Bangladesh Med J. 2022 May; 51(2)
DOI: https://doi.org/10.3329/bmj.v51i2.69257

Original Article

Delay in Care Seeking for Menstrual Regulation

* Sultana S[1], Nahar S[2], Yeasmin S[3]

Abstract

In Bangladesh menstrual regulation (MR) services are available at all major government and private hospitals, and even at government primary health care facilities. In spite of wide availability, women who do not use menstrual regulation services from proper facilities may resort to induce unsafe abortion by non-medical or untrained health workers in unhygienic condition. Worldwide, nearly 1 in 10 pregnancies end in unsafe abortion and World Health Organization (WHO) estimates that 18 out of 20 unsafe abortions takes place in developing countries. Induced abortion leading to complication such as bleeding, infection injuries and even death, these deaths could be prevented if women had an access to safe abortion facilities. This cross sectional study was carried out among fifty two women from family planning unit of Institute of Child and Mother Health (ICMH), Dhaka from December 2009 to May 2010. The purpose of this study was to identify the factors for delay in care seeking of menstrual regulation (MR). The data were collected by using the pretested questionnaires and cases were selected from the women who came for seeking care of MR after 10 weeks of amenorrhoea. Duration of amenorrhoea was confirmed by taking history and in some cases by ultrasonography. After incorporation of the socio-demographic data; factors or reasons of delay in MR were found due to personal, social, service and family related events. The mean age of respondents was 22.14 years. About 75% of the respondents were housewives and 79% were illiterate. The mean age of marriage 19.5 years. Regarding husband's educational level of the respondent, more than one-third (37%) was class I – V, others one-third (33%) was above the primary level rest of the husbands were higher secondary and above. More than two-third (70%) of the respondents delivered 1 to 3 live children and used oral contraceptive pills. Most of the (87%) of women gave right answer about MR and most of them (85%) had knowledge about adverse effect of MR. Nearly two-third (65%) came to know about MR form relatives/neighbors, where one-fourth (25%) from health workers and rest them from mass media/ others. Most of the (87%) respondents answered correctly about advantages of MR, however, 60% did not know about the proper time of performing MR after cessation of menstruation. Most of the respondents (85%) knew about the side effects of MR; among them more than one-third (37%) told excessive bleeding was adverse effects of MR, however 33%, 8%, 6% and rest 4% told pain, sterility, perforation and infection respectively were the adverse effects of MR. Three-fifth (60%) of the patients didn't know about the right time of pursue care for MR and 63% of them were unaware about legal aspects of MR that they have right to seek MR. More than half of the respondents (56%) stated the reasons for the delay due to their personal problem where, 19%, 15% and 10% of them were specified the reasons as social factor, service related reason and family conflict respectively. Among the respondents of personal reason for delaying MR, more than half of them (52%) took oral tablets for abortion at home, 41% failed to understand their amenorrhoea and only 7% were unaware about service facility for MR. Regarding familial reasons for delay of MR, 60% pointed out the security problem and remaining 40% told about resistance by husband/others or absence of husband in the houses. The main (70%) social reasons of delaying MR was due to spiritual bindings and 30% was due to public disgrace. Service facility related reasons for delaying MR were treatment cost (62%), distance of facility (25%) and substandard services (13%). The study findings suggested that women had good knowledge about MR even they made delay due to unawareness of their legal rights, personal issues, social and service related causes. Strengthening of reproductive health services through community clinic at community level with available awareness building program on MR may minimize the delay for care seeking of MR among women.

Keywords: delay in care seeking, MR, unsafe abortion.

1 * Dr. Sohana Sultana, Department of Gynecology and Obstetrics, Assistant Surgeon, 250 bed, General Hospital, Munshiganj, Email: drsohanasultana1980@gmail.com
2 Dr. Sabikun Nahar, Medical Officer, Department of Gynecology and Obstetrics, Sheikh Hasina National Burn & Plastic Surgery Institute (SHNBPSI), Dhaka.
3 Dr. Sabina Yeasmin, Department of Gynecology and Obstetrics, Junior Consultant, OCC, DMCH.
*For Correspondence

INTRODUCTION

Safe motherhood is the legitimate demand and right of all women all over the globe. But it remains one of the most important and unsolved issues. Unwanted or unplanned pregnancy leads to unsafe abortion and it is a major cause of concern in safe motherhood program. Each year women around the world experience 75 million unwanted pregnancies. According to the Bangladesh Demographic and health survey (DHS), 2% of a sample of 9640 currently married women said that they had terminated an unwanted pregnancy.[1] Two-thirds of these terminations (65%) involved menstrual regulation which is considered as an interim method of establishing non-pregnancy, for a woman at risk of being pregnant, whether or not she is pregnant infact.[2] The method is safe, effective and easy to maintain risks are less. In Bangladesh menstrual regulation services are available at all major government hospitals and health facilities and are legal for pregnancies of 6-10 weeks. In spite of wide availability, women who do not use menstrual regulation services may resort to induce unsafe abortion herself, by non-medical person or by health workers in unhygienic condition. They do it by inserting a foreign object into the uterus or by indigenous oral medicine.[3] swallowing harmful substance or by improperly performed dilatation and curettage. Some of these are women who have been rejected from MR facilities due to longer duration of their pregnancy. Most women seeking abortion are married and having children. Adolescents are also resort to abortion. In comparison with adults, adolescents are more likely to delay the abortion, resort to unskilled persons to perform it, use dangerous methods and present late when complications arise.[4] Abortion performed after 12 weeks of gestation pose greater risks of medical complication than performed during the first trimester. Induced abortion is a national problem in women's health as it is for the whole world. Worldwide, nearly one in 10 pregnancies end in unsafe abortion[6] and WHO estimate showed that 18 out of 20 unsafe abortions takes place in developing region of the world. Induced abortion leading to complication such as bleeding, infection injuries and even maternal death, these deaths could be prevented if women had an access to safe abortion facilities. Menstrual regulation (MR), an early termination within 6-10 weeks without pregnancy confirmation, is widely provided through a network of the government health services since 1978. Menstrual regulation (MR) using vacuum aspiration is widely available in. Bangladesh through public, NGO and private sector facilities, even though abortion is illegal except to save a women's life. For more than two decades the MR program was run as a vertical program. In 1998 the government of Bangladesh introduced the health and population sector program (HPSP) incorporating menstrual regulation into the essential services package. In wide availability, barriers such as distance to health facilities and transportation costs, unofficial fees, lack of privacy, 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] Rationale of study: Millions of women around the world risk their lives and health to end unwanted pregnancies. The situation is no different in Bangladesh. Overall, one third of births in Bangladesh can be considered as unplanned. 19% are mistimed and 14% unwanted. Low contraceptive continuation rates, method failure and high unmet need for contraceptives are some of the leading causes of unwanted pregnancies and abortions. The issue under this study has important implications for the family planning program in Bangladesh. As noted, most of the women interviewed were not practicing contraception at the time they become 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. As lack of proper knowledge about MR, its timing some of them come delay in seeking for menstrual regulation. But when they are rejected for MR they get frustrated and attempts to get rid of it by induced abortion by themselves or by untrained persons. This unsafe procedure results in serious forms of morbidity and extreme cases death may occurs due to septic abortion. In addressing future challenges the government plans to reduce maternal mortality by providing adequate support for antenatal care, post delivery services and emergency obstetric care. The government policy also emphasizes management of complication arising from unsafe abortions. This proposed

study will try to find out the causes of delay in care seeking behavior, thus the government may need to publicize the risks involved in delaying MR care seeking behavior of these women, so that service seekers can make safer choices.

MATERIALS AND METHOD

This cross sectional study was carried out among women at MR clinic, family planning unit of Institute of Child and Mother Health (ICMH), Dhaka, Bangladesh from December 2009 to May 2010 (Six months). Among the women 52 cases were selected purposively according to inclusion and exclusion criteria. The inclusion criteria of the study were women of reproductive age having amenorrhoea for more than 10 weeks and women agreeing to participate in this study. On the other hand, the exclusion criteria were women with molar pregnancy with sepsis and suffering from any associated medical diseases. Data was collected using a structured questionnaire containing all the variables of interest. The questionnaire was finalized following pre-testing. All women were informed about the purpose of the study and informed written consent was taken from all the study subjects after full explanation of nature and purpose of the study. Data were collected by interviewing and examining the patients MR clinic.

Data analysis and quality assurance

Statistical analyses were carried out by using the Statistical Package for Social Sciences version 16.0 for Windows (SPSS Inc., Chicago, Illinois, USA). The mean values were calculated for continuous variables. The quantitative observations were indicated by frequencies and percentages. It is extremely important that data was of good quality. Patient of incomplete abortion was the target group (within 12 weeks)

Ethical Implications

Permission for the study was taken from the concerned departments. All the study subjects were thoroughly appraised about the nature, purpose and implications of the study, as well as spectrum of benefits and risk of the study. All study subjects was assured of adequate treatment in relation to study purpose. Women were also assured about their confidentiality and freedom to withdraw themselves from the study any time. Data was collected in approved data collection form. Finally written consent of all study subjects were taken free of duress and without exploiting any weakness of subjects. The study subjects were informed verbally about the study design, the purpose of the study, and their right to withdraw them from the study at any time, for any reason, whatsoever. Subjects who gave informed consent to participate in the study were included as study sample.

RESULTS

Among the respondents 94% were married and 6% were divorced. Occupation respondents; 75% were house wives, 19% were laborer, 4% were service holder and 2% were in business. The mean age of marriage of the respondents was 19.5 and 42% were married during 17 to 20 year. Regarding the family income, 67% husbands of respondents were the only earning member of the family and both husband and wife were 25%; however 56% family's monthly income were within 3001-5000 taka, 29% was more than 5000 taka, 11% family's income were 1000-3000 taka and only 4% family's income was within1000 taka.

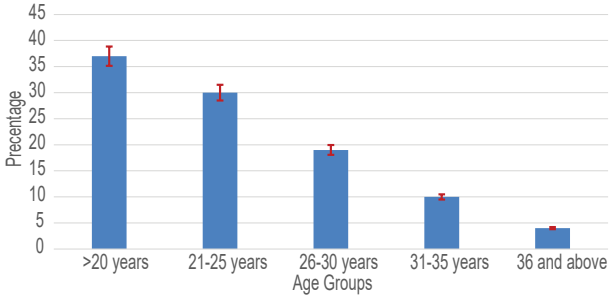

Figure- 1: *Distribution of the respondents by age (n= 52)*

Figure 1 shows the distribution of age of the respondents, here 37% were in age group below 20 years, 30% were from 21-25 years, 19% were from 26-30 years, 10% were from 31-35 years and 4 % of the respondents were from above 35 years of age group. Mean age of the respondents was 22.14 years.

Table I states the respondents by level of education. It shows that 79% were illiterate, 11.5% were from Class I to V, 6% were from Class VI to X and 4% had passed SSC and above.

Table- I: Distribution of the respondents by level of education (n= 52)

Level of education	Frequency	Percent (%)
Illiterate	41	79
Class I-Class V	6	11.5
Class VI- Class X	6	6
SSC and above	2	4

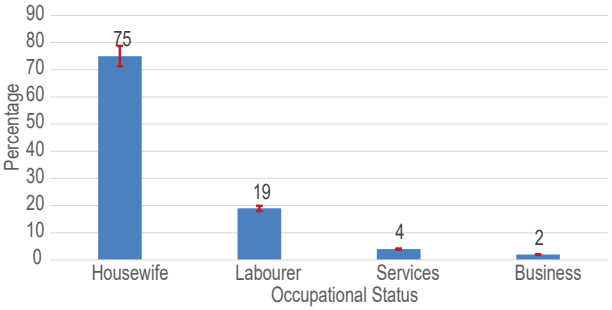

Figure- 2: *Occupational status of the respondents*

Figure 2 represents the occupational status of the respondents; here, 75% were house wives, 19% were laborer, 4% were service holder and 2%were businessman.

Table II describes the education level respondent's husband, here 37% passed class I to V, 33% were illiterate, 19% passed class VI to X and only 11% completed SSC and above level of education.

Table- II: Distribution of the respondents by their husband's education status (n= 52)

Level of education	Frequency	Percent
Illiterate	11	33%
Class I - V	19	37%
Class- VI - X	10	19%
SSC and above	6	11%

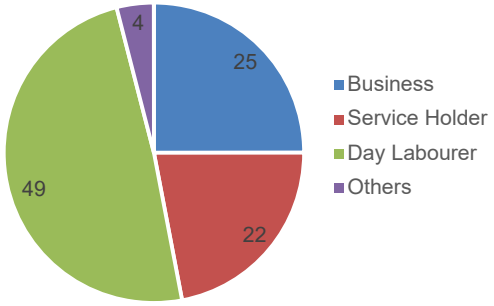

Figure- 3: D*istribution of the respondents by their husband's occupation status (n= 52)*

Figure 3 showing the distribution of the respondents by their husband's occupation, here 49% were day laborer, about 22% were service holder, 25% were business and rest 4% were from other occupation.

Table III shows the distribution of respondents by age at first marriage. The mean age of their first marriage was 19.5. Among the respondents 19% of them got married at and before 16 years. Usual age of marriage 17 to 25 years was found in 69% of respondents and others 12% got married by 26 to >30 years.

Table- III: Distribution of the respondents by their age at first marriage (n= 52)

Age in years	Frequency	Percentage (%)	Mean
<16 Years	10	19	
17-20	22	42	19.5
21-25	14	27	
26-30	5	10	
>30	1	2	

Table IV shows that 67% husbands of the respondents were the only earning member of their family, both husband and self was 25% and only self was 4%.

Table- IV: Distribution of the respondents by earning member in the family

Earning member	Frequency	Percent (%)
Only self	2	4
Only husband	35	67
Both	13	25
Son	1	2
Daughter	1	2

Table V states that 56% had monthly family income 3001-5000 taka, 29% had more than 5,000 Taka, 11% had 1000-3000 taka and 4% had 1000 taka or less.

Table- V: Distribution of respondents by monthly family income

Monthly income	Frequency	Percent
Up to 1000 taka	2	4
1000-3000 taka	6	11
3001-5000 taka	29	56
>5000 taka	15	29

Table VI states that 73% women had 1- 3 children, whereas 16% had 4 - 5 children and 11% had no children.

Table- VI: Distribution of respondents by number children

Number of children	Frequency	Percent
Nil	6	11
1	9	17
2	13	25
3	16	31
4	5	10
5 and >above	3	6

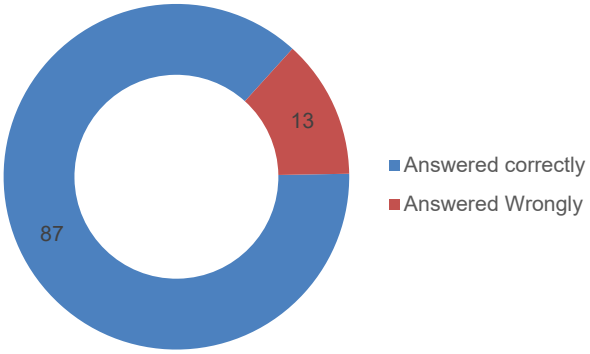

Figure- 4: Distribution of respondents who answered correctly about advantages of MR

Figure 4 illustrate the distribution of respondents who answered correctly about advantages of MR; 87% answered correctly about advantages of MR and 13% could not answer correctly.

Table VII shows the distribution of respondents by source of information about MR, here 65% received information form relatives/neighbors, 25% from health workers and 10% from mass media/ others.

Table- VII: Distribution of respondents by source of knowing about MR

Source of knowing	Frequency	Percent
Health workers	13	25
Radio/TB	2	4
Relative/neighbor	34	65
Others	6	6

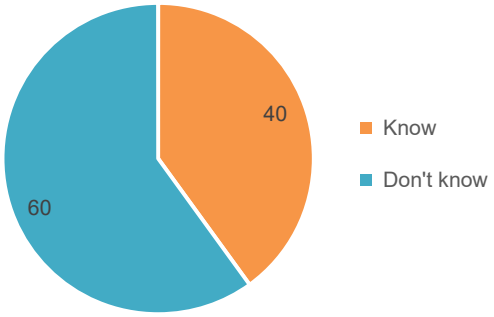

Figure- 5: showing that 60% didn't know about the proper time of performing MR after cessation of menstruation.

Figure 5 showing that 60% of the respondents didn't know the proper time of attend MR after cessation of menstruation.

Table VIII shows the distribution of respondents by their knowing about legal aspects of MR; here 63% didn't know about its legalization.

Table- VIII: Distribution of respondents by their knowing about legal aspects of MR

legal aspects	Frequency	Percent
Don't know	33	63
Know	19	37
Total	50	100

Table IX states that 85% knew about the side effects of MR and 15% respondents didn't know.

Table- IX: Distribution of respondents by knowledge about side effects of MR

Knowledge of Side effects	Frequency	Percent
Have knowledge	44	85
No knowledge	8	15
Total	52	100

Table X shows the distribution respondent about their knowledge on patterns of adverse effects of MR, here 37% told about excessive bleeding, 33% pain, 8% sterility, 6% perforation and rest of them told about infection.

Table- X: Knowledge about the patterns of adverse effects of MR

Side effects of MR	Frequency	Percent
Excessive bleeding	19	37
Pain	17	33
Infection	2	4
Perforation	3	6
Sterility	4	8

Table XI shows the distribution of respondents by reasons of delay in care seeking for MR, here 56% had personal reasons, 19% had social, 15% had service related and rest 10% had familial reasons.

Table XI: Distribution of respondents by reasons for delay in care (n= 50)

Causes for delay	Frequency	Percent
Personal	29	56
Family	05	10
Social	10	19
Service	08	15
Total	50	100

Table XII states distribution of respondents by personal reasons of delay in MR, here 51.72% delayed due to take oral tablets for abortion, 41.37% failed to understand about the amnaeorrhoea and rest 6.9% didn't know health facility for MR service.

Table- XII: Distribution of respondents by personal reasons (n=29)

Personal causes	Frequency	Percent
Failed to understand about the pregnancy	12	41.37
Took oral tablets for abortion	15	51.72
Don't know where get MR service	2	6.9
Total	29	100

Table XIII shows distribution of respondents by family reasons, 60% pointed out the security problem, 20% husband's absence and rest 10% specified security problem of the house as the reasons for delay.

Table- XIII: Distribution of respondents by family reasons (n= 5)

Family causes	Frequency	Percent
Resistance by husband/others	1	20
Husband absent	1	20
Security problem of the house	3	60
Total	05	100

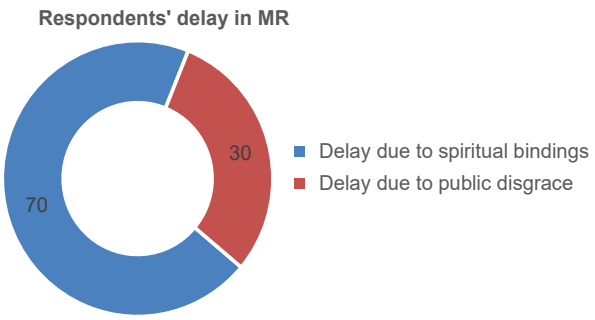

Figure- 6: *Showing the social reasons for delay of seeking care for MR; delayed due to spiritual bindings and fear of public disgrace.*

Figure 6 illustrate the social reasons for delay of seeking care for MR, here 70% delayed due to spiritual bindings and rest 30% due to fear of public disgrace.

Table XIV states the distribution of respondents by service center related reasons, 62% stated delay due to treatment cost, 25% due to distances of center and 13% of them told substandard services.

Table- XIV Distribution of respondents by service centre related causes

Service/service centre related causes	Frequency	Percent
Treatment cost	05	62
Distances of centre	02	25
Substandard service	01	13
Total	08	100

DISCUSSION

The termination of pregnancy by willful means has always created dilemmas for civil societies. Many citizens abhor the practice, other support the right of women to make their decisions; no one seems to be neutral on the subject. Menstrual regulation (MR) an early termination within 6-10 weeks without pregnancy confirmation is widely available in Bangladesh through public, NGO, and private sector facilities, even though abortion is illegal except to save a women's life.

This cross-sectional study was carried out to know the factors causing delay in care seeking behavior of menstrual regulation among fifty women in selected MR clinic in institute of child and mother health. The study was done with the objective to find out the personal and social factors for delay in seeking MR care and to find out the level of knowledge about MR like complication, advantages, disadvantages, indication, proper time of receiving MR and its Complication.

The mean age of respondents was 22.14 years. One study showed that the mean age of the MR clients was 26 years.[2] and few other study results stated the mean age of MR clients was 24 year. [23, 24] this findings showed that the MR clients were almost in the middle of their reproductive life. Most of them were married and 4% were divorced as their husbands left them after they conceived. The mean age of marriage was 19.5 years. Seventy five percent were housewives and 79% were illiterate. In 67% cases husbands were the only earning member.

The decision making process for MR by these uneducated, housewives women could not made by themselves, their elder family member played an important role. Women

were undecided in their decision to terminate pregnancy which leads to delay in seeking MR. The study showed that thirty seven percent of the respondent's husband's educational level was calss1 - class5 and 49% of them were day laborer, 22% were service holder and rest do small business. The monthly family income of the respondents was within 3000-5000 taka, in 56% cases. This indicates that the clients were poor. This findings was similar to the Bhuiyan and Begum.[24] Most of them having 1-3 for doing MR. living child, on the other hand 11% respondents had no living child still came

Similar to other study the study finding suggests that problems in suspecting a pregnancy were an important cause of delay[12, 21] 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. In the study about 41% were failed to understand about pregnancy as their cycle was irregular and took irregular oral contraceptive pill. About 83% respondents used family planning methods and of them majority 72% were pill users. But most of then took irregular OCP and inject able contraceptive though, 91% stopped contraceptive method before the present pregnancy. Despite limited use of contraceptive method, women did not make link between amenorrhea and pregnant On the other hand women experienced difficulties in detecting a pregnant with at least two months elapsing prior to pregnancy confirmation. This s result similar with findings of Harries et al. study.[22]

The study findings suggest that 87% knew about advantage of MR as it is safe for health, less chance of infection. Of them 70%pointed out excessive bleeding and pain as disadvantages of MR. the respondents said that they learnt about MR from relatives or NGO workers. But the study showed that though they had knowledge about MR, 65% don't know about its legal aspect. They did not consider it as their "right". And most were not aware of the time restrictions involved. [12]

Most women described multiple barriers to obtaining MR early and did not identify one reason as being more important than another. Women tended to relate more too personal (58%), social (18%) issues than service related barriers (14%).[12, 22] When the respondents confirm about their pregnancy at first majority (51%) tried home abortion by taking gynaecosid, cytomis, emergency pill or other abortificient drugs and when they failed they were already delay. The study showed that majority in this group belong to age group of less than 20 years.

This study revealed several important shortcomings in the health care system and with regards to MR care provision. Initial delays in suspecting pregnancy was underscored by further delays once women decided to have MR. Delays due to inappropriate referral evidenced by women attending numerous facilities before obtaining MR, waiting periods of over two weeks and difficulties locating a facility providing second trimester abortions is concerning. Unofficial fees and substandard service of some MR centre was also a factor for delaying.

Women intimated that reproductive choice was often difficult, particularly in a climate of judgmental and negative attitudes displayed by healthcare providers. Opportunities for values clarification training designed to promote more tolerant attitudes by service providers should continue and extend to health care providers working within all areas of reproductive health. Such interventions would play an important role in improving the quality of care and long term health outcomes of women seeking MR.

Limitation of the study

- Purposive sampling was done due to time constrain.. So, this result may not be representative to whole country.
- The study design was taken as a cross sectional one, though a comparative study would be more suitable for this topic.

CONCLUSIONS

The main social causes of delaying MR due to spiritual bindings and fear of public disgrace. Unofficial fees and insecurity of the house were the factors among the service related and familial causes. The study also showed that though that they had satisfactory knowledge about MR, they were unaware about its legalization and proper timing for doing it.

RECOMMENDATION

Information on the availability of MR services particularly the time restrictions and about its legal aspects should be included in reproductive health care counseling, so that women with unintended pregnancies are able to make informed choices. To contribute the achievement of the MDG 5 target to reduce the maternal mortality ratio by 75% from 1990-2015, quality of MR services should be

improved and made easily available to the rural people, where the mortality and morbidity due to abortion is high. For this purpose more mass advertisement should be present.

REFERENCES

1. Mitra SN et al. Bangladesh Demographic and Health Survey, 1993-1994, Dhaka: Mitra and Associates, 1994.
2. Dixon- Mueller R, innovations in reproductive health care: Menstrual regulation policies and programmes in Bangladesh, studies in family planning, 1988, 19 (3): 129-140.
3. Islam S, Indigenous abortion practitioners in rural Bangladesh, women abortionists: their perceptions and practices, Dhaka: Narigrantha Probartana, 1992.
4. Olukoya AA, kaya, Ferguson BJ, Abou Zahr c. unsafe abortion in adolescents. Int J Gynaecol obstet 2001 Nov; 79
5. World Health Organization (WHO). World health report 2005. Geneva, Switzerland: WHO; 2005
6. Choddhury SN, Moni D.Reproductive Health Maters, 2004; 24:95-10.
7. Sedgh G. Henshaw s, Singh s, Ahman and shah IH Induced abortion rates and trends worldwide Lancet 2007;370:1338-45.
8. Amin S, Menstrul regulation in Bangladesh, paper presented at the international union for scientific study of population (IUSSP) seminar on sociocultural and political Aspects of abortion from an Anthropological perspective, Trivandrum, india, Mst.25- 28.1996.
9. "Legal abortion worldwide: incidence and recent trends", international family planning perspectives 33:106-116,September 2007.
10. Initiative to strengthen national MR programme in Bangladesh, launching ceremony, 23june, 2008, Dhaka, Bangladesh.
11. World health organization (who) world report, 2005, geneva, Switzerland: who: 2005
12. World health health organization (WHO).Reduction of metermal mortality: a joint WHO/UNFPA/ UNICEF/WORLD BANK Statement. Geneva, Switzerland: WHO; 1999.
13. Fusun A 1, Rukiye G, Mahir I, and Murat Y. Abortion in turkey:women in rural areas and the law. Br. J Gen Pract. 2008 may 1:58(550):370373.
14. Boonstra HD et al. Abortion in women's lives new York GUTTMACHER institute, 2006.
15. Bracken MB, Kasl SD,Delay in seeking induced abortion: a review and theoretical analysis. Am J Obstet Gyneclo, 1975 April 1; 121(7):1008-19.
16. Fielding WL, Sachteben MR, Friedman LA, Friedman EA. Comparison of women seeking early and late abortion. Am J Obstet Gynecol, 1978 june 1; 131(3): 304-10.
17. Finer LB and Henshaw SK, Disparities in rates of unintended Pg in the united states, 1994 2001, perspectives on sexual and reproductive health, 2006, 38(2):90-96.
18. Jones RK et al. Abortion in theus: incidence and access to services, 2005, perspective on sexual and reproductive health, 2008, 40(1):6-16.
19. Ketting E.Second-trimester abortion as a social problem: delay in abortion seeking behavior and its causes. The Hague, Netherlands, Martinus Nijhoff, 1982,:12-9. (Boerhaave series for postgraduate Medical Education vol.22).
20. Morroni C. Myer L, Tibazarwa K: Knowledge of the abortion legislation among South African women: a cross-sectional study.
21. Morroni C, Moodley J: Characteristics of women booking for first capetown.SAJOG2006, 12(2):81-82, and second trimester abortions at public sector clinics in
22. Harries J, Orner P, Gabriel M and Mitchell E. Delays in seeking an abortion until the second trimester; a qualitative study in south Africa. Reproductive Health 2007, 4:7doi:10.1186/1742-4755-4-7.
23. Akhter et al. Demographic pattern of MR news letter, BAPSA. may 1995:2:25-19.
24. Bhuiyan N and Begum S.Experience with menstrual regulation and family planning services in Chittagong medical college Menstrual hospital between October 78 to july 79. A bibliography on Menstrual regulation and abortion studies in Bangladesh, BIRPERHT. 1996:149-152.