



Knowledge Brief

Health, Nutrition and Population Global Practice

BANGLADESH: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

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KEY MESSAGES:

- Bangladesh, a densely populated and low income country, has achieved several MDGs in education, health, and poverty reduction, and made remarkable progress in gender equality. Despite growth and progress in human development, poverty levels remain high.
- MMR declined by 70 percent from 1990 to 2013 and is now 170 deaths per 100,000 live births.
- Fertility declined to 2.2, while contraceptive prevalence rate increased to 61%. Fifty-five percent of women sought ANC from a qualified provider and nearly 32% of births were attended by qualified providers.
- While fertility and CPR are evenly distributed, wide gaps in access to maternal health services remain.
- Despite its decline, undernutrition still remains a challenge.
- Bangladesh would need to focus on increasing political commitment to adolescent health; focusing interventions on high-fertility and high MMR areas; addressing human resources constraints; and harnessing the use of technology.

Country Context

Bangladesh is among the most densely populated countries in the world. Its population (155 million) is the world's eighth largest and among the poorest in South Asia. Yet Bangladesh has sustained growth over 30 years and progressed in human development. Per capita GNI grew at a yearly compound rate of 4.9 percent from an average of \$25 in the 1980s to \$913 by 2013. While GNI growth in the 1980s and 1990s was mostly from GDP growth, remittances in the past decade are a significant source of income.^{1,2}

Poverty remains high: 43 percent of the population subsists on less than US\$1.25 per day (2010). Poverty fell from nearly 63 million in 2000 to 47 million in 2010.³ The main drivers were growth in labor income and dropping fertility rates.⁴ The large youth population — 32 percent are under 15 — offers an opportunity to benefit from the demographic dividend.^{1,2}

Bangladesh achieved several MDG targets in education, health, and poverty reduction. Its progress in social sectors compares favorably to similar income level countries. Child **mortality** is the third lowest in South Asia: 41 for under-fives and 33 for infants per 1,000 live births in 2013.^{1,2}

Gender equality and women's empowerment are important determinants of reproductive health. Bangladesh's progress in attaining gender parity is remarkable. It reached 110 in primary and secondary education. Over 7,000 NGOs are registered with the Ministry of Social Welfare. Some 400 NGOs work in maternal health, family planning, and microfinance. Bangladesh ranks 111 of 148 countries in the Gender Inequality Index.⁶

BANGLADESH: MDG 5 STATUS

MDG 5A indicators

Maternal mortality ratio (MMR; maternal deaths per 100,000 live births) – *UN estimate* **170**

Births attended by skilled health personnel (percent) **31.7**

MDG 5B indicators

Contraceptive prevalence rate, any method (percent) **61.2**

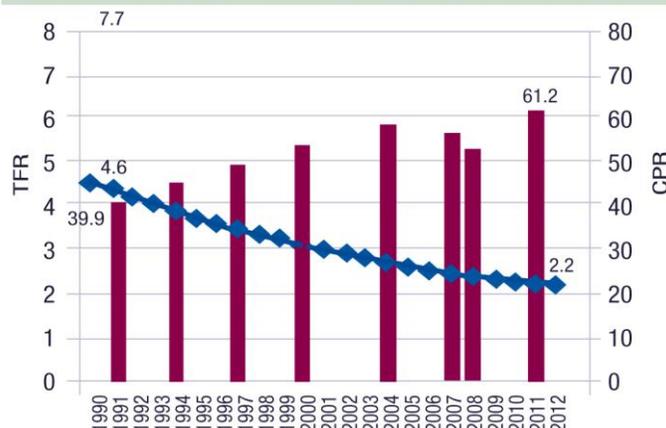
Adolescent fertility rate (births per 1,000 women ages 15–19) – *WDI* **80.6**

Antenatal care with health personnel (percent) **54.6**

Unmet need for family planning (percent) **13.5**

Sources: 2014 WHO/UNICEF/UNFPA/World Bank MMR report, 2011 BDHS, 2014 World Development Indicators (WDI)

FIGURE 2: TRENDS IN CONTRACEPTIVE PREVALENCE RATE (CPR) AND TOTAL FERTILITY RATE (TFR)

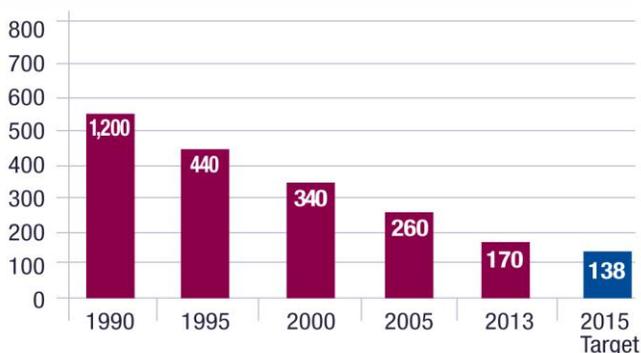


Source: World Development Indicators 2014

MDG Target 5a: Reduce the MMR by three-quarters, between 1990 and 2015

Bangladesh has made great progress over the past two decades on maternal health. The MMR declined from 550 deaths per 100,000 live births in 1990 to 170 in 2013 (figure 1). According to the latest Interagency estimates, Bangladesh is “making progress” toward achieving MDG5.i Maternal mortality declined 70 percent with an average annual decline of 5 percent between 1990 and 2013. ⁶

FIGURE 1: MATERNAL MORTALITY RATIO 1990-2013 AND 2015 TARGET



Source: 2014 WHO/UNICEF/UNFPA/World Bank MMR report

ⁱ “Making progress” is defined as a 2%–5.5% average annual decline between 1990 and 2013.

Fertility

Bangladesh has a long and well-established family planning program. Its current Population Policy (2009) aims to achieve replacement fertility by 2015. ⁷

Fertility has been declining over the past 20 years.

Between 1990 and 2012, the total fertility rate (TFR) fell by more than half from 4.6 to 2.2 (figure 2).¹

An increased contraceptive prevalence rate (CPR) has accompanied the fertility decline. The CPR (any method) has increased from about 40 percent in 1991 to 61 percent in 2011 (figure 2). ¹ Modern methods are the main choice of contraceptives and are used by 52.1 percent of currently married women. The pill (27 percent), injectables (11 percent), male condoms (6 percent), and female sterilization (5 percent) are the most commonly used form of modern methods. Traditional methods are used by 9.2 percent of currently married women. There is still an unmet need of 13.5 percent. ⁷

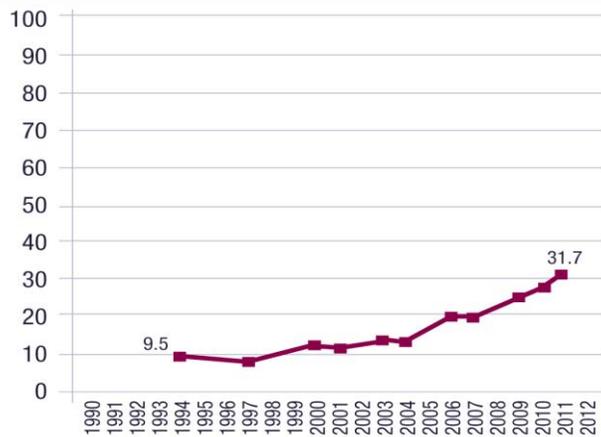
Early childbearing affects maternal health outcomes.

Among women age 20–49, the median age at first marriage is 15.8 years and the median age at first birth is 18.3 years. The share of women age 15–19 that have begun childbearing is 30.2 percent.⁷ The adolescent fertility rate is 80.6 births per 1,000 women age 15–19.¹

Pregnancy Outcomes

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2011, 54.6 percent of women sought ANC from a medically qualified provider, but only 25.5 percent of women received the recommended four or more ANC visits. Tetanus toxoid is a vaccination given as part of ANC: 41.7 percent of mothers received two or more injections during their last pregnancy and 89.9 percent had their last birth protected against neonatal tetanus. ⁷

FIGURE 3: TRENDS IN SKILLED BIRTH ATTENDANCE



Source: World Development Indicators 2014

Skilled birth attendance (SBA) is critical in reducing maternal deaths. SBA in Bangladesh by a medically trained provider increased from 9.5 percent in 1994 to 31.7 percent in 2011 (figure 3).¹ The majority of births are delivered at home with institutional delivery accounting for only 28.8 percent of all births (15.1 percent in public sector facilities, 11.8 percent in private sector facilities, and 1.9 percent in NGO facilities).⁷

Postnatal care is another important component for maternal health especially for managing post-delivery complications. It is recommended that postnatal care for mothers occur within the first two days of delivery. In Bangladesh, only 27.1 percent of women sought this type of care from a qualified provider within the first two days of delivery.⁷

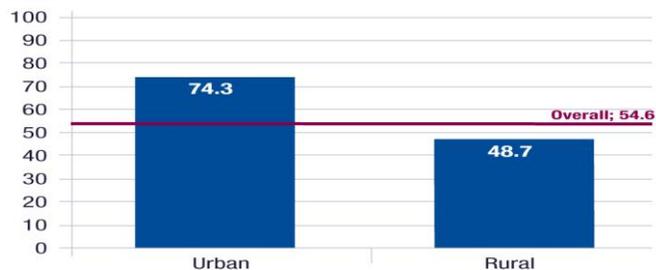
MDG5 is being addressed through the Health, Population and Nutrition Sector Development Program (HPNSDP). The HPNSDP covers 2011-2016 and aims to deliver a package of quality and essential health services.⁷

Equity in Access to Maternal Health Services

Inequity in access to maternal health services is a barrier toward MDG 5. Some indicators show a more equitable distribution than others. In Bangladesh, CPR and TFR show a somewhat even distribution across residence (rural/urban) and wealth quintiles.

While utilization of ANC has been increasing, wide disparities remain. Women in urban areas were more likely to seek antenatal care (74.3 percent) from a qualified professional than their rural counterparts (48.7 percent) (figure 4).⁷

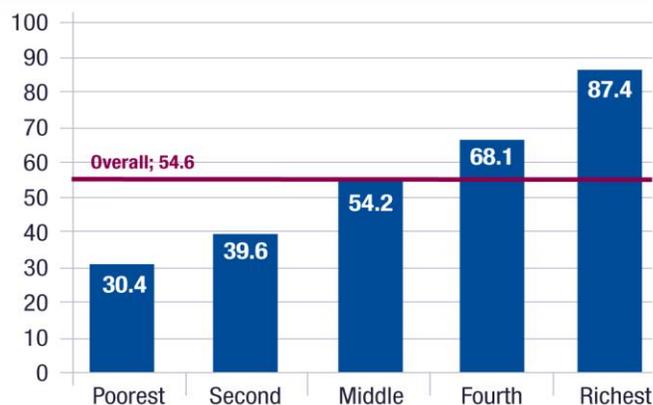
FIGURE 4: ANTENATAL CARE BY RESIDENCE



Source: 2011 Bangladesh DHS

There is also a large gap between wealth quintiles in receiving ANC: 87.4 percent of women in the richest quintile received ANC from a qualified professional, but only 30.4 percent of women in the poorest quintile (figure 5).⁷

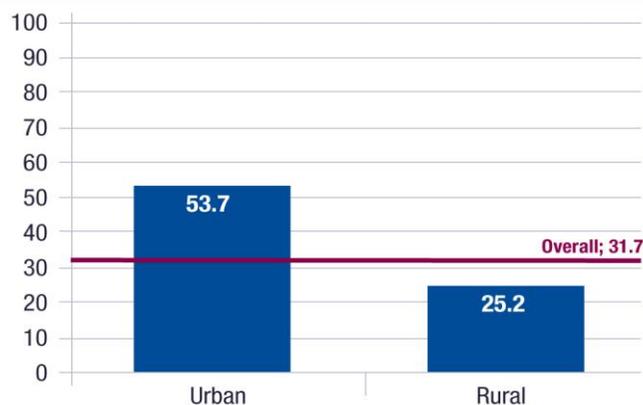
FIGURE 5: ANTENATAL CARE BY WEALTH QUINTILE



Source: 2011 Bangladesh DHS

Similar disparities are also found in SBA: 53.7 percent of urban women are assisted during delivery by a medically qualified professional but only 25.2 percent of rural women (figure 6).⁷

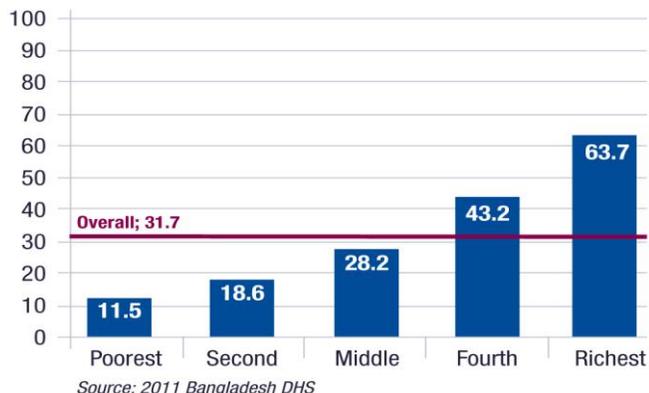
FIGURE 6: SKILLED BIRTH ATTENDANCE BY RESIDENCE



Source: 2011 Bangladesh DHS

Considerable variations in skilled birth attendance also exist amongst wealth quintiles. Women in the richest quintile were five times more likely than women in the poorest quintile to have skilled birth attendance. Only 11.5 percent of women in the poorest quintile received skilled birth attendance compared to 63.7 percent in the richest quintile (figure 7).⁷

FIGURE 7: SKILLED BIRTH ATTENDANCE BY WEALTH QUINTILE



Nutrition

Since the 1990s, undernutrition has declined gradually. However, the pace of decline has not matched the rapid improvements in other development indicators such as economic growth, child and maternal mortality, education and rice production. The undernutrition situation remains serious: 41% of children under five are stunted, 36% underweight and 16% wasted. Among women, 24% are underweight and 13% are of short stature, which increases the likelihood that their children will be stunted.

This situation reflects the underlying causes of undernutrition including sanitation and hand washing practices, access to food and health care, child feeding practices and the status of girls and women in the family and society. Nutrition is inextricably linked to persisting social norms embedded in gender inequity. A mother's age at marriage and first delivery has a significant effect on the birth weight and nutritional status of her children. The high rate of child marriage in Bangladesh also leads to early abandonment of education.

Key Strategies to Improve Maternal and Reproductive Health Outcomes

Increasing political commitment to adolescent health by reviewing the current adolescent health programs run by the public and private sectors and update the strategy; and introducing a specific focus on adolescents' nutrition in the updated Nutrition Policy and in the existing health related interventions.

Focusing interventions on high-fertility and high MMR areas and reducing inequalities by promoting female education and intersectoral collaboration to increase age at marriage, including first child birth; developing effective IEC and BCC to increase birth spacing and the uptake of long term/semi-permanent or permanent methods; empowering women through income generation and livelihood programs; targeting interventions in rural, urban, and hard to reach areas; increasing coordination between MOLGRDC and MOHFW and strengthening it in urban areas scaling up CRVS to register every pregnancy, birth, and maternal death; and addressing the quality issues in DSF voucher program and then proceeding to scale up.

Addressing the unavailability of human resources by increasing the number of skilled birth attendance, specially the Community SBAs with effective mentoring and supervision; strengthening the accreditation of training; addressing task shifting; ensuring teams, e.g., OBG, Anesthetists and trained nurses at the Comprehensive Emergency Obstetric Centers work round the clock; and strengthening structures to provide EmONC services; strengthening the referral linkage and support to appropriate facilities.

Harnessing the use of technology by improving HMIS and electronic record keeping; and using mobile phones for data collection and pregnancy related tracking.

References:

- 1 World Bank. World Development Indicators 2014: Accessed 19 May 2014
- 2 Bangladesh:Country Program Snapshot. March 2014, the World Bank
- 3 World Bank 2013. Bangladesh Poverty Assessment Report
- 4 Jolliffe, Dean; Sharif, Ifath; Gimenez, Lea; Ahmed, Faizuddin. 2013. Bangladesh - Poverty assessment: assessing a decade of progress in reducing poverty, 2000-2010. Bangladesh development series ; paper no. 31. Washington DC; World Bank.
<http://documents.worldbank.org/curated/en/2013/06/17886000/bangladesh-poverty-assessment-assessing-decade-progress-reducing-poverty-2000-2010>
- 5 UNDP. 2013 Human Development Report Gender Inequality Index
- 6 WHO, UNICEF, UNFPA and The World Bank. 2014. Trends in Maternal Mortality: 1990 to 2013: World Health Organization
- 7 National Institute of Population Research and Training (NIPORT), Mitra and Associates, and ICF International. 2013. Bangladesh Demographic and Health Survey 2011. Dhaka, Bangladesh and Calverton, Maryland, USA: NIPORT, Mitra and Associates, and ICF International.

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