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Evaluation of reported induced abortion in Bangladesh: Evidence from the recent DHS

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Abstract

Induced abortion is illegal in Bangladesh unless for clinical reasons. Using Bangladesh DHS conducted during 1993-94, 1996-97 and 1999-2000 this article compares the trend in reported induced abortion, decomposes the effect of abortion to fertility using the Bongaarts' model, and examines the level of under-reporting. An increasing trend in induced abortion is evident. BDHS 1999-2000 reveals that 3.7% of currently married women reported induced abortion. Among the abortion experienced women 20% were non-users of family planning (FP) and more than three-fifth made their FP decisions jointly with partners. The decomposition results suggest that 6% of total fertility were explained by reported induced abortions. Under-reporting is found considerably high. Binary logistic regression model reveals husband's approval of FP as one of the significant determinants of induced abortion. Program efforts should monitor early development of pregnancy and encourage couples to use spacing methods to reduce the burden of unnecessary abortions in Bangladesh.

Introduction

Abortion has been drawing increasing attention in Bangladesh under the reproductive health issues as an increasing rate of abortion has been observed every year. On the other hand for the last ten years total fertility rate (TFR) remains stagnant though contraceptive prevalence rate (CPR) is increasing with an encouraging rate. Now a main question arises as a proximate determinant of fertility what is the actual role of abortion here. In Bangladesh, the penal code permits induced abortion only to save a woman's life. However, menstrual regulation (MR) by vacuum aspiration is not regulated by the code and is considered to be an "interim method for establishing non-pregnancy." The procedure is allowed up to 10 weeks since the last menstrual period but in practice, it is sometimes provided up to 12 weeks

(Akhter, 1988 and BAPSA, 1996). Due to legal prohibition there have been poor reporting on abortion. Though MR service has extended restricted help in this regard still many illegal practices of pregnancy terminations are being performed in the society. In rural areas, some unhygienic measures are taken (often involving insertion of foreign bodies, such as roots, into the uterus) under the umbrella of traditional methods. Researchers should have some contribution in this regard to evaluate the health consequences as well as the social impacts of abortion.

In 1995-96, there were 3.8 legal abortions per thousand women aged 15-44 in Bangladesh. About 3.1% of the pregnancies were legally resolved by abortion. On the other hand there were 28 illegal abortions per thousand women aged 15-44 and 18% pregnancies were aborted illegally (Henshaw, et. al., 1999). There were also some extramarital abortions in Bangladesh. According to some ad hoc survey/hospital records in 1991 3.3% of the abortions in Bangladesh were extramarital (Bankole, et. al., 1999)

A study reveals that among the unintended pregnancies that are due to contraceptive failure 31% undergo menstrual regulation, 4.9% seek for induced abortion (Akhter, 1997). The incidence of abortions contributes to one quarter of all maternal deaths in Bangladesh (Chowdhury, 1997). Women who were rejected for MR, because, their pregnancy is too far advanced or for other reasons, often continue to seek a termination. Kamal and Begum (1990) reported that two-fifth of the rejected clients they interviewed made subsequent attempts to find pregnancy termination services.

Termination of pregnancy is one of the oldest and commonest forms of fertility control. No human community has ever shown a marked fall in its birth rate without a significant recourse to induced abortion and it is unlikely that contraceptive procedures alone will provide a sufficient measure of population control in developing nations wishing to lower their birth rate (Potts et al., 1977). The contraceptive method failure as a reason for seeking MR services must be highlighted because of its implications on a national level (Population Council, 1999). Still it should not be encouraged. According to Bongaart (1978) an induced abortion always averts less than one birth. There are two principal explanations for this finding. First, an induced abortion may be unnecessary because a spontaneous abortion or stillbirth would have prevented the pregnancy from ending in a live birth. Second, and more importantly, after an induced abortion a woman resumes ovulation much sooner than would

have been the case if she had carried the pregnancy to term, especially if pregnancy is followed by a period of lactation. At the International Conference on Population and Development in 1994 (UN, 1995a) delegations agreed that " In no case should abortion be promoted as a method of family planning……Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion……In all cases, women should have access to quality service for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortion."

Men have a great influence on induced abortion or MR. In Bangladesh even though MR is legal women are required to have their husband's permission before menstrual regulation (Rob and Piet-Pelon, 2001). Some research indicates men have multiple roles in decisions and actions. These roles are usually positive as they help their wives make the decision and then proactively seek information and services (Piet-Pelon, 1998). Studies suggests in most of the cases financing the pregnancy termination, particularly the complications, was also a male role (Hossain et al., 1997; Rob and Piet-Pelon, 2001).

In Bangladesh severe economic hardship, debilitated health, and completed family size are principal reasons for pregnancy termination and have an inherent legitimacy. To make early induction safer, Bangladesh offer MR services. MR occupies a unique position in the reproductive health services. In an environment where abortion is illegal, MR is accepted and widely practiced throughout the country. Religious teaching has not directly interfered in MR practice in Bangladesh (Piet-Pelon, 1998).

The number of pregnancy termination performed in Bangladesh, either through legal or traditional means is unknown (Piet-Pelon, 1998). Ross et al. (1996) describes the problem: "In the health and family planning sector of the country a vacuum seems to exit regarding nationwide statistics on abortion. It is very difficult to identify and record abortion, including induced abortion. There is no way of knowing as to how many pregnancies actually end up in being induced. Similarly, nothing can be said about the proportion of MR conducted out of the total number of abortions done in the country, especially in rural areas. This is a priority research area." According to Amin et al. (1989) government service statistics captured only 29% of the total MRs.

Most of the recent researches on abortion conducted in Bangladesh are based on Matlab data of ICDDR,B which should not be claimed to represent Bangladesh in all respect as trend in abortion in Matlab is decreasing while it is of increasing trend for overall Bangladesh which was also addressed by Bairagi (2001). Again experience of Bangladesh does not conform to the observation by Marston and Cleland (2003) in their recent study that increase in contraceptive use results in reduced abortion incidence in settings where fertility itself is constant. Because, for Bangladesh in the last three Demographic and Health Surveys i.e., 1993-94, 1996-97 and 1999-2000 both contraceptive prevalence rate (CPR) (44.6, 49.2 and 53.8 respectively) and recourse to abortion (1.86%, 2.86% and 3.71% respectively during the last five years preceding the survey) have increasing trend while TFR (3.4, 3.3 and 3.3 respectively) is almost static through out the period. This situation inspires the researchers to work in this field with a nationally representative sample.

In this article an effort is made to investigate the characteristics of the women who reported to experience induced abortion during the last five years preceding the survey and finally to identify the factors that have influence on the decision of induced abortion.

Data and methods

The study is based on the BDHS, 1999-2000 data, which employed a nationally representative, two-stage sample that was selected from the master sample maintained by the Bangladesh Bureau of Statistics. The master sample consists of 500 primary sampling units. A total of 341 primary sampling units were selected for BDHS survey (99 in urban areas and 242 in rural areas). A total of 10,544 ever-married women were interviewed in the individual survey and among the ever-married women there were 9696 currently married women. From that currently married women sample we have separated 360 currently married women who had stated that they had performed an induced abortion (including MR) after April, 1994, for in-depth analysis. It should be taken into mind that some of the respondents in the remaining part of the sample might also have performed induced abortion. For the convenience of the article this fact may not always be mentioned in the text.

Results and discussion

Prevalence, under-reporting and contribution of induced abortion to fertility

This section explores the prevalence of, possible under-reporting of and the contribution of induced abortion to fertility. Table 1 shows an increasing trend in the number of induced abortion overtime in Bangladesh. It is believed that many of the induced abortions are under-reported due to social, cultural and legal reasons. Singh et al. (1997) suggested an indirect estimation technique to capture the real abortion figure. They combined separate estimates of the total number of women having induced abortion other than menstrual regulations and the total number of menstrual regulation procedures, to produce an overall estimate of the number of voluntary pregnancy terminations occurring in Bangladesh. To gather data on the first part they employed a sample survey of the hospitals to estimate the number of women hospitalized for abortion complications and for the second part they used the MR data provided by the MR providers. They estimated abortion rate* for Bangladesh in 1995 ranges from 26 to 30 considering different assumptions regarding the prevailing conditions in the society.

As the technique employed by Singh et al. (1997) is a costly one; estimate of abortion rate for the recent years is beyond the scope of this study. But using the BDHS 1999-2000 survey information we can estimate the under-reporting in abortion data at least for the year 1995, which was about 87% (footnote of Table 1) using the conservative abortion rate (26) suggested by Singh et el. Due to gradual changes in different parameters over the years, the under-reporting in abortion data will be changed but not that much distant from the 1995 estimate of 87%.

Using the index C_a suggested by Bongaarts (1978) an attempt was also made to estimate the contribution of induced abortion to fertility (Table 2). The index C_a equals the proportion by which fertility is reduced as the consequence of the practice of induced abortion.

* Number of abortions per 1000 women in reproductive age

Bongaarts suggested C_a as:

$$\mathbf{C_a} = \frac{TFR}{TFR + 0.4(1+u)TA} \quad ; \quad \text{where}$$

TFR= Total fertility rate

u = Average proportion of married women currently using contraception

TA = Total abortion (induced) rate

= (Number of induced abortion / Total number of women in reproductive age) X 35

35 is the span of reproductive life

Contribution of induced abortion to fertility is measured by 1 - C_a

It reveals from the table (Table 2) that contribution of induced abortion to fertility is increasing over time. While in the period 1993-94 only 2% of fertility was likely to be reduced due to abortion, it reached to 6% in the period of 1999-2000. The trend remains the same considering the estimated abortion rate (26) suggested by Singh et al. (1997) and the contribution of abortion to fertility reaches up to 15% in the period 1999-2000 (Table 2, Figure 1).

Background characteristics

About 3.71% of the currently married women declared that they had experienced a pregnancy termination intentionally during the last five years preceding the survey (after April, 1994) of which 37.5% reported to perform menstrual regulation and the rest 62.5 % had to have induced abortions (Table 3). Nearly 23% of the mothers that declared to experience pregnancy termination belong to age group 25-29, which is closely followed by age groups 30-34 (22.2%) and 20-24 (21.7%) (Table 4). More than 65% of the abortions were performed in these three age groups. Average age of the respondents who reported to experience (for declared cases only) an abortion is a little lower than 30 years. Among the mothers who stated that they had to have abortion 56.7% live in rural areas. Around 27.5% of the respondents that faced pregnancy termination are illiterate. The percentage drastically decreased to 10% for women having education level higher than secondary. Most of the abortion incidences were observed among Muslims (88.3%). Only 21.8% among the abortion experienced women were employed. Little over 6% of the mothers had to terminate their first pregnancies. The percentage for mothers having only one child is 21%, for mothers having

two children is 28.6%. About 28% of the women that faced pregnancy termination belong to Dhaka division. It is followed by Khulna (18.6%), Rajshahi (18.1%), Barishal (14.2%), Chittagong (13.3%) and Sylhet (8.1%) divisions (Table 4).

Current pregnancy status and previous abortion experience

Among the women who declared to have induced abortion 6.7% are currently pregnant; about one eighth of these pregnancies are completely unwanted (Table 5). Most of these unwanted pregnancies are in the risk of abortion. About 18% of the abortion experienced women mentioned to have previous abortion experience.

Contraception

A little less than 74% of the respondents who stated that they had experienced abortion during the last five years are currently using family planning (Table 6). About 6.7% of the respondents are not using family planning due to their current pregnancy. The rest of the non-users of family planning (19.6%) are in the threat of being pregnant again. Slightly more than 58% of the women are currently using modern methods. Another 15.3% of the respondents are still under the risk of further pregnancy as they are using traditional methods, which may lead them to seek further abortion (Table 6). Some other threatening information is that among the respondents 4.2% never used FP, 4.4% does not intend to use FP in future (Table 7). Around 74% (266 out of 360 respondents) of the respondents mentioned that they discontinued their last FP method (Table 8). More than 27% of the respondent that reported to have an abortion and discontinued their last method, mentioned unwanted pregnancies (method failure) as their reason of last method discontinuation (Table 8). Discontinuation of method due to husband's disapproval, side effects and health concern along with method failure indicate a existing risk of unwanted pregnancy as well as induced abortion in the consequence in future.

Participation in decision making

Table 9 reveals the decision-making status among the respondents. About 20% of the respondents who were current users of contraceptives claimed that they had the sole authority to decide about family planning. Decision depends only on the husbands was found for 13.5% of the respondents. Joint decision was reported by 65.5% of the respondents. Independent decision regarding respondent's own health care was enjoyed by 20.6% of the respondents who reported to have an induced abortion. The decision taken entirely by the

husbands was reported by 36.7% of the women. Decision regarding respondent's own health care taken jointly was claimed by 36.9% of the respondents.

Regression analysis

Linear logistic regression was performed to identify the factors that have significant effects on the pregnancy termination. In this section, the women who declared that they had an abortion have been compared with the rest of the women in the total sample of 9696 who did not declared to have abortion but might do so. Here the dependent variable was **declared induced abortion** (Yes=1, No=0). Table 10 reveals that division, type of place of residence, education, employment status of the respondent, husband's approval of FP and access to TV have significant positive effect while age and number of living children have significant negative effect on the declaration of an induced abortion by the respondent.

Respondent from Barisal division is more likely to declare to have an induced abortion than those from Sylhet division. We know that all the abortions performed have not been declared. The reason is associated with the social, cultural, educational and other conditions prevailing in the society. In this respect, it is to be admitted that respondents from Barisal division enjoy more favourable conditions e.g., education level (which is about 1.5 times of Sylhet division) relative to the respondents from Sylhet division to be open regarding abortion information. Respondents residing in urban areas are more open than those from rural areas regarding reporting of abortion information. This is due to the higher access to MR / abortion services, and as well as for the favourable socio-cultural and economic conditions that are prevailing in urban areas. Urbanization changes couple's family building aspiration and behaviour and consequently leads them towards small family than those residing in rural areas (AGI, 2003). This may also be one of the reasons behind the increased number of abortion in urban areas.

Increasing educational attainment, which often leads a couple to the desire for a more modern lifestyle, tends to raise the age at which couple first have a child (Xenos et al., 2001) and hence inspires them to keep the family size small. So in case of an unwanted pregnancy educated couple shows higher odds in favour of pregnancy termination. This result is similar to the findings by Ahmed et al. (1998). Positive effect of employment means the more respondents are employed, the more they show positive attitude towards abortion practices as well as sharing the information. It reveals the careerist tendency among the employed women.

Likelihood of induced abortion is found to be high among those women whose husbands approve of family planning. Approval of family planning from the husband's side ensures mental and financial support to the women with unwanted pregnancy toward performing an abortion. The respondents with access to TV have higher odds of reporting abortion than their counterparts. This may be due to the effect of television messages as well as the advertisements on people's life aspiration towards individualistic, consumer-oriented values that foster the desire for smaller families (AGI, 2003).

As age increases respondents show a negative attitude towards abortion practice as found by Ahmed et al. (1998) and become reserve to disclose the information even though they had to have one. Women having one or three children show lower odds of reporting abortion experience relative to those who have no children. This result is the opposite than the result that was found by Ahmed et al. (1998) in their Matlab study. But, considering the decreasing abortion trend in Matlab that is overall increasing for the entire Bangladesh we can not oppose this result. It needs further investigation. Sex preference or tendency to have same number of children of either sex may be among the possible reasons.

Conclusion and recommendations

In the countries where abortion is illegal, consequences of induced abortion become a major reproductive health problem. This study tried to unfold the abortion scenario in Bangladesh using the demographic and health survey data. Recourse to abortion is increasing in Bangladesh. For many of the respondents reported induced abortions were not the first such events in their lives. Still many respondents do not have the proper FP orientation that may help those avoiding further unwanted pregnancies. High level of under-reporting of abortion was found in the data. This study decomposed the contribution of induced abortion to fertility as 15% after adjusting for under-reporting. Education, access to TV and husband's approval of FP has been found to have positive influences on having an induced abortion (reported).

Worldwide abortions are now being considered from the ethical point of views. So incidence of abortion should be lowered. In Bangladesh as MR is legal awareness regarding identification of regular menstrual cycle and pregnancy in early stage (within 10 weeks) should be increased so that a client can go for MR. At the same time contraceptive failure rate should also be lowered with the implementation of effective family planning campaign.

Many of the unwanted pregnancies are the result of contraceptive failure. Induced abortion is likely to decrease with increased and more efficient contraceptive practices (Ahmed, et. al., 1998). Some times abortion becomes threatening to a mother, especially when performed illegally. For the cases of contraceptive failure, concept of emergency contraceptive may be introduced. There should be separate campaign regarding abortion / MR and mass media could be one of its vital parts. Women empowerment regarding their decision making on reproductive issues should be increased. The factors that have significant impact on the decision of induced abortion should be considered in the government policy to address the future clients. Husbands should be involved in family planning and reproductive health programmes. DHS should take efforts to capture the abortion information more accurately. The FP policy should not encourage abortion practices except pregnancy complications, as untimely, unsafe, non-medical and unskilled effort of pregnancy termination is very much associated with maternal health.

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Figure 1 Trend in contribution of induced abortion to fertility

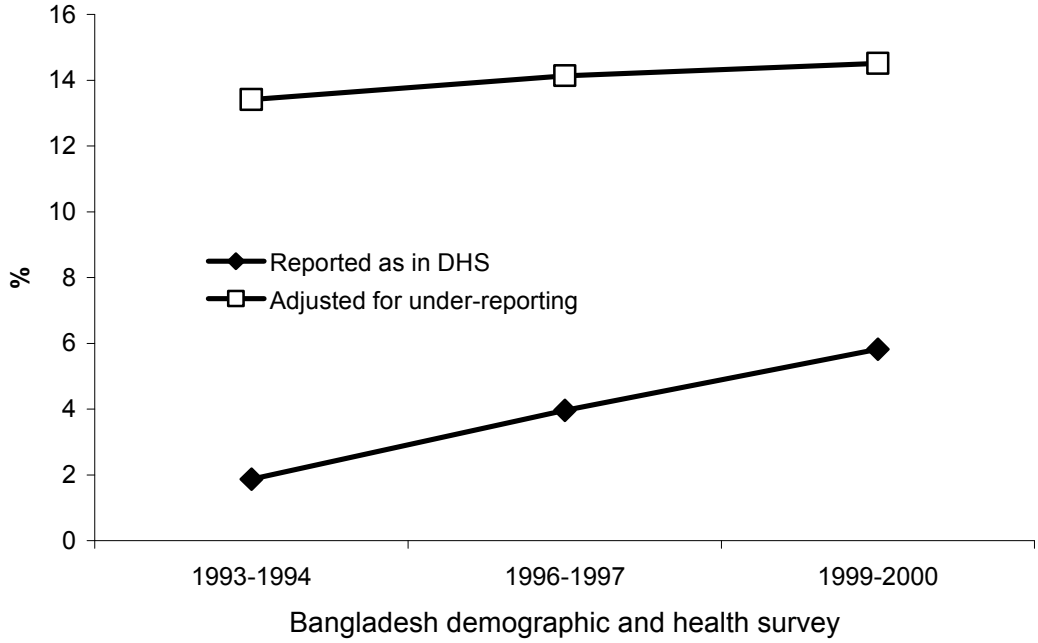

Table 1 Experience of induced abortion over the last five years among the surveyed women (BDHS, 1999-2000)

Year	Number of abortion
1994	31
1995	33
1996	47
1997	63
1998	93
1999	92
Total Women	**9696**

Footnote: From the BDHS, 1999-2000 data in the year 1995 Abortion rate = (33 / 9696) X 1000 = 3.4. Considering the estimates for 1995 suggested by Singh at el. (1997) i.e., 26, 28 and 30 the under-reporting come out as 86.9 %, 87.8 % and 88.6 % respectively.

Table 2 Contribution of induced abortion to fertility

Year	TFR	u	TA*	C_a*	TA†	C_a†
1993-1994	3.4	.446	.1119	.9813	.91	.8659
1996-1997	3.3	.492	.2274	.9604	.91	.8586
1999-2000	3.3	.538	.3321	.9417	.91	.8549

* Based on the abortion data of BDHS, 1999-2000.

† Considering the estimated abortion rate as 26 suggested by Singh et al. (1997) remaining the same for all the periods

Table 3 Percentage distribution of abortion by type

Type of abortion	Percentage
Menstrual regulation	37.5
Induced abortion	62.5
Total number of respondents	**360**

Table 4 Percentage distribution of women declared to have abortion by background characteristics

Background characteristics	Women having abortion
Age	
10-14	0.3
15-19	8.3
20-24	21.7
25-29	22.5
30-34	22.2
35-39	16.4
40-44	6.4
45-49	2.2
Mean age	29.22 (s.d.=7.4)
Type of place of residence	
Urban	43.3
Rural	56.7
Education	
No education	27.5
Primary	28.6
Secondary	33.9
Higher	10.0
Religion	
Islam	88.3
Others	11.7
Employment status	
Employed	21.8
Unemployed	78.2
Number of living children	
0	6.4
1	21.1
2	28.6
3	19.7
4+	24.2
Division	
Barishal	14.2
Chittagong	13.3
Dhaka	27.8
Khulna	18.6
Rajshahi	18.1
Sylhet	8.1
N (Number of respondents)	**360**

Table 5 Percentage distribution of mothers declared to perform abortion by current pregnancy status and previous abortion experience

Characteristics	Percentage
Current pregnancy status	
Currently pregnant	**6.7**
Pregnancy wanted then	4.4
Pregnancy wanted later	1.4
Pregnancy wanted not at all	.8
Not currently pregnant	**93.3**
Previous experience of abortion	
Yes	17.8
No	82.2
N (Number of respondents)	**360**

Table 6 Percentage distribution of respondents by current use status of contraceptives

Current use status of contraceptives	Percentage
Not currently using any method	**26.3**
Non use due to current pregnancy	6.7
Non use due to other reasons	19.6
Currently using family planning	**73.7**
Folkloric method	0.3
Traditional method	15.3
Modern method	58.1
N (Number of respondents)	**360**

Table 7 Percentage distribution of respondents according to ever use and intention to future use of FP

Ever use and future intention to use	Percentage
Ever use	
Ever used FP	95.8
Never used FP	4.2
Future intention to use	
Non user intend to	21.9
Does not intend to	4.4
N (Number of respondents)	**360**

Table 8 Percentage distribution of respondents that discontinued their last method

Reason of discontinuation	**Percentage**
Became pregnant	27.4
Wanted to become pregnant	16.2
Husbands disapproved	3.4
Side effects	24.8
Health concerns	10.2
Others*	18.0
N (Number of respondents)	**266**

*Other includes access/availability, wanted more effective method, inconvenient to use, husband away etc.

Table 9 Percentage distribution of respondents by their decision making status

Decision taken by	**Decision on the use of FP**	**Decision on respondent's own health care**
Respondent alone	19.7	20.6
Husband alone	13.5	36.7
Jointly	65.5	36.9
Some one else	1.3	3.3
Respondent and some one else	0.0	2.5
N (Number of respondents)	**223***	**360**

* Current users of FP who responded the question

Table 10 Linear logistic regression estimates of the effect of different socio-economic and background characteristics on declaration of abortion

Independent variables	Co-efficient	Standard Error
Age (Continuous)	-.015*	.009
Division (base: Sylhet)		
Barishal	.488**	.245
Chittagong	-.373	.244
Dhaka	.129	.222
Khulna	.052	.233
Rajshahi	-.052	.235
Type of place of residence (base: rural)		
Urban	.347***	.125
Education (base: no education)		
Primary	.311**	.148
Secondary	.693***	.160
Higher	.891***	.253
Religion (base: others)		
Islam	.241	.174
Living children (base: no children)		
1	-1.067***	.248
2	.100	.182
3	-.336**	.163
4+	.059	.165
Employment (base: unemployed)		
Employed	.276**	.134
Husband approves FP (base: no)		
Yes	.645***	.205
Access to newspaper once a week (base: no)		
Yes	-.189	.180
Access to TV every week (base: no)		
Yes	.376***	.133
Access to radio every week (base: no)		
Yes	-.048	.121
Constant	-4.165***	.409

* Note Significance level: * p<.10, ** P<.05, *** p<.01