Bangladesh

Multiple Indicator Cluster Survey 2025

Preliminary Report

MICS
GENERATING EVIDENCE TO DELIVER FOR CHILDREN

Bangladesh Bureau of Statistics
Statistics and Informatics Division
Ministry of Planning

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Bangladesh

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November 2025

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The Bangladesh Multiple Indicator Cluster Survey (MICS) 2025 was implemented by the Bangladesh Bureau of Statistics (BBS) in collaboration with the United Nations Children's Fund (UNICEF), as part of the global MICS programme. Financial contributions were provided by Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The Institute of Epidemiology, Disease Control and Research (IEDCR) and the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) served as technical partners for blood and soil specimen collection and laboratory testing.

Developed by UNICEF in the 1990s, the global MICS programme is an international, multi-purpose household survey initiative that helps countries collect internationally comparable data on the situation of children and women across a wide range of indicators. MICS measures key indicators to inform policies, programmes, and national development plans, and to monitor progress towards the Sustainable Development Goals (SDGs) and other internationally agreed commitments.

This report aims to facilitate the timely dissemination and use of key indicator results from Bangladesh MICS 2025 and to compare them with comparable indicators from MICS 2012–13 and MICS 2019. It also presents selected statistical snapshots.

For more information on the Global MICS Programme, please go to www.mics.unicef.org

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List of Acronyms

ANC	Antenatal Care
BBS	Bangladesh Bureau of Statistics
BLLs	Blood Lead Levels
CAPI	Computer-Assisted Personal Interviewing
CSPro	Census and Survey Processing System
DIRC	Data Interpretation and Report Compilation
icddr,b	International Centre for Diarrhoeal Disease Research, Bangladesh
IEDCR	Institute of Epidemiology, Disease Control and Research
IRB	Institutional Review Board
KMC	Kangaroo Mother Care
MICS	Multiple Indicator Cluster Surveys
PHC	Population and Housing Census
PNC	Postnatal Care
SDC	Swiss Agency for Development and Cooperation
SDGs	Sustainable Development Goals
SID	Statistics and Informatics Division
ToT	Training for Trainers
UNFPA	United Nations Population Fund
UNHCR	United Nations Refugee Agency
WASH	Water, Sanitation, and Hygiene

Foreword

Director General
Bangladesh Bureau of Statistics

The Bangladesh Bureau of Statistics (BBS) has been implementing the Multiple Indicator Cluster Survey (MICS) since 1993. The seventh round of the MICS is being conducted in 2025. This survey serves as a vital source of demographic and health statistics and is designed to uphold global standards in methodology, questionnaire development, survey design, and data collection procedures.

The preliminary report of the MICS presents 172 indicators, of which 27 are related to the Sustainable Development Goals (SDGs). Key indicators include child nutrition, stunting, wasting, child mortality, Infant and Young Child Feeding (IYCF), birth registration, child discipline, child functioning, child marriage, family planning, and fertility, among others. This round of the survey covers a wide range of indicators reflecting overall demographic and health conditions in Bangladesh. In addition, it incorporates aspects of child and maternal nutrition through the testing of blood lead levels of mothers and children.

I would like to express my sincere gratitude to the Secretary of the Statistics and Informatics Division for her valuable guidance and support throughout the survey. The survey was conducted with the support of UNICEF, to whom I extend my heartfelt thanks for their generous assistance to BBS in implementing the survey. I am also grateful to the Institute of Epidemiology, Disease Control and Research (IEDCR) and International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) for their contributions to the survey through blood and soil sample collection and testing. My sincere appreciation goes to the members of the Steering Committee and the Technical Committee for their invaluable contributions, from survey design to the completion of field activities and report preparation. Finally, I would like to acknowledge the Focal Point Officer and his team for their dedicated efforts in ensuring the successful implementation of the survey.

I believe that the results of this survey will assist the Government in formulating policies related to maternal and child health development. Furthermore, the findings will serve as a valuable resource for researchers conducting further studies in the field of health development.

I would appreciate any suggestions and comments for further improvement of the survey and its report.

Dhaka
November 2025

Mohammed Mizanur Rahman

Message

UNICEF Representative in Bangladesh

Reliable data are far more than numbers on a page, they tell us a story, the story of children, families, and communities across Bangladesh. MICS 2025 gives us a clear and compelling picture of the lives of children and women in Bangladesh, a mirror reflecting both how far we have come and how much more must be done for every child. It provides the evidence that decision-makers need to act with urgency and precision to put children at the heart of policies, budgets, and services, while keeping us all accountable as we have more precise information on the needs and challenges affecting children.

This survey's strength lies not only in its methodology and rigour but also in the children and families whose realities it brings to light. Behind every statistic is a child, whose dignity must be respected, whose rights to survive, thrive, and learn. The findings remind us that while progress is possible—as seen in the decline in child marriage—other indicators such as the rise in child labour, worsening child wasting, and alarming levels of caesarean sections are urgent warning signs. These are not abstract challenges; they are daily realities that limit the rights of women and children and threaten their potential.

MICS 2025 also breaks new ground. For the first time, blood lead level testing gives us a clearer picture of environmental threats to children's health. Data on nutrition, disability, learning, and water and sanitation deepen our understanding of what it truly takes for a child to grow up healthy and strong. These insights must now drive targeted investments in maternal and newborn care, nutrition, safe water and sanitation, education, and child protection—so that every child, in every community, has the chance to survive and grow in a safe and healthy environment, and no one is left behind.

This important work was only possible through strong partnership. UNICEF is deeply grateful to the Bangladesh Bureau of Statistics for its leadership; to the families who welcomed the survey teams into their homes; and to our partners—the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, the United Nations Population Fund (UNFPA), and the Institute of Epidemiology, Disease Control and Research (IEDCR) whose support made this round of MICS a reality. We also thank the wider community of development partners and UN agencies working together to strengthen data systems and improve services for every child.

As Bangladesh moves toward its national development goals and the Sustainable Development Goals (SDGs), timely and trusted data is essential. But data alone cannot change lives. It is how we use them that matters. Let us use these findings boldly to shape smarter policies, to focus resources where the needs are greatest, and to bring every child in Bangladesh into the circle of opportunity, protection, and hope.

Dhaka
November 2025

Rana Flowers

Acknowledgment

Director, Demography and Health Wing, BBS
&
Focal Point Officer, MICS 2025

The 'Multiple Indicator Cluster Survey (MICS) 2025' has made possible through the collaborative efforts of numerous institutions and individuals whose dedication and contributions were essential to its successful completion. It is my immense pleasure to acknowledge the contribution of those who were engaged in conducting the survey and preparation of the report MICS 2025. Bangladesh Bureau of Statistics (BBS) conducted the survey in collaboration with the United Nations Children's Fund (UNICEF) using two-stage stratified cluster sampling method. Total of 3149 primary sampling units (PSUs) were selected from where 62,980 households were enumerated. This report presents 172 indicators of which 27 indicators are directly related to Sustainable Development Goals (SDGs). District representative data have been generated with this survey.

We extend our deepest gratitude to Honorable Adviser Dr. Wahiduddin Mahmud, Ministry of Planning; Honorable Secretary Ms. Aleya Akter, Statistics and Informatics Division; Respected Director General Mr. Mohammed Mizanur Rahman, Bangladesh Bureau of Statistics for their valuable suggestions, continuous guidance and all out support for smooth completion of all activities and bringing the report into its final shape.

Special appreciation goes to UNICEF for its technical and financial support throughout all stages of the survey design, training, data collection, analysis, and dissemination of MICS 2025. I take the opportunity to express my indebtedness to Global MICS team, Institute of Epidemiology, Disease Control and Research (IEDCR), International Centre for Diarrheal Disease Research, Bangladesh (icddr,b) for their cooperation and support.

I would like to convey my heartfelt gratitude to Professor Dr. M. Nurul Islam, Pro-Vice Chancellor, World University; Professor Muhammad Shuaib, Institute of Statistical Research and Training (ISRT), University of Dhaka (DU); Professor Dr. Syed Shahadat Hossain, ISRT, DU; Dr Shams El Arifeen, Emeritus Scientist, icddr,b; Professor Dr. Md Aminul Haque, Population Sciences, DU; Professor Dr. Mohd. Muzibur Rahman, Department of Statistics and Data Science, Jahangirnagar University; Professor Dr. Md. Sheikh Giash Uddin, Department of Statistics, Jagannath University; Professor Dr. Mohammad Mainul Islam, Population Sciences, DU for their contributions in finalizing the report.

I am grateful to Mr. Md. Mashud Alam, Joint Secretary and Ex- Focal Point officer of MICS; Mr. Md. Mahabub Alam, Deputy Director, BBS; Mr. Stanley Gwavuya, Chief – SPEAR; Mr. Mahboob E Alam, Statistics and Monitoring Specialist – SPEAR; Mr. Md. Irfan Hossain, National MICS Consultant, UNICEF Bangladesh, all other Consultants related to MICS, all the members of the Steering, Technical and Core Committee, all the members of Bangladesh MICS 2025 team, the field supervisors, enumerators, and all respondents, whose professionalism and dedication for their technical inputs and kind cooperation in conducting the survey.

Finally, I thank all individuals and organizations both governmental and non-governmental who contributed to the success of the MICS 2025. Their collective efforts will help guide policies and programs that improve the lives of women and children across the whole country. I hope this report will be very useful for the policy-makers, planners, researchers, development partners and other stakeholders to take national development priorities and policy needs. All the indicators generated by this survey will also be useful to monitor the progress of SDGs and other governmental plan of Bangladesh. Suggestions and comments for further improvement will be highly appreciated.

Dhaka
November 2025

Md. Emdadul Haque

Introduction

Bangladesh's Multiple Indicator Cluster Survey (MICS) 2025 provides the country's most comparable snapshot of the situation of children, adolescents, women, and households, aligned to global standards and national priorities. Developed and supported by UNICEF, MICS has grown over three decades from 28 indicators in its first round to more than 200 in MICS7 and now underpins monitoring of child protection, early learning, health and nutrition, and progress towards the SDGs.

Bangladesh MICS 2025 is linked to national plans and the SDG framework. Estimates are produced for the nation, eight divisions, all 64 districts, and three City Corporations, enabling equity-focused decisions closest to service delivery. Key features include:

- A nationally representative sample of 62,980 households drawn from the 2022 Population and Housing Census frame.
- One hundred seventy-two (172) standard indicators, including 27 SDG indicators, with disaggregation by sex, residence, division, wealth and disability/functioning where relevant.
- Rapid water-quality testing (arsenic, *E. coli* and salinity) in 6,106 households with quality-control blank testing.
- Biomarkers: blood samples from 10,667 children aged 12–59 months, and 1,940 pregnant women for anaemia and heavy-metal markers (including lead levels in blood).

This Preliminary Report distils headline results across child health and development, nutrition, education and learning, WASH, social protection, child protection, and safe/clean environments; highlighting progress, gaps, and inequities. It complements detailed statistical tables and a set of Statistical Snapshots for rapid policy use.

The Bangladesh Bureau of Statistics (BBS), under the guidance of Statistics and Informatics Division (SID), Ministry of Planning implements MICS 2025 with technical and financial support from UNICEF. A national Steering Committee provides oversight led by the Secretary, a Technical Committee, with specialized committees for methodology and sampling, water quality, and heavy metals and anaemia, ensuring methodological rigor from design through dissemination.

Four core questionnaires (Household; Women 15–49; Children 5–17; Under-5) and three supplementary instruments support water-quality testing and blood testing among children 12-59 months and pregnant women. Foundational learning (7–14), child and adult functioning, social transfers, energy use, hygiene, and other MICS7 modules are included. All tools are adapted from the MICS7 model, translated into Bangla, back translated, and pre-tested.

A two-stage stratified cluster design is used. Simulation work with MICS 2019 informed a uniform allocation of about 940 households per domain, maintaining district-level precision. Twenty households per cluster yield 3,149 clusters (62,980 households). Two households per cluster are selected for water testing. Field teams (five interviewers, one measurer, one porter, one phlebotomist, one supervisor) target one cluster per day. Main data collection was conducted during mid-February to mid-June 2025 using CAPI.

Quality assurance comprised mandatory re-interviews, weekly field-check tables, structured supervision, and monthly quality-control visits. Data were processed in CSPro (MICS7 CAPI), and analyses were conducted in SPSS using design weights with Taylor linearisation. MICS protection protocols governed informed consent, confidentiality, and safeguards for sensitive topics. Ethical approval for biomarker collection was obtained from icddr,b's Institutional Review Board (IRB).

A national Data Interpretation and Report Compilation (DIRC) workshop convenes government, academia, and partners to validate and co-draft narratives, followed by a high-profile national launch.

The chapters that follow present concise indicators and trends, disaggregated to make inequities visible and actionable. By pairing internationally comparable methods with Bangladesh-specific innovations, such as rapid water testing, and first-ever national biomarker surveillance for lead and anaemia, MICS 2025 provides the evidence to target resources, sharpen programmes, and uphold every child's right to survive and thrive.

A Summary of the Survey

SUMMARY TABLE OF SURVEY IMPLEMENTATION AND THE SURVEY POPULATION			
SURVEY SAMPLE AND IMPLEMENTATION			
Sampling Frame	Population and Housing Census 2022	**Questionnaires**	1. Household 2. Women (age 15-49) 3. Children under five 4. Children age 5-17 5. Water Quality Testing 6. Heavy Metal and Anaemia
Training for Trainers (ToT)	13 Dec 2024 – 2 Jan 2025	**Field Team Training**	21 Jan – 18 Feb 2025
Listing Operation	Oct – Nov 2024	**Fieldwork**	24 Feb – 30 Jun 2025

Survey Sample			
Households		**Water Quality Testing**	
▪ Sampled	62,980	▪ Eligible	6,298
▪ Occupied	61,470	▪ Interviewed	6,106
▪ Interviewed	61,207	▪ Response rate (Per cent)	99%
▪ Response rate (Per cent)	99%		
Women (age 15-49)		**Pregnant women (blood)**	
▪ Eligible for interviews	67,246	▪ Eligible for Interview	2,711
▪ Interviewed	64,405	▪ Interviewed	1,940
▪ Response rate (Per cent)	96%	▪ Response rate (Per cent)	73%*
Children under five		**Children 12-59 months (blood)**	
▪ Eligible	24,680	▪ Eligible for Interview	17,132
▪ Mothers/caretakers interviewed	23,357	▪ Interviewed	10,667
▪ Response rate (Per cent)	95%	▪ Response rate (Per cent)	65%*
Children age 5-17			
▪ Eligible	37,671		
▪ Mothers/caretakers interviewed	36,709		
▪ Response rate (Per cent)	97%		
Survey Population			
Average household size	4.1	**The percentage of the population living in**	
		▪ Rural areas	71%
		▪ Urban areas	29%

*Heavy Metal and Anaemia response rate(s) will be addressed in the upcoming Survey Findings Report (SFR) in consultation with experts.

Key Indicators

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
MICS7 Base[4] Questionnaire Indicator and definitions							
SAMPLE COVERAGE AND CHARACTERISTICS OF THE RESPONDENTS							
SR.1	Access to consistent sources of electricity	7.1.1	HC	Percentage of household members with access to consistent sources of electricity	61.5	92.2	98.3
SR.18	Children's living arrangements		HL	Percentage of children age 0-17 years living with neither biological parent	3.8	4.1	4.6
SR.19	Prevalence of children with one or both parents dead		HL	Percentage of children age 0-17 years with one or both biological parents dead	4.3	4.0	3.2
SR.20	Children with at least one parent living abroad		HL	Percentage of children age 0-17 years with at least one biological parent living abroad	4.8	7.6	11.6
SURVIVE [5]							
CS.1	Neonatal mortality rate	3.2.2	BH	Probability of dying within the first month of life	NA	26	22
CS.2	Post-neonatal mortality rate		BH	Difference between infant and neonatal mortality rates	NA	8	7
CS.3	Infant mortality rate		CM / BH	Probability of dying between birth and the first birthday	46	34	29
CS.4	Child mortality rate		BH	Probability of dying between the first and the fifth birthdays	NA	6	5
CS.5	Under-five mortality rate	3.2.1	CM / BH	Probability of dying between birth and the fifth birthday	58	40	33

1 Sustainable Development Goal (SDG) Indicators, http://unstats.un.org/sdgs/indicators/indicators-list/. Metadata for the SDG Indicators are regularly updated. MICS covers many SDG indicators with an exact match of their definitions, while some indicators are only partially covered. The latter cases are included here as long as the current international methodology allows only for the MICS Indicator definition, and/or a significant part of the SDG Indicator can be generated by the MICS Indicator. For more information on the metadata of the SDG Indicators, see http://unstats.un.org/sdgs/metadata/

2 Some indicators are constructed using questions in more than one topic/module in the MICS questionnaires. In such cases, only the topic(s)/module(s) which contain(s) most of the necessary information is indicated.

3 All MICS indicators are or can be disaggregated, where relevant, by wealth quintiles, sex, age, ethnicity, migratory status, disability, and geographic location (as per the reporting domains), or other characteristics, as recommended by the Inter-agency and Expert Group on SDG Indicators: Global indicator framework for the Sustainable Development Goals and targets of the 2030 Agenda for Sustainable Development

4 The MICS7 List of Indicators is split between indicators captured in the Base Questionnaires and a List of Indicators available through the Complementary Topics.

5 Mortality indicators are calculated for the last 5-year period.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
THRIVE - REPRODUCTIVE, MATERNAL, NEWBORN, AND ADULT HEALTH							
TM.1b	Adolescent birth rate	3.7.2	CM / BH	Age-specific fertility rate for women age (15-19 years)	83	83	92
TM.1.1	Total fertility rate		CM / BH	Total fertility rates (women age 15-49 years) for the three years preceding the survey	2.3	2.3	2.4
TM.2	Early childbearing		CM / BH	Percentage of women age 20-24 years who have had a live birth before age 18	24.4	24.2	22.3
TM.3	Contraceptive prevalence rate		CP	Percentage of women age 15-49 years currently married who are using (or whose partner is using) a (modern or traditional) contraceptive method	61.8	62.7	58.2
TM.4	Need for family planning satisfied with modern contraception	3.7.1 & 3.8.1	UN	Percentage of women age 15-49 years currently married and have their need for family planning satisfied with modern contraceptive methods	81.7	77.4	73.5
TM.5a TM.5b TM.5c	Antenatal care coverage	3.8.1	MN	Percentage of women age 15-49 years with a live birth in the last 2 years who during the pregnancy of the most recent live birth were attended a) at least once by skilled health personnel b) at least four times by any provider c) at least eight times by any provider	a) 58.7 b) 24.7 c) NA	a) 75.2 b) 36.9 c) 4.9	a) 89.7 b) 43.3 c) 5.5
TM.6	Content of antenatal care		MN	Percentage of women age 15-49 years with a live birth in the last 2 years who, during the pregnancy of the most recent live birth, at least once, had blood pressure measured and gave urine and blood samples as part of antenatal care	38.0	58.0	75.7
TM.8	Institutional deliveries		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was delivered in a health facility	31.0	53.4	71.0
TM.9	Skilled attendant at delivery	3.1.2	MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was attended by skilled health personnel	43.5	59.0	77.0

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TM.10	Caesarean section		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was delivered by cesarean section	19.1	36.0	51.8
THRIVE - CHILD HEALTH, NUTRITION, AND DEVELOPMENT							
TC.44a TC.44b	Underweight prevalence		AN	Percentage of children under age 5 who fall below: a) minus two standard deviations (moderate and severe) b) minus three standard deviations (severe) of the median weight for age of the WHO standard	a. 31.9 b. 8.8	a. 22.6 b. 5.2	a. 23.0 b. 5.0
TC.45a TC.45b	Stunting prevalence	2.2.1	AN	Percentage of children under age 5 who fall below: a) minus two standard deviations (moderate and severe) b) below minus three standard deviations (severe) of the median height for age of the WHO standard	a. 42.0 b. 16.4	a. 28.0 b. 8.8	a. 24.0 b. 6.3
TC.46a TC.46b	Wasting prevalence	2.2.2	AN	Percentage of children under age 5 who fall below: a) minus two standard deviations (moderate and severe) b) minus three standard deviations (severe) of the median weight for height of the WHO standard	a. 9.6 b. 1.6	a. 9.8 b. 2.3	a. 12.9 b. 2.5
TC.47a TC.47b	Overweight prevalence	2.2.2	AN	Percentage of children under age 5 who are above: a) two standard deviations (moderate and severe) b) three standard deviations (severe) of the median weight for height of the WHO standard	a. 1.6 b. NA	a. 2.4 b. 0.8	a. 1.8 b. 0.6
TC.49a TC.49b TC.49c	Early stimulation and responsive care		EC	Percentage of children age 24-59 months engaged in four or more activities to provide early stimulation and responsive care in the last 3 days with: a) Any adult household member b) Father c) Mother	a. 78.0 b. 10.1 c. 40.8	a. 62.9 b. 10.9 c. 46.9	a. 35.1 b. 2.6 c. 27.2
TC.50	Availability of children's books		EC	Percentage of children under age 5 who have three or more children's books	8.8	6.1	7.6

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TC.51	Availability of playthings		EC	Percentage of children under age 5 who play with two or more types of playthings	60.3	66.5	76.5
TC.52	Inadequate supervision		EC	Percentage of children under age 5 left alone or under the supervision of another child younger than 10 years of age for more than one hour at least once in the last week	7.7	11.2	13.1
TC.53	Early childhood development index 2030[6]	4.2.1	EC	Percentage of children age 2-4 years who are developmentally on track in health, learning, and psychosocial well-being	NA	NA	70.9
TC.53	Early childhood development index	4.2.1	EC	Percentage of children age 3-4 years who are developmentally on track in health, learning, and psychosocial well-being	63.9	74.5	NA
LEARN AND ACQUIRE SKILLS							
LN.1	Attendance in early childhood education		UB	Percentage of children age 36-59 months who are attending an early childhood education programme	13.4	18.9	16.6
LN.2	Participation rate in organised learning (one year before the official primary entry age) (adjusted)	4.2.2	ED	Percentage of children in the relevant age group (one year before the official primary school entry age) who are attending an early childhood education programme or primary school	NA	77.4	79.6
LN.3	School readiness		ED	Percentage of children attending the first grade of primary school who attended an early childhood education programme during the previous school year	43.5	72.7	77.5
LN.4	Net intake rate in primary education		ED	Percentage of children of school-entry age who enter the first grade of primary school	33.1	61.4	59.8
LN.5a LN.5b LN.5c	Net attendance rate (adjusted)		ED	Percentage of children of: a) primary school age, currently attending primary, lower, or upper secondary school b) lower secondary school age, currently attending lower secondary school or higher c) upper secondary school age, currently attending upper secondary school or higher	a. 73.2 b. NA c. NA	a. 85.9 b. 57.8 c. 48.1	a. 84.3 b. 59.6 c. 50.5

6 The updated version of the index considers data to report on the percentage of children aged 24 to 59 months who are developmentally on track in areas like literacy, numeracy, and social-emotional learning.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LN.6a LN.6b LN.6c	Out-of-school rate		ED	Percentage of children of : a) primary school-age children who are not attending any level of education b) lower secondary school-age students who are not attending any level of education c) upper secondary school age who are not attending any level of education	a. 26.8 b. NA c. NA	a. 6.4 b. 13.1 c. 31.5	a. 6.7 b.13.0 c.33.6
LN.7a LN.7b	Gross intake ratio to the last grade		ED	Ratio of children attending the last grade for the first time to children at the appropriate age for the last grade: a) Primary school b) Lower secondary school	a. NA b. NA	a. 89.5 b. 84.8	a. 86.3 b.72.0
LN.8a LN.8b LN.8c	Completion rate	4.1.2	ED	Percentage of children age 3-5 years above the intended age for the last grade who have completed that grade: a) Primary school b) Lower secondary school c) Upper secondary school	a. 79.5 b. NA c. NA	a. 82.6 b. 64.7 c. 29.4	a. 83.8 b. 69.3 c. 43.8
LN.9	Effective transition rate to lower secondary school		ED	Percentage of children attending the last grade of primary school during the previous school year and not repeating in the current school year who are attending the first grade of lower secondary school in the current school year	94.7	94.5	93.9
LN.10a LN.10b	Over-age for grade		ED	Percentage of children attending school who are at least 2 years above the intended age for the grade: a) Primary school b) Lower secondary school	a. NA b. NA	a. 9.0 b. 13.2	a. 8.4 b. 10.0
LN.11a LN.11b LN.11c	Education Parity Indices (a) Gender (b) Wealth Area	4.5.1	ED	Net attendance rate (adjusted) for girls divided by net attendance rate (adjusted) for boys: a) Organised learning (one year younger than the official primary school entry age) b) Primary school c) Lower secondary school d) Upper secondary school	a. NA b.1.07 c. NA d. NA	a. 1.04 b. 1.06 c. 1.26 d. 1.24	a. 1.04 b. 1.07 c. 1.36 d. 1.21

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LN.11a LN.11b LN.11c	Education Parity Indices (a) Gender (b) Wealth Area	4.5.1	ED	Net attendance rate (adjusted) for children in the poorest wealth quintile divided by net attendance rate (adjusted) for children in the richest wealth quintile: a) Organised learning (one year younger than the official primary school entry age) b) Primary school c) Lower secondary school d) Upper secondary school	a. NA b. 0.79 c. NA d. NA	a. 0.82 b. 0.92 c. 0.58 d. 0.45	a. 0.85 b. 0.94 c. 0.64 d. 0.49
LN.11a LN.11b LN.11c	Education Parity Indices (a) Gender (b) Wealth Area	4.5.1	ED	Net attendance rate (adjusted) for children in rural areas divided by net attendance rate (adjusted) for children in urban areas: a) Organised learning (one year younger than the official primary school entry age) b) Primary school c) Lower secondary school d) Upper secondary school	a. NA b. 0.94 c. NA d. NA	a. 0.96 b. 1.00 c. 0.92 d. 0.89	a. 1.04 b. 1.03 c. 1.00 d. 0.91
				Percentage of girls with foundational learning skills divided by percentage of boys with foundational learning skills: a) Reading, age 7-14 years b) Numeracy, age 7-14 years c) Reading, age for grade 2/3 d) Numeracy, age for grade 2/3 e) Reading, attending grade 2/3 f) Numeracy, attending grade 2/3	NA	NA	a. 1.2 b. 1.03 c. 1.00 d. 1.04 e. 1.04 f. 0.91
				Percentage of children with foundational learning skills in the poorest wealth quintile divided by percentage of children with foundational learning skills in the richest wealth quintile: a) Reading, age 7-14 years b) Numeracy, age 7-14 years	NA	NA	a. 0.50 b. 0.46
				Percentage of children with foundational learning skills in rural areas divided by percentage of children with foundational learning skills in urban areas: a) Reading, age 7-14 years b) Numeracy, age 7-14 years	NA	NA	a. 0.86 b. 0.82

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LN.19	Reading habit at home		FL	Percentage of children age 7-14 years who read books or are read to at home	NA	93.3	93.8
LN.20	School and home languages		FL	Percentage of children age 7-14 years attending school who at home speak the language that teachers use at school at home	NA	99.1	98.8
LN.22a LN.22b LN.22c LN.22d LN.22e LN.22f	Children with foundational reading and numeracy skills	4.1.1	FL	Percentage of children who completed three foundational reading tasks: a) Age 7-14 years b) Age for grade 2/3 c) Attending grade 2/3 Percentage of children who completed four foundational numeracy tasks: a) Age 7-14 years b) Age for grade 2/3 c) Attending grade 2/3	NA NA	a. 48.8 b. 20.2 c. 24.6 a. 27.9 b. 9.8 c. 12.6	a. 50.1 b. 24.4 c. 28.6 a. 39.2 b. 18.2 c. 21.2
LN.604	Households with a radio		HC	Percentage of households that have a radio	3.9	0.6	0.2
LN.605	Households with a television		HC	Percentage of households that have a television	37.7	50.6	40.4
LN.606	Households with a telephone		HC IC	Percentage of households that have a telephone (fixed line or mobile phone)	87.2	95.9	97.0
LN.607	Households with a computer		HC	Percentage of households that have a computer	3.4	5.6	6.1
LN.608	Households with internet		HC	Percentage of households that have access to the internet by any device from home	NA	37.6	72.1
LN.609	Use of a computer		IC	Percentage of women age 15-49 years who used a computer during the last 3 months	NA	1.9	2.9
LN.610a LN.610b	Ownership of a mobile phone	5.b.1	IC	Percentage of women age 15-49 years who own a a) mobile phone b) smartphone	NA	71.4	a. 72.2 b. 44.2
LN.611	Use of a mobile phone		IC	Percentage of women age 15-49 years who used a mobile telephone during the last 3 months	NA	97.8	95.4
LN.612a LN.612b	Use of the internet	17.8.1	IC	Percentage of women age 15-49 years who used the internet: a) during the last 3 months b) at least once a week during the last 3 months	NA	a.12.9 b.11.5	a. 48.3 b. 41.7

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LN.613a LN.613b	ICT skills[7]	4.4.1	IC	Percentage of women who have carried out at least one specific computer-related activity during the last 3 months: a) age 15-24 b) age 15-49	NA	NA	a. 37.6 b. 26.0
LN.613a LN.613b	ICT skills	4.4.1	IC	Percentage of women who have carried out at least one specific computer-related activity during the last 3 months: a) age 15-24 b) age 15-49	NA	a.2.3 b.1.4	NA
PROTECTED FROM VIOLENCE AND EXPLOITATION							
PR.2	Violent discipline	16.2.1	UCD – FCD	Percentage of children age 1-14 years who experienced any physical punishment and/or psychological aggression by adult household members in the past one month a) 5-9 b) 10-14	82.3 a. 86.6 b. 80.7	88.8 a. 92.6 b. 85.7	85.7 a. 89.8 b. 80.9
PR.3	Child labour	8.7.1	CL	Percentage of children age 5-17 years who are involved in child labour[8]	NA	6.8	9.2
PR.4a PR.4b	Child marriage	5.3.1	MA	Percentage of women age 20-24 years who were first married: a) before age 15 b) before age 18	a. 18.1 b. 52.3	a. 15.5 b. 51.4	a. 13.4 b. 47.2
PR.5	Young people age 15-19 years are currently married		MA	Percentage of women age 15-19 years who are married	34.3	32.9	38.9
PR.6	Polygyny		MA	Percentage of women age 15-49 years who are in a polygynous union	4.2	3.1	2.1
PR.7a PR.7b	Spousal age difference		MA	Percentage of women who are married and whose spouse is 10 or more years older: a) age 15-19 years b) age 20-24 years	a. 20.4 b. 21.8	a. 30.8 b. 27.9	a. 23.8 b. 25.7

7 From the 7th Round of MICS, the ICT Skills is calculated based on 11 different computer related activities where as earlier it was calculated on the basis of 9 computer related activities

8 Child labourers are defined as children involved in economic activities or in household chores above the age-specific thresholds. While the concept of child labour includes exposure to hazardous working conditions, and this is collected in MICS and was previously included in the reported indicator, the present definition, which is also used for SDG reporting, does not include children who are working under hazardous conditions. Refer to tables for more detailed information on thresholds and classifications.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LIVE IN A SAFE AND CLEAN ENVIRONMENT							
WS.1	Use of improved drinking water sources		WS	Percentage of household members using improved sources of drinking water	97.9	98.5	99.0
WS.2	Use of at least basic drinking water services	1.4.1 & 6.1.1	WS	Percentage of household members using improved sources of drinking water either on premises (within their dwelling/yard/plot) or within 30 30-minute round-trip collection time	94.6	98.0	98.6
WS.2a	Use of improved water sources on premises	6.1.1	WS	Percentage of household members using improved sources of drinking water on premises (within their dwelling/yard/plot)	NA	NA	85.9
WS.2b	Use of an improved water source with water available when needed	6.1.1	WS	Percentage of household members with an improved water source with sufficient drinking water available when needed in the last month	NA	96.9	99.0
WS.3a	Availability of drinking water in the last month	6.1.1	WS	Percentage of household members with a water source with sufficient drinking water available when needed in the last month	NA	NA	100.0
WS.3b	Availability of drinking water in the last 12 months		WS	Percentage of household members with a water source with sufficient drinking water available when needed in the last 12 months	NA	NA	100.0
WS.4	Faecal contamination of source water		WQ	Percentage of household members whose source water was tested and with *E. coli* contamination in the source water (point of collection)	41.7	40.3	47.2
WS.4a	Use of an improved water source free from faecal contamination	6.1.1	WQ	Percentage of household members with an improved drinking water source and with no *E.coli* contamination in the source water (point of collection)	NA	NA	46.9
WS.5	Faecal contamination of household drinking water		WQ	Percentage of household members whose household drinking water was tested and with *E. coli* contamination in household drinking water (point of use)	61.7	81.9	84.9
WS.6	Use of safely managed drinking water services	6.1.1	WS – WQ	Percentage of household members with an improved drinking water source on premises, whose source water was tested and free of *E. coli,* and available when needed	52.8	47.9	42.4

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
WS.7	Handwashing facility with water and soap at home	1.4.1 & 6.2.1	HW	Percentage of household members with a handwashing facility at home where water and soap or detergent are present	59.1	74.8	68.6
WS.701	Bathing facility on premises with water		HW	Percentage of household members with a bathing facility on premises (within their dwelling/yard/plot) and with water available	NA	NA	78.9
WS.8	Use of improved sanitation facilities		WS	Percentage of household members using improved sanitation facilities	76.9	84.6	91.7
WS.9	Use of basic sanitation services	1.4.1 & 3.8.1 & 6.2.1	WS	Percentage of household members using improved sanitation facilities that are not shared with other households	55.9	64.4	72.9
WS.10	Safe disposal in situ of waste/excreta from improved on-site sanitation facilities	6.2.1	WS	Percentage of household members with improved on-site sanitation facilities from which waste/excreta has never been emptied or has been emptied and buried in a covered pit	NA	90.7	75.8
WS.11	Removal of waste/ excreta from improved on-site sanitation facilities for treatment off-site	6.2.1	WS	Percentage of household members using an improved on-site sanitation facility from which waste/excreta has been removed off-site for treatment	NA	1.5	0.5
WS.12	Safe containment of waste/excreta in improved sanitation facilities	6.2.1	WS	Percentage of household members with improved sanitation facilities with waste/excreta safely contained in the last year	NA	NA	23.7
WS.13	Safely managed on-site sanitation	6.2.1	WS	Percentage of household members with improved on-site sanitation facilities where waste is safely disposed of in situ (excluding shared and inadequately contained)	NA	NA	0.3
EQUITABLE CHANCE IN LIFE							
EQ.1	Children with functional difficulty		UCF – FCF	Percentage of children age 2-17 years reported with functional difficulty in at least one domain	NA	7.3	5.2
MICS7 Complementary Topics Indicators and definitions							
SAMPLE COVERAGE AND CHARACTERISTICS OF THE RESPONDENTS							
SR.601	Primary reliance on clean fuels and technologies for cooking		EU	Percentage of household members with primary reliance on clean fuels and technologies for cooking (living in households that reported cooking)	NA	NA	24.2

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
SR.603	Primary reliance on clean fuels and technologies for lighting		EU	Percentage of household members with primary reliance on clean fuels and technologies for lighting (living in households that reported the use of lighting)	NA	NA	99.4
SR.604	Primary reliance on clean fuels and technologies for cooking and lighting	7.1.2	EU	Percentage of household members with primary reliance on clean fuels and technologies for cooking, space heating and lighting[9]	NA	NA	24.2
THRIVE - REPRODUCTIVE, MATERNAL, NEWBORN, AND ADULT HEALTH							
TM.3	Contraceptive prevalence rate		CP	Percentage of women age 15-49 years currently married who are using (or whose partner is using) a (modern or traditional) contraceptive method	61.8	62.7	58.2
TM.4	Need for family planning is satisfied with modern contraception[10]	3.7.1 & 3.8.1	UN	Percentage of women age 15-49 years who have their need for family planning satisfied with modern contraceptive methods	81.7	77.4	73.5
TM.11	Children are weighed at birth		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live-born child was weighed at birth	35.9	51.9	73.4
TM.11a	Children without a reported birthweight		MN	Percentage of women age 15-49 years with a live birth in the last 2 years for whom a valid birthweight was not reported (from record or recall) for the most recent live-born child	NA	NA	26.6
TM.12	Post-partum stays in a health facility		PN	Percentage of women age 15-49 years with a live birth in the last 2 years and delivered the most recent live birth in a health facility who stayed in the health facility for 12 hours or more after the delivery	82.8	87.4	87.4
TM.13	Post-natal health check for the newborn		PN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live-born child received a health check while in a facility or at home following delivery, or a post-natal care visit within 2 days after delivery	41.2	66.7	72.7
TM.14	Newborns dried		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live-born child was dried after birth	NA	94.2	91.0

9 Household members living in households that report no cooking, no space heating, or no lighting are not excluded from the numerator.
10 Refer to tables for a detailed description.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TM.15	Skin-to-skin care		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live-born child was placed on the mother's bare chest after birth	NA	4.7	6.6
TM.16	Delayed bathing		MN	Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live-born child was first bathed more than 24 hours after birth	NA	80.1	85.8
TM.17	Cord cut with a clean instrument		MN	Percentage of women age 15-49 years with a live birth in the last 2 years and delivered the most recent live-born child outside a facility whose umbilical cord was cut with a new blade or boiled instrument	NA	97.3	91.0
TM.18	Nothing harmful was applied to the cord		MN	Percentage of women age 15-49 years with a live birth in the last 2 years and delivered the most recent live-born child outside a facility who had nothing harmful applied to the cord	NA	61.3	65.3
TM.19	Post-natal signal care functions[11]		PN	Percentage of women age 15-49 years with a live birth in the last 2 years for whom the most recent live-born child received at least 2 post-natal signal care functions within 2 days of birth	NA	56.5	64.2
TM.20	Post-natal health check for the mother		PN	Percentage of women age 15-49 years with a live birth in the last 2 years who received a health check while in a facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live birth	40.4	65.3	70.5
TM.S1[12]	Eclampsia during pregnancy		MR	Percentage of women who are currently pregnant or who gave live birth in the last 42 days with eclampsia during pregnancy	NA	1.1	0.4
TM.S2	Eclampsia in the immediate postpartum		MR	Percentage of women who gave live birth in the last 42 days with eclampsia in the immediate postpartum	NA	0.8	2.9

11 Signal functions are 1) Checking the cord, 2) Counseling on danger signs, 3) Assessing temperature,4) Observing/counselling on breastfeeding, and 5) Weighing the baby (where applicable).

12 Indicators TMS1-TMS9 are country specific indicators.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TM.S3	Uterine infection during pregnancy		MR	Proportion of women who are currently pregnant or who gave live birth in the last 42 days with uterine infection during pregnancy	NA	0.5	0.7
TM.S4	Uterine Infection in the Immediate Postpartum		MR	Percentage of women who gave live birth in the last 42 days with uterine Infection in the immediate postpartum	NA	0.3	0.3
TM.S5	Jaundice during pregnancy		MR	Proportion of women who are currently pregnant or who gave birth in the last 42 days with jaundice during pregnancy	NA	1.6	0.4
TM.S6	Jaundice in the immediate postpartum		MR	Percentage of women who gave live birth in the last 42 days with jaundice in the immediate postpartum	NA	0.6	0.5
TM.S7	Antepartum haemorrhage (haemorrhage) during pregnancy		MR	Percentage of women with 5 or more months of pregnancy or who gave live birth in the last 42 days with antepartum haemorrhage during pregnancy	NA	1.7	2.9
TM.S8	Postpartum haemorrhage		MR	Percentage of women who gave live birth in the last 42 days with postpartum haemorrhage	NA	2.8	4.1
TM.S9	Prolonged labour		MR	Percentage of women who gave live birth in the last 42 days with prolonged labour	NA	8.6	9.7
THRIVE - CHILD HEALTH, NUTRITION, AND DEVELOPMENT							
TC.12	Care-seeking for diarrhoea		DA	Percentage of children under age 5 with diarrhoea in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	NA	29.5	22.2
TC.13a TC.13b	Diarrhoea treatment with oral rehydration salt solution (ORS) and zinc		DA	Percentage of children under age 5 with diarrhoea in the last 2 weeks who received a) ORS b) ORS and zinc	a. 73.0 b. na	a. 72.4 b. 35.0	a.75.8 b. 41.7
TC.14	Diarrhoea treatment with oral rehydration therapy (ORT) and continued feeding		DA	Percentage of children under age 5 with diarrhoea in the last 2 weeks who received ORT (ORS packet, pre-packaged ORS fluid, recommended homemade fluid or increased fluids) and continued feeding during the episode of diarrhoea	64.6	50.9	49.6

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TC.19	Care-seeking for children with acute respiratory infection (ARI) symptoms	3.8.1	AR	Percentage of children under age 5 with ARI symptoms in the last 2 weeks for whom advice or treatment was sought from a health facility or provider	35.8	46.4	77.5
TC.30	Children ever breastfed		MN	Percentage of most recent live-born children to women with a live birth in the last 2 years who were ever breastfed	97.1	98.5	97.8
TC.31	Early initiation of breastfeeding		MN	Percentage of most recent live-born children to women with a live birth in the last 2 years who were put to the breast within one hour of birth	57.4	46.6	30.4
TC.32	Exclusive breastfeeding under 6 months		BD	Percentage of infants under 6 months of age who are exclusively breastfed[13]	56.4	62.6	56.6
TC.38	Introduction of solid, semi-solid, or soft foods		BD	Percentage of infants age 6-8 months who received solid, semi-solid, or soft foods during the previous day	42.4	75.5	78.0
TC.39	Minimum acceptable diet		BD	Percentage of children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day	NA	a. 27.8 b. 16.6	a. 31.2 b. 13.7
TC.40	Minimum milk feeding frequency for non-breastfed children		BD	Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings during the previous day	NA	48.8	39.9
TC.41	Minimum dietary diversity		BD	Percentage of children age 6–23 months who received foods from 5 or more of the 8 defined food groups[14] during the previous day	NA	33.8	35.2
TC.42	Minimum meal frequency		BD	Percentage of children age 6-23 months who received solid, semi-solid, and soft foods (plus milk feeds for non-breastfed children) the minimum number of times[15] or more during the previous day	NA	65.5	73.4
TC.43	Bottle feeding		BD	Percentage of children age 0-23 months who were fed with a bottle during the previous day	12.1	18.3	23.8

13 Infants receiving breast milk, and not receiving any other fluids or foods, with the exception of oral rehydration solution, vitamins, mineral supplements, and medicines.

14 The 8 defined food groups are: 1) breastmilk, 2) grains, roots, and tubers, 3) legumes and nuts, 4) dairy products (milk, infant formula, yogurt, cheese), 5) flesh foods (meat, fish, poultry, and liver/organ meats), 6) eggs, 7) vitamin-A rich fruits and vegetables, and 8) other fruits and vegetables.

15 Breastfeeding children: Solid, semi-solid, or soft foods, two times for infants age 6-8 months, and three times for children 9-23 months; non-breastfeeding children: Solid, semi-solid, or soft foods, or milk feeds, four times for children age 6-23 months.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TC.48[16]	Iodised salt consumption		SA	Percentage of households with salt testing positive for any iodide/iodate among households in which salt was tested or where there was no salt	73.7	76.0	78.6
TC.702	Exclusively breastfed for the first two days after birth		MN	Percentage of most recent live-born children to women with a live birth in the last 2 years who were fed exclusively with breast milk for the first two days after birth	NA	NA	72.0
TC.703	Mixed milk feeding under 6 months		BD	Percentage of infants under 6 months of age who received formula and/or animal milk in addition to breast milk during the previous day	NA	NA	18.6
TC.704	Continued breastfeeding 12-23 months		BD	Percentage of children age 12-23 months who received breast milk during the previous day	NA	NA	87.6
TC.705	Child food poverty		BD	Percentage of children age 6–23 months who received foods from 4 or fewer of the 8 defined food groups during the previous day	NA	NA	64.8
TC.706	Egg and/or flesh food consumption		BD	Percentage of children age 6–23 months who consumed egg and/or flesh food during the previous day	NA	NA	63.2
TC.707	Sweet beverage consumption		BD	Percentage of children age 6–23 months who consumed a sweet beverage during the previous day	NA	NA	20.5
TC.708	Unhealthy food consumption		BD	Percentage of children age 6–23 months who consumed selected sentinel unhealthy foods[17] during the previous day	NA	NA	54.2
TC.709	Zero vegetable or fruit consumption		BD	Percentage of children age 6–23 months who did not consume any vegetables or fruits during the previous day	NA	NA	28.2
LEARN AND ACQUIRE SKILLS							
LN.12	Availability of information on children's school performance		PR	Percentage of children age 7-14 years attending school for whom an adult household member received a report card for the child in the last year	NA	61.7	63.1
LN.13	Opportunity to participate in school management		PR	Percentage of children age 7-14 years attending school for whom their school's governing body is open to parental participation	NA	66.4	63.2

16 MICS6 Indicator; Iodised salt consumption, is included in the Bangladesh MICS 2025.

17 In the context of this indicator, "sentinel unhealthy foods" are foods or categories of foods (e.g., "sweets" or "candies") that are likely to be consumed by infants and young children and are high in sugar, salt and/or unhealthy fats. Refer to tables for more detailed information.

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
LN.14	Participation in school management		PR	Percentage of children age 7-14 attending school for whom an adult household member attended a school governing body meeting in the last year	NA	40.4	45.2
LN.16	Discussion with teachers regarding children's progress		PR	Percentage of children age 7-14 attending school for whom an adult household member discussed the child's progress with teachers in the last year	NA	65.8	72.9
LN.18	Availability of books at home		PR	Percentage of children age 7-14 years who have three or more books to read at home	NA	3.7	8.5
LN.21	Support with homework		PR	Percentage of children age 7-14 attending school and having homework who receive help with homework	NA	59.1	70.4
PROTECTED FROM VIOLENCE AND EXPLOITATION							
PR.1	Birth registration	16.9.1	BR	Percentage of children under age 5 whose births are registered with a civil authority	37.0	56.2	59.1
PR.15	Attitudes towards domestic violence		DV – MDV	Percentage of women age 15-49 years who state that a husband is justified in hitting or beating his wife in at least one of the following circumstances: (1) she goes out without telling him, (2) she neglects the children, (3) she argues with him, (4) she refuses sex with him, (5) she burns the food	NA	25.4	26.6
LIVE IN A SAFE AND CLEAN ENVIRONMENT							
WS.702	Sufficient menstrual materials		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months with sufficient menstrual materials to meet their needs during their last period	NA	NA	85.1
WS.703	Changing menstrual materials in privacy at home		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months who, during their last period, worried about being able to change materials in privacy at home	NA	NA	83.0
WS.704	Ability to reduce menstrual pain when needed		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months who, during their last period, were able to reduce menstrual pain when needed	NA	NA	54.1

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
WS.705	Seeking health care for menstrual problems		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months who, during their last period, felt comfortable seeking help for menstrual problems from a health care provider	NA	NA	75.5
WS.706	Knowledge of menstruation before the first period		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months who knew about menstruation before their first menstrual period	NA	NA	30.8
WS.707	Participation in activities during menstruation		UN	Percentage of women age 15-49 years reporting menstruating in the last 12 months who, during their last period, did not participate in work, education/training, or social activities due to their period	NA	NA	72.7
WS.S1	Salinity contamination of source drinking water 3,000 µS/cm (GoB standard)		WQ	Percentage of household population with salinity in source water containing over 3,000 µS/cm salinity concentration	NA	NA	1.0
WS.S2	Arsenic contamination of source drinking water 10ppb (WHO standard)		WQ	Percentage of household population with Arsenic in source water containing over 10ppb Arsenic concentration	25.5	18.6	15.8
WS.S3	Arsenic contamination of source drinking water 50ppb (GoB standard)		WQ	Percentage of household population with Arsenic in source water containing over 50ppb Arsenic concentration	12.5	11.8	9.9
WS.S7	Safely managed drinking water services adjusted for arsenic contamination <=10ppb (WHO standard) and E.coli		WQ	Percentage of household members with an improved drinking water source located on premises, free of *E. coli*, available when needed and <=10ppb Arsenic	NA	39.1	37.1
WS.S8	Safely managed drinking water services adjusted for arsenic contamination <=50ppb (GoB standard) and E.coli		WQ	Percentage of household members with an improved drinking water source located on premises, free of *E. coli*, available when needed and <=50ppb Arsenic	NA	42.6	39.3
WS.S4	Drinking water affected by natural hazards		WS	Percentage of household population whose main drinking water was affected by one or more natural hazards in the last 12 months	NA	NA	10.2

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
WS.S4a	Drinking water source disrupted by natural hazards		WS	Percentage of household members whose main drinking water source was disrupted by one or more natural hazards in the last 12 months	NA	NA	7.8
WS.S6	Knowledge of drinking water source protective measures		WS	Percentage of households that know one or more measures on how to protect their drinking water source from natural hazards	NA	NA	18.1
WS.S6a	Implementation of drinking water source protective measures		WS	Percentage of households that have taken one or more measures to protect their drinking water source from natural hazards	NA	NA	9.2
WS.S11a	Sanitation facility was affected by natural hazards		WS	Percentage of household population whose sanitation facility was affected by one or more natural hazards in the last 12 months	NA	NA	5.2
WS.S11	Inability to use the toilet facility		WS	Percentage of household population whose sanitation facility was affected by one or more natural hazards in the last 12 months who were unable to use the sanitation facility	NA	NA	3.9
WS.S9	Knowledge of toilet facility protective measures		WS	Percentage of households that know one or more measures on how to protect their toilet facility from natural hazards	NA	NA	18.7
WS.S10	Implementation of toilet facility protective measures		WS	Percentage of households that have taken one or more measures to protect their toilet facility source from natural hazards	NA	NA	10.7
EQUITABLE CHANCE IN LIFE							
EQ.2a EQ.2b EQ.2c	Health insurance coverage		IN FIN UIN	Percentage of women and children covered by health insurance a) women age 15-49 b) children age 5-17 c) children under age 5	NA	NA	a. 0.8 b. 0.4 c. 0.4
EQ.3	Population covered by social transfers	1.3.1	ST – ED	Percentage of household members living in households that received any type of social transfers and benefits in the last 3 months	NA	58.1	34.4
EQ.5	Children in the households that received any type of social transfer	1.3.1	ST – ED	Percentage of children under age 18 living in households that received any type of social transfers in the last 3 months	NA	67.7	36.2

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
EQ.6	School-related social transfers		ED	Percentage of children and young people age 5-24 years currently attending school who received any type of school-related social transfers in the current/most recent academic year	NA	NA	9.3
EQ.704	Decision-making on reproductive health	5.6.1	DM	Percentage of women age 15–49 years currently married and make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care	NA	NA	59.0
HEAVY METAL TESTING							
TM.S4	Mean blood lead level in pregnant women		TM	Mean blood lead level in pregnant women age 15 – 49 years	NA	NA	2.51
TM.S4a	Median blood lead level in pregnant women		TM	Median blood lead level in pregnant women age 15 – 49 years	NA	NA	2.04
TM.S5	Pregnant women with elevated blood lead levels		TM	Percentage of pregnant women 15 – 49 years with elevated blood lead levels (≥ 5 µg/dl)	NA	NA	7.5
TM.S6	Pregnant women with elevated arsenic levels		TM	Percentage of pregnant women 15 – 49 years with elevated blood arsenic levels (> 1.2 µg/dl)	NA	NA	1.6
TM.S7	Pregnant women with elevated mercury levels		TM	Percentage of pregnant women 15 – 49 years with elevated blood mercury levels (> 0.8 µg/dl)	NA	NA	0.0
TM.S8	Pregnant women with elevated cadmium levels		TM	Percentage of pregnant women 15 – 49 years with elevated blood cadmium levels (> 0.5 µg/dl)	NA	NA	3.3
TM.S9	Heavy metal contamination in pregnant women		TM	Percentage of pregnant women with elevated blood level of at least one heavy metal	NA	NA	12.3
TM.S10	Potential exposure to lead in pregnant women through regular contact		TM	Percentage of pregnant women age 15-49 years with possible exposure to lead at least once per week during the last three months	NA	NA	2.2
TM.S15	Elevated blood lead levels in pregnant women and anaemia status		TM	Percentage of pregnant women age 15 – 49 years with elevated blood lead level by anaemia status a. Any anaemia b. Mild c. Moderate d. Severe	NA	NA	a) 57.5 b) 31.7 c) 25.8 d) 0.0

MICS INDICATOR		SDG[1]	Topic/ Module[2]	Definition[3]	MICS5 2012-13	MICS6 2019	MICS7 2025
TC.S4	Mean blood lead level in children aged 12-59 months		TC	Mean blood lead level in children age 12-59 months	NA	NA	5.21
TC.S4a	Median blood lead level in children aged 12-59 months		TC	Median blood lead level in children aged 12-59 months	NA	NA	4.32
TC.S5	Children aged 12-59 months with elevated lead levels		TC	Percentage of children aged 12 – 59 months with elevated blood lead levels (≥ 5 µg/dl)	NA	NA	38.3
TC.S6	Children aged 12-59 months with elevated arsenic levels		TC	Percentage of children aged 12 – 59 months with elevated blood arsenic levels (> 1.2 µg/dl)	NA	NA	1.3
TC.S7	Children aged 12-59 months with elevated mercury levels		TC	Percentage of children aged 12 – 59 months with elevated blood mercury levels (> 0.8 µg/dl)	NA	NA	0.0
TC.S8	Children aged 12-59 months with elevated cadmium levels		TC	Percentage of children aged 12 – 59 months with elevated blood cadmium levels (> 0.5 µg/dl)	NA	NA	3.8
TC.S9	Heavy metal contamination in children aged 12-59 months		TC	Percentage of children aged 12-59 months with an elevated level of at least one heavy metal	NA	NA	41.5
TC.S1	Potential exposure to lead in children 12-59 months through regular contact		TC	Percentage of children 12-59 months with possible exposure to lead at least once per week during the last three months	NA	NA	8.0
TC.S15	Elevated blood lead levels in children and anaemia status		TC	Percentage of children aged 12 – 59 months with elevated blood lead level by anaemia status a. Any anaemia b. Mild c. Moderate d. Severe	NA	NA	a) 43.5 b) 28.5 c) 14.5 d) 0.5
TM.S16	Mean level of haemoglobin in pregnant women		TM	Mean blood haemoglobin level in pregnant women age 15-49 years	NA	NA	10.7
TC.S16	Mean level of haemoglobin in children age 12-59 months		TC	Mean blood haemoglobin level in children age 12-59 months	NA	NA	10.99

Conclusion

MICS 2025 offers a clear picture of progress and of the course corrections needed to keep Bangladesh on track for 2030. Survival continues to improve; under-five mortality fell further since 2019, with the largest relative declines at ages 1–59 months. Yet the newborn period remains the frontier; roughly three-quarters of infant deaths occur in the first month, so stronger, earlier care is essential.

Service coverage and quality have risen together. Content-rich antenatal care is up, and more women deliver in facilities with skilled attendants. But follow-through across pregnancy is still uneven, and the cesarean rate (52% of births) signals over-medicalization that strains families and systems. The goal now is not just contact, but the *right* care at the *right* time, especially for small and sick newborns and high-risk pregnancies.

Nutrition trends are mixed. Stunting continues to fall, reflecting long-run gains in living conditions and care practices. Underweight has stalled, and wasting has worsened since 2019, an acute warning light likely linked to price shocks, illness, and seasonal vulnerabilities. Rapid scale-up of prevention and treatment for wasting must sit alongside continued investments in diets, WASH, and primary health care.

Learning access is broad at the start, but leaks at the transition. Primary attendance is near universal, and completion is inching up, yet upper-secondary out-of-school has risen. Protecting girls' progression through lower and upper secondary is pivotal for skills, fertility choices, and lifetime earnings.

Protection signals are encouraging but incomplete. While the overall child marriage rate among women aged 20–24 has slightly decreased, the proportion of currently married adolescents (15–19) has risen sharply, while birth registration's momentum has slowed, and child labour has not budged. Reported functional difficulty among children declined; if measurement is comparable, services and environments may be improving, but sustained inclusion efforts remain essential.

WASH tells a two-part story: access up, safety and hygiene down. Basic drinking water and improved sanitation are high and rising. Still, microbial contamination increased at the source and in the home, and handwashing facilities with water and soap have slipped since 2019. The priority is to convert access into *safely managed* services and consistent hygiene.

The heavy-metal results indicate that lead is the dominant hazard, with nearly two in five children (38.3%) and about one in thirteen pregnant women (7.5%) showing elevated blood lead; the lower medians than means in both groups point to a right-skewed distribution driven by a smaller subset with very high levels. Multi-metal elevation is far more common in children (≥1 metal: 41.5% vs 12.3% in pregnant women), while arsenic and cadmium elevations are uncommon and mercury is negligible at current thresholds.

Elevated lead frequently co-occurs with anaemia (43.5% among affected children; 57.5% among affected pregnant women), and mean haemoglobin sits near anaemia cut-offs, underscoring clinical and programmatic relevance. Together, these findings argue for child-centred source control and environmental mitigation, surveillance that goes beyond self-report, and integration with nutrition/anaemia services, while noting that these are associations and not evidence of causality.

Finally, a stark headwind: social transfer coverage has fallen sharply since 2019, especially for children weakening a critical cushion against shocks and risking reversals in nutrition, schooling, and protection.

What needs to happen next:

- Win the first month of life: Scale evidence-based newborn packages (quality intrapartum care, early essential newborn care, KMC, timely referral); strengthen continuity from ANC to PNC.
- Re-balance obstetric care: Enforce clinical governance to reduce unnecessary C-sections and protect quality, safety, and affordability.
- Tackle acute malnutrition now: Expand prevention and treatment of wasting while sustaining stunting reduction through food systems, PHC, and WASH.
- Keep adolescents, especially girls, in school: Target upper-secondary retention with cash/transfer linkages, safe transport, and flexible pathways.
- Make water safe and hygiene habitual: Invest in risk-based water safety planning, household water treatment, fecal-sludge management, and behaviour change to restore handwashing.
- Restore the child-first safety net: Prioritize transfers to households with children to protect learning, nutrition, and care-seeking.
- Target with precision, monitor relentlessly: Use district and City Corporation estimate to direct resources; institutionalize DIRC follow-through; and keep a pulse between rounds with rapid, MICS-compatible systems and open microdata.
- Bangladesh should act on two tracks: protect now and prevent next. Immediately issue clinical/counselling guidance to ANC/PNC and child health sites, verify hotspots with targeted source testing (spices, paint/dust, cookware, toys, informal battery recycling), run focused risk communication, and confirm lab QA.
- In parallel, cut exposures at the source by routine market surveillance and recalls, lead-safe paint and dust control in schools/clinics, safer cookware initiatives, and engagement with municipalities to formalize battery recycling.
- Integrate lead responses with anaemia services (iron/folate, diet counselling, deworming) and establish sentinel biomonitoring sites to track BLLs in high-risk districts.
- Lock in policy with strict standards and enforcement (e.g., paint ≤90 ppm), public procurement that requires lead-safe materials, and a costed, multi-ministry plan.
- Measure success by reductions in median BLL and ≥5 µg/dL prevalence, increased compliance in markets and public works, and timely follow-up testing of affected children and pregnant women.

The message of MICS 2025 is hopeful and urgent: Bangladesh is moving forward, but to accelerate and to ensure no child is left behind, we must focus on quality, safety, inclusion, and protection where the gaps are now most visible.

Appendix: Statistical Snapshots

Statistical Snapshots

1. Sample & Survey Characteristics
2. Child Mortality
3. Maternal & Newborn Health
4. Fertility & Family Planning
5. Nutritional Status of Children
6. Infant & Young Child Feeding (IYCF)
7. Education
8. Early Grade Learning & Parental Involvement
9. Early Childhood Development (ECD)
10. Birth Registration
11. Child Discipline
12. Child Functioning
13. Child Health & Care of Illness Seeing
14. Child Labour
15. Child Marriage
16. Drinking Water, Sanitation & Hygiene (WASH)
17. Adolescent
18. Gender Equity
19. Mass Media
20. Heavy Metal & Anaemia

BANGLADESH 2025

Sample & Survey Characteristics

MICS
Multiple Indicator Cluster Surveys

Response Rates

Household	Number	Response rates
Sampled	62,980	
Occupied	61,470	
Interviewed	61,207	99.6
Women age 15-49		
Eligible for interview	67,246	
Interviewed	64,405	96
Children under 5		
Eligible for interview	24,680	
Mothers/Caretakers interviewed	23,357	95
Children age 5-17		
Eligible for interview	37,671	
Mothers/Caretakers interviewed	36,709	97
BLL for Pregnant Women age 15-49 years		
Eligible for interview	2,711	
Interviewed	1,940	73
BLL for Children age 12-59 months		
Eligible for interview	17,132	
Interviewed	10,667	65

Survey Implementation

Implementing agency:
Bangladesh Bureau of Statistics

Sampling frame:
Bangladesh Population and Housing Census 2022

Listing & mapping:
October – November 2024

Interviewer training:
21 January – 18 February 2025

Fieldwork:
24 February – 30 June 2025

Questionnaires:
Household
Women age 15-49
Children under 5
Children age 5-17
Water Quality testing
Blood Collection Form (Pregnant Women)
Blood Collection Form (Children 12-59 months)

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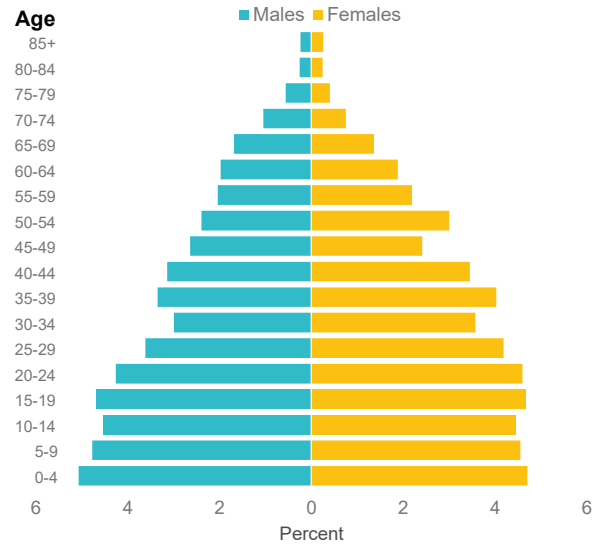
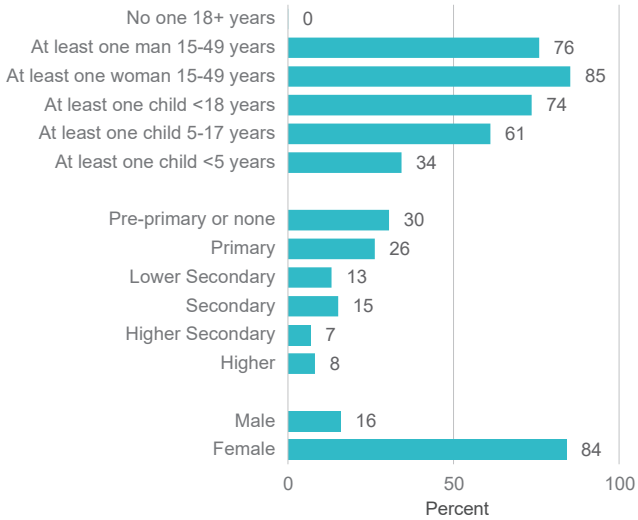
Population Characteristics

Household Population Age & Sex Distribution



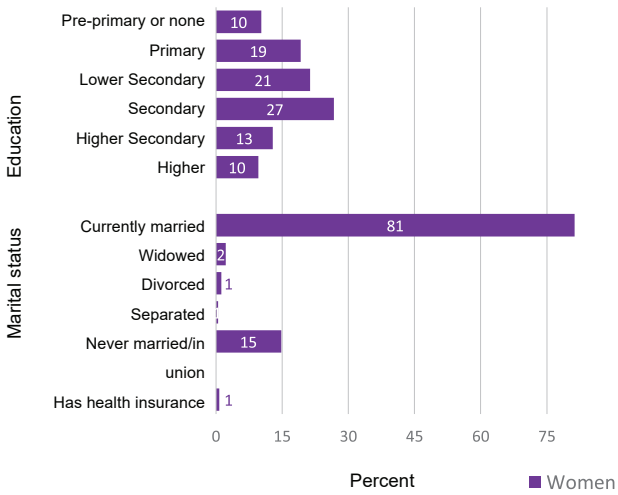
Percent distribution of household population by age group and sex

Household Composition & Characteristics of Head of household



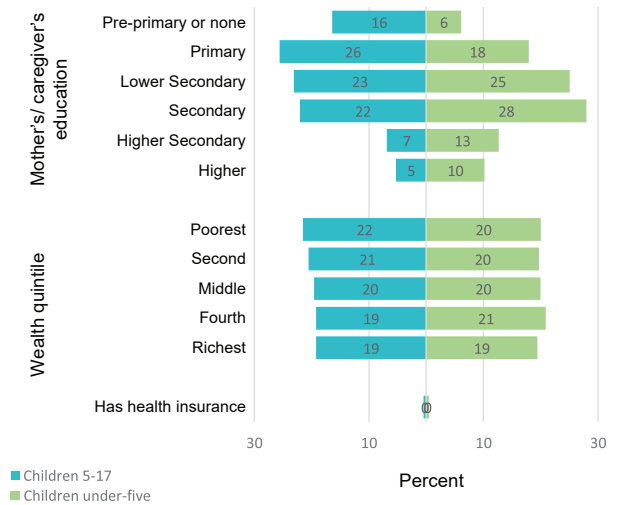
Percent of households by selected characteristics

Women's Profile



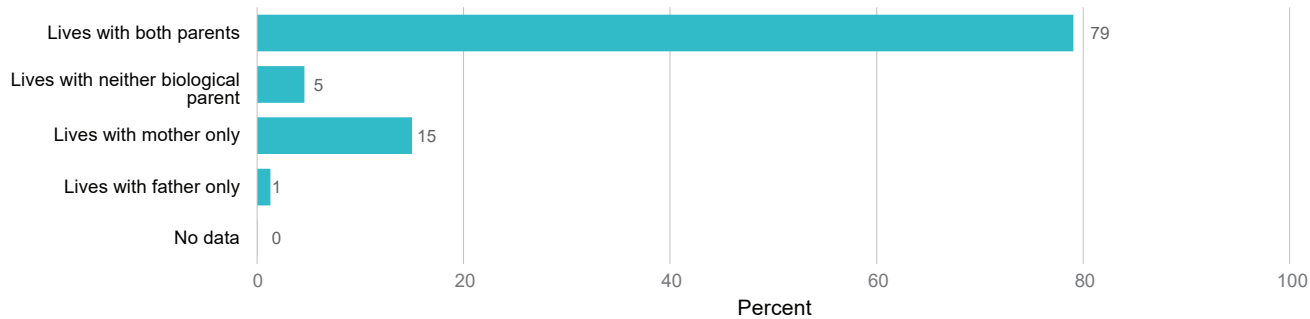
Percent distribution of women and men age 15-49 by background characteristics

Children's Profile



Percent distribution of children age 5-17 and under-five by background characteristics

Children's Living Arrangements*



Percent distribution of children age 0-17 years according to living arrangements

*Children age 0-17 years

Divisional Distribution of Population (percent)

Division	Households	Women 15-49	Children under 5	Children 5-17
National	**100**	**100**	**100**	**100**
Barishal	5	5	5	6
Chattogram	18	21	24	22
Dhaka	27	27	24	25
Khulna	12	11	10	10
Mymensingh	8	7	8	8
Rajshahi	14	13	11	11
Rangpur	11	11	11	11
Sylhet	5	6	6	7

Key Messages

- For this MICS, 62,980 households from 64 districts and three major city corporations (DNCC, DSCC, CCC) were sampled; 61,207 households were interviewed, for an overall response rate of ~99%.
- Altogether, 67,746 women aged 15–49 were eligible; 64,405 completed the interview (~96% response rate).
- Mothers/caretakers of 23,357 children under age 5 and 36,709 children aged 5–17 were interviewed. These represent 95% of eligible under-5s and 97% of eligible 5–17-year-olds.
- Among eligible women 15–49: 81% were married, 15% never married, and 4% widowed/divorced/separated.

Information on fertility, maternal/newborn health, postnatal checks, contraception, maternal morbidity, and family planning was collected from ever-married women (currently married, widowed, divorced, separated).

The Bangladesh Multiple Indicator Cluster Survey (MICS) 2025 was conducted by the Bangladesh Bureau of Statistics (BBS) as part of the global MICS programme, with technical support from the United Nations Children's Fund (UNICEF) and financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the United States Government (USAID), and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Survey and Sample Characteristics.

Further statistical snapshots and the Survey Findings Report for this, and other surveys are available on mics.unicef.org/surveys.

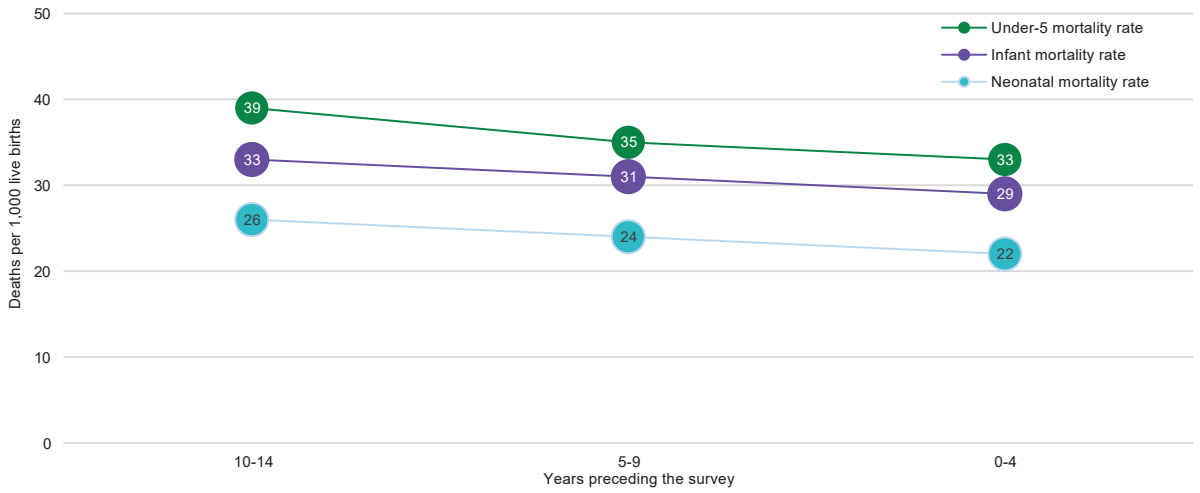
BANGLADESH 2025

Child Mortality

MICS

Multiple Indicator Cluster Surveys

Mortality Rates among Children Under-5



Years preceding the survey	Neonatal mortality rate: SDG 3.2.2	Post-neonatal mortality rate	Infant mortality rate	Child mortality rate	Under-5 mortality rate: SDG 3.2.1
0-4	22	7	29	5	33
5-9	24	7	31	5	35
10-14	26	7	33	7	39

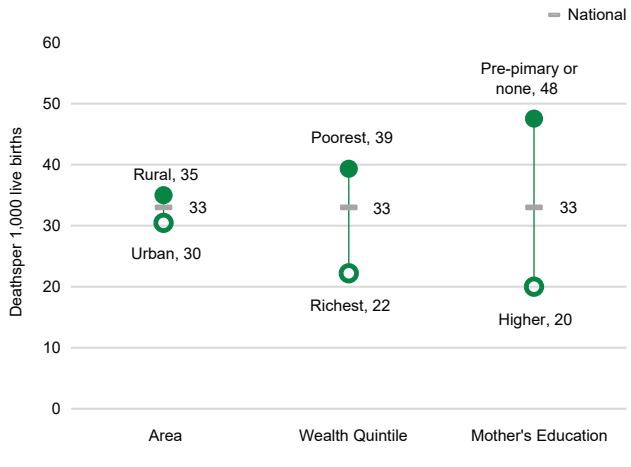
Neonatal mortality (NN): probability of dying within the first month of life
Post-neonatal mortality: calculated as the difference between infant and neonatal mortality rates
Infant mortality (1q0): probability of dying between birth and first birthday
Child mortality (4q1): probability of dying between the first and fifth birthday

Under-5 mortality (5q0): probability of dying between birth and fifth birthday

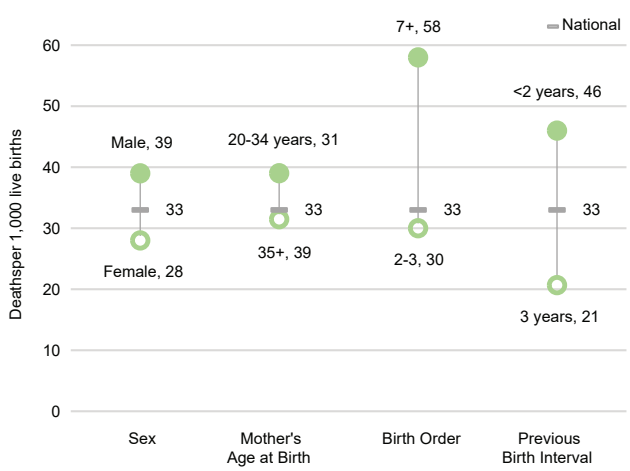
MICS uses a direct method for estimation of child mortality. This involves collecting full birth histories whereby women age 15-49 are asked for the date of birth of each child born alive, whether the child is still alive and, if not, the age at death.

Differentials in Child Mortality

Under-5 mortality rate by socio-economic characteristics & area



Under-5 mortality rate by demographic risk factors



Under-five mortality rates for the five-year period preceding the survey, by socio-economic characteristics, area and demographic risk factors

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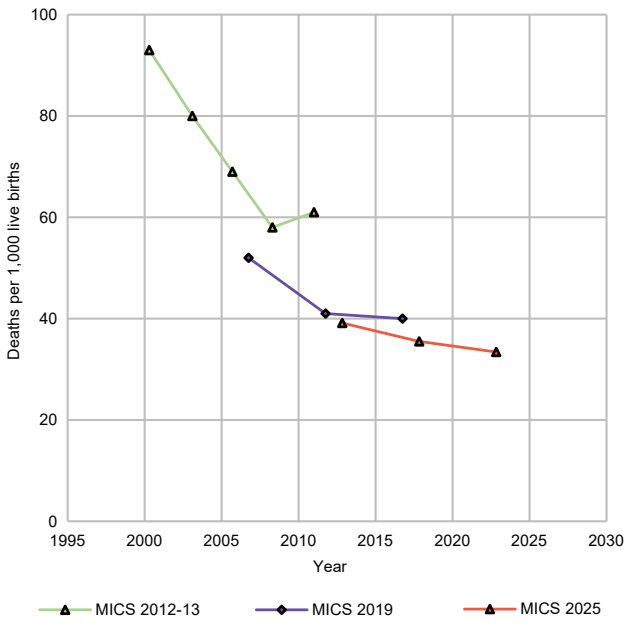
Neonatal & under-5 mortality rates by Division

Division	Neonatal mortality	Under-5 mortality
National	**22**	**33**
Barishal	21	34
Chattogram	22	36
Dhaka	25	37
Khulna	15	21
Mymensingh	18	33
Rajshahi	21	29
Rangpur	22	31
Sylhet	29	43

Neonatal mortality and under-5 mortality rates (deaths per 1,000 live births) for the five-year period preceding the survey, by Division

Trends in under-5 mortality rates



The data used in the above graph is taken from MICS 2025, MICS 2019, and MICS 2012-13.

Key Messages

- Over time, the under-five mortality rate, infant mortality rate, and neonatal mortality rate in Bangladesh have all declined, although this decline has been slow during the last fifteen years prior to the survey.
- In the five years prior to this MICS, the under-five mortality rate stood at 33 deaths per 1,000 live births, which is a reduction from 35 deaths per 1,000 live births in the 10 years prior to the survey and 39 deaths per 1,000 live births in the 15 years prior to the survey.
- In the five years prior to this MICS, the infant mortality rate has remained at 29 deaths per 1,000 live births, which is a reduction from 31 deaths per 1,000 live births in the 10 years prior to the survey. In the 15 years prior to the survey, the infant mortality rate was 33 deaths per 1,000 live births.
- In the five years prior to this MICS, the neonatal mortality rate stood at 22 deaths per 1,000 live births, which is reduced from what was reported in the 10 years prior to the survey (24). In the 15 years prior to the survey, the neonatal mortality was 26 deaths per 1,000 live births.
- In Bangladesh, children from poor households or whose mothers/caretakers have a low level of education are likelier to die before their fifth birthday. The under-five mortality rate for children from the poorest households is 39 deaths per 1,000 live births compared to 22 deaths per 1,000 live births for children from the wealthiest households.
- Children with mothers/caretakers with higher education (20 deaths per 1,000 live births) are less likely to die before the age of 5 compared to the children whose mothers/caretakers have Pre-primary or no education (48 deaths per 1,000 live births).
- The under-five mortality rate (deaths per 1,000 live births) for the five years period preceding the survey is highest in Sylhet division at 43 deaths per 1,000 live births and lowest in Khulna division at 21 deaths per 1,000 live births. These data indicate a disparity between divisions in Bangladesh.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Child Mortality.

Further statistical snapshots and the Survey Findings Report for this and other surveys are available on mics.unicef.org/-surveys.

BANGLADESH 2025

Maternal & Newborn Health

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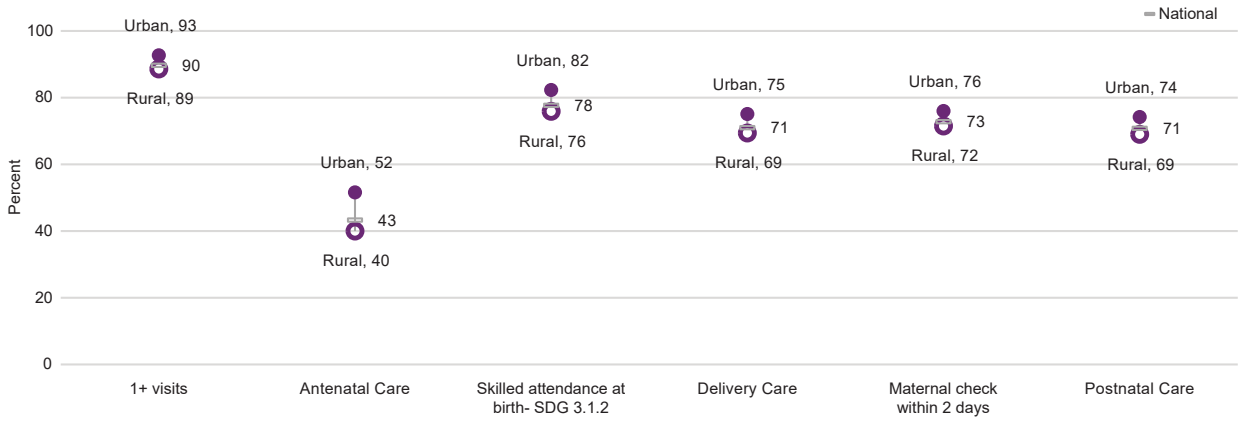
Multiple Indicator Cluster Surveys

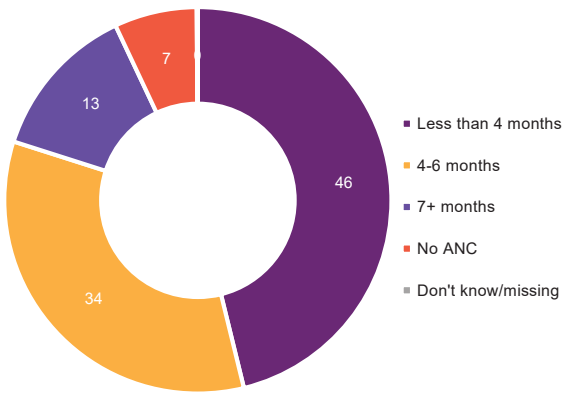
Key Elements of Maternal & Newborn Health

Maternal & Newborn Health Cascade by Area



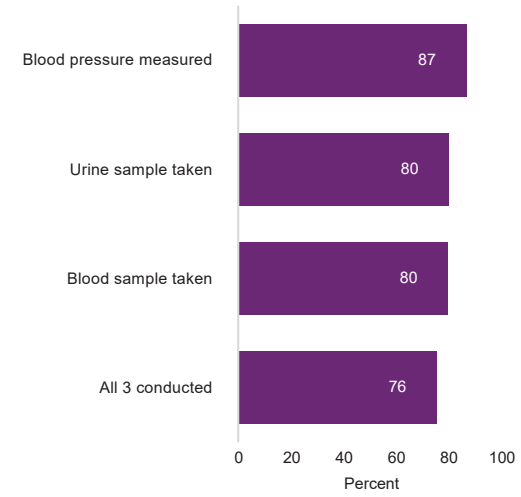
Percentage of women age 15-49 years with a live birth in the last 2 years who were attended during their last pregnancy that led to a live birth at least once by skilled health personnel or at least four times by any provider, who were attended by skilled health personnel during their most recent live birth (SDG 3.1.2), whose most recent live birth was delivered in a health facility, who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live and percentage of last live births in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery, by area

Timing of First Antenatal Care Visit



Percentage of women age 15-49 years with a live birth in the last 2 years who were attended during their last pregnancy that led to a live birth at least once by skilled health personnel, by the timing of first ANC visit

Content & Coverage of Antenatal Care Services



Percentage of women age 15-49 years with a live birth in the last 2 years who had their blood pressure measured and gave urine and blood samples

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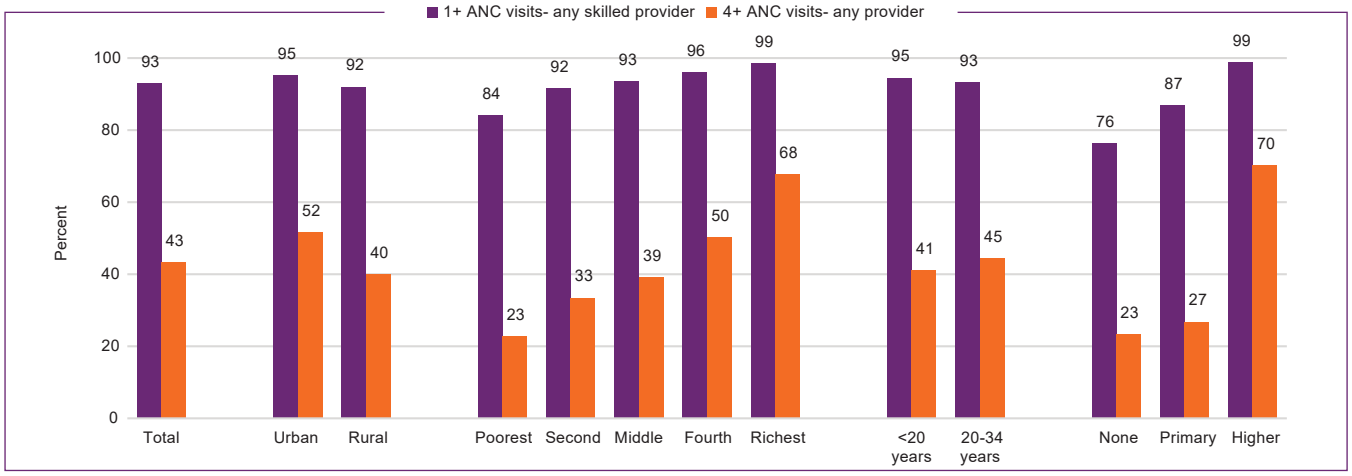
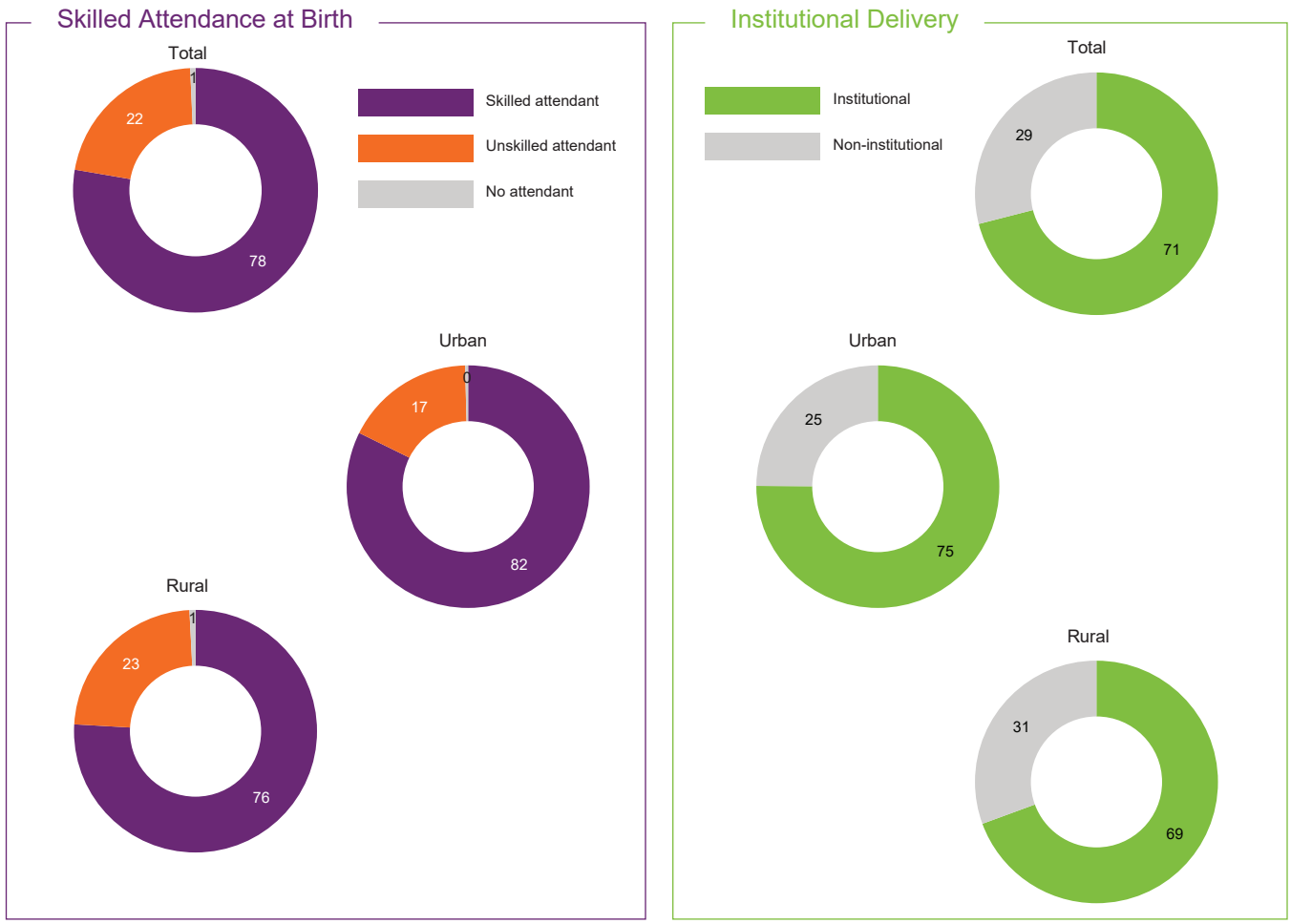
Coverage of Antenatal Care by Various Characteristics



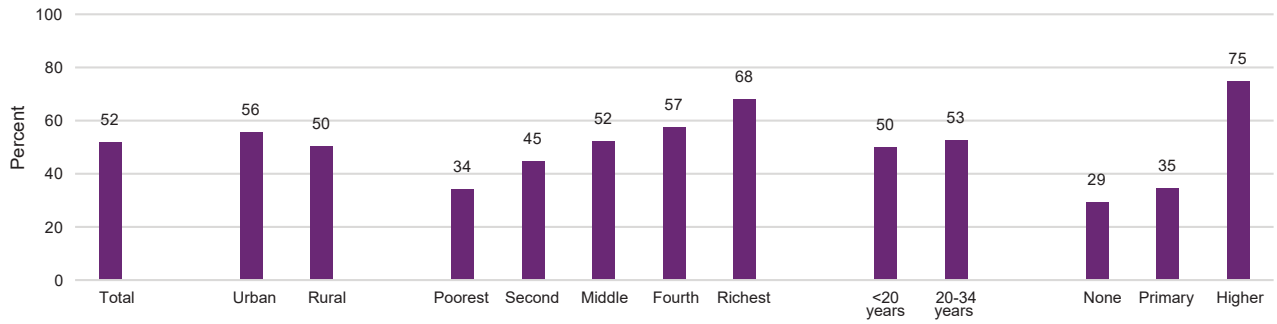
Percentage of women age 15-49 years with a live birth in the last 2 years who were attended during their last pregnancy that led to a live birth at least once by skilled health personnel or at least four times by any provider

Coverage of Skilled Attendance at Birth & Institutional Delivery by Area



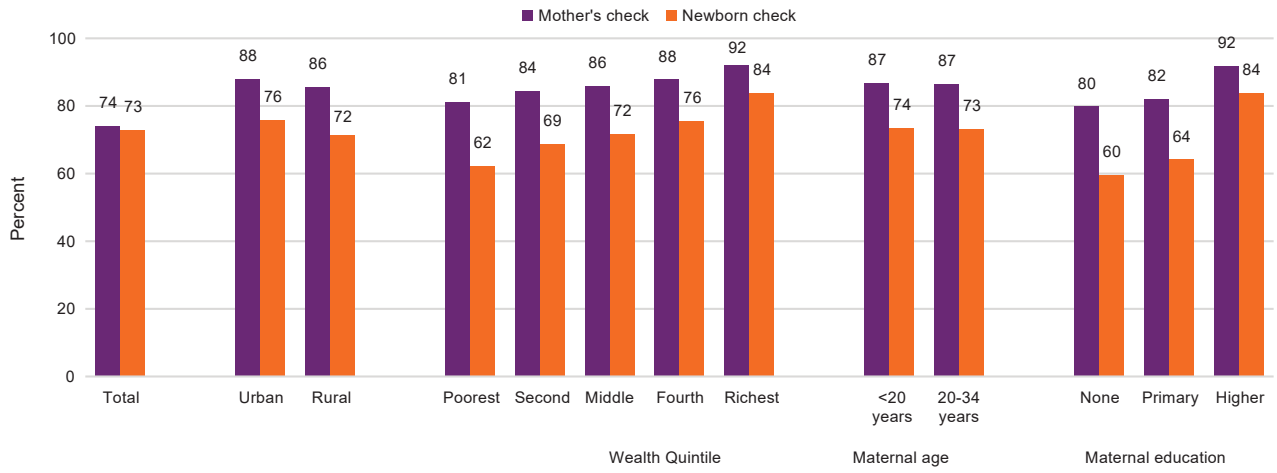
Percentage of women age 15-49 years with a live birth in the last 2 years who were attended by skilled health personnel during their most recent live birth and percentage whose most recent live birth was delivered in a health facility (institutional delivery) by area

Caesarian Section by Various Characteristics



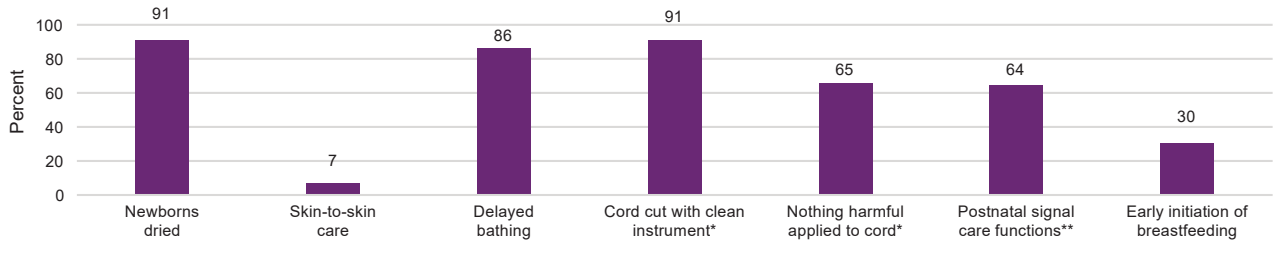
Percentage of women age 15-49 years with a live birth in the last 2 years whose most recent live birth was delivered by caesarean section by various characteristics

Postnatal Care within 2 Days of Birth by Various Characteristics



Percentage of women age 15-49 years with a live birth in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live and percentage of last live births in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery, by various characteristics

Coverage of Newborn Care



Among the last live-birth in the last 2 years, percentage who were dried after birth; percentage who were given skin to skin contact; percentage who were bathed after 24 hours of birth; percentage where the umbilical cord was cut with a new blade or boiled instrument*; percentage where nothing harmful was applied to the cord*; percentage where the newborn received at least 2 postnatal signal care functions within 2 days after birth**; and percentage put to the breast within one hour of birth

* Among the last live-births in the last 2 years delivered outside a facility

** At least 2 of i) umbilical cord examination, ii) temperature assessment, iii) breastfeeding counselling or observation, iv) weight assessment, and v) counselling on danger signs for newborns

Divisional Data on Maternal and Newborn Cascade

Division	ANC: At least 1 visit (skilled provider)	ANC: At least 4 visits (any provider)	Skilled Attendance at Birth	Institutional Delivery	Postnatal Care for Mother <2 days	Postnatal Care for Newborn <2 days
National	**89.7**	**43.3**	**77.7**	**71.0**	**70.5**	**72.8**
Barishal	88.7	43.3	74.8	61.3	65.9	69.7
Chattogram	92.1	46.0	76.1	69.5	74.9	77.1
Dhaka	92.2	48.5	80.9	74.3	71.0	73.4
Khulna	91.0	47.0	88.5	83.7	74.7	77.2
Mymensingh	88.1	28.5	68.3	60.3	71.0	72.0
Rajshahi	87.8	42.2	83.4	78.6	69.1	71.9
Rangpur	82.7	38.8	73.9	67.2	62.4	64.9
Sylhet	87.0	34.9	64.4	57.9	64.0	65.5

For indicator definitions, see earlier charts

Key Messages

- Nationally, ninety-three percent of women aged 15-49 years with a live birth in the past two years received at least one ANC contact by a skilled health personnel; only 43% received at least four ANC contacts from any personnel. Most urban women (95%) received at least one ANC contact by a skilled provider and about half received at least ANC contacts. Similarly, most of rural women (92%) received one ANC contact and about four-tenth (40%) received at least four ANC contacts. The current WHO recommen dation is that women receive eight ANC contacts during pregnancy, which increases the chances that perinatal complications will be detected. In Bangladesh, all women receive far fewer ANC contacts than are recommended.
- In Bangladesh, almost half of the women (46%) received their first ANC contact during their first four months of pregnancy, meaning that other half of the women in Bangladesh receive too few ANC contacts and too late.
- This MICS asked women about the content of the ANC contact they received during their most recent pregnancy in the past two years. Women were asked if their blood pressure was measured and if urine and blood samples were taken. Results from these questions provide a measure of the quality of care received by women during ANC contacts. About three-fourth (76%) of the women who receive ANC in Bangladesh received all three measures of quality of care (blood pressure measured, urine, and blood sample taken). So still there is a room for improvement, these data indicate that the health system in Bangladesh is responding to WHO standards for quality of ANC care.
- More than two-third (69%) of rural women with a live birth in the past two years delivered in a health facility compared to 75% of urban women. Urban women were also more likely to give birth aided by a skilled attendant (82%) compared to rural women (76%). Almost a quarter of the women in Bangladesh give birth without a skilled provider, which is a critical intervention for safe motherhood.
- An alarming number of women in Bangladesh give birth via caesarean section. In urban areas, more than half (56%) of the women give birth via caesarean section. Birth via caesarean section increases as women become wealthier and more educated. Even in rural areas, far too many women (50%) deliver via caesarean section. There is an urgent need to understand who these women are, from whom they received delivery services, and the motivations for these caesarean deliveries. Education for women and health workers about the appropriate use of caesarean section interventions and the health risks associated with unnecessary caesarean section delivery is urgently needed. Furthermore, data on how high rates of caesarean section delivery impact other health outcomes, such as early initiation of breastfeeding need to be understood better.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Maternal and Newborn Health.

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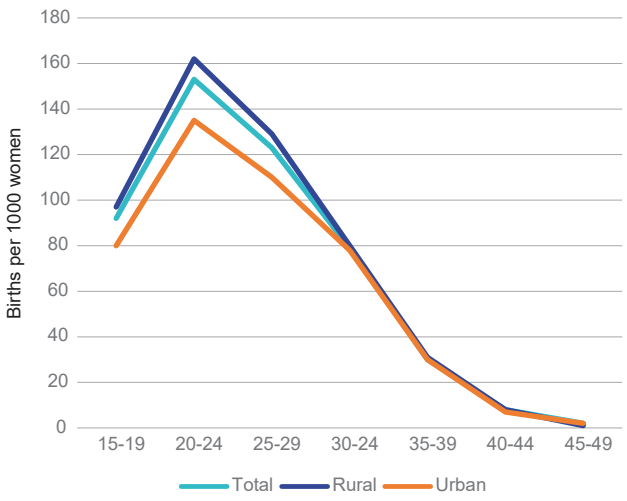
BANGLADESH 2025

Fertility & Family Planning

MICS
Multiple Indicator Cluster Surveys

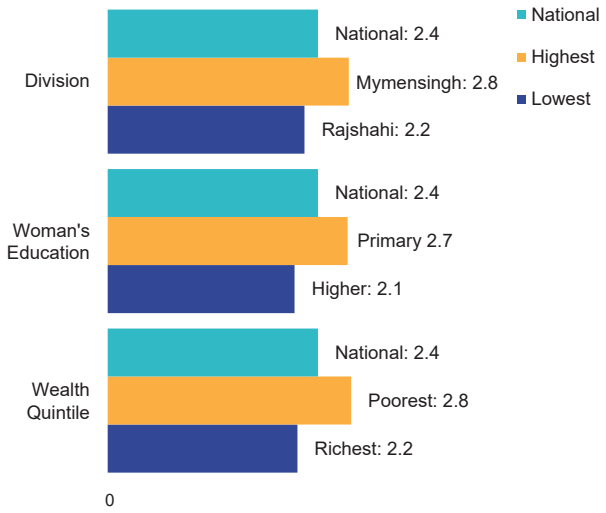
Fertility

Age Specific Fertility Rates



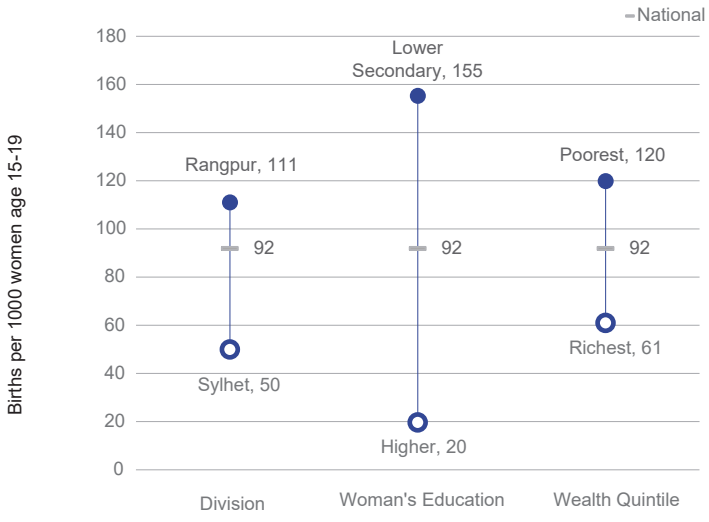
Age-specific fertility rates (ASFR) are the number of live births in the last 3 years, divided by the average number of women in that age group during the same period, expressed per 1,000 women

Total Fertility Rate



The total fertility rate (TFR) is calculated by summing the age-specific fertility rates (ASFRs) calculated for each of the five-year age groups of women, from age 15 through to age 49

Adolescent Birth Rate: SDG indicator 3.7.2



Age-specific fertility rate for girls age 15-19 years for the three-year period preceding the survey

Adolescent Birth rate SDG 3.7.2 indicator is under target 3.7: By 2030, 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

Reducing adolescent fertility and addressing the multiple factors underlying it are essential for improving sexual and reproductive health and the social and economic well-being of adolescents. Preventing births very early in a woman's life is an important measure to improve maternal health and reduce infant mortality.

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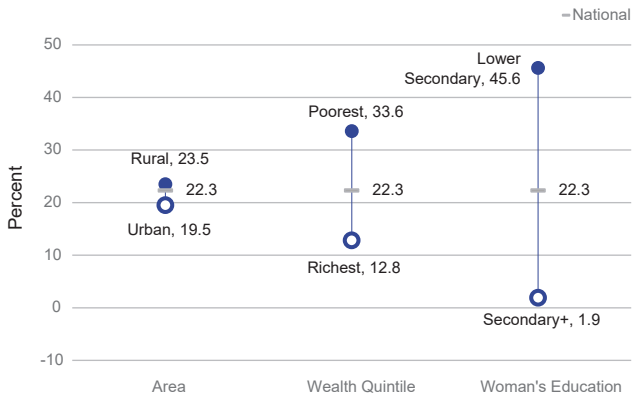
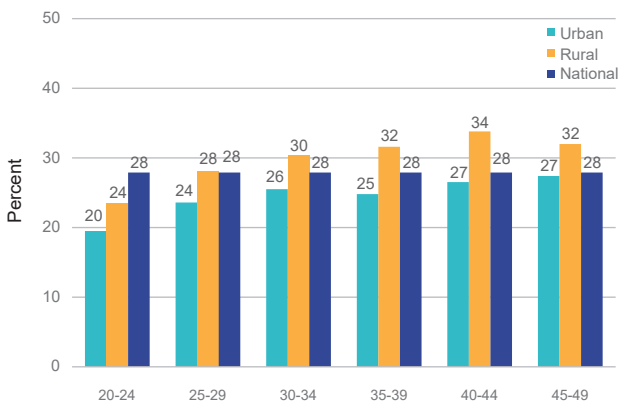
Early Child Bearing - by Age 18



Percentage of women age 20-24 years who have had a live birth before age 18, by background characteristics

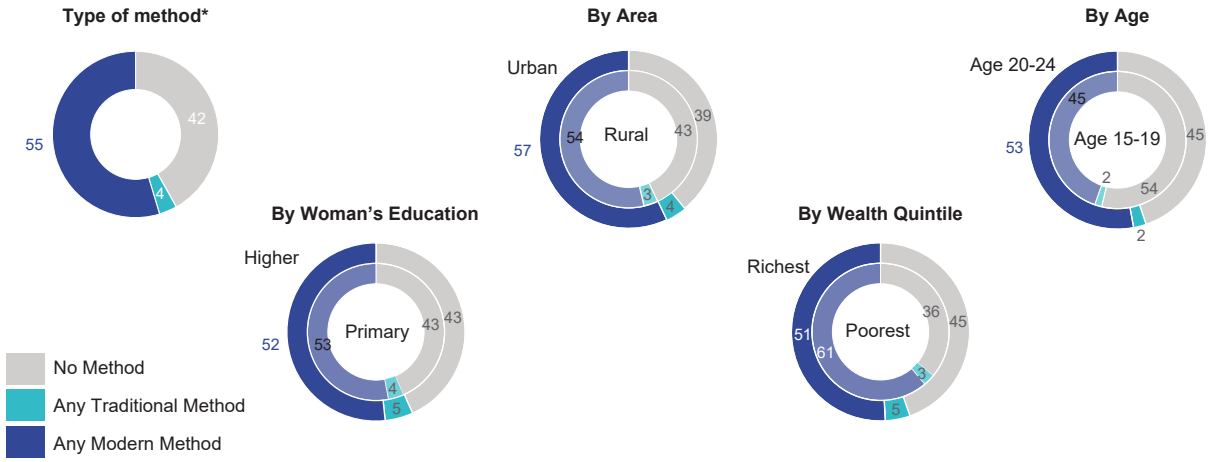
Trends in Early Child Bearing - by Age 18



Percentage of women age 20-49 years who have had a live birth before age 18

Family Planning

Method of Family Planning by Various Characteristics

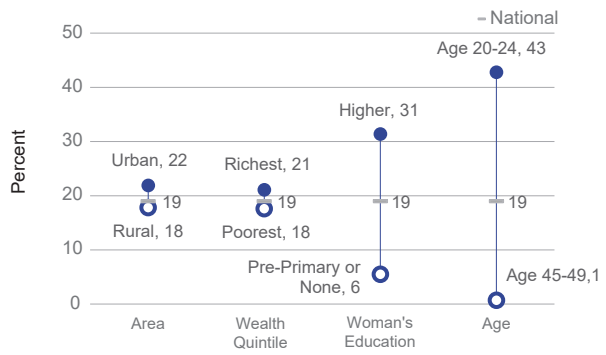


Percentage of women age 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method

*Modern Methods include female sterilization, male sterilization, IUD, injectables, implants, pills, male condom, Female condom, diaphragm, foam, jelly and contraceptive patch Traditional methods refer to periodic abstinence and withdrawal

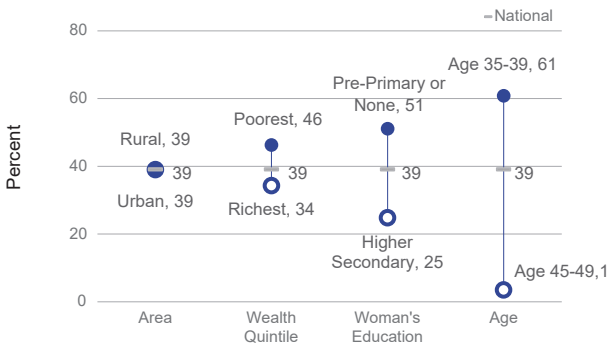
Met Need for Family Planning

Met Need for Family Planning - Spacing



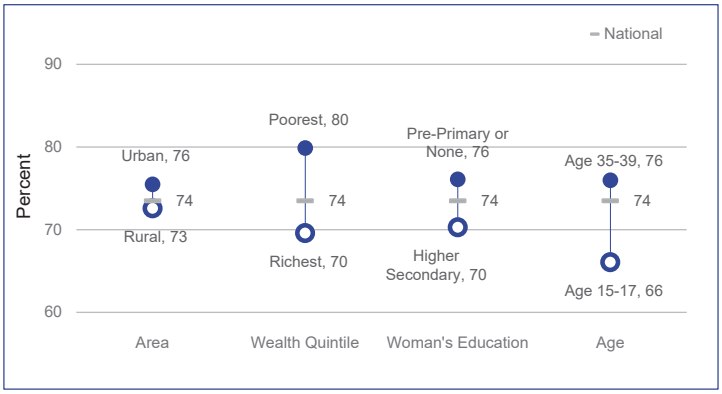
Percentage of women age 15-49 years currently married with met need for family planning for spacing, by background characteristics

Met Need for Family Planning – Limiting



Percentage of women age 15-49 years currently married with met need for family planning for limiting, by background characteristics

Percentage of Demand for Family Planning Satisfied with Modern Methods - SDG indicator 3.7.1



The proportion of demand for family planning satisfied with modern methods (SDG indicator 3.7.1) is useful in assessing overall levels of coverage for family planning programmes and services. Access to and use of an effective means to prevent pregnancy helps enable women and their partners to exercise their rights to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. Meeting demand for family planning with modern methods also contributes to maternal and child health by preventing unintended pregnancies and closely spaced pregnancies, which are at higher risk for poor obstetrical outcomes.

Divisional Data on Fertility & Family Planning

Division	Adolescent Birth Rate	Total Fertility Rate	Child bearing before 15#	Child bearing before 18*	Contraception Use of modern method among married women	Contraception Use of any method among married women	Demand for family planning satisfied with modern methods among married women
National	**92**	**2.4**	**1.2**	**22**	**55**	**58**	**74**
Barishal	86	2.4	0.6	23	54	56	73
Chattogram	94	2.7	0.9	19	46	49	64
Dhaka	84	2.3	0.9	22	55	60	74
Khulna	109	2.3	1.4	27	54	59	71
Mymensingh	91	2.8	1.5	24	61	62	80
Rajshahi	104	2.2	2.0	29	58	63	76
Rangpur	111	2.4	2.0	28	65	67	84
Sylhet	50	2.4	0.2	9	49	51	73

#Percentage of women age 15-19 years who have had a live birth before age 15, *Percentage of women age 20-24 years who have had a live birth before age 18

Key Messages

- Information presented in this snapshot refers to married women aged 15-49 years only. In Bangladesh MICS 2025, some questions for modules were not asked to unmarried women aged 15-49 years.
- Findings from this MICS show higher age-specific fertility rates and adolescent birth rates for households in rural areas, among the poorest and those with only primary education.
- The education level of women aged 15-19 shows the most significant difference in adolescent fertility, which suggests that increased access to education could be a decisive factor in reducing adolescent fertility, and thus ensuring the well-being of adolescents. Alternatively, adolescent women with high birth rates might be deprived of education and therefore in need of increased policy priority.
- Amongst women aged 20-24 years, one in four in rural areas and one in five in urban areas had a live birth before 18 years of age. Women from the poorest households are thrice as likely to have a live birth before the age of 18 than women from the wealthiest households. However, data from this MICS demonstrate that education is the most decisive factor when it comes to determining if a woman will have a baby before the age of 18.
- Disparities exist in early childbearing in Bangladesh. In Rajshahi, two percent of women aged 15-19 years had a live birth before age 15, and 29% of women aged 20-24 years had a live birth before age 18. While childbearing before 15 years of age has reduced over time in Bangladesh, findings from this MICS indicate that early childbearing is still prevalent amongst the population.
- The percentage of women who had a child before 18 years of age varies across the country. In Sylhet division 9% of women aged 20-24 years had a live birth before 18 years of age compared to 29% in Rajshahi division. These data indicate a high prevalence of child marriage throughout the country, requiring more significant awareness-raising and better implementation of the law.
- Three out of five 15-49 years married women (58%) reported to used any family planning method which is lower than earlier round of MICS and other surveys conducted by BBS and DHS. Awareness activities and door-to-door service provided by frontline family planning workers need to be monitored to point out the gaps for mitigation.

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BANGLADESH 2025

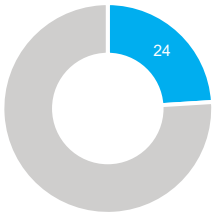
Nutritional Status of Children

MICS
Multiple Indicator Cluster Surveys

Anthropometric Malnutrition Indicators

Stunting: SDG 2.2.1

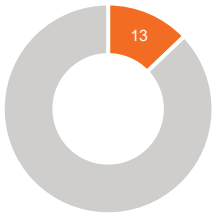
Stunting refers to a child who is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition.



Percentage children under-5 who are stunted

Wasting: SDG 2.2.2

Wasting refers to a child who is too thin for his or her height. Wasting, or acute malnutrition, is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted has an increased risk of death, but treatment is possible.



Percentage children under-5 who are wasted

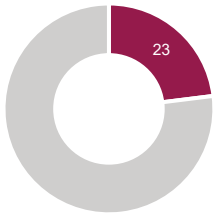
Overweight: SDG 2.2.2

Overweight refers to a child who is too heavy for his or her height. This form of malnutrition results from expending too few calories for the amount consumed from food and drinks and increases the risk of noncommunicable diseases later in life.

Percentage children under-5 who are overweight

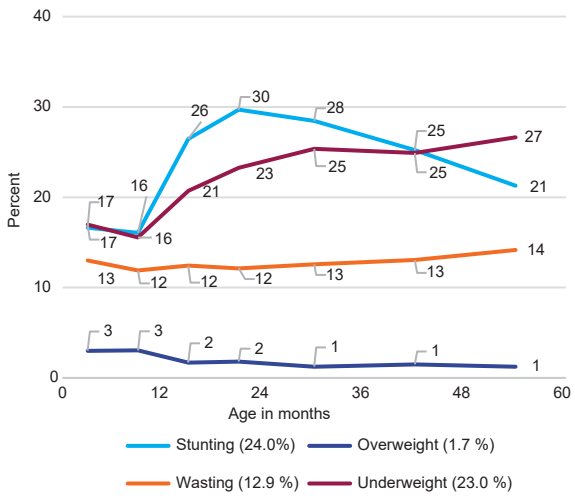
Underweight

Underweight is a composite form of undernutrition that can include elements of stunting and wasting (i.e. an underweight child can have a reduced weight for their age due to being too short for their age and/or being too thin for their height).



Percentage children under-5 who are underweight

Anthropometric MalnutritionIndicators by Age



Percentage children who are underweight, stunted, wasted and overweight, by age in months

Key Messages

- In Bangladesh, 24% of children under five years of age are stunted, which is defined as when a child is too short for his or her age. Stunting is the failure to grow both physically and cognitively and is the result of chronic or recurrent malnutrition. Likewise, 13% of children under five years of age in Bangladesh are wasted, which is defined as when a child is too thin for his or her height. According to the WHO-UNICEF Joint Child Malnutrition Estimates, a wasting prevalence exceeding 10% is classified as high. Wasting, or acute malnutrition, is the result of recent rapid weight loss or the failure to gain weight. A child who is moderately or severely wasted faces an increased risk of death, but treatment is possible.
- In Bangladesh, two percent of children under five years of age are overweight, which is defined as when he or she is too heavy for his or her height. This form of malnutrition results from expending too few calories for the amount consumed from food and drinks; it increases the risk of non-communicable diseases later in life. While the proportion of overweight children in Bangladesh is small, this data indicates that the problem of overweight children, which is often associated with wealthier and more developed populations, is manifesting in Bangladesh. Measures to educate women, families, communities and health providers about healthy food and appropriate quantities of food for optimal development of young children is important to avert increased proportions of overweight children.
- In Bangladesh, nearly a quarter (23%) of children under five years of age are underweight for their age, which means they are suffering from a composite form of undernutrition that can include elements of stunting and wasting. Increased investments to support families and communities to understand healthy food choices and more strategies, investment, and resources so that these choices are available are needed.
- Stunting is the most common form of malnutrition in Bangladesh, followed by children who are underweight, wasted, and overweight, respectively.

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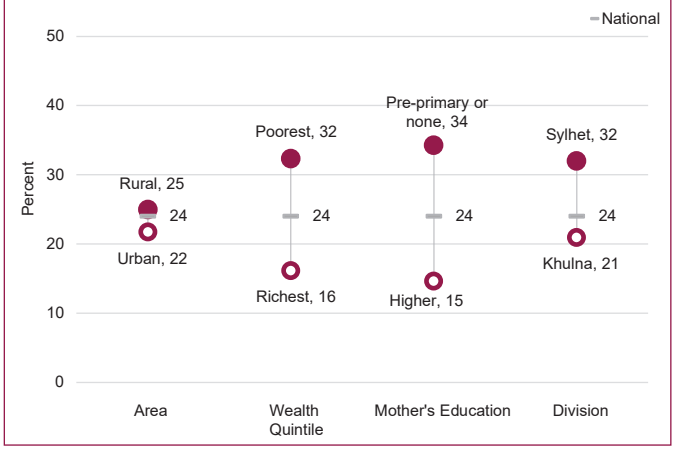
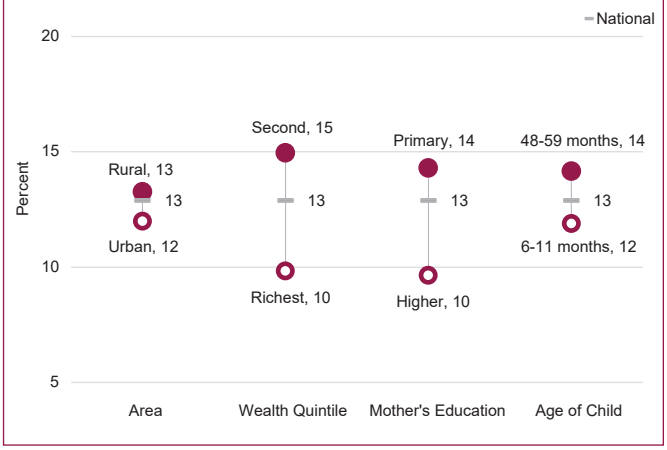
Nutritional Status of Children: Disaggregates

Stunting: SDG 2.2.1



Percentage of under 5 children who are stunted, by background characteristics

Wasting: SDG 2.2.2



Percentage of under 5 children who are wasted, by background characteristics

Divisional Data on Stunting, Overweight & Wasting

Division	Stunting: SDG 2.2.1	Overweight: SDG 2.2.2	Wasting	
	% stunted (moderate and severe)	% overweight (moderate and severe)	% wasted (moderate and severe, SDG 2.2.2)	% wasted (severe)
National	**24**	**1.7**	**13**	**2.5**
Barishal	26	1.4	13	2.4
Chattogram	26	1.2	14	3.2
Dhaka	22	3.4	11	2.4
Khulna	21	1.1	13	2.0
Mymensingh	25	1.3	12	2.5
Rajshahi	23	1.2	15	2.1
Rangpur	23	0.9	14	2.5
Sylhet	32	1.6	14	2.3

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The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to the Nutritional Status of Children.

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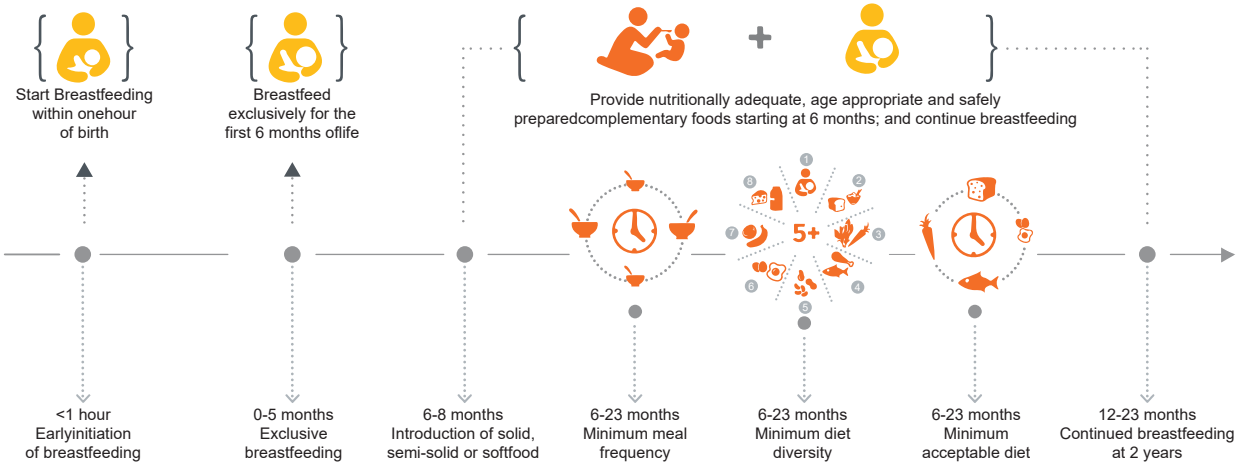
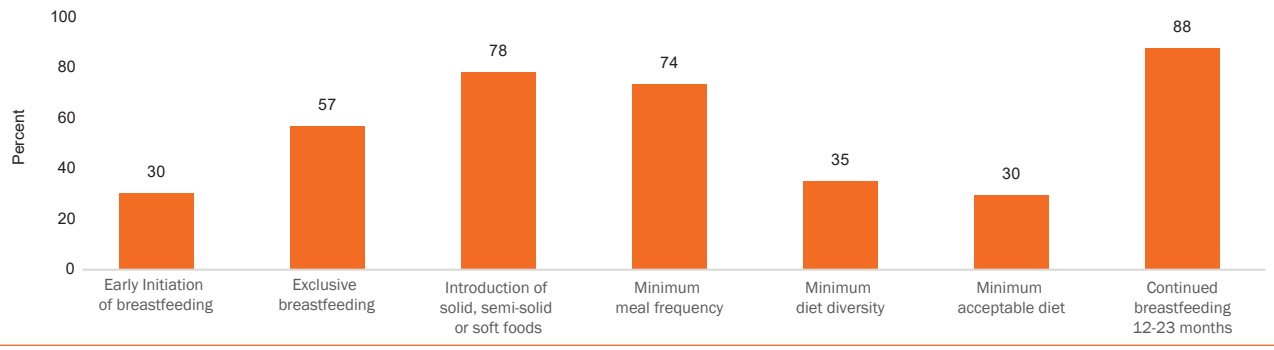
BANGLADESH 2025

Infant & Young Child Feeding (IYCF)

MICS
Multiple Indicator Cluster Surveys

Infant & Young Child Feeding





Early initiation: percentage of newborns put to breast within 1 hour of birth; Exclusive breastfeeding: percentage of infants aged 0-5months receiving only breastmilk; Introduction to solids: percentage of infants aged 6-8 months receiving solid or semi-solid food; Minimum diet diversity: percentage of children aged 6-23 months receiving 5 of the 8 recommended food groups; Minimum meal frequency: percentage of children aged 6-23 months receiving the recommended minimum number of solid/liquid feeds as per the age of child; Minimumacceptable diet: percentage of children aged 6-23 months receiving the minimum diversity of foods and minimum number of feeds; Continued breastfeeding 12-23 months: percentage of children aged 12-23 months who continue to receive breastmilk.

Key Messages

- Findings from this MICS show low overall rates of early initiation of breastfeeding (30%). Richer women live in urban areas and have higher levels of education, and women who gave birth in health facilities and via caesarean section are substantially less likely to breastfeed within one hour of birth. There is a great need to improve awareness amongst women and health professionals in Bangladesh about the benefits of early initiation of breastfeeding.
- In Bangladesh, most women (88%) continue breastfeeding beyond a year, indicating that many children in Bangladesh experience the benefits of receiving breastmilk into their second year of life. However, only 74% of children aged 6-23 months receive the minimal meal frequency recommended for children this age. Even fewer children aged 6-23 months receive the recommended minimum diet diversity (35%) and a minimum acceptable diet (30%).
- These data indicate poor transition from breastfeeding to a healthy diet, which puts children at risk for stunting, wasting, and other illnesses caused by malnutrition. Children who live in a rural and poor households, whose mothers/ caretakers have low levels of education and younger children are far less likely to receive the minimum recommended diet diversity. However, less than half the children who live in urban and wealthy households, whose mothers/caretakers attained higher secondary education and older children receive the minimum recommended diet diversity. These data indicate that poor nutrition for children in Bangladesh is not only a result of a lack of access to good food and economic constraints. Lack of knowledge regarding a healthy and diverse diet is evident even in urban, wealthy, and educated households. There is an urgent need to provide mothers, caretakers and health professionals knowledge about appropriate feeding of young children, including the consumption of appropriate, adequate and safe complementary foods after six months, which leads to better health and growth outcomes for children.

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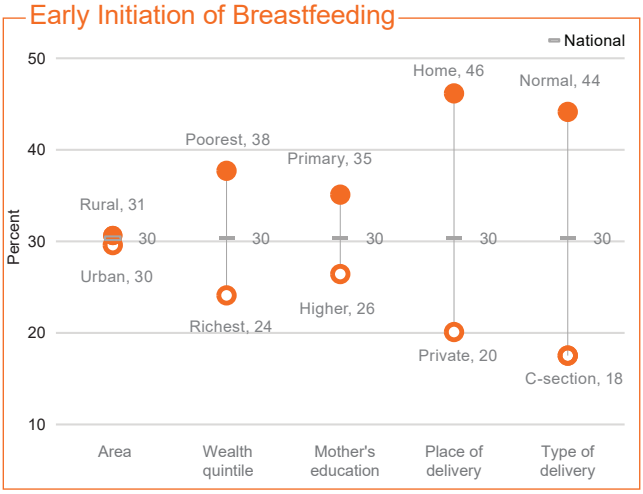
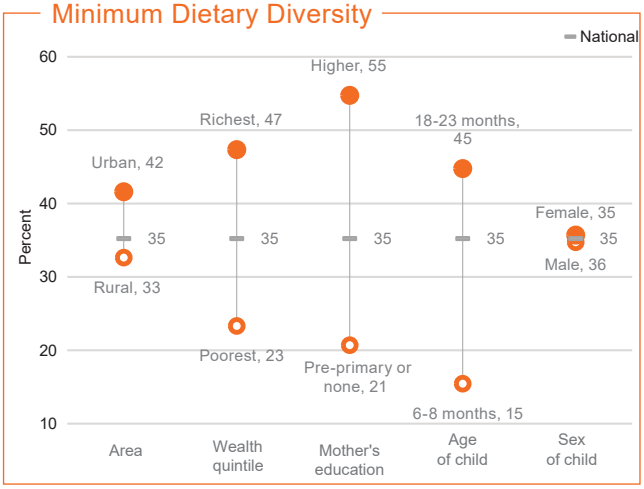
IYCF: Equity

Early Initiation of Breastfeeding



Percent of newborns put to the breast within one hour of birth, by background characteristics

Minimum Dietary Diversity



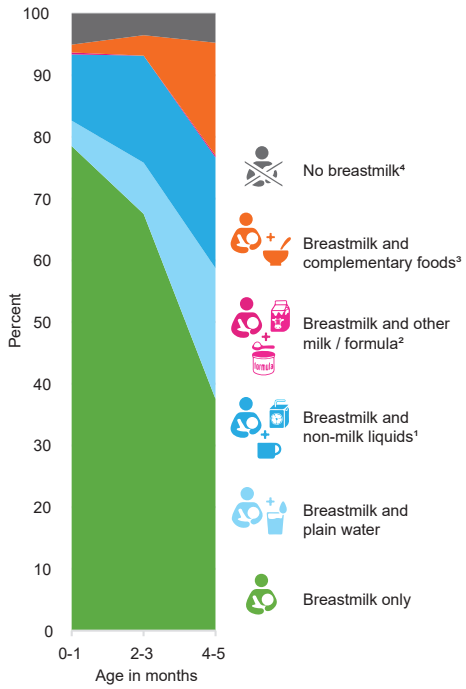
Percent of children aged 6-23 months that were fed food from at least 5 out of 8 food groups, by background characteristics

IYCF: What are the Youngest Infants Fed?

Liquids or foods consumed by infants 0-5 months old

Percent of infants aged 0-5 months receiving breastmilk only, breastmilk and plain water, breastmilk and non-milk liquids, breastmilk and other milk/formula, breastmilk and complementary foods and no breastmilk

Notes: 1) may also have been fed plain water; 2) may also have been fed plain water and/or non-milk liquids; 3) may also have been fed plain water, non-milk liquids and/or other milk/formula; 4) may have been fed plain water, non-milk liquids, other milk/infant formula and/or solid, semi-solid and soft foods.



Divisional Data

Division	Early Initiation of breastfeeding	Minimum Dietary Diversity
National	**30**	**35**
Barishal	38	39
Chattogram	30	33
Dhaka	26	42
Khulna	30	32
Mymensingh	34	29
Rajshahi	33	36
Rangpur	32	36
Sylhet	32	28

Percent of newborns put to the breast within one hour of birth, and percent of children aged 6-23 months that were fed food from at least 5 out of 8 food groupsby geographic region

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The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Infant & Young Child Feeding (IYCF).

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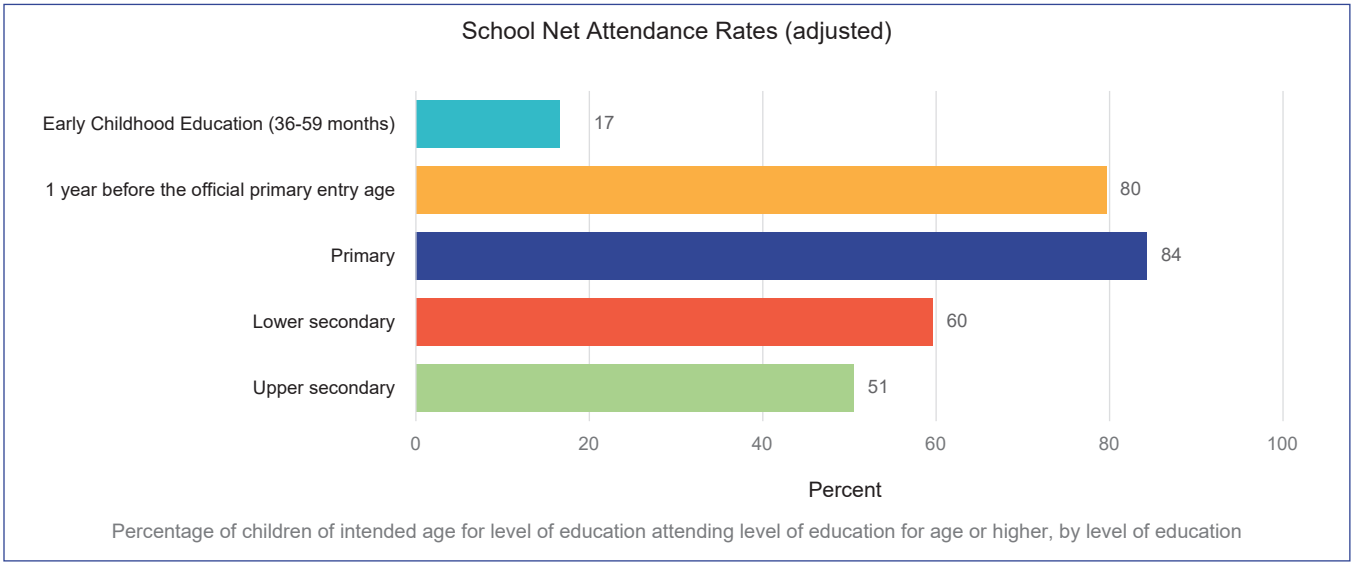
BANGLADESH 2025

Education

MICS

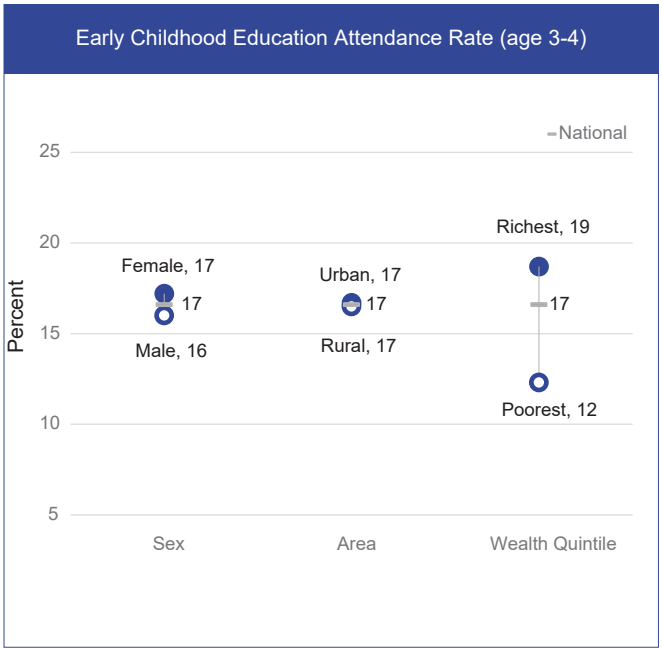
Multiple Indicator Cluster Surveys

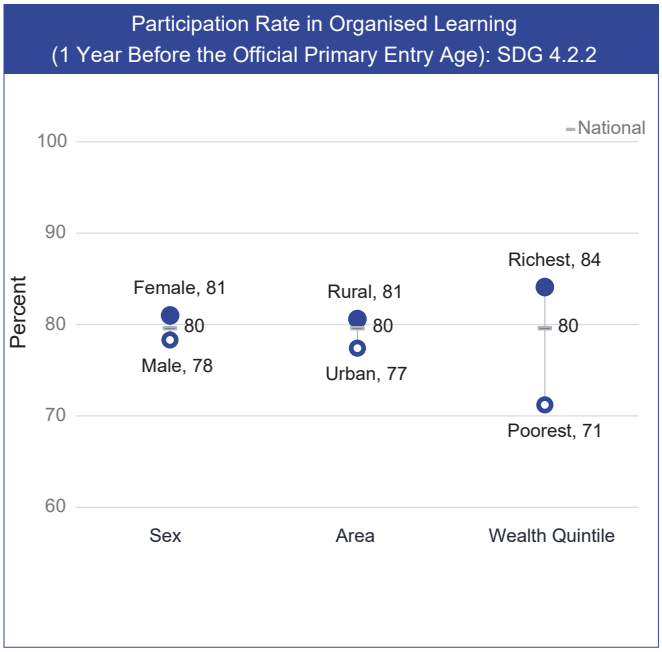
Attendance Rates & Inequalities



Percentage of children of intended age for level of education attending level of education for age or higher, by level of education

Inequalities in Attendance in Early Childhood Education & Participation in Organized Learning





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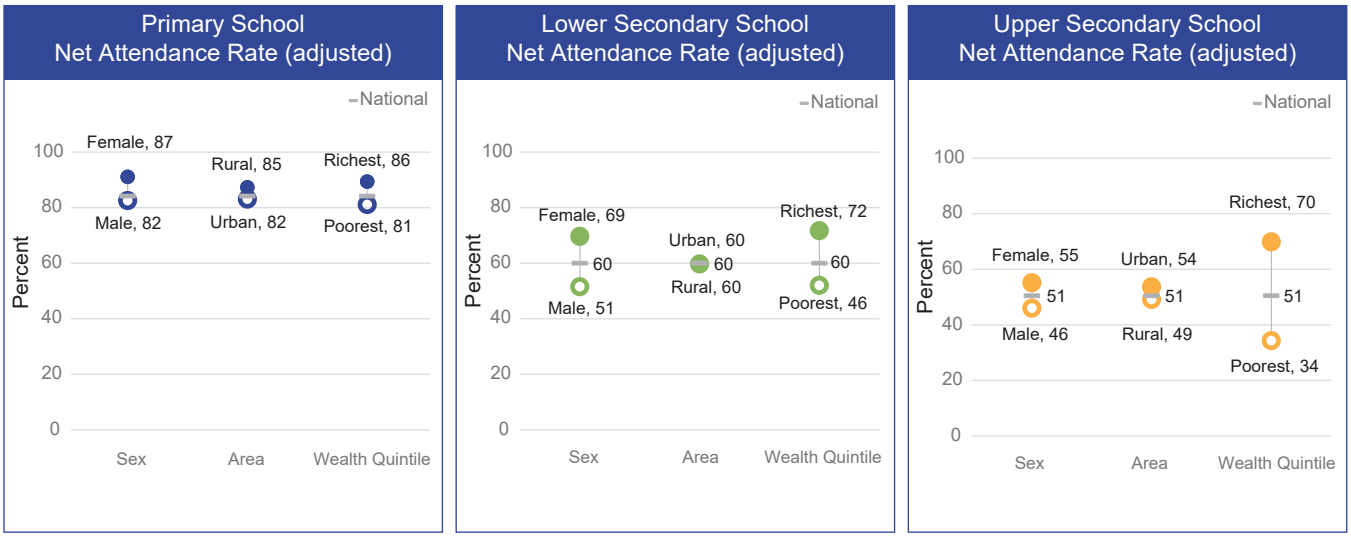
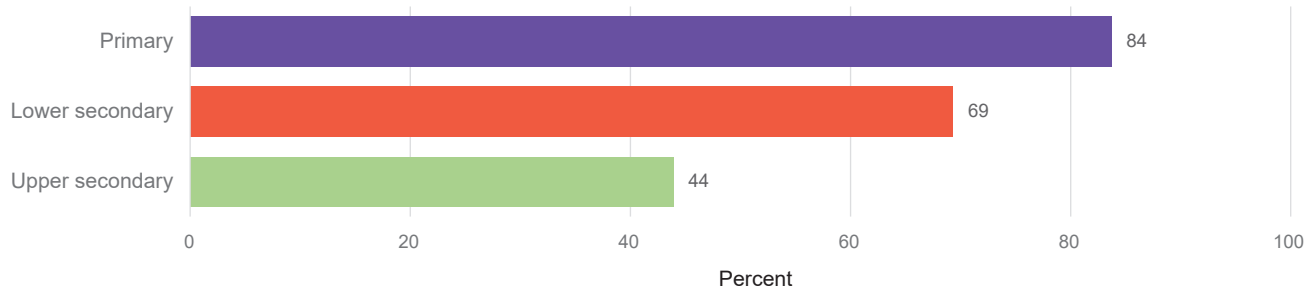
Inequalities in Attendance Rates



Divisional Data for Net Attendance Rates (adjusted)

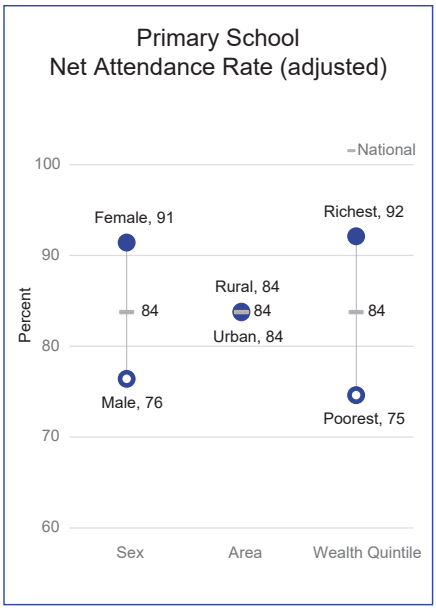
Division	Early Childhood Education (age 3-4)	Participation rate in organized learning (age 5)	Primary (age 6-11)	Lower Secondary (age 12-14)	Upper Secondary (age 15-17)
National	**16.6**	**79.6**	**84.3**	**59.6**	**50.5**
Barishal	15.3	81.5	89.0	66.0	58.1
Chattogram	21.4	83.6	87.0	64.1	48.8
Dhaka	15.2	77.6	82.1	56.1	49.2
Khulna	14.8	82.9	86.0	68.7	55.4
Mymensingh	18.5	73.4	78.7	52.2	47.3
Rajshahi	14.2	79.3	82.4	59.0	53.8
Rangpur	14.5	80.0	83.5	56.4	51.4
Sylhet	13.0	75.1	87.9	54.6	44.4

Completion Rates: SDG 4.1.2

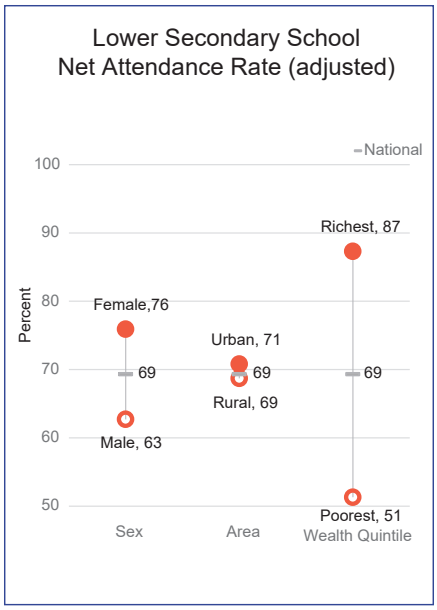


Percentage of children age 3 to 5 years above the intended age for the last grade who have completed that grade, by level of education

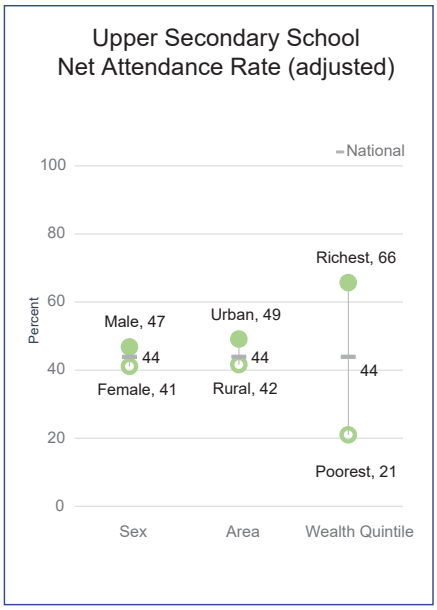
Inequalities in Completion Rates



Percentage of children age 3 to 5 years above the intended age for the last grade of primary school who have completed primary education



Percentage of children age 3 to 5 years above the intended age for the last grade of lower secondary school who have completed lower secondary education

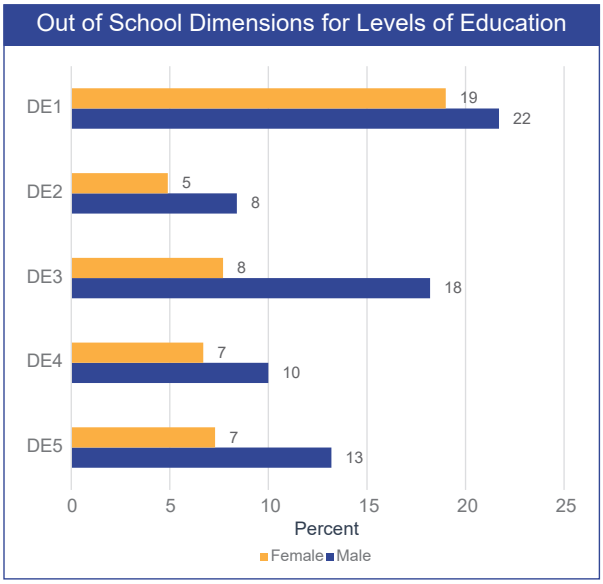


Percentage of children age 3 to 5 years above the intended age for the last grade of lower secondary school who have completed lower secondary education

Divisional Data in Completion Rates

Division	Primary (age 6-11)	Lower Secondary (age 12-14)	Upper Secondary (age 15-17)
National	**83.7**	**69.3**	**43.9**
Barishal	88.2	74.6	46.4
Chattogram	83.4	66.3	40.7
Dhaka	81.6	68.0	42.7
Khulna	87.9	72.7	47.8
Mymensingh	78.8	68.8	41.2
Rajshahi	87.3	74.0	50.7
Rangpur	84.8	74.1	49.2
Sylhet	81.5	59.5	34.0

Out of School Rates



Dimension 1: Children age one year younger than primary entry age not attending an early childhood education programme or primary school

Dimension 2: Children of primary school age who are not attending any level of education

Dimension 3: Children of lower secondary school age who are not attending any level of education

Dimension 4: Children who are in primary school but at risk of dropping out (over-age for grade by 2 or more years)

Dimension 5: Children who are in lower secondary school but at risk of dropping out (over-age for grade by 2 or more years)

SDG Summary for Education

SDG	MICS Indicator	Definition & Notes	Value		
			Primary	Lower Secondary	Upper Secondary
4.1.2	LN.8a,b,c	Completion rate	83.8%	69.3%	43.8%
4.5.1	LN.5a	Gender Parity Indices (attendance, girls/boys)	1.07	1.36	1.21
4.5.1	LN.5b	Wealth Parity Indices (attendance, poorest/richest)	0.94	0.64	0.49
4.5.1	LN.5c	Area Parity Indices (attendance, rural/urban)	1.03	1.00	0.91
			Total	**Boys**	**Girls**
4.2.2	LN.2	Participation rate in organized learning (one year before the official primary entry age)	79.6%	78.3%	81.0%

Key Messages

- In Bangladesh, 8 out of 10 children in the primary school age group are enrolled in primary education. However, only 6.7% of the primary school age group are out-of-school. The rest 9% are still attending early childhood education programmes. By lower secondary level, the net attendance rates decrease to 60% of the relevant age group, and by upper secondary, only 51% of upper secondary school age children are enrolled in school. The current policy in Bangladesh that focuses on universal primary education, as well as the need to prioritize attendance at higher levels, are reflected in these data.
- Children from the poorest households and male children are less likely to attend school than children from the wealthiest households and female children. These data may reflect economic imperatives.
- While 84% of children in Bangladesh complete primary school, only 44% of children complete upper secondary school. Children from poor households are more likely to not complete school at all levels. Male children are more likely than female children not to complete primary school. At the lower and upper secondary levels, the disparity between school completion rates for male and female children is less, although male children are still less likely to complete lower secondary school.
- Data from this MICS demonstrate a declining trend in school attendance from lower secondary to upper secondary across all divisions, though the declining trend is more pronounced in some divisions than in others. This decline could be context-specific, socio- cultural, or economic.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

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BANGLADESH 2025

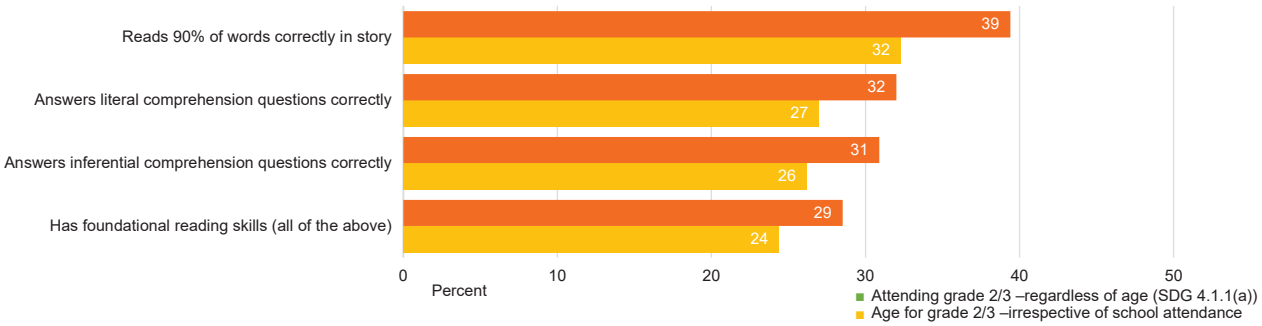
MICS

Multiple Indicator Cluster Surveys

Early Grade Learning & Parental Involvement

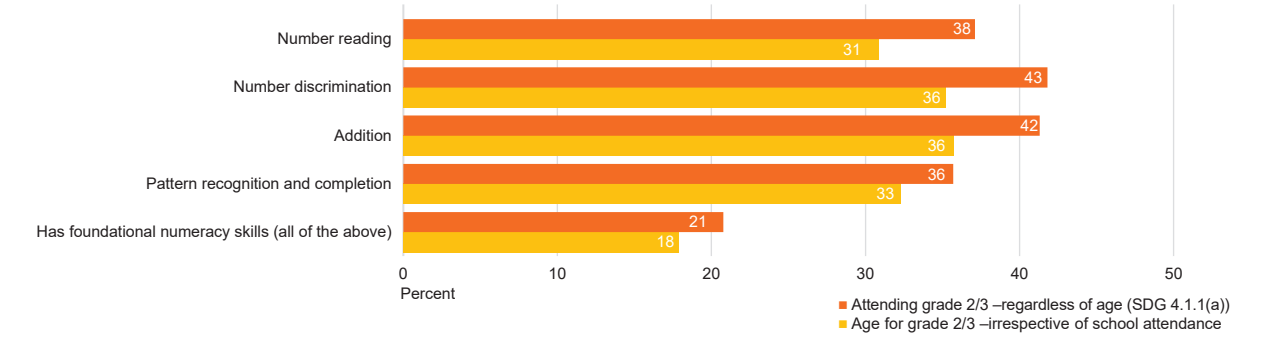
Early Grade Learning: SDG 4.1.1(a)

Foundational Reading Skills: SDG 4.1.1(a) (i: reading)



Percentage of children attending grade 2/3 who can 1) read at least 90% of words in a story correctly, 2) answer three litera comprehension questions, 3) answer two inferential comprehension questions

Foundational Numeracy Skills: SDG 4.1.1(a) (ii: numeracy)

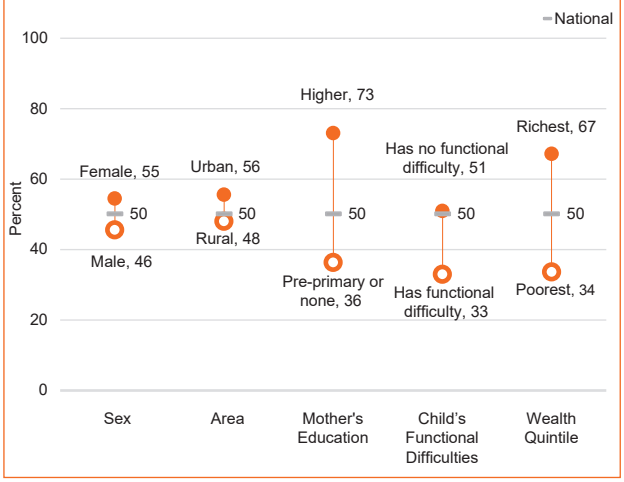


Key Messages

- In Bangladesh, only 24% of children of age for grade 2/3 demonstrated foundational reading skills. Only 39% of children could read 90% of the words in a story correctly, and only 32% could correctly answer three literal comprehension questions; 30% could correctly answer two inferential comprehension questions.
- Children's performance in numeracy is worse, with only 18% of children of age for grade 2/3 demonstrating foundational numeracy skills. Only 31% of children were able to perform a number reading task successfully, while 36% could perform a number discrimination exercise. Only 36% of children of age for grade 2/3 could perform “addition” tasks, and only 33% could complete pattern recognition and completion tasks.
- Findings from early-grade learning assessments underscore the need for the government to prioritize foundational literacy and numeracy (FLN) in the early years of schooling. Key areas of focus include: (i) equipping teachers with structured pedagogical tools and approaches; (ii) tailoring instruction to children's learning levels than by grade; and (iii) enhancing caregiver and community awareness and practices through providing relevant information on education.
- The proportion of parents' involvement with school authority and teachers is at a satisfactory level as 63% of children received a report card, and 63% of schools have a governing body that is open to parents. A further 73% of parents met with a teacher to discuss a child's progress in school.

Early Grade Learning: Disaggregates (age 7-14 years)

Disaggregates in Foundational Reading Skills

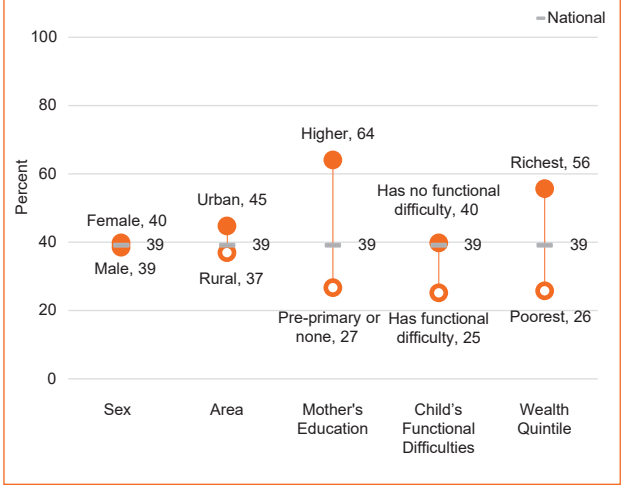


Divisional Data on Foundational Reading Skills

Division	Boys	Girls	Total
National	46	55	50
Barishal	43	51	47
Chattogram	45	55	51
Dhaka	50	57	54
Khulna	47	57	52
Mymensingh	39	47	43
Rajshahi	50	57	54
Rangpur	44	53	48
Sylhet	35	51	43

Percentage of children age 7-14 years who demonstrate foundational reading skills by successfully completing three foundational reading tasks, by background characteristics

Disaggregates in Foundational Numeracy Skills



Divisional Data on Foundational Numeracy Skills

Division	Boys	Girls	Total
National	**39**	**40**	**39**
Barishal	36	34	35
Chattogram	40	41	40
Dhaka	40	40	40
Khulna	42	45	43
Mymensingh	35	33	34
Rajshahi	41	41	41
Rangpur	37	42	39
Sylhet	34	39	36

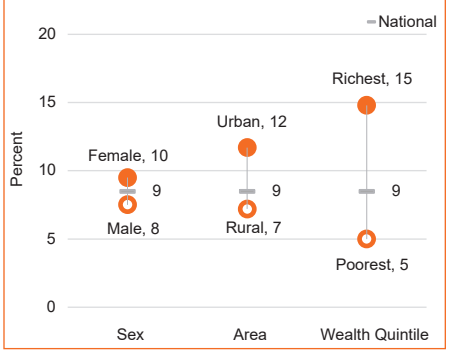
Percentage of children age 7-14 years who demonstrate foundational numeracy skills by successfully completing four foundational numeracy tasks, by background characteristics

Measuring Reading & Numeracy Skills in MICS

- The Foundational Learning Skills (FL) module is a direct assessment of children's reading and numeracy competencies. It is designed to assess foundational learning skills expected upon completion of 2nd grade of primary education, thus contributing to SDG indicator 4.1.1(a).
- The FL module is part of the Questionnaire for Children Age 5-17 administered to one randomly selected child in each household. Children age 7-14 years are eligible for module.
- The reading assessment in the FL module consists of a reading passage and a set of comprehension questions related to the story. The assessment is customised in each country to ensure vocabulary and cultural references are relevant and appropriate. The numeracy assessment consists of four number tasks based on universal math skills expected at 2nd grade level.
- The reading assessment of Bangladesh MICS was conducted in English, and Bangla.
- As MICS also collects data on school attendance and numerous individual and household characteristics, such as location, household socio-economic status, and ethnicity, the most marginalized sub-populations of children can be identified for support to improve learning outcomes.

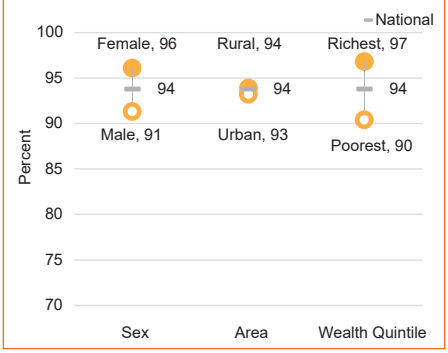
Parental Involvement: Learning Environment at Home

Children with 3 or more books to read at home



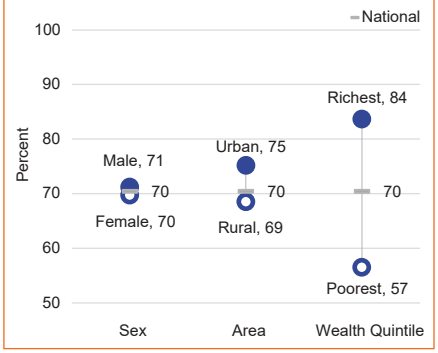
Percentage of children age 7-14 years with 3 or more books at home, by background characteristics

Children with 3 or more books to read at home



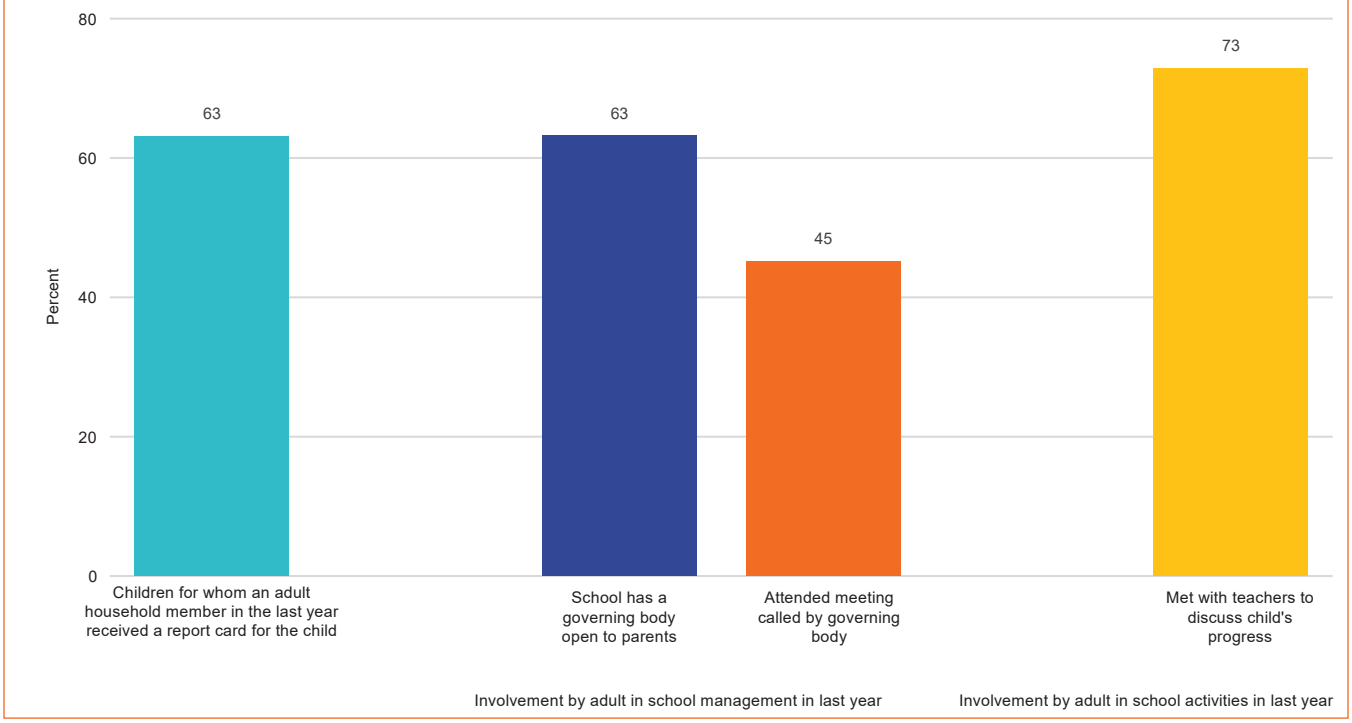
Percentage of children age 7-14 years who read books or are read to at home, by background characteristics

Children who receive help with homework



Percentage of children age 7-14 years attending school and having homework who receive help with homework, by background characteristics

Parental Involvement in school



Percentage of children age 7-14 years attending school, by indicators of parental support

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Early Childhood Development (ECD)

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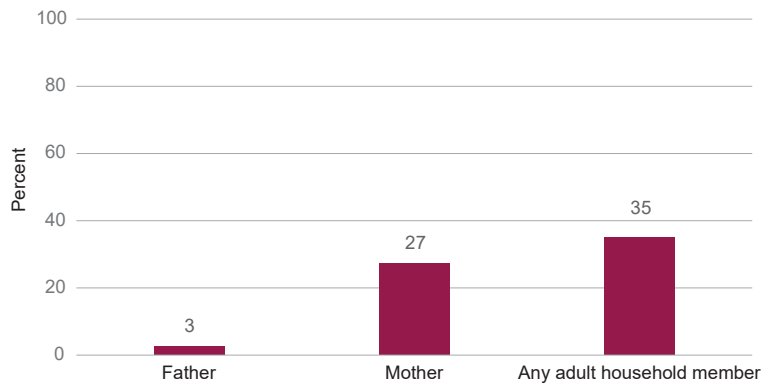
Multiple Indicator Cluster Surveys

Early Stimulation and Early Childhood Education

Early Stimulation & Responsive Care



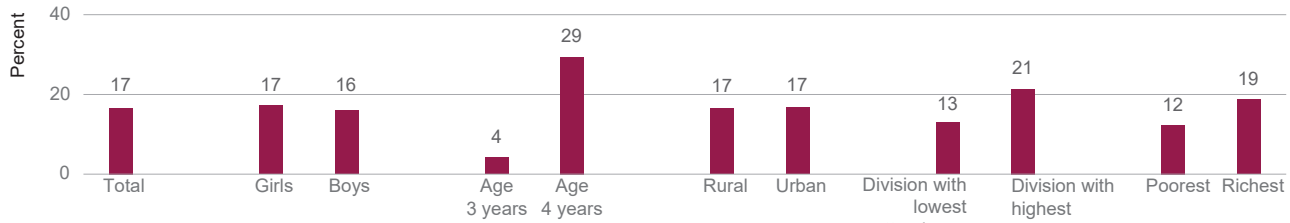
Percentage of children age 2-4 years with whom the father, mother or adult household members engaged in activities that promote learning and school readiness during the last three days

Note: Activities include: reading books to or looking at picture books with the child; telling stories to the child; singing songs to or with the child; taking the child outside the home; playing with the child; and naming, counting or drawing things for or with the child.

Early childhood, which spans the period up to 8 years of age, is critical for cognitive, social, emotional, and physical development. During these years, a child's newly developing brain is highly plastic and responsive to change. Optimal early childhood development requires a stimulating and nurturing environment, access to books and learning materials, interactions with responsive and attentive caregivers, adequate nutrients, access to good quality early childhood education, and safety and protection. All these aspects of the environment contribute to developmental outcomes for children.

A broad range of factors can prevent children from reaching their full developmental potential. These risks are often interrelated and include poverty, poor health, exposure to violence and high stress levels, inadequate care, and limited learning opportunities. Timely and effective interventions can prevent these risks and address the barriers disproportionally affecting children living in the most vulnerable contexts. Investments during the early years are one of the most cost-effective ways countries can reduce inequalities among children and promote the best start in life for all.

Attendance at Early Childhood Education Programmes



Percentage of children age 3-4 years attending an early childhood education programme, by background characteristics

Key Messages

- Mothers (27%) are more likely to engage in early stimulation and responsive care activities with young children compared to fathers (3%). While 35% of children aged 2-4 years received early stimulation or responsive care from any adult household member in the three days prior to the survey, responsive care and early stimulation by fathers was very low.
- In Bangladesh, children are far more likely to be enrolled in formal early learning programmes at the age of 4 (29%) compared to children who are aged 3 (4%).
- In Bangladesh, young children are ready to learn in many important ways. Moreover, 88% of children have manufactured toys or toys from a shop, and 77% of children have two or more playthings. However, only eight percent have three or more books at home.
- Low levels of participation in early learning programmes and low rates of early stimulation and responsive care activities deprive children in Bangladesh of opportunities to expand their language skills, learn co-operation by helping and sharing, and practice pre-writing and pre-reading skills before entering primary school.
- Throughout Bangladesh, children are commonly left alone or in the care of another child who is less than 10 years old; this referred to as inadequate supervision. Children in Mymensingh were most likely to be inadequately supervised (19%), while children in Sylhet were least likely to be inadequately supervised (8%). Inadequate supervision of children denies them their right to live in an environment where they are protected from harm.

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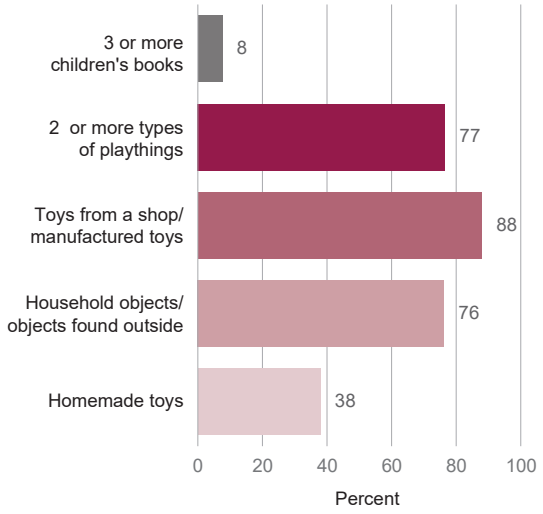
Access to Books and Playthings, and Child Supervision

Toys and children's books



Percentage of children under age five according to the number of children's books available in their homes, and their access to different types of playthings and toys.

Inadequate supervision of children

Division	Left in inadequate supervision
National	**13**
Barishal	11
Chattogram	14
Dhaka	11
Khulna	10
Mymensingh	19
Rajshahi	15
Rangpur	16
Sylhet	8

Percentage of children under age five left alone or under the supervision of another child younger than 10 years of age for more than one hour at least once in the last week, by Division

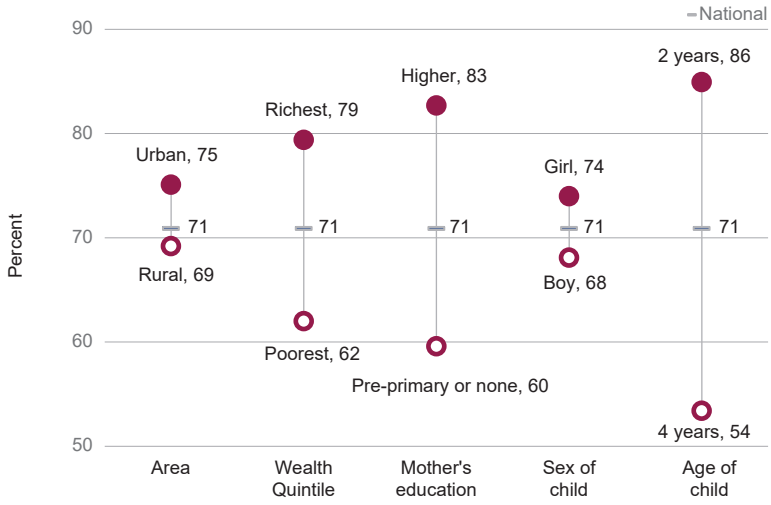
Early Childhood Development Index 2030 (ECDI2030)

The ECDI2030 captures the achievement of key developmental milestones by children between the ages of 24 and 59 months.

The measure includes 20 questions about the way children behave in certain everyday situations, and the skills and knowledge they have acquired, reflecting the increasing difficulty of the skills children acquire as they grow. The 20 items are organised according to the three general domains of health, learning and psychosocial well-being. A child is considered to be developmentally on track if they have achieved the minimum number of milestones expected for their age group.

The data generated by the ECDI2030 can be used for monitoring and reporting on SDG indicator 4.2.1, and to inform government efforts to improve developmental outcomes among young children.

ECDI: Disaggregates



Percentage of children aged 2-4 years who are developmentally on track in health, learning, and psychosocial well-being, by background characteristics
ECE: Early childhood education. Children age 2 are excluded, as early childhood education attendance is only collected for age 3-4 years.

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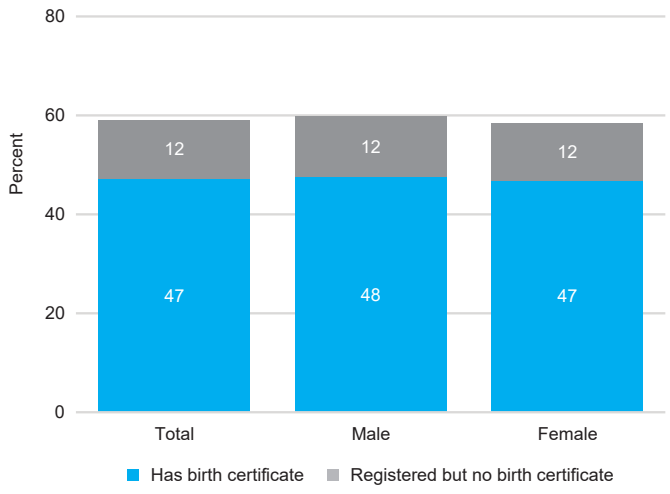
Birth Registration

MICS
Multiple Indicator Cluster Surveys

Birth Registration Levels

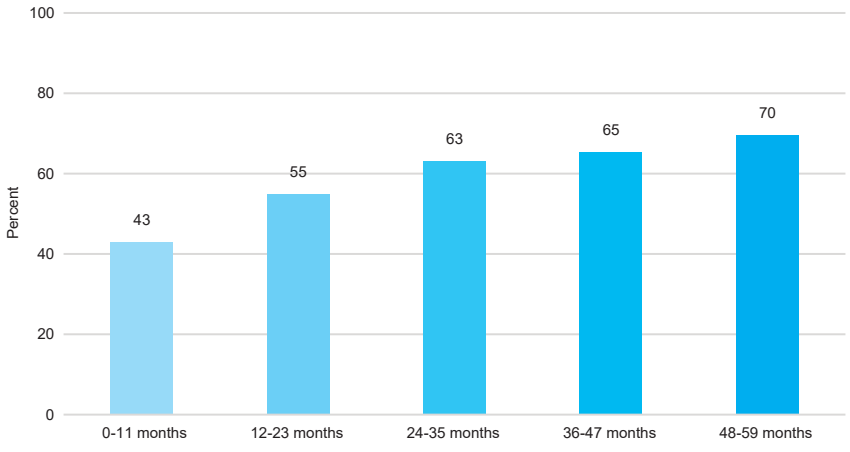
Birth registration for Children Under-Five: SDG 16.9.1



Percentage of children under age 5 whose births are registered, by whether or not they have a birth certificate and by sex

National birth registration has reached 59%, with 47% of children holding certificates. Gains are strongest among older preschool children and in higher-income households.

Birth registration by Age



Percentage of children under age 5 whose births are registered, by age in months

Key Messages

- Birth registration is improving but still incomplete. 59% of children under five are registered, up slightly from 56% in 2019.
- More children now have certificates. 47% have a birth certificate, compared to 39% in 2019.
- Barriers are not about awareness. Over 90% of caregivers know how to register, but poverty, cost, and access to union councils remain obstacles.
- Progress varies by division. Registration is highest in Sylhet (76%) and lowest in Khulna (53%).
- Strengthening digital CRVS systems can accelerate universal registration by 2030.
- Health and registration services remain disconnected. Most births occur in health facilities, yet few are registered at the point of delivery. Linking CRVS and health systems would improve timeliness and completeness.
- Universal registration by 2030 is achievable. Sustained investment in digital infrastructure, simplified procedures, and community mobilization can ensure every child is counted and protected from birth.

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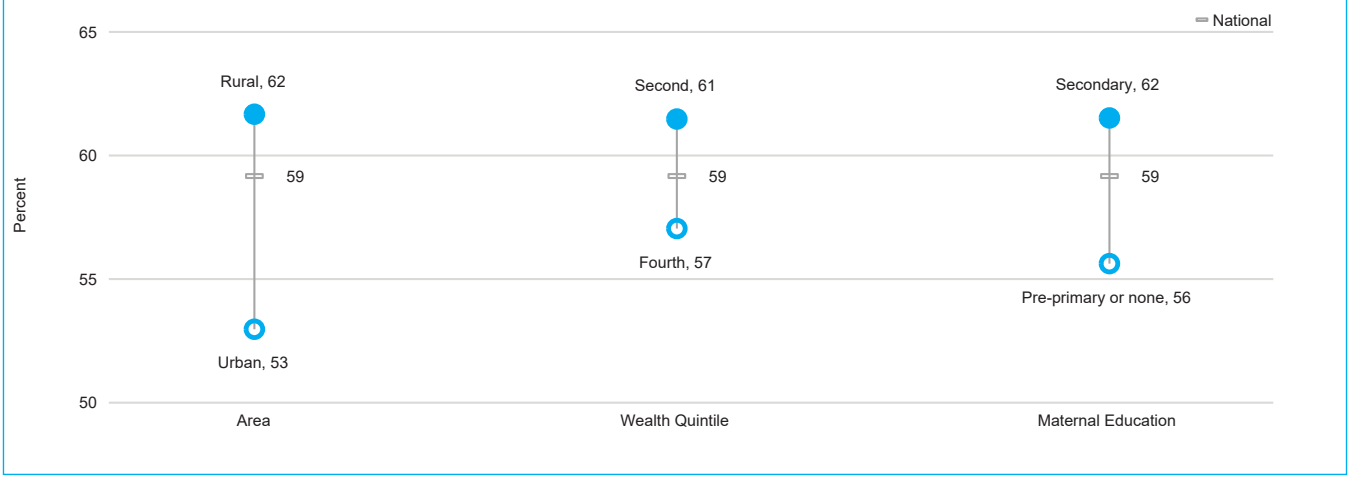
Birth Registration: Inequalities

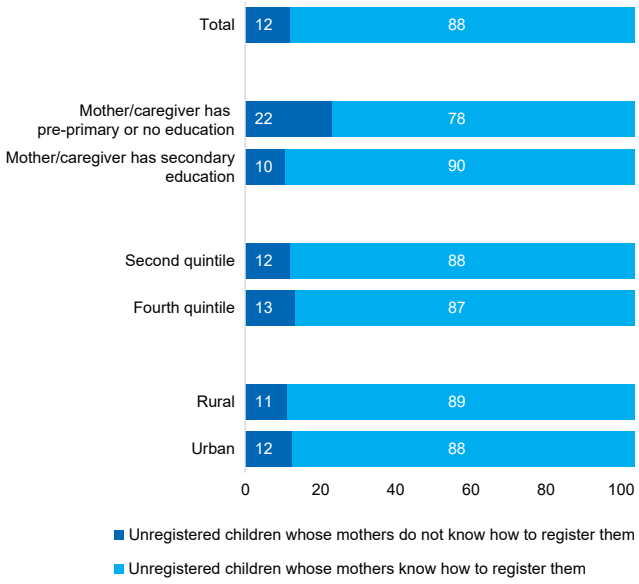


Percentage of children under age 5 whose births are registered, by background characteristics

Divisional Data on Birth Registration

Division	Total registered
National	**59**
Barishal	54
Chattogram	59
Dhaka	53
Khulna	57
Mymensingh	60
Rajshahi	71
Rangpur	62
Sylhet	64

Mother's (or Caregiver's) Knowledge of How to Register



Percentage of children under age 5 whose births are not registered, by mother's (or caregiver's) knowledge of how to register a child

Regional progress is uneven.

All divisions show modest gains since 2019, led by Sylhet (+4) and Khulna (+5). Expanding digital registration services through union councils and health facilities is key to reaching the remaining 41% of children without official identity.

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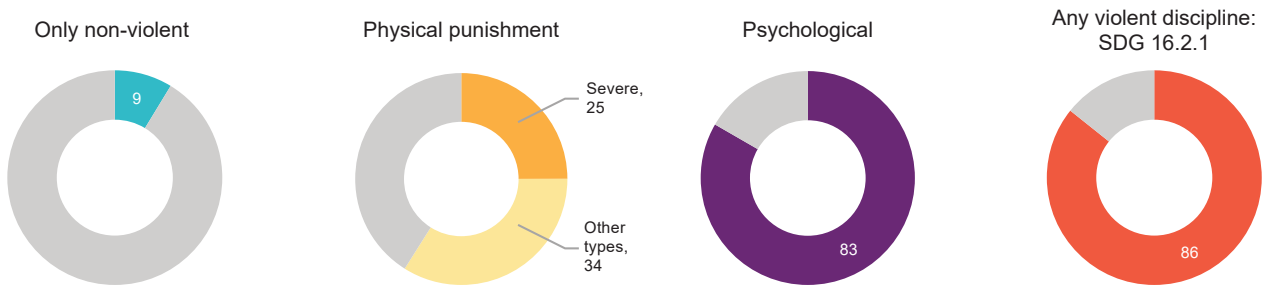
Child Discipline

MICS
Multiple Indicator Cluster Surveys

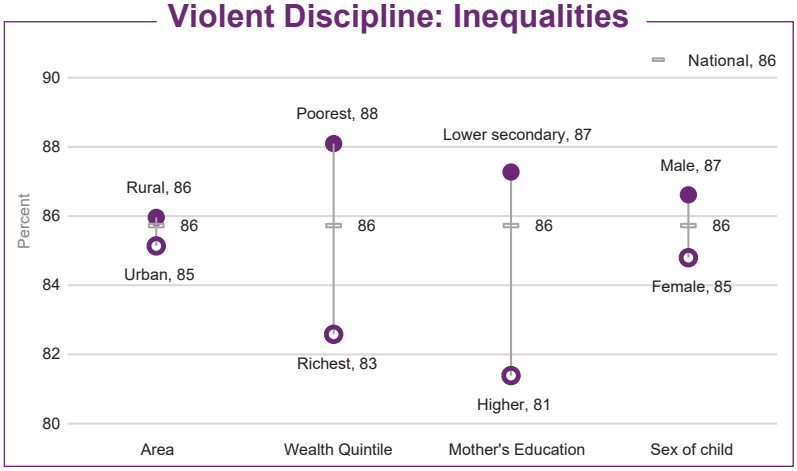
Child Discipline

Types of Child Discipline



Percentage of children age 1 to 14 years who experienced any discipline in the past month, by type

Violent Discipline: Inequalities



Physical punishment: Shaking, hitting or slapping a child on the hand/arm/leg, hitting on the bottom or elsewhere on the body with a hard object, spanking or hitting on the bottom with a bare hand, hitting or slapping on the face, head or ears, and hitting or beating hard and repeatedly.

Severe physical punishment: Hitting or slapping a child on the face, head or ears, and hitting or beating a child hard and repeatedly.

Psychological aggression: Shouting, yelling or screaming at a child, as well as calling a child offensive names such as 'dumb' or 'lazy'.

Violent discipline: Any physical punishment and/or psychological aggression.

Percentage of children aged 1 to 14 years who experienced any violent discipline in the past month, by background characteristics

Key Messages

- Violent discipline remains widespread — 86% of children aged 1–14 experienced physical or psychological violence in the past month, though slightly down from 89% in 2019.
- Physical punishment has declined to 80%, and severe punishment to 26%, showing gradual progress toward safer parenting.
- Only 9% of children experience non-violent discipline, highlighting the need to scale up positive-parenting approaches.
- One-third of adults (32%) still believe physical punishment is necessary, indicating slow change in social norms.
- Continued legal enforcement, expansion of the social service workforce, awareness and community-based parenting programmes are key to ending violence against children.

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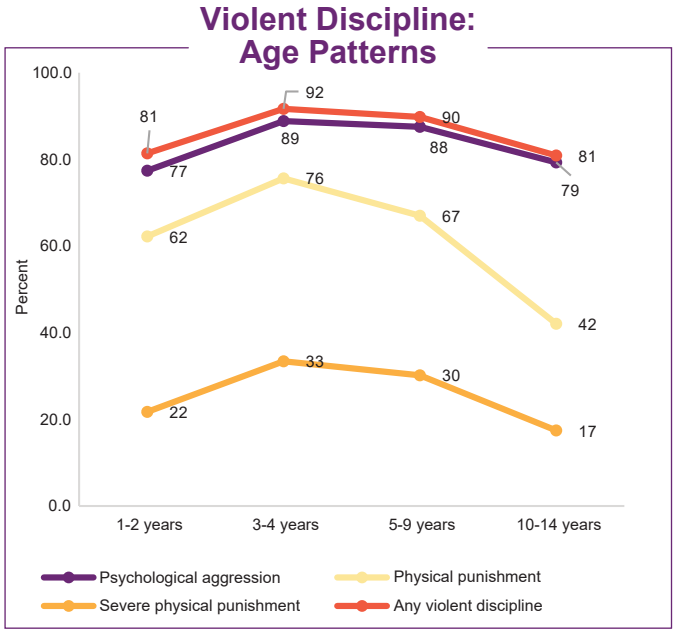
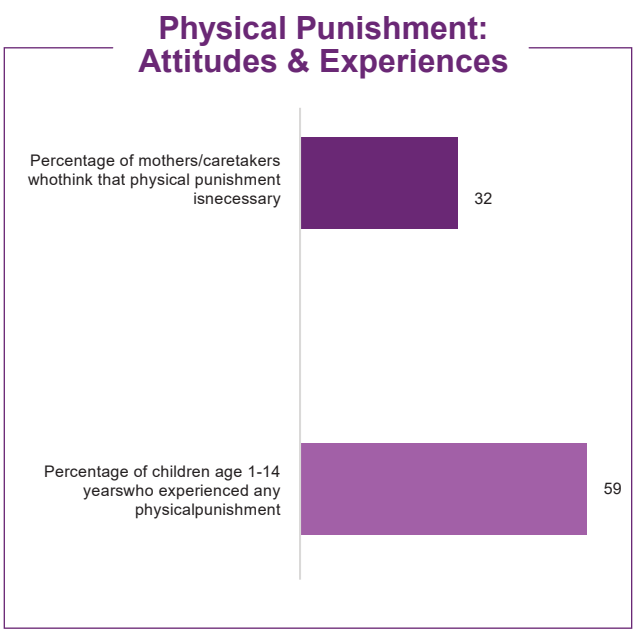
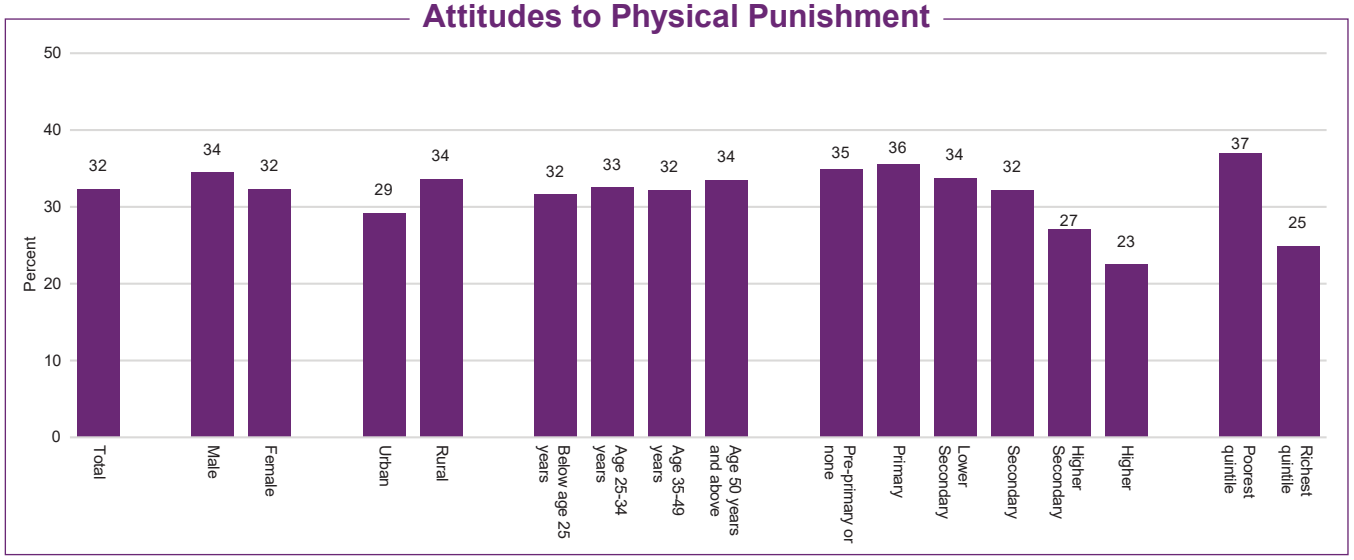




Percentage of children aged 1–14 years who experienced any discipline in the past month, by type

Most Bangladeshi children still face violent discipline at home. Psychological aggression remains the most common form, while non-violent approaches are slowly increasing.



Attitudes toward physical punishment are slowly changing.

While 32% of adults still consider physical punishment necessary, this has declined from 35% in 2019. Parents with higher education are less likely to support it, yet approval remains widespread across all groups.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF). Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Child Discipline.

Further statistical snapshots and the Survey Findings Report for this and other surveys are available on mics.unicef.org/surveys.

BANGLADESH 2025

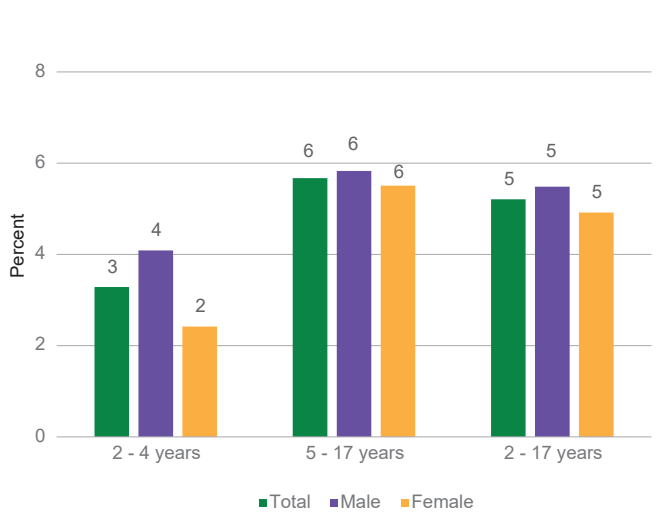
Child Functioning

MICS

Multiple Indicator Cluster Surveys

Child Functioning: Levels & Domains

Child Functioning Levels by Age-Group



Percentage of children age 2–17 years with functional difficulty, by age-group

Children with disabilities are among the most marginalized groups in society. Facing daily discrimination in the form of negative attitudes, and lack of adequate policies and legislation, they are often likely to be among the poorest members of the population and are less likely to attend school, access medical services, or have their voices heard in society. Discrimination against and exclusion of children with disabilities also puts them at a higher risk of physical and emotional abuse or other forms of neglect, violence and exploitation.

The Convention on the Rights of the Child (UNICEF, 1989) and the Convention on the Rights of Persons with Disabilities (UN, 2006) explicitly state the rights of children with disabilities on an equal basis with other children and call for improvements in their access to services, and in their participation in all aspects of life.

In order to achieve these goals, there is a need for cross-nationally comparable, reliable data. The Child Functioning module is designed In line with the WHO's International Classification of Functioning, Disability and Health and the UN Convention on the Rights of Persons with Disabilities, to collect information on functional difficulties that children experience in different domains including hearing, vision, communication/comprehension, learning, mobility and emotions. Children with functional difficulties may be at risk of experiencing limited participation in an unaccommodating environment and limit the fulfilment of their rights.

Child Functioning Domains

	Seeing	Hearing	Walking	Fine Motor	Communication	Learning	Playing	Controlling Behaviour	Self care	Remembering	Concentrating	Accepting Change	Making Friends	Anxiety	Depression
2-4 years	0.1	0.3	0.6	0.6	0.9	1.2	0.6	1.8	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5-17 years	0.2	0.2	1.6	N/A	0.6	1.2	N/A	1.2	1.0	1.3	0.7	0.9	0.7	1.4	1.5

Percentage of children age 2–4 and 5-17 years with functional difficulty in at least one domain, by domain of difficulty
N/A- Not Applicable

Key Messages

- About 5% of children aged 2-17 years had functional difficulty in at least one domain. Boys were more likely to have a functional difficulty than girls.
- The proportion of children with functional difficulties increases with age, from 3% at 2-4 years to 6% at 5-17 years.
- Walking, depression, and anxiety were the most common functional difficulties reported amongst children aged 5-17 (1.6%, 1.5%, and1.4%, respectively).
- Disparities exist for functional difficulties reported for children. Children who live in rural areas and come from the poorest households are more likely to have functional difficulty in at least one domain. Children whose mothers received only primary education are also more likely to have a functional difficulty in at least one domain than children whose mothers received higher secondary education.
- Children in Sylhet division, in the north-central region of the country, have the highest rate of functional difficulties in all three age groups, followed by Mymensingh division. The lowest proportion of children with functional difficulties recorded in Dhaka.

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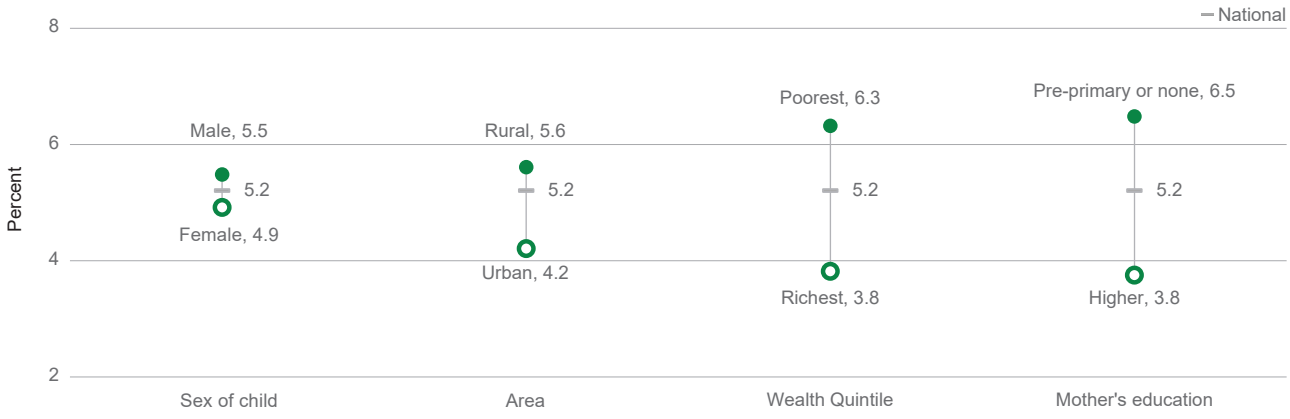
Child Functioning: Inequalities



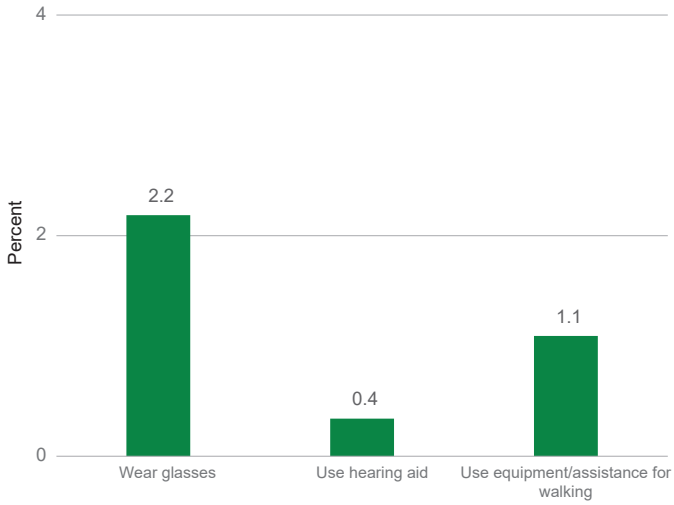
Percentage of children age 2–17 years with functional difficulty, by background characteristics

Divisional Data on Child Functioning

Division	2-4 years	5-17 years	2-17 years
National	**3.3**	**5.7**	**5.2**
Barishal	2.2	4.7	4.2
Chattogram	3.4	5.5	5.1
Dhaka	1.7	2.9	2.7
Khulna	4.5	6.9	6.4
Mymensingh	4.4	9.1	8.1
Rajshahi	4.9	5.4	5.3
Rangpur	3.2	6.9	6.2
Sylhet	3.3	9.5	8.5

Percentage of children age 2–17 years with functional difficulty in at least one domain, by region

Children who use Assistive Devices & have Functional Difficulties



Percentage of children age 2-17 years with difficulties seeing when wearing glasses among those who wear glasses, percentage of children age 2-17 years with difficulties hearing when using a hearing aid among those who use a hearing aid, and percentage of children age 2-17 years with difficulties walking when using equipment or receiving assistance among those who use equipment or receive assistance walking

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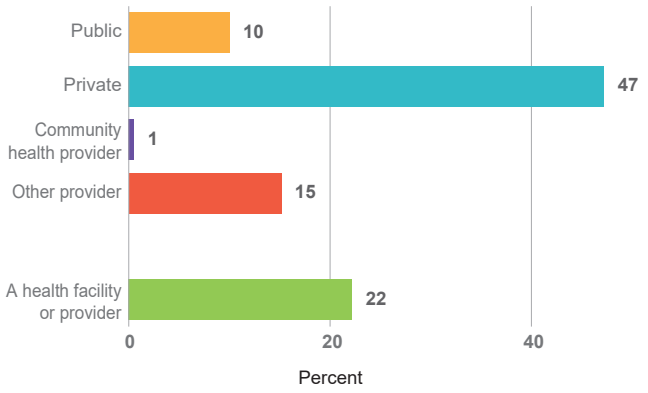
BANGLADESH 2025

Child Health & Care of Illness

MICS
Multiple Indicator Cluster Surveys

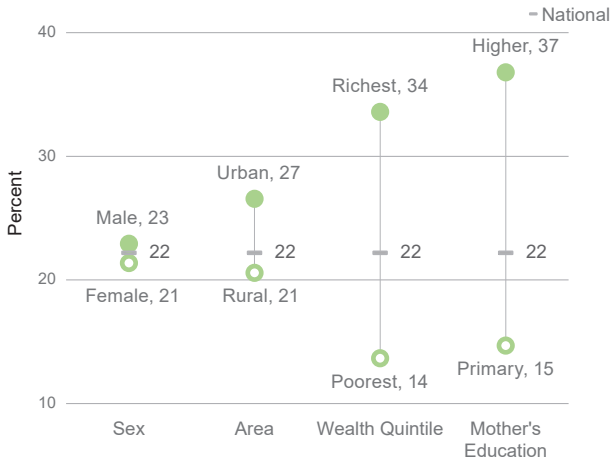
Diarrhoea

Care-seeking for Diarrhoea



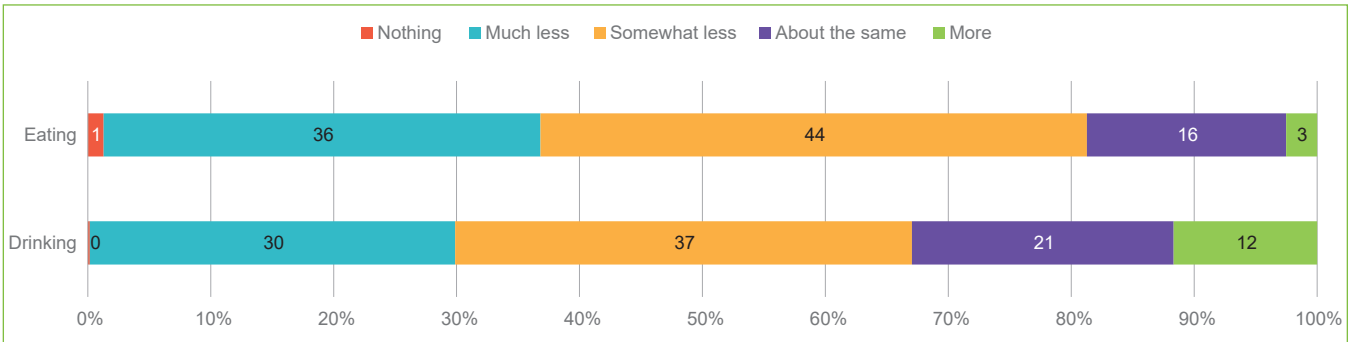
Percentage of children age 0-59 months with diarrhoea in the last two weeks for whom advice or treatment was sought by source of provider

Disparities in Care-seeking for Diarrhoea



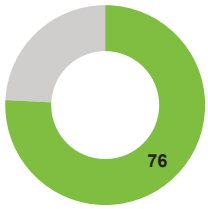
Percentage of children age 0-59 months with diarrhoea in the last two weeks for whom advice or treatment was sought at a health facility or provider

Feeding during Diarrhoea



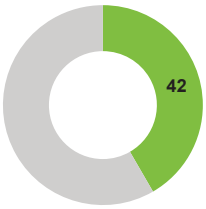
Percent distribution of children age 0-59 months with diarrhoea in the last two weeks by amount of liquids and food given during episode of diarrhoea

ORS Treatment for Diarrhoea



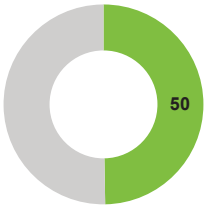
Percentage of children age 0-59 months with diarrhoea in the last two weeks treated with oral rehydration salt solution (ORS)

ORS + Zinc Treatment for Diarrhoea



Percentage of children age 0-59 months with diarrhoea in the last two weeks treated with oral rehydration salt solution (ORS)

ORT + Continued Feeding for Diarrhoea



Percentage of children age 0-59 months with diarrhoea in the last two weeks treated with oral rehydration salt solution (ORS)

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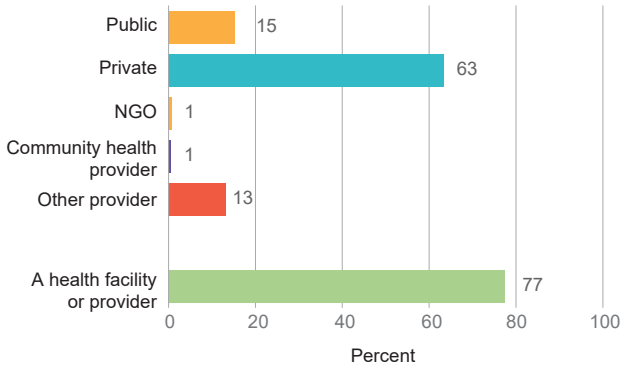
Symptoms of Acute Respiratory Infection (ARI)

Care-seeking for Symptoms of ARI



Percentage of children age 0-59 months with symptoms of ARI in the last two weeks for whom advice or treatment was sought, by source of advice or treatment

Disparities in Care-seeking for Symptoms of ARI

Percentage of children age 0-59 months with symptoms of ARI in the last two weeks for whom advice or treatment was sought at a health facility or provider

Divisional Data on Care-seeking for Childhood Illness

Division	Care-Seeking at a health facility or provider for	
	Diarrhoea	Symptoms of ARI
National	**22.2**	**77.5**
Barishal	17.1	60.9
Chattogram	21.2	79.7
Dhaka	27.7	93.7
Khulna	22.5	65.2
Mymensingh	15.6	61.4
Rajshahi	24.4	71.5
Rangpur	18.8	67.7
Sylhet	22.1	84.8

Key Messages

- For one in three children with diarrhoea in Bangladesh, no advice or treatment is sought for the illness.
- Children aged 0-59 months who suffered from diarrhoea in the two weeks prior to the survey were more likely to be taken to a private care provider (47%) than any other type of provider. Only 10% of children who had suffered from diarrhoea taken to a health facility or provider. Similar results found for acute respiratory infection (ARI), where only 77% of children received treatment for ARI from a health facility, compared to 63% who take to a private provider.
- These results indicate that the use of private health providers, including community providers, is a common practice in Bangladesh.
- Poor households, or whose mothers/caretakers have no education are less likely to be taken to a provider for the care of diarrhoea, and ARI. In some instances, the disparities are acute. For example, only 74% of children with symptoms of ARI in rural areas taken to a health facility or provider for care, compared to 87% of children in urban areas.
- Seventy-six percent of children with diarrhoea received ORS, but only 42% received ORS and zinc, which is the recommended treatment for diarrhoea for children aged 0-59 months. Just around half (50%) of the children who had suffered from diarrhoea received oral rehydration therapy and continued feeding

The Bangladesh Multiple Indicator Cluster Survey (MICS) The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

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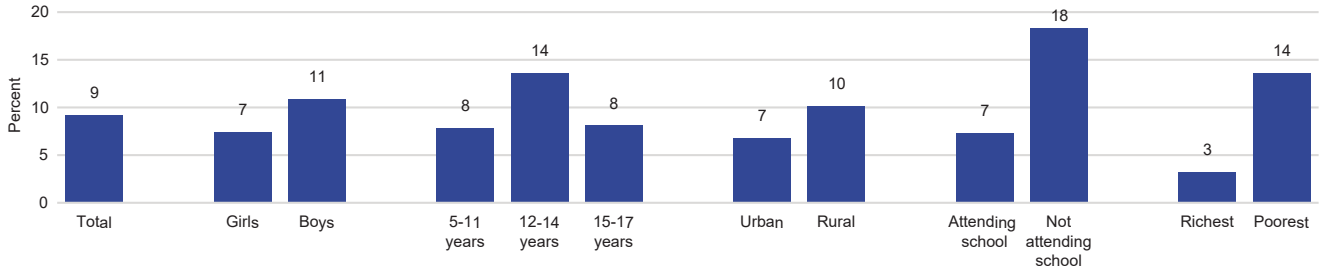
BANGLADESH 2025

Child Labour

MICS
Multiple Indicator Cluster Surveys

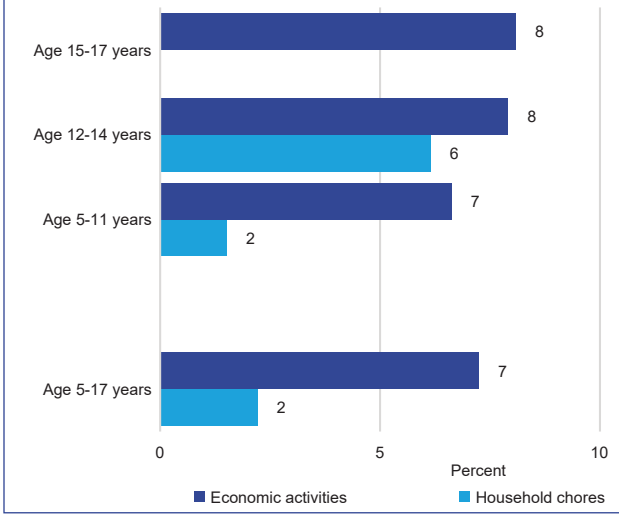
Child Labour: Levels & Disaggregates

Child Labour for Age 5-17 years: SDG 8.7.1



Percentage of children age 5 to 17 years engaged in child labour, by background characteristics

Types of Child Labour



Definition of Child Labour

Age 5 to 11 years: At least 1 hour of economic activities or 21 hours of unpaid household services per week.

Age 12 to 14 years: At least 14 hours of economic activities or 21 hours of unpaid household services per week.

Age 15 to 17 years: At least 43 hours of economic activities. No threshold for number of hours of unpaid household services.

Economic activities include paid or unpaid work for someone who is not a member of the household, work for a family farm or business. Household chores include activities such as cooking, cleaning or caring for children.

Note that the definition of the child labour indicator changed during the implementation of the sixth round of MICS. Changes include age-specific thresholds for household chores and exclusion of hazardous working conditions. While the overall concept of child labour includes hazardous working conditions, the definition of child labour used for SDG reporting does not.

Percentage of children age 5 to 17 years engaged in child labour, by type of activity and by age

Note: These data reflect the proportions of children engaged in the activities at or above the age specific thresholds outlined in the definitions box.

Key Messages

- Child labour has increased nationally since 2019, now affecting around 9.2% of children aged 5–17 years. Boys remain more likely to work than girls (around 11% vs 4%).
- Rural children and those out of school are most at risk, children not attending school are four times more likely to be in labour.
- Regional gaps persist, with higher prevalence in Rajshahi and Rangpur despite overall progress.
- The new MICS definition aligns with SDG 8.7.1, using refined age and work-hour thresholds and reporting hazardous work separately.

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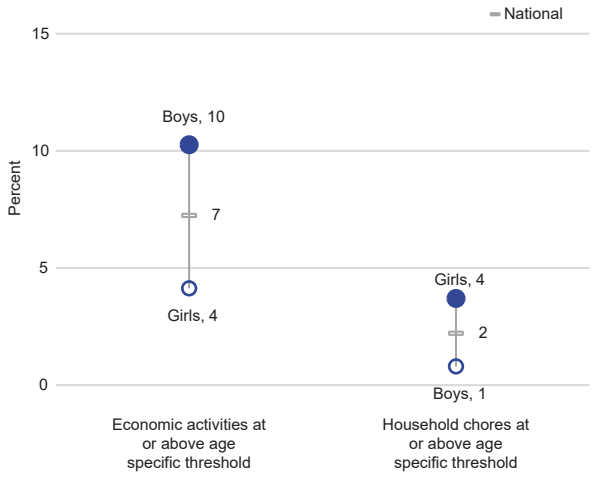
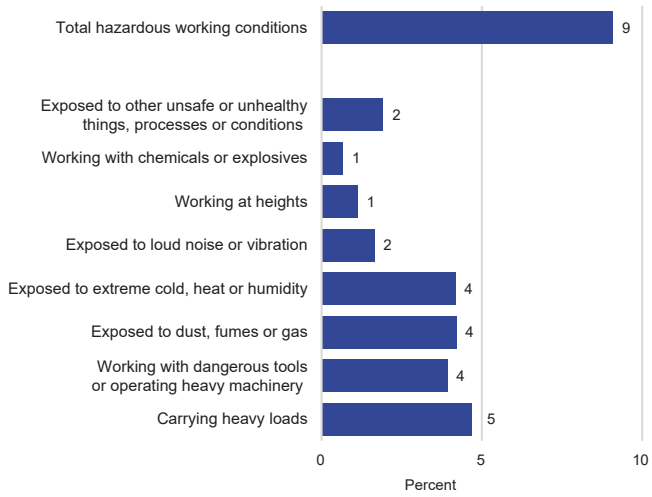
Inequalities in Child Labour



Percentage of children age 5 to 17 years engaged in child labour, by type of activity and by sex

Inequalities in Child



Percentage of children age 5 to 17 years working under hazardous conditions, by background characteristics

Divisional Data on Child Labour

Division	Total Child Labour
National	**9.2**
Barishal	9.2
Chattogram	7.9
Dhaka	7.3
Khulna	9.8
Mymensingh	10.1
Rajshahi	12.4
Rangpur	11.8
Sylhet	8.9

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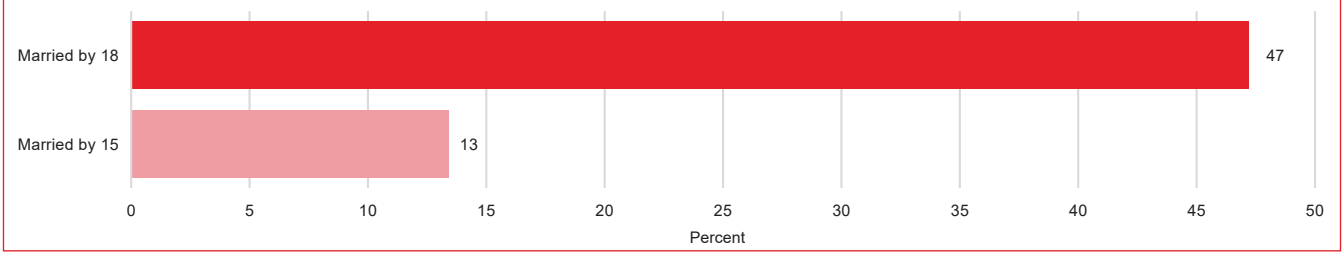
BANGLADESH 2025

Child Marriage

MICS
Multiple Indicator Cluster Surveys

Child Marriage: Levels & Disaggregates

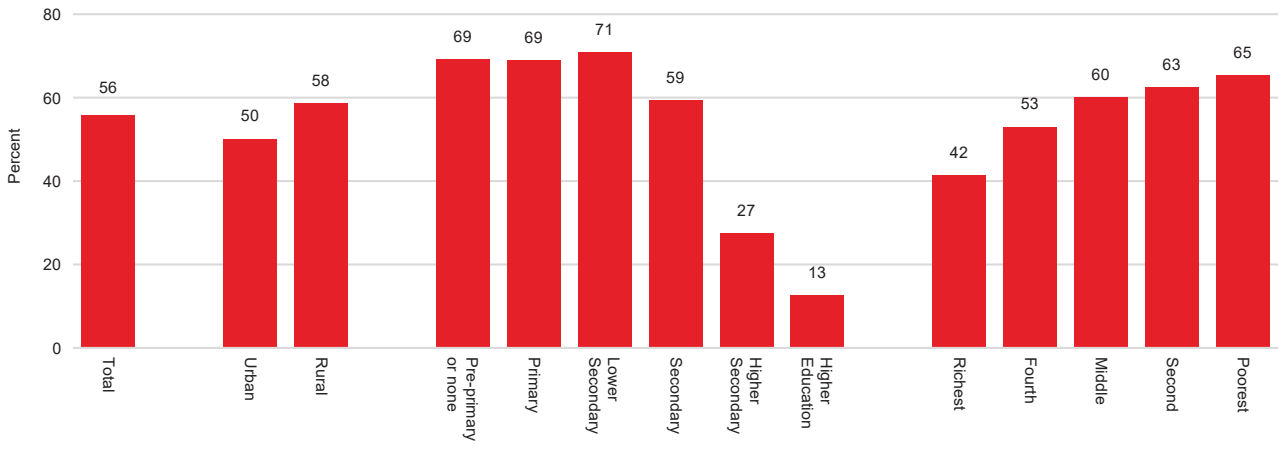
Marriage before Age 15 & Age 18: SDG 5.3.1



Percentage of women aged 20–24 years who were first married before age 15 and before age 18

Among young women aged 20–24 years, 13% were married before 15 and 47% before 18, a modest decline since 2019 (−2 and −4 percentage points). This cohort reflects the most recent prevalence of child marriage in Bangladesh.

Disaggregates in Marriage before Age 18



Percentage of women aged 18–49 years who were first married before age 18, by residence, education and household wealth quintile

Child marriage is higher in rural areas (59%) than in urban areas (50%). Rates rise sharply among women with no education (69%) and the poorest households (65%), compared with 28% for those with higher secondary education and 41% for the richest households. Gaps remain wide despite the overall decline since 2019.

Key Messages

- Child marriage is declining but remains widespread. Among women aged 20–24 years, 47% were married before 18 and 13% before 15, down slightly since 2019.
- Poverty and education drive disparities. Women with no schooling (69%) or from the poorest households (65%) are twice as likely to marry early as the richest (41%).
- Rural girls remain at higher risk. Prevalence is 59% in rural areas versus 50% in urban.
- Progress is uneven across divisions. Rates have fallen in Dhaka and Sylhet but remain high in Rajshahi and Khulna.

Divisional Data on Child Marriage

Division	Marriage by age 18
National	**56**
Barishal	61
Chattogram	51
Dhaka	53
Khulna	65
Mymensingh	56
Rajshahi	67
Rangpur	63
Sylhet	29

Marriage before the age of 18 remains a reality for many girls in Bangladesh.

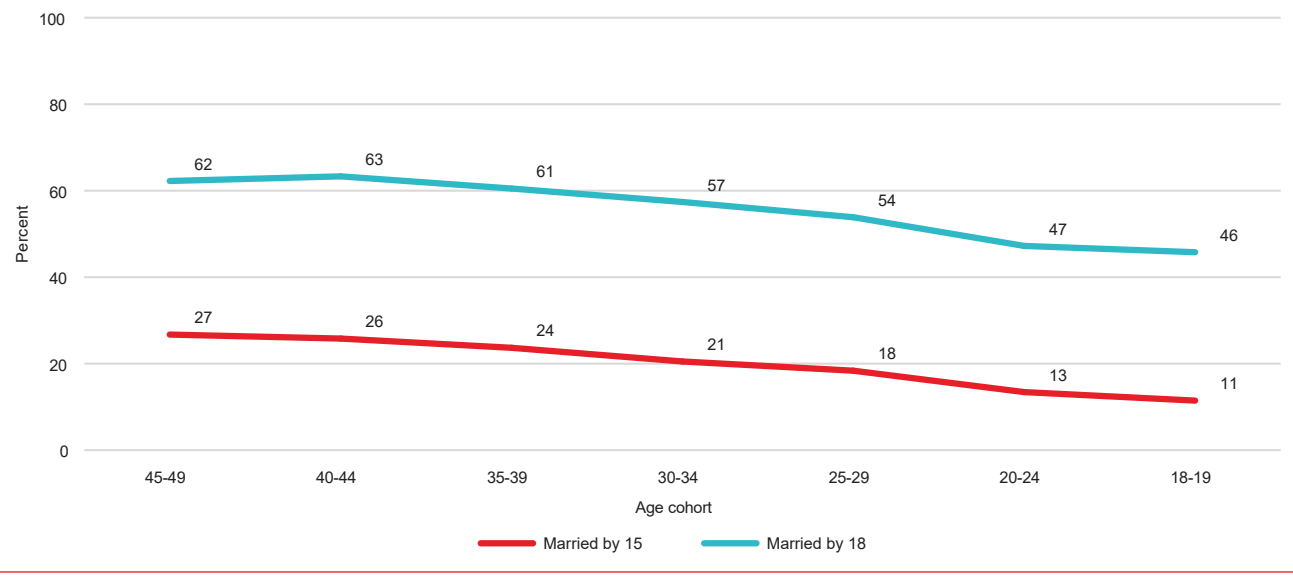
While the national rate has fallen from 60% in 2019 to 56% in 2025, progress is uneven. All divisions show modest declines, yet prevalence remains highest in Rajshahi (67%) and Khulna (65%), and lowest in Sylhet (29%).

Economic pressures, service poverty and social norms still drive child marriage, particularly in rural and poorer districts. Child marriage limits girls' education, increases early pregnancy, and reinforces gendered cycles of poverty.

Ending the practice is essential to protect girls' rights and achieve SDG 5.3

Percentage of women aged 18 to 49 years who were first married before age 18, by Division

Trends in Child Marriage



Percentage of women age 18 -49 years who were first married before age 15 and before age 18, by age cohort

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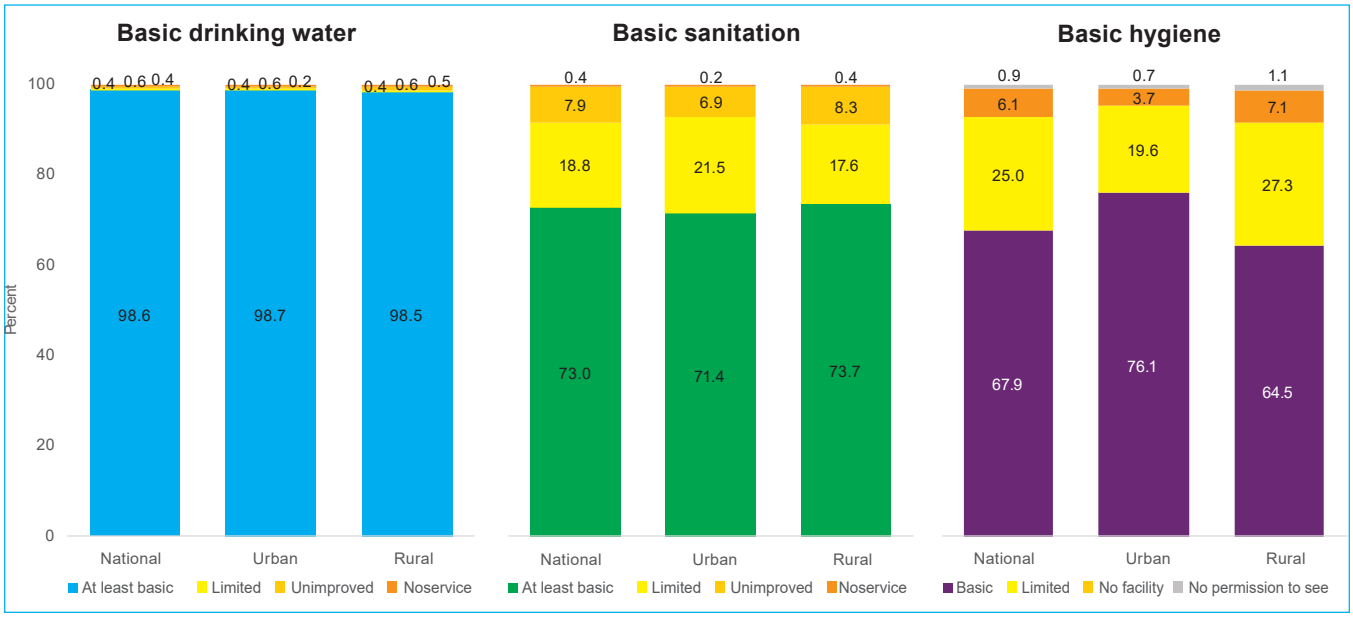
BANGLADESH 2025

Drinking Water, Sanitation & Hygiene (WASH)

MICS
Multiple Indicator Cluster Surveys

Basic Drinking Water, Sanitation & Hygiene Services



Percent of population by drinking water, sanitation and hygiene coverage

Drinking water ladder: **At least basic** drinking water services (SDG 1.4.1) refer to an improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing. **Improved** drinking water sources are those that have the potential to deliver safe water by nature of their design and construction, and include piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water. **Limited** refers to an improved source more than 30 minutes roundtrip. **Unimproved** sources include unprotected dug wells and unprotected springs. **No service** refers to the direct collection of water from surface waters such as rivers, lakes or irrigation channels.

Sanitation ladder: **At least basic** sanitation services (SDG 1.4.1) refer to the use of improved facilities which are not shared with other households. Improved sanitation facilities are those designed to hygienically separate excreta from human contact and include flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs. **Limited** sanitation service refers to an improved facility shared with other households. **Unimproved** sanitation facilities include flush/pour flush to an open drain, pit latrines without a slab, hanging latrines and bucket latrines. **No service** refers to the practice of open defecation.

Hygiene ladder: **A basic** hygiene service (SDG 1.4.1 & SDG 6.2.1) refers to the availability of a handwashing facility on premises with soap and water. Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include ash, soil, sand or other handwashing agents. **Limited** hygiene service refers to a facility lacking water and/or soap. **No facility** means there is no handwashing facility on the household's premises.

Key Messages

- The majority of the population of Bangladesh has access to basic drinking water (98.6%), but only 73% of households have access to basic sanitation (57.6% of the poorest households). Nationally, 67.9% of households have access to basic hygiene, with urban households (76.1%) having a higher proportion than rural households (64.5%).
- While many households in Bangladesh have access to basic drinking water and most report access to adequate amounts of water, this water is highly contaminated with *E. coli* at both the source (47.1%) and household level (84.9%). In the second poorer households in Bangladesh, 90.4% of household water is contaminated with *E. coli. E. coli* contamination amongst the richest households is also high (74.3%).
- Most households in Bangladesh (95.7%) spend up to 30 minutes each day collecting water; however, among them who collects - women and young girls (85.6%) are mostly responsible for water collection.
- While only 4.3% of households in Bangladesh are connected to a sewer line, the majority (75.8%) safely dispose of excreta in situ from improved on-site sanitation facilities. More work is needed to educate households that currently dispose of excreta unsafely, use unimproved sanitation facilities, or practice open defecation (0.4%) about the health risks associated with unsafe excreta disposal.
- While most women of 15-49 years in Bangladesh reported having sufficient menstrual hygiene management materials (85.1%), and 83% women reported having no privacy concern while changing menstrual materials at home; 27.3% of women from all age groups reported facing trouble participating in work, education, and social activities during menstruation.
- Overall, household members inform that 10.2% of their primary drinking water source and 5.2% of their sanitation facilities were affected due to one or more natural hazards in last one year.

BANGLADESH BUREAU OF STATISTICS

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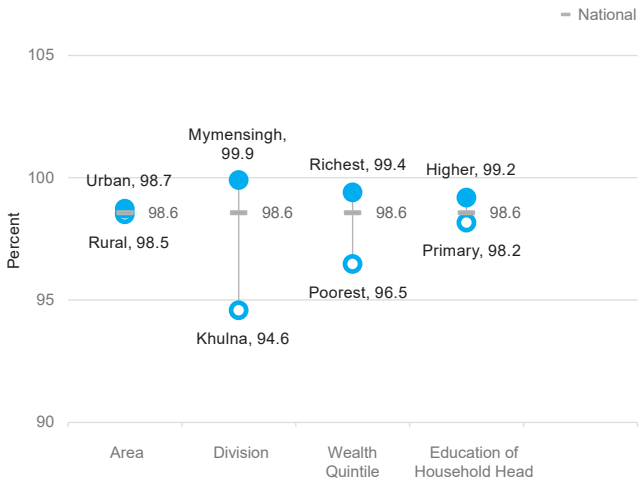
WASH: Inequalities in Basic Services

Basic Drinking Water



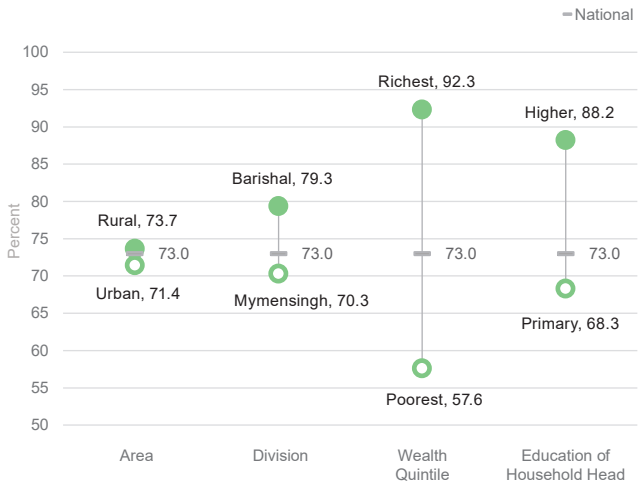
Percent of population using basic drinking water services by background characteristics

Divisional Data on Basic Services

Division	Basic Drinking Water	Basic Sanitation	Basic Hygiene
National	**98.6**	**73.0**	**67.9**
Barishal	97.9	79.3	51.8
Chattogram	98.2	72.2	68.9
Dhaka	99.6	70.6	70.8
Khulna	94.6	78.6	61.2
Mymensingh	99.9	70.3	58.0
Rajshahi	99.8	72.7	75.0
Rangpur	99.7	71.4	74.1
Sylhet	97.0	76.5	66.0

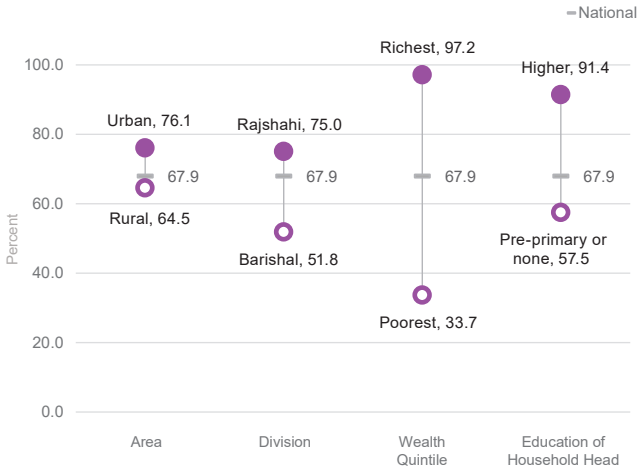
Percent of population using basic drinking water, sanitation and hygiene services by division

Basic Sanitation



Percent of population using basic sanitation services by background characteristics

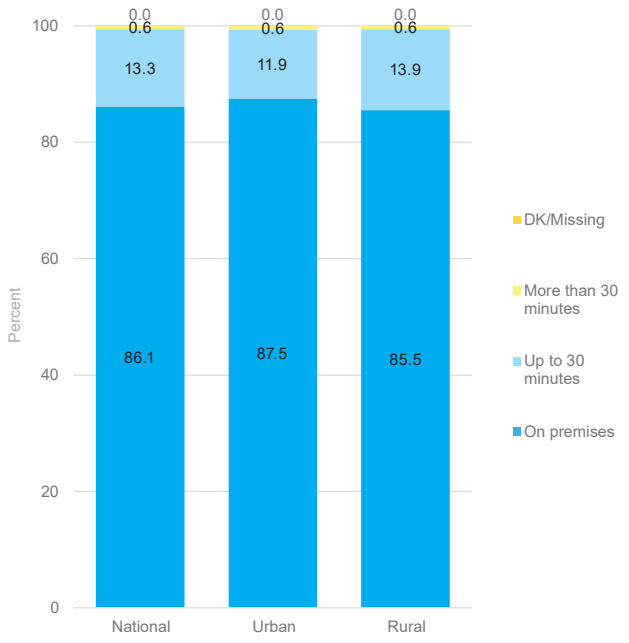
Basic Hygiene



Percent of population using basic hygiene services by background characteristics

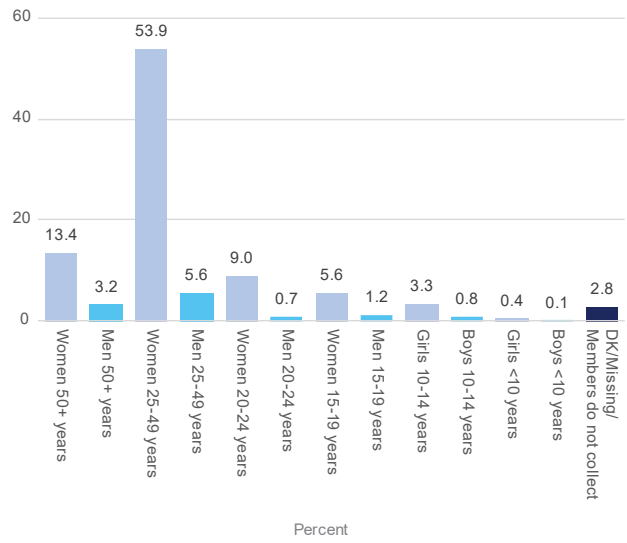
Accessibility of Drinking Water & Sanitation Facilities

Accessibility of drinking water



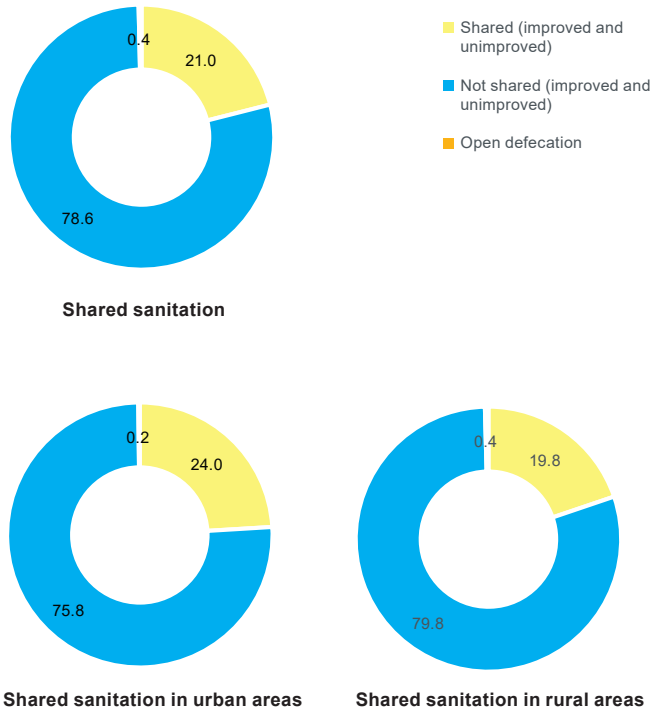
Percent of population by average time spent per day by household members collecting drinking water

Who Primarily Collects Drinking Water for the Household



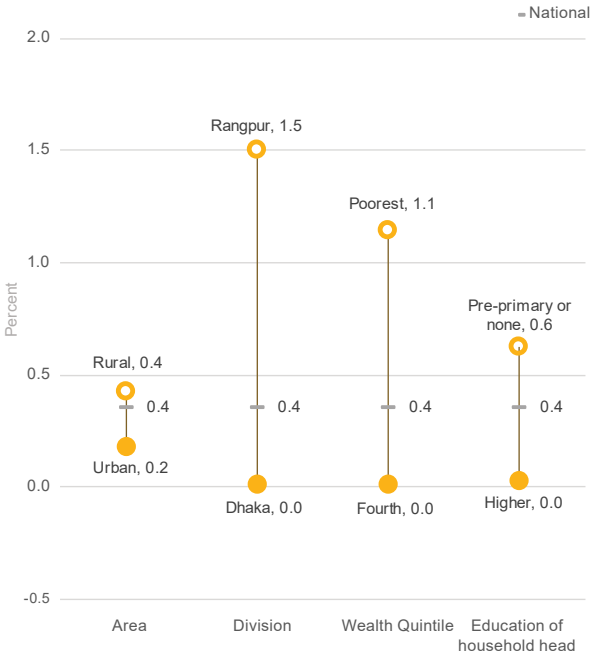
Percent of population in households without drinking water on premises, by gender and age of person primarily responsible for collecting drinking water

Shared sanitation



Percent of the population sharing sanitation facilities, by residence

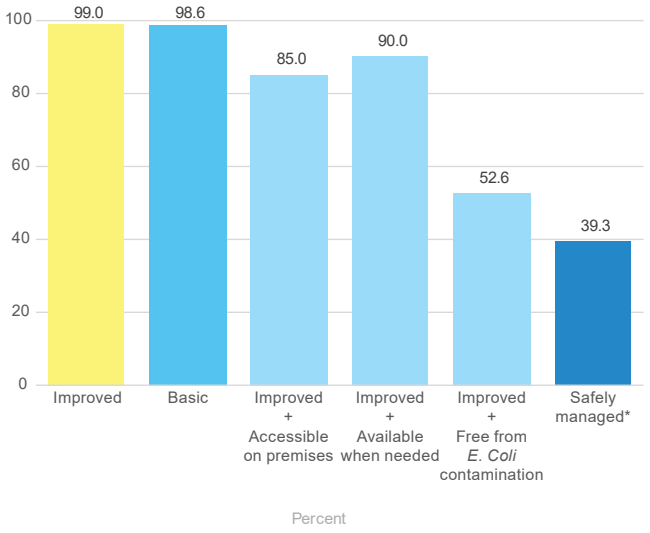
Open Defecation



Percent of the population practising open defecation, by background characteristics

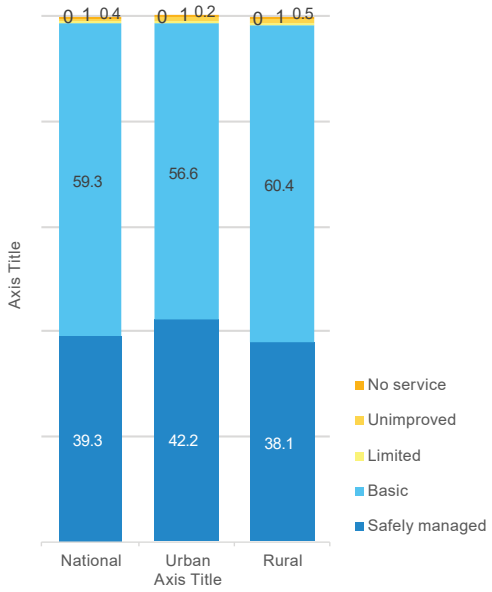
Safely Managed Drinking Water Services: SDG 6.1.1

Improved, basic & safely managed drinking water



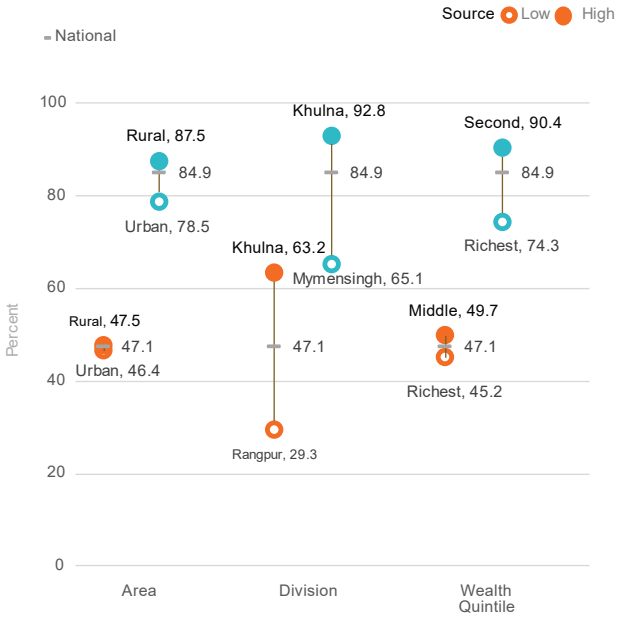
*Safely managed (SDG 6.1) are improved sources: accessible on premises, available when needed, free from *E. Coli* & Arsenic (<=50ppb) contamination

Drinking water coverage: National, urban & rural



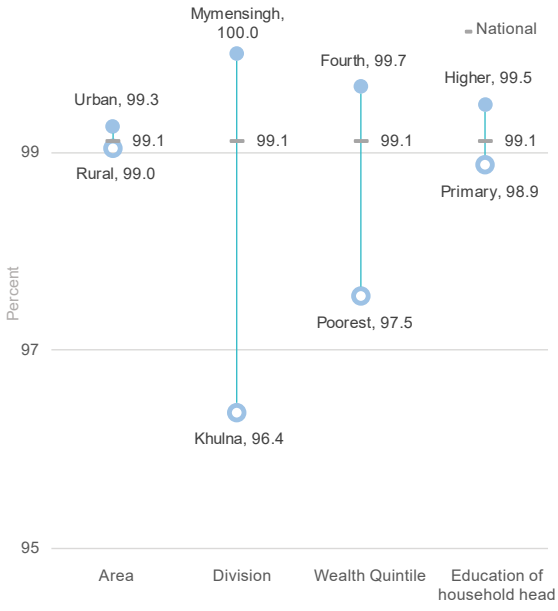
Percent of population by drinking water coverage

Drinking Water Quality at Source & Home



Percent of population using drinking water sources with *E. coli* (orange) and proportion with *E. coli* in glass of drinking water in household drinking water (teal) Water Quality Testing response rates for Household and Source testing are 99.5% and 97.9% respectively

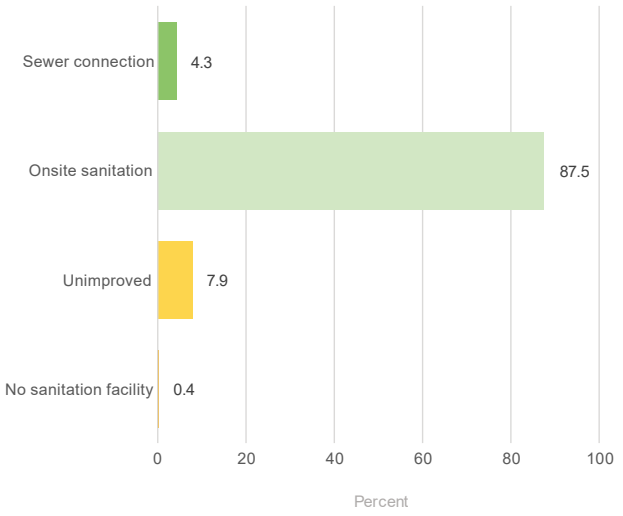
Availability of Drinking Water



Percent of population using drinking water sources with sufficient drinking water in the last 12 months

Safely Managed Sanitation Services: SDG 6.2.1

Types of Sanitation Facility



Percent of population by type of sanitation facility, grouped by type of disposal

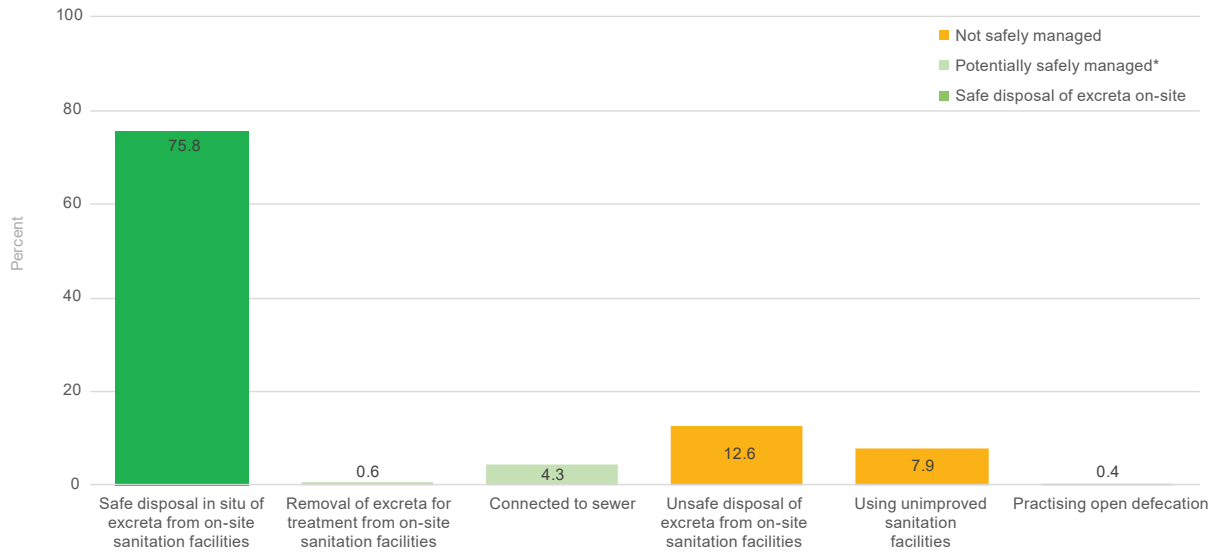
Sewer connections include "Flush/pour flush to piped sewer system"
Onsite sanitation facilities include "Flush/pour flush to septic tank", "Flush/pour flush to latrine", "Flush to DK where", "Ventilated improved pit latrine", "Single Pit latrine with slab", "Twin Pit latrine with slab" and "Composting toilet"

Types of Sanitation Facility by Division

Division	Sewer connection	Onsite sanitation
National	**4.3**	**87.5**
Barishal	0.0	87.9
Chattogram	0.0	87.1
Dhaka	17.1	76.3
Khulna	0.0	95.4
Mymensingh	0.0	96.1
Rajshahi	0.0	93.7
Rangpur	0.0	90.9
Sylhet	0.0	90.0

Percent of population using sewer connections and onsite sanitation, by division

Management of excreta from household sanitation facilities

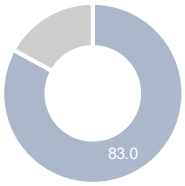


Percent of population by management of excreta from household sanitation facilities

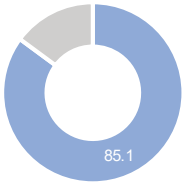
*Additional information required to determine whether faecal sludge and wastewater is safely treated.

Safely managed sanitation services represents an ambitious new level of service during the SDGs and is the indicator for target 6.2. Safely managed sanitation services are improved facilities that are not shared with other households and where excreta are safely disposed of in situ or transported and treated offsite. The MICS survey collected information on the management of excreta from onsite facilities. For households where excreta are transported offsite (sewer connection, removal for treatment), further information is needed on the transport and treatment of excreta to calculate the proportion that are safely managed.

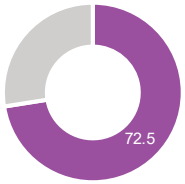
Menstrual Hygiene Management



Women with a private place to wash & change at home



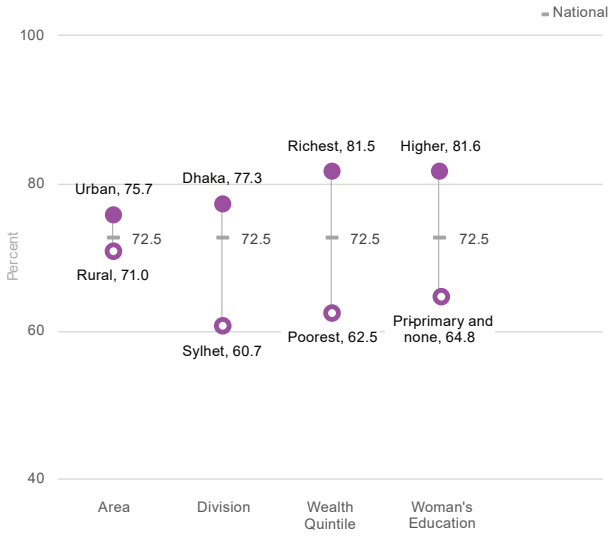
Women with appropriate materials



Women with appropriate materials & a private place to wash & change at home

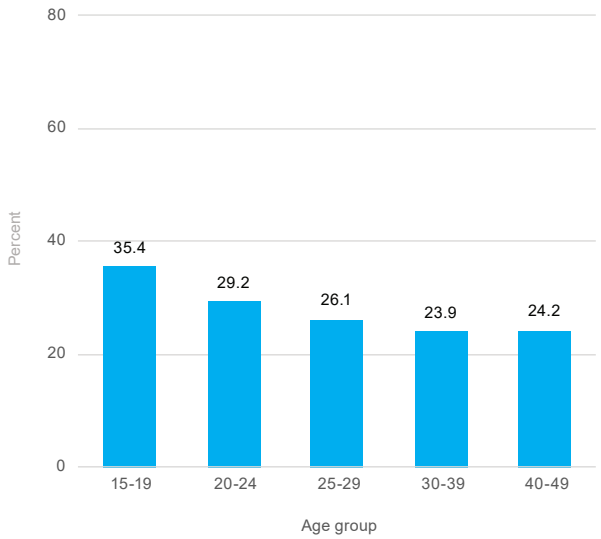
Denominator for all 3 indicators: women age 15-49 who reported menstruating in the last 12 months

Inequities in Access to Appropriate Materials & Private Place to Wash & Change at Home



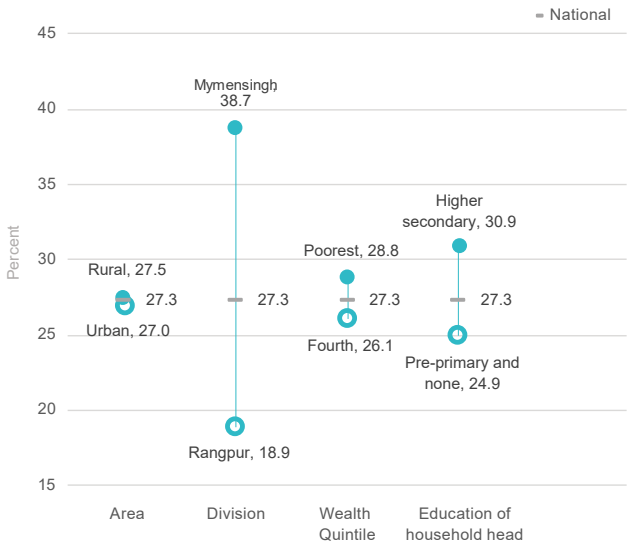
Percent of women age 15-49 using appropriate menstrual hygiene materials with a private place to wash and change while at home, among women reporting menstruating in the last 12 months

Exclusion from Activities during Menstruation



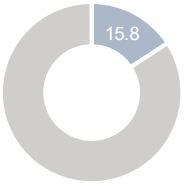
Percent of women who did not participate in social activities, school or work due to their last menstruation in the last 12 months, by age, among women reporting menstruating in the last 12 months

Exclusion from Activities during Menstruation by Various Characteristics

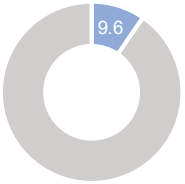


Percent of women who did not participate in social activities, school or work due to their last menstruation in the last 12 months, by residence, wealth quintile, education and region, among women reporting menstruating in the last 12 months

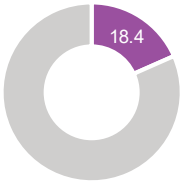
Arsenic concentration (WHO Standards)



Source water containing over 10ppb Arsenic concentration (WHO Standards)

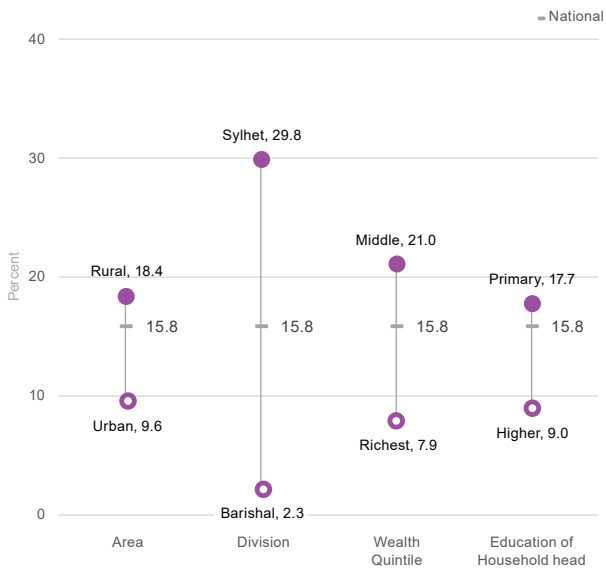


Urban source water containing over 10ppb Arsenic concentration (WHO Standards)



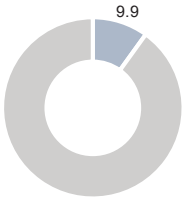
Rural source water containing over 10ppb Arsenic concentration (WHO Standards)

Inequities in Source water containing over 10ppb Arsenic concentration (WHO Standards)

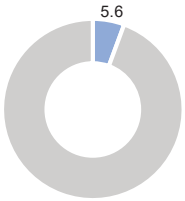


Percent of Household members

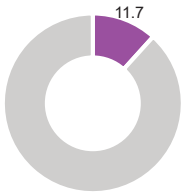
Arsenic concentration (GoB Standards)



Source water containing over 50ppb Arsenic concentration (GoB Standards)

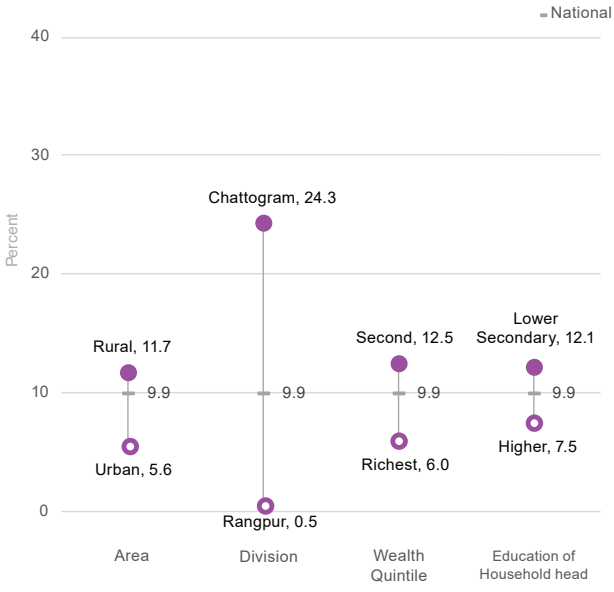


Urban source water containing over 50ppb Arsenic concentration (GoB Standards)



Rural source water containing over 50ppb Arsenic concentration (GoB Standards)

Inequities in Source water containing over 50ppb Arsenic concentration (GoB Standards)

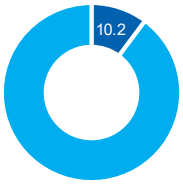


Percent of Household members

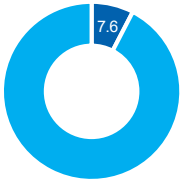
Salinity contamination (GoB standard)

Division	Low (<1,500 µS/cm)	Moderate (1,500-3,000 µS/cm)	High (3,001-4,500 µS/cm)
National	**94.8**	**4.2**	**1.0**
Barishal	86.5	10.8	2.7
Chattogram	92.4	6.5	1.1
Dhaka	96.1	3.3	0.6
Khulna	86.3	10.1	3.6
Mymensingh	98.4	0.8	0.8
Rajshahi	99.0	1.0	0.0
Rangpur	98.7	0.9	0.4
Sylhet	100.0	0.0	0.0

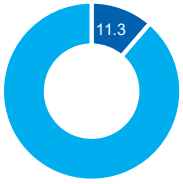
Climate Resilience



Drinking water source affected by at least one natural hazard in the last 12 months

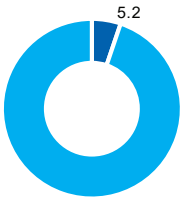


Drinking water source affected by at least one natural hazard in the last 12 months - Urban

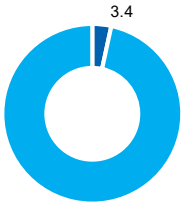


Drinking water source affected by at least one natural hazard in the last 12 months - Rural

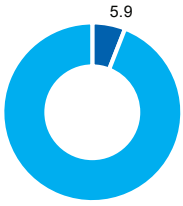
Climate Resilience



Sanitation facility affected by at least one natural hazard in the last 12 months

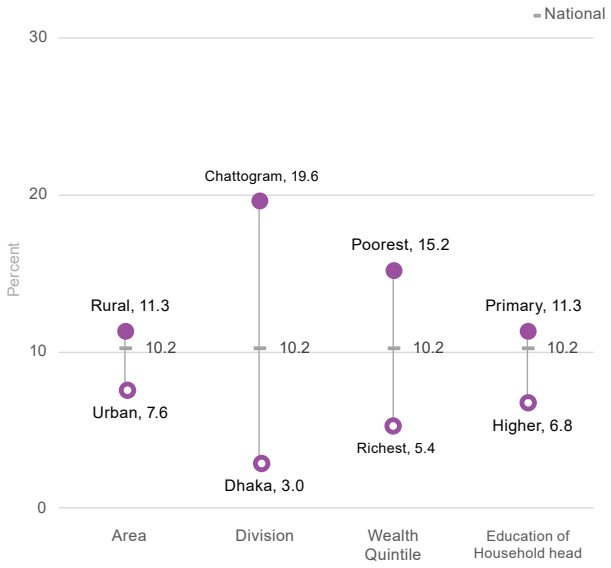


Sanitation facility affected by at least one natural in the last 12 months - Urban



Sanitation facility affected by at least one natural hazard in the last 12 months - Rural

Inequities in Drinking water source affected by at least one natural hazard



Percent of Household members

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Drinking Water, Sanitation & Hygiene (WASH).

Further statistical snapshots and the Survey Findings Report for this, and other surveys are available on mics.unicef.org/surveys.

For further information on the WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply, Sanitation and Hygiene indicator definitions and methods please visit washdata.org.

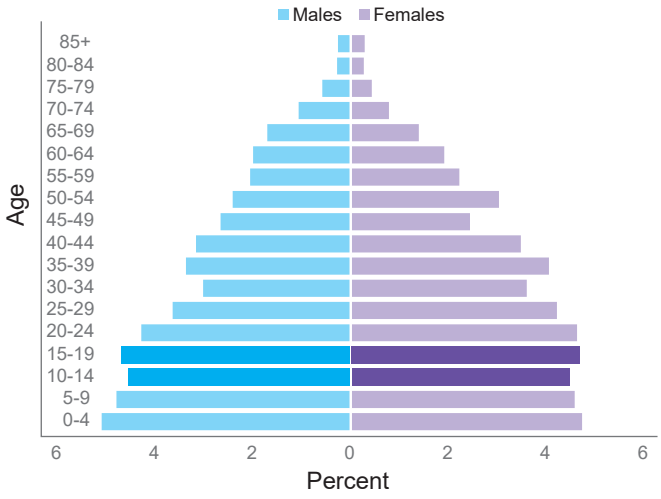
BANGLADESH 2025 MICS

Adolescents

Multiple Indicator Cluster Surveys

The Adolescent Population: Age 10

Age & Sex Distribution of Household Population



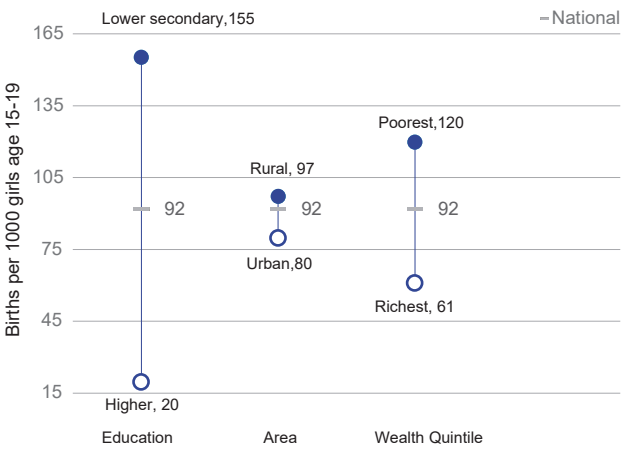
This snapshot of adolescent well-being is organized around key priority areas for adolescents:

- Every adolescent survives and thrives
- Every adolescent learns
- Every adolescent is protected from violence and exploitation
- Every adolescent lives in a safe and clean environment
- Every adolescent has an equitable chance in life

Every Adolescent Survives & Thrives

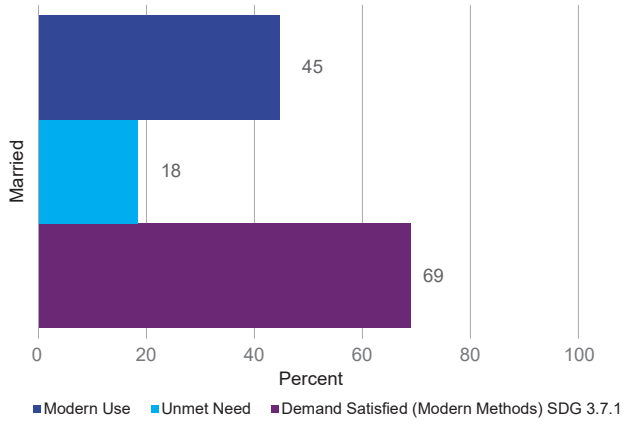
Adolescence is often the healthiest stage of the life course, yet it is also when risk behaviours with lifelong consequences, such as unsafe sex, early childbearing and substance use, can first emerge. Evidence shows that timely, adolescent-friendly health interventions have enduring benefits. Ensuring access to appropriate contraceptive methods is essential to prevent adolescent pregnancy and its consequences, enabling young people to plan and space pregnancies and to transition to adulthood in good health, with greater educational and economic opportunities.

Adolescent Birth Rate: SDG 3.7.2



Age-specific fertility rate for girls age 15-19 years: the number of live births in the last 3 years, divided by the average number of women in that age group during the same period, expressed per 1,000 women

Modern Contraceptive Use, Unmet Need & Demand Satisfied for Modern Methods: SDG 3.7.1



Percentage of girls age 15-19 years who are married and are using a contraceptive method, percentage with an unmet need for contraception and percent of demand for modern methods of family planning satisfied

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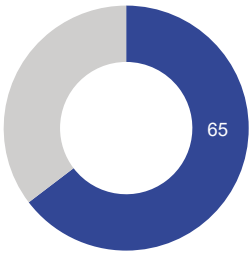
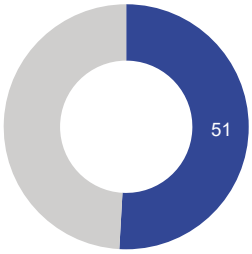
Every Adolescent Learns

Foundational Reading Skills SDG 4.1.1.(a) (i: reading)



Percentage of children age 10-14 who can 1) read 90% of words in a story correctly, 2) Answer three literal comprehension questions, and 3) Answer two inferential comprehension questions

Foundational Numeracy Skills SDG 4.1.1.(a) (ii: numeracy)

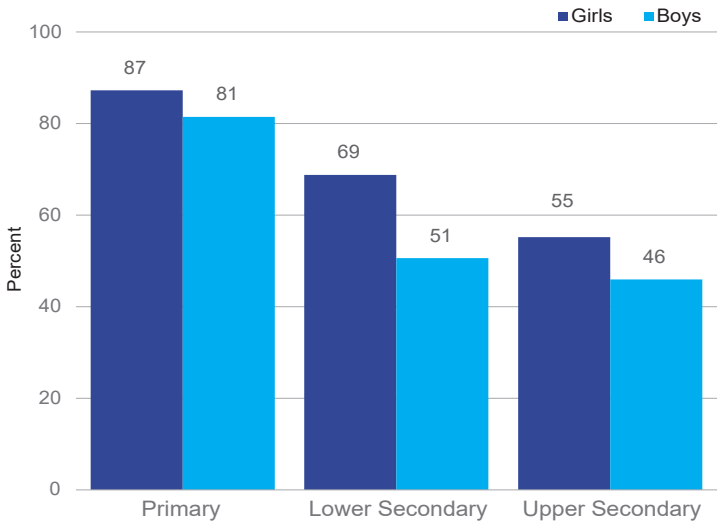


Percentage of children age 10-14 who can successfully perform 1) a number reading task, 2) a number discrimination task, 3) an addition task and 4) a pattern recognition and completion task

Quality education and positive school experiences support physical and mental health, safety, civic engagement, and social development. Yet adolescents may also face risks such as dropping out, early marriage or pregnancy, or premature entry into the workforce.

In MICS, reading and numeracy are measured through direct assessment. The Foundational Learning module captures children's early reading and numeracy skills at the Grade 2 level of primary education.

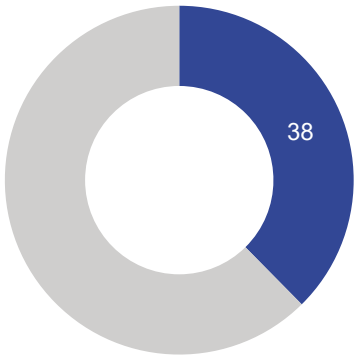
School Attendance Rates



Adjusted net attendance rate, by level of education and by gender

Information & Communications Technology (ICT) Skills*

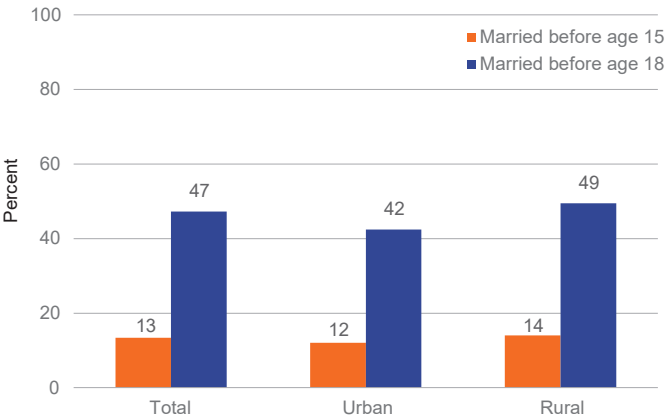
Girls



Percentage of girls age 15-24 who in the last 3 months have performed at least one of eleven specific computer related activities
*Age disaggregate of SDG 4.4.1: Proportion of youth and adults with information and communications technology (ICT) skills

Every Adolescent is Protected from Violence & Exploitation

Child Marriage: SDG 5.3.1

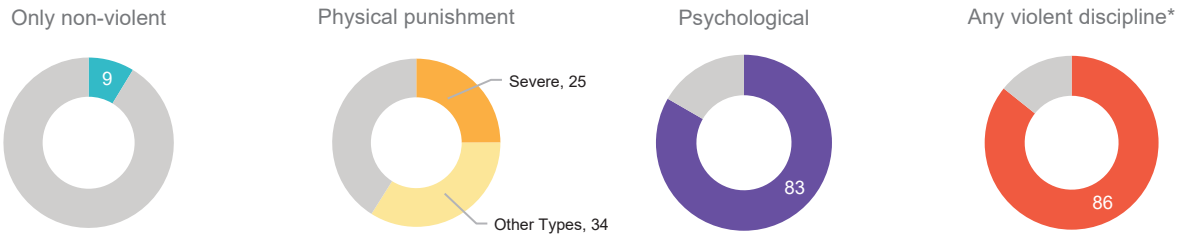


Percentage of women aged 20 to 24 years who were first married before age 15 and before age 18, by area

Adolescence is a period of heightened risk of certain forms of violence and exploitation. The onset of puberty marks a major transition in girls' and boys' lives as gender, sexuality, and sexual identity assume greater salience, increasing vulnerability, particularly for adolescent girls. Harmful practices such as child marriage often occur around this time. As children enter adolescence, they also spend more time outside the home and form closer relationships with a wider circle, including peers and romantic partners. The change in social worlds at this stage of life requires skills to develop violence free, equal and respectful relationships.

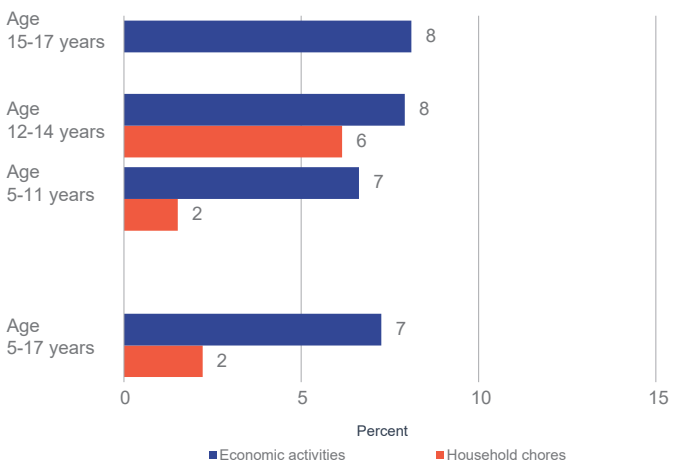
Every Adolescent is Protected from Violence & Exploitation

Child Discipline



Percentage of children age 1 to 14 years who experienced any discipline in the past month, by type *Age disaggregate of SDG 16.2.1

Child Labour: SDG 8.7.1



Percentage of adolescents age 5-17 years engaged in child labour, by type of activity and by age
Note: These data reflect the proportions of children engaged in the activities at or above the age specific thresholds outlined in the definitions box.

Definition of Child Labour

Age 5 to 11 years: At least 1 hour of economic activities or 21 hours of unpaid household services per week.

Age 12 to 14 years: At least 14 hours of economic activities or 21 hours of unpaid household services per week.

Age 15 to 17 years: At least 43 hours of economic activities. No threshold for number of hours of unpaid household services.

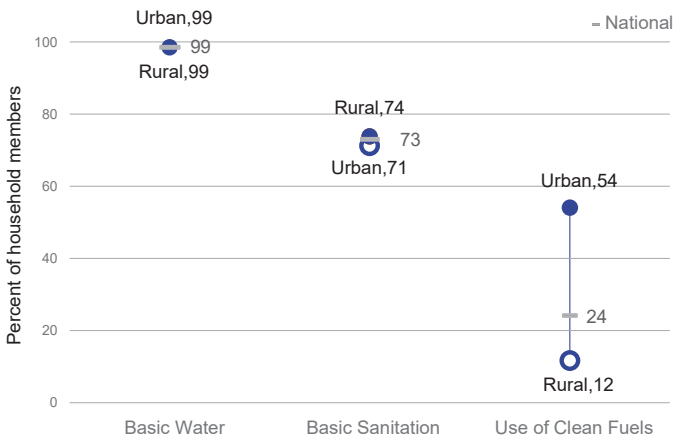
Economic activities include paid or unpaid work for someone who is not a member of the household, work

for a family farm or business. Household chores include activities such as cooking, cleaning or caring for children as well as fetching water

Note that the child labour indicator definition has changed during the implementation of the sixth round of MICS. Changes include age-specific thresholds for household chores and exclusion of hazardous working conditions. While the overall concept of child labour includes hazardous working conditions, the definition of child labour used for SDG reporting does not.

Every Adolescent Lives in a Safe & Clean Environment

Water, Sanitation & Clean Fuel Use



The data presented here are at the household level. Evidence suggests that adolescent access to these services are comparable to household-level data.

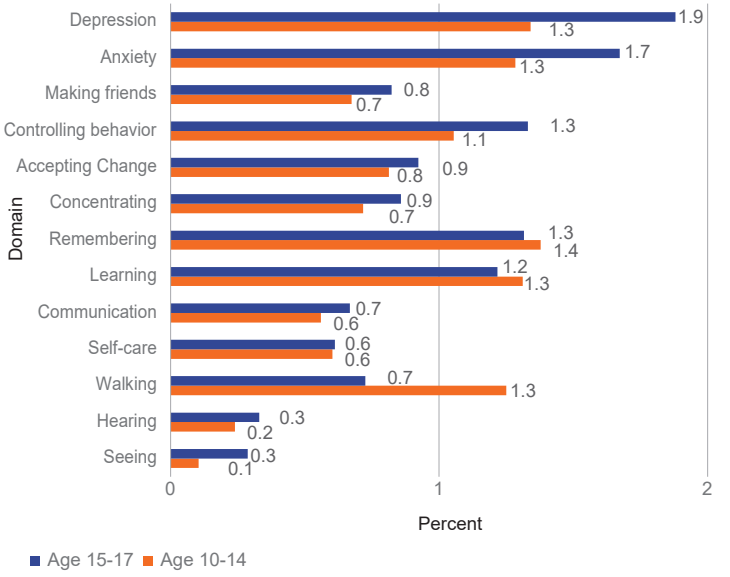
Basic Drinking Water SDG 1.4: Drinking water from an improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing. Improved drinking water sources are those that have the potential to deliver safe water by nature of their design and construction, and include piped water, boreholes or tubewells, protected dug wells, protected springs, rainwater, and packaged or delivered water

Basic Sanitation Services SDG 1.4.1/6.2.1 : Use of improved facilities which are not shared with other households. Improved sanitation facilities are those designed to hygienically separate excreta from human contact, and include flush/pour flush to piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs

Clean Fuels SDG 7.1.2: Primary reliance on clean fuels and technologies for cooking, and lighting

Every Adolescent has an Equitable Chance in Life

Functioning Difficulties in Adolescents



Achieving sustainable, equitable progress requires a human rights–based approach. At the core of international human rights law is the principle of non-discrimination, supported by instruments that prohibit discrimination against women, indigenous peoples, migrants, minorities, and persons with disabilities, as well as on the basis of race, religion, sexual orientation, and gender identity. As adolescents develop their identities, discrimination can become more pronounced, manifesting as harassment, bullying, or exclusion from activities. Research indicates that discrimination during adolescence can strongly affect stress-hormone regulation, with potential lifelong mental and physical health consequences.

Children and adolescents with disabilities are among the most marginalized. Confronted by negative attitudes, inaccessible environments, and gaps in policy and legislation, they are too often denied equal access to health, education, protection, and other fundamental rights necessary to survive and thrive.

Percentage of adolescents who have a functioning difficulty, by domain and age

Key Messages

- **Adolescent fertility:** The adolescent birth rate is 92 per 1,000 girls aged 15–19. Rates are higher among girls with lower secondary education or less, those from poorer households, and those living in rural areas than among their more educated, wealthier, and urban peers. 45% of women aged 15–19 use a modern contraceptive method, and 18% of married women aged 15–19 have an unmet need for family planning. Ensuring access to appropriate contraception is critical to preventing adolescent pregnancy and its consequences.
- **Child marriage:** Among women aged 20–24, 13% were married before age 15 and 47% before age 18. Early marriage violates girls' rights and prevents them from realizing their full potential. It results in early pregnancy, contributes to maternal mortality and perpetuate inter-generational cycle of poverty. More work needs to be done in Bangladesh specifically commitment and investments are needed to change long-standing cultural practices of child marriage and enforcement of policies for creating an enabling environment for girls in Bangladesh
- **Foundational learning:** 50% of children aged 7–14 can read at a Grade 2 level or higher, while only 39% can perform Grade 2-level mathematics. Despite high primary enrolment for girls and boys, weak learning outcomes highlight the need for greater investment in education quality.
- **Violent discipline:** Children in Bangladesh are widely exposed to physical and emotional violence. 25% of children aged 1–14 experience severe physical punishment, 83% experience psychological aggression, and 86% are subjected to some form of violent discipline. Stronger protection measures are urgently required.
- **WASH:** Among the households surveyed, about 27% of children lack access to adequate sanitation—essential for child survival and development.
- **Adolescent functioning:** 5% of adolescents aged 10–17 report functional difficulty in at least one domain; the most commonly reported difficulties relate to depression and anxiety.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Adolescents.

Further statistical snapshots and the Summary Findings Report for this, and other surveys are available on mics.unicef.org/surveys.

BANGLADESH 2025

Gender Equality

MICS

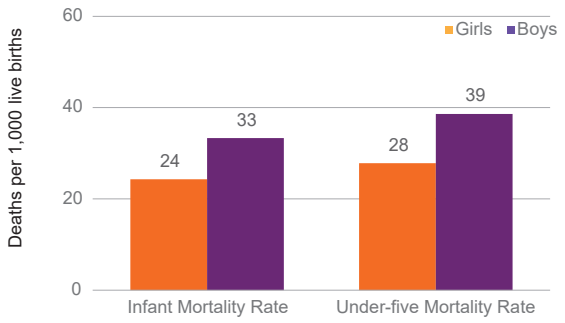
Multiple Indicator Cluster Surveys

Gender equality means that girls and boys, women and men, enjoy the same rights, resources, opportunities and protections. Investments in gender equality contribute to lifelong positive outcomes for children and their communities and have considerable inter-generational payoffs because children's rights and well-being often depend on women's rights and well-being. This snapshot shows key dimensions of gender equality during the lifecycle. It is organized around: 1) the first decade of life (0-9 years of age) when gender disparities are often small, particularly in early childhood; 2) the second decade of childhood (10-19 years of age) when gender disparities become more pronounced with the onset of puberty and the consolidation of gender norms; and 3) adulthood, when gender disparities impacts both the wellbeing of women and girls and boys.

Every Girl & Boy Survives & Thrives: The First Decade of Life

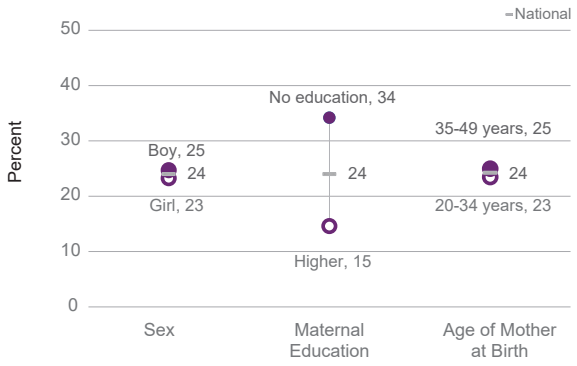
Nutrition and a supportive environment in early childhood are among the key determinants of the health and survival of children and their physical and cognitive development. Generally, girls tend to have better biological endowments than boys for survival to age five, and thus higher survival chances under natural circumstances. However, gender discrimination against girls can affect survival, resulting in higher than expected female mortality. Similarly, stunting rates are typically lower among girls than boys, potentially due to the higher risk for preterm birth among boys, which is inextricably linked with lower birth weight. However, children with mothers who gave birth at a young age or who have no education may be more likely to be malnourished. Children with restricted cognitive development during early life are at risk for later neuropsychological problems, poor school achievement, early school drop-out, low-skilled employment, and poor care of their own children. Stimulation and interaction with parents and caregivers can jumpstart brain development and promote well-being in early childhood. This is also the period of development when gender socialization, or the process of learning cultural roles according to one's sex, manifests. Caregivers, particularly fathers, may respond to, and interact with, sons and daughters differently.

Mortality Rates among Children Under-5, SDG 3.2.1 Sex Disaggregate



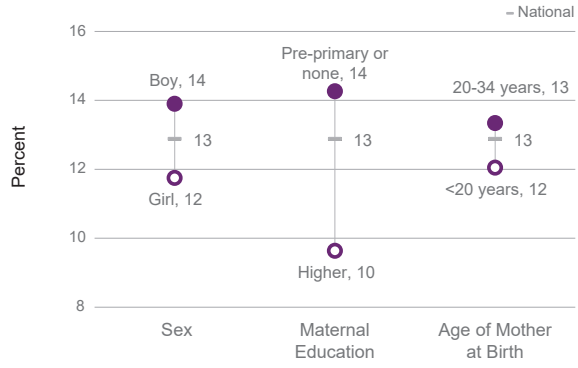
Infant mortality: probability of dying between birthand the first birthday
Under-five mortality: the probability of dying between birth and the fifth birthday

Malnutrition: Stunting (Moderate & Severe) among Children Under-5, SDG 2.2.1



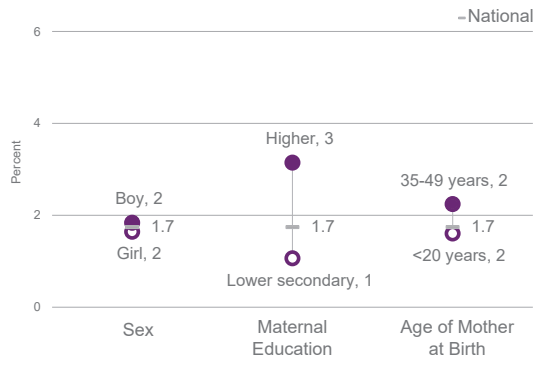
Stunting refers to a child too short for his or her age

Malnutrition: Wasting (Moderate & Severe) among Children Under-5, SDG 2.2.2



Wasting refers to a child who is too thin for his or her height

Malnutrition: Overweight (Moderate & Severe) among Children Under-5, SDG 2.2.2



Overweight refers to a child who is too heavy for his or her height

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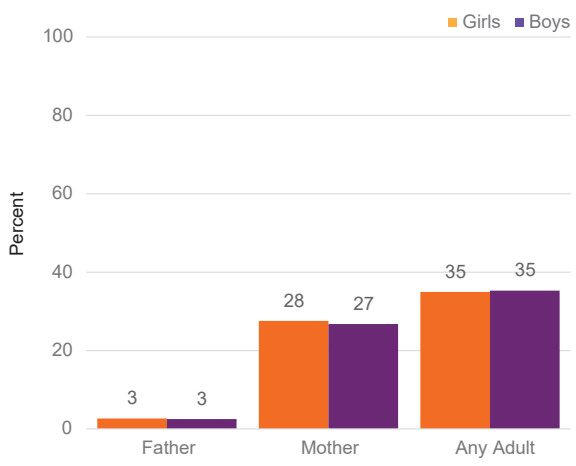
Every Girl & Boy Survives & Thrives: The First Decade of Life

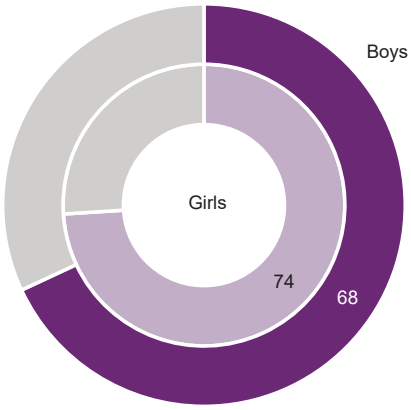
Early Stimulation & Responsive Care by Adults



Percentage of children age 2-4 years with whom adult household members engaged in activities that promote learning and school readiness during the last three days, by person interacting with child and sex of child.

Note: Activities include: reading books to the child; telling stories to the child; singing songs to the child; taking the child outside the home; playing with the child; and naming, counting or drawing things with the child

Early Childhood Development Index, SDG 4.2.1

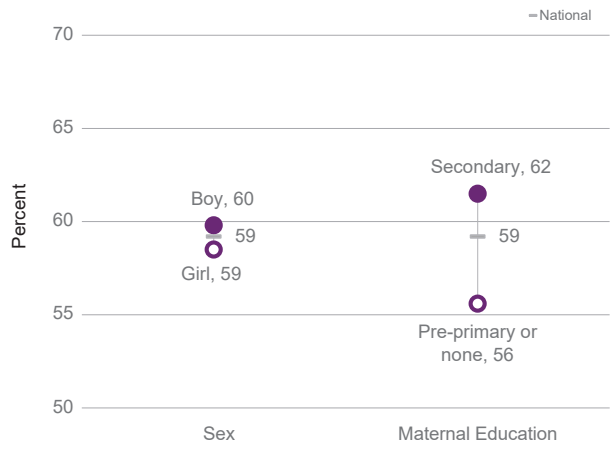


Percentage of children age 3-4 years who are developmentally on track in at least 3 of the following 4 domains: literacy-numeracy, physical, social-emotional, and learning domains, by sex

Every Girl & Boy Is Protected From Violence & Exploitation: The First Decade of Life

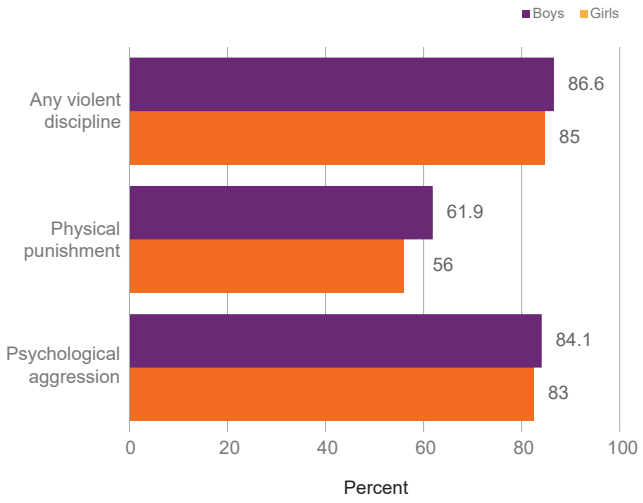
Registering children at birth is the first step in securing their recognition before the law, safeguarding their rights, and ensuring that any violation of these rights does not go unnoticed. While vitally important for both girls and boys, the implications of low birth registration rates for girls are significant, rendering them more vulnerable to certain forms of exploitation they are at greater risk of, including child marriage and international trafficking. Although average birth registration rates are similar for girls and boys, children with mothers who have no education may be less likely to have their births registered. While girls and boys face similar risks of experiencing violent discipline -which includes physical punishment and psychological aggression- by caregivers in the home, gender inequality and domestic violence are among the factors associated with an elevated risk of violence against both girls and boys.

Birth Registration, SDG 16.9.1 Sex Disaggregate



Percentage of children under age 5 whose births are registered, by sex and maternal education level

Violent Discipline, SDG 16.2.1 Sex Disaggregate



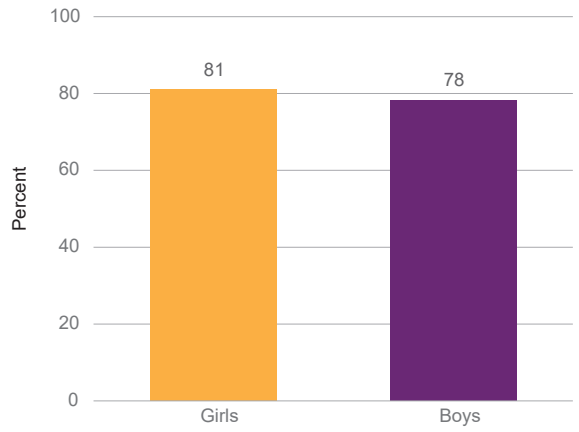
Percentage of children age 1-14 years who experienced violent discipline in the past month, by sex
Note: The age group 1-14 spans the first and second decades of life.

Every Girl & Boy Learns: The First Decade of Life

Investment in good quality early childhood education services prior to entering school improves learning outcomes for children. It also enhances the efficiency of the school system by reducing repetition and drop-out and improving achievement, especially among girls and marginalized groups. Primary education provides the foundation for a lifetime of learning. Considerable progress has been made in achieving universal education and closing the gender gap but gender disparities to the disadvantage of girls still exist in some countries. Further, girls still comprise the majority of the world's out-of-school population.

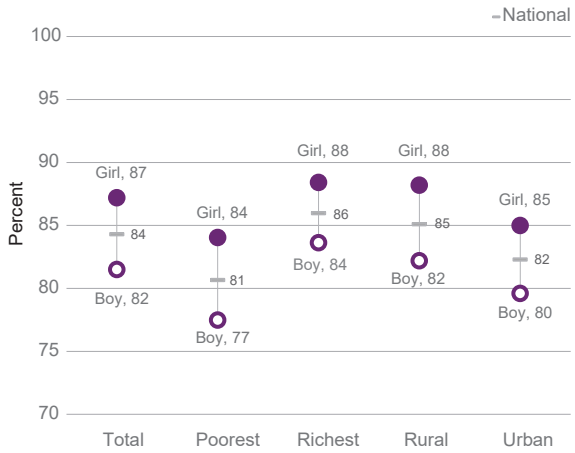
Note: Because children of primary school age range from 6-14 years, these indicators include some children in their second decade of life.

Participation Rate in Organized Learning, SDG 4.2.2



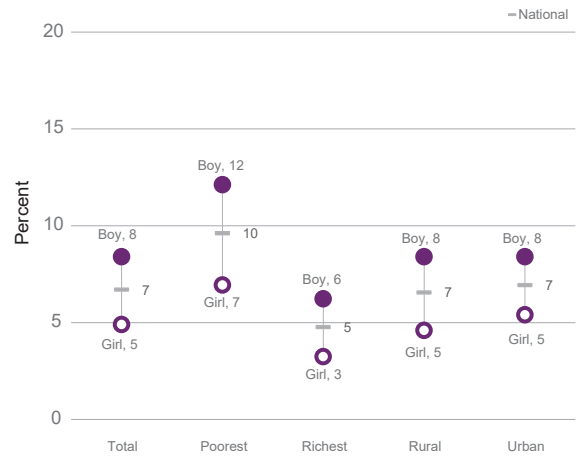
Percentage of children age one year younger than the official primary school entry age at the beginning of the school year who are attending an early childhood education programme or primary school (adjusted net attendance rate), by sex

Participation Rate in Organized Learning, SDG 4.2.2



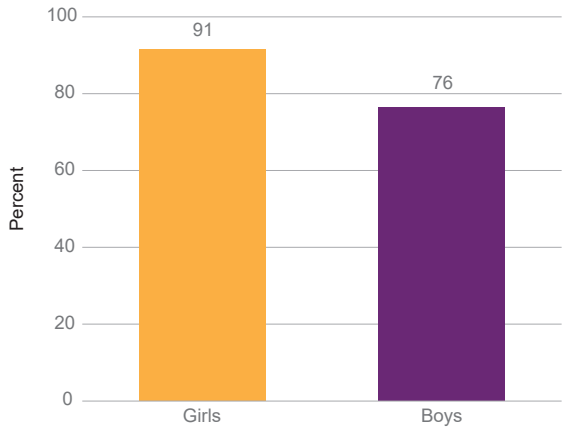
Percentage of children of primary school age attending primary, lower or upper secondary school (adjusted net attendance rate), by wealth quintile and urban/rural residence

Children of Primary School Age Out of School



Percentage of children of primary school age who are not attending any level of education, by wealth quintile and area

Primary Completion, SDG 4.1.2



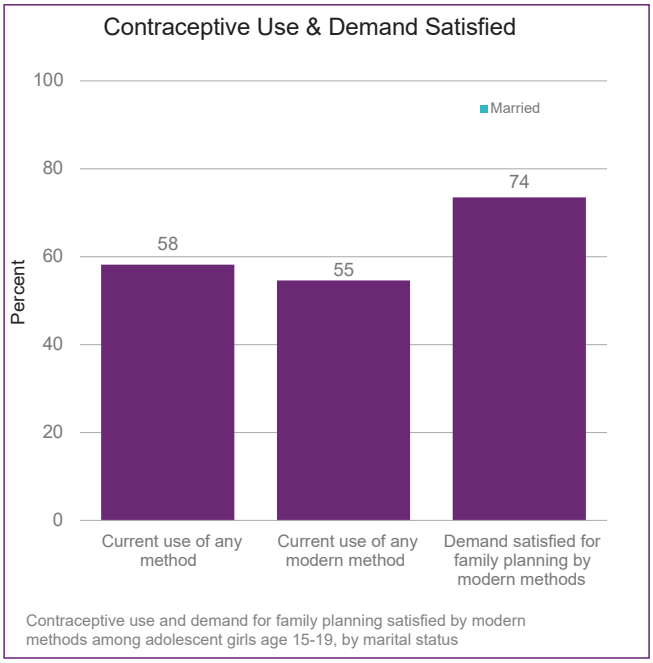
Percentage of children age 3 to 5 years above the intended age for the last grade of primary school who have completed primary education, by sex

Key Messages

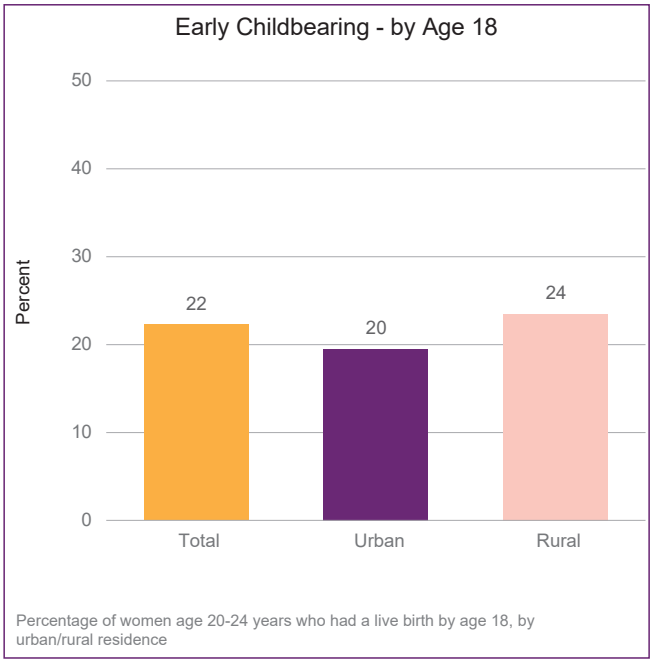
- In the first decade of life (0-9 years of age) gender disparities – the right of males and females to enjoy the same rights, resources, opportunities and protections – are often small, particularly in early childhood. But during the second decade of childhood (10-19 years of age) gender disparities become more pronounced, especially with the onset of puberty and the consolidation of gender norms. During adulthood, gender disparities seriously affect the wellbeing of women, girls and boys.
- The infant and child mortality rate is higher for boys than for girls. These data align with what is observed for child survival in many countries under natural circumstances.
- In Bangladesh, many indicators related to development of children show low or little disparities between boys and girls. However, boys are less likely than girls to participate in organized learning and they are less likely to attend primary school. Boys are also less likely to complete primary school (76%) than are girls (91%).
- These data show promising for girls over the years. However, more work needs to be done to understand why boys are now lagging behind girls for participation in and completion of primary school.

Every Adolescent Girl & Boy Survives & Thrives: The Second Decade of Life

While adolescence carries new health risks for both girls and boys, girls often face gender-specific vulnerabilities, with lifelong consequences. Complications related to pregnancy and childbirth are among the leading causes of death worldwide for adolescent girls age 15 to 19. Preventing adolescent pregnancy not only improves the health of adolescent girls, but also provides them with opportunities to continue their education, preparing them for jobs and livelihoods, increasing their self-esteem and giving them more say in decisions that affect their lives. Yet, too often, adolescent girls lack access to appropriate sexual and reproductive health services, including modern methods of contraception. Additionally, despite having a higher risk of contracting HIV due to both greater physiological vulnerabilities and gender inequalities, adolescent girls are often less knowledgeable than adolescent boys about how HIV is transmitted. However, gender norms adversely impact adolescent boys as well. For example, norms around masculinity that encourage risk taking may heighten adolescent boys' use of alcohol and tobacco, increasing their likelihood of developing noncommunicable diseases later in life.

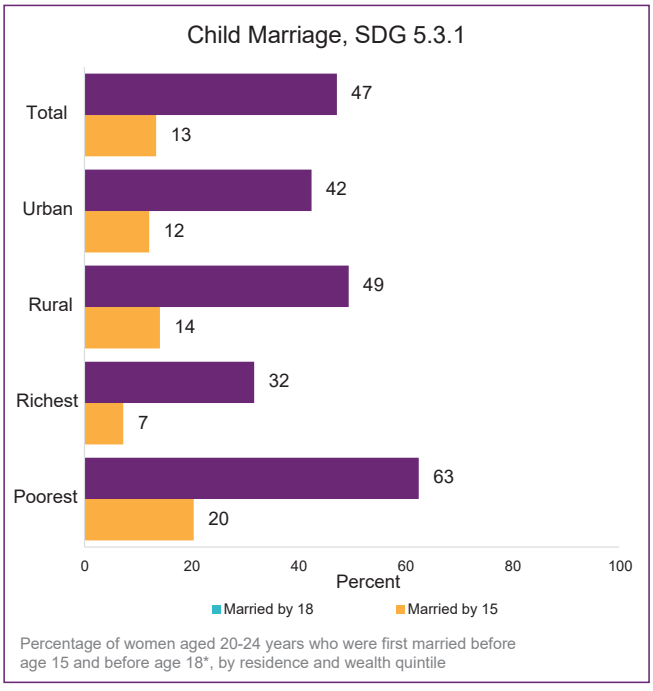


Contraceptive use and demand for family planning satisfied by modern methods among adolescent girls age 15-19, by marital status

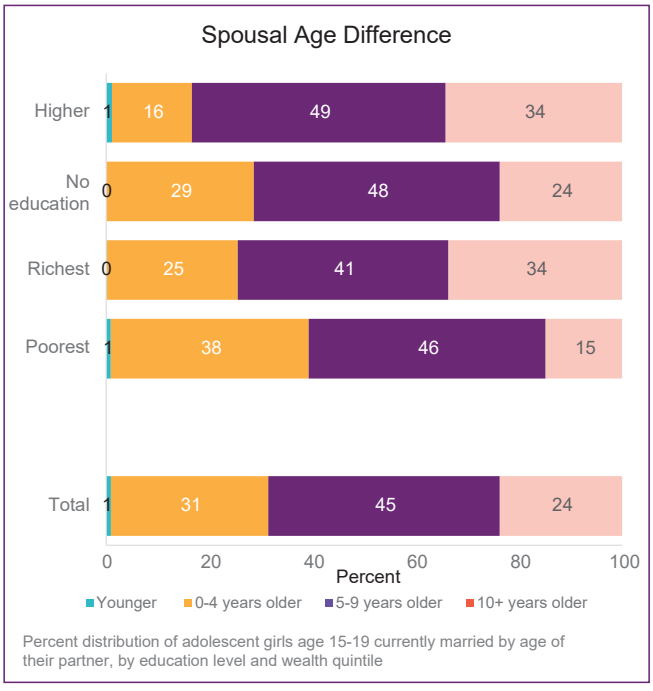


Percentage of women age 20-24 years who had a live birth by age 18, by urban/rural residence

Every Adolescent Girl & Boy is Protected from Violence & Exploitation: The Second Decade of Life



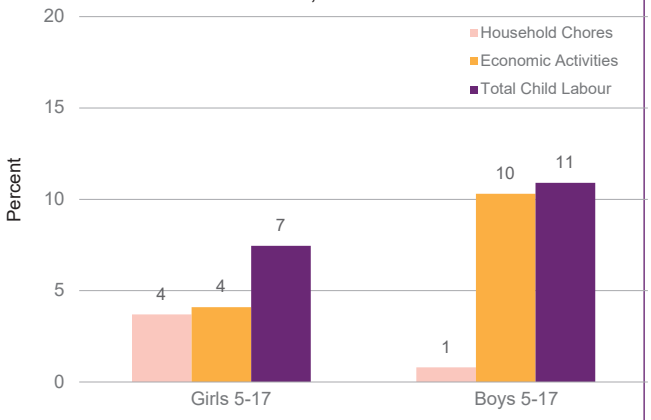
Percentage of women aged 20-24 years who were first married before age 15 and before age 18*, by residence and wealth quintile



Percent distribution of adolescent girls age 15-19 currently married by age of their partner, by education level and wealth quintile

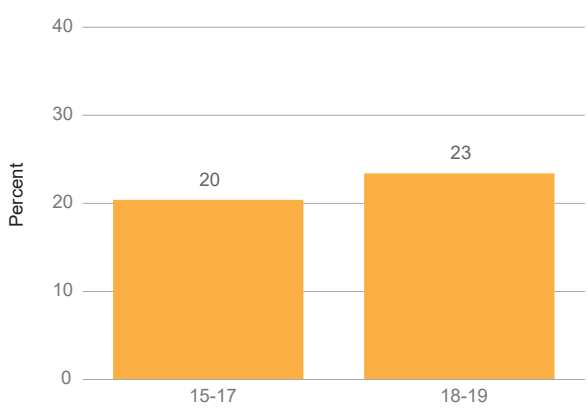
Every Adolescent Girl & Boy is Protected from Violence & Exploitation: The Second Decade of Life

Adolescence presents unique vulnerabilities to violence and exploitation for girls. In many countries, marriage before the age of 18 is a reality for girls due to the interaction of several factors that place a girl at risk, including poverty, social norms, customary or religious laws that condone the practice, an inadequate legislative framework and the state of a country's civil registration system. Child marriage often compromises a girl's development by resulting in early pregnancy and social isolation, interrupting her schooling, and limiting her opportunities for career and vocational advancement. It also often involves a substantial age difference between the girl and her partner, thus further disempowering her and putting her at greater risk of partner violence, sexually transmitted diseases and lack of agency. Attitudes about wife beating serve as a marker for the social acceptability of intimate partner violence. Acceptance of wife beating among adolescent girls and boys suggests that it can be difficult for married girls who experience violence to seek assistance and for unmarried girls to identify and negotiate healthy and equitable relationships. Gender-based discrimination may be one of the most ubiquitous forms of discrimination adolescent girls face, and it has long-lasting and far-reaching effects on their personal trajectories as well as on all aspects of social and economic development. While in most regions, girls and boys are equally likely to be involved in child labour, gender is a determinant of the types of activities boys and girls engage in, with girls more likely to be involved in domestic work.



Percentage of children age 5 to 17 years engaged in child labour, by sex, age group and type of activity

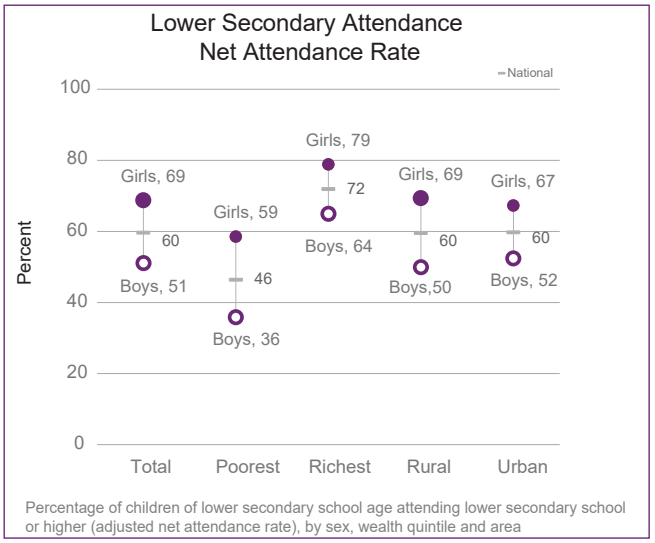
Note: Indicator includes children in the first & second decade of life



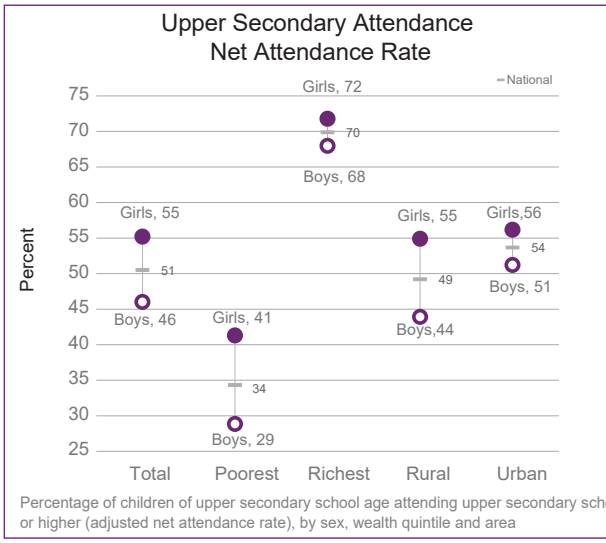
Percentage of adolescents age 15 - 19 years who justify wife beating for any of the following reasons: she goes out without telling him; she neglects the children; she argues with him; she refuses sex with him; she burns the food, by sex and age group

Every Adolescent Girl & Boy Learns: The Second Decade of Life

Globally, participation in secondary education is expanding, progress lags behind primary education. Gender disparities disadvantaging girls are also wider and occur in more countries at the secondary level than at the primary level. Yet, advancing girls' secondary education is one of the most transformative development strategies countries can invest in. Completion of secondary education brings significant positive benefits to girls and societies – from increased lifetime earnings and national growth rates, to reductions in child marriage, stunting, and child and maternal mortality.

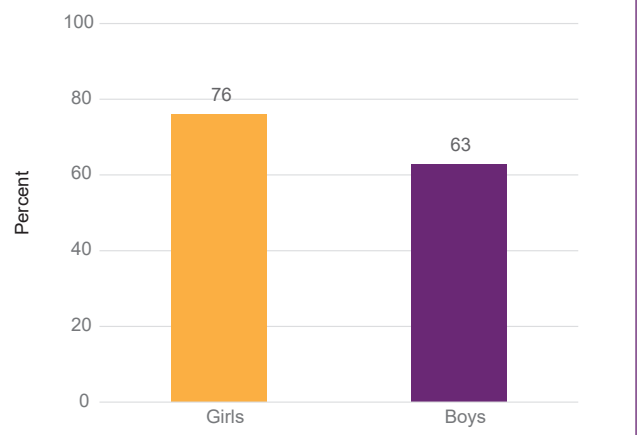


Percentage of children of lower secondary school age attending lower secondary school or higher (adjusted net attendance rate), by sex, wealth quintile and area

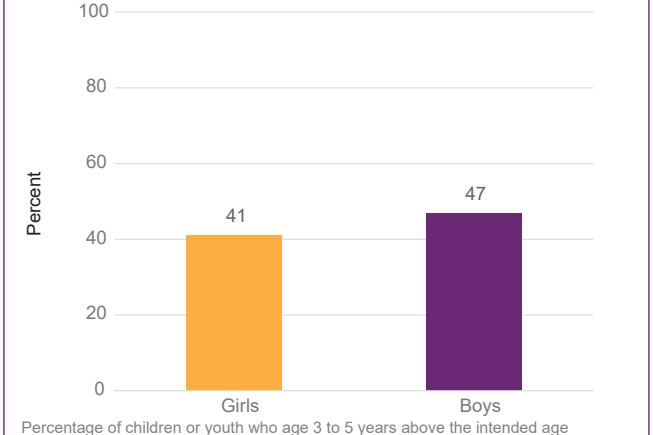


Percentage of children of upper secondary school age attending upper secondary school or higher (adjusted net attendance rate), by sex, wealth quintile and area

Every Adolescent Girl & Boy Learns: The Second Decade of Life

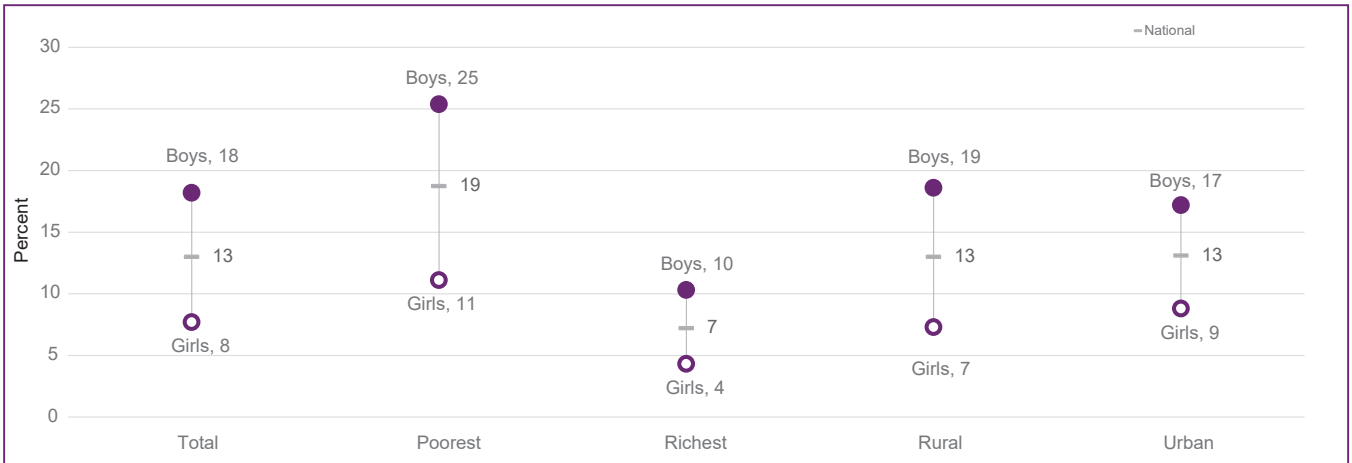


Percentage of children who age 3 to 5 years above the intended age for the last grade of lower secondary school who have completed lower secondary education, by sex



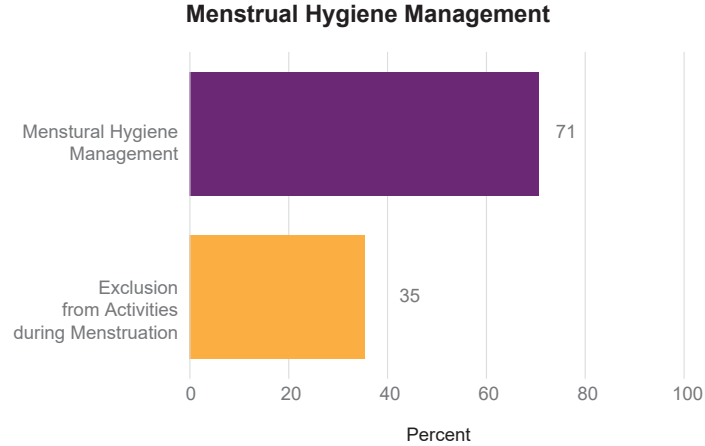
Percentage of children or youth who age 3 to 5 years above the intended age for the last grade of upper secondary school who have completed upper secondary education, by sex

Children of Lower Secondary School Age Out of School



Percentage of children of lower secondary school age who are not attending any level of education, by wealth quintile and area

Every Adolescent Girl & Boy Lives in a Safe & Clean Environment: The Second Decade of Life



The ability of adolescent girls to safely manage their monthly menstrual cycle in privacy and with dignity is fundamental to their health, psychosocial well-being and mobility. Girls in low-resource and emergency contexts without access to adequate menstrual hygiene management facilities and supplies experience stigma and social exclusion while also forgoing important educational, social and economic opportunities.

Menstrual Hygiene Management: Among adolescent girls age 15-19 who reported menstruating in the last 12 months, percentage using appropriate menstrual hygiene materials with a private place to wash and change while at home

Exclusion from Activities during Menstruation: Among adolescent girls age 15-19 who reported menstruating in the last 12 months, percentage of women who did not participate in social activities, school or work due to their last menstruation in the last 12 months

Key Messages

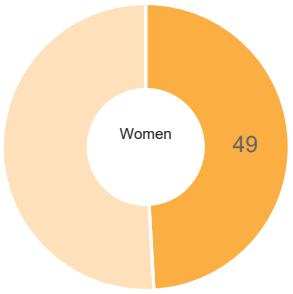
- Child marriage has implications on all aspects of a girl's life during her lifecycle. Child marriage is common in Bangladesh, as is early childbearing. About half of women age 20-24 years married before they reached their 18th birthday. Women from the poorest households were most likely (63%) to be married before their 18th birthday. Little more than one fifth (22%) of married women in Bangladesh had their first birth before their 18th birthday.
- Equipping girls with skills and information, increasing their access to resources, building their agency, and shifting broader social norms related to child marriage and gender equality are central.
- More than half of the married girls 15-19 years currently use any modern method of contraception, and 74% have their need for family planning satisfied by modern methods of contraception.
- In Bangladesh, boys are nearly twice as likely to be engaged in child labour than are girls; they are also less likely to attend lower or upper secondary school. While girls are more likely to complete lower secondary school (76% for girls compared to 63% for boys), boys who attend secondary school are more likely to complete (47%) than are girls (41%). More work is needed to understand the social processes that engage boys in labour early in life and keeps them out of school. While participation in lower and upper secondary school has improved for girls, more work is needed to ensure that both boys and girls attend and complete secondary school.
- Just over two-thirds girls age 15-19 years (71%) were able to manage their menstrual cycle; 35% reported they excluded from activities during their recent menstruation.

Gender Equality in Adulthood

To survive and thrive, all children require care and support from women and men. Care and support can be substantively improved by fostering gender equality, an important goal in its own right, and by reducing the gender-related barriers. Gender-related barriers include women's and girls' disproportionate lack of information, knowledge and technology, resources, and safety and mobility, as well as the gender division of labour and gender norms. For example, a mother's lack of mobility, due to prohibitive norms or lack of transportation, may impede birth registration, nutrition, and other child outcomes. The internalization of gender norms around masculine and feminine expectations and behaviours may influence women's and men's attitudes toward intimate partner violence and physical punishment of children as well as self-perceptions of well-being, including life satisfaction and expectations for the future.

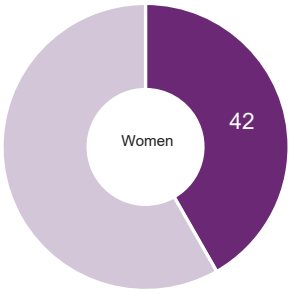
Access to Knowledge, Information & Technology

Literacy (secondary level education)



Percentage of women age 15-49 who have completed at least secondary level education

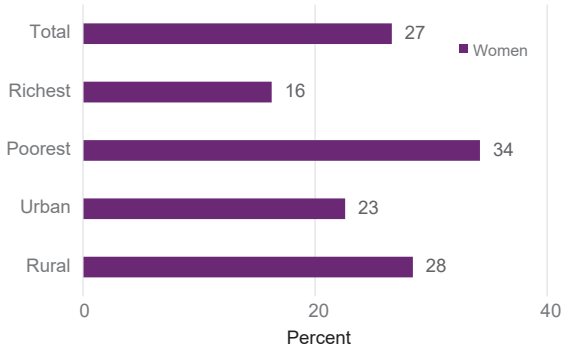
Internet Use: SDG17.8.1



Percentage of women age 15-49 using the internet at least once in the past 3 months

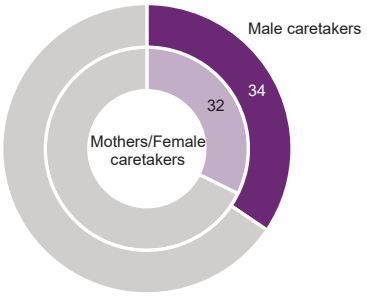
Feminine & masculine attitudes & expectations

Attitudes toward domestic violence



Percentage of women age 15-49 who justify wife beating for any of the following reasons: she goes out without telling him; she neglects the children; she argues with him; she refuses sex with him; she burns the food, by wealth quintile and area

Attitudes toward physical punishment

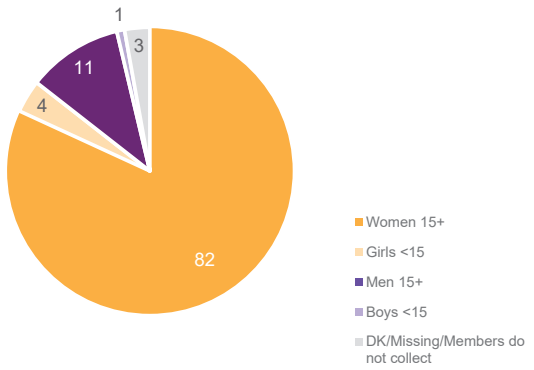


Percentage of caretakers who believe that physical punishment is needed to bring up, raise, or educate a child properly, by sex of caretaker

Gender Equality in Adulthood

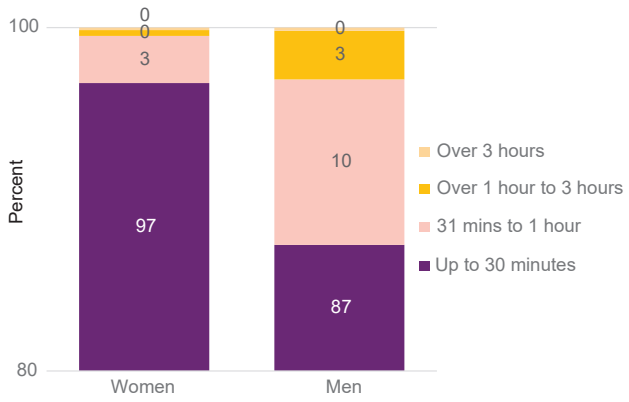
Time on Household Chores: Water Collection

Who collects water?



Percent distribution of household members without drinking water on premises by person usually collecting drinking water used in the household

Time spent on water collection



Percent distribution of average amount of time spent collecting water per day by sex of person primarily responsible for water collection in households without drinking water on premises

Key Messages

- In Bangladesh, 49% of women 15-49 years are exposed to at least secondary level education. Access to the internet among women in Bangladesh increased substantially as 42% of women reported to use the internet at least once a week during the last three months. Water collection remains a very gendered chore in Bangladesh. Eighty-two percent of women age 15 years or older usually collect water for use by the household; a further 4% of households often send a female child under the age of 15 years to collect water.
- Little over one in four married women in Bangladesh see it justified for a husband to beat his wife as punishment for doing something wrong (going out, neglecting children, burning food, refusing sex, arguing). These attitudes are even more prevalent in rural areas (28%) and amongst poor women (34%). These data indicate a great need for awareness-raising in communities in Bangladesh regarding how women understand their rights to live in a safe environment free from violence and their right to make decisions for themselves.
- A substantial share of parents / caretakers in Bangladesh endorse physical punishment as a necessary part of child-rearing, with about 34% of men and 32% of women agreeing with this view. Men are slightly more likely than women to see physical punishment as needed, suggesting that the practice is socially normalized across sexes and may be reinforced within households. High endorsement rates point to a persistent barrier to child protection and positive parenting. Programmes should therefore prioritize behaviour-change communication, caregiver training in non-violent discipline, and community-level awareness to shift norms and reduce children's exposure to corporal punishment.

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Gender Equality.

Further statistical snapshots and the Summary Findings Report for this and other surveys are available on mics.unicef.org/surveys.

BANGLADESH 2025

MICS

Multiple Indicator Cluster Surveys

Mass Media, Communications & Internet (Women)

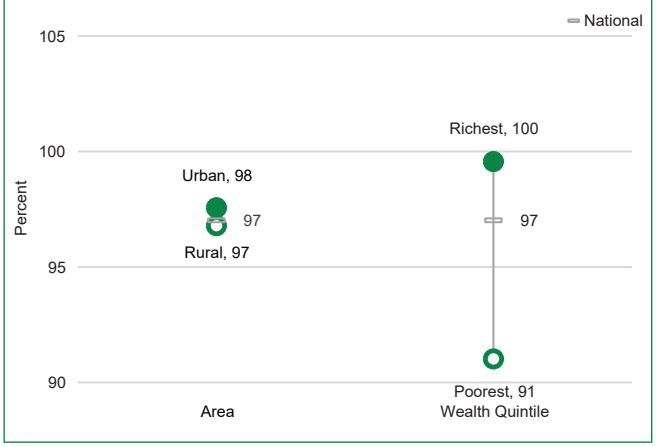
Household Ownership of Information & Communication Technology (ICT) Equipment & Internet at Home

Division	Radio	Television	Telephone-Fixed line	Telephone-Mobile	Computer	Internet at Home
National	**0**	**40**	**0**	**97**	**6**	**72**
Barishal	0	27	0	97	4	66
Chattogram	0	31	0	98	5	83
Dhaka	0	51	0	98	9	81
Khulna	1	40	0	97	6	69
Mymensingh	0	27	0	96	4	62
Rajshahi	0	51	0	96	6	64
Rangpur	0	40	0	95	5	53
Sylhet	0	26	0	97	4	77

Percentage of households which own a radio, television-fixed line, telephone- mobile, computer and that have access to the internet at home

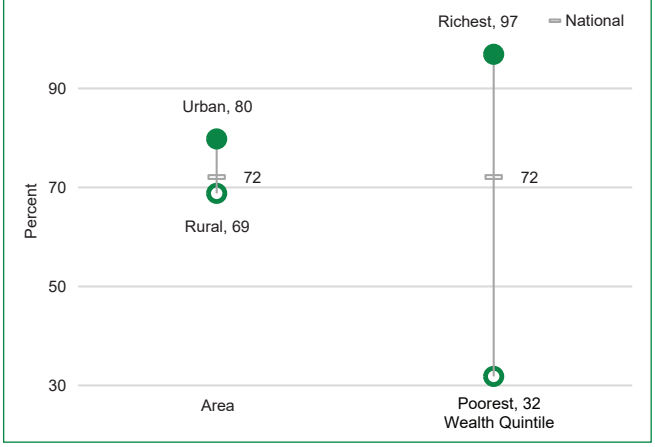
Inequalities in Household Ownership of ICT Equipment & Internet at Home

Household Ownership of a Mobile Telephone



Percentage of households with mobile telephone

Households with Internet



Percentage of households with access to the internet at home

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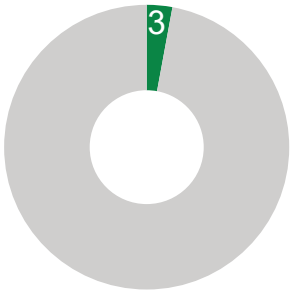
Key Messages

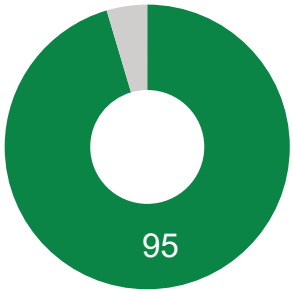
- Near-universal phone reach: 97% of women are reached by mobile phones, an excellent channel for delivering health messages.
- Access vs. use: While 91% of women in the poorest quintile have access to a mobile phone (vs. ~100% in the wealthiest quintile), reported use in the past three months is high across urban/rural residence, education levels, and wealth groups.
- Computer and internet: Only 3% of women used a computer in the past three months; internet access is higher among wealthier, more educated, and urban women.
- Digital skills: Just 26% of women aged 15–49 carried out at least one computer- or smartphone-based activity in the past three months, underscoring very low ICT access and skills.

Use of Information & Communication Technology

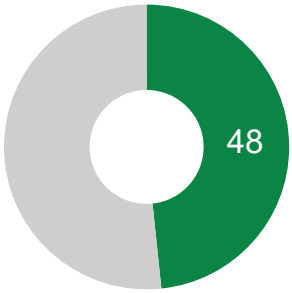
Computer Use



Mobile Phone Use



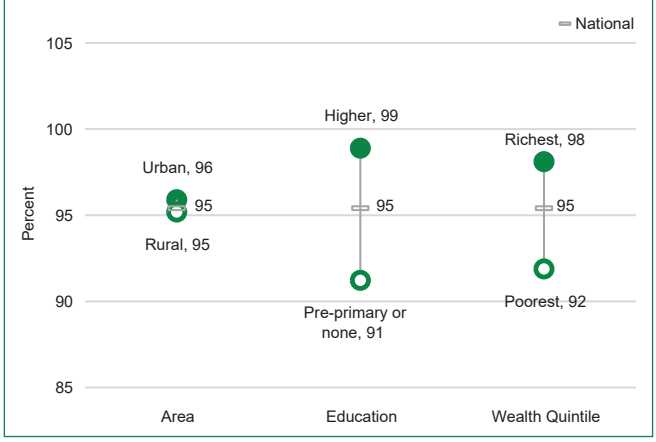
Internet Use: SDG17.8.1



Percentage of women age 15-49 years who during the last 3 months used a computer, used a mobile phone and used the internet

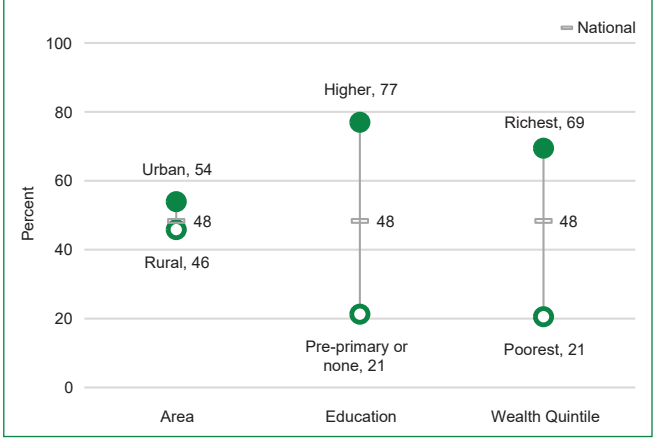
Disparities in Use of Information & Communication Technology

Disparities in Mobile Phone Use among Women



Percentage of women age 15-49 years who during the last 3 months used a mobile phone

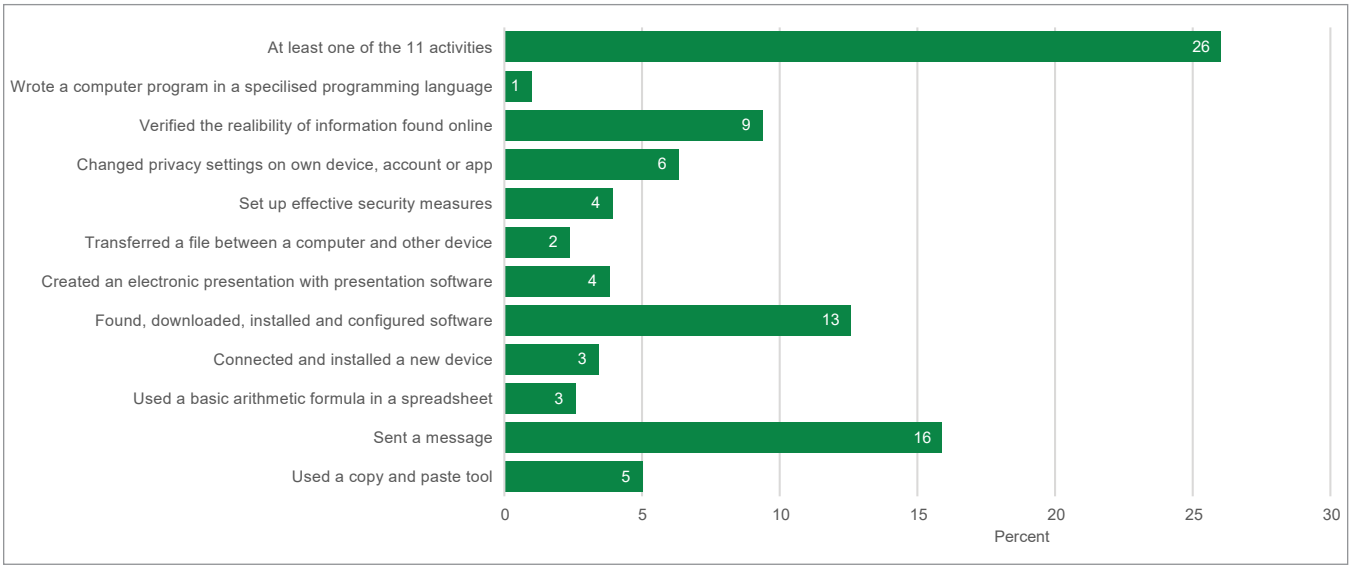
Disparities in Internet Use among Women: SDG17.8.1



Percentage of women age 15-49 years who used the internet in the last 3 months

Information & Communication Technology (ICT) Skills

Specific Skills Performed at Computer or Smartphone



Percentage of women age 15-49 years who in the last 3 months have carried out specific computer related activities and the percentage who have carried out at least one of these activities

Divisional Data on ICT Use & Skills among Women

Division	Computer Use	Mobile Phone Use	Internet Use	Performed at Least 1 computer-related activity
National	**2.9**	**95**	**48**	**26**
Barishal	2.6	94	40	26
Chattogram	2.1	95	58	32
Dhaka	4.2	97	58	35
Khulna	2.7	97	49	19
Mymensingh	1.6	96	37	15
Rajshahi	3.0	96	39	22
Rangpur	2.9	95	34	14
Sylhet	1.8	86	38	22

Percentage of women age 15-49 years who during the last 3 months used a computer, used a mobile phone and used the internet and percentage who performed at least 1 computer-related activity

The Bangladesh Multiple Indicator Cluster Survey (MICS) was carried out in 2025 by the Bangladesh Bureau of Statistics as part of the global MICS programme. Technical support was provided by the United Nations Children's Fund (UNICEF), with financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the U.S. Government, and the United Nations Population Fund (UNFPA).

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to Mass Media, Communications & Internet.

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BANGLADESH 2025

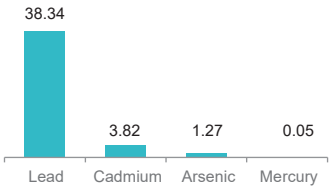
Heavy Metal Exposure and Anaemia

MICS
Multiple Indicator Cluster Surveys

Heavy Metal and Anaemia Indicators

Heavy metals in blood of children

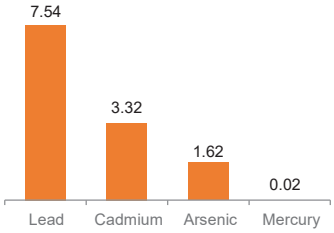
Heavy metals in blood of children aged 12- 59 months, refers to the percentage of children who had elevated heavy metals in the blood above the threshold. The threshold for lead ≥ 5 µg/dL, cadmium > 0.5 µg/dL, mercury > 0.8 µg/dL, arsenic > 1.2 µg/dL



Percentage of children aged 12-59 months with elevated heavy metals in the blood

Heavy metals in blood of pregnant women

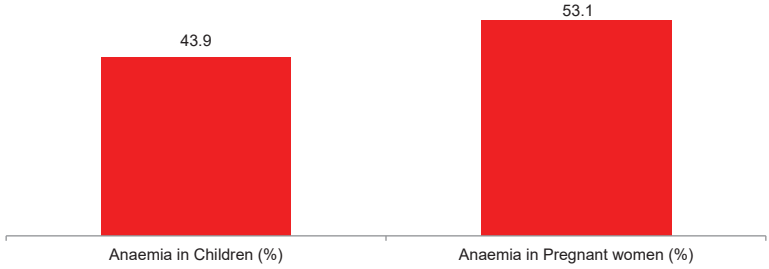
Heavy metals in the blood of pregnant women aged 15-49 years, refers to the percentage of pregnant women who had elevated heavy metals in the blood above the threshold. The threshold for lead ≥ 5 µg/dL, cadmium > 0.5 µg/dL, mercury > 0.8 µg/dL, arsenic > 1.2 µg/dL



Percentage of pregnant women aged 15-49 years with elevated heavy metals in the blood

Anaemia in children and pregnant women

Anaemia is a condition where the number of healthy red blood cells or the haemoglobin concentration in the body is lower than normal, which decreases the capacity of the blood to carry oxygen to the body's tissues.



Key Messages

- The Bangladesh Multiple Indicator Cluster Survey (MICS) 2025 marks the first integration of a Blood Lead Level Plus module (BLL+), testing 13,707 children (12–59 months) and pregnant women (15-49 years) for lead and three other heavy metals - cadmium, arsenic, mercury; and haemoglobin.
- Findings reveal that heavy metal exposure remains a major public-health concern. Thirty-eight (38%) percent of the children aged 12–59 months and nearly 8% of the pregnant women had blood lead levels above the threshold (≥5 µg/dL). Smaller proportions showed elevated cadmium (4%) and arsenic (1%) among children and elevated cadmium (3%) and arsenic (2%) among pregnant women, indicating that lead poisoning was more prevalent than cadmium, arsenic and mercury poisoning.
- Household environmental contamination continues to contribute to heavy metal exposure.
- Anaemia remains highly prevalent, affecting 44% of children 12-59 months and 53% of pregnant women. The MICS 2025 data show a clear relationship between anaemia and elevated blood heavy-metal levels. Children and mothers with higher concentrations of lead and other metals were more likely to be anaemic, suggesting that environmental exposure may worsen nutritional deficiencies and impair haemoglobin synthesis.
- These findings underscore the urgent need for integrated interventions that combine improved maternal and child nutrition interventions, national environmental health surveillance systems, public awareness campaigns, and reduction of heavy-metal exposure through safer industrial practices, improved waste management, clean household environments, and strengthened regulatory enforcement.
- Addressing these dual burdens of environmental pollution and nutrition will accelerate Bangladesh's progress toward SDG 3.9 (reducing illness from hazardous chemicals) and SDG 12.4 (sound management of chemicals and waste), ensuring a healthier environment for every child and every mother.

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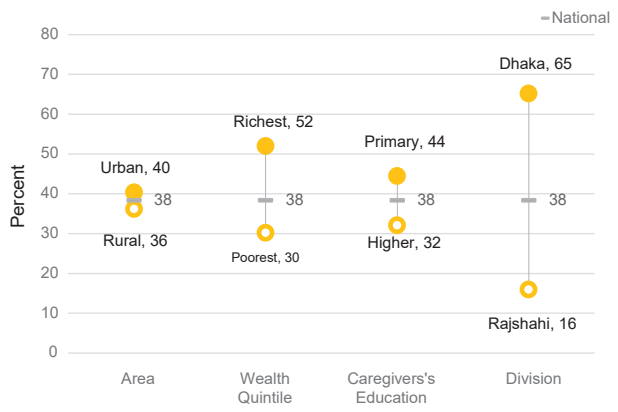
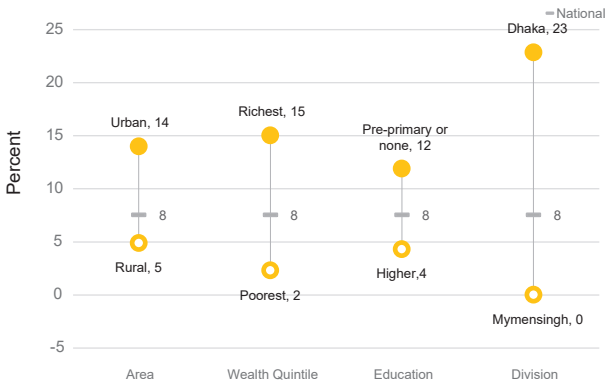
Elevated Blood Lead Levels in Children and Pregnant Women

Children 12-59 months



Percentage of children aged 12-59 months with elevated blood lead levels

Pregnant Women



Percentage of pregnant women aged 15-49 years with elevated blood lead levels

Divisional Data on Elevated Blood Heavy Metal Levels and Anaemia

Division	Percentage of children and pregnant women with elevated lead level in blood		Percentage of children and pregnant women with elevated cadmium level in blood		Percentage of children and pregnant women with elevated mercury level in blood		Percentage of children and pregnant women with elevated arsenic level in blood		Percentage of children and pregnant women with anaemia	
	% of children 12-59 months	% of pregnant women	% of children 12-59 months	% of pregnant women	% of children 12-59 months	% of pregnant women	% of children 12-59 months	% of pregnant women	% of children 12-59 months	% of pregnant women
National	**38.3**	**7.5**	**3.8**	**3.3**	**0.05**	**0.02**	**1.27**	**1.62**	**43.9**	**53.1**
Barishal	29.0	2.5	7.4	3.4	0.17	0.00	0.15	0.00	54.1	55.3
Chattogram	42.1	2.2	4.1	4.7	0.00	0.00	3.35	5.17	40.6	49.0
Dhaka	65.2	22.8	2.7	1.2	0.10	0.09	0.25	0.17	42.1	53.4
Khulna	17.8	1.9	3.5	3.5	0.12	0.00	0.73	0.82	48.0	56.3
Mymensingh	30.6	0.0	5.3	2.9	0.00	0.00	0.91	0.00	45.3	54.7
Rajshahi	15.9	5.5	2.6	2.3	0.00	0.00	0.98	0.73	49.9	52.9
Rangpur	19.6	1.5	2.8	6.0	0.00	0.00	0.98	0.27	45.2	58.3
Sylhet	46.7	3.9	6.7	3.4	0.00	0.00	0.90	0.62	33.4	52.1

The Bangladesh Multiple Indicator Cluster Survey (MICS) 2025 was conducted by the Bangladesh Bureau of Statistics (BBS) as part of the global MICS programme, with technical support from the United Nations Children's Fund (UNICEF) and financial contributions from the Swiss Agency for Development and Cooperation (SDC), the United Nations Refugee Agency (UNHCR), the United States Government (USAID), and the United Nations Population Fund (UNFPA). The Institute of Epidemiology, Disease Control and Research (IEDCR) and the International Centre for Diarrhoeal Disease Research, Bangladesh (icddr,b) served as technical partners for blood and soil specimen collection and laboratory testing.

The objective of this snapshot is to disseminate selected findings from the Bangladesh MICS 2025 related to the Environmental Health and Nutritional Status of Children and Pregnant Women.

Further statistical snapshots and the Survey Findings Report for this and other surveys are available on mics.unicef.org/surveys.

GENERATING EVIDENCE TO DELIVER FOR CHILDREN

Preliminary Report

Bangladesh Bureau of Statistics
Statistics and Informatics Division
Ministry of Planning

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