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Delay in care seeking for menstrual regulation among the women attending a selected clinic

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Abstract

Each year women around the world experience 75 million unwanted pregnancies. Millions of women around the world risk their lives and health to end unwanted pregnancies. This descriptive type of cross-sectional study was conducted among 103 respondents from Mohammadpur Fertility Centre, Dhaka, Bangladesh to find out the factors influencing delay in care seeking for menstruation regulation among the women attending selected MR clinic from March to June 2015. Respondents were enrolled in the study using Purposive sampling technique. Data was collected by face to face interview with a semi-structured questionnaire. Here, 85% gave right answer about Knowing of MR. Respondent's main personal cause for delaying MR was that 37% home abortion by taking gynaecosid or other tablet. About familial causes of delaying MR shows that majority (47%) had in security of the house, 38% resistance by husband/others. The main social causes of delaying MR shows that majority (61%) was due to spiritual bindings and service or service center related causes for delaying MR due to treatment cost, male doctor, complexity of services and rest due to the substandard services. Women had good knowledge about MR and its timing even they make delay due to unawareness of their legal rights, personal, social and service related causes.

Keywords: Menstrual regulation (MR); Delay in care seeking; Age at marriage; Parity; MR Clients

1. Introduction

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.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[1]. In 1979, the government issued a circular distinguishing between abortion, which remains illegal under legislation derived from British colonial land menstrual regulation, which is considered "an interim method of establishing non pregnancy" for a woman at risk of being (but not known to be) pregnant[2].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 [3].A study found that clients who do not meet the official criteria for menstrual regulation often obtain the procedure unofficially [4].

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 [5].In 1998 the Government of Bangladesh introduced the Health and Population Sector Program (HPSP) incorporating menstrual regulation into the essential services package. In spite of wide availability, barriers such as distance to health facilities and transportation costs, unofficial fees, lack of privacy,

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confidentiality and cleanliness in public health facilities, and in some cases attitudes of service providers, are limiting access to MR services. Quality of care is compromised by inadequacies in infection control and in provider training and counseling. Health system weaknesses include gross under-reporting of cases by providers who do not wish to share unofficial fees, which affects monitoring and adequate provision of supplies. The HPSP has caused uncertainty regarding supervision in public sector facilities, and adversely affected training by NGOs and government-NGO coordination [6].

Menstrual regulation services are available at all major government hospitals and health facilities and are legal for pregnancies of 6-10 weeks. At thana (sub-district) 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 welfare 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. Therefore, this study was carried out to find out the factors influencing delay in care seeking for menstruation regulation among the women attending selected MR clinic.

2. Material and methods

2.1. Study Design

The study was a descriptive type of cross-sectional study.

2.2. Study place

The study was conducted in Mohammadpur Fertility Centre, Dhaka, Bangladesh.

2.3. Study period

The study lasted for a period of four months-March to June 2015.

2.4. Study population

This study was done on the women with amenorrhea seeking for menstruation regulation attended Mohammadpur Fertility Centre, Dhaka.

2.5. Sampling Method

Purposive sampling technique was followed and the sample size was 103.

2.6. Research Approach

At first, purpose of the study was informed to the respondents. A complete assurance was given that all information would be kept confidentially. Informed written consent was obtained from respondents. Informed consent was documented properly. Data was collected by face to face interview in Bengali. The right was being given to the participants not to participate and to discontinue participation at any time in study with consideration/without penalty. Their participation and contribution was acknowledge with due respects.

2.7. Data processing and analyses

All the data were checked and edited after collection. Data were then entered into computer, with the help of SPSS for Windows (IBM SPSS Statistics for Windows, version 26). An analysis plan was developed keeping in view with the objectives of the study. Statistical analyses were be done by using appropriate statistical tool.

2.8. Data quality management

The data collected from the respondents were analyzed. After completion of data collection, the data were checked and edited manually and verified before tabulation. Data were coded, entered and analyzed in a computer. The statistical analysis was conducted using SPSS (Statistical Package for Social Science) version 26 statistical software.

2.9. Ethical issues

The study was done through collection of data using questionnaire and neither any intervention nor any invasive procedures was be undertaken. However, prior to initiation of the study ethical clearance was taken from appropriate Ethical Committee.

3. Results

This study was done to find out the factors influencing delay in care seeking for menstruation regulation among the women attending selected MR clinics.

Table 1 Distribution of the respondent by their socio-demographic characteristics (n=103)

Age in years	**Frequency**	**Percent**
24 years and below	38	37
25-34 years	41	39.8
34-44 years	21	20.2
45 years and above	3	3
Married	97	95.1
Unmarried	6	4.9
Level of education		
Illiterate	26	25.2
No formal education	32	31.1
Class 1- Class 5	23	22.3
Class 6- Classic	21	20.4
SSC	1	1.0
Housewife	77	74.8
Service holder	23	22.3
Labor	2	1.9
Educational status of husband		
Illiterate	19	18.4
No formal education	19	18.4
Class 1- Class 5	10	9.7
Class 6- Classic	44	42.7
SSC	8	7.8
HSC	3	2.9
Husbands occupation		
Labor	49	47.6
Service holder	41	40
Businessman	11	10.7
Other	2	1.7
Earning members		
Only self	22	21.4
Only husband	59	57.3
Both	16	15.5
Son	5	4.9
Daughter	1	1.0
Total	103	100.0

Table 1 shows that the majority 41 (39.8%) of the respondents were 25-34 years. The mean age of respondents was 27.87 (SD ± 6.79) years. Here, majority (95.1%) were currently married, 4.9% were divorced, (31%) respondents had no formal education, majority (74.8%) of the respondents occupation were housewife, 22.3% laborers and rests 1.9% were service holder. Husbands education level shows that majority (43%) were from Class 6, about 36.8% respondents were either illiterate, majority (47.6%) of respondents husbands occupation were day laborer and (57.3%) respondents earning members was only husband.

Table 2 Distribution of the respondent by their level of knowledge regarding indication, proper time gestational period for receiving MR (n=103)

Know about MR	**Frequency**	**Percent**
Right answer	87	85
Wrong answer	16	15
Source of knowing		
Television	1	1.0
NGO worker	1	1.0
Relatives/Neighbor	101	98.1
Time of performing MR after cessation of period		
Know	16	15
Don`t know	87	85
Time of MR		
6 weeks after cessation of menstruation	36	40.9
7 weeks after cessation of menstruation	1	1.1
8 weeks after cessation of menstruation	50	56.8
1 0 weeks after cessation of menstruation	1	1.1
Reasons for (MR)		
Physical problem	13	12.6
Economic reason	49	47.6
Too young the youngest child	22	21.4
Newly married	9	8.7
Problem in job/ study/work	21	20.4
Force created by husbands	10	9.7
Others	22	21.4
Persons helped		
Self	18	17.5
Husband	13	12.6
Husband-Wife	57	55.3
Doctor	6	5.8
Friends / neighbors	9	8.7
Knowledge on adverse effects		
Do not know	28	27.2
Know	75	72.8
Total	103	100.0

Table 2 shows that the majority (85%) gave right answer and about 15% could not answer correctly about Knowing of MR, source of knowing about MR shows that majority (98%) learnt from relatives/neighbor, 1% from television and rest 1% from NGO workers, 85% respondents knows and 15% don't know about the time of performing MR after cessation of period.Here, 57% respondents think 8 weeks after cessation of menstruation is probable time of doing MR, 47.6% respondents accept MR due to their economic hardship, 55.3% respondent combinedly take decision with husband about MR acceptance and 73% respondents had knowledge about adverse effects of MR.

Table 3 Distribution of the respondent by proportion of women delay seeking MR care (103)

Delay in care seeking for MR.	**Frequency**	**Percent**
Did not make any delay in performing MR	66	57.5
Took delayed decision in doing MR	37	42.5
Legal aspect		
Don't know	95	92.2
Know	8	7.7
Cause for late(n=46)		
Personal	17	37.0
Family	6	13.0
Social	9	19.6
Service	14	30.4
Total	46	100.0

Table 4 Distribution of the respondent by personal, familial, social and service related factors that influence delay in MR (n=46)

Personal causes	**Frequency**	**Percent**
Failed to understand about the pregnancy	15	32.6
Not sure about the pregnancy	14	30.4
Took gynaecosid or other tablet for abortion	17	37.0
Social causes(n=36)		
Spiritual bindings	22	61
Fear of public disgrace	14	39
Family causes (n=32)		
Resistance by husband/others	12	37.5
Husband/guardian absent	5	15.6
Insecurity of the house	15	46.9
Service/service centre related causes (n=36)		
Treatment cost	16	44.44
Substandard service	2	5.56
Male doctor	9	25.0
Complexity of service	9	25.0
Total	36	100

Table 3 shows that out of 103 respondents, 57.5% did not make any delay in performing MR while 42.5% respondents took delayed decision in doing so, 92% doesn't know about legal aspect of MR, and 37% had personal cause, nearly 30% had service related cause, about 20% social cause and rest 13% had familial cause for delay in care seeking for MR.

Table 4 shows personal causes of delaying MR shows that majority 17(37%) had a gynaecosid or other tablet for abortion, 33% failed to understand about the pregnancy and rest 30% not sure about the pregnancy. Here, respondents by social causes of delaying MR shows that majority 22(61%) was due to spiritual bindings and rest 14(39%) due to fear of public disgrace. Majority 15(47%) pointed out in security of the house as the cause, 38% said resistance by husband/others and rest 16% indicated husband /guardians absent as the cause and respondents by service/service centre related causes for delaying MR shows that majority 16(44.44) due to treatment cost, 9 (25%) due to male doctor, another (25%) due to complexity of services and rest 2(5.56%) due to the substandard services.

4. Discussion

The purpose of this study was to find out the reasons for delay in MR seeking behavior among the women attended Mohammadpur Fertility Center. The decision making process for MR by these uneducated, mostly housewives women cannot make by themselves, their elder family member plays an important role. Women were undecided in their decision to terminate a pregnancy which led to delays in seeking an abortion. These delays were further compounded by health service related barriers such as inappropriate referrals and long waiting-periods.

Similar to other studies, the study findings suggest that problems in suspecting a pregnancy were an important cause of delay Reported problems [7,8,9] with irregular periods and poor recall and recording of menses, resulted in difficulties recognizing pregnancy symptoms, which, if identified earlier, may have prompted women to confirm a pregnancy sooner. Despite limited or no contraceptive use, women did not make the link between amenorrhea and a possible pregnancy. On the one hand, women experienced difficulties in detecting a pregnancy with at least two months elapsing prior to pregnancy confirmation. Yet on the other hand, they had satisfied knowledge about MR and its complications. This study result similar with findings of Harries et al. study[10].

Regarding decision for MR, most of the respondent stated (55%) that both the clients and the husbands took decision for termination of their pregnancy. Next highest percentage (17%) showed the respondent take decision herself. This finding was consistent with most of the previous study[11'12]. It was observed that, MR decision was mostly limited within husband and wife. It may be due to the fact that MR is not openly accepted in our society.

Most women described multiple barriers to obtaining MR early and did not necessarily identify one reason as being more important than another. Women tended to relate more to social and personal issues than service related barriers[13'10]. However, with further probing it did become clear that many women had reservations about judgmental and negative attitudes displayed by providers at public sector facilities and overall concerns about being further stigmatized for seeking an MR.

Partners, family and friends played an important role in decisions whether to have an MR, yet women independently emphasized their own decision-making autonomy. Religious beliefs could have been a contributing factor in delaying seeking MR.

5. Conclusion

The study findings suggested that women had good knowledge about MR and its timing even they make delay due to unawareness of their legal rights, personal, social and service related causes. A wide range of factors explain why MR is delayed. Many of these reasons are 'woman related rather than service related, due to lack of knowledge about signs and symptoms of pregnancy. A significant proportion of women do not suspect they are pregnant until it is too late for them to access MR, and it leads to further delays by taking any abortificient drug.

Depending on the study findings following study recommendations were made

- More mass media advertisement should be present
- Legal aspects of MR should be well-known to its target population.
- Service related hassles should be minimized.
- Raising greater awareness about the signs and symptoms of early pregnancy.

- Male doctors should not be encouraged to work in the MR clinics.
- The quality of MR services should be improved
- To improve the acceptability of MR, education on the benefits of MR has to be made available to the whole population.

Compliance with ethical standards

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Disclosure of conflict of interest

No conflict of interest statement must be inserted here.

Statement of ethical approval

Ethical clearance was taken from appropriate Ethical Committee.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

References

[1] Amin S., March 25-28, 1996. Menstrual regulation in Bangladesh, paper presented at the International Union for the Scientific Study of Population (IUSSP) Seminar on Sociocultural and Political Aspects of Abortion from an Anthropological Perspective, Trivandrum, India,

[2] Dixon-Mueller R.,1988. Innovations in reproductive health care: menstrual regulation policies and programmes in Bangladesh, Studies in Family Planning, 19(3):129-140; and Akhter HH, Unsafe abortion: a situational analysis, in Akhter HH and Khan TF, 1996, op. cit.

[3] Islam S., 1992.Indigenous abortion practitioners in rural Bangladesh, women abortionists: their perceptions and practices, Dhaka: Narigrantha Prabartana.

[4] Kamal H, Hossain A and Akhter R., 1999. Septic abortion: an anthropological study of 52 cases in Bangladesh, Dhaka: Bangladesh Association for Prevention of Septic Abortion (BAPSA), forthcoming.

[5] Mitra SN et al., 1994.Bangladesh Demographic and Health Survey, 1993-1994, Dhaka: Mitra and Associates.

[6] Chowdhury SN, Moni D.,2004. Reproductive Health Matters, 12 Suppl 24:95-104.

[7] World Health Organization (WHO)., 2005. World health report 2005. Geneva, Switzerland: WHO;

[8] Fusun A I,Rukiye G, Mahir I, and Murat Y., 2008. Abortion in Turkey: women in rural areas and the law. Br J Gen Pract. 1; 58(550): 370-373.

[9] Morroni C, Moodley J: 2006. Characteristics of women booking for first and second trimester abortions at public sector clinics in Cape Town. SA JOG, 12(2):81-82

[10] Harries J, Orner P, Gabriel M and Mitchell E., 2007. Delays in seeking an abortion until the second trimester: a qualitative study in South Africa . Reproductive Health, 4:7doi:10.1186/1742-4755-4-7

[11] Comparison Characteristic of family planning and M.R. Clients of Rural Reproductive Health Clinic, BAPSA, MR Newsletter, Fifteenth Year, March 2000;3:1-5.

[12] Bhuiyan N, Begums S. Experience with Menstrual Regulation and Family Planning Services in Chittagong Medical College Hospital, Nov. 1979

[13] Fusun A I, Rukiye G, Mahir I, and Murat Y., 2008. Abortion in Turkey: women in rural areas and the law. Br J Gen Pract. May 1; 58(550): 370-373