153 maternal deaths among these 110,152 pregnancies.*

We compared the mortality risks associated with MR and abortion with that associated with live birth, separately for the time periods 1989–1999 and 2000–2008† and separately for the two areas of Matlab. We calculated the maternal mortality risk, or case-fatality rate, for each outcome by dividing the number of deaths associated with that outcome by the number of such outcomes, and present these as risks per 100,000 outcomes. We note that some of the cell sizes are quite small for assessing case-fatality rates; although the level of maternal mortality in Bangladesh is high compared with that in other countries, maternal death is still a relatively rare event. Appendix Table 1 (page 116) shows case-fatality rates and the numbers of deaths and cases for the subgroups we consider. For example, in the MCH-FP area, there were 329 abortions and seven deaths in 1989–1999, and 197 abortions and one death in 2000–2008.

To compare risks by pregnancy outcome, time period and area, we calculated odds ratios. To assess whether the mortality risks associated with MR or abortion differ from that associated with live birth when demographic and socioeconomic characteristics are held constant, we estimated adjusted odds ratios using logistic regressions that adjusted for factors linked to maternal mortality in previous studies: maternal age, pregnancy order, interpregnancy interval, previous child deaths, previous pregnancy losses, maternal education, household space (a proxy for household wealth), religion and calendar year.

We also performed a simulation to understand the relative contributions of changes in the type of termination method and in method-specific case-fatality to the overall case-fatality rate. In particular, we applied the method-specific case-fatality rates for 2000–2008 to the distribution of termination methods in 1989–1999 and compared the resulting rate to the actual maternal mortality rates in both periods. We did this for Matlab as a whole and for each subarea.

In addition, to shed more light on trends in maternal mortality, we looked at changes in pregnancy duration prior to MR or abortion to see if termination services were sought at an earlier stage of pregnancy than in the past. We used data on the duration of pregnancy at the time of termination for cases in which the date of a woman’s last menstrual period was reported. We also looked at the distributions of methods for abortions reported in the DSS to see if there had been a change in the proportion of women using each abortion method. We did this for each time period for Matlab as a whole; however, sample sizes were too small to permit us to look at differences between the two subareas. Similarly, our sample was not large enough for us to examine differences in case-fatality rates according to pregnancy duration or abortion method.

### RESULTS

For Matlab as a whole, the proportion of pregnancies that were terminated (by either MR or abortion) increased from 3.5% in 1989–1999 to 5.4% in 2000–2008 (Table 1). Increases occurred in both subareas—from 2.3% to 3.9% in the MCH-FP area and from 4.6% to 6.8% in the comparison area. The incidence of MR increased as well, and to a greater extent than did overall termination: from 1.9% to 4.2% for Matlab as a whole, from 1.3% to 3.1% in the MCH-FP area and from 2.4% to 5.3% in the comparison area. The incidence of abortion, however, declined from 1.6% to 1.1% for Matlab as a whole, from 1.0% to 0.8% in the MCH-FP area and from 2.1% to 1.5% in the comparison area. In both time periods, the incidence of MR and abortion was lower in the MCH-FP area than in the comparison area, as we had hypothesized (odds ratios, 0.5–0.6). For Matlab as a whole, the share of terminations done by MR increased from 55% in 1989–1999 to 79% in 2000–2008. This share also increased in both subareas. However,