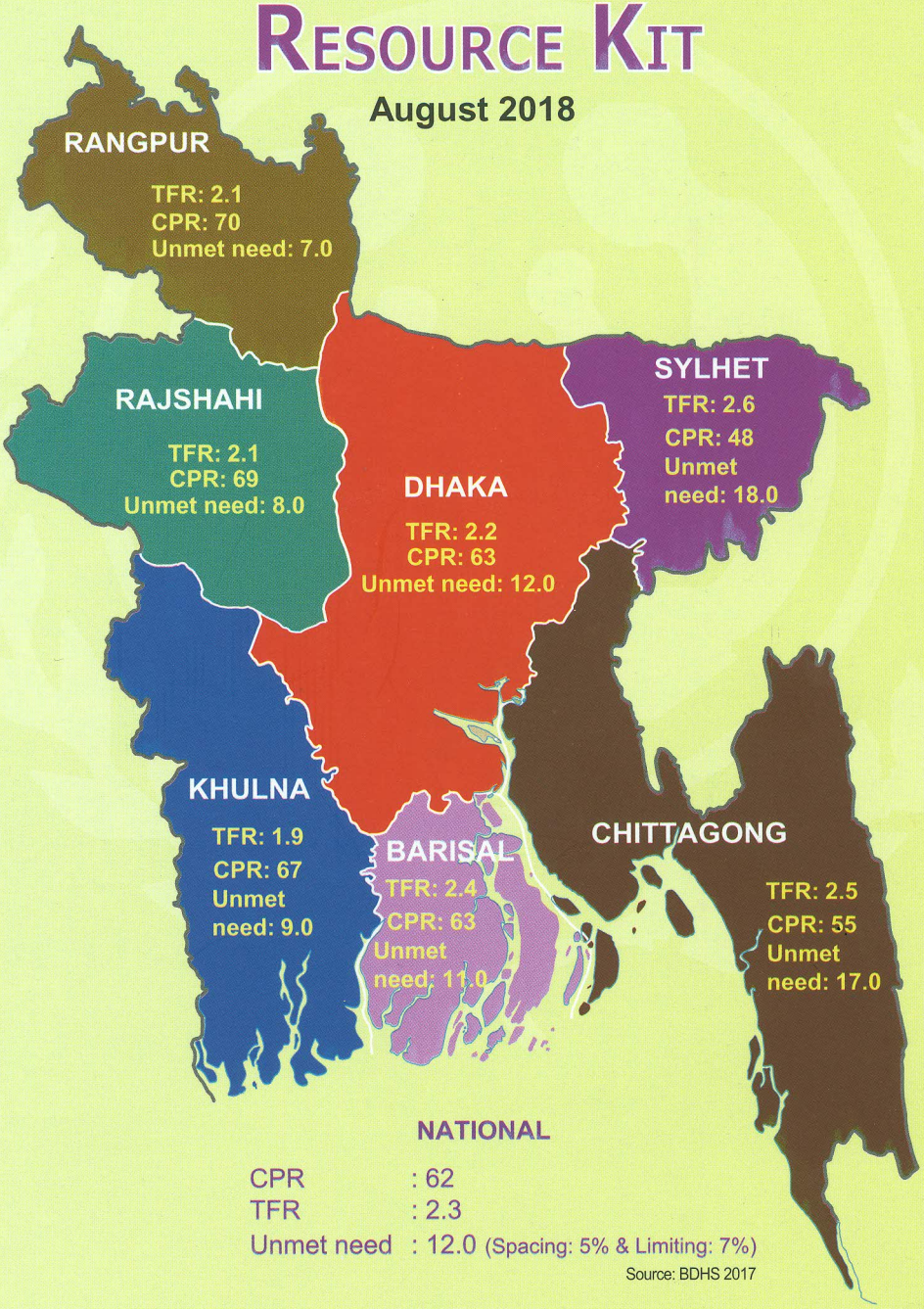
'Family Planning is a Lifestyle'

Ministry of Health & Family Welfare

Family Planning and Maternal & Child Health Programme in Bangladesh

RESOURCE KIT

August 2018



NATIONAL

CPR : 62
TFR : 2.3
Unmet need : 12.0 (Spacing: 5% & Limiting: 7%)

Source: BDHS 2017

IEM Unit
Directorate of Family Planning

স্বাস্থ্য শিক্ষা ও পরিবার কল্যাণ বিভাগ
স্বাস্থ্য ও পরিবার কল্যাণ মন্ত্রণালয়



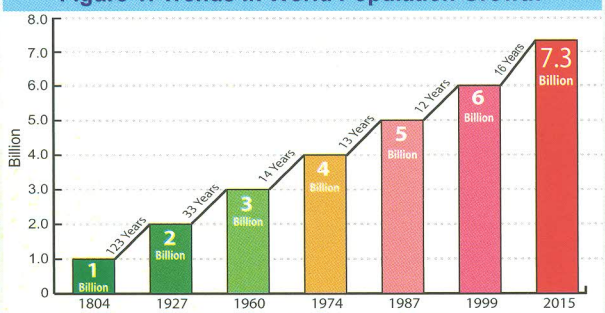
Population and Development: Population dynamics, including family planning, fertility, maternal and child mortality, age structure, growth rates, gender equity and equality, migration and more, influence every aspect of human, social and economic development. The 1994 Program of Action, adopted during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

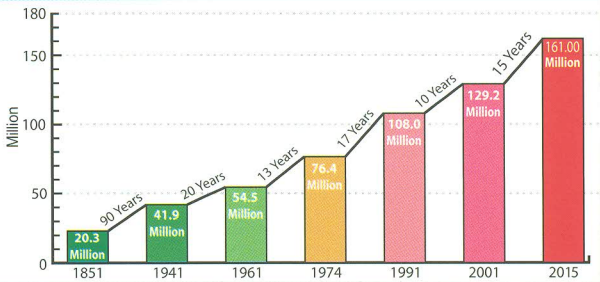


Source : The world-wide web virtual library: Demography & Population Studies, WPD Report -2011, UNFPA; UN Population Division-2015

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 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.

Figure 2: Trends in Bangladesh Population Growth



Source: BBS 2014, Bangladesh Population & Housing Census 2011 (revised), UN Pop Division 2015

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).

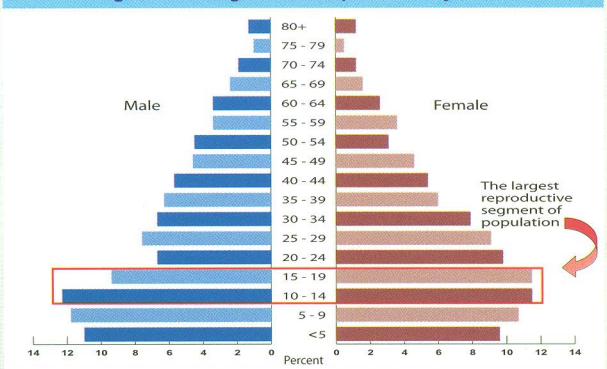
Mission: "To create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health".

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.

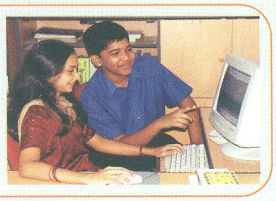
Bangladesh Population Pyramid: The age-sex structure of Bangladesh population is shown below in the population pyramid. The pyramid is wider at the base than the top and narrows slightly at the youngest age group. This pattern is typical of a historically high-fertility regime that has recently started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

Figure 3: Bangladesh Population Pyramid



Source: BDHS-2014



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.

(Source: Population Bulletin, PRB 2010).

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.

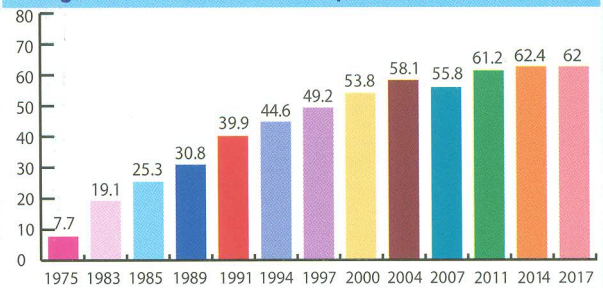
Figure 4: CPR in some Rich & Poor Countries

Country	Any Method	Modern Method
Countries with High FP Method users (%)		
Ireland	89	89
Norway	88	82
China	87	86
Switzerland	82	78
Hungary	81	71
Thailand	81	80
Countries with Low FP Method users (%)		
Chad	3	2
Angola	6	5
Mali	8	6
Sierra Leone	8	6
Sudan	8	6

Source: State of World Population 2010

Trends in Contraceptive Prevalence Rate-CPR (1975-2017): The contraceptive prevalence rate for married women (10-49) in Bangladesh has increased from 7.7% in 1975 to 62% in 2017 irrespective of their socio-economic status. Use of modern methods also increased from 5.0% in 1975 to 52% in 2017, a ten times increase in last three decades.

Figure 5: Trends in Contraceptive Prevalence Rate



Source: BDHS- 2017

FP Method-wise Performance (1993-2017): The method-wise FP performance has changed over the past two decades. The contraceptive prevalence rate increased to 62% in 2017 from 44.6% in 1994 while the permanent method users decreased to 6% in 2017 from 9.2% in 1994. During the last 23 years (1993/94-2017) the users of modern FP methods increased to 52% from 36.2%. (BDHS 2017)

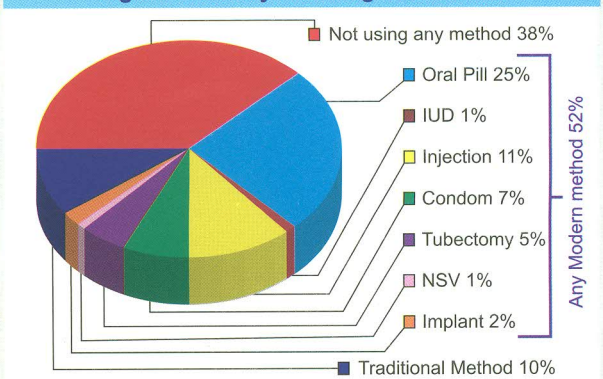
Figure 6: Family Planning Method-wise Performance (1993-2017)

FP Method	1993-94 (BDHS)	2004 (BDHS)	2007 (BDHS)	2011 (BDHS)	2014 (BDHS)	2017 (BDHS)
Any Method	44.6	58.1	55.8	61.2	62.4	62
Mordern Method	36.2	47.3	47.5	52.1	54.1	**52**
Oral Pill	17.4	26.2	28.5	27.2	27.0	25
IUD	2.2	0.6	0.9	0.7	0.6	1
Injectables	4.5	9.7	7.0	11.2	12.4	11
Condom	3.0	4.2	4.5	5.5	6.4	7
Tubectomy	8.1	5.2	5.0	5.0	4.6	5
NSV	1.1	0.6	0.7	1.2	1.2	1
Implant	-	0.8	0.7	1.1	1.7	2
Traditional Method	8.4	10.8	8.3	9.2	8.4	10

Source: BDHS 2017

Family Planning Method-Mix: Family planning method-mix varies with the increase or decrease of CPR. BDHS 2017 data shows that pill (25%) is the most widely used method among women of all age group, followed by Injectables (11%), condom (7%) and female sterilization (5%).

Figure 7: Family Planning Method-mix

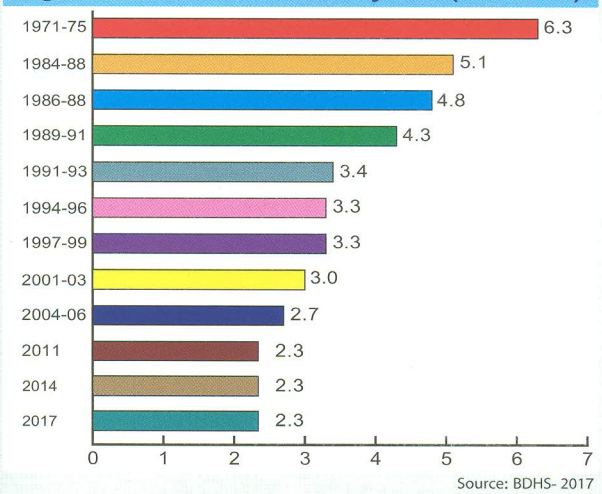


Source: BDHS- 2017




Trends in Total Fertility Rate- (1971-2017): 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% in 2017 and TFR decreased from 6.3 in 1975 to 2.3 in 2017 in last four decades (BDHS 2017). 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 eight administrative divisions including Rangpur have reached replacement level fertility or below. Sylhet division has the highest fertility (2.6) followed by Chittagong division (2.5). As per BDHS 2017, the TFR for rural women is higher (2.3) than that of urban women (2.0).

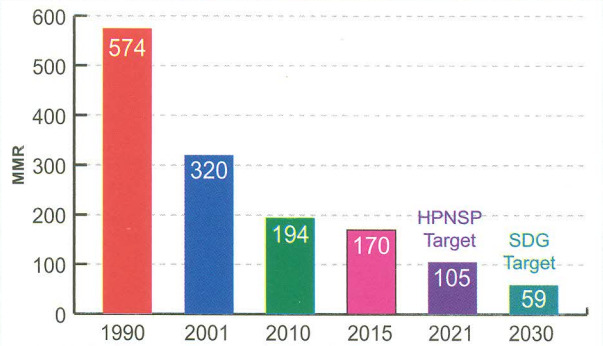
Figure 8: Trends in Total Fertility Rate (1971-2017)



Source: BDHS- 2017

Maternal Health: 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 (UN Pop. Div. 2014). 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 SDG 3

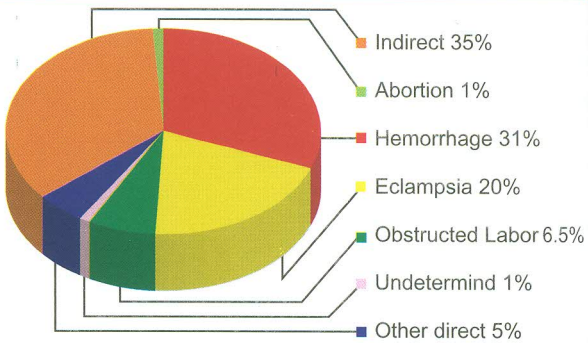


Source: BMMS 2010; UN Pop Division 2014; BDHS 2014 Policy Brief

To achieve the SDG goal 3.1, Bangladesh has to bring its maternal mortality rate (MMR) down to 59 from the current level of 170. The average annual rate of reduction of MMR between 2001 and 2010 was 5.63%. If a steady decline at a rate of 5.5% can be maintained, reaching the target (MMR 59) seems to be achievable.

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.

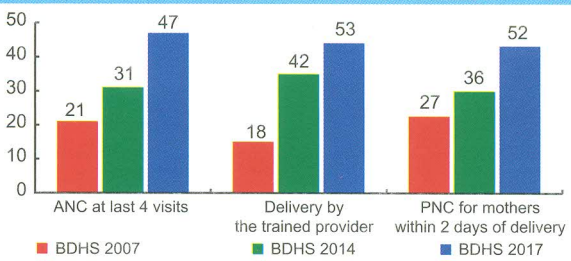
Figure 10: Causes of Maternal Death



Source : BMMS 2010

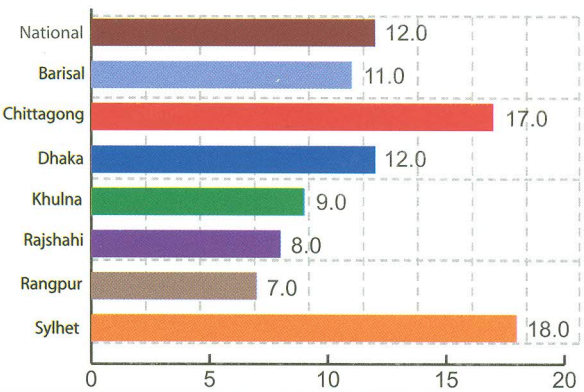
Delivery at Service Centers: The proportion of births delivered at health facilities has been increasing rapidly since 2004, from 12 percent in 2004 to 17 percent in 2007, to 37 percent in 2014 and 57 percent in 2017 (BHFS-2017). The proportion of deliveries by medically trained providers has increased from 16 percent to 53 percent in 2017 (BDHS 2017).

Figure 11: Maternal Health Care (ANC, delivery & PNC)



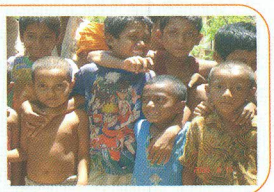
Unmet Need for Family Planning Services: In Bangladesh, 12 percent of currently married women have an unmet need for family planning services, of which, 7 percent for limiting births and 5 percent for spacing births. The unmet need decreased from 13.5 percent in 2011 to 12 percent in 2014 (BDHS 2014).

Figure 12: Unmet Need for Family Planning



Source : BDHS- 2014



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.

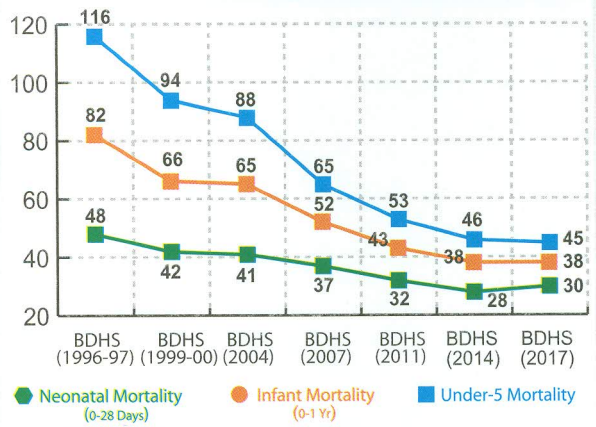
Figure 13: High and Low Maternal & Infant Mortality

Countries	MMR (per 1000 LB)	IMR (per 1000 LB)
High Maternal & Infant Mortality Rate		
Sierra Leone	21	102
Afganistan	18	152
Niger	18	84
Chad	15	127
Angola	14	111
Somalia	14	106
Rwanda	13	96
Libe ria	12	91
Congo	11	114
Low Maternal & Infant Mortality Rate		
Italy	.03	04
Sweden	.03	03
Iceland	.04	03
Germany	.04	04
Israil	.04	05
kuwait	.04	09
Spain	.04	04
Germany	.04	04
Switzerland	.05	04

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 1996-1997 and 2014-2017 periods, infant mortality declined by 56 percent, from 82 to 38 deaths per 1,000 live births. An almost 59 percent further reduction in infant mortality is needed to achieve SDG target of 12 deaths per 1,000 live births by 2030.

Figure 14: Trends in Child Mortality in Bangladesh



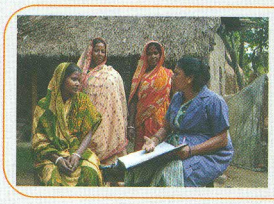
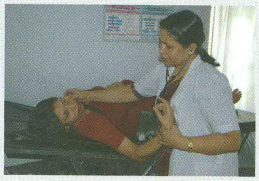
Major Success in FP-MCH Programmes:

- 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 62% in 2017 (BDHS 2017);*
- **TFR** declined from 6.3 in 1971-75 to 2.3 in 2017 (BDHS 2017);
- 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% in 2014 (BDHS 2014);
- **Neonatal mortality rate** (0-28 days) declined from 52 (per 1000 LB) in 1994 to 30 in 2017 (BDHS 2017);
- **Infant mortality rate** (0-1 yr.) came down from 87 (per 1000 LB) in 1994 to 38 in 2017 (BDHS 2017);
- **Under-five mortality rate** declined from 133 (per 1000 LB) in 1994 to 45 (per 1000 LB) in 2017 (BDHS 2017);
- **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 72.0 in 2016 (BBS 2016);
- **Delivery by trained providers** increased from 16% in 2004 to 53% in 2017 (BDHS 2017);
- **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 65% in 2017 (BDHS 2017);
- **EPI coverage** increased from 68% in 2004 to 88% in 2017 (BDHS 2017);
- The level of **stunting (height-for-age/** <5 children) has declined from 51% in 2004 to 31% in 2017 (BDHS 2017);
- The level of **underweight (weight-for-age/** <5 children) has declined from 43% in 2004 to 22% in 2017 (BDHS 2017).

*BDHS 2017 Preliminary Report

Key Challanges: Access to and Utilization of FP-MCH Services:

- Over Population of 161 Million (UN Population Division-2015);
- Rapid increase of urban population;
- Sharp regional variation of TFR (Sylhet-2.6, Chattagram 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% condom-7%) (BDHS 2017);
- High Maternal mortality (170/100000 LB), (UN Population Division-2014);
- Childhood mortality is still high (neonatal-30, infant-38 and under five mortality 45 per 1000 LB) (BDHS 2017);
- High child marriage (59% women aged 20-24, being married by 18 years) and adolescent (15-19) fertility (113 per 1000 women) (BDHS 2014);
- 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.
- Low coverage of post-partum family planning mathod.

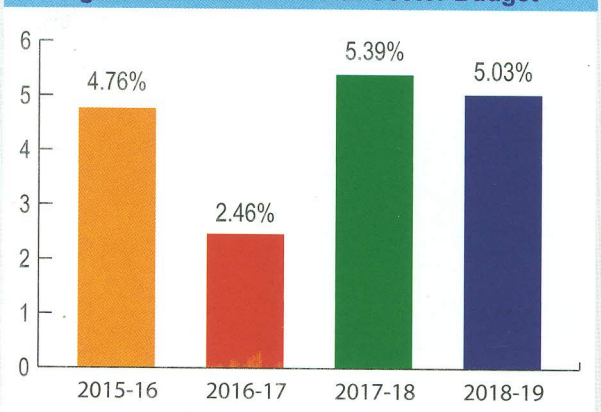



Major Interventions Undertaken to Addressing the Challenges:

- Favorable policies & strategies: **a)** National Population Policy (2012); **b)** National Communication Strategy for FP-RH (2008); **c)** ARH Strategy (2017); **d)** Maternal Health Strategy (2006); **e)** Reproductive Health Commodity Security- RHCS Strategy (2010); **f)** SBCC Strategy 2016;
- 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 19,583 FWAs (Family Welfare Assistants);
- Introduced 24/7 days normal delivery services at 2,800 UH&FWCs 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;
- Established adolescent friendly corner at 303 service centers for providing intensive adolescent reproductive health services.
- Introduced Family Planning services to the women working in ready made garments sector;
- Targeted intervention for adolescent couples;
- Intensive Family Planning services for the people residing in slums;
- Awareness raising initiative to prevent early marriage
- Special focus on Post-Partum Family Planning (PPFP) services.

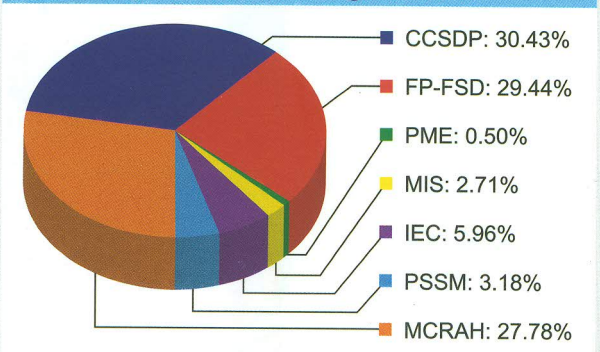
Health Budget: In fiscal year 2014-2015 the total budget for health, population and nutrition was 4.35 percent of the national budget while in 2015-2016, 2016-2017, 2017-2018 and 2018-2019 fiscal years, the allocated budgets were 4.76 percent, 2.46 percent, 5.39 percent, and 5.03 percent respectively which shows NO significant increase in budget allocation for health sector.

Figure15: Trends in Health Sector Budget



Budget Allocation for Different OPs under DGFP (2018-2019): 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 5.96% budget allocation for SBCC activities under IEC OP in the fiscal year 2018-2019.

Figure17: DGFP Budget 2018-19



Some Facts about Family Planning:

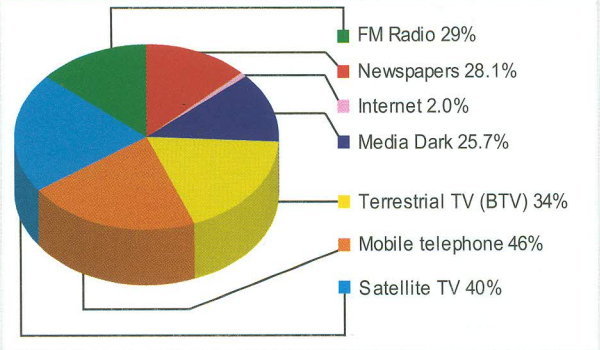
- Family planning is the best documented practice to reduce maternal mortality. Use of modern contraceptives in the developing world will prevent 218 million unintended pregnancies, which, in turn, will avert 55 million unplanned births, 138 million abortions (40 million of them unsafe), 25 million miscarriages and 118,000 maternal deaths (Guttmacher Institute & UNFPA Fact sheet, June 2012);
- Increased contraseptive use and reduced unmet need for family planning are central to achiving SDG 3.1.
- 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 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.

Figure 15: Exposure to Media



Source: National Media Survey 2010, SIRIUS

Benefits of Investing in Family Planning: Despite it's 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)						
		Education	Immunization	Water & sanitation	Maternal health	Malaria	Total	Savings per $ invested in family planning
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	1 Population (in million)	2 Population Density (per sq.km)	3 Population Growth Rate (%)	4 CPR Any Method (%)	5 TFR	6 MMR (per 100000 LB)	7 IMR (per 1000 LB)	8 Adolesant Birth Rate (per 1000 women)	9 Unmet Need	10 Literacy Rate (Youth: 15-24)*
SAARC Countries										
Bangladesh	161.0 (UN Pop Division 2015)	1015	1.37	62	2.3	170	38	113	12.0	Male- 80.6 Female- **85.8**
Afghanistan	32.5	48	3.0	29	5.1	400	71.1	90	27	-
Bhutan	0.8	20	1.5	68	2.1	120	30.5	28	11	Male- 89.9 Female- **87.2**
India	1311	436	1.3	60	2.5	190	44.4	52	13	Male- 92.9 Female- 87.2
Maldives	0.36	1337	1.8	42	2.2	31	9	14	25	Male- 99.8 Female- 98.8
Nepal	28.5	197	1.2	52	2.3	190	32.4	87	24	Male- 91.0 Female- 83.1
Pakistan	188.9	240	2.1	39	3.7	170	69.8	48	20	Male- 81.7 Female- 72.2
Srilanka	20.7	331	0.5	72	2.1	29	8.2	24	7	Male- 98.4 Female- **99.2**
East and Southeast Asian Countries										
China	1376	145	0.5	83	1.6	32	11.6	6	4	Male- 99.7 Female- **99.7**
Indonesia	257.6	140	1.3	63	2.5	190	25	47	11	Male- 98.9 Female- **99.1**
Iran	77.4	48	1.3	77	1.7	23	14.8	35	7	Male- 99.0 Female- **99.2**
Japan	126.6	349	(-) 0.1	57	1.4	6	2.2	4	16	-
Malaysia	30.3	91	1.5	57	2.0	29	6.8	13	15	Male- 98.3 Female- 98.5
Thailand	67.95	133	0.4	79	1.5	26	11.2	60	6	Male- 98.7 Female- **98.7**
Vietnam	93.44	293	1.1	77	2.0	49	19.3	36	7	Male- 97.9 Female- **97.2**
World	**7.34 billion**	**52**	**1.2**	**64**	**2.5**	**2.10**	**40**	**51**	**12**	-

Source: UN Pop Division-2015; BDHS-2014 & 17; BMMS-2010; State of World Population-2015; PRB World Population Data Sheet-2015; Worl Bank-2015; UNESCO-2013 : Adult & Youth Literacy (2015 Projection*) - National, Regional & Global Trends (1985-2015).

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Better Health for a Prosperous Society