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 division.

Bangladesh is unusual in having the private and public 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 (see also). The ratio of induced abortions to live births was 18 per 100 nationally, Khulna and Rajshahi had the highest abortion ratios (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 of 18 per 100 births means that approximately one woman in every 100 is estimated to have had an abortion for every woman who gives birth. It is also useful to calculate a combined ratio of MR procedures and induced abortions. The combined ratio of 37 per 100 live births indicates that about two pregnancies are ended for every five that result in births; this combined ratio for Bangladesh is higher than the estimated abortion rate for South-central Asia in 2008 (26 per 100). Combining the national numbers of induced abortions and MR procedures shows that induced abortions represented 50% of this total.

Change in Morbidity, MRs and Induced Abortions

Comparisons of results from the 1995 study with the estimates for 2010 yields insights into change in the safety of MR and induced abortion services, as well as the incidence of these procedures. However, given differences in both sample coverage and methodology, care must be taken in making comparisons. Because the 2010 sample design included comprehensive coverage of the private sector, while the 1995 study did not, we limit comparisons to public-sector treatment rates for complications resulting from MRs and induced abortions. The treatment rate for MR complications was 53% higher in 2010 than in 1995 (1.1 vs. 0.7 per 1,000), while that for abortion complications by ratio of 59% (43 vs. 2.7—Table 5, page 127). It is possible that most, if not all, of this increase is due to improvements in access to health services, reflecting existing demand for pregnancy-related care. For example, the proportion of women delivering in health facilities increased manifold during this period—from 4% in 1996–1997 to 15% in 2007 and to 29% in 2011 (not shown).13

The incidence of induced abortion and MR, and any change in these measures over time, must be understood in the context of unintended pregnancy, fertility, contraceptive use and changes in contraceptive behavior. For example, the incidence of induced abortion and MR in Bangladesh was estimated to have increased by 39% over this 15-year period,12 the MR rate increased only slightly, by an estimated 3% (from 17.8 to 18.3 MRs per 1,000 women—Table 3), indicating that much of the absolute increase reflects the growing population of women aged 15–44 (which increased by 35% during this period). Furthermore, the earlier study used a different approach in estimating the number of MRs in 1995: It projected forward from a 1987 study that had estimated MRs based on average case loads reported by MR providers. The current study used a more robust approach; however, because of the widely recognized and extensive underreporting by both public and private providers, adjustments were made, and thus introduced a further element of uncertainty. Overall, given differences in methodology, we cannot determine whether there has been a true change in the MR rate between 1995 and 2010.

Over this same period, the induced abortion rate appears to have increased by 82% (from 10.0 to 18.2 abortions per 1,000 women). It is likely that much of this increase is spurious. In comparison with the 2010 rate, the 1995 rate is likely to be underestimated, for two reasons: First, unlike the 1995 HFS, the 2010 HFS had nationally representative coverage of abortion complications. In 2010, the private sector, and second, the 1995 multiplier likely overestimated access to postabortion services—health facilities and 2010 HFS do not account for safe abortion services provided in the private sector. Between 1995 and 2010, this combination of factors likely resulted in a small increase in the induced abortion rate, but at a slower pace (from 82 to 74 pregnancies per 1,000 women, a decrease of 10%—see Table 3). The large increase in the induced abortion rate is mostly due to better measurement in 2010. Even though the rate may have increased, the size of the increase is likely much smaller than these two factors indicate.


discussion

This study presents updated information on the incidence of induced abortion and MR in Bangladesh. By comparing 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).10

The unintended pregnancy rate in Bangladesh in 2010