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The Impact of Imposing Time Limits on Access to Safe Abortion Care in Bangladesh

by
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Introduction: Unsafe abortion is a serious health concern for women in both developed and developing countries. The World Health Organization (WHO) defines unsafe abortion "as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both" (WHO, 2007). WHO estimates that globally 210 million women become pregnant each year and that around 80 million of these pregnancies are unplanned (WHO, 2004). It is estimated that approximately 50 million pregnancies, or about 25 percent of all pregnancies, are due to induced abortion (Berer, 2000). In 1995, it is estimated 25 million legal abortions and 20 million illegal abortions occur per year (Grimes et al. 2006).

Among all unsafe abortions, 97 percent occur in developing countries and more than half (55 percent) are in Asia, particularly in south-central Asia (Grimes et al., 2006). Globally, five million women are estimated to be hospitalised because of abortion related complications (WHO, 2007) and 67, 900 maternal deaths are the result of unsafe abortions annually, representing 13 percent of maternal mortality deaths, with 54 percent in Africa and 42 percent in Asia (Singh, 2006; WHO, 2007; Fawcus, 2008). Every eight minutes, a woman dies in the developing world due to complications from unsafe abortion (id21, 2007; cited in Bhandari et al., 2008).

The unsafe abortion rate remains high in Bangladesh (Singh, 2006). In Bangladesh 33 percent of all births are unplanned and 45 percent of all unplanned pregnancies end in Menstrual Regulation (MR) procedures and 'back-yard' abortions (Singh et al., 1997). In Bangladesh abortion is illegal, permitted only as a life-saving means. Ground on which abortion is not permitted are: to preserve physical health, to preserve mental health, rape or incest, foetal impairment, economic or social reasons, available on request (UN, 2002). However, MR, the regularizing of menstruation by terminating the foetus within six to ten weeks after a missed period, is permitted under the law (Bhuiya et al., 2001). A therapeutic abortion requires the approval of two physicians and must be performed by a qualified physician in a hospital. No approval is required in the case of MR, as the procedure is considered a family planning method rather than an abortive technique.

The Bangladesh Demographic and Health Survey (DHS) of 1999-2000 estimated that approximately 5 percent of married women go through the menstrual procedure (BDHS 2000) and the rate of these procedures is on the rise. According to a 1983 study,an estimated t 163,000 abortions were conducted by traditional health care providers[1] in a year (Khan et al.,

[1] Traditional health care providers have no formal & institutional training

1986). It is also estimated that 25 percent of all clients presenting themselves at the menstrual regulation clinics are refused services for various reasons, consequently pushing these women to resort to illegal and unsafe back-alley abortions. This data indicates that a large number of abortions performed by the traditional health care providers' result in complications due to the unsafe nature of the procedure. In 1990 it was estimated that at least 450,000 menstrual regulations and induced abortions were performed each year in Bangladesh (Singh et al., 1997). A study in 1995 found that the total number of estimated abortions occurring in Bangladesh was 730,000 (Singh et al., 1997a, Gipson et al., 2008). The same study found that 468,000 abortions took place in the government hospitals, health and welfare clinics and other clinics[2] whereas an estimated additional 262,000 abortions (clandestine and unsafe) were carried out by the traditional providers (Singh et al., 1997a). Similar research from 1997 estimated 500,000 menstrual regulation procedures are performed annually in Bangladesh (Chowdhury et al., 2004). The evidence indicates an increase of menstrual regulation procedures, safe and unsafe abortions performed by trained and untrained, local and traditional providers in Bangladesh over the period.

A study in a rural area of Bangladesh showed that the highest number of induced abortions occurred at three months (more than 10 weeks) of gestation, with the average time at which abortion occurred being 3.5 months of gestation (Rahman et al., 1986). That means that most of the induced abortions occurred after the legal boundary (six to eight weeks) of menstrual regulation in Bangladesh.

The consequences of unsafe abortions contribute to complications, including maternal mortality and morbidity. In the late 1970s a survey conducted in Bangladesh found that as many as 26 percent of maternal deaths were due to abortion-related complication (Singh et al., 1997). The 1978 study revealed that, regional variations would give an annual estimate of 5,078 deaths due to induced abortion (Khan et al., 1986). In 1996, a study found that 90,800 abortion patients were hospitalized and among them almost 14,000 were treated in teaching hospitals, 13,800 in district hospitals, 33,200 in Thana[3] hospitals, and 29,800 in voluntary facilities. At the same time, the hospital survey showed that about 19,300 of all women were hospitalized nationwide for treating complications due to menstrual regulations, and 52,400 women for induced abortion except menstrual regulations (Singh et al., 1997). This data indicates that a high number of women were admitted to hospital due to severe complications from unsafe induced abortion in Bangladesh. According to WHO, 13 percent of overall maternal mortality in Bangladesh is due to these unsafe abortion practices (2003).

In Bangladesh, women of childbearing age constitute about one fourth of the population (Ahmed et al., 1999). Low contraceptive continuation rates, methods failure and a high unmet need for contraception lead to unwanted pregnancies and abortions (Bhuiya et al., 2001). According to the 2010 Bangladesh Maternal Mortality Health Survey, the maternal mortality ratio in Bangladesh is 194/100,000 live births. Almost 28,000 women die due to pregnancy-related causes every year and 8000 deaths are estimated to be from abortion-related complications (Sedgh et al., 2007). Only abortions carried out in the government hospitals or recognized health facilities are included in government reports. Abortions conducted apart from the government facilities remain largely unreported in Bangladesh (Mishra et al., 1998; Sedgh et al., 2007).

Although unsafe abortion has been recognized as a public health issue since 1967, little has been done to overcome the legal, socio-cultural and religious barriers for safe reproductive health, including safe abortion services (Shah, 2007). Moreover, in many

[2] Government hospital and health and family welfare clinics are well equipped and services are provided by trained health care professionals.

[3] Second administrative unit next to district

countries the legislative status of abortion may have an impact on women's access to both safe and unsafe abortion.

Previous studies have focused mostly on the failure of public health services including the failure of family planning and contraceptive methods (Berer, 2000), the state policy impact on abortion rates, illegal grounds and association of unsafe abortion in many developing countries (Grimes et al., 2006). Some authors argue that gender-power relations, socio-cultural norms, beliefs and religious values regarding abortion play a critical role in decision making in favour of safe or unsafe abortion (Whittaker, 2002; Rashid, 2006).

Until recently, some research on unsafe abortion focused on policies or services for the patients (usually married women) treated for abortion complications (WHO, 1996). Very few studies and even fewer interventions have addressed the problems of female adolescents and young adults. Additionally, preliminary research revealed that other factors have been overlooked – notably, men's role and perspectives related to unwanted pregnancy and in decision-making regarding unsafe abortion, poverty and women's lack of access to safe abortion due to financial restriction and the cost impact of unsafe abortion (WHO, 1996).

Through extensive review of existing published and unpublished literature from different sources in Bangladesh and globally, this paper explores the influence of legal restrictions and 'time limits' on the incidence of unsafe abortion and the socio-cultural, religious, political-economic and health system factors that influence the abortion decision-making process and access to safe abortion care.

The first author is an anthropologist from Bangladesh who carried out this review in Australia as part of her Master's in Public Health. She has been involved in sexual and reproductive health and working on safe motherhood, family planning, menstrual regulation/abortion issues for the past four years. The second author is a medical anthropologist from Bangladesh who has done research on sexual and reproductive health, safe motherhood and menstrual regulation/abortion.

Methods

Sources of information: This is a non-empirical study based on a critical analysis and extensive review of published and peer-reviewed literature on abortion legislation, associated factors related to menstrual regulation, and abortion decision making procedures. Literature and documents were collected via a systematic search for published literature in different peer reviewed journals, books and research reports derived from different organizations from the Government of Bangladesh, UNICEF, WHO, icddr,b (International Centre for Diarrhoeal Disease Research, Bangladesh). Literature was sourced through University of Melbourne Super Search Engine. The electronic data-bases explored were Academic Search Premier (EBSCO), CINAHL PLUS (EBSCO), Expanded Academic ASAP (Gale), Google Scholar, MEDLINE (ISI), PubMed, ScienceDirectory (Elsevier), SCOPUS (Elsevier), University of Melbourne Library Catalogue, Web of Science (ISI). Key words used for search were: 'clandestine and unsafe abortion', 'abortion law and policy', 'gender and reproduction', 'public health, decision making', 'culture/cultural beliefs', 'contraception failure', 'contraception barrier', Bangladesh, religion and abortion, safe and unsafe abortion service providers, traditional health care providers, cost of abortion, socio-cultural factors, economic factors, abortion estimation, abortion rate, consequences of unsafe abortion, Bangladesh menstrual regulation service, health system and health structure, abortion decision-making, family planning services, feminist approach in sex-selective abortion. Few gray literatures were collected via a systematic search for documents relating to the menstrual regulation and abortion issues, including official government publications, formal studies of different service providers and researchers.

Data analysis process: The analysis used for this qualitative study was thematic analysis (Liamputtong and Ezzy, 2005). Data was coded and categorized under different

themes (Clarke, 2005; Strauss and Corbin, 1998). Three broad themes were used for categorization of data. The critical analysis of the literature review involved looking at how legislation has changed over of time, evaluating the impacts of the legislation regarding safe/unsafe abortion, socio-cultural and economic factors influencing safe/unsafe abortion decision-making by women. Other themes were added and categorised under these broad themes.

Feminist approach in analyzing data: We employed feminist approaches to underpin and shape the findings that emphasized women's health rights and provision of appropriate menstrual regulation and/or abortion services. Feminist approaches highlight the relationship between knowledge and power, which is tied to social structures of male dominance (Green and Thorogood, 2009: 19). Liberal feminist argument is about the women's reproductive rights and choices (Moazam, 2004). As Hardacre (1997) argues that, power relations structure gender and sexuality, which is an inseparable issue with abortion (cited in Whittekar, 2002). Feminist theorists demonstrates that, what counted as "knowledge" reflected mainly a male-dominating worldview, with the result that only male experiences or concerns are privileged over those of women (Green and Thorogood, 2009). This school of thought guided us to understand the various socio-cultural factors associated with gender and power relastionship, which further influence decision making regarding abortion and abortion related choices. Such factors include, for example, why women go for abortion, son preference, when and who makes the decision to seek abortion, why women seek secret and informal or non-registered providers for their menstrual regulation and/or abortion services in the context of Bangladesh.

We needed to understand 'agency' to take feminist approaches in analyzing the data. The term 'agency' is an important part of the decision-making process as used by medical anthropologists (Whittaker, 2000). Through this concept, the research questions examine the woman's understanding of abortion legislation and the correlation of legislative shifts with decision-making, abilities of negotiation with different and changing socio-cultural and economic circumstances for aborting fetus in Bangladesh. Petchesky argues that decision-making about abortion involves "a series of "negotiations", back and forth between ideology, social reality and desire" (Petchesky 1990: 367, cited in Whittaker, 2002). This understanding (or lack thereof) is very important to capture women's vulnerable position in a patriarchal society such as Bangladesh and the lack of support from the state that effectively excludes women from receiving safe reproductive health care services and so inhibits them from taking autonomous decisions regarding procreation.

Results

Historical shift in abortion legislation in Bangladesh: Abortion law in Bangladesh is based on the Penal Code of India of 1860 and the British Offences Against the Person Act of 1861. The Penal Code (sections 312-316) permits abortion for the good faith purpose of saving the life of the woman (UN, 2002). Prior to the 1970s, pregnancy termination (abortion) was prohibited except to save a women's life (Ahmed et al., 1999). However, the law was changed slightly in 1972 for the 200,000-400,000 women who were raped by Pakistani soldiers during the war of liberation in 1971 (Ahmed et al., 1999; Oliveras et al., 2007).

In 1974, the government of Bangladesh introduced menstrual regulation services in a few isolated family planning clinics. The aim was to reduce population growth as well as to reduce the huge number of unsafe abortions which contributed to high rates of mortality and morbidity (Ahmed et al., 1999). In 1976, the Bangladesh National Population Policy attempted to legalize and liberalize the law on abortion within 12 weeks (first trimester abortion) on vast medical and social grounds. However, legislative action was not taken and restrictive legislation remains in effect (Ahmed et al., 1999; Oliveras et al., 2007).

In 1978, Pathfinder[4] began a menstrual regulation training services programme which was introduced in seven medical colleges and two government district hospitals. Moreover, the Menstrual Regulation Training and Services Programme (MRTSP) began to train government doctors and paramedics to provide such services during that time (Chowdhury et al., 2004, Nashid et al., 2007). In 1979, the Family Planning Ministry of Bangladesh circulated a memorandum with a legal interpretation by the Bangladesh institute of Law and International Affairs (BILIA) to authorise menstrual regulation as a family planning method (Zahir et al., 1978; Ross 2002; cited in Oliveras et al., 2007).

Finally, the government of Bangladesh included menstrual regulation in the National Family Planning Programme and encouraged doctors and paramedics to provide menstrual regulation services in all government hospitals and in health and family planning centres (Ahmed et al., 1999; Chowdhury et al., 2004). Menstrual regulation also began to be available in a limited number of non-government regulated clinics and the private sector (Ahmed et al., 1999).

Menstrual regulation by means of vacuum aspiration is not regulated by the Penal Code because it is considered an 'interim method for establishing non-pregnancy' (Ahmed et al., 2005; Dixon-Muller, 1988; Piet-Pelon, 1997). The procedure is not legally defined as abortion because the vacuum aspiration procedure performed until the 10th week following a missed menstrual period usually is before the pregnancy is clinically confirmed (Ahmed et al., 1998). Menstrual regulation is legal if it is done within 6-10 weeks of amenorrhoea whereas after 10 weeks it is considered an "abortion" and therefore illegal in Bangladesh (Ahmed et al., 1999).

Menstrual regulation service providers in Bangladesh: In Bangladesh, the services are provided in district and higher level hospitals, Health and Family Welfare Centres (H&FWC) and the service units providing menstrual regulation at the union level (consisting of 15-20 villages), and in rural hospitals or Thana Health Complexes (THCs) at the sub-districts level (Ahmed et al., 1999; Chowdhury et al., 2004). The government and the Coordination Committee of Menstrual Regulation Aassociations in Bangladesh (CCMRA,B) manage the program jointly (Chowdhury et al., 2004). International donor agencies -- such as USAID, Ford Foundation, Population Crisis Committee and Swedish International Development Authority (SIDA) -- supported the programme, with SIDA as the principal donor from 1989 to 1999 (Chowdhury et al., 2004).

Three leading NGOs from Bangladesh -- Bangladesh Women's Health Coalition (BWHC), Menstrual Regulation Training and Services Programme (MRTSP) and Bangladesh Association for the Prevention of Septic Abortion (BAPSA) -- have provided menstrual regulation services and training. They worked together with the government and donors to maintain good standards of care within their own organizations. They coordinate to provide training and logistical support for the national programme (Chowdhury et al., 2004). The National Technical Committee for Menstrual Regulation sets standards and takes policy decisions on technical issues (Chowdhury et al., 2004).

Nurse and Family Welfare Visitors (FWVs) can provide menstrual regulation services if the length of gestation is no more than eight weeks while physicians can do so through 10-12 weeks of gestation (Caldwell et al., 1999). In 1974, it was estimated that 12,000 doctors were trained by joint government and non-governmental organizations (Nashid et al., 2007). There were 6,500 family welfare visitors[5] (FWVs) and 8000 doctors trained for promoting menstrual regulation services within the country in 2003 (Chowdhury et al., 2004). In 1998 the government of Bangladesh began to implement a five year "Health and Population Sector

[4] International donor agency

[5] Government health care providers who received 6 months training in obstetrics and 12 months training in family planning from the government. Who are working with the women.

Programme (HPSP)" to improve the performance and efficiency of health resources through the implementation of a sector-wide management approach (Chowdhury et al., 2004). To improve the services in 2001, nearly 7000 paramedics[6] were trained to provide menstrual regulation in government clinics as well as in private clinics (Berer, 2009). The community clinics do not provide menstrual regulation services but refer women to the government hospitals and the limited number of NGO clinics. In the NGO clinics family welfare visitors, nurses, female medical assistants and midwives provide the menstrual regulation services instead. The Urban Primary Health Project, funded by Asian Development Bank (ADB) is working in four large cities in Bangladesh and providing menstrual regulation services with Family Planning Programme (Chowdhury et al., 2004).

This health structure gives a snapshot of the menstrual regulation services provided by the government and NGO's in Bangladesh and reflects the availability of well-structured menstrual regulation services in the country. Despite the presence of trained menstrual regulation providers employed by the government, the unsafe abortion rate remains prevalent among women in Bangladesh. However, the provision of abortion services within the health system does not mean that women have access to safe abortion facilities because some lack good hygiene, use improper methods and lack appropriate logistical supports.

Decision-making regarding abortion: The reviewed literature provides explanations of factors affecting decision making regarding abortion despite legislation and the legal and illegal barriers to abortion. Making decisions about abortion is both a dynamic and a complex process. The reasons for seeking abortion also play a role in determining who takes the decision to seek an abortion (Bhuiya et al., 2001; Visaria et al. 2007). In South Asia, including Bangladesh, patriarchal societies culturally predominate where husbands and mothers-in-law play a major role in decisions about unwanted pregnancies (Ganatra and Johnston, 2002). Moreover, such factors such as education, landholding and economic status influence the decision making for seeking abortion in Bangladesh (Visaria et al., 2007; Ahmed et al., 2005).

Factors associated with decision-making regarding abortion: In Bangladesh, village women have limited mobility to go outside the home and the village and they also lack transport facilities. They also lack proper knowledge and correct information about available menstrual regulation services provided by the government and private sectors. Moreover, the health care facilities for menstrual regulation available in Bangladesh are underutilized (Ahmed et al., 1998). Women do not use the services or are not eligible to use the services (within restrictive legislation 6-10 weeks) provided by the public and private authorized facilities. As a result, they seek and practice induced unsafe abortion. Also due to inaccessibility and legal barriers to abortion services, many rural women in Bangladesh need to depend on the traditional and untrained local providers for terminating their pregnancy in unhygienic and clandestine conditions (Ahmed et al., 1999). In Bangladesh, clients who do not meet the criteria for menstrual regulation (6 to 10 weeks of gestation) often obtain the procedure unofficially, which is often unsafe (Caldwell et al., 1999). Unsafe induced abortion methods include inserting a foreign object into the uterus or taking an indigenous oral medicine, abortion tablets or potions, which are collected from a local pharmacy or from traditional health care providers (Caldwell et al., 1999). Unsafe induced abortion results in long term morbidity and mortality of womens (WHO, 2007; Fawcus, 2008, Chowdhury et al., 2009).

In Bangladesh, abortion in late pregnancy, even in the sixth month period, is common (Nashid et al., 2007, Varkey et al., 2000). This is because it takes a long time for many women to obtaining their family members' consent and financial support for menstrual

[6] Health care providers having a diploma degree from government institute.

regulation/abortion (Ahmed et al., 1999; Bhuiya, et al., 2001). In addition, young girls, both married and unmarried, may not recognize their pregnancy at an early stage (Bhuiya, et al., 2001). This situation leads women and girls to opt for unsafe induced abortion from available sources which are easily accessible, affordable and with no pressure from legislative barriers.

Other factors also affect decision-making regarding abortion in Bangladesh. For termination of pregnancy, women seek support from untrained providers they are familiar with and whom they can trust. Women have less knowledge and education about the facilities provided by the government hospitals and there is an absence of a trusted person with whom they can discuss the abortion related complications (Caldwell et al., 1999; Rahman et al., 2003; Nidadavolu and Bracken 2006). Lack of confidentiality and privacy is one of the main reasons for not seeking menstrual regulation services from government hospitals. Women fear that an 'abortion' could become public if it is sought from a public hospital (Begum, 1993; Ahmed et al., 1998; Caldwell et al., 1999; Ganatra and Johnston, 2002).

In Bangladesh, women prefer local and village practitioners because they often use oral preparations for pregnancy terminations. Moreover, the local providers also keep confidentiality and have no waiting time in comparison with public hospitals (Ahmed et al., 1998). Moreover, the services are relatively inexpensive and the procedure can be performed at the client's home privately with no major side effects (Ahmed et al., 1998; Caldwell et al., 1999). Women in Bangladesh prefer to seek abortion related services from the untrained providers living near them. They perceive that those providers will keep the confidentiality because the untrained providers' income depends largely on the client flow from the neighbourhood (Caldwell et al., 1999). Very few women associated late or induced abortion with high levels of risk (Caldwell et al., 1999). For many women, the advantages of seeking abortion from the untrained providers outweighed the risk associated with the procedure. As well, they consider that the risk is minor compared to the accessibility and affordability of abortion from the local, untrained village providers (Caldwell et al., 1999). Ahmed et al. (1998), Caldwell et al. (1999), Bhuiya et al. (2001) argue that women only choose trained abortion service providers when they know the providers personally (Caldwell et al., 1999; Ahmed et al., 1998; Bhuiya et al., 2001).

Although menstrual regulation is legally provided at government level in Bangladesh, many procedures are not recorded and the actual abortion rate may be much higher (Caldwell et al., 1999). Women often preferred providers who performed menstrual regulation or abortion secretly at the residence of providers and who did not keep records. Such services were often provided by the *'ayas'*[7] or traditional birth attendants,) who have learned abortion by observing the practices of nurses and doctors (Streatfield, 2001; Chowdhury et al., 2004, Nashid et al., 2007).

Abortifacients used by both trained and untrained providers involved side effects although they are more common from village practitioners' medicine. In Bangladesh, government facilities are limited in terms of availability of drugs, convenience, location and visiting times compared to traditional health care providers and pharmacists. According to the research by Begum (1993), Caldwell et al. (1999) and Ganatra and Johnson (2002), Family Welfare Assistants directly or indirectly played an important role in decisions to select a government provider and the location of the clinic. In practice, it was found that termination occurred after the pregnancy was more advanced. The reasons for seeking late abortions are failure or ineffectiveness of the methods from traditional health care providers, not knowing in early stage about their pregnancies, waiting for husbands' concerns and permission for aborting foetus (Caldwell et al., 1999).

[7] Nurse maids

The government of Bangladesh has the central management and control system in the health sector. The Ministry of Health and Family Welfare (MOHFW) is responsible for health policy formulation, planning and decision making at the macro level. Two sub-divisions ,the Directorate General of Health Services (DGHS) and Director General of Family Planning (DGFP), act as implementation sectors (Rahman et al., 2003). Menstrual regulation services and technical supports are provided within the Family Planning Services by the Director General of Family Planning (Rahman et al., 2003). However, sometimes providers ignore or modify abortion law and service provision according to their own interests, which also creates barriers to access safe abortion.

Our review also examines the availability and limitations of abortion services and the relationship with contraceptive failure. Contraceptive failure is one of the key reasons for seeking unsafe abortion globally (WHO, 2007). Ahmed et al. (1999) showed that overall incidence of abortion in Bangladesh is increasing simultaneously with the increased use of in contraceptives. Incorrect, inconsistent use and poor quality of contraceptive methods or failure of the method increase the incidence of abortion in Bangladesh (Ahmed et al., 1998; Ahmed et al., 2005). In a patriarchal society such as Bangladesh, men are unwilling to use condoms. Moreover, they prohibit their wives from using any sort of contraception resulting in unwanted and unplanned pregnancy and high rates of induced abortion (Ahmed et al., 1998; Nashid et al., 2007). Failure of contraceptives, such as broken condoms, forgetting to take oral pills and inadequate knowledge about the lactating amenorrhea method period, is also are reasons for unplanned and mistimed pregnancies for which women seek menstrual regulation/ abortion (Nashid et al., 2007). Even though a few developing countries have good uptake of contraception, there are still unintended pregnancies requiring terminations (Fawcus, 2008). Oral contraceptives can fail when women suffer diarrhoea or take antibiotics for any disease. Resource -poor countries have lower contraception uptake because of poor provision of reproductive health services; further, couples may have very little knowledge about contraception and poor access to emergency contraception for accidental pregnancy (Fawcus, 2008). In Bangladesh young married girls face strong objection from family members, especially the mother-in-law and husband, about the use of contraception before the first pregnancy and childbirth. To avoid unwanted pregnancies and the burden of rearing and caring for another a child, women go for an abortion or menstrual regulation (Nashid et al., 2007).

Rahman et al. (2001) argue that the rates of both abortion and contraceptive use are on the rise simultaneously in Bangladesh. Because of declining desired family size and increasing costs of managing unwanted births, people prefer thete option of menstrual regulation or abortion as a means of fertility control offered as a part of high-quality family planning services (Rahman et al., 2001). Research shows that, in Matlab, a rural area of Bangladesh, high quality contraception services are widely available, although 2 percent of pregnancies (compared to 10 percent or more nationwide) are still aborted (Singh et al., 1997; Rahman et al., 2001). Thus, failure of contraceptive use remains a challenge in Bangladesh. Bhuiya et al. (2001) found that in a rural area of Bangladesh half of the women were seeking abortion, as they did not use any contraception over a period of four months since their last childbirth. They argue that those pregnancy prevention services alone are not enough and the demand for safe abortion facilities and services will remain high. Women seek abortion either as a back-up for the failure of contraceptive methods or as a new method for limiting their family size or terminating unplanned and mistimed pregnancy which is very similar in Bangladesh (Amin et al., 1989; Ganatra and Hirve 2002a; Ganatra and Johnston 2002; Visaria et al., 2007).

Economic factors are particularly important in determining to abort the pregnancy. The family economic situation also leads couples to decide on terminating the pregnancy. On the other hand, separated from the extended family to set up a nuclear family and financial constraints also result in aborting the unwanted fetus (Bhuiya et al., 2001; Ahmed et al., 2005, Ganatra and Hirve, 2002a, Visaria et al., 2007).

The most common reason that married women seek abortion is limiting family size. A very short interval between conceptions was also cited as a reason for abortion. During postpartum amenorrhoea and while breast-feeding the child some women become pregnant without realizing it. In such cases, abortion served as a viable way to avoid having two children in rapid succession (Bhuiya et al., 2001; Ganatra and Hirve 2002a;). A common practice found in Bangladesh is that when the previous child was a male infant, the mother and family members might be anxious about the next pregnancy that might put in danger the health and survival of the male child (Abrejo et al., 2009).

In South Asian countries sex-selective abortion constitutes a considerable proportion of induced abortions. This is a major public health issue due to its association with high maternal mortality and morbidity (Abrejo et al., 2009). The preference for sons is very common in Bangladesh, where the patriarchal system means that married women are seen to 'belong' to their husband's family and so are not bound to give support to their own parents. Sons are needed to ensure 'support in old age', to 'continue the family line' and for the 'performance of death rites' (Caldwell et al., 1999; Ganatra, 2000; Visaria et al., 2007). Additionally, in Bangladesh, there are gendered stereotypes where males are considered the main earning hands for families that bring wealth and fortune. In contrast, having a daughter is considered to be a burden to the family. The preference for sons presents an important barrier to the use of contraception and to the control of fertility in the country (Abrejo et al., 2009). Research showed that mothers with sons prefer to limit the family size and want no more children whereas mothers with daughters want more children, preferably sons (Akhter et al., 1983). Therefore, a woman will give birth to one after another child until she gives birth a son.

In both liberal and restrictive abortion jurisdictions, cost is a barrier to safe abortion care. Ganatra and Johnston (2002) argue that in Bangladesh less resourceful and poor women cannot access safe abortion services, not because of the legislation, but because of the structure of the health system. Although government hospitals and health centers are supposed to provide the services free of charge (Ganatra and Johnston 2002; Ahmed et al., 2005), they often charged BDT 100-200 depending on the stage of the pregnancy (Caldwell et al., 1999; Nashid et al., 2007). The cost for a termination of pregnancy started form 100 BDT (1 US $ = approximately 70 BDT) to 12000 BDT (Caldwell et al., 1999). The cost of the treatment therefore may impose a very heavy burden on the family. Ahmed, et al. (2005) found in Matlab region that menstrual regulation services are considered to be relatively expensive and are often performed after 10 weeks of gestation. Hence, doctors and FWVs charged fees for carrying out the menstrual regulation or abortion. Moreover, necessary drugs are not available and patients need to buy them from other places with costs sometimes up to BDT 2000. NGOs and population programs providing menstrual regulation services are situated mostly in the urban areas. They generally charge less (BDT 500-2000) as compared to private clinics (Chowdhury et al., 2004), whichs could charge BDT 5000-12000 depending on the stage of the pregnancy and the procedure they employ for termination, as well as the marital status and pregnancy gestation of the women (Nashid et al., 2007).

Such hidden costs as medication, unauthorized service fees, or under-the-table payments are very common practice in Bangladesh (Piet-Pelon, 1997; Ahmed et al., 1997; Akhter, 2001, Ganatra and Hirve, 2002a). The cost of the abortion depends on the number of weeks of pregnancy (Ahmed et al., 2005). The use of similar abortion methods, women's

marital status, type of medication such as anaesthesia, medicine etc and any type of diagnostic tests (for example, pregnancy test, sonography, laboratory tests) needed for an abortion procedure also contribute to the hidden costs. Location of the clinic and certified and registered clinics does matter for the high cost of the abortion services (Gupte et al., 1999; Ganatra and Hirve, 2002a; Duggal, 2004a). So-called informal fees charged by providers in the public sector and excessive charges in the private sector exploit vulnerable women (unmarried, widowed, separated pregnant women) for their low awareness of abortion law, and for the unwanted pregnancy which is not socially acceptable (Hirve, 2004) in Bangladesh (Ahmed et al., 2005).

Perception of abortion among women in Bangladesh: It has been argued that menstrual regulation is socially acceptable in Bangladesh and people distinguish it from abortion (Nashid, et al., 2007). In contrast, researches from Bangladesh show that women do not differentiate between menstrual regulation and abortion (Caldwell et al., 1999; Nashid, et al., 2007). The Bengali term used for menstrual regulation derives from women's interpretation of the process which refers to "washing out the uterus" or "clearing the period" (Dixon-Mueller, 1988: 131). The Bengali terms used are "*baccha naushto*", *"bachaa nosto kora"* meaning 'to destroy the foetus', *"pete fela"*, *"baccha fela*" meaning 'to throw out the fetus' using these same terms both for menstrual regulation and abortion (Caldwell et al., 1999) and refers to killing the fetus by doctors, nurses or persons with or without menstrual regulation training (Nashid et al., 2007). We found a case in a qualitative study conducted in rural Bangladesh (Bhuiya et al., 2001) in which a woman went through an abortion but kept it secret from her family members. A few days later her mother-in-law learned about it and rebuked her for obtaining an abortion which is commonly perceived as committing a sinful act. The woman felt guiltier after doing this and soon after that incident she became pregnant as she did not use any contraception.

Nashid et al. (2007) argued that unwanted pregnancies are considered as a problem, an accident or a mistake in a woman's life. Furthermore, abortion is promoted as a sin by the religious leaders in Bangladesh, considered a sin among women from a religious point of view. Menstrual regulation or abortion also are perceived as disrespectful acts when committed without being married (Nashid, et al., 2007). This social embarrassment can lead unmarried, widowed and separated women to commit suicide due to the fear of social ostracism and being ashamed of a pregnancy out-of-wedlock (Nashid et al., 2007). Premarital and extramarital sex is also perceived as a sinful act in predominantly Muslim countries such as Bangladesh. Hence, unmarried, widowed and separated women abort pregnancies due to the stigma attached to these pregnancies, and this sort of act is unacceptable in the society (Ahmed et al., 1998).

Moreover, families can force unmarried, separated or widowed women to have a menstrual extraction/abortion to avoid social exclusion and difficulties in finding a future husband (Nashid, et al., 2007). In these situations menstrual regulation or abortion provide an escape from shame for women and their families. Often these types of abortion are unreported due to its secrecy (Ahmed et al., 1998). Caldwell et al. (1999) found that women believe that two-three months of gestation should be the good time for pregnancy termination. However many woman do not know about the availability of menstrual regulation and abortion services, as well as having limited knowledge of providers and being unaware of time limits of gestation (Singh et al., 1997)

Discussion and Conclusion: The findings of this study may be useful to service providers for future understanding for appropriate interventions regarding abortion. This research may also support future researchers leading to improved legislation and interventions through policy development and programs that will both reduce the need for abortion and ensure or facilitate women's use of safe abortion services, not only in

Bangladesh but all other countries where abortion is legally restricted. According to the United Nations, the high rate of maternal mortalityand morbidity is related to the incidence of unsafe abortion (UN, 2002). The increase in attention to these issues indicates international recognition of the necessity for research on women's reproductive health and reproductive health rights.

The review of literatures from Bangladesh, with its unique abortion law, suggests that the strong 'patriarchal bias' in the laws and family structures encourage women to handle this matter secretly. The perception about abortion and menstrual regulation as 'illegal', 'sinful', 'guilt' and 'shame' contribute to keeping this matter more secret and silent in Bangladesh. Moreover, unmarried, widowed, separated women are more susceptible to social blame and social exclusion from family members, neighbors and the society which contributes to their decisions to seek dangerous pharmaceutical preparations, resort to self harmful remedies and unqualified traditional abortionists to carry out abortions. Furthermore, women with less education and no work totally depend on their husbands and often have little decision-making power within the family (Akhter and Rider, 1983; Amin et al., 1989; Akhter, 2001; Rashid, 2006). While qualified practitioners may be present in the vicinity, women may be unwilling or unable to afford these services or may not trust them, which influences their decision-making for unsafe abortion provision. There also is a lack of awareness and misperception about abortion law among women and there are problems of access in urban or sub-urban[8] based public and private clinics.

In recent years, women's mobility has increased and women often work outside the home, with a large proportion of women working in garment factories in Bangladesh (Rashid, 2006). Woman's involvement in work for their career and financial contribution to maintain the household is an important factor associated with abortion decisions. Childbearing is considered as a burden for married working women, especially for women living in socio-economically vulnerable situations or in poverty. In Bangladesh, the rapid social and economic changes after independence and the shift from an agricultural to an industrial economy extended to the nuclear family; the expansion of family planning services contributes to change lifestyle patterns and expectations.

Economic hardship remains a strong ground for abortion in Bangladesh as does the vision of a better and more comfortable life. The preference for planned family size relates to less household work and limited child care so that more time can be spent in wage labour or work for a higher income or a better career. This socioeconomic and cultural transition reflects couples' desire to live a better life, provide (or consume) good food, education for their existing children rather than extending their family size with more children.

Safe and legal induced abortion is women's right and choice of appropriate services is an important issue of feminist thought (Moazam, 2008). Autonomy and the right to be an autonomous agent mean that women can make their own choices in shaping their lives (Whittaker, 2002). Gender inequality is most significant in cultures where accepted gender roles devalue women's work and status and capacity to take autonomous decisions. As Petchesky notes: "Often women may go along with decisions not of their own making, which may violate their sense of bodily integrity and well-being but with the hope of gaining some advantage in the context of limited options" (cited in Rashid, 2006).

Frequent childbirths for a son in Bangladesh reflects the strong cultural preference for sons. This is a way by which women hope to gain family honor or some advantage in the context of limited options. Abrejo et al. (2009) and Bhuiya et al. (2001) argue that in many Asian societies women are discriminated against with regard to education, health, food and security which start even before their birth. Moreover, women with low socioeconomic status

[8] Sub urban is the settlement between urban and rural

have little role in decision making processes. The concept of daughters as financial and cultural burdens and sons as supports in old age, to continue the family line and to perform death rites (in Hindu religion) has been defined by liberal feminists as discrimination against women in the male-dominated, patriarchal society.

WHO guidelines state that all women in Bangladesh are legally eligible to use menstrual regulation services, free of discrimination on the basis of marital status, age, access, residence or income (WHO, 2004); this is, however, rare in practice. Access to safe abortion provision and quality of abortion complications management are significant in woman's reproductive lives. But safe abortion is sometimes not accessible because of additional requirements of spousal consent or laws that restrict the gestational time for abortion. Abortion is a controversial issue in many countries and anti-abortion movements are active in many parts of the world, supported by the religious authority (Rahman et al., 1998). Induced abortions are generally stigmatized and frequently portrayed negatively by religious teaching and ideology (WHO, 2007). Even though there are strong grounds to permit early abortion from different Muslim theologies, different interpretations by Muslim theologians argued about gestational grounds for abortion. Most scholars agreed that abortions areallowed before emolument of the fetus occurring between 40, 90 or 120 days after conception (Musallam, 1983). In Bangladesh, limited knowledge of religious explanations regarding abortion is often misinterpreted by the community and translations on this issue are presented to women according to men's understanding of abortion. In this regard, to increase the access to safe abortion legislative reform is clearly needed. One possibility within the current religious/cultural context is the extension of the time period of menstrual regulation, which might reduce the risk of unsafe abortion which would also be supported by the Muslim religious point of view.

In Bangladesh, menstrual regulation services are available in the sub-district level but not in the village level. However, late termination of pregnancy often occurs because of late notice of the pregnancy, economic reasons and socio-cultural context. The choice of pregnancy termination is a complex process involving the social relationships in patriarchal societies. It also includes the gender power relationship, access to the heath care facilities and the ability to decide woman's reproductive health issues. Moreover, husbands and extended family members impose their opinions on pregnancy and termination of pregnancy. Overall, larger socio-cultural, political and economic inequalities and familial relationships strongly influence reproductive and abortion decision-making among women in Bangladesh.

It is clear that abortion law is important. However liberal laws do not necessarily translate into service availability and safer abortion choices. Poor training of providers, inadequate supplies and substandard facilities as well as economic, health service structure and socio-cultural and religious factors all are factors that influence women to seek unsafe abortions even within liberal legislative conditions. Economic development in a country is very important for the improvement of the health care system, including availability of safe abortion services. Bangladesh is one of the middle income countries in the world, where economic development is a lengthy process. Furthermore, uneven distribution of trained providers, mismanagement in the health system facilities, and lack of monitoring and evaluation of that sector has created barriers to women's access to safe abortion.

In conclusion, access to safe and legal abortion is a fundamental right of women, irrespective where they live (WHO, 1992). However, access to abortion related health services affects specific groups of women in relation to race, age, language, ethnicity, culture, disability or indigenous, refugee/immigrant status (WHO,1996). It is hoped that our findings will contribute to useful assessments by service providers, donors and policy makers for future understanding and appropriate/interventions related to abortion in Bangladesh. This research may support future research leading to improved legislation and interventions

through development of policies and programs that will both reduce the need for abortion and ensure that women use safe abortion services not only within Bangladesh but also in other countries where abortion is legally restricted.

Abortion is a serious women's reproductive health issue in public health. The United Nations explains the link between high prevalence of maternal morbidity and mortality in relation to unsafe abortion worldwide (UN, 2002). The increase in attention to these issues indicates international recognition of the necessity for research on women's reproductive health and issue of reproductive health rights.

However, it is important to bridge the gaps between networks of health structures for safe abortion provision and to ensure the accessibility and availability of safe abortion in the micro level among women in Bangladesh. Therefore, there is a strong need for decentralised and community based abortion facilities with strong monitoring and evaluation. Appropriate knowledge of abortion legislation, procedures and awareness of sexual and reproductive health could be disseminated through Family Planning Services among women in Bangladesh. Further, there are very few literatures that discuss the male perception and dominance in Bangladesh. There is a need for further and continuous research to explore more about men's dominance in decisionmaking and perceptions, their perspectives within socioeconomic and cultural contexts in regards to improving provision of legal and safe abortion services for women in Bangladesh.

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