

# How Menstrual Regulation was introduced in post-conflict Bangladesh

The liberation war in Bangladesh ended in December 1971. It left many legacies, one of which is the provision of Menstrual Regulation services. Prior to the Liberation war, abortion services were restricted by the Penal Code of 1860.

In the aftermath of war in Bangladesh many women were pregnant due to rape by war perpetrators. Menstrual Regulation was a medically reliable, politically expedient, culturally acceptable, morally correct, and humane response to this.

Menstrual Regulation is the termination of pregnancy of up to 12 weeks gestation through Menstrual Regulation Medication (misoprostol) or manual vacuum aspiration.



## KEY MESSAGES

- The post-conflict moment in Bangladesh provided an opportunity for the introduction of Menstrual Regulation services in Bangladesh which have increased women's reproductive health options and strengthened the realisation of related rights. It provides lessons for other countries which aim to adopt a gendered approach to health system reconstruction post-conflict or crisis.
- In a plural health system, Menstrual Regulation services are delivered by both the public and private sectors, including informal providers like pharmacists and village doctors which raises challenges around providing timely information on safe Menstrual Regulation options, coordination of care pathways, quality of services, and training of health care providers.
- While service access is widespread, stigma and social and religious norms and poverty effect women's health seeking behaviour, as is the case in many countries. This needs to be taken into account in efforts to coordinate the health system and support uptake.

## IMPACT OF THE CHANGES

Service provision is widespread and has positive impacts: The Menstrual Regulation policy is pioneering and has far reaching consequences for reproductive rights in the country. While abortion remains illegal, Menstrual Regulation is part of the health system in Bangladesh. A large proportion of Menstrual Regulation services are provided by the public sector (about two thirds). Union Health and Family Welfare Centers are the primary providers in rural areas. They accounted for close to half (46%) of all Menstrual Regulation procedures performed in 2010.

### Challenges remain:

- An estimated 572,000 women suffer complications from unsafe abortion each year and only 40% of those who need treatment actually receive care from a facility. Women's choice of health provider is mediated by complex factors: availability, accessibility, relationships with providers (formal and informal), expenses and perceived quality of care, the latter being shaped by notions of trust, respect, privacy and familiarity.

- Women who use services may experience stigma at the community and family levels (e.g. as destroying fetus can be viewed as a sinful), face gossip, and worry about their reputations. Stigma is more pronounced against women who have non-normative sexualities (e.g. women who have extra-marital sex; sexually active single women, young working women, divorcees, widows, and older women who continue to have sex past an age deemed appropriate by mainstream society).
- Care pathways to these services are by no means straightforward and are mediated by a number of formal and informal health systems actors. Bangladesh has a famously complex and plural health system with a range of paid, unpaid, public, private, formal and informal providers – many of whom cross these categories from time to time. There is no effective link or partnership between formal/private and informal sector for referral, coordination and communication regarding sexual and reproductive health services. Many clandestine operators and brokers exist in this mix of providers and some lack adequate training.

- Many women have a preference for providers in the informal sector because they are cheaper, easier to access, with no waiting time, and their husband can purchase pills on their behalf from local pharmacies. Increasingly Menstrual Regulation Medication is available at pharmacies which women prefer to access, as some fear the invasive procedure (manual vacuum aspiration) of Menstrual Regulation. Informal providers are usually the first point of contact even for those clients who subsequently access sexual and reproductive health services from formal providers. In addition, women who are often confused about the duration of their pregnancy, get rejected by formal clinics because they have passed the 12 weeks allowed for legal termination, and may seek assistance in the informal sector and from clandestine operators.
- There is poor quality of care in many formal facilities, which included punitive behaviors by providers and discrimination against poor women. This includes mistrust around costs incurred, poor quality counselling services at facilities. Clinical services may also be sub-optimal, for example lacking standard protocols for infection prevention and insufficient drugs and supplies.

## CONCLUSIONS

While the adoption of Menstrual Regulation services within the Bangladeshi health system has had positive effects to capitalize on this innovation in reproductive health policy further health system shifts are needed.

Quality Menstrual Regulation services remain inaccessible to a proportion of women who need them and they should be expanded as part of a simultaneous push to make modern methods of contraception available. This should be accompanied by health worker training to improve the quality of services, including the respectful treatment of clients in the public sector. Support and counselling for women should be oriented to their needs and stress the right to sexual and reproductive health services. There is a need for better

linkages and partnerships between the informal and public and private sector, creating incentives for close-to-community and service providers to ensure timely referrals to Menstrual Regulation services and to ensure that appropriate care is given.

These changes will require continued investment on the part of government – ensuring supplies, drugs, incentives for providers, continual training of providers, and other support required in clinics and facilities. Community awareness raising is needed and training for CTC providers on importance of timely referral, within an effective referral system.

## A FEW KEY REFERENCES

“Menstrual Regulation and Induced Abortion and MR”, Guttmacher Institute, <https://www.guttmacher.org/fact-sheet/menstrual-regulation-and-induced-abortion-bangladesh>

“Menstrual Regulation: Past, Present, and Future Challenges”, Policy Dialogue by Population Council, Bangladesh, (June, 1999) <http://www.popcouncil.org/uploads/pdfs/banglapolicydialogue9.pdf>

Nashid, T. and Olsson, P. (2007), “Perceptions of Women about Menstrual Regulation Services: Qualitative Interviews from Selected Urban Areas of Dhaka”, *Journal of Health, Population, and Nutrition*, 25(4):392-398

“Menstrual Regulation and Induced Abortion in Bangladesh”, (September, 2012), Guttmacher Institute <https://www.guttmacher.org/fact-sheet/menstrual-regulation-and-induced-abortion-bangladesh>

Mahmud et al. “Supporting the Health System to Respond to the Needs of Women in Bangladesh: Close to Community Health Service Providers and Menstrual Regulation”, *Health Systems Global*, February, 29, 2016 <http://www.healthsystemsglobal.org/blog/99/Supporting-the-health-system-to-respond-to-the-needs-of-women-in-Bangladesh-Close-to-community-health-service-providers-and-Menstrual-Regulation.html>

Nashid, T. and Olsson, P. (2007), “Perceptions of Women about Menstrual Regulation Services: Qualitative Interviews from Selected Urban Areas of Dhaka”, *Journal of Health, Population, and Nutrition*, 25(4):392-398

“Menstrual Regulation and Induced Abortion in Bangladesh”, (September, 2012), Guttmacher Institute <https://www.guttmacher.org/fact-sheet/menstrual-regulation-and-induced-abortion-bangladesh>

Mahmud et al. “Supporting the Health System to Respond to the Needs of Women in Bangladesh: Close to Community Health Service Providers and Menstrual Regulation”, *Health Systems Global*, February, 29, 2016 <http://www.healthsystemsglobal.org/blog/99/Supporting-the-health-system-to-respond-to-the-needs-of-women-in-Bangladesh-Close-to-community-health-service-providers-and-Menstrual-Regulation.html>

Vlassoff, et al. (September, 2012), “Menstrual Regulation and Post-abortion Care in Bangladesh: Factors Associated with Access to and Quality of Services”, Guttmacher Institute

## ACKNOWLEDGEMENTS

This brief was written by based on research done by the BRAC JPG School of Public Health, BRAC University and the REACHOUT Consortium. The REACHOUT programme has received funding from the European Union Seventh Framework Programme ([FP7/2007-2013] [FP7/2007-2011]) under grant agreement No. 306090. Research in gender and ethics (RinGs): Building stronger health systems is funded by the UKAID. The views expressed are not necessarily those of the Department for International Development.

### Suggested reference:

Rashid SF, Mahmud I, Hawkins K, Theobald S, Mahfuza R, Chowdhury S, and Sarker M (2017) “How Menstrual Regulation policy and services were introduced in post-conflict Bangladesh”, *Building Back Better/Research in gender and ethics: Building stronger health systems (RinGs)*