

Ordeal of Women for Induced Abortion in a Rural Area of Bangladesh

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ABSTRACT

The study was carried out to document the context of induced abortion, nature of its management, and post-abortion complications in Matlab, Bangladesh. The study included all 91 cases of induced abortion that took place in the study area from July to October 1995. Information was collected from women within 60 days after the abortion. A physician carried out in-depth interviews and physical examinations of 20 randomly-selected cases. The findings depicted a complex context, within which the women had to go for an abortion. In most cases, the complete lack of use or lack of use-effectiveness of family-planning methods resulted in unwanted pregnancies. The women in desperation sought abortion services from traditional sources first. When their conditions worsened, they contacted the available modern service facilities. At times, it was too late and led to serious health consequences. Limited access to safe abortion services, together with an absence of social support, put women in a life-threatening situation. Prevention of unwanted pregnancies and access to safe abortion services are needed to improve the situation.

Key words: Abortion, Induced; Reproductive health; Family planning; Bangladesh

INTRODUCTION

About 10% of pregnancies in Bangladesh end in abortion, half of which are induced, and the trend in induced abortion (deliberate attempt to terminate a pregnancy or a suspected pregnancy) is on increase (1-2). Fatal and myriad consequences of unsafe induced abortion are prevalent in developing countries, including Bangladesh (3-6). Socioeconomic and cultural factors and absence of any effective legal abortion-related services (abortion being lawful in Bangladesh only as a life-saving means, and menstrual regulation services are

available for regularizing menstruation within six weeks after missed period) probably place Bangladesh in a similar, if not worse, situation as in other developing countries (7).

In the light of declarations made in the International Conference on Population and Development in Cairo (8), Bangladesh is committed to taking appropriate steps to improve the health of women. Set in this scenario, the issue of unsafe abortion is of particular relevance, and appropriate strategies need to be developed to address the problem effectively. It is, thus, important to know the context in which abortion takes place as well as the practices associated with the management of abortions. This paper presents findings from a community-based study in rural Bangladesh, which took advantage of a credible demographic surveillance system and combined quantitative and qualitative methods to shed light on the induced abortion-related issues.

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MATERIALS AND METHODS

Study area

The study was carried out in 142 villages within Matlab and Daudkandi upazilas (subdistricts) under Chandpur district, Bangladesh. The villages have been covered by the Health and Demographic Surveillance System (HDSS) of ICDDR,B: Centre for Health and Population Research since 1966. The fortnightly registration of demographic events through the HDSS has been in place in all the 142 villages. One hundred ten female Community Health Workers residing in the villages collect information on birth, death, marriage, and migration. The birth-related information includes date of pregnancy termination and outcome of birth, whether a live-birth, spontaneous or induced abortion, and other relevant information.

In 1995, the study villages had a population of 210,000. Half of the study villages are served by the ICDDR,B's intensive maternal-child health and family-planning programme. The ICDDR,B service package includes house-to-house delivery of family-planning and maternal-child health (MCH) services. The health facilities at the headquarters level include a 30-bed government general hospital and ICDDR,B's facilities for the treatment of diarrhoea and for clinical, family-planning and MCH services. In the villages without ICDDR,B's services, the usual government family-planning and MCH services are in operation. The contraceptive prevalence rate in the ICDDR,B area was over 60%, while in the areas without the ICDDR,B's programme, it was less than 40%.

The population of Matlab is predominantly dependent on agriculture. Eighty-eight percent of them are Muslims, and the rest are Hindus. Their educational level is also quite low: only 40% of males and 30% of females aged over six years have had some formal schooling. Participation of women in cash earning is also very low. It is only since 1993 that BRAC, a national non-government organization, started a woman-focused development programme to provide credit, skill-development training, and the like (9).

Data and procedures

The study respondents were all women who were recorded by the HDSS as having had an induced abortion during June-October 1995. Data were collected from women or other knowledgeable family members in case of deceased women through in-depth

interviews, following a guideline, henceforth referred to as case studies and by simple interview, henceforth referred to as quantitative survey. Participation of the women in the study was voluntary. Interview was carried out privately after obtaining verbal consent from them. To aid the development of the questionnaire and interview guidelines, exploratory in-depth interviews of 10 women with a recent history of abortion were carried out at an early stage of the study. The questionnaire used in the quantitative survey was duly pre-tested. Locally-recruited female interviewers collected data within two months after abortion. Detailed case studies of an additional 21 randomly-chosen women, with a recent history of abortion as recorded by the HDSS, were carried out by a female co-investigator, a medical graduate with training in gynaecology and obstetrics, with the assistance of a female social science graduate experienced in in-depth interviewing.

The survey covered issues on behavioural risk factors of abortion, management practices, and attitudes of the family members toward abortion. The in-depth interviews mainly documented the process and management practices of abortion. The context in which the abortion decision was taken was also examined through in-depth interviews. The clinical history of women was substantiated by their non-invasive physical examinations. The demographic characteristics of the respondents were extracted from the HDSS records. Although data on various aspects of induced and spontaneous abortions were collected, the findings mostly associated with induced abortions are reported here.

RESULTS

Characteristics of survey respondents: The HDSS registered 61 induced and 107 spontaneous abortion cases during the study period. Some discrepancies in the type of registered abortion cases were detected during the interview. Of the 107 reported spontaneous abortion cases, 30 were induced after probing. Thus, the quantitative survey included 91 induced abortion cases. In-depth interviews/case studies, on the other hand, included 21 induced abortion cases. One of the women having induced abortion died reportedly of post-abortion complications on the 45th day after the abortion.

The modal age group for the induced abortion cases was 30-34 years, while for the spontaneous abortion cases, it was 25-29 years. The proportion of induced abortion cases was higher than spontaneous abortion cases among women aged 30 years or over. The spontaneous abortion

cases were more common among illiterate than literate women. Women's engagement in cash-earning activities did not make any difference in terms of proportion of the induced and spontaneous abortion cases. The proportion of the induced abortion cases was lower than the spontaneous cases in the ICDDR,B's intervention area, while the reverse was true for the non-intervention area.

The pregnancies associated with all induced abortion cases included in the case studies, except two, were unwanted. Two of the wanted pregnancies had to be aborted on medical ground. Two of the unwanted pregnancies were outcome of premarital sexual union and had to be aborted for social reasons.

Insights from case studies

Some salient features of the 21 induced abortion cases are presented in Table 1. The respondents of most case studies had terminated unwanted pregnancies and went through a common process of unsafe induction of abortion and management practices. The unwanted pregnancies resulted mostly from non-use or, to a lesser extent, incorrect use of family-planning methods. This phenomenon was common, particularly among women experiencing either their first pregnancy or pregnancies after already having the desired number of children. The birth-control methods that mostly failed were the safe period and condom. Failures associated with hormonal methods were quite rare—one was due to the irregular use of pills, and another was due to the irregular use of injectables (This varied from the findings of the quantitative survey presented later in this paper). Unwanted pregnancy also occurred during lactational amenorrhoea, when a woman did not consider herself at risk of pregnancy. It was not clear, in general, whether the incorrect use of family-planning methods was a result of negligence or lack of effective knowledge about the methods.

Normally, the news of induced abortion was kept secret. As soon as a woman realized that she was expecting, and if it was unwanted, she discussed the matter with her husband or with a married sister-in-law. In most cases, the women first contacted a senior member of the family, especially grandmother, or an aunt, and then they contacted traditional healers for abortion. The traditional healers provided herbal tablets for oral intake and creepers for vaginal insertion to induce abortion. In most cases, it was after the failure of the traditional method to cause abortion or continuous bleeding and/or

fever after using the creeper that a modern healthcare provider was contacted. At times, the homeopathic healthcare providers were also contacted for inducing abortion. Almost always the traditional abortion procedures included the insertion of a foreign material deep inside the vaginal passage without any consideration of sterilization. A large majority of the induced abortion cases that resorted to the traditional methods experienced continuous bleeding for long duration and had fever for more than five days. The cost of services associated with induced abortion and management of post-abortion complications ranged from US\$ 12 to US\$ 500.

The following is an account of three case studies chosen from the lot to provide an understanding of the context in which an induced abortion takes place, the process of abortion and its management, and risk a woman goes through in performing the abortion:

Case 1: A 17-year-old woman with eight years of schooling had an abortion within six months of marriage. Her story as narrated below provides a description of the whole process. Her husband is a marginal farmer with less than 20 decimals of land, had never been to school, and lived on share-cropping. The woman did not make any effort to avoid pregnancy, and on the fourth month after marriage, she realized that she was pregnant. In her own words, "I was scared about the pregnancy and was worried that I am too young to be a mother and not ready to raise a baby; I decided to have abortion." She knew that the brown tablets, which come with the oral birth-control pills, cause abortion. She stole four brown tablets from her sister-in-law, who was on pills, and ingested all four at a time before going to bed. Not getting the expected result, she informed her husband about her decision about the abortion. Her husband did not extend any cooperation to solve the problem. Then she managed to buy four abortion tablets, perhaps high-dose oestrogen, from the market and ingested all of them together at night. Next day, after moving to her mother's house, she also approached a traditional healer who gave her some herbal tablets. She ingested them. She then returned to her husband's house where, within a few days of her return, she developed a lower abdominal pain. The pain gradually increased and was followed by bleeding. Within a few days, she found a fish-like solid mass coming out with blood. She bled for 30 days and had fever for 12 days. She did not consult any healthcare provider after taking the herbal pills. She tried to keep it secret. Eventually, her mother-in-law came to know

Case no.	Age (in years)	Years of schooling	Length of pregnancy (in months)	Type of abortifacient contacted	Who went along	Method used	Healthcare provider after abortion	Cost (in Taka)	Duration of fever (in days)	Duration of bleeding (in days)
1	35	2	2	<i>Kabiraj</i> , hospital	Husband	Tablet, creeper, menstrual regulation	Not required	960	None	None
2	17	8	2	Allopath, <i>kabiraj</i>	At home	Tablet	None	300	12	30
3	24	0	6	Allopath	Husband	Dilation and curettage	Not required	2,000	15	7
4	37	0	6	<i>Kabiraj</i> , allopath	Mother, relatives	Creepers	Hospital	Unknown	45	45
5	32	6	3	Family members, allopath	Husband	Herbal, allopath, dilation and curettage	Not required	700	2	2
6	18	7	4	Allopath	Family member	Dilation and curettage	Hospital	2,000	2	4
7	37	0	5	<i>Kabiraj</i> , traditional birth attendant (TBA), allopath	Sister-in-law, husband	Creepers, dilation and curettage	Hospital	11,000	60	60
8	34	5	5	<i>Kabiraj</i> , allopath	Aunt, husband	Tablet, menstrual regulation	Not required	500	None	None
9	38	5	2	TBA, allopath	Nobody, husband	Allopath, menstrual regulation	Not required	2,650	2	2
10	25	5	3	<i>Kabiraj</i> , homeopath	Nobody, husband	Creepers, herbal tablet, and homeo tablet	Allopath	22,000	None	2
11	30	0	6	Medical doctor, <i>kabiraj</i>	Husband	Herbal tablet	<i>Kabiraj</i> , allopath	430	60	25
12	36	9	2	Self, <i>kabiraj</i>	Husband	Creepers	None	1,205	30	12
13	27	0	3	<i>Kabiraj</i> , allopath	Self	Chanted water; allopathic tablet	Allopath, <i>kabiraj</i>	1,200	12	12
14	38	5	3	<i>Kabiraj</i> , allopath	Husband	Herbal tablet, intravenous saline	<i>Kabiraj</i> , allopath	300	3	20
15	32	0	2	Allopath	Husband	Tablet	Allopath	600	70	70
16	32	0	2	Allopath	Husband	Allopathic tablet, menstrual regulation	Allopath	910	70	70
17	26	6	4	<i>Kabiraj</i>	Husband	Herbal tablet	Homeopath, <i>kabiraj</i>	620	60	0
18	29	4	3	Family Welfare Visitor, <i>Kabiraj</i> , allopath	Husband	Allopathic tablet, herbal tablet, dilation and curettage	Allopath	3,010	30	60
19	22	4	5	<i>Kabiraj</i>	Husband	Herbal tablet	Allopath	1,250	None	15
20	31	0	4	Homeopath, <i>kabiraj</i> , pharmacist, medical doctor	Husband	Homeo tablet, herbal tablet, dilation and curettage	Homeopath, <i>kabiraj</i> , allopath	7,500	45	90
21	41	0	4	Allopath	Husband	Allopathic tablet	Allopath	1,000	3	30
Mean	31	3.1	3.6	-	-	-	-	2,864	24.8	26.5
SD	6.7	4.0	3.0	-	-	-	-	5,109	26.5	28.1
Median	32	3.1	1.4	-	-	-	-	1,000	12	15

about it. The mother-in-law said that she had committed a sinful act and would never be a mother. The woman suffered from a guilty feeling and decided not to use any birth-control measures. She soon became pregnant again and was looking forward to a successful outcome.

The above scenario depicts an unplanned pregnancy: young women may become pregnant immediately after marriage without any careful thinking. At times, they may also seek measures, which ultimately lead to pregnancy termination. Due to social and cultural reasons, women, especially the young girls, like the 17-year-old girl in this case, have nobody to consult. Husbands and other family members do not come forward with adequate support to deal with her predicament.

Case 2: This case study depicts the story of a woman who, after having the desired number of children, tried her best to avoid another pregnancy using family-planning methods. At times, the use of contraceptive methods was discontinued due to side-effects, and this eventually led to an unwanted pregnancy. In this situation, the woman was compelled to resort to unsafe practices, resulting in life-threatening conditions. The limited health services available eventually saved her life. The following is her account:

She was 37 and had six ever-born children, of whom four were alive at the time of the interview. She had no schooling. Her husband was a marginal farmer who, at times, also worked as a day-labourer. She started with injectables for birth control but had to discontinue due to side-effects. She had the same problem with oral pills. She did not like other methods and eventually became pregnant for the seventh time. She was very unhappy about it, because the daughter-in-law of her husband's second wife was also pregnant. She found it extremely embarrassing and decided to have her pregnancy terminated. She went to a traditional healer who gave her six creepers for insertion into the uterus. She used the creepers twice a day, which led to abdominal pain, but the bleeding did not start. Without waiting anymore, she decided to go to the Upazila Health Complex, a 30-bed government hospital. On her way to the hospital, she met a traditional birth attendant who offered her services for abortion. The birth attendant took the woman to her house and introduced an instrument into her uterus. After some time, she started bleeding profusely and went back home. After three days, she aborted a solid mass, but the bleeding continued for a long time. Her husband and others in the household came to know about it. After

nearly two months, her son and husband took her to the district hospital. The doctor performed a dilation and curettage (D&C) under deep sedation. She was saved.

Although women try abortion in desperation, the process can be extremely dangerous. One of the abortion cases, which took place in a hospital, resulted in loss of life. The following story of the abortion process was gathered from other family members of the deceased.

Case 3: The woman was aged 37 years, married for second time, and living with her mother and three children. Of the three children, one was from her first marriage. She had no schooling. Her present husband was a rickshaw (tri-cycle)-puller in a distant town and hardly provided any family support. So, the woman did not want any more child and was an irregular user of injectables. She had recently become a member of a non-government development organization, and when she became pregnant, she decided to have abortion. She went to a traditional healer who gave her herbal roots and tablets. After using the herbs, she started to bleed, and this initially continued for 10-12 days. She started bleeding again after four days. She was losing appetite and had very high temperature, and her abdomen became distended and hard. She used to say, "my abdomen is going to burst." One day when she became unconscious, she was taken to the nearby government hospital and was admitted. The conditions on admission as reported by the family members indicated that she was in endotoxic shock, developed anuria and anaemic heart failure, and her whole body was swollen (a condition of grade III septic abortion). The doctors put her on antibiotics with intravenous infusions, resuscitated her, and referred her to a higher-level hospital. The family members could not take her to the higher-level hospital due to economic constraints. The doctor asked the family members to collect blood for transfusion, which also the relatives could not arrange. She was on nothing by mouth, nasogastric suction, and oxygen. The family members did not like the tubes introduced inside her nose and requested the doctors to remove them. The doctors angrily removed the tubes, and she was taken back home by the relatives. She died within a few days.

Thus, it is evident that the adoption of traditional means to induce abortion can be dangerous and delay the use of modern healthcare services. Non-acceptance of the life-saving devices/methods by the family members can make the modern methods ineffective, causing loss of life.

The clinical history and physical examination revealed that most respondents had pain in the lower abdomen, had backaches, were mildly anaemic, and complained of weakness and giddiness. None of the women who participated in the in-depth interview had any mass in the lower abdomen implying completeness of the abortion.

Quantitative assessment from survey data

The survey data provided scope to quantify the various aspects relating to abortions. The results of the survey are presented in Table 2 through 6.

Table 2. Distribution of women (n=91) by various factors relating to abortion

Factor relating to abortion	%
Was the pregnancy desired?	
Yes	5.5
No	94.5
Total	100
Family-planning methods used immediately before pregnancy	
None	45.1
Pill	27.5
Injection	12.1
Condom	2.2
Safe period	7.7
<i>Tabij</i>	1.1
<i>Kabiraji</i> (herbal)	3.2
IUD	1.1
Total	100
Reasons for abortion (multiple answers)	
Economic	13.2
Social	6.6
Undesired pregnancy	86.8
Health	14.3
Illegitimacy of pregnancy	5.5
Family problems	4.4
Fear of having daughter	2.2
Fear of delivery complications	1.1
Old age of husband	1.1
Very soon after marriage	1.1

Context of induced abortion

Ninety-four percent of the induced abortion cases reported that their pregnancies were unwanted. The main reason for abortion of wanted pregnancies included deterioration of the relationship with husbands.

Fifty-five percent of the women who had induced abortions reported the use of family-planning methods immediately before the pregnancy (conceived while using the method). Of them, 50% were on pills, 22% on

injectables, 14% on safe period, 6% on *kabiraji* (herbal), 4% using condom, 2% had IUD, and 2% had *tabij* (amulets). Thirty-six percent of the women who had induced abortions thought that the pregnancy was due to the failure of family-planning methods they were using. The perceived failure was prevalent among users of all the above methods, except IUD. Among all the methods, the perceived failure rate was highest for *kabiraji* (3 of 3), *tabij* (1 of 1), and condom (2 of 2), followed by safe period (5 of 7), pills (5 of 25), and injections (2 of 11).

The gestational age at pregnancy termination ranged from 2 to 6 months with a mean of 3.3 months. The highest proportion (43%) was of 3 months, followed by two (26%), four (13%), five (12%), and six (6%) months.

Forty-five percent and 36% of the induced abortion cases maintained complete and partial secrecy of the event of abortion respectively. The major reasons for keeping induced abortions a secret included: blame, shame, embarrassment, and pregnancy outside marriage. The embarrassment was, at times, also related to religious disapproval of the induced abortion.

Process of induced abortion

The women sought assistance from individuals with varied backgrounds during induced abortion (Table 3).

Table 3. Distribution of women by type of persons contacted for abortion during first, second and third instances

Type of person	First contact (%) (n=91)	Second contact (%) (n=39)	Third contact (%) (n=9)
Family member	5.5	2.6	0
Traditional birth attendant	2.2	7.7	11.1
Family Welfare Visitor	7.7	5.1	0
<i>Kabiraj</i>	24.2	23.1	0
Medical doctor	34.1	43.6	77.8
Pharmacist/drug dispenser	3.3	7.7	0
Homoeopath	5.5	5.1	11.1
Allopathic village doctor	12.1	5.1	
Self	3.3	0	
Others	3.2		
Total	100	100	100

The type of persons from whom help was sought included family members, traditional birth attendants,

Family Welfare Visitors (FWVs) of the government health and family-planning services, *kabiraj*, qualified medical doctors, village doctors, homeopathic doctors, and pharmacists/drug-sellers. For 43% and 10% of the cases, a contact with a second and a third person was respectively made. The qualified medical doctor was dominant in the first contact (34%), followed by a *kabiraj* (24%), a village allopathic doctor without formal training (12%), an FWV (8%), and a homeopath (6%). Seventeen percent and 10% of the total cases consulted a qualified medical doctor in their second and third contacts respectively.

The actual process of abortion involved various procedures. Fifty-seven percent of the induced abortions were done using medical procedures (44% menstrual regulation by vacuum aspiration, and 13% dilation and curettage), 24% used creepers/roots, 8% took allopathic tablets (most are likely to be hormonal tablets other than family-planning pills), and 7% took hormonal family-planning methods, including injectables. Four percent of the respondents took homeopathic medicine (Table 4). Only 6% had general anaesthesia while

the abortion (Table 4). The TBAs and *kabiraj* mostly used creepers/roots, whereas the allopathic practitioners, including FWVs, used medical procedures.

Half of the induced abortions were performed either in a doctor's chamber or in a hospital. Of these, 5% started the process at home, but eventually contacted a healthcare provider. The remaining 45% went through the whole process of abortion without any assistance sought from a healthcare provider. They only contacted a medical doctor when the situation got out of control due to complications.

Post-abortion complications and behaviour

The nature of post-abortion complications was varied. Two percent of the induced abortions were incomplete, i.e. incomplete expulsion of the product of conception from the uterus. Some also had bleeding, fever, and pain following the abortion.

Table 5 presents the distribution of various post-abortion complications experienced by the women who had induced abortions. Most (92.3%) women had post-abortion bleeding. The duration of bleeding varied: 34.1% had bleeding up to one week and 29.6% for more than three weeks. The distribution of duration of bleeding was skewed, with a mean and median of 21 days and 12 days respectively.

About 70% of the women experienced fever. The mean and median durations of fever were 11.6 and 4 days respectively. Thirty-seven percent suffered from pain after the abortion. Nearly two-thirds of those who had pain also experienced sweating during pain.

Management of post-abortion complications

Table 6 presents information on the nature of post-abortion management practices. Eighty-one percent of the women contacted a healthcare provider for managing their post-abortion complications. In some instances, they also contacted multiple healthcare providers. The allopathic healthcare providers were dominant (71%), followed by *kabiraj* (32%), traditional birth attendants (15%), and homoeopath (13%).

The cost of post-abortion complications-related services also varied by type of healthcare providers. The highest cost was incurred in the case of allopathic providers, including medical doctors, followed by homeopaths, traditional birth attendants, and *kabiraj*. The mean expenses incurred were Tk 879 (US\$ 22) for services by allopathic healthcare providers, Tk 283 by

Table 4. Distribution of women (n=91) by procedures and materials used in performing abortions

Procedure and material	%
How it was done?	
Menstrual regulation	44
Dilation and curettage	13.2
Creepers/root	24.2
Family-planning pill/injection	6.6
Other allopathic tablets	7.7
Homeopathy	4.3
Total	100
Was general anaesthesia administered?	
Yes	5.5
No	94.5
Total	100
Was any oral drug given immediately before abortion?	
Yes	68.1
No	31.9
Total	100
Was any intravenous fluid given immediately before abortion?	
Yes	26.4
No	73.6
Total	100

undergoing the abortion. Some kind of oral drug was given to 68% of the cases. Intravenous injection was given to 26% of the cases immediately before performing

Table 5. Distribution of women (n=91) by nature of post-abortion complications

Nature of complications	%
Duration of bleeding (in days)	
No bleeding	7.7
1-7	34.1
8-14	14.3
15-21	14.3
22+	29.6
Total (n=91)	100
Mean, median (for those who had bleeding)	mean=21.1 median=12.0 SD=25.0
Duration of fever (in days)	
No fever	34.1
1-3	29.7
4-6	12.1
7+	24.1
Total	100
Mean, median (for those who had fever)	mean=11.6 median=4 SD=16.8
Pain after abortion	
Yes	36.3
No	63.7
Total	100
Sweating during pain (for those who had pain)	
Yes	65.9
No	34.1
Total	100
SD=Standard deviation	

homeopaths, Tk 180 by traditional birth attendants, and Tk 112 by *kabiraj* (Table 6).

DISCUSSION

The present study was based on the records maintained by the Health and Demographic Surveillance System (HDSS) in Matlab. Even if the system is believed to generate high-quality demographic data in a developing-country set-up, it is likely that the abortion cases may have been under-registered and misclassified. Given this limitation of the data, the study attempted to document the level of susceptibility of women to life-threatening conditions and permanent injury due to unsafe abortion practices in rural Bangladesh. The first level of contact for performing an abortion has been the traditional healthcare providers (quantitative survey somehow under-estimated this) who almost invariably prescribe plant roots or other foreign materials to be inserted into the uterus. This has been practised in the past and has not changed much with time (10). Contact with modern service personnel/facility is rarely been made in the first

Table 6. Distribution of women (n=91) by management of post-abortion complications

Aspect of management	%
Contact with any healthcare provider	
Yes	81.3
No	18.7
Total (n=91)	100
Type of healthcare provider (multiple answers, n=91)	
Homoeopath	13.2
<i>Kabiraj</i>	31.9
Allopath	71.4
Traditional birth attendant	15.4
Religious practitioner	2.2
Hospital	2.2
Family Welfare Visitor	2.2
Cost incurred by type of healthcare providers in Taka	
Homoeopath	Mean=283 Median=150
<i>Kabiraj</i>	Mean=112 Median=50
Allopath	Mean=879 Median=250
Traditional birth attendant	Mean=180 Median=200
Religious practitioner	80 (one observation)
Hospital	None (two observations)
Family Welfare Visitor	100 (one observation)

instance. Almost similar findings were also reported from a study conducted in another rural area of Bangladesh (11). The impression obtained during in-depth interviews leads to the suspicion that the actual prevalence of insertion of foreign materials for performing abortions may be much higher than what was reported. Not only the traditional healers prescribe it, even an individual on her own initiative may resort to such measures for abortion. Other likely means of performing abortions may include ingestion of a large number of hormonal pills or a dose of hormonal injection. Stories from the study area also showed that IUD was inserted for abortion. Be it the insertion of unsafe foreign materials or intake of hormonal substances, the danger to women's life and health remains. Women visit a modern clinic only when the situation is grave (12), but such services involve substantial cost.

The question remains to be answered as to how women can be saved from the potential danger of unsafe abortion. It is known that most induced abortions are a result of unwanted pregnancies. Hence, one possible solution could be to find a way to prevent unwanted pregnancies. It is also known that family-planning methods may fail, and in some instances, a family-planning method user may also become pregnant. Thus, the prevention of unwanted pregnancies alone may not

be enough, and a complementary healthcare service, offering facilities for safe abortion, needs to be made accessible to women.

It is possible to avert unwanted pregnancies through popularizing family-planning methods and ensuring their maximum use-effectiveness. The prevalence of unwanted pregnancies and abortions among the newlywed women demonstrates the unmet need for family-planning methods among them. This group particularly needs more attention from the family-planning service providers. This should not be target-oriented only. Even in communities with a well-organized family-planning service-delivery system, the method failure has been reported to be quite high (13). Ensuring optimum use-effectiveness of family-planning methods may also depend on the effective knowledge of users about the methods. An intensive target-oriented service-delivery system may not necessarily lead to an increased level of effective knowledge about family-planning methods among the clientele (14). Thus, there is an urgent need to inform users adequately about the existing family-planning methods, so that they know when and how a method can become ineffective. Introduction and promotion of post-coital emergency contraceptive can also be of help.

Abortion for reasons other than life-saving is not legal in Bangladesh; the lack of legal endorsement is not a major hindrance to getting abortion services. No law-breaching abortion cases have so far been reported. Menstrual regulation services within six weeks of the last menstrual period are, however, available both in public and private sectors in the country. The menstrual regulation service in the public sector, a component of the existing family-planning services, is available at all levels, starting from the Family Welfare Centres at the village level to the tertiary facilities at the teaching hospitals. Thus, it is not clear why so many women visited the traditional practitioners for abortion. Social stigma attached to induced abortion may be a reason for not seeking safe abortion services, since it may not remain confidential. On the other hand, the traditional methods with herbal roots and tablets can be self-administered and more convenient. It was also not clear whether the study women preferred traditional methods to modern methods for abortion despite the health risk involved, or they are chiefly convinced on the ground of confidentiality without any knowledge of the hazard, or they are totally unaware of the modern methods.

The situation of induced abortion in Bangladesh, both in terms of number and unsafe practices, is believed to be alarming. Unless bold and innovative steps are taken to prevent unwanted pregnancies and unsafe abortion practices, "championing reproductive health for all" will be a far cry for quite some time.

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