



**World Health  
Organization**

Regional Office for South-East Asia

# **Family Planning in South-East Asia**

## **Factsheets**



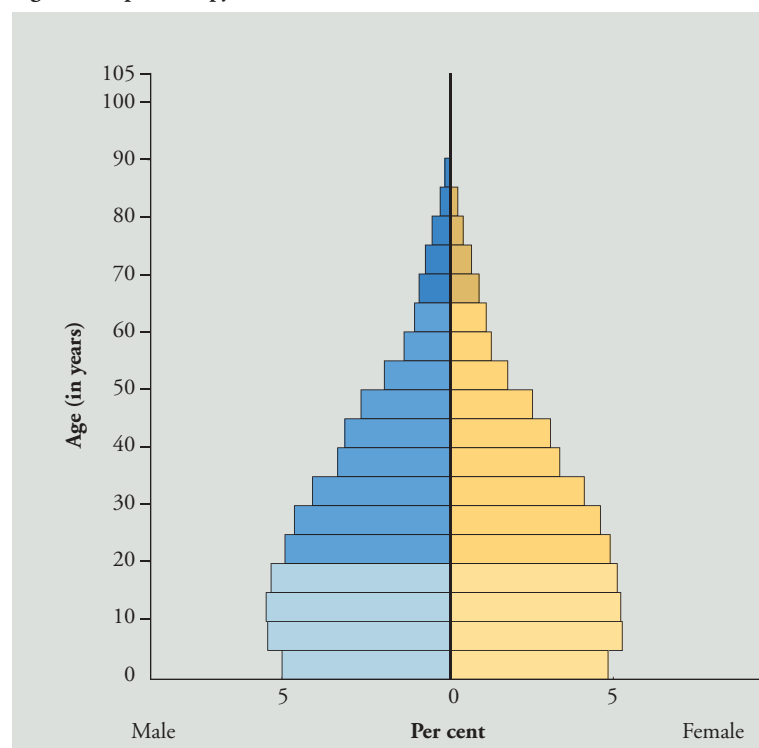
# Bangladesh and Family Planning: An overview



## Background

The 2011 census pegs the population of Bangladesh at 150.6 million, reflecting an increase of more than 20 percent over the 2001 census population levels. This decadal growth rate is higher than the 17 percent growth in population seen from 1991 to 2001. With an area of just 147,570 sq. kms., this population load translates into an average population density of 1015 persons per sq.km which is one of the highest in the world. In face of the relatively poor economic status of the country, the large population size puts an excessive strain on the countries resources and is a major impediment to its economic development.

Figure 1: Population pyramid, 2010



Source: UN Population Projections 2010

now stands at 2.3 according to the Bangladesh Demographic and Health Survey 2011, which is still some distance away from replacement fertility levels. According to a an analysis done by the Population Reference Bureau in 2003, even if Bangladesh reached replacement level fertility by 2010, population stabilization would take another 15 years, the growth being fuelled by the large proportion of youth in the country.

## Situation Analysis

The rapid growth in Bangladesh's population can largely be attributed to the age distribution of its people. As can be seen from the population pyramid (Figure 1), 56% of the women in Bangladesh are in the reproductive age group of 15–49 years. Another 31% of the population is below the age of 15 years and will soon be entering the reproductive life span and contributing to the increasing numbers.

### Total fertility rate

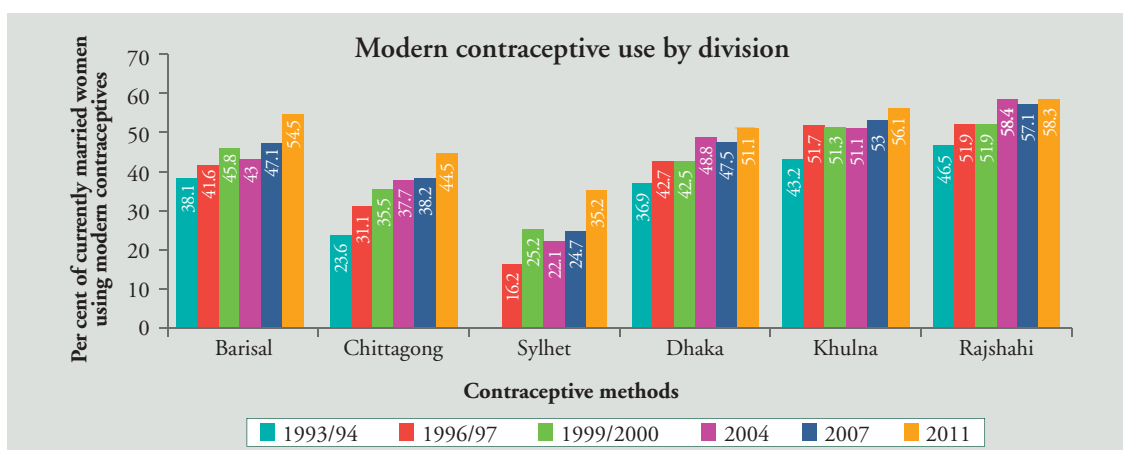
Owing to intense efforts in the country to control the population growth, the total fertility rate (TFR) has been steadily reducing over the past almost four decades. From extremely high levels of 6.3 in 1975, to 3.3 in the year 2000, the TFR



### Contraceptive prevalence rate (CPR)

A large proportion of this reduction in TFR can be attributed to the growing availability and use of contraceptives by Bangladeshi couples. According to the Bangladesh Demographic & Health Survey 2011, contraceptive use among currently married women has been increasing steadily from 1993–94, when it was 44.6% (not shown in graph) to 53.8% in the year 1999–2000, and reached 58.1% in 2004. Then with a slight dip in contraceptive use at 55.8% as per DHS 2007, it now pegs at 61.2% as per latest DHS 2011.

There exists an urban-rural divide in the use of contraception with 52% of the urban women using a modern method of contraception compared to only 46% of the rural women. However, more alarmingly, these averages mask the geographic (inter-division) differentials in contraceptive use. For example, Sylhet division of Bangladesh has the lowest modern method CPR of only 25%, while it is more than double in Rajshahi division, where modern method CPR is 57%. The DHS found no significant difference in contraceptive use between married women belonging to different wealth quintiles, thus showing that poverty is not a factor that restricts access of women and couples to contraceptive products and services.



Source: BDHS, 2011

As the TFR continues to show a steady decline despite the fluctuations in CPR, it can be inferred that increase in contraceptive use is not the sole factor responsible for decrease in fertility levels. One of the other reasons that may be contributing to this reduction is the improvement in access to maternal health services, including safe abortion services (including menstrual regulation), which has helped reduce the number of unplanned and unwanted births. It must be noted that the Bangladesh government does not promote abortion as a family planning method, but provides facilities for the same as an integral part of maternal health services, and in concordance with the international treaties on women's rights.

### Contraceptive method mix

Of the 56% of married women who are using a contraceptive method, 8% are using traditional methods such as withdrawal and periodic abstinence, and only 48% are using a modern method of contraception. The pill continues to be the most preferred method with 29% of the married women relying on the same to prevent conception. Another hormonal method, injectables, comes a distant second in the list with 7% of the women using the same. Five percent of the women in the survey had relied on tubal ligation as the method of choice. Condoms were the only male centric method that found any substantive proportion of acceptors (5%).



Comparing to the DHS 1999–2000 figures of contraceptive method mix, there is a reduction of more than 2 percentage points in the proportion of non-users of contraception as well as in the users of traditional methods. Similarly, female sterilization rates also show a decline of 1.7% percentage points. The reduction in all these areas is reflected in the increase in pill use from 23% in 2000 to 29% in 2007. The rate of injectable use peaked to about 10% in 2004, but has again dropped down to 7% in 2007, which is almost similar to the uptake levels in 2000. Other modern methods of contraception such as IUDs, implants, vasectomy etc. continue to find very few takers.

### Unmet need for family planning

The Bangladesh Demographic Health Survey 2007 reveals that 17% of all married women have an unmet need for family planning. This has increased significantly from 11% in 2004. The reduction in contraceptive use from 58% to 56% in the corresponding time frame, can only partially explain the increase in unmet need, and is probably due a reduction in availability and/or utilization of family planning services. The larger reason would be an increase in the felt need for family planning among married women, which, when coupled with stagnant or reducing service accessibility, led to the rise in unmet need.

Of the 17% unmet need, 7% is for spacing and 11% for limiting births. There is a very wide inter-division variation in unmet need. It is highest among those living in Sylhet (26%) and Chittagong (23%) divisions and lowest in Khulna and Rajshahi (12% each). This corresponds very well with the CPR levels in these districts.

The overall situation is shown by the relevant indicators in the following table.

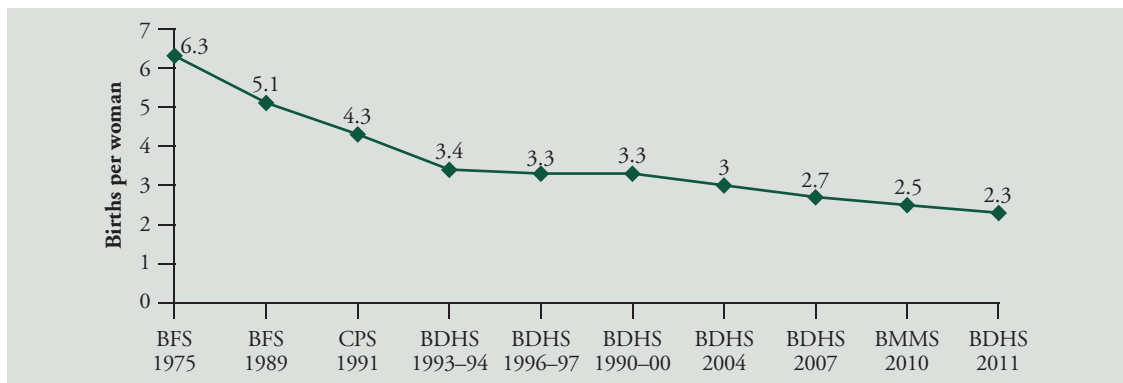
**Table 1: Key indicators**

Total Population, (in million), 2011 (Census)	150.6
Population Growth Rate, Census 2011	1.37%
Population Density, (people per square km), 2011	1021
Urban Population, 2011	39.8%
Population <15 years of age (percent), 2010	31.3%
Total Fertility Rate (TFR), 2011	2.3
Contraceptive Prevalence Rate (CPR), 2011	61%
- Pill	27.2
- Injectable	11.2
- Female sterilization	5.0
- Other modern methods	3.2
- Condom	5.5
- Periodic abstinence	6.9
- Withdrawal	1.9
- Other traditional methods	0.4
Unmet Need, 2011	14%
Average (median age) at first marriage, 2011	15.5
Median age at first birth, 2011	18
Crude Birth Rate (CBR) (per 1,000 population), 2011	19.2
Maternal Mortality Ratio (MMR), per 100,000 live births, 2011	209
Infant Mortality Rate, 2011	35
HIV adult prevalence (age 15–49), 2012	<0.1%

Source: UN Population Projections 2010; BDHS, 2011

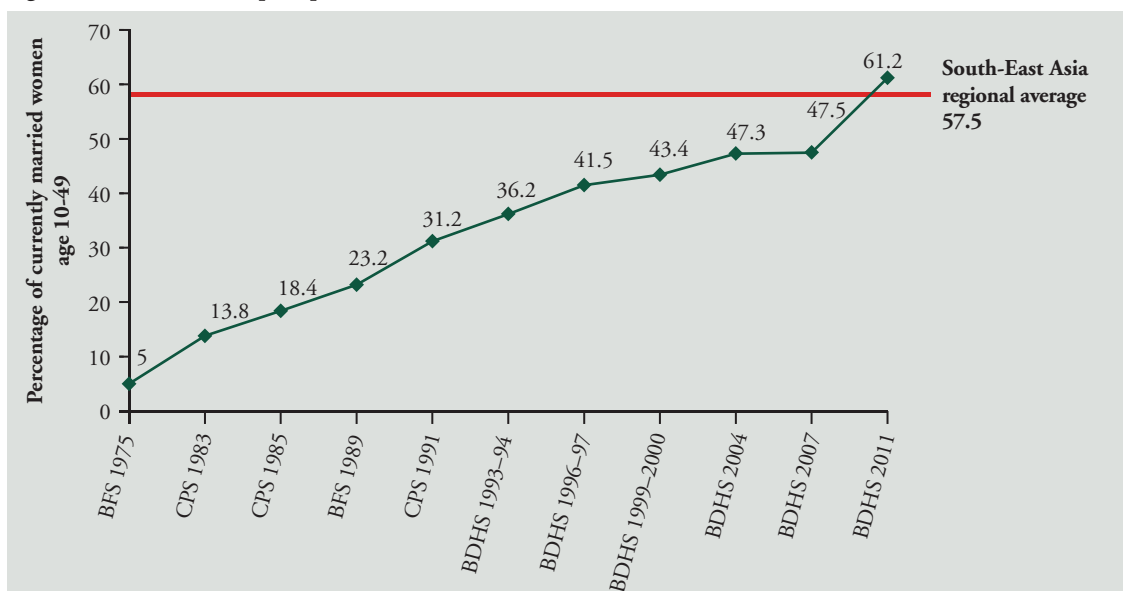


Figure 2: Trends in total fertility rates, 1975–2011



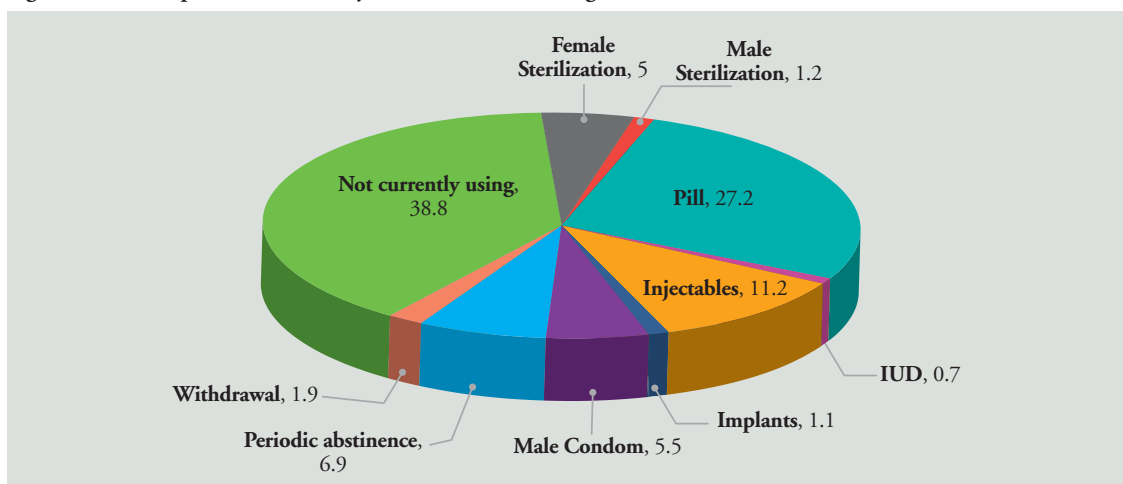
Source: Bangladesh DHS 2011

Figure 3: Trend in contraceptive prevalence rates (%), 2005–2011



Source: Bangladesh DHS 2011

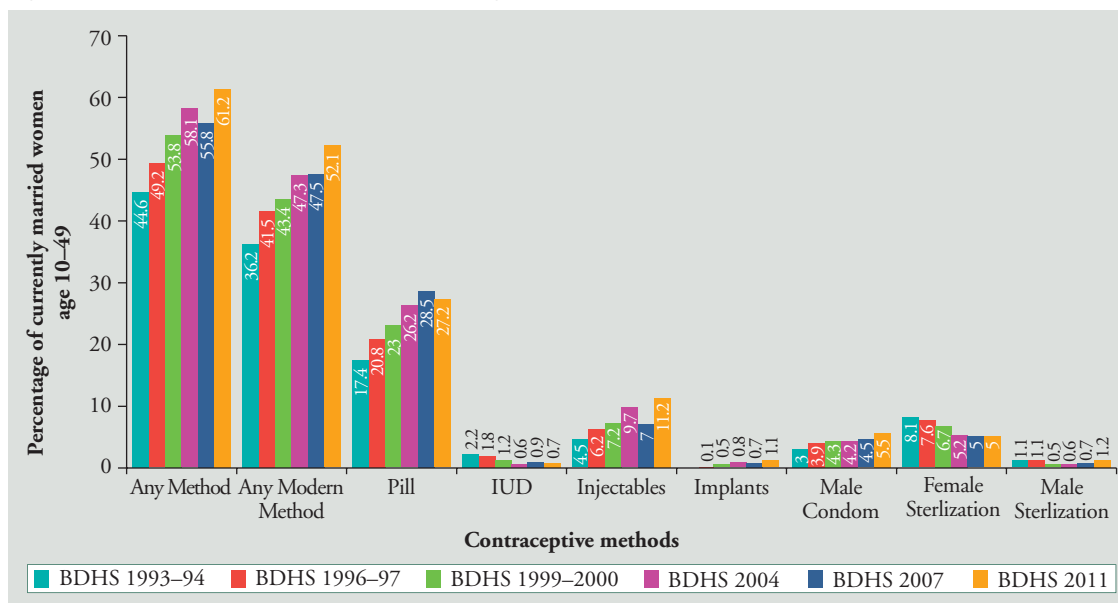
Figure 4: Contraceptive method use by married women in Bangladesh, 2011



Source: Bangladesh DHS 2011



Figure 5: Trends in modern contraceptive use in bangladesh



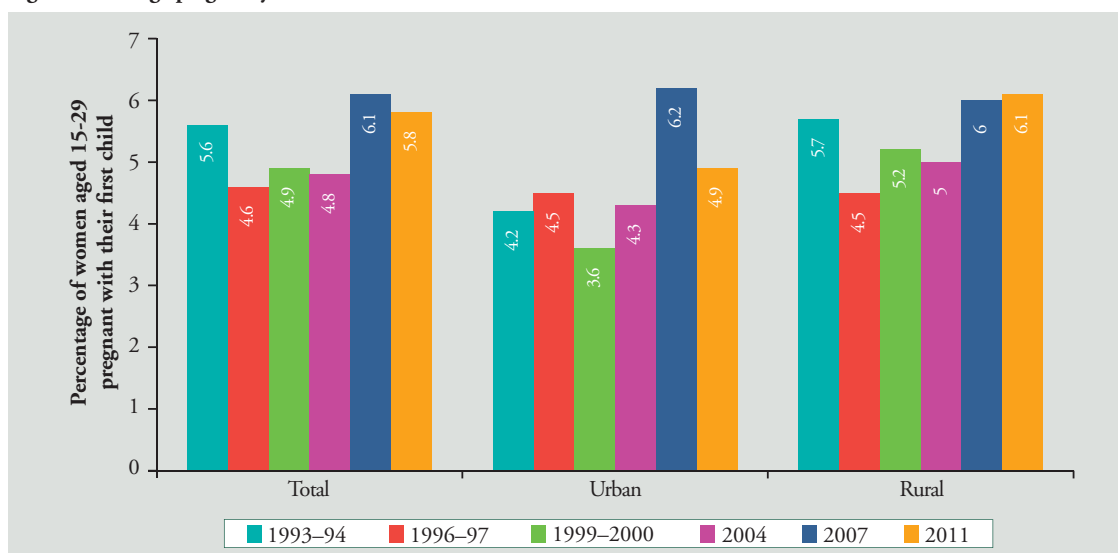
Sources: Bangladesh DHS 2011

## Adolescent fertility

Bangladesh is a country where the adolescent fertility rate is relatively high. Most of these teenage pregnancies occur within the confines of marriage due to the cultural practice of early marriage. It is about 73 per 1,000 girls aged 15–19 years.

In Bangladesh, the legal minimum age of marriage is 18 for girls and 21 for boys. However, despite the law governing the age of marriage, early teenage marriages are common and the average age for a girl at first marriage has reduced from 16 years in 2003 to 15 in 2007. About 11% of girls aged 10–14 and 46% of 15–19 years olds are married (Adolescent Health Fact Sheet, WHO, January 2007). Moreover, during the 2007 survey, 6% of the girls aged 15–19 years were reported to be pregnant with their first child.

Figure 6: Teenage pregnancy

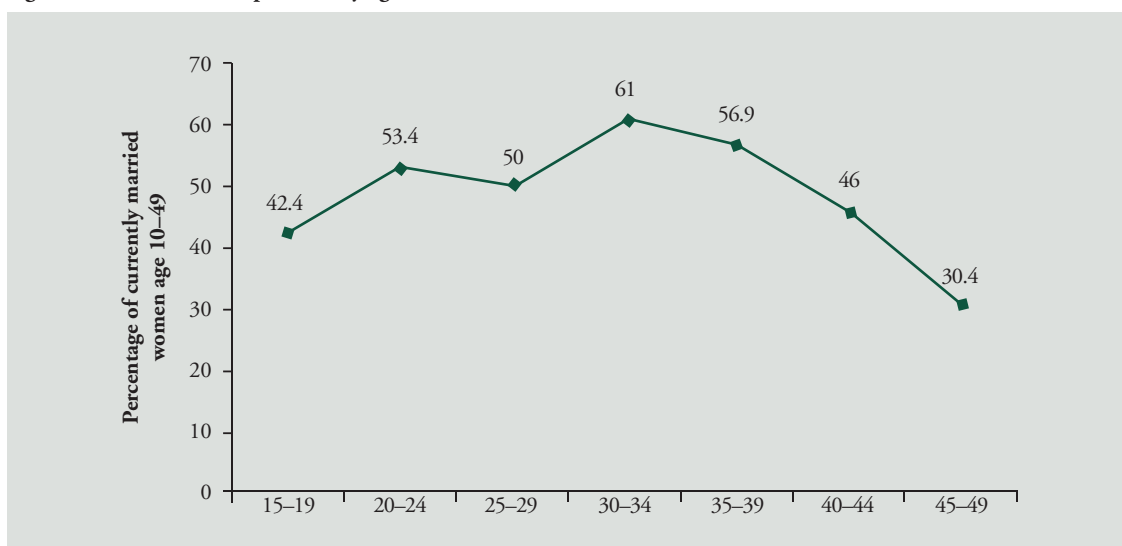




Over one-fifth of births to adolescents are unplanned. In all the age groups, adolescents have the highest unmet need for family planning. While awareness about family planning methods is high among Bangladeshi couples (99%) irrespective of their age, the use of contraceptives by adolescents aged 15–19 years is much lower than by older married women. According to the 2007 DHS, while about 56% of married women aged 25–34 years were using a modern method of contraception, only two thirds of that percentage, i.e. about 38% of married teenage girls were using a family planning method. Though relatively low, current usage levels reflect a gradual improvement over the situation in 1992–93 when only 25% of the married adolescent girls (15–19 years) were using a contraceptive to prevent pregnancy.

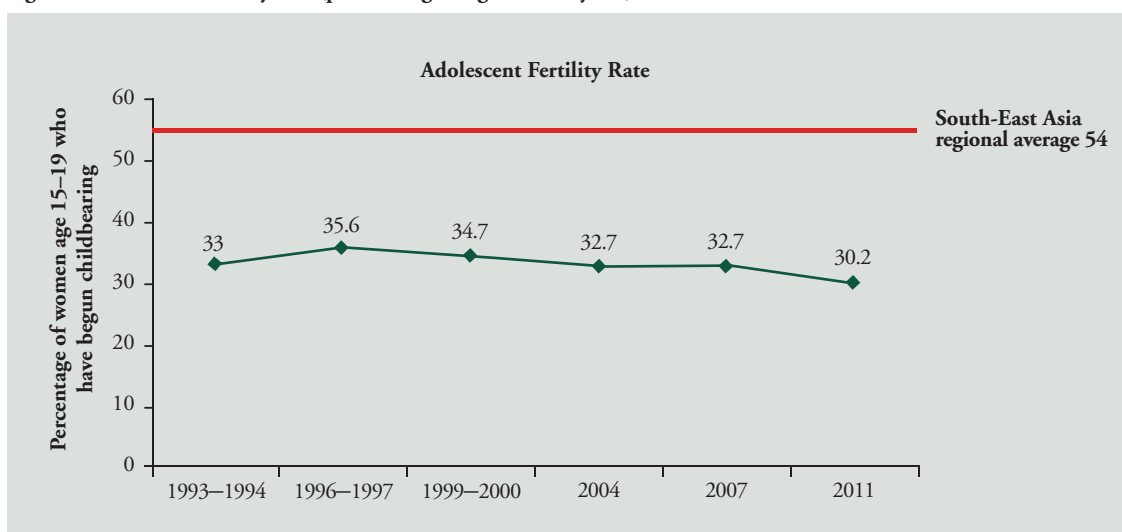
Given the age, the contraceptive method mix used by adolescents reflects a reliance on reversible methods. In line with the overall pattern in Bangladesh, pills and injectables are the most preferred methods of contraception. Use of condoms is relatively low.

**Figure 7: Modern contraceptive use by age, 2011**



Source: Bangladesh DHS 2011

**Figure 8: Adolescent fertility rate (per 1,000 girls aged 15–19 years)**



Sources: Bangladesh DHS 2011





## Access to family planning information and services

In the 2007 DHS, 38% of women and 59% of men acknowledged that they had read, seen or heard family planning messages through mass media. Television was the most common source of family planning messages for both men and women. Men also named mid-level media such as posters, billboards, and leaflets etc. as vehicles for family planning related information.

About 75% of the married women reported that a satellite clinic had been arranged in their community in the three months preceding the survey. One in five women in the reproductive age group also mentioned visits to their home by a peripheral health worker in the past six months. Given the preference for reversible family methods especially pills and injectables, such outreach sessions coupled with home visits serve as the platform for counseling to ensure continuation of method use and replenishment of contraceptive supplies with the clients.

Various multilateral agencies such as UNFPA, UNDP, and UNICEF, along with NGOs such as FPAB, BCCP, SMC, NDSP, PSTC, BRAC, Engender Health, Marie Stopes Clinic Society as working with the government of Bangladesh for expanding communication outreach of family messages as well as increasing access to needed services.

## Current Family Planning Efforts

The Bangladesh government is now running a comprehensive health programme called the Health Population and Nutrition Sector Development Program (HPNSDP) which aims to not only reduce the population growth rate but also reduce morbidity and mortality levels in the country along with and improvement in the nutritional status of the population, especially the women and children. HPNSDP, which began in July 2011 and is planned for five years till June 2016, is the third sector-wide program in Bangladesh, following in the wake of HPSP (1998–2003 and HNPS (2003–2011).

HPNSDP strategises strengthening of FP services to reach replacement fertility levels. A new operational plan has been drawn up for delivery of maternal, neonatal, child and adolescent health services. The program will make special efforts to reach out to disadvantaged communities and hard to reach areas with the needed services. Areas with high unmet need will receive additional inputs through area based targeted interventions. While continuing with the community-based distribution of contraceptive supplies, HPNSDP will attempt to expand the current method mix, and reach out to a greater number of eligible couples, the program plans to lay special emphasis on provision of long acting permanent methods of contraception such as sterilization. Counseling of eligible couples, especially adolescents for using family planning methods will be an important intervention area of the program.

The Bangladesh Family Planning Program has made remarkable progress over the last thirty years due to continuous political commitment, innovative program approach, government and non-government collaboration, strong IEC program, method-mix cafeteria approach and commitment of the field-level functionaries.

## Challenges and Opportunities

1. **Continuing population expansion:** The population growth of the country is fuelled by a) large base population, b) population momentum due to a large proportion of youths, and c) a stagnating CPR.

While not much can be done about the first two factors, a stagnating CPR is a cause for concern. Despite the efforts by the government and the development partners, CPR in Bangladesh is not seeing an increase. On the contrary, there has been a 2 percentage point reduction in the same between 2004 and 2007. However, the silver lining in this decline is





the minimal increase in the modern-method CPR from 47.3% to 48%. This indicates the possibility of converting non-users and/or users of traditional methods to modern methods of contraception. While the government through its new HPNSDP plans to expand the contraceptive mix by specially promoting permanent methods, it should also think of fertility awareness based methods, such as SDM and LAM, which mimic traditional methods and may be more acceptable to users of traditional methods.

The other window of opportunity is the increasing levels of unmet need in the country. This reflects that communication efforts for promoting family planning are working. Thus the government, with help from its non-governmental partners, should continue with its family planning messaging and counseling services and try and match the demand thus generated by ensuring availability of family planning services and supplies. It is hoped that the program's special efforts to reach out to disadvantaged areas and communities will reduce the regional divide in the availability of services and result in a concomitant and balanced increase in CPR in all the divisions.

2. **High adolescent fertility:** Bangladesh has a high adolescent fertility rate, one of the highest amongst the SEAR nations. Early initiation of child bearing leads to rapid increases in population by not only lengthening the productive period in the woman's life, but also by shortening the inter-generational span. As most of the adolescent child bearing occurs within the realm of marriage, it means that the law governing the age at marriage needs a much stricter reinforcement. It is heartening that through HPNSDP the government plans to make special efforts to reach out to adolescents with family planning messages and individual and community level counseling services. Convincing the adolescents to delay the first pregnancy and child birth beyond the adolescent age frame will go a long way in bring TFR down to replacement levels.
3. **Family Planning Service provision:** The human resources issues such as insufficient training for health providers, inappropriate placement and personnel and inadequate supervision and the infrastructure in health sector are the keys challenges that government is facing to improve the health and family planning services. HPNSDP plans to not only increase the number of trained service providers both at the community and facility levels, but also ensure their skill and capacity development through continuing in-service education and training. It also plans to improve coordination between public, private and NGO sectors, and thus hoping to increase coverage levels for various health services, including family planning services.

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# Bhutan and Family Planning: An overview

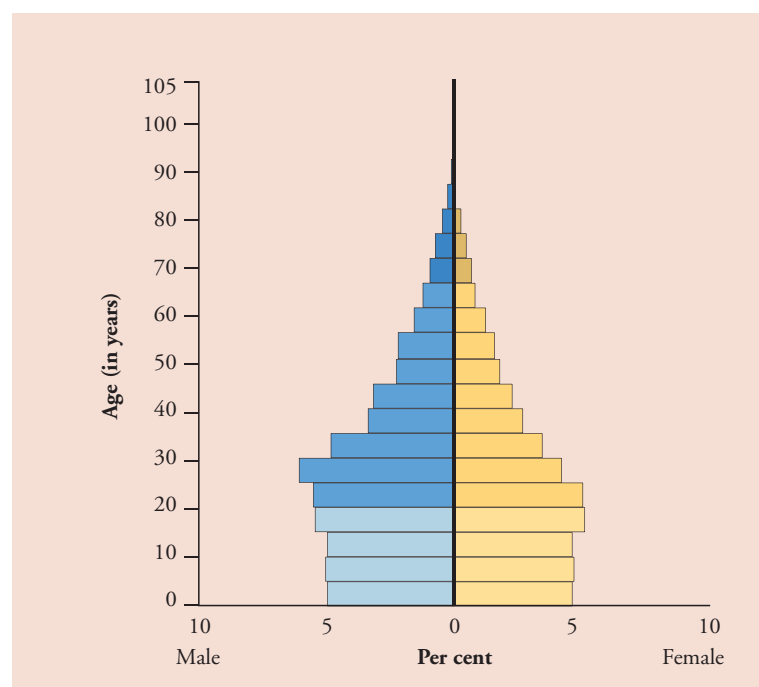


## Background

Bhutan covers a land area of about 38 394 square kilometres, most of which is hilly terrain. With a population of only 729 429<sup>1</sup> in 2011, leading to a population density of 19 people per square kilometre, it is the smallest and least populated country in the South-East Asia Region. In 2005–2010, the average annual population growth rate stood at 1.95% (UN World Population Prospects, 2012).

Due to a significant decrease in fertility rates (as discussed below), the shape of the population pyramid of Bhutan has changed. While the 2002 pyramid was bottom-heavy owing to about 40% of the population being under the age of 15 years, this bulge is gradually shifting upwards. As can be seen in Figure 1, an increasing proportion of women (about 60%) are now in the reproductive age group.

Figure 1: Population pyramid, 2010



Source: UN, World Population Prospects 2012

## Situation Analysis

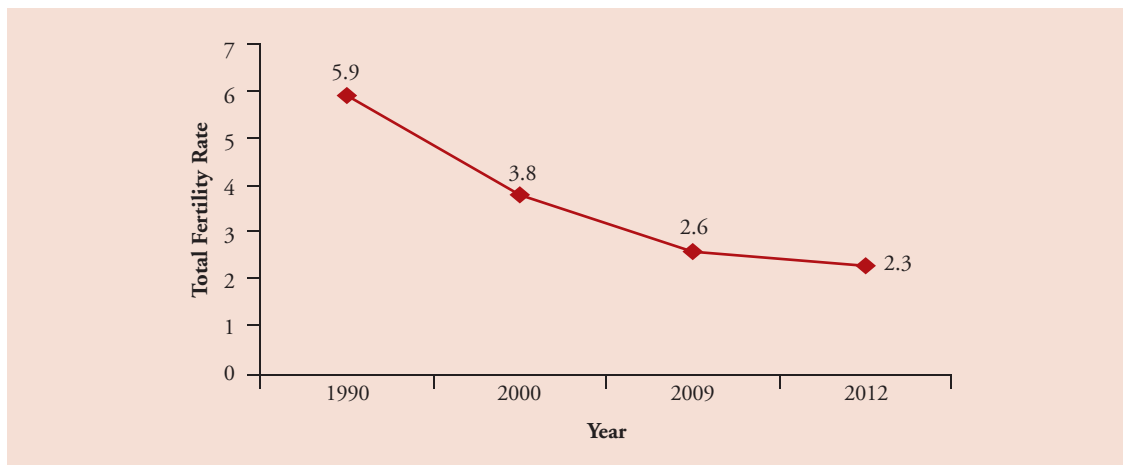
### Total fertility rate (TFR)

Bhutan has made relatively quick progress in reducing the TFR over the past three decades. As shown in Figure 2, while the TFR stood at 2.8 in 2005 (National Statistics Bureau, 2010), it was just above 2.3 in 2011 (World Bank). According to an estimate made in 2010 by the Population Division of the UN Department of Economic and Social Affairs, and given the efforts made in this direction, the rapid decline in TFR will be sustained and will reach replacement fertility levels by around 2020 (Figure 3) (UN Department of Economic and Social Affairs, 2010).

<sup>1</sup>The CPR figures quoted in Figure 6 are from Population Reference Bureau reports and may not exactly match BLS 2007 figures.

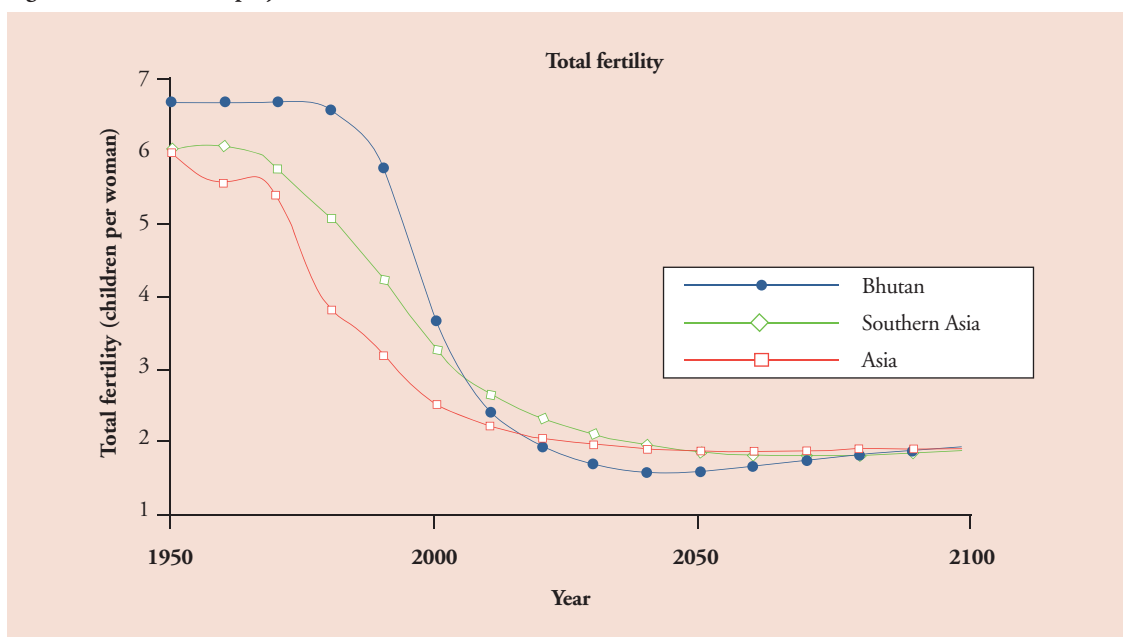


Figure 2: Trends in TFR



Source: World Health Statistics 2011 and 2014.

Figure 3: Historical and projected decline of TFR



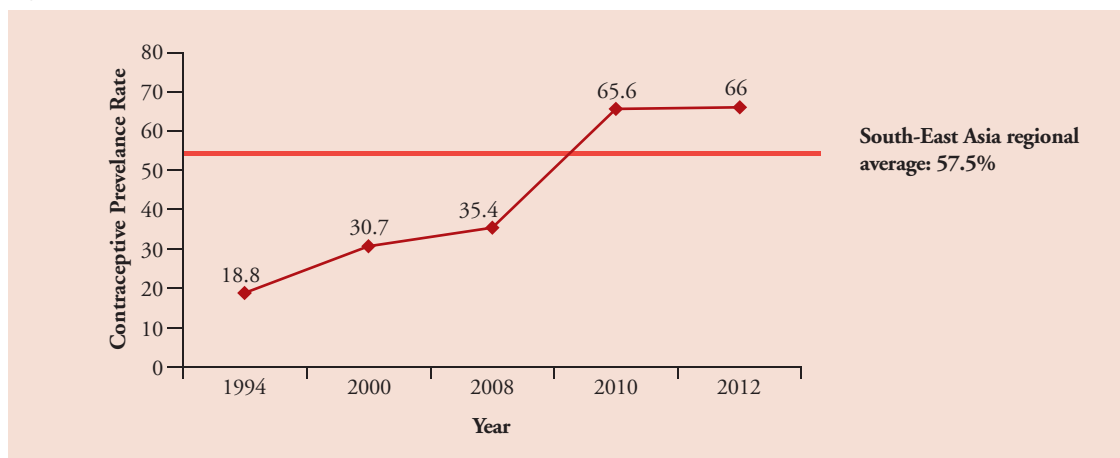
Source: UN Department of Economic and Social Affairs/Population Division, 2010.

## Contraceptive prevalence rate (CPR)

The fast-paced decline in TFR can be attributed to the sharp increase in uptake of contraceptives, especially over the past decade or so. While in 2007 only about 36% of couples in the reproductive age group were using a contraceptive method (Bhutan National Statistics Bureau, 2007), the CPR rose to about 66% in 2010 (Bhutan Multiple Indicator Survey, 2010). This rate is high compared with many other countries in the South-East Asia Region.



Figure 4: Trends in CPR, 1994–2010



Source: NHS 2000, BLS 2007 and BMIS 2010, World Health Statistics, 2014

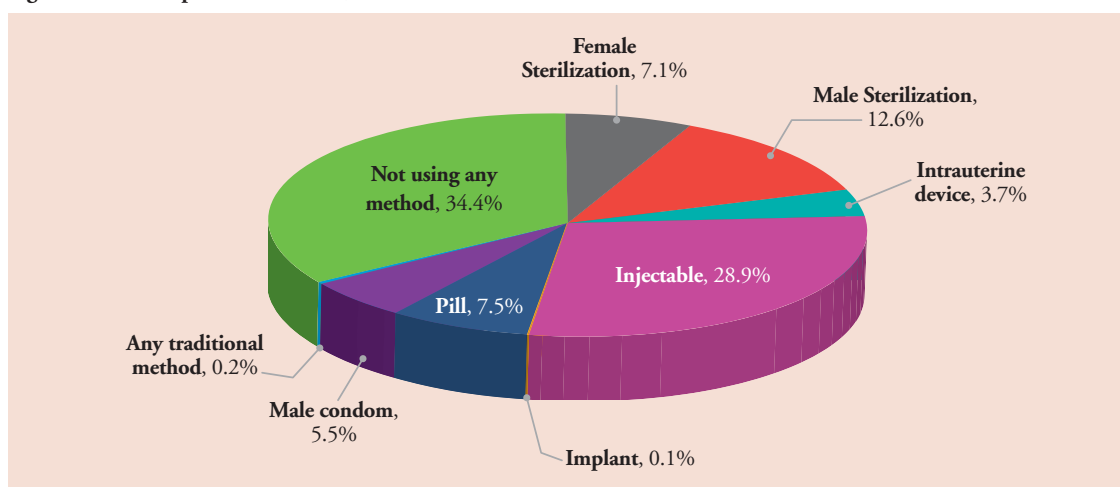
### Contraceptive method mix

As shown in Figure 5, almost all women in Bhutan using contraception rely on a modern method. A negligible 0.2% of these women are using traditional methods. Unlike some other countries in the Region, where there is a greater reliance on sterilization, about 46% of married women in Bhutan are using spacing methods. This could explain the sharp fall in age-specific fertility rates, leading to a concomitant decline in the TFR in recent years.

The Bhutan Multiple Indicator Survey (BMIS) 2010 reported that about 29% of all married women were using injectable hormonal contraceptives as a family planning method, while another 7.5% were using hormonal contraceptive pills. The injectable remains the most popular method, irrespective of women's education or economic status.

Even among the limiting methods, Bhutan shows an unusual trend, wherein the vasectomy rates at 12.6% far exceed the tubectomy rates at only 7.1%. Male participation and responsibility in family planning decisions is also evident by the moderate use of male condoms, by 5.5% of couples.

Figure 5: Contraceptive method mix, 2010

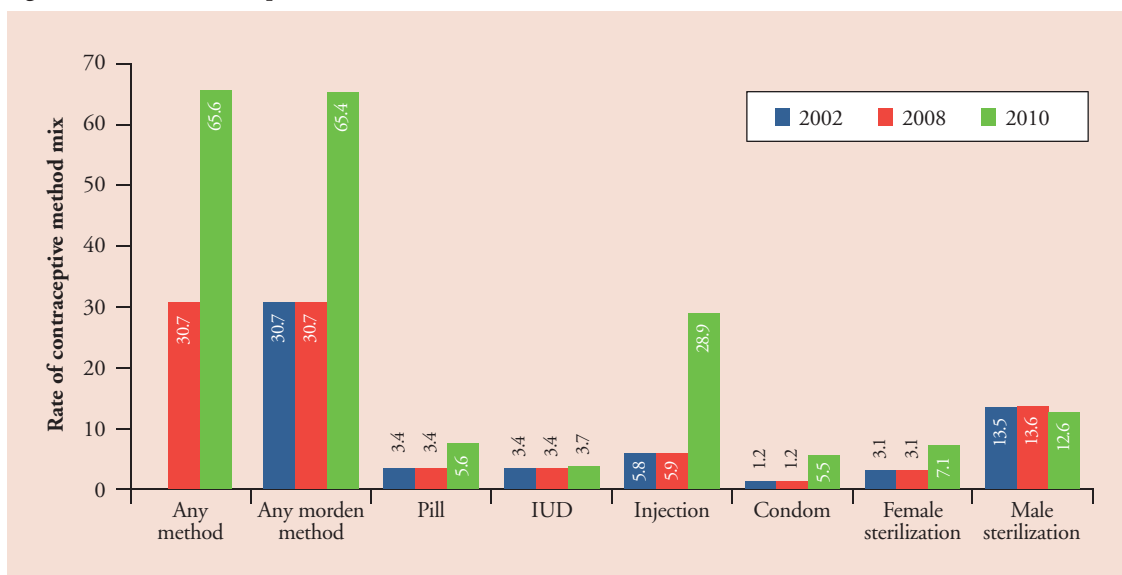


Source: BMIS, 2010.



From comparison of previous surveys and reports on contraceptive use and fertility trends in Bhutan, it can be seen that the current jump in CPR can almost exclusively be attributed to the rise in acceptance of injectable contraceptives, the utilization rate of which rose from about 6% in 2008 to as high as 29% in 2010 (Figure 6). Oral contraceptive pills and female sterilization also show modest increases.

**Figure 6: Trends in contraceptive method mix, 2002, 2008 and 2010**



Sources: Population Reference Bureau<sup>1</sup> 2002, 2008 and BMIS 2010.

## Unmet need for family planning

With such a high CPR, about 1 in 10 women in Bhutan has an unmet need for family planning, which is much lower than other countries in the South-East Asia Region. In 2010 (Bhutan Multiple Indicator Survey, 2010), the unmet need for spacing was found to be 4.7%, while the unmet need for limiting was slightly higher at 6.9%. These averages mask a wide age-related variation in unmet need. The unmet need (spacing and limiting combined) for family planning in women aged 15–19 years is much higher at 27.4% compared to only 6.5% in women aged 45–49 years. Thus, while nationally the contraceptive needs of about 85% of women are met, only slightly more than half of adolescents have their family planning requirements satisfied.

## Adolescent fertility

Bhutan Multiple Indicator Survey, 2010, found a wide age-related variation in the use of contraception. About 57% of 20–24 year olds were using a contraceptive method, and this increased to 71% among 40–44 year olds. However, only 30% of married women in the age group 15–19 years were using contraception.

This relative lack of contraceptive usage is reflected in high adolescent fertility rates of 59 births per 1000 women in the age group (Bhutan Multiple Indicator Survey, 2010). While 8.5% of girls aged 15–19 years had already given birth to a baby, another 2.5% were pregnant with their first child at the time of the survey. Thus, 11% had begun childbearing. Added to this were another 0.5% women who had had a child before they reached the 15-year age mark.



While the percentage of women with a live birth has remained relatively unchanged over the last 25 years, the latest survey (Bhutan Multiple Indicator Survey, 2010) finds a positive correlation between late childbearing and the educational and economic status of a woman. Early childbearing among women aged 20–24 years is about 10 times more common in women with no education (24%) compared to women with secondary education (2.7%).

In the South-East Asia Region, as most childbearing occurs within the context of marriage, age at marriage is a very important determinant of sexual debut and childbearing. Slightly more than 15% of girls in the age group 15–19 years were married. There was a wide urban–rural divide in this indicator, with only 6% of urban girls already married compared to about 21% of girls from rural areas.

## Current Family Planning Efforts

The family planning programme is guided by the overall goals and objectives set in the national five-year plans, which are geared towards the achievement of Gross National Happiness. Bhutan is currently implementing the Tenth Five Year Plan (2008–2013), which puts major emphasis on the achievement of the MDG and International Conference on Population and Development (ICPD) targets. Some of the objectives are to:

- increase CPR from 30.7% to 60%;
- reduce population growth rate to from 1.8 to 1.3;
- achieve fertility replacement rate;
- reduce maternal mortality from 255 to 100 deaths per 100 000 live births;
- reduce infant mortality from 40.1 to 20 deaths per 1000 live births;
- reduce under-5 mortality from 61.5 to 30 deaths per 1000 live births.

The strategies to achieve the stated objectives include improving quality and accessibility to health services; developing adequate and competent human resources; increasing community awareness and empowerment; and, promoting institutional delivery to reduce maternal and newborn mortality. A large proportion of the programme in Bhutan is donor driven.

## Challenges and Opportunities

1. **Reaching out to the unreached:** Despite a high CPR at the national level, wide variations exist between different regions, between urban and rural populations, between different wealth quintiles and – most importantly – between age groups. Controlling high adolescent fertility rates will not only help to bring down the overall TFR, but also result in improvement in other maternal and child health-related indices.
2. **Weaning off donor support:** A sparse population living in difficult mountainous terrain makes access to health services and supplies not only practically difficult, but also requires increased funds. The improvement of the health sector in Bhutan, including on the family planning front, has been due to a considerable extent to financial and technical support from the donor community. Bhutan needs to allocate more resources to the health programme in order to ensure sustainability of efforts once donor support phases out.



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# Democratic People's Republic of Korea and Family Planning: An overview

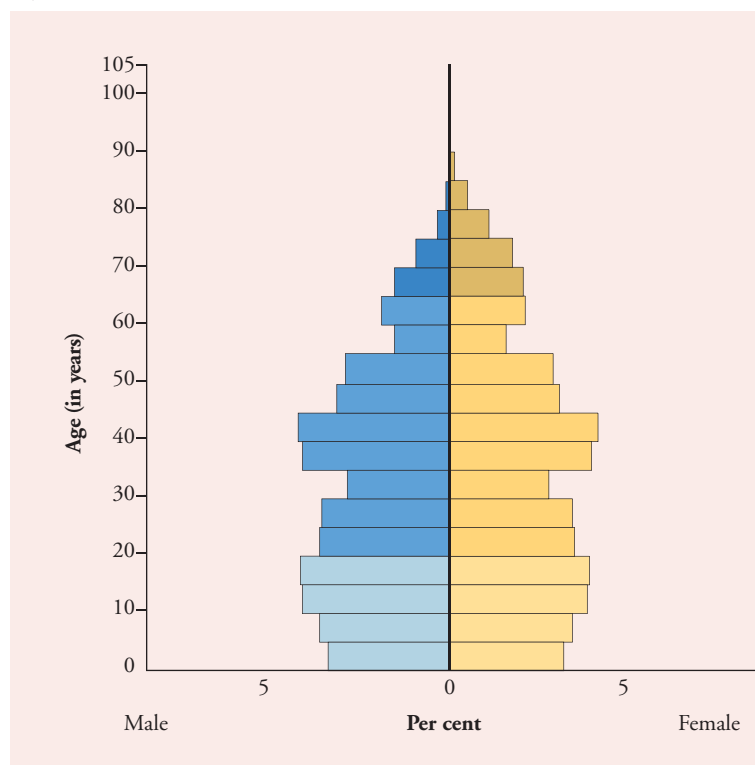


## Background

The Democratic People's Republic of Korea is formed largely by the Korean peninsula, located in central East Asia. Geographically, it is largely made up of difficult mountainous terrain, and less than one fifth of the land is cultivable.

The total population was 24 million in 2010, with an annual population growth rate of 0.4%. As can be seen from the population pyramid (Figure 1), while 23% of the population is less than 15 years of age, another 14% is over the age of 60 years (Democratic People's Republic of Korea Statistic Summary, 2002). Thus, the population structure is in a transitioning phase, as typically seen in countries with concomitant declines in birth and death rates.

Figure 1: Population pyramid, 2010



Source: UN Population Projection 2010.

## Situation Analysis

The Democratic People's Republic of Korea has an extensive health system and an adequate number of health workers. However, due to multiple natural disasters, economic downturn and political isolation, many of the health gains the country made up to the 190s have now been reversed (DPR Korea Country Profile, 2011). A multiple indicator cluster survey (MICS) was conducted in 2009 by the Central Bureau of Statistics with support from UNICEF (DPR Korea Multiple Indicator Survey, 2009). However, this survey did not capture any information on family planning related indicators. Hence, fertility and family planning related data in this fact sheet are based on the 2002 national Reproductive Health Survey, as well as from international agency estimates for the country.

**Table 1: Key indicators**

Total population (in millions), 2009 census	24.05
Population growth rate, 2010	0.4%
Population density (people per square km), 2002	190
Urban population, 2010	60%
Population <15 years of age, 2003	22.9%
Total fertility rate, 2012	2.0
Contraceptive prevalence rate, 2008	67.2%
– Pill	3.7
– IUD	42.8
– Female sterilization	4.4
– Male sterilization	0.8
– Condom	5.8
– Other modern methods	0.9
– Traditional or natural methods	10.4
Unmet need, 2003	16.7%
– For spacing births	6.3
– For limiting births	10.4
Average age at first marriage, 2002	24.8
Average age at first birth	NA
Crude birth rate (per 1000 population), 2002	15.6
Maternal mortality ratio (per 100 000 live births), 2012	68.1
Infant mortality rate (per 1000 live births), 2012	16.7
HIV adult prevalence, 2001	<0.01%

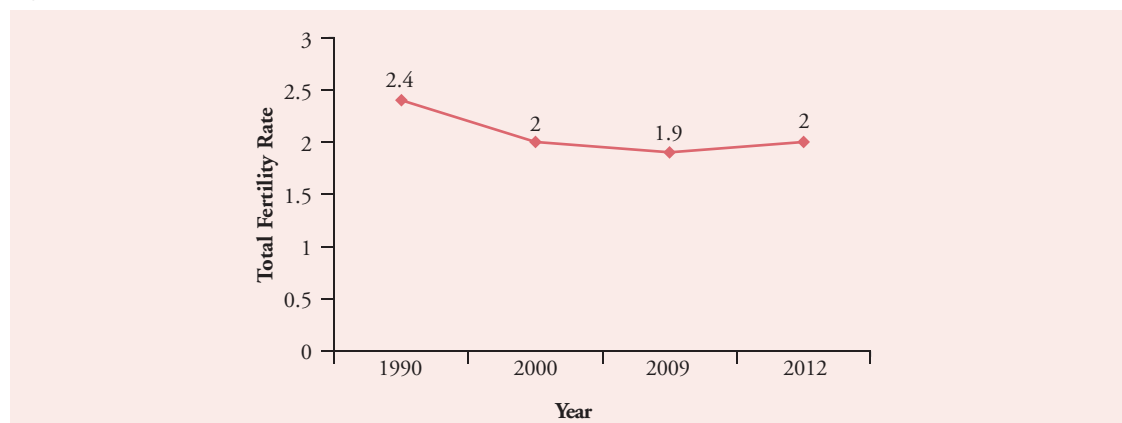
Source: Democratic People's Republic of Korea Statistic Summary, 2002; DPR Korea Multiple Indicator Cluster Survey, 2009, DPRK Key Facts, 2010; Human Rights Watch, 2012

### Total fertility rate (TFR)

Interagency estimates pegged the TFR of Democratic People's Republic of Korea at 2.0 in 2010 (DPR Korea Country Profile, 2011), which – although 0.1% higher than statistical estimates in 2009 (see Figure 2) – is still lower than replacement level fertility. Even back in 1990, the TFR was 2.4, which is considerably lower than the levels in other countries in the South-East Asia Region.



Figure 2: Trends in TFR, 1990–2009



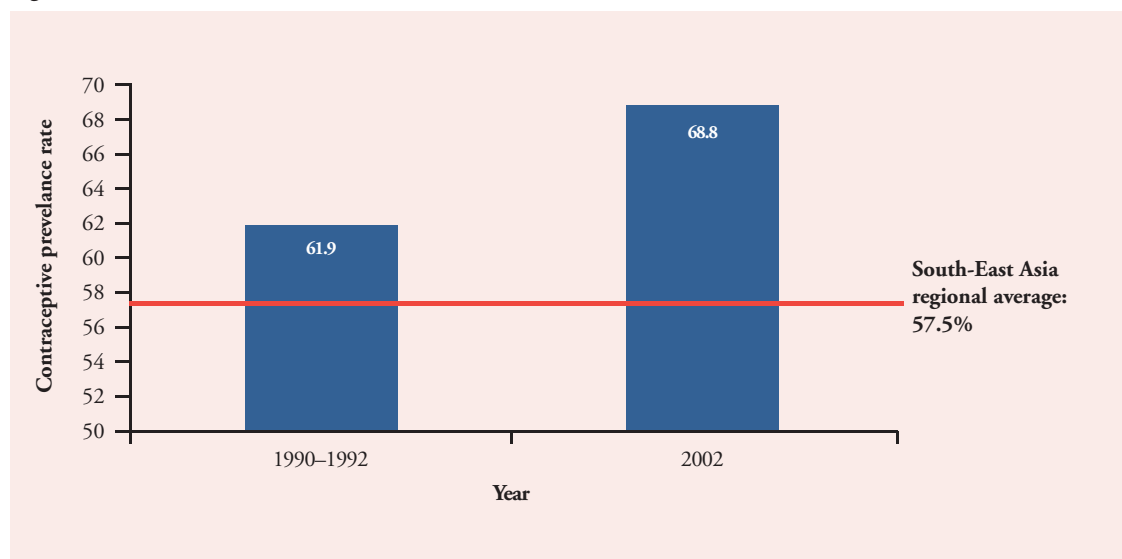
Source: World Health Statistics 2011 and 2014

### Contraceptive prevalence rate (CPR)

The CPR for married women in Democratic People's Republic of Korea was estimated to be 67.2% in 2008 (DPRK Key Facts, 2010). This reflects a 1.6% decline compared to 2002 levels. Disruption in access to health services due to political strife may be one of the causes of this slight decline. The difference could also be due to lack of comparative measurements, as the 2002 levels are based on a nationwide reproductive health survey.

The increase in contraceptive uptake is linked to a concomitant reduction in induced abortion rates, which fell from 17.7 abortions per 1000 women in 1997 to 11.1 in 2002.

Figure 3: Trends in TFR, 1990–2009



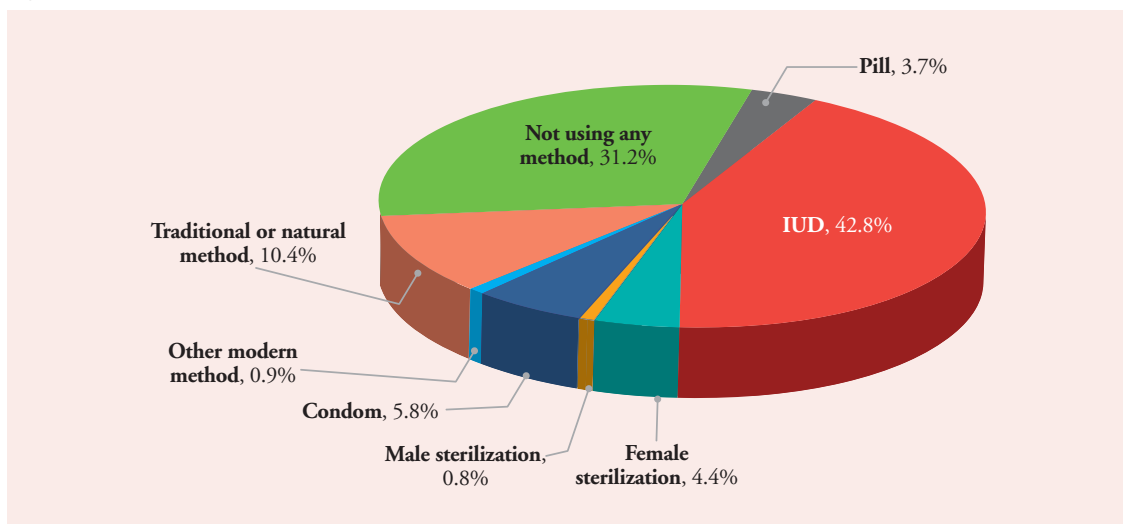
Source: Reproductive Health Survey 2002.



### Contraceptive method mix

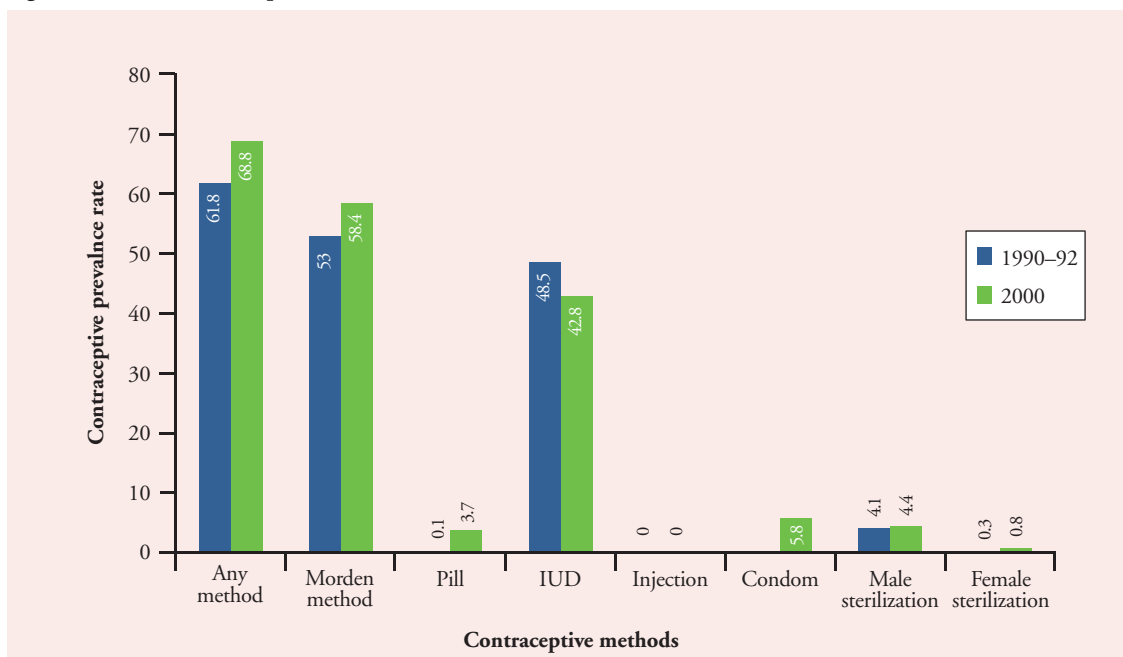
The 2002 survey revealed that couples rely on long-term or permanent methods for their contraceptive needs (Figure 4). The IUD emerged as the method of choice, with almost 43% of married women opting for the same. While sterilization (female and male) was chosen by slightly more than 5% of the couples, another 6% or so opted for condoms. As can be seen from Figure 5, the contraceptive method mix has remained largely unchanged since the 1990s.

Figure 4: Contraceptive method mix for married women, 2002



Source: Reproductive Health Survey, 2002.

Figure 5: Trends in contraceptive method mix



Source: Reproductive Health Survey 2002.



### Unmet need for family planning

Despite the relatively high CPR, 16.7% of married women have an unmet need for family planning, of which 6.3% is for spacing and 10.4% is for limiting births. Thus, the health programme is able to satisfy about 80% of the felt family planning need in the country.

### Adolescent fertility

About one sixth of the country's population are adolescents (aged 10–19 years) and one fourth consists of young people (aged 10–24 years) (Adolescent Health fact sheet - DPR Korea, 2007). Unlike other countries in the Region, teenage pregnancies and early childbirth is not an issue in Democratic People's Republic of Korea. Adolescent fertility is low, at 0.6 births per 1000 girls aged 15–19 years (Democratic People's Republic of Korea Statistics Summary, 2002). The regional average is 54 births per 1000 girls. This is due to a very high mean age at first marriage in the country, of 24.8 years for girls and 27 years for boys. Only 1% of girls get married at an age of less than 19 years. Similarly, the mean age of women at first birth is 25.9 years (Adolescent Health fact sheet - DPR Korea, 2007).

This delay in marriage and subsequent first birth are important factors that have led to low fertility levels, despite a relatively high unmet need for family planning.

### Current Family Planning Efforts

The Government runs its health programme on the socialist principles that are the basis of the adopted Law on Public Health, Family Law, the Law of Educating and Upbringing Children, the Law of Education etc. (Country Health System Profile - DPR Korea, 2013). The Government has recognized the ability to decide when and how many children to have as a basic human right and, therefore, has ensured a programmatic focus on family planning since the 1970s.

Contraceptive services and supplies are available free of cost at hospitals and at clinics. Counselling for family planning and provision of supplies, such as oral pills and condoms, are also offered to women who attend antenatal clinics and as part of post-abortion services. Doctors and midwives are trained in the provision of services, including performance of sterilization surgeries and insertion of IUDs.

For geographically hard-to-reach and disaster-affected areas, the health system relies on mobile health units to deliver services, including family planning.

To ensure that youth are aware of reproductive health needs and issues and are able to protect themselves against adverse and unwanted outcomes, including reproductive health morbidities, topics related to reproductive health and hygiene are included in the school curriculum. As education is free and compulsory for all children, inclusion of these topics in the education system means that information reaches out to all youth across the country.



## Challenges and Opportunities

Long-standing geographical and political isolation of the country, coupled with large-scale famines, have led to a shifting of national Government priorities and reversal of some health gains. The Government needs to ensure adequate funding of the health system, including the provision of regular supplies. The high level of awareness among the population regarding reproductive health issues and self-care, including family planning, reduces the burden on the Government as minimal effort is required on the demand side. The assistance of various international nongovernmental organizations as well as UN bodies working in the country may be sought to once again streamline health service delivery systems, including those for family planning.

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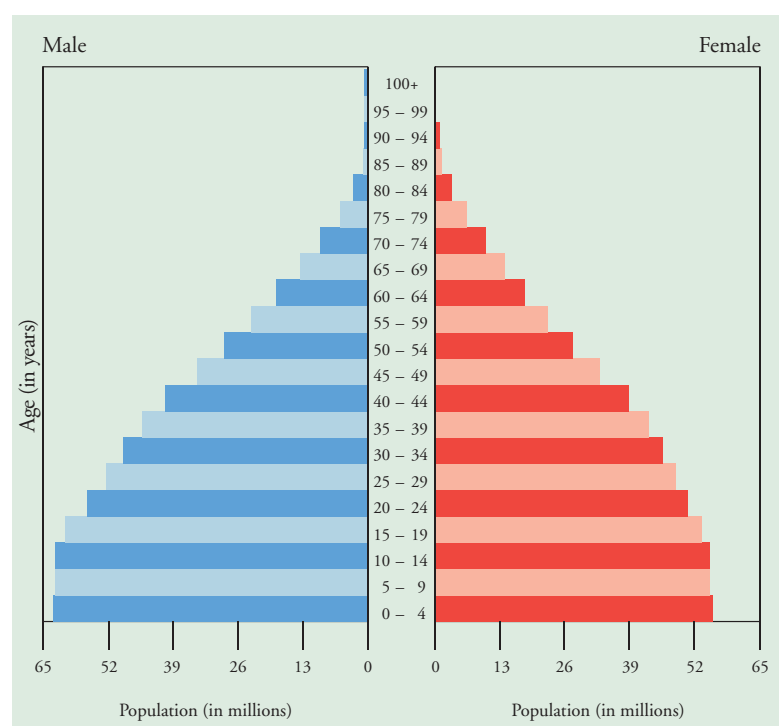
# India and Family Planning: An overview



## Background

India has experienced remarkable growth over the past two decades and is ranked third globally in terms of purchasing power parity (after the United States of America and the People's Republic of China) (National Family Health Survey - 3, 2005–06). It is home to 17% of the world's population – a population of diverse

**Figure 1: Population age pyramid, 2011**



Source: Census of India 2011

women are in the reproductive age group (15–49 years).

## Situation Analysis

India was the first country in the world to launch a family planning programme, in 1952, with the objective of “reducing birth rate to the extent necessary to stabilise the population at a level consistent with requirement of national economy”. Gradually, the focus of the programme moved away from population control to population stabilization, and then was integrated with the maternal and child health programme, as family planning became viewed as an important tool to reduce maternal and child mortality.

cultures, languages and religions. India has also made progress on most of the MDGs and has invested resources generated from growth into programmes to deliver services to the poor (Reproductive Health at a Glance, World Bank, June 2010).

The relevance and importance of family planning in India has to be understood in the context of the burgeoning population, and the persistence of relatively poor social indicators in spite of a booming economy. India, the second most populous country in the world, is projected to exceed 2 billion people by the turn of the twenty-first century. According to the Census of India 2011, the population was nearly 1.210 million, of which 31% are below the age of 15 years and 53% of





Data for India, especially regarding contraceptive use, are a little out of date as no nationally representative surveys have been undertaken following the third round of the National Family Health Survey (NFHS) – India's DHS – in 2005–2006.

**Table 1. Key indicators**

Total population (in million), 2011	1.21
Annual population growth rate, 2011	1.25%
Population density (people per square km), 2011	382
Urban population, 2011	31.1%
Population below 15 years of age, 2011	30.8%
Total fertility rate, 2012	2.4
Contraceptive prevalence rate, 2005–2006	56.3%
– Pill	3.1
– IUD	1.7
– Female sterilization	37.3
– Male sterilization	1.0
– Condom	5.2
– Injectable	0.1
– Any modern method	48.5
– Any traditional method	7.8
– Not currently using	43.7
Unmet need for family planning, 2005–2006	12.8%
– Unmet need for spacing	6.2
– Unmet need for limiting	6.6
Median age at first marriage for girls (in years), 2005–2006	17.2
Median age at first birth (in years), 2005–2006	20
Crude birth rate (per 1000 population), 2012	21.6
Maternal mortality ratio(per 100000 live births), 2010–2012	178
Infant mortality rate (per 1000 live births), 2012	42
HIV adult prevalence rate (age 15–49 years), 2005–2006	0.28%

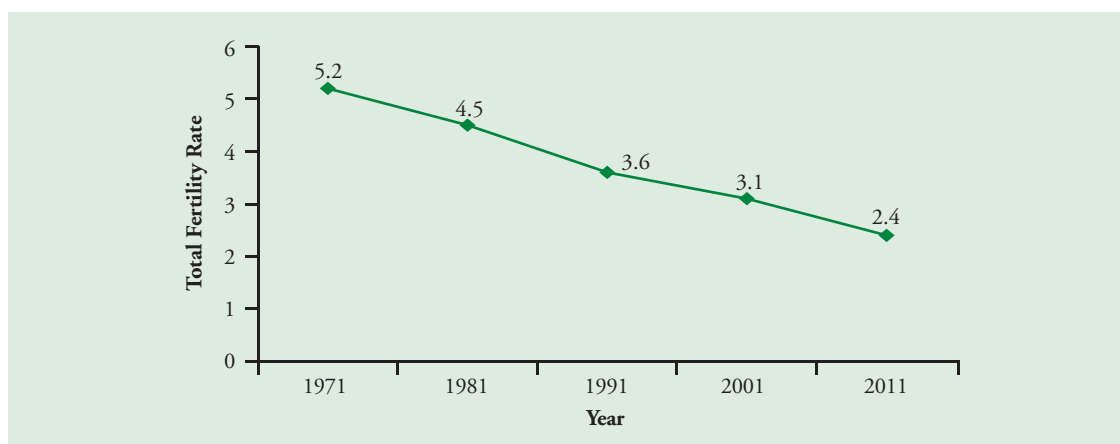
Sources: Census of India 2011; NFHS-3, 2005–2006; Sample Registration System (SRS), 2012; and SRS, 2010–2012.

## Total fertility rate (TFR)

Due to intense efforts to control population growth in India, the TFR has been steadily declining over the past few decades. The current TFR of 2.4 in 2012 is down from 3.1 children per woman in 2001, but is still above replacement level fertility. In urban areas, the TFR has reached below replacement levels at 1.8, but in rural areas the TFR is 2.6.



Figure 2: Trends in TFR, 1971–2011



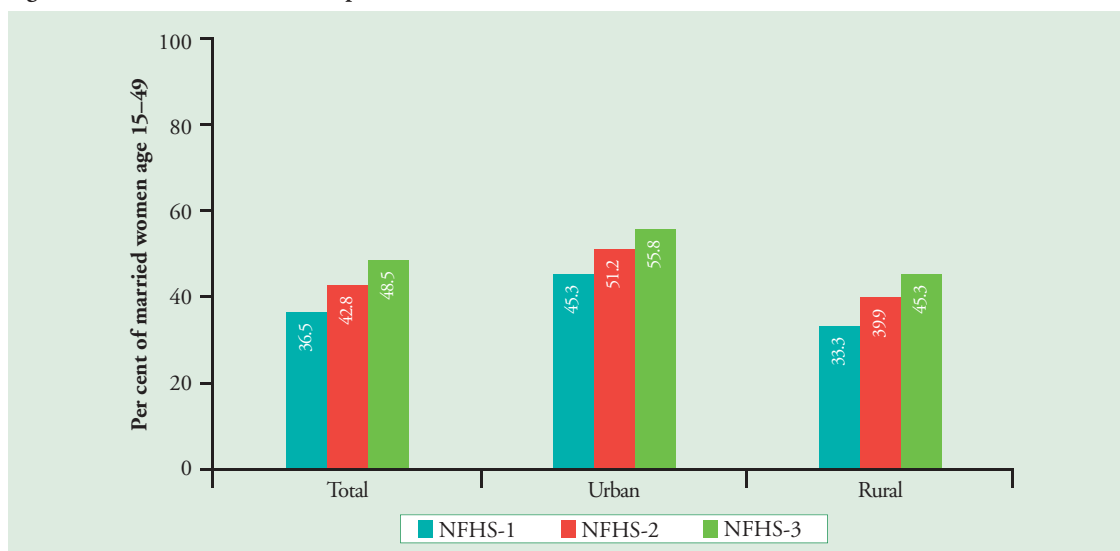
Source: SRS, 1971–2011.

### Contraceptive prevalence rate (CPR)

According to NFHS-3 in 2005–2006, the CPR among currently married women was 56.3% for any method and 48.5% for modern methods of contraception. CPR for modern methods has been increasing steadily from 36.5% in 1992–1993 (the time of NFHS-1), to 42.8% in 1998–1999, and reaching 48.5% in 2005–2006. CPR varies considerably with socioeconomic parameters. For example, in 2005–2006 use of any modern methods of family planning was significantly less among Muslims (36%) as compared to Hindu women (50%), while it was highest among Sikh women (63%). Similarly, CPR for modern methods was only 35% among women in the lowest wealth quintile, compared to 58% among women in the highest wealth quintile.

An urban–rural divide in the use of contraception was seen to exist in all rounds of NFHS, with 56% of urban women using modern methods of contraception compared to only 45% of rural women in 2005–2006. The use of contraception has increased steadily in both urban and rural areas, but the pace of change has been somewhat faster in rural areas. The geographical diversity of this vast country is also reflected in the CPR, which varies substantially across the states from a low of 19% in Meghalaya to a very high 71% in Himachal Pradesh for modern methods.

Figure 3: Trends in modern contraceptive use, 1992–2006



Source: NFHS-3, 2005–2006.

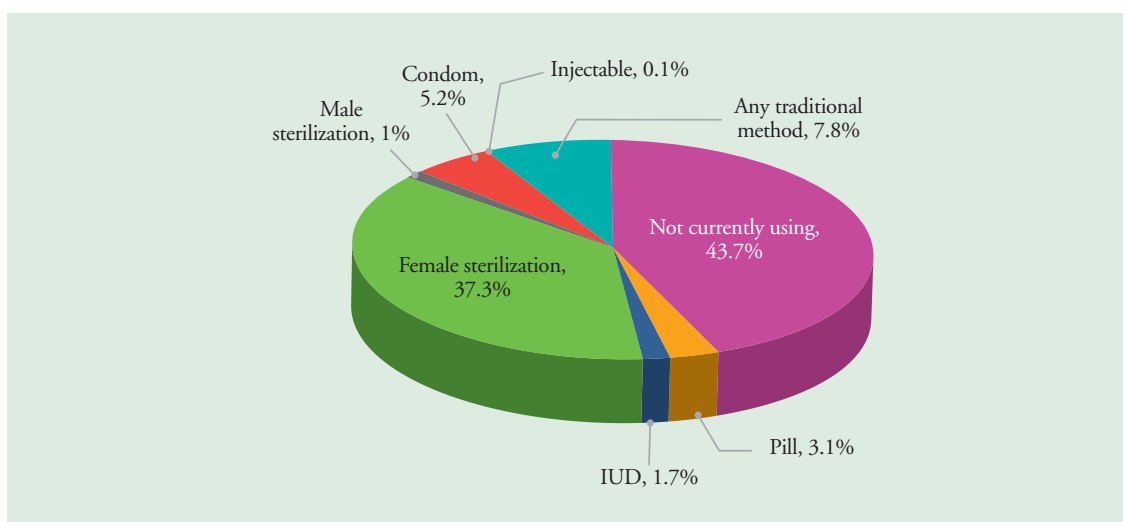


### Contraceptive method mix

Contraceptive use by type of method indicates a dominance of female-oriented contraceptive methods in India. In 2005–2006, female sterilization was reported to be the most used method (37%). Conversely, male sterilization was least used. Among temporary modern methods, use of condoms was 5%, followed by pills (3%) and IUDs (2%). A significant proportion of current users were using traditional methods (8%), primarily the rhythm method (5%) and withdrawal method (3%)(Figure 4). Condom use was three times higher in urban than rural areas.

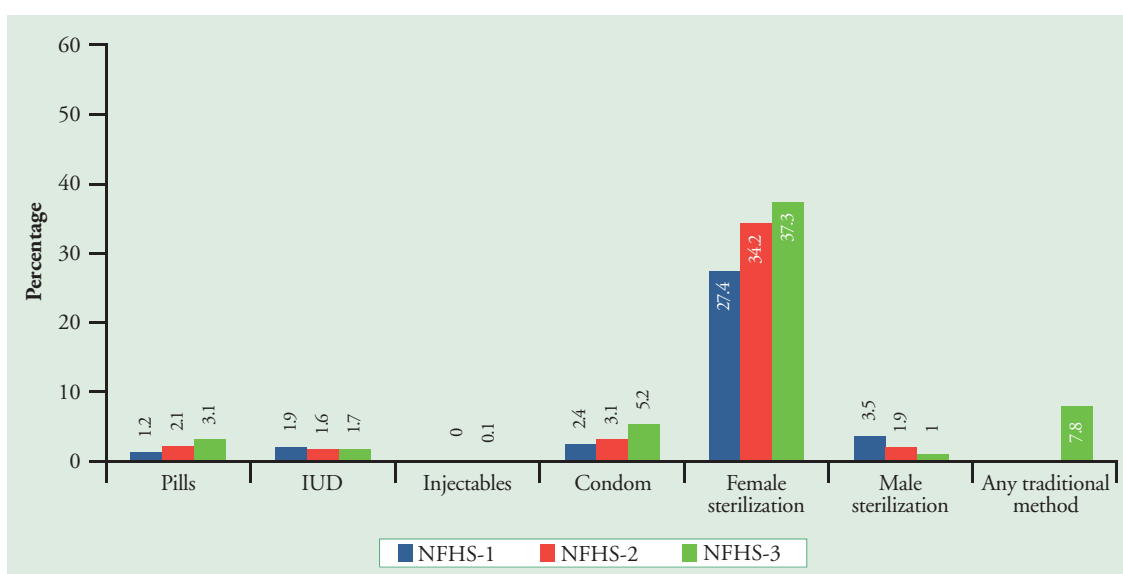
Since 1998–1999, the CPR due to female sterilization has increased by 3%; on the other hand, male sterilization has declined by 1%. Use of condoms and pills has increased by 3 and 2 percent points since 1992–1993 (Figure 5). Other modern methods of contraception such as IUDs and vasectomy continue to find very few takers.

Figure 4: Contraceptive method use by married women, 2005–2006



Source: NHFS 3 2005–2006.

Figure 5: Trends in contraceptive use, 1992–2006



Source: NHFS-3, 2005–06



## Unmet need for family planning

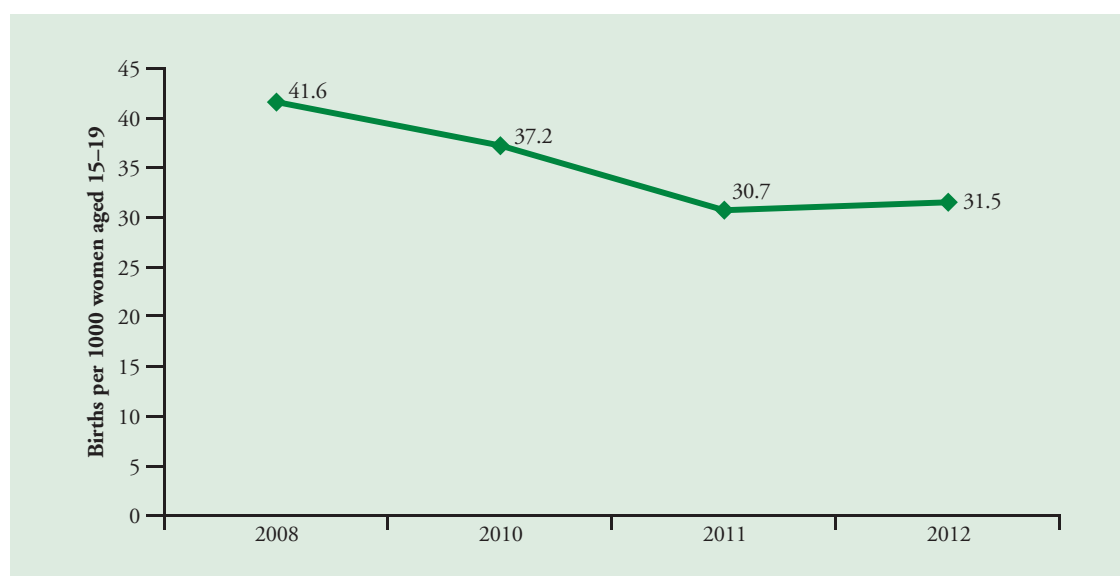
In 2005–2006, nearly 13% of currently married women had an unmet need for family planning. The unmet need for limiting (7%) is slightly higher than unmet need for spacing (6%). With the increase in CPR, total unmet need for family planning has declined by 3% since 1998–1999; a higher decline is observed in unmet need for spacing than for limiting methods. The decline in unmet need for family planning is slower than the increase in CPR, revealing that overall demand for family planning has increased; however, the system has not been able to address the increased demand fully.

Unmet need in 2005–2006 varied from 5% in Andhra Pradesh to 35% in Meghalaya. Urban women have a lower unmet need than rural women. It is particularly high for Muslim women and low for Sikh and Jain women, and decreases with an increase in wealth quintiles.

## Adolescent fertility

The adolescent fertility rate is relatively high in India. Most teenage pregnancies occur within the confines of marriage, due to the cultural practice of early marriage. The adolescent fertility rate has declined, from 42 births per 1000 girls aged 15–19 years in 2008 to about 32 in 2012 (Figure 6). In India, according to the law, the minimum age of marriage is 18 years for girls and 21 for boys. Despite such a law governing the age of marriage, early and teenage marriages are common. In 2005–2006, 47% of women aged 20–24 were married before the age of 18. The median age at marriage for women (aged 20–49 years) was 17 years and median age at first birth was 19.8 years. More than a fifth (22%) of women in the age group 20–24 years had already given birth before the age of 18. Moreover, 16% of adolescent girls (aged 15–19 years) have begun childbearing<sup>1</sup> in India; this percentage ranges from 3% in Himachal Pradesh to more than 25% in Bihar, Jharkhand and West Bengal.

Figure 6: Trends in adolescent fertility rate, 2008–2012



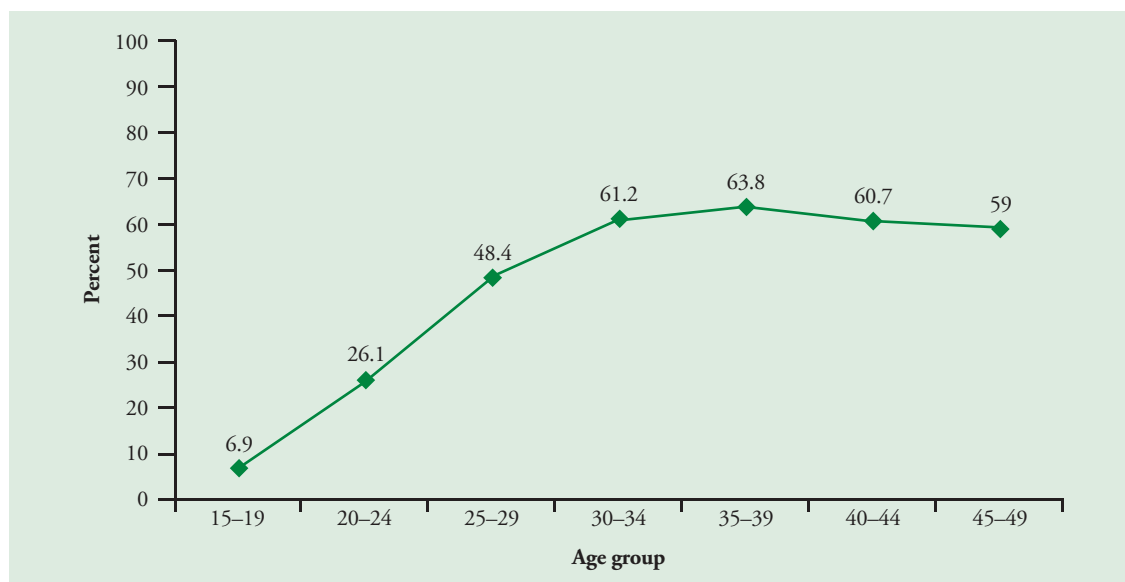
Source: SRS 2008, 2010, 2011 and 2012.

<sup>1</sup> Were either pregnant at the time of the survey or had already given birth to a child.



In 2005–2006, only 7% of women in the age group 15–19 years were currently using any modern method of family planning as compared to 64% of women aged 35–39 years (Figure 7).

Figure 7: Women using modern methods by age category, 2005–2006

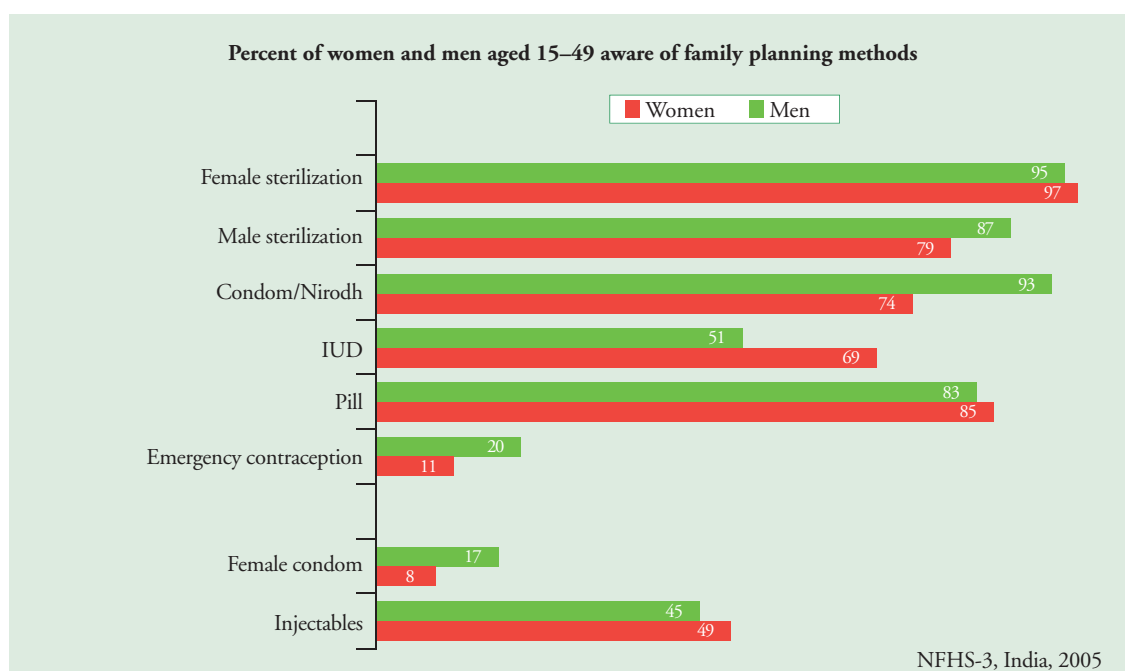


Source: SRS 2008, 2010, 2011 and 2012.

### Access to family planning information and services

In India, knowledge of permanent methods of contraception is high among both men and women. More than 90% of men know about condoms compared to three quarters of women. Similarly, about 70% of women and half of men know about intrauterine devices, a female-oriented method. Less than half of men and women know about injectable contraceptives.

Figure 8: Knowledge of modern contraceptive methods, 2005–2006





In 2005–2006, nearly 61% of women and 92% of men acknowledged that they had read, seen or heard family planning messages through mass media in the few months preceding the survey. Television was the most common source of family planning messages for both men and women. Nearly half of women saw a family planning message on television; one-third heard a family planning message on the radio; about one-quarter saw a family planning message on a wall painting or hoarding; and, 22% saw a family planning message in a newspaper or magazine. Two-thirds (67%) of currently married women and more than four-fifths (82%) of currently married men who are not currently using contraception know a place where a method of contraception can be obtained. However, less than one-fifth (18%) of women said they were ever informed by a health or family planning worker about any method of family planning.

## Current Family Planning Efforts

The current family planning programme in India is run under the National Health Mission. The programme has been repositioned from being a means for population stabilization to being an important intervention for reducing maternal and newborn mortality and improving maternal and childhealth. The family planning programme focuses on the strategies listed below.

- Increasing use of spacing methods (reversible contraceptives). To enable this, the Government has started a programme for doorstep delivery of contraceptives through community-based health workers, known as accredited social health activists (ASHAs).
- Owing to a phenomenal increase in institutional deliveries, utilizing the increased access to women in the postpartum period to promote postpartum family planning, especially postpartum IUD insertion and postpartum female sterilization.
- Availability of fixed day static services for sterilization at all facilities.
- Emphasis on minilap tubectomy services, due to its logistical simplicity and requirement of only MBBS doctors and not postgraduate gynaecologists/surgeons.
- A rational human resource development plan is in place for provision of IUD, minilap and no-scalpel vasectomy to empower health facilities (district hospitals, community health centres, primary health centres, sub-health centres) with at least one provider each for each of the services and sub-centres with auxiliary nurse midwives trained in IUD insertion.
- Ensuring quality of care in family planning services by establishing quality assurance committees at state and district levels.
- Accreditation of more private/non-governmental facilities to increase the provider base for family planning services under public private partnerships.
- Increasing male participation in family planning and promoting no-scalpel vasectomy.
- Compensation scheme for sterilization acceptors – under the scheme, the Ministry of Health and Family Welfare provides compensation for loss of wages to both the beneficiary and service provider (and team) for conducting sterilizations.
- National Family Planning Insurance Scheme under which clients are insured in the eventuality of death, complications and failures following sterilization. The providers/ accredited institutions are indemnified against litigations in such eventualities.
- Focusing on adolescents and young couples. To enable this, the Government has initiated an incentive scheme for ASHAs called “Ensuring spacing of birth”, where in the ASHA is given a monetary incentive if she is able to convince a young couple in her catchment area



to delay their first childbirth to beyond 2 years of marriage, and space the subsequent birth by at least 3 years.

- Improving contraceptives supply management up to peripheral facilities.
- Demand generation activities in the form of poster displays, billboards and other audio and video materials in the various facilities.

## Challenges and Opportunities

1. **Limited method mix:** India is a signatory to the Family Planning 2020 (FP2020) commitment, and is responsible for increasing contraceptive access to an additional 48 million girls and women by the year 2020. This is 40% of the global target, and will require a significant increase in CPR. Although past surveys have shown a gradual but steady increase in CPR, the rate of increase will need to be accelerated significantly if India hopes to achieve the FP2020 goals. Apart from strengthening the existing programme, India needs to add more products to the contraceptive basket available within the public health sector, as global evidence shows a significant jump in CPR with the addition of any new product.
2. **Focus on adolescents:** India has the largest number of adolescent population in the whole world. While it can prove to be a great demographic dividend, investing in adolescents would necessarily mean taking steps to reduce adolescent pregnancy rates so that these girls and women can actively contribute to the nation's economic growth. Beyond the provision of contraceptives to adolescent boys and girls, the country also needs to focus on intersectoral linkages to delay age at marriage. Investing in girls' education is a known strategy to delay marriage. Also, adolescents will need comprehensive sexual education to enable them to make informed choices regarding contraception.
3. **Linkages with the private sector:** Survey data show that while public health facilities account for the provision of a significant proportion of sterilization services, women and couples access reversible methods through the private sector. Thus linkages with the private sector, whether through initiatives such as social marketing and social franchising or through accreditation, will go a long way in increasing access to services.
4. **Focus on quality:** The Government of India's programme is focusing on quality of services, especially in relation to quality of services for clinical and surgical methods of contraception, by training service providers, and ensuring infection prevention practices etc. Greater focus is needed on important areas of quality, especially ensuring informed choice through good quality counselling, so that the programme adheres to the commitments made under the ICPD programme of action.

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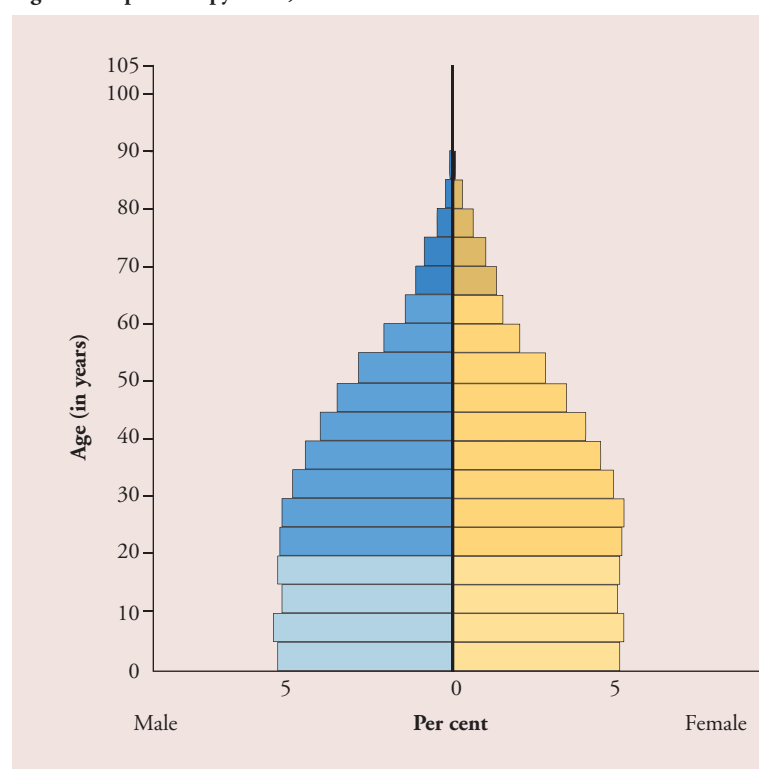
# Indonesia and Family Planning: An overview



## Background

Indonesia comprises a cluster of about 17 000 islands that fall between the continents of Asia and Australia. Of these, five large islands (Sumatra, Java, Kalimantan, Sulawesi and Papua), along with two island groups (Maluku and Nusa Tenggara) host the majority of the population, while most of the other islands are small and uninhabited. This means that the country sees extremely uneven population densities not only between islands, but also within an island. From an administrative viewpoint, the country is divided into 33 provinces, each of which is further subdivided into districts and municipalities.

**Figure 1: Population pyramid, 2010**



Source: UN Population Projections 2010.

According to the 2010 census, the population of Indonesia is 237.6 million (Statistics Indonesia), of which 50.17% are male and 49.83% are female (Population percentage by Province & Gender, 2009, 2010, 2011). The annual population growth rate is declining. It was 1.98% in the decade 1980–1990, and reduced to 1.49% over the next decade. The projected average annual growth rate in the decade starting in 2000 was 1.28% (Statistics Indonesia). As can be seen from Figure 1, a large proportion of the Indonesian population is constituted of children and people in the reproductive age group.

## Situation Analysis

The national DHS are one of the most important sources of information on family planning and

related matters. In 2007, the Government of Indonesia with support from donors such as United States Agency for International Development (USAID) and UNFPA conducted the sixth DHS, which captured data from a sample of ever-married women aged 15–49 years as well as currently married men in the age group 15–54 years.

**Table 1: Key indicators**

Total population (in millions), 2010 census	237.6
Population growth rate, 2005–2010	1.08%
Population density (people per square km), 2010	126
Urban population, 2010	44%
Population <15 years of age, 2010	27%
Total fertility rate, 2012	2.6
Contraceptive prevalence rate, 2012	61.9%
– Female sterilization	3.2
– Male sterilization	0.2
– Pill	13.6
– IUD	3.9
– Injectable	31.9
– Implant	3.3
– Male condom	1.8
– Periodic abstinence	1.3
– Withdrawal	2.3
– Folk method	0.4
Unmet need, 2012	11%
Median age at first marriage (in years), 2012	20.1
Median age at first birth (in years), 2012	22.0
Crude birth rate (per 1000 population), 2005–2010	19.1
Maternal mortality ratio (per 100 000 live births), 2010	220
Infant mortality rate (per 1000 live births), 2012	32
HIV adult prevalence (age 15–49 years), 2013	0.43%

Source: *Achieving the Health-related, Millennium Development Goals in the South-East Asia Region: Measuring Indicators 2014*

### Total fertility rate (TFR)

As can be seen in Figure 2, the TFR has been gradually declining in Indonesia over the years. DHS 2007 showed that the TFR was 2.6, which was no change from the previous DHS in 2003–2004. However, an urban–rural differentiation shows that while the TFR in urban areas has reduced from 2.4 to 2.3, it has increased from 2.7 to 2.8 in rural areas. The significant inter-provincial differences in TFR reflected in DHS 2003–2004 were also reflected in DHS 2007, with TFR being 1.8 in the Special Region of Yogyakarta and as high as 4.8 in East Nusa Tenggara.

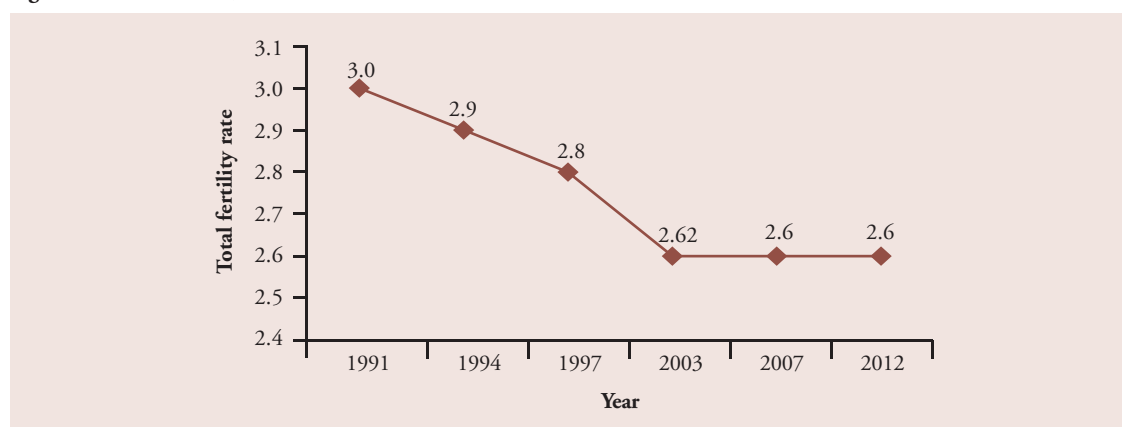


A comparison of age-specific fertility rates between the last two surveys shows that (a) women are choosing to delay childbirth to their late twenties, and (b) women in urban areas start having children later than their rural counterparts.

The 2007 survey shows an unusual inverted U-shaped relationship between education and fertility, wherein women with no education and those with the highest level of education have the lowest fertility rates. There was no clear-cut association seen between fertility rates and wealth quintiles.

Global evidence says that the ideal birth interval for reducing maternal and infant mortality ranges from 3 to 5 years. In Indonesia, DHS 2007 found that for second and higher order births that took place in the 5 years preceding the survey, the median birth interval was 54.6 months, and 70% of the births took place after a gap of 3 years or more.

Figure 2: Trends in TFR, 1991–2012

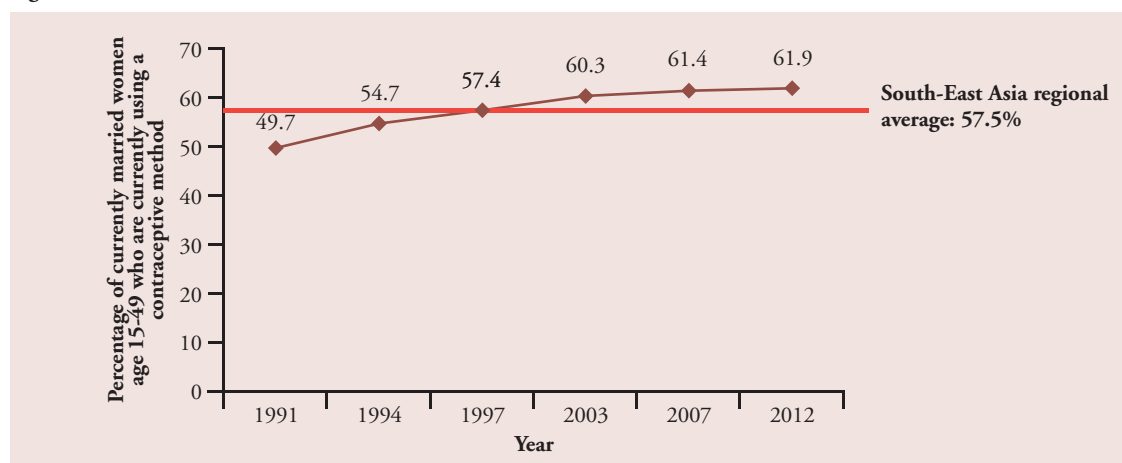


Source: Indonesia DHS 2012.

### Contraceptive prevalence rate (CPR)

According to DHS 2007, about 61% of currently married women were using a contraceptive method. Of these, 57% were using a modern method of contraception. As can be seen in Figure 3, these rates are similar to those found in the 2003 survey, and about 4% higher than the 1997 survey results, thus reflecting a plateauing in the uptake of contraceptives. The urban–rural difference in CPR was not high, at 63% and 61%, respectively.

Figure 3: Trends in CPR, 2005–2011



Source: World Health Statistics 2005, 2006, 2007, 2008, 2009 and 2011.



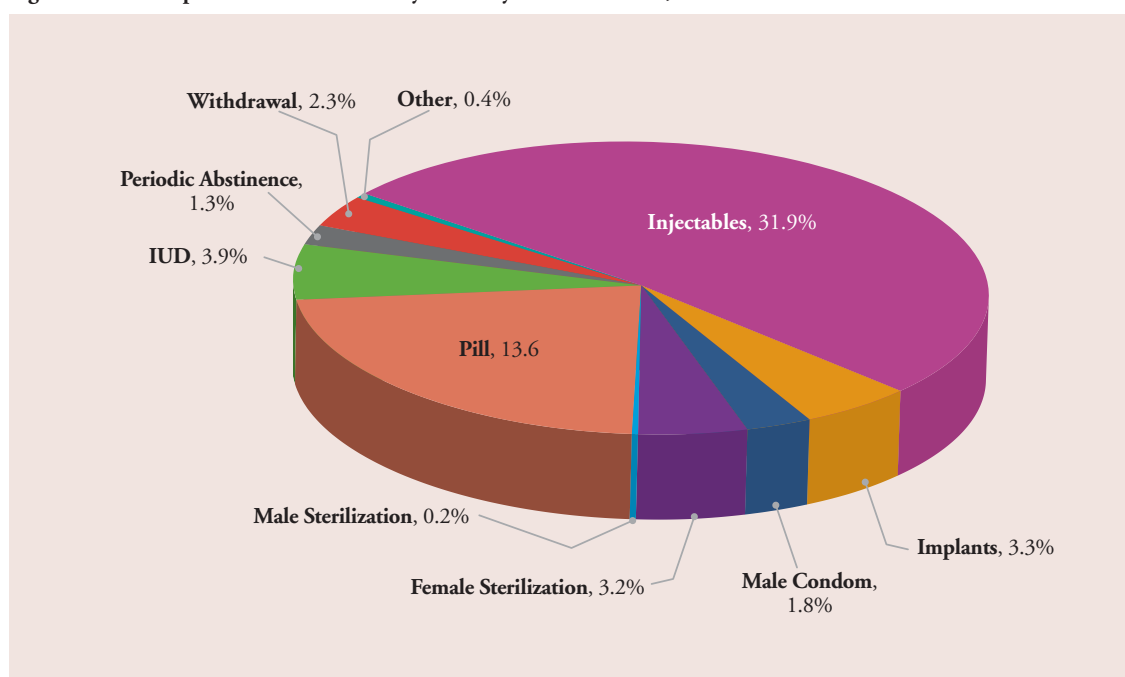
### Contraceptive method mix

As can be seen from Figure 4, Indonesian women largely rely on reversible methods of contraception. Injectable contraceptives are the most preferred method, with about one third of the women opting for the same. Figure 5 shows that the use of injectables had increased by 4% in 2007, compared to the previous survey in 2003. On the other hand, IUD use has been constantly declining over the years. Unlike many countries in the South-East Asia Region, permanent methods are not very popular in Indonesia and only 3% of women are opting for female sterilization, and another 0.2% are opting for male sterilization as the contraceptive method of choice.

The contraceptive method mix varies among urban and rural women in Indonesia, with urban women opting for IUD, condoms and female sterilization, while rural women prefer injectables and implants. Also, younger women (aged 20–34 years) are more likely to use injectables, pills and implants, whereas older women (35–44 years) prefer longer acting contraceptives such as IUDs or permanent methods such as female and male sterilization.

Use of reversible contraceptives, especially hormonal contraceptives, requires regular intake of pills or timely repetition of shots to ensure protection against pregnancy. DHS 2007 found that 80% of women using the pill were regular with their daily pill intake and over 90% of injectable users were current with their doses at the time of the survey.

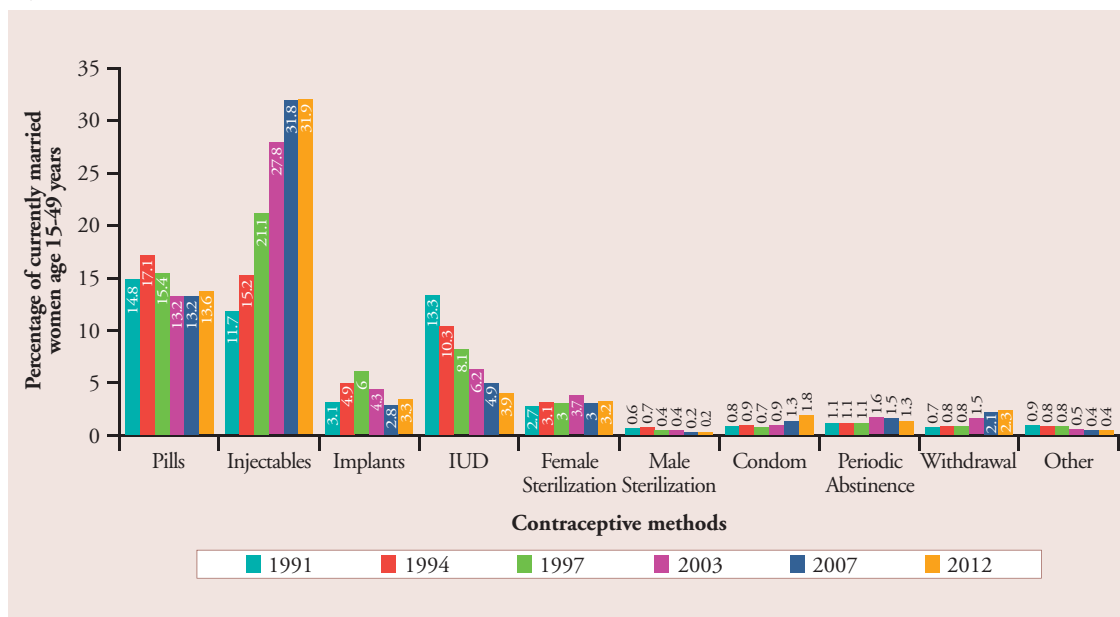
Figure 4: Contraceptive method mix used by currently married women, 2007



Source: Indonesia DHS, 2012



Figure 5: Trends in contraceptive method use, 1987–2007



Source: Indonesia DHS, 2012

## Unmet need for family planning

Both DHS 2003 and 2007 showed that 54% of couples wanted to limit their family size at the time of the survey. The wanted fertility rate was about 2.2 children on average compared to the actual TFR of 2.6.

The total unmet need for family planning in Indonesia has been stagnant at 9% since 1997. Of this unmet need, 4% is for spacing and 5% is for limiting. Also, of all the pregnancies in the 5 years preceding the survey, about 10% were mistimed (a further subindicator reflecting unmet need for spacing), and 10% were not wanted at all (indicating unmet need for limiting). If all the unmet need of the population is covered, the CPR in Indonesia would be 71%.

## Adolescent fertility

Figure 6 shows that adolescent fertility in Indonesia is reducing over the years, and is lower than the regional average. In 2007, 9% of married teenage girls (15–19 years) had begun childbearing, with 7% already having delivered a live child and 2% pregnant with their first child. This represents a 1% reduction in teenage childbearing rates compared to 2003. The proportion of teenage girls entering the childbearing phase increases rapidly with age. The survey of DHS, 2007 found that while only 1% of girls aged 15 years had begun childbearing, about one in five girls aged 19 years had done so.

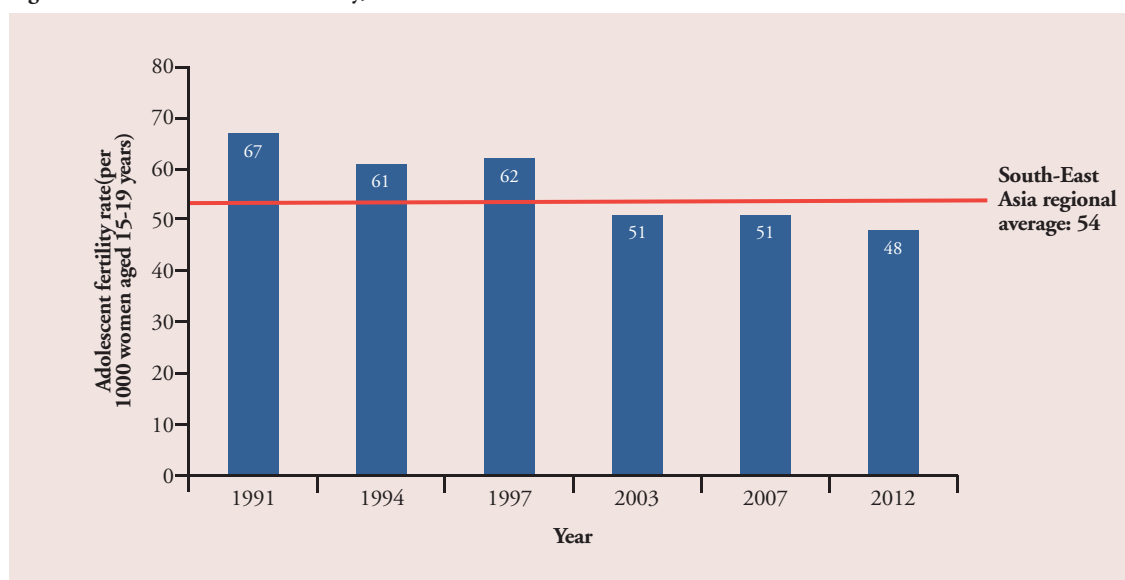
DHS 2007 found that the median age at marriage (measured for women aged 25–49 years) was 19.8 years, which had increased from 19.2 years as per DHS 2003–2004, indicating an increasing preference of girls and women to delay their first marriage. As most childbearing in Indonesia occurs within the context of marriage, this change in age at marriage is also reflected in the median age at first birth, which increased from 21.0 years to 21.5 between the last two surveys. This shift was also seen in the age-wise disaggregated data of the DHS, 2007 survey, which showed that while the median age at first birth was 20.4 years for women aged 45–49 years, it was 22.5 years for women aged 25–29 years.



Women in urban areas begin childbearing about 2 years later than their rural counterparts. While the median age at first birth was 22.9 years for the women living in urban areas, it was only 20.6 years for those living in rural Indonesia.

The gradual and steady increase in age at first marriage since the 1970s can be attributed to improvement in the educational attainment of girls. In 1971, 62% of boys and 58% of girls aged 7–12 years were enrolled in schools. These proportions had increased to 93% and 98%, respectively, by 2007. This is also reflected in the survey results, wherein a positive relationship was observed between women's educational status and a delay in childbearing. On an average, women who had no education gave birth to their first child at the age of 19.6 years, whereas those with at least some secondary education had their first childbirth at 21.2 years.

Figure 6: Trends in adolescent fertility, 2008–2011



Source: Indonesia DHS 2012

### Access to family planning information and services

Family planning-related messages are disseminated in Indonesia through both interpersonal communication led by family planning-related grass-root level functionaries as well as through the use of mass media such as radio, television and print. Men and women from urban areas, those with a higher educational status and those belonging to a higher wealth quintile have greater exposure to mass media messages on family planning.

Knowledge about contraceptive methods is very high among Indonesian women and men, with over 98% of married women and 94% of married men able to identify at least one modern contraceptive method. The most common methods quoted were injectables and pills, which tallies closely with the actual method mix in use. However, very few people were aware of emergency contraception in 2007, as it had been newly introduced into the programme at that time.

Most Indonesian women (69%) rely on private medical sources such as private midwives or pharmacy and drug stores for procuring contraceptive supplies. Only 22% rely on government sources, and this proportion decreased by 6% between the last two surveys. Almost all contraceptive users (91%) pay for the services they receive. This payment is highest among users of injectables and pills (96% and 97%, respectively), and lowest for IUDs (69%)



## Current Family Planning Efforts

Family planning activities were initiated in 1957 by the Indonesian Planned Parenthood Association, which provided family planning counselling and services along with maternal and child health care. The Government committed to promoting family planning, in order to control population size to result in economic development, and formed the National Family Planning Institute in 1968, which was later re-named the National Family Planning Coordination Board (BKKBN in Bahasa Indonesia). BKKBN is an autonomous body that reports directly to the President of Indonesia, thus according the programme the highest national importance.

The family planning programme focuses not just on controlling births, but on improving family welfare through delaying marriage, spacing births and fostering family resilience. With the decentralization of Government programmes to the district level in 2004, BKKBN reformulated its family planning strategy and promoted community participation and involvement (“All Families Participate in Family Planning”) as the cornerstone of the programme. The five strategies of the family planning programme are given below.

1. Mobilizing and empowering the community.
2. Readjustment of family planning management.
3. Strengthening human resources for the programme.
4. Enhancing resilience and welfare of families.
5. Increasing financial resources for family planning at all levels.

## Challenges and Opportunities

1. **Reliance on supply-centric methods:** Most contraceptive users are opting for reversible methods of contraception. While this means that contraception is used to ensure appropriate spacing between births rather than only as a tool to limit the number of births, it also means that the Government needs to focus on provision of a regular and assured supply of contraceptives. The programme also needs to ensure uptake of other methods such as IUDs, condoms, etc. The general population also needs to be informed about emergency contraception through an extensive communication campaign.
2. **Unmet need:** Despite the rising CPR, unmet need has been stagnant at 9% since 1997. This means that services have not been able to keep pace with the rising demand for family planning services. The Government would benefit from conducting an assessment of the epidemiology of this unmet need, and planning programmes to address the same.
3. **Population growth momentum:** The large young population base means that even if Indonesia achieves replacement fertility levels, the population will continue to grow. Indonesia needs to ensure that the trend seen in increasing CPR and decreasing TFR is maintained in the coming years.





4. **Decentralized programme:** The recent initiative to decentralize the family planning programme gives an opportunity for planning, implementing and monitoring the programme at the local level, thus ensuring that the services are in sync with local needs. However, in order for this approach to be successful, district- and municipal-level officials need to be trained in planning and management of the family planning programme.

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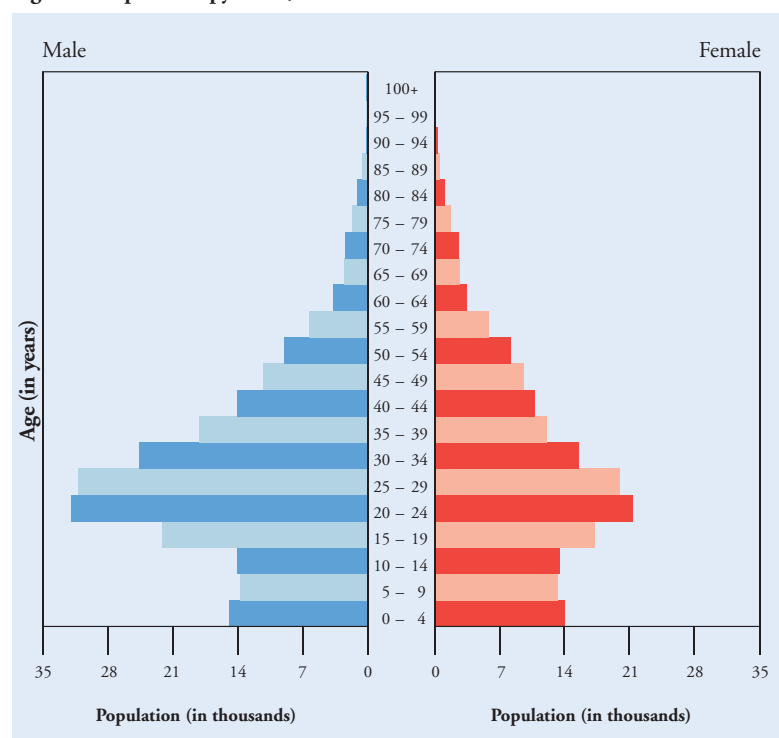
# Maldives and Family Planning: An overview



## Background

The Republic of Maldives is an archipelago in the Indian Ocean, located 600 kilometres south of the Indian subcontinent. It consists of 1192 tiny islands that form a chain stretching 820 kilometres in length and 120 kilometres in width. Currently, a total of 187 islands are officially inhabited. In addition, another 107 islands are designated as tourist resorts and around 14 islands are used for industrial purposes (Maldives Demographic Health Survey 2009).

**Figure 1: Population pyramid, 2010**



Source: CIA World Factbook

In the first census enumeration in 1911, the population of Maldives was just 72 237; by 2010, the population had grown fourfold to 326 000. In 2010, young people aged 15 years and below comprised a relatively large proportion of the population (30%), while 58.4% of women were in the reproductive age group (15–49 years) (World Population Prospects, 2012).

## Situation Analysis

In 1986, the Republic of Maldives adopted a policy to promote and implement family planning programmes in the country. By 1990, all the islands were covered under the programmes. The Maldives DHS 2009 is the most recent source of data available for Maldives.



The relevant demographic and health indicators are presented in Table 1.

**Table 1: Key indicators**

Total population, 2013	336 000
Annual population growth rate, 2006	1.69%
Population density (persons per square km), 2006	2.59
Urban population, 2006	35.0%
Population below 15 years of age, 2006	31.4%
Total fertility rate, 2009 (MDHS)	2.5
Contraceptive prevalence rate (%) , 2009 (MDHS)	34.7%
– Pill	4.6
– IUD	0.8
– Female sterilization	10.1
– Male sterilization	0.5
– Condom	9.3
– Injectable	1.2
– Any modern method	27.0
– Any traditional method	27.8
– Not currently using	65.3
Unmet need for family planning, 2009	28.1%
– Unmet need for spacing	14.9
– Unmet need for limiting	13.2
Median age at first marriage for girls (in years), 2009	20.0
Median age at first birth (in years), 2009	22.5
Crude birth rate (per 1000 population), 2012	22
Maternal mortality ratio (per 100 000 live births), 2012	13
Infant mortality rate (per 1000 live births), 2012	9
HIV adult prevalence rate (age 15–49 years), 2002	<0.01%*

\* Maldives country reported data for Core Health Indicators brochure ; Country update, August 2013 (VRS) (Reported for MDG Analytical kit 2014); Joint United Nations Programme on HIV/AIDS (UNAIDS), Report on the Global HIV/AIDS Epidemic, 2002.

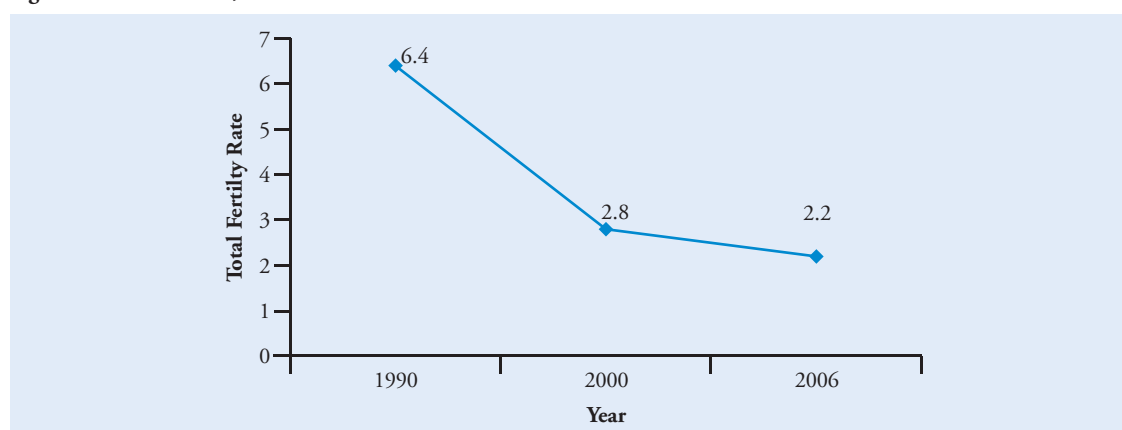
### Total fertility rate (TFR)

Over the past few decades, Maldives has made significant progress in human and social development. Credible macroeconomic and public investment policies as well as a largely favourable external environment has facilitated this progress, lifting Maldives from its status as one of the 20 poorest countries in the world in the 1970s to one that shares characteristics of a lower middle-income country today. As a result of the socioeconomic development that Maldives has experienced during the past few decades, the fertility level is falling steadily in the country. The decline in fertility was especially rapid between 1990 and 2006. As shown in Figure 2, the TFR was 6.4 in 1990 and progressively declined to 2.2 in 2006.



The latest TFR is 2.5,<sup>1</sup> and the rate is lower among urban women (2.1 births per woman) than rural women (2.8 births per woman). The peak age for childbearing in urban women is age 25–29 years, while for rural women it is age 20–24 years. Among almost all age groups, the age-specific fertility rates for urban women are lower than those for rural women (Maldives Demographic and Health Survey, 2009).

Figure 2: Trends in TFR, 1990–2006

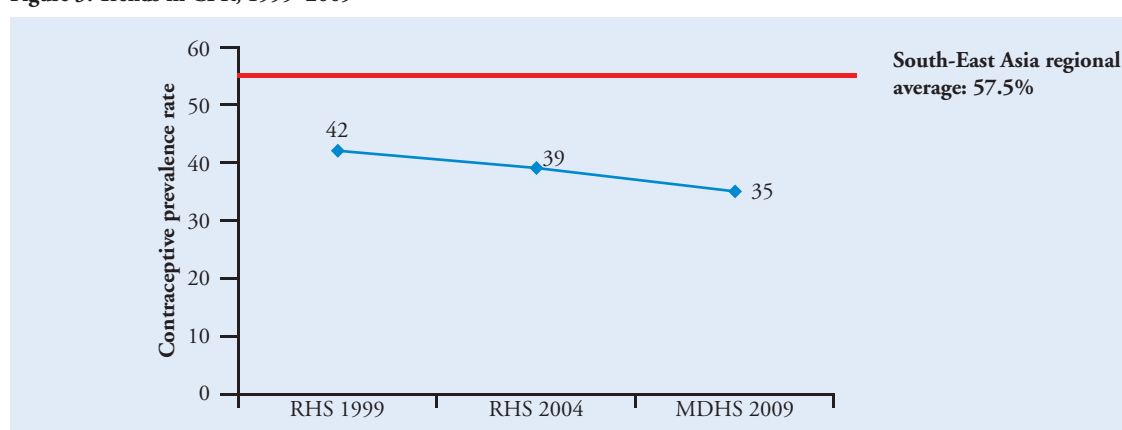


Source: Census 1990, 2000 and 2006.

## Contraceptive prevalence rate (CPR)

Figure 3 shows trends in the use of contraceptive methods among currently married women during 1999–2009. Surprisingly, contraceptive use among currently married women has declined progressively by 3–4%, from 42% in the Reproductive Health Survey (RHS) 1999 to 35% in DHS 2009. Overall, around one third of currently married women in Maldives were using contraception in 2009. The socioeconomic and demographic differentials in CPR among currently married women were clearly observed in MDHS 2009 data. Unlike in most other countries in the South-East Asia Region, rural women were slightly more likely than urban women to use family planning (35% and 34%, respectively). Use levels varied markedly by region, from 28% in the South to 42% in the Central region. According to the 2009 RHS, and in contrast to other countries, CPR showed a general decline with rising education levels. While 44% of uneducated women were using contraception, only 27% of women with secondary education were using a contraceptive. This figure though rose up slightly to 33% for women who were educated beyond the secondary level. Though it still did not come close to the CPR levels of women with no education.

Figure 3: Trends in CPR, 1999–2009



Sources: RHS 1999 and 2004; and Maldives DHS 2009.

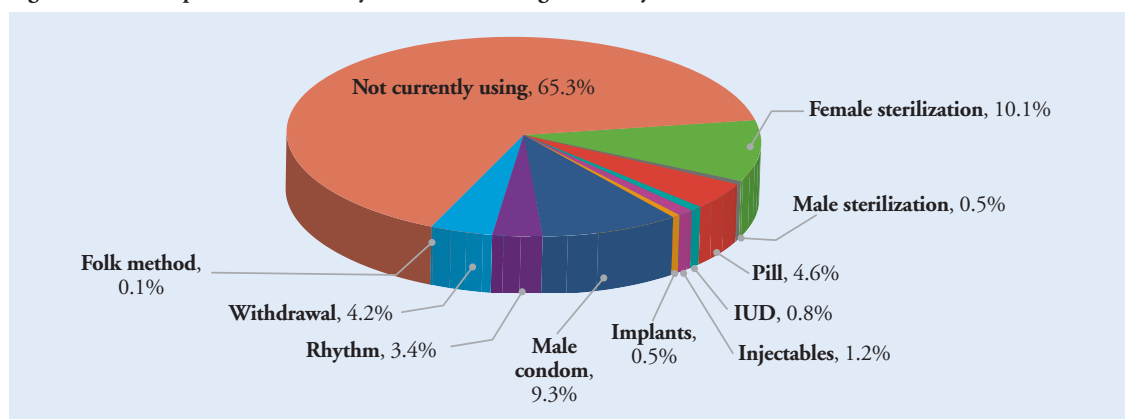
<sup>1</sup>Figure 2 does not show the latest TFR of 2.5 as the source of earlier figures is the census, while the source for the latest data (Maldives Demographic and Health Survey, 2009).



## Contraceptive method mix

Figure 4 illustrates the pattern of contraceptive use among currently married women aged 15–49 years. Overall, MDHS 2009 indicated that around one third of currently married women were using contraception. Female sterilization was the most popular contraceptive method, followed closely by the male condom (10% and 9%, respectively). Five per cent of married women used the pill. A smaller percentage of women were using other modern methods: 1.2% used injectables, 0.8% used IUDs and 0.5% used implant contraceptive methods. About 8% of women reported use of traditional methods of contraception, with 4.2% using the withdrawal method and 3.4% using the rhythm method.

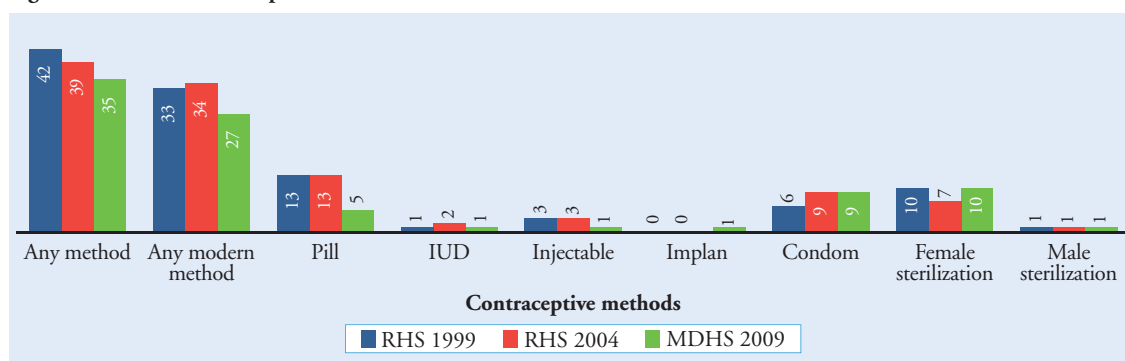
Figure 4: Contraceptive method use by married women aged 15–49 years, 2009



Source: Maldives DHS 2009.

Figure 5 presents trends in use of specific contraceptive methods among currently married women during the period 1999–2009. As noted earlier, use of any method by currently married women decreased from 42% in 1999 to 35% in 2009. There was a shift in the use of some modern methods. In 1999, the pill was used by 13% of currently married women; this rate has decreased steadily since, with only 5% of currently married women using the pill in 2009. Use of condoms increased from 6% in 1999 to the current rate of 9%. The proportion of married women who were sterilized declined from 10% in 1999 to 7% in 2004, but increased again to 10% in 2009. Use of traditional methods also declined slightly, from 9% in 1999 to 8% in 2009, after dipping to 5% in 2004. While the pill was the most commonly used modern method in RHS 1999 and 2004, female sterilization had become the most commonly used modern method by MDHS 2009.

Figure 5: Trends in contraceptive use, 1999–2009



Source: Maldives DHS 2009.



### Unmet need for family planning

The major concerns of family planning programmes include defining the size of potential demand for contraception and identifying the women who are most in need of contraceptive services. In 2009, the total unmet need among currently married women in Maldives was 28%; 15% were in need of family planning because of a desire to space the next birth, and the remainder were in need due to an interest in limiting births. Although the drop was not uniform, the level of unmet need declined with age. Unmet need was slightly higher among rural women than urban women, and varied from a level of 25% in the North and Central regions to 36% in the South.

### Adolescent fertility

In recent years, the proportion of adolescents and youth in Maldives has increased substantially, and is rapidly approaching 40% of the country's total population. The percentage of adolescents and young people between the ages of 15 and 24 now constitute approximately more than 25% of the country's total population (World Population Prospects, 2012). These statistics clearly show that the current period is crucial for policy interventions and strengthening programmes that meet the needs of Maldivian youth, who represent the future and are an inexhaustible resource for the nation. Tapping into and nurturing young people's talent and energy in a positive way will enable Maldives to achieve its national potential and boost its competitiveness in the global economy in the years to come.

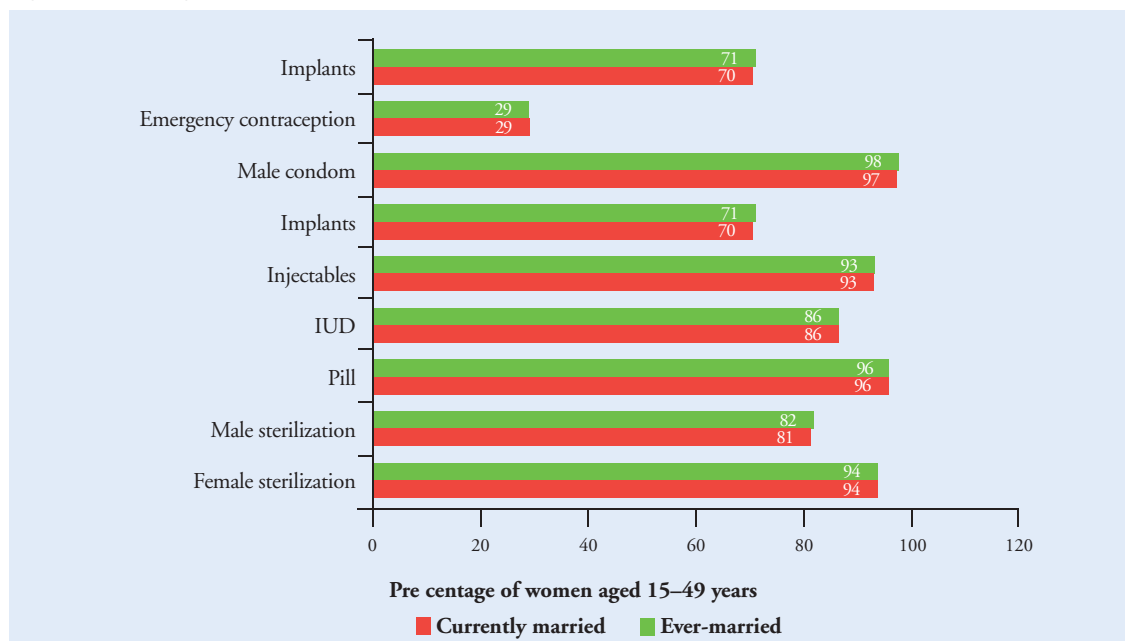
Unlike many other countries in the Region, pregnancies among adolescents are relatively rare in Maldives. Only 2% of adolescents have begun childbearing, 1% are mothers and less than 1% are pregnant with their first child. The proportion of teenagers who have entered motherhood varies little across subgroups of women. Women in the South begin childbearing earlier than women in other regions. Although the differences are small, there is an inverse relationship between early childbearing and education level. In terms of economic status, the proportion of teenagers who have begun childbearing is highest in the lowest wealth quintile (4%). In 2009, the adolescent fertility rate in Maldives was 12 births per 1000 adolescent women aged 15–19 years (Maldives Demographic and Health Survey, 2009).

### Access to family planning information and services

Awareness of family planning methods is crucial when deciding to use contraception and then in selecting which method to use. Figure 6 shows that knowledge of family planning methods is virtually universal among married women in Maldives. Almost all currently married women aged 15–49 knew at least one modern family planning method. The male condom was the most widely recognized method (98%), followed closely by the pill (96%). More than 90% were also aware of female sterilization and injectables, more than 80% knew about IUDs and male sterilization, and 71% had heard of implants. Implants were introduced in 2002 and are only available in Malé. Emergency contraception, introduced in Maldives in 2007, was the least widely recognized, with only 29% of married women aware of this method. The mean number of methods known by women was 7.7. Seven in 10 married women had heard of at least one traditional method of contraception (Maldives Demographic and Health Survey, 2009).



Figure 6: Knowledge of modern contraceptives, 2009



Source: Maldives DHS 2009.

## Current Family Planning Efforts

The unique geographical situation poses a challenge for the Government of Maldives. Although the size of the population is relatively small (compared to some other countries in the Region), it is dispersed in scattered settlements across a large number of tiny islands making health-care delivery, including reproductive health, a major challenge.

The Government of Maldives recognizes reproductive health as a crucial component of the overall health needs of the population. It aims to provide reproductive health services in a manner that ensures affordability, equitable access and quality of care corresponding to the needs of each individual through the principles of primary health care.

The goal of the Maldives national reproductive health strategy is “Reproductive health and rights for all Maldivian women, men and adolescents.”

Under the reproductive health programme of the Republic of Maldives, the following seven broad thematic approaches have been adopted.

1. Safe motherhood and newborn care
2. Family planning
3. Adolescent sexual and reproductive health
4. Sexually transmitted infections and HIV/AIDS
5. Gender-based violence
6. Partnering with men in sexual and reproductive health
7. Reproductive morbidities (including infertility and cancers)



A policy to implement family planning programmes was adopted in Maldives in 1986. By 1990, the programmes had reached all islands. Most family planning outlets are in the public sector, while private pharmacies are registered to provide contraceptives prescribed by private physicians. Contraceptives are also available through the Society for Health Education, a non-governmental organization. Oral contraceptive pills, injectables and male condoms are available in all government facilities. IUD insertion and removal and female and male sterilization are performed in all hospitals. Implants, however, are available only in Malé. All contraceptive methods offered by government health facilities are provided free of charge (Maldives Demographic and Health Survey, 2009).

## Challenges and Opportunities

With the significant reduction in the maternal mortality ratio over the last 8 years, Maldives has performed well in achieving MDG 5. However, some challenges still remain. Fertility levels continue to be very high; contraceptive use remains low among women and has even declined in recent years; and issues of accessibility to essential obstetric care and quality of care, especially at the very peripheral level, remain to be addressed. Ensuring delivery by skilled birth attendants in small peripheral islands is also still a challenge. A focus on adolescents' reproductive health needs is crucial to reduce unwanted pregnancies that lead to maternal morbidity and mortality. It is also difficult for those who are not married, and for youth in general, to get access to family planning information.

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# Myanmar and Birth Spacing: An overview



## Background

Myanmar is bordered by three of the world's most populous countries: China, India and Bangladesh. The total population of Myanmar is 59.13 million and, with an annual population growth rate of 1.29%, the TFR is 2.03. Approximately 30% of Myanmar's population live in urban areas. The population is made up of the majority Bama ethnic group who live predominately in the lowlands and the central dry zone, and some 135 ethnic groups who live mainly in the highlands and on the far eastern and western borders of the country. In 2014, 25.6% of the population is below 15 years old and 56.8% of women are in the reproductive age group (15–49 years) (Figure 1).

There are 14 states and regions in Myanmar, which are divided into 330 administrative units known as townships. Each township has a hospital providing tertiary-level health services and at least one maternal and child health centre.

Figure 1: Population pyramid 2014



Source: CIA World Factbook.

## Situation Analysis

Myanmar formulated draft national population policies in 1992, shifting from a pro-nationalist policy to a health-oriented approach. This included the promotion of birth spacing to improve the health status of women and children; community-level information, education and communication; promotion of responsible reproductive behaviour; male involvement in reproductive health; and, addressing adolescent and youth needs. Reproductive health, as an inclusive and coherent approach, has been in place in Myanmar since 1996.



The overall situation is shown by the relevant indicators in Table 1.

**Table 1: Key indicators**

Total population (in millions), 2012	52.79
Population growth rate, 2012	1.29%
Population density (people per square km), 2010	76.8
Urban population, 2012	33%
Population <15 years of age, 2012	25%
Total fertility rate, 2012	2
Contraceptive prevalence rate, 2012	46%
– Pill (daily)	10.1
– Pill (monthly)	0.7
– IUD	1.8
– Injectable (monthly)	0.4
– Injectable (3-monthly)	19.3
– Female sterilization	4.4
– Male sterilization	1.0
– Condoms	0.7
– Traditional or natural methods	2.6
Unmet need, 2001	19.1%
– For spacing births	6.3
– For limiting births	12.8
Average age at first marriage (in years), 2003	22.8
Median age at first birth (in years)	22
Crude birth rate (per 1000 population), 2012	17.4
Maternal mortality ratio (per 100 000 live births) (2013, UN estimation)	200
Infant mortality rate (per 1000 live births), 2012	41
HIV adult prevalence, 2012 (USAID)	0.6%

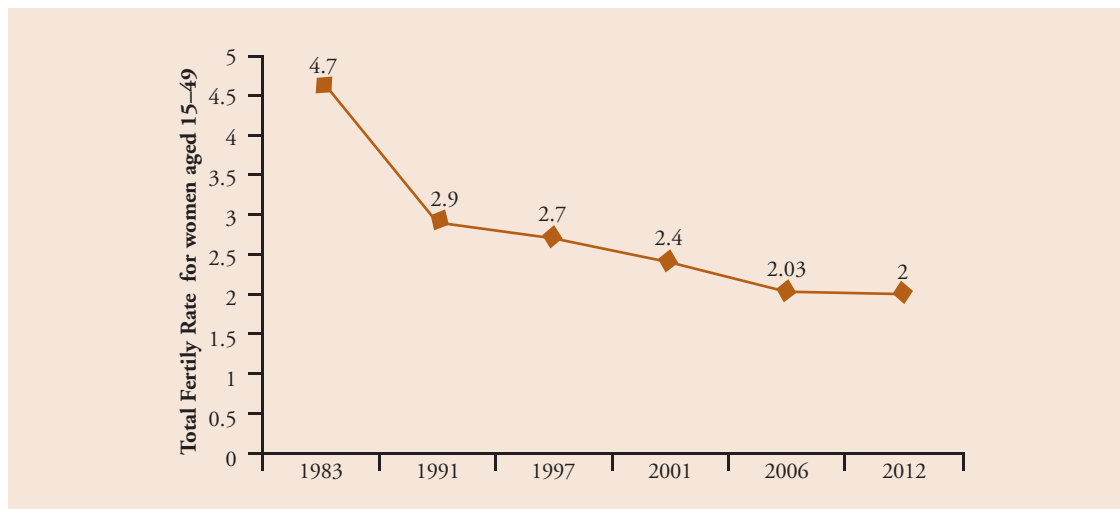
Source: CIA World Factbook; World Health Statistics, 2014.

### **Total fertility rate (TFR)**

Myanmar has made a progress in terms of decreasing the TFR, from 4.7 in 1987 to 2.0 in 2012 (Figure 2).



Figure 2: Trends in TFR for women (aged 15–49), 1983–2012

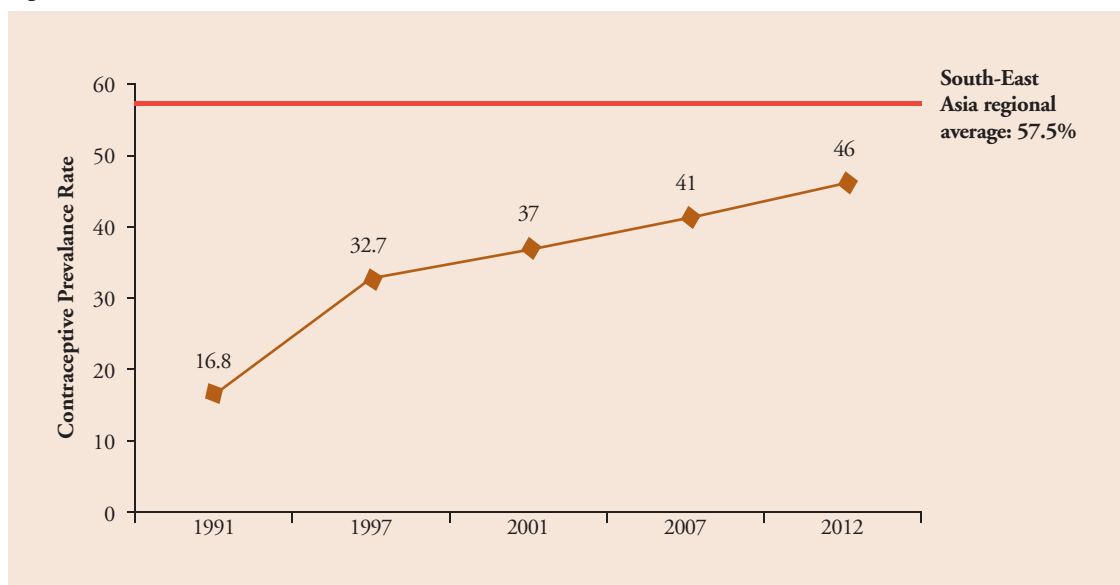


Source: Myanmar Fertility and Reproductive Health Survey 2001; *The Status of Birth Spacing in Myanmar*, UNFPA, 2010; *World Health Statistics* 2014.

### Contraceptive prevalence rate

While the TFR is declining, trends show that the contraceptive prevalence rate (CPR) has been progressively increasing, from 16.8 % in 1991 to 46% in 2012 (Figure 3).

Figure 3: Trends in CPR, 1991–2012



Source: *The Status of Birth Spacing in Myanmar*, UNFPA 2010; *World Health Statistics* 2014.

In Myanmar, knowledge of at least one modern method of contraception is almost universal. While knowledge of most modern methods of birth spacing has increased, knowledge about use of condoms to prevent pregnancy has remained the same. Condoms tend to be associated with the prevention of sexually transmitted infections and for use by men with sex workers, and are not seen as a birth spacing method.



Early childbearing in Myanmar is unusual. Only 10% of women aged 15–49 years have given birth before the age of 18. The low proportion of women giving birth in their teens can be attributed to the high age of first marriage, which has been around the age of 22 for the past 15 years. Median age at first birth is also 22 years. Only 1.9% of women had their first birth before the age of 15, and slightly more than 25% before the age of 20 years. Forty five per cent of married women had given birth before the age of 22, and another 41% had their first birth between the ages of 20 and 24.

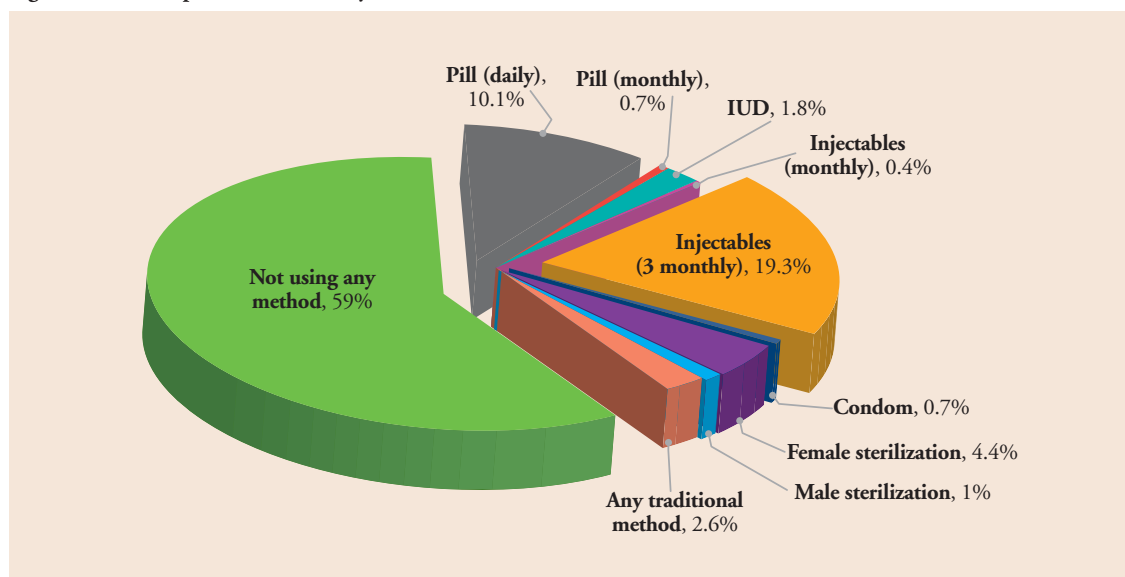
Abortion is illegal in Myanmar and it is the leading cause of maternal mortality, with at least 50% of maternal deaths and 20% of all hospital admissions resulting from complications due to unsafe abortions. One study found that the smaller the health institution, the higher the abortion rate in the surrounding area, due to lack of access to contraceptive methods.

Resorting to the use of illegal and unsafe abortion is in large part the result of unmet contraceptive need among women in Myanmar. The Fertility and Reproductive Health Survey (FRHS) 2007 found that of the 17.7% of women who did not want to get pregnant but were not using contraception and were at risk of pregnancy, 13.3% wanted to limit their births and 4.9% wanted to delay their next pregnancy. This suggests a lack of acceptable long-term methods of contraception.

### Contraceptive method mix

According to FRHS 2007, approximately 40.9% of currently married women are using a method of contraception, including traditional methods. The use of birth spacing methods continues to increase, but at a slower pace. Method failure appears to be a common problem in Myanmar, as 37% of women seeking treatment for complications of abortion report contraceptive use at the time the pregnancy occurred. The Department of Health is currently conducting a study on safety and efficacy of the one-month injectable approved by WHO, in the hope of adding it to Myanmar's contraceptive method mix.

Figure 4: Contraceptive method use by married women, 2007



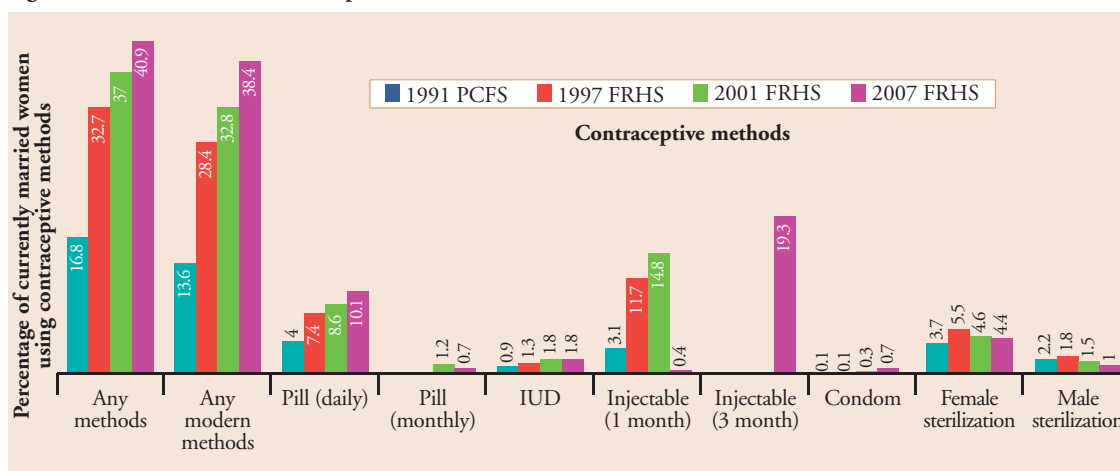
Source: FRHS 2007.



The rise in the use of birth spacing methods since 1997 is mostly due to increased use of the pill and injectables, the two most common methods of contraception in Myanmar. Use of female and male sterilization is low, due to a lengthy and difficult approval process. Female sterilization is only available after approval by a sterilization board. Male sterilization is restricted by law to those men whose wives have been approved for, but are not able to undergo, sterilization.

The CPR increased from 16.8% in 1991 to 40.9% in 2007, mainly due to an increase in the use of injectables and oral contraceptive pills. In 2007, the 3-monthly injection was the most common method used by 19.3% of the women.

Figure 5: Trends in modern contraceptive methods, 1991, 1997, 2001 and 2007

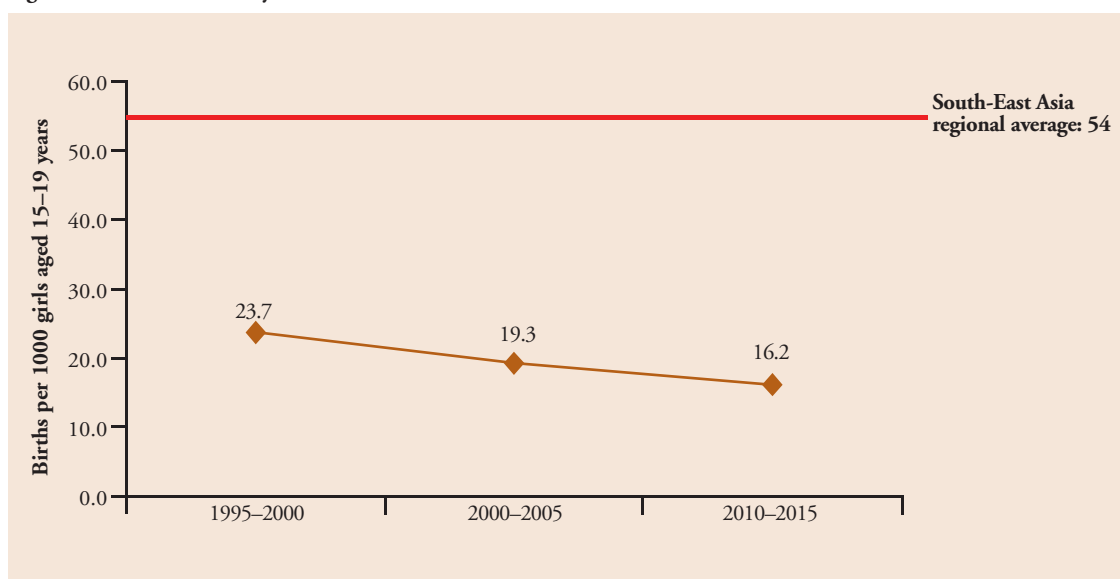


Source: FRHS 2007.

## Adolescent fertility

In 2011, the adolescent fertility rate was 17 births per 1000 girls aged 15–19 years, which is well below the regional average of 54.

Figure 6: Adolescent fertility rate



Sources: World Health Statistics 2008, 2009, 2010, 2011, 2012, 2013 and 2014.



## Current Family Planning Efforts

Birth spacing methods have been available in the public sector since 1991 in Myanmar. That same year, the Government initiated a birth spacing project. By 1995 the project covered 33 townships, by 2001 it covered 117, and by 2011 it covered 132 of the country's 320 townships.

A draft reproductive health policy was debated in 2001 and 2003, but has not yet been finalized and officially adopted. The key features of this policy are listed below.

- Integration of reproductive health services into existing services.
- Partnership between the Government, non-governmental organizations, and the private sector.
- Research and monitoring of services to identify priorities and needs.
- Assuring that services are accessible, acceptable, and affordable.
- Incorporation of a gender-based approach to ensure equity and equality.
- Implementation of appropriate sociocultural approaches.
- Sustainability of services.

There are six main aspects of reproductive health that have been identified as priority areas for policy implementation, including birth spacing. Future actions include the approval of a national five-year strategic plan for reproductive health, focusing on four strategic approaches to improve the enabling environment, the evidence base for decision-making, the health system and capacity for delivery of quality reproductive health services, and community and family practices. A separate five-year adolescent health and development strategic plan will focus on adolescent reproductive health as a major component.

Reproductive health services are provided by the public sector, private sector, and national and international nongovernmental organizations. A number of nongovernmental organizations are involved in reproductive health services and advocacy. For example, in UNFPA-supported townships birth spacing services are provided at urban health centres, maternal and child health centres, rural health centres and sub-centres. In townships that are not externally supported there is very little provision of birth spacing services in the public sector.

Training in birth spacing methods was not included in pre-service midwifery training until 1998. Midwives are now trained in the provision of contraceptive methods, including injection of DMPA (although they are not legally authorized to give injections) and insertion of IUDs. They have also been trained in indications, contraindications, side-effects and warning signs. In addition, there is in-service training of all basic health staff in UNFPA-supported townships. Provision of birth spacing services has increased dramatically over the last decade and provider knowledge and practice has improved as birth spacing services have been introduced in more townships across Myanmar.



## Challenges and Opportunities

Myanmar has an explicit pro-natalist policy as there is concern in the political circles that it continues to be under populated. However, use of contraception to space births has been adopted as part of efforts to improve maternal and child health. Hence, the country uses the term “Birth spacing” for its programmes as opposed to “Family Planning”. One of the challenges in Myanmar is to improve the consistent and correct use of birth spacing methods in order to reduce unplanned pregnancies and the recourse to abortion.

1. **Limited data and resources:** Myanmar is data-poor, and official statistics are often dated and inaccurate.<sup>1</sup> It is a conservative country with strong cultural norms regarding sexual behaviour. As a result, research to identify priorities is difficult. Social and cultural values can serve as barriers, particularly for young women, in accessing reproductive health services including those for birth spacing. While there is a shortage of funds, nongovernmental organizations are playing an increasing role in birth spacing.
2. **Limited method mix:** Due to its pro-natalist policy, methods like sterilisation are not easily available, both due to policy barriers and provider biases. Provider opinion is also a barrier to women receiving a suitable method of contraception. Due to cultural sensitivities, providers refuse to provide contraceptives to unmarried women.
3. **Lack of secure contraceptive commodities in the public sector:** Even where contraceptive services are available in the public sector, commodities may not be, leading most women to turn to the private sector as an alternative source. It is normal practice for providers or clients to buy IUDs or injectables from drug shops for later insertion or injection. Oral contraceptives and injectables are readily available from general shops, drug shops and markets.

<sup>1</sup>The main sources of demographic data for Myanmar are the vital registration and statistics system and population censuses. The last population census was in 1983. Other sources of demographic data in Myanmar are the Fertility and Reproductive Health Survey (FRHS) conducted in 1997 and 2001.





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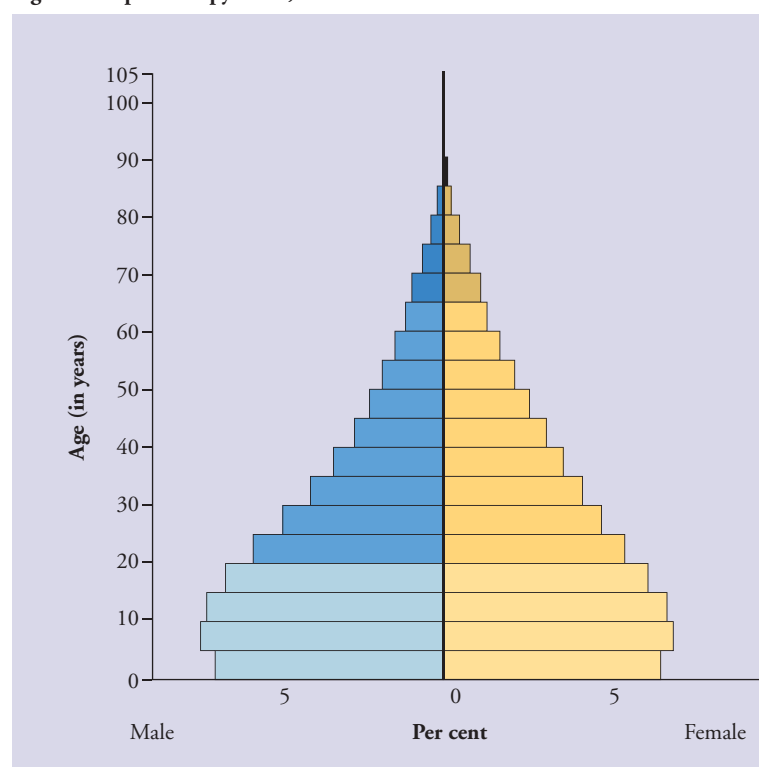
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# Nepal and Family Planning: An overview



## Background

Figure 1: Population pyramid, 2010



Source: World Population Prospects The 2010 Revision.

Located in the mighty Himalayas, Nepal has a largely rugged terrain. With relatively little cultivable land to support its 30-million-plus population, Nepal too is fighting the problem of population explosion due to its high fertility rate, like many other countries in the South-East Asia Region.

The population pyramid (Figure 1) reveals a Nepalese population that is largely constituted of children and youth. With such a high proportion of the population either currently in the reproductive age group, or on the threshold of it, the growth momentum will continue to increase the population size for at least a generation to come, even in the face of best efforts to contain the fertility levels.

## Situation Analysis

The overall situation is shown by relevant demographic and health indicators in Table 1.

Table 1: Key indicators

Total population (in millions), 2011	26.5
Population growth rate, 2001–2011	1.35%
Population density (people per square km), 2011	180
Urban population, 2011	17%
Population <15 years of age, 2011	34.9%
Total fertility rate, 2011	2.6
Contraceptive prevalence rate, 2011	49.7%
– Pill	4.1



Injectable	9.2
– Implants	1.2
– IUD	1.3
– Female sterilization	15.2
– Male sterilization	7.8
– Condom	4.3
– Traditional or natural methods	6.6
Unmet need	27%
– Spacing	10
– Limiting	17
Median age at first marriage	17.8
Median age at first birth	20.2
Crude birth rate (per 1000 population), 2011	24.3
Maternal mortality ratio (per 100 000 live births), 2011	170
Infant mortality rate (per 1000 live births), 2011	46
HIV adult prevalence (age 15–49 years), 2011	0.3%

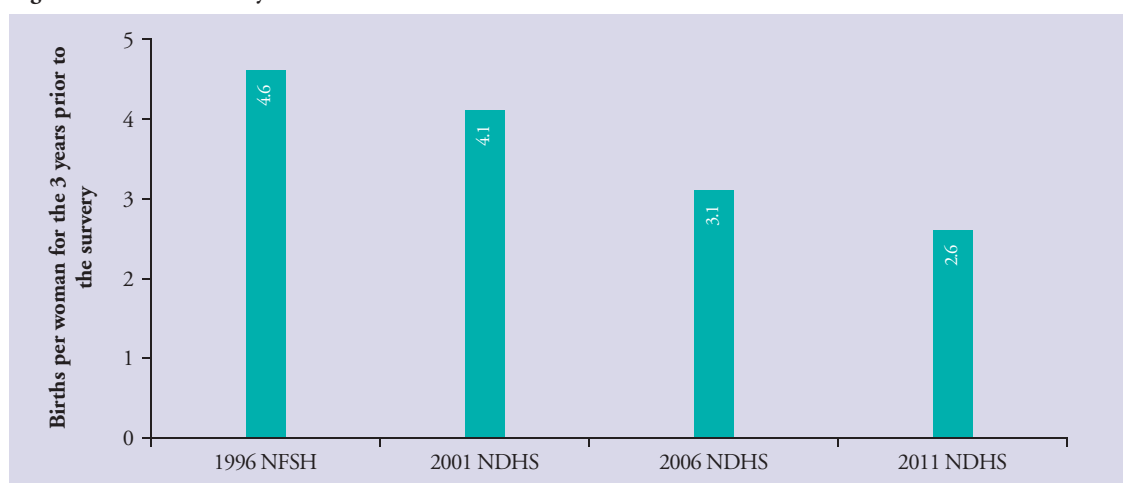
Source: Nepal Population and Housing census 2011, Nepal DHS 2011, Nepal in Figures 2013

### Total fertility rate (TFR)

Fertility rates in Nepal have been gradually dropping over the decades. While the TFR was 5.8 in the 1970s, it gradually reduced to 5.1 births per woman in 1985 and then to 4.1 in 2001. In the past few years, owing to intense efforts towards population stabilization by the Government of Nepal as well as partner agencies, the country saw a sharp decline in TFR to 3.1 in 2006 and to 2.6 in 2011 (Nepal DHS 2011) (Figure 2). The fertility rate shows an inverse trend when mapped against the socioeconomic status of women, with women in the lowest wealth quintile having a fertility rate of 4.1 as against 1.5 for women in the highest quintile (Figure 3).

The reduction in TFR is also reflected in the gradually changing shape of the population pyramid of the country. In 2001, children under 15 years of age accounted for about 45% of the total population. This has reduced to less than 40%, with the “bulge” in the pyramid shifting upwards towards the adolescent and youth population.

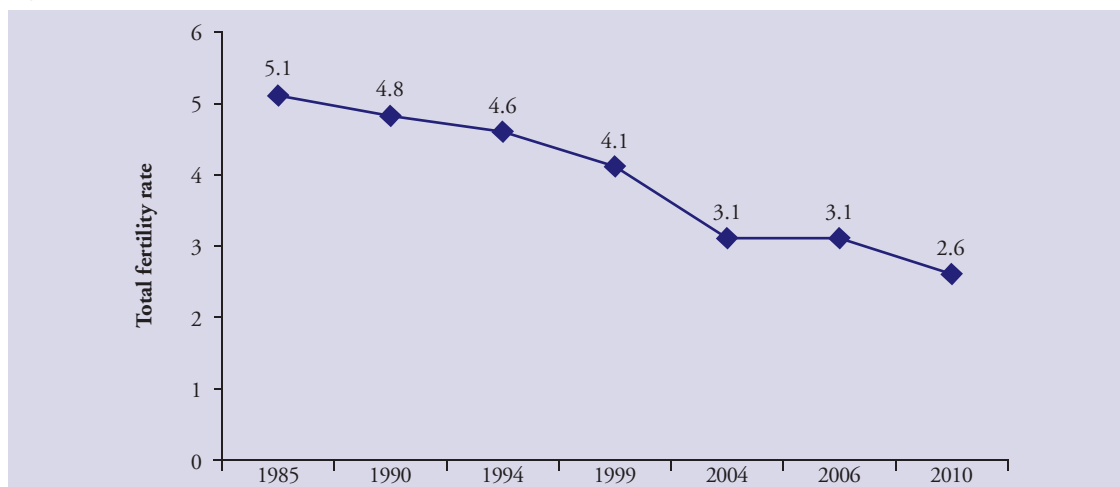
Figure 2: Trends in Fertility



Source: Nepal DHS 2011 (Key findings).

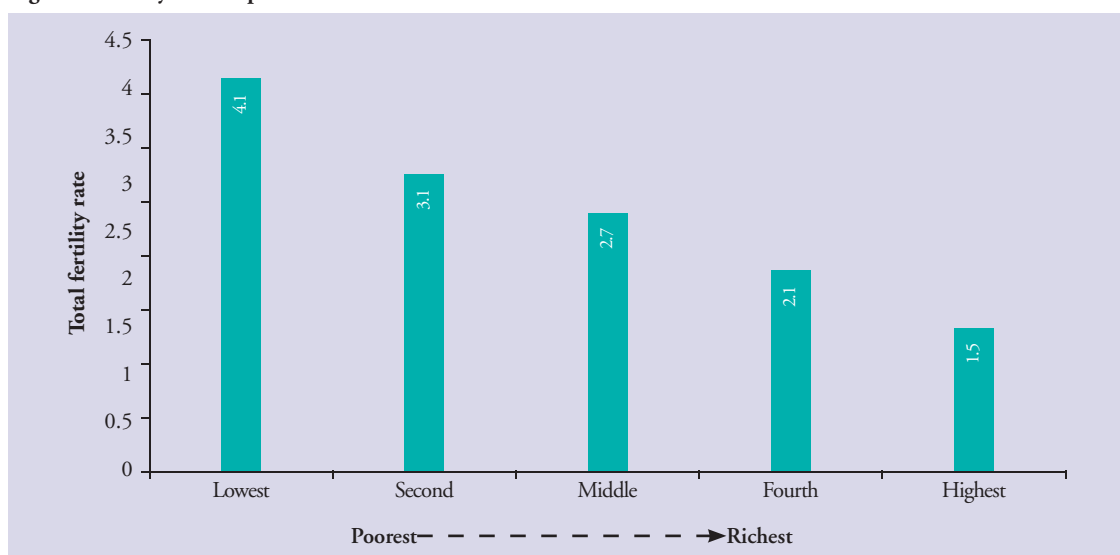


Figure 3: Trends in TFR, 1985–2010



Source: Nepal DHS 2006; World Health Statistics 2011.

Figure 4: TFR by wealth quintile



Source: Nepal DHS 2011 (Key findings).

## Contraceptive prevalence rate (CPR)

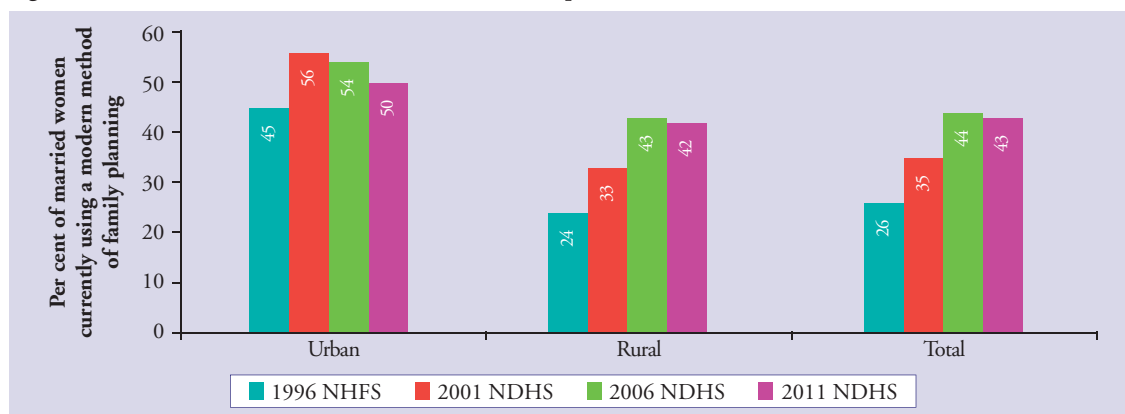
The steep reduction in TFR can be attributed to an impressive increase in the use of contraception in Nepal over the past 10 years. As can be seen in Figure 5, the CPR in Nepal for modern methods showed a marked increase in the decade from 1996 to 2006. Based on the national DHS in 2006, CPR for modern methods stood at 44.2%, while overall CPR (including traditional methods) had increased to 48%. A large proportion of this success in improving women's acceptance of modern contraceptive methods can be attributed to the Nepal Health Sector Programme Implementation Plan launched by the Government of Nepal in 2004.

The rising trend in CPR, however, was not reflected over the next 5 years. According to DHS 2011, the CPR for modern methods remained almost unchanged at 43%. Owing to an increase in acceptors of traditional methods of contraception to 7% of all women, half of all married women were using some method of contraception during the 2011 survey.



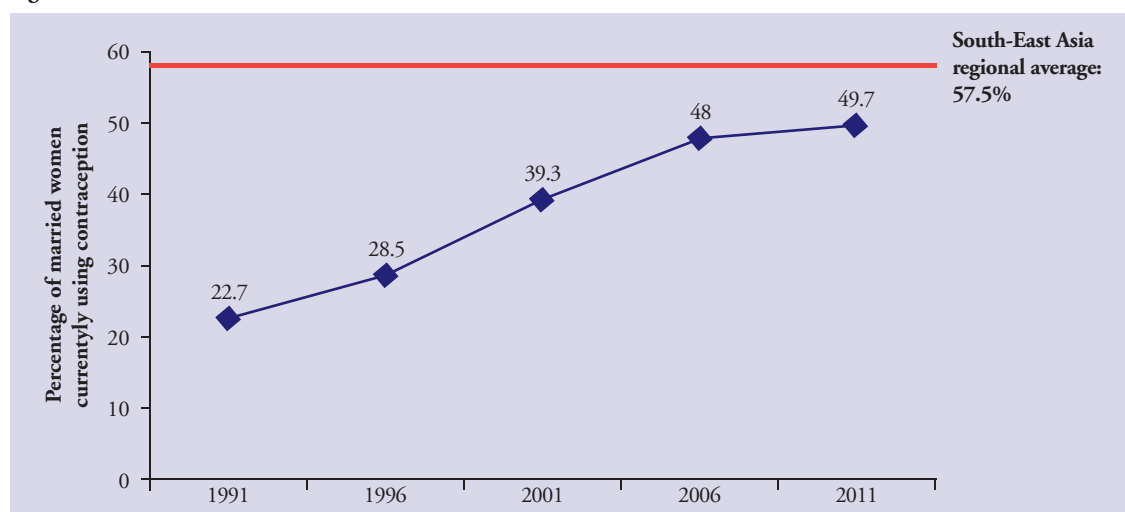
While the interregional differences within the country were minimal, the use of contraception by women residing in urban areas was significantly higher than by their rural counterparts. While over 54% of urban women in the reproductive age group were using a modern method of contraception, only 42% of rural women were doing so in 2006 (Figure 4).

Figure 5: Trends and urban-rural divide in modern contraceptive use



Source: Nepal DHS 2011 (Key findings).

Figure 6: Trends in CPR, 1991–2006



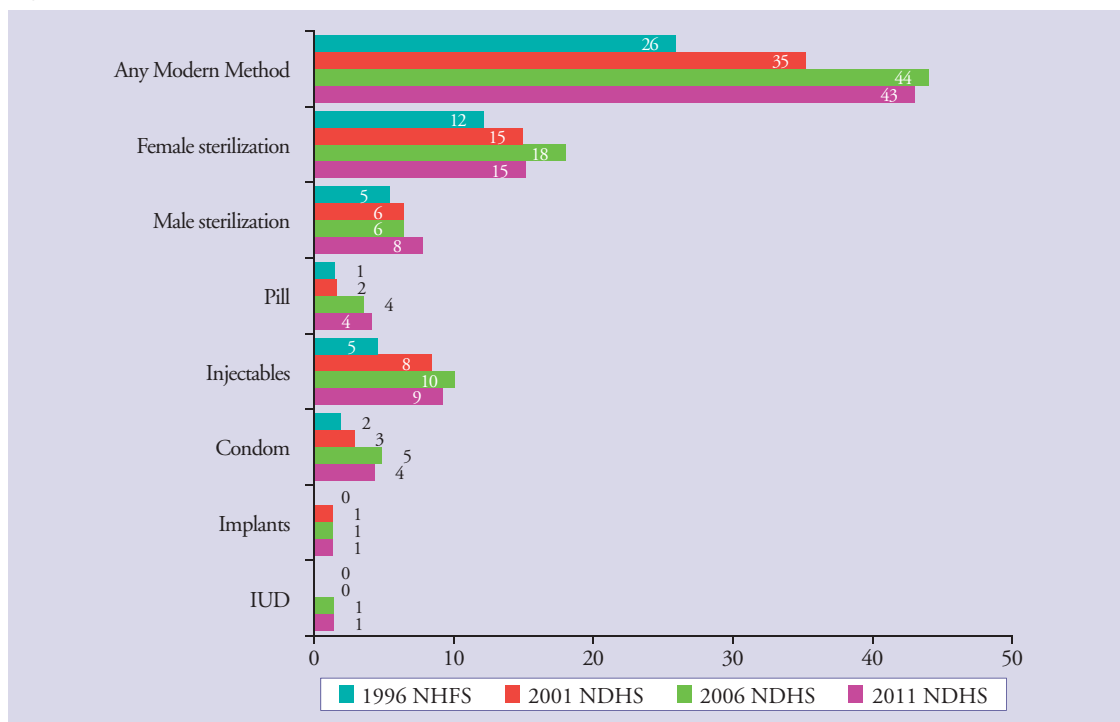
Source: Nepal DHS 2006 and 2011

## Contraceptive method mix

The method mix pattern observed in DHS 2006 and 2011 in Nepal was similar to the findings of DHS 2001. Permanent methods, that is, female and male sterilization accounted for more than half of the modern method mix (15% and 8%, respectively). Among temporary/spacing methods, injectable contraceptives were the method chosen by one fifth of all contraceptive users. As seen in figure 6, there has been an increasing acceptance of the pill over the years. While pills and condoms each accounted for contraceptive preferences of about 4% of all married women, IUDs and implants – despite showing an improving trend over the years – continue to find very few takers in the overall picture of contraceptive use mix in the country.



Figure 7: Trends in modern contraceptive method mix used by currently married women, 1996–2006



Source: Nepal DHS 2011 (Final report).

### Unmet need for contraception

As can be seen from Figure 7, almost 40% of all births in 2001 were the result of an unwanted pregnancy. The 2011 survey found that while the fertility rate was 2.6, the ideal family size for a Nepalese couple is about 2 children (2.1 for women and 2.3 for men).

About half of married women do not want any more children and, of these, 23% are already sterilized. Another 14% want to wait for at least 2 years before the next birth. Overall, about 27% of married women had an unmet need for family planning, signifying a minimal improvement from the 28% found in the 2001 survey. Of this, 10% have an unmet need for spacing the next birth for at least 2 years, while 17% have an unmet need for limiting the family size.

Figure 8: Proportion of wanted versus unwanted fertility in Nepal



Source: ORC Macro, 2007, MEASURE DHS STAT compiler. <http://www.measuredhs.com>, September 28, 2007.

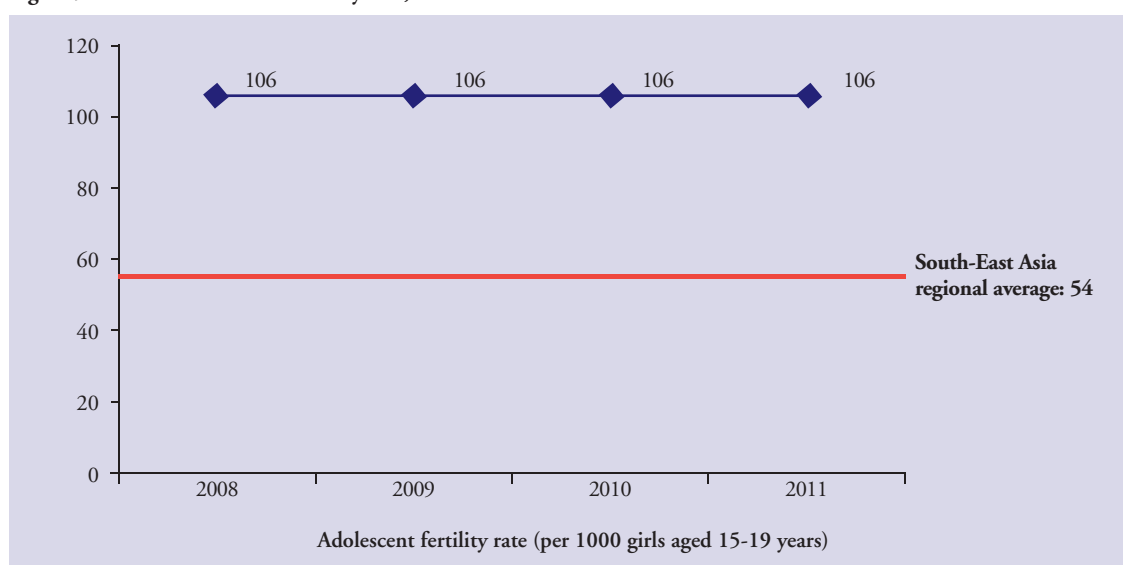


### Adolescent fertility

The adolescent fertility rate in Nepal is relatively high and the second highest, after Bangladesh, in the South-East Asia Region (Figure 8). According to DHS 2011, it stood at 81 births per 1000 girls aged 15–19 years, which although a reduction from 98 per 1000 as estimated in DHS 2006, is still high compared to the regional average of 54.

While the median age of girls at first birth is 20.2 years in Nepal, 23% of women aged 25–49 had given birth to their first child before they were 18 years of age, while 2% had become mothers before they were 15 years of age. According to DHS 2011, 17% of women aged 15–19 had either already had a baby or were pregnant with their first child.

**Figure 9: Trends in adolescent fertility rate, 2008–2011**



Source: World Health Statistics 2008, 2009, 2010 and 2011.

As most births take place within the realm of marriage, age at marriage is a very important determinant of age at first birth. The median age at marriage is gradually increasing in Nepal. DHS 2011 pegged the median age at marriage at 17.5 years for girls and 21.6 years for boys. More than half of girls (55%) are married before the age of 18. The median age at first sexual intercourse is 17.7 years for girls and closely follows their median age at marriage, thus signifying that for most girls sexual debut takes place within the context of marriage. However it is not so for the men, whose age at sexual debut is 20.5 years and is about a year before their marriage.

The relatively high teenage pregnancy rate is linked to the low use of contraception among married adolescents. Less than 18% of married girls in the age group 15–19 years were using a contraceptive according to DHS 2011. It needs to be mentioned that the unmet need for contraception at more than 41% (largely for spacing methods) is highest in this age group as compared to other age groups in the reproductive span.

### Access to family planning information and services

According to DHS 2011, knowledge of family planning methods is almost universal among Nepalese men and women, with 100% of currently married women and 99.8% of currently married men able to identify at least one method of contraception. Men and women were more familiar with



modern methods of contraception especially female sterilization, injectables, condoms and male sterilization. Relatively few men and women had heard about emergency contraception (39% and 29%, respectively). It is interesting to note that never-married men and women were more familiar with this method than currently married ones.

The public health sector is the largest provider of contraceptive services. For example, about four fifths of men and women in Nepal accessed the government health facilities for sterilization procedures, with the rest reaching out to hospitals run by nongovernmental organizations or the private sector. However, the private sector (hospitals and pharmacies) plays a larger role in the supply of product-based contraception such as pills, injectables and condoms.

## Current Family Planning Efforts

Family planning services have been available in Nepal for over 50 years. At the start of this millennium, the Government of Nepal set a goal to meet the health-related MDGs in the context of Nepal's country-specific challenges. In 2004, the Ministry of Health and Population committed themselves to the Nepal Health Sector Programme Implementation Plan phase 1 (NHSP-IP, 2004–2009), supported by 11 external development partners. This was extended and expanded in its second phase (NHSP-IP 2010–2015). The NHSP-IP focuses on reproductive, maternal and child health. The national family planning programme is an integral component of the same.

Due to inadequate funds as well as a loss of focus on family planning, the targets set for CPR and TFR have not been met. With an eye to reinvigorating family planning efforts, the Family Health Division of the Ministry of Health and Population is focusing on expanding the reach of family planning services through its chain of public health facilities such as primary health centres, health posts, subhealth posts, primary health centre outreach clinics and mobile surgical contraception camps. Satellite clinics have been initiated in all districts. Community health volunteers provide family planning counselling services and also act as depot holders of family planning products.

The public health sector is supported by various nongovernmental organizations such as Marie Stopes and the Family Planning Association of Nepal. A vibrant private sector that includes not just private clinics and hospitals, but also pharmacies, is also involved in the provision of family planning services and products. For example, the Sangini Franchising Network provides injectable contraceptives (local brand name: Sangini-Tin Mahine Sui) through a network of pharmacies present in all 75 districts of Nepal.

Other special efforts include the postpartum intrauterine contraceptive device programme launched by the Government of Nepal to meet the special demands of postpartum women. The pilot programme was implemented in six hospitals (five government and one private) in June 2011, and is now in the process of expanding through private-sector facilities nationally.

## Challenges and Opportunities

1. **Sustaining the programme momentum:** The massive increase in CPR between 1996 and 2006 and concomitant reduction in TFR can be credited to the efforts of the Government of Nepal and non-governmental partners. However, the slight decline in CPR between 2006 and 2011 reflects a loss of momentum of the programme. Political will, with a focus on ensuring adequate fund allocation to the family planning effort, will go a long way in sustaining and building on previous efforts.





2. **Access to information and services:** Despite universal awareness about family planning efforts, uptake remains relatively low and there is a high unmet need. The Government, with support from non-governmental organizations and the private sector, needs to expand the reach of family planning products and services. The relatively recent initiatives by the Government of Nepal to provide family planning services through satellite and mobile clinics, as well as using community health volunteers as distributors of family planning products, provide the ideal platform to expand the reach of services to cover women even in the lowest wealth quintile.
3. **Appropriate method mix:** Like in many other countries in the South-East Asia Region, there is a high reliance among Nepalese couples on sterilization as a family planning method. Data show that a large proportion of women undergo sterilization after their third or fourth child, which does not have much impact on reduction in fertility rates and population stabilization. Focus on spacing methods, including relatively long-term spacing methods such as IUDs and implants, will go a long way towards population stabilization. It will also contribute to reduction in maternal and child mortality by increasing the inter-pregnancy gap.
4. **Adolescent fertility:** The gradual increase in age at marriage and age at first birth is an encouraging trend. The Government of Nepal, through its efforts to expand the reach of family planning services, has to focus on the special needs of both married and unmarried adolescents as unmet need for contraception is very high in the teenage group. In addition, as sexual activity among men begins before marriage, educating young boys about responsible sexual behaviour and increasing their access to contraceptives will contribute towards a reduction in overall fertility.

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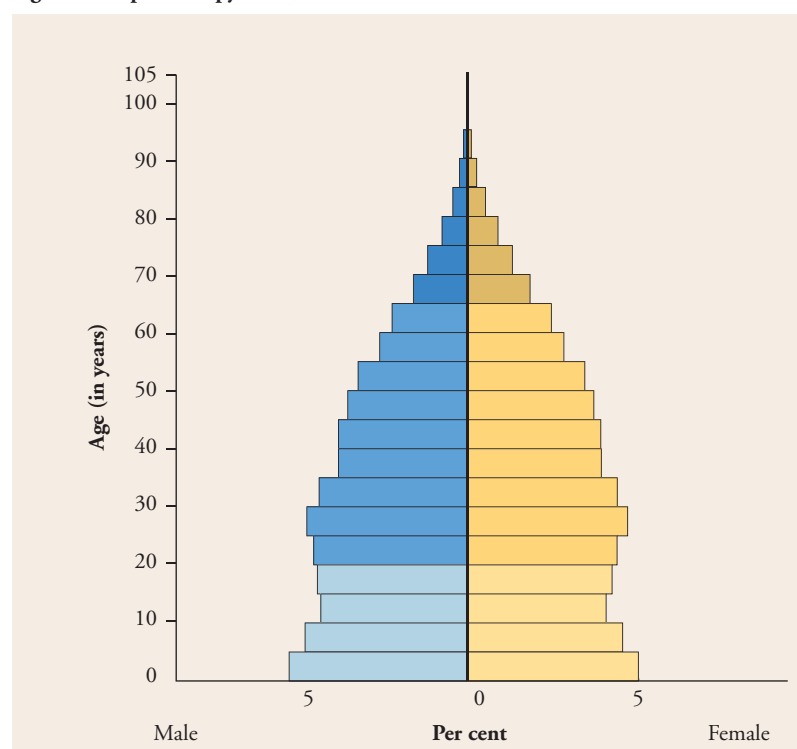
# Sri Lanka and Family Planning: An overview



## Background

Sri Lanka is an island country that has made heavy investments in the public health system to ensure the access of primary health care to the majority of the population. The results of this are seen in the form of a steep reduction in mortality rates, especially maternal and infant mortality, along with a decline in fertility rates. Nonetheless, as can be seen from the population pyramid (Figure 1), about 25% of Sri Lanka's population are below the age of 15 years, and therefore have yet to enter the reproductive lifespan (Population Reference Bureau, 2012).

Figure 1. Population pyramid, 2010



Source: Population Projections 2010.

## Situation Analysis

The Government of Sri Lanka began its programmatic initiative into the family planning arena in 1965, when family planning was integrated with the national maternal and child health programme. The national population policy was formulated in 1977 and focused on population reduction as a means to sustainable development.

The first Sri Lanka DHS was carried out in 1987, followed by two more in 1993 and 2000. The latest DHS was conducted in 2006–2007, in which the respondents were ever-married women 15–49 years of age and children under the age of 5 years. This survey is not reflective of the Northern Province of Sri Lanka,

as no data collection could be done in the area due to unsettled political conditions. Comparison to the previous DHS in 2000 also needs to be made with caution, as DHS 2000 did not capture the Eastern Province.



The overall situation is shown by relevant indicators in Table 1.

**Table 1: Key indicators**

Total population (in millions), 2012	20.3
Population growth rate, 2012	0.9%
Population density (people per square km), 2012	324
Urban population, 2012	18.3%
Population <15 years of age, 2012	25.2%
Total fertility rate, 2006–2007	2.3
Contraceptive prevalence rate, 2006–2007	68%
– Female sterilization	16.9
– Male sterilization	0.7
– Pill	7.9
– IUD	6.3
– Injectable	15
– Norplant	0.3
– Male condom	5.5
–LAM	0.1
–Periodic abstinence	9.6
– Withdrawal	5.5
– Folk method	0.1
Unmet need	7.3%
- Spacing	3.5
- Limiting	3.8
Median age at first marriage, 2006–2007	23.3
Median age at first birth, 2006–2007	25.1
Crude birth rate (per 1000 population), 2012	17.5
Maternal mortality ratio (per 100000 live births), 2012	37.7
Infant mortality rate(per 1000 live births, 2012)	9.2
HIV adult prevalence (age 15–49 years), 2012	<0.1%

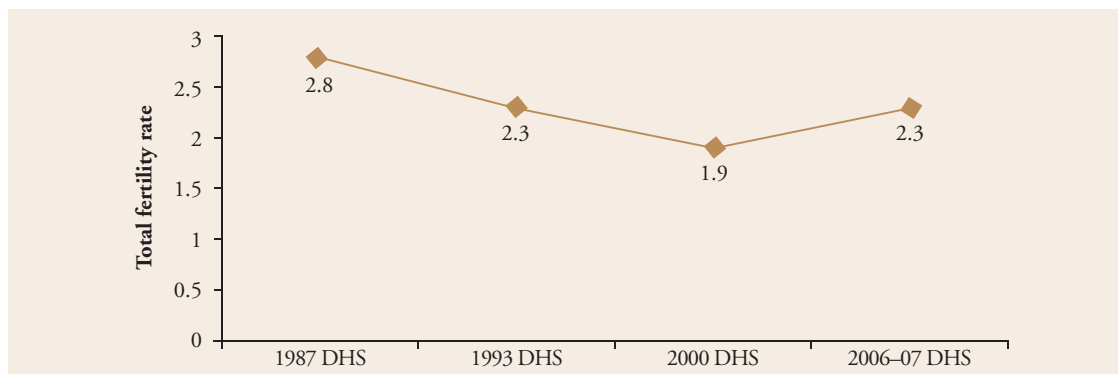
Source: Sri Lanka Statistical Data Sheet 2013; Census of Population and Housing 2012; Sri Lanka DHS 2006-07

### **Total fertility rate (TFR)**

The TFR of Sri Lanka (excluding the Northern Province) as measured in 2006–2007 was 2.3. According to more recent data published by the Population Reference Bureau in 2012, the TFR has further reduced to 2.2. DHS 2006–2007 showed a geographical variation in the TFR, with estate areas showing the highest levels (2.6), followed by rural areas (2.4) and urban areas (with a TFR of only 2.2). As can be seen from Figure 2, the TFR has shown a significant reduction from close to 8 in the 1970s to almost replacement levels in current times.



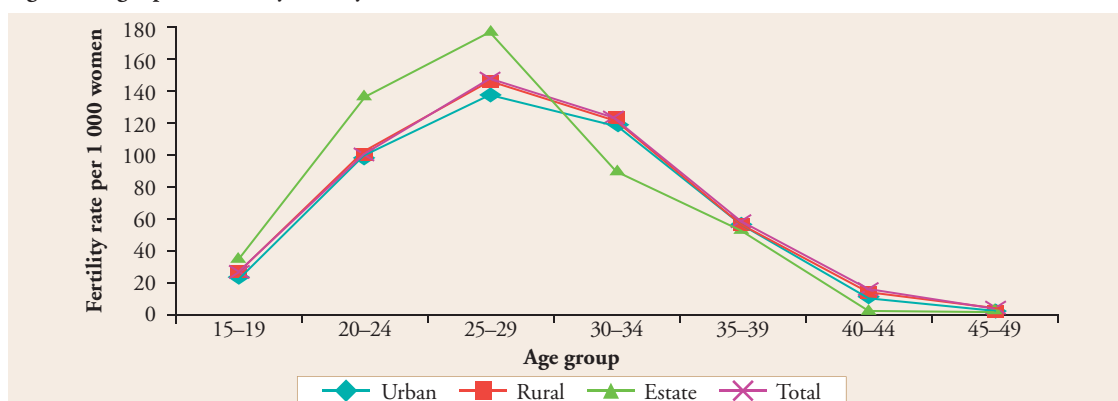
Figure 2. Trends in TFR, 1980–2006



Source: Sri Lanka DHS 1987, 1993, 2000 and 2006–2007 <http://www.statistics.gov.lk/social/DHS%20200607%20FinalReport.pdf>

A study of age-specific fertility rates shows that childbearing begins relatively late in Sri Lanka, with maximum fertility seen in women in the age group 25–29 years (Figure 3). The trends in age-specific fertility rate across urban and rural areas are very similar, as can be seen by the almost overlapping lines in the graph. However, childbearing for women living in the estate areas not only starts relatively early, but also shows a steep decline at the age of 30 years and beyond.

Figure 3. Age-specific fertility rates by residence, 2006–2007



Source: Sri Lanka DHS 2006–07.

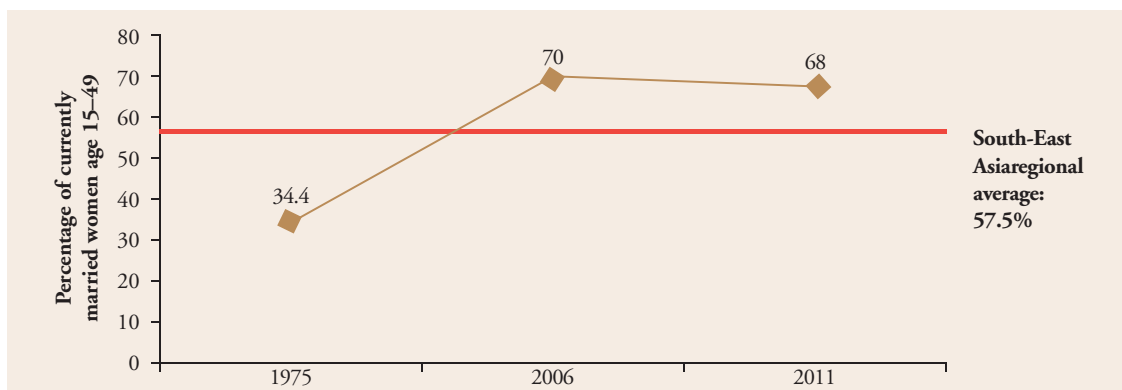
## Contraceptive prevalence rate (CPR)

Most Sri Lankan women in the reproductive age group are currently using contraceptives. The decline in TFR is linked to a gradual rise in CPR, from about 35% in 1975 to 68% in 2006–2007. A comparison of two consecutive DHS data shows a slight reduction in CPR of about 2 percentage points between 2000 and 2006 (Figure 4).

Contraceptive use varies with age and with other demographic factors, such as place of residence. Figure 5 shows that the proportion of women using contraception rises with increasing age up to the age of 40 years, after which a declining trend is seen. Unlike other countries in the South-East Asia Region, contraceptive use is relatively more prevalent among rural women (70%) compared to women living in estate areas (64%). Out of the three areas, urban women are the least likely to use contraception (59%) (Figure 6). There is a gradual declining trend in contraceptive use concomitant with increasing education levels of women up to GCE Ordinary Level, following which an increase in use is seen. Women with three or four children are the most likely to use contraception. Even about one-fifth of women with no living children use contraception, reflecting a social trend towards the delaying of first pregnancy.

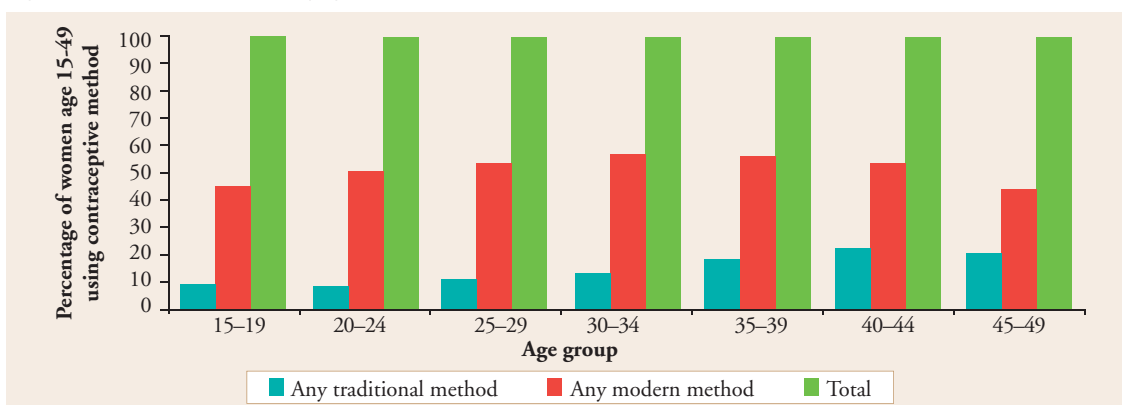


Figure 4. Trends in CPR, 1975–2011



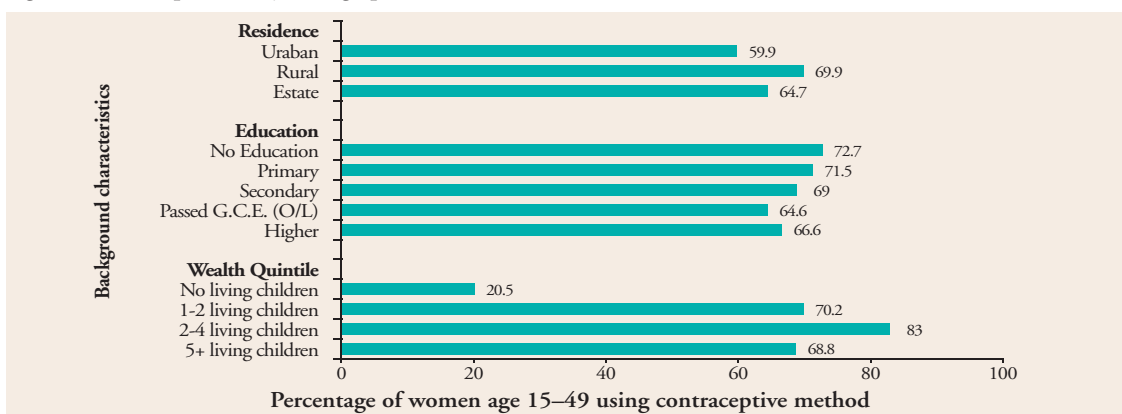
Sources: Sri Lanka DHS 2006–2007; World Health Statistics 2006 and 2011.

Figure 5. Contraceptive use by age group, 2006–2007



Source: Sri Lanka DHS 2006–2007.

Figure 6. Contraceptive use by demographic factor, 2006–2007



Source: Sri Lanka DHS 2006–2007.

### Contraceptive method mix

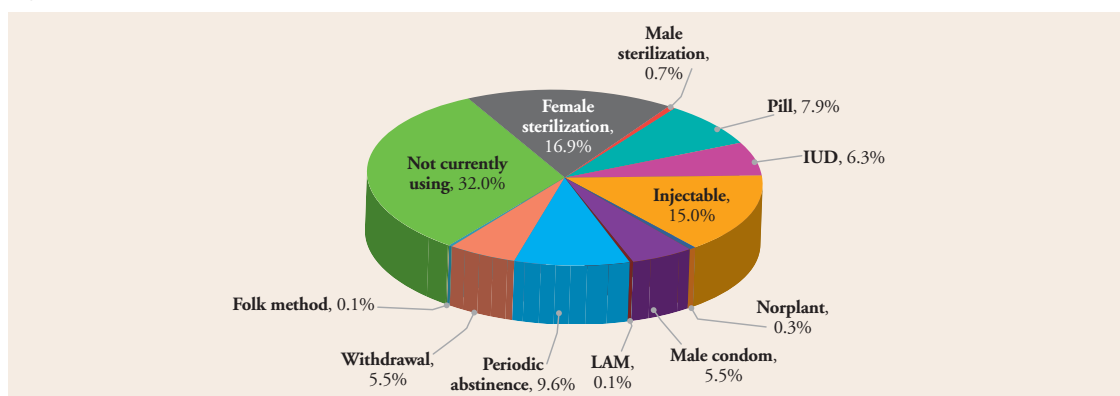
Of the 68% of currently married women using a contraceptive in 2006–2007, about 15% were using a traditional method while the remaining 53% were using a modern method of contraception. It is also clear from Figure 8 that the reduction in overall CPR between DHS 2000 and DHS 2006–2007 is due to a reduction in the use of traditional methods, as the use of modern contraceptive methods during the same period actually increased from 49.5% to 52.5%.



Despite a relatively steep drop in the proportion of women accepting female sterilization, from 23% in 2000 to about 17% in 2006, it still continues to be the most popular contraceptive method chosen by Sri Lankan women. An increasing proportion of women are opting for injectable hormonal contraceptives, and it is now the second most prevalent method in the country, used by 15% of married women.

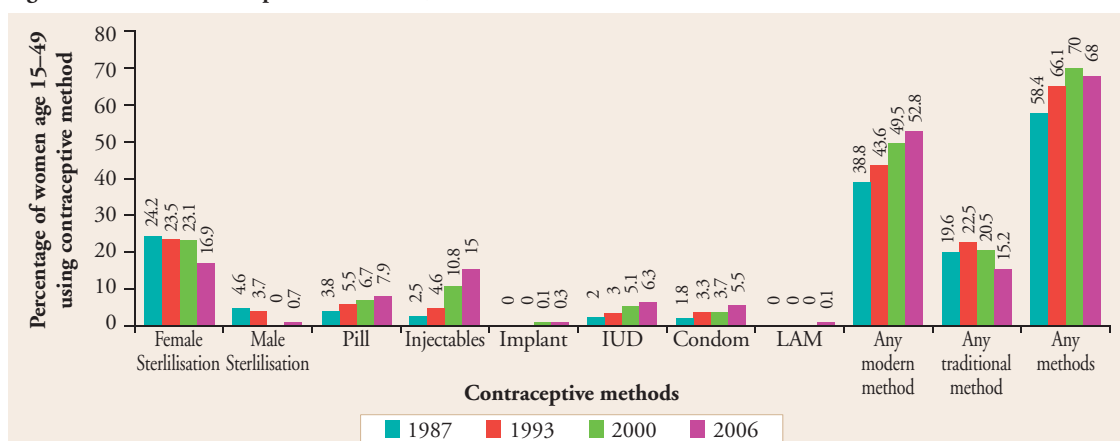
For male-centric methods, while condom use shows a gradual increase over the years, the acceptance of male sterilization is gradually losing ground and only 0.7% of women stated in 2006 that they were relying on the latter as their contraceptive method of choice.

Figure 7. Contraceptive method mix, 2006–2007



Source: Sri Lanka DHS 2006–2007.

Figure 8. Trends in contraceptive method mix, 1987–2006



Source: Sri Lanka DHS 1987, 1993, 2000 and 2006–2007.

## Unmet need for family planning

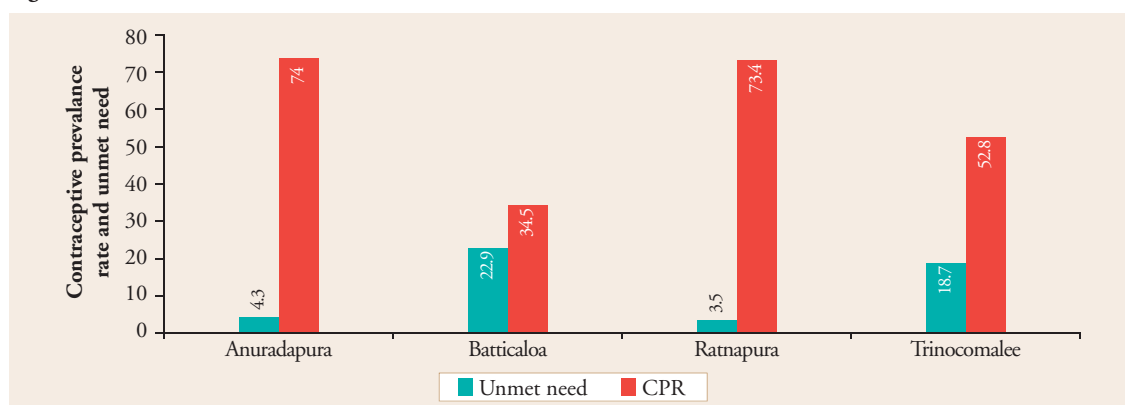
DHS 2006–2007 reflects relatively low levels of unmet need, which is in tandem with the relatively high levels of contraceptive use. Overall, 7.3% of married women had an unmet need for family planning. Of this, about half (3.5%) was for spacing the pregnancy and childbirth, while the rest (3.8%) was for limiting the family size. This correlation between CPR and unmet need is clearly reflected in Figure 9. Districts such as Anuradhapura (North Central Province) and Ratnapura (Sabaragamuwa Province) that have relatively high CPRs of 73–74% also have low unmet need of 3–5%. In contrast, districts such as Batticaloa and Trincomalee (both in the Eastern Province) that have some of the lowest CPRs in the country also have high levels of unmet need at about 23% and 19%, respectively.



The relatively low levels of unmet need can also be understood by comparing the fertility preferences of women with the CPR. As seen in Figure 10, about 78% of women either want to delay having another child for at least 2 years, or do not want any more children. As over 68% of the women are already using contraceptives, it follows that unmet need levels in the country are less than 10%.

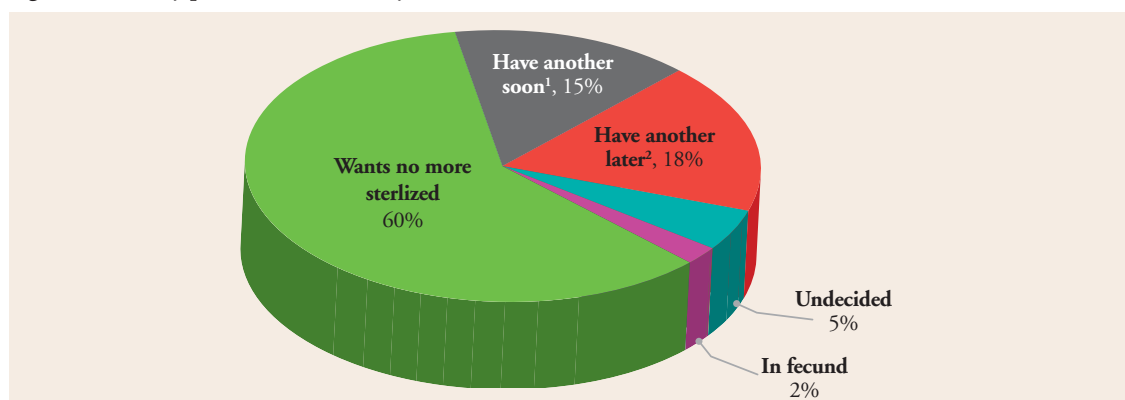
DHS 2006–2007 also shows that the unmet need for family planning is highest among women in the age group of 35–49 years. Following this information, the Family Health Bureau has now started to integrate family planning services to reach older women through the Well Women's Clinics programme.

Figure 9. Correlation between CPR and unmet need in four districts, 2006–2007



Source: Sri Lanka DHS 2006–2007.

Figure 10. Fertility preferences of currently married women, 2006–2007



Source: Sri Lanka DHS 2006–2007.

### Adolescent fertility

Sri Lanka is one the leading countries in Asia as far as delaying first marriage for women (and therefore first birth) is concerned. Even as early as 1901, the mean age at first marriage was 18.3 years. By the mid-seventies, most Sri Lankan girls were getting married not at puberty, but a decade later. By 2000, only 7% of girls aged 15–19 years were married (The Journal of Family Welfare, 2000).

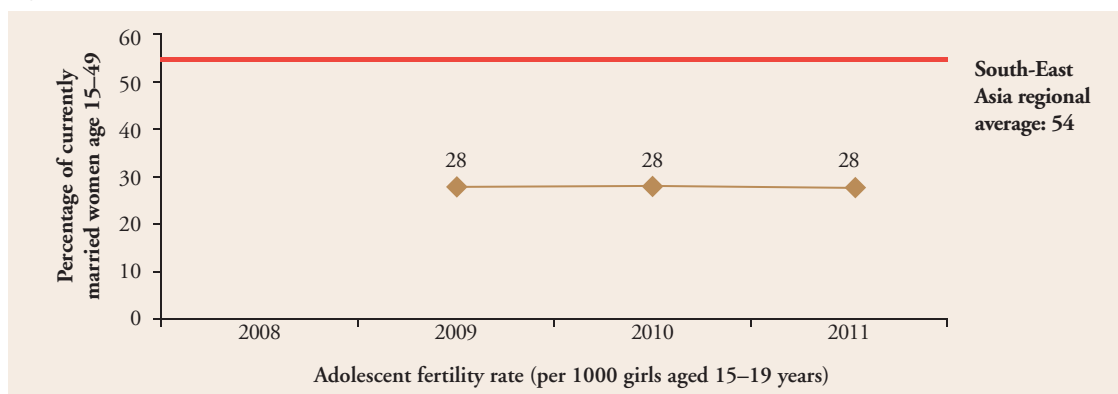
This custom of delaying marriage, and the fact that most childbearing in Sri Lanka occurs within the context of marriage, can explain the relatively low adolescent fertility rates, especially when compared to neighbouring countries in the South-East Asia Region.

<sup>1</sup>Wants next birth within 2 years

<sup>2</sup>Wants to delay next birth for 2 or more years



Figure 11. Trends in adolescent fertility rate, 2008–2011



Source: World Health Statistics 2008, 2009, 2010 and 2011.

### Access to family planning information and services

DHS 2006–2007 showed that knowledge of contraception is almost universal in Sri Lanka. More than 97% of women knew about the pill and injectable contraceptives as potential methods to prevent pregnancy. On the other hand, relatively fewer women were aware of “newer” and “less available” methods such as female condoms and implants. Only a third of the women knew about

emergency contraception, reflecting a great need to educate people about the same.

Table 2. Awareness of ever-married women about contraceptive methods, 2006–2007

Method	Percentage of women who know about method
Female sterilization	94.5
Male sterilization	74.0
Pill	97.5
IUD	90.1
Injection	97.3
Norplant	47.7
Male condom	82.5
Female condom	16.6
LAM	38.9
Safe period	66.7
Withdrawal	67.4
Emergency contraception	33.8

Source: Annual Health Statistics, 2006.

this programme was integrated with the maternal and child health programme of the Ministry of Health. In 1975, the country carried out its first fertility survey under the aegis of the Registrar General that revealed a CPR of 34.4% (Reproductive Health and Family Planning Programme in Sri Lanka, 2009).

In 1979, the management of the family planning programme was shifted to the Population Division of the Ministry of Plan Implementation. While this shift provided the much needed thrust and focus to family planning efforts in the country, it also led to de-linking of the programme from other maternal and child health efforts. Following ICPD, in 1995, the control of the family planning

### Current Family Planning Efforts

Family planning efforts in Sri Lanka date back to the 1950s, with the establishment of the Family Planning Association. A survey conducted in 1958 by the Government of Sri Lanka, with support from the Government of Sweden, revealed no religious opposition to family planning and a high latent demand for contraception among married couples. This, coupled with rising youth unemployment rates due to the population increase, led the Government to formally launch the family planning programme in 1965. Even 30 years before ICPD,





programme was back with the Family Health Bureau under the Ministry of Health. The current family planning programme is embedded in the national Maternal and Child Health Policy and involves the delivery of a complete package of services as defined under reproductive health.

Enabling all couples to have the desired number of children, with optimal spacing, while preventing unwanted pregnancies, is an important goal of the Maternal and Child Health Policy. The strategies for achieving this goal are given below (Family Health Bureau).

1. Ensuring availability of, and accessibility to, quality modern family planning services.
2. Addressing the unmet need for contraception.
3. Ensuring availability of sterilization services in institutions.
4. Establishing an appropriate system for post-abortion care.
5. Ensuring the uninterrupted availability of contraceptive commodities (Reproductive Health Commodity Security).
6. Strengthening, rationalizing and streamlining services for subfertile couples.

## Challenges and Opportunities

1. **Reaching the unreached pockets:** The survey data reveal significant geographic variation in family planning services. Even within geographic areas, certain ethnic groups have reduced access to services. The Government of Sri Lanka needs to identify such populations and ensure a more equitable distribution of services.
2. **Logistic management:** Ensuring a regular supply of contraceptives has been a long-standing challenge in Sri Lanka. The introduction of Reproductive Health Commodity Security, as an important element in maternal and child health programme strategy, provides the right platform to solve this problem.
3. **Focus on adolescents:** Even though early marriage and adolescent fertility rates are significantly low in Sri Lanka, the programme needs to focus on other reproductive health needs of this population group, including provision of life skills education.
4. **Gender equity:** Data show that the burden of family planning lies largely with women and that the uptake of male-centric contraception methods is relatively low. The current programme states that ensuring gender equity is an important policy goal, and thus can be the base for ensuring male participation in the programme.
5. **Sustainability:** Sri Lanka has come a long way in increasing the CPR and reducing the TFR of the country. With the integration of family planning efforts with larger reproductive health effort, the Government of Sri Lanka needs to ensure that programmatic focus on family planning is further strengthened and not lost in the provision of a broader spectrum of services.

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# Thailand and Family Planning: An overview

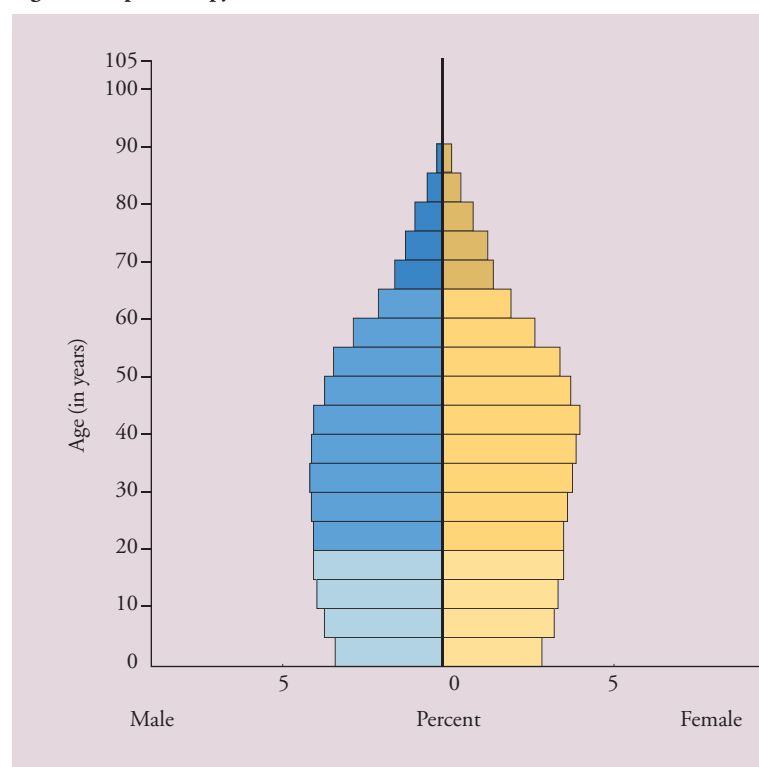


## Background

The Thai mainland is bordered by Cambodia, Lao People's Democratic Republic, Malaysia and Myanmar; the country also includes hundreds of islands. According to the 2010 Thai census report, the population is 65.98 million (The 2010 Population and Housing Census). It is also one of few countries in the South-East Asia Region where the female population (33.63 million) marginally exceeds the male population (32.35 million). The population is unevenly spread across the country, with the capital Bangkok being the most densely populated region.

The success of the family planning programme in Thailand is acknowledged worldwide. The population pyramid seen in Figure 1 shows a smooth distribution of the population across age groups, which is typical of populations that have not only managed to tackle issues related to excessive fertility, but have also made tremendous progress in terms of health improvement and increased life expectancy.

Figure 1: Population pyramid, 2010



Source: UN Population Projections 2010.

## Situation Analysis

Thailand introduced its first population policy in 1970, and it is one of the most successful programmes in the South-East Asia Region. The programme has moved beyond a focus on family planning to include other vital components of reproductive health. In 2006 and 2009, the National Statistical Office of Thailand in collaboration with the Reproductive Health Division of the Department of Health, conducted special surveys focused on various aspects of reproductive health of the population (Reproductive Health Survey, 2009). Earlier fertility-related surveys were conducted in 1975, 1985 and 1996.



The relevant demographic and health indicators are presented in Table 1.

**Table 1. Key indicators**

Total population (in millions), 2010	65.98
Population growth rate, 2000–2010	0.8%
Population density (people per square km), 2010	127.5
Urban population, 2010	45.7%
Population <15 years of age, 2010	19.8%
Total fertility rate (TFR), 2011	1.5
Contraceptive prevalence rate (CPR), 2009	79.6%
– Pills	35
– Injectable	14
– Implants	0.4
– IUD	0.8
– Female sterilization	23.7
– Condom	2.3
– Emergency contraceptive pill	0.3
– Traditional or natural methods	2.2
Unmet need, 2001	1.2%
– For spacing births	0.9
– For limiting births	0.3
Average age at first marriage (in years), 2009	22.2
Average age at first birth (in years), 2009	24.8
Crude birth rate (per 1000 population), 2011	12.4
Maternal mortality ratio (per 100 000 live births), 2010	31.8
Infant mortality rate (per 1000 live births), 2012	11
HIV adult prevalence, 2001	1.8%
HIV prevalence among female sex workers, 2010	2.82%
HIV prevalence among indirect female sex workers, 2010	2.05%
HIV prevalence among male sex workers, 2010	21.0%
HIV prevalence among pregnant women, 2010	0.7%
HIV prevalence among blood donors, 2010	0.17%
HIV prevalence among intravenous drug users, 2010	26.0%
HIV prevalence among fishermen, 2010	2.52%

Source UN/IGME, *Levels & trends in child mortality Report 2013*, [http://www.childinfo.org/files/Child\\_Mortality\\_Report\\_2013.pdf](http://www.childinfo.org/files/Child_Mortality_Report_2013.pdf);  
Trends of maternal mortality 1990–2010 World Health Organization

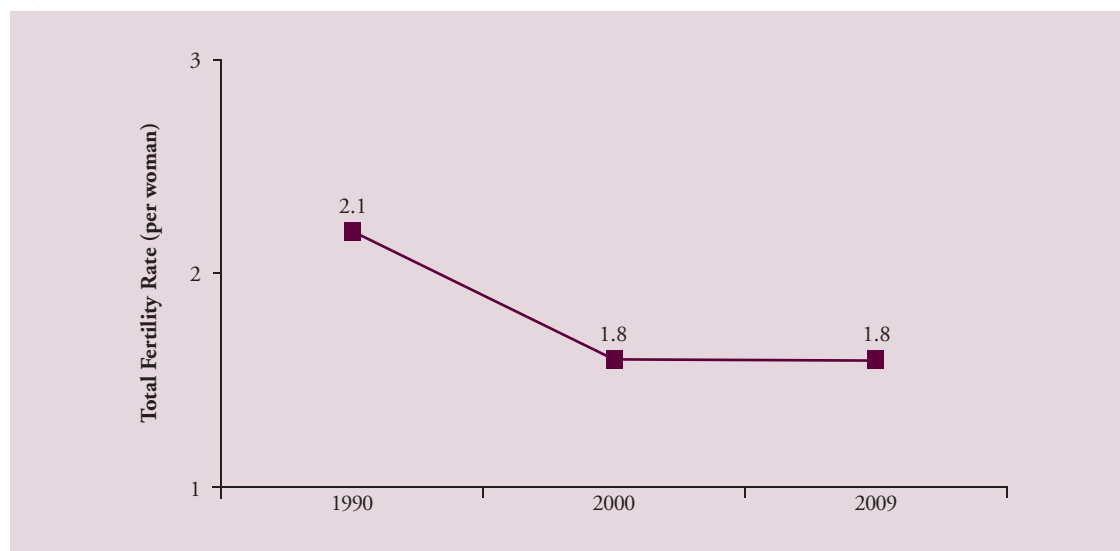
### Total fertility rate (TFR)

The Reproductive Health Survey (RHS) 2009 revealed that the average number of children ever born for women aged 15–49 years was 1.30 per women, which was slightly higher than the 1.23 found in the 2006 survey. There was a slight difference between municipal and non-municipal areas, with the former showing lower fertility rates of 1.11 compared to 1.40 in non-municipal areas. Thailand is amongst the countries that largely maintained TFR (Figure 2) though non-significant slight variations were noted between results of 2006 and 2009 survey.



Thailand is also one of few countries in the South-East Asia Region where the actual fertility is lower than the wanted fertility. In RHS 2009, ever-married women aged 15–49 years wanted 1.93 children, but actually had 1.67 children on average. There was an interregional difference in these levels, with women in the Southern region wanting the highest number of children (2.33) and Bangkok the lowest (1.69). Similarly, older women had slightly higher wanted fertility than younger women, suggesting declining fertility norms.

**Figure 2: Trends in TFR, 1990–2009**



Source: World Health Statistics 2011.

### Contraceptive prevalence rate (CPR)

The low fertility rates in Thailand can be directly attributed to the high rates of contraceptive usage by women in the reproductive age group. According to RHS 2009, 79.6% of married women aged 15–49 years were using some method of contraception. This represented a slight decline from the 81.1% found in the 2006 survey. However, as seen in Figure 3, the World Health Statistics 2011 report that CPR is back to over 81%.

**Figure 3: Trends in CPR, 2005–2011**

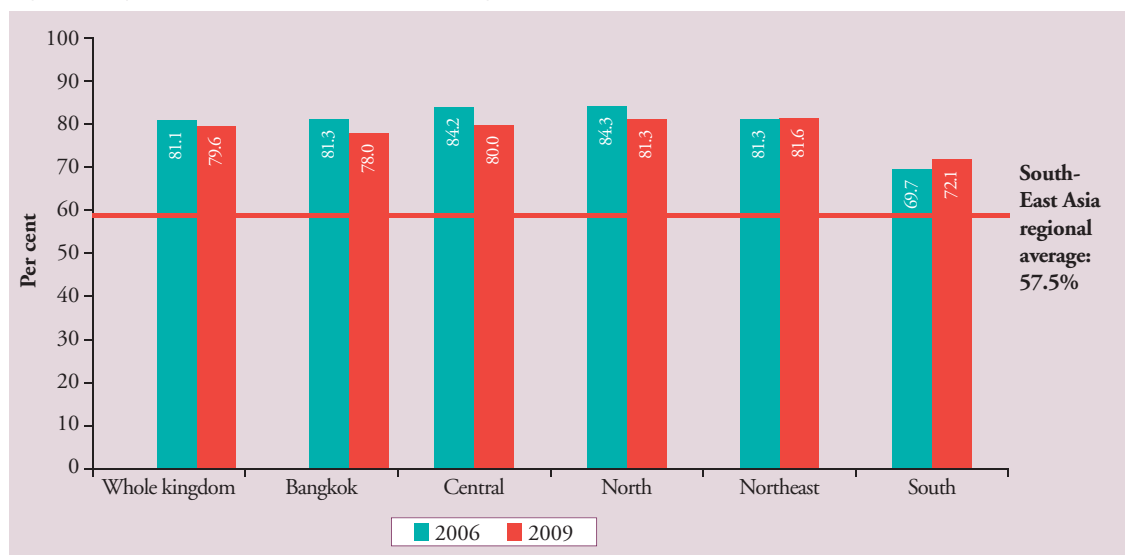


Source: World Health Statistic 2005, 2007 and 2011.



Figure 4 shows that contraceptive usage rates by married women are close to 80% in almost all regions of Thailand; the Southern region is an exception, with a CPR of only 72%. Nonetheless, it is encouraging to note that while national figures and those for all the regions show declining rates from 2006 to 2009, the Southern region is the only one to show an increase in CPR during this timeframe.

**Figure 4: Regional differences in CPR for women aged 15–49 years, 2006 and 2009**



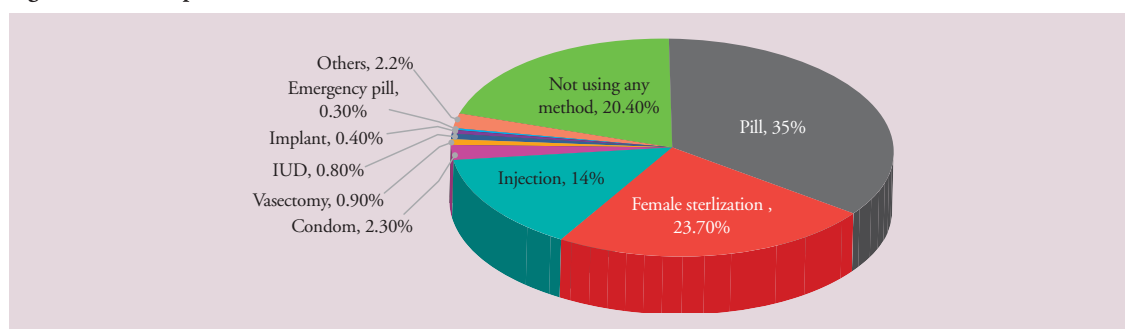
Source: National Statistical Office, Thailand. Key Findings: Reproductive Health Survey. Department of Health, Ministry of Public Health, Government of Thailand. Bangkok: s.n., 2009

### Contraceptive method mix

Almost all women in Thailand that use contraception are relying on a modern method. The proportion of women using a traditional method of contraception has hovered around 2% for the past 25 years or so. In 2009, among the 2.2% of women using traditional methods, 1.7% relied on periodic abstinence and 0.5% used other traditional methods.

The pill continues to be the most preferred contraceptive method, with more than one third (35%) of women relying on the same (Figure 5). About 24% of women used female sterilization as their contraceptive method of choice. Despite a thriving commercial sex market in Thailand, condom usage was relatively poor at only 2.3%. As shown in Figure 6, the increase in the use of the pill over the years has resulted in a proportionate decline in the usage of IUDs and male vasectomy as contraceptive methods.

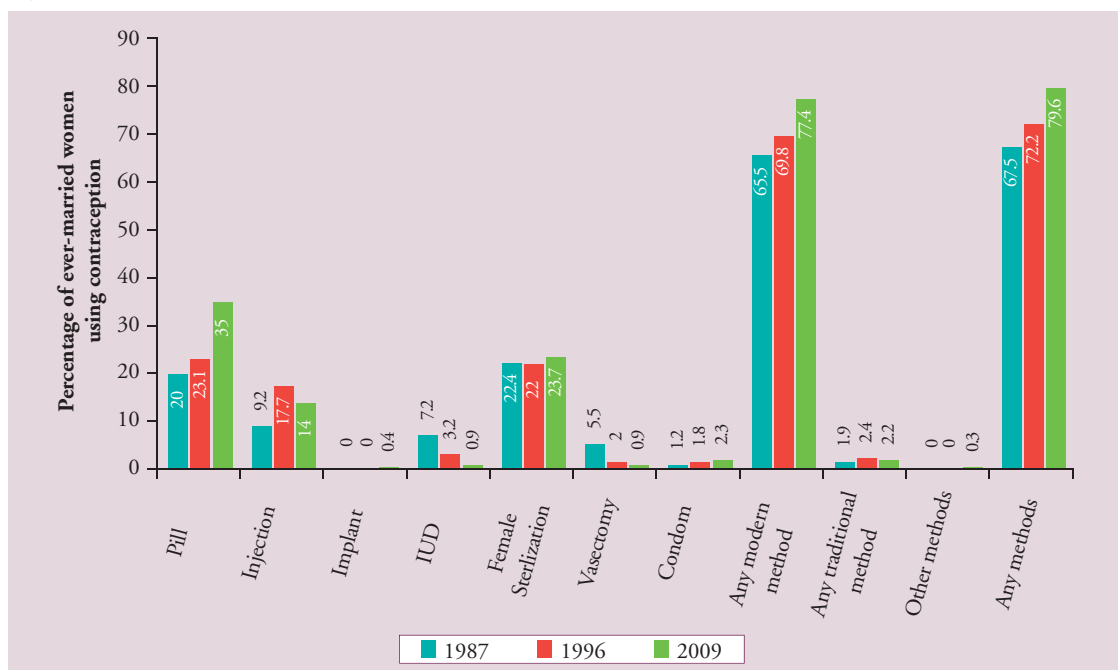
**Figure 5: Contraceptive method mix, 2009**



Source: National Statistical Office, Thailand. Key Findings: Reproductive Health Survey. Department of Health, Ministry of Public Health, Government of Thailand. Bangkok: s.n., 2009



Figure 6: Trends in contraceptive method mix



Source: Fertility surveys 1985, 1996, RHS 2009

## Unmet need for family planning

According to RHS 2009, 16.2% of ever-married women aged 15–49 years with an infant reported that their last pregnancy was unintended. Of these, 5.5% had wanted to delay the last pregnancy and 10.7% wanted to limit their family size. On disaggregating the data by age, the rate of such unintended pregnancies was nearly twice this level in girls aged 15–19 years.

However, in the Thai context, where the access to contraceptive services is almost universal, rates of unintended pregnancies cannot be directly extrapolated as unmet need. On the contrary, this survey clearly showed that most of these pregnancies were due to contraceptive failure (such as due to women forgetting to take the pill or missing an appointment for contraceptive injection). Even in the adolescent age group, only 25.6% stated that the unwanted pregnancy resulted because they had planned on having sex, thus reflecting some degree of “unmet need” for this age group.

## Adolescent fertility

The adolescent fertility rate in Thailand is much lower than the regional average, and is declining further (Figure 7). The mean age at first birth is 23.3 years. Only 16% of all births in Thailand are to mothers aged less than 20 years (Figure 8). There are many reasons for this, some of which are listed below.

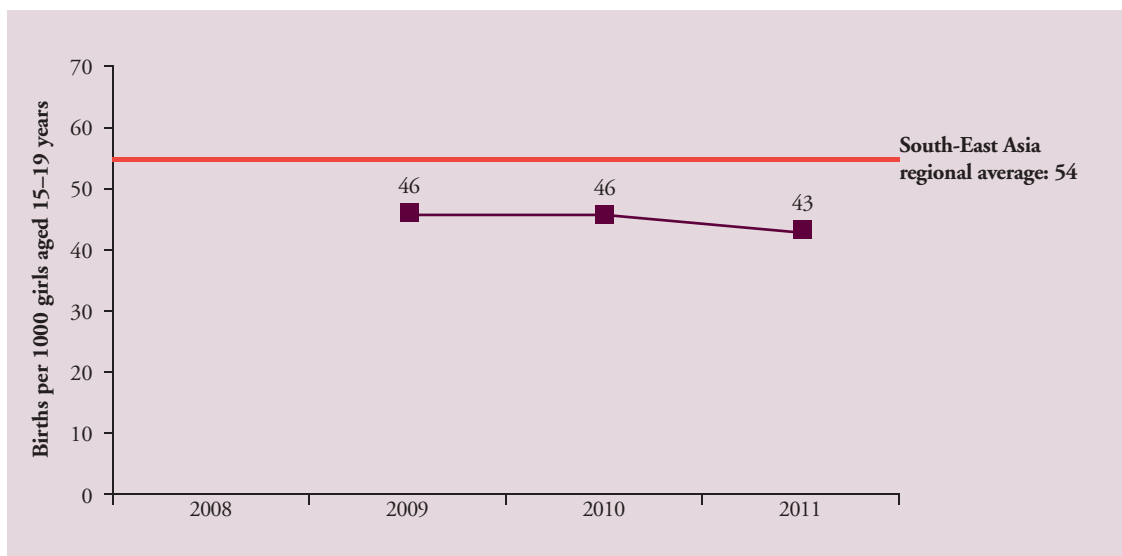
- **Delayed marriage:** According to RHS 2009, the mean age at first marriage was 22.2 years. Even though this represents a slight decrease over the 2006 results, it is much higher than in other countries of the Region (Figure 9).
- **High use of contraceptives among youth (aged 15–24 years):** About 83.5% and 70.3% of currently married and ever-married youth, respectively, have used contraceptives. Even 16.2% of never-married adolescents acknowledge having used a contraceptive. Of the young people



who use contraceptives, 91.9% used them during their last sexual intercourse reflecting that contraceptive use is a “regular” practice for them when indulging in sex. This figure is even higher (98.8%) among “single” adolescents.

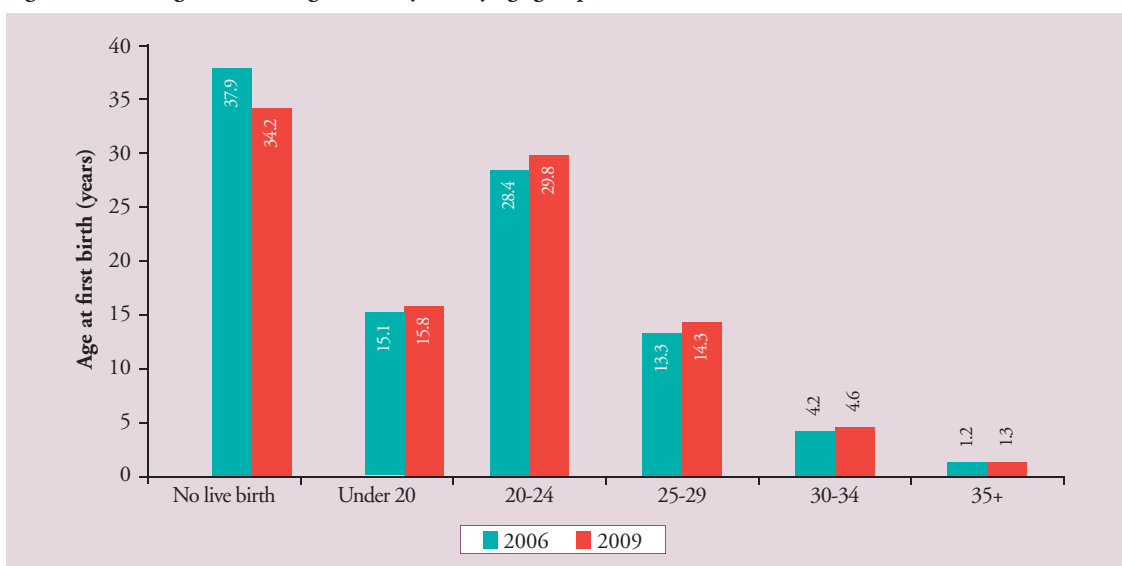
- Reproductive health education: The 2009 survey revealed that 85.2% of youth aged 15–24 years had received some formal instruction in sex education, family planning and reproductive tract infections. Most of them had received this information while at school.

**Figure 7: Trends in adolescent fertility rate, 2008–2011**



Sources: World Health Statistics 2008, 2009, 2010, 2011.

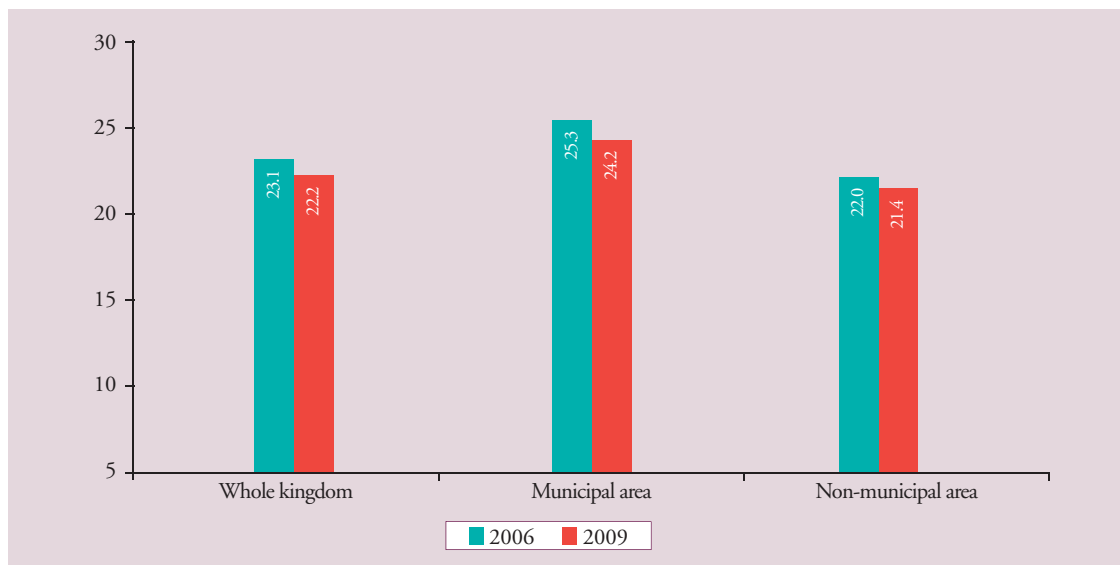
**Figure 8: Percentage of women aged 15–49 years, by age group at first birth**



Source: National Statistical Office, Thailand. Key Findings: Reproductive Health Survey. Department of Health, Ministry of Public Health, Government of Thailand. Bangkok: s.n., 2009



Figure 9: Mean age of women at first marriage, 2006 and 2009



Source: National Statistical Office, Thailand. Key Findings: Reproductive Health Survey. Department of Health, Ministry of Public Health, Government of Thailand. Bangkok: s.n., 2009

## Current Family Planning Efforts

Thailand officially launched its family planning programme in 1971, with the release of the national Population Policy. The next 15 years saw an impressive halving of the growth rate from 3.2% to 1.6%. The success and sustainability of the programme can be attributed to factors and initiatives, as follows.

- **Innovative family planning campaigns:** Tying up with the Population and Community Development Association, a large non-governmental organization, the Department of Health launched one of the acclaimed marketing and distribution campaigns for contraceptives.
- **Increasing the basket of choice:** Thailand was the one of the first few countries globally to introduce the use of injectable contraceptives on a large scale. It also conducted revolutionary research into simpler and quicker methods for female sterilization, such as minilap, and was a pioneer in no-scalpel vasectomy.
- **Inclusion of the private sector:** Upon payment of a small fee, the distribution network of the private sector was tapped into to ensure access to contraceptives even in far-flung areas. Other innovative and commercially viable ventures were also introduced.
- **The social fabric of Thailand:** A more egalitarian and equitable social structure where women are respected, and where the dominant religion (Buddhism) emphasizes personal responsibility for behaviour, individual autonomy and decision-making (International Family Planning Perspectives)

Currently, family planning is one of many reproductive health efforts, which include relatively newer initiatives such as screening for breast and cervical cancer and pre-marital counselling, including voluntary counselling and testing of the couple for their HIV status and other genetic disorders especially thalassaemia.





## Challenges and Opportunities

1. **Increasing the scope of reproductive health services:** Thailand has achieved worldwide recognition for running a successful and sustainable family planning programme. Even though the process has begun, Thailand needs to build on this success to ensure that access to other reproductive health initiatives such as emergency obstetric care, diagnosis and management of reproductive tract infections, screening for cervical cancer, etc. are made as accessible as contraceptives. The challenge here is twofold: first, is the relative shortage of health personnel in the Thai health system; and, second is educating communities on the importance of these services.
2. **Improving services in the Southern region:** For most health services, including access to contraception, the Southern region lags behind the rest of the country and therefore needs special attention from policy-makers and programme implementers.
3. **Ensuring male participation:** The use of male-dependent family planning methods, such as condoms and vasectomies, has been reducing over the years and the burden of family planning is being shifted solely to women. Male involvement in other reproductive health interventions, such as accessing antenatal care services, is also less than ideal. Health programmes should take advantage of the general social and religious fabric of the country, which encourages equality of the sexes, to increase male participation in decision-making and taking on greater responsibility for the reproductive health of the couple.

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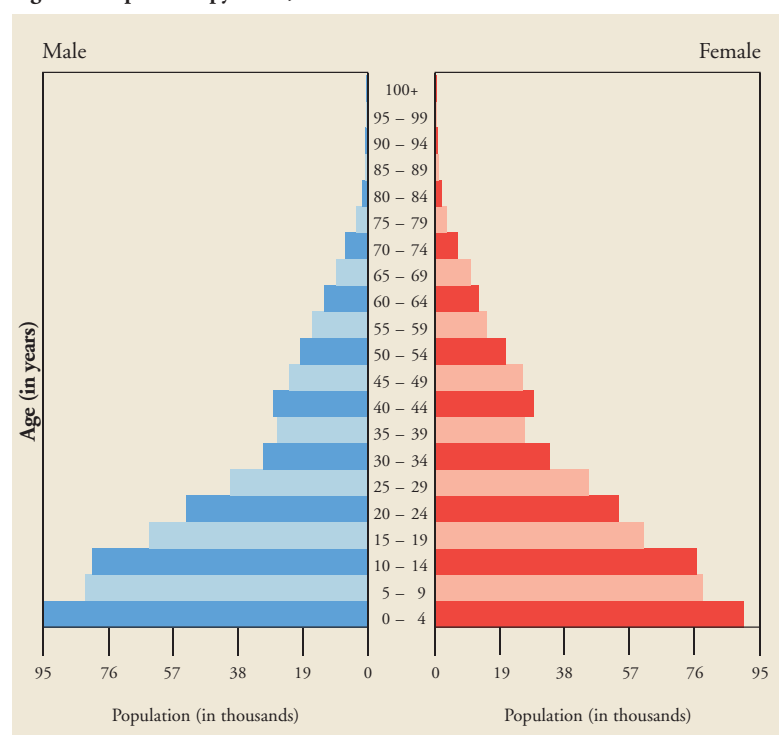
# Timor-Leste and Family Planning: An overview



## Background

Timor-Leste is a small country primarily occupying the eastern half of the island of Timor, with West Timor being part of the Republic of Indonesia. Timor-Leste also includes the nearby islands of Ataúro and Jaco,

Figure 1: Population pyramid, 2013



Source: CIA World Factbook.

as well as Oecussi, an exclave in Indonesian West Timor. “Timur” in Malay and “Leste” in Portuguese mean “east”. Timor-Leste is divided into 13 administrative districts, 65 subdistricts, and 442 sucos and 2225 aldeias. The 13 districts are Ainaro, Alieu, Baucau, Bobonaro, Cova-Lima, Dili, Ermera, Lautém, Liquiçá, Manatuto, Manufahi, Oecussi-Ambeno and Viqueque. Thirty per cent of the population live in urban areas, and the rest live in rural areas. Dili is the capital.

According to the 2010 census, the population of Timor-Leste is 1066409. The annual population growth rate is 2.4%. As can be seen from Figure 1, a large proportion of the population is constituted of children or people in the reproductive age group.

## Situation Analysis

Timor-Leste conducted its first national DHS in 2003 and a second in 2009–2010. The latest is in tandem with other DHS conducted as part of the global programme, supported by many bilateral and multilateral agencies. The relevant demographic and health indicators are presented in Table 1.

**Table 1: Key indicators**

Total population, 2014	1 201 542
Population growth rate, 2014	2.44%
Population density (people per square km), 2010	76
Urban population, 2014	28.3%
Population <15 years of age, 2010	44.8%
Total fertility rate (TFR), 2014	5.11
Contraceptive prevalence rate (CPR), 2010	22.3%
– Pill	1.7
– IUD	1.3
– Injectable	15.7
– Implant	0.8
– Condom	0.2
– Standard days	0.4
– Traditional methods	2.5
Unmet need, 2010	31%
Median age at first marriage (in years), 2010	20.9
Median age at first birth (in years), 2010	22.4
Crude birth rate (per 1000 population), 2014	34.48
Maternal mortality ratio (per 100 000 live births), 2010	557
Infant mortality rate (per 1000 live births), 2014	38.79
HIV adult prevalence, 2014	NA

Source: CIA World Factbook; World Health Statistics, 2014; Country MDG Report 2010.

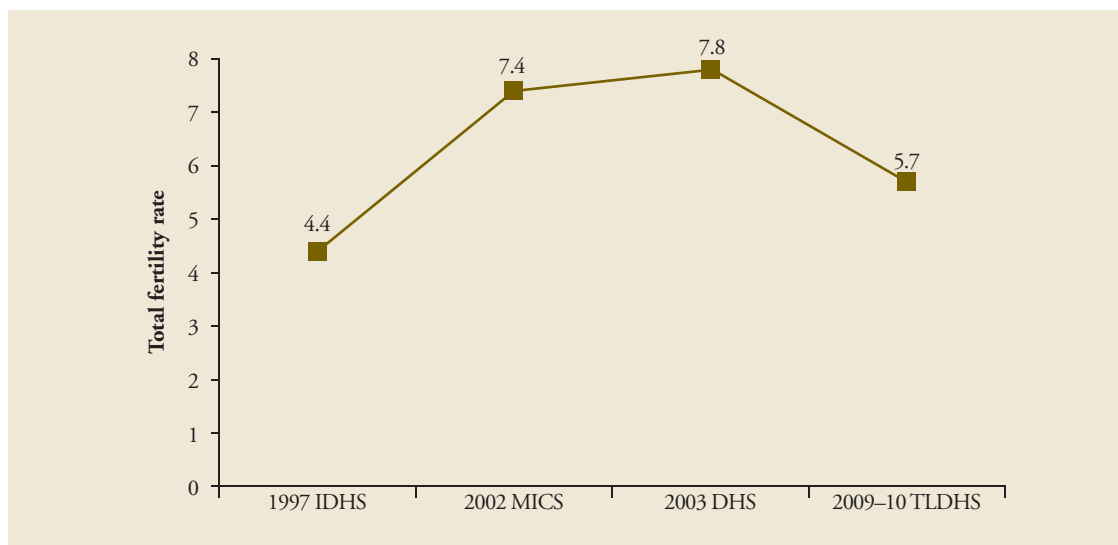
### Total fertility rate (TFR)

The TFR of Timor-Leste (as per latest Demographic and Health Survey 2010) is the highest in Asia at 5.7 (Figure 2). At this rate, the total population of the country is expected to increase by more than 50% (from 1.2 million to 1.9 million) by 2025.

Fertility differentials are seen between urban and rural areas (TFR of 4.9 and 6.0, respectively), between districts (highest in Ainaro at 7.2, and lowest in Covalina at 4.4), and with reference to the educational and socioeconomic status of women. Women with no education give birth to about three times the number of children born to women with at least secondary education (6.1 versus 2.9). Similarly, women in the lowest wealth quintile have a TFR of 7.3 compared to 4.2 for women in the highest wealth quintile.



Figure 2. Trends in TFR, 1997–2010

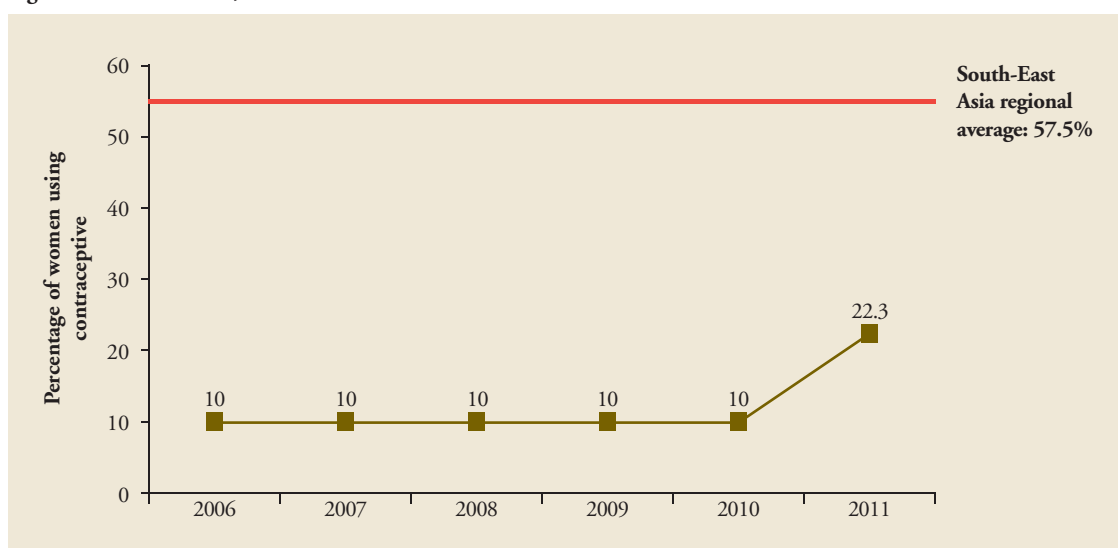


Source: Timor-Leste DHS, 2009–2010.

### Contraceptive prevalence rate (CPR)

According to DHS 2006, about 10% of currently married women were using a contraceptive method. These rates are similar to the CPR found in subsequent surveys, up until 2010. By 2011, CPR had increased to 22.3% (Figure 3).

Figure 3. Trends in CPR, 2006–2011



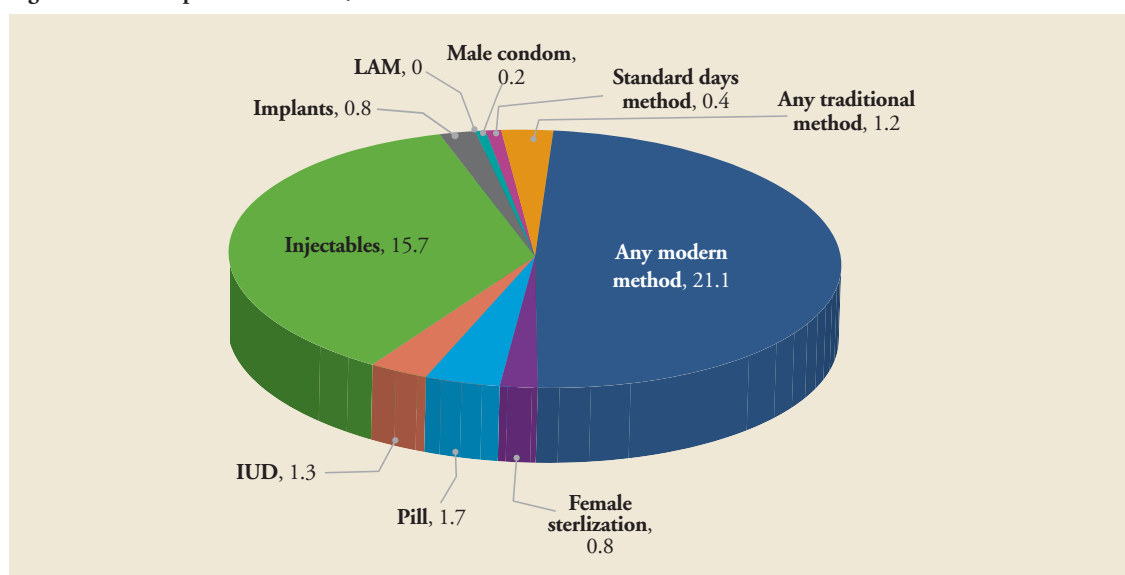
Source: World Health Statistics 2006, 2007, 2008, 2009, 2010 and 2011.



### Contraceptive method mix

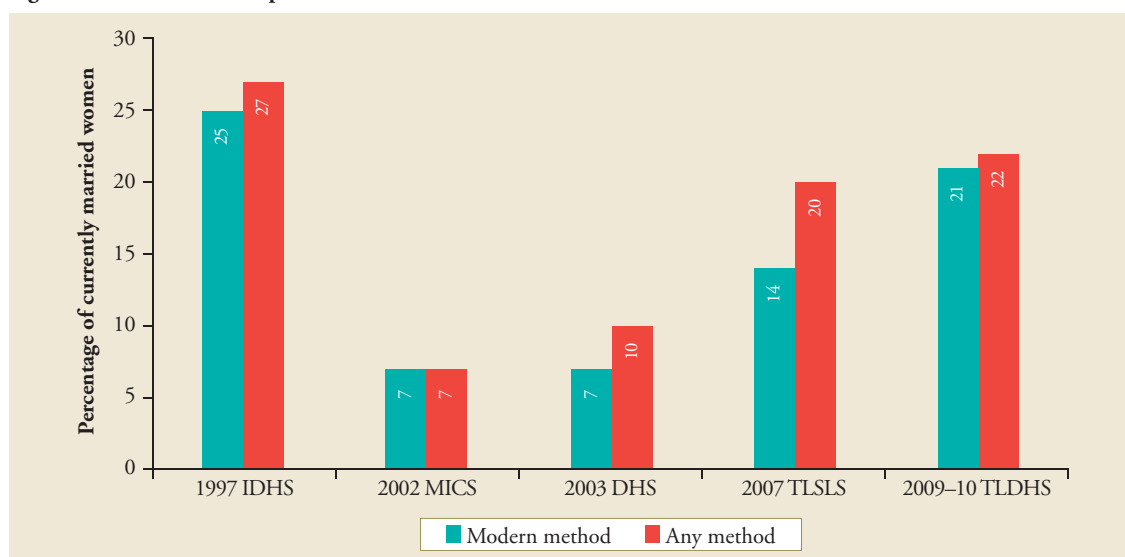
More than one in five currently married women (22%) use a method of family planning, with 21% using a modern contraceptive method. This indicates that modern methods are highly favoured over either natural family planning methods or other traditional methods. Only 1% of women report currently using a traditional method. The rhythm method is slightly more popular than withdrawal. Injectables are by far the most popular modern method, and are used by 16% of currently married women. The pill is used by 2% of women, while IUDs, implants and sterilization are each used by about 1% of women. Most women who are sterilized are over the age of 30. Injectables are popular among women aged 20–44 years.

Figure 4. Contraceptive method mix, 2009–2010



Source: Timor-Leste DHS, 2009–2010.

Figure 5. Trends in contraceptive use, 1997–2010



Source: Timor-Leste DHS, 2009–2010.



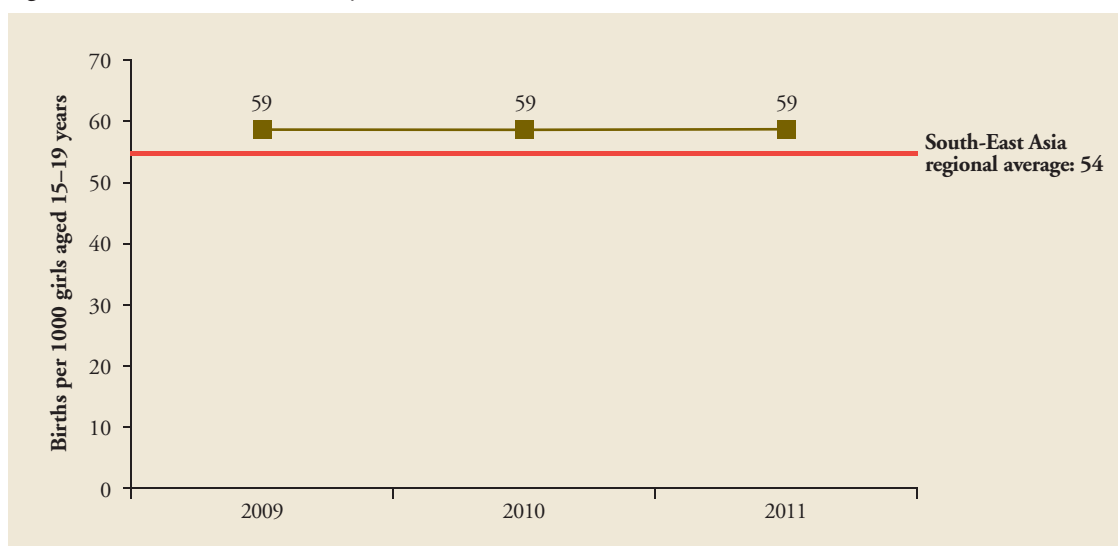
### Unmet need for family planning

One in three currently married women has an unmet need for family planning, with 21% having an unmet need for spacing and 10% having an unmet need for limiting. If all currently married women who say they want to space or limit their children were to use a family planning method, the CPR would increase to 53% from the current 22%. Currently, only 42% of the family planning needs of currently married women are being met.

### Adolescent fertility

Adolescent fertility in Timor is close to the average in SEAR region. While in-depth information is lacking due to absence of detailed demographic surveys, UN estimates show that the adolescent fertility has reduced from 59 births per 1000 girls in the age group 15–19 years in the early 2000s to 54 in the time period 2007–2012.

Figure 6. Trends in adolescent fertility rate, 2009–2011



### Current Family Planning Efforts

Adolescent reproductive health is a key area for UNFPA youth programming in Timor-Leste, focusing on the promotion of available, quality and sustainable sexual and reproductive health information and services. Youth-friendly services are being provided, and there are plans to incorporate an adolescent sexual and reproductive health module into pre-secondary and secondary school curricula.

Overall assessment shows that UNFPA plays a crucial role in the procurement and distribution of reproductive health commodities, and strengthening of maternal health care, at both the central and district levels through the training of health-care workers. The supply of adequately trained and qualified health-care workers is integral to the functioning of the system and the overall improvement of health outcomes in Timor-Leste. The UN funds, programmes and specialized agencies should continue to support the efforts of the Government of Timor-Leste to improve the quality of care in the districts.



## Challenges and Opportunities

Key challenges include the unmet need for family planning and the relatively high rates of HIV infection among youth. Poor infrastructure, a restrictive environment, sustainability and cost also remain important challenges. Co-financing and partnerships between UN organizations and the Government fill the gap, based on needs assessment and comprehensive planning. Collaboration with the government, coordination between UN organisations is a good opportunity to provide financial and technical support.

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1. *Timor-Leste Demographic and Health Survey 2009–2011*. <http://www.measuredhs.com/pubs/pdf/FR235/FR235.pdf>
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3. *Improving Maternal, Newborn and Child Health in the South-East Asia Region*. World Health Organization. 2005
4. *The World Factbook*. <https://www.cia.gov/library/publications/the-world-factbook/geos/tt.html>

Family Planning is central to securing good health and autonomy of women. Family planning allows individuals and couples to have the desired number of children and to plan the spacing of pregnancies. It is achieved through use of contraceptive methods and the treatment of infertility. A woman's ability to space and limit her pregnancies has a direct impact on her survival, health and well-being as well as on the outcome of each pregnancy. Family planning enables a woman to prevent unintended pregnancy, thus reduces the need for unsafe abortion.

This document contains country-wise fact sheets on the current situation of family planning services in countries of the South-East Asia Region. It also addresses challenges and opportunities at national level in family planning programme. The available national level information on contraceptive prevalence rate, unmet need, adolescent fertility and current efforts at national level, has been collated for each member country of South-East Asia Region.

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