Menstrual regulation (MR) services were first introduced in the Bangladesh national family planning program in 1974. Hundreds of thousands women have undergone MRs to control their fertility and maintain desired family size since the inception of services. MR services are offered throughout the country in government and selected NGO clinics by trained Family Welfare Visitors (FWVs) and physicians.

One of the outstanding questions of the program is how many MRs are actually performed each year. Reported numbers have remained almost constant since 1986-87 when just over 80,000 was reported. According to the government service statistics 85,000 MRs were performed in 1998. Although during the past fifteen years the number of trained providers and clinics where MRs can be performed has increased dramatically. It has raised questions about whether trained providers are accurately reporting the services they provide. Unfortunately, no recent studies have focussed on the question. One of the most recent, which was conducted a decade ago concluded that the 2,000 providers interviewed reported only 44 percent of the MRs they performed and that the government service statistics captured only 29 percent of the total MRs (Amin et al. 1989). Other studies during the same period confirmed these findings (Begum et al. 1987).

Another question is who uses MR services? With contraceptive prevalence rate (CPR) more than 50 percent, and unmet need for family planning contraceptives reported at 16 percent, it would seem there are few women who experience an unwanted or mistimed pregnancy (Mitra et al. 1997). Apparently this is not so. MR is used by all types of women in Bangladesh to control their fertility – rural and urban, younger and older, rich and poor. The most recent profile of women indicates that majority of MR acceptors are 25-30 years old and are housewives. Education levels among the MR clients are higher than the national average and only about a quarter of MR clients have no education (SIDA 1996).

This Policy Dialogue examines the MR services that have been available in the past and continue to this day. Using the most recent studies, the Policy Dialogue will consider essential issues of the present program and the challenges for the future. Finally, it will pose policy questions particularly concerning issues of quality, which require the attention of policymakers, program managers and service providers.

What Is MR?

MR is a unique reproductive health care service in Bangladesh. It is defined as “…an interim method of establishing non-pregnancy for a woman who is at risk of being pregnant, whether or not she is pregnant in fact” (Akhter 1986, Dixon-Mueller 1988). Done by vacuum aspiration, and without a pregnancy being established, MR can be used within eight to ten weeks after a missed menstruation. In a sense, MR
offers an insurance policy for women who do not wish to be pregnant but may not be contracepting properly. It is also useful for women who have a contraceptive failure.

Effective MR services are an essential part of a comprehensive reproductive health service program. The Programme of Action, which emanated from International Conference on Population and Development (ICPD1994), stresses the essential nature of those service, and the prevention of unwanted or mistimed pregnancies. Clearly, after appropriate family planning services, the availability of appropriate MR services are an essential service for women who are trying to control their fertility and avoid unsafe abortions.

The strategy of the Bangladesh government is to ensure easy access that women have to essential health care services of acceptable quality. Adequate training and supplies are ensured to minimize unsafe abortion or MR. Ministry of Health and Family Welfare policy documents suggest that “provision of quality MR services will also play an important role in lowering the number of septic abortions with low complication rate and thus reducing morbidity and mortality due to illegal abortion” (MOHFW 1997).

Historical Perspective

In the mid-1970s when MR services were introduced in Bangladesh, it was a bold step born out of the war of independence. Prior to 1972, abortion services were restricted by the Penal Code of 1860 that allowed abortions only to save the life of a mother. Yet, in spite of this severe limitation the First Five-Year Plan (1973-78) observed:

“Legalization of abortion has been known as probably the best and most effective method for control of population growth. It should be seriously considered how this method can be adopted to control the population growth in Bangladesh.”

This observation opened the door to develop a MR program in urban clinics. The purpose was “birth control” and a back up for contraceptive failure. The initial criteria for receiving a MR were very strict, as described in documentation from the Model Clinic in Mohammadpur.

“This service is available in Model Clinic to married women who request medical treatment for delayed menstruation for family planning purposes only (Khan 1977).”

In addition to these strict criteria, women needed spousal consent and the MR had to be done prior to the tenth week of gestation. The program was always under special care and scrutiny in the early years and many studies were conducted to insure that the “right women” were receiving services. Among the issues studied were socio demographic characteristics of acceptors (Akhter and Rider 1983); the complications (Akhter 1982, Bhatia et al. 1980, Obaidullah and Khan 1981); the clients’ knowledge of family planning and contraceptive use (Rahman 1980).

As early as 1986, researchers raised questions about the number of procedures being conducted. Akhter (1986) reported that 60,000 MRs were performed in Bangladesh annually and linked that to the figure of Rochat et al. (1981) who estimated 800,000 abortions were done each year. The author expressed concerned that MR services were not reaching enough women – particularly those of high parity, less educated rural women.

The MR Services Today

The services for MR are provided through three main channels: the training centers of the government – Menstrual Regulation Training and Services Program (MRTSP); at government facilities provided by FWVs and physicians; and by selected NGOs – the Bangladesh Association for the Prevention of Septic
Abortion (BAPSA); the Bangladesh Women’s Health Coalition (BWHC), BRAC and the Marie Stopes Clinic Society. The services are coordinated by the government through the Coordination Committee of MR Associations in Bangladesh (CCMRA,B). This association includes MRTSP, BAPSA, the BWHC and the Mohammadpur Fertility Services and Training Centers (MFSTC).

Who Provides MR?

Most MRs are provided by FWVs in government clinics. More than 12,000 physicians and paramedics have been trained and the services are available in 4,000 service points (MOHFW 1998). These service points include: the Health and Family Welfare Centers (H&FWCs), the Thana Health Complexes, the Maternal Child Welfare Centers (MCWCs), District Hospitals and Model Clinics attached to medical colleges. There are large numbers of NGO clinics, that provide MR services, most located in urban areas.

BAPSA maintains records on training and reports these regularly in its newsletter. The most recent figures indicate that a total of 5,933 FWVs and 7,338 physicians have been trained (BAPSA 1998). However, not all of these trained providers are at their posts. Ross and Chowdhury (1997) estimated that only 3,800 FWVs and several hundred trained physicians are actually at government service points.

The possible MR services provided in the private sector have not been documented recently. It has been reported that 30 percent of formally trained physicians and 35 percent of those informally trained provide MRs in private clinics (Amin et al. 1989). An additional 34 percent of the trained physicians and 25 percent of those informally trained reported performing MRs in private homes. It is certainly possible that physicians continue to provide this service privately. In the same study, formally trained FWVs reported performing two percent of their cases in private clinics and an additional 22 percent in private homes. Similarly informally trained FWVs performed two percent in private clinics and 18 percent in private homes.

Who Seeks MR Services?

MR is used by women in all age groups. The Bangladesh Demographic and Health Survey (BDHS) conducted in 1996-97 reports that 20 percent of women said they had a pregnancy termination at some time during their reproductive life (Mitra et al. 1997). Sixteen percent reported more than one termination. Approximately six percent of women ages 25-39 reported ever using MR whereas only two percent of 15-19 year olds and nearly four percent of 40-44 year olds reported MRs. The majority of women who had a pregnancy termination did so in the first trimester. However, pregnancy termination was reported as late as the sixth month of gestation. There are urban and rural, as well as regional differences in pregnancy termination. Urban women are more likely to have a MR than rural women.
The most recent profile of urban MR clients is available from BAPSA (September 1998) and is based on their Dhaka clinic clients. During an eight-month period in 1997, 3,473 women sought MR services of which 17 percent were randomly selected for a profile analysis. More than ninety percent of the clients came from the area immediately surrounding the clinic. The average age was 27 years, and 98 percent were currently married. One third of the clients were non-literate while 61 percent had education to class V and above. Most of the women reported they were housewives. The mean number of living children was less than two (1.83) and most clients indicated they did not want any more children. The youngest child was reported to be nearly four years old. Approximately one-quarter of the clients seeking MR services had a history of a previous MR. Just over sixty percent of the clients reported using a contraceptive methods at the time they became pregnant and one-quarter reported that the pregnancy was due to contraceptive method failure. Fifty percent of condom users and 18 percent of oral pill users failed to use the method correctly and conceived.

Ahmed examined more than 14,000 pregnancy outcomes in 6,668 rural women and found three percent were cases of induced abortion (Ahmed et al. 1996). The profile of these women is similar to those from the BAPSA study. They are about 28 years old, the majority had no education, and the probability of an abortion increased after two children. Caldwell et al. (1977) also reported that the probability of a woman terminating pregnancy increased with her age and number of living children.

The contraceptive method failure as a reason for seeking MR services must be highlighted because of its implication on a national level. Nearly half the current method use is oral pill. If oral pill failures are as common in the national program as these appear to be for the BAPSA clients, it indicates that thousands of couples may be experiencing unwanted pregnancies due to incorrect oral pill use. Other small studies in rural areas also corroborate this finding. Caldwell et al. (1997) found that several women who had accepted abortion services were condom users at the time they became pregnant. Hossain et al. (1997) reported more than half of the women were using contraceptives at the time they fell pregnant. The majority was using a modern method – mainly oral pills or condoms.

How Many MRs are Being Reported?

Since the inception of the MR program, 1.4 million MR have been reported by the government service statistics. However, as early as 1989, that number was disputed by several authors (Amin et al. 1989). After interviewing providers, the authors concluded that the providers reported only 44 percent of the MRs they performed and that the government service statistics captured only 29 percent of the total MRs performed in the country. In an earlier study, Begum et al. (1987) found that one-fifth of formally and informally trained physicians submitted MR performance reports and only five percent of informally trained “others” did so. Better reporting compliance was done by FWVs, with three-quarters submitting regular performance reports.

Under reporting persists even today. Fewer than 100,000 MRs are reported each year though the actual number is estimated to be much higher (Akhter and Rider 1993). The number of MR officially reported includes more than one third performed annually by the training organizations. Findings from studies conducted by BAPSA suggest that on the average a trained FWV performed more than 70 MR cases per year, which would total 300,000 cases per year compared to around 100,000 cases reported by the service statistics. It is not fully clear why this under reporting persists but the phenomenon is also confirmed by Caldwell et al. (1997). Their research points to a problem of reporting associated with charging for services. In theory, MR is provided free of charge by government hospitals and health facilities. In practice, however, charges are often levied.
What Happens to Rejected MR Clients?

Women who are rejected for MR because their pregnancy is too far advanced or for other reasons, often continue to seek a termination. Kamal and Begum (1990) report that two-fifths of the rejected clients they interviewed made subsequent attempts to find pregnancy termination services. The limited information available on rejection indicates that it is high. A review of the MR program by the International Women’s Health Coalition (1994) reported that 30,000 clients (17 percent of all clients) were rejected in training centers alone between 1991-94. Most clients were rejected because they came too late after their missed menstruation. This principal reason for rejection has changed little in the nearly two decades of the program. The results of a systematic study of why clients are rejected and their subsequent behavior could facilitate improved client counseling in MR facilities. Rahman (1980) reported the principal reason for rejection as no consent of husband (27 percent) followed by missed menstruation of more than ten weeks. Consequently IWHC concluded that “the challenge of informing women that services are available and helping them understand that they must seek services early, is as yet largely unaddressed (IWHC 1994). The results of a systematic study of why clients are rejected and their subsequent behavior could facilitate improved client counseling in MR facilities.

What about Quality?

There has been no recent comprehensive study of the quality of MR services. The limited information, however, is a cause for concern. In a situation analysis of the Rajshahi Division’s government service points it was reported that complete MR kits were found in only 22 percent of clinics (Rahman et al. 1996). The IWHC review of MR services also mentions equipment shortages as a quality concern. In addition, this review highlighted following quality issues for immediate attention:

- need to improve training, particularly the techniques used by trainers; lessons should include on adopting aseptic technique maintaining an MR register and ordering MR kits
- the review of medical protocols, particularly in four areas, including post-MR IUD insertion and developing protocols for clients with symptoms of RTIs
- counseling
- contraceptive services

This list of quality issues needs attention because the MR program has not received the attention to quality of the family planning program. It is possible that less-than-optimal services may be offered in some circumstances.

Are MR Services Serving All Women in Need of Pregnancy Termination?

The question is whether MR has eliminated the need for traditional abortion services. This does not appear to be the case. Studies of the subject are small and limited. However, there is clear evidence that women still use traditional abortion when they have an unwanted or mistimed pregnancy. The 1996-97 BDHS data
indicate nearly nine percent of women who had their last pregnancy terminated did so by traditional means (Mitra et al. 1997). The greatest number of abortions were reported by women in the 25 to 29 age group. The majority had their abortions in the third or fourth month of gestation though an alarming 15 percent waited until the sixth month. Ahmed et al. (1996) reported half the cases of induced abortion were done in potentially unsafe conditions, done at home either by non-medical personnel or the women themselves. The authors further report that one-third of pregnancy termination clients waited until the 12th week of gestation, or beyond, before seeking services. Caldwell et al. (1997) found their respondents could not differentiate between MR and abortion by traditional means. Informants use a number of closely related Bengali terms to describe pregnancy termination – pete fela, baccha naushto and baccha fela.

Like MR itself, there are no systematic studies of traditional abortion providers or the clients who chose to use them. This is clearly a difficult study topic since all parities involved in traditional abortion practice are reluctant to talk about their work. However, it is apparent from limited hospital-based studies that traditional abortions still have a deleterious effect on women’s health in Bangladesh. A hospital-based study found that, out of 1,300 cases of abortion complications approximately two-thirds resulted from induced abortions (Begum et al. 1991). The clients average 26 years of age and were equally from urban and rural areas. The vast majority (96 percent) were married with three or more children. The personal costs to women were high, as was the cost of the services. The majority required extensive clinical services, i.e. more than 75 percent required a dilation and curettage evaluation (D&C) which would have to be supported by medications and nursing care. Even with appropriate care, 18 women in this study died as a result of their pregnancy termination. In an anthropological study of cases of septic abortion in four hospitals, Hossain et al. (1997) learned the costs to the client for hospital services ranged from Taka 200 to Taka 25,000. Most clients spent between Taka 1,000-2,000 with some having to borrow money, sell their assets or use emergency savings to pay for hospital services. The use of traditional abortions and the resulting costs to the health system require further study and analysis.

**Policy Questions**

There are many outstanding and critical questions concerning MR services. Considering that MR is an essential reproductive health service, it is unacceptable that these questions remain unanswered. It is particularly unacceptable that pregnancy termination figures first established in the late 1970s are still used today. This figure (800,000) is not based on current fact and should be reexamined.

The quality of the MR program also demands immediate attention. The family planning service program has been enhanced by sustained attention to quality. The same level of attention is required for MR services. The following are some of the policy questions that, which require immediate attention. Some of these require research but others can be answered through supervision and monitoring of the facilities and personnel trained to provide MR services.

- The first benchmark to establish is the number of MRs being performed in sanctioned facilities. A rapid survey of all levels of service points where MRs are performed, followed by interviews with service providers would begin to establish correct numbers.
- A profile of MR clients should be collected from the training facilities; other government service points; and, NGO clinics. This profile should include: demographic characteristics; pre-pregnancy contraceptive use; post-MR contraceptive use; reasons for rejection of contraception; MR history; and complications experienced during or following the procedure. The latter findings on complications should be incorporated in the training curricula.
- The MR training curricula should be reviewed and updated to ensure that the full benefit of new clinical procedures in infection prevention and pain management are fully incorporated.
• Counseling is another training area that requires review, particularly the counseling of rejected clients and of clients, who may need RTI treatment following the MR.
• Because of constraints from donors, it has not been possible in the recent past to always provide MR services that are fully integrated with family planning, RTI, or other reproductive health services. This is no longer the case since ICPD. Thus a systematic review to ensure that MR facilities provide an integrated approach to services could successfully be undertaken now.
• Potential clients are not adequately informed regarding MR, either when it should be performed or why there is a clear advantage to MR over traditional abortion services. Efforts to develop and disseminate appropriate Information Education Communication (IEC) for MR are essential.

REFERENCE:


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