The Determinants and Consequences of Pregnancy Termination in Rural Bangladesh: The Wider Context

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Abstract

This study examines the factors that motivate rural Bangladeshi women to terminate pregnancies, the decision-making process involved, the service providers used, the sources of information available to the women on pregnancy termination, and the broader consequences of terminating a pregnancy. These are issues of major policy interest in Bangladesh, a country with an inordinately high maternal mortality rate. Although the government-provided menstrual regulation (MR) services are available for the first 6-10 weeks, many abortions are conducted by unlicensed practitioners, often during the second trimester.

Forty-one currently-married women who had underwent pregnancy terminations, were interviewed to examine how specific circumstances affected the behaviour of individual couples.

The primary reason given for having terminations was to limit family size, while the second most-cited reason given was for birth spacing. Most of these women were not using any contraceptive methods, either because they did not believe that they required them or because they were concerned about possible side-effects. Other women reported that they were using methods incorrectly or that the method had failed. Most had subsequently adopted a contraceptive method, but none adopted any permanent methods, which is alarming, given the common desire to limit family size, concerns about side-effects and method failure.

Half of the respondents initially sought treatment from untrained providers or conducted their own terminations, despite the availability of trained government providers. This was due to greater familiarity with local providers, inadequate information about safer alternatives, and often low-quality government services, and in many cases, concerns over high charges in the government system for services that are intended to be free.

Introduction

This paper examines the factors that lead rural Bangladeshi women to induce abortion, the decision-making process involved, any distinctive health-seeking behaviours, the service providers used, and the broader consequences of an induced abortion. These are issues of major policy interest in Bangladesh, which has one of the highest levels of maternal mortality in Asia, a major contributor of which is believed to be complications due to induced abortion [1]. In this paper, the term "induced abortion" will include menstrual regulation (early termination without pregnancy confirmation, within the first 6-8 weeks by a trained paramedic and 6-10 weeks by a physician), although a legal distinction is made in Bangladesh between induced abortion which is prohibited and menstrual regulation (MR) which is not only legal but offered by the government service providers.

Background

Prior to the 1970s, all induced abortions in Bangladesh were illegal, except when a woman's life was considered to be endangered by the pregnancy. A study conducted in 1978 estimated that about 800,000 abortions were being conducted per year, which, if correct, implies that one-fifth of all pregnancies were being terminated [2]. Furthermore, considering the controversy surrounding abortion, clandestine abortions must have accounted for a large percentage of those abortions which took place. Such concerns were supported by studies in hospitals of obstetric complications, which found that substantial numbers of abortions were being conducted using highly risky procedures, often at advanced stages of gestation [3,4].

In 1974, the Government of Bangladesh (GoB) allowed a clinic in Dhaka to offer MR, and in 1978 began to train government doctors and paramedics to provide such services [1]. In 1979, the GoB issued a circular distinguishing between abortion, which is illegal in Bangladesh, under

legislation derived from British colonial law,[1] and MR, which was considered an interim method of establishing a non-pregnant state for a woman at risk of being pregnant, whether or not she was, in fact, pregnant [5].

MR services are available at all major government hospitals and health facilities. At the sub-district (thana) level, this includes the Thana Health Complex (THC), where MR is normally provided by physicians; and at the union level, the Union Health and Family Welfare Centre (H&FWC), where MR is provided by a female paramedic, the Family Welfare Visitor (FWV). At these facilities, MR is provided during the first 6-8 weeks of pregnancy by an FWV or a nurse and 6-10 weeks by a physician, using vacuum aspiration.

Women who do not use MR may resort to illegal providers which include traditional midwives who primarily induce abortion by inserting a foreign object in the uterus or by providing indigenous (*kabiraji*) medicine for oral consumption [2]. Woman may also use the services of local pharmacies and untrained village doctors.

The precise number of MRs and abortions being performed is unknown. While MR is legally provided by government workers, it is accepted that many are not officially recorded. In theory, MR is provided free of charge by government hospitals and health facilities. In practice, however, charges are often levied. Moreover, according to Kamal [6], clients who, according to the official criteria, are not eligible for MR, often unofficially receive MR. Even less is known about the number of abortions performed by illegal providers.

Some data are provided by the Bangladesh Demographic and Health Survey (DHS), which asked a sample of 9,640 currently married women whether they had experienced a pregnancy which ended in a miscarriage, abortion, or still-birth: 1,674 (17.4%) reported that they experienced such a pregnancy. Only a small portion of these, however, ended in induced abortion. Of the 9,640 women, 2,054 (21.3%) said that they had an

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[1] Amin [1] notes, however, that there have been no known prosecutions under this law.

unwanted pregnancy, of whom 181 said that they had the pregnancy terminated (1.9% of all respondents). Two-thirds of these terminations (65.2%) involved MR.

Whatever the level of induced abortion, it is clear that, for many women, MR has fulfilled an important need. While there may be some abuses of the provision of MR, its availability has, as Dixon-Mueller [2] noted, almost certainly reduced the incidence of dangerous abortions and abortion-related deaths.

Nevertheless, it remains a concern that many women continue to receive abortion services from non-trained practitioners. A clinic-based study, undertaken by the Bangladesh Association for Prevention of Septic Abortion (BAPSA), found that 30 per cent of all women seeking abortion were rejected, mostly because their pregnancies were too advanced. The lack of information about where services were available and knowledge about the gestation period up to which MR was allowable was identified to be responsible for nearly 90 per cent of all rejections [7,8].

Objectives and Methodology

This study examines induced abortion, including MR, by interviewing a sample of women who underwent induced abortions between 1990 and 1995. The objective of the study was to examine the factors influencing a client's decision to terminate a pregnancy, how the decision was made, any distinct health-seeking behaviours, the provider chosen, and the consequences of undergoing a termination. Forty-two married women of reproductive age (MWRA) were selected from the Sample Registration System (SRS),[2] the longitudinal data set of the MCH-FP Extension Project (Rural) of the International Centre for Diarrhoeal Disease Research,

[2] SRS collects data on a 60-day cycle (previously 90-day) on vital events which have occurred, including pregnancy outcomes, since the last visit. Data are also collected on changes in the reproductive status of married women of reproductive age (MWRA) and important family planning programme variables, such as contraceptive use.

Bangladesh (ICDDR,B). The selected respondents comprised all women living in Paira and Rajghat unions of Abhoynagar Thana in western Bangladesh who reported having undergone induced abortion during 1990-1995. The women were asked about abortion in general, and specific follow-up questions were only asked if the women themselves said that had experienced an abortion. In only one case did a woman not volunteer that she had an abortion. This case was subsequently excluded from the study. The high proportion of women who offered the information that they had undergone abortions was not surprising given the fact that they had earlier reported their abortion to the SRS. The interviews were conducted by two experienced ICDDR,B women staff members, including one of the authors of this paper, Ms. Fazilatun Nessa, using a semi-structured questionnaire.

SRS data are regarded as being of high quality. Nevertheless, there may have been some understatement of pregnancy termination reporting. Since no clinical procedures were conducted to positively identify all pregnancies, the word of the client was considered true and has been recorded as such, in the data. Furthermore, since questions on pregnancy outcomes are only asked of MWRA, no data are presented here of unmarried, separated or widowed women having had pregnancy terminations. This is a significant limitation, since some authors argue that such women have been among the chief clients of abortion services [4]. Clearly too, any data are restricted to survivors.

Both Paira and Rajghat unions are primarily rural. Rajghat is, however, situated on an important road, rail and water transport corridor, and several men work in jute mills. Although few women work outside their homes, about one-third of them undertake some activity within the household (such as, poultry raising and the making of handicrafts) to earn cash income.

Of the women interviewed, 27 were Muslims and 14 were Hindus. The proportion of Hindus in the sample is marginally higher than that of the two unions as a whole, but is representative of women having terminations. Nineteen women (nearly half) had received no formal education, 12 had attended primary school (1-5 years), and ten secondary school. Of the 41 women interviewed, we were able to obtain information on 39 of the husbands. Sixteen of them had received no schooling, six had received

primary schooling, and 17 had attended secondary school. Of the 39 husbands, 18 were farmers, 8 worked in mills (primarily in jute manufacturing), four in business, three in small trade, two were agricultural labourers, one each was a government service worker, a fisherman, a student, and an unemployed.

Before analyzing the information gathered through the indepth interviews, we will examine some background information drawn from SRS on abortion trends in Abhoynagar [9,10].

Between 1983 and 1995, SRS recorded 5,779 pregnancies in Abhoynagar, of which 240 (4.1%) ended in induced abortion. The proportion of recorded pregnancy terminations increased over time. During 1983-1989, there were 3,503 pregnancies at Abhoynagar, of which 131 (3.7%) ended in induced abortion. In comparison, during 1990-1995, there were 2,276 pregnancies at Abhoynagar, of which 109 were terminated (4.8%). It is possible that in the 1990-1995 data, a higher level of induced abortion was recorded because of better reporting rates, resulting from the increasing familiarity of the women with the SRS workers along with the increasing acceptance of MR over time. A small contribution to better reporting may have been made by a reduction in the SRS interviewing round from 90 to 60 days.

The proportion of pregnancies terminated was higher for women with more education, women who worked outside the home, non-Muslims, women who were older and of higher parity, and for women who had recently given birth [9].

Findings

Who Terminate Pregnancies, and Why?

The respondents covered in the indepth study reported that they had sought terminations primarily because they either did not want any more children, or wished to space births. What we found was that the reasons given for terminations were essentially the same reasons that Bangladeshi respondents give for practising family planning [11]. Three women reported that they had

undergone terminations for reported ill-health. Twenty-five of the women said that the key reason for choosing to terminate their pregnancy was that they already had enough children. Of the 25 women, 17 specifically cited the economic costs of raising children, two referred to the specific costs of female children and of meeting the dowry for their marriage, and six said that they had been physically weak and that it would have either been difficult to bear or to raise a child.

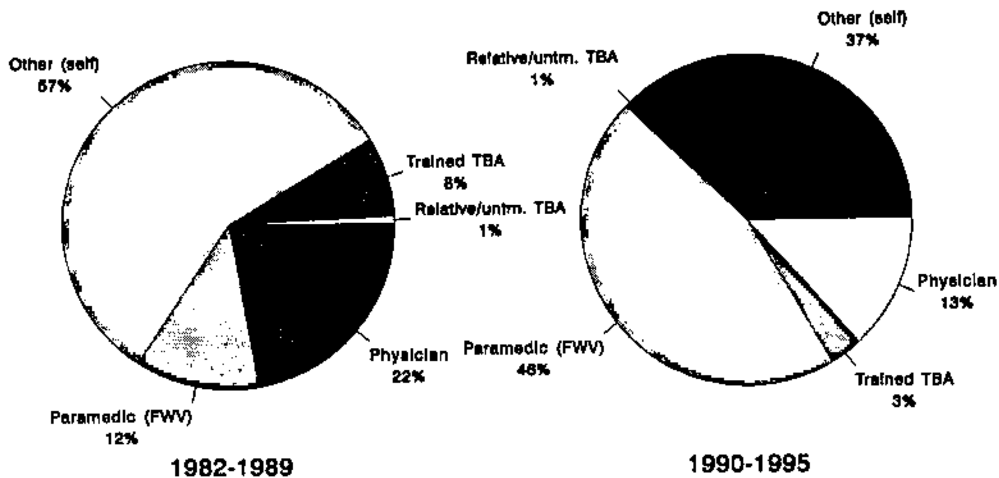
Eight women indicated, as a principal reason for termination, the short interval since their last baby's birth; the physical and economic difficulties of looking after two young children; and the potentially detrimental effect on the child already born. Four women said that they had terminations because they already had grown-up children. Three respondents reported that they had undergone terminations because their husbands were unreliable, and were threatening to desert them, or in one case, had already done so.

The findings on the importance of family limitation and child spacing are in conformity with SRS data. The probability of a woman terminating a pregnancy sharply increases with her age and the number of living children. Less than two per cent of women aged less than 25 years terminate a pregnancy, as compared to 6.3 per cent of the women aged 35 to 39 years and 7.8 per cent of the women aged over 40 years. Only 2.1 per cent of the women with one or two children terminated a pregnancy but among women with five or more children, 9.5 per cent did so. Similarly, women are more likely to have induced an abortion the shorter the time period between the previous live-birth and the current pregnancy [9,10].

The Service Provider and Place

According to the SRS data (Fig. 1), in nearly 60 per cent of all pregnancy terminations during 1982-1989, the woman used an untrained provider (the data for Figures 1 and 2 are for two SRS field sites - Abhoynagar and Sirajgonj). In most cases, the provider did not attend the abortion but provided an abortifacient. The proportion of pregnancy terminations without a trained provider declined between the 1982-1989 and 1990-1995 time periods. In the 1990-1995 data set, a paramedic was present, either a nurse

or a Family Welfare Visitor, in a little under half of the terminations. In another one-eighth of the cases, a physician was present; in six per cent a trained TBA; and in one per cent of the cases, an untrained person attended. However, in nearly 40 per cent of the cases, the woman was without a trained provider.

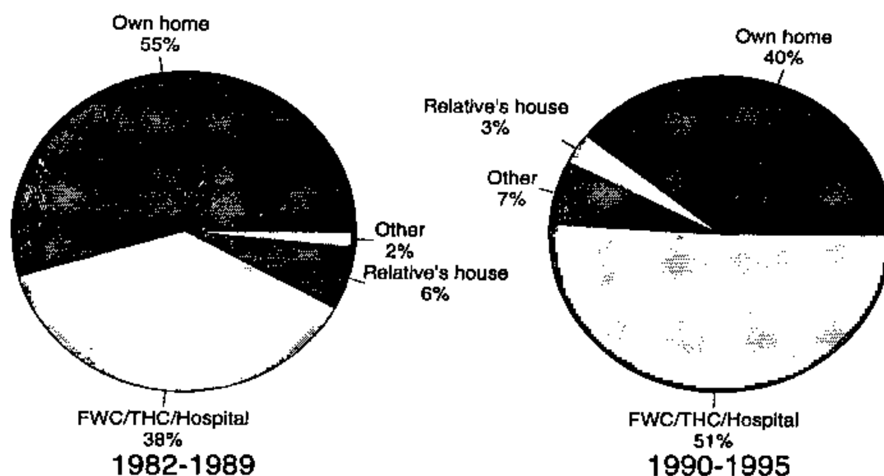


Source: SRS

Fig.1. Induced abortion by attendant

Figure 2 presents the data regarding the place of abortion, grouped into two time periods: 1982-89 and 1990-95. During 1982-89 over half (61%) of all induced abortions took place at the woman's house or a relative's house. While this proportion declined in the 1990-95 period, it continued to constitute over two-fifths (43%) of all abortions. The place of the induced abortion was closely related to the identity of the provider. In cases where the provider was untrained, three-quarters of the terminations took place at the woman's home. As noted, in most cases, the provider did no more than supply an abortifacient. Likewise, in cases where terminations

involved paramedics or physicians, most took place at health facilities. The increased proportion of terminations undertaken by paramedics indicates that more terminations are taking place in modern health facilities. While the



Source: SRS

Fig.2. Induced abortion by place

proportion of induced abortions which take place at health clinics/hospitals has increased, it, nevertheless, remains a source of concern that many continue to take place at the woman's home.

Of the five terminations that the respondents in the indepth study referred to as having been performed by physicians, three were conducted at the physician's private clinic, and two at THC. Of the 16 involving an FWV, 14 were conducted at FWC, one at FWV's house and one at a village doctor's house. Of the nine terminations involving a nurse, eight were conducted at THC and one at the nurse's house, while terminations

involving the provision of an abortifacient by a village doctor, homeopath, or other (self), the actual abortion generally took place at the woman's own home.

Health Care-seeking Behaviour

While investigating data from the indepth interviews, we found that selecting a provider for pregnancy termination is not a simple process. Of the 41 pregnancy termination cases in the sample, three of the women initially obtained services from a physician (MBBS), 13 from an FWV, eight from a nurse, eight from a "village doctor"[3], four from a homeopathic practitioner[4], one from an indigenous doctor - "*kabiraj*", and four who conducted their own abortions by inserting a foreign object, such as a tree root or plastic "catheter." In the discussion that follows, we refer to physicians, nurses and FWVs as trained providers and all others as untrained, but this is not always accurate. The government has trained many Medical Officers (MCH) and FWVs in MR, but has not provided MR training to other physicians or nurses and they are not authorized to provide MRs.

One respondent who had received services from a village doctor had initially approached a government physician and an FWV, but had been refused because of two previous caesarian births. Two of the women who had received services from a village doctor, and one from a homeopath were unsuccessful in terminating their pregnancies, and subsequently, went to trained allopathic providers (physician, nurse, or FWV). One, who had successfully aborted her pregnancy under the direction of a village doctor, was subsequently treated successfully by a homeopath for complications. One woman who suffered severe bleeding from ingesting pills from a

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[3] A village doctor is an untrained village practitioner, also known as a "quack", who dispenses western-style "allopathic" medical advice and drugs, such as antibiotics.

[4] Homeopathic medicine originated around 1800 in Germany and involves the use of medicines that are supposed to possess qualities which resemble and, thus, counteract a client's symptoms. As practised in rural Bangladesh, it has evidently absorbed many aspects of the indigenous "*kabiraji*" or "*ayurvedic*" medicine as well.

homeopath was subsequently "washed" by a nurse at THC (Fig. 3 illustrates the process. On the left side is listed the provider first approached, on the right the provider who ultimately provided the abortion).

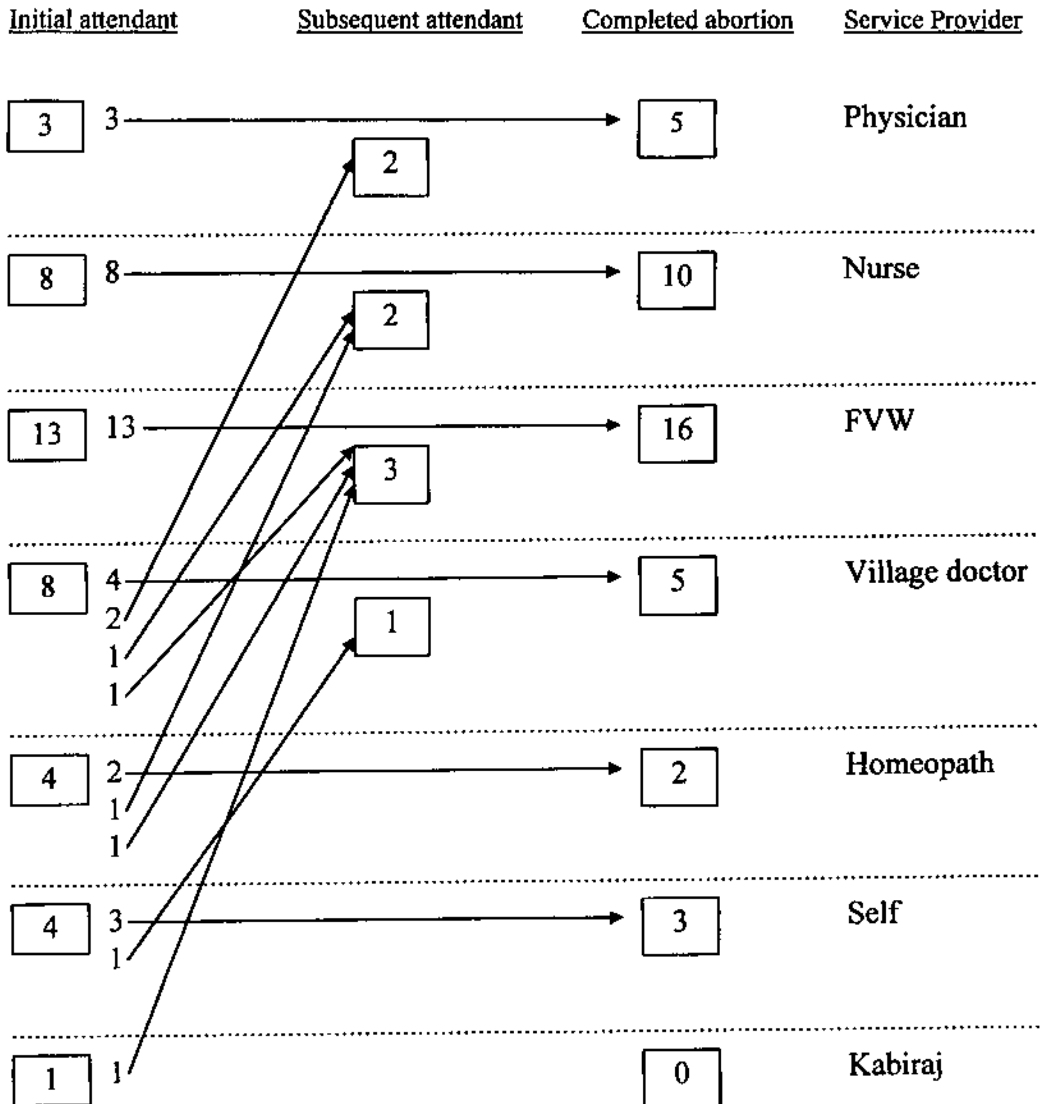

Fig. 3. Attendant sought for termination (n=41)

* Two of the terminations performed by a nurse were supervised by a physician.

The respondents, in general, placed little emphasis on the risks of using untrained providers. A few women reported that they used the services of the government providers because their services were safer, but most women did not associate high levels of risk with abortion. For the 17 women who initially approached an untrained provider or conducted their own abortions, the risks as they understood them were minor when compared to the advantages of doing so. The reasons given for using the latter were principally: knowledge, familiarity, and trust of the provider (7 respondents); confidentiality (5 respondents); and proximity to the respondent's house (3 respondents). Cost was mentioned explicitly as determining the type of provider by only two respondents, but concern about cost was a common theme. An example of the first category of response was provided by a respondent who remarked that she had little knowledge of the government hospital, and, moreover, did not know anyone working there. She added that she would not advise someone to use the government hospital, because of the poor service there.

The issue of confidentiality is linked to the nature of government health services where it is apparent that people are attending a clinic for a particular purpose and where there is little privacy. In contrast, abortions involving village practitioners, generally involve the use of oral preparations to induce abortion and are inherently more private - provided no major side-effects ensue. Confidentiality is also related to whether a person can trust the provider who is closer at hand and whose custom depends on meeting the needs of his clients. An example of a breach of trust was given by a respondent whose MR was arranged by the FWA. When she only paid the FWA Tk.40.00 (US$1.00) instead of the Tk.100.00 requested, the FWA told the woman's relatives and neighbours.

In theory, government service providers undertake abortions free of charge, but in reality, many providers charge a fee. The amounts generally cited by the respondents varied from Tk.100.00 to Tk.300.00 (US$2.5 to $7.00). The amount is small by western standards, but is significant in a Bangladeshi village.

While the cost of terminations involving trained personnel may discourage some people from receiving them, such costs are, in many cases,

much less than the cost of the treatment following an unsuccessful abortion. One respondent reported that she paid Tk.60.00 for tablets from a village doctor, but she subsequently paid Tk.500.00 for the treatment of heavy bleeding. Another respondent conducted her own abortion but then suffered from heavy bleeding, and had to spend Tk. 600.00 for medicine.

The women who used trained providers rarely cited the greater safety in doing so. Rather they usually referred to their familiarity with the provider or to the FWA who often accompanied them to the provider. It is perhaps significant that a high proportion of cases among our small sample by both trained and untrained providers involved side-effects.

Interestingly, while most abortions were conducted by trained providers, the treatment of side-effects most commonly involved medicines from village practitioners. This reflects the general health-seeking care among rural inhabitants. The government health services generally have only a limited range of drugs available. Furthermore, they are often less convenient for many people, in terms of location and visiting times, than the local village doctors and pharmacists.

Several points stand out. First, 31 of the 41 women had been treated by trained paramedics or physicians, either initially, or subsequent to unsuccessful treatment by others. In all the cases attended by authorized attendants (nurse, FWV, physician), the women successfully had terminations, though some subsequently required further treatment. In contrast, in seven of the 14 cases in which the women were provided abortifacient by untrained providers, the women had not successfully aborted and subsequently went to trained providers. The term successful abortion used here is restricted to meaning completed abortion.

FWAs played an important, if indirect, role in at least eight cases in the final decision, with regard to the choice of provider and location. One respondent reported that the FWA had played a key role in advising her to use the services of the FWV at the FWC, and accompanied her to it. Another respondent said that the FWA had been the primary advocate of her termination. She had accompanied the respondent to the FWC and, after consulting the FWV, helped her conduct it.

Gestation

Gestation of the pregnancy is an issue of great concern. As noted earlier, MR is legal during the first 6-10 weeks of pregnancy. Health risks increase with later termination. During the 1982-1989 period, however, approximately 36 per cent of the terminations were recorded as having taken place after the first trimester. This figure fell slightly to about 32 per cent during the 1990-1995 period.

The number of late-term abortions involved was too small to record statistically significant results. Although limited, the evidence suggested that uneducated women were slightly more likely to have terminations at late term than educated women (Table 1). These figures also indicate that the reduction in late terminations has occurred primarily among the least educated, suggesting an improvement in access to MR service.

Table 1: Induced abortion by gestation*

Educational level	1983-1989				1990-1995			
	Trimester				Trimester			
	1	2	3	**Total**	1	2	3	**Total**
0	43 (54)	36 (45)	1 (1)	**80** **(100)**	57 (64)	29 (33)	3 (3)	**89** **(100)**
1-5	32 (74)	11 (26)	0 (0)	**43** **(100)**	39 (71)	16 (29)	0 (0)	**55** **(100)**
6+	19 (79)	5 (21)	0 (0)	**24** **(100)**	24 (80)	6 (20)	0 (0)	**30** **(100)**
Total	**94** **(64)**	**52** **(35)**	**1** **(1)**	**147** **(100)**	**120** **(69)**	**51** **(29)**	**3** **(2)**	**174** **(100)**

Source: SRS

* Figures in parentheses indicate percentages of induced abortion by trimester.

Thirty-seven per cent of the second trimester terminations reportedly involved a paramedic as the attendant. This is alarming, since government paramedics are not provided training on abortion techniques required for more advanced pregnancies.

Most respondents in the indepth survey reported that a termination should occur at around two months gestation and on the information provided most conformed to this. Among the 14 women who indicated that they waited until the pregnancy was more advanced, the reasons given were that they had tried ineffective methods from a village practitioner first (six); they had not known that they were pregnant (five); the respondent had followed a provider's recommendation to wait until she was more advanced in gestation to terminate the pregnancy (one), the woman waited for her husband to return (one) and that the couple lacked the necessary money (one).

What is Abortion? What is MR?

Dixon-Mueller [5] has argued that MR is socially acceptable in Bangladesh, because people distinguish it from abortion. She suggests that Bangladeshi women perceive regular periods as part of good healthy life. The results of the indepth study do not support this thesis. The respondents were asked what they actually associated with the terms "MR" and "abortion." None of the respondents, including those who had received an MR from the FWV, were able to make any distinction between MR by vacuum aspiration and abortion. A number of closely-related Bengali terms were used, including "*baccha naushto,*" "*pete fela,*" and "*baccha fela.*" All of the terms used directly imply destroying the foetus. Only four of the respondents used the term MR. None of the respondents who had received MR expressed any doubt that they had been pregnant.

Decision-making

Initiation of the discussion

The decision-making process usually involved the wife initiating a discussion on the need for a termination and the final decision being taken either

jointly or by the husband alone. Twenty-three of the indepth interview respondents reported that they had initiated the discussion on whether to have an abortion. Seven respondents said that they had raised the subject jointly with their husbands. In four cases, the husband had initiated it; in one case, the husband had consulted with the FWA; and in three cases, the respondent's mother was the initiator (these are the cases where the respondents' marriages had broken down). In summary, the women were the primary initiator or were directly involved in the initiation in at least 30 of the 38 cases.

In the final decision to terminate a pregnancy, the wife took primary responsibility for making the decision in six cases. In ten cases, the wife and husband decided jointly. In 14 cases, the husband was the sole decision-maker. While the dominant role in deciding to have a termination was performed by husbands with their wives, in eight cases, others had a significant role (e.g. FWA, mother, physician, brother-in-law, sister-in-law). In many more cases, others were consulted for their views (in eight cases, FWAs were either directly involved in the decision or were consulted).

Nevertheless, while others were on occasion influential, the key point is that in all but six cases both husband and wife were involved in the decision, and, in most cases, were the primary decision-makers. The exceptions were the three cases initiated by the wife's mother, and three cases where the husband decided alone (a respondent commented that 'I did not want to destroy my baby, but my husband decided to, because he did not want any more children).' Many respondents commented that a termination is a private matter for the couple. It is significant that most couples having an abortion are older and less likely to accept interference from others in making their decision. The 1993 DHS also showed that the older a women is, the less likely other family members were to have a major role in whether a woman practised family planning [12].

Contraceptives and Pregnancy Termination

The SRS data indicate that women who had previously used contraception were much more likely to terminate pregnancy. Most respondents of the indepth survey responded positively when asked whether (in retrospect)

contraception would have been a favourable alternative to pregnancy termination.

Type of contraceptive used at conception of unwanted pregnancy

The three cases where effective contraception was clearly not an alternative to termination were the three newly-married women who had abortions due to marital breakdown. In these cases, the respondents stated that they, as newly married brides, were not using any contraceptive methods, because they wanted to become pregnant. Of the remaining women, five said that they had been using a contraceptive method regularly, and that it had failed. All five had been using condoms. It is worth noting that condoms are often used in conjunction with rhythm, using the condom during the fertile period, which may explain, in part, the high failure rate [13].

Contraceptive use history

Twelve respondents (the largest single category) said that they stopped using contraception due to side-effects, and another four said they did not practise family planning due to the perceived fear of side-effects. The latter response, in particular, might well reflect a lack of motivation in using contraception. Nevertheless, surveys in Bangladesh record a high level of reported side-effects, perhaps related to inadequacies in the quality of services and a lack of proper information on side-effects [14]. Two respondents reported that they stopped using condoms as a method; in one case, because she did not like it, and in the other, because her husband did not like it. One woman discontinued pill use when she was sick, on the advice of the doctor. Three of the women indicated that since they had been post-partum amenorrheic, they had not expected to become pregnant. Another was sub-fertile, having had one child three years after marriage and the second, some years later. And still another woman had two children by caesarian section and reportedly believed that this would reduce her fertility.

Four of the women reported difficulties in using contraceptives on a regular basis. Of them, one said that she had stopped, because she had not been able to obtain pills; one had lapsed in taking the pill, because she was

away from home; one didn't have a condom when she needed it; one had stopped taking pills, because she found remembering to take it daily troublesome. Several other reasons the respondents gave specifically indicated an over-reliance on the delivery of methods to their houses by field workers.

Post-abortion contraceptive use

Most respondents had continuously used contraceptive methods since the abortion. The SRS data for the area indicate that contraceptive use following pregnancy terminations increased from less than 40 per cent to about 59 per cent during 1982-1988 and from 47 per cent to 76 per cent during 1989-1995.

Of the women in our indepth study who were still married after their terminations, all but one indicated that they had begun to use contraception following the termination. Nine first used pills and another nine first used condoms. Seven used injectables; six IUD; one, withdrawal; and one, rhythm. It is alarming, given the strong emphasis on limiting child births, however, that while some respondents had changed their method since the abortion, none had moved to a permanent method.

Most of the respondents who used a trained provider for their terminations (MBBS, government nurse, or FWV) had been advised to use contraception, either by the provider or by FWA. Of the three women who had undergone more than one abortion, all were using contraception on the advice of the termination provider, one, IUD; one, injectable; and one, condom. Interestingly, while some providers recommended the use of more reliable methods, such as IUD and injectables, none recommended a permanent method.

Consequences of Having Pregnancy Terminations

Physical

The respondents were asked about the physical consequences of the abortion and about any treatment which was necessary afterwards. Of the

41 respondents, 14 had experienced moderate to severe complications, five had suffered minor problems, and 22 had suffered problems not serious enough to require any further treatment. The only pattern in the severity of complications by provider was that three of the four women, who had inserted a foreign object, such as a tree root or plastic "catheter," into their uterus to induce abortion, had all suffered from severe bleeding.

Of those who suffered severe side-effects, several referred to the inability to work for long periods, the high cost of treatment, and even to coming close to death. One respondent used a twig from a tree to induce abortion. She suffered severe bleeding for 14 days. 'After seven days my husband came here and found that I was dying,' she said. 'He went to a village doctor, who did not come to the house but gave a prescription according to which my husband bought medicine and an injection. Then I delivered a dead baby.' She experienced bleeding, fever and weakness for three to four months. Another respondent said that she suffered from infection and fever, was in bed for 45 days, and could not do housework for one year. She borrowed Tk.5,000.00 (US$120) to pay for treatment and Tk.400.00 (US$10) for transport, in addition to Tk.700.00 (US$17) she paid for the abortion. By village standards, these are huge sums of money. The story highlights, however, that expenditure for post-abortion treatment, when required, may far exceed the original cost of the treatment, and, given that the money is often borrowed, such expenditures may constitute a very heavy burden on the family.

Economic and social

Of particular interest to our study was the perceived social impact of terminations, what the families and communities knew about the terminations, and to what degree the terminations had been supported or opposed. The indepth investigation also set out to determine what the respondents believed to be the long-term consequences of having an abortion. The respondents were asked whether there had been any specific positive or negative consequences resulting from the decision to terminate the pregnancy, whether they would have an abortion again if in a similar situation, and whether they would advise someone else to have one.

In general, the respondents indicated that knowledge of termination was relatively restricted. In ten cases, knowledge was restricted to the immediate decision-makers, whereas in 14 cases, relatives outside the nuclear family also knew. In nine cases, non-relatives, such as neighbours also knew. Generally, knowledge was somewhat restricted, because it was not necessary for people to know, and not because secrecy was essential.

While several respondents said that some people who knew, disapproved, most of those who knew seem, according to the respondents, to have approved, or at least to have expressed no strong dissenting view. Social opposition was not considered by any respondent as a reason not to have a termination.

Of the women interviewed, 16 felt that there were few religious consequences. While eight women referred to abortion as being a necessary sin, 12 said that they felt guilty, but confident that if the situation arose again, they would make the same decision.

Virtually all respondents emphasized the economic necessity of having the termination to preserve the family's welfare. Some women, particularly those who had severe side-effects and had to stop work or had expensive treatment, emphasized the economic and physical costs of abortion itself. They too, however, generally believed that the abortion had been necessary to preserve the family's welfare. The only women who said they would definitely not have another abortion were women who had suffered severe side-effects from the abortion.

Several respondents said that, while under the same circumstances they, themselves, would have an abortion again, they would not recommend it to others, because to do so would, in itself, be inappropriate. The implication was that it was for each individual to make their own decision.

Discussion

In this study, we sought to understand the motivations and actions of individual women having terminations in a rural area of Bangladesh.

The low and declining use of permanent contraceptive methods is a major concern in the Bangladesh family planning programme and is due,

among other things, to cultural resistance to permanent methods, internal conflicts between medical and non-medical personnel [15], and the success of the programme in providing modern temporary methods. The high rates of termination among the older women and women with very young children in our study indicate a need for better education on contraceptive use, particularly with regard to side-effect management, post-partum amenorrhoea, and the advantages of long-term methods, among the general population.

The increased acceptability of pregnancy termination reflects, in part, continuing social change which has increased the mobility and, to a lesser degree, the autonomy of women. More clearly, it reflects the impact of the provision of MR by the government health and family planning workers. MR services are becoming increasingly widespread and well known, even though the government has chosen not to widely publicize MR as part of the national family planning programme. The very existence of MR has undoubtedly helped legitimize the termination of unwanted pregnancies.

According to our study, paramedics - both FWVs and nurses - currently provide the majority of pregnancy terminations. Another smaller proportion are provided by physicians and TBAs (both trained and untrained). Terminations by untrained providers are probably higher than the country's average, because Abhoynagar Thana is in an area regarded as relatively advanced, both socially and developmentally. However, many terminations continue to be provided by untrained providers indicating that the government-provided MR services have not fully been addressing the needs of all rural Bangladeshi women.

We found a low-success rate among the terminations assisted by untrained practitioners. The question arises, then, as to why a significant minority of women continue to undertake their own abortions, with the assistance of untrained practitioners.

Although MR is officially provided without cost, in practice it is often charged for. The impression given to the clients may, therefore, be that the worker is providing MR in her personal capacity, and that it is natural that he or she charges a fee, or conducts the procedure outside properly equipped clinics or health centres.

Some authors [6] also note that most rural women rarely use any government health services, and indeed, that many have never used them. Most health services are provided by unqualified village practitioners, who are conveniently located and who will provide what assistance they can. And while social opposition may not stop women from having terminations, women do not want it widely known that they have had one. They often, therefore, prefer to use the services of a village practitioner with whom they are familiar, who is close by, and whose services are simple to use. Their actions reflect continuing concerns among clients about confidentiality, provider familiarity, and cost.

A high proportion of terminations involving untrained providers were unattended. Whereas trained providers perform the termination themselves, using specialized equipment. Village practitioners usually provide only information and sometimes the substance for abortion, leaving the actual performance of termination to the woman. Unfortunately, along with the benefit of privacy, the non-attendance of the provider also assures the provider a decreased sense of responsibility for the risks of termination to a woman [4]. The greatest problem involved with the consultation of local practitioners, however, appeared to be that they were often ineffective and delayed the woman's visit to a trained provider until the pregnancy was advanced, often past the gestation date allowable for an MR.

The most risky abortions in our small sample appeared to be those involving no provider; where the woman herself inserted a foreign object. In three of the four cases where this was done the woman suffered from severe bleeding.

Women are, however, slowly becoming more familiar with government services and the service providers. A key role here is being performed by FWAs, who accompany many of the women to FWCs.

The final factor that may have contributed to an increased use of trained personnel is a diminishing concern among some women about the confidentiality of terminations. While some women did express strong concerns about confidentiality, others said that it really didn't matter, since both the decision and the consequences were the business of the woman and her husband, and no one else.

Conclusion

From an intensive indepth survey of 41 women, this study attempted to understand the determinants and consequences of pregnancy terminations in rural Bangladesh. The results are complex, the women concerned are varied, and many different factors influenced their behaviour. Nevertheless, certain points stand out.

Results of the study showed that there was little awareness or apparent concern about the risks associated with abortion. None of the women interviewed in our study made any distinction between MR by vacuum aspiration and abortion. By not publicizing MR and its advantages, the health service is hampered in communicating essential health knowledge concerning abortion to the population at large.

Other issues we have raised, concern the side-effect management of contraceptives and the low use of permanent methods. The major reasons given for pregnancy termination were the desire to limit and space births. Since most women having terminations are doing so to limit the number of their children, a preferable solution may be to encourage many of these women to adopt longer-term and permanent methods of contraception. Another significant proportion of the respondents who required terminations did so because they did not use contraception for fear of side-effects. A renewed commitment toward providing women with better knowledge about appropriate contraceptive use and side-effect management, therefore, should receive priority in the Bangladesh family planning programme.

References

1. Amin S. Menstrual regulation in Bangladesh. Paper presented at the IUSSP Seminar on Socio-cultural and Political Aspects of Abortion from an Anthropological Perspective, Trivandrum, Kerala, India, March 1996.

2. Rochat RW, Jabeen S, Rosenberg MJ, Measham AR, Khan AR, Obaidullah M. Maternal and abortion related deaths in Bangladesh, 1978-1979. *Int J Gynaecol Obstet* 1981;19:155-64.

3. Burhanuddin AF. Abortion as a measure of population planning and its relevance for Bangladesh. *Int J Gynaecol Obstet* 1974;12:93-100.

4. Islam S. Indigenous abortion practitioners in rural Bangladesh, women abortionists: their perceptions and practices. Dhaka: Narigrantha Prabartana, 1992.

5. Dixon-Mueller R. Innovations in reproductive health care: menstrual regulation policies and programmes in Bangladesh. *Stud Fam Plann* 1988;19:129-40.

6. Kamal H, Hossain A, Akhter R. Septic abortion: an anthropological study of 52 cases in Bangladesh. Dhaka: Bangladesh Association for Prevention of Septic Abortion. [Forthcoming].

7. Begum SF, Kamal H, Kamal GM. Evaluation of MR services in Bangladesh. Dhaka: Bangladesh Association for Prevention of Septic Abortion, 1987.

8. Kamal H, Hossain A, Begum SF, Kamal GM. Prospects of menstrual regulation services in Bangladesh. Dhaka: Bangladesh Association for Prevention of Septic Abortion, 1993.

9. Ahmed S, Haque I, Barkat-e-Khuda, Hossain MB, Alam S. Abortion in rural Bangladesh: evidence from the MCH-FP Extension Project. Dhaka: International Centre for Diarrhoeal Disease Research, Bangladesh, 1996. (MCH-FP Extension Project (Rural) Working paper, 121; ICDDR,B Working paper, 63).

10. Ahmed MK, Sarkar AH, Rahman M. Determinants of induced abortion in rural Bangladesh. Paper presented at the IUSSP Seminar on Socio-cultural and Political Aspects of Abortion from an Anthropological Perspective, Trivandrum, Kerala, India, March 1996.

11. Caldwell B, Barkat-e-Khuda. The first generation to control family size: understanding Bangladesh's fertility decline from the perspective of the participants. Paper presented at the Population Association of America Annual Meeting, Washington, D.C., 1997.

12. Mitra SN, Ali MN, Islam S, Cross AR, Saha T. Bangladesh demographic and health survey, 1993-1994. Dhaka: Mitra and Associates, 1994.

13. Gray A, Chowdhury J, Caldwell B, Al-Sabir A. Traditional birth control in Bangladesh. [Forthcoming].

14. Rahman M, Khan MA, Caldwell B, Kane T. Factors associated with reported side-effects of oral pills and injectables in rural Bangladesh. Paper presented at the Population Association of America Annual Meeting, Washington, D.C., 1997.

15. Barkat-e-Khuda, Barkat AH, Miller P, Haaga J. The Bangladesh population policy: a review of ten priority areas. A report jointly prepared by University Research Council (Bangladesh) and the Population Council, 1994.