Family Planning and Maternal & Child Health Programme in Bangladesh

Resource Kit

June 2016

**RANGPUR**
- TFR: 1.9
- CPR: 70
- Unmet need: 7.0

**RAJSHAHI**
- TFR: 2.1
- CPR: 69
- Unmet need: 8.0

**DHAKA**
- TFR: 2.3
- CPR: 63
- Unmet need: 12.0

**SYLHET**
- TFR: 2.9
- CPR: 48
- Unmet need: 18.0

**KHULNA**
- TFR: 1.9
- CPR: 67
- Unmet need: 9.0

**CHITTAGONG**
- TFR: 2.5
- CPR: 55
- Unmet need: 17.0

**NATIONAL**
- CPR: 62.4; TFR: 2.3
- Unmet need: 12.0 (Spacing: 5% & Limiting: 7%)

Source: BDHS 2014
Population and Development: Population dynamics, including family planning, fertility, maternal and child mortality, age structure, growth rates, gender equity and equality, migration and more, influence every aspect of human, social and economic development. The 1994 Program of Action, adopted during the ICPD in Cairo, represented a watershed shift in thinking about how population and development are inextricably linked. All countries across the globe including Bangladesh have formulated policies and strategies to implement the decisions made in different international conferences.

Political Commitment of the Government of Bangladesh: The commitments made by the Hon’ble Prime Minister of Bangladesh Sheikh Hasina while addressing the 65th General Assembly of the UN on progress in attaining the MDGs are as follows:

- **Doubling the percentage of births attended by the skilled health workers by 2015** (from the current level of 24.4%) through: i) training an additional 3000 midwives, ii) staffing all 427 Upazila Health Centers to provide round the clock midwifery services and, iii) upgrading all 59 district hospitals and 70 MCWCs as Centers of excellence for EmOC;
- **Reducing the rate of adolescent pregnancies** through: i) social mobilization, ii) implementation of the minimum legal age for marriage and, iii) upgrading one third of MNCH Centers to provide adolescent friendly sexual and reproductive health services;
- **Halving unmet need for family planning** (from the current level of 17.6%) by 2015 and ensure universal implementation of the Integrated Management of Childhood Illness Program (Source: HPNSIDP Brochure).

Population Growth - Bangladesh Context: Bangladesh has experienced a high population growth from 1960 to 1990s, but due to the success of family planning programs, the level of total fertility rate has declined rapidly. According to UN Population Division (2015), Bangladesh’s population stands at approximately 161 million. In Bangladesh, population growth rate is 1.37 (BP&Housing Census 2011). Current TFR is 2.3 and further decline is expected to reach replacement level fertility by 2016. Nevertheless, Bangladesh’s population will grow by 60 million over the next 40 years which will eventually stabilize at around 230 million by 2050, a 50% increase of today’s population.

Fourth Sector Program (2016-2021): The Vision, Mission and Goal

**Vision:** “To see the people healthier, happier and economically productive to make Bangladesh a middle income country by 2021” (Vision 2021).

**Mission:** “To create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health.”

**Goal:** “To ensure that all citizens of Bangladesh enjoy health and well-being by ensuring access to quality and equitable healthcare and a healthy and safe living environment”.

The Strategic Objective-7 under component-3 of the strategic investment plan (SIP) of 4th Sector Program promised to improve equitable access to and utilization of quality health, nutrition and family planning services. This strategic objective includes the main service delivery component of the 4th sector program. It captures primary, secondary and tertiary services including preventive and curative services.

Bangladesh Population Pyramid: The age-sex structure of Bangladesh population is shown below in the population pyramid. The pyramid is wider at the base than the top and narrows slightly at the youngest age group. This pattern is typical of a historically high-fertility regime that has recently started to stabilize or decline.

Globally, people are living longer and healthier lives, and couples are choosing to have fewer children. But huge inequalities in health and demographic indicators persist and daunting challenges lie ahead. While many richer countries are concerned about low fertility and ageing, many poorer nations struggle to meet the needs of rapidly growing populations. And more people than ever before are vulnerable to food insecurity, water shortages and climate-related disasters. Whether we can live together on a healthy planet depends on the ‘policy and funding decisions’ we make now about ‘family planning, maternal and child health care, girl’s education and expanded opportunities for women and young people.’
The largest reproductive segment of population (15-24) which constitutes about 19% of the total population (BDHS 2014). A large cohort of youthful population will be entering their reproductive age in the coming decades which will open up a not-to-be-missed demographic ‘window of opportunity’ in Bangladesh. The adolescent (15-19) fertility rate in Bangladesh is 113 per 1000 women (BDHS 2014) which has not decreased significantly for decades. Without a further decrease in adolescent fertility rate, it is hard to make further progress in maternal health, family planning as well as empowerment of women and girls in economic and social spheres.

Demographic Dividend: High youth dependency can create opportunities for economic growth in countries that increase contraceptive use and reduce fertility. As young populations grow into adulthood and have fewer children than earlier generations, the number of working-age adults increases and youth dependency declines. The phenomenon is known as the ‘demographic dividend’ because countries can benefit from the large bulge of economically active adults who enter the workforce.

In fact, the accelerated economic prosperity of East Asia over the past few decades is often attributed to this demographic dividend. Countries that significantly reduced fertility in recent decades may also benefit from the demographic dividend in coming years. To capitalize on the demographic dividend, countries with high youth dependency must also provide high-quality and accessible education and FP-RH services to their large number of young population. Without these investments, children are less likely to grow into healthy and productive adults. If fertility decreases, a population’s age structure changes and proportionately there are fewer children and more people of working age. According to the theory of the ‘demographic dividend,’ this favorable age structure can boost development. The experience of the Asian Tigers (Hong Kong, South Korea, Singapore, and Taiwan), who translated their population boom in the working-age group into rapid economic growth, is proof of this dividend.

The Asian Tigers had a demographic starting point comparable to many sub-Saharan African countries today. Through massive investments into ‘education, family planning and employment’ these Asian countries managed to take advantage of their demographic dividend.

Countries with Highest & Lowest CPR: The table below shows the highest CPR in Ireland which is 89 percent followed by Norway 88 percent, China 87 percent, Switzerland 83 percent and Hungary & Thailand 81 percent. The lowest CPR in African countries namely, Chad 3 percent followed by Angola 6 percent and Mali, Sierra Leon & Sudan 8 percent.

<table>
<thead>
<tr>
<th>FP Method</th>
<th>1993-94 (BDHS)</th>
<th>2004 (BDHS)</th>
<th>2007 (BDHS)</th>
<th>2011 (BDHS)</th>
<th>2014 (BDHS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Method</td>
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<td>58.1</td>
<td>55.8</td>
<td>61.2</td>
<td>62.4</td>
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<tr>
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<td>54.1</td>
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<td>Oral Pill</td>
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<td>26.2</td>
<td>28.5</td>
<td>27.2</td>
<td>27.0</td>
</tr>
<tr>
<td>IUD</td>
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<td>0.6</td>
<td>0.9</td>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Injectable</td>
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<td>9.7</td>
<td>7.0</td>
<td>11.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Condom</td>
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<td>4.2</td>
<td>4.5</td>
<td>5.5</td>
<td>6.4</td>
</tr>
<tr>
<td>Tubectomy</td>
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<td>5.0</td>
<td>5.0</td>
<td>4.6</td>
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<td>NSV</td>
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<td>1.2</td>
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<tr>
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<td>0.7</td>
<td>1.1</td>
<td>1.7</td>
</tr>
<tr>
<td>Traditional Method</td>
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<td>10.8</td>
<td>8.3</td>
<td>9.2</td>
<td>8.4</td>
</tr>
</tbody>
</table>

Family Planning Method-Mix: Family planning method-mix varies with the increase or decrease of CPR, BDHS 2014 data shows that pill (27.0%) is the most widely used method among women of all age group, followed by injectables (12.4%), condom (6.4%) and female sterilization (4.6%).
Trends in Total Fertility Rate: (1971-2011): In Bangladesh, the decline in Total Fertility Rate (TFR) since 1975 has been sharp and consistent with a rise in contraceptive use. The CPR increased from 7.7% in 1975 to 62.4% in 2014 and TFR decreased from 6.3 in 1975 to 2.3 in 2014 in last three decades (BDHS 2014). There was a rapid decline by nearly two children per woman between mid 1980s and early 1990s, a plateau at around 3.3 births per woman for most of the 1990s, followed by another noteworthy decline during the current decade. TFR varies widely by administrative divisions. Four of seven administrative divisions including Rangpur have reached replacement level fertility or below. Syhet division has the highest fertility (2.9) followed by Chittagong division (2.5). As per BDHS 2014, the TFR for rural women is higher (2.4) than that of urban women (2.0).

Figure 8: Trends in Total Fertility Rate (1971-2014)

Maternal Health: Bangladesh has gained commendable success in reducing MMR and appears to be on track to achieve MDG Goal 5. The maternal mortality ratio in Bangladesh declined significantly from 3.2 (per 1000 LB) in 2001 to 1.70 (per 1000 LB) in 2014, a 50% decline in 13 years (BMMS 2010). More encouragingly, the fall in fertility has significant implications on reductions of risks of maternal deaths. The decline in TFR since 1980s has been sharp and consistent with a decline in maternal mortality.

Figure 9: Bangladesh is on-Track on MDG-5

Unmet Need for Family Planning Services: In Bangladesh, 12 percent of currently married women have an unmet need for family planning services, of which, 7 percent for limiting births and 5 percent for spacing births. The unmet need decreased from 13.5 percent in 2011 to 12 percent in 2014 (BDHS 2014). Unmet need also varies by division, such as unmet need for family planning services highest in Syhet (17.7%) followed by Chittagong (17.3%), Dhaka (12%), Barisal (11.3%), Khulna (9.4%), Rajshahi (7.7%) and Rangpur (6.7%). The HPNSDP results framework has set a target to reduce the unmet need to 9 percent by 2016 and FP 2020 has set a target to reach 7 percent by 2021.

Figure 12: Unmet Need for Family Planning

Delivery at Service Centers: The proportion of births delivered at health facilities has been increasing rapidly since 2004, from 12 percent in 2004 to 17 percent in 2007 and to 37 percent in 2014. Facility deliveries increased at a rate of 2 percent per year, the increase is more marked in the non-public sector than the public sector. The proportion of deliveries by medically trained providers has increased from 16 percent in 2004 to 42 percent in 2014 (BDHS 2014).

Figure 11: Delivery at Service Centers

Despite the fact, it is one of the most important challenges to reduce MMR from the present level of 1.70 (per 1000 LB) to 1.43 within 2015. The Bangladesh Maternal Mortality and Health Care Survey (BMMS) 2010 also produced the finding that hemorrhage and eclampsia are responsible for more than half (51%) maternal deaths which can be preventable.
Every year more than 500,000 women die in pregnancy and child-birth and estimated 30 times suffer from pregnancy related complications. One in ten births worldwide is to a teenage mother (one in six in the poorest countries). Child birth is the leading cause of death for young women aged 15 to 19. The percentage of births to women under 20 years of age in the least developed countries is double that of the developed countries.

**Figure 13: High and Low Maternal & Infant Mortality**

<table>
<thead>
<tr>
<th>Countries</th>
<th>MMR (per 1000 LB)</th>
<th>IMR (per 1000 LB)</th>
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<tbody>
<tr>
<td><strong>High Maternal &amp; Infant Mortality Rate</strong></td>
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<td>Sierra Leone</td>
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<tr>
<td>Afganistan</td>
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<td>152</td>
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<tr>
<td>Niger</td>
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<td>84</td>
</tr>
<tr>
<td>Chad</td>
<td>15</td>
<td>127</td>
</tr>
<tr>
<td>Angola</td>
<td>14</td>
<td>111</td>
</tr>
<tr>
<td>Somalia</td>
<td>14</td>
<td>106</td>
</tr>
<tr>
<td>Rwanda</td>
<td>13</td>
<td>96</td>
</tr>
<tr>
<td>Liberia</td>
<td>12</td>
<td>91</td>
</tr>
<tr>
<td>Congo</td>
<td>11</td>
<td>114</td>
</tr>
<tr>
<td><strong>Low Maternal &amp; Infant Mortality Rate</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>.03</td>
<td>04</td>
</tr>
<tr>
<td>Sweden</td>
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<td>03</td>
</tr>
<tr>
<td>Iceland</td>
<td>.04</td>
<td>03</td>
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<tr>
<td>Germany</td>
<td>.04</td>
<td>04</td>
</tr>
<tr>
<td>Israel</td>
<td>.04</td>
<td>05</td>
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<tr>
<td>kuwait</td>
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<td>09</td>
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<td>Spain</td>
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<tr>
<td>Germany</td>
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<td>04</td>
</tr>
<tr>
<td>Switzerland</td>
<td>.05</td>
<td>04</td>
</tr>
</tbody>
</table>

Source: State of World Population 2010, UNFPA

**Child Mortality:** A Bangladeshi child was around three times more likely to die before reaching his/her fifth birthday in the early 1990 than in 2014. In last couple of years, child mortality has become increasingly concentrated in the earliest months of life. Between the 1989-1993 and 2010-2014 periods, infant mortality declined by 56 percent, from 87 to 38 deaths per 1,000 live births. An almost 20 percent further reduction in infant mortality is needed to achieve HPNSDP target of 31 deaths per 1,000 live births in 2016.

**Figure 14: Trends in Child Mortality in Bangladesh**

**Major Success in FP-MCH Programmes:**
- Bangladesh received MDG Award in 2010 for being on track to achieve MDG 4;
- Population growth rate declined from 2.61% in 1974 to 1.37% in 2011 (BPS & H Census 2011-Revise);
- CPR increased from 7.7% in 1975 to 62.4% in 2014 (BDHS 2014);
- TFR declined from 6.3 in 1971-75 to 2.3 in 2014 (BDHS 2014);
- Contraceptives drop-out rate reduced from 49% in 2004 to 30.0% in 2014 (BDHS 2014);
- Unmet need for family planning services declined from 17.6 in 2007 to 12.1% in 2014 (BDHS 2014);
- Neonatal mortality rate (0-30 days) declined from 52 (per 1000 LB) in 1994 to 28 in 2014 (BDHS 2014);
- Infant mortality rate (0-1 yr.) came down from 87 (per 1000 LB) in 1994 to 38 in 2014 (BDHS 2014);
- Under-five mortality rate declined from 133 (per 1000 LB) in 1994 to 46 (per 1000 LB) in 2014 (BDHS 2014);
- Maternal mortality rate also declined from 320 (per 100000 LB) in 2001 to 170 in 2014 (UN Population Division 2014);
- Life expectancy at birth increased from 56.1 in 1991 to 70.0 in 2009 (BBS 2013);
- Delivery by trained providers increased from 16% in 2004 to 42% in 2014 (BDHS 2014);
- Facility deliveries increased from 12% in 2004 to 37% in 2014 (BDHS 2014);
- Antenatal care (4 or more visits) increased from 17% in 2004 to 31% in 2014 (BDHS 2014);
- Exclusive breast feeding increased from 46% in 1993-94 to 55% in 2014 (BDHS 2014);
- EPI coverage increased from 68% in 2004 to 78% in 2014 (BDHS 2014);
- The level of stunting (height-for-age) <5 children has declined from 51% in 2004 to 36% in 2014 (BDHS 2014);
- The level of underweight (weight-for-age) <5 children has declined from 43% in 2004 to 33% in 2014 (BDHS 2014).

**Challenges Ahead:**
- Over population of 161 million (UN Population Division 2015);
- Sharp regional variation in TFR (Sylhet-2.9, Chittagong-2.5), (BDHS 2014);
- Unmet need for family planning services is still high (12.0%), (BDHS 2014);
- High discontinuation rate (30%) of contraceptive use (condom-40%, pill-34%, injectable-25%), (BDHS 2014);
- Low male participation in contraceptive use-7.6% (NSV-1.2%, condom-6.4%), (BDHS 2014);
- High Maternal mortality (170/100000 LB), (UN Population Division 2014);
- Childhood mortality is still high (neonatal-28; infant-38 and under five mortality 46 per 1000LB), (BDHS 2014);
- High child marriage (59% women aged 20-24, being married by 18 years) and adolescent (15-19) fertility (113 per 1000 women), (BDHS 2014);
- Reaching replacement level of fertility in Sylhet and Chittagong;
- High adolescent (10-19) population (35 million; 22% of total population), (BDHS 2014);
- Field worker (FP) and couple ratio is 1:1200-1500 or more;
- Gender inequality and son preference.

NSV is an ‘Easy and Safe’ Permanent Method for Men
Major Interventions Undertaken to Addressing the Challenges:
- Recruited more than 10,000 staff filling the vacant positions (FWAs, FFWs and other Staff);
- Introduced client-segmented service delivery;
- Undertaken strategic IEC and BCC interventions nationwide targeting media-dark populations, adolescents, newly-wed couples, pregnant mothers, their husbands and in-laws including community gatekeepers;
- Given special focus on LAPM (long acting & permanent methods);
- Commenced six months 'midwifery training' for FFWs;
- Providing FP-MCH services through satellite clinics (30,000 per month);
- Providing primary health care services including FP-MCH services through more than 13,000 community clinics;
- Providing FP-MCH services at door-step level by 23,500 FWAs (Family Welfare Assistants);
- Introduced 24 hours normal delivery services at 500 UH&FWCs (one for each Upazila) throughout the country;
- Undertaken extensive IEC activities which include installation of billboards, advertisements in national dailies and private TV channels, production & airing of TV spots, drama serials, short-films, TV scrolling on private TV channels;
- National Family Planning Campaign (2012-2016): As a part of UNFPA’s assistance to the Directorate General of Family Planning (DGFP) under Ministry of Health and Family Planning (MOHFW) in revitalizing family planning program in Bangladesh, a five years long National Family Planning Campaign (2012-2016) has been designed and being implemented under the leadership of DGFP.

Health Budget: In 2013-2014 fiscal year, the budget allocation for health, nutrition, population and family welfare was 4.7 percent of the national budget while in 2014-2015 and 2015-2016 fiscal years, the allocated budgets were 4.78 percent and 4.83 percent respectively which shows no significant increase in budget allocation for health sector.

Budget allocation for DGHS and DGFP (2013-2016): Of the total development budget for two directorates, the allocations for DGHS and DGFP in 2013-2014 fiscal years were 78.73% and 21.27% respectively. In 2014-2015, it was 85.78% for DGHS and 14.22% for DGFP while in 2015-2016 fiscal year, the allocation for DGHS and DGFP were 88.22% and 11.78% respectively. The graph below shows sharp decline in budget allocation for DGFP in last three fiscal years.

Budget Allocation for Different OPs under DGFP (2015-2016): SBCC interventions are considered to be the heart of all interventions in demand generation initiatives. Information, Education and Motivation-IEM Unit of DGFP has a rich history in creating awareness throughout Bangladesh on family planning, maternal, newborn and child health; and population and development issues. In spite of the proven benefits of the investment in family planning program in general and SBCC program in particular, budgetary allocation for SBCC has not been significantly increased over the last couple of years. The graph below shows only 5.86% budget allocation for SBCC activities under IEC OP in the fiscal year 2015-2016.

Some Facts about Family Planning:
- Family planning is the best documented practice to reduce maternal mortality. Use of modern contraceptives in the developing world will prevent 218 million unintended pregnancies, which, in turn, will aver 55 million unplanned births, 138 million abortions (40 million of them unsafe), 25 million miscarriages and 119,000 maternal deaths (Guttmacher Institute & UNFPA Fact sheet, June 2012);
- Increased contraceptive use and reduced unmet need for family planning are central to achieving three MDGs – improving maternal health (MDG-5), reducing child mortality (MDG-4) and combating HIV/AIDS (MDG-6), and also contribute directly or indirectly to achieving all eight goals (Guttmacher Institute & UNFPA Fact sheet, June 2012);
- Every minute a woman dies during pregnancy or child birth which is over 500,000 annually. Maternal mortality is the largest health inequity in the world; 99% of maternal deaths occur in developing countries of which 40% are in Africa (WHO, UNICEF, World Bank, UNFPA 2007);
- Globally, 215 million women go without family planning. One in four women who want to avoid or space a pregnancy are not using an effective method of contraception (UNFPA and Guttmacher Institute, 2009);
- In developing countries, a woman’s lifetime risk of dying due to pregnancy and child birth is one in 75, or almost hundred times higher than the one in 7300 risk in developed countries. (PRB, USA 2011);
- A recent study showed that if all births were spaced at least 2-3 years apart, the number of deaths among children younger than five would decline by 13% to 25% (Guttmacher Institute & UNFPA Fact sheet, June 2012);
- Female education have a more consistent and stronger effect on delay of child bearing, increased use of contraception, desire for fewer children and reduced fertility, decreased infant and child mortality, higher immunization rates, improved household nutrition and lower rates of domestic violence.

Exposure to Media: According to the media survey 2010, TV is still 'the mainstream media' for Bangladesh, with 74% viewership. Higher growth of Satellite TV than that of Terrestrial TV over the years have resulted a
higher viewership of Satellite TV (40%) than that of Terrestrial (34%). Radio reach (29%) has interesting trend of reaching more people of rural population (18.4%) than urban population (16.8%). Newspapers, which has a long shelf life as media, has 28.1% penetration. However, one of the most emerging media of Bangladesh is Mobile Telephony with already a formidable penetration of 46%. Cell phone has the special advantage of being an interactive and personal media for the audience. One of the biggest challenges is to reach the 25.7% media dark population. The best way to reach the media dark is to adopt door to door communication and community sessions driven by FWAs.

**Benefits of investing in Family Planning:** Despite its proven connection to development, funding for family planning has been stagnant regardless of increasing need in the last decade. This has hindered efforts to lower maternal and infant death rates including morbidity, curb the HIV epidemic and prevent unintended pregnancies. In Bangladesh, fulfilling of 17.6 percent unmet need for family planning would contribute to US$1 billion in the national economy (HDRC). If US$ 50 million is invested in the family planning programme, it would save US$ 327 million to achieve development goals. In Thailand, every dollar invested in the country’s family planning programme saved the government more than US$ 16 and in Egypt US$ 31. The demand for family planning programme is growing yet there is still a vast unmet need in low income countries.

**Figure 17: Exposure to Media**

- FM Radio 29%
- Newspapers 28.1%
- Internet 2.0%
- Media Dark 25.7%
- Terrestrial TV (BTV) 34%
- Mobile telephone 46%
- Satellite TV 40%

Source: National Media Survey 2010, SIRIUS

**Figure 18: Cost Benefit of Investing in FP and MCH**

<table>
<thead>
<tr>
<th>Country</th>
<th>Cost to meet need in US$ million</th>
<th>Education</th>
<th>Immunization</th>
<th>Water &amp; sanitation</th>
<th>Maternal &amp; reproductive health</th>
<th>Malaria</th>
<th>Total</th>
<th>Savings per $ invested in family planning</th>
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<td>Bangladesh</td>
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<td>153</td>
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<td>125</td>
<td>555</td>
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<td>10</td>
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<td>44</td>
<td>26</td>
<td>105</td>
<td>109</td>
<td>2.0 US$</td>
<td></td>
</tr>
</tbody>
</table>

Source: Population Reference Bureau, 2009, USA

**Reasons to Invest in Family Planning:** Benefits beyond health family planning contributes to individual, family and social well-being and therefore multiplies the return on government’s investments. Examples of non-medical benefits include:

- For individuals:
  - Less worry about unplanned pregnancies
  - Greater self-esteem and decision-making power
  - More time with children
  - Greater educational and employment opportunities, especially for girls and women
  - Greater ability to participate in civil society

- For families and households:
  - More attention and parental care for each child
  - Higher health, nutrition and educational expenditures per child
  - Fewer orphaned children

- For communities and societies:
  - Higher productivity
  - Less social burden of caring for neglected children
  - Reduced public expenditures in education, health care and other social services
  - Higher savings and investment

**10 Elements of Success in Family Planning Programme:** Family planning professionals can improve programmes by applying the following 10 important elements:

1. **Supportive Policies:** Policies that increase access to information and services support family planning. Family planning advocates who mobilize support for family planning—can bring key issues to the attention of policy makers, define needs for policy changes and work toward supportive policies.

2. **Effective Communication Strategies:** Strategic BCC programmes use a systematic process (P-Process) to develop and implement communication interventions using a mix of three major communication channels—mass media, interpersonal and community channels.

3. **Evidence-Based Programming:** Successful family planning programmes use research, monitoring and evaluation data to guide programme design and implementation. By providing crucial information, research findings help programme managers decide wisely how to take new directions, solve problems, assess effectiveness and make adjustments.

4. **Strong Leadership and Good Management:** Leadership and management have been described as two sides of the same coin: each is equally essential for any organization to achieve its purpose. Often programme managers play the roles of both manager and leader.

5. **Contraceptive Security:** A strong supply-chain which covers planning, procuring, transporting, storing and distributing contraceptives and other clinical supplies and equipment is essential for contraceptive security.

6. **High Performing Staff:** According to the 2007 worldwide poll of nearly 500 health care professionals, a sufficient, well-trained, and motivated staff is the most important element of success in family planning programme. Task-shifting and performance improvement both help increase the efficiency of the existing staff and the quality of work.

7. **Client-centered Care:** It means that services meet medical standards which require providers’ commitment and expertise. However, programmes, providers, and clients all play roles in achieving client-centered care.

8. **Easy Access to Services:** A population has good access to services when service delivery points are conveniently available to everyone. Offering services through multiple channels increases access.

9. **Affordable Services:** Shifting users who can afford to pay from the public sector to the private sector can reduce financial pressures on government, donors and NGOs. Understanding how demand and supply are segmented across different socioeconomic groups helps managers make services more affordable and target subsidies more efficiently.

10. **Appropriate Integration of Services:** Offering multiple health care services at the same facility or through a community-based programme can benefit clients, providers and programmes. Integrated services can increase programme efficiency and clients’ convenience.

(Source: Population Report 2008, CCP, Johns Hopkins University)
### FP-MCH & Demographic Indicators of SAARC and some Asian Countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Population (in million)</th>
<th>Density (per sq km)</th>
<th>Population Growth Rate (%)</th>
<th>CPR Any Method (%)</th>
<th>TFR</th>
<th>MMR (per 100000 LB)</th>
<th>IMR (per 1000 LB)</th>
<th>Adolescent Birth Rate (per 1000 women)</th>
<th>Unmet Need</th>
<th>Literacy Rate (Youth: 15-24)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
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<td>1.37</td>
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<td>1.3</td>
<td>60</td>
<td>2.5</td>
<td>190</td>
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<td>52</td>
<td>13</td>
<td>Male-92.9 Female-87.2</td>
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<tr>
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<td>2.2</td>
<td>31</td>
<td>9</td>
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</tr>
<tr>
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<td>1.2</td>
<td>52</td>
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<td>190</td>
<td>32.4</td>
<td>67</td>
<td>24</td>
<td>Male-97.0 Female-83.1</td>
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<td>39</td>
<td>3.7</td>
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<td>69.8</td>
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<tr>
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<td>29</td>
<td>8.2</td>
<td>24</td>
<td>7</td>
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### East and Southeast Asian Countries

<table>
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<th>Population (in million)</th>
<th>Density (per sq km)</th>
<th>Population Growth Rate (%)</th>
<th>CPR Any Method (%)</th>
<th>TFR</th>
<th>MMR (per 100000 LB)</th>
<th>IMR (per 1000 LB)</th>
<th>Adolescent Birth Rate (per 1000 women)</th>
<th>Unmet Need</th>
<th>Literacy Rate (Youth: 15-24)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>China</td>
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<td>190</td>
<td>25</td>
<td>47</td>
<td>11</td>
<td>Male-99.9 Female-99.1</td>
</tr>
<tr>
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<td>48</td>
<td>1.3</td>
<td>77</td>
<td>1.7</td>
<td>23</td>
<td>14.8</td>
<td>35</td>
<td>7</td>
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<tr>
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<td>349</td>
<td>(-) 0.1</td>
<td>57</td>
<td>1.4</td>
<td>5</td>
<td>2.2</td>
<td>4</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Malaysia</td>
<td>30.3</td>
<td>91</td>
<td>1.5</td>
<td>57</td>
<td>2.0</td>
<td>29</td>
<td>6.8</td>
<td>13</td>
<td>15</td>
<td>Male-98.3 Female-99.5</td>
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<tr>
<td>Thailand</td>
<td>67.95</td>
<td>133</td>
<td>0.4</td>
<td>79</td>
<td>1.5</td>
<td>26</td>
<td>11.2</td>
<td>60</td>
<td>6</td>
<td>Male-98.7 Female-99.7</td>
</tr>
<tr>
<td>Vietnam</td>
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<td>49</td>
<td>19.3</td>
<td>36</td>
<td>7</td>
<td>Male-97.9 Female-97.2</td>
</tr>
</tbody>
</table>

World: 7.34 billion

Density: 52

Population Growth Rate: 1.2

CPR Any Method: 64

TFR: 2.5

MMR (per 100000 LB): 2.1

IMR (per 1000 LB): 10

Adolescent Birth Rate (per 1000 women): 40

Unmet Need: 51

Literacy Rate (Youth: 15-24)*: 12

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**Reviewed by:**

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Better Health for a Prosperous Society