POLICY BRIEF

Expanding Access: Scaling Up Comprehensive Menstrual Regulation Care In Bangladesh

The experience of Menstrual Regulation (MR) service in Bangladesh is relatively old, however the access to quality MR service remains a critical public health, equality, and human rights issue. MR service has been available and free of charge in the government's family planning program since 1979. Ministry of Health and Family Welfare (MoH&FW) included MR service in the Essential Service Package (ESP) in 2016, making them available at union and higher-level health facilities. Despite the availability of MR services, gaps remain in accessibility as well as in providing respectful and stigma free care, particularly in rural and underserved areas. As a result, women aged 15 to 49 often resort to unsafe abortions performed by untrained individuals using unsafe and invasive methods, leading to maternal mortality and morbidities. The Government's leadership – including the Directorate General of Family Planning (DGFP), the Directorate General of Health Services (DGHS), the support of Sexual and Reproductive Health and Rights (SRHR) implementers, professionals, and donors has been instrumental in expanding the access by scaling up Comprehensive MR Care throughout the country.

Menstrual Regulation (MR): is defined as uterine evacuation with or without laboratory or ultrasound confirmation of pregnancy for women who report recent delayed menses.

Source: Bangladesh National Comprehensive Menstrual Regulation (MR) and Post-abortion Care Guideline, MoH&FW, 2021.

Comprehensive Menstrual Regulation Care (CMRC): Comprises counseling, safe MR service, post abortion care (PAC), post-abortion family planning, address other sexual and reproductive health services and stigma free service.

Source: According to Abortion Care Guideline 2022, (WHO)

AIMS OF THIS BRIEF

This policy brief focuses on initiatives and interventions at the national, divisional, district, union health facility, and community levels to create an enabling environment for the availability and accessibility of MR care through a comprehensive national scale-up. It aims to inform decision-makers about the country's MR service context, helping prioritize initiatives for the effective expansion of MR services to enhance women's health and reproductive rights in Bangladesh.

KEY AUDIENCES

- Policymakers under MoH&FW and Ministry of Local Government, Rural Development and Co-operatives (MoLGRD&Co)
- Directors, managers under DGFP, DGHS, Directorate General of Nursing & Midwifery (DGNM)
- Private facility managers
- NGO managers (national and international)
- Humanitarian response actors
- Development partners
- SRHR stakeholders
- Civil society actors

MAGNITUDE OF BURDEN IN BANGLADESH

The World Health Organization (WHO) recommends supportive laws and policies for access to quality abortion care[i] . However, under the Penal Code of 1860, induced abortion in Bangladesh is permissible only to save a woman's life.

The unintended pregnancy rate declined by 37% between 1990–1994 and 2015–2019 in Bangladesh. [ii] During the same period, the abortion rate increased 26% and the share of unintended pregnancies ending in abortion rose from 30% to 60%[iii] . Unsafe abortion is an important preventable cause of maternal deaths, which contributes to 7% of maternal mortality[iv].

SERVICE AVAILABILITY AND ACCESSIBILITY IN HEALTH CARE FACILITIES [v]

The report 'Access to and Quality of Menstrual Regulation and Post-abortion Care in Bangladesh: Evidence from a Survey of Health Facilities, 2014' by the Guttmacher Institute, explores MR and PAC services situation in Bangladesh.

42% of public- and private- facilities permitted to provide MR services

50% of all union health and family welfare centers (UH&FWCs) provided MR services

92% of service providers aged 20–29 reported they do not provide MR due to a lack of training at UH&FWCs who do not offer MR services

71% of all types of facilities reported having both the equipment and trained staff required to provide MR. However, only half of these facilities provided MR services

27% of women seeking MR services at public and private facilities were rejected

63% of private facilities were equipped to provide MR, only a third of them provided MR services

38% of service providers at UH&FWCs do not offer MR services as they do not like to perform MR.

85% of non-poor urban women would receive care for complications, compared with only 47% of poor rural women

84% Oral contraceptive pills are provided to the MR client as contraceptives among the facilities offering services

BANGLADESH CONTEXT ON MENSTRUAL REGULATION: LAW AND POLICIES

Law	Restrictive under the Penal Code 1860, induced abortion is permissible only to save a woman's life.
Policy situation	1974: MR services introduced by Government of Bangladesh. 1979: MR has been part of Bangladesh's national family planning program. 2016: MoH&FW includes MR in the ESP of the ministry. Post abortion care (PAC) is an integral part of Emergency Obstetric and Newborn Care (EmONC) irrespective of Gestational age.
	MR as per the demand of the women can be performed by Manual Vacuum Aspiration (MVA) • By trained midlevel providers within 10 weeks of the missed period. • By trained doctor within 12 weeks of the missed period. 2014: MR by Medication (MRM) introduced in the national program and is currently allowed up to 10 weeks of the missed period.
National Strategy	Not available
National Guideline	Available and endorsed in 2021

EXISTING SERVICE PROVISION OF MR, PAC SERVICES

Level, Types of Providers, Facilities		Up-to 12 weeks	Up-to 24 weeks	Post- abortion Care
WHO can provide?	Specialist physician*	✓	Not available	✓
	Doctor*	✓	Not available	✓
	Mid-level provider**	✓	Not available	✓
How to provide?	By Manual vacuum aspiration	✓	Not available	✓
	By medication (up-to 10 weeks of missed period)	✓	Not available	Not defined
Facility level	All tiers of health facilities up to the union level	✓	Not available	Upazila health complex and above level. Union level facility can provide upon the availability of trained service provider

* Trained provider and can perform MR up-to 12 weeks of missed period.

** Mid-level provider: Midwives, Nurse, Family Welfare Visitor (FWV), Sub Assistant Community Medical Officer (SACMO)-Female, paramedics-Trained provider and can perform MR up- to 10 weeks of missed period).

NATIONAL READINESS FOR IMPLEMENTATION OF COMPREHENSIVE MR CARE (CMRC)

Focal point	No designated focal person is available at DGHS and DGFP. Other existing Program Managers under the DGFP and DGHS are providing support.
National committee	• National Technical Committee (NTC) led by the Director General, DGFP formed in 1987, provides technical and clinical approval on SRHR issues. • No national steering committee to monitor implementation of MR and PAC services.

Funding	• Government funding is limited but the operational plans (OP) of the 5th Health Population Nutrition Sector program (HPNSP) under MoH&FW have incorporated several health systems strengthening interventions. The OPs are
	  • MCRAH, FSD, MIS, IEM, CCSDP of DGFP,
	  • MNCH, HSM, MIS of DGHS
	  • DGNM
	• Less Donor support to implement MR services for increasing quality access.

National training manual on CMRC	Government of Bangladesh (GoB)-approved training manual on CMRC is available. However, the duration, content, and facilitation techniques differ between the GoB and NGO settings.
Logistic availability	MVA, MRM, and other necessary logistics and equipment integrated into OPs since 2017 but the availability of MVA and MRM medicines in government supply is challenging due to budget constraint for procurement and unavailability of local authorized distributors of MVA.
Advocacy	SRHR stakeholders, NGOs, Professional organizations- Obstetrical and Gynecological Society of Bangladesh (OGSB), CSO platforms, and UN agencies have a positive commitment to MR and PAC services. However, negative notions of some provider and government officials about the safety of abortion self-care and easy access to MRM drugs.
Awareness campaign	Limited MR specific community awareness program is implemented by MoH&FW and its Directorates (e-health e.g Shukhi Pariber, Sathaya Batayon provide information in limited scale).

Monitoring and research	DGHS	DGFP
Indicators included in the national HMIS	Included in the DHIS 2	Standard indicators are not included. Standardized variables and indicators are essential across the MIS inluding e-MIS, DHIS-2.
Data recorded at health facilities	DGHS starts reporting of MR and PAC from September 2022 through DHIS-2.	Need to Strengthen record keeping system. In 2023, 90 DGFP's facility received the service register. Rest of the facilities need supply MR-PAC register.
Research	• Limited initiatives on research for the evidence-based practice by GoB. • Study on the incidence of MR and induced abortion, access to and Quality of Menstrual Regulation and Post-abortion Care in Bangladesh should be conducted which needs budget allocation.	

Recommendations

1. **National scale-up:** Plan to scale up of Comprehensive MR Care to increase accessibility and availability of MR services across the country
2. **Government commitments:** Government commitments and a positive policy environment are crucial for the acceleration and sustainability of quality MR services as per national guideline.
3. **National scale-up strategy:** A National scale-up strategy with a costed action-plan on comprehensive MR care is essential to ensure equitable, accessible, and respectful safe MR services for women and girls in the country.
4. **National steering committee:** It is essential to establish for national scale-up to monitor implementation and provide necessary directives.
5. **Funding:** Appropriate allocation and proper utilization of GoB funding for the national scale up and donor support is essential along with GOB allocation.
6. **Designated focal person:** A designated focal person at the Directorate level to lead the national scale up to ensure alignment with national policies, monitoring and facilitate coordination among stakeholders.
7. **Skilled and competent service provider:** A structured training program should be scaled up to increase the skill, and competencies of service providers.
8. **Stigma reduction:** The GoB program should include interventions like 'Values Clarification and Action for Transformation (VCAT),' which is specifically designed to reduce stigma among service providers, managers, and community health workers. Additionally, the program should focus on identifying local champions who can motivate and mentor others, fostering a positive and supportive environment.
9. **Commmunity awareness** initiatives, e-health services should be stregthened.
10. **Planning for strengthening procurement and supply chain management** at the relevant directorate level under MoH&FW.
11. **Strengthen the tracking system:** Establish and functional service tracking system (MIS) to monitor data and to monitor the progress of routine MR services.
12. **Create a Civil Society Organization (CSO) platform:** CSO acts as an advocacy platform to support the policy environment and put the SRHR issues on the policy agenda.
13. **Encourage research:** Research provides evidence-based insights that can shape effective policies and guidelines for comprehensive MR care.

CHALLENGES AND MITIGATION STRATEGIES

Challenges	Mitigation Strategies
Political instability, budget constraints, and resistance from certain stakeholders may pose challenges to the scale-up of comprehensive MR care.	Advocacy, continuous stakeholder engagement, commitment and contingency planning will be essential to overcoming these challenges.

The successful scaling up of Comprehensive MR Care in Bangladesh is crucial for safeguarding women's sexual health and rights. Immediate policy implementation, resource allocation and sustained commitment from government and all SRHR stakeholders are necessary to achieve this.

Reference:

[i] Abortion Care Guideline WHO 2022- citation is World Health Organization. (2022). *Abortion care guideline*. World Health Organization. https://apps.who.int/iris/handle/10665/349316

[ii] Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015–2019. BMJ Global Health 2022;7:e007151. doi:10.1136/ bmjgh-2021-007151

[iii] Bearak JM, Popinchalk A, Beavin C, et al. Country-specific estimates of unintended pregnancy and abortion incidence: a global comparative analysis of levels in 2015– 2019. BMJ Global Health 2022;7:e007151. doi:10.1136/ bmjgh-2021-007151

[iv] Bangladesh maternal mortality and health care survey (BMMS) 2016

[v] Hossain A et al., Access to and Quality of Menstrual Regulation and Postabortion Care in Bangladesh: Evidence from a Survey of Health Facilities, 2014, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/menstrual-regulation-postabortion-care-bangladesh.

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