REPRODUCTIVE HEALTH *at a* GLANCE BANGLADESH

April 2011

Country Context

Bangladesh has made great strides toward achieving the Millennium Development Goals (MDGs) including poverty reduction, maternal health, and primary school enrollment. However, its large population size of 160 million and high population density pose significant challenges to sustain the successes achieved. Poverty remains high; 49.6 percent of the population still subsists on less than US $1.25 per day.[1]

The country's large population share of youth (32 percent of the country population is younger than 15 years old) offers a window of opportunity for high growth and poverty reduction—the demographic dividend. For this opportunity to result in accelerated growth, the government needs to continue to invest in the human capital formation of its youth.

Gender equality and women's empowerment are important determinants of women's reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[2] Sex ratio, the number of males per 100 females in the population, is considered a summary measure of women's status because it reflects gender differences in survival rates; a sex ratio greater than 100 signals low status of women. With the exception of Nepal and Sri Lanka, sex ratio in South Asia is high. In 2005, the sex ratio in Bangladesh was 105.[3] Beyond this summary measure, the country has achieved success in increasing girls' school enrollment. The literacy rate among females ages 15 and above is 50 percent. More girls than boys are enrolled in secondary schools with a 105 percent ratio of female to male secondary enrollment.[1] However, only 26 percent of women aged 15–59 participate in the labor force and among those in the labor force only 4 percent are engaged in paid work.[3] Gender inequalities are reflected in the country's human development ranking; Bangladesh ranks 121 of 157 countries in the Gender-related Development Index.[4]

Economic progress and greater investment in human capital of women will not necessarily translate into better reproductive outcomes if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[2]

Bangladesh: MDG 5 Status

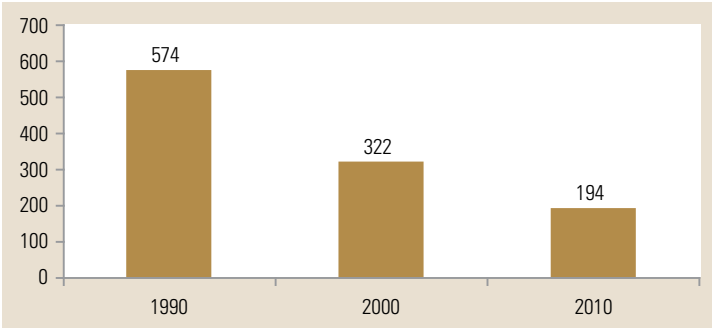
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	194
Births attended by skilled health personnel (percent)	26.0
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	55.8
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	126
Antenatal care with health personnel (percent)	56.0
Unmet need for family planning (percent)	17.1

Source: Table compiled from multiple sources.
[a] Bangladesh Maternal Mortality and Health Care Survey 2010.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Bangladesh has been making progress over the past two decades on maternal health.[5]

Figure 1 ▪ Maternal mortality ratio 1990–2010



Source: Bangladesh Maternal Mortality and Health Care Survey 2010.

World Bank Support for Health in Bangladesh

The Bank's current ***Country Assistance Strategy*** is for fiscal years 2011 to 2014.

Current Project:
P074841 HNP Sector Program ($300m)

Pipeline Project:
P118708 BD-HNP Sector Development, Decision meeting 3/7//2011 (US$ 350m)

Previous Health Project:
P037857 Health and Population Sector Programme ($250m)

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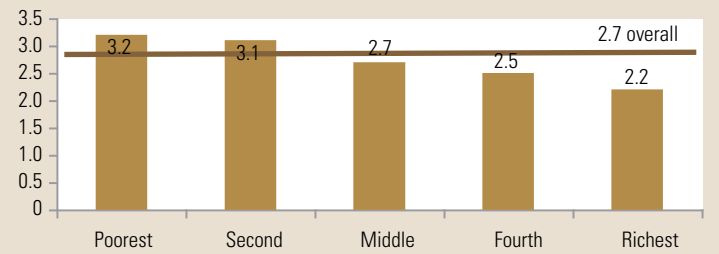
Key Challenges

Fertility

Fertility has been declining over time but remains moderately high among the poorest. Under the Government of Bangladesh's population policy, promulgated in 1976, the country has seen a decrease in total fertility rate (TFR), from 6.3 births per woman to the current level of 2.7.[6]

Figure 2 ▪ Total fertility rate by wealth quintile



Source: BDHS 2007.

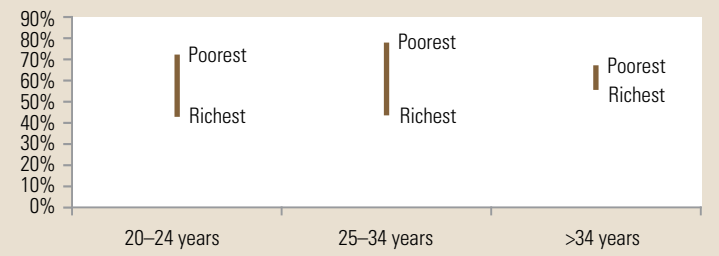
The updated 2004 Population Policy includes further reduction of TFR as one of its aims.[7] While fertility among women in the wealthiest quintile is close to replacement fertility of 2.1, women in the poorest quintile have a TFR of 3.2.

Adolescent fertility adversely affects not only young women's health, education and employment prospects but also that of their children. Births among 15–19 year olds are associated with the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[2, 8] In Bangladesh, adolescent fertility rate is high at 126 births per 1,000 women aged 15–19 years.[6]

Despite the decline in TFR over time, early childbearing remains prevalent especially among the poor. Most births to teenagers take place within marriage as early marriage is common despite a law that sets the minimum age at marriage for women at 18. In 2007, the median age at first marriage among 20–24 year old women was 16.4 years. Early childbearing varies by socioeconomic characteristics. While 71 percent of the poorest 20–24 years old women have had a child before reaching 18, about 43 percent of their richer counterparts did (Figure 3). Furthermore, across cohorts, the prevalence of early childbearing has declined among the rich where younger cohorts of women are less likely than older cohorts to have a child early in life.

About two-third of all married women use contraception. Current use of modern contraceptives is high among married women; more than half used modern contraceptive methods (54.1 percent) in 2010, up from the 5 percent in 1975.[6] This remarkable increase in the use of contraceptives is partly attributable to the first population policy.[7] Further, there is little variation in modern contraceptive use by women's socio-economic status: wealth (Figure 4), education, or residence.[9]

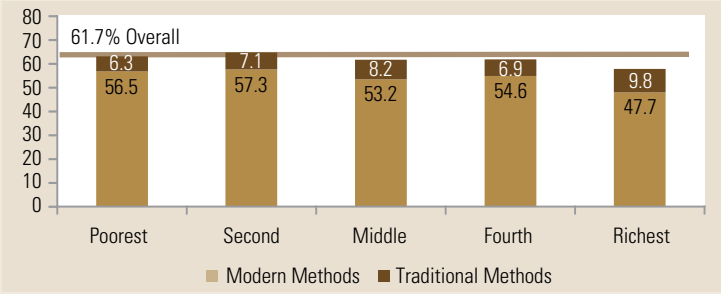
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile



Source: BDHS 2007 (author's calculation).

The pill is the predominant contraceptive method (30 percent), followed by injectables (12 percent). Following the shortage in supply of injectables during 2006–2007, use of injectables has increased from 7 percent in 2007 to the current level. Use of long-term methods such as intrauterine device and implants are negligible.

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: UESD 2010.

Despite the high prevalence of modern contraceptive use, unmet need for contraception is noteworthy at 17 percent with minimal variation among women different socio-economic groups.[6] The unmet need suggests that some women may not be achieving their desired family size.[10]

In the 1970s, the government sanctioned menstrual regulation (defined as "an interim method of establishing non-pregnancy for a woman who is at risk of being pregnant, whether or not she is pregnant in fact").[11] Nevertheless, about 50,000 hospitalizations per year arise from abortion complications and about 19,000 women require additional treatment resulting from menstrual regulation procedures.[12]

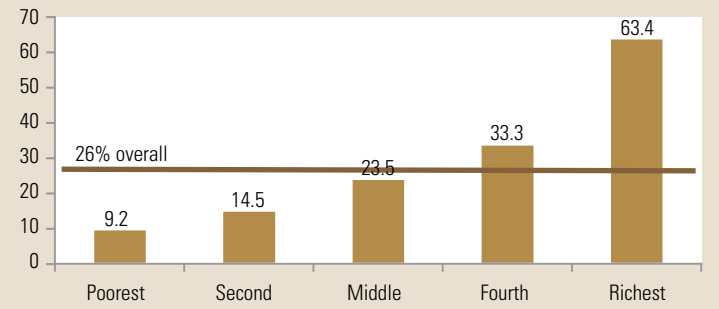
Fertility-related reasons such as infertility and menopause are the predominant reasons women do not intend to use contraception in future.[6] The next frequent reason is opposition to use (12 percent), primarily by women themselves, their husband, or due to their religion. Cost and access are lesser concerns, indicating further need to strengthen family planning services

Poor Pregnancy Outcomes

Use of antenatal care and institutional deliveries are rising but are low compared to Sub-Saharan African countries. 56 percent of pregnant women receive antenatal care from a medically trained provider, a steady rise from 52 percent in 2007 and 49 percent in 2004.[6] Just 20 percent of have the recommended 4 or more antenatal visits. Further, 47 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L) increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[13] Only 26 percent of pregnant women deliver with the assistance of medically trained provider. Unlike contraceptive use, socioeconomic variations in deliveries with medically trained providers are stark: 63 percent of women in the wealthiest quintile delivered with medically

trained provider while only 9 percent of women in the poorest quintile obtained such assistance (Figure 5). Although institutional births remain low, there has been a steady increase from 4 percent in 1993 to 24 percent in 2010.

Figure 5 ▪ Birth assisted by health personnel (percentage) by wealth quintile



Source: UESD 2010.

Seventy-four percent of women never received postnatal care following their last birth; 4 percent of women got postnatal check-up following last birth from a non-medically trained provider (such as TBA).[6]

Nearly three-quarters of recent mothers who did not seek antenatal care believed it was not needed while a quarter cited affordability (Table 1).[6]

Human resources for maternal health are limited with only 0.3 physicians per 1,000 population but nurses and midwives are slightly less common, at 0.28 per 1,000 population.[1]

The high maternal mortality ratio at 194 maternal deaths per 100,000 live births[5] indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[14]

STIs/HIV/AIDS prevalence is low but a growing public health concern

HIV prevalence is low in Bangladesh (0.01 percent) just 67 percent of women have ever heard of HIV/AIDS.[6, 15]

Table 1 ▪ Reasons for Not Seeing Anyone for Antenatal Care women age 15–49

Reason	%
Not needed	72
Service too expensive	25
Did not know of need for care	7
Unable to go/not permitted to leave house	5
Other	5
Too far	4
Religious reasons	3
Issues related to quality of service	2

Source: BDHS 2007.

Knowledge about ABC message (abstinence, be faithful to one uninfected partner, and condom use) is higher among young people than adults. Nearly 26 percent of women and 60 percent of men age 15–24 cited condoms use and limiting sex to one faithful uninfected partner as means of reducing the risk of HIV/AIDS.

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Development Partners Support for Reproductive Health in Bangladesh

WHO: Health workforce development; continuum of care throughout the life cycle

UNFPA: Reproductive health and rights

UNICEF: Informed choices for families; ending sexual violence; increased female participation ,Emergency Obstetric care

WB: Availability of RH commodities and financial support for capacity development

USAID: Reduce fertility; perinatal health service delivery

DFID: Access, utilization, and quality of MNH services with focus on the poor and socially excluded

SIDA: SRH rights and MR training

CIDA: MCH delivery systems strengthening

AUSAID: MNCH project

GIZ: Health systems strengthening ; multidisciplinary HIV/AIDS program

SNV: Gender equity and social inclusion

MSH: RH/FP logistics management

Marie Stopes: Post-abortion care; FP services; HIV/STIs

FHI: HIV/AIDS prevention

IntraHealth International: NGO capacity building for FP/RH and MNCH service delivery

Engender Health: Expanding access to FP; obstetric fistula prevention and treatment

Pathfinder International: Safe motherhood and infant care; postpartum hemorrhage care; adolescents

BRAC: Maternity and child health services; family planning education and contraceptive provision

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.
- Reducing high fertility
- Secure reproductive health commodities and strengthen supply chain management.
- Address the service needs of women in remote and hard-to-reach areas. Improve and expand recruitment and training of community health workers, skilled birth attendants, etc. particularly in areas where formal health care infrastructure is lacking.
- Promote the use of ALL modern contraceptive methods, including long term methods, through proper counseling which may entail training/re-training health care personnel.
- Strengthen post-abortion care (treatment of abortion complications with manual vacuum aspiration, post-abortion family planning counseling, and appropriate referral where necessary) and link it with family planning services.

Reducing maternal mortality

- Address the perception that it not necessary to seek antenatal care or deliver at a health facility. This will require a combination of Behavior Change Communication (BCC) programs via mass media and community outreach as well as deploying midwives to assist women with home deliveries.
- Increase access to and quality of antenatal, delivery and postpartum services.
- Improve health systems bottle necks including: referrals, availability of essential commodities, skills of health personnel and sound transportation systems. Engage stakeholders at all levels, including male household heads, to reduce barriers to timely and effective care. Strengthen existing and increase availability of EmONC
- Create youth-friendly services in government and NGO programs.

Reducing STIs/HIV/AIDS

- Help maintain the low infection rate by communication, information and make available voluntary testing and counseling through the antenatal care system.
- Focus HIV/AIDS education efforts on adolescents and youth and other high risk groups including IDUs, sex workers and their clients, and migrant workers.
- Bring the issue of sex-trafficking to the forefront, involve policy- and decision-makers and communities in advocacy and preventive measures.

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BANGLADESH REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2007	2.7
Adolescent fertility rate (births per 1,000 women ages 15–19)	2007	126
Contraceptive prevalence (% of married women ages 15–49)	2010	61.7
Unmet need for contraceptives (%)	2007	17.1
Median age at first birth (years) from DHS	2007	18.2
Median age at marriage (years)	2007	15.3
Mean ideal number of children for all women	2007	2.3
Antenatal care with health personnel (%)	2010	56
Births attended by skilled health personnel (%)	2010	26
Proportion of pregnant women with hemoglobin <110 g/L	2008	47
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	574
Maternal mortality ratio (maternal deaths/100,000 live births)	2001	322
Maternal mortality ratio (maternal deaths/100,000 live births)	2010	194
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	143
Infant mortality rate (per 1,000 live births)	2007	52
Newborns protected against tetanus (%)	2010	91.3
DPT3 immunization coverage (% by age 1)	2007	90
Pregnant women living with HIV who received antiretroviral drugs (%)	—	—
Prevalence of HIV, total (% of population ages 15–49)	—	—
Female adults with HIV (% of population ages 15+ with HIV)	2007	16.7
Prevalence of HIV, female (% ages 15–24)	—	—

Indicator	Year	Level
Population, total (million)	2008	160.0
Population growth (annual %)	2008	1.4
Population ages 0–14 (% of total)	2008	32
Population ages 15–64 (% of total)	2008	64.1
Population ages 65 and above (% of total)	2008	3.8
Age dependency ratio (% of working-age population)	2008	55.9
Urban population (% of total)	2008	27.1
Mean size of households	2007	5
GNI per capita, Atlas method (current US$)	2008	520
GDP per capita (current US$)	2008	497
GDP growth (annual %)	2008	6.2
Population living below US$1.25 per day	2005	49.6
Labor force participation rate, female (% of female population ages 15–64)	2008	61.4
Literacy rate, adult female (% of females ages 15 and above)	2008	49.8
Total enrollment, primary (% net)	2008	85.5
Ratio of female to male primary enrollment (%)	2008	105.7
Ratio of female to male secondary enrollment (%)	2007	105.1
Gender Development Index (GDI)	2008	121
Health expenditure, total (% of GDP)	2007	3.4
Health expenditure, public (% of GDP)	2007	33.6
Health expenditure per capita (current US$)	2007	14.7
Physicians (per 1,000 population)	2005	0.3
Nurses and midwives (per 1,000 population)	2005	0.28

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2007	3.2	3.1	2.7	2.5	2.2	2.7	1.0	1.5
Current use of contraception (Modern method)	UESD	2010	56.5	57.3	53.2	54.6	47.7	54.1	8.8	1.2
Current use of contraception (Any method)	UESD	2010	62.8	64.4	61.4	61.5	57.5	61.7	5.3	1.1
Unmet need for family planning (Total)	DHS	2007	17.4	18.6	17.1	17	15.6	17.1	1.8	1.1
Births attended by skilled health personnel (percent)	UESD	2010	9.2	14.5	23.5	33.3	63.4	26.0	–54.2	0.1

National Policies and Strategies that have Influenced Reproductive Health

National Population Policy: Universal access to quality RH/FP services, including assurance of opportunity and freedom to choose contraceptive methods; address the causes of maternal and infant mortality, including unsafe abortion, antenatal, delivery, and post-natal care, and EmONC

"Menstrual Regulation", or abortion before the 11th week of pregnancy, is legal and provided through the Essential Service Delivery (ESD) package

Source: Bangladesh Ministry of Health and Family Welfare