

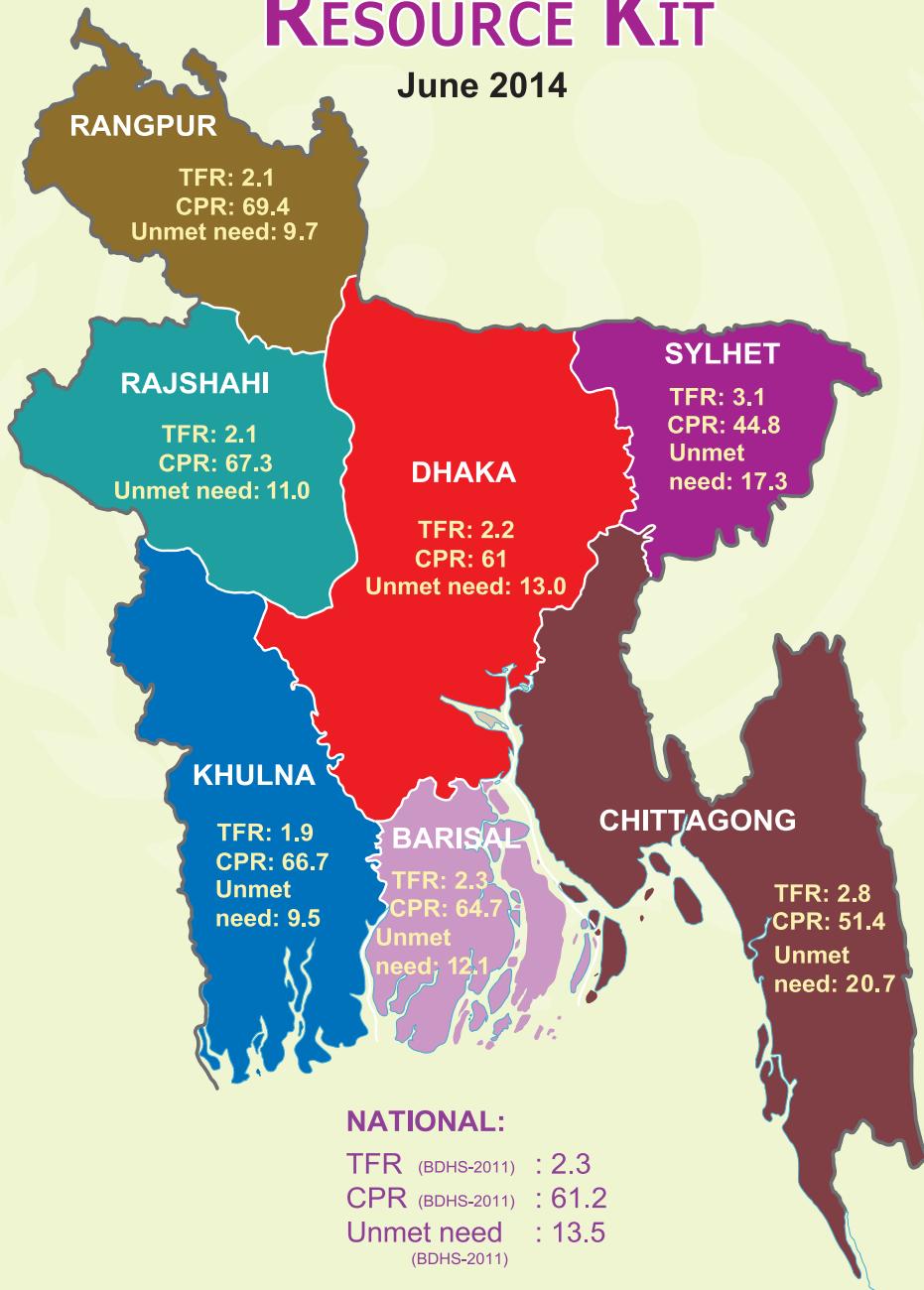


Ministry of Health & Family Welfare

Family Planning and Maternal & Child Health Programme in Bangladesh

RESOURCE KIT

June 2014



'Family Planning is a Lifestyle'



USAID
আমেরিকার জনগণের পক্ষ থেকে



IEM Unit
Directorate of Family Planning



স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়



UN Population Fund



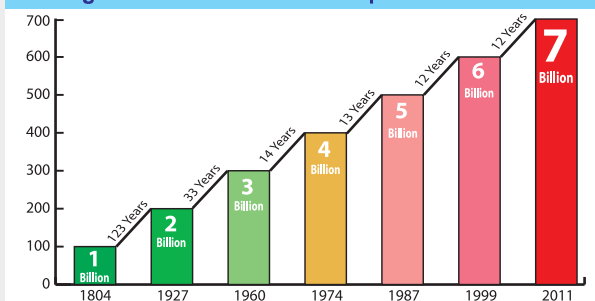
Population and Development: Population dynamics, including family planning, fertility, maternal and child mortality, age structure, growth rates, gender equity and equality, migration and more, influence every aspect of human, social and economic development. The 1994 Program of Action, adopted during 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: HPNSDP Brochure).

Population Growth - World Context: The world's population grew from one billion to 7 billion from 1804 to 2011, in slightly more than 200 years. Interestingly, at the beginning of the 20th century, the world had 1.6 billion people, whereas at the closing of it, the figure was just reversed to 6.1 billion. Currently, about 83 million people are being added to the planet annually, 1.2 percent per year. According to median projection of the UN Population Division, the world population will reach 8 billion in 2025, 9 billion in 2043 and 10 billion in 2083.

Figure 1: Trends in World Population Growth

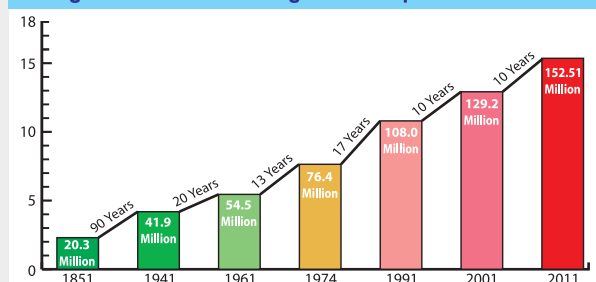


Source: The world-wide web virtual library: Demography & Population Studies, WPD Report -2011, UNFPA.

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

Population Growth - Bangladesh Context: Bangladesh has experienced a high population growth from 1960 to 1990s, but due to the success of family planning programmes, the level of total fertility rate has declined rapidly. **According to the revised *BP&H Census 2011, Bangladesh's population stands at approximately 152.51 million (Projected Population on 16 July, 2012) with population growth rate 1.37.** Current TFR is 2.3 and further decline is expected to reach replacement level fertility by 2015. Nevertheless, Bangladesh's population will grow by 60 million over the next 40 years which will eventually stabilize at around 230 million by 2050, a 50% increase of today's population.

Figure 2: Trends in Bangladesh Population Growth



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

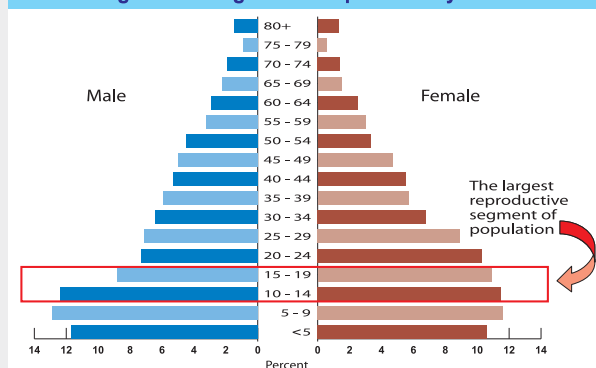
HPNSDP: Ministry of Health and Family Welfare has undertaken the Health, Population and Nutrition Sector Development Programme (HPNSDP) for a period of five years (2011-2016) to be implemented through 32 Operational Plans (OPs). After HPSP (1998-2003) and HNPSP (2003-2011) the HPNSDP is the third sector program prepared following the SWAp for overall improvement of health, population and nutrition sub-sectors.

Key Results to be Achieved During 2011-2016:

- Reduce total fertility rate (TFR) from 2.5 to 2.0;
- Increase contraceptive prevalence rate (CPR) from 61.7% to 72%;
- Reduce maternal mortality ratio from 1.94 to less than 1.43 per 1000 LB;
- Reduce neonatal mortality rate from 37 to 21 per 1000 LB;
- Reduce infant mortality rate from 52 to 31 per 1000 LB;
- Reduce under-5 mortality rate from 65 to 48 per 1000 LB;
- Increase percentage of delivery by skilled birth attendant from 26% to 50%;
- Number of CSBA to be increased from 6,500 to 13,500;
- Reduce prevalence of underweight children (under-5) from 41% to 33%.

Bangladesh Population Pyramid: The age-sex structure of Bangladesh population is shown in the population pyramid. The pyramid is wider at the base than the top and narrows slightly at the youngest group.

Figure 3: Bangladesh Population Pyramid



Source: BDHS-2011



The largest reproductive segment of population (15-24) which constitutes about 19% of the total population (BDHS 2011). 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 118 per 1000 women (BDHS 2011) 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.

(Source: Population Bulletin, PRB 2010).

Countries with Highest & Lowest CPR: The table below shows the highest CPR in Norway (88%) followed by China (85%), Switzerland (82%), Hungary (81%), Thailand (80%) and Ireland (65%). The lowest CPR in African countries namely, Chad (5%) followed by Mali (8%), Sudan (9%), Sierra Leon (11%) and Angola (18%).

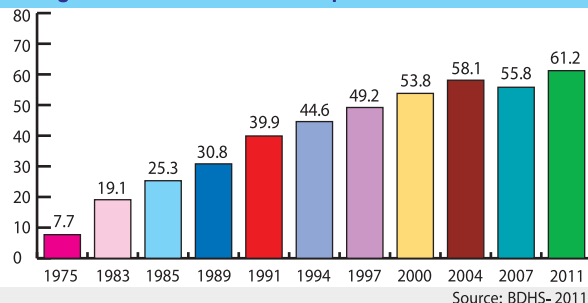
Figure 4: CPR in some Rich & Poor Countries

Country	Any Method	Modern Method
Countries with High FP Method users (%)		
Norway	88	82
China	85	84
Switzerland	82	78
Hungary	81	71
Thailand	80	78
Ireland	65	61
Countries with Low FP Method users (%)		
Chad	5	2
Mali	8	6
Sudan	9	-
Sierra Leone	11	10
Angola	18	-

Source: State of World Population 2013

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

Figure 5: Trends in Contraceptive Prevalence Rate



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

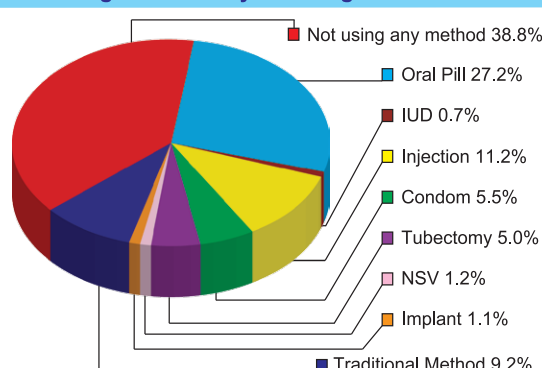
Figure 6: Family Planning Method-wise Performance (1993-2011)

FP Method	1993-94 (BDHS)	2004 (BDHS)	2007 (BDHS)	2011 (BDHS)
Any Method	44.6	58.1	55.8	61.2
Modern Method	36.2	47.3	47.5	52.1
Oral Pill	17.4	26.2	28.5	27.2
IUD	2.2	0.6	0.9	0.7
Injectables	4.5	9.7	7.0	11.2
Condom	3.0	4.2	4.5	5.5
Tubectomy	8.1	5.2	5.0	5.0
NSV	1.1	0.6	0.7	1.2
Implant	-	0.8	0.7	1.1
Traditional Method	8.4	10.8	8.3	9.2

Source: BDHS 2011

Family Planning Method-Mix: Family planning method-mix varies with the increase or decrease of CPR. BDHS 2011 data shows that pill (27.2%) is the most widely used method among women of all age group, followed by Injectables (11.2%), condom (5.5%) and female sterilization (5.0%).

Figure 7: Family Planning Method-mix

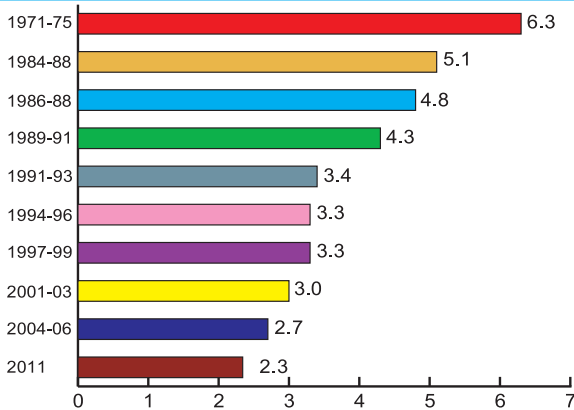


Source: BDHS- 2011



Trends in Total Fertility Rate- (1971-2011): In Bangladesh, the decline in Total Fertility Rate (TFR) since 1975 has been sharp and consistent with a rise in contraceptive use. The CPR increased from 7.7% in 1975 to 61.2% in 2011 and TFR decreased from 6.3 in 1975 to 2.3 in 2011 in last three decades (BDHS 2011). There was a rapid decline by nearly two children per woman between mid 1980s and early 1990s, a plateau at around 3.3 births per woman for most of the 1990s, followed by another noteworthy decline during the current decade. TFR varies widely by administrative divisions. Four of seven administrative divisions including Rangpur have reached replacement level fertility or below. Sylhet division has the highest fertility (3.1) followed by Chittagong division (2.8). As per BDHS 2011, the TFR for rural women is higher (2.5) than that of urban women (2.0).

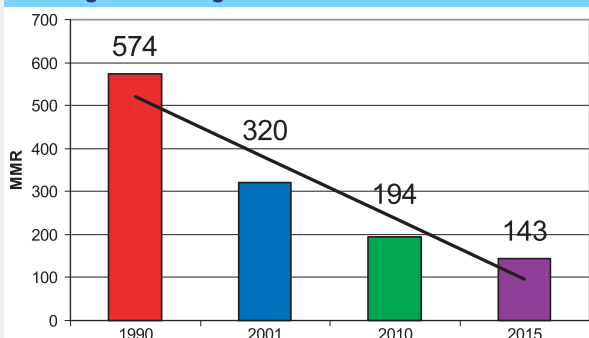
Figure 8: Trends in Total Fertility Rate (1971-2011)



Source : BDHS-2011

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 1.94 (per 1000 LB) in 2010, a 40% decline in 9 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.

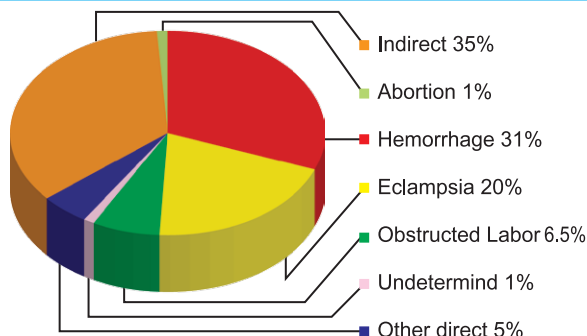
Figure 9: Bangladesh is on-Track on MDG-5



Source: BMMS 2010

Despite the fact, it is one of the most important challenges to reduce MMR from the present level of 1.94 (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 death which can be preventable.

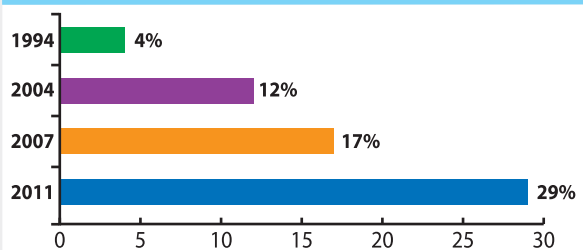
Figure 10: Causes of Maternal Death



Source : BMMS 2010

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 29 percent in 2011. 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 doubled from 16 percent in 2004 to 32 percent in 2011 (BDHS 2011).

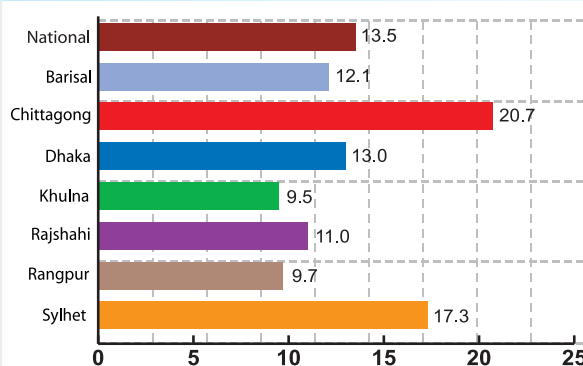
Figure 11: Delivery at Service Centers



Source : BDHS-2007,2011

Unmet Need for Family Planning: Bangladesh has an unmet need for family planning services, 5.4 percent for spacing and 8.1 percent for limiting. The unmet need increased from 11.3 percent of currently married women in 2004 to 17.6 percent in 2007, and then decreased to 13.5 percent in 2011 (BDHS 2011). Unmet need for family planning among currently married women (age 15-19) varies by division, such as Chittagong is the highest (20.7%) followed by Sylhet (17%), Dhaka (13%), Barisal (12%), Rajshahi (11%), Khulna (9.5%) and Rangpur division (9.7%). The HPNSDP 2011-2016 results framework has set a target to reduce unmet for family planning services to 9 percent by 2016.

Figure 12: Unmet Need for Family Planning



Source : BDHS 2011



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.

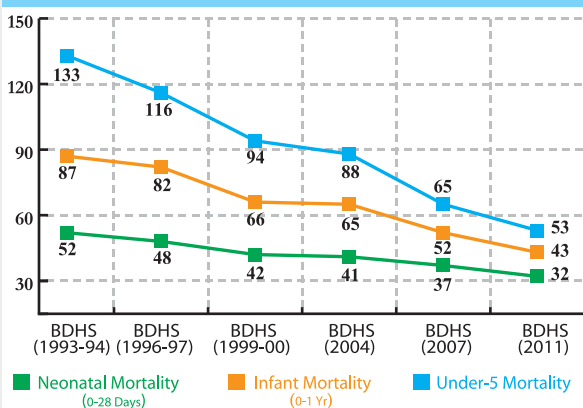
Figure 13: High and Low Maternal & Infant Mortality

Countries	MMR (per 1000 LB)	IMR (per 1000 LB)
High Maternal & Infant Mortality Rate		
Chad	11.0	106
Somalia	10.0	83
Sierra Leone	8.9	128
Liberia	7.7	63
Niger	5.9	51
Congo	5.6	66
Afganistan	4.6	71
Angola	4.5	98
Rwanda	3.4	51
Low Maternal & Infant Mortality Rate		
Italy	0.04	3.2
Sweden	0.04	2.6
Iceland	0.05	1.8
Spain	0.06	3.1
Germany	0.07	3.3
Israil	0.07	3.5
Switzerland	0.08	3.8
kuwait	0.14	8

Source: State of World Population 2013, UNFPA

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

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 (BP&H Census 2011-Revised);
- **CPR** increased from 7.7% in 1975 to 61.2% in 2011 (BDHS 2007, 2011);
- **TFR** declined from 6.3 in 1971-75 to 2.3 in 2011 (BDHS 2007, 2011);
- Contraceptives **drop-out rate** has been reduced from 49% in 2004 to 35.7% in 2011 (BDHS 2011);
- **Unmet need** for family planning services declined from 17.6 in 2007 to 13.5% in 2011 (BDHS 2011);
- **Neonatal mortality rate** (0-30 days) came down from 52 (per 1000 LB) in 1994 to 32 in 2011 (BDHS 2011);
- **Infant mortality rate** (0-1 yr.) came down from 87 (per 1000 LB) in 1994 to 43 in 2011 (BDHS 2011);
- **Under-five mortality rate** has declined from 133 (per 1000 LB) in 1994 to 53 (per 1000 LB) in 2011 (BDHS 2011);
- **Maternal mortality rate** also declined from 3.2 in 2001 to 1.94 in 2010 (BMMS 2010);
- **Life expectancy** at birth increased from 56.1 in 1991 to 66.9 in 2009 (BBS 2010);
- **Delivery by trained providers** increased from 16% in 2004 to 32% in 2011 (BDHS 2011);
- **Facility deliveries** increased from 12% in 2004 to 29% in 2011 (BDHS 2011);
- **Complete maternity care** (ANC, delivery care and PNC) increased from 5% in 2001 to 19% in 2010 (BMMS 2010);
- **Exclusive breast feeding** increased from 46% in 1993-94 to 63.5% in 2011 (BDHS 2011);
- **EPI coverage** increased from 81.9% in 2007 to 82.5% in 2011 (BDHS 2011);
- The level of **stunting (height-for-age/ <5 children)** has declined from 51% in 2004 to 41% in 2011 (BDHS 2011);
- The level of **underweight (weight-for-age/ <5 children)** has declined from 43% in 2004 to 36% in 2011 (BDHS 2011).

Challenges Ahead:

- Over Population of 152.51 Million (BP&H Census 2011-Revised);
- Sharp regional variation of TFR (Sylhet-3.1, Kulna-1.9), (BDHS 2011);
- Unmet need still high (13.5%) for family planning services (BDHS 2011);
- High discontinuation rate (35.7) of contraceptive methods (condom-47% pill-39%, Injectables-36.1%, IUD-22.4%), (BDHS 2011);
- Low male participation in contraceptive use- 6.7% (NSV-1.2%; condom-5.5%) (BDHS 2011);
- Maternal mortality rate is still high (1.94/1000 LB, BMMS 2010);
- Childhood mortality is still high (neonatal-32; infant-43 and under five mortality 53 per 1000 LB), (BDHS 2011);
- Early marriage and early child bearing;
- Reaching replacement level of fertility in Sylhet and Chittagong;
- High adolescent (15-19) fertility rate (118 per 1000 women, BDHS 2011);
- Largest segment of population (19%) in reproductive age (15-24 yrs), (BDHS 2007);
- Field worker (FP) and couple ratio is 1:1200-1500 or more;
- Reaching out population in hard to reach areas such as coastal belt, hilly, char (islet) and haor (fenland) areas;
- Contraceptive insecurity due to lengthy and complex procurement process and dependency on foreign procurement;
- Gender inequality and son preference.



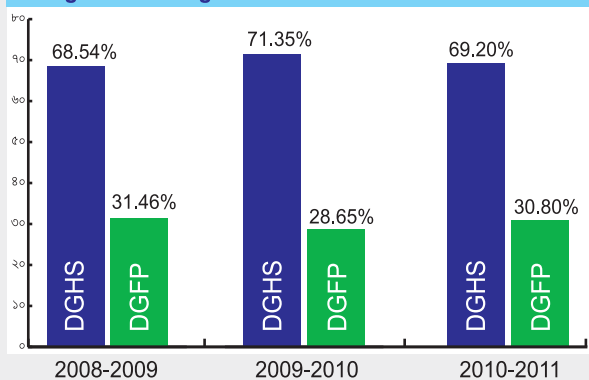
Major Interventions Undertaken to Addressing the Challenges:

- Recruited more than 10,000 staff filling the vacant positions (FWAs, FVVs and other Staff);
- Favorable policies & strategies: **a)** National Population Policy (2012); **b)** National Communication Strategy for FP-RH (2008); **c)** ARH Strategy (2006); **d)** Maternal Health Strategy (2006); **e)** Reproductive Health Commodity Security- RHCS Strategy (2010) are in place;
- Introduced client-segmented service delivery;
- Undertaken strategic IEC and BCC interventions nationwide targeting media-dark populations, adolescents, newly-wed couples, pregnant mothers, their husbands and in-laws including community gatekeepers;
- Given special focus on LAPM (long acting & permanent methods);
- Commenced six months 'midwifery training' for FWVs;
- Providing FP-MCH services through satellite clinics (30,000 per month);
- Providing primary health care services including FP-MCH services through more than 13,000 community clinics;
- Providing FP-MCH services at door-step level by 23,500 FWAs (Family Welfare Assistants);
- Introduced 24 hours normal delivery services at 500 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 Budgeting: In 2011-2012 fiscal year, the budget allocation for MOH&FW was 5.82 percent of the national budget. During 2010-2011 and 2009-2010 fiscal years, the health budgets were 6.83 percent and 8.05 percent respectively that shows no proportional increase in budget allocation for health sector.

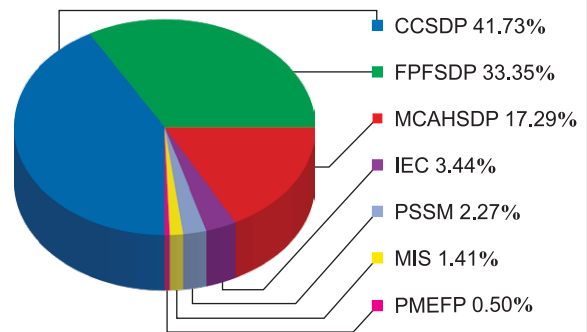
Budget Allocation for DGFP and DGHS (2008-2011): Of the total development budget for two directorates, the allocation for DGHS and DGFP in 2008-2009 fiscal year were 68.54% and 31.46% respectively. In 2009-2010 fiscal year, it was 71.35% for DGHS and 28.65% for DGFP while in the fiscal year 2010-2011, the allocation for DGHS and DGFP were 69.20% and 30.80% respectively. The graph below shows no significant increase in budget allocation for family planning programme in last three years.

Figure 16: Budget Allocation for DGFP and DGHS



Budget Allocation for Different OPs under DGFP (2008-2011): IEC and BCC programmes are considered to be the heart of all interventions in demand generation for FP-MCH services. Information, Education and Motivation- IEM Unit of DGFP has been implementing different IEC&BCC activities throughout the country since its inception in 1970. As a result commendable success has been made in population and family planning sector in terms of increasing CPR, lowering TFR, MMR, IMR and population growth rate. In spite of the proven benefits of the investment in family planning programmes in general and IEC programmes in particular, budgetary allocation has not been significantly increased in IEC&BCC activities in last couple of years.

Figure 17: DGFP Budget



Some Facts about Family Planning:

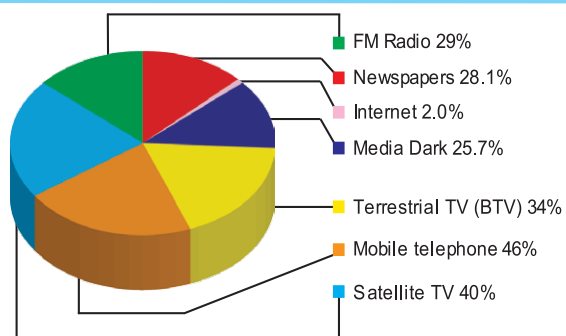
- Family planning is the best documented practice to reduce maternal mortality. Use of modern contraceptives in the developing world will prevent 218 million unintended pregnancies, which, in turn, will avert 55 million unplanned births, 138 million abortions (40 million of them unsafe), 25 million miscarriages and 118,000 maternal deaths (Guttacher 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 (Guttacher 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- half of them 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 Guttacher 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% (Guttacher 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.

Figure 15: Exposure to Media



Source: National Media Survey 2010, SIRIUS

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 18: Cost Benefit of Investing in FP and MCH

Country	Cost to meet need For family planning (In US\$ millions)	Savings incurred by category (US\$ million)						Savings per \$ invested in family planning
		Education	Immunization	Water & sanitation	Maternal health	Malaria	Total	
Bangladesh	50	153	4	68	102	-	327	6.5 US\$
Indonesia	67	338	5	78	125	9	555	8.3 US\$
Bolivia	5	21	0.1	10	14	-	45	9.0 US\$
Guatemala	19	73	1	25	29	-	128	6.7 US\$
Madagascar	26	20	13	11	29	3	76	2.9 US\$
Ethiopia	103	23	44	26	105	10	208	2.0 US\$

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

Country	Population (in million)	Population Density (per sq.km)	Population Growth Rate (%)	Contraceptive Prevalence Rate (%)	Total Fertility Rate	MMR (per 1000 LB)	IMR (per 1000 LB)	Adolescent Birth Rate (per 1000 women)	Unmet Need	Life Expectancy at Birth
SAARC Countries										
Bangladesh	152.51* <small>(Projected Population on 16 July, 2012)</small>	1015*	1.37*	61.2	2.3	1.94	43	118	13.5	Male- 65.7 Female-68.3
Afghanistan	30.6	47	2.4	22	5.0	4.6	71	90	-	Male- 59 Female- 62
Bhutan	0.8	16	1.6	66	2.3	1.8	47	59	12	Male- 68 Female-68
India	1252.1	388	1.2	55	2.5	2.0	44	76	21	Male- 65 Female- 68
Maldives	0.3	1208	1.9	35	2.3	0.6	9	19	29	Male- 77 Female-79
Nepal	27.8	182	1.2	50	2.3	1.7	46	81	28	Male- 67 Female-69
Pakistan	182.1	230	1.7	27	3.2	2.6	74	16	25	Male- 66 Female- 67
Sri Lanka	21.3	312	0.8	68	2.4	0.35	12	24	7	Male- 71 Female- 77
East and Southeast Asian Countries										
China	1385.6	142	0.6	85	1.7	0.37	16	6	2	Male-74 Female-77
Indonesia	249.9	130	1.2	62	2.3	2.2	32	66	11	Male- 69 Female-73
Iran	77.4	46	1.3	73	1.9	0.21	19	31	-	Male-72 Female-76
Japan	127.1	337	(-) 0.1	54	1.4	0.05	2.2	5	-	Male- 80 Female- 87
Malaysia	29.7	90	1.6	49	2.0	0.29	7	14	-	Male- 73 Female-77
Thailand	67.0	129	0.3	80	1.4	0.48	11	47	3	Male- 71 Female- 78
Vietnam	91.7	270	1.0	78	1.8	0.59	16	35	4	Male- 71 Female-80
World	7,162	52	1.1	64	2.5	2.10	40	49	12	Male- 68 Female-72

Source: *BP&H Census 2011 (Revised); BDHS-2011; BMMS 2010; State of World Population 2013; PRB World Population Data Sheet 2013.



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