coalesce support for population and motivated the policy community to formulate clear and feasibly policy alternatives.

As a result of all of these factors coexisting, the intent to implement was strong, multi-sectoral and had the support of all stakeholders involved. A separate Directorate of Family Planning and an independent

Division of Family Planning were created in the Ministry of Health, and an intense family planning program was implemented and sustained for twenty years (mid-1970s to mid-1990s). The massive recruitment and deployment of female field workers for the door-step delivery of information and supplies greatly reduced the barriers to access and changed social norms – reducing economic, social and cultural costs to zero. In addition, various training programs and workshops obtained buy-in from stakeholders at the community level to overcome religious obstacles. Due partly to the substantial funds flowing in from external sources, there was a "prestige factor" associated with working on family planning from both financial and non-financial perspectives. Thus, in Bangladesh, the ideas were generated by political leaders and ministry officials with cooperation of the international donor community. Policy formulation and adoption were top-down political directives but the decision-making process included implementers at all levels. The involvement and commitment of all stakeholders resulted in a strong intention to implement the policies.

In West Bengal, on the other hand, I did not find evidence of these agenda-setting factors coexisting to favor population policy, and while population did not make it onto the state's policy agenda, it was adopted *pro forma* following the national government's lead. While the GoI made population a priority, its promotion of coercive practices resulted in a political backlash, leading to both a defeat of the party in power and a dilution of focus on family planning by politicians and the public. At the state level, the increasing popularity of the Left Front in West Bengal led to a philosophically different set of priorities on the policy agenda with a focus on land and education reforms for rural development. *Pro forma* adoption of national population policies and programs resulted from a lack of priority for population at the state level. Advocacy at the state level was mixed – while some credible indicators and policy alternatives existed, I did not find evidence of political entrepreneurs or the use of focusing events for the population issue, and there was a lack of cohesion within the policy community. The actors at the state level were largely excluded from the policy discussions that were taking place at the national level.

As a result of the combination of factors discussed above, the intent to implement was weak in West Bengal. While the external influences (GoI) supported the issue of population (as evidenced by policy formulation and provision of financing), at the state level population was not a priority for a number of reasons. The lack of political champions, policy community cohesion, use of indicators, and focusing events – combined with dilution of family planning resulting from political transitions at both the national and state levels – resulted in a weak intent to implement at the state level. Some of the main factors for this included the separation between those who were designing the policies and those who were responsible for implementing them, as well as a disconnect between policy designers at the national level

and the political realities at the state level. While the policies, programmatic direction, and financing was coming from the center, implementation was the responsibility of the state – yet the GoWB was not involved in the policy discussions within the GoI. As one retired researcher and member of the state government summarized,

> "If there was any success in family planning in West Bengal, it was due to individual effort - not the government."
> *I-21*

The weak intent to implement is reflected in poor implementation as documented in the literature as well as during the interviews. Implementation was limited to urban areas, and there was poor outreach due to lack of administrative capacity and poor management at the state level (Chaudhry 1989). In the 1970s, numbers of acceptors of family planning were fabricated to meet national targets (I-17, I-25), and poor quality of service provision (including reported deaths in other states) discouraged the public from using family planning. Instead of there being a "prestige factor" as in Bangladesh, there was more of a "fear factor" in West Bengal due to punishments for providers not meeting targets and poor outcomes for clients resulting from poor quality of service provision. Thus, in the case of West Bengal, ideas on population were generated by the GoI with little to no involvement of the state. West Bengal adopted the national policies *pro forma* through a decision-making process that excluded leaders and implementers at the state level (I-19, I-25). There was no top-down mobilization of efforts, and commitment at the state level did not match commitment at the national level. Combined with a different set of priorities at the state level, this resulted in a weak intention to implement population policies. This is an example of a common problem of non-aligned interests as suggested by the principal-agent theory (Bossert 1998; Chubb 1985; Hedge et al. 1991).

This comparative analysis yields several lessons about agenda-setting and subsequent implementation of policies. Political environment, external influences and government advocacy and mobilization are critical for both agenda-setting and the intent to implement policies. Specific political events and priorities, external technical and financial support, and government and individual actions largely determine whether an issue has priority on the political agenda and the strength of the intent to implement. Furthermore, the results of the Bangladesh and West Bengal comparison, in conjunction with the quantitative results from Chapter 2, lead to some hypotheses regarding fertility decline. The fertility decline in Bangladesh in the 1970's and 1980's was driven mainly by the family planning programs with some contribution of women's education and empowerment. The agenda-setting process in Bangladesh reflects these priorities. The latter factors had more of an impact on the fertility decline in the 1990's, after the onset of microcredit programs and female education policies in 1980's. Fertility decline in West

Bengal, in contrast, took a different path and resulted from improvements in contextual factors rather than family planning programs. The earliest declines occurred among the economically and educationally elite. The small-family social norm then diffused throughout society, and the diffusion process was facilitated by political priorities on improving the socioeconomic conditions of the poorer classes through land and education reforms. Moreover, since the policy changes in Bangladesh occurred in a top-down command-driven manner (i.e. by key champions within government, policy transfer from international organizations, external donor influences), I suggest that population policies acted exogenously to increase FP use. In West Bengal, on the other hand, population was not prioritized and weak intent to implement policies did not result in an exogenous effect. Rather, demand for smaller families was generated by broader social changes such as underlying economic conditions, modernization, reaction to population pressures, and women's status. While I do not claim to establish causality between policy process and its effect on fertility, the results support the role of FP programs in the fertility decline in Bangladesh and contextual factors in West Bengal. In addition, I show that existing agenda-setting analytical frameworks can be extended to sub-national analyses, which has not been done previously, but is useful (and necessary) in many settings.

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