

Induced Abortion in a Rural Area of Bangladesh

Process Management Health Consequences

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Abstract

The study was carried out to document the context of induced abortion, nature of management and post-abortion complications in Matlab, Bangladesh. The study included all 91 induced abortion cases that took place in the study area from July to October 1995. Information was collected from women within six weeks of the abortion. In-depth interviewing and physical examination by a physician was carried out for 20 randomly selected cases.

The findings depicted a complex context within which women go through for an abortion. In most cases, the complete lack of use or lack of use-effectiveness of the family planning method resulted in unwanted pregnancies. Women in desperation sought abortion services from traditional sources at the beginning. As the condition 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 condition. Prevention of unwanted pregnancies and access to safe abortion services will be needed to improve the situation.

Introduction

Nearly 10 percent of the pregnancies in Bangladesh end in abortion—half of which is induced, and the trend is on the increase (ICDDR,B 1995; Ahmed *et al.* 1996; Mitra *et al.* 1994). Fatal and myriad consequences of unsafe induced abortion are believed to be highly prevalent in developing countries including Bangladesh (Fauveau and Blanchet 1989; Measham *et al.* 1981; Henshaw 1990; Royston and Armstrong 1989). Socioeconomic and cultural factors, together with the absence of any effective legal abortion-related services (abortion being lawful in Bangladesh only as a life-saving means), probably place Bangladesh in a similar, if not worse, situation as other developing countries (Akhter and Khan 1996).

In the light of declarations made in the International Conference on Population and Development (ICPD, 1994) in Cairo, Bangladesh is committed to take appropriate steps to improve women's health. Set in this scenario, the issue of unsafe abortion is of particular relevance, and appropriate strategies need to be developed to address and effectively deal with the problem. Thus, it is important to know the context in which abortion takes place and the practices associated with abortion management. This paper presents findings from a community-based study which took advantage of a credible demographic surveillance system, and combined quantitative and qualitative methods to shed light on the induced abortion-related issues.

Materials and Methods ■

Study area

The study was carried out in 142 villages within Matlab and Daudkandi *thanas* (sub-district) under Chandpur district in rural Bangladesh. The villages have been covered by the Demographic Surveillance System (DSS) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B) since 1966. The fortnightly registration of demographic events through DSS has been in place in all the 142 villages. In total, 110 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.

The study villages had a population of 210,000 in 1995. Half of the study villages are served by ICDDR,B's intensive health and family planning programme. The ICDDR,B package includes house-to-house delivery of family planning and maternal child health 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 ICDDR,B's programme, it was less than 40%.

The Matlab population is predominantly dependent on agriculture. Eighty-eight percent of the population is Muslim and the rest is Hindu. The educational level in the area is also quite low: only 40% of males and 30% of females aged over six years have had some formal schooling. Women's participation in cash-earning is also very

low. It is only since 1993, that BRAC, a national non-governmental organization, started a woman-focused development programme to provide credit, skill development training, and the like (Bhuiya and Chowdhury 1995).

Data and procedures

All women who were recorded by DSS as having had an abortion during June to October 1995 were the study respondents. Data were collected through in-depth interview following a guideline, henceforth referred to as case studies, and by simple interview, henceforth referred to as quantitative survey. 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. Data were collected by locally-recruited women interviewers within two months of the abortion. Detailed case studies of an additional 21 randomly chosen women, with a recent history of abortion as recorded by the DSS, were carried out by the female co-investigator, a medical graduate with training in gynaecology and obstetrics, with the assistance of a female social science graduate with experience in in-depth interviewing.

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

Findings

Background characteristics of the survey respondents

In total, 61 induced and 107 spontaneous abortion cases were registered by DSS 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 found to have been induced after probing. Thus, the quantitative survey included 91 induced abortion cases. In-depth interview/case studies, on the other hand, included a total of 21 induced abortion cases. One of the induced abortion cases of the case studies died of post-abortion complications on the 45th day after the abortion.

The modal age group for induced abortion cases was 30-34 years while for spontaneous abortion, it was 25-29 years. The proportion of induced abortion cases was higher than spontaneous abortion cases among women aged 30 years or more. 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 induced and spontaneous cases. The proportion of induced abortion cases was lower than spontaneous cases in ICDDR,B's intervention area while the reverse was true for the non-intervention area.

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

Insights from the case studies

Some of the salient features of the 21 induced abortion cases are presented in Table 1. The respondents of most of the case studies

Table 1. Salient features of the induced abortion cases

Case no	Age in years	Years of schooling	Length of pregnancy in months	Type of abortionist 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	Kabiraj, hospital	Husband	Tablets, creepers, MR ¹	Not required	960	None	None
2	17	8	2	Allopath, kabiraj	At home	Tablet	None	300	12	30
3	24	0	6	Allopath	Husband	D&C ²	Not required	2,000	15	7
4	37	0	6	Kabiraj, allopath	Mother, relatives	Creepers	Hospital	Un- known	45	45
5	32	6	3	Family members, allopath	Husband	Herbal, allopath, D&C	Not required	700	2	2
6	18	7	4	Allopath	Family member	D&C	Hospital	2000	2	4
7	37	0	5	Kabiraj, TBA, allopath	Sister-in-law, husband	Creepers, D&C	Hospital	11,000	60	60
8	34	5	5	Kabiraj, allopath	Aunt, husband	Tablets, MR	Not required	500	None	None
9	38	5	2	TBA, allopath	None, husband	Allopath, MR	Not required	2,650	2	2
10	25	5	3	Kabiraj, homeopath	None, husband	Creepers, herbal tablet, homeopath tablet	Allopath	22,000	None	2
11	30	0	6	Medical doctor, kabiraj	Husband	Herbal tablets	Kabiraj, allopath	430	60	25
12	36	9	2	Self, kabiraj	Husband	Creepers	None	1,205	30	12
13	27	0	3	Kabiraj, allopath	Self	Charmed water, allopathic tablets	Allopath, Kabiraj	1,200	12	12
14	38	5	3	Kabiraj, allopath	Husband	Herbal tablets, intravenous saline	Kabiraj, allopath	300	3	20
15	32	0	2	Allopath	Husband	Tablets	Allopath	600	70	70
16	32	0	2	Allopath	Husband	Allopath tablets, MR	Allopath	910	70	70
17	26	6	4	Kabiraj	Husband	Herbal tablets	Homeopath, Kabiraj	620	60	0
18	29	4	3	FWV ³ , kabiraj, allopath	Husband	Allopath tablets, Herbal tablet, D&C.	Allopath	3,010	30	60
19	22	4	5	Kabiraj	Husband	Herbal tablets	Allopath	1,250	None	15
20	31	0	4	Homeopath, kabiraj, p ⁴ , d ⁵	Husband	Homeopath tablets, herbal tablets, D&C	Homeopath, kabiraj, allopath	7,500	45	90
21	41	0	4	Allopath	Husband	Allopath tablets	Allopath	1,000	3	30

Note: 1 MR=Menstrual regulation; 2 D&C= Dilation and curettage; 3 FWV=Family Welfare Visitors; 4 p=Pharmacist ;and 5 d=Doctors

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had terminated unwanted pregnancies, and went through a common process of unsafe abortion induction 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 irregular use of pills and another was due to irregular use of injectables (This was at variant with the findings of the quantitative survey presented later in the 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 realised that she was expecting, and if 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 grandma, or an aunt, and then she contacted a traditional healer for the abortion. The traditional healers provided herbal tablets and creepers. Tablets were for oral intake and the creepers were for vaginal insertion to induce abortion. In most cases, it was after the failure of the traditional method to cause abortion or due to continuous bleeding and/or fever after using the creeper that a modern healthcare provider was contacted. At times, homeopathic healthcare providers were also contacted for inducing abortion. Almost always the traditional abortion procedures included the insertion of a foreign material inside the vaginal passage without any consideration of sterilization. A large majority of the induced abortion cases that resorted to traditional methods resulted in continuous bleeding for long duration and had fever for more than five days. The cost of

services for an induced abortion was found to range 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 go through in performing an abortion:

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, has never been to school, and lives on share-cropping. She 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 she moved to her mother's house and 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 coming out with the blood. She bled for 30 days and had fever for twelve 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

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about it. The mother-in-law said 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 is 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 one in the above case), have nobody to consult with. Husbands and other family members do not come forward with adequate support to deal with her predicament.

The next case study depicts the story of a woman who, after having the desired number of children, tries her best to avoid another pregnancy by using family planning methods. At times, the use of contraception is discontinued due to side-effects, and this eventually leads to an unwanted pregnancy. In this situation, a woman is 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, had six ever-born children, of which four were alive at the time of the interview. She had no schooling. Her husband is a marginal farmer, who at times, also works 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 any more she decided to go to the Thana Health Complex, a thirty-bed government

hospital. On her way to the hospital she met with a traditional birth attendant who offered her services to the woman for the 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 D&C under deep sedation. She was saved.

Although women try abortion in desperation, the process is 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.

She was also 37 years of age, living with her mother and three children. Of the three children, one was from her first marriage. She had no schooling. Her present husband is a rickshaw-puller (tri-cycle puller) in a distant town and hardly provides any family support. So the women did not want any child and was an irregular user of injectables. She had recently become a member of a non-governmental development organization, and when she became pregnant she decided to have an abortion. She went to a traditional healer who gave her pieces of herbal roots and tablets. After using the herbs, she started to bleed and this continued for 10 to 12 days. She started bleeding again after four days. She was losing appetite, had very high temperature, and her abdomen became distended and hard. She used to say "my abdomen is going to burst." One day she became unconscious. She was then 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

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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 lead to loss of life. When the available health services are approached, it is usually too late. The 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 almost all respondents had pain in the lower abdomen and had backaches. Almost all of them were mildly anaemic. Most women complained of weakness and giddiness. None of the women who participated in the in-depth interview had any mass in the lower abdomen.

Quantitative assessment from the 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.

Context of Induced Abortion

Ninety-four percent of the induced abortion cases reported their pregnancies to be unwanted. The main reasons 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). This data, however, do not reflect the extent of failure of these methods

Table 2. Reasons for abortion

Factors related to abortion	% (n=91)
Was the pregnancy desired?	
Yes	5.5
No	94.5
Total	100.0
Family planning methods used immediately before pregnancy	
None	45.1
Pill	27.5
Injection	12.1
Condom	2.2
Safe period	7.7
Tabij	1.1
Kabiraji	3.2
IUD	1.1
Total	100.0
Reasons for abortion (multiple answers)	
Economic	13.2
Social	6.6
Demographic	86.8
Health	14.3
Illegitimacy of pregnancy	5.5
Family problems	4.4
Fear of having daughter	2.2
Fear of delivery complication	1.1
Old age of husband	1.1
Very soon after marriage	1.1

rather reflect the use percentage. Thirty-six percent of the women who had induced abortions thought 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 out of 3), *tabij* (1 out of 1) and condom (2 out of 2), followed by safe period (5 out of 7), pills (5 out of 25), and injections (2 out 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%)

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Table 3. Type of persons contacted for abortion during first, second, and third instances

Type of person	First contact (%)	Second contact (%)	Third contact (%)
Family member	5.5	2.6	0.0
Traditional birth attendant	2.2	7.7	11.1
Family Welfare Visitor	7.7	5.1	0.0
Kabiraj	24.2	23.1	0.0
Medical doctor	34.1	43.6	77.8
Pharmacist/Drug dispenser	3.3	7.7	0.0
Homoeopath	5.5	5.1	11.1
Allopathic village doctor	12.1	5.1	
Self	3.3	0.0	
Others	3.2		
Total	100.0	100.0	100.0
n	91	39	9

was of 3 months, followed by two (26%), four (13%), five (12%), and six (6%) months.

Complete and partial secrecy of the event of abortion was maintained for 45% and 36% of the induced abortion cases respectively. The reasons behind the secrecy were multifarious. The major reasons for keeping induced abortions a secret included: blame (20%), 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 in the process of performing the induced abortion (Table 3). 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 pharmacist/drug sellers. For 43% and 10% of the cases, a contact with a second and third person was respectively made. The qualified

Table 4: Procedures and materials used in performing the abortion

Procedure and material	%
How it was done	
Menstrual regulation (MR)	44.0
Dilation and curettage (D&C)	13.2
Creeper/root	24.2
Family planning pill/injection	6.6
Other allopathic tablet	7.7
Homeopathy	4.3
Total	100.0
Was general anaesthesia administered	
Yes	5.5
No	94.5
Total	100.0
Was any oral drug given immediately before abortion	
Yes	68.1
No	31.9
Total	100.0
Was any intravenous given immediately before abortion	
Yes	26.4
No	73.6
Total	100.0
n	91

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 contacted 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 abortion cases were done by using medical procedures (44% menstrual regulation by vacuum aspiration and 13% dilation and curettage), 24% used the traditional method of insertion of creepers/roots, 8% took allopathic tablets (most are likely to be hormonal tablets other than family planning pills), 7% took hormonal family planning methods including injectables. Homeopathic medicine was taken by 4% of the respondents (Table 4).

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Table 5: Nature of post-abortion complications

Nature of complications	% (n=91)
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)	100.0
Mean, median (for those who had bleeding)	mean=21.1, median=12.0, s.d.=25.0
Duration of fever in days	
No fever	34.1
1-3	29.7
4-6	12.1
7+	24.1
Total	100.0
Mean, median (for those who had fever)	mean=11.6, median=4, s.d.=16.8
Pain after abortion	
Yes	36.3
No	63.7
Total	100.0
Sweating during pain (for those who had pain)	
Yes	65.9
No	34.1
Total	100.0

Only 6% had general anaesthesia while 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 the abortion (Table 4).

Half of the induced abortions were performed either in a doctor's chamber or in a hospital. Five percent of the induced abortion cases started the process at home, but eventually contacted a healthcare provider. The remaining 45 percent of the cases 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.

Table 6. Management of post-abortion complications

Aspect of management	%
Contact with any healthcare provider	
Yes	81.3
No	18.7
Total (n=91)	100.0
Type of healthcare provider	(multiple answers, n=91)
Homoeopath	13.2
Kabiraj	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
Kabiraj	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)

Post-abortion complications and behaviour

The nature of post-abortion complications was varied. Two percent of the induced abortion cases were incomplete, meaning 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. Almost all (92.3%) of the women had post-abortion bleeding. The duration of bleeding varied: 34.1% of the women 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.

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Fever was experienced by 65.9% of the women. The mean and median duration of fever was 11.6 and 4 days respectively. Thirty-seven percent of the women suffered 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 the management of postabortion complications. In some instances they also contacted multiple healthcare providers. Allopathic healthcare providers were dominant (71%), followed by *kabiraj* (32%), traditional birth attendant (15%), and homeopath (13%).

The cost of post-abortion complication-related services also varied by type of healthcare providers. The highest cost was incurred in case of allopathic providers, followed by homeopaths, traditional birth attendants, and *kabiraj*. The mean expenses incurred for the services from allopathic healthcare providers was Taka 879 (US\$ 22), Taka 283 for homeopaths, Taka 180 for traditional birth attendants, and Taka 112 for *kabiraj* (Table 6).

Discussion

The study documented the level of women's susceptibility 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 who almost invariably prescribe plant roots or other foreign materials to be inserted into the uterus. Contact with modern service personnel/facility is rarely made in the first instance. The impression obtained during in-depth interview leads to the suspicion that the actual prevalence of insertion of foreign materials for abortion may be much higher than what was reported. Not only is it prescribed by the traditional healers, even an individual on her own initiative may resort to such measures for abortion. Other means of abortion also seemed to be practised may include ingestion of a large number of hormonal pills or a dose of hormonal injection. Stories from the study area also included insertion of IUD 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 go to a modern clinic only after the situation becomes grave (Begum *et al.* 1996) and such services also incur substantial economic cost.

Now the question is: how can women be saved from the potential danger of unsafe abortion? We know that most induced abortions were a result of unwanted pregnancies. Hence, one possible solution could be to find a way to prevent unwanted pregnancies. We also know 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.

How can unwanted pregnancies be averted? Clearly, it is possible through popularizing family planning methods and ensuring

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maximum use-effectiveness of the methods used. The prevalence of unwanted pregnancies and abortions among the newlywed women demonstrates the unmet need for family planning methods among the newlywed couples. Thus, this group in particular needs more attention from the family planning service providers. This should not be only target-oriented. Even in communities with a very well-organized family planning service delivery system, the family planning method failure has been reported to be quite high (Bairagi and Rahman, 1996). Insurance of optimum use effectiveness of the family planning methods may also depend on users' effective knowledge about the methods. An intensive target-oriented service delivery system may not necessarily lead to an increased level of effective knowledge about the family planning methods among the clientele (Nasreen *et. al.*, 1996). Thus, there is an urgent need to communicate adequate knowledge about existing family planning methods to the users so that they know when and how a method can become ineffective.

As to the provision of safe abortion services, performance of abortion for reasons other than life-saving is not legal in Bangladesh. Nevertheless, the lack of legal endorsement in case of abortion does not seem to be a major hindrance in getting abortion services. So far, no law-breaching abortion case has been publicly reported. Moreover, menstrual regulation services within six weeks of the last menstrual period are available both in the public and private sectors in the country. The public sector menstrual regulation services have been a component of the existing family planning services for quite some time. The service 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 unclear why so many women go to traditional practitioners for abortion. Social stigma attached to induced abortion may be one of the reasons for not seeking safe abortion services, for the matter may not remain confidential. On the other hand, the traditional methods with herbal roots and tablets can be self-administered and more convenient. Nevertheless, it is not clear

whether the women prefer 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 ignorant about the modern methods.

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

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(From inside of the front cover)

The **Public Health Sciences Division (PHSD)**, with staff comprising public health professionals, epidemiologists, social scientists, and economists, focuses on the evaluation of population-based interventions to improve child health, reproductive and sexual health, and public health programmes. Research includes: reproductive health; high-risk sexual behavioural patterns; family planning; safe motherhood; child health at the community level; epidemiological patterns and transmission of infectious diseases (especially diarrhoeal, acute respiratory and nutrition-related illnesses); healthcare delivery services; illness prevention, behaviour-modification; and vaccine trials. The Division has the responsibility of conducting field studies at Matlab involving 210,000 people under the Demographic Surveillance System (DSS).

The **Director's Division** provides support to the scientific divisions. As part of an infrastructural reorganization of the Centre, the Director's Division was newly created through merger of the Administration and Personnel Division, the Finance Division, and all offices under the Director's Bureau (External Relations and Institutional Development Office, Training and Education Department, Dissemination and Information Services Centre, Audiovisual Department).

What is the Centre's Plan for the Future?

In the 38 years of its existence, ICDDR,B has evolved into a research centre whose scientists have wide-ranging expertise. Future research will be directed toward development of cost-effective and sustainable solutions to the health and population problems of the most disadvantaged people in the world. The Centre's Strategic Plan: "To The Year 2000" outlines work in the following key areas:

Child Survival: Priority areas for research in child survival include: improvement of the case management of diarrhoea; acute respiratory infections; determination of risk factors for low birth rate and potential interventions; nutritional deficiency (including micronutrients); immunization-preventable infectious diseases; and strategies for prevention, including modifications in personal and domestic hygiene behaviours, provision of appropriate water supply to and sanitation for the households, and the development of effective vaccines

Population and Reproductive Health: The Centre played a key role in conducting pioneering research in the areas of population and family planning. Contraceptive use rate among women of reproductive age in Bangladesh has raised to almost 45% through its technical assistance and operations research. The 1994 Cairo Conference hailed Bangladesh as a family planning success story, using Matlab as the model for MCH-FP programmes throughout the world. The Centre continues its research in maternal health and safe motherhood and has initiated community-based research on reproductive health and STD/RTI/HIV infections.

Application and Policy: The Centre recognizes and gives a high priority to the need to transform research findings into actions by replicating the successful interventions piloted in its projects and through its research and training activities. The Centre will increase its communication, dissemination and training in its efforts to influence international and national health policies in the areas of its expertise.

New Initiatives and Approaches to Research: As a means of addressing the new initiatives in child survival and population and health research and structuring our existing programmes into Centrewide initiatives, interdivisional scientific research work and training courses have been proposed. The key areas include: Nutrition; Emerging and Re-emerging Infectious Diseases; Integrated Management of Childhood Illnesses; Vaccine Evaluation; and Reproductive Health. The interdivisional research themes will be multidisciplinary with scientists from each of the four scientific divisions engaged in formulating strategies and workplans, developing research protocols, and conducting clinical, laboratory-, hospital, and community-based trials. Outputs will include research findings, policy development and training capacity that will be used nationally and internationally and can be applied regionally and globally.



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