Use of high-quality, nationally representative data from two household surveys was the primary strength of this study. Moreover, appropriate statistical adjustments for the survey design and modelling for the confounding effects make the findings of this study more reliable. However, the primary source of limitation was recall bias. Data analysed in this study were retrospective response for the women having at least one child six months or younger. Therefore, sometimes women might not had been in a position to recall correctly all the events that took place in the time of breastfeeding initiation, intrapartum, and postpartum care use.

The study involved a nationally representative and large data set with high response rate. However, the study has a drawback in that it utilized cross-sectional dataset and unable to establish causality.

There are some limitations of the study. Looking into the study sampling distribution across 7 regions over two periods (S1 and S2 Tables), it reveals that sampling distribution varies over regions. Thus, adjusted weighted factors may explain some differences in stunting reductions especially for Dhaka where covariates play a minimum role in explaining the reduced level of stunting. Also, due to matching problem in two data sets, we had lost six observations for the distance variable which however, did not change our conclusion. Although, we adjusted the models for clustering effects, owing to omitted variable problems, our results may suffer from unobserved heterogeneity. For example, environmental factors or specific interventions can play a role in explaining regional differences in stunting among under-fives. The limitation of our analysis is that, we could not disentangle unobserved heterogeneity from the observed covariates effects.

The main limitation of the study is absent of qualitative information from mothers regarding their feelings about unwanted births and biases inherent retrospective information on unwanted births. The data of cultural and psychological factors are also absent in this study. Unfortunately, Bangladesh Demographic and Health Survey data doesn’t collect above information. The finding also gives the need for further research to detect cultural and psychological factors associated women with higher risk of unwanted births. It may conclude that fertility impact especially on unwanted births is the main offender of unplanned births in Bangladesh. Policy planners should take appropriate policy in developing strategy to reduce unwanted births among married women of reproductive age in Bangladesh.

The study had limitations. Verbal autopsy data are limited to the symptoms that family members can recall. They do not include a systematic medical assessment of the ill child, physical exam, laboratory records or postmortem evaluation. Although some causes of death are likely well captured by verbal autopsy for example drowning or severe diarrhea, other causes with less specific presentations including immune deficiencies and congenital metabolic problems are less likely to be recognized. Indeed, with the small sample of deaths in this study, there was limited statistical power to identify less common causes of death. A second limitation is that a large proportion of the population migrated out of the study area. If households that experienced a child death, were more likely to migrate out of the community, then we may have under-estimated child mortality in these communities. However, most people who migrate in these communities migrate to nearby neighborhoods, often still within the hospitals catchment, and the socio-economic status of households that migrated in were similar to the households that they replaced in the study, so we believe they are a reasonable proxy. A third limitation is that the enrollment criteria for households would have excluded some households which had a child death more than one year ago, and so underestimated mortality. In the 2006 survey, houses were selected if they had children under five or a child under five who died within one year of the survey date. In the 2007 survey, these same households were visited and asked about child deaths during the longer recall period. Households with a child who died under age five more than one year ago would only be included if they had a living child or a child who died within one year of the 2006 survey. Thus, some deaths from the extended recall period would be excluded from the survey because their household did not meet the inclusion criteria. However, this limitation only affects the estimates of mortality from recall periods >1 year. Moreover, the small differences in cumulative hazards between the ≤1 year recall period and the >1 year recall period suggests that impact of this limitation on the mortality estimates was minor. A fourth limitation is that deaths among children under five within five years of the survey were included, whereas living children were included only if they were under five at the time of the survey. This creates selection bias in the direction of overestimating mortality because deceased children were included who would not have been included had they survived. We addressed this problem in the analysis by excluding children born more than five years before the survey date. In effect, our estimates of mortality are for an open cohort of children born in the last five years in the study area. Any household with one of these children, living or deceased, would have been eligible for the survey, and we would have data on all such children from any household that participated in the study. The mortality estimates from the <1-year recall period are similar to those that would be obtained from a synthetic cohort, whereas the mortality estimates from the >1-year recall period are those of an actual open cohort. The two methods produce similar mortality estimates when age-specific mortality rates are stable over time. Since the mortality estimates from the two periods are indeed similar (Figure 1), comparison with the BDHS estimates is reasonable despite the methodological differences. A fifth limitation is that this study population represents a single geographic area. It is neither representative of all of Dhaka, nor of urban Bangladesh generally. Because it is only one site, limited inferences can be drawn regarding the relationship between available characteristics and child survival. However, the study population represents a large socio-economically diverse population and suggests that access to appropriate clinical care may contribute to improved child survival. Although these data suggest that under-five child survival is better in this study community in urban Dhaka than in the country as a whole, however the mortality is still high. Improving child survival in Bangladesh will require reducing serious child respiratory disease, reducing neonatal deaths, and extending effective health services to both rural and urban areas.