GUTTMACHER INSTITUTE

Fact Sheet

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Menstrual Regulation and Induced Abortion in Bangladesh

• Menstrual regulation (MR) has been part of Bangladesh's national family planning program since 1979. MR is a procedure that uses manual vacuum aspiration (MVA) to safely establish nonpregnancy after a missed period.

• Government criteria provide for MR procedures up to 8-10 weeks after a woman's missed period, with timing depending on the type of provider.

• In Bangladesh, under the penal code of 1860, induced abortion is illegal except when performed to save a women's life.

• Despite the fact that MR services are approved and available, hundreds of thousands of women in Bangladesh put their health at risk every year by having an unsafe abortion. These women are either unaware of the availability of MR services, lack access to procedure or do not understand the difference between MR and unsafe abortion.

INCIDENCE OF INDUCED ABORTION AND MR

• In 2010, an estimated 653,100 MR procedures were performed in health facilities nationwide. Two-thirds of the procedures were performed in public facilities, including Union Health and Family Welfare Centres.

• The annual rate of MR was 18.3 per 1,000 women aged 15–44. The rate was lower than average in Sylhet and Khulna (12–14 per 1,000) and above average in Rajshahi (22).

• An estimated 646,600 induced abortions were performed in Bangladesh in 2010, the majority of which were unsafe.

• Nationally, the annual abortion rate was 18.2 per 1,000 women aged 15–44. The rate was higher than average in Khulna (25 per 1,000) and lower than average in Chittagong (12) and Barisal (7). The low rate in Barisal may reflect an undercount of women receiving treatment for postabortion complications or a lower propensity to obtain abortion services in this division.

PROVISION OF MR SERVICES

• Nationally, just 57% of facilities that would be expected to provide MR services actually did so in 2010, and there were stark variations among divisions: In Barisal, 76% of facilities provided services, while in Khulna, only 37% did.

• Many facilities that have the equipment and staff to provide MR procedures do not do so. This is especially common among private-sector clinics, of which one-third provided MR in 2010, while 60% had the capacity to do so.

• Nationally, the public sector accounts for about two-thirds of all MR services. NGOs provide about one-quarter of MR services, and private clinics provide 9%.

• Two-thirds of all Union Health and Family Welfare Centres provide MR procedures. These facilities are the primary providers in rural areas, where the majority of the population lives. They accounted for close to half (46%) of all MR procedures performed in 2010.

• Nearly 75% of public and private facilities (excluding Union Health and Family Welfare Centres) had at least one staff person trained in MVA.

• However, there appears to be a great need for increased and improved training: In 2010, some 43% of Health Facilities Survey respondents and 72% of Health Professional Survey respondents said inadequate training among providers hindered women's access to MR services.

MORBIDITY RELATED TO UNSAFE ABORTION AND MR

• An estimated 572,000 women suffer complications from unsafe abortion each year, but only 40% of those who need treatment actually receive care from a facility.

• An estimated 6.5 women out of every 1,000 aged 15–44 are treated for complications from induced abortions annually. This rate is comparable to other countries where abortion is highly restricted, but where MR procedures are not available.

• In 2010, 84% of health facilities provided some form of postabortion care. The most common complications treated were hemorrhage and incomplete abortion; however, more serious complications such as shock, sepsis and uterine perforation were also reported.

• Poor women and rural women are most at risk for complications from induced abortion. In general, rural women are less likely than their urban counterparts to go to safe providers.

• Poor urban women are less likely than nonpoor urban women to go to a doctor for an induced abortion (12% vs. 32%).

• Roughly 120 out of every 1,000 MR procedures result in complications that are treated in health facilities. In the

case of clandestine abortion, three times that rate—approximately 358 per 1,000—result in complications that are treated in facilities.

• While the complication rate for MR procedures is much lower than that of unsafe abortion, it is still much higher than would be expected for the MVA procedure, which is extremely safe when performed in appropriate settings by adequately trained health professionals.

• MR complications likely result from improper use of MVA equipment, use of unsterilized equipment, other unhygienic practices and use of a MVA syringe more than the recommended 50 times.

• In 2010, an estimated 102 deaths from abortion complications occurred at health facilities, the majority of which were medical colleges and district hospitals. This rate translates to a national case fatality rate of 44 per 100,000 women aged 15–44 treated in facilities for induced abortion complications. This rate undercounts the true prevalence of abortion-related deaths, however, as it does not include deaths occurring outside of facilities and does not account for misclassification or underreporting of abortion-related deaths within facilities.

BARRIERS TO MR SERVICES

• One-third of facilities that could potentially provide MR services lack either basic MR equipment or trained staff, or both.

• An estimated 26% of women seeking MR services (approximately 166,000) each year are turned away by facilities.

• More than three in 10 facilities reported rejecting women's requests for MR for social or cultural reasons, including because women have not yet had a child, are unmarried, are too young or do not have their husband's consent—reasons that go beyond government criteria on the timing of the procedure.

• Women's limited knowledge about MR limits the reach of the program. Even though the MR program has been supported by the national government since 1979, many women are unaware of its services. In 2007, nearly one-fifth of married Bangladeshi women had never heard of MR. Among the least educated and poorest women, that proportion was higher (25–26%).

• Other barriers women face include opposition to MR by their husband or another family member, financial hardship and long distances to facilities.

RECOMMENDATIONS

• The availability of MR services needs to be increased. Particular attention must be paid to making the procedure more widely available in small and midsize facilities that provide primary care because these facilities are the most accessible to women living in rural communities and in areas without access to a hospital.

• All facilities should have equipment available and staff trained to provide MVA.

• Providers need to comply with official criteria on the timing of MR services to ensure that women have full access to this government-approved health service. They should not arbitrarily deny women MR services for reasons beyond these criteria.

• The quality of MR care must be improved. The high rate of complications makes it clear that there is a great need for better training of providers and better implementation of clinical best practices to increase the safety of procedures.

• The prevalence of unsafe abortion underscores the need for greater efforts to educate women about MR services. All women should know that an authorized, safe alternative to unsafe abortion is available free of charge. Women need to know where the service is offered, who is able to provide it and the number of weeks since the last menstrual period during which MR is permitted.

• The quality and the availability of family planning services need to be improved to reduce rates of unintended pregnancy and thus lower the number of unsafe abortions and MRs. High-quality contraceptive care includes providing a wide range of methods for women and couples to choose from and offering counseling on consistent and effective use.

• Improved provision of postabortion care is needed to treat the injuries and prevent the deaths that can occur following an unsafe abortion. Particular attention should be given to meeting the needs of poor women and rural women, who have the highest probability of experiencing complications.

The data in this fact sheet are the most current available and are drawn from Hossain A et al., Menstrual regulation, unsafe abortion and maternal health in Bangladesh, In Brief, *New York: Guttmacher Institute, 2012, No. 3; Singh S et al., The incidence of menstrual regulation procedures and abortion in Bangladesh, 2010,* International Perspectives on Sexual and Reproductive Health, *2012, 38(3):122–132; Vlassoff M et al.,* Menstrual Regulation and Postabortion Care in Bangladesh: Factors Associated with Access to and Quality of Services, *New York: Guttmacher Institute, 2012.*

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