



Urban Health Survey 2021

**National Institute of Population Research and Training (NIPORT)
Medical Education and Family Welfare Division
Ministry of Health and Family Welfare
Dhaka, Bangladesh**

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Dhaka-1207, Bangladesh**

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This report presents the findings of the Urban Health Survey 2021. The study was carried out by the National Institute of Population Research and Training (NIPORT) under the Operational Plan – Training, Research and Development of the Health, Population and Nutrition Sector Programme (HPNSP).

Associates for Community and Population Research (ACPR), private research firm was appointed to data collection, data processing, and report writing for the study. The opinions expressed in this report do not necessarily reflect the views of different involved agencies or organizations.

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Honorable Secretary

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FOREWORD

The National Institute of Population Research and Training (NIPORT), with funding from USAID and technical assistance from icddr, b and MEASURE Evaluation, conducted the 2006 Bangladesh Urban Health Survey (2006 UHS) and 2013 Bangladesh Urban Health Survey (2013 UHS) to examine the health profile and health-care seeking behaviors of urban residents living in slum and non-slum areas of City Corporations and District Municipalities. Eight years have elapsed since the 2013 UHS. To see the changes or improvement, NIPORT commissioned 2021 Urban Health Survey (2021 UHS) to obtain a profile of key aspects of health conditions and behaviors of urban residents in slum, non-slum and rest urban areas as well as to have updated information on the coverage of different healthcare services delivered models.

The 2021 UHS collected information on residents from 35,860 households of slum, non-slum areas of 11 City Corporations, district municipalities and large towns (Pourashavas) with a population over 45,000 people, administering 12,000 short questionnaires and 23,860 long questionnaires. Findings of the survey did show that in CC slums under five mortality rate (U5MR) declined by 20 percent during the last eight years whereas infant mortality rate (IMR) declined by 22 percent. In the slums, one third of all under-5 children were stunted, 16.0 percent were wasted and 27.8 percent were underweight. Thus, the results of the UHS expanded the knowledge base regarding population health and health-related behaviors in urban areas of Bangladesh, with a particular emphasis on understanding the determinants of intra-city inequality in health outcomes, vulnerability and environmental risks in the urban setting.

This report is an outcome of the concerted efforts, contributions and involvement of a number of institutions, researchers, professionals and individuals, including the members of Stakeholder Advisory Committee (SAC), Technical Working Committee (TWC); officials of the Directorate General of Health Services (DGHS); Directorate General of Family Planning (DGFP); ACPR research team members; the field staffs; data processing team and specially the respondents. I would like to acknowledge with great appreciation the professional and individuals for their contributions. I would like to congratulate the professionals of the Research Unit of NIPORT and guidance of the Director General of NIPORT Mr. Md. Shahjahan and Associates for Community and Population Research (ACPR) for successfully completing the task. We are deeply indebted and grateful to the Government of Bangladesh (GOB) for providing financial support.

I hope that the survey results would be useful for monitoring as well as development of urban health programs focusing underserved groups, especially the slum population.

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PREFACE

The 2013 Bangladesh Urban Health Survey (2013 UHS) was a follow-up survey conducted after seven years from the first UHS conducted in 2006. It was a representative household survey of slums and non-slums of City Corporations and other urban areas that was implemented through a collaborative effort of the National Institute of Population Research and Training (NIPORT), Measure Evaluation, University of North Carolina at Chapel Hill, USA, and icddr,b. Associates for Community and Population Research (ACPR), a Bangladeshi private research agency, conducted the field survey in the City Corporation areas, municipalities and large towns with population over 45,000. The financial support for the survey was provided by The Government of Bangladesh (GOB). The 2021 UHS is the third-round follow-up urban health survey in Bangladesh.

The 2021 UHS is designed to examine the changes in the health service utilization of the urban population with explicit attention to examine differences between slum and non-slum groups. The information collected in the 2021 UHS concerning important urban health issues like migration, fertility and family planning, maternal and newborn health, childhood mortality, child health, infant feeding practices, nutritional status, intra-urban differentials, and trends in health service utilization are crucial in designing policies and programs in Bangladesh.

This 2021 UHS study was commissioned under the Training, Research, and Development (TRD) operational plan of the Health, Population, and Nutrition Sector Programme (HPNSP), and conducted by NIPORT. ACPR helped in field data collection, data processing, and report writing.

The 2021 UHS is an admirable undertaking of NIPORT. It is the result of dedication, support, involvement and inputs of a number of institutions, and professionals convened under the Stakeholder Advisory Committee (SAC) and the Technical Working Committee (TWC) consisting of experts, researchers and professionals working in Health Nutrition and Population Sector. I would like to extend my thanks to the SAC and TWC members, officials of Directorate General of Family Planning (DGFP) and Directorate General of Health Services (DGHS) for their support, and valuable suggestions in all stages of the study. I would like to congratulate the professionals of the Research Unit of NIPORT, particularly the guidance of the Director (Research) and Line Director, OP-TRD, NIPORT, Mr. Mohammad Ahsanul Alam.

I express my heartfelt thanks to the professionals and the staff of ACPR, and the professionals of research unit of NIPORT for their sincere efforts in successful completion of the survey. Our sincere thanks to the study respondents who willingly cooperated with the study teams by providing information. We are deeply indebted and grateful to the GOB for providing financial support. Last, but not the least, I would like to express my special gratitude to the honorable Director General of NIPORT for his valuable guidance and direction at every stage of the survey's implementation.

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ACRONYMS AND ABBREVIATIONS

ACPR	Associates for Community and Population Research
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BRAC	Bangladesh Rural Advancement Committee
CBR	Crude Birth Rate
CHW	Community Health Worker
CM	Child Mortality
CPR	Contraceptive Prevalence Rate
CSBA	Community Skilled Birth Attendant
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
EmOC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
FP	Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
HA	Health Assistant
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HNP	Health, Nutrition and Population
GFR	General Fertility Rate
GOB	Government of Bangladesh
HA	Health Assistant
HPNSDP	Health, Population, and Nutrition Sector Development Program
icddr,b	International Center for Diarrhoeal Disease Research, Bangladesh
IMCI	Integrated Management of Child Illness
IMR	Infant Mortality Rate
IUD	Intrauterine Device
IYCF	Infant and Young Child Feeding
LAPM	Long Acting and Permanent Method
LARC	Long-acting and Reversible Contraceptive

MA	Medical Assistant
MCWC	Maternal and Child Welfare Centre
MOHFW	Ministry of Health and Family Welfare
MOLGRDC	Ministry of Local Government, Rural Development, and Cooperatives
NHSDP	NGO Health Service Delivery Project
NGO	Non-government Organization
NIPORT	National Institute of Population Research and Training
NNM	Neonatal Mortality
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PM	Permanent Method
PNC	Postnatal Care
PNM	Post-neonatal Mortality
SAC	Stakeholder Advisory Committee
SACMO	Sub-Assistant Community Medical Officer
SAM	Short-acting Method
SBA	Skilled Birth Attendant
SES	Socioeconomic Status
SMC	Social Marketing Company
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TWC	Technical Working Committee
UESD	Utilization of Essential Service Delivery
UHC	Upazila Health Complex
U5MR	Under-five Mortality Rate
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development

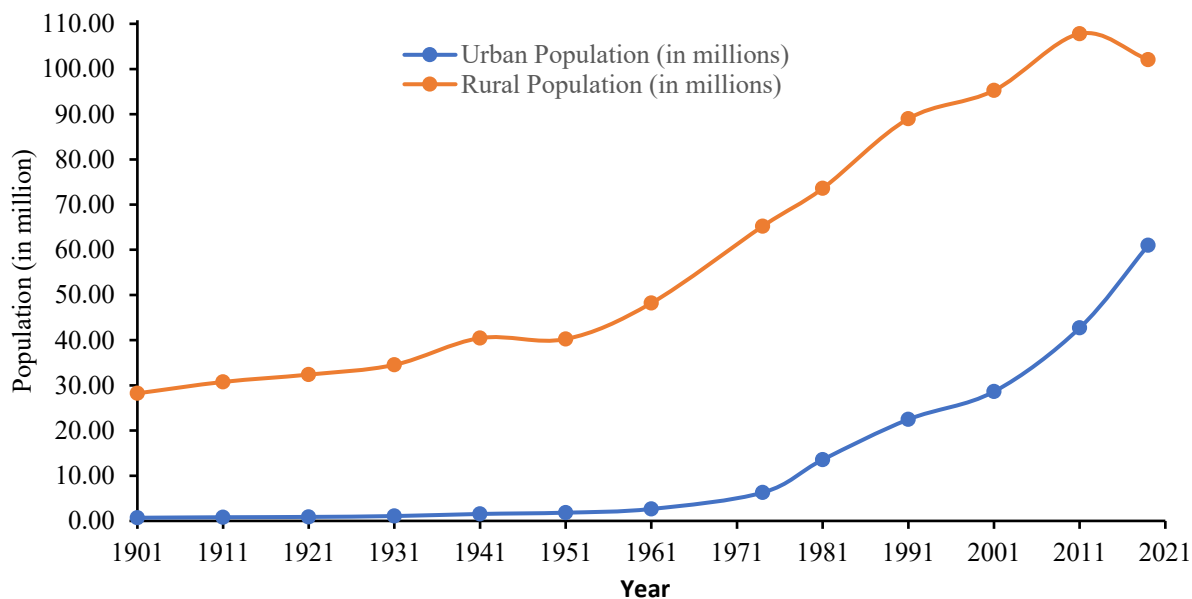
1.1 Background

Urban population refers to people living in urban areas as defined by national statistics offices. Urbanization means the share of urban population in the total population of a country. It refers to the population shift from rural to urban areas, the corresponding decrease in the proportion of people living in rural areas, and the ways in which societies adopt to the change. It is a process through which cities grow, and higher and higher percentages of the population come to live in the city.

In Bangladesh urbanization takes the pattern of rapid increase of urban population, largely because of natural growth and rural-urban migration. About two-thirds of the urban population growth is due to rural to urban migration. The urban population of Bangladesh was only 6.27 million in 1974 but grew to over 60.98 million in 2019. The urbanization level (percentage of population living in urban areas) has jumped from 8.78 per cent in 1974 to 27.66 per cent in 2011 and 37.40 percent in 2019, and 38.9 percent in 2021. The exponential long run trend of growth of urban population in Bangladesh over the period 1974-2019 has been 5.18 per cent, as against only 1.36 per cent of the rural population. During the period of 1974-2011, the long run trend of growth of the total population has been only 2.18 per cent, which indicates the rapidity of the pace of urbanization. The urban rural growth differential in terms of the annual exponential growth rates has averaged a sizeable 4.25 per cent in the last 45 years which illustrates the transformation of the country towards urbanization at a remarkable pace (2018).

Rapid urbanization is a global phenomenon. Bangladesh is experiencing the same. Significant variation exists in the level of urbanization by geographic or administrative regions. Bangladesh has some 570 urban centres that include 11 metropolitan cities (city corporations), over 322 Paurashavas (Municipalities) and a number of urban centres and cities (with population of over 100,000), of which Dhaka is the sixth largest megacity in the world (defined as having more than 10 million inhabitants) with 21 million people, up from being 24th in the population ranking in 1990. Dhaka is the 5th fastest growing megacity with a growth rate of 3.6 per cent per year. Primacy of Dhaka is very prominent with over 44 per cent of the total urban population of Bangladesh.

Figure 1.1: Trends of urban and rural population growth, Bangladesh, 1901–2021



Source: World Bank population estimates based on United Nations' World Urbanization Prospects: 2018 Revision.

The implications of massive size of national population and that of the urban population are manifold and extremely critical and challenging. Cities are characterized by inequalities in economic and health related conditions. Approximately one-third of urban inhabitants, mostly migrants, live in slums, which are highly crowded with little provision of basic amenities for healthy living.

The National Institute of Population and Research and Training (NIPORT), with funding from USAID and technical assistance from icddr,b and MEASURE Evaluation, conducted the 2006 Bangladesh Urban Health Survey (2006 UHS) and 2013 Bangladesh Urban Health Survey (2013 UHS) to examine the health profile and health-care seeking behaviors of urban residents living in slum and non-slum areas of City Corporations and District Municipalities. Along with individual and household interviews, the UHS included a community-level survey that gathered information about the broader circumstances within which urban residents live. The 2013 UHS revealed that Bangladesh has made progress in improving overall health of the marginalized slum population. The intra-urban differentials have narrowed for most of the health indicators between 2006 and 2013, the fertility fell below replacement level in all urban areas, indicating that the HPNSDP TFR goal of reaching 2.0 births per woman has already been achieved in urban areas. Maternal health has also articulated a success story for urban areas since it showed expected progress in ANC visits and use of skilled providers for delivery. However, the disparity between slums and non-slum areas still prevail.

Rationale: The Ministry of Health and Family Welfare (MOHFW) is implementing the Health, Population and Nutrition Sector Programme (HPNSP) for a period of five and half years from January 2017 to June 2022. The priority of HPNSP is to stimulate demand and improve access to and utilization of health, population and nutrition (HPN) services in order to reduce morbidity and mortality, particularly among infants, children and women; and reduce population growth rate and improve nutritional status, especially of women and children. HPNSP has an M&E component

with a provision of monitoring of the sector programme in every year to oversee its implementation progress. The Annual Programme Review (APR) supposes to assess implementation performance against agreed upon indicators in the Results Framework of HPNSP.

Although MIS exists in health and family planning programmes, this MIS cannot be expected to provide all necessary data for programme performance monitoring. The other credible national data sources that exist are either not implemented annually, or do not contain the information needed for the performance monitoring. Hence, there is a need to collect new data on urban health to aid M&E of HPNSP.

The results of the past Urban Health Surveys expanded the knowledge base regarding population health and health-related behaviors in urban areas of Bangladesh, with a particular emphasis on understanding the determinants of intra-city inequality in health outcomes, vulnerability and environmental risks in the urban setting. Seven years elapsed since the 2013 UHS. To see the changes or improvement, NIPORT commissioned 2021 Urban Health Survey (2021 UHS) to obtain a profile of key aspects of health conditions and behaviors of urban residents in slum and non-slum areas as well as to have updated information on the coverage of different health services delivery models. This report presents key findings of the 2021 UHS.

1.2 Objectives

The objectives of the 2021 UHS were:

- To document changes and obtain updated information on migration patterns in the main urban areas of Bangladesh with reasons of migration such as demographic, environmental, economic and pull factors, with emphases on examining population groups in urban slums, health conditions, health care-seeking behaviors, child/under-five mortality, maternal health and nutrition status of children.
- To explore individual, household and neighborhood-level factors associated with health outcomes, health behaviors, and nutritional status in urban areas, and
- To examine coverage of different health care delivery modes and
- To assess intra-urban differences and trends in key health outcomes.

1.3 Methodology

Similar to the 2006 UHS and 2013 UHS, the 2021 Urban Health Survey (2021 UHS) has been a multi-level study designed to illustrate the circumstances at the community/ neighborhood, household and individual level. The 2021 UHS was mainly composed of (1) a quantitative population-based household survey and (2) a community survey.

The household survey was based on representative sample drawn from three urban domains:

- Slum populations in the 11 City Corporations (CCs);
- Non-slum populations in the 11 City Corporations; and

- Rest Urban population (District Municipalities and large towns/ *Paurashavas* with a population over 45,000 inhabitants) as listed and documented by Bangladesh Bureau of Statistics (BBS).

The sampling frame of the survey was the complete list of urban Mohallahs/Mauzas in 11 CCs, all district Municipalities and large towns with population over 45,000 as maintained by the Bangladesh Bureau of Statistics (BBS). The City Corporations included were: Dhaka (North and South), Chattogram, Khulna, Rajshahi, Barishal, Sylhet, Rangpur, Narayanganj, Gazipur, Mymensing and Cumilla. Table 1.2 presents the population sizes of urban domains as provided by the BBS.

For the household survey, ever married female age 12–49 years, ever married male age 15–54 years and children age under five were the target populations. For the Community Survey, participants were the community leaders.

1.3.1 Sampling Design

The 2021 UHS did select representative samples from three domains of analysis: (1) Slum populations in the 11 CCs, (ii) non-slum populations in the 11 CCs, and (iii) the rest of the urban areas (all district municipalities and large towns with a population over 45,000 people) following a stratified three-stage sampling procedure.

Sample Size: The primary criteria for sample size estimation was to provide estimates with acceptable precision for (1) under-five mortality and (2) percentage of birth/ deliveries in health facilities for all births in the last three years for the three domains themselves and for comparing across domains.

Since large sample size is required for estimating under-five mortality, similar to the 2013 UHS, the 2021 UHS also used a long and short questionnaire. The short questionnaire was administered to the entire sample and its main purpose was to estimate under-five mortality. The long questionnaire was applied to alternative households selected from the total sample and its main objective was to measure the percentage of births delivered in health facilities. NIPORT estimated 12,000 short questionnaire households and 23,860 long questionnaire households, giving a total of 35,860 households in the sample.

Selection of sample households: The 2021 UHS followed a stratified three-stage sampling procedure for selection of sample households. The strata were (1) City Corporation, and (2) rest urban areas (district municipalities and large towns). In the first stage of sample selection, 450 *Mahallas* were selected in City Corporation and 184 were selected in the rest urban areas using proportional allocation, proportional to the size of City Corporations and District Municipalities/towns. In the second stage, in City Corporations, two clusters from each selected *Mahalla*, keeping the overall proportion 2:1 from non-slum and slum areas were selected. In case a selected *Mahalla* had no slum areas two non-slum clusters were selected from it and from next *Mahalla* with slum areas one from slum and one from non-slum areas were selected. Ultimately, 300 slum and 600 non-slum clusters were selected from 11 City Corporation areas. Also 245 clusters were proportionately selected from 184 *Mahallas* of rest urban municipality areas. A

cluster was either a segment of a non-slum or slum areas within a *Mahalla*, consisting of approximately 150 households. Mapping activity was conducted in each selected Mahalla, segmentation was done if necessary and then a randomly chosen segment was taken as a selected cluster. Household listing was done in each selected cluster, 30/35 households were systematically selected and then all eligible respondents from these households were interviewed. BBS assisted in selecting the *Mahallas*(Table 1.1).

A community interview was conducted in each selected *Mahalla* in which 5/6 key informants and community leaders were identified and gathered in a place within the *Mahalla* for community survey. Thus, 634 community interviews were conducted.

Table 1.1 presents the sample size, number of clusters, and cluster size per domain.

Table 1.1: Sample sizes of households and clusters for major domains of analysis

Domains	Short questionnaire households	Long questionnaire households	Total households	Number of HHs per cluster	Number of clusters	Number of mahallas
CC Slum	-	10,500	10,500	35	300	450
CC Non-slum	12,000	6,000	18,000	30	600	
Rest Urban	-	7,360	7,360	30	245	184
Total	12,000	23,860	35,860		1,145	634

1.4 Survey Sample and Response Rates

Table 1.2 shows the results of the household and individual interviews with ever-married women age 15-49 and ever-married male age 15-54. Among the 10,500 households selected from City Corporation slums, 10,377 were occupied. Interviews were successfully completed in 10,289 (99.2 percent) of the occupied households. Among the 17,880 households selected from City Corporation non-slums, 17,543 were occupied. Interviews were successfully completed in 17,376 (99.0 percent) of the occupied households. The corresponding household response rate among Rest urban households was 99.7 percent.

Among the selected 10,699 ever-married women age 12-49 eligible for interviews from City Corporation households, 10,281 were interviewed, yielding a response rate of 96.1 percent. The corresponding response rates among the women of City Corporation non-slums and Rest urban were 96.6 and 97.3 percent respectively. The household and individual interview response rates among the ever-married male age 15-54 were similar and varied from 95.6 to 97.7 percent. The principal reason for non-response among women and male was their absence from home despite repeated visits. Response rates did not vary notably.

Table 1.2: Results of the household and individual interviews

Number of households, number of interviews, and response rates, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

	City Corporation slum	City Corporation non-slum ²	Rest urban
Households			
Households selected	10,500	17,880	7,350
Households occupied	10,377	17,543	7,326
Households interviewed	10,289	17,376	7,307
Household response rate (%) ¹	99.2	99.0	99.7
Interview with ever-married women age 12-49			
Eligible women found	10,699	17,952	7,782
Eligible women Interviewed	10,281	17,333	7,572
Eligible women response rate (%)	96.1	96.6	97.3
Interviews with ever-married male age 15-54			
Eligible male found	3,402	2,275	2,485
Eligible male Interviewed	3,287	2,176	2,427
Eligible male response rate (%)	96.6	95.6	97.7

¹ Household interviewed/Household occupied

² Long questionnaire sample

1.5 Questionnaires

The 2021 UHS used four types of questionnaires: (1) Household Questionnaire; (2) Women's Questionnaire (Long & Short); (3) Men's Questionnaire; and (4) Community Questionnaire. These questionnaires were developed based on the model questionnaires used in 2006 UHS, and 2013 UHS and adapted to the situation and needs in Bangladesh. The adaptation process for the 2021 UHS involved a series of meetings with a Technical Working Committee (TWC). Draft questionnaires were circulated to other interested groups and were reviewed and approved by the TWC and Stakeholder Advisory Committee (SAC). The questionnaires were developed in English and then translated into and printed in Bangla.

Household Questionnaire: The Household Questionnaire was administered to the female head of household or to the most knowledgeable woman of the household and collected information on age, sex, and marital status of all household members and on household characteristics like dwelling ownership, housing condition (floor, wall and roof material, water source, sanitation facilities, etc.), and availability of assets and durable goods.

Women's Questionnaire (Long & Short): Ever married women aged 12-49 in sample households were the eligible respondents. The short questionnaire was administered to all respondents and collected information on individual background characteristics and birth history. The long questionnaire had additional modules on migration, family planning, maternal health care practices, child health and nutrition (child anthropometry), and was administered to a subsample of women.

Men's Questionnaire: This questionnaire collected information from ever married male aged 15-54 on basic background characteristics, exposure to mass media, brief migration history, family planning and intention to use long acting methods, and participation on maternal and child health care.

Community Questionnaire: The questionnaire, administered in each selected Mahalla during the household listing operation. It was administered to a group of four to six key individuals who were knowledgeable about socioeconomic conditions and the availability of health and family planning services/facilities in the *Mahalla*. It collected information on availability of health and public services in the community, presence of NGOs and development activities, and other general characteristics of the community.

All the instruments related to the survey were approved prior to the commencement of data collection by the institutional review board (IRB) at the Bangladesh Medical Research Council (BMRC).

Pretest and Finalization of Questionnaires:

Prior to conducting pretest, the questionnaires drafted in English, were translated into Bangla. The questionnaires were then pre-tested in both slum and non-slum settings outside the segments drawn in the sample. Twelve interviewers were trained and engaged for the pretest. Fifty women and 50 men were interviewed from 50 households in the pre-test. A quality control specialist was engaged to organize the fieldwork for the pre-test. The pretest training and fieldwork took place during January 02-15, 2021. Based on the observation in the field and suggestions made by the pretest teams, revisions were made in the wording and translations of the questionnaires. Pretest results were shared with NIPORT and the questionnaires were finalized with their approval.

1.6 Training of Field Staff, Field Work and Data Processing

The survey had two major components – (1) Household listing/mapping operation in selected clusters and a Community Survey in each selected *Mahalla*, and (2). Data Collection in the main survey. Separate teams of field staff were used for household listing/ mapping and data collection.

A total of 60 male field staff were recruited and trained for the household listing/mapping operation. Training for the household listers/mappers was organized for five days during December 17-20, 2020. After completion of listers/mappers training, teams were formed with successful trainees for household listing. About 200 field staff (both male and female) were recruited for data collection in the main survey based on their educational level, prior survey experience, maturity, and willingness to spend 4 months on the project. They were then trained for 15 days including two days of field practice. Training was provided in four separate classrooms, each with approximately 50 trainees, from 9:30 a.m. to 5.00 p.m. with one hour break for lunch. Training of fieldworkers was conducted from January 02-18, 2021. All the research team members and other senior professionals from Associate for Community and Population Research (ACPR) contributed in the training. Director General (DG), NIPORT, Research Director, and senior Evaluation Specialist, NIPORT attended the training as resource persons. Based on performance

of the trainees, teams were formed with successful trainees for data collection. The trainees with superior performance were selected as supervisors, and those with high performance were selected as data collection staffs. Experienced trainees with exceptionally high-performance were selected as Quality Control Officers (QCOs).

1.7 Fieldwork and Data Collection

Fieldwork for Household listing/mapping operation and Community Survey in selected clusters commenced on December 20, 2020 and was completed on February 20, 2021. Twenty-five teams of two persons each carried out the household listing operation and administered the Community Questionnaire. In addition, five Quality Control Officers (QCOs) monitored and guided household listing operation by remaining in the field. The work was done in two phases, one month in each

Fieldwork for the main survey was carried out by 33 six-member teams, with each team consisting of one male supervisor, one female supervisor, one male interviewers, two female interviewers and one male field assistance/ logistic person. Female interviewers did interview female and male interviewers interviewed male respondents. The male supervisor acted as the team leader to coordinate the works of the team members. The female supervisor did observe interviews, conduct field editing of filled-in questionnaire and ensure data quality through supportive supervision. Uniscale and height measuring tools were used for anthropometric measurements of under-five children. The Field Assistant in the team did assist in carrying the scales and tools and in taking the measurements. The work was done in three equal phases. Data collection commenced on January 24, 2021 and was completed on June 10, 2021. Data collection was delayed by three weeks due to prevailing COVID-19 pandemic and Eid ul Fitr.

ACPR fielded five quality control teams of two people, consisting of one male and one female, to monitor the field activities of the teams. In addition, research team members from ACPR monitored the fieldwork by visiting the teams in the field. Special teams from NIPORT also visited teams in the field. After completion of each phase of fieldwork, a debriefing session was conducted by ACPR to discuss in details the field experience, and appropriate decisions were made collectively. Field check tables, generated on a weekly basis by the data processing specialist, allowed the quality control teams to advise the field teams of problems detected during data entry.

1.8 Data Processing

After field editing and correction in the field, completed UHS questionnaires were returned to ACPR survey office in Dhaka for logging in and supplementary editing prior to data entry. Data entry and editing commenced at ACPR's own computer facility on March 20, 2021, and was completed April 20, 2021. The data were processed on 11 microcomputers working in double shifts, carried out by 22 data entry operators and two data entry supervisors. Data entry and editing programs were written in software program CSPro 4.1. To minimize errors, a double data entry procedure was followed

An analysis plan addressing all the objectives was developed by the ACPR research team and shared with NIPORT for comments and suggestions. Incorporating the feedbacks received, ACPR conducted the analysis as per the agreed plan, and prepared the draft report. Addressing the comments and suggestions received from NIPORT on the draft, report was modified, finalized and submitted to NIPORT.

1.9 Implementing Organizations

The UHS 2021 is intended to serve the programmatic and information needs of the Government of Bangladesh, development partners, and other organizations working on urban health. The UHS 2021 was conducted under the authority of NIPORT. A Technical Working Committee (TWC), and a Stakeholders Advisory Committee (SAC), composed of representatives from NIPORT, development partners and professionals, were formed to develop the objectives, scope and coverage, and to oversee the implementation of the survey. ACPR was selected for conducting the data collection, data processing, data analysis, and preparation of the report under the supervision of the TWC.

Key Findings:

Age

- ❖ The de facto population in slum and rest urban households was slightly younger; 31.3 percent were less than 15 years old in both the areas, compared to 29 percent of non-slum households.

Marital Status

- ❖ Slum women tend to marry earlier than women living in non-slum households. Thirty-five percent of teenage female in slums were ever married compared to 32.3 percent in non-slum households.

Drinking water

- ❖ Most urban households (97.7 percent of slum, 97.5 percent of non-slum and 98.1 percent of rest urban households) obtained their drinking water from a piped source or tube well.

Sanitation

- ❖ Disparities existed between slum and non-slum households in terms of access to improved and hygienic sanitation facilities. Fifty four percent of non-slum against only 27.9 percent of slum households used improved non shared toilet facility.

Electricity

- ❖ Ninety nine percent of slum and rest urban households and nearly all the non-slum households have access to electricity.

Wealth

- ❖ Fifty six percent of slum households were in the two lowest quintiles compared with 31.3 percent in non-slum areas.

Living Space

- ❖ In slums, more than half (54.8 percent) of households had one room for living, while it was just half (27.0 percent) in non-slum areas.

Information on the socioeconomic characteristics of the household population in the 2021 Urban Health Survey provides a context to interpret demographic and health indicators and can furnish an approximate indication of the representativeness of the survey. In addition, this information sheds light on the living conditions of the population. This chapter presents information on the

characteristics of the household population, selected features of the sampled households and socioeconomic status of households. This will allow to compare the population and housing profiles of slums, non-slums, and rest urban households. Such comparisons will provide insights regarding policy relevant issues.

The main focus in this section include age-sex composition, households' composition, housing characteristics, family living arrangements, access to electricity, drinking water and sanitation, hand washing, waste disposal, and possession of durable goods used for ranking households according to socioeconomic status.

2.1 Characteristics of Household Population

Household: The 2021 Urban Health Survey defines a household as a person or group of related or unrelated persons who live together in the same dwelling unit(s), who acknowledge one adult male or female as the head of the household, who share the same housekeeping arrangements, and who are considered a single unit. Information collected in the household roster allows for calculation of both the *de jure* and *de facto* household populations

Defacto population: All persons who stayed in the selected households the night before the interview (whether usual residents or visitors).

Dejure population: All persons who are usual residents of the selected households, whether or not they stayed in the household the night before the interview.

The tabulations presented in this chapter, unless otherwise stated are for the *de facto* household population. In the survey, interviews were completed for a total of 10,289 households in slums, 17,376 in non-slums, and 7,307 in rest urban areas. Households in the slum neighborhood of the City Corporation contained 2,04,160 *de facto* members(1,02,623 males and 1,01,537 females). The corresponding figure for non-slum neighborhood was 3,63,241 (1,81,642 males and 1,81,600 females), while for the rest urban areas was 1,67,623 (82,802 males and 84,820 females).

2.1.1 Age and Sex Composition

Table 2.1 provides the age and sex distribution of the *de facto* populations in the three survey domains by five-year age groups. Overall, the number of men exceeded the number of women. The population in slum and rest urban households was slightly younger (31.3 percent were less than 15 years old in both the areas), compared to 28.8 percent of non-slum households (Table 2.1 and Figure 2.1). The proportion aged 60 and over in slum households was 5.9 percent, compared to 7.8 percent in non-slum and 8.7 percent in other urban households. The proportion aged 65+ in slum households was 3.5 percent, while it was 4.9 and 5.7 percent in non-slum and rest urban households respectively.

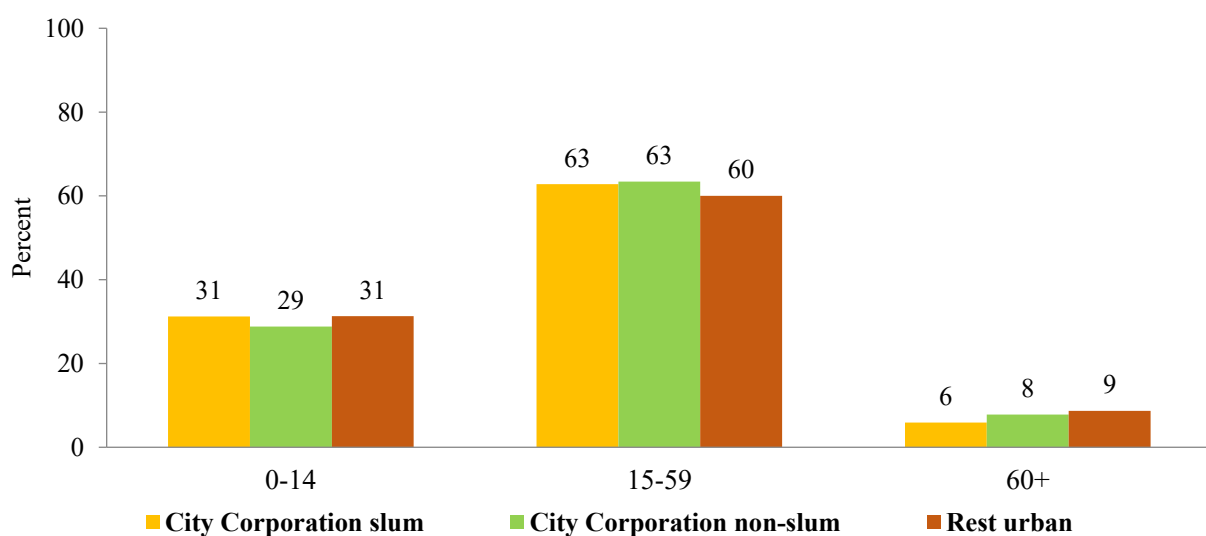
Table 2.1: Household population by age, sex, and domain

Percent distribution of the de jure household population by five-year age groups, according to sex, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Age	City Corporation slum			City Corporation non-slum			Other municipalities/urban		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4	10.3	10.2	10.3	9.8	10.2	10.0	10.5	10.4	10.5
5-9	10.5	10.0	10.2	9.6	9.5	9.5	10.9	10.5	10.7
10-14	10.6	10.8	10.7	9.4	9.2	9.3	10.0	10.1	10.1
15-19	10.7	12.3	11.5	9.0	10.1	9.6	8.7	10.1	9.4
20-24	9.3	10.6	9.9	8.7	10.9	9.8	7.9	9.8	8.8
25-29	8.7	9.5	9.1	7.9	9.5	8.7	7.5	8.9	8.2
30-34	7.4	8.4	7.9	7.4	8.4	7.9	7.5	8.5	8.0
35-39	8.0	7.9	8.0	8.4	8.2	8.3	7.9	7.2	7.5
40-44	6.3	5.1	5.7	6.9	5.7	6.3	6.9	5.5	6.2
45-49	5.4	4.4	4.9	5.9	5.2	5.5	5.5	4.7	5.1
50-54	4.3	2.1	3.2	4.9	2.5	3.7	5.1	2.4	3.7
55-59	2.2	3.0	2.6	3.6	3.6	3.6	2.5	3.6	3.1
60-64	2.7	2.2	2.4	3.1	2.7	2.9	2.9	3.0	3.0
65-69	1.4	1.3	1.4	2.2	1.7	2.0	2.3	2.0	2.2
70-74	1.2	0.9	1.1	1.7	1.4	1.5	1.9	1.6	1.7
75-79	0.5	0.4	0.5	0.7	0.4	0.6	0.9	0.6	0.7
80+	0.5	0.5	0.5	0.7	0.9	0.8	1.2	1.0	1.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	1,02,623	1,01,537	2,04,160	1,81,642	1,81,600	3,63,241	82,802	84,820	1,67,622

The age structure in all three domains were almost identical and the child dependency ratio (percentage of children aged 0-14 to adults age 15-59) appeared to have increased in all three domains compared to 2013UHS results.

Figure 2.1: Age distribution of household population, 2021 UHS.



2.1.2 Household Composition

Table 2.2 shows that a small minority of households in all three domains are headed by females, with about 90 percent headed by males. The declining trend as observed between 2006 and 2013, the female-headed households continued to decline slightly between 2013 and 2021, but were most common in slums (11.7 percent), followed by non-slums (11.0 percent), and rest urban areas (9.4 percent). The overall mean number of usual members per household was 4.1, 4.3, and 4.5 respectively, in slum, non-slum and rest urban households. It appeared that the average household size remained the same in the three domains as that was observed in 2013 UHS.

Table 2.2: Household composition

Percent distribution of households by sex of the head of household, household size, according to study domain, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Sex of household head			
Male	88.3	89.0	90.6
Female	11.7	11.0	9.4
Total	100.0	100.0	100.0
Number of usual members			
1	1.8	1.4	0.8
2	11.5	9.8	7.2
3	22.2	20.5	18.7
4	29.6	31.9	31.2
5	18.6	20.0	22.0
6	9.0	8.6	10.6
7	3.9	3.4	4.4
8	1.9	2.0	2.3
9+	1.4	2.4	2.7
Total	100.0	100.0	100.0
Number	10,177	17,123	7,295
Mean household size	4.1	4.3	4.5

2.1.3 Marital Status

Figures in Table 2.2 show that slum women tend to marry earlier than women living in non-slum households. Thirty five percent of teenage females in slums were ever married compared to 28.3 percent in non-slum households. The proportion of ever married women aged 20-24 was also higher in slums (78.4 Percent) compared to non-slum (72.0 Percent) areas.

The proportion of ever married among teenage slum women appeared to have decreased by 2 percentage points (from 37.2 to 34.9 percent) in slums, increased by 2.3 percentage points in non-slums, and decreased by 9.7 percentage points in rest urban areas (Figure 2.2).

There was a small number of ever married men age less than 20 years in all the three domains (1.1 to 4.4 percent).

Figure 2.2: Percent of female population ever married in City Corporation slum and non-slum, UHS 2006, 2013 and 2021

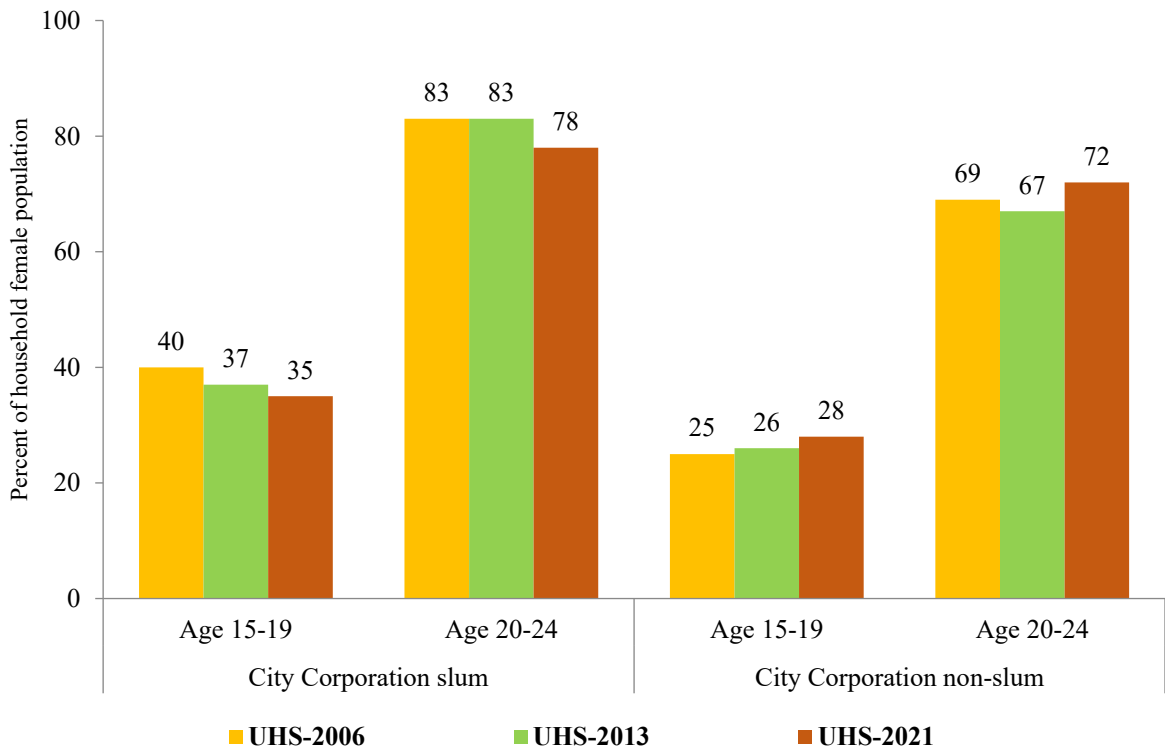


Table 2.3: Marital status of household population

Percentage of household female and male population by five-year age groups, according to marital status, and major domains, UHS 2021

Age group	City Corporation slum			City Corporation non-slum			Other municipalities/urban		
	CM*	FM	NM	CM	FM	NM	CM	FM	NM
Female									
10-14	0.6	0.0	99.4	0.8	0.0	99.2	1.3	0.0	98.7
15-19	33.9	1.0	65.1	27.7	0.6	71.7	28.5	0.2	71.3
20-24	74.6	3.8	21.6	70.1	1.9	28.0	75.9	1.7	22.5
25-29	89.5	5.0	5.5	90.4	2.6	7.0	91.6	2.7	5.7
30-34	92.5	6.1	1.5	94.6	3.4	2.0	95.8	2.6	1.5
35-39	92.6	7.1	0.2	94.1	3.7	2.2	95.7	3.2	1.1
40-44	89.4	9.0	1.6	89.6	9.5	0.9	93.0	6.3	0.6
45-49	84.1	15.4	0.6	83.9	15.3	0.8	88.7	10.7	0.6
50-54	65.8	34.1	0.1	78.2	21.1	0.7	78.8	19.9	1.3
55-59	65.0	35.0	0.0	72.9	26.8	0.3	72.2	27.7	0.1
60-64	42.1	57.0	0.8	53.6	44.9	1.5	52.2	46.8	0.9
65-69	29.2	70.4	0.4	38.6	61.2	0.1	38.4	60.9	0.7
70-74	15.7	84.1	0.2	27.4	72.6	0.0	29.1	69.8	1.1
75-79	10.5	89.5	0.0	18.3	78.8	2.9	20.8	79.2	0.0
80+	5.0	95.0	0.0	7.5	92.5	0.0	8.2	91.8	0.0
Dk/Missing	0.0	100.0	0.0	0.0	100.0	0.0	0.0	0.0	0.0
Total	61.4	11.2	27.5	63.9	10.4	25.7	63.8	10.6	25.7
Number	49,681	9,046	22,226	93,221	15,170	37,437	42,760	7,078	17,215
Male									
10-14	0.1	0.0	99.9	0.2	0.2	99.6	0.0	0.0	100.0
15-19	4.1	0.2	95.7	2.1	0.1	97.8	1.1	0.0	98.9
20-24	33.4	0.8	65.9	23.0	0.4	76.6	20.7	0.5	78.8
25-29	73.4	1.1	25.5	60.0	0.5	39.5	58.8	0.6	40.5
30-34	93.4	0.8	5.7	87.3	0.6	12.1	86.7	0.7	12.6
35-39	97.3	1.2	1.5	94.7	1.3	4.0	96.9	0.9	2.1
40-44	98.1	1.8	0.1	97.9	0.8	1.4	98.1	0.6	1.3
45-49	98.1	1.0	0.9	96.9	1.5	1.6	98.7	0.4	0.9
50-54	98.3	1.3	0.4	97.0	1.2	1.8	98.3	1.1	0.6
55-59	94.8	4.4	0.8	96.4	2.7	0.9	96.2	2.6	1.2
60-64	95.7	3.9	0.4	96.3	3.4	0.3	97.7	2.1	0.1
65-69	94.0	6.0	0.0	93.9	4.3	1.7	95.9	3.9	0.1
70-74	89.3	10.7	0.0	88.8	10.9	0.3	93.2	6.8	0.0
75-79	81.9	18.1	0.0	93.9	6.1	0.0	86.4	12.5	1.1
80+	75.6	24.4	0.0	79.5	20.5	0.0	76.2	23.8	0.0
Dk/Missing	100.0	0.0	0.0	45.7	54.3	0.0	29.5	70.5	0.0
Total	60.8	1.5	37.7	61.9	1.4	36.7	61.5	1.4	37.2
Number	49,456	1,217	30,620	90,691	2,063	53,679	40,008	887	24,198

* CM: Currently married, FM: Formerly married, NM: Never married.

2.2 Housing Characteristics

2.2.1 Ownership of land and Dwelling

Table 2.4 provides the distribution of household ownership of dwelling and land. Renting was the predominant form of tenure in slum (60.7 percent) areas, followed by non-slum (43.1 percent) and

rest urban areas (21.3 percent). Dwelling owned by households was the highest in rest urban areas (78.0 percent), followed by non-slum (50.7 percent) and slum areas (36.3 percent). These results are in line with 2013 UHS results.

Consistent with the rented dwellings, the same proportion of slum and non-slum households reported that the land for their dwellings was owned by the landlord. The proportion of slum households on government land was higher in slums (18.8 percent), a two-fold increase compared to 2013 UHS results.

Table 2.4: Housing characteristics: Living space

Percent distribution of households¹ by living space and number of living rooms, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Usable space per usual resident¹			
<= 25 square feet	7.8	2.7	2.0
26-50 square feet	27.8	12.8	10.2
51-75 square feet	22.1	14.3	14.1
76-100 square feet	13.9	11.5	10.9
100 ⁺ square feet	28.4	58.7	62.8
Total.	100.0	100.0	100.0
Mean (sq. feet)	93.9	175.3	185.6
Median (sq. feet)	67	126	135
Number of living rooms			
1	54.8	27.0	20.4
2	32.5	35.9	35.4
3	8.8	21.9	24.5
4 ⁺	3.9	15.2	19.7
Total	100.0	100.0	100.0
Mean household size	4.1	4.3	4.5
Number	10,177	17,123	7,295

¹Excludes 88, 252 and 12 mess-households from CC-slum, CC-non-slum, and rest urban domains, respectively.
Note: Usable space includes all rooms/spaces including kitchen and bathrooms.

2.2.2 Living Space

Table 2.5 presents information on the households by usable living space that includes all rooms/spaces including kitchen and bathrooms, and the number of living rooms by three domains. For purposes of this survey, 25 square feet per person of floor space was considered a bare minimum requirement.

Results show that median living space per person was much smaller in slums, 67 square feet, compared to 126 square feet in non-slums and rest urban areas (135 square feet).

In slums, more than half (54.8 percent) of households lived in one room, while it was just half (27.0 percent) in non-slum and one-fifth (20.4 percent) in rest urban areas. Proportion of 4+ living room households was negligible in slum areas (3.9 percent).

Table 2.5: Housing characteristics: Ownership

Percent distribution of households² by tenure of dwelling and land ownership, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Tenure of dwelling			
Rented by household	60.7	43.1	21.3
Owned by household	36.3	50.7	78.0
Owned by employer	2.1	5.4	0.3
Other	0.8	0.8	0.4
Total.	100.0	100.0	100.0
Ownership of land			
Owned by family	20.4	47.4	77.5
Owned by govt.	18.8	8.3	0.8
Owned by NGO	0.9	0.4	0.2
Owned by landlord	59.1	42.9	20.1
Relatives/other	0.5	0.9	1.3
Other	0.3	0.1	0.1
Total	100.0	100.0	100.0
Number of households*	10,177	17,123	7,295

²Excludes 88, 252 and 12 mess-households from CC-slum, CC-non-slum, and rest urban domains, respectively.

*Excludes mess households and missing values.

Figure 2.3a: Living space per persons in City Corporation slum and non-slum areas, UHS 2006, UHS 2013 & UHS 2021

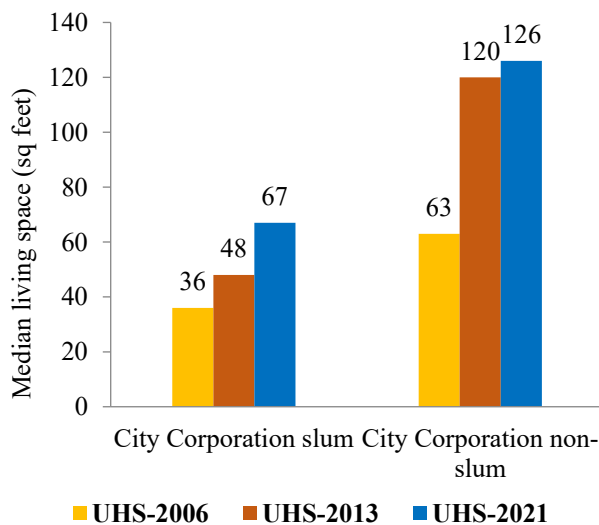
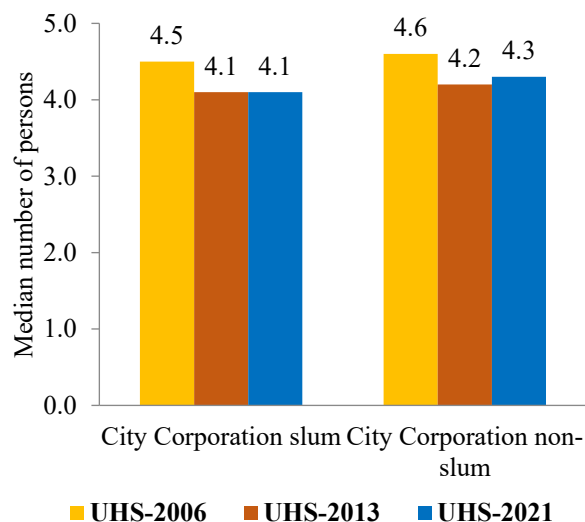


Figure 2.3b: Mean number of persons per household in City Corporation slum and non-slum areas, UHS 2006, UHS 2013 & UHS 2021



2.2.3 Access to Electricity, Cooking Facilities and Cooking Fuel

The survey collected data on access to electricity, cooking facilities and fuel the households use for cooking. Ninety-nine percent of households in slum and rest urban households (98.9 percent in slum and 98.9 percent in rest urban), and 99.7 percent of non-slum households have access to electricity (Table 2.6).

Exposure to smoke inside the home, for example from cooking with solid fuels (coal/lignite, charcoal, wood, straw/shrubs/grass, agricultural crops, and animal dung), has potentially harmful health effects. Results show that many of the households in three urban domains had a separate cooking space/room either inside or outside the house. The proportion of separate cooking space/room inside the house was more common in non-slum households (64.5 percent) as compared to rest urban and slum households (53.7 percent and 44.8 percent, respectively). A substantial proportion of households in slums (46.2 percent) and rest urban (39.8 percent) areas cook in separate rooms outside the house.

About 61.6 percent of rest urban, 38.7 percent of slums and 28.6 percent of non-slum households use solid fuel for cooking, while 70.8 percent of non-slum, 60.2 percent of slum and 38.1 percent of rest urban households use clean fuel (electricity, and liquid petroleum gas/natural gas/biogas). Wood is the most common type of solid fuel for cooking, used by 47.9 percent of rest urban, 35.4 percent of slum and 24.5 percent of non-slum households (Table 2.7).

Table 2.6: Housing characteristics: Electricity and cooking facilities

Percent distribution of households by availability of electricity and cooking facility, according to major domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Household has electricity			
Yes	98.9	99.7	98.9
No	1.1	0.3	1.1
Total.	100.0	100.0	100.0
Cooking facilities in the household			
Inside household	44.8	64.5	53.7
In separate room outside house	46.2	30.3	39.8
Open space	9.0	5.1	6.5
Others	0.1	0.0	0.0
Total	100.0	100.0	100.0
Number of households ¹	10,177	17,123	7,295

¹Excludes 88, 252 and 12 mess-households from CC-slum, CC-non-slum, and rest urban domains, respectively.

Table 2.7: Type of cooking fuel

Percent distribution of households by type of cooking fuel, according to major domains, UHS 2021

Type of fuel used for cooking	City	City	Rest urban
	Corporation slum	Corporation non-slum	
Electricity	1.3	0.4	0.3
Liquid gas/natural gas/bio-gas	59.0	70.2	37.8
Kerosene/coal/coke/charcoal	0.4	0.2	0.1
Wood.	35.4	24.5	47.9
Rice husk/wood powder/grass/dung cakes/other	3.5	4.5	13.8
No cooking in household	0.4	0.3	0.1
Total	100.0	100.0	100.0
Number of households	10,177	17,123	7,295

2.2.4 Household Drinking Water and Sanitation

Improved sources of drinking water: Include piped water, public taps, stand pipes, tubewells, boreholes, protected dug wells and springs, rainwater, water delivered via a tanker truck or a cart with a small tank, and bottled water.

Drinking water

Improved sources of drinking water protect against outside contamination so that water is more likely to be safe to drink. Access to improved water source is almost universal in all the three urban domains: slum, non-slum, and rest urban areas (Table 2.8). Most urban households (97.7 percent of slum, 97.5 percent of non-slum and 98.1 percent of rest urban households) obtained their drinking water from a piped source or a tube-well.

Sharing of drinking water source was a common phenomenon in slum households (77.7 percent). More than half (58.5 percent) of non-slum, and 48.6 percent of rest urban households did not share their drinking water source. Fifty two percent of slums and 15 percent of non-slum households should a water source by 10 or more households.

Table 2.8: Household drinking water

Percent distribution of households by source of drinking water, percentage sharing the source of drinking water, according to major domains, UHS 2021

Source of drinking water	City	City	Rest urban
	Corporation slum	Corporation non-slum	
Piped water into dwelling/yard/plot	56.8	69.3	28.2
Public tap/pipe	8.3	3.0	1.0
Tube well or borehole	32.6	25.2	68.9
Protected (dug well/spring)/rainwater/bottled water	1.3	1.1	1.7
Unprotected (dug well/spring)/surface water/other	1.0	1.4	0.2
Total.	100.0	100.0	100.0
Share water source with other			
Not shared	22.3	58.5	48.6
2-4 households	13.0	18.9	24.5
5-9 households	12.6	7.4	9.3
10+ households	51.5	14.7	17.2
Don't know/missing	0.6	0.4	0.4
Total	100.0	100.0	100.0
Number of households	10,177	17,123	7,295

Access to improved sanitation facilities is an important determinant of health and environmental safety. Use of improved sanitation facilities prevents people from coming into contact with human waste and helps reduce the transmission of communicable diseases such as diarrhea, dysentery, and typhoid.

Sanitation Facilities

Improved toilet facilities include flush/pour flush toilets that flush water and waste to a piped sewer system, septic tank, pit latrine, or unknown destination; ventilated improved pit (VIP) latrines; pit latrines with slabs; or composting toilets.

Results presented in Table 2.9 shows that disparities existed between slum and non-slum households in terms of access to improved and hygienic sanitation facilities. Fifty four percent (54.0 percent) of non-slum against only 27.9 percent of slum households used improved-not shared toilet facility. Proportion of households used improved but shared toilets was much higher in slum (41.9 percent) compared to non-slum (17.7 percent) and rest urban (20.9 percent) areas.

Table 2.9: Household sanitation facilities

Percent distribution of households by availability of electricity and cooking facility, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Improved, not shared facility			
Flush to piped sewer system/septic tank	12.5	31.6	32.8
Ventilated improved pit	15.4	22.4	38.5
Shared facility¹			
Flush to piped sewer system/septic tank	13.8	6.1	4.8
Ventilated improved pit	28.1	11.6	16.1
Non-improved facility			
Flush to somewhere	26.4	27.0	4.5
Pit latrine without slab	2.7	1.0	2.9
Bucket latrine/open/hanging latrine	0.9	0.2	0.3
No facility	0.2	0.2	0.1
Total	100.0	100.0	100.0
Shared sanitation facility			
Not shared	36.3	73.1	76.4
2-4 households	23.6	18.8	19.4
5-9 households	17.5	4.9	3.2
10 ⁺ households	22.5	3.2	1.1
Don't know/missing	0.1	0.0	0.0
Total	100.0	100.0	100.0
Number	10,177	17,123	7,295

¹ Shared facility of an otherwise improved type.

Hand washing

Proper hand washing is the most effective way to prevent germs from spreading. In the 2021 UHS, interviewers were instructed to observe the place where household members usually washed their hands, and whether the households had cleansing agents near the place of hand washing. Table 2.10 shows that, a place for hand washing was observed in most households in all the three domains. Eighty five percent of slum, 92.8 percent of non-slum and 86.5 percent households of rest urban had a fixed place for hand washing. Three-fourth of non-slum (78.5 percent) and rest urban (72.1 percent) households had soap, water and other cleansing agent at the place of hand washing facilities, while it was only in 49.2 percent of slum households.

Table 2.10: Hand washing

Percent distribution of households in which the place most often used for washing hands was observed, percent distribution by availability of water, soap, and other cleaning agent, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Percentage of households where place for washing hands observed	85.2	92.8	86.5
Number of households	10,177	17,123	7,295
Hand washing facilities			
Soap and water	47.4	76.1	70.4
Water and cleaning agent other than soap	1.8	2.4	1.7
Water only	50.6	21.3	27.8
No water	5.2	1.4	2.5
Number of households with place for hand washing observed	8,668	15,883	6,312

Note: Soap includes soap or detergent o bar. Cleaning agent other than soap includes: ash, mud, or sand.

Waste Disposal

Table 2.11 provides percent distribution of households by main method of garbage disposal, according to the survey domains. About 43.2 percent of slum households disposed of their garbage in an open space outside, 30.6 percent of garbage was collected from home and 22.2 percent was disposed of in bins outside house. Disposing of garbage in open space outside home was the main method in rest urban (71.8 percent) areas, while 38.5 percent of non-slum households did the same. Forty five percent (44.8 percent) of non-slum households had the garbage collected from home.

Table 2.11: Household waste disposal

Percent distribution of households by main method of garbage disposal, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Principal method for garbage disposal			
Collected from home	30.6	44.8	10.4
Household disposes within premises	2.2	2.9	7.1
Household disposes in bin outside house	22.2	12.9	8.5
Household disposes in open space outside house	43.2	38.5	71.8
Garbage burned/buried/other	1.8	0.7	2.1
Total	100.0	100.0	100.0
Number of households	10,177	17,123	7,295

2.2.5 Roof Wall and Floor Material

Housing conditions are characterized by the materials used to construct the dwelling. Cement was the most commonly used flooring material in urban households. Seventy seven percent (76.8 percent) of slum households had cement as the floor material, while it was 64.1 percent of non-slum and 56.7 percent of rest urban households. One-third (35.0percent) of rest urban households had earth/sand floor.

Eighty-seven percent (86.6percent) of slum households used tin/wood in roofs, the corresponding percentage was 73.8 percent in rest urban and 50.1 percent in non-slum areas. Half of the non-slum households had roof made of cement/ceramic tiles.

Seventy four percent of the walls of non-slum households were made of cement and 20.9 percent were made of tin. Cement and tin were also the predominant materials used for walls of slum households (50.8 percent of cement and 41.0 percent of tin). Similar was the case for the rest urban households. Housing condition remained the same as that was observed in 2013 UHS (Table 2.12).

Table 2.12: Housing characteristics: Dwelling material

Percent distribution of households by dwelling materials of house, according to major domains, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Main material of floor			
Earth, sand	18.5	14.2	35.0
Wood planks/palm, bamboo	1.6	0.2	0.1
Parquet, polished wood/ceramic tiles	3.0	21.5	8.2
Cement	76.8	64.1	56.7
Other	0.1	0.0	0.0
Main roof materials			
No roof/Thatch/palm leaf/polythin	0.5	0.0	0.1
Bamboo/wood planks/cardboard	0.1	0.1	0.1
Tin/ wood	86.6	50.1	73.8
Ceramic tiles/cement	12.8	49.9	25.8
Other	0.0	0.0	0.3
Main wall materials			
No wall/jute stick/palm/trunks/soil/mud	0.6	1.4	2.0
Bamboo with mud stone with mud/plywood/cardboard	2.8	0.5	1.9
Tin	41.0	20.9	42.1
Cement	50.8	74.1	48.6
Brick without plaster	4.3	2.9	5.1
Wood planks/shingles/other	0.5	0.1	0.3
Total	100.0	100.0	100.0
Number of households	10,177	17,123	7,295

2.2.6 Household Possession of Durable Items

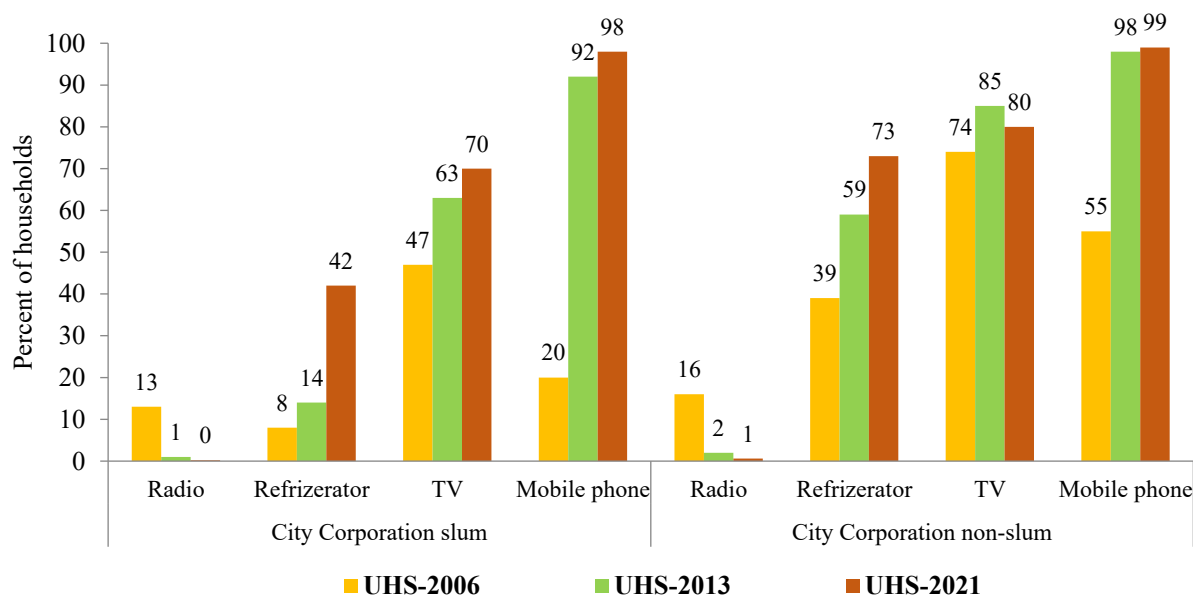
Table 2.13 present information on the distribution of households possessing various durable household goods, including household furnishings and various items associated with media, transportation and communication. It is to be noted that information on ownership of a common set of durable goods has been used for ranking households according to socio-economic status (i.e. wealth index). Results in Tables 2.13 show that sharp disparities between slum and non-slum households in terms of ownership of such items are apparent. Only 41.7 percent of slum households possessed refrigerator against 72.9 percent non-slum households. Similar was the ownership situation for computer. About 60.6 percent of slum, 84.0 percent in non-slum and 76.4 percent in rest urban households owned computer/laptop. Mobile phone were equally and universally available in slum, non-slum and rest urban households, but non-slum households are more likely to own television (80.1 percent), compared to slum (69.9 percent) and rest urban (71.9 percent) households. Ownership of furniture like Almira/ wardrobe was higher among non-slum households (84.0 percent) than among slum households (60.6 percent).

Table 2.13: Household possessions of durable goods

Percentage distribution of households possessing various durable household goods, according to major domains, UHS 2021

Durable goods	City Corporation	City Corporation	Rest
	slum	non-slum	urban
Radio	0.2	0.6	0.3
Television	69.9	80.1	71.9
Mobile telephone	97.6	99.0	98.8
Non-mobile telephone	0.7	3.1	1.1
Refrigerator	41.7	72.9	62.2
Computer/laptop	3.7	19.7	10.5
Almirah/ wardrobe	60.6	84.0	76.4
Fan	96.1	98.2	97.2
Bicycle	9.5	12.8	20.4
Motorcycle	2.7	9.2	14.4
CNG/tempo	0.8	0.8	1.3
Car/truck/bus/microbus	0.4	2.1	0.9
Rickshaw/van	5.6	2.3	4.0
DVD/VCD player	0.1	0.4	0.1
IPS/generator	0.4	4.8	1.7
Air-conditioned	0.1	4.2	0.8
Do not own any durable goods	0.3	0.1	0.0
Number	10,177	17,123	7,295

Figure 2.4: Ownership of durable goods in City Corporation slum and non-slums, UHS 2006, UHS 2013 and UHS 2021.



2.3 Socio-economic Status

Households across all the three domains were given scores based on the number and kinds of consumer goods they own, ranging from a television to a bicycle or car, and housing characteristics such as source of drinking water, toilet facilities, and floor, wall and roof materials. These information was used to categorize households according to their socio-economic (SES) status. Each variable was assigned a factor score or weight and a SES index is constructed as a weighted sum of these variables. This index is constructed using a version of the principal component approach. The index is then used to rank and classify households into quintiles referred to as household asset quintiles or “Wealth quintile”.

Table 2.14: Socio-economic status index

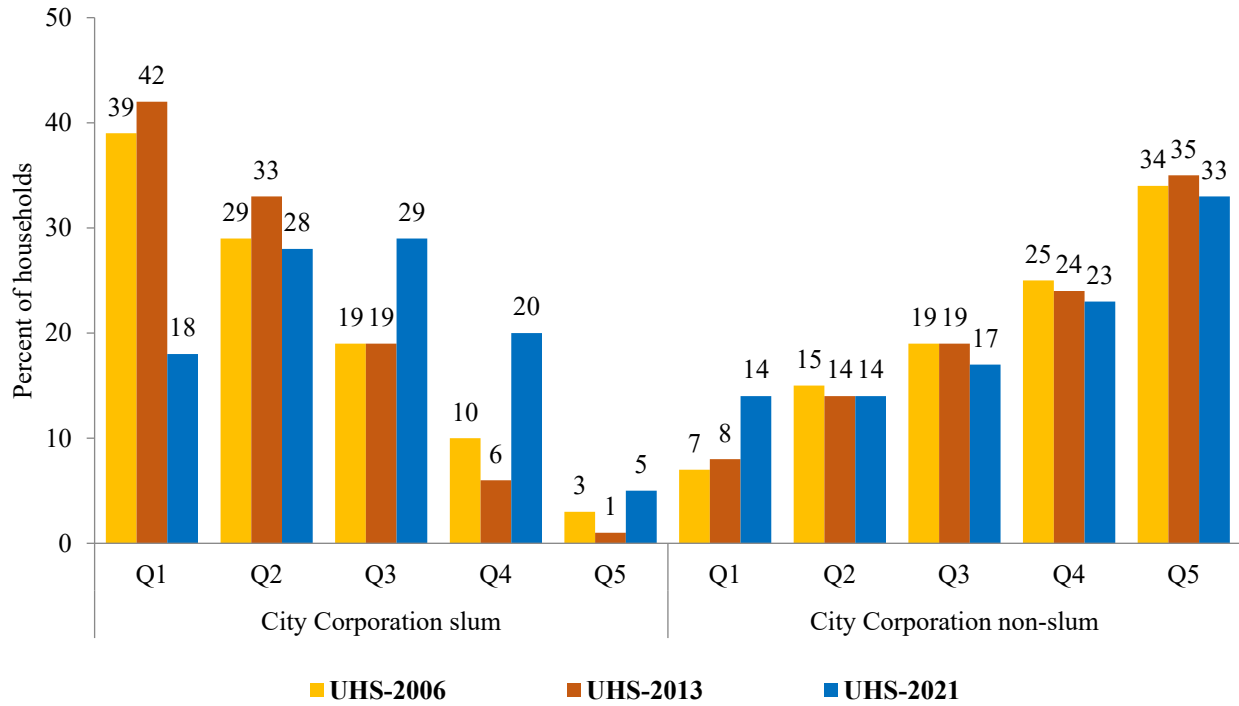
Percentage distribution of household by SES quintile index, according to major domains, UHS 2021

SES quintile	City Corporation slum	City Corporation non-slum	Rest urban	All
Poorest	18.3	13.5	38.0	20.1
Poorer	28.2	14.1	22.8	20.1
Middle	28.9	16.9	14.8	20.0
Richer	20.1	22.7	13.2	19.9
Richest	4.5	32.8	11.2	19.9
Total	100.0	100.0	100.0	100.0
Number of households	10,177	17,123	7,295	34,595

Table 2.14 presents distribution of household by wealth quintile (SES) across the three domains. About 18.3 percent of the slum households belong to the poorest quintile, as compared with 13.5 percent of non- slum and 38.0 percent of rest urban households.

Differences in the wealth distribution are skewed both in slum and non-slum areas, but in opposite direction. Poorer households in slums and rest urban areas are more concentrated in lower quintiles, while in non-slum areas wealthiest are more in numbers in higher quintiles. This pattern prevailed also in 2006 and 2013 UHS.

Figure 2.5: Distribution of household by wealth quintiles in City Corporation slums and non-slums, UHS 2006, UHS 2013 and UHS 2021.



Key Findings

Age

- ❖ Women in slums were younger than those in non-slums; 27.0 percent of women in slums were aged under 25 years, compared to 22.6 percent in non-slums and 22.3 percent in rest urban areas.

Education

- ❖ Women in slums were less likely to be educated than women in non-slums and rest urban areas. Fifty seven percent women in slums had completed at least primary education compared with 81.7 percent in non-slums and 80.4 percent in rest urban domains.
- ❖ Percentage of slum women with no formal education has declined by 12 percentage points from 32.0 percent in 2013 to 20.0 percent in 2021.
- ❖ Fifty six percent Men in slums had completed at least primary education compared with 75.7 in non-slums and 71.4 percent in rest urban domains.

Employment Status

- ❖ Thirty two percent women in slums worked full time compared with 14.7 percent in non-slums and 9.1 percent in rest urban areas.

Ownership of Cell Phone

- ❖ More than 77 percent women in slums owned a cell phone, a 23 percentage points increase from 54.0 percent in 2013. In comparison, 88.5 women in non-slums and 84.6 percent in rest urban owned a cell phone.

Exposure to Media

- ❖ More than eight in ten women in non-slums, and three-fourths of rest urban areas watched television at least once a week. Among slum women TV exposure was 79.4 percent.

NGO Membership

- ❖ Twenty six percent women in slums had NGO membership, while this was 18.5 percent in non-slums and 28.7 percent in rest urban areas.

Awareness and Incidence of COVID-19

- ❖ Almost all the women and men across the three domains had heard about COVID pandemic, and majority were found aware of how it spreads and how to prevent its transmission.
- ❖ Less than one percent of slum women (0.5 percent) against 2.1 percent of non-slum and 1.1 percent of rest urban reported COVID-19 incidence in their household.

This chapter presents information on the background characteristics of the eligible male and female respondents to the 2021 Urban Health Survey. This will provide some context to compare disparities in health-related indicators that may exist across survey domains. The basic socio-demographic characteristics of 35,186 ever married women aged 12-49 and 7,890 ever married men aged 15-54 who responded to the survey are presented here. Among them, 48 women were in the age 12-14, the total number of ever married women age 15-49 was 35,138.

3.1 Basic Characteristics of Survey Respondents

Table 3.1 presents distribution of ever married women aged 15-49 by selected background characteristics. Women in slums were younger than those in non-slum; 26.5 percent in slums were aged 15-24 years, compared to 22.0 percent in non-slum and 21.8 percent in rest urban areas. The proportion of women in the middle reproductive age group (25-34 years) were almost the same across all the domains. The proportion of women in the older age group is higher in non-slum (42.1 percent) and rest urban (41.0 percent) areas compared to the slum areas (36.6 percent).

Table 3.1: Background Characteristics of respondents: Women

Percent distribution of ever married women age 15-49 by selected background characteristics, according to domains, UHS 2021

Background Characteristics	City Corporation slum		City Corporation non-slum		Rest urban	
	Weighted percentage	Weighted number	Weighted percentage	Weighted number	Weighted percentage	Weighted number
Age						
15-24	26.5	2,721	22.0	3,807	21.8	1,645
25-34	36.9	3,790	35.9	6,220	37.3	2,814
35-49	36.6	3,758	42.1	7,288	41.0	3,095
Region						
Dhaka	27.6	2,836	52.9	9,157	21.5	1,621
Other division	72.4	7,433	47.1	8,157	78.5	5,934
Marital status						
Currently married	92.4	9,484	94.1	16,290	95.4	7,208
Divorced/separated/widowed	7.6	785	5.9	1,025	4.6	347
Wealth quintile						
Poorest	18.2	1,873	13.7	2,371	37.5	2,829
Poorer	27.9	2,864	14.0	2,430	23.2	1,754
Middle	28.4	2,920	17.0	2,943	15.2	1,151
Richer	20.7	2,121	22.6	3,919	13.2	997
Richest	4.8	491	32.6	5,649	10.9	823
Education						
No education	20.0	2,011	7.8	1,307	9.1	672
Primary incomplete	22.9	2,307	10.5	1,771	10.5	776
Primary complete	17.7	1,785	11.2	1,889	13.4	991
Secondary incomplete	27.7	2,790	34.1	5,738	35.3	2,604
Secondary complete or higher	11.7	1,180	36.4	6,138	31.7	2,344
Religion						
Muslim	92.5	9,496	91.2	15,787	88.0	6,649
Non-Muslim	7.5	772	8.8	1,527	12.0	905
Total	100.0	10,269	100.0	17,315	100.0	7,554

Majority of the ever-married women were currently married across all the three domains. Three-fourths of slum and rest urban women were from divisions other than Dhaka. Forty six percent of slum women belonged to the lowest two quintiles, while it was only 27.7 percent among non-slum women.

Women in slums were less likely to be educated than women of non-slums and rest urban domains. Twenty percent of slum women had no education, while it was only 7.8 percent among non-slum and 9.1 percent among rest urban women. Twelve percent of ever married slum women had a secondary education or higher, while this was 36.4 percent among non-slum and 31.7 percent among rest urban women (Table 3.1).

Figure 3.1: Wealth distribution of ever married women age 15-49 by domains, UHS 2021

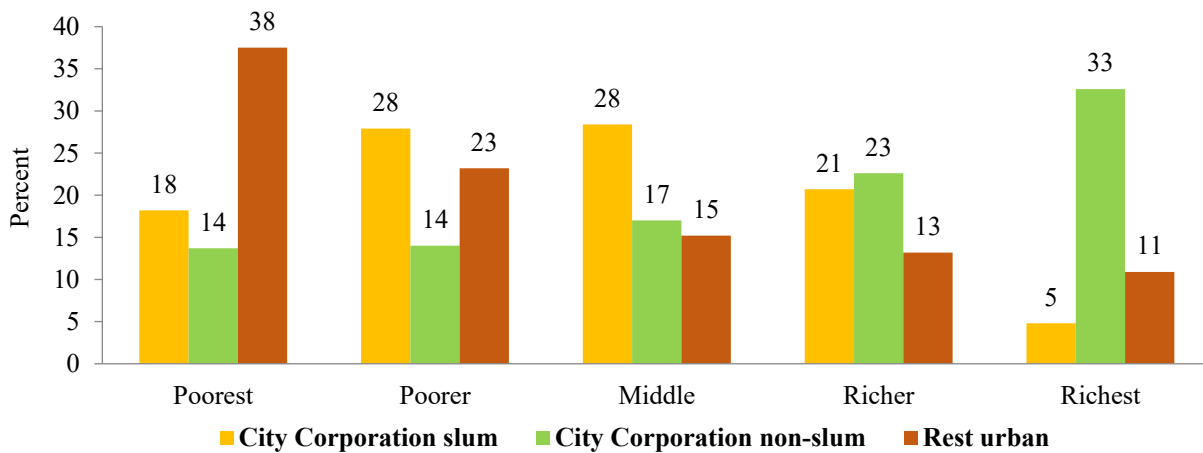


Table 3.2 provides the same indicators for ever married men across the three domains that Table 3.1 presented for female respondents. Majority of men belong to the older age groups.

Figure 3.2: Educational attainments of ever married women age 15-49 by domains, UHS 2021.

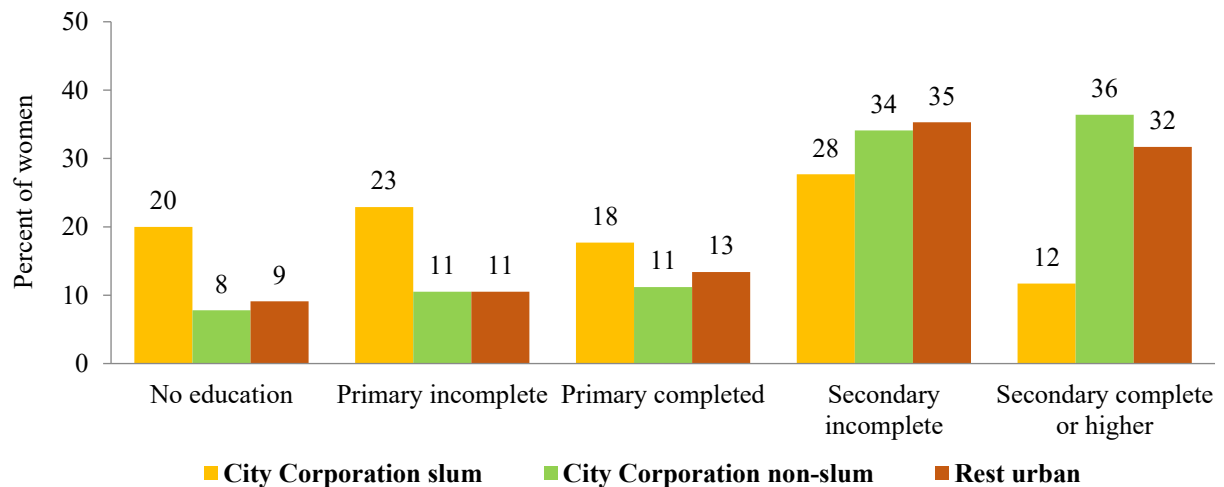


Table 3.2: Background Characteristics of respondents: Men

Percent distribution of ever married men age 15-54 by selected background characteristics, according to domains, UHS 2021

Background Characteristics	City Corporation slum		City Corporation non-slum		Rest urban	
	Weighted percentage	Weighted number	Weighted percentage	Weighted number	Weighted percentage	Weighted number
Age						
15-24	10.4	333	7.0	146	4.2	98
25-34	34.7	1,112	31.2	652	28.4	663
35-54	54.9	1,761	61.9	1,295	67.4	1,573
Region						
Dhaka	26.7	855	51.8	1,084	21.6	505
Other division	73.3	2,351	48.2	1,008	78.4	1,830
Marital status						
Currently married	98.7	3,164	98.5	2,062	98.8	2,306
Divorced/separated/widowed	1.3	42	1.5	30	1.2	29
Wealth quintile						
Poorest	18.7	599	16.1	337	36.2	844
Poorer	28.9	927	14.7	307	24.7	576
Middle	26.9	863	17.0	356	15.1	352
Richer	20.9	671	21.9	459	13.1	305
Richest	4.5	145	30.3	633	11.0	257
Education						
No education	18.7	599	9.4	196	11.6	270
Primary incomplete	25.0	802	15.0	313	17.0	397
Primary complete	15.8	505	12.7	266	12.7	296
Secondary incomplete	24.0	771	22.9	478	21.9	512
Secondary complete or higher	16.5	530	40.1	839	36.9	860
Religion						
Muslim	91.5	2,935	91.7	1,918	88.1	2,056
Non-Muslim	8.5	271	8.3	174	11.9	278
Total	100.0	3,206	100.0	2,092	100.0	2,335

As expected, majority of men of slum and rest urban areas were from the lower quintiles, while majority of non-slum women were from richer and richest quintiles. Similar to the situation of women, men in slums were less likely to be educated than men in non-slum and rest urban areas. Fifty six percent men in slums had completed at least primary education, compared with 75.7 percent in non-slums and 71.4 percent in rest urban areas. Non-slum and rest urban men were more likely to complete secondary education or higher than slum men.

3.2 Employment

Table 3.3 presents distribution of women age 15-49 by employment status. Result showed that women in slums were more likely to work full time than women in non-slums and rest urban areas; 31.6 percent of slum women had full time employment in the last 12 months prior to the survey, compared to 14.7 percent women of non-slum, and 9.1 percent of rest urban areas. About 82.9 percent women of non-slum, 88.9 percent of rest urban, and 63.6 percent women of slum areas did

not work in the past year preceding the survey. Among those women who were in employment, large majority had their place of work outside home. This is a major shift from the situation in 2013 UHS when majority of currently working women of all the three domains were working inside the home.

Table 3.3: Employment of Women

Percent distribution of ever married women age 15-49 by employment status and among currently working women by place of work and by domain, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Employment status in last 12 months			
Worked full time	31.6	14.7	9.1
Worked seasonal	1.3	0.7	0.6
Worked occasionally	3.6	1.7	1.4
Didn't work in last year	63.6	82.9	88.9
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554
Place of work			
Inside home	11.3	20.0	31.0
Outside home	88.7	80.0	69.0
Total	100.0	100.0	100.0
Number of currently working women	3,457	2,774	794

Result presented in Table 3.4 showed that almost all the ever-married men across all the three domains worked full time (95.5 percent to 96.9 percent) in the past 12 months preceding the survey.

Table 3.4: Employment of Men

Percent distribution of ever married men age 15-54 by employment status and among currently working men by place of work and by domain, UHS 2021

Characteristics	City Corporation slum	City Corporation non-slum	Rest urban
Employment status in last 12 months			
Worked full time	95.5	96.9	96.3
Worked seasonal	1.6	0.9	1.1
Worked occasionally	2.0	0.6	0.9
Didn't work in last year	0.9	1.6	1.7
Total	100.0	100.0	100.0
Number of currently working men	3,287	2,176	2,427

3.3 Ownership of Cell Phone

Result provided in Table 3.5 shows that 77.5 women in slums owned a cell phone, while this was 88.5 percent in non-slum and 84.6 percent women of rest urban areas. A substantial increase was recorded in the ownership of cell phone among women across all the three domains since 2013 UHS; a 24 percentage points increase from 54.0 percent in 2013 among slum women, 9 percentage points rise from 79.2 percent among non-slum women, and 20 percentage points increase in women of rest urban areas since 2013 UHS.

Table 3.5: Ownership of cell phone: Women

Percentage of ever married women age 15-49 who own a cell phone by background characteristics, according to domains, UHS 2021

Ownership of cell phone	City Corporation slum	City Corporation non-slum	Rest urban
Yes	77.5	88.5	84.6
No	22.5	11.5	15.4
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554

3.4 Exposure to Mass Media

Ever married women aged 15-49 were asked about their exposure to three types of mass media: television, radio and newspaper. Women across the three domains hardly listened to the radio. In contrast, television viewership was far more common. Four-fifths of slum and non-slum women watch television at least once a week, and it was 75.2 percent in rest urban areas. Access to all three media at least once in a week was very rare. Only 19.8 percent women in slums, 24.0 percent of rest urban and 15.4 percent women of non-slums reported of no exposure to any of the three-mass media (Table 3.6).

Table 3.6: Exposure to mass media: Women

Percentage of ever married women age 15-49 who are exposed to specific media on a weekly basis by domain, UHS 2021

Exposure to mass media	City Corporation slum	City Corporation non-slum	Rest urban
Reads a newspaper at least once a week	3.2	11.4	7.2
Listens to the radio at least once a week	2.3	2.4	1.6
Watches television at least once a week	79.4	83.4	75.2
Accesses all three media at least once a week	0.3	0.5	0.4
Accesses none of the three media at least once a week	19.8	15.4	24.0
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554

3.5 NGO Membership

The distribution of ever married women by NGO membership is presented in Table 3.7. Results in Table 3.7 show that majority women across three domains did not have any membership in NGO. Only a small portion of women in all domains (26.5 percent in slums, 18.5 percent in non-slum and 28.7 percent in rest urban) reported to have membership in NGO.

Table 3.7: NGO membership: Women

Percentage distribution of ever married women age 15-49 by membership of NGO, according to urban domains, UHS 2021

NGO membership of NGO	City Corporation slum	City Corporation non-slum	Rest urban
Not a member of NGO	73.6	81.5	71.3
1 NGO	22.7	16.0	23.3
2 or more NGO	3.8	2.5	5.4
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554

3.6 COVID-19: Awareness, Incidence and Treatment

The 2021 Urban Health Survey collected information on awareness, incidence in households and treatment of corona infection in recent episode of corona pandemic. Results in Table 3.8 and Table 3.9 show that both ever married women and men were well and equally aware of the COVID-19 pandemic; almost all of them across three domains had heard of it.

As regards knowledge of ways of COVID-19 transmission, men and women were found equally aware and they mentioned that COVID viruses spread mainly from breathing, sneeze, cough and coming in contact with affected persons. Respondent (both men and women) also reported that wearing mask, frequent washing hands with soap and maintaining social distancing were the key activities to avoid or minimize COVID infection.

Respondents were asked if they had any incidence of COVID infection in their households prior to the survey. There was hardly any such incidence in slum households (less than one percent). However, about two percent of non-slum and 1.1 to 1.4 percent of rest urban households reportedly had experienced COVID incidences.

Among those who suffered from COVID infection, about one third of women and men of slum and non-slum reported of facing some problem in getting the tests done.

Table 3.8: Awareness of COVID-19: Women

Percentage of ever married women ae 15-49 by their awareness of COVID – 19, according to domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Heard of COVID – 19			
Yes	99.9	99.6	99.9
No	0.1	0.4	0.1
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554
Knowledge of COVID – 19 transmission			
From touching an affected patient	50.5	59.1	54.3
From breathing/sneeze/cough of affected patient	83.6	84.6	86.7
From touching mouth, nose, eye after getting in contact with a contaminated object	17.1	25.6	14.2
Others	0.4	0.2	0.4
Knowledge of prevention of COVID – 19 transmission			
Wear mask	94.1	96.2	94.9
Use sanitizer	19.9	30.3	23.9
Frequently wash hands with soap	87.3	84.2	86.9
Maintain social distancing	20.2	24.2	21.6
Maintaining at least 1 m/ 3 feet distance	11.6	15.7	12.5
Don't touch face, nose, eyes without washing hand	8.4	14.2	7.5
Don't go outside if it is not urgent	4.1	5.0	4.8
Avoid crowd	4.7	6.4	4.4
Avoid public transportation as much as possible	1.4	2.0	1.2
Others	0.7	0.4	0.6
Number of women	10,261	17,252	7,548

Table 3.9: Awareness of COVID – 19: Men

Percentage of ever married men ae 15-54 by their awareness of COVID – 19, according to urban domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Heard of COVID – 19			
Yes	99.2	99.7	99.8
No	0.8	0.3	0.2
Total	100.0	100.0	100.0
Number of men	3,287	2,176	2,427
Knowledge of COVID – 19 transmission			
From touching an affected patient	56.7	63.1	68.4
From breathing, sneeze, cough of affected patient	77.1	77.0	79.3
From touching mouth, nose, eye after getting in contact with a contaminated object	17.3	29.4	15.0
Others	0.4	0.0	0.1
Knowledge of prevention of COVID – 19 transmission			
Wear mask	98.4	98.5	98.9
Use sanitizer	24.9	31.2	33.8
Frequently wash hands with soap	79.2	76.7	82.6
Maintain social distancing	18.7	28.8	27.6
Maintaining at least 1 m/ 3 feet distance	15.0	17.7	17.2
Don't touch face, nose, eyes without washing hand	10.4	15.0	11.5
Don't go outside if it is not urgent	2.5	3.6	3.3
Avoid crowd	5.9	13.2	8.3
Avoid public transportation as much as possible	1.9	3.1	2.6
Others	0.1	0.1	0.0
Number of men	3,262	2,170	2,423

During the initial stage of COVID pandemic, health facilities and service providers were not ready to cope with the situation. Existing facility was not adequate to cope with the situation. In many cases, this prevented care seekers in getting general health care. According to the respondents (both men and women), the main difficulty they encountered was in accessing doctors/health workers for treatment and advice on general health problems. A good number did not visit hospital/clinic due to fear of corona virus infection.

Table 3.10: Incidence of COVID – 19 Infection: Women

Percentage of ever married women age 15-49 by incidence of COVID – 19 infection in the household, treatment sought, and problems faced in seeking care, according to urban domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Any incidence of COVID infection in households			
Yes	0.5	2.1	1.1
No	99.5	97.9	98.9
Total	100.0	100.0	100.0
Number of women	10,261	17,252	7,548
Steps taken for treatment			
Taken to hospital/clinics	33.4	33.6	39.9
Consulted doctors	51.4	66.8	50.8
Given medicine or advice from others	22.7	22.6	20.2
Drink/inhale of steam of tea, ginger, lemon and other spice mixed warm water	51.2	49.6	49.5
Others	2.2	1.8	1.4
Did not do anything	2.7	1.1	2.6
Problems faced while sought care for COVID infection			
Difficulty in getting test done	33.6	22.2	27.8
Hospital/clinic refused to admit without test result	11.3	8.7	11.4
Could not get hospital bed	0.5	11.7	3.2
Could not get ICU bed	0.5	4.4	1.9
Irregular supply of Oxygen	0.0	1.9	0.0
Too expensive, had not enough money	22.6	7.8	5.7
Health provider did not take proper care	18.2	9.2	4.9
Others	3.0	1.4	3.4
Didn't face any problem	38.0	59.4	58.6
Number of women	50	355	80

Table 3.11: Incidence of COVID – 19 Infection: Men

Percentage of ever married men age 15-54 by incidence of COVID – 19 infection in the household treatment sought, problems faced in seeking care, according to urban domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Any incidence of COVID infection in households			
Yes	0.9	1.7	1.4
No	99.1	98.3	98.6
Total	100.0	100.0	100.0
Number of men	3,262	2,170	2,423
Steps taken for treatment			
Taken to hospital/clinics	25.4	38.3	50.1
Visited Doctor	7.5	29.1	32.5
Took medicine referred by other's	5.6	15.1	28.1
Drank warm water with tea, ginger, lemon, other spice/taken steam	47.3	5.9	6.3
Did not do anything	14.3	16.4	0.0
Problems faced while sought care for COVID infection			
Getting tests was difficult	35.3	35.3	7.0
Could not get admitted to the hospital without test result	0.0	0.0	0.0
Beds are not available in Hospital	0.0	0.0	7.7
Beds are not available in ICU	0.0	0.0	0.0
Irregular supply of Oxygen	0.0	0.0	0.0
Too expensive, did not have money	9.6	2.5	0.0
Health Care Provider did not take care properly	3.4	0.0	8.0
Others	0.0	2.1	3.4
Didn't face any problem	40.7	43.8	73.8
Number of men	28	36	33

Table 3.12: Problems faced during COVID pandemic for general health care: Women
 Percentage of ever married women age 15-49 by their problems faced during COVID-19 pandemic for general health care, according to urban domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Faced problems in general healthcare			
Yes	1.7	2.4	1.4
No	82.8	78.7	81.6
Did not need it	15.6	18.9	16.9
Total	100.0	100.0	100.0
Number of women	10,269	17,315	7,554
Type of problems faced			
Did not go to Hospital/clinic due to fear of COVID-19	13.7	29.0	6.9
Anxious about visiting Hospital/clinic	17.0	18.8	13.0
Could not understand where to go	3.0	2.1	8.2
Hospital/clinic only provided treatment for corona	3.7	16.5	9.0
It was difficult to access doctor/health worker	46.1	47.8	63.7
It was difficult to get transportation	2.0	1.6	12.7
Could not get admitted to the hospital without test result	2.3	9.0	1.0
Beds are not available in Hospital	4.5	8.3	2.6
Did not have money	17.0	8.2	7.2
Health Care Provider did not take care properly	24.4	20.3	29.8
Others	0.0	1.4	0.0
Number of women	169	415	107

Table 3.13: Problems faced during COVID pandemic for general health care: Men

Percentage of ever married men age 15-54 by their problems faced during COVID-19 pandemic for general health care, according to urban domains, UHS 2021

	City Corporation slum	City Corporation non-slum	Rest urban
Faced problems in general healthcare			
Yes	1.7	2.3	2.1
No	79.0	81.0	77.3
Did not need it	19.3	16.7	20.6
Total	100.0	100.0	100.0
Number of men	3,287	2,176	2,427
Type of problems faced			
Did not go to Hospital/clinic due to fear of COVID-19	12.8	36.0	4.2
Anxious about visiting Hospital/clinic	4.2	17.5	12.6
Could not understand where to go	5.6	4.4	2.4
Hospital/clinic only provided treatment for corona	.5	15.4	5.6
It was difficult to access doctor/health worker	43.7	51.6	76.0
It was difficult to get transportation	7.9	1.3	8.8
Could not get admitted to the hospital without test result	10.9	16.0	3.6
Beds are not available in Hospital	3.1	0.2	11.2
Did not have money	18.6	5.5	2.5
Health Care Provider did not take care properly	20.7	17.2	41.5
Others	3.6	0.0	0.0
Number of men	56	49	52

MIGRATION AND MIGRANTS' CHARACTERISTICS

4

Key Findings:

- ❖ Around two-fifths of female and half of male slum dwellers were born in the same city. In comparison, around 58 percent female and 48 percent male slums dwellers arrived from elsewhere. The pattern is similar for males in all three urban domains.
- ❖ More than three-fifths of women living in slums were migrants, while the remaining two-fifths had always lived there. About 15 percent had been living in their current city of residence for less than five years.
- ❖ More than 15 percent of slum women have been living in their current city of residence for less than five years compared with 9 percent of men.
- ❖ Recent migrants (residing in the current city for less than two years) in the slums are poorer than those who have been living there longer. In regard to economic status, slum dwellers who have always lived there were about 60 percent in poorest quintile. In similar, one third newer arrivals (up to 5+ years) were more likely to be in the poorest quintile, and about half (49.8 percent) were richer wealthier quintile'.
- ❖ The education levels of women in slums who have migrated recently (less than two years ago) were substantially higher than recent male migrants. This may be because reasons for migration are somewhat different for females, many of whom migrated for marriage, compared to males who predominantly migrated in search of work.
- ❖ Less than one-third of male migrants in slum, non-slum and rest urban areas reported to have received some support in seeking accommodation or employment when they first arrived in cities. Employment among men was more or less universal across all domains. But in the case of female of slum domain only one-third got the employment.
- ❖ Females were most likely to migrate because of joining with spouse/in-laws- 50 percent, 66 percent and 83 percent in slums, non-slums and rest urban areas respectively. Work-related reasons for migration in slums were: looking for work (33.4 percent), more earning (31.0 percent) and service/work/transfer (18.9 percent). More or less same pattern can be seen in non-slums and rest urban domain.

Migration is the movement of people from one geographical/administrative area to another area for a particular time period (six months or more) for intention to stay permanently or semi-permanently in that place (from origin to destination).

The annual increment in the urban population of Bangladesh is currently 1.6-1.7 million, which will peak at 1.9 to 2 million in the year 2025, according to UN estimates in World Urbanization Prospects, 2020. One-third of this annual increase will be due to natural increases, with two-thirds due to in-migration from rural areas. This annual increment will slowly decline to 1.72 million over the next 25 years to mid-century.

To identify migrants within the urban population, the Urban Health Survey (UHS) 2021 included questions on place of birth and current residence by gender, and length/duration of stay in current residence, working status in current place of residence and support received upon first arrival to city. Among migrants, the survey also obtained information on place of prior residence and reasons for migrating to their current residence for ever married women and men.

For purposes of this study, a 'migrant' is defined as a respondent whose place of birth was different from their current place of residence and/or one who said they had not 'always lived' at their current location, which means he or she was from a different city. This chapter describes the characteristics of the migrant population, their reasons for migration, duration of stay in urban areas, and patterns of movements. Where possible, comparisons are made between the change in characteristics of urban migrants between 2013 and 2021 in slum, non-slum and Rest urban domains.

4.1 Place of Birth of Urban Residents

Table 4.1 shows the place of birth of females and males currently residing in slums, non-slums, and rest urban areas. Migrants to urban areas, both female and male, were preferentially moving to the slums. About 42 percent of female and 52 percent of male slum dwellers were born in the same city. Rest 58 percent of female and 48 percent of male slums dwellers arrived from elsewhere. The likelihood of migrating from other divisions was not proportional to the population of those divisions, as arrivals from Barishal accounted for 10 percent of female and 8.6 percent of male, whereas the Barishal division has about only 6 percent of the national population. On the other hand, about 19.8 percent of female and 16.2 percent of male migrants were found from Chattogram division. Born in Chattogram and Dhaka city corporation non-slum areas were 12.5 percent and 12.9 percent respectively for female population and 8.5 percent and 8.2 percent for Chattogram and Dhaka division male population. In the case of rest urban female population 8.1 percent and 7.5 percent were born in Chattogram and Dhaka division respectively. Other divisions accounted for a smaller proportion than their size of the national population. In 'Rest urban' both the female (65.1 percent) and male (86.2 percent) are higher in percentage that has originated in same City (Table 4.1). The "Rest urban" population was least likely to have originated in other divisions, with proportions to slums, non-slums and rest urban areas. Overall picture is that two third female slum dwellers and half of male slum dwellers were born in the same city.

Table 4.1: Place of birth and current residence

Percent distribution of women and men's place of current residence, according to place of birth (Division), City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Place of Birth	City Corporation slum	City Corporation non-slum	Rest urban
Women (age 15-49)			
Same city	41.9	53.6	65.1
Barishal	10.0	6.6	2.8
Chattogram	19.8	12.5	8.1
Dhaka	8.1	12.9	7.5
Khulna	3.3	2.5	3.2
Rajshahi	2.6	3.8	4.2
Rangpur	3.8	2.9	2.8
Sylhet	2.3	1.4	1.3
Mymensingh	8.0	3.7	4.8
Abroad & other	0.1	0.1	0.1
Total	100.0	100.0	100.0
Number of women	10,269	5,709	7,554
Men (age 15-54)			
Same city	51.8	65.0	86.2
Barishal	8.6	6.1	1.5
Chattogram	16.2	8.5	3.3
Dhaka	5.8	8.2	2.3
Khulna	3.0	2.0	1.9
Rajshahi	2.0	3.0	1.9
Rangpur	3.4	2.3	0.6
Sylhet	2.5	1.4	0.9
Mymensingh	6.5	3.5	1.3
Abroad & other	0.2	0.0	0.0
Total	100.0	100.0	100.0
Number of men	3,287	2,176	2,427

More detail scenario of the origin of female migrants of slum, non-slum and rest urban area dwellers is presented in Tables 4.2, Appendix 4.2.B and Appendix 4.2.C respectively. It presents the place of current residence by place of birth of women (both urban and rural). About 42 percent, 54 percent, and 65 percent were born in same city corporation slums, City Corporation non-slums, and rest urban areas respectably. Place of birth by current residence of City Corporation slums are 31 percent, 34 percent, 51 percent, 53 percent, 57 percent, 44 percent, 66 percent, 69 percent 49 percent and 55 percent in Dhaka, Chattogram, Barishal, Cumilla, Khulna, Naraynganj, Rajshahi, Rangpur, Sylhet and Mymensingh respectively. Place of birth of urban dwellers in Dhaka city corporation slums was only 3.7 percent (Table 4.2), but figure was about 10 percent in the case of non-slum areas (Appendix Table 4.2.B), and place of birth in Dhaka city corporation was 6.8 percent. On the other Tables 4.3, Appendix Table 4.3.B, and Appendix Table 4.3.C show about 52 percent, 65 percent, and 86 percent were born in same city corporation slum, City Corporation

non-slum and rest urban areas respectably. For detail can be seen in Table 4.2, Appendix Table 4.2.B and Appendix Table 4.2.C. Overall scenario is that a very low female and male percentage born in slum areas. The more detail scenario of the origin of female migrants of slum dwellers is presented Table 4.2. It shows how the proportions of females that currently reside in the slums of different City Corporations but was born outside city that varied widely. Among the residents of Dhaka slums, three-Fifths were born outside of Dhaka city (could be other urban areas of Dhaka Division). In contrast, only about one-quarter of residents of slums in Rangpur were born outside those cities. Because Dhaka accounts for more than two-fifths of the total urban slum population, it weighs heavily on the overall proportion, it means the slum residents nationally having migrated from outside their city of current residence. The major source of migrants to the slums of any of the listed City Corporations were originated in the rural areas of the same Division. More detail scenario can be seen in Appendix Table 4.2.B and Table 4.2.C in the case of non-slum CC and rest urban areas.

Figures 4.1.1 and 4.1.2 present the place of prior residence of female slum dwellers of Dhaka and Chittagong before they moved to their current residence. These figures show that there was very little difference between the place of birth and the place of residence prior to moving to their current residence, implying that their prior residence was the place where they were born. The distribution of the place of prior residence of men was almost identical to that of the women presented in these figures.

The proportion of males born in the city in which they currently reside (Table 4.3) was more than fifty percent, with the exceptions of Rajshahi and Rangpur, where males were less likely to migrate from outside the city of current residence. That is, in these two cities men residing in slums were more likely to have been born in the same city but not necessarily in the slums. Place of birth by current residence of City Corporation slums are 37 percent, 39 percent, 75 percent, 65 percent, 65 percent, 47 percent, 85 percent, 87 percent, 30 percent, and 89 percent in Dhaka, Chattogram, Barishal, Cumilla, Khulna, Naraynganj, Rajshahi, Rangpur, Sylhet and Mymensingh respectively. More detail scenario of non-slum and rest urban can be depicted in Appendices Table 4.3.B and Table 4.3.C respectively.

Table 4.2: Place of current residence by place of birth (Urban or rural): City Corporation slum: Women
Percent distribution of ever married women age 15-49 by place of birth and current place of residence, UHS 2021

Place of birth	Place of current residence – City Corporation slum										All CC
	Dhaka City Corporation	Chattogram City Corporation	Barishal	Cumilla	Khulna	Narayanganj	Rajshahi	Rangpur	Sylhet	Mymensingh	
Born in the same city	31.0	33.7	50.6	52.7	56.7	44.5	65.6	69.2	48.9	55.1	41.9
Barishal urban	2.7	1.1	7.4	0.0	0.6	1.0	0.2	0.1	0.4	0.2	1.5
Barishal rural	11.7	8.4	32.9	0.0	8.6	10.2	0.3	0.2	0.0	0.2	8.5
Chattogram urban	2.4	8.6	0.0	0.8	0.6	2.9	0.3	0.5	1.2	1.0	4.1
Chattogram rural	6.9	34.9	0.0	30.2	1.3	5.1	0.0	0.0	3.8	1.2	15.7
Dhaka urban	3.7	0.8	4.4	1.7	1.7	6.2	2.4	0.3	1.8	4.3	2.3
Dhaka rural	11.7	4.1	1.6	3.6	5.5	9.5	0.6	0.4	5.3	4.0	5.8
Khulna urban	0.5	0.2	0.1	0.8	2.8	0.3	0.6	0.1	0.0	0.3	0.6
Khulna rural	0.7	1.0	1.7	0.0	20.6	0.6	0.8	0.0	0.8	0.3	2.7
Rajshahi urban	0.7	0.2	0.1	0.0	0.0	0.9	10.9	1.3	0.0	1.5	0.9
Rajshahi rural	2.4	0.6	0.0	0.0	0.5	1.7	15.1	0.3	0.4	0.3	1.6
Rangpur urban	1.2	0.5	0.0	0.8	0.3	1.1	1.9	16.9	0.0	0.8	1.5
Rangpur rural	3.0	1.8	1.2	0.0	0.4	5.1	0.7	10.2	2.4	0.8	2.3
Sylhet urban	0.6	0.5	0.0	3.6	0.0	0.0	0.0	0.0	4.4	0.6	0.5
Sylhet rural	2.1	2.0	0.0	3.9	0.1	0.6	0.0	0.0	19.8	0.4	1.8
Mymensingh urban	3.3	0.2	0.0	0.0	0.1	0.9	0.5	0.0	2.0	4.0	1.3
Mymensingh rural	15.5	1.3	0.1	1.7	0.2	9.2	0.0	0.3	8.9	25.1	6.8
Born abroad	0.0	0.2	0.0	0.0	0.1	0.4	0.2	0.0	0.0	0.0	0.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	2,478	3,855	393	161	1,028	358	469	494	232	800	10,269

Note: Comparable tables for City Corporation non-slums (Table 4.2.B) and Rest urban areas (Table 4.2.C) can be found in Annex B.

Table 4.3: Place of current residence by place of birth (Urban or rural): City Corporation slum: Men
Percent distribution of ever married men age 15-54 by place of birth and current place of residence, UHS 2021

Place of birth	Place of current residence – City Corporation slum										All CC
	Dhaka City Corporation	Chattogram City Corporation	Barishal	Cumilla	Khulna	Narayanganj	Rajshahi	Rangpur	Sylhet	Mymensingh	
Born in the same city	36.7	39.1	74.7	64.8	64.6	46.9	84.7	87.2	29.9	88.5	51.8
Barishal urban	3.5	2.6	1.9	3.4	1.4	4.1	1.0	0.3	0.0	0.2	2.3
Barishal rural	9.4	7.6	12.4	0.0	7.8	2.6	0.0	0.0	0.0	0.0	6.3
Chattogram urban	1.7	9.8	1.9	2.8	0.4	4.8	0.0	0.0	0.0	1.1	4.4
Chattogram rural	6.1	26.0	0.0	15.2	0.5	6.8	0.0	1.0	5.6	0.1	11.8
Dhaka urban	2.4	0.7	2.1	0.0	2.0	7.2	1.2	0.0	0.0	0.6	1.4
Dhaka rural	8.9	3.8	0.2	0.0	2.9	5.6	0.6	0.0	9.3	0.9	4.3
Khulna urban	0.8	0.4	0.0	0.0	2.3	0.0	0.0	0.0	0.0	0.0	0.6
Khulna rural	0.5	1.0	4.3	5.6	16.9	0.3	0.0	0.0	0.0	0.2	2.4
Rajshahi urban	0.6	0.1	0.0	0.0	0.2	1.3	4.1	0.0	1.2	0.0	0.5
Rajshahi rural	3.0	1.2	0.0	0.0	0.7	1.3	4.4	1.3	0.0	0.0	1.6
Rangpur urban	1.1	1.1	0.0	0.0	0.0	4.0	0.0	4.2	0.0	0.2	1.0
Rangpur rural	2.9	2.1	2.4	5.6	0.0	6.8	1.9	6.1	5.0	0.0	2.4
Sylhet urban	0.3	0.6	0.0	2.7	0.0	0.0	0.0	0.0	10.7	0.2	0.6
Sylhet rural	2.4	1.7	0.0	0.0	0.2	0.0	0.0	0.0	27.1	0.9	1.9
Mymensingh urban	2.7	0.6	0.0	0.0	0.0	1.7	0.0	0.0	1.2	2.2	1.1
Mymensingh rural	16.9	1.6	0.0	0.0	0.0	6.7	0.7	0.0	10.0	4.0	5.4
Born abroad	0.0	0.1	0.0	0.0	0.0	0.0	1.4	0.0	0.0	0.9	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of men	772	1,219	121	51	331	110	165	172	75	272	3,287

Note: Comparable tables for City Corporation non-slums (Table 4.3.B) and Rest urban areas (Table 4.3.C) can be found in Annex B.

Figure 4.1.1: Prior residence of Dhaka female slum dwellers

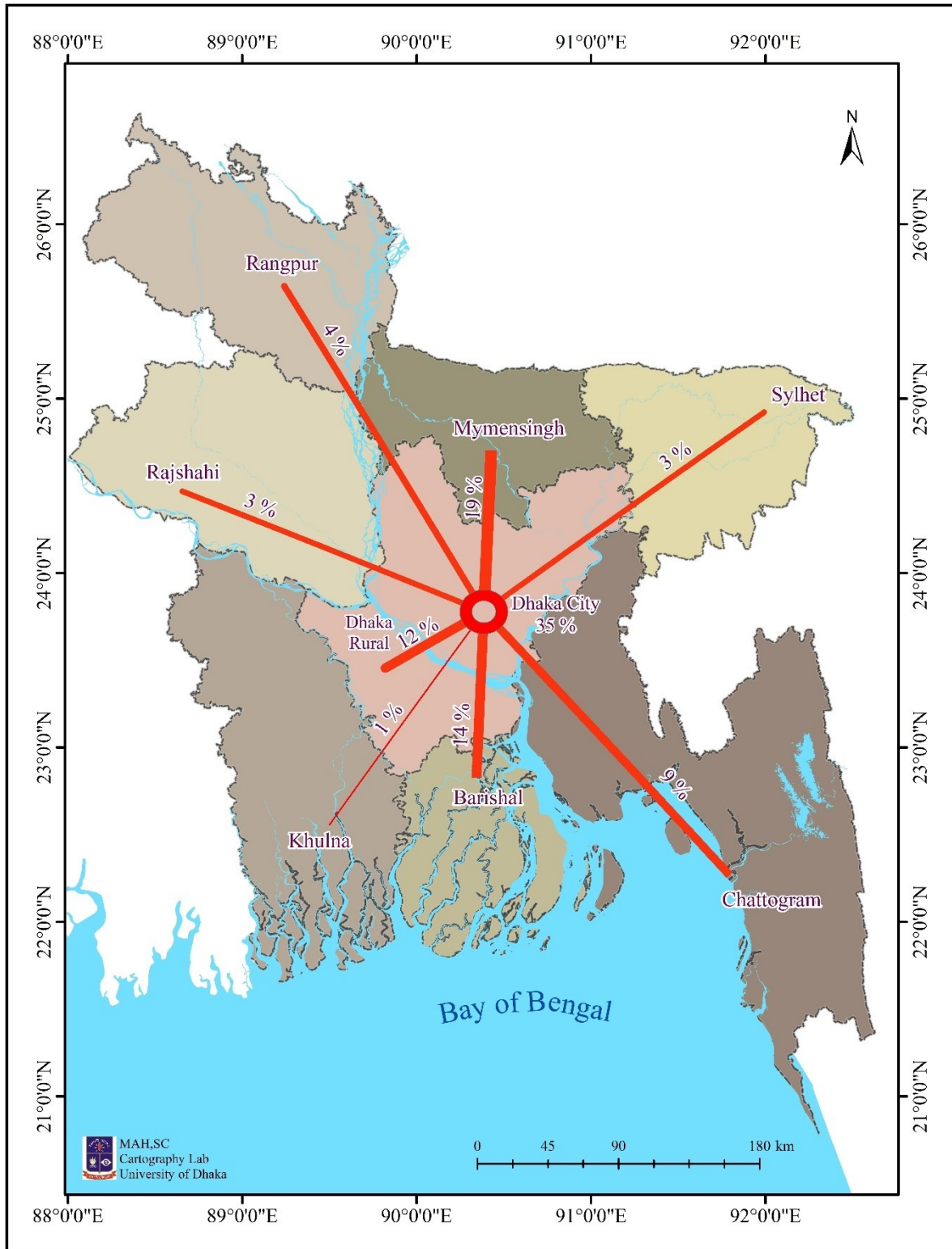


Figure 4.1.2: Prior residence of Chattogram female slum dwellers

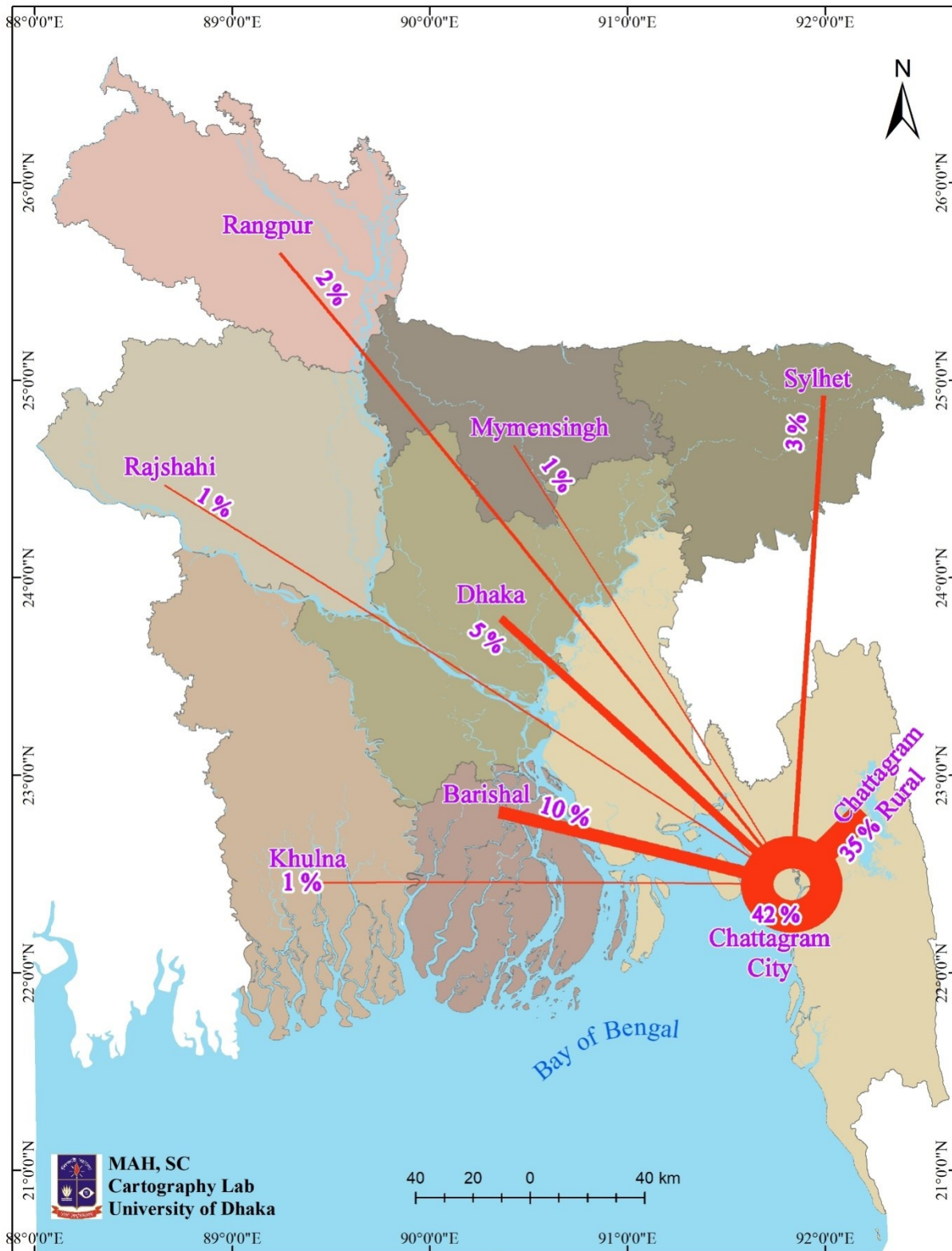


Table 4.4: Place of birth by background characteristics: City Corporation slum: Women
Percent distribution of ever married women age 15-49 by background characteristics, according to place of birth, UHS 2021

Background characteristics	Place of birth		
	Same city	Other city/ urban town	Rural
Age			
15-19	9.0	7.8	8.4
20-34	54.0	54.8	55.7
35+	37.1	37.4	35.9
Total	100.0	100.0	100.0
Education			
No education	16.6	22.1	24.0
Primary incomplete	19.5	22.4	26.0
Primary complete	17.3	18.6	17.5
Secondary incomplete	31.4	26.1	24.0
Secondary complete or higher	15.2	10.9	8.5
Total	100.0	100.0	100.0
Region			
Dhaka	21.6	32.2	31.9
Other division	78.4	67.8	68.1
Total	100.0	100.0	100.0
Wealth quintile			
Poorest	25.5	16.1	12.2
Poorer	27.2	24.0	29.7
Middle	25.0	31.6	30.6
Richer	17.6	22.6	22.9
Richest	4.7	5.6	4.6
Total	100.0	100.0	100.0
Number of women	4,301	1,301	4,657

Note: Comparable tables for City Corporation non-slums (Table 4.4.B) and Rest urban areas (Table 4.4.C) can be found in Annex B.
Excludes the place of birth in abroad, and the responded of short interview.

The patterns of some background characteristics were similar (i.e., little differential) for slum dwelling females who were born in the same city, or other city/urban area, or rural area (Table 4.5). Those born in the same city and other city/urban town were about same proportion i.e., 37 percent in same city and other city/urban town. However, those born in the same city had considerably higher education (47 percent secondary plus, versus 41 percent other city /urban town). Not surprisingly, those born in the same city were also wealthier (22 percent in the top two economic quintiles, versus 29 percent other city/urban town).

Table 4.5: Place of birth by background characteristics: City Corporation slum: Men
Percent distribution of ever married men age 15-54 by background characteristics, according to place of birth, UHS 2021

Background characteristics	Place of birth		
	Same city	Other city/ urban town	Rural
Age			
< 20	1.0	1.3	0.6
20-34	45.4	45.0	42.3
35+	53.7	53.7	57.0
Total	100.0	100.0	100.0
Education			
No education	14.1	23.7	23.5
Primary incomplete	22.7	18.1	30.6
Primary complete	15.8	16.7	15.3
Secondary incomplete	27.7	23.5	19.1
Secondary complete or higher	19.7	18.0	11.5
Total	100.0	100.0	100.0
Region			
Dhaka	19.4	31.6	35.5
Other division	80.6	68.4	64.5
Total	100.0	100.0	100.0
Wealth quintile			
Poorest	27.5	14.0	7.7
Poorer	28.9	28.0	29.4
Middle	22.5	29.4	32.3
Richer	17.0	21.8	26.4
Richest	4.2	6.9	4.3
Total	100.0	100.0	100.0
Number of women	1661	382	1161

Note: Comparable tables for City Corporation non-slums (Table 4.5.B) and Rest urban areas (Table 4.5.C) can be found in Annex B.

The patterns seen for females were similar to males living in slums (Table 4.4). Males born in the same city same city were older (91 percent) in top two groups and similar picture were found in other city/ urban town. There seems to be a less teenagers than among females. Higher education rate was lower (15 percent) than males (20 percent) population in same city. This is possibly because males were less likely to migrate from rural areas for marriage or seeking education.

Males born in the same city had similar education levels as those born in other cities, but better education than those born in other urban areas. The pattern by wealth quintile was a little different, with those males born in the same city being less likely to be poor (53 percent in the poorest two quintiles, versus 40 percent in other city/urban town).

4.2 Duration of Stay in Current Residence by Background Characteristics

More than three-fifths of women living in slums were migrants, while the remaining two-fifths had always lived there. About 15 percent had been living in their current city of residence for less than five years. More than half female non-slum and more about two-third were always lived there. One third CC non-slums female migrants lived in their current residence for more than 5 years (Table 4.6).

More than half of male residents in slums had always lived in the city of their current residence. It is more interesting that 65 percent of CC non-slum and more than 86 percent of rest urban men were lived always in their current residence. About 9 percent in slums had been living there for less than five years. The proportion of migrants was relatively lower in the other two urban domains (Table 4.6).

Table 4.6: Length of stay of females and males in city of current residence, City Corporation slum, City Corporation non-slum, and rest urban
Percent distribution of women and men by number of years that they lived in their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domain	Reported length of time in current residence				Total	Number of women
	< 2 year	2- 4 years	5+ years	Always		
Women (age 15-49)						
City Corporation slum	6.9	7.6	43.6	41.9	100.0	10,269
City Corporation non-slum	4.4	8.8	33.2	53.5	100.0	5,709
Rest urban	3.4	4.5	27.3	64.7	100.0	7,554
Men (age 15-54)						
City Corporation slum	3.4	5.4	39.5	51.8	100.0	3,287
City Corporation non-slum	2.2	4.5	28.5	64.8	100.0	2,176
Rest urban	1.4	2.1	10.2	86.2	100.0	2,427

Table 4.7 shows the duration of stay in current city, up to the time of the survey, in the slums for female by background characteristics (i.e., age, education, region, and wealth quintile).

Somewhat surprisingly, age was not a factor among those slum dwellers that had always lived in the same city, amounting more than two in five women. As expected, younger women tended to have resided for a shorter duration than older women, while more than half of older women (35+ years) had lived five or more years there.

Education showed a bimodal distribution with one group of well-educated women residing for a short duration-presumably those who came to the city to study, and a second group of well-educated women (55 percent) who had always lived in the same city. Fifty-five percent women with no education tended to have lived the long time (5+years) in the current city.

For region (Table 4.7), slum residents in Dhaka were less likely than slum residents of other Divisional City Corporations to have always lived there, or to have lived there for a shorter duration if in-migrants. This was consistent with the observation that Dhaka is the primary city for receiving in-migrants; about half (48 percent) female migrants lived more than 5+ years. It can be said that the other Divisional capital cities are more stable and attract fewer in-migrants proportionate to city size.

In regard to economic status, slum dwellers who have always lived there were about 60 percent in poorest quintile. In similar, one third of newer arrivals (up to 5+ years) were more likely to be in the poorest quintile, moreover about half (49.8 percent) in richer ‘wealthier quintile’.

Table 4.7: Duration of stay* in current place by background characteristics: City Corporation slum: Women

Percent distribution of women age 15-49 by duration of stay in current place, according to background, UHS 2021

Background characteristics	Duration of stay in current city				Total	Number of women
	<2 year	2- 4 years	5+ years	Always		
Age						
15-19	27.4	13.3	15.4	43.9	100.0	880
20-34	6.8	9.0	43.0	41.2	100.0	5,631
35+	2.3	4.2	51.1	42.4	100.0	3,758
Education						
No education	4.4	5.5	56.4	33.7	100.0	2,120
Primary incomplete	5.8	7.2	51.3	35.7	100.0	2,345
Primary complete	5.9	7.9	45.6	40.6	100.0	1,636
Secondary incomplete	8.5	9.2	34.3	48.1	100.0	2,976
Secondary complete or higher	11.0	8.1	26.2	54.7	100.0	1,192
Region						
Dhaka	9.3	9.8	48.1	32.7	100.0	2,836
Other division	6.0	6.8	41.9	45.3	100.0	7,433
Wealth quintile						
Poorest	3.2	5.2	33.1	58.5	100.0	1,873
Poorer	7.4	7.4	44.5	40.8	100.0	2,864
Middle	9.5	9.2	44.6	36.7	100.0	2,920
Richer	6.6	7.8	49.8	35.8	100.0	2,121
Richest	4.8	8.5	45.3	41.4	100.0	491
Total	6.9	7.6	43.6	41.9	100.0	10,269

*The duration of stay includes “always lived there,” which refers to slum residents who were born in the same city, though not necessarily in the slums.

Note: Comparable tables for City Corporation non-slums (Table 4.7.B) and rest urban areas (Table 4.7.C) can be found in Appendix A.

The Appendix Table 4.7.B shows age, education, region and wealth quintile of the non-slum city dwellers. Average age was higher for the always lived city dwellers than the in-migrants. Educational background was also higher among city dwellers but wealth quintile shows the descending order of wealth quintile from poorest to richest in the always lived there. Rest urban

depicted the better scenario of education, wealth quintile for always lived in city corporation area than the in-migrants (detail can be seen in Appendices Table 4.7.B and Table 4.7.C).

When the wealth quintiles are presented as column percent's (Table 4.8), it is easier to see the patterns. Again, the recent migrants were convex type from poorest to richest quintiles but those who had always lived in the slums found descending hierarchical pattern from poorest to richest wealth quintiles. Moreover, those who had always lived in the slums were about equally likely to be in the wealthiest quintile in relation to recent migrants (<5 years). As duration of residence in the slums increased there was a shift from the poorer quintiles to the richer quintiles, presumably reflecting improvement in economic status over time as in-migrants assimilated to the urban environment, improved their employment prospects, and formed effective support networks of their relatives (Table 4.8).

More migrant males in higher age had spent higher durations than females (45 percent versus 51 percent staying 5+ years) in the slums (Table 4.7 and Table 4.9). Levels of higher education were somewhat higher for male (28 percent) than female (26 percent), suggesting that male from rural areas may be more likely to migrate to a city for seeking education.

Table 4.8: Duration of stay* in current place by wealth quintile: City Corporation slum: Women

Percent distribution of women age 15-49 by duration of stay in current place, according to wealth quintile, UHS 2021

Wealth quintile	Duration of stay in current city				Total
	< 2 year	2- 4 years	5+ years	Always	
Poorest	8.3	12.5	13.9	25.5	18.2
Poorer	29.6	27.1	28.5	27.2	27.9
Middle	39.0	34.1	29.1	25.0	28.4
Richer	19.7	21.0	23.6	17.6	20.7
Richest	3.3	5.3	5.0	4.7	4.8
Total	100.0	100.0	100.0	100.0	100.0
Number of women	711	784	4,476	4,298	10,269

*The duration of stay includes "always lived there," which refers to slum residents who were born in the same city, though not necessarily in the slums.

Note: Quintiles do not account for 20 percent each here because these are slum populations, which are poorer.

Table 4.9: Duration of stay* in current place by background characteristics: City Corporation slum: Men

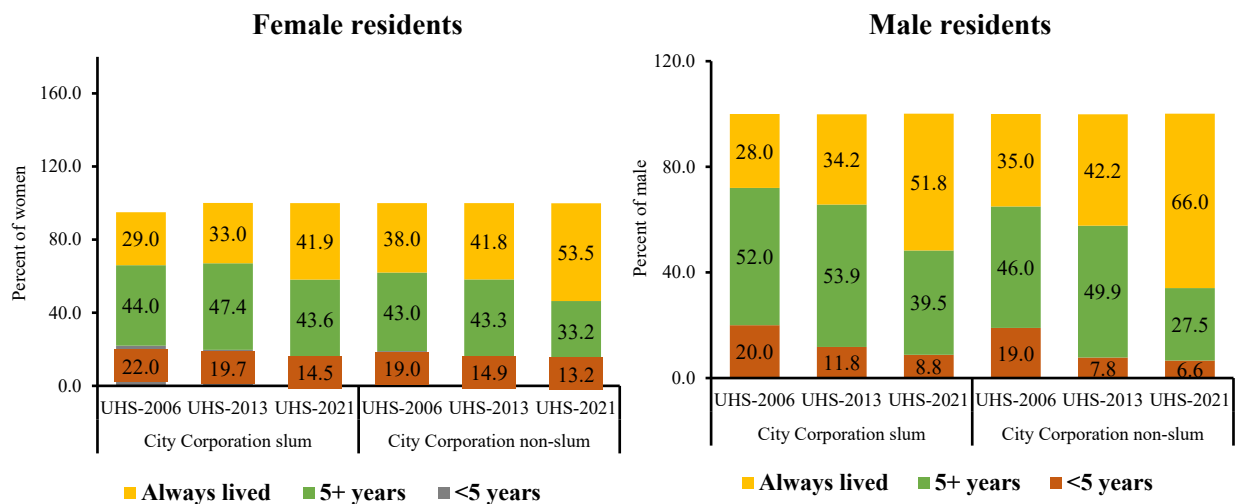
Percent distribution of men age 15-54 by duration of stay in current place, according to background, UHS 2021

Background characteristics	Duration of stay in current city				Total	Number of men
	<2 year	2-4 years	5+ years	Always		
Age						
< 20	11.4	3.9	28.2	56.6	100.0	28
20-34	4.7	8.9	33.1	53.2	100.0	1,417
35+	2.3	2.6	44.5	50.6	100.0	1,842
Education						
No education	4.1	4.5	52.7	38.7	100.0	612
Primary incomplete	3.3	6.7	42.5	47.5	100.0	832
Primary complete	3.1	4.3	39.0	53.6	100.0	495
Secondary incomplete	2.1	5.1	34.5	58.4	100.0	805
Secondary complete or higher	5.0	5.7	27.8	61.5	100.0	543
Region						
Dhaka	4.3	7.3	50.3	38.0	100.0	881
Other division	3.1	4.6	35.5	56.8	100.0	2,406
Wealth quintile						
Poorest	0.5	2.7	20.5	76.3	100.0	615
Poorer	3.3	5.2	39.8	51.7	100.0	946
Middle	5.0	8.0	43.8	43.2	100.0	886
Richer	3.8	5.0	49.2	41.9	100.0	692
Richest	4.5	3.2	45.1	47.3	100.0	147
Total	3.4	5.4	39.5	51.8	100.0	3,287

Note: Comparable tables for City Corporation non-slums (Table 4.9.B) and rest urban areas (Table 4.9.C) can be found in Appendix A.

Figure 4.2 shows the comparative scenario of migrants who always lived there by last three UHS. It shows in the figure that 5+ years duration of stay of female residents in current city were 44 percent, 47 percent and 71 percent in the years of 2006, 2013 and 2021 respectively. It indicates that slum migrants are gradually increasing and on the other hand, similar pattern depicted for always lived there. In all categories female migrants and always lived there were gradually increasing among non-slum population. But regarding male migrants and always lived their bimodal situation were observed.

Figure 4.2: Duration of stay of female and male residents in City Corporation slums, UHS-2006, UHS-2013 and UHS-2021.

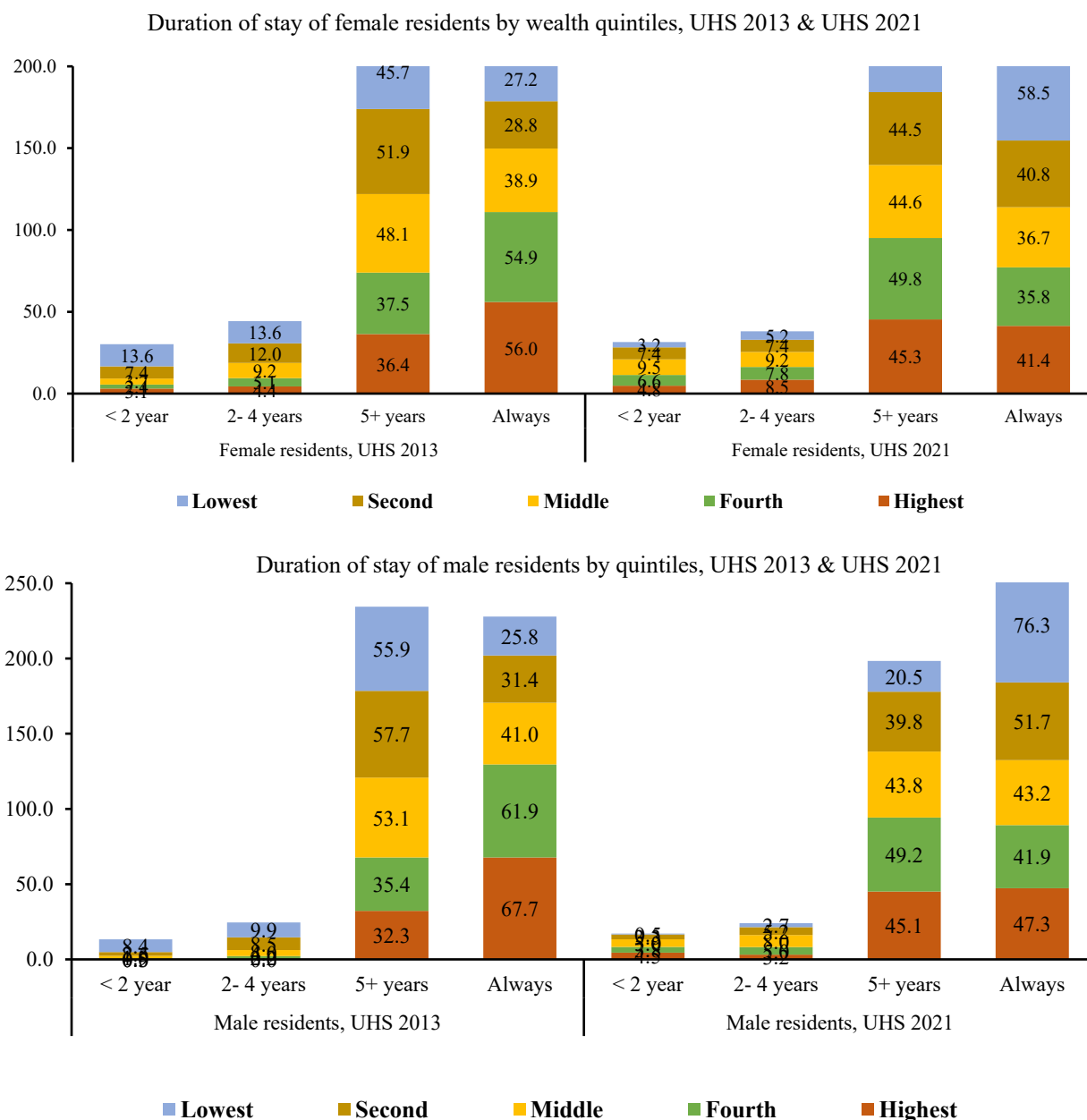


Incidence of recent migration among female (<5 years) was much higher both in slums and non-slums is compared to the rate in previous surveys.

Figure 4.3 shows the comparative situation of duration of stay of both female and male by wealth quintile in City Corporation slums for the 2013 and 2021.

In the case of 2021 UHS, recent female migrants (residing in the current city for less than two years) in the slums were in lowest wealth quintile compared to those who had been living there for longer than two years (Figure 4.3). Around 3 percent of recent female migrants and 0.5 percent of recent male migrants in slums (residing in the current city for less than two years) belonged to the poorest wealth quintile. In comparison, 31 percent of long-term female migrants and 21 percent of long-term male migrants (residing in the current city for 5+ years) belonged to the poorest quintile. The scenario of wealth quintile was quite different in the 2013 UHS data. It is possible that economic status improves over time as they settle into city life (Figure 4.3).

Figure 4.3: Duration of stay of female and male residents by wealth quintiles in City Corporation slums, UHS 2013 and UHS 2021.



The education levels of women in slums who had migrated recently (less than two years ago) were substantially higher than for recent male migrants. This may be because of different reasons for migration for females, many of whom migrated for marriage, compared to males who predominantly migrated in search of work (Figure 4.4).

Males were most likely to migrate to look for work, or service transfers. Females were most likely to migrate because of marriage, though seeking work was high among female slum dwellers.

Environmental reasons, surprisingly, were negligible. However, upon probing, it was found that environmental reasons accounted for about 7 percent of all migration to city slums (Figure 4.5).

Figure 4.4: Duration of stay of female and male residents by education in City Corporation slums, UHS 2013 and UHS 2021.

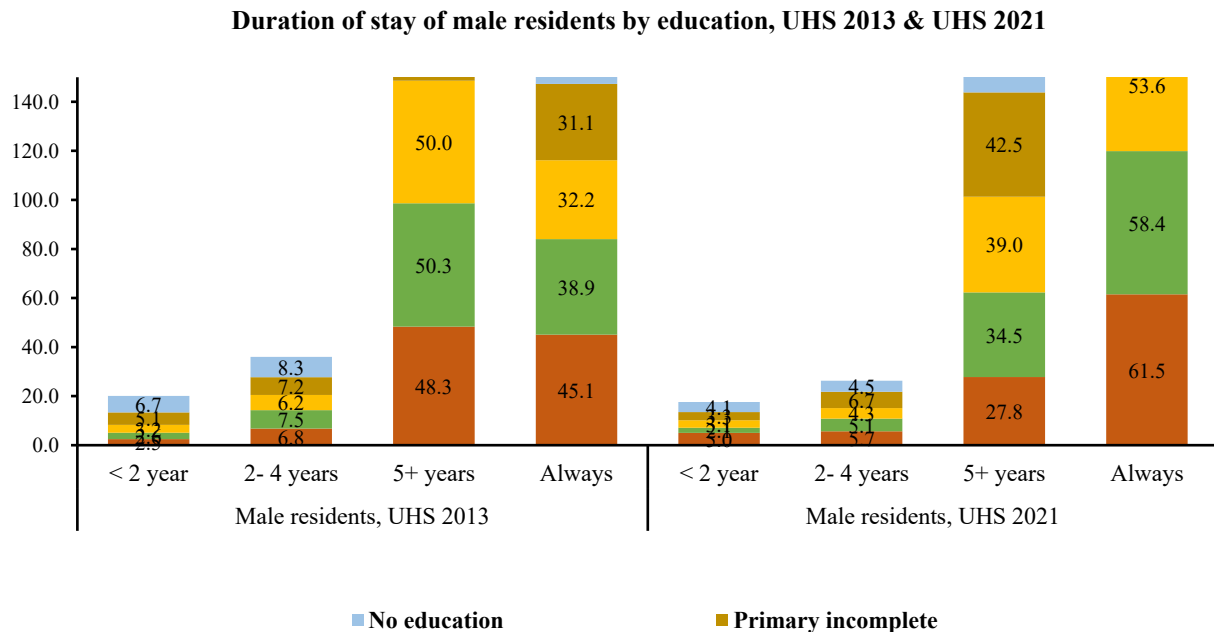
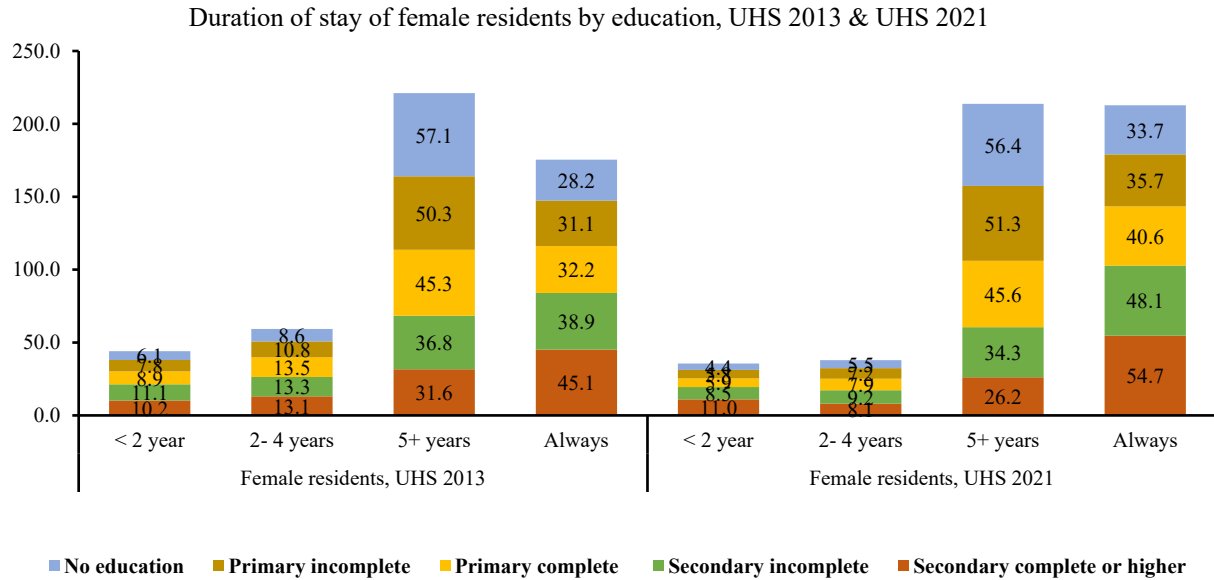
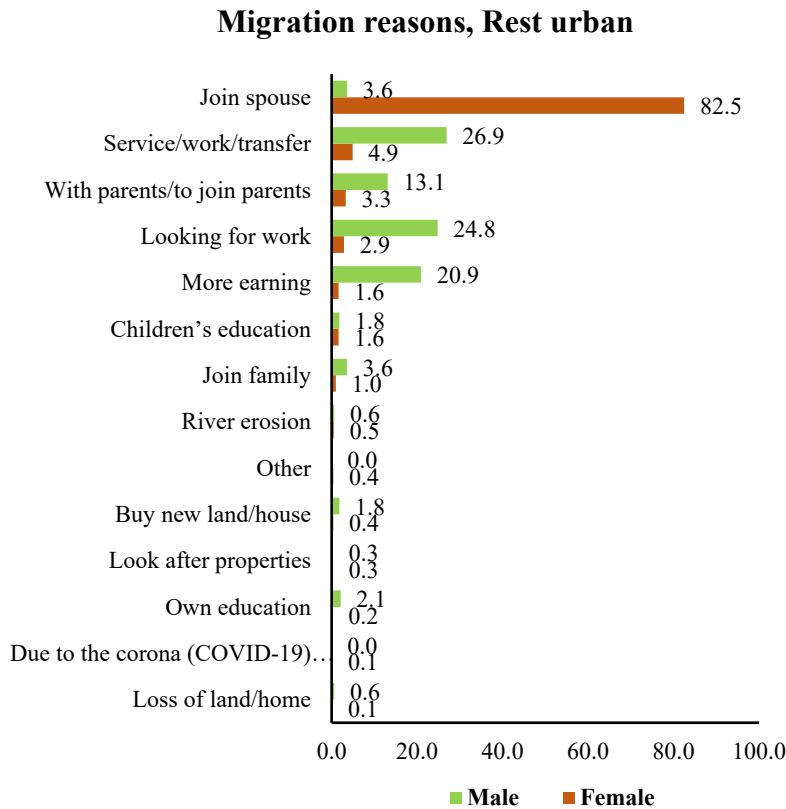
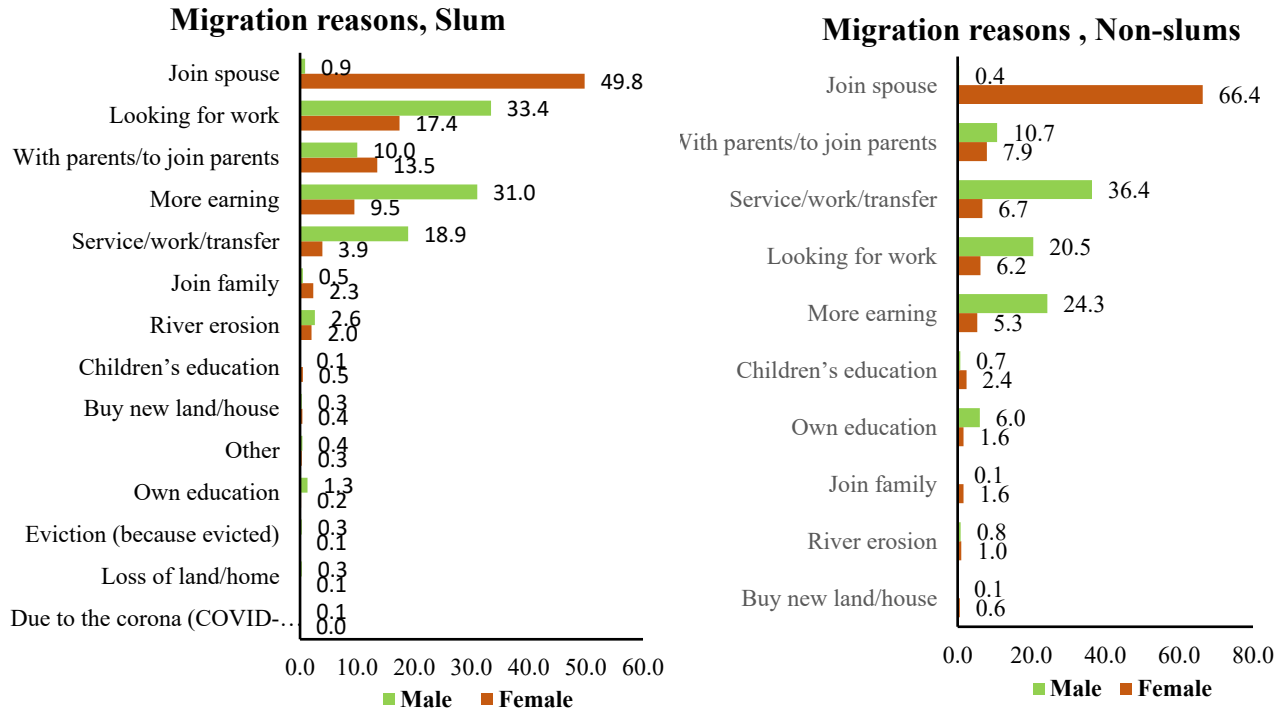


Figure 4.5: Reasons for migration, females and males, to cities (CC slums, CC non-slums and Rest urban areas), UHS-2021



4.3. Employment and Support for Migrants

Respondents in the survey were asked if they were involved in any kind of income-generating activity at the time of interview. Employment among men was more or less universal across all domains, as seen in Table 4.10. In slums, almost everyone (97.6 percent) among those who had migrated in the preceding two year was engaged in some form of paid work as seen in the other two domains also, that is, there was close to universal employment in the sampled urban domains irrespective of duration of stay.

Table 4.10: Working status by duration of stay in current place of residence: Men

Percent distribution of ever-married men age 15-54 by working status by number of years that they had lived at their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Currently working	City Corporation slum				City Corporation non-slum				Rest urban			
	< 2 year	2- 4 years	5+ years	Always lived there	< 2 year	2- 4 years	5+ years	Always lived there	< 2 year	2- 4 years	5+ years	Always lived there
Yes	97.6	99.3	98.7	98.3	93.1	100.0	99.0	97.3	100.0	99.7	98.7	97.1
No	2.4	0.7	1.3	1.7	6.9	0.0	1.0	2.7	0.0	0.3	1.3	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of men	112	176	1,298	1,702	49	97	621	1,409	35	52	248	2,093

Among the female respondents in slums, about one in four women was engaged in some form of income-generating activity (Table 4.11). About 80 percent of women residing in slums for over two years were employed at the time of interview, compared with over 32 percent and 25 percent among female migrants living in non-slums and rest urban areas respectively. Fewer of the women who had not migrated to slums but had always lived there were in paid employment— around 26 percent in slums, 14.6 percent in non-slums and 9.6 percent in rest urban areas.

Table 4.11: Working status by duration of stay in current place of residence: Women

Percent distribution of ever-married women age 15-49 by working status by number of years that they had lived at their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Currently working	City Corporation slum				City Corporation non-slum				Rest urban			
	< 2 year	2- 4 years	5+ years	Always lived there	< 2 year	2- 4 years	5+ years	Always lived there	< 2 year	2- 4 years	5+ years	Always lived there
Yes	33.4	39.6	40.5	25.5	14.0	14.3	17.8	14.6	3.0	11.4	13.5	9.6
No	66.6	60.4	59.5	74.5	86.0	85.7	82.2	85.4	97.0	88.6	86.5	90.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	711	784	4476	4298	253	505	1898	3053	261	337	2065	4891

The questionnaire for male respondents in the survey included questions on whether the male migrants received any form of support upon arrival to cities (Table 4.12). In slums, one in three males reported to have received support among both the new and longer-term migrants. In the other two urban domains, the newer migrants were less likely to have received support from external sources when they first arrived at their current residence. 'Relative' was the main provider of support in slums and other urban domains, followed by a 'family member' among the urban migrants who had received support. In all three domains, support was received primarily in finding a place to live in. Among the recent migrants (those who migrated less than five years ago) in

slums who had received support, 72.7 percent received assistance in finding accommodation in the new city they had arrived in. The second most common area in which migrants in all domains received support was in finding employment. In slums, more than half of those who received support reported that it was in the form of assistance in finding a job/employment in the city. About one-fifth of migrants receiving support in slums reported that they were given cash support.

Table 4.12: Support received upon first arriving to city: Men

Percent distribution of ever-married men age 15-54 who received support and type of support by number of years that they had lived at their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

	CC slum		CC non-slum		Rest urban	
	< 5 year	5 or more years	< 5 year	5 or more years	< 5 year	5 or more years
Currently working						
Support received						
Yes	28.7	38.8	31.9	43.3	31.3	37.3
No	71.3	61.2	68.1	56.7	68.7	62.7
Number of men	268	1307	207	781	99	287
Person received support from						
Family member	18.2	39.4	39.4	38.5	35.5	36.4
Relative	77.9	52.9	50.0	56.8	64.5	71.0
Friend	15.6	18.1	33.3	18.9	12.9	11.2
Other	0.0	2.4	3.0	1.2	6.5	4.7
Type of support received						
Residence	72.7	73.4	71.2	71.3	80.6	81.3
Employment	53.2	51.7	45.5	60.7	38.7	49.5
Cash money	18.2	18.5	25.8	18.3	29.0	15.0
Material support	5.2	10.3	10.6	9.8	6.5	7.5
Other	0.0	0.4	0.0	0.0	0.0	0.0
Number of men who received support	77	507	66	338	31	107

Among migrants in slums who received support in the last 12 months (Table 4.13), all together (up to more than 5 years) more than 21 percent slum dwellers reported to have received support from within the country and very negligible slums dwellers (0.4 percent) from overseas. The overwhelming majority in slums, about nine in ten, reported that they did not receive any support from others in the last 12 months. More or less the pattern was similar for migrants in the other two urban domains (non-slum and rest urban).

Table 4.13: Source of support received in last 12 months: Men

Percentage of migrant men age 15-54 who received support and type of support by number of years that they had lived at their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Characteristics	CC slum		CC non-slum		Rest urban	
	< 5 year	5 or more years	< 5 year	5 or more years	< 5 year	5 or more years
Bangladesh	6.8	14.3	5.9	11.9	14.2	11.2
Overseas	0.2	0.2	0.0	0.2	0.0	0.4
Both	0.0	0.1	0.0	0.1	0.0	0.0
No support received	92.9	85.4	94.1	87.8	85.8	88.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of men	288	1,298	146	621	86	248

Male respondents were asked if they provided support to relatives, beyond immediate family, in the form of cash or kind (Table 4.14). In the slum domain, migrants were less likely to support their relatives than those residing in the longer-term migrants. The same pattern was observed in rest two domains, which is that the longer-term migrants were more likely to provide support to their extended families. But the scenario was reversing for in kind support in non-slum domain.

Table 4.14: Support provided to others in cash or kind: Men

Percentage of migrant men age 15-54 who provided support to relatives by number of years that they had lived at their current residence, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

	CC slum		CC non-slum		Rest urban	
	< 5 year	5 or more years	< 5 year	5 or more years	< 5 year	5 or more years
Support offered to relatives						
Yes, in cash	9.1	7.3	11.8	12.8	16.9	15.7
Yes, in kind	0.7	1.9	4.1	2.1	0.7	1.1
Yes, both in cash & kind	3.4	3.2	3.5	9.0	8.7	7.0
No	86.8	87.6	80.6	76.1	73.7	76.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Number of men	288	1,298	146	621	86	248

Main reasons for migration for situation analysis of the female and male in all three domains can be seen in table 4.15. Females were most likely to migrate because of joining with spouse/in-laws- 50 percent, 66 percent and 83 percent in slums, non-slums and rest urban areas respectively. Work-related reasons were: looking for work (33.4 percent), more earning (31.0 percent) and service/work/transfer (18.9 percent). More or less same pattern can be seen in non-slum and rest urban domain. Other reasons are negligible.

Table 4.15: Main reasons for migration

Percent distribution of ever married women age 15-49 and men age 15-54 by main reasons for migration in City slum, City non-slum and Rest urban areas, UHS 2021

Main reasons	Place of current residence		
	City slums	City non-slum	Rest urban
Ever married women (15-49)			
Work related reasons			
Service/work/transfer	3.9	6.7	4.9
More earning	9.5	5.3	1.6
Looking for work	17.4	6.2	2.9
Loss of land/home	0.1		0.1
River erosion	2.0	1.0	0.5
Familial reasons			
With parents/to join parents	13.5	7.9	3.3
To join spouse/in-laws	49.8	66.4	82.5
To join children	0.4	0.5	0.2
To join other relatives	1.9	1.1	0.8
Other reasons			
Own education	0.2	1.6	0.2
Children's education	0.5	2.4	1.6
Buy new land/house	0.4	0.6	0.4
Look after properties			0.3
Eviction (because evicted)	0.1	-	
For security	0.1	0.1	0.2
Due to the corona (COVID-19) outbreak	0.0	-	0.1
Other	0.3	0.3	0.4
Number of women	5,972	2,658	2,663
Ever married men (15-54)			
Work related reasons			
Service/work/transfer	18.9	36.4	26.9
More earning	31.0	24.3	20.9
Looking for work	33.4	20.5	24.8
Loss of land/home	0.3	-	0.6
River erosion	2.6	0.8	0.6
Familial reasons			
With parents/to join parents	10.0	10.7	13.1
To join spouse/in-laws	0.9	0.4	3.6
To join children	-	0.1	0.6
To join other relatives	0.5	-	3.0
Other reasons			
Own education	1.3	6.0	2.1
Children's education	0.1	0.7	1.8
Buy new land/house	0.3	0.1	1.8
Look after properties	-	-	0.3
Eviction (because evicted)	0.3	-	-
Due to the corona (COVID-19) outbreak	0.1	-	-
Other	0.4	-	-
Number of men	1,583	766	335

AVAILABILITY OF HEALTH SERVICES

5

Key Findings:

- ❖ About ninety percent of communities in slums, non-slums, and other urban area domains, had a health facility available within two kilometers.
- ❖ In all the three domains (slum, non-slum and rest urban areas), community health workers were predominantly from NGOs. Half of slum and two-fifths non-slum and about one-fifth of rest urban clusters were dominated by the NGO non-BRAC health workers. In other urban areas, government health facilities were most commonly available within two kilometers.
- ❖ Availability of BRAC birthing hut/ maternity centre within one kilometer was almost nil (except non-slum domain). Only 0.3 percent of clusters had BRAC birthing hut/ maternity center available within one kilometer.
- ❖ Four-fifths of slum and rest urban communities and about three-fourths of non-slum communities reported having a community health worker.
- ❖ In the case of types of services provided by community health workers in the clusters, where they were available, family planning, maternal, and child health services delivery (counseling or providing methods) were provided by community health workers. Community workers provided nutrition-related services less often-in three-fifths of City Corporation clusters (slum and non-slum) and rest urban areas clusters.
- ❖ Visiting house to house was almost universal in all three domains. Other types of community health worker activities were also remarkable.

Availability, accessibility and affordability are the main key components of health services. These three components make questions on:

- Are the health facilities existed in the community?
- Are the health facilities available in that community?
- Are the health facilities affordable and provide quality services for that community people?

Proximity of the health center is very important for quality health management services. Health services consist of medical professionals, organizations, and ancillary health care workers who provide medical care to those in need. Health services serve patients, families, communities, and populations. They cover emergency, preventative, rehabilitative, long-term, hospital, diagnostic,

primary, palliative, and home care. These services are centered around making health care accessible, high quality, and patient-centered. Many different types of care and providers are necessary in order to offer successful health services. In the case of Bangladesh, the health services facilities are—1. Government facilities like- Hospital, Upazila Health Complex, Union Health and Family Welfare center; 2. NGO facility; 3. Private facility and 4. Other facilities.

The Urban Health Survey (UHS) 2021 implemented the community questionnaire in all the sampled clusters—for a total of 634 clusters (60 slums, 390 non-slums, and 184 other urban clusters) to collect information on the availability of health services.

5.1 Availability of Health Facility

Table 5.1 and Figure 5.1 show the availability of health facilities within a specified distance according to the type of facility by three urban domains. As shown in the table below, around 60 percent of clusters in slums, non-slums and rest urban had a health facility within one kilometer. The similar percentage was observed within one kilometer in all three domains for government facilities. Private facilities were also widely available in all three urban domains within one kilometer. Other facilities were mostly uncommon in the cluster of all the three domains. Overwhelmingly, the overall scenario was that around 60 of clusters in all three domains (slum, non-slum and rest urban areas) have health services facilities within one kilometer. So, it is a very positive sign that majority cluster peoples were getting health support services in the close proximate.

Table 5.1: Availability of health facility

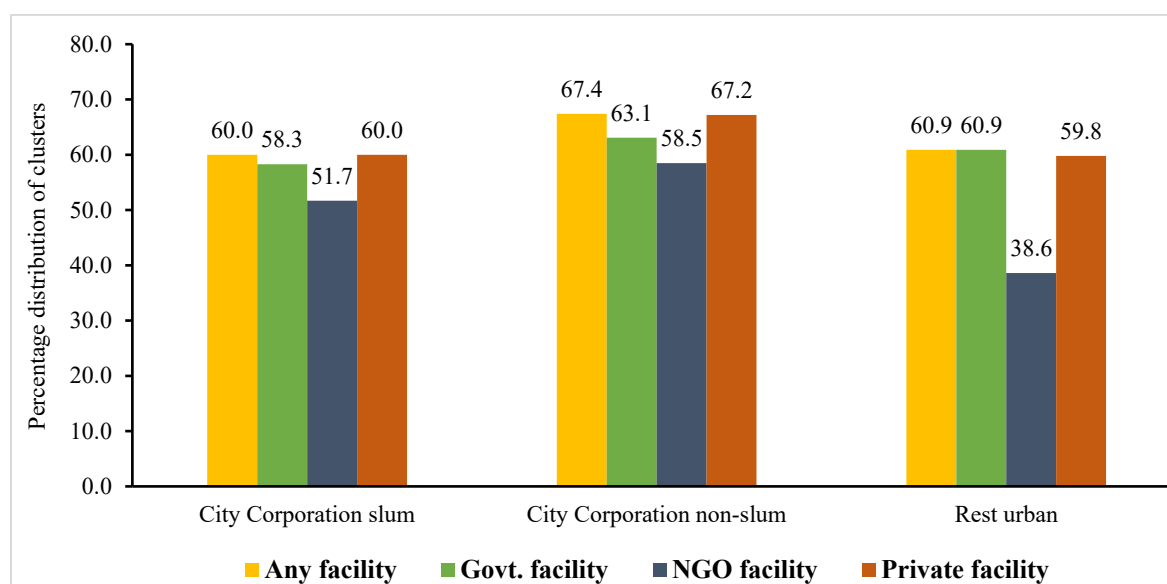
Percentage distribution of clusters by availability of health facility* within specified distance, according to type of health facility, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Distance in kilometers (km)	Any facility	Govt.	NGO	Private	Other
		facility	facility	facility	facility
City Corporation slum					
< 1 km	60.0	58.3	51.7	60.0	1.7
1 to <2 km	25.0	23.3	23.3	25.0	0.0
2 to <5 km	10.0	10.0	6.7	10.0	0.0
5 km or more	5.0	5.0	3.3	5.0	0.0
No facility	-	3.3	15.0	-	98.3
Total	100.0	100.0	100.0	100.0	100.0
Number of clusters	60	60	60	60	60
City Corporation non-slum					
< 1 km	67.4	63.1	58.5	67.2	1.5
1 to <2 km	19.7	18.7	15.4	19.2	0.0
2 to <5 km	10.0	9.0	6.4	10.0	0.0
5 km or more	2.3	2.3	1.5	2.3	0.0
DK distance	0.5	0.5	0.5	0.5	0.0
No facility	-	6.4	17.7	0.8	98.5
Total	100.0	100.0	100.0	100.0	100.0
Number of clusters	390	390	390	390	390

Distance in kilometers (km)	Any facility	Govt. facility	NGO facility	Private facility	Other facility
			Rest urban		
< 1 km	60.9	60.9	38.6	59.8	0.0
1 to <2 km	29.3	29.3	17.9	28.8	0.0
2 to <5 km	7.1	7.1	3.8	7.1	0.5
5 km or more	1.6	1.6	0.5	1.6	0.0
DK distance	1.1	1.1	0.5	1.1	0.0
No facility	-	-	38.6	1.6	99.5
Total	100.0	100.0	100.0	100.0	100.0
Number of clusters	184	184	184	184	184

*Does not include BRAC birthing hut.

Figure 5.1: Availability of health facility within one kilometer, UHS-2021



Almost absent the availability of BRAC birthing hut/maternity center within one-kilometer distance, except non-slum domain. Only 0.3 percent non-slum cluster people are receiving the BRAC birthing hut/ maternity within a distance of one kilometer (table 5.2).

Table 5.2: Availability of BRAC birthing hut/maternity center

Percentage distribution of clusters by availability of BRAC birthing hut/maternity centre within a distance of one kilometer, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Distance in kilometers (km)	City Corporation slum	City Corporation non-slum	Rest urban
< 1 km	0.0	0.3	0.0
Number of clusters	60	390	184

5.2 Availability of a Community Health Worker

Four-fifth of slum and rest urban communities and about three-fourths of non-slum communities reported having a community health worker (Table 5.3).

Around one-fifth cluster people informed that health and family planning workers were not available in all the three domains. In both slum and non-slum clusters, one in three and more than two in three in rest urban area domains the health and family planning workers were available. In all the three domains (slum, non-slum and rest urban areas), community health workers were predominantly from NGOs. Half of slum and two-fifths of non-slum and about one-fifth of rest urban clusters were dominated by the NGO non-BRAC health workers.

Table 5.3: Availability of community health worker

Percentage distribution of clusters by availability of a community health worker, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Availability of health and FP workers	City Corporation slum	City Corporation non-slum	Rest urban
Any health worker	80.0	73.8	81.0
Number of workers			
No worker	20.0	26.2	19.0
1	33.3	25.4	36.4
2	28.3	24.9	21.7
3 or more	18.3	23.6	22.8
Total	100.0	100.0	100.0
Number of clusters	60	390	184
Type of workers*			
No worker	-	13.8	3.8
Government worker	33.3	33.3	63.6
NGO BRAC worker	15.0	10.3	10.3
NGO non-BRAC worker	50.0	39.0	16.3
Private worker	1.7	3.1	4.3
Other	-	0.5	1.6
Number of clusters	60	390	184

*Include multiple responses.

Around one in ten slum, non-slum and rest urban area clusters had BRAC community health workers.

Table 5.4 shows the types of services provided by community health workers in the clusters, where they were available. Family planning, maternal, and child health services delivery (counseling or providing methods) were provided to more than two-third in all communities that community health workers worked in. Community workers provided nutrition-related services less often-in three-fifths of City Corporation clusters (slum and non-slum) and rest urban areas clusters.

In City Corporation slum and non-slum areas, among the community health workers two-thirds were NGO health workers and one-third Government workers. However, in rest urban areas, the situation was exactly opposite: 64 percent Government health workers and 27 percent NGO workers.

Table 5.4: Service delivered by community health worker

Percentage distribution of clusters where there was at least one community health worker working, by type of service provided, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Type of service	City Corporation slum	City Corporation non-slum	Rest urban
Maternal health	73.3	71.0	74.5
Child health	71.7	70.5	77.7
Family planning	70.0	63.3	67.9
Nutrition	56.7	59.0	58.7
Other	1.7	4.4	4.9
Number of clusters with at least one worker	60	390	184

Types of activities by the community health workers in all the three domains can be shown in Table 5.5. Visiting house to house was almost universal in all three domains. Other types of community health worker activities were also remarkable.

Table 5.5: Type of activities by community health worker

Percentage distribution of clusters where there was at least one community/field health worker working, by type of activities of community worker, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Type of activities	City Corporation slum	City Corporation non-slum	Rest urban
Provides services at static clinic	45.0	45.1	42.9
Does Uthaa boithak	58.3	42.1	62.5
Provides services at satellite clinic	51.7	53.1	59.8
Visiting house to house	73.3	56.7	69.0
Number of clusters with at least one worker	60	390	184

Key Findings:

Fertility

- ❖ Fertility was below the replacement level in non-slums (TFR 1.91), indicating that the HPNSDP's TFR goal of 2.0 births per woman has already been achieved in 2010-2013 and as well as in 2018-2021.
- ❖ The comparative scenario of CBR of 2010-2013 and 2018-2021 indicate that it has slightly increased in all the three domains during the past seven years.
- ❖ Total Fertility rate (TFR) was lowest (1.91 births per woman) in non-slums, highest (2.22 births per woman) in rest urban, and 2.14 births per woman in slum areas in 2018-2021.
- ❖ TFR was 2.01 births per woman in the slums in 2013, which rose to 2.14 in 2021—about 13 percent rise over a period of seven years. In non-slums, TFR was already low in 2013 at 1.74 births per woman, which rose slightly to 1.91 births per woman in 2021. In non-slums, fertility rise was about 17 percent during 2013 and 2021. TFR has risen by about 29 percent from 2013 to 2021 in rest urban domain.
- ❖ A comparison with UHS 2006 shows that the median birth interval has increased, rising from 45 months in 2006 to 54 months in 2013 and 63 months in 2021 in slums, and 52 months in 2006 to 60 months in 2013 and 61 months in non-slum areas.

Age at Marriage

- ❖ Median age at marriage remained very low—16.0 years in the slums, 17.0 years in non-slum and rest urban areas.
- ❖ Childbearing begins in approximately 2.5 years of marriage in the slums, about 2.3 years in non-slum and rest urban areas.

Teenage Pregnancy and Motherhood

- ❖ It appeared that incidence of teenage pregnancy and motherhood (at age 15-19) have slightly increased in 2021 UHS compared with 2013 UHS estimates. About 22.1 percent of teenagers of slums against 20.3 percent in non-slums began childbearing.

Fertility is the actual performance of live births or it can be noted actual level of reproduction of a human population, based on the number of live births that occur. Fertility is normally measured in terms of women of childbearing age, defined as 15-49 years, although births to women outside this age range can, and do, occur. In other words, marriage is the legally or formally (religiosity/socially/culturally/judicially) recognized union of two people as partners in a personal relationship (historically and in some jurisdictions specifically a union between a man and a woman). It needs three components mainly i.e., Commitment, Love and Respect among the couple.

Analytically, fertility preferences indicate the demand for children (latent or manifest), which may have a direct bearing on the demand for contraception—one of the proximate variables that determine fertility.

The estimates of urban fertility are important in determining environmental and economic inequalities and their impact on socio-economic development and resource allocation. This chapter elaborates on a description of urban fertility estimates, birth intervals; age at first birth, and the reproductive behavior of adolescents. The study also noted comparative scenario of some selected fertility indicators between the 2013 Urban Health Survey (UHS) and the current survey, the Urban Health Survey (UHS) 2021.

The fertility measures presented in this chapter are based on the retrospective reproductive histories of ever married women aged 15-49 who were interviewed (10,269 in slums; 17,315 in non-slums, and 7,554 in rest urban areas) in the UHS 2021. Each woman was asked to provide information on the number of sons and daughters to whom she had given birth and who were living with her, the number living elsewhere, and the number who had died. The women were then asked for a history of all their live births, including such information as: name, month and year of birth, sex, and survival status. Based on this information, measures of age-specific fertility and total fertility rates were examined. The information was also analyzed to provide information on the length of interval between births, age at first birth, and the extent of childbearing among teenage women.

6.1 Current Fertility Level

The study has measured fertility level mainly through two inter-related indicators—age-specific fertility rate (ASFR) and total fertility rate (TFR). Firstly, calculated ASFR based on the reported number of births in the three-year period preceding the survey per 1,000 women. TFR is the weighted sum of ASFRs, which is a useful means of summarizing the level of fertility. It can be interpreted as the number of births a woman would have by the end of her childbearing years if she were to pass through those years bearing children at the currently observed age-specific rates. It also shows the general fertility rate (GFR), which represents the annual number of live births in a population per 1,000 women aged 15-49. All of these measures were calculated using the birth history data for the three-year period preceding the survey.

Table 6.1 shows ASFR, GFR, and TFR for the slum, non-slum, and rest urban areas for the three years period of preceding the UHS 2021. For the slum and non-slum areas, a comparison of ASFRs

for the period 2003-2006 2010-2013 and 2018-2021 can be seen for the slum and non-slum areas in Figure 6.1.

Table 6.1: Current fertility

Age-specific fertility rates, general fertility rate, crude birth rate, and total fertility rate for the three years preceding the survey (1-36 months), by domains, UHS 2021

Age group	Age-specific fertility rate per 1,000		
	City Corporation slum	City Corporation non-slum	Rest urban
15-19	96	80	85
20-24	134	115	147
25-29	103	103	103
30-34	56	62	77
35-39	29	18	27
40-44	11	3	4
45-49	0	1	1
GFR	82	71	81
CBR	20.9	18.3	19.8
TFR	2.14	1.91	2.22

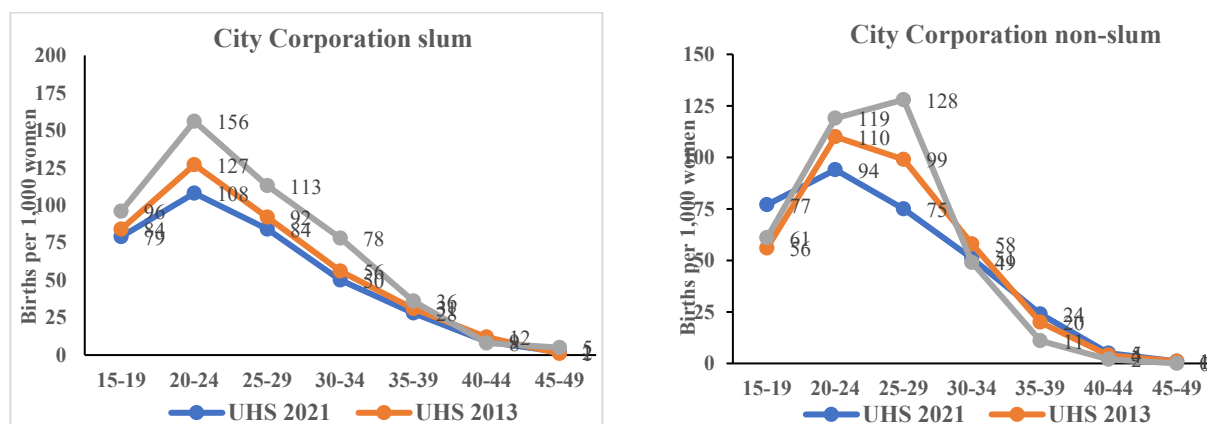
Note: Age-specific rates are per 1,000 women. Rates are for the period 1-36 months prior to be interview; during 2018-2021.

TFR: Total fertility rate expressed per women

GFR: General fertility rate expressed per 1,000 women age 15-49

CBR: Crude birth rate expressed per 1,000 populations.

Figure 6.1: Trends in age-specific fertility rates, UHS 2006, UHS 2013 and UHS 2021.



Women in the non-slum domain achieved below replacement fertility during the period 2018-2021. TFR was lowest (1.91 birth per woman) in non-slums and highest (2.22 births per woman)

in rest urban; it was 2.14 births per woman in slum areas (Table 6.1). The prime age of childbearing was 20-24 years with ASFR at 134 per 1,000 in slums (147 per 1,000 in rest urban), followed by the age group 25-29 (103 per 1,000) in slum, non-slum and rest urban domain. Fertility rate was lowest in age group 40 and onward. (Women achieved about 1.67 births in the City Corporation slum, 1.49 births in the City Corporation non-slum, and 1.68 births in the rest urban areas before age 30 years).

Childbearing occurred at younger ages in the slums and rest urban areas than in the non-slums areas.

During 2010-2013, TFR was highest in the slums at 2.01 births, followed by 1.93 births in rest urban (now rest urban/ other urban) areas, and lowest at 1.74 in non-slums. It has since rose to 2.14, 2.22 and 1.91 in these respective domains. Therefore, absolute rise was 0.17 births in non-slums, 0.13 birth in slums and 0.29 births in rest urban areas. In figure 6.1, it has examined the trend of ASFRs between the periods 2003-2006, 2010-2013 and 2018-2021. In the slum areas, fertility reduction occurred in all age groups from 20-24 through 30-34; the age groups in which most births occurred. In non-slums, a noticeable reduction of fertility was observed for the age groups 25-29, and for other age groups there was no reduction, rather increased in age groups 30-34 and found static in age groups 40-44 and 45-49. It may be worth noting that the prime age of fertility (having the highest ASFR) was 20-24 during 2010-2013 and also in 2018-2021 in slum area. More or less similar pattern has been observed in all other groups except 30-34 age group. The prime age group of fertility was 20-24 in all domains during 2010-2013 and also during 2018-2021 (Figure 6.1).

Figure 6.1a: Comparative scenario of CBR in UHS 2013 and UHS 2021



Crude Birth Rate (CBR) is the ratio between the number of live births in a population of a given area during a given year and the total mid-year population for the same year, usually multiplied by 1,000. The CBR increased in all the three domains during 2018-2021 from the previous UHS 2013 survey period (Figure 6.1a).

6.2 Trends in Total Fertility Rates

The study compared the fertility trend between 2013 and 2021 for the slum, non-slum and rest urban areas (Figure 6.2). Fertility has risen in all the three domains with a greater relative rise in the rest urban areas than in slums and non-slums. Total fertility was 2.01 births per woman in the slums in 2013, which rose to 2.14 in 2021—about 13 percent rise over a period of seven years; in non-slums total fertility was already low in 2013 at 1.74 births per woman, which again rose to 1.91 births per woman in 2021. In non-slums, fertility rise was about 9 percent during 2013 and 2021. TFR has risen about 13 percent from 2013 to 2021 in rest urban domain.

Figure 6.2: Comparative scenario of total fertility rate (TFR) in UHS 2013 and UHS 2021.



6.3 Birth Intervals

A birth interval is defined as the length of time between two live births, provides information about birth spacing patterns. Studies indicate that short birth intervals may adversely affect maternal health and children's chances of survival. Children born too close to a previous birth, especially if the interval between the births is less than two years, are at an increased risk of health problems and dying. Longer birth intervals, on the other hand, contribute to the improved health status of both mother and child. By and large, for populations that have entered into fertility transition, birth interval is inversely related to the level of fertility, that is, birth interval is longer in populations where TFR is low, and vice versa. This section presents the percent distribution of non-first births (second and higher order) in the five years preceding the UHS 2021 by the number of months since the previous birth.

Table 6.2: Birth intervals

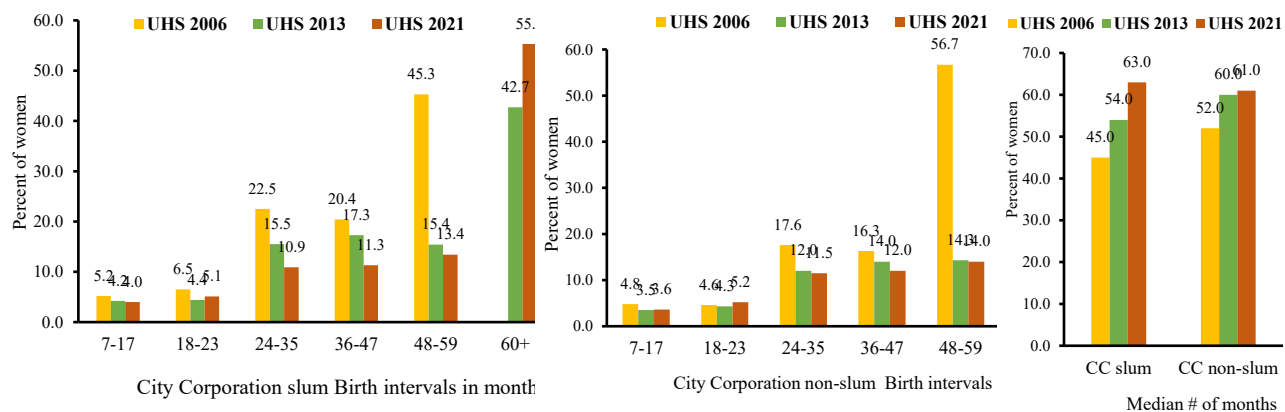
Percent distribution of non-first births in the five years preceding the survey, by number of months since preceding birth, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Months since preceding birth						Total	Number of non-first births	Median number of months since preceding birth
	7-17	18-23	24-35	36-47	48-59	60+			
City Corporation slum	4.0	5.1	10.9	11.3	13.4	55.3	100.0	2592	63.0
City Corporation non-slum	3.6	5.2	11.5	12.0	14.0	53.8	100.0	4093	61.0
Rest urban	3.7	5.6	13.3	14.3	14.8	48.3	100.0	2089	58.0

Note: First-order births are excluded. The interval for multiple births is the number of months since the preceding pregnancy that ended in a live birth.

Relatively long birth intervals, between 58 and 63 months, were found in all three major domains of the 2021 UHS. The intervals (median number of months) were in the expected direction, highest (63 months) in slums where TFR was 2.14 and lowest (58 months) in the rest urban areas where TFR was the highest (2.22) and in non-slum domain median number of months since preceding birth was 61 months and TFR was 1.91.

Figure 6.3: Birth intervals and median number of months since preceding birth, UHS 2006, UHS 2013 and UHS 2021.



Only a small proportion of non-first births occurred in the high-risk birth intervals in the urban areas of Bangladesh. Approximately 9 percent, or about one in 11 non-first births, occurred in less than 24 months of interval, almost equally in the three domains. In contrast, about half of non-first births occurred after 60 months of interval in slums, non-slums and rest urban areas.

Time trend of birth interval is shown in Figure 6.3 for the slum and non-slum areas. There was a sizeable increase in birth interval: between 2013 and 2021 birth interval increased by nine months in the slums and one month in non-slum areas. This increase was expected as there had been a decline of fertility. The birth interval improvement was observed from the distribution of intervals:

the proportion of births with 60 months or higher intervals increased from 54 to 63 percent in the slums and 60 to 61 percent in non-slums.

Annex Tables 6.2 A-C show differentials of birth intervals for the slum, non-slum, and other urban areas. Median birth interval was positively associated with women's age, education, and household asset quintile in all areas. There was one exception, in non-slums. The median birth interval was almost the same across the education groups. The distributions also reflect the differentials.

6.4 Trends in Birth Intervals

A comparison with UHS 2006 shows that the median birth interval increased, rising from 45 months in 2006 to 54 months in 2013 and 63 months in 2021 in slums and 52 months in 2006 to 60 months in 2013 and 61 months in non-slum areas. Between UHS 2006 and UHS 2013, the median birth interval increased by above eight percentage points and between UHS 2013 and UHS 2021, the median birth interval increased by ten percentage points in rest urban areas (Figure 6.3).

6.5 Age at First Marriage

Marriage took place at young ages in all areas. Median age at first marriage for the women aged 20-49 and women aged 25-49 is shown in Table 6.3. Median age was 16 years for women aged 20-49 and women aged 25-49 in slum area, and it was 17 years for non-slum domain for both groups. But in the case of rest urban area women age 20-49 it was 16.9 years and for women age 25-49 it was 16.8 years. However, there was no remarkable difference in median age at first marriage value in all three domains in women age group 20-49 and 25-49 (Table 6.3).

Table 6.3: Median age at first marriage

Median age at first marriage among women age 20-49 and 25-49, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Median age at first marriage	City Corporation slum		City Corporation non-slum		Rest urban	
	Women age 20-49	Women age 25-49	Women age 20-49	Women age 25-49	Women age 20-49	Women age 25-49
Median age	16.0	16.0	17.0	17.0	16.9	16.8
Number of women	9,389	7,548	16,301	13,508	7,107	5,909

It has been observed that marriage took place at younger ages in all the domains, as shown in Table 6.3. A noticeable difference was found between the slum and non-slum areas—age at marriage was higher in non-slums for age groups 20-49 and 20-49 by more than one year compared to slum and non-slum areas (16.0 years vs. 17.0 years). In rest urban area, median age at marriage for women age 20-49 was 16.9 and in age group 20-49 years women median age at marriage was 16.8 years.

6.6 Age at First Birth

The minimum legal marriageable age of girls has remained unchanged at 18. A rule of the proposed Child Marriage Restraint Act would allow girls, aged 16 to 18, to get married under special circumstances, with permission from courts or their parents. However, age at first birth is an important determinant of fertility. It has significant demographic and health consequences for mother and child. Usually, the postponement of first births—reflecting an increase in the age at marriage—contributes greatly to overall fertility decline. The proportion of women who become mothers before age 20 is also a measure of the magnitude of adolescent fertility, which is a major health and social concern in many countries. Table 6.4 presents the percent distribution of women by age at first birth according to current age.

Like age at marriage, childbearing also began early in the urban areas. Median age at first birth was between 18.4, 19.5 and 19.3 years in slum, non-slum and rest urban areas respectively. It began roughly two years after marriage.

Childbearing begins earlier in the slums compared to rest urban and non-slums areas. Median age at first birth was more than one year lower in the slum than in non-slum areas. Median age at first birth was lower in the slums than rest urban areas but the difference was only 0.9 years. The incidence of early childbearing, as well as its difference between domains, was also reflected in the age distribution of first birth, as seen in Table 6.4. About half (43.2 percent) of first births took place by age 18 in the slums, more than one-third (35.2 percent) took place by age 18 in non-slum areas, and in rest urban areas 38.1 percent. It is interesting that large majority (83.3.9 percent) has given birth at the age of 25 years in rest urban areas. Four-fifths (79.7 percent) of non-slum and about four-fifths of slums women gave birth at 25 years of age. Another noticeable point is that 3.6 percent, 5.1 percent and 3.9 percent women have never given birth in slum, non-slum and Rest urban areas respectively (Table 6.4).

Table 6.4: Age at first birth

Percentage of women 25-49 who gave birth by exact ages, percentage who have never given birth, and median age at first birth, according to survey domains, UHS 2021

Survey domains	Percentage who gave birth by exact ages					Percentage who have never given birth	Number of women	Median age at first birth
	15	18	20	22	25			
City Corporation slum	8.9	43.2	62.2	73.9	81.9	3.6	7,548	18.4
City Corporation non-slum	6.8	35.2	54.9	67.9	79.7	5.1	13,508	19.5
Rest urban	7.0	38.1	58.9	72.2	83.3	3.9	5,909	19.3

The age distributions of age at first birth are further shown by domain in Annex Tables 6.4.A-C. It appears that incidence of early childbearing is very slowly declining for younger cohorts, which is true for almost all the domains. For example, between age groups 30-34 and 35-39, the percentage of women who had their first birth by age 18.5 and 18.0 respectively decline with age, an indication that older women had their first birth earlier than younger women. But basically, it has no remarkable difference between early childbearing in younger and older cohorts.

Median age at first birth was 18.5 and 18.4 years in women in age groups 20-49 and 25-49 in slums, in rest urban areas was about similar picture that in both cases (women age 20-49 & 25-49) median age at first birth was 19.2 and 19.3 years. Non-slum scenario was little better than other two domains. Women age 20-49 were 19.3 and 25-49 was 19.5 years (Table 6.5).

Table 6.5: Median age at first birth

Median age at first birth among women age 20-49 and 25-49, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

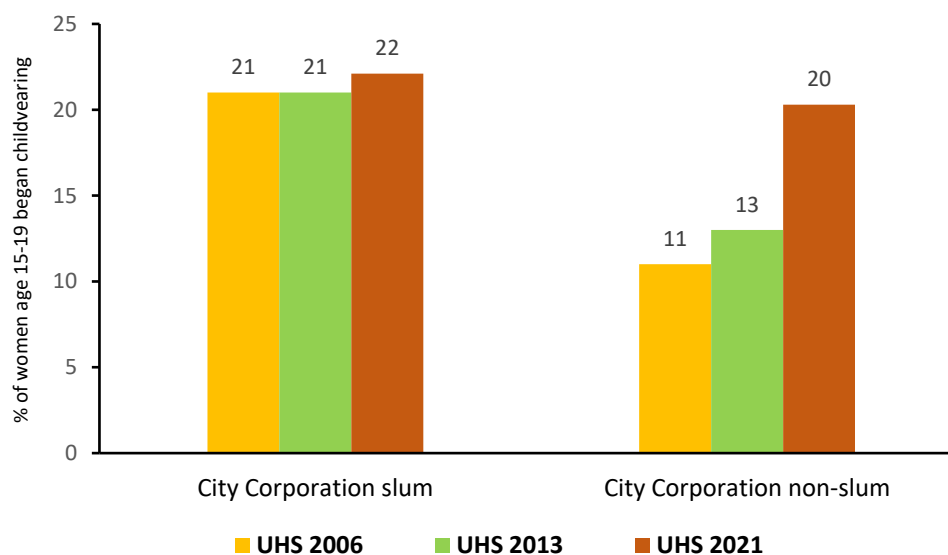
Median age at first birth	City Corporation slum		City Corporation non-slum		Rest urban	
	Women age 20-49	Women age 25-49	Women age 20-49	Women age 25-49	Women age 20-49	Women age 25-49
Median age	18.5	18.4	19.3	19.5	19.2	19.3
Number of women	8,778	7,274	14,852	12,815	6,665	5,679

6.7 Teenage Pregnancy and Motherhood

It is well known that teenage pregnancy, early childbearing, and motherhood have negative socioeconomic and health consequences. Teenage mothers are more likely to have complications during labor, which results in higher morbidity and mortality for both themselves and their children. Childbearing among teenagers also has adverse social consequences, particularly on female education and job opportunities.

Teenage pregnancy or childbearing was common among the urban residents of Bangladesh, as between 11 percent and 22 percent of 15-19-year-old women had begun childbearing (Table 6.6). There was quite a bit of variation of this behavior between domains, especially between non-slums and slums or non-slums and rest urban areas. Teenage pregnancy was more prominent in the slums and rest urban areas than in non-slum areas. Teenagers from the slums were two percentage points more likely to be mothers than teenagers from non-slum areas (22 percent in the slums vs. 20 percent in non-slums). The proportion of teenage childbearing in rest/ other urban areas was 11 percent. Figure 6.4 shows that there has been a big change in the incidence of teenage pregnancy and motherhood over the period of eight years between 2013 and 2021 in the slum and non-slum areas. But it was about the same in 2006 UHS and 2013 UHS.

Figure 6.4: Trends in teenage pregnancy, UHS 2006, UHS 2013 & UHS 2021.



Further tables of teenage childbearing are shown in Annex B (Tables 6.6.A-C). Teenage childbearing increased with age of women in all three domains and slightly decreased with education in the slum and non-slum areas. But convex picture found in rest urban areas.

On the other hand, there was sharp decline in early childbearing by household wealth quintile in non-slum and rest urban domains. A haphazard scenario was observed in slum domain (Tables 6.6. A-C).

In the slums, about 16 percent of teenagers (age 15-19) were already mothers and another 6.2 percent were pregnant with their first child (Table 6.6.). This means, 22.1 percent of women age below 19 had already begun childbearing in slum areas. One-fifth women age 15-19 in the non-slums and 10.9 percent in rest urban areas began childbearing. But there was a tendency for early childbearing to decrease with education and increase with wealth quintile in all three domains (Tables 6.6. A-C). Teenage pregnancy and motherhood appeared to have increased in 2021 compared with 2013 estimates.

Table 6.6: Teenage pregnancy and motherhood

Percentage of women age 15-19 who are mothers or pregnant with their first child, in City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Survey domains	Percentage who are:		Percentage who have begun childbearing	Number of women
	Mothers	Pregnant with first child		
City Corporation slum	15.8	6.2	22.1	880
City Corporation non-slum	18.4	1.9	20.3	1014
Rest urban	7.8	3.0	10.9	447
Total	15.5	3.7	19.2	2341

6.8 Fertility Planning

The incidence of an unplanned birth was quite common among women in the three domains, though it was relatively more common in the slums than rest urban and non-slum areas (Table 6.7). In the slums, 78 percent of women wanted to have the last birth in the three years preceding the survey. About 15 percent wanted the birth later, and around 7 percent did not want to have any children at all. In rest urban areas, about 84 percent of women wanted the birth then, 9 percent wanted it later, and 7 percent did not want any children. In non-slum areas, about 83 percent wanted the birth then, around 10 percent wanted it later, and 8 percent of women did not want to have any children. Compared with the 2013 UHS, percentage of women wanted then (preceding of 36 months of survey) was low in 2021 UHS in all the domains (Table 6.7).

Table 6.7: Fertility planning status

Percent distribution of most recent births to women age 15-49 in the three years preceding the survey, by planning status of birth, UHS 2021

Birth order and mother's age at birth	Planning status of birth				Total	Number of births
	Wanted then	Wanted later	Wanted no more	Missing		
City Corporation slum	77.9	15.3	6.8	0.0	100.0	592
City Corporation non-slum	82.5	9.8	7.7	0.0	100.0	320
Rest urban	84.0	9.0	7.0	0.0	100.0	413

It appears that the TFR of 2.14 that was observed in the slums could have been lower if women could have fulfilled their fertility planning. More than twenty-two percent of women in slums wanted to avoid or delay the pregnancy but could not do so. This partly indicates the unmet need for contraceptives in the slum areas.

6.9 Fertility Preferences Among Women and Men

Desire for children has shown in table 6.8, where the desire is divided into several categories of spacing and limiting of birth, based on the information obtained from women and men. The desire pattern was quite similar in the three domains for both women and men. However, there was a dissimilarity of desire for children between women and men in the sense that wanted no more children was relatively higher among men than women. For example, 53-54 percent of women wanted to have no more children, compared with 53-58 percent of men.

The average 53 percent of women and 56 percent of men in slums wanted no more children, and such desire was similar across the three domains. Over 13 percent of women and men in slums wanted to have a child soon and about 22 percent of women and 23 percent of men wanted to have another child later.

Desire for children was tabulated by the number of living children (Annex B, Tables 6.8.A-C). The data in the tables can be used to identify women's tendency of having an additional number of

children. There were some women who did not have any children (Number of children = 0) and did not want to have any children at all. That percent was between 1-4 percent in the three domains. Additionally, 15-19 percent of women who had one living child did not want to have any more children. Combining these two percentages, it seems that one in five women wanted to have only one child or no child. This pattern of desire in fact was reflected in the total fertility rate. It has been observed that TFR was 2.14, 2.22, and 1.91 in slum, rest urban and non-slum domains respectively. Therefore, now-a-days a considerable proportion of women were having only one child, a commonly observed phenomenon among urban women worldwide.

Table 6.8: Fertility preferences among women and men

Percent distribution of currently married women age 15-49 and married men age 15-54 according to desire for children, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Survey area	Desire for children							Total	Number of women /men
	Have another soon ¹	Have another later ²	Have another, undecided when	Un-decided	Want no more ³	Sterilized ⁴	Missing		
Women									
City Corporation slum	12.9	24.1	2.7	1.3	53.2	5.9	0.0	100.0	9,484
City Corporation non-slum	14.9	21.1	2.8	1.8	52.5	7.0	0.0	100.0	5,410
Rest urban	14.3	20.6	3.2	1.3	54.3	6.3	0.0	100.0	7,208
Men									
City Corporation slum	12.5	23.0	0.0	2.5	55.5	6.5	0.0	100.0	3,243
City Corporation non-slum	15.5	23.3	0.0	2.3	52.8	6.1	0.0	100.0	2,142
Rest urban	14.8	18.2	0.0	3.9	57.9	5.2	0.0	100.0	2,397

¹ Want next birth within two years,

² Want to delay next birth for two or more years,

³ Includes those pregnant women who did not want the child,

⁴ Includes both female and male sterilization.

Key Findings:

Contraceptive use

- ❖ Family planning performance in slums surpassed that in non-slums. The contraceptive prevalence rate (CPR) was highest in the urban slums (72 percent) and lowest in rest urban areas (67.9 percent) in 2021. Couples in the slum areas were very close to achieving the HPNSDP's goal of reaching CPR of 75 percent by 2022.
- ❖ Pill was the most widely used contraceptive method in all three urban domains (31.8 percent in the slums, 31.1 percent in rest urban and 27.6 percent in the non-slums). The next most common method was injectables (7.7 to 14.9 percent) and condom (7.4 to 14.7 percent).
- ❖ The long-acting reversible contraceptive (LARC) and permanent method (PM) including female and male sterilization, IUD and Implants use was low between four to six percent, and it was predominantly female sterilization (6.0 percent in the non-slums, 5.7 percent in rest urban, 4.4 percent in the slum areas). The demand for these methods was also low.

Trends in Current use of FP

- ❖ Between 2013 and 2021, CPR increased by 2 percentage points in the slums (from 69.6 to 71.6 percent), while in the non-slums the increase was by 3 percentage points (from 65.0 to 68.0 percent).

Sources of Modern Contraceptive Methods

- ❖ The private sector was the major source of contraceptive methods in each of the three urban domains. Nearly eight out of ten couples in the non-slums (77.5 percent) and seven out of ten couples in the slums (73.6 percent) or rest urban areas (68.4 percent) obtained contraceptive methods from the private sector.

Awareness and Intention of Adopting Permanent Methods

- ❖ Awareness of permanent method of FP among currently married women age 15-49 was almost universal (94 to 97 percent). This awareness was found to be relatively low among married men age 15-54 (77 to 88 percent).
- ❖ Among currently married non-pregnant women age 15-49 and men age 15-54 from slum, non-slum, and rest urban areas who did not want any more children, and were not sterilized, their intention to use a permanent method in next one year was very low (less than 2.0 percent among women and 2 to 3 percent among men).

Fertility regulation is an important proximate determinant of fertility. Couples can use contraceptive methods to limit the number of children they have. The 4th Health, Population and Nutrition Sector Program (HPNSP) 2017-22 aims to increase the contraceptive prevalence rate (CPR) to 75 percent by 2022, with an emphasis on increasing the use of modern methods in lagging divisions (Sylhet and Chattogram). In alignment with the 4th HPNSP, Family Planning 2020 (FP 2020) updated its commitment to increasing the use of long-acting and permanent methods to 20 percent, reducing unmet need for family planning to 10 percent, and reducing the contraceptive discontinuation rate to 20 percent by 2021 (Government of Bangladesh 2017).

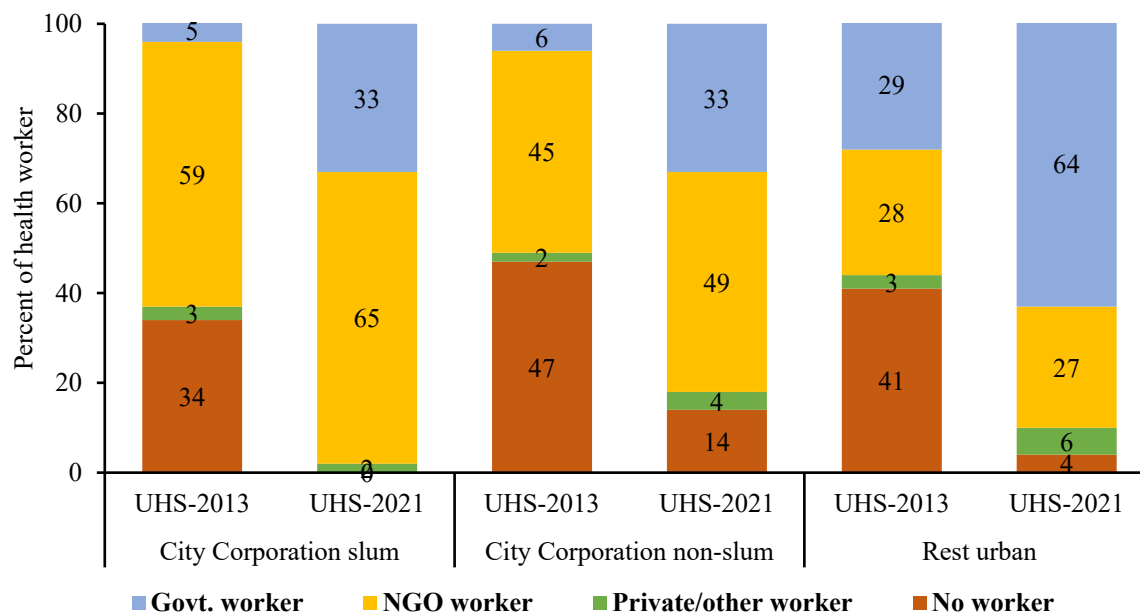
This chapter presents information on awareness and use of contraceptive methods, trends in contraception use among currently married women age 15-49, awareness of permanent methods and intention of adopting permanent methods, and other issues associated with family planning. It also discusses the sources of supply of modern contraceptive methods, and availability of health and family planning workers in urban areas, which has practical relevance for analyzing the market share of different sectors and formulating strategies to address customer choice.

7.1 Availability of Health and FP workers

In Bangladesh, family planning (FP) services are available through public, NGO, and private sectors. But FP service delivery channels are different in urban areas from that of rural areas, and within urban areas they are different for City Corporations (slums and non-slums) and rest urban areas (district and lower level municipalities). Residence in rest urban areas obtain FP services from public, NGO, and private sectors. The public sector district hospitals, UHCs, and some NGO static clinics located in rest urban areas deliver implants and female and male sterilization. There is no public sector infrastructure for FP service delivery in the City Corporations. NGOs and private sectors provide IUD, implants, and female and male sterilizations there. These methods are also available in public sector medical colleges and district hospitals that are located in City Corporations. Pills and condoms are available in shops and pharmacies, and injectables are available from Blue Star Pharmacies. Outreach workers of NGOs provide information and counseling on FP methods and deliver pills and condoms.

Results from the Community Survey as presented in Table 5.3 of chapter 5 and Figure 7.1 show that the availability of health and FP workers was higher in slums than in non-slums and rest urban areas. Most of the workers were from NGOs in the City Corporations, while in rest urban areas government health workers were higher. Presence and promotional activities of health and FP workers have positive impact on contraceptive use.

Figure 7.1: Availability of health and FP workers, UHS-2013 and UHS-2021.



7.2 Current Use of Contraception

Use of family planning helps women avoid unintended and unplanned pregnancies and reduces the risk of unsafe abortions. Contraceptives also help women space the births of their children, which directly benefits the health of both the mother and the infant.

Contraceptive Prevalence Rate: Contraceptive prevalence rate (CPR) is defined as the proportion of currently married women who use any contraceptive method.

Modern methods: Modern methods of contraception include male and female sterilization, injectable, intrauterine devices (IUDs), contraceptive pills, implants, and male condoms.

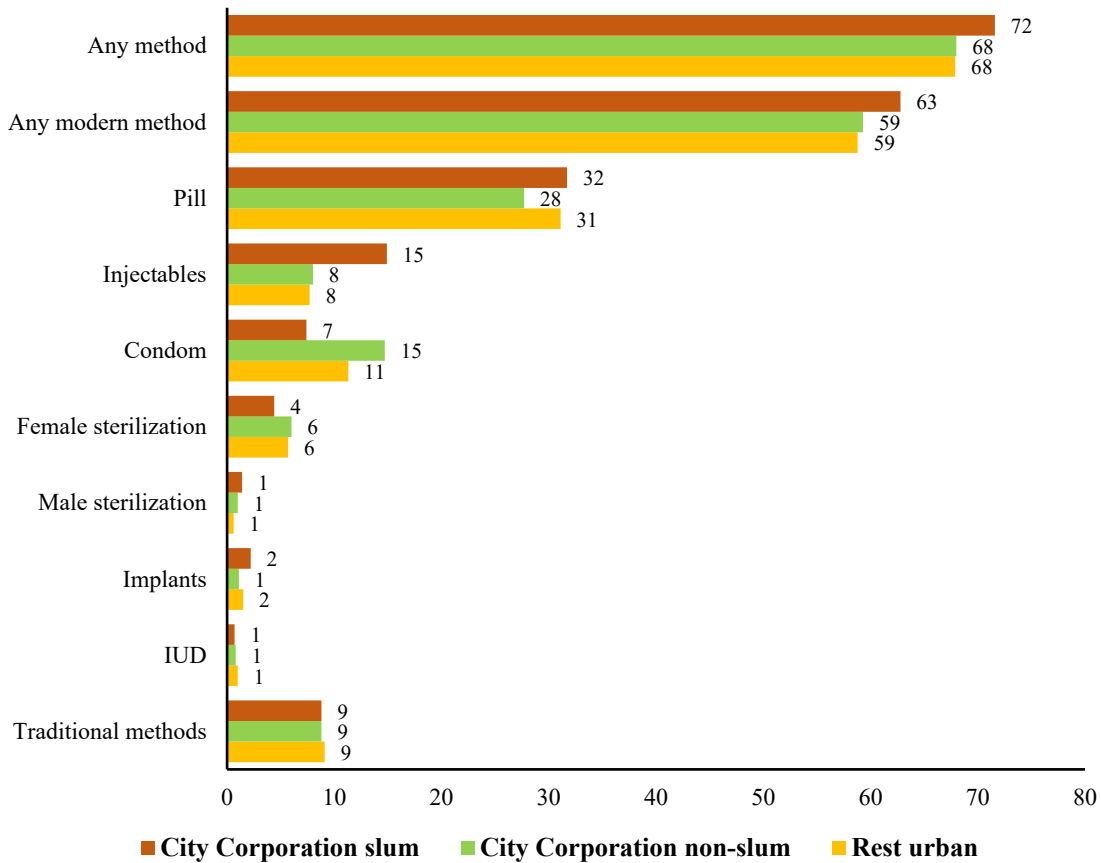
The UHS 2021 asked currently married women age 15-49 living in the urban slums, non-slums, and rest urban areas whether they were currently using a family planning (FP) or contraceptive method. Results presented in Table 7.1 shows that the contraceptive prevalence rate among currently married women age 15-49 living in the slums was higher at 71.6 percent compared with those living in the non-slums (68.0 percent) and rest urban areas (67.9 percent).

About 62.9 percent of currently married women in the slums, 59.2 percent of non-slums, and 58.7 percent women in the rest urban areas were using modern contraceptive methods.

The oral pill was by far the most widely used method. Approximately one in three currently married women in all three domains (31.8 percent in slums, 27.6 percent in non-slum and 31.1 percent in rest urban) were using pills. Injectables were the second most popular method among

women in the slums (14.9 percent), while condoms were the second most popular method in the non-slums (14.7 percent) and rest urban (11.3/ 11.2 percent) areas

Figure 7.2: Contraceptive use (Percentage of currently married women age 15-49 using a contraceptive method)



7.2.1 Current Use of Contraception by Background Characteristics

Use of contraception by background characteristics such as age, number of living children, education, household asset quintiles, working status, and length of migration to urban residence is presented in Tables 7.1A-C in Annex B. In the slums, contraceptive use increased with age, reaching a high of 82.6 percent in age group 35-39, then declined. Similarly, it increased with the number of living children, being highest at 74.4 percent among women who had three to four children, and then declined. Similar relationship also observed in the other two domains between contraceptive use with age of women and number of living children.

No definite relationships were evident between the overall contraceptive use with level of education, wealth quintiles, working status, and length of migration/stay in current place of residence. This was true in all the three domains. However, specific method use was associated with some background characteristics. Figure 7.3 shows contraception use by background characteristics.

Long-acting (IUD, injectable, implant) and permanent methods (female and male sterilization) use was low, between 0.6 percent and 6.0 percent, in the slums, non-slums, and rest urban areas.

Figure 7.3: Contraception use by background characteristics, UHS-2021.

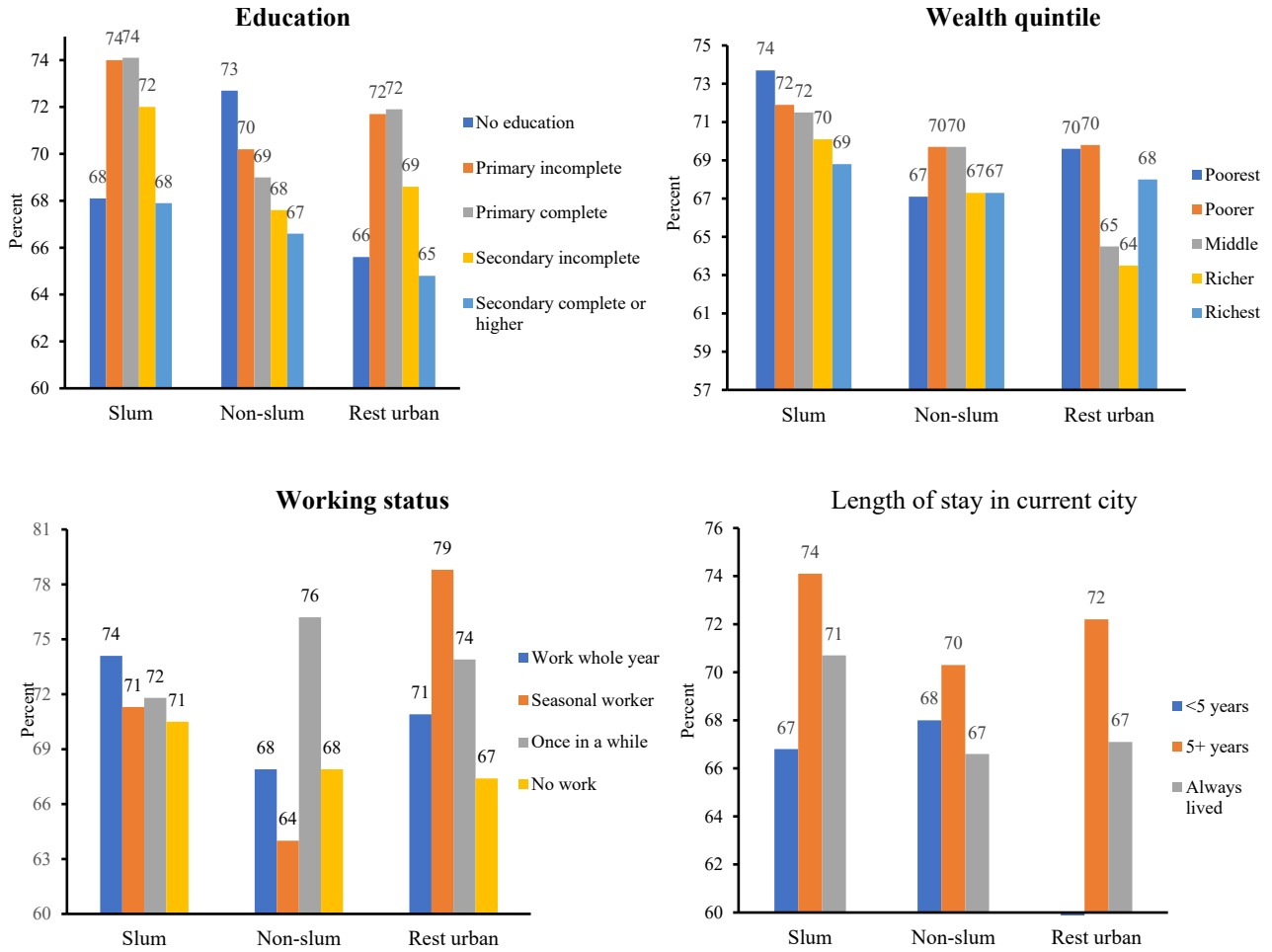


Table 7.1: Current use of contraception

Percent distribution of currently married women by current use of contraceptive method, according to City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

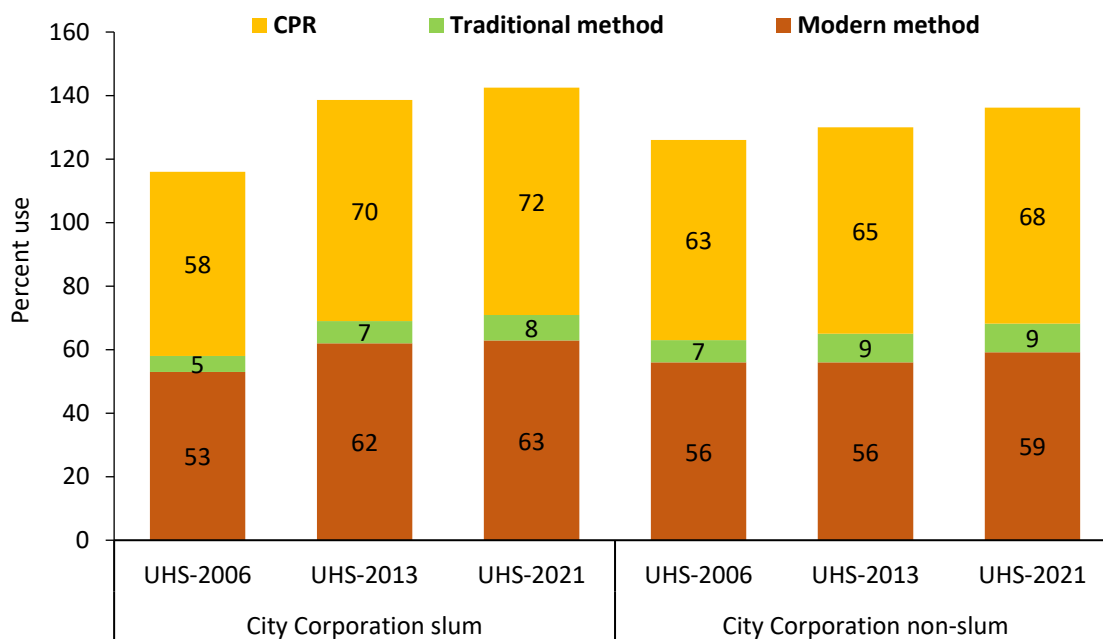
Survey areas	Any method	Any modern method	Family planning methods										Total	Number of women	
			Female sterilization	Male sterilization	Pill	IUD	Injec-tables	Im-plants	Condom	Periodic abstinence	With-drawal	Other			No method
City Corporation slum	71.6	62.9	4.4	1.4	31.8	0.7	14.9	2.2	7.4	6.4	1.5	0.9	28.4	100.0	9,484
City Corporation non-slum	68.0	59.2	6.0	1.0	27.6	0.9	8.1	1.1	14.7	6.5	1.6	0.7	32.0	100.0	5,410
Rest Urban	67.9	58.7	5.7	0.6	31.1	1.0	7.7	1.5	11.2	6.7	1.6	0.8	32.2	100.0	7,208

Note: If more than one method was used, only the most effective method was considered in the tabulation

7.3 Trends in Current Use of Contraception

Between 2013 and 2021, Contraceptive Prevalence Rate (CPR) among currently married women in urban areas of Bangladesh has increased by 2 percentage points in the slums (69.6 to 71.6 percent), 3 percentage points in the non-slums (65.0 to 68.0 percent), and from 66.6 to 67.9 percent in the rest urban areas. The situation was opposite in 2006; 58.1 percent in the slums, 62.7 percent in the non-slums, and 58.1 percent in the district municipalities. Figure 7.4 shows the trends in contraception use among currently married women age 15-49 for slums and non-slums areas.

Figure 7.4: Trends in contraception use among currently married women age 15-49, UHS-2006, UHS-2013 and UHS-2021.



7.4 Sources of Modern Contraceptive Methods

All current users of modern contraceptive methods were asked to report the most recent source of supply of their methods. The source of modern contraceptive methods varied greatly by the specific method. Overall, the private sector was the major source of contraceptive methods in City Corporations (slums and non-slums).

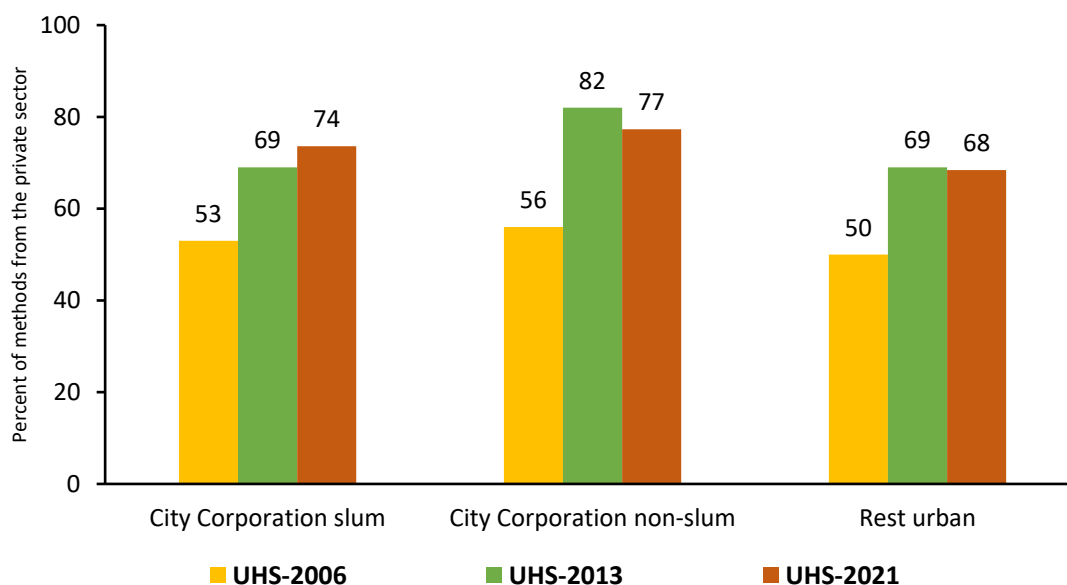
Table 7.2: Source of modern contraceptive methods

Percent distribution of current users of modern contraceptive methods age 15-49 by most recent source of supply, according to specific method, by survey domain, UHS 2021

Source	Family planning methods							Total
	Female sterilization	Male sterilization	Pill	IUD	Injec-tables	Im-plants	Condom	
City Corporation slum								
Public sector	57.2	67.9	5.6	69.7	12.6	64.8	1.4	14.6
NGO	6.4	12.0	5.7	21.3	27.4	21.1	6.0	11.8
Private sector	36.5	20.1	88.7	9.0	60.0	14.1	92.6	73.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	418	137	3,012	67	1,412	209	706	5,961
City Corporation non-slum								
Public sector	47.8	70.9	11.6	67.4	24.4	68.3	4.4	18.0
NGO	4.6	1.3	2.0	11.1	18.1	17.9	1.1	4.6
Private sector	47.6	27.7	86.4	21.5	57.5	13.8	94.5	77.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	325	52	1,493	46	436	59	794	3,205
Rest urban								
Public sector	42.3	81.3	24.4	86.9	42.7	94.2	7.4	28.7
NGO	1.3	0.0	1.9	3.8	11.4	3.0	0.6	2.9
Private sector	56.3	18.7	73.7	9.3	45.9	2.8	92.0	68.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of users	411	45	2,241	69	555	109	805	4,233

Table 7.2 shows that nearly three-fourths of current users in the slums obtained their most recent contraceptive methods from a private sector source. The corresponding proportions in the non-slums and rest urban areas were 77.3 percent and 68.4 percent.

Figure 7.5: Percent of modern contraceptive methods obtained from the private sector, UHS 2006, UHS-2013 and UHS-2021



Three short-acting methods (pill, condom and injectable) of modern contraceptive users obtained their method mostly from the private sector (mostly pharmacy or drug store). Share of public sector in the supply of modern contraceptive methods was 14.6 percent in the slums, 17.9 percent in the non-slums, and 28.6 percent in the rest urban areas.

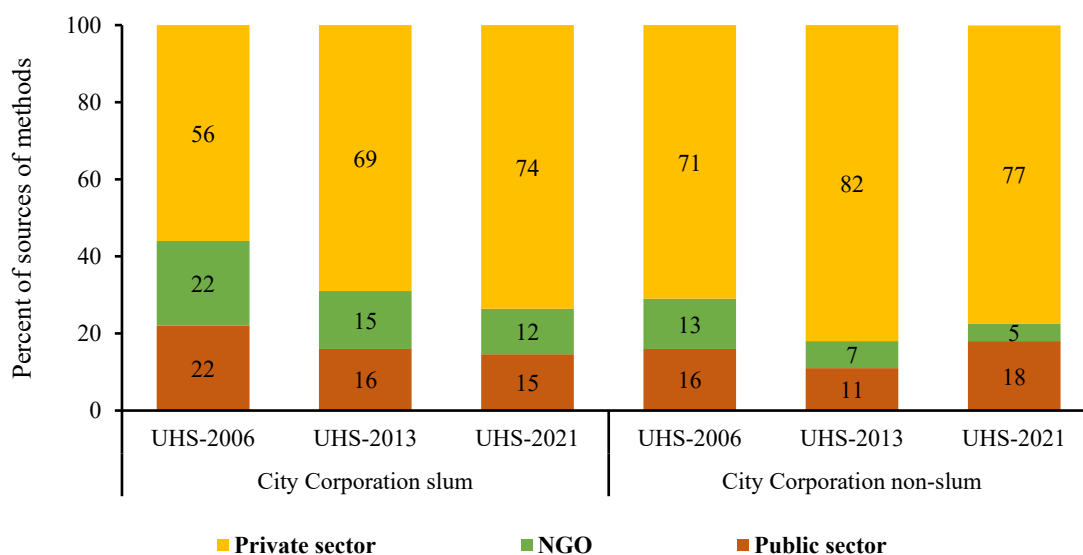
Public sector was the major source of obtaining long-acting reversible contraceptive (LARC) methods and permanent methods (female and male sterilization and NSV). Since the share of these methods in method mix was small, the role of the public sector appears to have been minimal. Figure 7.5 shows the share of private sector in the supply of modern contraceptive methods by survey years.

The share of NGOs in contraceptive method mix seems also to have been small, between 2.9 percent to 11.8 percent, in the slums, non-slums, and rest urban areas.

7.4.1 Trends in Sources of Modern Contraceptive methods

The private sector has surpassed the public sector as the dominant source of contraceptive methods. The share of private sector has substantially increased over the years. Between 2013 and 2021, the percentage of women who obtain their contraceptive methods from the private sector increased from 68.7 to 73.6 percent in the slums, decreased from 82.1 to 77.3 percent in the non-slums, and 68.9 percent to 68.4 percent in rest urban areas. There has been a negligible change over time in the proportion of female sterilization procedures that occur in private medical sector facilities (from 20.9 to 36.5 percent in the slums, 43.7 to 47.6 percent in the non-slums, and 42.3 to 56.3 percent in other urban areas). Figure 7.6 gives trends in sources of modern contraceptive methods among current users for slums and non-slum areas.

Figure 7.6: Trends in sources of modern contraceptive methods among current users, UHS-2006, UHS-2013 and UHS-2021.



7.5 Awareness of Permanent Methods and Intention of Adopting Permanent Methods

Currently married non-pregnant women age 15-49, and married men age 15-54, who do not want any more children and are not sterilized, were asked whether they had heard about permanent method of contraception. Results presented in Table 7.3 show that more women (94 to 97 percent) than men (77 to 88 percent) of slums, non-slums and rest urban areas were aware of permanent contraceptive methods.

The intention of adopting a permanent method was found to be extremely low among both men and women. In response to a question on whether they have any intention of adopting a permanent method in the next one year, only 0.9 percent of currently married non-pregnant women of age 15-49 who do not want any more children and are not sterilized in the slums, 1.8 percent in the non-slums, and 0.8 percent in rest urban areas replied in the positive. Similarly, only 2.9 percent of men of age 15-54 in the slums, 2.3 percent in the non-slums, and 2.2 percent in the rest urban areas were found to have intention of adopting a PM in next one year.

Table 7.3: Awareness of permanent methods and intention of adopting permanent methods, by survey areas

Percentage of currently married non-pregnant women age 15-49, and men age 15-54, who do not want any more children and are not sterilized who have heard about permanent method. Among those who have heard, the percentage who intend to use permanent method in the next on year, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Survey areas	Percent heard of permanent method*	Number	Intention of adopting permanent methods in next one year			Total	Number who heard of permanent method
			Yes	No	Don't know		
Women							
City Corporation slum	93.6	5,468	0.9	98.5	0.6	100	4,560
City Corporation non-slum	95.8	3,154	1.8	98.0	0.2	100	2,644
Rest urban	97.2	4,256	0.8	98.8	0.3	100	3,681
Men							
City Corporation slum	77.4	1,837	2.9	94.7	2.4	100.0	1,211
City Corporation non-slum	80.3	1,164	2.3	97.3	0.4	100.0	804
Rest urban	88.4	1,403	2.2	92.8	5.0	100.0	1,111

*Includes male and female sterilization

The intention of adopting a permanent method did not vary appreciably over the age of women, as seen in Table 7.4.

Table 7.4: Awareness of permanent methods and intention of adopting permanent methods, by current age of women

Percentage of currently married non-pregnant women age 15-49, who do not want any more children and are not sterilized who have heard about permanent method. Among those who have heard, the percentage who intend to use permanent method in the next on year, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Current age of women	City Corporation slum			City Corporation non slum			Rest urban		
	Percent heard of permanent methods	Intention of adopting permanent methods in next one year	Total number of women	Percent heard of permanent method*	Intention of adopting permanent methods in next one year	Total number of women	Percent heard of permanent method*	Intention of adopting permanent methods in next one year	Total number of women
< 20	57.3	0.0	37	89.9	0.0	10	95.6	0.0	20
20-34	91.4	0.8	2,371	93.6	2.0	1,240	96.1	1.0	1,651
35+	91.2	0.8	3,059	94.6	1.2	1,903	96.2	0.6	2,585
Total	91.0	0.8	5,468	94.1	1.5	3,153	96.1	0.7	4,256

*Includes female sterilization

7.6 Husbands Living Elsewhere and Their Visits to Home

Many of the currently married women age 15-49 whose husbands live elsewhere and occasionally visit the family. Husbands live elsewhere for the purpose of earning income, and this living arrangement had implications for fertility. The effect of spousal separation because of husbands living away from home in reducing fertility varied with the length of separation as well as the frequency of the husband's visit at home. The cumulative impact of spousal separation would be expected to be greater in areas of relatively high fertility and low prevalence of modern contraceptive use.

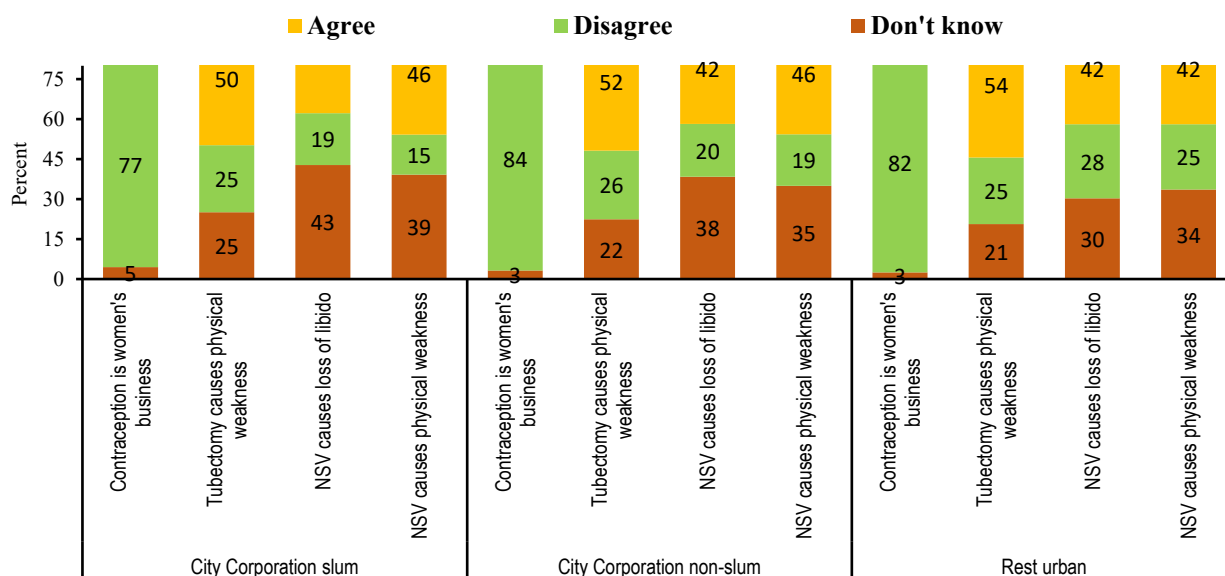
Table 7.5 shows the percentage of currently married women age 15-49 whose husbands lived elsewhere and the frequency of their husbands' visits in the last twelve months. Overall, 3.9 percent of currently married women age 15-49 in the slum areas, 6.7 percent of such women in the non-slum areas and 7.9 percent of them in the rest urban areas reported that their husbands lived elsewhere. Among those whose husbands lived outside the home, 42-51 percent reported that their husbands had visited home in less than 12 months before the survey.

Table 7.5: Husband’s visit

Percentage of currently married women age 15-49 whose husband lives elsewhere, and among currently married women whose husband lives elsewhere, percent distribution by husband’s visit in the last 12 months, according to background characteristics, by survey domain, UHS 2021

Domains	Percentage of women whose husband lives elsewhere	Number of currently married women	Percent			Total	Number of women
			Lives elsewhere less than 12 months	Lives elsewhere 12 months or more but last visit within 12 months	Lives elsewhere 12 months or more but last visit 12 months or more		
City Corporation slum	3.9	9,484	45.4	20.6	34.0	100.0	368
City Corporation non-slum	6.7	16,290	25.0	14.2	60.8	100.0	1,098
Rest urban	7.9	7,208	20.6	18.3	61.1	100.0	567

Figure 7.7: Men's perception on family planning issues, UHS-2021



Key Findings:

Antenatal Care (ANC)

- ❖ Ninety three percent of women in non-slum, 86.9 percent of rest urban, and 79.9 percent women in slum areas received ANC from medically trained provider.
- ❖ Receiving ANC from medically trained provider increased noticeably over the last seven years in all the three domains; 26 percentage points increase was observed in the slum, 10 percentage points in the non-slum and 13 percentage point increase in rest urban areas.
- ❖ Fifty three percent women living in non-slums received at least four ANC visits, compared to 39.8 percent in slums, and 39.2 percent in rest urban areas.
- ❖ Coverage of four or more ANC visits in non-slums have slightly declined between 2013 and 2021 (58 to 53.1 percent), while there has been 11.3 percentage points increase in slums (28.5 to 39.8 percent), and 3.4 percentage points increase (28.8 to 39.2 percent) in rest urban areas.
- ❖ Private sector was the leading source for ANC; 68.2 percent women in non-slums, 74.7 percent of rest urban, and 53.5 percent of slum areas received ANC from private sector. NGO was a prominent source for providing ANC in slum areas (30.8 percent).
- ❖ Women who received ANC from medically trained Providers were more likely to have essential health check-ups done compared to those who sought ANC from non-medically trained providers.

Delivery Care

- ❖ Institutional/facility delivery was highest among women living in non-slums (77.3 percent) and lowest in slums (53.7 percent).
- ❖ Facility delivery increased between 2013 and 2021 by 17 percentage points among women living in slums and rest urban areas, while the increase was 12.2 percentage points in non-slums.
- ❖ Large variation existed in the use of medically trained providers for delivery; 80.2 percent of deliveries in non-slums were attended by medically trained providers, while this was 56.1 percent in slums and 72.0 percent in rest urban areas.
- ❖ Deliveries conducted by skilled/medically trained providers increased substantially in all the three domains over the last seven years.
- ❖ C-section delivery was unacceptably high among women in non- slum, slum and rest urban areas; 59.4 percent of births in non-slums, 50.5 percent in rest urban, and 31.3 percent births in slums were delivered by C-sections.
- ❖ Nearly 77 percent of facility deliveries among women in non-slums and 75 percent of rest urban areas compared to 58.3 percent in slums were done through C-sections.

Postnatal Care

- ❖ Seventy eight percent of women in non-slums received PNC within two days of delivery from medically trained providers, compared to 72.3 percent in rest urban and 55.6 percent in slum areas.
- ❖ Coverage of PNC for mothers increased substantially in all the three domains during the last seven years; coverage of PNC increased by 18 percentage points among women in non-slum and 22 percentage points among slum and rest urban women between 2013 and 2021.
- ❖ In all the three urban domains, newborns were almost equally likely of their mothers to have received PNC from medically trained providers within two days of delivery.
- ❖ Coverage of PNC for the newborns nearly doubled in slums between 2013 and 2021 (26.5 to 52.6 percent), increased by more than 1.5 times in non-slums (49.2 to 75.4 percent), and rest urban areas (45 to 71.8 percent).

Cost of Delivery

- ❖ The median cost of delivering at NGO facilities for women living in slums and non-slums was much lower compared to the delivery cost at private facilities.

Essential Newborn Care

- ❖ The use of boiled instrument to cut the umbilical cord was around 90 percent in all the urban domains. However, the practices of other components of essential newborn care was low irrespective of place of residence of women.
- ❖ Essential newborn care practices include use of clean delivery kit for delivery, boiled instruments for cord cutting, nothing applied to the umbilical cord after cord cutting, drying and wrapping newborn within 0-4 minutes of birth, delaying bath 72⁺ hours after birth, and immediate breastfeeding. Less than one percent of newborns in all urban domains received all essential newborn care practices.

The healthcare that a woman receives during pregnancy, at the time of delivery, and soon after delivery is important for the survival and wellbeing of both the mother and the infant. This chapter provides information from the Urban Health Survey 2021 on important aspects of maternal and newborn health, including antenatal care, place of delivery, assistance to delivery, cost of delivery, postnatal care (PNC) for mothers and their newborns, and essential newborn care. Information in this chapter was collected from women aged 15-49 years who had given birth in the three years preceding the survey. The findings are presented by three urban domains. This information will assist policy planners in formulating appropriate strategies and interventions to provide quality healthcare for urban population.

8.1 Antenatal Care

Antenatal care (ANC) is the gateway for many critical maternal, newborn and child healthcare services. Antenatal care by a medically trained provider is intended to monitor the status of a pregnancy, identify the complications associated with the pregnancy and prevent adverse pregnancy outcomes. There should be regular ANC visits throughout pregnancy.

8.1.1 Antenatal Care from Skilled Provider

Antenatal Care (ANC) from a Medically Trained Provider: Pregnancy care received from medically trained providers, such as qualified doctors, nurses, midwives or paramedics; family welfare visitors (FWVs); Community skilled birth attendants (CSBAs); and sub-assistant Community Medical Officers (SACMOs).

Table 8.1 provides distribution of women age 15-49 years who had a live birth in the three years preceding the survey by antenatal care providers during pregnancy for the most recent birth, in the three domains—City Corporation slum, City Corporation non-slum and rest urban areas. Results in Table 8.1 show that 93.2 percent women in non-slum, 86.9 percent of rest urban, and 79.9 percent women in slum areas received ANC at least once from a medically trained provider for the most recent birth. Women in the non-slum areas were more likely to receive ANC from qualified doctors (91.1 percent) than women in the slum (76.4 percent) and rest urban areas (84.0 percent).

Tables 8.1A, 8.1B, and 8.1C in the appendix show that antenatal care from skilled/medically trained providers in all the three domains: slum, non-slum, and rest urban areas were positively associated with mother's age at birth, their level of education, and wealth quintiles.

The proportion of women receiving ANC from medically trained provider increased noticeably since 2013 UHS in all the three domains. Highest increase was observed in slums from 53.8 to 79.9 percent, and then from 83.2 to 93.2 percent in non-slums and from 75.8 percent in 2013 to 89.0 in rest urban areas. A sizeable proportion of slum women (8.5 percent) received ANC from non-medically trained providers, while only 3.1 percent women in non-slums and 2.1 percent of those living in rest urban areas received ANC from this category of providers.

Table 8.1: Antenatal care coverage

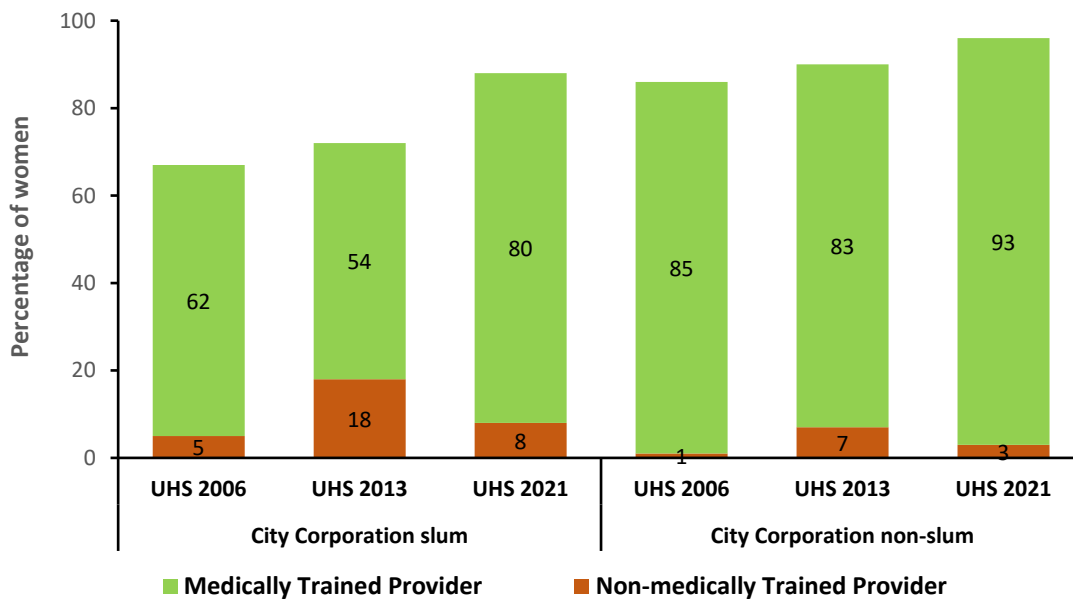
Percent distribution of women age 15-49 who had a live birth in the three years preceding the survey by antenatal care (ANC) provider during pregnancy for the most recent birth, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Medically trained			Non-medically trained				No one	Missing	Total	Any ANC	ANC from medically trained provider ¹	Number of women
	Qualified doctor	Nurse/midwife/paramedics/FWV	CSBA/MA/SACMO	HA/FWA	NGO worker	Trained TBA/untrained TBA/unqualified doctor/other							
City Corporation slum	76.4	3.5	0.0	0.7	7.4	0.4	11.7	0.0	100.0	88.3	79.9	2,713	
City Corporation non slum	91.1	2.1	0.0	0.1	2.8	0.2	3.7	0.0	100.0	96.3	93.2	1,405	
Rest urban	84.0	2.8	0.2	0.4	1.5	0.2	11.0	0.0	100.0	89.0	86.9	1,987	

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications was considered in the tabulation.

¹ Medically trained provider includes qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

Figure 8.1: Trend in utilization of antenatal care by type of provider, UHS 2006, UHS 2013 and UHS 2021



8.1.2 Place of Antenatal Care

The place where a woman receives antenatal care influences the frequency and quality of care received. Information on the ANC source also assist policy-planners on how to allocate resource. Women who had a live birth in the past three-years preceding the survey were asked whether they received ANC for their most recent birth and where they received ANC. As women may visit more than one type of facility for ANC during the same pregnancy, the facility categories are not mutually exclusive and do not sum to 100 percent.

Result presented in Table 8.2 show that private sector was the leading source for ANC. Sixty eight percent women in non-slums received ANC from private sector, while this was 74.7 percent in rest urban and 53.5 percent in slum areas. One-fourth of women of slum (23.1 percent) and non-slum areas (24.8 percent) received ANC from public sector health facilities, and this was 24.8 percent for women of non-slum areas. NGO was a prominent source for providing ANC in slum areas (30.8 percent).

Mothers of higher age groups and those with higher education level were more likely to use private sector facilities for the ANC care. This pattern was same in all the three domains (Tables 8.2A, 8.2B, and 8.2C).

Table 8.2: Place of antenatal care

Among women age 15-49 who had a live birth in the three years preceding the survey, the percentage who received antenatal care (ANC) during the pregnancy of the most recent birth by place of ANC care, in City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Domains	Home	Public sector	Private sector	NGO sector	Other	Number of women
City Corporation slum	15.4	23.1	53.5	30.8	0.2	2,396
City Corporation non-slum	5.0	24.8	68.2	15.2	0.2	1,353
Rest urban	3.8	30.3	74.7	5.5	0.2	1,768

Note: Multiple responses possible.

8.1.3 Number of Antenatal Visits

Bangladesh Maternal Health Strategy recommends at least four ANC visits during a pregnancy. The coverage of the recommended four or more ANC visits varied among the three domains. Table 8.3 shows that, women living in non-slums were most likely to have received four or more ANC visits compared to women in other two domains. Fifty three percent of women living in non-slums received at least four ANC visits (53.1 percent), compared to 39.8 percent in slums and 39.2 percent in rest urban areas.

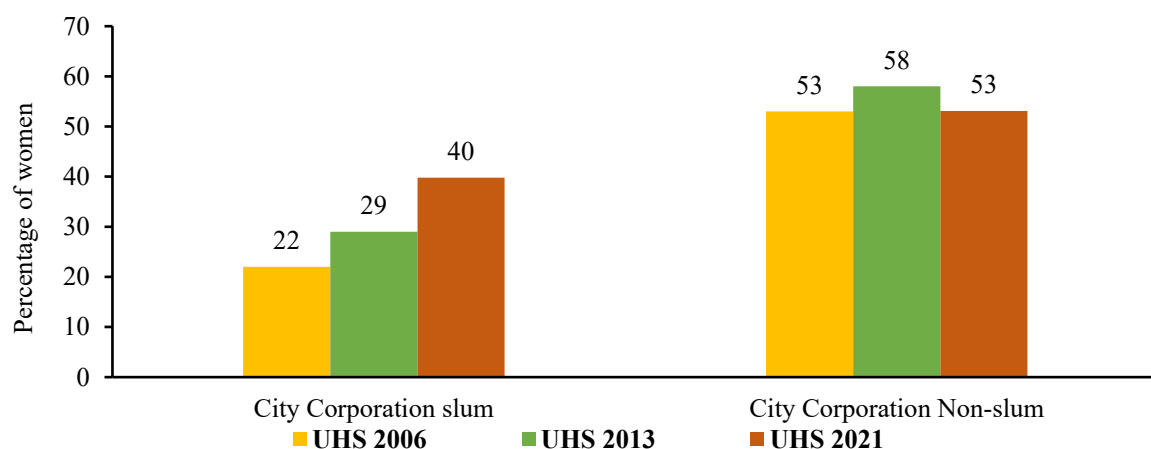
Although coverage of four or more ANC visits in non-slum have slightly declined between 2013 and 2021 by 5 percentage points from 58 to 53.1 percent, there has been 11.3 percentage points increase (28.5 to 39.8 percent) in slums and 3.4 percentage points in rest urban areas (35.8 to 39.2 percent).

Table 8.3: Number of antenatal care visits

Percent distribution of women aged 15-49 who had a live birth in the three years preceding the survey by number of antenatal care (ANC) visits for the most recent live birth, according to domain, UHS 2021

Number of ANC visits	City Corporation slum	City Corporation non-slum	Rest urban
None	11.7	3.7	11.0
1	10.4	7.5	10.7
2	20.6	17.5	18.6
3	17.6	18.3	20.5
4 ⁺	39.8	53.1	39.2
DK/missing	0.0	0.0	0.0
Total	100.0	100.0	100.0
Median number of visits for those with ANC	3	4	3
Number of women	2,713	1,405	1,987

Figure 8.2: Trends in the number of ANC 4+ in slums and non-slums, UHS 2006, UHS 2013 and UHS 2021



8.1.4 Components of ANC Visits

Contents of ANC provide some indication of service quality. In the 2021 UHS, over 90 percent of women receiving ANC had their blood pressure checked, weight measured, and ultrasonogram done. This was true for women in all three domains. A substantially lower proportion of women got urine and blood tested, with the women living in slums getting the lowest level compared to women in non-slums and rest urban areas (Table 8.4).

Table 8.4: Health services received by sources of antenatal care

Percent distribution of women age 15-49 who received antenatal care for their most recent birth during the three years before the survey, by specific health services received during pregnancy, according to source of antenatal care (ANC), in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Source of ANC	Components of ANC					Number of women
	Blood pressure	Urine test	Blood test	Weight taken	Ultra-sonogram done	
City Corporation slum						
Medically trained provider ¹	95.0	84.2	83.0	93.2	93.3	2,168
Non-medically trained provider	89.0	59.4	56.0	74.6	60.3	229
Total	94.4	81.8	80.4	91.4	90.2	2,396
City Corporation non-slum						
Medically trained provider ¹	97.6	92.2	89.1	96.1	96.6	1,310
Non-medically trained provider	94.6	74.0	75.5	92.4	79.6	44
Total	97.5	91.6	88.6	96.0	96.0	1,353
Rest urban						
Medically trained provider ¹	96.8	86.2	86.8	94.2	93.8	1,727
Non-medically trained provider	83.8	52.7	43.1	73.9	44.8	42
Total	96.5	85.4	85.8	93.7	92.7	1,768

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications was considered in the tabulation.

¹ Medically trained provider includes qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

Note: Women who got ANC from HA/FWA or TTBA, and others were excluded from the analysis.

Receiving health services during ANC visits varied substantially by type of ANC provider. Women who received ANC from medically trained providers were more likely to have the five specific health checkups done compared to those who sought ANC from non-medically trained providers. Women living in slums were least likely to have urine tests, blood tests, or ultrasonograms done. Figure 8.3.1, Figure 8.3.2, and Figure 8.3.3 show respectively the health services received during ANC by type of provider for slum, non-slum, and rest urban areas.

Figure 8.3.1: Health services received during pregnancy, by type of ANC provider, City Corporation slums, UHS 2021

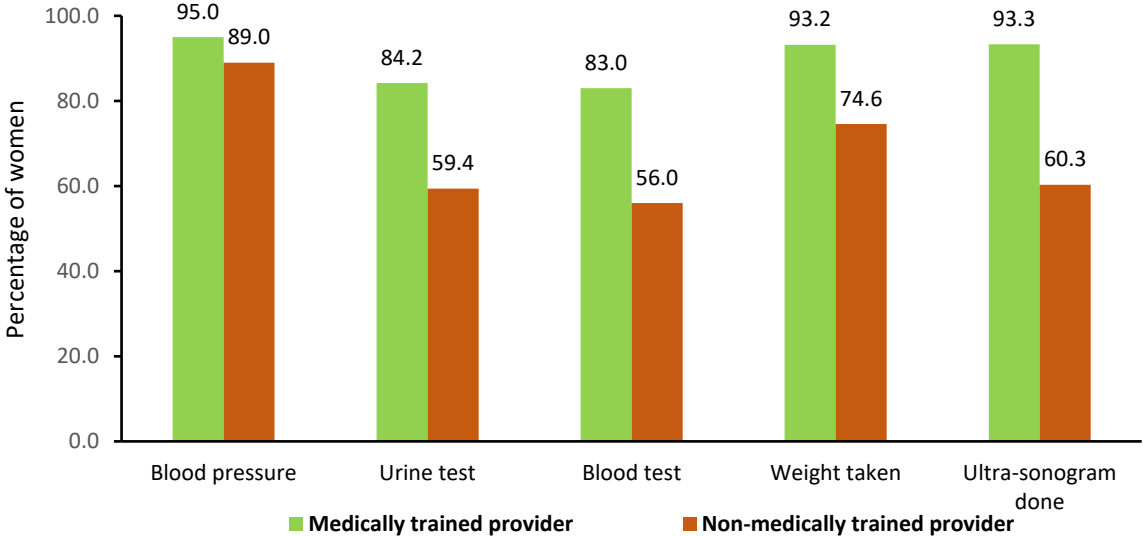


Figure 8.3.2: Health services received during pregnancy, by type of ANC provider, City Corporation non-slums, UHS 2021

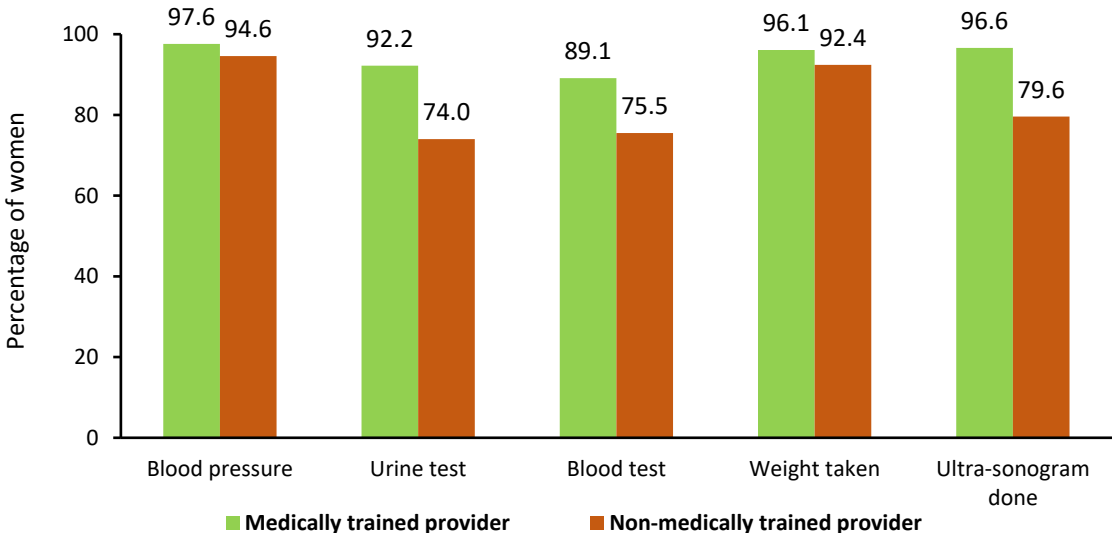
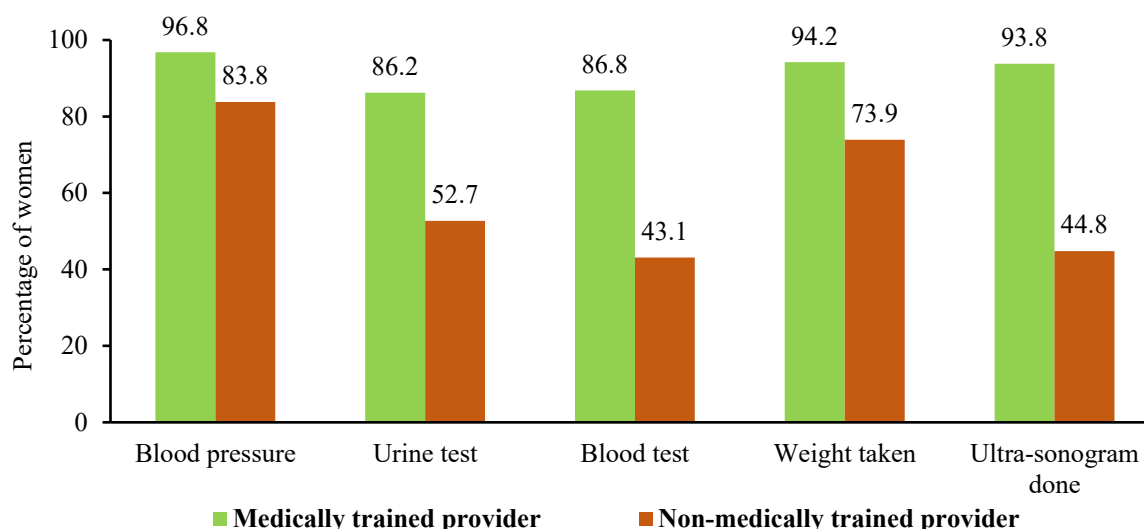


Figure 8.3.3: Health services received during pregnancy, by type of ANC provider, Rest urban areas, UHS 2021



8.2 Delivery Care

Proper medical attention under the supervision of skilled professionals in hygienic environment for delivery can reduce the risk of complication and infections that can cause death or serious illness for the mother or the newborn. The Bangladesh Maternal Health Strategy encourages women to deliver in a health facility under the care of medically trained providers. In the following, we present information on delivery care among all births in the three years preceding the survey in the three urban domains.

8.2.1 Skilled Assistance during Delivery

Delivery by a medically trained /skilled provider: Qualified doctors, nurses, midwives, or paramedics; family welfare visitors (FWVs); Community Skilled Birth Attendants (CSBAs); and Sub Assistant Community Medical Officers (SACMOs) are considered as medically trained/skilled providers for assisting/conducting deliveries. They are also known as skilled birth attendants.

Women who had a live birth in the three years preceding the survey were asked about assistance they might have received with the delivery. Information provided for the three urban domains in Table 8.5 show large variation existed in the use of medically trained provider for deliveries. Four-fifths of deliveries (80.2 percent) among women in non-slums were attendant by medically trained providers, while 56.1 percent deliveries among women in slums were attended by medically trained providers. In the rest urban areas, it was 72.0 percent. The most prominently used providers to assist in delivery in all the three domains were qualified doctors (71.1 percent in non-slum, 61.2 percent in rest urban, and 44.5 percent in slums). Untrained birth attendant was the second

prominent provider to assist in delivery in slums (29.2 percent), non-slum (12.4 percent), and rest urban (20.0 percent) areas.

Skilled assistance during delivery was found to be positively associated with age of mothers at births, level of education of mothers, and wealth quintiles in which they belong. Fifty-three percent of mothers age 15-19 years against 94.1 percent of age 35+ years used medically trained provider for delivery. Similarly, 36.9 percent mother having no education and 81.9 percent of those having secondary education or higher used medically trained/skilled providers for their last deliveries in the three years preceding the survey (Tables 8.5A, 8.5B, and 8.5C in appendix).

Between 2013 and 2021, births assisted by skilled providers increased by 19 percentage points in slums, and 12 percentage points in non-slums. Figure 8.4 shows the trends in the skilled assistance in deliveries in slums and non-slums. Deliveries conducted by skilled/medically trained providers increased substantially in all the three domains over the last fourteen years.

Table 8.5: Assistance during delivery

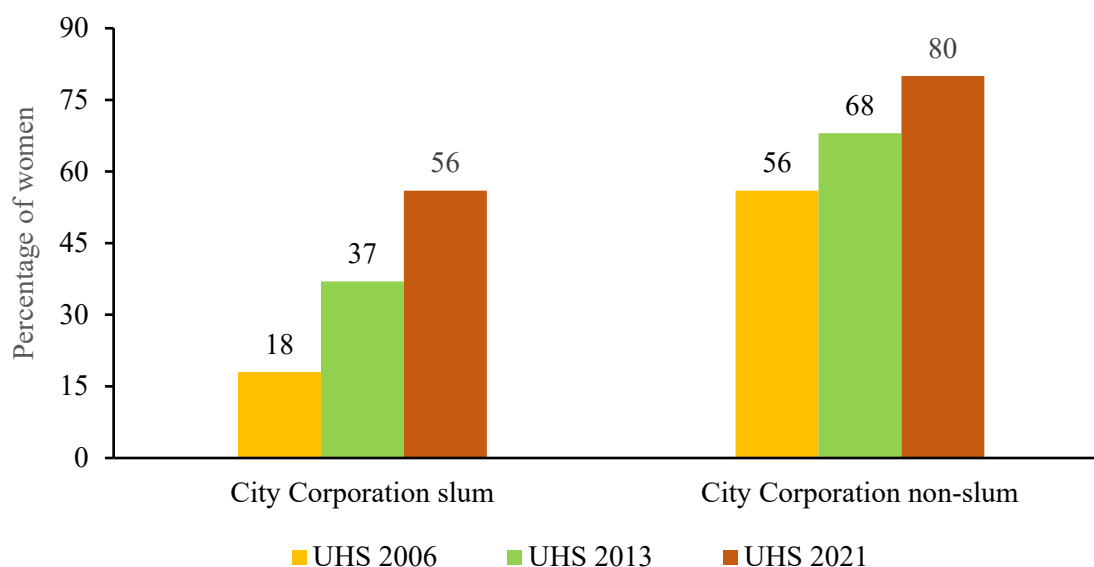
Percent distribution of live births in the three years preceding the survey by person providing assistance during delivery and percentage of births assisted by a medically trained provider for the most recent birth, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Assistance during delivery											Total	Percentage delivered by a medically trained provider ¹	Number of women
	Qualified doctor	Nurse/midwife/paramedics	FWV	CSBA	HA/ FWA	NGO worker	Trained TBA	Un-trained TBA	Un-qualified provider	Relatives/friends	No one			
City Corporation slum	44.5	11.7	0.0	0.0	0.2	1.9	9.5	29.2	0.1	3.0	0.0	100.0	56.1	2,713
City Corporation non slum	71.1	8.8	0.3	0.0	0.1	1.0	5.6	12.4	0.0	0.7	0.0	100.0	80.2	1,405
Rest urban	61.2	10.6	0.2	0.0	0.1	0.3	5.5	20.0	0.2	1.7	0.2	100.0	72.0	1,987

Note: If more than one source of ANC was mentioned, only the provider with the highest qualifications was considered in the tabulation.

¹ Medically trained provider includes qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

Figure 8.4: Trend in use of medically trained provider for delivery, UHS 2006, UHS 2013 and UHS 2021



8.2.2 Location of Delivery

A significant proportion of urban residents are migrants, and there is some custom or tendency among them to deliver at women’s natal homes. The survey asked questions on whether the most recent birth in the three years preceding the survey occurred in any other place outside the city of residence of women. Table 8.6 shows that 17.8 percent of deliveries among woman from slum occurred outside their city of residence, mainly in villages. Among the non-slum women, 15.5 percent of deliveries occurred outside their city of residence, while this was 17.0 percent among women of rest urban areas. It is to be noted that cent percent of women of all the three domains always lived at current place.

Table 8.6: Location of delivery

Percentage of ever married women age 15-49 who delivered in the three years before the survey* by location of delivery and migration status, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Location of delivery									
	Migrated to current place before the delivery of recent birth					Always lived at current place				
	Current city	Other city	Village	Total	Number of women	Current city	Other city	Village	Total	Number of women
City Corporation slum	82.2	5.7	12.1	100.0	2,713	99.8	0.0	0.2	100.0	1,120
City Corporation non slum	84.5	8.8	6.7	100.0	1,405	100.0	0.0	0.0	100.0	663
Rest urban	83.0	13.2	3.8	100.0	1,987	100.0	0.0	0.0	100.0	1,269

* Excludes women who delivered in the three years before the survey and migrated after the delivery.

8.2.3 Place of Delivery

Institutional deliveries: Deliveries that occur in a health facility are termed as institutional deliveries.

Table 8.7 presents the distribution of live births in the three years preceding the survey by place of delivery for the three urban domains. Facility/institutional delivery was the highest among women living in non-slums (77.3 percent), and lowest among those living in slums (53.7 percent). Institutional delivery rose between 2013 and 2021 by 17 percentage points among women living in slums and rest urban areas, while facility delivery increased by 12.2 percentage points in non-slum areas. Use of private health facility for delivery increased substantially in the past seven years in the three domains with 19 percentage points increase among women living in slums, 18.4 percentage points among women in rest urban and 14 percentage points increase among women living in non-slum areas. Use of public facilities remain the same as that in UHS 2013. Figure 8.5 gives trends in the use of health facility for delivery in slums and non-slums by survey years UHS 2006, UHS 2013, UHS 2021.

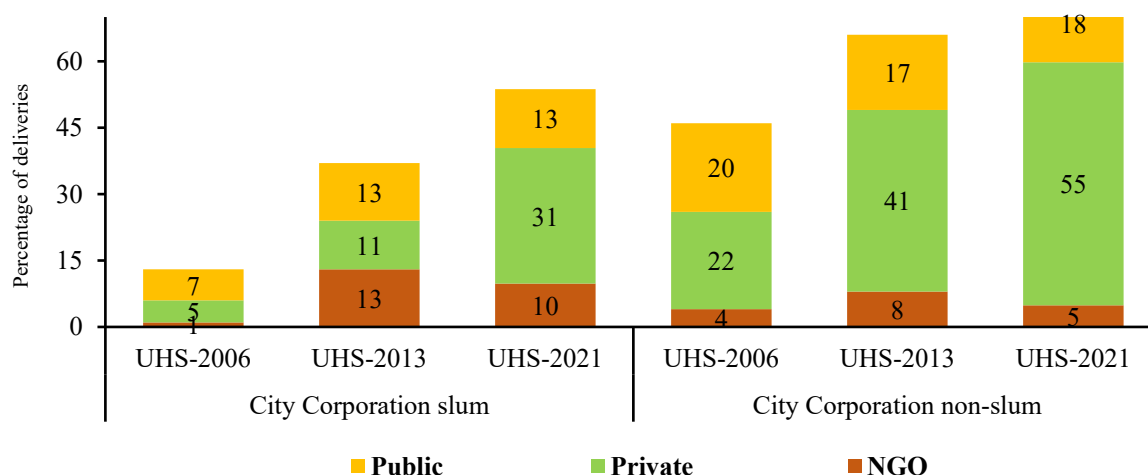
Table 8.7: Place of delivery

Percent distribution of live births in the three years preceding the survey by place of delivery, percentage delivered in health facility, and percentage delivered by C-section, for the most recent birth, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Place of delivery						Total	Percentage delivered in a health facility ¹	Percentage delivered by C-section	Number of women
	Public facility	Private facility	NGO facility	BRAC delivery/Maternity centers	Other	Home				
City Corporation slum	13.3	30.6	9.8	0.4	0.0	45.9	100.0	53.7	31.3	2,713
City Corporation non slum	17.5	54.9	4.9	0.4	0.0	22.3	100.0	77.3	59.4	1,405
Rest urban	15.9	50.0	1.4	0.1	0.3	32.4	100.0	67.3	50.5	1,987

¹ Health facility includes public, private, and NGO facilities but excludes BRAC Delivery/Maternity centers.

Figure 8.5: Trend in use of health facility for delivery, UHS 2006, UHS 2013 and UHS 2021



Data from the UHS 2021 shows that not all facility deliveries were conducted by medically trained providers. Table 8.8 and Figure 8.6 show the percentages of births delivered by medically trained/skilled providers by place of delivery. A high proportion of births delivered at NGO facilities were not attended by medically trained providers. Only 86.6 percent births to women from slums who delivered in NGO facilities were attended by medically trained/skilled providers. In non-slums and other urban areas, the corresponding percentages were 87.1 and 85.1 percent respectively.

Table 8.8: Delivery by medically trained provider by place of delivery

Percentage of live births in the three years preceding the survey delivered by medically trained provider¹ for the most recent birth according to place of delivery, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

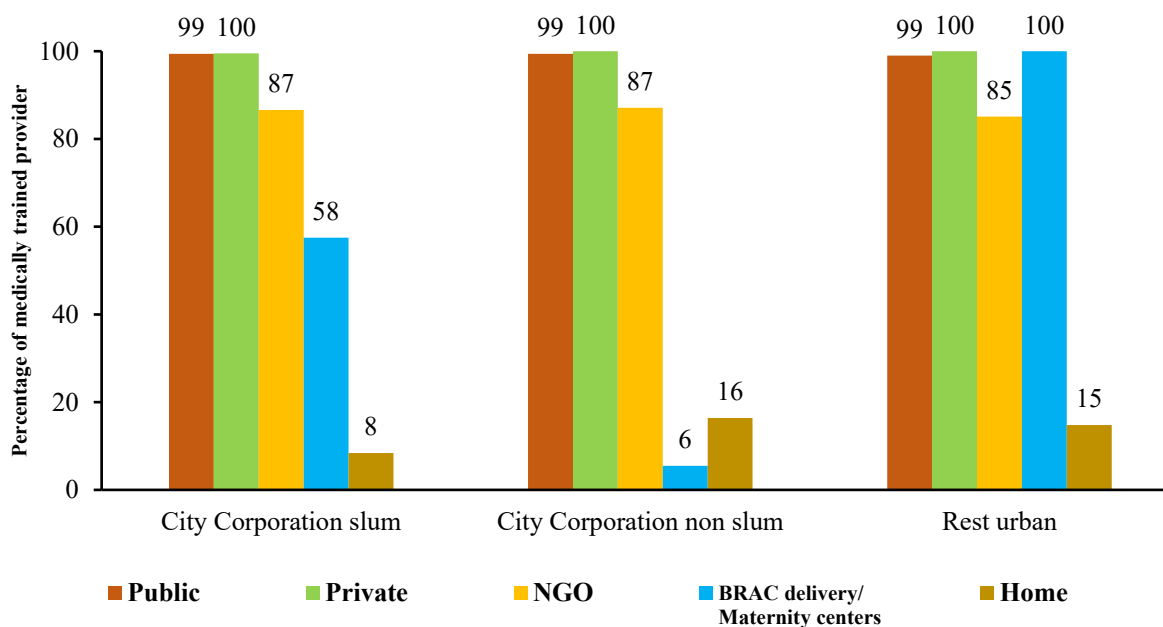
Domain	Place of delivery				
	Public facility	Private facility	NGO facility	BRAC delivery/ Maternity centers	Home
City Corporation slum	99.4	99.5	86.6	57.5	8.4
City Corporation non slum	99.4	100.0	87.1	5.5	16.4
Rest urban	99.0	100.0	85.1	100.0	14.8

Note: Figure in parentheses is based on less than 50 weighted cases.

¹ Medically trained provider includes qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

² Not enough sample.

Figure 8.6: Percentage of births delivered by medically trained providers by place of delivery, UHS 2021



Reasons for Choosing Health Facility for Delivery

Table 8.9 presents primary reasons for choosing to deliver in a health facility among women who had their last birth in the three years before the survey in a facility. According to women living in slums and who had their last birth at a health facility, the main reasons for choosing health facility for delivery were—complication during delivery (35.1 percent), facility delivery was perceived as in safe (31.7 percent), complications during pregnancy (13.9 percent) and there was a referral by doctor/service provider (8.3 percent). The reasons stated by women living in non-slums and rest urban areas for choosing a health facility for delivery were almost identical.

Table 8.9: Reasons for choosing health facility for delivery

Percentage of women 15-49 years of age who delivered in a facility for the most recent birth in the three years preceding the survey by reasons for choosing to delivery at a facility: City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Reasons for choosing health facility for delivery	Domain		
	City Corporation slum	City Corporation non-slum	Rest urban
Complications during pregnancy	13.9	16.2	15.2
Complications during delivery	35.1	28.6	38.1
Referred by doctor/service provider	8.3	9.3	5.5
It is safe	31.7	30.7	28.7
Complications may be easily managed	4.9	5.7	4.8
Blood transfusion can be given	0.3	0.0	0.5
Cesarean section can be performed	3.2	4.4	3.8
Baby's health can be checked	0.2	0.4	0.3
Infusion can be given	0.1	0.0	0.0
Doctor/trained person available	1.0	2.6	1.7
Other	1.4	1.9	1.4
Number of women	1,466	1,091	1,337

Referral for Facility Birth

Woman who delivered in a health facility were asked whether they were referred by anyone to the health facility where they delivered their most recent birth in the three years preceding the survey. If they were referred, a question was asked on who provided the referral. About 60 percent women of each of three domains were referred by someone to a facility where they delivered. In slums, relatives/neighbor (55.9 percent), doctors/nurses (43.8 percent), and NGO worker (16.3 percent) were the prominent sources of referral. In non-slums, 59.2 percent were referred by doctor/nurse and 48.1 percent by relatives/friends: while in rest urban areas 60.3 percent were referred to the facility by relatives/neighbor and 52.6 percent by doctors/nurses.

Table 8.10: Referral for facility birth

Percentage of women delivery in a facility for the most recent birth in the three years preceding the survey by reasons for whether she was referred to the facility: among those who were referred by persons who provided the referral, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Characteristics	Domain		
	City Corporation slum	City Corporation non-slum	Rest urban
Was referred to facility for delivery	59.3	60.1	58.7
Number of women	1466	1091	1337
Persons providing referral to the delivery facility			
Doctor/Nurse	43.8	59.2	52.6
FWV/SACMO	0.0	0.0	0.0
CSBA/HA/FWA	0.0	0.2	0.2
NGO worker	16.3	11.6	7.2
TTBA/UTBA	1.2	1.9	1.1
Relatives/neighbor	55.9	48.1	60.3
Other	1.2	0.0	0.5
Number of women who were referred	870	656	785

Reasons for Not Delivering at a Health Facility

Table 8.11 shows the reasons stated by women who had given birth in the three years preceding the survey at home, and not delivering in a health facility in three urban domains. The stated reasons by women in all the three domains for not delivery at a health facility were identical. The main cited reasons were not necessary/customary (more than 8 in 10 in three domains), followed by cost (17.0 percent in slums, 12.9 percent in non-slums, and 12.7 percent in rest urban areas), and perceived better care at home (7 to 8 percent).

Table 8.11: Reasons for not delivering at a health facility

Percent distribution of women 15-49 years of age whose last birth in the three years preceding the survey was not delivered at a health facility, by reasons for not choosing to deliver at a health facility, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Reasons for not choosing health facility for delivery	Domain		
	City Corporation slum	City Corporation non-slum	Rest urban
Not necessary/customary	80.9	88.6	87.5
Did not feel the need	1.6	0.3	1.9
Cost related	17.1	12.9	12.7
Access related	2.2	2.5	2.7
Quality issues	0.3	0.4	0.6
Family did not allow	2.6	0.5	4.1
Better care at home	8.0	7.0	7.4
No time to go for services	1.0	0.2	1.3
Not want service from male doctor	0.2	0.4	0.6
For fear	2.5	2.9	2.3
Clinic/hospital insist for caesarian	3.0	2.7	0.6
Had sudden delivery	2.5	3.7	4.5
Other	0.5	0.0	0.0
Number of women	1,247	314	649

8.2.4 Caesarean Section

C-section: Caesarean section, also known as C-section or caesarean delivery, is the surgical procedure by which one or more babies are delivered through an incision in the mother’s abdomen, often performed because vaginal delivery would put the baby or mother at risk.

WHO guidelines indicate that about 15 percent of deliveries may need C-sections. Access to C-section can reduce maternal and neo-natal mortality and complication such as obstetric fistula. However, use of C-sections without medical need can put women at risk of short term and long-term health problems.

Table 8.7 presents the proportion of births that occurred in a health facility, and proportion of facility births that were delivered by C-sections in the slums, non-slums, and rest urban areas. C-sections were unacceptably high in all three domains. About 59.4 percent of all births in non-slums, 50.5 percent of all births in rest urban, and 31.3 percent of all births in slums were delivered by C-sections. This means seventy-seven percent of facility deliveries among women in non-slums and 75.0 percent in rest urban areas, compared to 58.3 percent in slums were done through C-sections. Women delivering in NGO facilities were least likely to have C-sections and those delivered in private facilities were most likely to have C-section.

Mothers of higher age groups, living in Dhaka, and receiving 4+ ANC visits were more likely to have C-section delivery.

Figure 8.7: Percentage of facility delivers by C-section by type of facility, UHS 2021



Women who had their most recent birth delivered by C-sections were asked a question on who suggested delivery to be done through C-section. Seventy-four percent women in slums reported that the doctor suggested a C-section delivery. Seven out of ten women in non-slum and rest urban areas also stated that doctors suggested them to go for C-section delivery. Twenty-six percent

women in slums, and thirty percent of non-slum and rest urban women themselves or their family members took the decision for C-section delivery (Table 8.13).

Complications during delivery, record of previous C-section delivery, convenience or avoiding labor pain appears to have been the major reasons for suggesting C-section delivery (Table 8.13).

Table 8.12: Suggestion for C-section delivery

Percent distribution of women 15-49 years of age whose most recent birth in the three years preceding the survey was delivered by C-section by person who suggested child delivery by C-section: City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Person suggesting C-section delivery	CC slum	CC non-slum	Rest urban
Respondent	5.9	6.3	5.1
Family member	20.2	23.4	25.0
Doctor	73.9	70.4	69.9
Number of women	850	834	1,004

Table 8.13: Reasons for suggesting delivery by C-section

Percent distribution of women 15-49 years of age whose most recent birth in the three years preceding the survey was delivered by C-section by reasons for suggesting C-section delivery: City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Reasons for C-section	CC slum		CC non-slum		Rest urban	
	C-section proposed by doctor	C-section proposed by family	C-section proposed by doctor	C-section proposed by family	C-section proposed by doctor	C-section proposed by family
Convenience	7.1	13.4	7.8	18.2	7.5	14.4
Don't want to go through labor pain	1.7	5.9	1.0	12.0	1.2	5.9
Mal-presentation	0.8	1.2	1.6	0.2	1.0	0.8
Premature baby	4.2	0.5	4.7	13.1	4.0	3.2
Cord prolapsed	1.0	1.2	0.3	0.0	1.4	0.1
Multiple births	0.0	0.3	0.8	1.1	0.3	0.7
Failure to progress in labor	17.2	27.6	15.4	16.7	11.6	24.6
Pre-eclampsia	0.5	0.0	0.3	0.1	1.1	0.0
Diabetes	1.3	0.0	0.4	0.0	0.7	0.0
Previous C/S	29.8	29.0	35.8	30.7	35.9	31.9
Less pressure on baby's brain	1.5	0.0	0.4	1.4	0.9	1.7
Other complications during delivery	58.5	43.6	50.4	30.0	52.0	38.8
Doctor did not provide any reason	1.4	0.0	1.7	0.0	1.6	0.0
Number of women	628	172	587	195	702	251

8.2.5 Cost of delivery

The survey collected information on cost incurred by the household related to the delivery of the most recent birth in the three years preceding the survey. For women living in slums the median cost of delivery at NGO facilities was much lower than delivery cost in public or private facilities (Table 8.14.1). Median cost of delivery at a public facility was Tk. 7,000, almost 1.5 times more compared to the cost of delivering at NGO facilities (Tk. 5,000). The cost at private facilities were 4 times more (Tk. 20,000). Higher proportion of C-sections were conducted in private and public facilities relative to NGO facilities, and the median cost for C-section at private facilities was Tk. 20,000 and this was Tk. 15,000 at public and NGO facilities.

For women living in non-slums, the cost of facility delivery at public and NGO facilities, did not vary much, but cost was much higher at private facilities. The median cost of delivery for women in rest urban areas was almost similar (Tables 8.14.2, 8.14.3).

Table 8.14.1: Cost of delivery: City Corporation slum

Percent distribution of women who had a birth in the three years preceding the survey by amount spent, median and mean amount spent for the most recent birth, by place of delivery and whether C-section was performed, UHS 2021

Type and place of delivery	Percent of women paying (in Taka)						Total	Number	Payment in Taka Mean	Payment in Taka Median
	Nothing	<500	500-999	1,000 - 4,999	5,000 - 9,999	10,000 or more				
Normal delivery										
Public facility	0.2	1.5	2.3	49.8	29.5	16.7	100.0	202	5,428.6	4,000
Private facility	1.0	0.0	2.0	23.9	37.6	35.6	100.0	205	8,479.8	6,000
NGO facility	2.5	0.0	1.7	58.1	30.6	7.1	100.0	199	8,571.9	3,500
BRAC birthing hut	0.0	0.0	0.0	73.8	26.2	0.0	100.0	11	3,528.4	3,000
Home	7.3	6.5	17.5	61.1	6.4	1.2	100.0	1,246	1,789.6	1,000
Delivery with C-section										
Public facility	0.1	0.0	0.0	7.4	17.6	75.0	100.0	158	18,330.5	15,000
Private facility	0.0	0.0	0.0	1.6	2.1	96.3	100.0	625	26,647.9	20,000
NGO facility	2.7	0.0	0.0	5.2	9.0	83.1	100.0	67	15,571.2	15,000
All delivery										
Public facility	0.2	0.9	1.3	31.2	24.2	42.3	100.0	361	11,094.8	7,000
Private facility	0.2	0.0	.5	7.1	10.9	81.3	100.0	829	22,160.1	20,000
NGO facility	2.5	0.0	1.3	44.8	25.2	26.2	100.0	266	10,331.8	5,000
BRAC birthing hut	0.0	0.0	0.0	73.8	26.2	0.0	100.0	11	3,528.4	3,000
Home	7.3	6.5	17.5	61.1	6.4	1.2	100.0	1,246	1,789.6	1,000

Table 8.14.2: Cost of delivery: City Corporation non-slum

Percent distribution of women who had a birth in the three years preceding the survey by amount spent, median and mean amount spent for the most recent birth, by place of delivery and whether C-section was performed, UHS 2021

Type and place of delivery	Percent of women paying (in Taka)						Total	Number	Payment in Taka Mean	Payment in Taka Median
	Nothing	<500	500-999	1,000 - 4,999	5,000 - 9,999	10,000 or more				
Normal delivery										
Public facility	0.1	0.4	0.0	47.4	35.1	16.9	100.0	120	5,216.9	5,000
Private facility	0.0	0.9	2.6	13.6	35.3	47.6	100.0	98	32,701.8	8,000
NGO facility	0.0	0.0	0.0	70.6	28.6	0.8	100.0	33	3,575.6	3,000
BRAC birthing hut	94.5	0.0	0.0	5.5	0.0	0.0	100.0	5	110.9	0
Home	5.1	6.2	21.2	56.5	10.7	0.2	100.0	314	1,801.9	1,000
Delivery with C-section										
Public facility	5.1	0.0	0.0	3.8	17.8	73.3	100.0	126	18,272.7	15,000
Private facility	0.1	0.0	0.0	1.7	2.1	96.1	100.0	673	26,512.6	20,000
NGO facility	0.0	0.0	0.0	.0	10.0	90.0	100.0	35	22,108.1	20,000
All delivery										
Public facility	2.7	0.2	0.0	25.1	26.2	45.8	100.0	246	11,906.6	8,000
Private facility	0.1	0.1	0.3	3.2	6.4	89.9	100.0	771	27,299.3	20,000
NGO facility	0.0	0.0	0.0	34.5	19.1	46.4	100.0	68	13,049.8	8,000
BRAC birthinghut	94.5	0.0	0.0	5.5	0.0	0.0	100.0	5	110.9	0
Home	5.1	6.2	21.2	56.5	10.7	0.2	100.0	314	1,801.9	1,000

Table 8.14.3: Cost of delivery: Rest urban

Percent distribution of women who had a birth in the three years preceding the survey by amount spent, median and mean amount spent for the most recent birth, by place of delivery and whether C-section was performed, UHS 2021

Type and place of delivery	Percent of women paying (in Taka)						Total	Number	Payment in Taka Mean	Payment in Taka Median
	Nothing	<500	500-999	1,000 - 4,999	5,000 - 9,999	10,000 or more				
Normal delivery										
Public facility	1.3	0.0	3.4	58.2	28.8	8.3	100.0	199	4,018.4	3,000
Private facility	0.9	0.0	0.0	19.8	35.9	43.5	100.0	119	8,540.9	8,000
NGO facility	0.0	0.0	18.2	22.2	52.3	7.2	100.0	14	4,935.3	5,000
BRAC birthing hut	0.0	0.0	0.0	100.0	0.0	0.0	100.0	1	4,000.0	4,000
Home	12.8	7.3	22.4	51.6	5.6	0.3	100.0	643	1,443.3	1,000
Delivery with C-section										
Public facility	3.9	0.0	0.0	11.7	23.0	61.4	100.0	117	12,849.5	10,000
Private facility	0.1	0.0	0.0	1.4	2.3	96.2	100.0	874	22,473.8	20,000
NGO facility	0.0	0.0	0.0	0.0	11.3	88.7	100.0	13	20,284.0	20,000
All delivery										
Public facility	2.3	0.0	2.1	41.0	26.7	28.0	100.0	316	7,290.0	5,000
Private facility	0.2	0.0	0.0	3.6	6.3	89.9	100.0	993	20,806.9	20,000
NGO facility	0.0	0.0	9.6	11.7	32.9	45.8	100.0	27	12,198.1	8,000
BRAC birthing hut	0.0	0.0	0.0	100.0	0.0	0.0	100.0	1	4,000.0	4,000
Home	12.8	7.3	22.4	51.6	5.6	0.3	100.0	643	1,443.3	1,000

8.3 Post-natal Care

Post-natal care (PNC) is an important component of safe motherhood and neonatal health. Postnatal checkup provides an opportunity to assess and treat delivery complications and to counsel mothers on how to care for themselves and their newborn babies. The survey asked women who had a live birth in the last three years preceding the survey whether she or her child received any health checkup after the delivery, the timing of the first check up, and the type of health care provider who provided the care. Information is presented separately for the mother and the child by the three domains.

8.3.1 First Post-natal Check-up for Mothers

Result presented in Table 8.15 show that the coverage of PNC for mothers increased substantially in all the three domains during the last 7 years. Fifty six percent of women in the slums received PNC checkup from medically trained providers within two days of delivery. Women in non-slums and rest urban domains were 1.5 times more likely to receive PNC within two days of delivery from medically trained providers compare to slum women (78.3 percent in non-slum and 72.3

percent in rest urban). Coverage of PNC increased by 18 percentage points among women in non-slum and 22 percentage points among slum and rest urban women between 2013 UHS and 2021 UHS.

Qualifications and skills of PNC providers have important implications for the health of the mother and the newborn. Among the PNC recipients, 43.4 percent of slums, 63.4 percent of non-slums and 58.4 percent of rest urban women received PNC from qualified doctors and 14 to 17 percent received from nurse/midwife/paramedic/FWVs. About 55.6 percent of mothers received PNC check-up from medically trained providers in the slums, 78.3 and 72.3 percent respectively of non-slums and rest urban mothers received PNC check-up from medically trained providers within two days of delivery (Table 8.15).

Figure 8.8 shows the trend in postnatal care for mothers from medically trained providers within two days of delivery, UHS 2006, UHS 2013 and UHS 2021.

Figure 8.8: Trend in postnatal care for mothers from medically trained provider within two days of delivery, UHS 2006, UHS 2013 and UHS 2021.

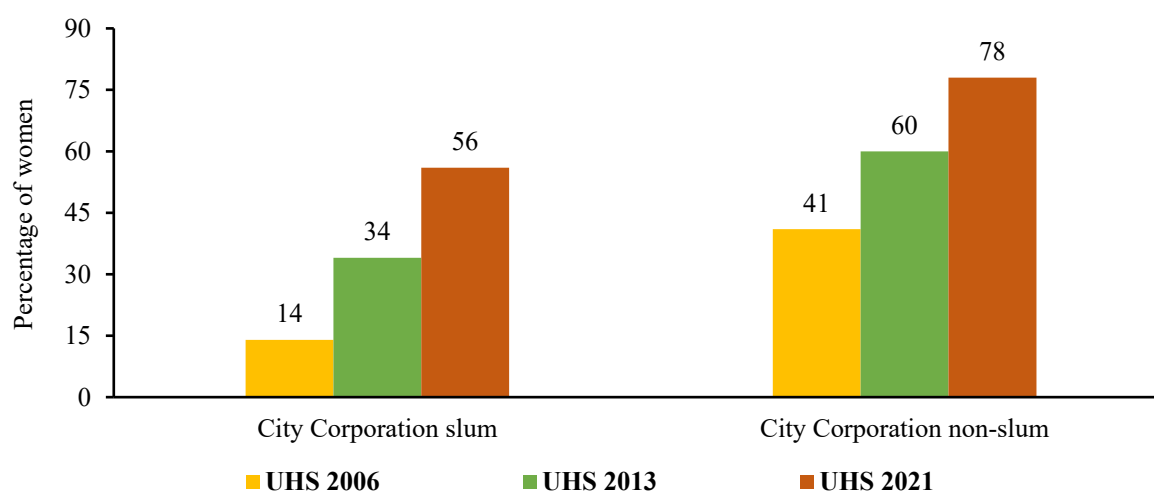


Table 8.15: Type of provider of first postnatal checkup for mother

Percent distribution of last births in the three years preceding the survey for which the mothers received postnatal care within two days of the last live birth from a medically trained provider, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Domain	Qualified doctor	Nurse/ midwife/ para-medics /FWV	CSBA/ MA/ SACMO	Non-medically trained provider	No post-natal checkup	Total	Percentage receiving checkup within 2 days of delivery from a medically trained provider	Number of women
City Corporation non-slum	63.4	16.7	0.0	5.5	14.4	100.0	78.3	1,405
Rest urban	58.4	14.6	0.0	5.8	21.2	100.0	72.3	1,987

Note: Medically trained provider included qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

8.3.2 Post-natal Care for the Newborn

In all the three urban domains, newborns were almost equally likely of their mothers to have received postnatal checkup from a medically trained provider within two days of delivery. Fifty three percent of newborns in slums received PNC from a medically trained provider within two days of delivery, while 75.4 percent of newborns in non-slums and 71.8 percent in rest urban areas received PNC from medically trained providers within two days of delivery.

Coverage of PNC for newborns nearly doubled in slums during the last 7 years (26.5 percent in 2013 to 52.6 percent in 2021), increased by more than 1.5 times in non-slums (49.2 percent in 2013 to 75.4 percent in 2021) and rest urban areas (45.0 percent in 2013 to 71.8 percent in 2021). Among the PNC receiving newborns, majority received PNC from qualified doctors in all three domains, and 13 to 16 percent received from nurse/midwives/paramedics/FWVs (Table 8.16).

Figure 8.9: Trend in postnatal care for newborn from medically trained provider within two days of delivery, UHS 2006, UHS 2013 and UHS 2021.

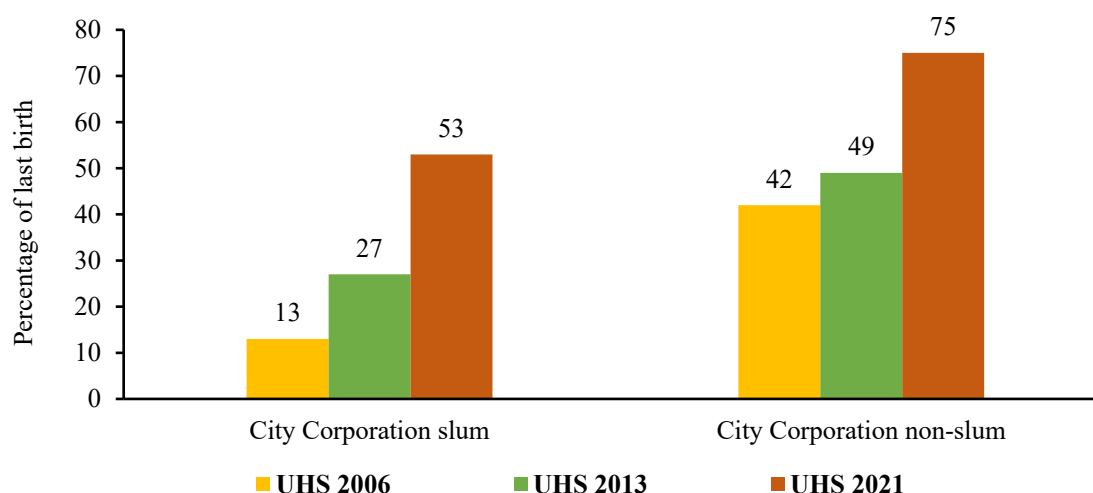


Table 8.16: Type of provider of first postnatal checkup for newborn

Percent distribution of last births in the three years preceding the survey for which children received postnatal care in the two days after the last live birth from a medically trained provider, City Corporation slum, City Corporation non-slum, and rest urban, UHS 2021

Domain	Qualified doctor	Nurse/midwife/paramedics /FWV	CSBA/MA/SACMO	Non-medically trained provider	No post-natal checkup	Total	Percentage receiving checkup within 2 days of delivery from a medically trained provider	Number of women
City Corporation non-slum	59.4	16.0	0.0	5.7	18.8	100.0	75.4	1,405
Rest urban	57.1	14.7	0.0	7.1	21.0	100.0	71.8	1,987

Note: Medically trained provider included qualified doctor, nurse/midwife, paramedics, FWV, CSBA, and MA/SACMO.

8.4 Essential Newborn Care

Essential Newborn Care practices focuses on the use of clean instruments to cut the umbilical cord, applying nothing to the cord, immediate drying and wrapping of the newborn, delaying bathing to 72 hours after birth, and initiating breastfeeding within one hour of delivery (Bangladesh National Neonatal Health Strategy, MOHFW 2009). Table 8.17 presents the percentage of non-institutional last live births in the three years preceding the survey by specific newborn care practices and the percentage that received all essential newborn care practices.

As can be seen in the table, use of clean delivery kit/bag during delivery was low during home deliveries in all three domains; 25.6 percent in slums, 30.6 percent in rest urban, and 33.7 percent in non-slum areas. The use of boiled instrument to cut the cord was around 90 percent in all the urban domains. However, the practice of other components of essential newborn care was low irrespective of place of residence of women. Only 0.4 to 0.6 percent of newborn in urban domains received all essential newborn care practices.

Table 8.17: Essential newborn care

Percentage of non-institutional births which were their mother's most recent live birth in the three years preceding the survey by essential newborn care practices, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domain	Clean delivery kit/bag used during the delivery	Instrument boiled before the cord was cut	Nothing applied to the umbilical cord after it was cut and tied	Dried within 0-4 minutes of birth	Wrapped within 0-4 minutes of birth	Delayed bathing (72+ hours after birth)	Immediate breast-feeding (within 1 hours after birth)	All the essential newborn care practices	Number of non-institutional births
City Corporation slum	25.6	89.7	41.7	58.1	44.5	34.7	53.2	0.4	1,247
City Corporation non-slum	33.7	90.0	40.6	50.4	30.9	37.6	63.0	0.5	314
Rest urban	30.6	87.3	30.4	63.3	46.5	41.5	61.0	0.6	649

Note: All essential newborn care excludes the use of clean delivery kit/bag used during delivery.

8.5 Effects of COVID Pandemic on Maternal Health Care

During the recent episode of Corona pandemic since March, 2020 in Bangladesh, access to health care facilities for general healthcare including maternal healthcare was very difficult or limited. Women who had a live birth in the last three years prior to the survey or who were current users of any family planning (FP) methods were asked whether they faced any problem due to corona prevalence in accessing maternal health care.

Among the FP users, less than one percent across all the domains reported of facing any problem in getting methods. Those who reported to have faced some problems, the type of problems they faced were: did not find method when in need, fear of visiting hospital/clinic for corona infection, and fieldworkers did not make home visit.

About 2 to 6 percent of women reported of facing problems in getting ANC care. The main stated problem was fear of visiting hospital/clinic due to COVID pandemic. Similar was the situation in seeking delivery and postnatal care (PNC), and the problems faces were also similar for the women of all the domains.

Table 8.18: Effect of COVID-19 on maternal health care
 Percentage of women age 15-49 who have currently users of any FP methods, or who had a live birth in the last one year by problems they faced due to COVID prevalence, according to major domains, UHS 2021

Problems/difficulties faced due to COVID-19 prevalence	Major domain		
	City Corporation slum	City Corporation non-slum	Rest urban
Faced problems in getting FP method			
Yes	0.2	0.1	0.2
No	75.8	73.7	72.5
Didn't use any method	24.0	26.3	27.4
Number of FP users' women	9,287	5,265	6,876
Type of problems faced:			
Didn't find method when need	60.1	45.4	39.3
Fear of visiting hospital/clinic/shop for corona	16.8	24.8	32.7
Fieldworker didn't visit our home	35.3	17.4	41.4
Didn't know where to get the methods, learned later	0.0	0.0	0.0
Hospital/clinic only provide treatment for Corona	0.0	32.6	0.0
Other	0.0	0.0	11.8
Number of FP users' women	21.0	4.0	10.0
ANC:			
Faced any problems			
Yes	2.4	5.9	2.0
No	84.1	89.8	86.4
Didn't checkup	13.4	4.3	11.6
Number of women	1,080	528	744
Type of problems faced			
Fear of visiting hospital/clinic/shop for corona	67.7	45.4	53.9
Hospital/clinic only provide treatment for Corona	17.8	41.1	10.0
Other	17.7	26.4	43.0
Number of women	26	31	15
Delivery care:			
Type of problems faced			
Did not face any problem	94.6	93.8	95.8
Fear of visiting hospital/clinic/shop for corona	3.0	1.2	2.2
It was difficult to access doctor/Health worker	2.6	5.5	2.3
It was difficult to get transportation	0.6	1.5	0.3
Number of women	982	444	678
PNC:			
Any problem faced during PNC check-up			
Yes	0.7	1.8	1.3
No	73.5	83.3	80.6
Didn't health checkup the newborn	25.1	14.6	18.0
Number of women	1,080	528	744
Type of problems faced			
Fear of visiting hospital/clinic/shop for corona	57.5	77.9	67.9
Hospital/clinic only provide treatment for Corona	60.9	22.1	58.4
Other	10.9	0.0	15.7
Number of women	8	10	10

Key Findings:

Child Mortality

- ❖ Childhood mortality showed a declining trend in slums during 2016-2021. One in twenty-six children (41 per 1,000 live births) in slums died before reaching their fifth birthday.
- ❖ Deaths in the neonatal period (27 deaths per 1,000 live births) accounted for 69 percent of all under-five deaths in slums.
- ❖ In slums, during the last seven years, neonatal mortality rate declined by 4 percent, under-five mortality by 18 percent, and infant mortality rate declined by 13 percent.

Child Health

- ❖ Thirty five percent of children with ARI symptoms in the slums were taken to a health facility or a qualified provider for treatment, compared to 48.7 percent in non-slums.
- ❖ Treatment for under-five children with ARI with antibiotics was 10 percentage points higher in slums (62.5 percent) than in non-slums (52.0 percent).

Infant Feeding

- ❖ Prevalence of exclusive breastfeeding among children under six months declined from the 2013 level. The decline was from 59.2 to 54.0 percent in slums, and 57.7 to 49.4 percent in non-slums.
- ❖ Only 34.5 percent of children age 6-23 months in slums, compared with 41.0 percent in non-slums, and 46.8 percent in rest urban areas were fed with proper IYCF practices.

Child Nutrition

- ❖ In the slums, about one-third (33.7 percent) of all under-five children were stunted (height for age below -2 SD), compared with 27.1 percent in non-slums, and 28.5 percent in rest urban areas.
- ❖ Overall, 15.9 percent of under-five children in slums were wasted, compared with 14 percent in non-slums and 16.2 percent in rest urban areas. Underweight among under-five children was considerably higher in slums (27.8 percent) than in non-slums (19.9 percent) and rest urban areas (22.6 percent).
- ❖ Compared with the previous rounds of the UHS (UHS 2006 and UHS 2013), there has been a modest decline in stunting, wasting, and underweight levels among under-five children in slums and non-slums.

Information on infant and early childhood mortality is relevant to a health and bio-demographic assessment of a population and is an important indicator of the socioeconomic development and quality of life. It can also help identify children who may be at higher risk of death and lead to strategies to reduce this risk, such as provision of services and promoting birth spacing.

Bio-demographic factors and fertility behaviors increase mortality risks for infants and children. This chapter presents information on the levels, trends, and differentials in neonatal, post-natal, infant, under-5 and child mortality rates. It also examines overall health and associated care seeking patterns, feeding practices and nutritional status of under-five children in three urban domains in Bangladesh: slum, non-slum and other urban areas.

9.1 Infant and Child Mortality

In Bangladesh, infant and childhood mortality estimates are available for the national and divisional levels as are overall urban estimates. But child mortality estimates are not available for the slums. Bangladesh Demographic and Health Surveys (BDHSs) provide estimates on infant and childhood mortality rates. The definitions given below are used for estimating the rates.

Neonatal mortality (NNM): The probability of dying within the first month of life.
Post-neonatal mortality (PNM): The probability of dying between the first month of life and the first birthday (computed as the difference between infant and neonatal mortality).
Infant mortality (1_{q0}): The probability of dying between birth and the first birthday
Child mortality (4_{q1}): The probability of dying between the first and the fifth birthday.
Under-5 mortality (5_{q0}): The probability of dying between birth and the fifth birthday.

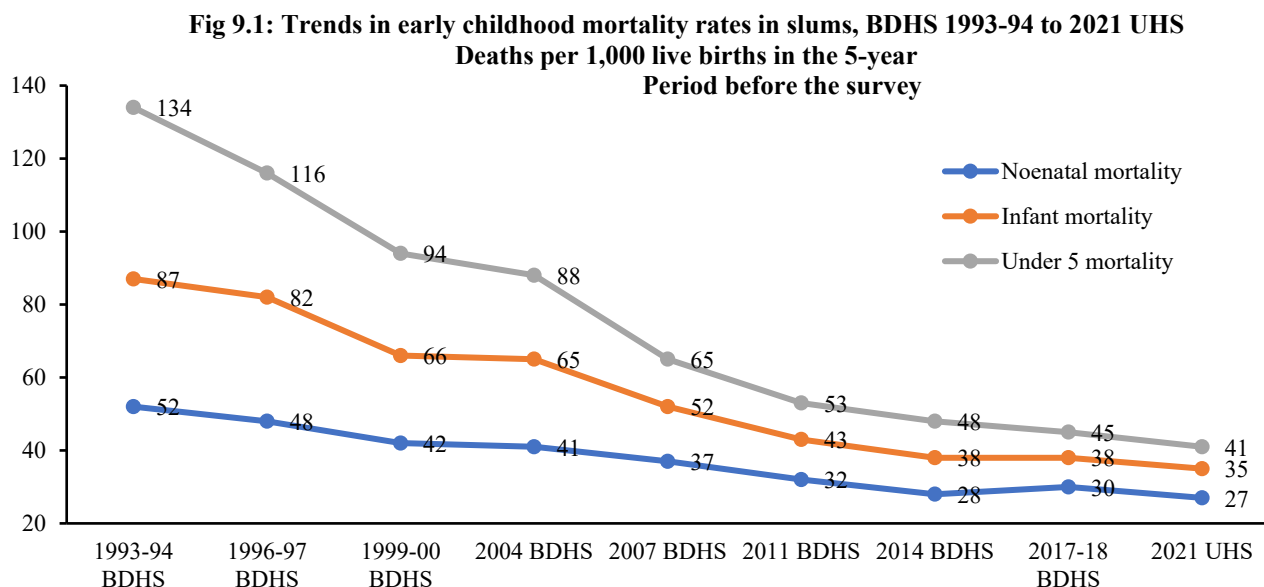


Figure 9.1 shows the trends in early childhood mortality rates in slums in Bangladesh. The under-5 mortality rate has declined gradually over the last 2 decades. Between 2014 and 2017-18, however, the decline slowed noticeably. Infant and neonatal mortality rates remained stable from 2014 to 2017-18.

9.1.1 Levels and Trends in Infant and Child Mortality in City Corporation Slums

The levels of infant and child mortality are quite often considered as indicators of national development. Bangladesh has made laudable progress in reducing infant and child mortality during the last three decades. The proposed SDG (Sustainable Development Goal) target for child mortality aims to end, by 2030, preventable deaths of newborns and children under-five years of age, to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-five mortality to at least as low as 25 deaths per 1,000 live births.

The country has been undergoing rapid social changes, especially the rapid increase in the urban population living in slums, and in particular, in the City Corporations. Although national and divisional level estimates for infant and childhood mortality are available, as are overall urban estimates, data on the current levels of infant and child mortality in the slums are nonexistent.

In the UHS 2021, the birth history section of women questionnaire collected the month and year of birth for each live birth and age at the time of the survey or age at death. Age at death was recorded in days if age is less than one month, in month if less than two years, and years otherwise. These data were used to estimate infant and child mortality rates for the slum areas. The mortality rates for children under age five in CC slum are presented in Table 9.1 for the three five-year periods (0-4, 5-9, 10-14 years) preceding the survey. Data from the UHS 2021 show that under-five mortality rate (U5MR) was 41 per 1,000 live births in the five years preceding the survey (2016-2021), meaning one in 26 in slums died before reaching their fifth birthday. The infant mortality rate (IMR) was 35 deaths per 1,000 live births, and the child mortality (CM) rate was 6 deaths per 1,000 live births surviving to 12 months of age, but not their fifth birthday. Deaths in the neonatal period (27 deaths per 1,000 live births) accounted for 69 percent of all under-five deaths, which was slightly higher compared with the preceding five-year period corresponding to 2012 to 2016 years prior to the survey (54percent).

Table 9.1: Early childhood mortality rates

Neonatal, post-neonatal, infant, and under-5 mortality rates for five-year periods preceding the survey in the City Corporation slums, UHS 2021

Years preceding the survey	Neonatal mortality (NNM)	Post-natal mortality (PNM)¹	Infant mortality (1q0)	Child mortality (4q1)	Under-5 mortality (5q0)
0 – 4	27	8	35	6	41
5 – 9	24	9	33	3	37
10-14	28	17	45	7	52

¹ Computed as the difference between the infant and neonatal mortality rates.

Figures in Table 9.1a shows the early childhood mortality rates by survey domains. It is evident that prevailing mortality rates in slums remains higher in slums compared with non-slum areas (27 vs. 20 neo-natal deaths per 1000 live births, 35 vs.30 infant deaths, and 41 vs. 35 deaths per 1,000 live births for under-five mortality).

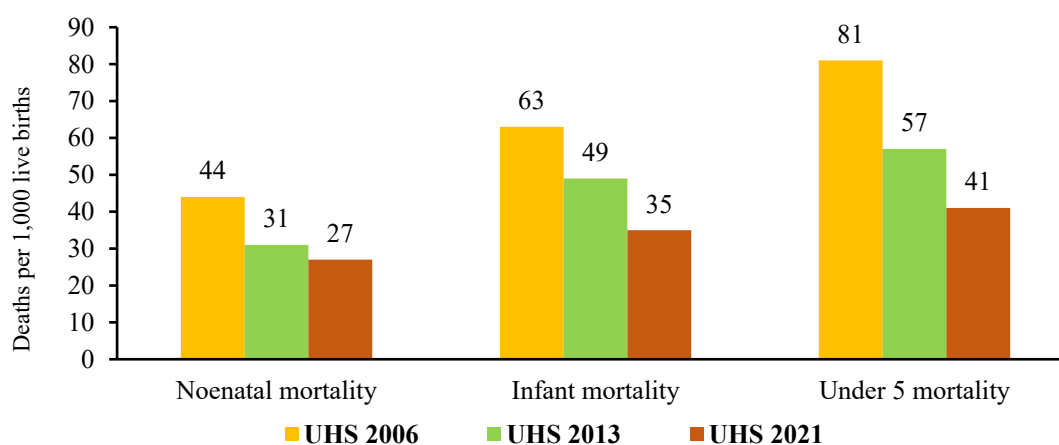
Table 9.1a: Early childhood mortality rates by the survey domains

Neo natal, post-neonatal, infant, child and under-five mortality rates for five-year periods preceding the survey, by the survey domains, UHS 2021

Domains	Neonatal mortality (NN)	Postnatal ¹ mortality (PNN)	Infant mortality (1q0)	Child mortality (4q1)	Under-five mortality (5q0)
City Corporation slum	27.1	7.8	34.9	6.1	40.8
City Corporation non-slum	20.4	9.1	29.5	5.3	34.6
Rest urban	18.6	5.4	24.0	2.4	26.4

If compared to mortality estimates for the urban areas from the 2017-2018 BDHS, the disparity was less pronounced (42 vs. 35 deaths per 1,000 live births for infant mortality rate, and 48 vs. 41 deaths per 1,000 live births for under-five mortality rate). Compared to the earlier round of the UHS 2013, declining trend was evident in childhood mortality from 2009-2013 to 2016-2021; 04 percent decline in neonatal mortality rate, 16 percent for under-5 mortality rate and 14 percent for infant mortality rates (Figure 9.2).

Figure 9.2: Trends in early childhood mortality rates in the city slums, UHS 2006, UHS 2013 & UHS 2021.



9.2 Prevalence, Care Seeking and Treatment of Acute Respiratory Infection (ARI)

Acute Respiratory Infection (ARI): ARI is defined as having a cough with either rapid or difficult breathing or chest in-drawing which is chest related.

Acute respiratory infection (ARI) is one of the most common childhood illnesses. Most ARI-related deaths occur in low- and middle-income countries where health service coverage is low and the quality of care is sub-optimum. Early diagnosis and treatment with antibiotics can reduce the number of deaths caused by ARI, particularly deaths resulting from pneumonia.

ARI is still one of the most important causes of death among the under-five children in Bangladesh. Thus, it is important to know the healthcare seeking behavior in relation to ARI in urban areas for designing and adopting interventions to reduce childhood mortality. The prevalence of ARI during the two weeks preceding the survey and health seeking behavior for their management was examined for slums, non-slums, and rest urban areas of Bangladesh.

The government of Bangladesh adopted the Integrated Management of Childhood Illness (IMCI) strategy in 1998, and facility-based IMCI had been scaled up in all districts and more than 420 Upazilas (sub-districts) by 2014 (DGHS 2017). In the majority of union health and family welfare centers (primary care facilities with outpatient services only), IMCI is performed by sub-assistant community medical officers (SACMOs) who have 13 days of IMCI in-service training. In addition, IMCI is practiced in most outpatient departments of union health centers (primary care referral hospitals with in-patient care). The 4th HPNSP (2017-2022) envisions improving the quality of IMCI services through strengthening of existing systems and innovations.

Table 9.2: Prevalence and treatment of acute respiratory infection

Among children under-five, the percentage who had symptoms of acute respiratory infection (ARI) in the two weeks preceding the survey, and among children who had symptoms of ARI, the percentage for whom advice or treatment was sought from a health facility or provider, according to background characteristics, UHS 2021

Domains	Percentage with symptoms of ARI ¹	Number of women	Percentage for whom advice or treatment was sought from a facility or provider ²				No one	Percentage who received antibiotic for treatment of ARI	Number of children with ARI
			Pharmacy	Traditional doctor	Other				
City Corporation slum	2.4	4315	35.3	43.2	3.9	0.0	6.4	62.5	102
City Corporation non-slum	3.6	2285	48.7	36.7	1.6	0.0	0.9	61.1	83
Rest urban	1.4	3294	28.3	22.8	8.6	.5	1.7	52.0	48

¹ Symptoms of ARI (cough accompanied by short, rapid, or difficult breathing which was chest related is considered as proxy pneumonia).

² Excludes pharmacy, traditional doctor, and others.

The prevalence of ARI among children under-five years of age in the two weeks preceding the survey in slums, non-slums, and rest urban areas is presented in Table 9.2. Table 9.2 shows that 2.4 percent of children under age 5 in the slums, 3.6 percent in the non-slums, and 1.5 percent in rest urban areas had symptoms of ARI in the 2 weeks preceding the survey. For 35.3 percent of children with symptoms of ARI in the slums, 48.7 percent in the non-slums, and 28.3 percent in the rest urban areas advice or treatment was sought from a health facility or qualified provider. Advice or treatment for a significant percentage of children with ARI symptoms was also sought from the pharmacies (43.2 percent in the slum, 36.7 percent in the non-slum, and 22.8 percent in rest urban areas).

Treatment of ARI with antibiotics was highest in the slum areas (62.5 percent), followed by 61.1 percent in the non-slum, and 52.0 percent in the rest urban areas.

Figure 9.3: Percentage of receiving antibiotics by sources of prescription, UHS 2013 and UHS 2021.

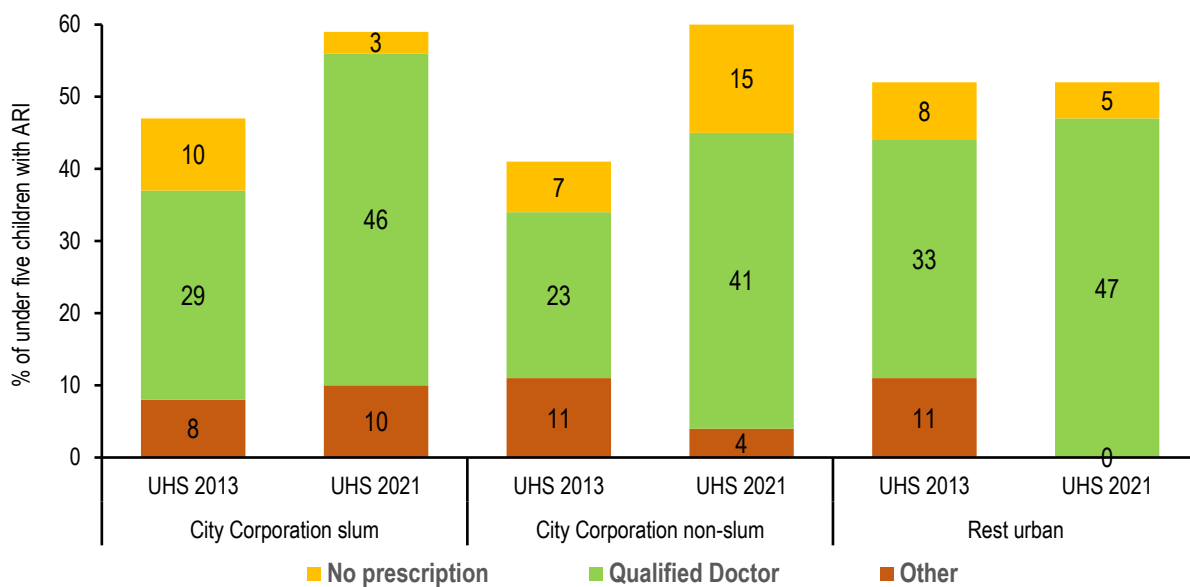


Figure 9.4: Percentage of receiving antibiotics by sources, UHS 2013 & UHS 2021.

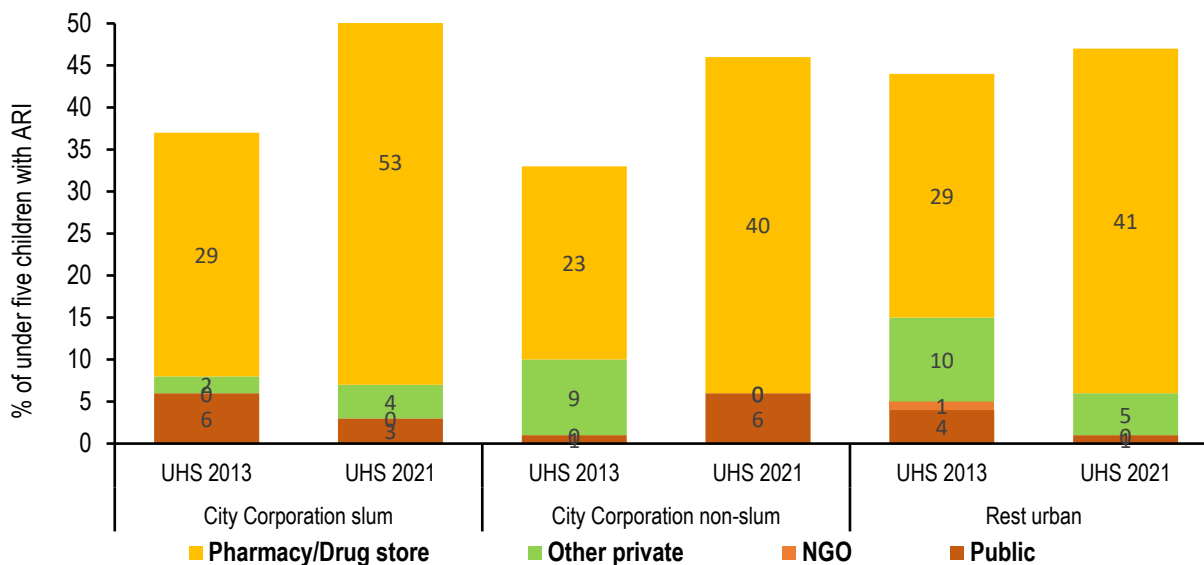


Figure 9.4.1: Percentage of seeking care for acute respiratory infection from health facilities or providers by sex, UHS 2013 & UHS 2021.

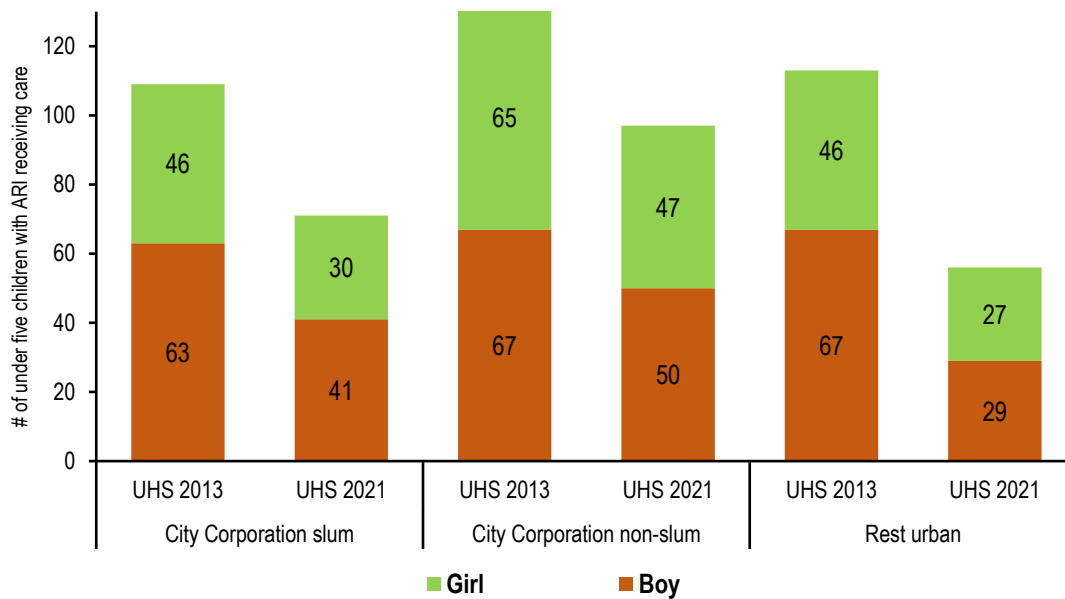
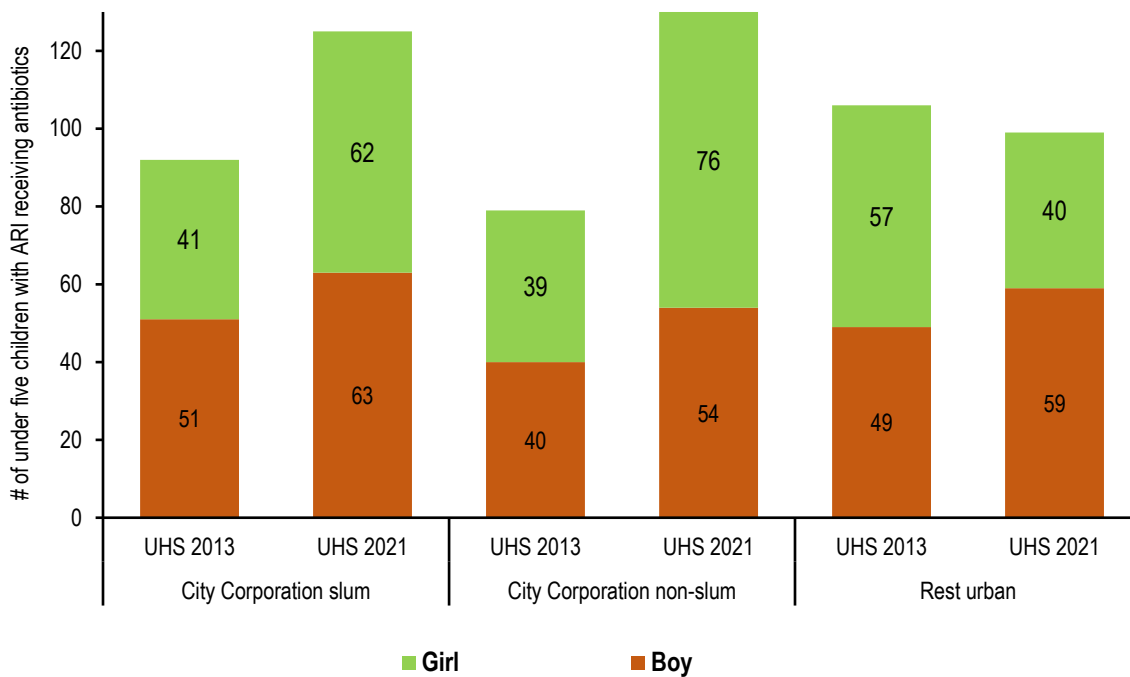


Figure 9.4.2: Percentage of receiving antibiotics for acute respiratory infection from health facilities or providers by sex, UHS 2013 & UHS 2021.



9.3 Use of Mobile Phone for Child Care

Contrary to the expectations, there was very low use of cell phones for seeking advice and assistance for the care of a child, even with critical conditions like ARI. Only 6.7 percent of mothers of children with ARI in slums and 43.4 percent in non-slums and 19.2 percent in rest urban areas used a cell phone to seek advice or assistance for their seek child.

9.4 Care for the Child

Many women residing in the urban areas work at or outside of their home. If working outside home, they either bring their child to work, or the child is taken care of by father, grandmother, elder sister, neighbors or a servant. Table 9.3 shows that in the slums 18.1 percent of mothers with a child of age under-five worked outside the home; this was 8.0 percent in the non-slums and only 4.2 percent in the rest urban areas. Interestingly, 13-28 percent of mothers who worked of these children. The other caretakers were elder sisters, friends/neighbors/relatives, fathers, and servants.

Table 9.3: Persons caring for the under-5 child of a working women

Among women age 15-49 with at least one child of age under-five and who work outside home, the percentage who cared for the child by sample domains, UHS 2021

Domains	Mothers currently working			Persons caring for the child of a women currently working outside home						
	Work outside home	Work at home	Number of women	Accompany mother to work	Father	Grand-mother	Elder sister	Friend/Neighbor/Relative	Servant/Other	Number of women who work outside home
City Corporation slum	18.1	4.3	3470	13.9	5.2	30.8	27.8	18.3	3.9	628
City Corporation non-slum	8.0	3.3	1784	12.6	8.4	40.0	8.9	23.3	6.9	142
Rest urban	4.2	3.2	2662	28.4	6.9	41.6	13.6	7.7	1.7	112

Table 9.4: Father's participation in children's healthcare

Percentage of fathers accompanying sick children of age under-five for treatment outside home in the last three months, UHS 2021

Domains	Children sick		Treatment sought outside home (among children who were sick)		Father accompanied child for treatment (among children who sought treatment outside home)	
	Percentage	Number of men	Percentage	Number of men	Percentage	Number of men
City Corporation slum	59.2	910	85.7	539	62.0	462
City Corporation non-slum	56.1	570	79.3	320	68.8	254
Rest urban	54.6	679	77.6	371	66.4	288

Father's participation in children's healthcare, particularly accompanying the child when treatment is sought outside home is an important support in caring of the child. Table 9.4 shows such practices in the slums, non-slums and rest urban areas. More than half of the children (59.2 percent

in slums, 56.1 percent in non-slums, and 54.6 percent in rest urban areas) reported having an illness in the last three months. Among them, treatment seeking outside the home was quite high at 84-88 percent. When treatment was sought outside the home, the fathers accompanied the children in 62.0 percent of cases in slums, 68.8 percent in non-slums and 66.4 percent of cases in rest urban areas.

9.5 Breastfeeding Practices

9.5.1 Initiation of Breastfeeding

Initiation of breastfeeding within the first hour of life is important for both the mother and the child. The first breast milk contains colostrum, which is highly nutritious and has antibodies that protect the newborn from diseases. Early initiation of breastfeeding also encourages bonding between the mother and her newborn, facilitating the production of regular breast milk.

Early initiation of breastfeeding: Initiation of breastfeeding within 1 hour of birth.

Sample: Last-born children who were born in the 2 years before the survey

As is evident from Table 9.5 (the percentage who were ever breastfed and the percentage who started breastfeeding within one hour and within one day of birth) that nearly 98 percent of children in all urban domains was breastfed at some time. Among them, two-thirds (68.3 percent in slums, 62.4 percent in non-slums, and 70.2 percent in rest urban areas) started breastfeeding immediately or within one hour of birth.

Table 9.5: Initial breastfeeding

Among last-born children who were born in the three years preceding the survey, the percentage who were ever breastfed and the percentage who started breastfeeding within one hour and within one day of birth in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Percentage ever breastfed	Percentage started breastfeeding within 1 hour of birth	Percentage started breastfeeding within 1 day of birth ¹	Number of children
City Corporation slum	98.1	68.3	87.6	2739
City Corporation non-slum	97.6	62.4	85.3	1396
Rest urban	98.2	70.2	88.0	2021

¹ Includes children who started breastfeeding within one hour of birth.

Table 9.6: Breastfeeding status

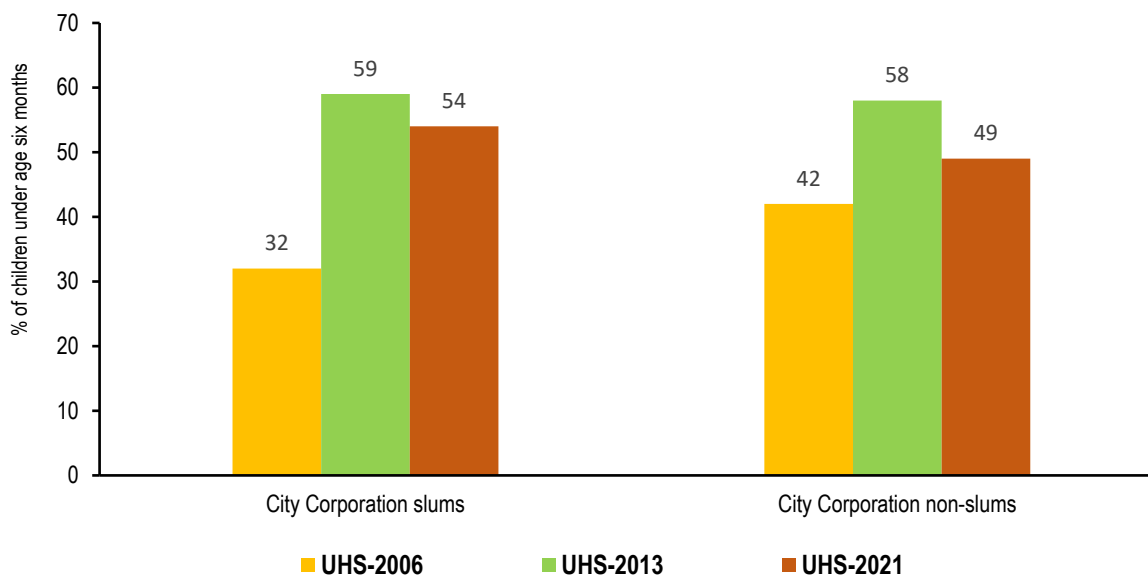
Percent distribution of youngest children under age six months who are living with their mother, by breastfeeding status, in City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domains	Breastfeeding status						Number of Children under 6 months
	Not breast-fed	Exclusively breast-fed	Breastfeeding and consuming plain water only	Breastfeeding and consuming non-milk liquids ¹	Breastfeeding and consuming other milk	Breastfeeding and consuming complementary foods	
City Corporation slum	0.1	54.0	15.0	3.1	15.6	10.0	442
City Corporation non-slum	1.1	49.4	17.3	1.3	13.1	11.1	220
Rest urban	0.0	49.9	16.3	5.0	13.4	11.7	270

Note: Breastfeeding status refers to a “24 hour” period (yesterday and last night). Children who are classified as “breastfeeding and consuming plain water only” and “consumed no liquid or solid supplements.” The categories of not breastfeeding, exclusively breastfed, and breastfeeding and consuming plain water, non-milk liquids, other milk, and complementary foods (solid or non-solid) are hierarchical and mutually exclusive, and their percentages add to 100 percent. Thus, children who receive breast milk and non-milk liquids and who do not receive other milk and who do not receive complementary foods are classified in the non-milk category even though they may also get plain water. Any children who get complementary foods are classified in that category as long as they are breastfeeding as well.

¹ Non-milk liquids include: Juice, Juice drinks, and other liquids.

Figure 9.5: Trends in exclusive breastfeeding among children under age six months in City Corporation slums and non-slums, UHS-2006, UHS-2013 and UHS-2021.



9.5.2 Exclusive Breastfeeding- Levels and Trends

Exclusive breastfeeding: Proportion of infants age 0-5 months who received only breast milk during the previous 24 hours. Exclusive breastfeeding allows the inclusion of ORS and Vitamins and/or mineral supplements.

In the first 6 months of life, children should be exclusively breastfed; that is, they should be given nothing but breast milk. Exclusive breastfeeding for 6 months prevents infections such as diarrhea and respiratory illnesses and provides all of the nutrients and liquid an infant requires for optimal growth and development. Feeding complementary foods within the first 6 months will have the adverse effect of reducing breast milk output because the production and release of breast milk are modulated by the frequency and intensity of suckling.

The UHS 2021 Survey results as presented in Table 9.6 on breastfeeding status show that 54.0 percent of children under age six months in slums, 49.4 percent in non-slum and 49.9 percent in rest urban areas received exclusive breast milk. Another 15.0 percent of children in slum, 17.3 percent in non-slum, and 16.3 percent in rest urban areas received breast milk and plain water only, nearly a similar percentage received breastmilk and other milk, and relatively less proportion received breastmilk and complementary foods.

9.5.3 Duration of Breastfeeding

Results, as presented in Table 9.7 show that the median duration (in months) of any breastfeeding, among children born last in the five years preceding the survey was 23.0 months in City Corporation non-slums as well as in slums, and 24 months in rest urban areas.

Table 9.7: Median duration of breastfeeding

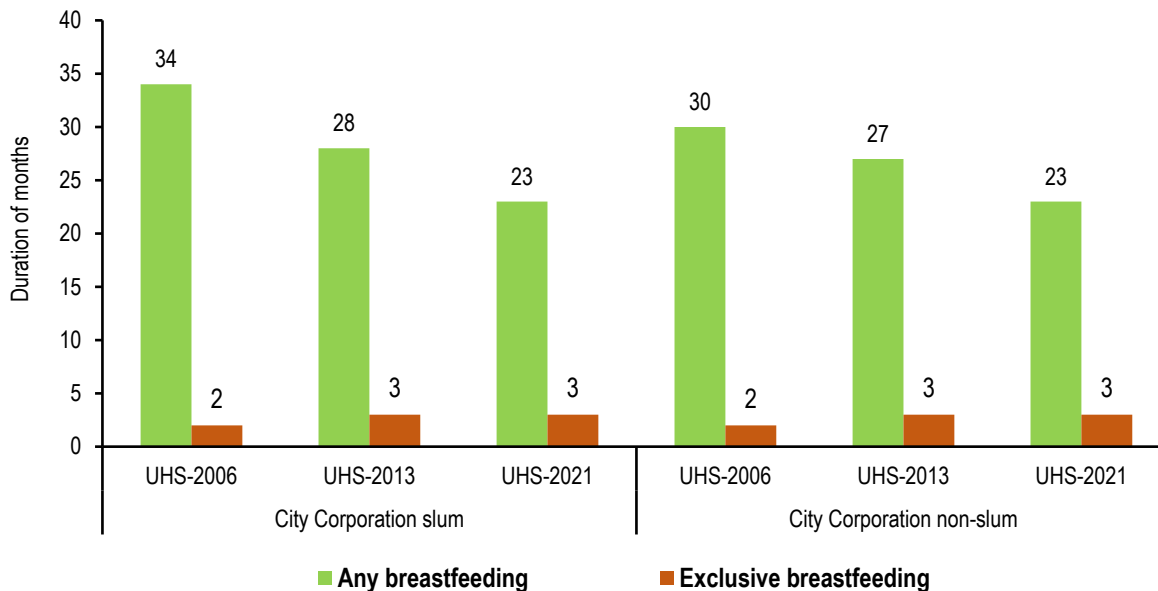
Median duration (in months) of any breastfeeding, exclusive breastfeeding, and predominant breastfeeding among children born last in the five years preceding the survey, UHS 2021

Domains	Any breastfeeding	Exclusive breastfeeding	Predominant breastfeeding	Number of children
City Corporation slum	23.0	3.0	3.0	3801
City Corporation non-slum	23.0	2.9	3.0	1970
Rest urban	24.0	3.0	3.0	2993

¹ Predominant breastfeeding includes either exclusively breastfed or received breast milk and plain water and/or non-milk liquids only.

Compared with the median duration of breastfeeding from the earlier rounds of the UHS (UHS 2006, UHS 2013), duration of any breastfeeding declined and exclusive breastfeeding increased slightly in slums and non-slums among children under six months of age (Figure 9.6).

Figure 9.6: Median duration of breastfeeding in City Corporation slums and non-slums, UHS-2006, UHS-2013 and UHS-2021.



9.6 Infant and Young Child Feeding (IYCF) Practices

Feeding practices and child nutrition are highly correlated. Adequate nutrition is vital for child health, their optimal growth and development, and that can be ensured when young children are properly fed. The period from birth up to two years of age is most important because of the rapid growth and brain development that occurs during this time. Poor breastfeeding and infant feeding practices have adverse consequences for the health and nutritional status of children.

UNICEF and WHO recommend that children should be exclusively breastfed, that is, given no other liquid or solid food or plain water for the first six months of life and that children are given solid or semi-solid complementary food at six completed months. It is also recommended that breastfeeding should continue throughout the second year of life.

The Infant and Young Child Feeding (IYCF) practice provides information on key indicators related to optimal feeding practices. Feeding practices described in this report are related to breastfeeding practices, introduction of solid and semi-solid foods to breastfed and non-breastfed children, and complementary feeding, including appropriate dietary diversity and meal frequency for children 6-23 months according to globally-agreed feeding guidelines.

The effort by an interagency working group has resulted in a set of simple, valid and reliable indicators that measure food-related aspects of complementary feeding, including dietary variety and frequency of eating episodes, and current guidance on the feeding of non-breastfeeding infants and young children up to 24 months of age. The usual indicator for exclusive breastfeeding is the percentage of children under age 6 month who are exclusively breastfed. The indicator for timely

complementary feed is the percentage of children age 6-8 months who receive solid, semi-solid or soft food at six completed months. The IYCF indicators are given below.

The 10 WHO recommended IYCF indicators:

IYCF 1: Timely/Early Initiation of Breast Feeding (0-23) months: Proportion of children 0-23 months / born in last 24 months who were put to the breast within one hour of birth.

IYCF 2: Exclusive Breast Feeding only (0-5) months: Proportion of infants 0-5 months who are fed exclusively with breast milk during the previous day.

IYCF 3: Timely Complementary Feeding (6-9) months: Proportion of infants 6-9 months/ children 12–15 months of age who received breast milk and a solid or semi-solid food (mushy or solid foods, not fluids. based on 24-hour dietary recall) during the previous day.

IYCF 4: Introduction of Solid/Semi-solid or soft food (6-8) months: Proportion of infants 6-8 months who receive solid, semi-solid or soft foods during the previous day.

IYCF 5: Continued Breastfeeding at (12-15) months: Proportion of children 12-15 months old who are fed breast milk during the previous day.

IYCF 6: Minimum Dietary Diversity (6-23) months: Proportion of children 6-23 months who receive foods from 4 or more (of 7) food groups during the previous day.

IYCF 7: Minimum Meal Frequency (6-23) months: Proportion of breastfed and non-breastfed children 6-23 months who receive solid, semi-solid or soft foods (but also including milk feeds for non-breastfed children) the minimum number of times or more during the previous day.

IYCF 8: Minimum Acceptable Diet (6-23) months: Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breast milk) during the previous day.

IYCF 9: Iron Rich or Fortified Solid/Semi-solid Foods (6-23) months at home: Proportion of children 6-23 months old who receive an iron-rich food or iron-fortified food that is specially designed for infants and young children, or that is fortified in the home during the previous day.

IYCF 10: Bottle Feeding (0-23) months: Proportion of children 0-23 months old who were fed with a bottle during the previous day.

After the first 6 months of age, breast milk alone is no longer sufficient to meet the nutritional needs of an infant. After 6 months, appropriate complementary foods should be introduced while breastfeeding is continued until age 2 or older. The transition from exclusive breastfeeding to complementing breastfeeding with family foods is when children are most vulnerable to becoming undernourished, and during this time it is important that they receive solid, semisolid, or soft foods.

Appropriate complementary feeding should include feeding children a variety of foods to ensure that nutrient requirements are met. A range of fruits and vegetables, including those rich in vitamin A should be consumed daily. Studies have shown that plant-based complementary foods by themselves are insufficient to meet the needs for certain micronutrients. Therefore, meat, poultry, fish, or eggs should also be part of the daily diet or eaten as often as possible (WHO 2003).

The UHS 2021 collected information on the types of liquids and foods the child had consumed during the day or night preceding the interview. Table 9.8 gives the percent distribution of youngest children age 6-23 months living with their mother who are fed according to three IYCF feeding practices based on breastfeeding status, number of food groups, and times they are fed during the day or night prior to the survey, according to City Corporation slum, City Corporation non-slum and Rest urban areas. Results indicate that IYCF practices were substantially lower for non-breastfed children compared to breastfed children, and overall, 34.5 percent of children of age 6-23 months in slums were fed with proper three IYCF practices. This proportion was considerably higher for children in non-slums (41.0 percent) and rest urban (46.8 percent) areas.

Table 9.8: Infant and young child feeding practice

Percent distribution of youngest children age 6-23 months living with their mother who are fed according to three IYCF feeding practices based on breastfeeding status, number of food groups, and times they are fed during the day or night [preceding the survey, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domain	Among breastfed children 6-23 months, percentage fed:				Among non-breastfed children 6-23 months, percentage fed:					Among all children 6-23 months, percentage fed:				
	4+ food groups	Minimu m times or more ¹	Both 4+ food groups and minimum time or more	Number of breasted children 6- 23 months	Milk or milk products ²	4+ food groups	4+ times or more	With 3 IYCF practic es	Number of non-breasted children 6-23 months	Breast milk, milk or milk products ³	4+ food groups	Minimu m times or more ⁵	With 3 IYCF practic es	Number of all children 6-23 months
City Corporation slum	40.9	79.1	35.5	1119	48.8	44.0	79.7	22.0	89	87.1	41.0	79.1	34.5	1271
City Corporation non-slum	53.0	67.2	42.0	566	56.5	51.0	85.7	29.5	48	87.6	53.1	68.8	41.0	636
Rest urban	55.5	83.5	48.2	808	71.3	47.5	90.7	29.1	64	90.8	54.8	84.1	46.8	918

¹ Food groups: a) Infant formula, milk other than breast milk, cheese of yogurt or other milk products, b) foods made from grains, roots, and tubers, including porridge and fortified baby food from Grains, c) vitamin A-rich fruits and vegetables (and red palm oil), d) other fruits and vegetables, eggs, e) meat, poultry, fish, and shellfish (and organ meats), and f) legumes and nuts,

² At least twice a day for breastfed infants 6-8 months and at least three times a day for breastfed children 9-23 months

³ Includes two or more feedings of commercial infant formula, fresh, tinned, and powdered animal milk, and yogurt,

⁴ Non-breastfed children ages 6-23 months are considered to be fed with a minimum standard of three infant and young child feeding practices if they receive milk or milk products and are fed at least the minimum number of times per day, with at least the minimum number of food groups.

⁵ Fed solid or semi-solid food at least twice a day for infants 6-8 months, 3+ times for other breastfed children, and 4+ times for non-breastfed children.

9.7 Nutritional Status of Under-Five Children

It is assumed that nutritional status might act as a covariate of biochemical markers among children. The standard indices of physical growth that describes the nutritional status of children are:

- Height-for-age (Stunting)
- Weight-for-height (Wasting)
- Weight-for-age (underweight).

Stunting: Stunting or inadequate length/height for age is a reflection of the failure to receive adequate nutrition over a long period of time and/or recurrent illness. Height-for-age indicates the long-term effects of nutrition and does not vary appreciably according to the season of data collection.

Wasting: Weight-for-height is a measure of body mass in relation to body length or height and indicates current nutritional status. Wasting or inadequate weight-for-height usually reflects inadequate nutrition during the period immediately before the survey and may be the result of inadequate food intake or recent episode of illness causing loss of weight. Prevalence of wasting tends to vary substantially with season.

Underweight: Weight-for-age is a composite indicator reflecting both height-for-age and weight-for-height. It does not distinguish between acute malnutrition (wasting) and chronic malnutrition (stunting). A child can be underweighting for her/his age because of stunting, wasting, or both, rendering this indicator difficult to interpret.

The nutritional indicators are expressed in standard deviations (*Z*-scores) from the mean of the WHO standard population. Children with measurements between less than -2 and -3 *Z*-scores are considered to have moderate stunting, wasting or underweight, while those below -3 *Z*-score are severely stunted, wasted or underweight. For children, the following definitions and cut-off points were used for assessing nutritional status:

State	Cut-off (moderate)	Cut-off (severe)
Wasting	<-2 SD weight-for-height z-score	<-3SD weight-for-height z-score
Stunting	<-2 SD height-for-age z-score	<-3 SD height-for-age z-score
Underweight	<-2 SD weight-for-age z-score	<-3 SD weight-for-age z-score.

Table 9.9: Nutritional status of children

Percent distribution of children under-five years classified as malnourished according to three anthropometric indices of nutritional status: height-for-age, weight-for-height, and weight-for-age, City Corporation slum, City Corporation non-slum, and rest urban areas, UHS 2021

Domain	Height-for-age		Weight-for-height		Weight-for-age		Number of children
	Percentage below -3SD	Percentage below -2SD	Percentage below -3SD	Percentage below -2SD	Percentage below -3SD	Percentage below -2SD	
City Corporation slum	13.7	33.7	5.6	15.9	6.9	27.8	3830
City Corporation non-slum	11.9	27.1	4.6	14.0	4.4	19.9	1991
Rest urban	11.3	28.5	5.4	16.2	5.4	22.6	3013

Note: Table is based on children who stayed in the household the night before the interview and who had a valid date of birth and valid height, weight measurement.

The means of the Z-scores for height-for-age, weight-for-height, and weight-for-age are also calculated as summary statistics representing the nutritional status of children in a population. These mean scores describe the nutritional status of the entire population of children without the use of a cut-off point. A mean Z-score of less than 0 (i.e., a negative mean value for stunting, wasting, or underweight) suggests a downward shift in the entire sample population's nutritional status relative to the reference population. The farther away mean Z-scores are from 0, the higher the prevalence of malnutrition.

The nutritional status assessment helps to identify subgroups of the child population that face increased risk of faltered growth and contributes data for comparison with previous survey for trend analyses. The 2021 UHS collected data on the nutritional status of children by measuring the height and weight of all children under age five who stayed in the household the night before the interview and who had a valid date of birth and valid height, weight measurement.

Health technicians were trained to measure the height and weight of children and adults. Training on child height measurement included standardization exercises. Weight of the children were measured by electronic digital display scale *beurer* (model number PS 240), with accuracy up to ± 50 gms. Mother and Child's weight was taken together, followed by the weight of the mother only, and then child's weight was obtained by taking the difference of the two measures. Height/length of a child was measured with locally made wooden length board. Children younger than 24 months of age were measured by lying down on the scale(recumbent length); height of older children or adults were measured standing up (height) position. Weight and length were measured three times and the average was taken. Measurements on height and weight were subsequently compared to the standards according to the WHO 2006 growth standards and the nutritional status was assessed by z-score.

Figure 9.7: Trends in nutritional status of under-five children, UHS-2006, UHS-2013 and UHS-2021.

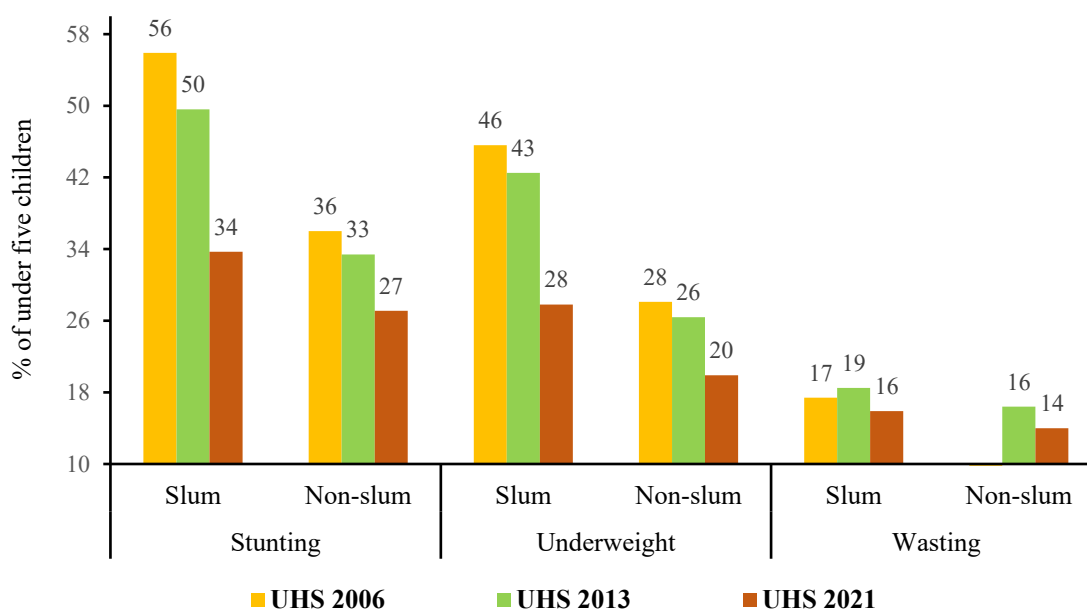


Table 9.9 provides the distribution of under-five children by nutritional status according to three urban domains. In the slums, about one-third of all under-5 children were stunted (33.7 percent). The rate of stunting in non-slums and rest urban areas were also high at 27.1 and 28.5 percent respectively. Nearly one in every seven (13.7 percent) children in slums were severely stunted, which was slightly higher than in non-slums (11.9 percent) and other urban (11.3 percent) areas.

The wasting level among under-5 children in urban areas was of great concern – in all three urban domains, the overall wasting rate surpassed the WHO specified emergency level of 15 percent (WHO, 2003). Overall, 15.9 percent of children in slums were wasted, compared with 14.0 percent in non-slums and 16.2 percent in rest urban areas.

As shown in Table 9.9, 27.8 percent of under-5 children in slums were underweight, against 19.9 percent in non-slums and 22.6 percent in rest urban areas. About 6.9 percent of under-5 children in slums were severely underweight, which was higher than that of non-slums and rest urban areas (4.4 percent in non-slums and 5.4 percent in rest urban areas).

Compared with the previous rounds of the UHS (UHS 2006 and UHS 2013), there has been a modest decline in stunting, wasting and underweight levels among under-five children in slums and non-slums (Figure 9.7).

It is generally assumed that urban slum residents live in worse environmental condition, and consequently have worse health status when compared with other urban populations. The important factors believed to be associated with this are environmental (crowding, poor living and sanitation, etc.), food consumption patterns, education, income, and access to quality healthcare. One of the objectives of the Urban Health Survey (UHS) 2021 was to assess intra-urban inequalities, examine trends and compare health and health-related indicators and outcomes between urban slum and non-slum populations in Bangladesh. The UHS 2013 reported that intra-urban inequalities between slums and non-slums had declined between 2006 and 2013 in some key health-related indicators.

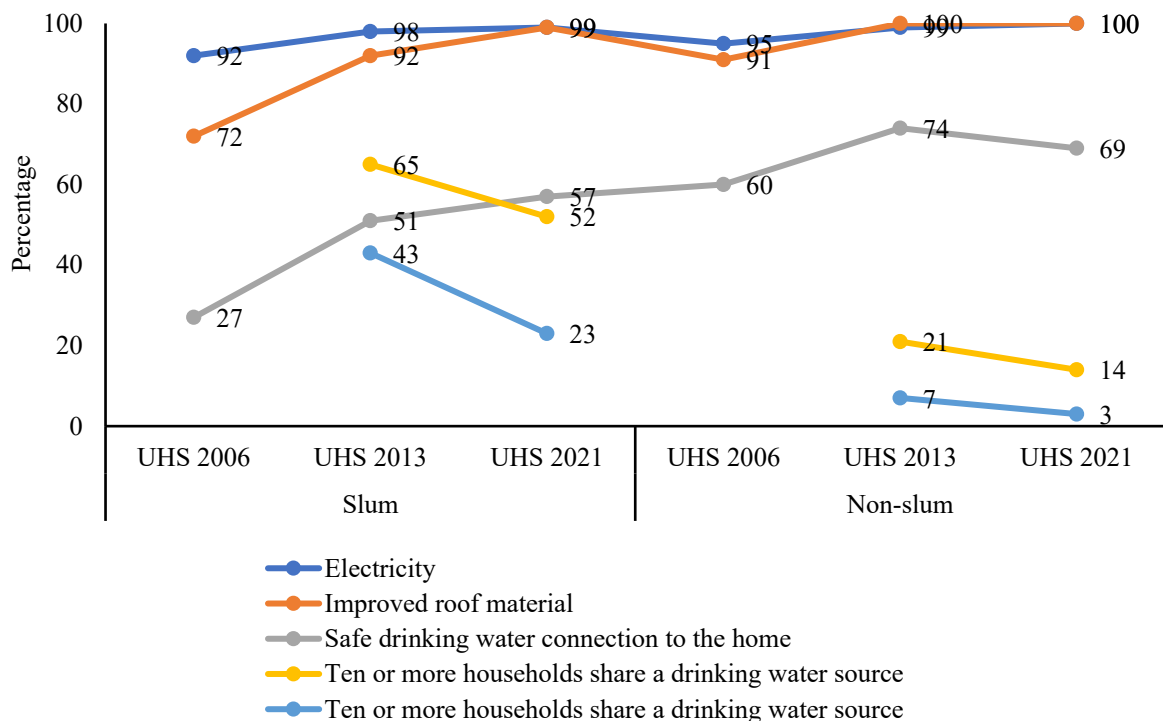
The purpose of this chapter is to examine whether intra-urban differentials in healthcare use and key health outcomes between slums and non-slums have narrowed further between the 2013 and 2021 Urban Health Surveys. The assessment was done in terms of the availability of the basic amenities and healthcare utilization and health outcomes.

10.1 Availability of Basic Amenities

Survey results presented in previous chapters show that availability of the basic amenities (such as access to electricity and use of improved material for the roof of dwelling houses) is now universal in both the slums and the non-slums. Ninety nine percent households of the slums and 100 percent of those in non-slums have now access to electricity. The proportion of households with improved roof material increased from 92 percent in 2013 to 99 percent in 2021 in slums and this is 100 percent in non-slums.

As regards access to safe drinking water, and hygienic sanitation facilities, intra-urban differentials substantially narrowed between 2013 and 2021. Availability of water connection to the home is an important indicator of water safety. Intra-urban differential between the slums and the non-slums with regard to availability of safe water connection to the home has declined from 23 percentage points to 12; in 2013, 51 percent of slum households had this safe water connection, compared with 74 percent of those in non-slums, while these percentages were 57 and 69 percent, respectively in 2021. Between 2013 and 2021, intra-urban difference in sharing water source by 10 or more households in slums and non-slums declined from 44 to 37 percentage points. In 2021, 52 percent households of the slums and 15 percent of the non-slums shared a water source by 10 or more households, and these were 65 percent in the slums and 21 percent in the non-slums in 2013. Sharing sanitation facilities has decreased both in slums and non-slums. Twenty three percent households in the slums and only 3 percent in the non-slums shared a sanitation facility by 10 or more households in 2021. These percentages were 43 and 7 percent, respectively in 2013. Figure 10.1 shows the trends in the availability of some basic amenities in slums and non-slums.

Figure 10.1: Trends in the availability of basic amenities



10.2 Healthcare Utilization and Outcomes

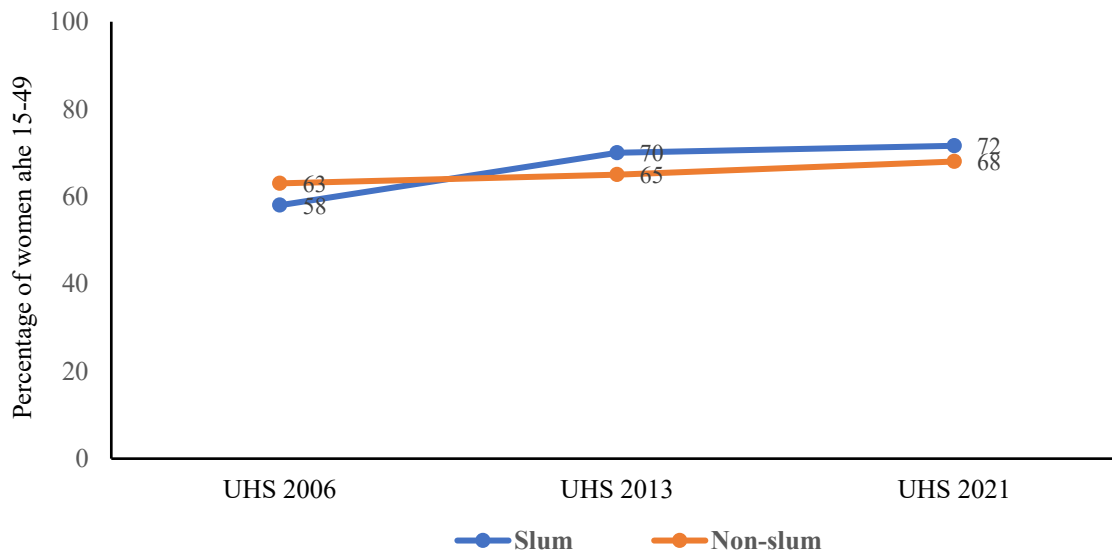
10.2.1 Family Planning

Family Planning performance in slums surpassed that in non-slums. Contraceptive prevalence rate (CPR) among currently married women age 15-49 was four percentage points higher in slum (72percent) than in non-slum (68.0 percent) areas. CPR was 67.9 percent in rest urban areas.

Vast majority women were ‘modern’ method users, 62.9 percent in slum, 59.2 percent in non-slum, and 58.7 percent in rest urban areas. Oral pill was the most frequently used method in all the three domains. Use of condom was higher in non-slums (14.7 percent) than in slums (7.4 percent). Use of long acting (IUD, Implant) and permanent (female sterilization, NSV) methods was low; 7.3 percent in slums and 7.9 percent in non-slums.

The UHS 2013 reported CPR at 70 percent in the slums and 65 percent in the non-slums. The situation was opposite in 2006; 58percent in the slums and 63 percent in the non-slums. NGO workers were perhaps the change agents in the slums.

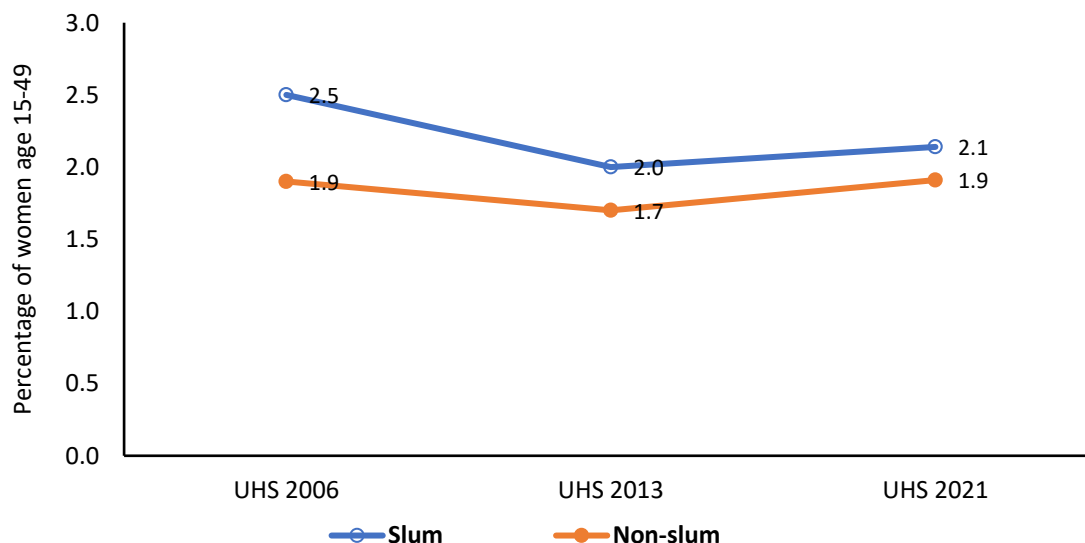
Figure 10.2: Trends in contraceptive use among currently married women age 15-49, in slums and non-slums



10.2.2 Fertility

Women in slums and non-slums achieved below-replacement fertility; total fertility rate (TFR) in 2021 was 1.91 births per woman in non-slums, while this was 2.14 births per woman in slums. The UHS 2013 estimated TFR at 2.01 for slums and 1.74 for non-slums. TFR was 2.5 in slums and 1.9 in non-slums in 2006. Thus, intra-urban difference in TFR between slums and non-slums narrowed from 0.6 births in 2006 to 0.3 births in 2013, and this difference has further narrowed from 0.3 births in 2013 to 0.2 births per woman in 2021.

Figure 10.3: Trends in total fertility rate in slums and non-slums.

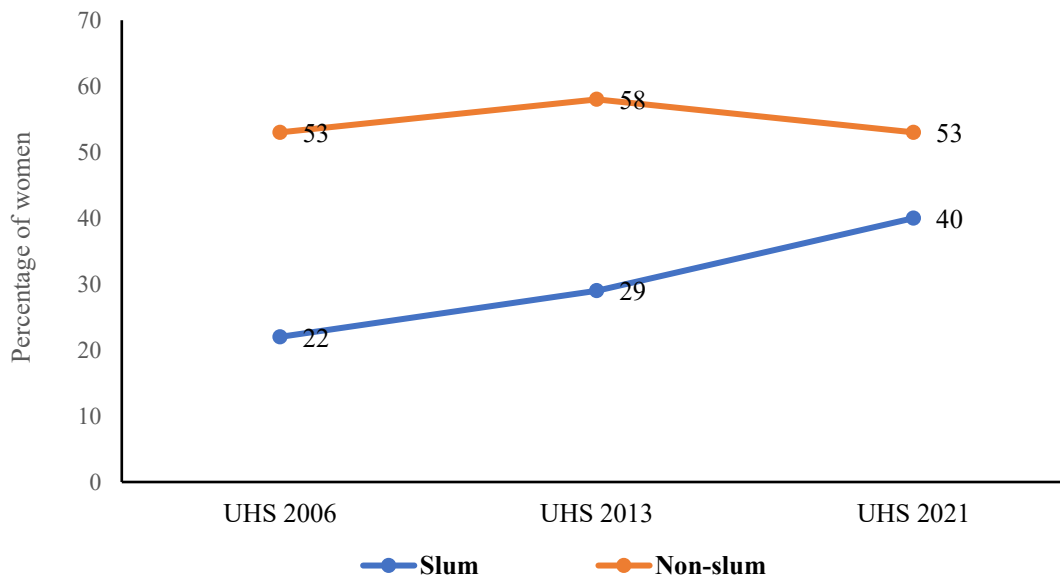


10.2.3 Antenatal Care

Women living in non-slums were most likely to receive at least four ANC (4⁺ ANC) compared to women living in slums. Receiving 4⁺ ANC was 13 percentage points higher in the non-slums at 53.1 percent, while this percentage was 39.8 percent in the slums.

Between 2013 and 2021, the intra-urban differentials in coverage of 4⁺ ANC visits between slums and non-slums increased by 11 percentage points in slums (28.5 to 39.8 percent) and declined by 5 percentage points in non-slums (58 to 53.1 percent). Inequality between slums and non-slums exists in coverage of 4⁺ ANC. Figure 10.4 shows the trends in coverage of 4⁺ ANC in slums and non-slums.

Figure 10.4: Trends in antenatal care (4⁺visits) in slums and non-slums.

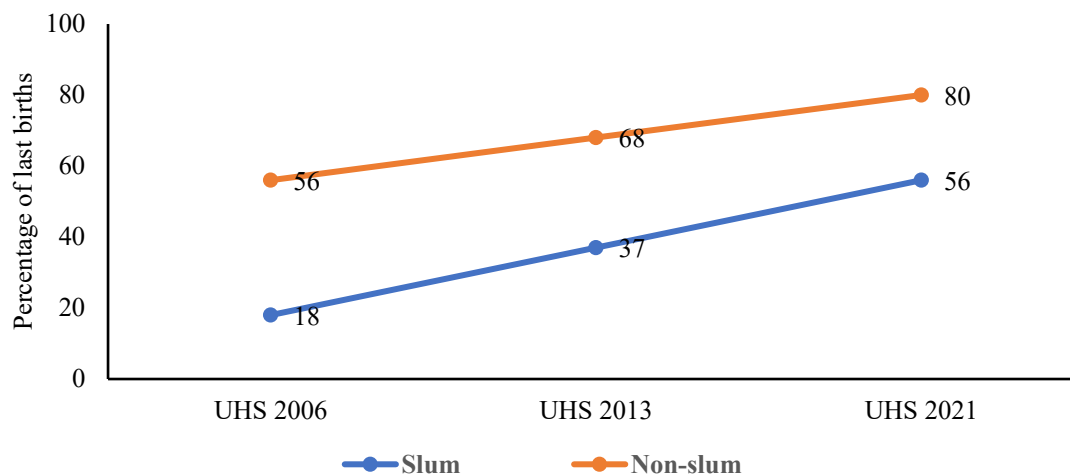


10.2.4 Skilled Birth Attendants

There was large variation in the use of skilled/medically trained birth attendants by place of residence of urban women. In 2021, births among non-slum women were 1.5 times more likely to be assisted by skilled birth attendants. Eight out of ten deliveries (80.2 percent) among women in non-slums were assisted by skilled birth attendants, while this percentage was 56.1 percent among women in slums. In rest urban areas, this was 72.0 percent.

Between 2013 and 2021, births assisted by skilled birth attendants increased by 19 percentage points in slums and 12 percentage points in non-slums. Figure 1.5 shows the trends in deliveries assisted by skilled birth attendants in slums and non-slums.

Figure 10.5: Trends in deliveries assisted by skilled births attendants in slums and non-slums.



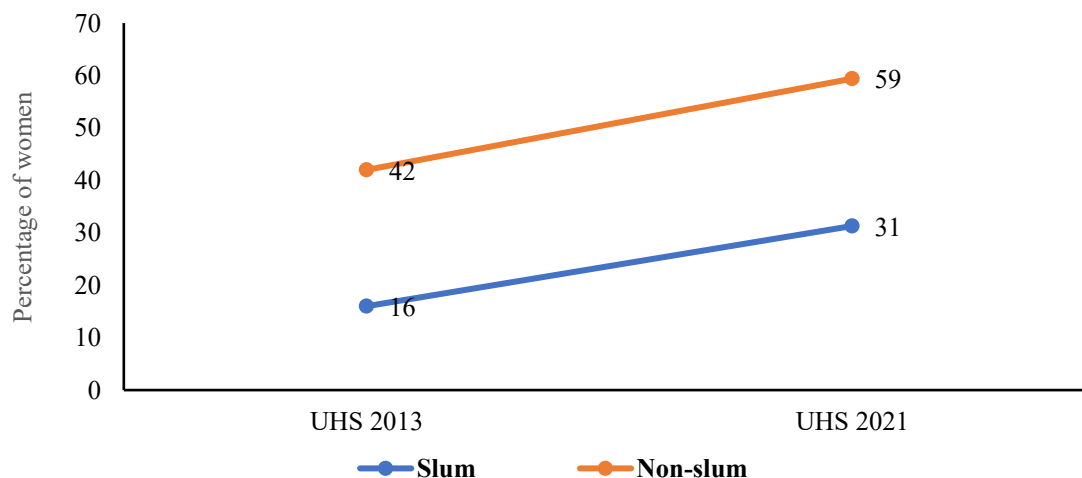
10.2.5 Delivery by C-section

WHO guidelines indicate that at most 15 percent of deliveries may need Caesarean operation (*C-section*). The expected *C-section* rate of 15 percent was exceeded among all the three urban populations, and it was exceedingly high at 59.4 percent in non-slums, 50.5 percent in rest urban, and 31.3 percent in slum areas.

Majority of facility deliveries were done by *C-section*. The proportion of facility births that were delivered by *C-section* in the slums, non-slums and rest urban areas were 58.4, 76.8, and 75.1 percent, respectively.

Between 2013 and 2021, *C-section* delivery increased by 15 percentage points from 16 to 31 percent in the slums, and by 17 percentage points from 42 to 59 percent in the non-slums.

Figure 10.6: Trends in facility deliveries by C-section in slum and non-slum areas.

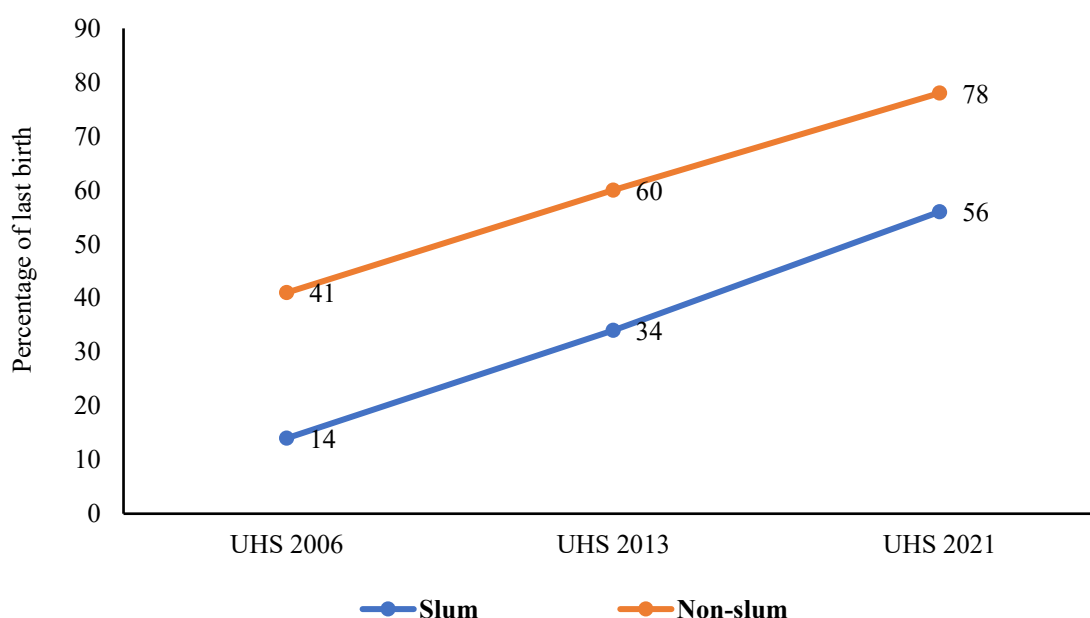


10.2.6 Postnatal Care

Between 2013 and 2021, the percentage of mothers receiving postnatal care (PNC) check-up from a medically trained providers within two days of delivery has increased by 22 percentage points (34 to 55.6 percent) in slums, and by 18 percentage points (60.4 to 78.3 percent) in non-slums.

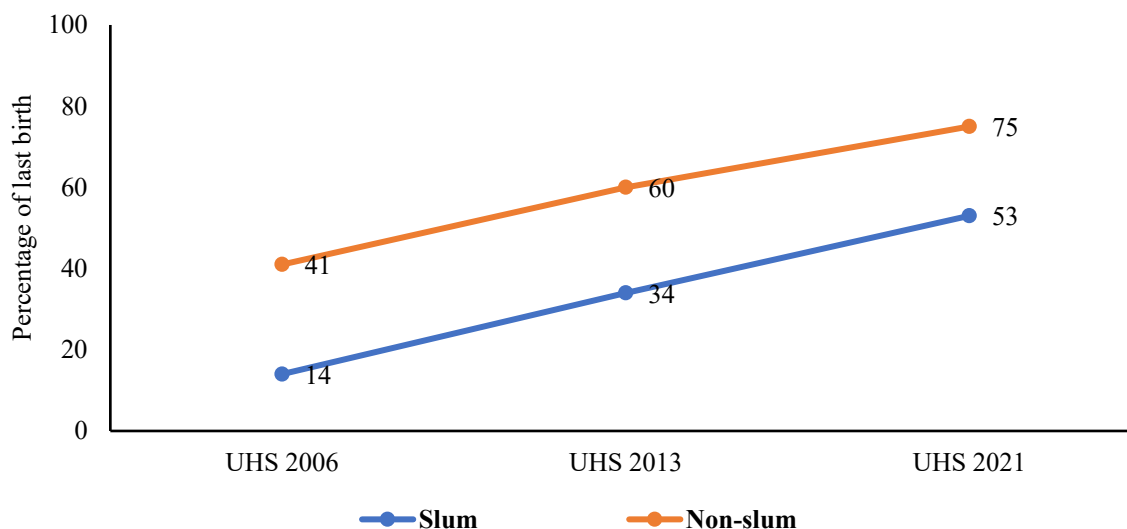
The percentage of mothers receiving PNC check-up from medically trained providers have also increased between 2006 and 2013 from 14 to 34 percent in slums and from 41 to 60.4 percent in non-slums.

Figure 10.7: Trends in PNC for mothers in slums and non-slums.



In all three urban domains, newborns were almost equally likely of their mothers to have received postnatal check-ups within two days of births from a medically trained provider. The percentage of newborns receiving PNC check-ups from medically trained providers doubled between 2013 and 2021 from 27 to 53 percent in slums, and increased 1.5 times from 49 to 75 percent in non-slums. In the rest urban areas, 72 percent of newborns received PNC from a medically trained provider in 2021, while this coverage was 45 percent in 2013. Figure 10.8 shows the trends in postnatal care for newborns from medically trained providers within two days of birth in slums and non-slums.

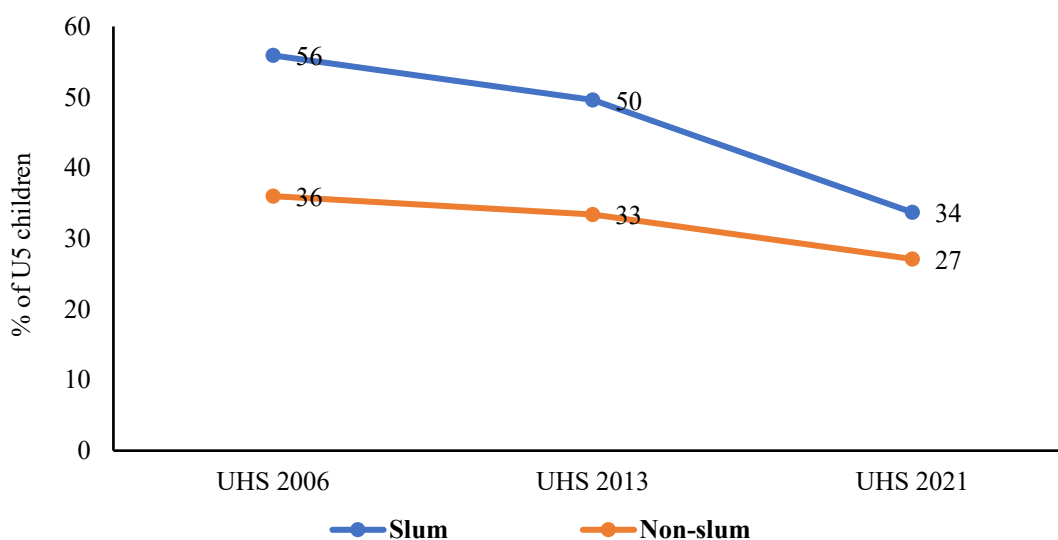
Figure 10.8: Trends in PNC for newborns in slums and non-slums.



10.2.7 Child Nutrition and Stunting

Between 2013 and 2021, intra-urban differential in nutritional status between slum and non-slum children appeared to have improved, but marginally. There is still high level of malnutrition as well as a large inequality between slum and non-slum children. Nutritional status measured by stunting (height-for-age) and wasting (weight-for-height) among children living in slums showed a reduction in stunting by 16 percentage points (50 to 34 percent), and wasting reduced by only one percentage point (19 to 18 percent) between 2013 and 2021. The UHS 2013 estimated prevalence of stunting at 33 percent among children living in non-slum. This has further reduced to 27 percent in 2021.

Figure 10.9: Trends in stunting among children in slums and non-slums



10.3 Concluding Remarks

There has been a steady improvement in the living condition of slum dwellers. Availability and access to basic amenities like electricity is now universal both in slums and non-slums. As regards access to safe drinking water and hygienic sanitation facilities, intra-urban differences substantially narrowed over the years. However, further improvement is needed in reducing the sharing of water source and sanitation facilities.

Although use of family planning methods in slums surpassed that in non-slums, use of long acting and permanent methods is low both in slums and non-slums.

Despite appreciable increase in the utilization of maternal healthcare in the slums, slum population is still lagging behind compared to those in non-slums. This has been reflected in important maternal health indicators. Performance of slum dwellers is considerably low compared to those in non-slums in receiving 4+ ANC, use of skilled birth assistants for delivery, and postnatal care from medically trained providers.

There exists high level of malnutrition as well as a large inequality between slum and non-slum children. Despite having steady improvement in child nutrition both in slums and non-slums in the past decade or so, still a long way to go to reduce the level of malnutrition to an acceptable level and the inequality that prevails between slum and non-slum children.

Household economic condition and cost of healthcare are important determinants of health outcomes. Healthcare services that are available at low or free of cost, intra-urban differential between slum and non-slum is low, and this has been reflected in the use of family planning methods. Bangladesh continues to experience a healthy economic growth as well as reduction in poverty. This has perhaps contributed in increased utilization of healthcare services. Rise in literacy rate and education and NGO activities might have influenced, to some extent, in increased health outcomes, particularly in slums.

Due to prevailing Corona pandemic since March, 2020, a section of slum dwellers and private sector workers with their families had to move from urban cities to rural areas for not being able to earn their livelihoods due to lock-down of work places and no work for day laborers. Moreover, similar to the UHS 2013, the UHS 2021 did not include the smaller/temporary slums in the peripheries of the City Corporations. The slum dwellers in the peripheries are likely to be economically worse off than those in the City Corporations. These factors might have had some effect on the results derived on health outcomes, particularly for the slums.

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APPENDIX A ADDITIONAL TABLES
