The Incidence of Menstrual Regulation Procedures and Abortion in Bangladesh, 2010

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Context: Bangladesh is unique in including menstrual regulation (MR) services as part of the government family planning program, despite having a highly restrictive abortion law. The only national estimates of MR and abortion incidence are from a 1995 study, and updated information is needed to inform policies and programs regarding the provision of MR and related reproductive health services.

Methods: Surveys of a nationally representative sample of 670 health facilities that provide MR and postabortion care services and of 150 knowledgeable professionals were conducted in 2010, and MR service statistics of nongovernmental organizations were compiled. Indirect estimation techniques were applied to calculate the incidence and rates of MR and induced abortion.

Results: In 2010, an estimated 647,000 induced abortions were performed in Bangladesh, and 231,400 women were treated for complications of such abortions. An estimated 653,000 MR procedures were performed at facilities nationwide. However, an estimated 26% of all women seeking an MR at facilities were turned away, and about one in 10 of those who had an MR were treated for complications. Nationally, the annual abortion rate was 18.2 per 1,000 women aged 15–44, and the MR rate was 18.3 per 1,000 women.

Conclusions: The incidence of induced abortion is the same as that of MR, which suggests considerable unsatisfied demand for the latter service. Furthermore, the high rates of complications from MRs highlight the need to improve the quality of clinical services. Increased access to contraceptives and MR services would help reduce rates of unplanned pregnancy and unsafe abortion.


Among the many developing countries where abortion is highly legally restricted, Bangladesh is unique in permitting the provision of menstrual regulation (MR) services as part of the government family planning program. MR procedures are generally performed using manual vacuum aspiration, with a maximum limit of 10 weeks after a woman’s last menstrual period, and without a test to confirm pregnancy. The MR program is considered to contribute significantly to protecting women’s health,1 manual vacuum aspiration, which is recommended by the World Health Organization,2,3 has a very low rate of complications from MRs and is highly legally restricted, Bangladesh is unique in permitting MR services as part of the government family planning program. Furthermore, an estimated 26% of all women seeking an MR at facilities were turned away, and about one in 10 of those who had an MR were treated for complications. Nationally, the annual abortion rate was 18.2 per 1,000 women aged 15–44, and the MR rate was 18.3 per 1,000 women.

Conclusions: The incidence of induced abortion is the same as that of MR, which suggests considerable unsatisfied demand for the latter service. Furthermore, the high rates of complications from MRs highlight the need to improve the quality of clinical services. Increased access to contraceptives and MR services would help reduce rates of unplanned pregnancy and unsafe abortion.


No national study on the incidence of MR and abortion has been conducted since the 1995 analysis. Yet in the past 15 years, notable changes have occurred in Bangladesh that may have affected access to MR services and women’s and couples’ motivation to resort to MR or abortion. Unmet need for contraception remained substantial at 12% in 2011, after declining from 17% in 2007.4,5 In addition, contraceptive use increased relatively slowly from the mid-1990s until 2011. The percentage of currently married women aged 15–49 using any method increased from 49% to 61%—an average annual increase of 0.8 percentage points. Although a majority of Bangladeshi couples who use contraceptives relied on modern methods in the past and continued to do so in 2011 (52% of married women), most used the pill, the injectable or condom (4%), and only a small proportion used methods with very low failure rates, such as sterilization, the IUD and the implants (8%).6,7 Clearly, unmet need for contraception, use of traditional methods (9% in 2011), and reliance on short-term, reversible methods with relatively high risks of contraceptive failure and discontinuation are important factors contributing to unintended pregnancy.

Bangladesh has made significant progress in reducing maternal mortality over the last two decades: The maternal mortality ratio is estimated to have fallen from 881 deaths per 100,000 live births in 1990 to 337 per 100,000 live births in 2009.4 The two most recent maternal mortality surveys conducted by the government confirmed that a significant decline continued over the last decade.8,9 Results from a national survey in 2010 indicate that abortion accounted for about 1% of all maternal deaths.5 According to a study in the Matlab district, large reductions in abortion-related deaths occurred between 1976 and 2005; these reductions, along with investments in family planning and emergency care, accounted for a significant proportion of the overall decline in the maternal mortality ratio.10 The new estimates of MR and abortion incidence from the present study will allow researchers to further investigate the role of MR in the reduction in maternal mortality in Bangladesh.

It is important to know if provision of MR services in Bangladesh has remained unchanged since 1995, and whether the role of those services (relatively to that of abortion services) has changed. A situation analysis conducted in 2002 highlighted important barriers to obtaining MR services: distance to facility, unequal access, lack of privacy, unfavorable provider attitudes, inadequate infection prevention and nonobservance of protocols.5 Another study documented the particularly poor access of rural women to MR services.11 In addition, the failure to train adequate numbers of MR providers to replace retiring cohorts may have reduced access further in recent years. An in-depth study in 2011 indicated that these barriers continue to exist, forcing poor women to use informal providers for health care services, including abortion.12

These concerns about possible declines in access to and quality of MR services are important reasons to collect new data on the incidence of MR and abortion (both safe and unsafe) to ensure that the reproductive health gains that Bangladesh has made in the past are not jeopardized. This study provides updated estimates of the incidence of MR and abortion in 2010 and its six major divisions. We also discuss changes in these measures between 1995 and 2007 while we are still understanding the limitations of data comparability, we examine broader demographic changes as well, including contraceptive use and unmet need for contraception.

Methods

Data sources

This study draws on three data collection efforts: a national survey of public and private-sector health facilities that provide postabortion care and MR services; a survey of knowledgeable key informants; and compilation of data obtained from nongovernmental organizations (NGOs) on MR and postabortion care services provided by their clinics. The study design and protocols for the two surveys were based on prior research that developed a methodology for estimating abortion incidences (Abortion Incidence and Quality of Services), and were adapted to the situation in Bangladesh. Questionnaires for both surveys were pretested in April 2010, the surveys were fielded from May to November 2010.

Other sources include Demographic and Health Survey (DHS) data sets for 1990–1997,19 1990–2000,20 2004,21 and 2007;22 3 and preliminary results from the 2011 DHS.23 These surveys provide information on contraceptive use, planning status of births and unmet need for contraception. The 2010 Household Income and Expenditure Survey24 provides information on poverty level.

• Health Facilities Survey (HFS): All public and private health facilities (excluding NGO facilities for which statistics were separately compiled) considered likely to provide postabortion care or MR services were included in the sample frame. Using the most recent Ministry of Health lists of health facilities in Bangladesh, the 2008 Statistical Yearbook of Bangladesh,24 and information obtained from the Directorate General of Health Services and Directorate General of Family Planning, we identified a total of 5,301 facilities (Table 1). The government sector includes five...
main types of health facilities: medical college hospitals,* districts general hospitals, upazila health complexes, mother and child welfare centers, and union health and family welfare centers (UH&FWCs). The last facility type is staffed by family welfare visitors (FWVs) and paramedics and provides post-MR services but not postabortion care. Private-sector clinics—which account for 29% of all facilities—were divided into three categories based on bed count to ensure adequate representation of facilities of all sizes. A stratified random sample design was used. Because of their large role in the treatment of postabortion care and MR cases, all public and private medical college hospitals were selected. For other categories of facilities, the sample was drawn from 16 distinct strata randomly selected out of the 64 districts in Bangladesh. The master list of all facilities was organized by type and by district within each type. A proportion of each type was selected. Sample fractions were determined by the degree of importance of each facility type in providing postabortion care and MR services and on the absolute number of facilities of each category. Because district hospitals, upazila health complexes, and mother and child welfare centers are critical sources of treatment for abortion complications and the numbers of these facilities are relatively small, 100% of each of these types in the 16 sample districts were included in the HFS sample. The sample fractions for the remaining facility types were 24% of UH&FWCs, 33% of private clinics, 55% of medium private clinics and 72% of large private clinics. Overall, 729 facilities were selected for the sample, representing 37% of the 1,945 facilities in the 16 sample districts. We successfully interviewed individuals at 670 facilities, for a response rate of 92%. At each selected facility, a senior staff member who was knowledgeable about the facility’s provision of postabortion care and MR services was interviewed; in hospitals, the interview was typically the chief of staff or another medical officer; in clinics, it was the director or another senior staff member. Informants were asked whether their facilities provided treatment of abortion complications, postabortion care, or induced abortion. If they were provided, they were asked the number of outpatient and inpatient treatments for abortions (spontaneous and induced) and whether the abortion complications were treated.† Respondents at all facilities were also asked the number of women treated for complications of spontaneous abortion.‡ These miscarriages are estimated to be 3.4% of all live births.‡‡

Estimating the Incidence of Menstrual Regulation

According to data from the HFS’s survey and NGO providers, an estimated 300,800 MR procedures were reported in 2010. However, adjustments are needed for the following source of underreporting: 41% had worked in rural areas for six months or longer, and compared to other professionals, they are less familiar with conditions in rural areas as well. Of the entire group, 41% had worked in rural areas for six months or longer in the five years prior to being interviewed. The HFS was designed to check professionals’ perceptions of various aspects of abortion and MR provision in Bangladesh. The survey provided the information necessary to calculate the multiplier, a factor used to estimate the total number of women who had induced abortions from the number of women who were treated for abortion complications.

†For the purposes of sampling and analysis, we grouped private and public-sector medical college hospitals together, as they offer similar services.

‡A small number of UH&FWCs, where more than one family welfare visitor works, were surveyed, and we assumed the data to determine whether they were answering individually or for the facility as a whole.‡‡‡

1 Although the additional person interviewed had not provided MMR services.

The purposes of the AICM, adapted to the context in Bangladesh. The estimated total number of women who had an unsafe induced abortion and needed treatment but did not obtain care at a health facility, and those who had a safe illegal induced abortion. Each component is discussed below.

a. Women treated for complications of spontaneous or induced abortion in 2010 was obtained from the HFS survey and NGO provider data—an estimated 280,500 women (Table 2), excluding 78,000 women treated for complications from MBs.

Because complications of induced and spontaneous abortion often are similar, and because restrictive abortion laws may lead to unwillingness to report complications of induced abortion, HFS respondents were not asked to provide separate estimates for each type of pregnancy loss. Instead, we employed an indirect estimation approach to estimate the number of patients with complications arising from each type. We used available data on the biological pattern of all spontaneous abortions (unrelated to hospitalization), established by clinical studies, 26 to27 to estimate the number of women who have miscarriages at 13–22 weeks’ gestation; these women are assumed to require care at a health facility. These miscarriages are estimated to be 280,500 women.

In addition, given that the World Health Organization classifies spontaneous abortions as less than 20 weeks’ gestation as fetal deaths, spontaneous abortion patients of this gestational age are excluded from the calculations.
Bureau of Statistics.25,26 Using the divisional distribution of women of reproductive age from the 2007 DHS,27 and the most recent age-specific population distribution,28 we calculated the number of women of reproductive age in each five-year age-group in 2010 for each division.29

The number of births in Bangladesh and in the six regions in 2010 were estimated by applying age-specific fertility rates from the 2007 DHS to the number of women in each age-group. According to these calculations, an estimated 3,551,682 live births and 121,000 late spontaneous abortions (0.01% of 3,551,682) occurred in 2010 in Bangladesh.

A further adjustment was needed because only a certain proportion of women who need treatment for complications of spontaneous abortion have access to a health facility. We assumed that this proportion was equivalent to the HPS-based estimate of the proportion obtaining care for complications of induced abortion—41% of all women seeking MR services. We therefore estimated that 49,100 women treated for complications of unsafe induced abortion each year in all public, private and NGO facilities.

Women who had unsafe legal abortions and whose abortions were not treated received treatment. This group was estimated using an adapted version of the clients who seek an MR will be the primary group obtaining care, as they are motivated and knowledgeable about clinics and trained providers. We therefore estimated the number of women obtaining safe abortions as a proportion of the number of MR-seeking clients whose requests were denied. Few studies have examined women who delay abortion after being refused an MR; however, an older study that followed up such MR clients found that 39% of them did try again, and about 80% of this group went to doctors and paramedics.21 From the HPS survey we know that 26% of all women who sought an MR were turned away. We estimated that half of those women will then obtain safe abortions (i.e., 13%), and we assumed that this estimate included not only women who were refused MR services, but also some other women who obtained such abortions (e.g., women who had not sought MR services, regardless of the number of weeks since their last menstrual period). Thus, 15%—that is, 13% of all women seeking an MR, expressed as a percentage of reported MRs, or 0.1297 (1−0.870)×0.149—the of the reported (unadjusted) number of MRs represents the estimated number of safe illegal abortions from 1.9 in Khulna and Basirhat to 2.9 in Dhaka. These figures indicate that approximately one in two women who needed treatment for complications of induced abortions obtained treatment in health facilities. Results of this interval to define low and high estimates of the pregnancy losses are estimated to be 20% of live births,10.11 The last measure was derived by multiplying the proportion of unplanned births (unwanted or unwanted at the time of conception) reported in the 2007 DHS by the number of live births. To estimate the number of unintended pregnancies that end in miscarriage, we used a model-based approach from clinical studies of pregnancy loss by time of conception—pregnancies are estimated to be 20% of live births, plus 10% of induced abortions—to the number of unplanned births. The number of planned pregnancies was calculated similarly, by summing planned births and miscarriages from intended pregnancies.

Incidence of Menstrual Regulation

An estimated 4,660,620 induced abortions were performed in Bangladesh in 2010 (Table 3). Nationally, the public sector accounted for almost two-thirds of all MR services, and private clinics for about one-quarter. The national incidence of MR was nearly identical to the national average for induced abortions (4.4% of all abortions). Women and men who sought MR services are, the lower the multiplier, because more women who require treatment will receive it. We calculated these multipliers using HPS estimates of the proportion of women who had complications who received treatment. Because the conditions under which women obtain abortions vary greatly by socioeconomic status and place of residence, these questions were asked separately in the HPS about each of four socioeconomic subgroups (urban poor and nonpoor, and rural poor and nonpoor). Results were weighted by the relative size of the subgroups to arrive at national and regional multipliers. The multipliers ranged from 2.2 to 2.9 for the private and NGO sectors and from 1.1 to 3.5 for the public sector.

Nongovernmental providers accounted for a little more than one-quarter of MR services, and private clinics for close to one-tenth.

There were substantial variations in the relative importance of the different categories of MR providers across the six divisions. The public sector accounted for 63% of services, but its share was larger in Basirhat and Rajshahi (71–79%), and smaller in Dhaka, Khulna and Sylhet (44–55%). Conversely, private clinics accounted for 9% of services for the country as a whole, their contribution was somewhat lower in Dhaka and Khulna (13–15%), but more important in the other four divisions (2–4%). NGO facilities accounted for 45% of MR services in Sylhet and 17% in Rajshahi, compared with 28% nationally.

Nationally, MR procedures were performed per 1,000 women of reproductive age in 2010. Across divisions, the MR rate ranged from 12 to 22 per 1,000 women. The rate was substantially below average in Sylhet and Khulna (12 and 14, respectively) and above average in Rajshahi (22).

Incidence of Induced Abortion

Estimates of the number of induced abortions were calculated separately from those of MR procedures. We focus on the medium estimate as representing the most likely situation.

An estimated 4,660,620 induced abortions were performed in Bangladesh in 2010, for an annual rate of 18 abortions per 1,000 women aged 15–49 (Table 4). The abortion rate was nearly identical to the national average in Dhaka and Sylhet, higher than average in Rajshahi and Khulna (22 and 25, respectively), lower than average in Chittagong (12) and exceptionally low in Basirhat (7). The
low rate in Barisal may reflect an undercount of women receiving treatment for postabortion complications in the HFS or a lower propensity to obtain abortion services in this district.

Bangladesh is unusual in having the public and private sectors play equal roles in the provision of postabortion care: Data from the HFS show that each sector accounted for about half of all women treated for abortion-related complications in 2010. Notably, small clinics with fewer than 20 beds accounted for two-thirds of private-sector postabortion care (not shown).

The ratio of induced abortions to live births was 18 per 100 nationally, Khulna and Rajshahi had the highest abortion ratio (34 and 25, respectively), while Barisal, Chittagong and Sylhet had the lowest (6–14). This measure is an indicator of the likelihood that, once pregnant, a woman will have an induced abortion: The national ratio is 23 per 100 women per 1,000 births, while the abortion complication rate was 16 per 1,000 births in 2010.12–14

The incidence of induced abortion and MR, and any changes in these measures over time, must be understood in the context of unintended pregnancy, fertility, contraceptive use and unmet need for family planning. Nationally, the overall pregnancy rate in 2010 was an estimated 160 pregnancies per 1,000 women aged 15–44, which is similar to that for Southeastern Asia (36 per 1,000).34 The overall pregnancy rate for South-central Asia in 2008 (26 per 1,000) was higher than the equivalent rate for South-central Asia in 2008 (26 per 1,000), but similar to that for Southeastern Asia (36 per 1,000).34

The unintended pregnancy rate was lower in Bangladesh than in other regions in Asia. Among women aged 15–44, the unintended pregnancy rate was 74 per 1,000 women in 2010 (Table 5). This is higher than the 57 per 1,000 women in 2004, which is similar to the prevalence of modern contraceptive use was already moderately high in 1996–1997 among married women (42%), and it increased to 52% by 2011 (Table 6). The proportion of married women using traditional methods, which have high failure rates, remained at 8–11% over this period. Method discontinuation remained common, but declined over the period 2007–2011. According to the 2011 DHS, 36% of married women who used modern methods other than female sterilization discontinued use within 12 months, a decrease from levels of 49% and 57% in the 2004 and 2007 DHS data sets, respectively.35 The proportion of married women with an unmet need for contraception,40 which had fluctuated between 1996–1997 and 2007 with no clear trend, fell from 17% to 12% between 2007 and 2011.

DISCUSSION

This study presents updated information on the incidence of induced abortion and MR in Bangladesh. By comparison with the only previous national study, conducted in 1995, the MR rate in 2010 is essentially unchanged. After accounting for improved measurement of abortion incidence, the induced abortion rate has also likely changed little over the past 15 years. Combining the MR and abortion rates to yield an estimate of the overall pregnancy termination rate shows that this rate in Bangladesh (37 per 1,000 women aged 15–44) is higher than the equivalent rate for South-central Asia in 2008 (26 per 1,000), but similar to that for Southeastern Asia (36 per 1,000).34

The unintended pregnancy rate in Bangladesh in 2010
is higher than those for South-central Asia and Southeast-Asia (18 per 1,000 women vs. 56 and 36 per 1,000, respectively). These data highlight the need for better contraceptive services in Bangladesh. Women’s use of induced abortion and menstrual regulation—which together account for about half of all unplanned pregnan-cies—is a further indication of the need to address barriers to women obtaining and using accurate contraceptive in-formation and quality services.

Findings from a series of contraceptive methods among married women increased from 4% in 1990–1997 to 21% in 2012, some aspects of method use contributed to unintended pregnancy. Nine percent of married women used a method in 1997, in 2012, 12% used no method, but did not want a child soon, and more than 80% of mod-ern method users were using methods (e.g., condoms, the pill and the injectable) that had higher failure and discon-tinuation rates than the most effective methods (i.e., the IUD, the implant and sterilization). The increase in modern method use between 2007 and 2011, coming after a few years of growth in use, supports the value of investing in improving contraceptive services.

The availability of safe MR services from a range of prov-iders—public, private and nongovernmental—is an impor-tant contributor to improvement in women’s reproductive health in Bangladesh. MR services were first offered in the 1970s, and service provision capacity increased until the mid-1990s. However, in recent years the practice of reverse smearing and multiple procedures has been inadequately to replace retrohoming, and even more so to increase the numbers of providers overall. Findings from this study point to large gaps in the reach and coverage of MR ser- vices, as well as the quality of these services. About one-third of all facilities that could provide MRs lack trained staff, or the availability of MR services, sources for these services and requirements regarding the maximum number of weeks since the last menstrual period.

Limitations

The methodological approach and data used in this study have some limitations. The calculation of the number of women treated for spontaneous abortions in facilities in Bangladesh is based on assumptions from clinical stud-ies conducted in the 1980s in the developed world. Even though these biological patterns are relatively stable, they may be somewhat different in Bangladesh and may have changed over the past 25 years. Given the lack of empirical data, the information on which multiples are based—the proportion of women having an unsafe induced abortion who need treatment but do not obtain care at a health facility—relies on key in-formants’ perceptions. In addition, the facility-based data have a margin of error because of selection bias and because they are based on a sample survey, albeit one that was designed to be nationally representative. Al-though questions in HFS respondents distinguished clearly between complications resulting from MR procedures and those from unsafe abortions, if some of the latter com-plications were mischaracterized as MR complications, then the reported rates of complications for MR procedures would be somewhat overestimated and that for postabortion complications would be underestimated.

Finally, our modified AICM method may underesti-mate the number of safe illegal abortions performed in the country: If this is the case, the abortion rate in Bangladesh would be higher than the one estimated in this article. Data on the extent of underreporting of MR services are scarce, although it is known that some of the factors we used to adjust for underreporting are approxi-mate figures only, and in fact may be somewhat conserva-tive as well.

Conclusions

Improvements in MR services are an important means of reducing the incidence of induced abortions, which for the most part in Bangladesh procedures that can lead to serious health complications. Studies have pointed to a number of reasons why women do not use existing MR services: High cost, inconvenient location and hours and location of services, and an actual or perceived poor quality of care. In addition, the 2007 DHS found that 19% of married women did not know that MR services are available in Bangladesh. It is clear that MR is a provision of such care. In contrast, the public sector was re-sponsible for nearly two-thirds of all MRs provided in 2010 and NGOs accounted for one-quarter, with the private sec-tor accounting for the remainder. These findings suggest the importance of monitoring the quality of postabortion care in the private as well as the public sector. The preva-lence of unsafe abortion underscores the need for greater efforts to educate women about the importance of quality and availabil-itv of MR services, sources for these services and requirements regarding the maximum number of weeks since the last menstrual period.

REFERENCES

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RESUMEN

Contexto: El gobierno de Bangladesh tiene la singularidad de incluir los servicios de regulación menstrual (RM) como parte de su programa de planificación familiar, a pesar de que la ley en cuanto al aborto es altamente restrictiva. Las únicas estimaciones nacionales disponibles de RM y aborto inducido provienen de un estudio realizado en 1995, por lo que se necesita información actualizada para dar soporte a las políticas y programas relacionados con la prestación de RM y servicios relacionados de salud reproductiva.

Métodos: En 2010 se condujeron una encuesta con una muestra representativa a nivel nacional de 670 instituciones de salud que proveen RM y servicios de atención postaborto, y otra de 151 profesionales conocedores del tema. También se compilaron estadísticas de los servicios de RM proporcionados por las organizaciones no gubernamentales. Se aplicaron técnicas de estimación indirecta para calcular la incidencia y las tasas de ambos, las RM y los abortos inducidos.

Resultados: Se estima que en 2010 se realizaron unos 647,000 abortos en Bangladesh; y 231,400 mujeres recibieron tratamiento por las complicaciones derivadas de esos abortos. Además, se realizaron unos 653,000 procedimientos de RM en instituciones en el país. Sin embargo, se estima que 26% del total de mujeres que solicitaron una RM en las instituciones fueron rechazadas; y cerca de una de cada 10 mujeres que tuvieron una RM fueron tratadas por complicaciones relacionadas. A nivel nacional, la tasa anual de aborto fue de 18.2 por mil mujeres en edades de 15 a 44 años y la tasa de RM fue de 18.3 por mil mujeres.

Conclusions: La incidencia del aborto inducido es la misma que la de RM, lo que sugiere una considerable demanda insatisfecha de este último servicio. Además, la alta tasa de complicaciones de RM destaca la necesidad de mejorar la calidad de los servicios clínicos. Un mayor acceso a los anticonceptivos y a los servicios de RM ayudaría a reducir las tasas de embarazos no planeados y del aborto inseguro.

RÉSUMÉ

Contexte: Le Bangladesh est unique en ce qu’il inclut les services de régulation menstruelle (RM) dans son programme national de la planification familiale, en dépit d’une législation fortement restrictive de l’avortement. Les seules estimations nationales d’incidence de la RM et de l’avortement remontent à une étude menée en 1995. Leur mise à jour est nécessaire à la documentation des politiques et programmes relatifs à la prestation de la RM et des services de santé génésique associés.

Méthodes: Des enquêtes ont été menées en 2010 auprès d’un échantillon nationalement représentatif de 670 établissements de santé prestataires de services de RM et de soins après avortement et de 151 professionnels informés sur la question et les statistiques de prestation RM des organisations non gouvernementales ont été compilées. L’incidence et les taux de RM et d’avortement provoqué ont été calculés selon les techniques d’estimation indirecte.

Résultats: On estime à 647,000 le nombre d’avortements provoqués au Bangladesh en 2010; 231,400 femmes ont été traitées pour cause de complications de ces avortements. On estime de plus à 653,000 le nombre de procédures de RM pratiquées dans les établissements du pays. Sur l’ensemble des femmes en âge de RM, environ 26% ont cependant été refusées dans les établissements de santé et environ 10% de celles admises ont été traitées pour cause de complications. À l’échelle nationale, le taux d’avortement annuel est de 18,2 pour mille femmes âgées de 15 à 44 ans et le taux de RM, de 18,3 pour mille.

Conclusions: L’incidence de l’avortement provoqué est égale à celle de la RM, laissant entendre une demande non satisfaite considérable de ce dernier service. De plus, les hauts taux de complications de la RM soulignent le besoin d’amélioration de la qualité des services cliniques. Un accès accru à la contraception et aux services de RM permettrait de réduire les taux de grossesse non planifiée et d’avortement non médicalisé.