

# Pregnancy Termination in a Rural Subdistrict Of Bangladesh: A Microstudy

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**Context:** In Bangladesh, menstrual regulation is legal and is provided at government health facilities through the 10th week of pregnancy, but some women, especially those in rural areas, still obtain illegal abortions from untrained providers. Little is known about the circumstances leading to pregnancy termination, about how a provider is chosen and about the physical, economic and social consequences of termination.

**Methods:** Forty-one married women in the Sample Registration System database who were identified as having had a pregnancy termination between 1990 and 1995 were asked detailed questions about the reasons for their termination, the decision-making process, the means and the consequences of termination.

**Results:** Four in five respondents said they had terminated their pregnancy because they wanted no more children or wanted to delay their next birth; these respondents generally cited the economic well-being of their family. Almost six in 10 had used a trained provider; the remainder had relied on an untrained provider or had induced their own abortion. Those who used untrained providers cited familiarity, confidentiality and proximity as reasons; few seemed concerned about safety. Only five of the women had been practicing contraception at the time they became pregnant; those who had not been using a method often cited side effects (either experienced or anticipated) as a reason for nonuse.

**Conclusions:** Better education about and management of contraceptive side effects would help to reduce pregnancy termination in rural Bangladesh. In addition, women need more information about possible health consequences of relying on untrained providers for pregnancy termination.

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Prior to the 1970s, pregnancy termination was illegal in Bangladesh except when a woman's life was considered to be endangered by the pregnancy. In 1974, however, the government of Bangladesh allowed a clinic in Dhaka to offer menstrual regulation (early termination without pregnancy testing), and in 1978 it began to train government doctors and paramedics to provide such services.<sup>1</sup> In 1979, the government issued a circular distinguishing between abortion, which remains illegal under legislation derived from British colonial law,<sup>\*</sup> and menstrual regulation, which is considered "an interim method of establishing nonpregnancy" for a woman at risk of being (but not known to be) pregnant.<sup>2</sup>

Menstrual regulation services are available at all major government hospitals and health facilities and are legal for pregnancies of 6–10 weeks. At thana (subdistrict) health complexes, they are normally provided by physicians, and at union health and family welfare centers, they are performed by female paramedics called family welfare visitors. Nurses and family wel-

fare visitors can provide menstrual regulation services if the length of gestation is no more than eight weeks; physicians can do so through 10 weeks of gestation.

Women who do not use menstrual regulation services may resort to abortion, which is sometimes induced by inserting a foreign object into the uterus or by indigenous oral medicine.<sup>3</sup> They may also obtain abortifacient tablets or potions for oral consumption from local pharmacies or untrained village doctors.

The precise number of menstrual regulations and abortions being performed in Bangladesh is unknown. Although menstrual regulation is legally provided at government facilities, many procedures are not recorded. A recent study found that clients who do not meet the official criteria for menstrual regulation often obtain the procedure unofficially.<sup>4</sup> Even less is known about the number of abortions performed illegally.

According to the Bangladesh Demographic and Health Survey (DHS), 2% of a sample of 9,640 currently married women said that they had terminated an unwanted pregnancy.<sup>5</sup> Two-thirds of these terminations (65%) involved menstrual regulation. Given the issue's sensitivity, the real figure may be much higher.

Studies of pregnancy termination in Bangladesh usually involve women who have obtained menstrual regulation at a clinic (most often in Dhaka) or women hospitalized for abortion complications. Even given limited and somewhat biased samples, the studies indicate that menstrual regulation clients are comparatively well-educated and of higher than average socioeconomic status. In general, they are in their 20s and have 2–3 children.<sup>6</sup>

A study of 212 menstrual regulation clients in Matlab found that the majority were motivated primarily by a desire to space births, with a minority wishing to limit overall family size.<sup>7</sup> However, the investigators also noted that clients often referred to economic problems and that contraceptive failure appeared to be a major problem. Two other studies found the desire to limit births to be the primary factor.<sup>8</sup> Women who had undergone forms of pregnancy termination other than menstrual regulation were poorer and less educated, closer to the community norm.<sup>9</sup> Several studies have described the risks of illegal abortion in Bangladesh. Studies of menstrual regulation have found it to be generally safe but have raised some concerns over the technical training and skills of service providers.<sup>10</sup>

In the study reported on in this article, we interviewed a sample of rural Bangladeshi women who had had pregnancy terminations to examine the factors influencing their decision to end their pregnancy, how the decision was made, any distinct health-seeking behaviors, the

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\*There have, however, been no known prosecutions under this law (Source: Amin S, reference 1).

provider chosen and the consequences of undergoing a termination.

## Methodology

The study participants were 42 married women drawn from the Sample Registration System (SRS),\* the longitudinal data set of the Maternal and Child Health–Family Planning Extension Project (Rural) of the International Centre for Diarrhoeal Disease Research, Bangladesh (ICDDR,B). These women, who lived in Paira and Rajghat unions of Abhoynagar Thana, were identified in the SRS as having undergone a pregnancy termination between 1990 and 1995. The limited size of our sample ensured that detailed information could be collected by highly trained and experienced interviewers familiar to the respondents and sensitive to their concerns.

Interviews were conducted in May and June 1996. The interviewers asked about pregnancy termination in general, and followed up with specific questions only if a woman said that she had had one. Only one woman did not volunteer that she had terminated a pregnancy and was subsequently excluded from the study. (In this article, pregnancy termination refers to both abortion and menstrual regulation.)

In the interviews, which were conducted by two experienced ICDDR,B female staff members, the respondents were asked a standardized set of questions. The major issues explored were why the women had sought termination; how they did so; whom they had consulted; who had provided the termination; the costs involved; and a variety of possible physical, economic, social and religious consequences. The authors tabulated the responses and grouped equivalent answers.

SRS data may have understated pregnancy termination because the data are self-reported. Furthermore, all of the respondents were married women, so no data were available for unmarried, separated or widowed women who had had pregnancy terminations. Some authors argue that such women have been among the chief clients of abortion services.<sup>11</sup> However, given that women marry at very young ages in Bangladesh and that divorced or widowed women experience considerable social and economic pressure to remarry, the great majority of women of reproductive age are married.<sup>12</sup>

## Findings

### Sample Description

Twenty-seven of the women interviewed were Muslims and 14 were Hindus. Nineteen had received no formal education, 12

had attended primary school (1–5 years) and 10 had some secondary education. Few women worked outside their homes, but about a third earned income at home (for example, through poultry raising or handicrafts).

Of the 39 husbands about whom we obtained information, 18 were farmers, eight worked in mills (primarily in jute manufacturing), four in business and three in small trade, while two were agricultural laborers, one was a government service worker, one a fisherman, one a student and one unemployed.

### Reasons for Termination

The respondents most frequently reported that they had sought terminations because they did not want any more children or wished to space births. Of 25 women who said that the key reason for choosing to terminate their pregnancy was that they already had enough children, 17 cited the economic costs of raising children, two referred to the specific costs of female children and of meeting the dowry for their marriage, and six said that they had been physically weak and that it would have been difficult to bear or to raise a child.

Eight women cited the short interval since their last baby's birth, emphasizing the physical and economic difficulties of looking after two young children and the potentially detrimental effect on the child already born. Four women said that they had terminated their pregnancy because they already had grown-up children, and three reported that they had undergone terminations because their husbands were threatening to desert them or had already done so. One woman did not answer the question.

### Service Providers

Of the 41 women, more than half received services from a physician (three), a family welfare visitor (13) or a nurse (eight). In addition, eight obtained their termination from a "village doctor,"<sup>†</sup> four from a homeopathic practitioner<sup>‡</sup> and one from an indigenous doctor, while four induced their own abortion by inserting a foreign object, such as a tree root or plastic "catheter." In the discussion that follows, we refer to physicians, nurses and family welfare visitors as trained providers and to all others as untrained providers.<sup>§</sup>

One respondent who received services from a village doctor had first approached a government physician and a family welfare visitor but had been refused because of two previous cesarean births. Two of the women who received services from a vil-

lage doctor and one who sought help from a homeopath were unsuccessful in terminating their pregnancies and subsequently went to a trained provider. Another woman, who had successfully aborted her pregnancy under the direction of a village doctor, was subsequently treated successfully by a homeopath for complications. One woman who suffered severe bleeding after ingesting pills from a homeopath was subsequently treated by a nurse at the thana health complex.

Most respondents expressed little concern about the risk of using untrained providers. A few women reported that they had used government providers because their services were safer, but the majority did not associate abortion with high levels of risk. For the 17 women who initially approached an untrained provider or conducted their own terminations, the risks as they understood them were minor compared with the advantages.

Seven of these women said the provider they used, though untrained, was someone they knew and trusted. For example, one respondent remarked that she had little knowledge of the government hospital and did not know anyone who worked there. She added that she would not advise anyone to use the government hospital given the poor service it provided.

Five women gave confidentiality as the main reason for their choice. At government health centers, there is little privacy and it is apparent that people are attending a clinic for a particular purpose. In contrast, terminations involving village practitioners generally involve the use of oral preparations and are inherently more private—provided no major side effects ensue. Confidentiality is also related to whether a person can trust the provider who is nearby and whose livelihood depends on meeting the needs of his clients.

Less frequently mentioned reasons for using an untrained provider were proxim-

\*SRS collects data on vital events on a 60-day cycle. Information is also collected on changes in the reproductive status of married women of reproductive age and important family planning programme variables, such as contraceptive use. In Abhoynagar, the SRS interviews every fifth household in four selected unions.

†A village doctor is an untrained village practitioner who dispenses Western-style medical advice and drugs, such as antibiotics.

‡Homeopathic medicine involves the use of medicines that are supposed to possess qualities that resemble and, thus, counteract a client's symptoms. As practiced in rural Bangladesh, it has evidently absorbed many aspects of indigenous medicine as well.

§ This classification is not always accurate: Not all physicians and nurses have been trained to provide menstrual regulation.

ity to the respondent's house (three women) and cost, which was cited as the main factor by only two respondents (although concern about cost was a common theme).

The women who had used trained providers rarely cited greater safety as a reason for doing so. (They usually referred to their familiarity with the provider or the family welfare assistant, who often accompanied them to the provider.) Indeed, a high proportion of terminations by both trained and untrained providers involved side effects. While most terminations were conducted by trained providers, the treatment of side effects most commonly involved medicines from village practitioners. The government health services generally have a limited range of drugs available and are often less convenient, in terms of location and visiting times, than the local village doctors and pharmacists.

Overall, 31 of the 41 respondents had been treated by trained paramedics or physicians, either initially or after unsuccessful treatment by others. All of the women attended by trained providers had successful terminations, although some subsequently required further treatment for complications. In contrast, seven of the 13 women who obtained abortifacients from untrained providers did not have a complete abortion and subsequently went to a trained provider.

Family welfare assistants played an important, if indirect, role in at least eight cases in decisions on provider and location. One respondent reported that the family welfare assistant had advised her to use the services of the family welfare visitor at the family welfare clinic and had accompanied her to the clinic. Another said that the family welfare assistant had been the primary advocate of her termination. She had accompanied the respondent to the family welfare clinic and, after consulting the family welfare visitor, had helped conduct a menstrual regulation procedure.

### *Pregnancy Duration*

Most respondents believed that a termination should be performed at about two months of gestation, and most conformed to this norm. Among 13 women whose termination had occurred after the pregnancy was more advanced, six indicated that they had first tried ineffective methods from a village practitioner and five said they had not known that they were pregnant. One reported that she had followed a provider's recommendation to wait until the pregnancy was more advanced, another had waited for her hus-

band to return from a trip and a third said that she and her husband had lacked the necessary money.

### *Abortion vs. Menstrual Regulation*

It has been argued that menstrual regulation is socially acceptable in Bangladesh because people distinguish it from abortion.<sup>13</sup> The respondents in this study were asked what they actually associated with the terms "menstrual regulation" and "abortion." None of the respondents, including those who had received a menstrual regulation procedure from the family welfare visitor, made any distinction between the two terms. They used several closely related Bengali terms, including "baccha naushto," "pete fela" and "baccha fela," all of which directly imply destroying the fetus. Only four of the respondents used the term menstrual regulation. None of the respondents who had received menstrual regulation expressed any doubt that they had been pregnant.

### *Decision-Making*

In most cases, both spouses were involved in the decision to terminate the pregnancy and were the primary decision-makers. The exceptions were three cases initiated by the wife's mother, and three cases in which the husband decided alone. Many respondents commented that a termination is a private matter for the couple. Most couples terminating a pregnancy were older and were less likely to accept interference from others in their decision.

### *Contraception*

Only five of the respondents said that they had been using a contraceptive regularly at the time they became pregnant; all had been using condoms. (In Bangladesh, condoms are often used during a woman's fertile period in conjunction with rhythm, which may explain, in part, the frequent failure seen here.<sup>14</sup>) The remainder of the women had not been practicing contraception. Of these, three recently married women had wanted a baby but terminated their pregnancy because of marital breakdowns.

• *Contraceptive use history.* Twelve respondents (the largest single category) said that they had stopped practicing contraception because of side effects, and four more said they did not use a method because of fear of experiencing side effects. Two respondents reported that they had stopped using condoms, one because she did not like them and the other because her husband did not like them. One woman had discontinued pill use when she was sick, on the advice of her doctor. Four women

had not expected to become pregnant, three because they were experiencing postpartum amenorrhea and the fourth because she was subfertile. Another woman, who had had two children by cesarean section, had believed that the surgical deliveries would reduce her fertility.

Four women reported difficulties in using contraceptives regularly. Of these, one said that she had stopped because she had not been able to obtain pills, one had lapsed in taking the pill because she was away from home, one didn't have a condom when she needed it and one had stopped using the pill because she found it troublesome to remember to take it daily. Several other reasons given by the respondents indicated an overreliance on the delivery of supplies to their houses by fieldworkers.

• *Contraceptive use after termination.* Of the 39 respondents who were still married after their terminations, all but two said that they had begun to use contraceptives following the termination. Ten used the pill and another nine used condoms. Eight used injectables; eight, the IUD; one, withdrawal; and one, rhythm. Despite the strong emphasis on limiting births, none had chosen a permanent method.

Most of the respondents who had used a trained provider for their termination had been advised to use contraceptives, either by the provider or by a family welfare assistant. Of the three women who had undergone more than one termination, all were practicing contraception on the advice of the termination provider—one, the IUD; one, the injectable; and one, condoms. Interestingly, none of the providers recommended a permanent method, although some recommended use of such reliable methods as the IUD and the injectable.

### *Consequences of Pregnancy Termination*

• *Physical.* The respondents were asked about the physical consequences of the termination and about any treatment that was necessary afterwards. Of the 41 respondents, 14 reported moderate to severe complications, five had suffered minor complications requiring treatment and 22 had not experienced problems serious enough to require further treatment. The only pattern in the severity of complications by provider was that three of the four women who had inserted a foreign object into their uterus to induce abortion suffered from severe bleeding.

Of the respondents who experienced severe side effects, several said they had been unable to work for long periods, that treatment had been costly or that they had

almost died. One respondent, who had used a tree twig to induce abortion, bled profusely for 14 days. "After seven days, my husband came here and found that I was dying," she said. "He went to a village doctor, who did not come to the house but gave a prescription according to which my husband bought medicine and an injection. Then I delivered a dead baby." She experienced bleeding, fever and weakness for three to four months.

Another respondent said that she had had an infection and fever, was in bed for 45 days and could not do housework for a year. She borrowed 5,000 taka (US\$120) to pay for treatment and 400 taka (US\$10) for transportation, in addition to 700 taka (US\$17) to pay for the abortion. By village standards, these are huge sums of money. Expenditures for postabortion treatment, when required, may far exceed the original cost of the treatment and may constitute a very heavy burden on the family.

•*Economic and social impact.* Of particular interest to our study was the perceived social impact of terminations, what the families and communities knew about the terminations, and to what degree the terminations had been supported or opposed. The respondents were asked whether there had been any specific positive or negative consequences resulting from the decision to terminate the pregnancy, whether they would have another termination if a similar situation occurred and whether they would advise someone else to have one.

Most indicated that few other people knew about their termination, generally because there was no reason to tell them. In 10 cases, only the immediate decision-makers knew, whereas in 14 cases, relatives outside the nuclear family also knew. In nine cases, nonrelatives such as neighbors also knew. Generally, respondents said that most people who knew approved or at least expressed no strong disapproval. None considered social opposition as a reason not to terminate a pregnancy.

Sixteen of the respondents felt that there were few religious implications. Eight referred to termination as a necessary sin, while 12 said that they felt guilty but would make the same decision if the situation arose again.

Virtually all respondents emphasized that the termination was necessary for the family's economic welfare. Some women, particularly those who had severe side effects and had to stop work or needed expensive treatment, stressed the economic and physical costs of abortion itself. They too, however, generally believed that the abortion had been necessary to preserve

the family's welfare. The only women who said they would definitely not have another termination were women who had suffered severe side effects. Several respondents said that although they would have a termination again, it would be inappropriate to recommend termination to others because each individual should make her own decision.

## Conclusions

This article examined the motivations of 41 married women in southwestern Bangladesh for terminating a pregnancy, and the consequences for them of doing so. Women using menstrual regulation and other forms of pregnancy termination were primarily motivated by the desire for family limitation and birth spacing.

This finding raises the issue of why the women turned to pregnancy termination rather than using family planning. Two recent Demographic and Health Surveys in Bangladesh have shown that many women who want to have no more births or to delay a birth do not use contraceptives, despite the presence of an extensive system of doorstep delivery.<sup>15</sup> In this study, 12 women had previously used contraceptives but had stopped doing so, with the most common reason being concern about side effects. Given the substantial proportions of women who have reported side effects in previous research in Bangladesh,<sup>16</sup> our results suggest that better education about and management of side effects could increase contraceptive use and reduce recourse to pregnancy termination. It may be equally valuable to provide women with access to additional methods, especially those not available through doorstep delivery. By giving women a greater selection of methods to choose from, this approach would allow them to select the method with which they feel most comfortable.

Although many of the women considered pregnancy termination morally ambiguous, they described the decision to have a termination in purely practical terms. Their answers suggested that their moral responsibility to their family's well-being was the most immediate issue. A general survey of the population might have registered greater concern about public opinion and religious morality than did the respondents. A woman who has experienced a termination is likely to respond in terms of the practicalities of her own experience rather than simply to reflect prevailing opinion.

A final point of interest is why some women used menstrual regulation services and other women used other forms of

pregnancy termination. In this sample, women generally chose a provider rather than a form of termination, and made their decision based on familiarity, proximity and a desire for confidentiality, as well as concern about cost. Few of the respondents were concerned about the safety of using untrained providers, although half of those who used such providers needed further treatment to have a successful termination.

The issues raised by our study have important implications for the family planning program in Bangladesh. As noted, most of the women we interviewed were not practicing contraception at the time they became pregnant, primarily because of side effects, fear of side effects or the inconvenience of contraceptive use. These concerns could be addressed to some extent by providing better counseling on, and management of, side effects and by offering women more convenient access to a wide selection of methods. However, even with the implementation of such measures, some demand for pregnancy termination is likely to exist. Thus, the government of Bangladesh may need to publicize the risks involved in using untrained providers so that women can make safer choices.

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## Resumen

**Contexto:** En Bangladesh, la regulación menstrual es legal y se suministra en los centros de salud del gobierno hasta la décima semana de embarazo, aunque algunas mujeres, especialmente las que residen en zonas rura-

les, aún recurren a abortos ilegales suministrados por personas no capacitadas. Se tienen pocos datos acerca de las circunstancias que conducen a la terminación de los embarazos, sobre cómo se elige al proveedor y sobre cuáles son las consecuencias físicas, económicas y sociales causadas por la terminación de un embarazo.

**Métodos:** Se seleccionaron a 41 mujeres casadas de la base de datos de un proyecto de salud materno-infantil y de planificación familiar en Bangladesh, identificadas como personas que habían terminado un embarazo, entre 1990 y 1995. A éstas, se les formuló preguntas detalladas acerca de las razones que las condujeron a terminar su embarazo, sobre el proceso para adoptar la decisión y sobre los medios y consecuencias de la terminación.

**Resultados:** Tres de cada cuatro mujeres indicaron que habían terminado su embarazo porque no deseaban tener más hijos o porque querían postergar el próximo nacimiento; generalmente mencionaron como causas para hacerlo, el bienestar económico de la familia. Casi seis de cada 10 habían usado los servicios de un proveedor capacitado; el resto había recurrido a una persona no capacitada o se habían inducido su propio aborto. Aquellas que usaron los servicios de una persona no capacitada mencionaron como razones para hacerlo, la familiaridad, la confidencialidad y la proximidad de la persona; a muy pocas les preocupaba la seguridad de la intervención. Sólo cinco de las mujeres se encontraban practicando la anticoncepción en el momento de quedar embarazadas; aquellas que no estaban usando un método con frecuencia mencionaron los efectos secundarios (experimentados o anticipados) como una razón para no hacerlo.

**Conclusiones:** Una mejor instrucción acerca de los anticonceptivos y su manejo y sus efectos secundarios ayudaría a reducir la cantidad de terminaciones en las zonas rurales de Bangladesh. Además, las mujeres necesitan más información sobre las consecuencias que tiene para su salud la terminación de un embarazo realizada por personas no capacitadas.

## Résumé

**Contexte:** Au Bangladesh, la régulation menstruelle est légale et offerte dans les centres médicaux d'Etat jusqu'à la fin de la dixième semaine de gestation. Certaines femmes, dans les milieux ruraux surtout, se font cependant toujours avorter illégalement par des prestataires non qualifiés. Les circonstances menant à la décision d'interrompre une grossesse, le choix d'un prestataire et les conséquences physiques et socio-économiques de l'avortement sont peu documentés.

**Méthodes:** Quarante et une femmes mariées répertoriées dans la base de données du système d'enregistrement d'échantillonnage et identifiées comme ayant subi un avortement entre 1990 et 1995 ont été invitées à répondre à un questionnaire détaillé sur les raisons de la procédure, la décision y ayant mené et les moyens et conséquences de l'opération.

**Résultats:** Trois répondantes sur quatre ont déclaré avoir fait interrompre leur grossesse car elles ne désiraient plus d'enfants ou souhaitaient différer la naissance du suivant, invoquant généralement la raison du bien-être économique de leur famille. Près de six sur 10 avaient eu recours aux services d'un prestataire qualifié, les autres s'étant adressées à des prestataires non qualifiés ou ayant provoqué elles-mêmes leur avortement. Celles qui avaient eu recours à des prestataires non qualifiés ont fait état de raisons d'intimité familiale, de non-divulgateur et de proximité: peu semblaient se soucier de questions de sécurité. Cinq femmes seulement pratiquaient la contraception au moment où elles s'étaient trouvées enceintes: les autres ont souvent invoqué les effets secondaires (vécus ou pressentis) pour justifier leur décision de ne pas la pratiquer.

**Conclusions:** Une meilleure information sur les effets secondaires de la contraception, et une meilleure gestion de ces effets, seraient utiles à la réduction des interruptions volontaires de grossesse dans les régions rurales du Bangladesh. Il serait également utile de sensibiliser davantage les femmes aux risques courus, pour leur santé, lors du recours à des prestataires d'avortement non qualifiés.