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Abortion : A Public Health Problem in Myanmar

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Complications following illegally induced abortions have been recognised as an important cause of mortality and morbidity in Myanmar. Based on a review of various studies, and comparing data from the 1970s and 1980s with data since 1990, this paper presents an overview of the problem of induced abortion in Myanmar. Maternal deaths have decreased dramatically since the 1970s in relation to pregnancy and childbirth, but remain very high for abortion complications. The causes of abortion-related deaths have changed very little. A majority of the women in all studies were married, had one or more children and belonged to low income groups. Women were aware of the risks of clandestine abortion but contraceptive prevalence in Myanmar is only 34 percent in urban areas gnd,10 percent in rural areas, and the contraceptive failure rate among women using a method is high. Women's experience and perceptions of abortion are also described. Information and counselling as well as better access to effective contraception could help to reduce abortion-related morbidity and mortality.

IN Myanmar, where the majority of the population is Buddhist, the issue of induced abortion is very sensitive. Buddhism contains a code of ethics based on five precepts, the first of which is to avoid killing or harming life. Induced abortion is therefore widely perceived as being against religious beliefs. Further, abortion is also not permitted by law. The penalty for providing an induced abortion is either a three-year jail sentence or a fine, or both. (1)

As in many other countries where it is illegal, abortion constitutes a serious public health problem in Myanmar. Analysis of pregnancy related hospital data in states and divisions in the 1975 country profile of what was then called Burma, gave an abortion admissions rate (for both spontaneous and induced abortion) of 48.6 per 100 deliveries, ranging from a low of 23.6 per 100 deliveries to a high of 77.3 per 100 deliveries in the different regions.(2) In the 1980s abortion complications constituted approximately 20 percent of total hospital admissions. For every three women admitted for deliveries, one was admitted for abortion complications. (3), (4), (5)

These figures remained exactly the same in 1994.(6) Hospital data for 1992 in fact showed that for some areas such as Kachin, Kayah and Chin states and the Mon Division, the rates were as high as one patient with abortion complications per woman admitted for delivery. (6) This may be because better access to

contraception through the family planning project of the .Department of Health had not yet been implemented in these areas.

The priority scoring for health problems in 1975 showed that complications following abortions (induced and spontaneous) ranked high, 13th out of a total of 50. This was based on hospital data on morbidity and mortality. Complications of abortion ranked highest of all among obstetric and gynaecological problems, even superceding cervical cancer and all other complications of pregnancy.(7) In 1985, abortion had become the 9th most important health problem and was ranked third among the leading causes of morbidity in Myanmar.(8) This change in ranking, however, was in fact a reflection of better and more complete hospital data on morbidity and mortality.

High Abortion Mortality

The maternal mortality ratio has shown a declining trend in urban Myanmar over the past 30-35 years. It has fallen from 380 per 100,000 live births in 1961 to 190/100,000 in 1971, to 130/100,000 in 1981 and 100/100,000 in 1991.(9) A general improvement in the socio-economic conditions and in the provision of health services is believed to be responsible for this decline. Data from rural Myanmar, available since 1991, give maternal mortality figures ranging from 180 to 190 per 100,000 in 1994-1995.(10)

Despite declining maternal mortality ratios, of which deaths from dangerous abortions are a part, mortality from abortion has remained high and unchanged. According to a 1983 prospective study of maternal mortality covering all specialist hospitals in the country, complications following abortion (both induced and spontaneous) were responsible for approximately 50 percent of maternal deaths. Immediate causes of deaths from abortion were mainly generalised peritonitis and septicaemia.(11), (12), (13)

Ten years later, a similar prospective study covering the same institutions revealed that sepsis, primarily sepsis following abortion, was responsible for 60 percent of direct obstetric deaths. Deaths resulted from septicaemia, peritonitis, renal failure and disseminated intra-vascular coagulation.(14), (15), (16)
Post-abortion morbidity is recognised as an important problem even though there are few studies on it. A 1982 study which followed up a random sample of 100 septic abortion patients admitted over a six-month period to the Central Women's Hospital in Yangon, revealed that one-third were readmitted for pelvic pain or tubo-ovarian mass.(3) Post-abortion pelvic inflammation, menstrual problems and psychological sequelae place a heavy burden of morbidity on women. Only a small proportion of this morbidity may ever come to the notice of health professionals.

Characteristics of Women with Abortion Complications

The significance of the problem of abortion as a threat to maternal health has prompted many studies in, Myanmar to determine the socio-demographic and clinical profile of women admitted for complications of (unspecified) abortion (All data are summarised in Table 1).

Table 1 : Characteristics of Women with Post-abortion Complications: Various Studies Myanmar 1981-1992 (%)

Place	Year	Criteria for Sample Selection	Sample Size	Currently Married	Parity > 1	Parity > 5	Age 20-34	Repeat abortion	Induced abortion	Low income
Central Women's Hospital Yangon	1980-81	Septic abortion[A]	583	95	84	25	75	39	82	84
Mandalay General Hospital	1983	Septic abortion[A]	262	97	78	na	72	67	11	99
Central Women's Hospital, Yangon	1991	Complications of induced abortion[B]	100	84	Mean Parity 2-3	Mean 27.4 yrs	30	69	61	
General Hospital North Okkalapa	1991-92	Post-abortion complications	145	93	Mean Parity 4	Mean 27.9 yrs	33	57[C]	Na	
North Okkalapa Tawnship	1994	Past history one or more abortions	582	100	na	na	31	11	na	

Notes : na = not available

A = Women admitted with one or more of the following symptoms: a temperature of 100.4° F maintained for 24 hours; or a temperature above this at any time before or after evacuation of the uterus in the absence of an extra-genital cause of fever; intrauterine sepsis or extra-uterine pelvic infection; generalised peritonitis; the presence of septicaemia.

B = Women with severe septi

In two hospital-based studies carried out in the early 1980s in the Central Women's Hospital in Yangon and Mandalay General Hospital respectively, as high as 82 percent in one study, and as low as 11 percent in the other, reported the abortion to have been induced.(3), (4) In both studies, a high proportion of repeat abortions (at least one previous abortion) was reported - by 39 percent of the women at the Central Women's Hospital and 67 percent in Mandalay General

Hospital. The nature of these previous abortions (that is, whether they were induced or spontaneous) was not specified but at least some were likely to have been induced. Although the precise nature of the abortions in many of the studies reviewed here cannot be determined, it is generally accepted that those who have had repeat abortions are more likely to have an induced abortion than women who have experienced only one abortion.

The majority of women admitted to these two hospitals for complications of abortion were between 20 and 34 years old. Nearly all of them were married and had had more than one pregnancy. However, a slightly higher proportion of women (22 percent) were pregnant for the first time in Mandalay, while in Yangon a quarter of them were of parity greater than five. In both instances, most of the women belonged to lower income groups.

In 1991-92, the profile of women admitted to hospitals for septic abortions in Yangon as well as in other townships, such as North Okkalapa, has remained virtually unchanded. They were young and married, and had been pregnant more than once before this most recent, terminated pregnancy. (17), (20), (21) A significant proportion (44 percent in Yangon and 62 percent in North Okkalapa) were gainfully employed, and the majority were from low income groups. In each study, a third of women reported a history of prior (unspecified) abortions. The women in the North Okkalapa study had a higher mean parity of four. In the Yangon study,16 percent of the women were not married, a much higher percentage than in previous studies. It is possible that this is related to the criteria used for sample selection, which consisted of women with severe septic abortion. (22)

The only community-based study carried out in Myanmar to date on the socio-economic, reproductive and behavioural factors related to abortion was carried out in North Okkalapa township in 1993.(23) Among 1,010 women, a history of abortion was reported by 582 (57.6 percent), of whom 64 women admitted to having had the abortion induced. The nature of abortion could not be ascertained among the others.

When risk for abortion was determined, it was the women with no formal education and low income who had a higher risk of abortions. More than half (57 percent) had had prior abortions. Employed women and women who had been married for more than ten years were more likely to have had repeat abortions than others.

Contraceptive Use Prior to Abortion

In women admitted to hospitals for abortion complications in the 1980s, use of modern contraceptives was generally low. According to the Yangon and Mandalay studies cited earlier, contraceptive prevalence among women in the study was only 10-12 percent.(3), (4) In the Yangon study, unplanned pregnancy (pregnancy came sooner than expected) and unwanted pregnancy (desired family size achieved) accounted for 27 percent and 21.6 percent of abortions reported to be induced.

The main significant difference between women admitted to hospitals for abortion complications in the 1980s and the 1990s is that contraceptive use among them is now much higher, about 37 per cent as compared to 10-12 percent earlier. This was true for both the Yangon and North Okkalapa hospital studies.(17),(20) However, although contraceptive use has risen in that period, contraceptive failure rates also seem to be high. While this issue was not addressed in these two studies, more recent studies show that women receive little information from providers on the efficacy, side effects or appropriate use of contraceptives.(18),(19)

A study of contraceptive practice among women with induced abortion was carried out in North Okkala General Hospital in 1993. (19),(21) Of the 256 women recruited during a six-month period, 19 percent had previously used contraceptive and 26 percent of these had become pregnant following contraceptive failure. Sixty percent expressed a desire to practise contraception in future, with female sterilisation being the most favoured method.
Given their contraceptive and abortion history, some women are probably using induced abortion as a primary means of family planning, but induced abortions are also sought following contraceptive failure. Traditional methods of abortion, such as herbal preparations for menstrual regulation, abdominal massage and vaginal manipulations, also appear to be used as birth-spacing methods, according to two recent studies.(19), (25)

The 1990 National Population Changes and Fertility Survey showed that the overall contraceptive prevalence for the country was 16.8 percent, higher in the urban areas at 34.3 percent and lower in the rural areas at 10.3 percent.(24) Contraceptive pills and injectables (approximately 40 percent each) were the most widely used methods, followed by intra-uterine devices and female sterilisation. While Depo-Provera and combined oral contraceptives are available in Myanmar, once-a-month hormonal pills and injectables brought in from across the Chinese border are also used by some women. Female sterilisation is preferred by many couples who have achieved their desired family size. However, special approval from a divisional/state level board is required for a sterilisation.

Studies point to a sizeable gap between women's contraceptive knowledge and practice. A 1989 study in Mandalay, the second largest cite in Myanmar, showed that all but three percent of women had knowledge of contraceptive methods but only 21 percent were current users.(26) In a rural area near Yangon in 1990, knowledge was as high as 84 percent whereas only 10 percent were current users.(27)

Lack of information and fear of side-effects appear to be important reasons for non-use of contraception. Qualitative studies reveal that women are afraid of perforation of the womb (by the IUD), deformities in babies born in cases of contraceptive failure (for pills and injectables) and cancer. There are also some religious and cultural constraints to use of contraceptives.(18),(22)

Limited access to contraceptive services is another factor. Birth-spacing services have been offered to the public since 1970 by specialists in the teaching hospitals, state and divisional hospitals, general practitioners in the private sector and public sector providers in private practice after public service hours. Many drug shops, kiosks and other shops sell various contraceptives directly to women.
In 1991, a government-sponsored birth-spacing project was launched. It is currently providing services in 79 of the 326 townships in Myanmar, thus covering 30 percent of married women of reproductive age in the country. There are plans gradually to expand these services to cover all the country's townships. The Myanmar Maternal and Child Welfare Association, a non-governmental organisation, began providing contraceptive services in 1991 as an affiliate of the International Planned Parenthood Federation.(18)

Women's ease of access to contraceptive services thus depends on whether they live in a government programme township or not and whether the providers have been trained. It also depends on the different geographical terrains of Myanmar and the ease or lack of transportation to reach existing services.
The cost of contraceptives, although low, may also be a barrier, for poor women. Oral contraceptives cost about 10 to 20 kyats, (29) and Depo-Provera costs approximately ten times more. The once-a-month- injections from across the Chinese border are preferred by some because they are cheaper, and also because they induce monthly bleeding.

Experiences and Perceptions of Clandestine Abortion

External massage and internal manipulations were mentioned by women as common methods for inducing abortions.(3),(4),(17),(19) In the North Okkalapa community-based study mentioned above, focus group discussions revealed that abortions were procured through use of indigenous medicines as well as by intra-uterine insertion of sticks, iron rods or drugs, or curettage of the uterus.All

were common knowledge. The women were aware of the dangers, such as heavy bleeding, intense pain and fever. They also spoke of mortality from abortion, 'She started to become yellow (jaundiced) and died soon afterwards' was said by one and another noted that some die after severe infections.(23)

Some women thought abortion was not difficult or dangerous to obtain: `they have done it once and become bold'. Some women were said to undergo abortion because of marital problems or financial difficulties: 'financial problems, bad husband and plenty of children'. Others were due to exhaustion after repeated childbearing. The causes of repeat abortion were similar. (23)

Socio-economic reasons are foremost among the reasons given by women for resorting to abortion:

With the high cost of living, there is no extra money to raise a child. I had to decide to induce or to keep it. This took me to 12 weeks. After I had made up my mind not to keep it, I talked it over with my friends who had experiences with induced abortions. One of my friends took me to a woman, she massaged,my abdomen and she put her hand into my womb and stirred it until it bled. I nearly died of the pain. I miscarried at home, the pain was not relieved and I had fever. 1 did not know people could lose their lives after an abortion.'
(Primary school teacher whose husband had no steady job)(28)

'*If I could have afforded to- have the baby, I would not have done this.... I thought that the baby might not want to come out of my womb. I felt as if the baby was grasping at my heart with his two hands*.(28)

Belief that the Buddhist religion disapproves of or even condemns abortion leads to feelings of guilt among some women. In a recent household survey in 1995, 99 percent of the women interviewed said that abortion was considered to be against religious beliefs.(19)

NN has just had an induced abortion. She is a Buddhist and regards her act as 'wrong' and `unacceptable by religion'. Her mother has said that she is suffering because she deserves it. On the other hand, she believes that at eight weeks of pregnancy 'it would still be a blood clot'.(28)

The dilemmas and conflicts facing women are often poignantly expressed:
`*I did this - not because I do not have a mother's heart - the baby is my own flesh, my own blood. But there is a saying in Myanmar that when the situation is intolerable, even a mother cannot be a relative of a son.*'(28)

What does the Future Hold?

The problem of unsafe abortion as a significant cause of maternal mortality and morbidity remains as married women, particularly those who have achieved their desired family, size, may choose induced abortion when confronted with an unplanned or unwanted pregnancy. Many of the studies reviewed here suggest that there is an unmet need for contraception. This may result from lack of knowledge, lack of social legitimacy for contraception, difficulty in accessing services and other limitations in contraceptive service delivery. However, even when women do use contraception, there is a relatively high proportion of failure leading to pregnancy.

The widespread and effective use of family planning methods by those most in need of them could possibly prevent many unsafe abortions. Contraceptive services in Myanmar need to be expanded and quality of care improved, both in the public and the private sectors. This would be a first step along the long road towards putting an end to needless pain, suffering and even death -the price women still have to pay in order to control their fertility.

References and Notes

1. According to Section 312A of the Penal Code.

2. Country Profile, Burma. Department of Health, Government of Burma, Rangoon, 1975.

3. Ba-Thike K, 1982. Septic abortion at the Central Women's Hospital. MMedSc dissertation, Institute of Medicine (1), Yangon.

4. Khin-San-Wai, 1984. Septic abortion at the Mandalay General Hospital. MMedSc dissertation, Institute of Medicine, Mandalay.

5. Mya-Mya, 1980. The problem of abortion in Myanmar. Proceedings of Seminar on Abortion, 1980. Obstetric and Gynaecological Section, Burma Medical Association, Rangoon.

6. Priority ranking of diseases based on scoring system. Department of Health, Ministry of Health, Yangon. 1993.

7. Leading causes of mortality and morbidity in Myanmar. Department of Health, Ministry of Health, Government of Myanmar, Yangon. 1985.

8. Priority ranking of diseases based on scoring system. Department of Health, Ministry of Health, Government of Myanmar, Yangon. 1993.

9. *Statistical Year Book* 1993. Central Statistical Organisation, Ministry of National Planning and Economic Development, Government of Myanmar, Yangon.

10. Report on financial, social and economic conditions 1994-1995. Department of National Planning, Ministry of National Planning and Development. Yangon, 1995.

11. Nilar-Wynn and Soe-Myint, 1993. Review of maternal mortality at the North Okkalapa General Hospital. Proceedings of Seminar on Maternal Mortality, Myanmar Medical Association, Yangon.

12. Ohn-Myint. 1983. Maternal mortality at the Central Women's Hospital, MmedSc dissertation, Institute of Medicine (1), Yangod.

13. Kyu-Kyu Swe, 1983. Study of maternal mortality at the Mandalay General Hospital. Proceedings of Seminar on Maternal Mortality, Myanmar Medical Association, Yangon.

14. Tun-Yi, 1990. Causes of maternal deaths in teaching hospitals. Proceedings of Seminar on Maternal Mortality, Myanmar Medical Association, Yangon.

15. Khin-Than-Tin and Khin-Saw-Hla, 1990. Causes of maternal deaths in affiliated and district hospitals. Proceedings of Seminar on Maternal Mortality, Myanmar Medical Association, Yangon.
16. Mynit-Maung-Maung, 1990. Maternal mortality - avoidable and unavoidable factors. Proceedings of Seminar on Maternal Mortality, Myanmar Medical Association, Yangon.

17. Ba-Thike K, Khin-Thet-Wai and Tin-Aye-Khine, 1992. Socioeconomic differentials of women with severe septic abortions. *Myanmar Medical Journal*. 37:1-4/55-66.

18. Contraceptive method mix in Myanmar. WHO/HRP, Geneva and Department of Health, Ministry of Health, Government of Myanmar, Yangon. 1997 (forthcoming)

19. Ba-Thike K, Saw-Kier-Khu, Khin-Thet-Wai and Myint-Maung-Maung, 1993. Contraceptive practices in women with induced abortion. Abstracts, Myanmar Health Research Congress, Yangon.

20. Ba-Thike K. Aye-Aung, Khin-Ther-Wai and Myint-Maung-Maung, 1993. Abortion at North Okkalapa General Hospital. Abstracts, Myanmar Medical Research Congress, Yangon.

21. In both the above studies, carried out in the North Okkalapa General Hospital, women admitted for abortion complications were classified as having a certainly, probably or possibly induced abortion or a spontaneous abortion, according to the following definitions of the World Health Organization:

    - A certainly induced abortion when the woman herself provides this information, or when- such information is provided by a health worker or a relative (in case of the woman dying), or when there is evidence of trauma or of a foreign body in the genital tract.

    - A probably induced abortion when the woman has signs of abortion accompanied by sepsis or peritonitis, and the woman states that the pregnancy was unplanned (she was either using contraception during the cycle of conception or she was not using contraception because of reasons other than desired pregnancy.

    - A possibly induced abortion if only one of the 'probably' induced conditions is present.

    - A spontaneous abortion - if none-of the-conditions listed above is present, or if the woman states that the pregnancy, was planned and wanted. See Belsey M, 1989. World Health. Organization studies differentiate between spontaneous and induced abortions. Methodological Issues in Abortion Research. Population Council, New York.

22. Because of social unacceptability, unmarried pregnant women may be more at risk of serious abortion complications, both because of delays in finding someone to do the abortion and also in seeking treatment for complications.

23. Report on abortion in North Okkalapa, 1995. Unpublished project report of research funded by WHO/HRP LID grant.

24. Population Changes and Fertility Survey 1991. Immigration and Population Department, Ministry of Immigration and Population. Yangon, September 1995.

25. Women's Health and Development Country, Profile - Myanmar, 1996. Unpublished report, sponsored by WHO South East Asia Regional Office, New Delhi.

26. Mya-Mya, Than-Win. Mi-Mi-Khaing and Sil-Lay-Khaing, 1989. Preliminary report, contraceptive prevalence survey, Mandalay (Phase 1 urban). Abstracts of papers. Myanmar Research Congress, Yangon.

27. Mya-Mya and Si-Lay-Khaing, 1990. Contraceptive prevalence survey in rural Hiegu, Myanmar *Health Science Research Journal.* 4:81-85.

28. Nang-Htawn-Hla, 1996. Women's accounts of their decision to have unsafe abortion and its immediate repercussions for them. MNursSci thesis, University of Adelaide.

29. According to official exchange rates, 6 kyats = US $1. However, open market rates in early 1997 were around 160 kyats to the dollar.

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