main types of health facilities: medical college hospitals,* districts 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 provided post-MR services but not postabortion care. Private sector clinics—which account for 28% of all facilities—were divided into three categories based on bed count and the number of women seeking an abortion who had not been approached for treatment: those for which they charge universally, those for which they charge unoffi- cial fees but are not registered as providing MR as a service, and those for which they charge official fees but do not provide MR services.

The sample from which data were drawn was divided into 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 type. 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 small private clinics, 55% of medium private clinics and 72% of large private sector clinics—which account for 29% of all facilities—were selected. Overall, 729 facilities were selected for the HPS sample, representing 37% of the 1,945 facilities in the 16 sample districts. We successfully interviewed attendees 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 interviewee was typically the chief of obstetrics and gynecology, while in smaller facilities it was typically the director or another senior staff member. Informants were asked whether their facility provided treatment of abortion complications, the number of patients treated and the number of women who had miscarriages at the time of the study, and the proportion of patients treated by police and paramedics for the procedure for any reason in the last past month. The survey data were weighted to produce national estimates, taking into account a facility’s proportion of facility response rates, by division and type. The weighting factor for a given category of facility is the inverse of the product of its sampling fraction and the response rate for its type and division. (For greater accuracy, we performed the weighting as a log transformation.) Factors for correction in an outpatient or inpatient setting; if treatment for abortion complications was sought outside the facility itself to ensure that NGO provision of these services was not double-counted. For most UH&FWCs, one family welfare visitor was interviewed and asked to estimate the number of MR procedures performed by all FWVs and paramedics working at that facility, as well as the number that these personnel performed outside the facility (typically at their home or clients’ homes). The sum of procedures performed inside and outside of each center by all staff yielded the total number of MRs provided by each facility. Respondents at all facilities were also asked the number of women treated for abortion complications. In addition, because the lack of public-sector, private sector facilities are assigned to underreport MR services‡ that do not follow regulations (e.g., those they provide out- side of facilities; in which the number of weeks past the last menstrual period is more than allowed or are the case of public facilities—those for which they charge underreporting, we made the following conservative corrections to avoid double counting. A similar method was used 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 hospi- talization), established by clinical studies,2,26 to indirectly estimate the number of women who have miscarriages at 13–22 weeks’ gestation; these women are assumed to re- ceive care at a health facility. These miscarriages are esti- mated to be 3.4% of all live births.

We estimated the total population of Bangladesh in 2010 using 2007 and 2011 estimates from the Bangladesh National Bureau of Statistics. To assess the incidence of induced abortion, we estimated the number of men who had a safe induced abortion. Each component is dis- cussed below: A small number of legal, safe abortions that may be taking place to save a woman’s life were excluded from our calculation because of the lack of registration and support from trained or untrained providers who do not work at a facility. In addition, instead of employing 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 hospi- talization), established by clinical studies,2,26 to indirectly estimate the number of women who have miscarriages at 13–22 weeks’ gestation; these women are assumed to re- ceive care at a health facility. These miscarriages are esti- mated to be 3.4% of all live births.

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