UNMET NEED FOR FAMILY PLANNING IN BANGLADESH
A COMMUNITY LEVEL ANALYSIS

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF

MASTER OF ARTS

IN

DEVELOPMENT STUDIES

BY

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412HS1005

DEPARTMENT OF HUMANITIES

AND SOCIAL SCIENCES

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Under the guidance of

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2012-2014

CERTIFICATE

This to certify that the thesis entitled "Unmet need for family planning in Bangladesh – a community level analysis" submitted by Miss Madhusmita Naik, roll no 412HS1005 in partial fulfillment of the requirements for the award of Master of Arts degree in Development Studies at the National Institute of Technology, Rourkela (Deemed University) is an authentic work carried out by her under my supervision and guidance.

To the best of my knowledge and belief, the matter embodied in the present thesis has not been submitted to any other University/ Institute for the award of any degree.

Date: Prof. J. Pradhan

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ABSTRACT

Maternal and child health is at the forefront of the development agenda nowadays worldwide. People are living longer and healthier lives, and couples are choosing to have fewer children globally. While many richer countries are concerned about low fertility and ageing, many poor nations struggle to meet the needs of rapidly growing populations. Currently in many developing countries, even the most basic health-care is unavailable to the majority of women and children leading to various other problems of underdevelopment. Family planning is one of the four pillars of improving maternal health along with antenatal care, skilled attendant delivery and access to emergency obstetric care. Unmet need for family planning has been a major concern in international population discourse for several decades. In Bangladesh unmet need for contraception marginally declined from 16.8% in 2007 to 13.5% in 2011. The Bangladesh Demographic Health survey (BDHS), 2011 is a most rationally representative sample survey of women of reproductive age 15-49.This study assesses the trend and patterns of unmet need for family planning in Bangladesh and also examines the linkages of various demographic, socio-economic, maternal(level I) and community level factors (level II) on unmet need for family planning. It assesses the effectiveness of the community level variables on unmet need for family planning by controlling the effect of other individual level factors. Surprisingly the impact of education and wealth index is marginal in determining the level of unmet need. On the other hand, three community level variables (%women exposed to family planning, %women with ideal number of children and %women with primary and higher education) significantly associated with the level of unmet need for family planning in Bangladesh.

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CHAPTER 1

INTRODUCTION

1. INTRODUCTION

Fecund women who are currently married and who either don't want any more children or want to delay two or more years before having next child, and are not using any contraception, these women have an unmet need for family planning. Unmet need for family planning has been a major concern for international population since several decades. The major reasons for non use can also be less knowledge, side effects, and social and familial disapproval. The major consequence of this is rapid rise in unintended births and rapid increase in the number of women of reproductive age. By this major abortions and maternal deaths can be prevented, deaths of infants and children can be reduced and an altogether environmental sustainability and expansion of education and health services can be promoted. The International Conference on Population and Development (ICPD) held at Cairo in 1994 presented a Program of Action (PoA) which pledged to achieve the goal of universal access to reproductive health services in all countries till 2015. Family Planning is considered to be the key in achieving Millennium Development Goals and unmet needs for family planning was added as fifth MDGs in 2006 in the way of tracing improvement in the maternal health. A signatory of ICPD's program of Action and MDGs is Bangladesh. It is the World's eighth most populous country with a population of more than 180 million people. From a demographic standpoint, reducing unmet need can lower fertility in Bangladesh which is struggling to cope with rapid population growth. In Bangladesh unmet need for contraception marginally declined from 16.8% in 2007 to 13.5% in 2011.There has been significant improvements in family planning in all other Asian countries but Bangladesh is still having a lower development which even the UN organizations are working upon. The Bangladesh Demographic Health Survey (BDHS), 2011 is a most recent nationally representative sample survey of women of reproductive age 15-49.

1.1 **The need for family planning**

Family planning is an efficient way to keep fertility under control. This public health involvement has numerous social benefits. It lowers fertility rates therefore paying a demographic dividend. Globally, the use of modern contraception methods and the desire for

smaller families has been increasing. Large disparities between rich and poor still exist in access to services, resulting in disproportionately high unmet need for the poor. The causes for unmet need are mainly related to poor access to services, lack of information, social opposition to use and concerns about side effects. Bangladesh's contraceptive use doesn't significantly vary according to the level of education (BDHS 1999-2000). In Bangladesh, rural women live and work within the confines of the extended family home and complex. Generally women have no source of income, very little or nil education with very less skills. For reproductive decision-making they are also dependent on men. Contraceptive prevalence can be increased to a great deal by proper organized family planning. The total fertility rate and contraceptive prevalence are in an inverse relationship. Thus, family planning facilitates to fertility decline. The supply and delivery system of contraceptives must be properly organized. An estimated 150 million married women in the developing world want to delay or stop childbearing and are not using contraception. Measuring the unmet need for family planning is in responding to unwanted fertility. In order to achieve increases in contraceptive use, changes must occur in fertility preference. Considerable increases in contraceptive occurrence can be achieved in the absence of changes in the demand for children by meeting the existing unmet need. Meeting the unmet need fulfills individual fertility aspirations and is a sensible reason for continuing the expansion of family planning programs. A successful family planning program should not only go for service provision but also address barriers to contraceptive use. It is all about giving people choice; not limit people's rights. This helps in achieving birth control with desirable family size and timing. Contraceptive use lessens the risk of maternal death by decreasing the odds of being pregnant. Therefore, Family planning plays a very defending role among women at high risk for maternal mortality. This includes adolescence, high parity, old age and brief birth intervals. It is generally observed that given the option most societies would prefer contraception to abortion. Unsafe abortion is the second largest cause of maternal death. They can be prevented by preventing unwanted pregnancies; in short, deaths related to unsafe abortion could also be averted. In addition family planning can help reduce abortions overtime.

1.2 **Expanded Definitions of Unmet Need**

The population under unmet need include women using an ineffective method or incorrectly using a method or most likely using an unsafe method. Reasons for unmet need include generally lack of access to a preferred method and sometimes a preferred provider. Physical distance may not be of major importance, but other "costs" are, such as monetary, psychological, physical, and time. Another basic concern is that of poor quality of services provided. This includes choice of methods, provider competence, information given to clients, related health care services, follow up care. Health concerns generally are actual side effects and also the fear of side effects which lead to unmet need for fertility. Lack of information and misinformation about available methods, mode of action/how used, side effects, source /cost of methods are also a major threat. Apart from all this, socio-cultural constraints play a major role in unmet need like family/community opposition (power relationships in the household), pro-natalist, unfaithfulness, fear of side effects, objections to male providers, religious objections, little perceived risk of pregnancy and ambivalence.

Figure 1: Schematic diagram defining total unmet need.

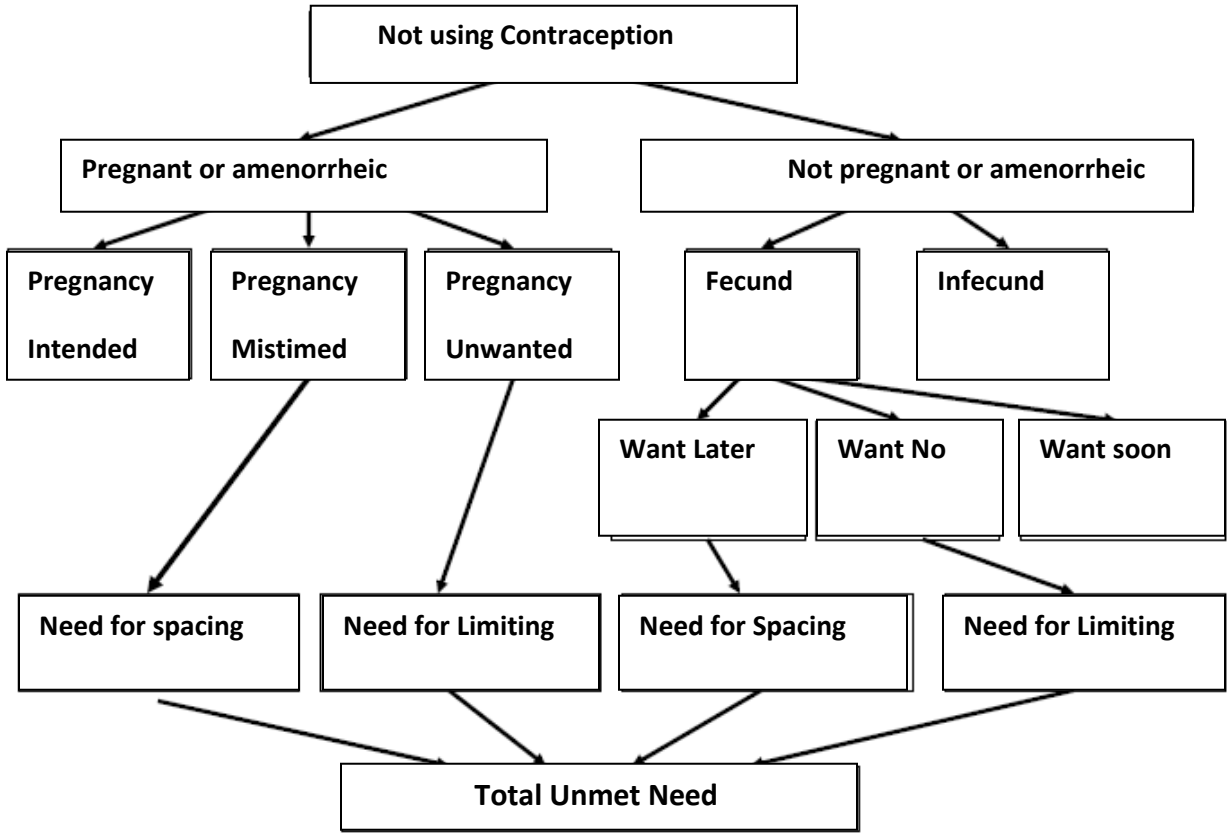


Figure 1 shows the schematic framework of defining total unmet need. The currently married women who were not using contraception were divided into pregnant or amenoerrheic women and non users who were neither pregnant nor amenorrheic. The pregnant or amenorrheic women were then classified by whether the pregnancy or birth was intended at that time, mistimed, or not wanted. Those in the mistimed or unwanted category categories were regarded as one component of total unmet need. The other unmet components consist of non-users who were neither pregnant nor amenorrheic who then were first divided into fecund and infecund women. The fecund women then subdivided into those who wanted another child soon, women who wanted to wait for at least 2years or who want no more children were classified in the unmet need category.

In Bangladesh unmet need for contraception marginally decreased from 16.8% in 2007 to 13.5% in 2011.There has been significant increase in improvements in family planning in all other Asian countries but Bangladesh is still having a lower trend which even the UN organizations are working upon. The Bangladesh Demographic Health Survey (BDHS), 2011 is a most recent nationally representative sample survey of women of reproductive age (15-49).

1.3 Situational analysis of unmet need for family planning in Bangladesh

Bangladesh has witnessed a high population growth from 1960 to 1990s. Incidentally because of the success of family planning programs, fertility rate has declined vastly. According to the revised Census 2011, Bangladesh's population stands at approximately 152.51 million, with a population growth rate 1.37. Present total fertility rate is 2.3 and further decline is expected to reach replacement level fertility by 2015. In Bangladesh unmet need for contraception marginally declined from 16.8% in 2007 to 13.5% in 2011. There has been significant increase in improvements in family planning in all other Asian countries but Bangladesh is still having a lower trend. The Bangladesh Demographic Health Survey (BDHS) 2011 is a nationwide sample survey of men and women of reproductive age. This survey aims at finding out information on fertility and childhood mortality levels; fertility preferences; the family planning methods in use; maternal, child and new born health, including practice of breast feeding, anemia symptoms and presence of iodine in cooking salt, awareness towards HIV/AIDs and other sexually transmitted infections (STI); and accessibility and availability of health and family planning services. BDHS 2011 is the 6^{th} survey of its kind conducted in Bangladesh. The BDHS included a household

survey of ever-married women age 12-49 and ever-married men age 15-54. It also included a questionnaire of community distributed during the listing of households to informants in communities around the sample points from which the households were selected. It lists important conclusions from data collected in the household survey using various questionnaires' the household, the women's and the men's. The 2011 BDHS included a numerous questions about current use of family planning. Currently married women were asked their contraceptive method and from where they have bought it

1.4 Problem of Study

Maximum of the studies on Bangladesh focuses upon the rural women at the individual level and household level. Thus the community factors have been largely ignored, which are more applicable for reducing the overall unmet needs. Analysis focusing on the unmet family planning needs to incorporate individual, household and community levels, as all these factors are highly correlated with each other. Community level factors include: % women exposed to family planning, % women with ideal number of children, % women with high socio-economic status, % women with primary and higher education in the PSU**.**

1.5 Objectives

- To assess the trends and patterns of unmet need for family planning in Bangladesh and also examine the linkages of various demographic, socio-economic, maternal (level I) and community level factors (level II) on unmet need for family planning.

- To assess the effectiveness of the community level variables on unmet need for family planning by controlling the effect of other individual level factors.

- To identify the level to which the community level variables (%women exposed to family planning, %women with ideal number of children and %women with primary and higher education) are significantly associated with the level of unmet need for family planning in Bangladesh.

CHAPTER 2

LITERATURE REVIEW

2. LITERATURE REVIEW

Women in the developing countries with unmet need constitute a significant fraction of all married women of reproductive age. There are an estimated 80 million unwanted pregnancies and more than 19 million unsafe abortions annually (WHO, 2004). However, evidence shows that given the option most societies would prefer contraception to abortion (Casterline & Sinding, 2000). Contraceptive use decreases the risk of maternal death by decreasing the odds of being pregnant (WHO/UNFPA, UNICEF, 1999). Demographic health survey data show that among currently married women in Rwanda is 36.9% and 35% in Senegal during the year 1990-2000. In Ethiopia, nationwide it was 36% in 2000 and 33.8% in 2005. . In Bangladesh unmet need for contraception marginally declined from 16.8% in 2007 to 13.5% in 2011. There has been significant increase in improvements in family planning in all other Asian countries but Bangladesh is still having a lower trend. While making a comparison between Bangladesh and the Philippines, it is found that Bangladesh's contraceptive use does not significantly vary according to the level of education (Bangladesh 1999-2000 DHS). In contrast, contraceptive use increases with the level of education in the Philippines (Philippines DHS 1998). Both the countries vary in their approach and methods to family planning provision. The rural women in Bangladesh live and work within the confines of their household. They have no independent source of income, are illiterate and technologically backward. They are influenced by a typical patriarchal oppression of decision making. The Bangladesh Demographic Health family planning programs in Bangladesh take into account these factors. In Philippines the low income women experiences problem in accessing modern family planning methods. In Indonesia, contributes to 75% of the fertility decline (Gertler & Molineaux). Unlike the fertility transition effects in many Asian countries (i.e. Indonesia, Thailand, South Korea, Vietnam, and others), fertility decline in sub-Saharan African countries has not been accompanied with rapid changes in socio-economic development – the exceptions being South Africa , Botswana and Namibia (ECA, 2003). An estimated 150 million married women in the developing world want to delay or stop child bearing and are not using contraception (Shane, 1996). Some point out that many women considered with unmet need will not use contraceptives due to their low risk perception of pregnancy, or for social, cultural, and health reasons (Pritchett, 1994). As per the Demographic and Health survey of Nepal 2001, the total demand for family planning is 67.1 per cent of which 39.35 is met. That leaves 27.85 per cent of need not yet met (11.4 percent for spacing and 16.4

percent for limiting). Therefore out of 67.1 percent of the requiring family planning services, the demand has been satisfied for 58.6 percent of these couples. There also exists another issue regarding unmet need of family planning i.e. the concept like Knowledge, Accessibility and Practices gap (KAP-gap). In several cases it was seen that couples had prior knowledge but they are not using any kind of contraception either willingly or due to other social or religious constraints. On the other hand it was seen that couples ready to use family planning but due to shyness or criticized by the neighbors they were not using any kind of contraception. Based on a study conducted in North India regarding fertility behaviors it was seen that the fertility behaviors of the newly married couple are determined by the grand parents or head of the household. The study also witnessed that if a newly married woman is not pregnant within two years of marriage then she would be criticized severely by grandparents or neighbors, even though they willing to use family planning methods they were unable to do so due to social or other factors. In short meeting the unmet need fulfills individual fertility aspirations and is a sensible reason for continuing the expansion of family planning programs. Eliminating the unmet need would increase contraceptive use, decrease fertility, and serve national population policy goals (Sinding, Ross, & Rosenfield, 1994). An effective family planning program should go beyond service provision and address barriers to contraceptive use (Bongaarts & Bruce, 1995). In the contemporary days, rising rates of contraceptive use have increased unmet need for family planning in most of the developing countries, Lori Ashford (2003), an empirical study on the DHS data collected from nearly 53 countries. In sub-Saharan Africa unmet need of 20 percent or higher, which is predominantly for spacing births rather than for limiting births is prevalent. In other regions, there is greater unmet need for limiting births. This indicates the regional variation of unmet need based on the demographic situation. It also found that the component of unmet need is different across space. Low unmet need in many African countries is mainly due to their desire for more children. Thus it needs to be addressed carefully with proper awareness among people.

Table- 1. Distribution of married women of reproductive age with unmet and met needs for contraception and total demand for contraception in selected South Asian countries, 1996/1997-1999/2000(Percentage).

Need for family planning	Bangladesh (1999-2000)	India (1998-1999)	Nepal (1996)	Pakistan (1996-1997)
Percentage of married women of reproductive age with unmet need				
Spacing	8.0	8.3	14.3	13.4
Limiting	7.3	7.5	17.1	24.1
Total	15.3	15.8	31.4	37.5
Met need for contraception (current contraceptive prevalence rate)				
Spacing	15.6	3.5	2.6	5.1
Limiting	38.2	44.7	25.9	18.8
Total	53.8	48.2	28.5	23.9
Total demand for contraception				
Spacing	23.6	11.8	16.9	18.5
Limiting	45.5	52.2	43.0	42.9
Total	69.1	64.0	59.9	61.4
Percentage of demand satisfied				
Spacing	66.1	29.6	15.4	27.6
Limiting	83.9	85.6	60.2	43.8
Total	77.9	75.3	47.6	39.0

Table 2: Progress in Millennium Development Goals 5 (MDG 5), Bangladesh:

Goals, Targets and Indicators	Base year	Current Status	Target 2015	Status of progress
Target 5 B : Achieve by 2015, universal access to reproductive health				
5.3 Contraceptive Prevalence rate %	39.9 (1991)	61.2 (2011)	-	-
5.4 Adolescent birth rate, per 1000 women	179 (1990)	128 (2009)	-	-
5.5 a Antenatal care coverage (at least one visit)%	25.7(1994)	54.6 (2011)	100	⬇
5.5 b Antenatal coverage (at least four visits)%	6.0 (1994)	25.5 (2011)	100	⬇
5.6 Unmet need for family planning %	21.6 (1994)	13.5 (2011)	7.6	⬇
Goals, Targets and Indicators	Base year	Current Status	Target 2015	Status of progress
Goal 5: Improve maternal health				
Target 5 A : Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.				
5.1 MMR per 1,00,000 live births	800 (1990)	240 (2010)	144	⬇
5.2 Proportion of births attended by skilled health personnel %	9.5 (1994)	31.7 (2011)	50	⬇

Source: ***http://mdgs.un.org/unsd/mdg/Data.aspx***

Table 3: Demographic and Family planning Indicators of SAARC and some Asian Countries

Country	Population (in millions)	Contraceptive Prevalence rate (%)	Total Fertility Rate	Unmet need
Bangladesh	152.51	61.2	2.3	11.7
India	1277	54	2.4	13.5
Sri Lanka	20.5	68	2.1	7
Bhutan	0.7	6	2.6	-
Nepal	26.8	50	2.6	25
Pakistan	191	35	3.8	25
Afghanistan	30.6	21	5.4	-
Maldives	0.4	35	2.3	-
China	1357.4	85	1.5	2
Malaysia	29.8	49	2.1	-
Indonesia	248.5	62	2.6	9
Thailand	66.2	80	1.6	3
Japan	127.3	54	1.4	-
Vietnam	89.7	76	2.1	5
Iran	76.5	73	1.9	-
WORLD	7136	62	2.5	22

Source: State of World Population 2010, BP&H Census 2011(revised), PRB World Population Data Sheet 2013, BDHS-2011.

CHAPTER 3

DATA SOURCES AND METHODOLOGY

3.1 Area of Study

The current study is based on the secondary data collected from the Bangladesh Demographic Health survey 2011. **Bangladesh** officially the **People's Republic of Bangladesh**, is a country in South Asia, sits in between 24° 00' North latitude and 90° 00' East longitude. It is bordered by India to its west, north and east; Burma to its southeast and separated from Nepal and Bhutan. To its south, it faces the Bay of Bengal. Bangladesh is the eighth-most populous nation in the world, with a population of over 160 million people, and is also among the world's most densely populated countries. It forms part of the ancient and historic ethno-linguistic region of Bengal, together with the neighboring Indian states of West Bengal and Tripura. It has seven administrative divisions and 64 districts. Dhaka is the capital and largest city of Bangladesh

Fig 2: Bangladesh map

3.2 Data source and methods

The present study uses data from the Bangladesh Demographic and Health Survey (DHS), 2011.The Bangladesh Demographic Health Survey (BDHS), 2011is a most recent nationally representative sample survey of women of reproductive age 15-49. It was designed to provide information on levels and trends in fertility and use of family planning methods among women in Bangladesh. The sample of currently married women aged 15-49 (16635) were considered for detailed analysis.

3.3 Dependent variable

The outcome variable of this study was the unmet needs of family planning in Bangladesh. The measure was generated from a constructed DHS survey, which employed different variables to explain the condition of women who are married or ever in union, do not want any more children or want to delay their next birth for at least two years but are not using any contraception. The variable is dichotomous and it was categories as (unmet need=1, otherwise=0).

3.4 Independent variables

At the individual and household levels independent variables include age of women, number of ideal children, region, ethnicity, education, education of partner, wealth index, residence and desire for children and regions.

Community level factors categorized as :
i) percentage of women exposed to family planning in the PSU;
ii) percentage of women with high socio-economic status in the PSU;
iii) percentage of women with ideal number of children and iv) percentage of women with primary or higher education in the PSU.

3.5 Methodology

For the core analysis data has been extracted from Bangladesh Demographic Health Survey (BDHS), 2011. Multi- level regression analyses will be employed to explore the relative effects of community, household level and individual level factors on unmet need for family planning among currently married women.

$$\text{Log}[Pij/(1-Pij)]= xij\ a+ wj\ b+ uj + eij$$

Where,

Pij is the probability that women i in a community j is having unmet need for family planning.

xij, wj are vectors of individual and community level characteristics respectively,

a, b are coefficients of the vectors.

uj is an error at community level

and at the individual level eij is the error.

CHAPTER 4

RESULTS AND DISCUSSION

RESULTS

Results from the following table depicts that the unmet need for family planning is the highest for the women age group 15-19 years (17%) in Bangladesh. Significant differences is seen in the unmet needs between urban and rural areas, as women in the rural areas are more likely to have unmet need than in the urban areas. Based on regional analysis, Chittagong is found to have the highest unmet need (20%). Religion wise data shows that Muslims have more unmet need than the rest religions in Bangladesh, though Buddhists have highest unmet needs (17.5), but very less in population, after Muslims. It is seen that unmet need is more for women who have never used any contraceptive for family planning (19.6%). Also Partners desire for having children was also highly responsible for the unmet need, either they wanted more children or they don't know. Surprising findings show that wealth index and level of education has little to do with the unmet need for family planning among women's, as highest unmet need was among the richer wealth quintiles (15.1%) followed by the poorest (13.8%). Level of education similarly is unable to reduce the unmet need as uneducated people have minimum unmet needs (12%) while, people who are above primary and secondary incomplete have highest unmet need (15.6%). Females completed primary or above have higher unmet needs (14.3 %), and partners education does not contribute in the reduction of unmet needs for family planning, as highest unmet needs were among women's whose husband/partners were secondary educated (15%).

Table 4: Percentage of Unmet Needs by Selected socio-economic covariates, BDHS, 2011

Background Characteristics	Unmet Needs (%)	N
Age		
15-19	17	1926
20-24	15.3	3397
25-29	15.2	3263

30-34	13.5	2533
35-39	11.5	2081
40-44	10.3	1937
45-49	7.7	1500
Residence		
Urban	11	4291
Rural	14.3	12343
Region		
Barisal	12.2	953
Chittagong	20.7	3014
Dhaka	13	5334
Khulna	9.7	1997
Rajshahi	11	2527
Rangpur	9.7	1927
Sylhet	17.3	884
Women's education		
No Education	12	4379

Primary Incomplete	12.9	3056
Primary Complete	12.9	1964
Secondary Incomplete	15.6	5176
Secondary Complete	12.7	795
Higher	12.4	1266
Religion		
Islam	14.1	14971
Hinduism	8	1591
Buddhism	17.5	40
Christianity	6.1	33
Wealth Quintile		
Poorest	13.8	2975
Poorer	12.4	3267
Middle	13.4	3373
Richer	15.1	3456
Richest	12.6	3565
Partners Desire For Children		

Both Wants Same	13.5	12572
Husband Wants More	17.6	1515
Husbands Wants Fewer	16.5	1078
Don’t Know	22.2	409
Husband's education		
No Education	12.6	4996
Primary	13.5	4576
Secondary	15	4740
Higher	12.1	2316
Total	13.5	16656

Unmet need for contraception is low among women 25 years and above. Results from multilevel analysis suggest that three community level variables (% women exposed to family planning, % women with ideal number of children and % women with primary and higher education in the PSU) significantly associated with the level of unmet need for family planning in Bangladesh. So, community level educational status plays a major role in determining the level of unmet need

for family planning compared to the individual level of education.

The trends in contraceptive use in Bangladesh shows a clear picture that nearly 44.9 % people in 1994 used any method of contraceptives and 36.6 % used modern contraceptives. An increasing trend in the use of contraceptives is seen in 2011, wherein 61.2 % people were using at least any method of contraceptives and 52.1 % using any modern contraceptives. Total unmet need in 1994 was 21.6 % while spacing was 10.7, limiting 10.9, in 2011 total unmet need dropped to 13.5 % and spacing declined to 5.4, limiting 8.1. From both the figures it is clear that there has been significant improvement in the family planning and unmet need has declined considerably. Contraceptive prevalence rate has increased (11%) from 49% in 1994 to 61% in 2011 and on the other hand proportion of currently married women who wish to regulate childbearing has increased 8% (i.e. 66% in 1994 to 74% in 2011).

Figure 3: Trends in contraceptive use by type, Bangladesh

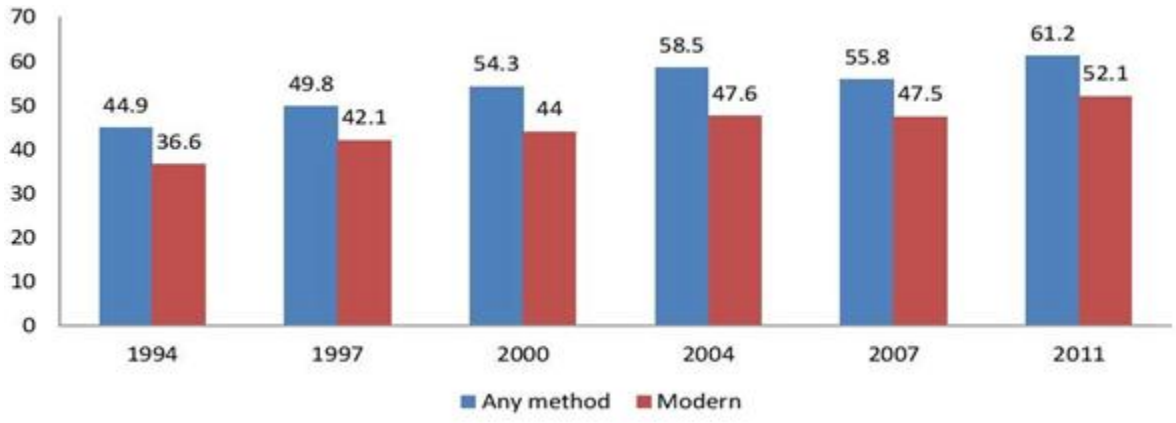
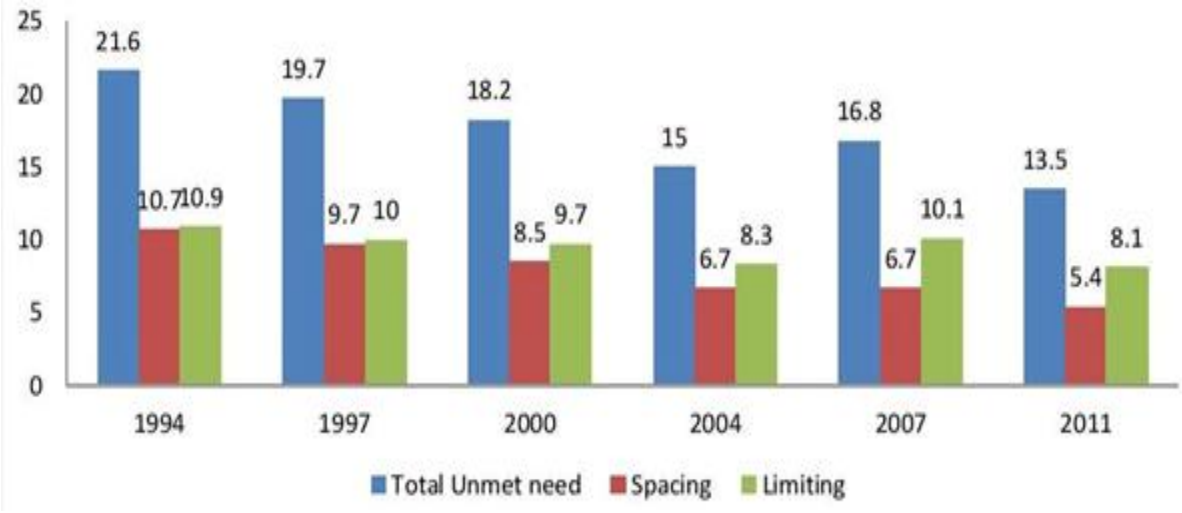


Figure 4: Trends in unmet need for family planning, Bangladesh



Conclusion

Benefits beyond health family planning contribute to individual, family and social well being and therefore multiply the return on government's investments. Examples of non-medical benefits include (for individuals) less botheration about unplanned pregnancies, greater self esteem, more decision making power, better social life, improved educational opportunities, more jobs for women and girls.For family and households: more attention and parental care for each child, higher health, nutrition and educational expenditures per child, fewer orphaned children. Also for communities and societies: higher productivity, less social burden of caring for neglected children, reduced public expenditure in education, health care and other social services, higher savings and investment. Family planning professionals can improve programs by applying certain important strategies like supportive policies which are based on increased information access and service support. A key role can also be played by family planning advocates by bringing to the forefront important issues of family planning gather support for the same and work for making supportive policy. Effective communication strategies such as mass media, interpersonal and community channels can be used to increase awareness. Evidence-based planning/programming like research, monitoring and evaluating data to guide program design and implementation. Strong leadership and good management both are essentially important for

any organization to achieve its goals and purposes, program managers often play the roles of both manager and leader. Contraceptive Security can be maintained by a supple chain of planning, procuring, transporting, storing and distributing contraceptives and other clinical supplies and equipment. High performing staffs are the most important aspect of a successful family planning program. The effectiveness of the already existing staff can be improved by task-shifting and performance improvement. Client-centered care: It means that services meet radical standards which require provider's commitment and expertise. However, program, providers, and clients all play roles in achieving client-centered care. Easy access to services like adequate number of service delivery points must be provided to the whole population. It can be achieved by offering services through multiple channels. Affordable services to decrease financial pressure on government, NGO's etc users must be shifted who can afford to pay from public sector to private sector. A proper study and knowledge of demand and supply is required by managers to achieve target subsidies easily and make services affordable.

References

Bangladesh, (1999-2000). Demographic and health survey. National institute of population research and training (NIPORT) Dhaka, Bangladesh, Mitra and Associates, ORC Macro, Calverton, Maryland USA. May (2001).

Bongaarts, J., & Bruce, J. (1995). The unmet need for contraception and the social content of services. *Studies in Family Planning*, 26(2), 57-75.

Casterline, J., & Sinding, S. (2000). Unmet need for family planning in developing countries and implications for population policy. *Population and Development Review*, 26(4), 691-723.

ECA (UN Economic Commission for Africa) Economic report on Africa. Africa recovery, vol. 17 #2, July 2003, p. 21).

Gertler, P.J., & Molyneaux, J.W. (1994). How economic development and family planning programs combined to reduce Indonesian fertility. *Demography*, 31(1).

John A. Ross and William L. Winfrey. (2002). Unmet Need for Contraception in the Developing World and the Former Soviet Union: An Updated Estimate. *International Family Planning Perspectives*, 28: 3.

Kiros G. (2002). Husbands, Wives, sons and Daughters Fertility Preferences and the Demand for Contraception in Ethiopia, *Population Research and Policy Review*, 21:377-402.

Philippines National Demographic and Health Survey, (1998). National Statistics office, Department of Health, Manila, Philippines and Macro International Inc. Calverton, Maryland. January 1999.

Pritchett, L. (1994). Desired fertility and the impact of population policies. *Population and Development Review*, 20(1), 1-55.

Shane, B. (1996). *Family planning saves lives*. (3rd ed.). Washington, D.C.: Population reference Bureau.

Sinding, S., Ross J, & Rosenfield A. (1994).Seeking common ground: Unmet need and demographic goals. *International family planning perspectives*, 20(1), 23-27.

Unmet Need of Family Planning among rural women in Bangladesh, (2010) Journal of Dhaka Medical College. Vol. 19 (1), 11-15.

WHO/UNFPA/UNICEF/World Bank (1999). Reduction of maternal mortality. A joint WHO/UNFPA/UNICEF/World Bank statement.

World Health organization (2004). Unsafe abortion – Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000. Geneva.

Willard Cates Jr. (2009). Family planning: the essential link to achieving all eight Millennium Development Goals. *Contraception* 81: 460–461.

Westoff, C F. (2006). New Estimates of Unmet Need and the Demand for Family Planning. DHS Comparative Reports No. 14. Calverton, Maryland, USA. Macro International Inc.

Westoff, CF. (1978). The unmet need for birth control in five Asian countries. *International Family Planning Perspectives* 10(3): 173–181.

Willard Cates Jr., (2009). "Family planning: the essential link to achieving all eight Millennium Development Goals" Contraception 81:460–461.

S.Ahmed , Maureen Norton, Emma William et. al. (2013). " Operations research to add postpartum family planning to maternal and neonatal health to improve birth spacing in Sylhet District, Bangladesh" global Health : Science and practice, vol. 1 :262-276.

Short E.S. and Kiros G. (2002). "Husbands, Wives, sons and Daughters Fertility Preferences and the Demand for Contraception in Ethiopia", Population Research and Policy Review, 21:377-402.