BHUTAN: MATERNAL AND REPRODUCTIVE HEALTH AT A GLANCE

Sameh El-Saharty, Naoko Ohno, Intissar Sarker, Federica Secci, and Somil Nagpal

November 2014

KEY MESSAGES:

- Bhutan has reduced poverty levels rapidly and improved human development outcomes in recent years, achieving gender parity in primary and secondary education. It is also slowly opening to outsiders.

- Bhutan has achieved MDG5 and its MMR is now 120 deaths per 100,000 live births.

- Fertility declined to 2.3, while contraceptive prevalence rate increased to 66 percent. Ninety-seven percent of women sought ANC from a qualified provider and nearly 65 percent of births were attended by qualified providers.

- CPR is higher among the poorest quintile than the richest. Large disparities in access to skilled birth attendant remain by geography and wealth quintile.

- Poor nutrition is a serious issue for pregnant mothers, since 55 percent of women are anemic.

- Bhutan would need to focus on increasing the focus on quality along the continuum of care; improving access and equity; and ensuring sustainability of health financing.

Country Context

Bhutan is a small landlocked country in the Himalayas between China and India. Twenty-eight percent of the population of 740,000 is younger than 15. Life expectancy is 67.8 years. Existing for centuries in isolation, Bhutan is slowly opening to outsiders. In 2012 its GDP was $2,399. The economy is based on agriculture, forestry, and hydropower exports.1,2

Poverty reduction has been rapid from about 23 percent in 2007 to 12-13 percent in 2012.3 Extreme poverty, measured as less than $1.25 per day in purchasing power parity, is only 1.6 percent. The primary drivers of rapid poverty reduction are the increasing commercialization of agriculture, the accelerated development of rural infrastructure, including roads, health facilities, and schools, and spillovers from hydro-related construction projects.1,2

Bhutan is progressing in improving human development outcomes. In education, net primary and secondary school enrollment is respectively 90 percent and 56 percent, with a higher proportion of girls enrolled. The country is close to achieving MDG 4 on child survival. The U5MR and IMR have fallen from 130 and 90 per 1,000 live births in 1990 to 44 and 35 in 2012. Immunization coverage measured by DPT and measles is above 90 percent. Chronic malnutrition among children remains high: one in three children is stunted.1,2

Gender equality and women’s empowerment are important determinants of reproductive health. Gender parity in primary and secondary schools has been achieved, while tertiary education requires improvement. Female labor participation is about 90 percent. Bhutan ranks 92 of 148 countries in the Gender Inequality Index.4
BHUTAN: MDG 5 STATUS

**MDG 5A indicators**
- Maternal mortality ratio (MMR; maternal deaths per 100,000 live births) – UN estimate: 120
- Births attended by skilled health personnel (percent): 64.5

**MDG 5B indicators**
- Contraceptive prevalence rate, any method (percent): 65.6
- Adolescent fertility rate (births per 1,000 women ages 15–19) – WDI: 40.9
- Antenatal care with health personnel (percent): 97.3
- Unmet need for family planning (percent): 11.7


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

Bhutan has made excellent progress over the past two decades on maternal health resulting in its achievement of MDG 5. The MMR declined from 900 deaths per 100,000 live births in 1990 to 120 in 2013 (figure 1), reflecting an average annual decline of 8.4 percent.⁵

**Figure 1: Maternal Mortality Ratio 1990-2013 and 2015 Target**

---

**Fertility**

Fertility has been declining. Between 1990 and 2012, the total fertility rate (TFR) fell from 5.6 to 2.3 (figure 2).¹

The contraceptive prevalence rate (CPR) has been increasing over the past 20 years.¹ The CPR (any method) increased from 18.8 percent in 1994 to 65.6 percent in 2010 (Figure 2). Modern methods are the main choice of contraceptives and are used by 65.4 percent of currently married women. Injectables (28.9 percent), male sterilization (12.6 percent), the pill (7.5 percent) and female sterilization (7.1 percent) are the most commonly used form of modern methods. Traditional methods are used by only 0.2 percent of currently married women. There is an unmet need of 11.7 percent.⁶

**Figure 2: Trends in Contraceptive Prevalence Rate (CPR) and Total Fertility Rate (TFR)**

---

**Early Childbearing**

Early childbearing affects maternal health outcomes: 6.7 percent of women were married before age 15 and 30.8 percent before 18. The adolescent fertility rate is 40.9 births per 1,000 women age 15–19. The share of women age 15-19 that have begun childbearing is 16.7 percent; 1.6 percent of women had a live birth before 15 and 15.2 percent before 18.⁶

**Pregnancy Outcomes**

Complete and timely antenatal care (ANC) is a necessary component for positive pregnancy outcomes. As of 2010, 97.3 percent of women had at least one ANC visit from a skilled sought provider; 77.3 percent of women received the recommended four or more ANC visits; 94.7 percent of women had their blood pressure measured (a component in a package of ANC services).⁶

Skilled birth attendance (SBA) is critical reducing maternal deaths. SBA by a medically trained provider has increased from 14.9 percent in 1994 to 64.5 percent in 2010 (figure 3).¹ Of all births, 63.1 percent are delivered in a health facility (63.0 percent in public sector facilities and 0.1 percent in private sector facilities).⁶
Equity in Access to Maternal Health Services

Inequity in access to maternal health services is a barrier toward MDG 5. Little variation in CPR is observed across residence in Bhutan. The CPR is slightly higher in rural than urban area (figure 4).\(^6\)

The CPR pattern across wealth quintiles is unusual. The CPR is higher among the poorest wealth quintile (69 percent) than the richest (62.3 percent) (figure 5).\(^5\)

Larger disparities are found in SBA across residence: 89.5 percent of urban women are assisted during delivery by a medically qualified professional compared with only 54.3 percent of rural women (figure 6).\(^6\)

Considerable variations in SBA also exist among wealth quintiles. Women in the richest quintile were three times more likely than women in the poorest quintile to have SBA. Only 34.3 percent of women in the poorest quintile received SBA compared with 95.1 percent in the richest quintile (figure 7).\(^6\)
Nutrition

Poor nutrition is a serious issue for pregnant mothers in Bhutan: Fifty five percent of Bhutanese women are anemic. The country has undergone a nutrition transition with a shift from traditional diets that included fruits and vegetables to diets that are processed involving more sugar, salt and fats. Migration to cities has also led to more sedentary lifestyles. Underlying factors that contribute to undernutrition are diarrheal diseases and parasitic infections as well as food insecurities in remote areas. Remoteness of villages also affects crop production. Lack of knowledge also contributes to undernutrition.7

Key Strategies to Improve Maternal and Reproductive Health Outcomes

Increasing the focus on quality along the continuum of care by implementing an evidence-based revision of National Standards and Guidelines; retaining healthcare providers’ skills; and monitoring and supervising effectively to track very mother and child during the critical first 1,000 days of life, known as the “golden days,” and beyond.

Improving access and equity by implementing focused interventions to reach the unreached, e.g., the poor, adolescents, and malnourished, particularly focusing on stunting, and neonates.

Ensuring sustainability of health financing by exploring mechanisms to manage the limited fiscal space in the health sector, for example by considering alternative measures such as social marketing for contraceptives and cost sharing mechanisms, e.g., public-private partnerships; strengthening collaboration and coordination at all stakeholder levels, including development partners, the Ministry of Health, the Ministries of Education and Agriculture, for example, and with nongovernmental organizations and civil society organizations; and enhancing human resource capacity at all levels to do more with less, with a special focus on public health, research, and epidemiology.

References:

1 World Bank. World Development Indicators 2014: Accessed 19 May 2014
2 Bhutan: Country Program Snapshot. March 2014, the World Bank
3 National Statistics Bureau. 2012. Bhutan Poverty Analysis
4 UNDP. 2013 Human Development Report Gender Inequality Index
6 Bhutan Multiple Indicator Survey, May 2011, National Statistics Bureau, Thimphu, Bhutan