Effects of being denied safe MR in Bangladesh

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Many women who are denied menstrual regulation services go on to seek unsafe abortion: further study could help identify strategies to improve access to safe abortion services

Background

Menstrual regulation (MR) services were introduced in 1974 on a pilot basis and included in the National Family Planning Program since 1979 [1]. MR commonly consists of manual vacuum aspiration (MVA) to safely regulate the menstrual cycle when menstruation is absent for a short duration [1]. The government approves physicians and trained paramedics to provide MR up to 12 and 10 weeks post last menstrual period (LMP), respectively [1,3,4]. Since mifepristone was approved in Bangladesh in 2013, it is also used for MR in combination with misoprostol up to nine weeks since last menstrual period [2]. Many attribute Bangladesh's significant reduction of maternal mortality in recent decades [5] to sustained declines in abortion-related deaths and increased availability of MR [6-8].

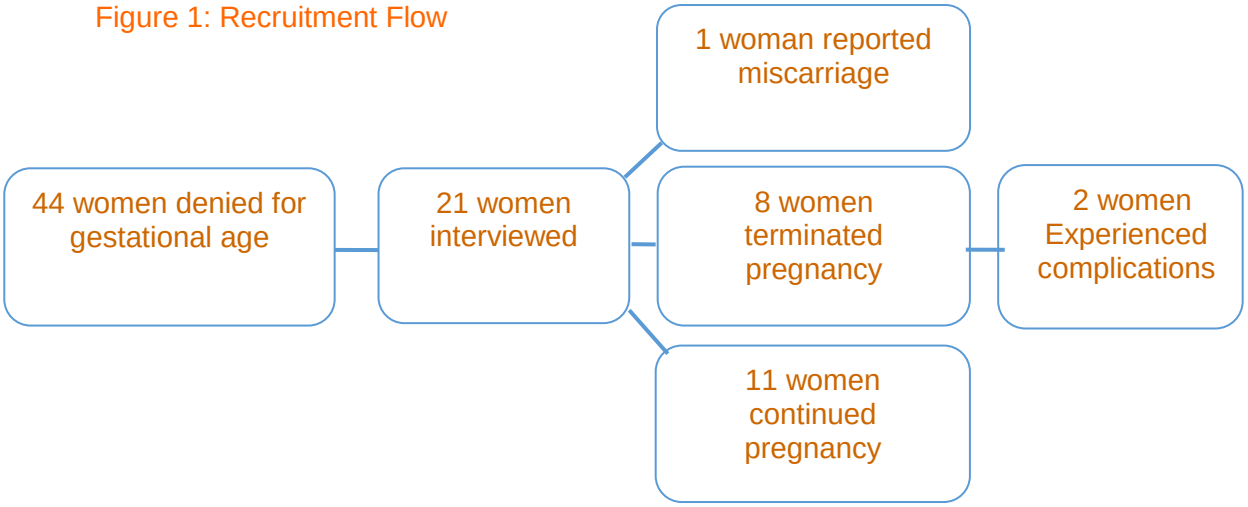
Though government-approved and free of cost, MR services are still difficult to access for many women in Bangladesh [9, 10]. Recent evidence shows that approximately one quarter of women are denied MR services annually [5, 11]. Another study shows that more than three in ten facilities reject women's requests for MR for reasons that are not sanctioned by the government, including being young, single, nulliparous, or lacking husband's consent [8]. In 2010, only 57% of designated facilities actually provided MR services, due to insufficient equipment and shortages of trained staff [8].

Additionally, many women do not know about access to safe MR. It is possible that women who cannot access services legally seek care outside of the formal health sector, which is more likely to be unsafe. In Bangladesh, about half of all terminations result from government sanctioned MR procedures, performed by a trained provider in a facility and within permissible number of weeks post LMP, and half result from induced abortions, defined as the termination of a pregnancy by a procedure or action taken by a provider or a woman herself, outside the definition of MR [8]. Complications from MR remain high – approximately 120 out of every 1,000 procedures [4, 8], which is higher than would be expected based on the safety of MVA in other settings [12]. Induced abortions have a complication rate three times higher than that of sanctioned MR procedures—358 out of every 1,000 illegal abortions [5].

Objectives

In 2013, researchers from BAPSA and the University of California, San Francisco in the United States came together to study access to MR services in Bangladesh. The study aimed to examine how often women are being denied care, reasons for denial of legal MR services, options considered after denial, experiences seeking illegal termination, and complications experienced. Similar studies have been conducted in South Africa, Nepal, Tunisia, and Colombia [13-15].

Figure 1: Recruitment Flow



(>12 weeks) from two public facilities and two private facilities in February 2014. The two public facilities were a mid-level public center and lower-level rural center; we did not select a facility within the lowest administrative unit, Unions, due to the low caseload in these areas. Participants were eligible if they were women between 18 and 49 years old, seeking MR services, and denied services due to advanced gestation on the day of recruitment. One woman was excluded from the study because she was 14 years old. Researchers obtained informed consent at recruitment, and then contacted women two months later for an open-ended in-depth qualitative interview. After 20 interviews, data collection was deemed complete due to limitations of project funding and staff availability. The Bangladesh Medical Research Council and University of California, San Francisco Committee on Human Research granted ethical approval. We use the broader term "abortion" for the pregnancy outcome and in reference to women who attempted to terminate a pregnancy following the denial of MR because it is unclear whether or not the services rendered in all cases were government sanctioned MR; in many cases the window for government sanctioned MR had already passed.

Delays and barriers in seeking MR

Some participants report that they did not recognize the pregnancy until they were beyond the gestational limit for MR, at which point they could no longer qualify for MR services during the government approved gestational window. Many participants were delayed recognizing their pregnancy due to misconceptions about pregnancy risk or irregular menstrual cycles. Other participants were either not familiar with pregnancy symptoms, had attributed pregnancy symptoms to ill health, or had been using contraception and did not expect that they were at all susceptible to becoming pregnant.

> I couldn't identify the pregnancy early as my period was very irregular and takes place in three to four month gaps. When the doctor told me about the pregnancy, it was already more than three months.

In addition to late pregnancy recognition, participants were delayed for other reasons including time needed to make the decision; changing relationship dynamics with a partner; and logistical concerns relating to employment, childcare, locating a provider, and securing funds. Due to obligations such as caring for children and other family members or due to inability to secure time off from employment, several participants were delayed more than one month. Finally, logistical reasons including safety and cost also delayed participants' ability to obtain services before the authorized gestational limit. Physical access to providers was a commonly cited barrier for rural participants.

Knowledge of MR services

Participants were uninformed about their right to access safe MR services within the sanctioned period. None of the participants were aware of the gestational age window in which MR is permitted, even though about one-third of the participants reported knowing someone who had undergone MR. Some said they were completely unaware of that MR existed. Other respondents had heard of women receiving the service, but did not know how or where they had obtained it. Most participants said they did not know about of alternative methods for self-induction and reported that they did not seek out alternatives or try to self-induce. Others were aware of clinic- or hospital-based options as well as medicines available at pharmacies, but did not mention methods of self-induction. Five women said that they had heard medication for termination was available at pharmacies and eight women said that they had heard of traditional methods for abortion. To the extent that participants were aware of MR and abortion services, they learned about it from word of mouth or personal experience rather than from governmental, educational or health care sources.

> It is not easy to get these services from villages like ours, because there are no providers in the village. Most of the village women do not know where to go or whom to go. Cost is also a factor.

Support and advice from others

Many women sought support and advice at three points throughout the process: 1) confirming the pregnancy, 2) deciding whether and how to seek MR, and 3) decided what to do following the first denial of MR services. Some participants disclosed information only to their husbands. Most participants, however, discussed the decision-making process with a friend, family member, or neighbour, in addition to their husbands. In some cases, family and friends had a strong influence; several participants reported that family members persuaded them to seek abortion even when their initial instinct was to continue the pregnancy. Some received advice to continue the pregnancy despite a desire for termination. After participants were denied MR services the first time, however, they often lacked the resolve to stand up to familial pressure a second time.

> After returning from maternity I discussed with my husband and my mother. Both my mother and husband advised me to give up the abortion idea. There is no difference having four or five children. My mother said, "If you are unable, I shall raise your kid.

Quality of care

Most of the participants who obtained services reported that they were satisfied by the quality of care they received. However, it was difficult to determine whether it was really the quality of care that the participants appreciated, or whether they were simply relieved to have received services and to not have experienced complications. It is not always clear what method was used for termination: three participants reported taking pills and four participants reported having had a surgical procedure. One participant reported that she had been given oral contraceptive pills that induced abortion; an OBGYN verified that the contraceptive pills themselves likely did not cause the termination but that perhaps she had a miscarriage due to other factors. Two of the eight participants who obtained abortions experienced severe bleeding. One of the two expressed regret about the process and the other reported satisfaction with the procedure because it achieved the desired outcome of ending the pregnancy.

> I had excessive post abortion bleeding…and had to be admitted to the hospital. They gave me three bags of blood. I had to go through D&C there. I had only wanted to get rid of the pregnancy. The clinic people told me not to tell anybody about the abortion service that I obtained there from them.

Conclusions

- Delays, such as financial and logistical barriers and difficulty recognizing pregnancy, prevent many women from receiving safe MR services
- Women are not sufficiently aware of the availability of government-approved MR services and where to obtain them
- Denial of approved MR services may increase the likelihood that women seek illegal, potentially unsafe, abortions

Recommendations for improving women's access to safe care

1. Minimize delays women face in seeking MR

- Improve awareness of pregnancy risk and availability of MR services
- Increase access to pregnancy tests at low costs
- Reduce stigma

2. Train more providers at all levels to provide MR and to refer appropriately

- Support women at the moment of denial of MR, regardless of the reason for denial
- Inform women about government-approved indications for MR/abortion according to the law
- Provide counseling to women and refer them to other facilities where they can get safe services
- Discuss the dangers of self-induction and unsafe abortion

3. Monitor the prevalence of illegal abortion and its impact on women's health

- Conduct additional qualitative and quantitative research on women's experiences with unsafe and/or illegal abortion providers
- Conduct further research on providers' perspectives of abortion denial
- Implement a longitudinal study on the impact of denial of abortion services on women's health and wellbeing

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