Pregnancy and birth

Antenatal care, delivery attended by skilled health professionals and access to health facilities for delivery are important for the health of both mothers and their babies as they reduce the risk of birth complications and infections (see indicators on "Infant feeding" in Chapter 4). WHO currently recommends a minimum of eight antenatal contacts (WHO, 2016[1]), and antenatal care coverage has been monitored to ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes by 2030 (Sustainable Development Goal 3.7). Receiving antenatal care at least four times increases the likelihood of receiving effective maternal health interventions during the antenatal period. This is one of the indicators in the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) Monitoring Framework, and one of the tracer indicators of health services for the universal health coverage (SDG indicator 3.8.1)

In Asia-Pacific, seven in ten pregnant women – on average – received the recommended four visits in lower-middle- and low-income countries and territories, but access to antenatal care varies across countries and territories (Figure 5.15, left panel). Malaysia and the Korea have nearly complete coverage of four antenatal visits. At the other end, in Bangladesh and Papua New Guinea the coverage of four antenatal care visits is less than 50%.

The majority of births (99%) in high and upper-middle-income Asia-Pacific are attended by a skilled health professional. This contrasts with lower-middle and low-income countries, where 81.5% of births are attended by a skilled health professional (Figure 5.15, right panel). Skilled birth attendance is relatively low in Papua New Guinea (56.4%), Bangladesh (59%) and Myanmar (60.2%), where home births supported by untrained traditional birth attendants are more common.

In Asia-Pacific, delivery in health facilities varies across countries and territories (Figure 5.16). In Thailand, Mongolia, Viet Nam and DPRK, almost all deliveries take place at a health facility. On the other hand, in Bangladesh, most deliveries occur at home and less than 55% of births takes place in a health facility. Across countries and territories, deliveries in health facilities are more common among mothers giving birth for the first time, or those who have had at least four antenatal visits, as well as among mothers living in urban regions and those with higher education and wealth.

Access to skilled birth attendants varies by socio-economic factors (Figure 5.17). Mongolia, Thailand and DPRK have a high coverage of births attended by skilled health professionals among mothers with different education and income levels, as well as living in different geographical locations. However, in other countries and territories, the coverage of births attended by skilled health professionals is highly unequal among women of different income and education levels. For example, in Lao PDR and Bangladesh, access differs almost three-fold between mothers of the lowest education level and mothers of the highest education levels. Disparity by household income is largest in Lao PDR and Bangladesh, again with almost three-fold difference between mothers living in household at the highest and at the lowest income quintiles. In contrast, differences in access to skilled care at birth remain relatively small between urban and rural areas across countries and territories (except in Lao PDR, Nepal, and Bangladesh).

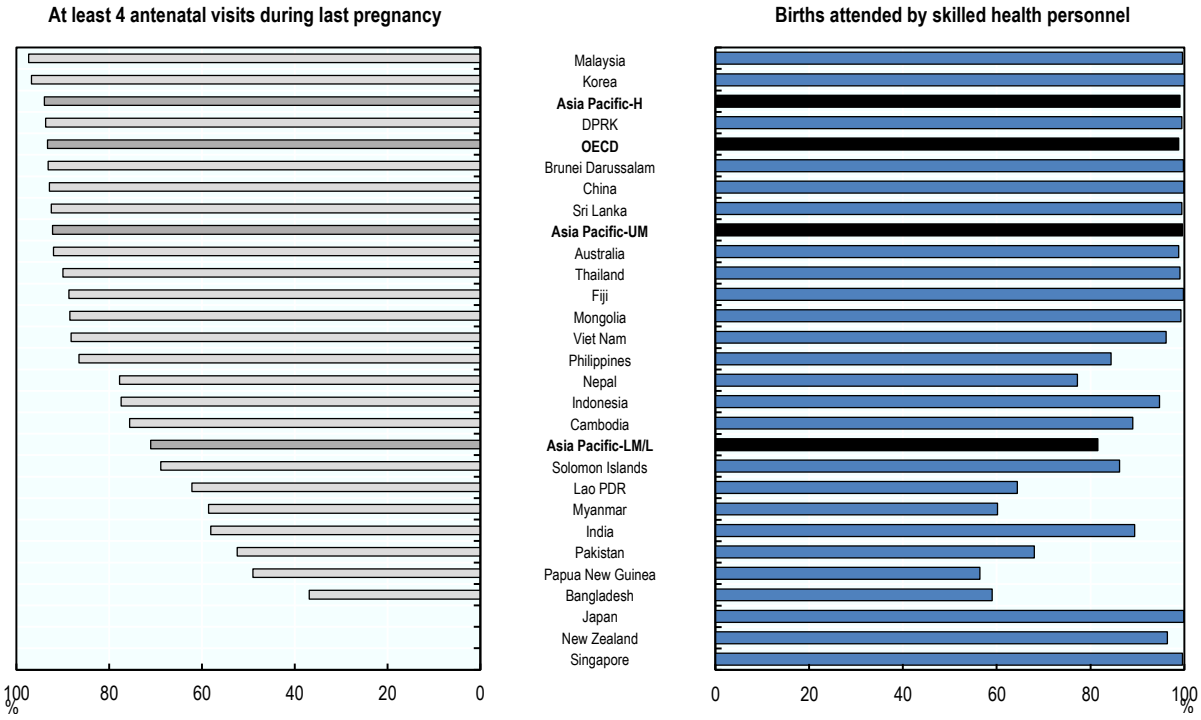
Definition and comparability

The major source of information on care during pregnancy and birth are health interview surveys. Demographic and Health Surveys (DHS), for example, are nationally representative household surveys that provide data for a wide range of indicators in the areas of population, health, and nutrition. Standard DHS Surveys have large sample sizes (usually between 5 000 and 30 000 households) and typically are conducted every five years, to allow comparisons over time. Women who had a live birth in the five years preceding the survey are asked questions about the birth, including how many antenatal care visits they had, who provided assistance during delivery, and where the delivery took place.

References

WHO (2016), *WHO recommendations on antenatal care for a positive pregnancy experience*, World Health Organization, https://apps.who.int/iris/handle/10665/250796. [1]

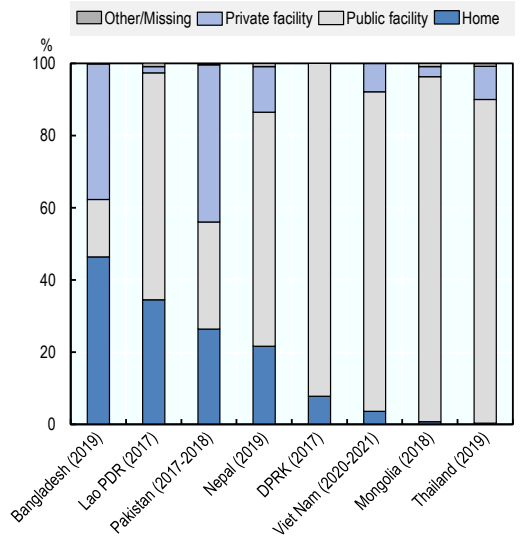
Figure 5.15. Provision of care during pregnancy and birth, 2021 or latest year available



Note: Women included are aged 15-49.
Source: UNICEF 2022.

StatLink https://stat.link/nacobx

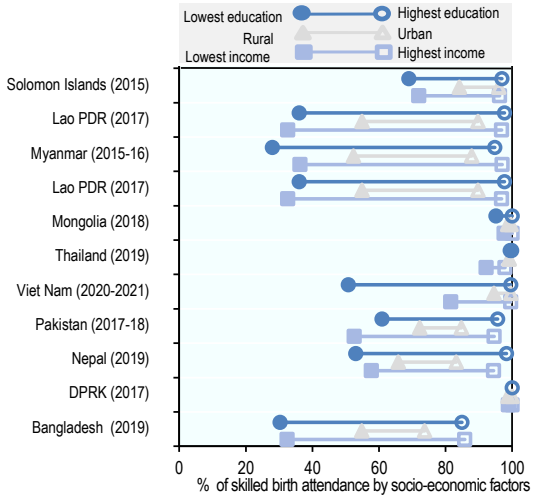
Figure 5.16. Place of delivery, latest year available



Source: DHS and MICS surveys, various years.

StatLink https://stat.link/xyhpls

Figure 5.17. Births attended by skilled health professionals, by socio-economic and geographic factors, latest year available



Source: DHS and MICS surveys, various years.

StatLink https://stat.link/8ydqjb