National Baseline Research
Claiming the Right to Safe Abortion: Strategic Partnerships in Asia

BANGLADESH

Determining the quality of MRM services in Southern and Central Bangladesh

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LIST OF ACRONYMS AND ABBREVIATIONS

BAPSA	Association for Prevention of Septic Abortion, Bangladesh
BCC	Behaviour Change Communication
BDT	Bangladesh Taka
BWHC	Bangladesh Women's Health Coalition
CSO	Civil Society Organisation
DGFP	Directorate General of Family Planning
D&C	Dilation (or dilatation) and curettage
FGD	Focus Group Discussion
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
IDI	In-Depth Interview
KII	Key Informant Interview
LMP	Last Menstrual Period
MCH	Maternal and Child Health
MCWC	Maternal and Child Welfare Centre
MOHFW	Ministry of Health and Family Welfare
MR	Menstrual Regulation
MRM	Menstrual Regulation with Medication
MSB	Marie Stopes Bangladesh
MVA	Manual Vacuum Aspiration
NGO	Non-Government Organisation
PAC	Post Abortion Care
RHSTEP	Reproductive Health Services Training and Education Program
SACMO	Sub-Assistant Community Medical Officer
SRHR	Sexual and Reproductive Health and Rights
UH&FWC	Union Health and Family Welfare Centre
UHC	Upazila Health Complex
WRA	Women of Reproductive Age

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EXECUTIVE SUMMARY

Bangladesh has a well-established system for terminating unwanted pregnancies called menstrual regulation (MR). In 1979, the Government of Bangladesh (GoB) approved MR as an "interim method of establishing non-pregnancy" for women at risk of being pregnant, regardless of whether they were actually pregnant. In 2013 the GoB introduced menstrual regulation with medication (MRM) with mifepristone and misoprostol in the public sector which is allowed up to nine weeks after a woman's last menstrual period (LMP). A guideline, Bangladesh National Service Delivery Guideline for MRM was launched in 2015 by the Directorate General of Family Planning (DGFP), GoB.

Considerable research on MR has been conducted in Bangladesh over the years but information on MRM is limited. A clearer understanding on the gaps in the quality of services is required from the perspective of service providers as well as clients. In addition, utilisation of post abortion care (PAC) services which have been found to be weak in Bangladesh also needs to be better understood. This study was therefore designed to understand gaps in service, barriers to accessing and receiving services and the needs of women who are clients of MRM. The information thus generated is expected to help inform policy makers and service providers to take evidence based action and to enhance demand for safe MRM services that take into account women's needs.

Based on this rationale the research objectives of the present study are:

1. To determine the quality of services for providing MRM, including counselling, at all levels (Government, NGO and pharmacies)
2. To determine whether women of reproductive age (WRA) receive full knowledge regarding MRM and have access to the full range of services
3. To determine whether complications experienced by women following MRM are treated adequately when receiving PAC services from different facilities (Government, NGO)
4. To determine sex worker's knowledge and access to MRM and quality of services received by them including their perception on whether they are treated with dignity and respect

The study was a cross sectional one using both qualitative and quantitative methods and was conducted in Dhaka and Barishal Divisions of Bangladesh.

Under the study, service providers and clients of MRM were sampled. Service providers included those from government facilities, NGOs and pharmacies. 31 government and NGO facilities were covered (24 from Dhaka and 7 from Barishal). Among these, only 24 facilities (Dhaka-18, Barisal-6) were providing MRM services currently. In addition, 63 drug sellers (Dhaka-25, Barisal-38) from different pharmacies were included. Clients included women of reproductive age (WRA) (18-49 years) who may or may not have used MRM and those with complications following MRM. Female sex workers from the streets of Dhaka city were included to represent a marginalised group of women. All clients were 18 years and above.

Data was collected using different methods and tools which were physical observation of facilities, in-depth interviews (IDIs) of service providers, administration of a semi structured questionnaire to service providers, and Focus Group Discussions (FGDs) with drug sellers, WRA with and without complications and female sex workers. Key Informant Interviews (KIIs) were conducted with senior personnel from DGFP, MOHFW, three NGOs and a senior drug seller, all from Dhaka.

The study was approved by the Ethical Review Committee of the Bangladesh Medical Research Council. Informed consent was taken from all participants – written for the IDIs and questionnaires and oral for the others.

The findings of the study showed that MRM is popular with women both urban and rural and also with female sex workers and there is a demand for this service. Many (service providers and clients) felt it should be made available to all women, irrespective of age and marital status but a some were against this. Pharmacies were the most used source of MRM but many service providers were not in favour of easy access through pharmacies and wanted more control over

who can prescribe; some were adamant that pharmacies should not be allowed to sell while others felt selling should only be permitted with a prescription from a registered doctor. The reason for this opposition was because complications were more frequent in women who took MRM medicines from pharmacies than from clinics which also created a negative impression of MRM on policy makers at the DGFP. Service providers in clinics, both government and NGO, were generally more likely to provide comprehensive services to women resulting in fewer complications.

General awareness regarding MRM was poor amongst women, especially rural women. Also, female sex workers who were younger and new to the sex trade were not aware of MRM. Women wanted more information while receiving services. There are no programmes or campaigns to raise awareness about MRM.

Female sex workers were found to be more aware than other women regarding MRM and, in some cases, frequent users. However, not all followed the dose regimen; many did not pay heed to precautions such as avoiding sexual intercourse soon after taking MRM medicines. This disregard stemmed from their need to return to earning their livelihood by selling sex as soon as possible.

Presence of male drug sellers and male service providers in facilities posed a barrier to many women seeking MRM as they felt inhibited talking about their reproductive health with men.

MRM medicine is not available in government clinics currently but service providers in some MCWCs do render services provided women purchase the MRM medicines from elsewhere. To overcome this shortcoming, the government has recently procured MRM medicines and has started distribution of those medicines. However, the number of MRM kits that have been procured is not based on what the demand may be as clinics have not placed a requisition. Some NGOs also had run out of their stock of MRM medicines at the time of visit.

Staffing in some clinics was not adequate, many were not trained on MRM and most of those trained had not received training recently. There are no refresher training programs. The vast majority of drug sellers in pharmacies have had no formal training. Very few clinics had dedicated counselling staff; in most clinics counselling was provided by other staff. Counselling tools were not used. National MRM guidelines were not available at most facilities and drug sellers were not even aware of its existence. BCC materials were by and large absent from most facilities.

Negative attitudes of service providers towards women seeking to terminate pregnancies was reported. Some did not approve of MRM based on personal and religious grounds but nonetheless service providers in clinics felt duty bound to provide services even if it went against their beliefs. Some expressed concern about unmarried girls and young girls seeking MRM and considered it as sinful behaviour and selling to them was equivalent to encouraging promiscuity. Behaviour of service providers towards MRM or PAC clients from clinics was often negative with disrespectful language being used frequently.

All NGO clinics took written consent in a standard format. They insisted on a guardian's consent only if the client was underage. Government facilities did not take consent neither did pharmacies.

Location of most clinics and pharmacies was close to the residences of clients. Pharmacies were open at all times even during holidays and weekends but timing of clinic facilities especially government facilities, was too short and service providers were often not available after lunch and they were shut on holidays and weekends. Clinic facilities kept records of women using MRM but pharmacies did not. Several clinics kept electronic records but robust record keeping was not always observed.

Cost was an issue for some women, for both MRM and PAC services, and this led to some buying part of the MRM Kit or not completing their PAC.

Complications were more commonly reported by women accessing MRM medicines from pharmacies. In most cases their complications were dealt with successfully by clinics/hospitals so that they recovered fully. However, a few women continued to suffer from various problems. The

case studies revealed that meagre means, limited information about existing services and limited access to those services were major hindrances to obtaining PAC services.

The government led working groups or committees on abortion are not functional at present as no meeting of the MR and MRM Alliance was held in 2018. There is very little coordination between NGOs and between government and NGOs.

Based on the findings, recommendations have been provided separately for government, NGOs and for Naripokkho.

1. INTRODUCTION

1.1 COUNTRY PROFILE: SOCIO-ECONOMIC AND POLITICAL CONTEXT

Bangladesh has a population of 1,61,750,000 (Bangladesh Bureau of Statistics 2014) of which 33% are under age 15 (BDHS 2014). The population growth rate is 1.37 (BDHS 2014), total fertility rate is 2.3 per women (BDHS 2014), the Adolescent (15-19 years) Fertility Rate is 113 live births/1000 women (BDHS 2014)and 31% adolescents (age 15-19) has already started childbearing (BDHS 2014). The sex ratio at birth is 1.04 male/female (Bangladesh Demographics Profile 2018). The Contraceptive prevalence rate is 62.4% (BDHS 2014) and the maternal mortality rate is 196 per 100,000 Live Births (BMMS, 2016). The median age of marriage is 17.2 years (MCH Services Unit and Directorate General of Family Planning 2016).

Bangladesh has a Parliamentary form of Government since 1991. The health care system comprises of Government, Private and non-government organisation (NGO) /philanthropic organizations. The government system is elaborate and extends down to the level of the community through community clinics that serve a population of 6000. However, the health system is weak, and generally services are poor and often absent, infrastructure is unreliable. Gaps are met by an active NGO community, however; their reach is not as wide as that of the government so that remote and isolated population groups do not have access to health services. Civil Society Organizations (CSOs) are highly active in Bangladesh and play a pivotal role in providing services and ensuring that these are rights based.Overall, the Out of Pocket Expenditure on health is very high (64.3% of the total health expenditure) (Huq et al. 2015).

Bangladesh is aspiring to reach the lower middle income status, but a large proportion of the population are poor and rural to urban migration is common. Displacement is sometimes due to climate change and river erosion. Migration abroad for work is common which often leaves women behind to manage the homestead but women also migrate to work abroad but in smaller numbers. Migration is often associated with negative societal attitudes especially towards women who are often seen as “loose women” and who are subject to discrimination when they return home (Alam et al. 2016).

1.2 SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN BANGLADESH: LAWS, POLICIES AND GOVERNMENT COMMITMENT

The Constitution of the People‘s Republic of Bangladesh has guaranteed human rights, such as the protection of the right to life and personal liberty (Article 32-Bangladsh Constitution: MoLJPA). It clearly states that there shall be no discrimination “against any citizen on grounds only of religion, race caste, sex or place of birth” and that, “women shall have equal rights with men in all spheres of the State and of public life”(Article 28-Bangladesh Constitution: MoLJPA).

The National Health Policy (NHP) of Bangladesh is based on the principle that “every citizen has the basic right to adequate health care. The State and the government are constitutionally obliged to ensure health care for its citizens.” The health sector seeks to support creation of an enabling

environment whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. With a vision that recognizes health as a fundamental human right the need to promote health is imperative for social justice. This vision derives from a value framework that is based on the core values of access, equity, gender equality and ethical conduct.

Some major objectives as outlined in the NHP states clearly articulates various provisions to develop the health and nutrition status of the people as per Section 18(A) of the Bangladesh Constitution by establishing a system to ensure easy and sustained availability of health services for the people, especially communities in both rural and urban areas and adopt necessary and satisfactory measures for ensuring improved maternal and child health and reproductive health resources and services. One of the most important objectives of NHP is to make health service equitably affordable and accessible to all and ensuring an efficient and effective quality health service. The NHP therefore emphasizes on Gender Equality in Health and focuses on (i) ensuring rights of women for a better physical and mental health at all stages of their life cycle, (ii) strengthening PHC for women with emphasis on reducing MMR and IMR, (iii) strengthening reproductive rights and reproductive health of women at all stages of population planning and implementation, (iv) preventing women from HIV/AIDS and STD through awareness raising, and (v) creating women-friendly physical facilities at all public health complexes. Moreover, efforts will continue to (i) communicate the importance of ANC, delivery care and PNC to all household heads at the grass root level, (ii) give special training to service providers at the community and higher levels on gender equity and (iii) include topics on the health needs of both males and females and their impact on gender disparities in school curriculum. (NHP: MOHFW 2011)

The strategies in the National Population Policy (NPP: MOHFW 2012) of Bangladesh has declared a client-centred approach to provide maternal and child health and reproductive health services from all levels of health facilities (including the Community Clinics) and to bring newlyweds, adolescents, parents of one or two children and couples with unmet need under the coverage of family planning services on priority basis. One of the major objectives of the population policy is ensure the availability of family planning methods to eligible couples by providing easy access to reproductive health services; build awareness among the poor and the adolescents of family planning, reproductive health, reproductive tract infections and HIV/AIDS. The other important objective is to prioritize counselling services and ensure gender equity and women's empowerment, and strengthen activities to eliminate gender discrimination in family planning and maternal and child health care programs. The policy also clearly articulated to ensure easy access to information on reproductive health including family planning at all levels.

Bangladesh has also ratified five major international human rights treaties including the International Covenant on Economic, Social and Cultural Rights; the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and its optional protocol; the Convention on the Rights of the Child (CRC) and its optional protocol; the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families; and the Convention on the Rights of Persons with Disabilities and its optional protocol. These treaties are legally binding documents under international law and compliance of each signatory nation is being monitored by routine reporting system. They call on governments to eliminate all forms of discrimination and some specifically address discrimination against women. Mechanisms for the adoption of convention articles into national laws are outlined in the treaties and periodic reports are tendered to the monitoring committees by states for review and recommendations.

Government of Bangladesh was in agreement of the Alma Ata Declaration (1978) and The World summit for Children 1990. The Government of Bangladesh has also made commitments to other major international declarations and goals that relate specifically to reproductive health, such as the International Conference on Population and Development (ICPD-1994) Programme of Action, the Beijing Platform for Action or Beijing Women's Conference(1995), the Millennium Development Goal (MDG 2000) Declaration and the United Nations General Assembly Special Session on

HIV/AIDS and the Special Session on Children and last of all the recent Sustainable Development Goal (SDG-2015) Declaration. Government Commitment to all these international declaration is also reflected in different policies and programmatic action to improve the reproductive health situation as well as protection of reproductive rights especially of women and adolescents.

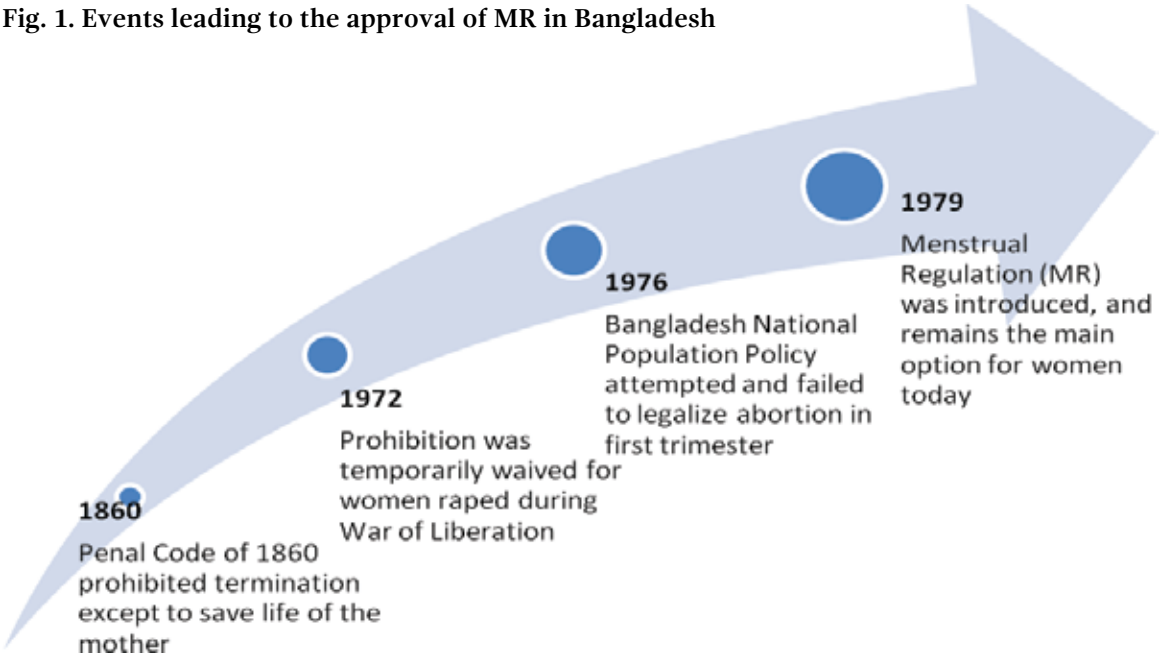
In Bangladesh a number of laws and policies relating to the adolescents have been adopted, which directly and indirectly contribute to addressing the overall health and wellbeing of adolescents. The government has given priority of ensuring adolescent health and has incorporated this issue in several of its policies: Bangladesh Population Policy of 2012 emphasize on the objective of raising awareness among adolescents on family planning, reproductive health, reproductive tract infection and HIV/AIDS. Moreover, the Bangladesh National Children Policy of 2013 also focuses on adolescent development including the development of the girl child and ensuring health services to the adolescent girls. The adolescent health related programmes under the preview of the MoHFW include provision of adolescents Friendly Health Services, school health programs, counselling and raising awareness on reproductive health issues, and preventing STI/and HIV/AIDS through education and treatment services. In this regard the role of the development partners, civil society and private sector support were encouraged to promote adolescent health. In the first Adolescent Reproductive Health strategy document mentioned that: all adolescents should have easy access to information, education and services required to achieve a fulfilling reproductive life in a socially secure and enabling environment (National Strategy for Adolescent Health-2017-2030).

It may be noted that neither the health policy nor the population policy specifies anything about MR as overall reproductive health policies and strategies encompasses all aspects related to reproductive health services.

1.3 ABORTION: COUNTRY SITUATION, CRITICAL ISSUES AND ATTEMPTS TO ENSURE THE RIGHT TO SAFE ABORTION

In 1979, the Government of Bangladesh (GoB) approved menstrual regulation (MR) as an "interim method of establishing non-pregnancy" for women at risk of being pregnant, regardless of whether they were actually pregnant (Johnston et al. 2011). The historical events leading to this approval is depicted in Fig 1.

Fig. 1. Events leading to the approval of MR in Bangladesh

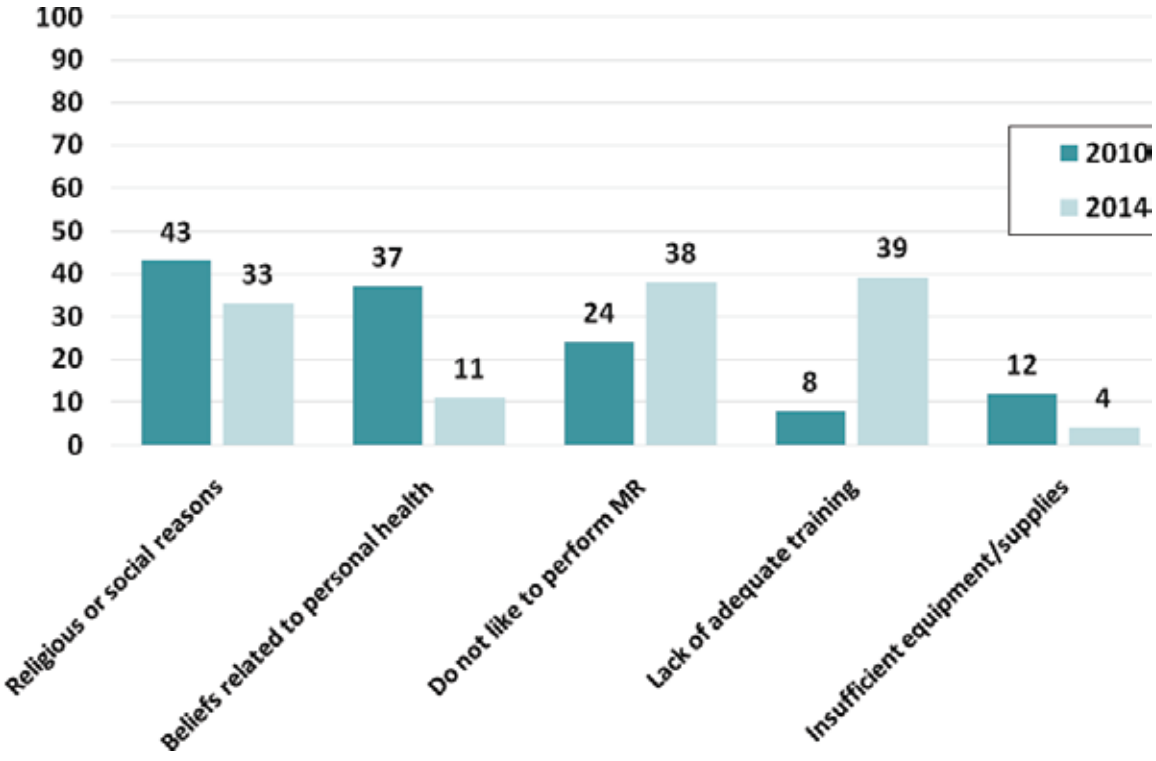


MR involves the use of manual vacuum aspiration (MVA) up to 12 weeks (paramedics are allowed to provide up to 10 weeks) after the woman's last normal menstrual period. MR is included in the Essential Service Delivery package allowing it to be made available at health clinics. It is widely available throughout the country at Union Health and Family Welfare Centres (UH&FWCs), Upazila Health Complexes (UHC) and Maternal and Child Welfare Centres (MCWC) and in some NGO and private clinics. There is a large range of private providers, from qualified physicians and FWVs to untrained MR practitioners. There are also traditional providers for MR and abortion services which include Kobiraj, homeopathic doctors, village doctors and quacks.

In Bangladesh, unintended pregnancies and abortions in women aged 15-49 years is not uncommon (Hossain et al. 2017) and in 2014, 58% of unintended pregnancies and 28% of all pregnancies ended in induced abortion and MR when there were an estimated 1,194,100 abortions (29 per 1,000) (Singh et al. 2017).

BDHS 2014 evidenced that 45% of ever married and 46% of currently married women knew about MR and those who heard about MR 12% for ever married women and to 13% for currently married women had ever used it and the use rate increased from nine percent in BDHS 2011. The 2017 study by NIPORT conducted facility based exit interviews of WRA at various levels of government, non-government and private facilities and documented that 57% of WRA knew the correct duration of doing MR indicating that wide knowledge and information gap still persisted. Complications from unsafe abortions often occur (Hossain et al. 2017). In 2014 treatment was provided in 257,000 women of which 48% was for haemorrhage. It has been suggested that the latter could be due to incorrect use of misoprostol with or without mifepristone (Singh et al. 2017). Between 2010 and 2014 the rate of MR declined by 40% in women aged 15-49 years and this was observed in government, private and the NGO clinics (Singh et al. 2017). The reasons provided by the Family Welfare Visitors (FWVs) for the decline were multiple as shown in Fig. 2.

Fig. 2. Reasons cited by FWVs for not providing MR (Singh et al. 2017)



Despite the wide availability of MR services, accessibility is often restricted due to a number of factors such as lack of women friendly environment in most primary level government facilities

with little privacy and lack of confidentiality, failure of the providers to generate confidence of their clients, unofficial payments for services (the service is supposed to be provided free of cost), distance of government health facilities and presence of unauthorized brokers especially around the government facilities who often mislead clients to visit private and often untrained providers. (Chowdhury et.al. 2004).

A recent study by NIPORT has also evidenced that access to MR services is restricted by rejection of clients for various reasons, most important of which is the longer duration of pregnancy (LMP more than 10-12 weeks), followed by medical reason, 'have no consent from husband', high cost and fear of the procedure (NIPORT 2017).

Consent for MR is required from women and in special cases where the woman may be mentally handicapped or young, consent is required from guardians/husbands/relatives (Directorate General of Family Planning 2015). And here again, cultural, religious and other barriers (Fig. 2) are prevalent so that women often access abortion services that are not legal leading to complications (Hossain et al. 2017).

High cost is a big barrier for the clients especially those from the poverty groups who may resort to take the service from the less qualified provider or unqualified traditional abortionists or quacks. Minor age of the clients and 'client was not married' were also evidenced as other reasons for rejection. The same study also evidenced that around one-third of the facilities do not provide MR services because of the lack of trained providers and that some providers even after receiving training do not provide the MR services for socio-religious reasons and personal attitude. (NIPORT 2017).

Similar findings were evidenced from other studies saying that of the public and private facilities that would be expected to provide MR services only 57% did so with a wide range of variations among divisions (37-76%). Only two-thirds of Union Health and Family Welfare Centres provided MR in 2010. Shortage of trained providers, lack of equipment and religious and cultural reasons are key reasons for not providing MR services. The rate of rejection of MR clients seeking services is estimated to be 26% and the most frequently cited reason for rejection was exceeding the official limit for performing the procedure (Vlassoff et al. 2012).

Many health facility managers do not see MR as an important service requirement and the attitudes of providers in the government sector vary widely. Some refuse to provide MR services on religious grounds while others refuse at public facilities but provide MR services privately. In cases of illegitimate pregnancies clients often face hostile behaviour from providers (Chowdhury et al. 2004).

Because of the lack of knowledge and awareness about the risk and consequences of pregnancy termination, and also about the duration within which pregnancy can be terminated, many clients who are often rejected by the MR providers resort to unsafe methods of abortion to take service from untrained providers and quacks. Women who come to hospital to get MR done after the permissible duration may not have the knowledge and information about the number of weeks up to which MR could be performed. Rejection has the risk of increased unsafe abortion and due to unavailability of services at the periphery the adolescent couples are at risk of having MR services as and when they need it mostly from easily available unqualified providers. (NIPORT, 2017).

These barriers have made menstrual regulation with medication (MRM) popular which is often not correctly used leading to incomplete abortion and complications. A clinical trial conducted under the close supervision of physician and midlevel provider in 10 facilities in Bangladesh reported 93% success rate and 92% women reported the use of medication satisfactory and very satisfactory and almost all women reported they would recommended using pills for menstrual regulation to a friend and would prefer the method if they required another procedure (92%). The providers were also supportive of the method as it reduced the risk of infection and engaged women's privacy and dignity (Anadil et al. 2013).

As only anecdotal evidence suggesting that MRM is gaining popularity was available, a rapid assessment was conducted in 2009 in 62 pharmacies by Marie Stopes Bangladesh (MSB) (Rasul

2009) to assess its use. This revealed that 51% of drug sellers knew of various drugs for inducing abortion and 30% of drug stores and pharmacies were selling these to women thus confirming the widespread availability of MRM. In order to assess feasibility of introducing MRM in Bangladesh, a study was conducted between January 2012 to June 2013 (Hena et al. 2013). In this study 14 sites were purposively selected from 8 Dhaka Division districts - 3 MCWCs of the GoB, 8 UH&FWCs of the GoB and 3 MSB clinics representing the NGO sector. Findings showed that MRM was popular as 63% women selected MRM and the reasons provided were that it was less invasive (54%), surgery not required (34%), less risky (29%). All service providers were trained on providing MRM during this survey and <5% required MVA following MRM, ~19% experienced side-effects with Mifepristone and ~63% with Misoprostol and quality of services (measured as a composite score) was found to vary between facilities with MCWC at 0.85, UH&FWC at 0.73 and MSB at 0.88.

Given the new evidence, the GoB introduced MRM with mifepristone and misoprostol in the public sector in 2013. MRM is now allowed up to nine weeks after a woman's last menstrual period (LMP). A guideline, Bangladesh National Service Delivery Guideline for MRM (MCH Services Unit and Directorate General of Family Planning 2015) was launched in 2015 by the Directorate General of Family Planning (DGFP), GoB.

Following the introduction, a cross-sectional survey was conducted (Huda et al. 2018) among 553 pharmacy workers followed by 548 mystery client visits to the same pharmacies in 3 municipal districts during July 2014-December 2015 to determine the quality of services provided through pharmacies. This study revealed considerable gaps in services received by clients as shown in Table 1.

Table 1. Comparisons of MRM services reportedly provided by pharmacy workers and those received by mystery clients

	Reported by Pharmacy workers	Findings from mystery clients
Correct dosage of mifepristone-misoprostol	36% knew the dose	54% were provided
Provided information on effectiveness of the medicines	70%	42%
Recommended at least one follow-up visit to them	50%	12%
explaining possible complications of MRM	63%	11%
offering any post-MR contraception to their clients	47%	5%

Another study that interviewed 20 women using MRM in rural and urban areas showed overall satisfaction with the method but also observed complications in four of them where MRM failed (Marlow et al. 2015). Women wanted assurance of greater privacy and confidentiality, less stigma around the use of the medication and most felt that information on MRM was not readily available in women's communities. Another study found that over 90% of 651 women taking MRM were satisfied with the method (Alam et al. 2013).

Among all women, female sex workers are particularly vulnerable because of the stigma associated with their profession. There are an estimated 92,572 female sex workers in Bangladesh among whom 36,593 operate from streets and the maximum number are found in the streets of the capital city Dhaka (NASP 2016). Despite enhanced attention towards sex workers primarily for HIV prevention services (UNAIDS 2000), they remain a highly marginalized and stigmatized group of women (Benoit et al. 2018) and commonly face violence including sexual violence from general members of society, family as well as their clients (ASP, IEDCR, and icddrb 2017). The main target of the HIV prevention programmes is towards HIV and overall sexual and reproductive health and rights (SRHR) services are secondary and often overlooked (Katz et al. 2015, Wahed, Alam, Sultana, Rahman, et al. 2017). Unwanted pregnancies among sex workers is

common and many have undergone MR and also use MRM services (Wahed, Alam, Sultana, Alam, et al. 2017, Katz et al. 2016) thus highlighting an unmet need among this highly vulnerable and marginalized group of women.

Moreover, the procedure needed more counselling than the surgical one, and time consuming to make the client understand the whole procedure and its physical consequences. The other challenge is the loss of control (loss to follow up) over the final outcome. Providers supporting of the method also expressed concern about the implication of widespread availability and lack of monitoring of the pharmacies (Anadil et al. 2013).

1.4 THE LEGAL AND HISTORICAL CONTEXT OF MR AND MRM

Under the Penal Code of 1860, in Bangladesh abortion is permissible only for saving the life of the mother. In all other cases abortion, self-induced or otherwise is a criminal offence punishable by imprisonment or fines. Abortion in Bangladesh as a Muslim country is permitted only if the continuation of a pregnancy would endanger a woman's life. The abortion law of Bangladesh, under the Penal Code of 1860, induced abortion is permitted in Bangladesh only to save the life of the mother. In 1972 the law was waved for women who were raped during the war of liberation. Abortions were performed in few district hospitals under guidance of expert teams from Bangladesh, India, UK and USA. Menstrual Regulation (MR) services have been available in the Government's family planning program as a public health measure since 1974 and in 1979 the MR program was officially included in the national family planning program. In 1976 the Bangladesh National Population Policy attempted to legalize first trimester abortions on broad medical and social grounds, but legislative action was not taken and restrictive legislation remains in effect. (Akhter, 1993).

Despite the restrictive nature of the law, the goB declared in 1979 that menstrual regulation is an "interim method of establishing non-pregnancy'" for a woman at risk of being pregnant, whether or not she is pregnant in fact. (Ali et al.,1978). MR is, therefore, not regulated by the Penal Code restricting abortion. A memorandum from Population Control and Family Planning Division (PCFPD) categorically stated that "menstrual regulation" (MR) is one of the methods used in the national Family Planning Programme. The memorandum quoted report from the Institute of Law (1979) to the effect that MR does not come under the provision of Penal Code Section 312 in regard to abortion because pregnancy cannot be established. Bangladesh Institute of Law (1979) mentioned the following:

In the eyes of law abortion is a punishable offence in many countries of the world including Bangladesh, but the use of menstrual regulation makes it virtually impossible for the prosecutor to meet the required proof. In our country menstrual regulation is being carried out till the tenth week following a missed menstrual period, and after that patients are referred as abortion cases. MR is now recognized as an interim method of establishing non-pregnancy for the woman who is at risk of being pregnant. Whether or not she is, in fact, pregnant is no longer an issue (p.31)'.

The MR program has evolved and become the part of Bangladesh national family planning program despite of restricted abortion law in the country. The Bangladesh government's Family Planning Division circular states that MR is included in the official policy and that a necessary logistic support for MR services and training will be provided by the Division. Another government memorandum permits that MR can be performed by an MR-trained registered medical practitioner and by any Family Welfare Visitor (FWV) who has specific training in MR. It also specifies that an FWV should perform MR only up to eight weeks from the last menstrual period (LMP) under supervision of physician. Any case with a longer duration must be referred to trained doctor (Akhter 1993). MR services are now widely available throughout government health facilities starting from Union Health and Family Welfare Centre (UHFWC), Upazila Health Complexes, Maternal and Child Welfare Centres(MCWC), District Hospitals and Medical College Hospitals where the procedure is mostly performed by the trained FWVs/nurses/ paramedics. In the non-government sector many NGOs and private clinics are providing MR services. Although NGOs providing the services get the procedure performed by paramedics specifically trained on MR and is regulated by the government

authority for reporting, the area remains grey in case of for profit private sector who does not report to the authority nor is it clear whether an MR-trained provider is providing the services. Recently in 2013 the government has increased the gestational age limit of MR from 8 weeks of LMP for FWV/SACMO/Nurse to 10 weeks and for the trained doctors from 10 weeks to 12 weeks.

In 2014 the MR with medication has also been approved by the government up to 9weeks of gestation. In 2002, Mifepristone, an abortificient, got approval in India following which different stakeholders in Bangladesh expressed their interest to introduce the drug in Bangladesh. In 2004, WHO launched a safe abortion guideline through a launching workshop held in Bangkok? Participants from Bangladesh who attended this workshop brought the idea of introducing Mifepristone. They submitted a proposal to National Technical Committee (NTC) to introduce Menstrual Regulation with Medication (MRM). An MRM working group was formed to introduce MRM in Bangladesh. The objective was to convince the government to introduce MRM in Bangladesh and act as an advocate for the approval of MRM in the country. Since 2007, a group of activists with the support of Gynuety and headed by icddr,b started working to introduce this new technology-Menstrual Regulation with Medication(MRM)in Bangladesh. A network of researchers and professionals were keen to support this initiative and during 2008-2010, icddr,b with a few reproductive health care service providing organizations such as BAPSA, RHSTEP, Marie Stopes Bangladesh (MSB) conducted a trial aimed at increasing provider's knowledge and interest in the topic and creating "Local Expert". Later, DGFP in collaboration with Population Council and MSB with the support of World Health Organization and DFID funded STEP-UP project and completed a study that assessed the acceptability of MRM drugs. Use of MRM in the national family planning programmewas approved by the NTC of DGFP.

Though MR with medication was approved in 2013 but abortificient medication was available even before the approval. The combination drugs (mifepristone and misprostol) are now widely available in the country over the drug stores as a kit and as many as 12 pharmaceutical companies are producing the drugs. Few doctors and paramedics were also given training to provide MRM services and it is being gradually expanded in the public facilities. Until 2012, MVA was the only option for MR in the country. In 2013, the Directorate General of Drug Administration (DGDA), Bangladesh approved the combination pack of mifepristone and misoprostol for MR, which was approved to use up to 9 weeks of missed period (memo #DA/lab/cart/242/011/2559, 25 Feb 2013).

DGFP in February 2015 circulated a memo regarding the approval of MRM in Bangladesh stating that 200 milligram (mg) of mifepristone tablet and 800 microgram (mcg) of misoprostol tablet can be used for MR within 6-9 weeks of LMP. For effective result, at first Mifepristone 200 mg should be taken orally followed by a single dose of Misoprostol 800 microgram in 24 hours either buccally, sublingually, or vaginally. The circular further added that MR Service Providers should have proper training on MRM prior to providing this service to their clients. (Memorandum 2015. No: DGFP/MCH-RH/pro-sha (admin) 23/05/108).

1.5 ABORTION: GAPS IN UNDERSTANDING THE ISSUES AND ADDRESSING OF THE ISSUE

In Bangladesh availability of MR has allowed women to terminate their unwanted pregnancy in a legal and safe way. However, it has always been challenging to make a precise estimate of the magnitude of MR and abortion in Bangladesh for various reasons as many women would like to keep the matter strictly private and confidential, there is no denial of under-reporting from the public sector, private sector performances are never reported into the system, performances of the clandestine untrained providers providing unsafe abortion facilities can never be captured and true statistics of illegal abortion is nowhere available. It is almost impossible to generate reliable data on incidence or prevalence through community-based surveys of such a culturally sensitive topic as abortion because under reporting will plague such attempt. This challenge of estimation further escalates with the wide-scale availability of MRM drugs in the open market leading to its indiscriminate and unregulated use. Considerable research on MR has been conducted in Bangladesh over the years but information on MRM which is relatively new in Bangladesh is limited. A clearer

understanding on the gaps in the quality of services is required from the perspective of service providers as well as clients. In addition, utilisation of post abortion care (PAC) services which have been found to be weak in Bangladesh (Owolabi, Biddlecom, and Whitehead 2019) also needs to be better understood. So, the measurement of the real contribution of MR and MRM to the reduction of total fertility has to be investigated in future adopting new research designs.

This study was therefore designed to understand gaps in service, barriers to accessing and receiving services and the needs of women who are clients of MRM. The information thus generated will help inform policy makers and service providers to take evidence based action and will enhance demand for safe MRM services that take into account women's needs.

2. RESEARCH OBJECTIVES

This study had the following specific objectives:

1. To determine the quality of services for providing MRM, including counselling, at all levels (Government, NGO and pharmacies)
2. To determine whether women of reproductive age (WRA) receive full knowledge regarding MRM and have access to the full range of services
3. To determine whether complications experienced by women following MRM are treated adequately when receiving PAC services from different facilities (Government, NGO)
4. To determine sex worker's knowledge and access to MRM and quality of services received by them including their perception on whether they are treated with dignity and respect

3. RESEARCH METHODOLOGY

This was a cross sectional, mixed method study utilising both qualitative and quantitative methods.

3.1 COVERAGE OF THE STUDY

3.1.1 Geographical coverage

The study was conducted in Dhaka and Barishal Divisions of Bangladesh. The selected geographical areas are shown in the map in Fig. 3. In Dhaka, Dhaka city was included covering both North and South City Corporation areas. In Barishal, the study was conducted in Barishal City and Barguna District under which four Upazilas and four Unions were included.

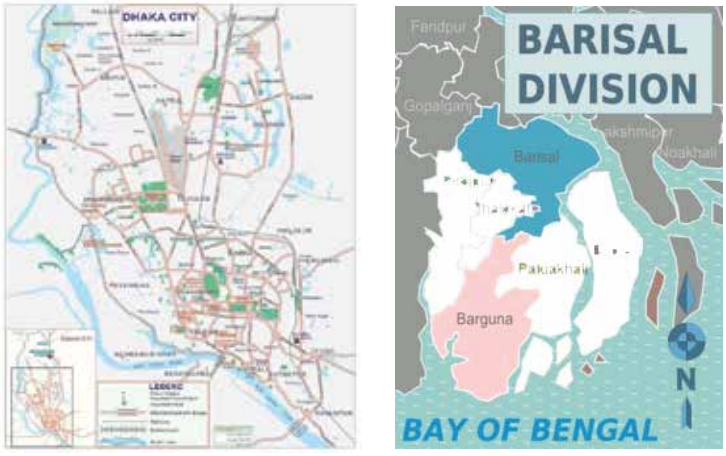


Fig. 3. Maps showing selected sites within Dhaka City and Districts in Barishal Division (Barishal City and Barguna)

Geographically, Barishal is located in the south-central part of Bangladesh. The division is bordered by the Bay of Bengal in south which is the unique feature of this area. There is a strong network of rivers and canals across the area. This is amongst the hard-to-reach region of Bangladesh with its limited resources. Some key features of the study area are presented in the table 2. The table shows the demographic health service (BDHS 2014) TFR (total fertility rate) for Barishal division is 2.2 and 2.3 for Dhaka, median age of first birth of child among women aged 20-49 is 18.4 and 18.5 for Barishal and Dhaka respectively. In Barishal 23% of women give birth to their first child is at the age of 15-19 while in Dhaka the number is 25.6%. Due to this fact, Naripokkho has been working closely in Barishal division on health and rights issues of women since 2003.

Table-1: Key features of Barishal and Dhaka District

	Barishal	Dhaka
TFR	2.2	2.3
Median age of first birth age 20-49	18.4%	18.5%
Women give birth of first child 15-19	23%	25.6%
Using any Family planning method	63.3%	63%
Median Number of Births since Preceding Birth	57.6*	53.9
Desired to Limit Child Bearing (including women with living children)	64.3%	60.3%
Wanted Fertility	1.6	1.6

* (4th highest among all divisions)

Source: BDHS 2014

Naripokkho has been conducting research and advocacy and lobbying to improve the status of women's health rights for three decades. Most of it's working areas include Barishal and Dhaka divisions which helped the study to access adequate respondents and resources. Naripokkho's strong linkage with DGFP (Directorate General of Family Planning) and MoHFP (Ministry of Health and Family Planning) was proven useful to have interview with services providers from government health facilities.

3.1.2 Coverage of facilities

Under the study, 31 government and NGO facilities were covered;24 from Dhaka and seven from Barishal. Among these, only 24 facilities (Dhaka-18, Barisal-6) were providing MRM services currently. Of theseven facilities that were not providing MRM services six never provided these services, however they did provide PAC services to women who came with complications following MRM. Only one facility had earlier (up to December 2016)provided MRM services which had to be stopped due to lackof supply of MRM medicines. It is noteworthy that government facilities that were currently providing MRM services, had no MRM medicines in stock and in order to provide services theyrequested clients to buy medicines elsewhere and return to them forreceiving all support services.

In addition to these facilities, 63 drug sellers (Dhaka-25, Barisal-38) from different pharmacies participated to 10 FGDs.

Table 2. Clinic facilities and pharmacies currently providing MRM services that were sampled

	Geographical area	Facilities sampled	Number of facilities
Dhaka Division	1 District – Dhaka City 2 City Corporation areas South and North	Government Maternal and Child Welfare Centre (MCWC) in Mohammadpur	1
		NGO Clinics	17
		Pharmacies	25
Barishal Division	2 Districts – Barishal City and Barguna	MCWC in Barishal city	1
		NGO Clinics	4
	4 Upazilas	Pharmacies	11
		Government Upazila Health Complex (UHC) in Baher Char	1
		Pharmacies	27

3.1.3 Study Groups sampled

Service providers of MRM and recipients (referred to as clients) were sampled. Service providers included those from government facilities, NGOs and pharmacies. The NGOs included were Bangladesh Women's Health Coalition (BWHC), BAPSA, MSB and Reproductive Health Services Training and Education Program(RHSTEP).Clients included WRA (18-49 years) who may or may not have used MRM services and those with complications following MRM. Female sex workers from the streets of Dhaka city were included to represent a marginalised group of women.

All clients who participated in the study were 18 years and above.

3.2 TOOLS USED FOR DATA COLLECTION

Data was collected using the following tools:

1. Physical observation of facilities – field staff directly observed facilities to check the services available using a guideline (annexe 1)
2. In-depth interviews (IDIs) of service providers –one-on-one interviews were conducted with different service providers using a guideline (annexe 2)
3. A semi structured questionnaire (annexe 3) was administered to different service providers at different facilities
4. Focus Group Discussions (FGDs) were conducted using guidelines (annexes 4-7) with drug sellers, WRA with and without complications and female sex workers. Two field staff were engaged with each FGD, one was responsible for conducting the FGD and another was a note taker. Discussions were also recorded.
5. Key Informant Interviews (KIIs) were conducted with senior personnel from DGFP,MOHFW, three NGOs (Ipas, MSB, RHSTEP) and a senior drug seller. All were from Dhaka.

Case studies were also documented from two WRA who experienced complications from MRM.

3.3 DATA ANALYSIS

Data from the IDIs and FGDs were manually noted. Each script was coded and analysed by Atlas.ti, a computer software for qualitative data analysis. Quantitative data were entered and frequencies analysed using SPSS.

Data from different sources were triangulated to obtain a holistic understanding of the situation from the perspective of service providers and clients.

3.4 ETHICAL IMPLICATIONS

The study was approved by the Ethical Review Committee of the Bangladesh Medical Research Council. Informed consent was taken from all participants – written for the IDIs and questionnaires and oral for the others.

Due to lack of decision making power of women in the family, it quite happens that women cannot decide for herself whether they want children or not and when to have them. Therefore, women sometimes have to hide the abortion (MR and MRM) from their husbands and other family members. Although we took their informed consents about their participation in the research, all the information will be preserved in a locked file and password protected computer which can only be accessed by the research personnel for the domestic and social protection of respondents. No personal identity is and neither will be disclosed in the research report.

3.5 STUDY PERSONNEL

Five field staff were recruited who conducted the field work. A ten-day training was provided to the newly recruited staff as well as voluntary staff from Naripokkho who were engaged in the study. A field trial was conducted prior to starting the field work in facilities and with personnel who were not included in the actual study. Monitoring was conducted by the Project Director and voluntary stafffrom Naripokkho.

4. BASELINE RESEARCH FINDINGS

Research findings are presented from the perspective of service providers and clients addressing the four objectives presented in section 2.

4.1 SERVICE PROVIDERS' PERSPECTIVE

For this data obtained through observations, IDIs, questionnaires, FGDs and KIIs that were conducted at facilities and with service providers have been considered and data were triangulatedto obtain a holistic understanding.

The facilities and service providers covered by each study tool is detailed below and summarised in Table 2.

- *Observation of facilities:* 24 health facilities which were currently providing MRM services were observed physically. Of these 24, 18 were from Dhaka and six from Barishal. In Dhaka, 17 were NGOs and one was a government institution. Of the six in Barishal, 4 NGOs and two government facilities were observed.
- *Interviews using a questionnaire:* 41 service providers (Doctor-8, Paramedic-21, Nurse-3. Counsellor-6, Technical Officer-1, FWV-1) were interviewed using the structured questionnaire. Among them 37 were from Dhaka and four from Barishal.
- *IDI of service providers:* 31 service providers participated in IDIs, 24 from Dhaka (Doctor-17, Paramedic-8, FWV-3, Sub-Assistant Community Medical Officer [SACMO]-1, Nurse-1, and Training Officer-1) and seven from Barishal (Doctor-1, Paramedic-3 and FWV-4).
- *FGDs with drug sellers:* Ten FGDs (4 in Dhaka and 6 in Barishal) were conducted with 63 drug sellers (Dhaka-25, Barisal-38) from different pharmacies.

Table 3. Sampling of service providers from different clinic facilitiesand pharmacies

Survey Methods	Study sites	Study participants
Observation n=24	Dhaka City n=18	
	1 MCWC	NA
	6 NGO clinics at 17 sites	NA
	Barishal n=6	
	MCWC and UHC - 2	NA
	4 NGO clinic and 4 sites	
Questionnaire n=41 At 22 facilities	Dhaka City n=37	
	1 MCWC	2
	6 NGOs clinics at 17 sites	35
	Barishal n=4	
	1 MCWC and 1 UHC	2
	4 NGOs in 2 Districts	2
IDI n=31 At 24 facilities	Dhaka City n=24	
	1 MCWC	2
	6 NGOs clinics at 17 sites	22
	Barishal n=7	
	1 MCWC and 1 UHC	2
	4 NGOs in 2 Districts	5
FGD n=10 With 63 drug sellers	Dhaka City n=4	
	Dhaka city	4 drug seller groups
	Barishal n=6	
	2 District	2 drug seller groups
	2 Upazila	4 drug seller groups
KIIs with 5 senior personnel	Dhaka City n=5	
	Dhaka city	From DGFP, MOHFW 3 NGOs 1 pharmacy

As services provided through clinic facilities are distinct from that from pharmacies, the data from these two sources (clinic facilities and pharmacies) are considered separately.

4.1.1 MRM SERVICE PROVISION THROUGH CLINIC FACILITIES (GOVERNMENT AND NGOs)

a) Opening times

All service providers interviewed said that the opening times were convenient for women. Government facilities provided services from 8:00am to 2:30 pm but in some cases such as in the UHC in Barishal, service providers did not start till later. In NGO clinics services started at 8:30 am or 9:00 am and continued up to 4:00 pm or 5:00pm in most cases and sometimes up to 8:00 pm. During observation in the NGOs, service providers were found to be present in their respective service stations. All clinics were shut during weekends.

b) Suitability of clinic facilities

At the clinics, 61% (25/41) of those interviewed using the questionnaire said space was adequate and during the IDIs this was said by 90.3% (28/31) of the interviewees. One interviewee from an NGO in Dhaka who said space was inadequate explained her reason for saying so - "Many patients come with excessive bleeding. They need a separate space to take rest. We do not have bed for such patients."And another interviewee, also from an NGO in Dhaka, said that the building being used is old and unsuitable for services.

During observation it was noted that in several locations the waiting area was not appropriate – in one NGO in Dhaka, sitting space was provided in a corridor while in another, clients waited at the main entrance which is visible from the main road. In Barishal, women did not have access to drinking water in an NGO clinic and in the UHC. The UHC also did not have adequate sitting space and fan in the waiting area.

Toilets were dirty and unusable in an NGO clinic in Barishal and in the UHC where there was also no running water. In Dhaka, in the MCWC and one NGO clinic there was no soap in the toilet.

Forty of 41 service providers responding to the questionnaire said that their clinics were easily accessible by clients; the one who said this was not the case in her clinic at the UHC in Barishal cited her reason as follows: “Clients from only two unions come to our clinic, others go to other hospitals as the road is not good and there is no bridge over the river to reach our clinic”.

Safety and security was not a problem at the clinic facilities according to all to whom the questionnaire was administered. However, at the UHC in Barishal it was mentioned that safety could be an issue as “We cannot claim that the way to our centre is safe, a few days back a college girl was sexually harassed.” However, some service providers were harassed by clients’ relatives and one provider from an NGO in Dhaka said “Three years ago, one MRM patient had severe bleeding and pain and her guardians along with local influential people became angry and harassed us”. Another from a government clinic in Barishal said “Sometimes women use MRM without their husband’s consent who, after getting to know about this, become angry and blame us for it”.

All service providers, interviewed both using the questionnaire and through IDIs, said that privacy of clients was ensured. They used a separate room for providing services and in some cases where there was no separate room designated, they used other rooms such as the operation theatre or their own officeand they locked their doors during examination. Others said they spoke softly so that no one could overhear.

Client records were maintained in all other than two clinics which were the two government clinics in Barishal – Barishal MCWC and Babuganj UHC. According to 38service providers), client records were confidential. Different methods were used in the different clinics for maintaining these records and confidentiality of those records. In 39 clinics records were paper based.However, 24 sites also computerised their data; these included 22 in Dhaka (one was the MCWC and 21 were NGO clinics) and two in Barishal, both in NGO clinics. Locking paper records in an almira was the most common method of ensuring confidentiality and was mentioned by 21 providers, two said records were locked in password protected computers while five said both almira and computer were locked. However, others said they did not lock the records. Of the 24 facilities observed,

in58% (n=14) MRM client records were maintained in the same register as that for MR clients while in the remaining (n=10) there were separate registers for MR and MRM clients.

c) Staffing and availability of skilled personnel

At the 41 clinics where the questionnaire was administered, MRM was provided by paramedics (n=36), doctors (n=34), counsellors (n=23), nurses (n=11) and FWV(n=6) depending on the clinic site. 93% of these interviewees said staffing was adequateand the three who said it was inadequate included those from two NGOs in Dhaka and the UHC in Lalbagh, Barishal. However, during IDI only 71% said therewere adequate number of skilled staff at their facilities including seven from Dhaka (both NGOs and government) and two from Barishal. Direct observation also revealed 9/24 clinics did not have adequate staff.The reason for inadequate staff could not be stated but some felt that funds were lacking to recruit more staff.

Counsellors were not available at three clinics (one in an NGO in Dhaka and two in Barishal government clinics). In those clinics counselling was provided by the FWV or the paramedic. During the IDIs it was revealed that in many cases counselling was provided by the doctor (n=11), paramedic (n=8), SACMO (n=1) Technical Officer (n=1), and FWV (n=2).

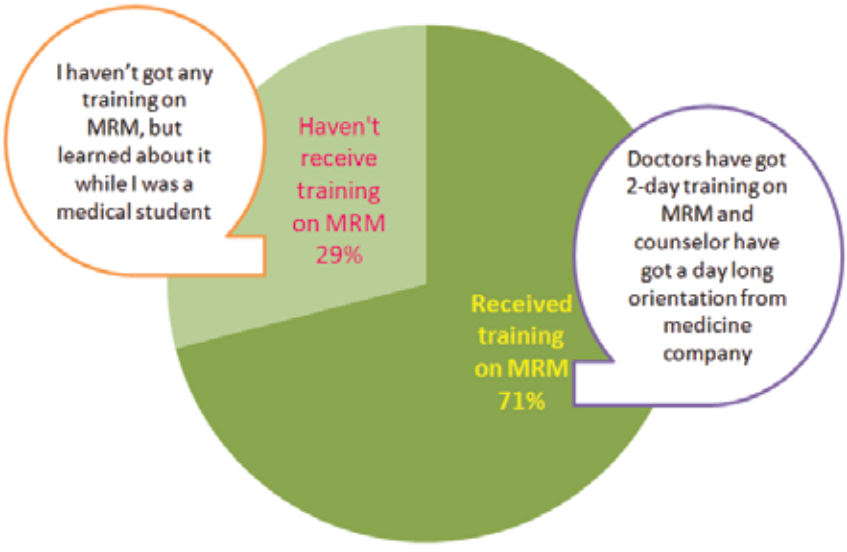
National MRM guidelines were said to have been followed by all service providers interviewed with the questionnaire. However, during observation, no guideline was available in 10/24 facilities. Behaviour change communication (BCC) materials weredisplayed on the walls in only two of the 24 facilities observed and both were NGOs, one in Dhaka and another in Barishal. RHSTEP have a poster specifically designed for MRM which is available only at their facilities.

Many service providers had not received training on MRM and this was mentioned by 29.3% (12/41) among those in whom the questionnaire was administered and 19.4% (6/31) who underwent IDI. Those not trained included both NGO and government staff in Dhaka and Barishal. Of those trained, 65.5% were trained more than 3 years ago. Availability of refresher training was limited and was mentioned only by 22/41 service providers. Also, of those trained, 44.8% felt training was inadequate as shown by the quote below from one such respondent from a government clinic in Barishal:

"The training we got was very general covering MR,D&C and MRM. We need training specifically on MRM"

An overall summary of training experience is shown graphically in Fig. 4.

Fig. 4.Summary of MRM training experience of personnel providing MRM services



d) Comprehensive integrated services

All those interviewed using the questionnaire said they provided information regarding MRM to clients to enable an informed decision.In most cases this was about the possible side effects (95.1%, n=39) while 90.2% (n=37) discussed dosage. Information on possible complications were provided by 68.3% (n=28), recognising potential complications by 63.4% (n=23) and how and where to seek help if required by 78% (n=32).

All service providers claimed they took a complete history and conducted physical examination related to reproductive health.

Counselling which is an essential aspect of providing MRM was conducted by different staff as presented earlier. Of the service providers interviewed, 63.4% (26/41) said appropriate counselling tools were not usedsuch as models, charts, etc. However, all those interviewed said they addressed all questions and anxieties of clients and providedemotional support as shown bythe following quotes:

> "Yes. We provide emotional support to clients. Some become emotional and upset and start crying in front of us. Then we try our best to support them mentally. We tell them, ''Don't worry, still you have chance to have baby in future". [Dhaka NGO].
>
> "Yes, of course we support them mentally. We give them courage so that they would not be frightened. We say, "It is like your normal menstruation. Nobody will know. You can do it staying at home". If the client is unmarried then we say to her, "Don't commit the same mistake again. Follow your family's decision". [Barishal government facility].

Other related services were available at the facilities visited which varied between the clinics and included family planning services, antenatal care services, ultra-sonogram,simple blood tests, etc. Other medications were also prescribed such as iron, folic acid, vitamins, pain medication, etc. but these had to be bought from pharmacies by the client.

All clinics had a referral mechanism in place including for emergencies. Referrals were conducted for different purposes most commonly for excessive bleeding. Referral forms/cards/slips were used by 73.1% (30/41) of the facilities and six also said that clients were accompanied to referral sites. 30 respondents said records of referred clients were maintained. Of the 41 service providers who responded to the questionnaire, 28 said that their facility had a list of referral services available with whom they had an understanding for easy referral. Ambulances were provided according to 12 IDI respondents and clients were usually referred to the larger government hospitals both in Dhaka and Barishal although in one case, a private clinic was the referral facility.

Following provision of MRM, all service providers (both through questionnaires and IDIs) claimed that they provided fullinformation on discharge including when normal work can resume (40/41), avoiding sexual intercourse for two weeks (40/41), possibility of bleeding (37/41), possibility of other complications (32/41).Signs indicating complications were explained by 40 of the 41 respondents. All said they reviewed the possibility of the client becoming pregnant again and provided advice to prevent future pregnancy by providing information on contraceptive options and 87.8% offered suitable contraceptives. During observation, inspection of registers in the facilities revealed that 90-100% women adopted family planning methods post MRM. A quote below from an IDI respondent from an NGO in Barishal show this was done:

> "In order to avoid the risk of getting pregnant again, contraceptive methods are explained to her in detail. With the help of models, flip charts and pictures, advantages and disadvantages of contraceptive methods such as pills, condom, implant, copper-T and other permanent methods are demonstrated so that she can choose the best one for her."

Clients were also advised to return for follow up after two weeks.

e) Ethical norms and service provider attitudes

Taking consent from MRM clients was mentioned by 95.1% (39/41) service providers interviewed using the questionnaire and all took written consent using a specific form. The two who did not take consent were both from government clinics in Barishal District - Babuganj UHC and Barishal MCWC. However, through IDIs 87% (27/31) said consent was taken and the four who did not were from government clinics in Dhaka (Mohammadpur MCWC) and Barishal. The consent form has provision for two signatures – one for the client and another for a guardian. Guardian's signature is essential for clients below 18 years as explained by a provider from an NGO clinic in Barishal:

> "In our clinic, it is a stringent rule that patients more than 18 years need not be accompanied by their guardians. But if she is less than 18, it is mandatory to bring her guardian with her to get MRM service".

Some providers insistedon signatures as they wanted to differentiate between married and unmarried women as shown in the quotes below from service providers from two NGOs in Dhaka:

> "We do not provide MRM service without signature in the consent form. Many patients come alone, and others are accompanied by someone. If the pregnancy is legal, woman usually brings her husband with her, but if it is illegal, she comes alone. About 60 percent cases women come with someone, but about 40% of cases come alone. When we take patient's history, it easily comes out which is legal and which is illegal".

The concern around marital status was not uncommon. Two respondents in the IDI said they tried to force a response regarding marital status from women they suspected to be unmarried while another two insisted on providing husband's name. Quotes below reflect this attitude:

> "Unmarried women do not want to tell husband's name easily" [Dhaka 2NGOs]

> "We do not ask whether she is married or unmarried. She has come for MRM service, so we do not ask such things. We just ask her husband's name." [Barishal NGO].

On the other hand, there are others who are concerned for unmarried women and girls and eager to serve them as illustrated by the quote below from a provider in a government facility in Dhaka:

> "All types of women come to us for this service. Both married and unmarried women come to us. We take special care of unmarried girls because we believe that they have to be saved from social stigma. We do this so that no one can neglect them due to this pregnancy."

All those participating in the IDIs said they provided services to everyone however it is clear from the above, that women who were suspected to be unmarried or girls under 18 years of age were pressurised. Some providers felt compelled to provide services although their personal views were in conflict as shown by the quote below from a government facility in Barishal:

> "Sometimes I wonder, `Am I committing sin', I can neither continue it nor leave it. As it is my job, I cannot stop doing this".

Regarding serving female sex workers, 21/41 service providers said they had given MRM medicines to female sex workers and that they did not discriminate against them for being sex workers. Some (n=11) did not know whether they had treated female sex workers: "They might come, but I cannot recognize whether sex workers come to us for MRM service".

However, although services were not denied, there appeared to be discrimination towards them as shown in the quotes below:

> "We often face problem with sex workers. They bring BDT 500 and ask for the whole package of MRM treatment. But the charge is BDT 800 in our centre. Being a very junior staff I cannot make any concession for them." [Dhaka NGO]

"Sex workers prefer MR instead of MRM so that all get cleared at a time. I have an experience of doing MR of a sex worker 6 times." [Dhaka NGO]

"To my knowledge, no sex worker has come to us for MRM service, but several of them come with complications after taking MRM medicine. We face many problems with them; such as, they are not interested to come for follow up, to use any family planning method, to maintain their personal hygiene. They start having sex with their clients before bleeding stops. They do not follow the instruction we to provide them." [Dhaka NGO]

"We can recognize sex workers. But what can I do! For the sake of my service, I have nothing to do except provide service, because often I feel I am committing sin. Instead, I often think giving service is a virtue". [Barishal government clinic]

f) Supply of MRM medicines

Although all 24 service providers who underwent IDIs said the MRM medicine supply was sufficient on further probing no medicines were in stock at five NGO facilities (3 in Dhaka & 2 in Barishal) and all government clinics. Providers from these facilities (both NGO and government) prescribed the medicines and advised women to buy from pharmacies and then return to them so they could advise on how to use.

When asked about storage of the medicines, 81.1% (30/37) interviewees said that they were stored properly and 31 said that the expiry date was always taken into account. During observation, 14 clinics were found to have a separate storage room for medicines others kept medicines in the almira and mostly in the paramedic's room (n=10).

g) Findings from KIIs

As mentioned earlier, KIIs were conducted with a senior government official from the Directorate General of Family Planning (DGFP) and from three NGOs providing MRM services in Bangladesh. The key points are summarised here:

Government policy maker:

He was aware that the demand for MRM is huge but the government is concerned about the complications post MRM. He said the government is taking steps for ensuring medicine procurement and it has already been included in their procurement policy, operational plan and budget. 8000 MMKits were bought in June 2018 by the Drug Administration and DGFP received the supply at the end ofJuly 2018. Medicines are now being distributed but distribution has not been completed. An issue of concern was that no requisitions for MRM medicines were received from any of the MCWCs on the basis of which they could calculate the requirement. The DGFP therefore, simply ordered 8000 kits which was not based on any ground reality in terms of actual requirement. Prior to this, no medicines had been bought by the government.

For the future, they will review the success of MRM services from MCWCs. One of the issues is that monetary remuneration is provided to service providers for MR and this may negatively affect service provision for MRM. The review will include these issues as well.

They also intend to include training for FWVs up to the Union level in the Operational Plan of 2019 as a priority. Once this is done, medicines can be provided up to the Union level in the future.

Monitoring of service providers as per the National Guideline was not conducted so far as no medicines had been provided. But it is being planned for the future and will be included in the Operational Plan from 2019.

Control of selling of MRM medicines will be enhanced so that pharmacies are not able to sell freely because of complications that appear to be common post MRM. They would like to ensure that medicines are not sold without prescription and that drug sellers are trained on providing MRM services. To this effect they plan to send a letter to the Drug Administration who is responsible for these activities and also for the Drug Administration to monitor the pharmacies in order to ensure that drug sellers followNational Guidelines.

Senior NGO service providers:

Senior personnel of all three NGOs said that they provided MRM services currently through their own clinics and some through clinics located within government facilities although run entirely by the NGO. All provided PAC services and one NGO sometimes provided staff trained on PAC to other NGOs.

Personnel from all three NGOs were of the opinion that MRM is popular with women and that they should have easy access to MRM and services should be rights based. In one NGO, records showed that the percentage of women using MRM has increased among those seeking termination of pregnancy.

They stressed that women must be treated with respect.

All provided training to their own staff using their own training guidelines and modules which varied in duration and were designed according to the technical level of the service providers. Two NGOs also had training programs available for government staff and one NGO specifically trained staff up to the Upazila level with future plans to extend to the Union level.

All said they had BCC materials which were used in their own clinics which is in contrast to what service providers said during the interviews and findings from the Observations.

NGOs monitored their own services using their own staff and methods.

Advocacy was carried out by all three NGOs. Their advocacy had led to approval by the DG Drug Administration for selling MRM medicines through pharmacies. All plan to advocate further to ensure MRM quality and how services from pharmacies can be improved. One NGO is in the process of conducting a situation analysis of MRM in Dhaka the findings of which will be used for advocacy. Another NGO aims to work with the government on establishing a system of Quality Assurance.

In 2015 an MRM Working Group under the DGFP was formed where all working on MRM could exchange and share views and experiences and was a useful platform for advocacy. This has recently been converted to MR and MRM Alliance with the same members and the first meeting was held in April 2017 followed by another in November 2017. However, since then no meetings have been held. Ipas has its own MRM Steering Committee which is a high level committee and members include the Line Director DGFP and their partner NGOs.

4.1.2 MRM SERVICES FROM PHARMACIES

Of the 63 drug sellers who participated in the FGDs, only one was female and all others were male.

a) Opening times

Pharmacies were generally open all day from morning till late night, even after midnight in some cases. Some took an afternoon break for lunch. Women could come anytime according to their convenience and the general opinion among drug sellers was that women usually came when the number of customers in the pharmacies were few.

b) Suitability of facilities

Pharmacies are located everywhere and are easily accessible to customers. Of the 63 drug sellers who participated in the FGDs, 11 said that there was a separate consulting room in their pharmacy which was meant for the doctor or as a resting space for staff; it was not used for MRM. However,

many drug sellers (n=22) said that their pharmacy consisted of only one room, and they did not have any other room for consultation. Some said that if required, they would take clients aside to a quiet area such as in the front of the pharmacy or to a quiet space next to the pharmacy. One drug seller in Dhaka said - "We have our mobile phone number on the signboard of our pharmacy. We tell them to consult with us over phone if there are any questions". Another drug seller from Dhaka frankly said that consultation was not carried out while dispensing MRM medicine as quoted below: "We work at the pharmacy. We do not have separate space to sit. If clients give us doctor's prescription, we give them medicine accordingly. If anyone wants to know the procedure of taking this medicine, we tell them. We have neither time nor space to do consultation with women who seek MRM".

All drug sellers in the FGDs said they maintained confidentiality of their clients and many said this was to protect their reputation as a sound and reliable business concern. Some also said they did this to protect their clients.

None maintained client records. According to one drug seller from Dhaka - "None of us keep client's record. We just sell the MRM medicine like any other medicine. We just keep accounts, to see how much has been sold".

c) Staffing and availability of skilled personnel

In the majority of cases the pharmacy owner is the only person available at the pharmacy to sell medicines. Others said they had several staff, all of whom were allowed to sell MRM medicines. In most cases (n=34) no doctors were available at pharmacies and where they were available, they were not responsible for MRM consultation.

Most drug sellers had received no training on MRM. Four drug sellers were trained by MSB, seven said they received a few hours training from the marketing company of the brand MMKit and some others said that MRM pharmaceutical companies explained to them how to use the medicine, its uses and possible side effects. The respondent of the KII, confirmed that no training had been provided to any drug seller. The main source of information were the leaflets inside the kits which provided detailed information. He also added that when a new medicine is introduced by a pharmaceutical company, their representatives train them to understand the leaflet as they do for any other medicine.

None were aware about the National MRM Guideline.

d) Comprehensive integrated services

As mentioned above the number of staff in pharmacies were limited, most received no training on MRM and among those that did were mostly given information by pharmaceutical companies. As a result, there was no scope for provision of comprehensive and integrated services.

Counselling was not provided and drug sellers said that brief information was provided only if clients asked but in most cases clients did not ask any questions. According to one drug seller in Dhaka - "The client would be angry if I start giving information or suggestions if they do not ask me."

The brief information that they usually provided included how to take medicines, possible side effects and rarely, how to recognise complications and where to seek help in case of complications. Some provided their phone numbers in case of complications. Commonly clients were advised to follow the instruction written in the leaflet inside the medicine box - "We do not tell them anything, we just say that everything is written on the leaflet inside the packet of the medicine. Read it carefully".

Majority did not ask women to return after two weeks. Three drug sellers mentioned that they would check the date of LMP before dispensing and if this was more than 63 days, the client would be referred to a hospital or clinic. Advise on contraception was provided by very few drug sellers.

Other medicines such as iron, folic acid, pain medication was suggested to clients in some case (four drug sellers mentioned this) while a few others (n=2) said that the clients themselves requested these medicines.

For referrals, drug sellers said that if they felt thatthe client needed medical support they would refer to the nearest clinic or hospital.

The situation can be summarised by the quote below from a drug seller in Dhaka:

> "For selling a medicine we can provide at best 5-10 minutes. We cannot run a business if we spend more time for a single product. Usually, we do not provide too much time to a client".

e) Ethical norms and service provider attitudes

All except one said there was consent was not taken. The one drug seller (from Barishal) who took consent had created his own system where he recorded name, age, phone number and signature in an exercise book as shown in the quote below:

> " I take written consent before giving MRM medicine. I write client's name, her age, phone number, and address in a *khata*(exercise book) and take signature of the client there. I do it because I have faced a problem after selling MRM. After that I invented this procedure."

Most drug sellers participating in the FGDs considered MRM to be beneficial for womenas it enabled them to maintain confidentiality because of itseasy access, ease in use, can be taken at home, its cost being less than MR, its relatively safety. Some drug sellers expressed an openness about who should have access to MRM and who they would sell the medicines to (from drug seller FGD in Amtoli Upazila in Barishal):

> "It is our business. We have to treat all customers equally. It is our business policy".
>
> "If an unmarried woman gets pregnant, people in our society disparage
>
> her, neglect her, and mistreat her. In this case, MRM medicine is very helpful".
>
> "It is good for unmarried women as it is related to her honour/dignity and social acceptance".
>
> "I do not need to know whether she is married or unmarried. I only need to know for how long her menstruation has stopped or date of last menstruation. That is enough for me."

However, many others were opposed as they considered it a sin, that it promoted promiscuity and illegitimate relationships, and because of the risk it posed due to heavy bleeding. Some also had qualms about selling to unmarried women, to girls under 18 years of age and to sex workers. These attitudes were expressed in different ways as shown by the quotes below (from drug seller FGD in North City Corporation, Dhaka):

> "Immoral acts have increased because of these medicines".
>
> "I feel we are killing babies"
>
> "I consider the age of the woman before selling to her. If she is less than 18 years I do not sell to her because if she has complications there may be a police case, I do not want to fall into any problem".
>
> "I do not sell this medicine to unmarried women. Why will I give her this? To increase her sin? I do not want to sin with her by giving this medicine"
>
> "If unmarried women get this medicine easily, they will engagein unlawful activity, fear will disappear from their mind".

"This MRM medicine is totally forbidden for unmarried women. They are engaged with abominable affairs. If they get this medicine easily, sin due to it will increase more. It is out of question to sell this medicine to unmarried girls".

"I do not give MRM medicine to married women without the presence of their husband. I do not give this medicine to unmarried girls considering religious aspect."

"There is no difference between sex workers and unmarried girls who need MRM. Both of them are bad women. do not sell MRM to them."

According to many drug sellers in the FGDs, women came alone to buy MRM medicines. Sometimes their husband or boyfriend would accompany them to buy the medicine or female relatives. Drug sellers also said that some women who came to buy MRM medicines were from the local area but some also came from distant areas for reasons of discretion, to hide from known people, known drug seller and family members. One drug seller from Dhaka said:

"Those who are unmarried do not buy MRM medicine from local pharmacy. They buy it from pharmacy in distant place. Unmarried women feel shy to buy this medicine from known people".

f) Supply of MRM medicines

All drug sellers said that their pharmacies had adequate supply of MRM medicine. Representatives from the pharmaceutical companies come to them regularly so they could place an order whenever needed. Storage conditions were similar to other medicines which were kept on the shelf i.e. at room temperature. They ensure that no medicine that was sold exceeded the expiry date and they would return expired medicines to company representatives.

The KII with a senior drug seller revealed names of some pharmaceutical companies from where MRM medicines were supplied and included Incepta, Ziska, Square, Euro Pharmaceuticals, Sharif Pharmaceutical Ltd. There were others whose names the informant could not recall. Several different MRM kits and medicines were available most common of which was MMKit containing 1 tablet of Mifepristone (200μg) and 4 tablets of Misoprostol (200μg) (Ziska Pharmaceuticals). Others were MRKit (same composition as above from Euro Pharmaceuticals), ABO Kit (same composition as above from Globe Pharmaceuticals) Cytomis (Misoprostol 200 μg, from Incepta Pharmaceuticals), Isovent (as above, Square Pharmaceuticals). Gynocosid, a product from Pakistan, was available several years ago but is no longer in the market. Cytomis andIsovent can also be used vaginally.

The key informant also said that previously when there were no kits available, misoprostol tablets were given from the original phial. At present, if doctors prescribed, then Cytomis tablets are also given from the original phial. Sometimes, if the clients do not want the entire kit, some drug sellers may give only a few tablets from the kit.

4.2 CLIENTS PERSPECTIVE

Clients included WRA who may or may not have used MRM, women who experienced complications post MRM and female sex workers who represented a marginalised group of women. The numbers of these different groups of women who participated in the FGDs from different sites are detailed below and summarised in Table 4.

FGD with women of reproductive age: 6 FGDs were conducted with WRA, two in Dhaka and four in Barishal with a total of 40 WRA (Dhaka-12, Barisal-28).

FGD with women who experienced complications after taking MRM: 6 FGDs were conducted, two in Dhaka and four in Barishal. Altogether 37 women (Dhaka-12, Barishal-25) who experienced complications after taking MRM medicines participated in these discussions.

FGD with sex workers: 2 FGDs were conducted, one each covering Dhaka North and South City Corporation areas. A total of 16 female sex workers participated in the FGDs.

Table 4. Participants in FGDs

Survey Methods	Study sites	Study participants
FGD n=6	Dhaka City	
With 40 WRA	2 City Corporation areas	2 FGDs with 12 women
	Barishal	
	4 Unions	4 FGDs with 28 women
FGD n=6	Dhaka City	
With 37 who experienced	2 City Corporation areas	2 FGDs with 12 women
complications post MRM	Barishal	
	4 Unions	4 FGDs with 25 women
FGD n=2	Dhaka streets from 2 sites	2 FGDs with 16female sex
With 16 female sex workers	(Dhaka North and South)	workers

In addition to FGDs, two case studies were compiled from women who experienced complications post MRM.

Findings from each group of women are presented separately.

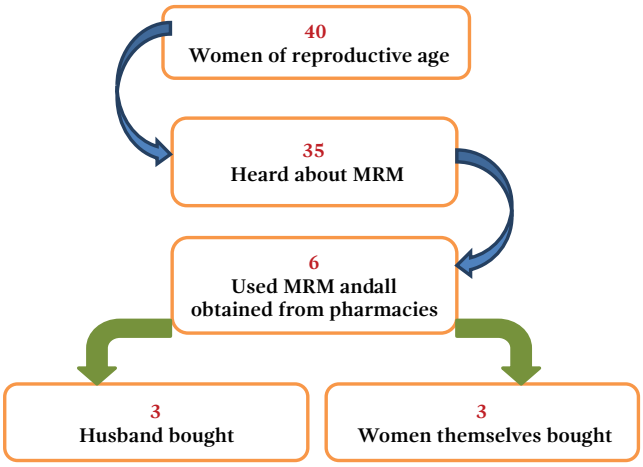
4.2.1 WOMEN OF REPRODUCTIVE AGE WHO MAY OR MAY NOT HAVE USED MRM

Women who participated in these FGDs were between 18-36 years with most women being between 21-30 years.Majority of women were housewives (n=32), three were domestic helpers, three service holders, one was a garment worker and another a student. All other than one was married.

a) Awareness and information about MRM

Of the 40 women, 35 had heard about MRM and the five who had not heard were all from Barishal. Only six had used MRM medicines all of whom were from Dhaka. Three of the six women had bought the medicines themselves from pharmacies and husbands had purchased for the other three. This is summarised in the Fig. 3.

Fig. 5. Women of reproductive age who knew and who took MRM medicine



Of those who knew about MRM, their information varied as shown in quotes below:

> "This medicine should be taken within 1-2 months of gestation" [n=6 from Dhaka]
>
> "We all know that it is a medicine to regularize menstruation"[n=6 from Dhaka]
>
> "Abortion can be done with it" [n=2 from Dhaka]
>
> "If all 5 pills are taken by following instruction, it works" [1 WRA in Dhaka]
>
> "A madam lives in my next flat. She works in a Family Planning office in Mirpur. She brings 3-4 women per week and helps them to abort their babies. If the gestation period is 1-2 month, she uses MRM medicines, but if it is 4-5 months then she opts for MR".[1 WRA in Dhaka]
>
> "This medicine should be taken with doctor's advice. After taking this medicine, bleeding occurs." [1 WRA in Barishal]
>
> "This medicine can be got from doctor, it is also available at pharmacy. It should be taken within 8 week of gestation." [1 WRA in Barishal]
>
> "Yes, I have heard about MRM. I have been married for two years. Doctor suggested this medicine to me, but I have never used it. It is a contraceptive medicine." [1 WRA in Dhaka]
>
> "I have heard that this medicine does not work. It needs to be cleaned up with washing finally." [1 WRA in Barishal].

Knowledge about how to take these medicines also varied as shown below (From WRA (FGD) Dhaka and Babugonj and Bakergonj Upazila):

> "There are three pills together. It is used in the passage of urination (vagina)"-[n=2]
>
> "There are three pills, one has to be swallowed first with water and remaining two should be kept under the tongue for half an hour and then swallowed "
>
> "Four pills have to kept under tongue two on each side"
>
> "There are 5 pills in the packet. One has to be swallowed first with water and remaining four should be kept under the tongue, 2 on each side".

Knowledge about where these medicines were available was common with only four saying did not know where these were available. Pharmacies (n=15) and hospitals or clinics (n=15) were commonly cited as sources of MRM medicines.

It seemed that they know there is a method called MRM and it is done through medicine. However, they lack the knowledge about the accurate process or the dosage of medicines. There is need for proper and accurate knowledge dissemination among the recipients.

b) Attitudes regarding MRM

Few (6/40) thought it was not good citing complications as the main reason or that it was against the will of Allah.

> "Sometimes, it does not work. In my locality, one young couple got married without consent of either set of parents. After few days, the girl got pregnant. They did not want others to know, so they took MRM medicine from pharmacy, but it did not work. Eventually, she was brought to hospital to get it washed[1] (1 NGO clinic service provider, Dhaka)"
>
> "One of my colleagues took MRM and bleeding occurred and it seemed that the baby had been aborted. But the baby was retained and later was born healthy. (Govt. health service providers in Babugonj Upazila Health Complex, Barishal) "
>
> "No it is not good. It is better to be cautious earlier. Allah has given it; it should not be destroyed (Govt. health service providers in Babugonj Upazila Health Complex, Barishal). "

"Killing life is a great sin (Govt. health service providers in Babugonj Upazila Health Complex, Barishal)."

"I feel guilty. Allah has given it. So, decision will be taken by him (Govt. health service providers in Babugonj Upazila Health Complex, Barishal)."

Two women felt the method had both advantages and disadvantages, but one said that the disadvantages outweighed the advantages.

Many women felt that MRM was good for women and among the different reasons cited for thinking so, the main ones were confidentiality and cost. Quotes below illustrate various reasons:

"Many women accidentally conceive baby, but do not want to continue the pregnancy. For those women it is useful (WRA FGD, Babuganj)."

"It is a good method. Because, those who have children in their families and are poor, if they conceive again then it would create a problem in their families. This method can easily be got from pharmacy. It can be bought easily. So, for these type of women it is good (WRA FGD, Bakerganj)."

"This method is good. If we know about its use then no one would get into trouble (WRA FGD, Amtoli)."

"One unmarried girl got pregnant after having sex with her boyfriend. Her mother brought her to hospital and got it cleaned. It cost BDT 10,000, and worse still, everyone in her locality came to know. It she had used MRM, no one would know and it would cost much less. It is very good for unmarried girls (WRA FGD, Patharghata)."

12/40 felt it should be available to all irrespective of marital status.

The 34 women in the FGDs who did not use MRM gave various reasons for not using which can be categorised as follows:

- *fear of failure of MRM:*

  - "I do not want to use MRM as I fear that it might not work. If it does not work then I have to do D&C." [WRA from Barishal]&
  - "It would need to do 'wash' [D&C] if MRM fails. It might create problem in uterus". [WRA from Barishal]
  - "If the medicine does not work then the cost would be very high for further treatment".[WRA from Barishal]
  - "If MRM does not work, some parts of the product will remain inside and start decaying. Then it would be known to all leading to a crisis of honour". [WRA from Barishal]

- *lack of availability:*

  "If I had it, I would use it"- [5 WRA from Dhaka]

- *lack of knowledge:*

  "When the age of my youngest child was 6 years, I got pregnant. My husband ordered me to wash it out from hospital. Accordingly, I went to hospital and got it done. After 5 years, I became pregnant again and again I went to the hospital and washed it. If I had known about MRM, I wouldn't have suffered so much".[WRA from Dhaka]

- *fear of resistance from other family members:*

  "We live with my parents-in-law. They take all decisions. If they came to know, it would create a lot of trouble in the family."- [4 WRA in Barishal]

- *no permission from husband:*

  "My husband said, " Don't use any method. Allah has given it, and He will take care of everything".[WRA from Barishal]

All six women who used MRM said it was important to share with husbands and five took permission from them. One participant from Dhaka said:

> "In many pharmacies they do not sell this medicine without the permission of husband or guardian. Permission of guardian is also required in case of getting this service from hospital."

Five of these women felt secrecy was important from other family members. One woman said she did not want it to be a secret.

Among the six who used MRM, three bought themselves of whom two went alone to the pharmacy and one was accompanied by a female friend who knew a hospital nurse.

c) Accessible, safe and confidential environment

According to all participants, the locations of the MRM service facilities were convenient with most saying it was very close to their house, journey was safe and not expensive to travel to. Pharmacies were open long hours but hospitals usually shut at 3:00 pm. There were complaints about hospital timings and punctuality of staff:

> "Doctors take their lunch at 1:00 pm and come back at 2:00pm, but sometimes they come at 3:00pm. After that time, they are not attentive to their patients" "[WRA from Dhaka]

> " We who are working women have to go there late in the afternoon. But doctors are not available at that time". [WRA from Dhaka]

All women who accessed services appreciated the pharmacies but felt that it was difficult to maintain privacy as one woman from Dhaka said:

> "I felt very shy to ask for MRM medicine from a pharmacy as there are other customers as well. I felt very uncomfortable then".

Two women from Dhaka were more confident and one said:

> "I beckoned the pharmacy staff that I wanted to talk to him privately. Then he managed other customers to leave the place. Then I shared my problem and sought help from him".

All women who used MRM said that their confidentiality was maintained

d) Comprehensive and integrated services

Two of the three women who bought the medicines themselves said the drug seller asked them about their LMP but according to the third woman, the drug seller did not ask her anything.

Thesix women who bought the MRM medicines from pharmacies said they got very little information, no one checked them physically andthey did not receive counselling. Drug sellers did ask two of the women whether they were hypertensive but did not measure their blood pressure.

Few side effects and potential complications were mentioned by drug sellers including pain for which pain medicine was given and that they would need to seek further treatment in case of incomplete abortion. Five women said they were not asked to return.

Women were not informed about precautions to be taken by the drug sellers but husbands of the two women bought the medicine received information from drug sellers and conveyed it to their wives.

No advice on contraception was proffered by the drug sellers.None of the six women suffered any complications.

4.2.2 WOMEN WHO EXPERIENCED COMPLICATIONS AFTER TAKING MRM

Women who participated in these FGDs were between 19-45 years with most women being between 26-30 years. Majority of women were housewives (n=30), six were service holders, one was a tailor.

Of the 37 women who participated in the FGDs, 35 boughtMRM medicine from pharmacies of whom 18 bought on their own while for 11 husbands bought the medicines, one got from her neighbour, one was helped by a nurse. Two women received services from NGO clinics.

a) Accessible, safe and confidential environment with skilled and respectful personnel

According to all participants, MRM service facilities were either located in their locality or very close to their homes. Most said the facility was not expensive to travel to and costs were borne by husbands (n=15), by the woman herself (n=8) and in one case by the mother. Some however, bought MRM medicines from a distant pharmacy in order to maintain secrecy as one woman from Dhaka said:

> "I live in Jatrabari, but I bought the medicine from a dispensary distant from my residence. It cost BDT 100 for travel. I did this so that none of my family members would know, I wanted to keep it secret. I myself bore the travel expenses. I tried to hide it, but for excessive bleeding I could not do this."

In general women were satisfied with the facilities where they bought their medicines from saying that they could speak openly and confidentially, no one made bad comments. One of the women who visited an NGO clinic said the service providers at the clinic were well behaved and no one other than the doctor was present so that confidentiality was maintained. Drug sellers treated them well but sometimes women were asked why they wanted to abort their child.One woman in Barishal was told:

> "You are young, this medicine might cause problem for you".

Five of those who bought from pharmacies, said privacy was ensured and the drug sellers would request other males present to leave so that they could talk freely. However, others said this was not the case and they could not talk frankly, some felt shy to speak to a male drug seller, also other males were present and in one case, a known person was at the pharmacy. The quote below from a woman in Dhaka shows this clearly:

> "I could not talk to the male drug seller in the pharmacy. It is not possible to openly discuss with males. There are other male persons as well, so obviously I felt ashamed. There is no opportunity to speak about gynaecological problems in the pharmacy. It is true for all pharmacies."

Those who received services from NGOs were seen by a doctor and in one case, also a nurse.

There were complaints about the timing of clinic operations andone woman from Dhaka said:

> "Clinics are supposed to be open up to 5 pm, but after lunch break at 1 pm you will not get any one. Doctors are supposed to be there up to 3pm. At least attendants or health care assistants should be there. Emergency does not come with a warning."

b) Comprehensive and integrated services

In most cases the drug sellers did not ask womenanything but some explained how to take the medicine (n=3), while others asked them to read the instructions provided in the leaflet (n=2). LMP was also checked in a few cases and also whether she was sure that she was pregnant.

Prior to dispensing medicines in pharmacies some women were asked if they had medical issues such as jaundice, heart disease, diabetes but no physical examination was conducted. However, in the NGOs medical history as well as physical examination with some blood tests were conducted.

26 women said that they were not asked to return for follow up and 12 said drug sellers told them to contact a doctor if there were any complications. 19 women said that they were not given any information regarding potential complications while a few others mentioned complications such as excessive bleeding, itching, vomiting. Those receiving services from clinics were provided with information including what to do in case of complications.

Regarding precautions to be taken post MRM, five said they were told to avoid sexual intercourse for a varying number of days (ranging from 14-90 days), avoid heavy work (n=4) while others were advised to eat well, rest and drink plenty of fluids. Contraceptive advice was given to seven women and six said different methods were suggested however, 17 women said they received no contraceptive advice.

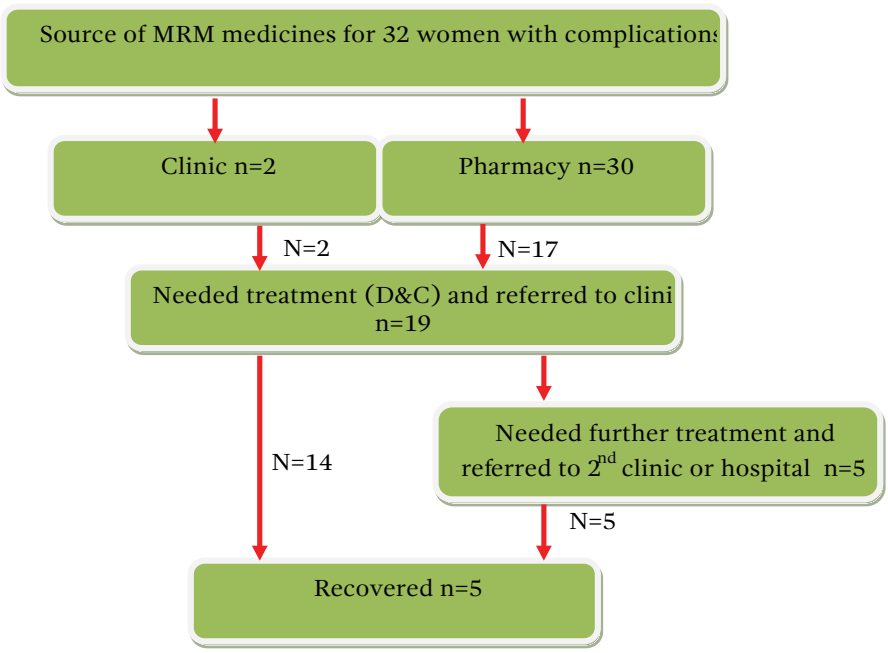
Other medicines such as iron tablets, vitamins, pain killers,were given to very few women and 19 women said they received no other medicine.

c) Comprehensive PAC services

The common complications that women faced after taking MRM medicine was related to bleeding -prolonged and excessive bleeding (n=10), irregular bleeding (n=9),spotting for a prolonged period (n=2). Severe abdominal pain(n=6), pain during urination (n=2) and foul smelling discharge (n=2) were also reported.

As mentioned earlier, 35/37 women participating in the FGDs got their MRM medicines from pharmacies and two from NGO clinics. Following complications, completeinformation on PAC services were obtained from 32. Of these 32 women, 17 received PAC services from clinics of whom 14 recovered and could return home. Five needed a second referral, two to another clinic and three to hospitals for better treatment. This is shown schematically in Fig. 6.

Fig. 6. Summary of PAC services received by women



A quote from a woman from Barishal below shows how she managed to obtain PAC services:

> "After the pregnancy test report came as positive, I took MRM medicine from pharmacy, but it did not work. Then I went to the pharmacy again and told them my problem. They asked me to test the pregnancy once again. Again I was positive. Then they suggested me to go to the UH&FWC. Doctor in UH&FWC said that it has become too late. Finally, doctor did MR with instruments".

22 women felt their treatment was adequate but some said they were not treated with respect when they sought PAC services as shown by quotes below from two women (WRA FGD, Dhaka):

> "Doctors scolded me for taking MRM medicine from pharmacy. But they treated my problem well".

> "When I was brought to a room in a clinic with excessive bleeding, there were some *aya* (health care assistants) there. One of them said, "Didn't you recognize earlier? Why have you come now? " in an insulting tone. They were gossiping among themselves about it. I reached there at 3.30pm. They were preparing to leave their working station. I went there at that time, and it might be the reason for such behaviour".

Most women recovered fully (n=21) but some still had complaints of irregular bleeding (n=3), severe weakness (n=2), cervical infection (n=1).

Expenditure for PAC varied and the range of costs incurred is shown in Table...

Table 5. Costs incurred by women for PAC services

Expenditure (In BDT)	**Number of women**
Less than 5,000	9
5,000- to 10,0008	
More than 10,000	4

Two women got free treatment although they still had to bear costs for medicines, etc. as shown by quotes below (WRA FGD, Dhaka):

> "I got free treatment, but I had to buy medicine. Including transportation, I had to spend BDT 2,000 altogether ".

> "I did not need too much money for treatment as it was a government hospital. For ultra-sonogram and transportation, I needed BDT 1,500 in total."

Two case studies are presented in boxes 1 and 2 that illustrate what some women faced following MRM. Both these cases are from women living in villages in Barishal.

BOX 1. Case study X

X was married at the age of 12 years and her husband was from the same village. She is 35 years old and has three living children. She lives with her husband and children in a village under a Union in Bakerganj Upazila, Barishal. Both she and her husband have studied up to grade 5 (primary school). Her husband was using condoms after the birth of their youngest child and when the child was nine months old, she noticed that her menstruation had stopped for three months. She and her husband decided to terminate the pregnancy and used MRM (MMKit) which her husband bought from a village doctor by paying BDT 300. After taking the first dose, she had severe pain in her abdomen at 3 am at night, and a large clot of blood came out. There was no bleeding after that. A month later, she was nauseous and dizzy. Her husband went to that village doctor again, he suggested that the pregnancy was probably not terminated and advised them to do an MR at a local private clinic which they did at the cost of BDT 3000. However, vomiting started again, dizziness, spotting, and she felt a lump in her abdomen. Then she returned to that private clinic and consulted with a senior doctor. Doctor advised her to do ultra-sonogram, and she was found to be 4 months pregnant. Doctor's fees and ultra-sonogram cost her BDT 2000. The doctor said that most likely the MR was not conducted properly and that it was too late to conduct another MR. X was not sure what the first practitioner at the private clinic had done as she is unaware of what MR entails and she trusted the provider. At 7 months of her pregnancy, doctor again advised ultra-sonogram which showed considerably less than normal quantity of fluid in the sac. Doctor therefore advised immediate caesarean section and a very small, premature baby was delivered. X needed five bags of blood for the operation and she spent BDT 20,000. X's eye sight is blurred, feels very weak, has restricted movement. Her husband said," I spent all the money I earned for her treatment. We can barely survive". The baby however, is alive and well.

BOX 2. Case study Y

Y is 33 years old, married from a village under a Union of Bakerganj Upazila. She has done her matriculation and provides tailoring services from home. Her husband has a small electronics shop. They have two living children and the youngest is 4 and half years old. She conceived again in August 2018. After a month and half of amenorrhoea she and her husband both jointly decided to terminate the pregnancy. Husband went to a local pharmacy for advice and the pharmacy owner gave him two options – MR and MRM. Khadija decided to use MRM. Husband returned to the pharmacy and was asked whether pregnancy test was done and for how long she was pregnant. The pharmacy owner gave them one strip for testing pregnancy which gave a positive result. After which he bought MMKit and was told to read the leaflet inside the packet. Khadija had the medicines as instructed. After the first dose, she felt nauseous. After the full dose she had severe abdominal pain and heavy bleeding with clots. This lasted for 4-5 days after which she went to the Bakerganj UHC. Here only a male medical officer was available and Y was too shy to speak openly about her problems to him. However, the doctor heard her complaints and suggested ultra-sonogram which was clear and the doctor only prescribed pain medicine. Her bleeding decreased as did her pain but again after 2 days irregular and intermittent bleeding started. After 10 days of this she visited a private clinic where there was a female doctor who examined her and advised another ultra-sonogram which showed that the product was still inside. The doctor checked her haemoglobin, gave her pain medicine and suggested a D&C but she could not afford the cost of a D&C. Till 45 days of this last consultation she had still not done a D&C and was still suffering from intermittent spotting and felt very weak, with mild abdominal pain, and complained of pain during urination.

Following recording of this case study, the Project Director of the study, referred her to RHSTEP after consulting her case with them, provided her transport cost and arranged for free treatment. Her D&C was done at the RHSTEP clinic in Barishal and she is now well.

These cases show that despite both women having full support from their husbands and taking the MRM medicines properly, they had to face severe problems because of meagre means, little information about existing services, limited access to those services and poor quality of PAC services.

4.2.3 FEMALE SEX WORKERS WHO MAY OR MAY NOT HAVE USED MRM

The ages of the 16 female sex workers who participated in the FGDs ranged between 20-45 years. Most were between 20-30 years old. Two sex workers, both 20 years old, were very new to the sex trade – one started 15 days ago and another 1 month ago. Most had been working as sex workers for more than 10 years, seven of whom for more than 15 years.

a) Awareness and information about MRM

Among the 16 female sex workers, 14 had heard about MRM and 11 had used MRM medicines. One woman got this service from a private clinic, one from a private doctor and remaining nine women bought this medicine from pharmacies. The two women who had not heard about MRM were very new to the sex trade and both were among the youngest (20 years old).

Sex workers knew that MRM can be used for aborting pregnancy but some said that it may be a riskier method than MR. Some also correctly mentioned what the dosage was and how to take the medicines.

The sources of information on MRM was varied; most had heard from NGO clinics when they went seeking treatment, one also had heard from a hospital and another from a pharmacy. Others mentioned friends or neighbours who informed them about a private doctor and pharmacies where MRM services can be obtained.

b) Accessible, safe and confidential environmentwith skilled and respectful personnel

Some women bought MRM medicines from their local pharmacies while others preferred to go to distant ones to avoid recognition and often bad behaviour by drug sellers as shown by the quote below:

> "We do not buy MRM medicine from our pharmacy close by. We buy it from distant pharmacies. Drug sellers in our locality know us. If we go to them for MRM they will scold us with bad language, they will tease us."
>
> "I do not buy this medicine from my local pharmacy. I prefer to buy it from distant places, as they do not know me. Drug sellers from my locality might make me feel ashamed if I ask this medicine from them."

Although most female sex workers said drug sellers behaved well with them but some did not agree:

> "Drug sellers in pharmacies often disgrace us for being a sex worker. If we go to them for MRM, they might abuse us with foul and humiliating words."

All said the pharmacies were open long hours, one said for 24 hours. They all preferred pharmacies for buying MRM medicines and five even said the pharmacies maintained privacy and they could talk to the drug sellers separately and speak frankly and openly with them. But one woman said:

> "I went to the pharmacy wearing *burkha* so that they would not recognize me. Then I could speak frankly with them."

In most cases women did not need to be accompanied by a guardian. But one female sex worker said:

"When I went to pharmacy to buy MRM medicine, I was asked to bring my husband for buying the medicine. I said my husband is a drug addict. He does not take care of me. Then the drug seller gave me the medicine".

Some female sex workers said they made up stories about husbands and children to hide their true profession. But approximately half of the female sex workers disclosed their profession as a sex worker or the drug sellers already knew that they were engaged in this profession as shown by the quotes below:

" hey know us. We buy condoms and other medicines from them".

"Nothing to hide, they know us. We roam around them from evening to midnight".

Sex workers who did not reveal their profession said:

"Why will I disclose it. I am buying the medicine with money."

"My profession is not written on my face, if I reveal it, they might neglect me."

c) Comprehensive and integrated services

Of 11 women who used MRM, seven said that service providers (doctor in private clinic [n=1], private doctor [n=1] and drug sellers [n=5]) told them about how to take the medicine, in which dose and for how long.Remaining four women who bought from pharmacies did not get much information from drug sellers. One female sex worker was told:

"Drink warm water, warm tea and milk after taking MRM medicine. Do not take sour food, drink warm water more. Take one tablet in the morning and another at night. Walk after taking the medicine. If you do repeated walking for few times, everything would be okay soon".

Female sex workers described different ways in which they took the medicines based on what they were told or what they preferred to do:

"Drug sellers in pharmacy provided me 4 tablets and told me to take all the medicine together at a time orally. Out of 4, I took 3 tablets, and threw away the last."

"Drug sellers in pharmacy provided me 5 tablets and told me to take them orally. Out of 5, I took 4 tablets, and remaining one is still in my house."

"I did not take this medicine. But I bought and help my younger daughter to take this medicine. Pharmacy staff gave me two tablets. Packet of the tablets were in a steel like white (silver colour) cover. My daughter took one of them and did not take another one. After taking the tablet, my daughter faced severe abdominal pain. Then I called that pharmacy staff over phone. He advised me to feed my daughter hot tea. After that, bleeding started and it continued for next 7 days."

" The drug seller in the pharmacy gave me two tablets. There were two tablets in a single leaf, next to each other. The drug seller advised me to take this medicine with warm water. I took second tablet 3 days after taking the first one, even though I was advised to take the second tablet earlier. I was cured eventually although it took time."

Except two, all other women who took MRM medicines said that service providers did not conduct any physical examination before giving the medicines.Two were asked to test their pregnancy before taking MRM.

None of the FGD participants were informed about side effects and potential complications, or how to recognise potential complications. None were advised when they could resume normal activities, how long to avoid sexual intercourse, whether and when to return for a follow up visit. Also, none received any advice about future contraception. None, other than one, received any other medicines; the one sex worker was given vitamin syrup.

d) Post MRM complications and PAC

Four of the 11 female sex workers who used MRM, faced complications. Three received PAC services from NGO clinics and one from a government hospital. One sex worker took MRM medicines two years ago, but she was still suffering:

> " I used MRM 2 to 2.5 years ago. After that I have been using condoms. But after using MRM my bleeding is prolonged sometimes even up to 3-4 months. Before using MRM, my condition was not like this. Now during menstruation, big clots of blood come out."

5. CONCLUSIONS

The study aimed at assessing the quality of MRM services, gaps and barriers as well as facilitators, from the perspective of both service providers and clients. The main issues that emerged from the study findings are discussed below:

i) Demand for MRM:

MRM is popular with women both urban and rural and also with female sex workers and there is a demand for this service. According to one NGO the proportion of women seeking MRM among those who want to terminate their pregnancy increased over the years. Women want easy access, where privacy and confidentiality can be maintained. Many felt it should be made available to all women, irrespective of age and marital status but a few others were against it being made available to all.

Ii) Sources of MRM medicines and services:

Pharmacies were the most used source of MRM. However, complications were more frequently reported from women who bought from pharmacies rather than from clinics. Service providers in clinics, both government and NGO, were generally more likely to provide comprehensive services to women while services from pharmacies was largely about selling the medicines just like any other medicine with little time given to any customer (not just clients of MRM), no counselling and little, if any, information.

iii) Easy access to MRM:

Many service providers were not in favour of easy access especially through pharmacies. The reason for this opposition was because complications were more frequent in women who took MRM medicines from pharmacies than from clinics. Policy makers at the DGFP also had a negative attitude towards MRM based on the conception that MRM frequently leads to complications and that misuse is rampant.

At the same time, many other service providers were of the opinion that all women need to have easy access. However, they felt that there needs to be more control over who can prescribe; some were adamant that pharmacies should not be allowed to sell while others felt selling should only be permitted with a prescription from a registered doctor.

Given the different viewpoints, some supporting easy access and others demanding more control and at the same time the high demand from women, the DGFP feels that selling of MRM medicines needs to be regulated but not to the extent that it will hinder access for women. To this end, the DGFP will request the Drug Administration for better control over the pharmacies selling MRM and regular monitoring.

iv) Awareness regarding MRM:

General awareness regarding MRM was poor amongst women, especially rural women. Many women had not heard about MRM especially in Barishal where none of those participating in the FGD had ever used MRM. Also, female sex workers who were younger and new to the sex trade were not aware of MRM. Many women who knew about MRM were not clear about the dosage and on how to take the medicines. Female sex workers also reported different ways of taking the medicines with some not being clear about what they had done. It appeared as though some knew but disregarded the prescribed method and did as they felt best. A service provider at a clinic had also complained that many female sex workers do not heed instructions.

In general, women want more information while receiving services. They want to know how to take the medicine properly, and have full support in case of complications. There are no programmes or campaignsto raise awareness about MRM.

v) Female sex workers as a special marginalized group:

Female sex workers are a special group representing stigmatised and marginalised women. Their profession results in their greater requirement for sexual and reproductive health services as a result those interviewed were found to be more aware than other women regarding MRM and, in some cases, frequent users. However, not all followed the dose regimen, many did not pay heed to precautions such as avoiding sexual intercourse soon after taking MRM medicines. This disregard stemmed from their need to return to earning their livelihood by selling sex as soon as possible.

In general, female sex workers relied on pharmacies for MRM medicines but in case of complications they went to clinics. Most female sex workers said that their profession was a not barrier to receiving services. However, others felt they would be discriminated against if they revealed their profession.

vi) Male service providers:

Presence of male drug sellers and male service providers in facilities posed a barrier to many women seeking MRM as they felt inhibited talking about their reproductive health with men. Some demanded that pharmacies should have female drug sellers and all clinics must have female service providers.

vii) Availability of MRM medicines:

MRM medicine is not available in government clinics currently but service providers in some MCWCs do render services provided women purchase the MRM medicines from elsewhere. To overcome this shortcoming, the government has recently procured MRM medicines and has started distribution of those medicines. However, the number of MRM kits that have been procured is not based on what the demand may be as clinics have not placed a requisition. Government facilities probably do not have an idea about how much is required as most do not provide services at present. Women on the other hand, want MRM services to be made available at government facilities as these are generally cheaper and many have said that MRM should become available up to the Union level as women in villages are in need of these services. The government will extend MRM medicine supply up to the Union level depending on the outcome from MCWCs which they will assess. However, how and when this assessment will be conducted is unclear.

Some NGOs also had run out of their stock of MRM medicines at the time of visit.

viii) Adequate and trained staff:

Staffing in some clinics was not enough as the same staff were performing multiple functions. A considerable proportion of service providers in clinic facilities were not trained on MRM and most of those trained had not received training recently and there are no refresher training programs. Although NGOs have their own training programmes, some of which are also available for government service providers, thereare not enough trained staff available. Refresher training is not carried out. The vast majority of drug sellers in pharmacies have had no formal training.

Very few clinics had dedicated counselling staff; in most clinics counselling was provided by other staff such as doctor, paramedic, FWV. Counselling tools were not used.

National MRM guidelines were not available at most facilities and drug sellers were not even aware of its existence.

The DGFP plans to include training for all its services providers in its 2019 Operational Plan.

ix) Attitudes of service providers regarding MRM and behaviour:

Negative attitudes towards women seeking to terminate pregnancies was reported. Some did not approve of MRM based on personal and religious grounds but nonetheless service providers in clinics felt duty bound to provide services even if it went against their beliefs. Some expressed concern about unmarried girls and young girls seeking MRM and felt they were engaged in sinful behaviour and selling to them was encouraging promiscuity in the society. In such cases, they would insist on the presence of a guardian or husband. Some said they denied services to unmarried women, underage girls and female sex workers.

Behaviour of service providers towards women seeking MRM or PAC services from clinics was often negative with disrespectful language being used frequently. Women complained about such behaviour saying that it was a deterrent forsome to seek services or from speaking openly about their problems.

x) Consent

All NGO clinics took written consent in a standard format. They insisted on a guardian's consent only if the client was underage. Government facilities do not take consent. No consent is taken in pharmacies.

Some NGO service providers said that consent was also protective for them as they had faced problems in cases where there had been complications and the client had not informed her family, specially her husband.

xi) Suitability of MRM clinic facilities and pharmacies:

Location of most clinics was in the vicinity of clients and not difficult to reach. Pharmacies were very close by and open at all times even during holidays and weekends. However, timing of clinic facilities especially government facilities, was too short and service providers were often not available after lunch. There were no clinic facilities available on holidays and weekends. A few clinic facilities were not in good condition with no running and/or drinking water for clients, dirty bathrooms, etc. Some did not have adequate space.

xii) Record keeping:

Clinic facilities kept records of women using MRM but pharmacies did not. Several clinics kept electronic records. Such record keeping has enabled oneNGO tocalculate changes in the number of MRM clients annually which is a useful method for calculating demand and ensuring adequate medicine supply. Unfortunately, robust record keeping was not always observed.

xiii) BCC materials:

BCC materials were by and large absent from most facilities. Although senior NGO personnel interviewed said that they had BCC materials, service providers at the facilities said they did not use any BCC material.

xiv) Cost of services:

Cost was an issue for some women, for both MRM and PAC services, and this led to some buying part of the MRM Kit or not completing their PAC.

xv) PAC:

Most clinics had a referral system in place and if contacted for complications, drug sellers informed women that they should visit hospitals or clinics. Most women in the FGDs with complications had taken MRM medicines from pharmacies and in most cases their complications were dealt with successfully by clinics/hospitals so that they recovered fully. However, a few women continued to suffer from various problems. The case studies revealed that meagre means, limited information about existing services and limited access to those services were major hindrances to seeking effective PAC services. In addition, poor PAC services in both cases led to prolonged suffering.

xvi) Coordination and advocacy:

The government led working groups or committees on abortion are not functional at present as no meeting of the MR and MRM Alliance was held in 2018. Such committees/groups are crucial in ensuring coordination and provide a platform for advocacy based on the experience of different service providers. No advocacy efforts have been made in a coordinated way in recent times. The NGOs have their own action plans, training and monitoring plans that are more or less restricted to their own services, with a few exceptions. There is very little coordination between NGOs and between government and NGOs.

In summary, MRM is highly popular with women but they need better services from all sectors with more information, at less cost and with more respect. At the same time, they need services to be easily accessible for allwith confidentiality and privacy ensured. In general, service providers from the NGO sector are providing more comprehensive services while government facilities lack medicines. More trained staff following the National Guidelines is required. Pharmacies, although the most popular source of MRM medicines as they are easily accessible, are not regulated at all and do not follow any guidelines and the majority of complications occur in women who obtain MRM medicines from pharmacies. The policy makers at the government are starting to realise the need for government services to become more active in providing MRM services and actions are gradually being taken towards this. At the same time, the government is planning to put in place mechanisms to regulate sale from pharmacies. Overall, there is lack of coordination between different sectors of service providers, no real understanding of the national demand for MRM, women's needs and hence, weak planning.

Finally, Bangladesh has made great strides in making services available for women so that they can terminate unwanted pregnancies legally through MR and more recently, MRM. Concentrating on improvement of MR and MRM services will better serve women and Bangladesh.

6. FUTURE SCOPES

Each study has some limitations regarding resources and timing. Therefore, some issues might be overlooked or missed from the study. According to the external reviewer of the research report following areas can be considered in future research

1. The MR service is a component of essential service package (ESP) of the MoH&FW in UH&FWCs and above level facilities. In the urban areas, this service needs to be available into NGO run Urban Health Clinics (Primary Health Care Center – PHCC of UPHCSDP). In future, availability, access and quality of MRM services in the PHCC of Dhaka and Barishal City Corporations can be explored.
2. The findings of the report on MRM services from pharmacies are very important, and the challenges of counselling during MRM drugs were identified. It was also identified that the post-abortion FP was not addressed. The stigma is also found high. Discussion about the regulatory issues of MRM drugs is highlighted. Therefore, IDI with DGDA officials and officials of Pharmaceutical industries regarding regulatory issues would increase the awareness among these groups as well as improve the quality of services.
3. As drug sellers are among the key providers, their knowledge about MRM doses, common complications of MRM and nearby referral facilities can be explored in future.
4. Pain management in case of MRM can be included for service providers in the next study.
5. PAC and post-partum family planning for the sex workers is a good insight to explore in future.

7. RECOMMENDATIONS

Based on the above conclusions and the recognition that women want easy access to safe and reliable MRM services that ensure respect, privacy and confidentiality, recommendations are provided separately for government, NGOs and for Naripokkho that will facilitate to ensure the rights of women for safe abortion and free from stigma and discrimination.

7.1 FOR GOVERNMENT

1. Availability of MRM medicinesin all government facilities providing reproductive health services starting from MCWCs in Districts to UH&FWC serving villages needs to be ensured. This should be done in a phased manner starting with MCWCs and utilising lessons learnt to expand to the Union level.
2. Presence of adequate and trained staff at all facilities providing MRM services is essential. Number and type of staff that need to be placed at each facility needs to be based on number of women taking services from that facility.
3. In order to determine demand, record keeping with data collection (inventory system) needs to be more robust that will allow analysis and provide the basis for calculating the supplies that will be needed.
4. The National Guideline should be the basis for providing services as well as training. Particular attention to counselling is necessary with appropriate tools. Training needs to stress the need for respectful behaviour by service providers as well as the need for privacy and confidentiality.
5. Accountability of government services to ensure quality is essential. For this monitoring of services at facilities need to be initiated once services start following a monitoring plan.

External monitoring should also be considered with women from the community as participants in the team. Quality Assurance systems need to be initiated.

6. Awareness raising on MRM for women, girls and men is essential through electronic and print media as well as special campaigns. Development of BCC materials that are vetted to ensure that it is understandable by women from different backgrounds is required. Engagement of women in developing these awareness programs and BCC tools will ensure that these are acceptable and therefore more likely to be adopted by women. Use of existing field staff needs to be considered to spread the information on MRM.However, messaging needs to be sensitive to avoid backlash.
7. Comprehensive planning for MRM services is required. The Annual Operational Plan and Budget needs to ensure that all service components are covered from different facilities as per need. For this to occur, each facility needs to place a requisition in a timely manner. Distribution of supplies including medicines also need to occur regularly so that there is no short fall at the facilities. The Operational Plan and Budget needs to include training and monitoring activities as well as awareness raising programs.
8. Regulation of sale of MRM medicines through pharmacies need to be considered carefully. While it is important that rampant selling without comprehensive services that endanger women's health is discouraged, at the same time regulations designed to provide women with better services should not curtail easy access. A balance needs to be struck between easy access and comprehensive services which needs discussion among service providers from different sectors, women's rights groups as well representatives from the community of both men and women.
9. Activation of the MR & MRM Alliance needs to be done on an urgent basis to allow for opinion and experience sharing and working in coordination.
10. Facilities have to be in good operating conditions and staff present during office hours. Ideally, service hours should be increased and also made available during weekends and holidays.

7.2 FOR NGOS:

1. Ensure a coordinated approach so asto avoid duplication and that strengths of eachorganisation are utilised for optimal service provision. All service providers need tobe aware of each other's activities through regular communication. Coordination with the DGFP is also required so that services including training plans, use of BCC materials,etc. are synchronised.
2. Work together to activate the MR &MRM Alliance. The MR & MRM Alliance can actas a platform for sharing experiences, ideas and ensuring a coordinated approach, this body therefore needs to be activated so that it meets regularly.
3. Work with government policy makers to ensure proper planning so that all requirements are included in the Annual Operational Plan and Budget.
4. Work with government to ensure that training is carried out for drug sellers and that services from pharmacies are monitored.
5. Develop and institute training programmes for drug sellers.
6. Ensure that all training includes respectful behaviour towards clients and emphasise the need for privacy and confidentiality.
7. Conduct refresher training programmes for all service providers.
8. Ensure use of the National MRM Guidelines at clinic facilities.
9. Advocate on women's and girls' needs regarding MRM so that their requirements are kept central to all service provision.

10. Conduct awareness raising programmes for women.
11. Ensure female staff at all service provision facilities. Advocate for female drug sellers.
12. Ensure that clinic facilities are ingood condition, open at hours that suit clients and that space is available to ensure privacy and confidentiality.
13. Ensure use of BCC materials and that counsellors are using appropriate tools.
14. Ensure data collection is carried out in a reliable manner, ideally electronically, and conduct data analysis at regular intervals to determine number of women using MRM with outcome also number requiring PAC services due to complications.

7.3 FOR NARIPOKKHO:

1. Immediately disseminate the study findings in a larger forum and use this as an entry point with all relevant stakeholders on MR and MRM. This would facilitate membership in the MR &MRM Alliance which is a key body for advocacy. At the same time, work with other partners to activate the Alliance.
2. Advocate with all concerned on the needs of women for MRM services i.e. easily accessible, safe and reliable services and services that guarantee respect, privacy and confidentiality.
3. Work with government to ensure that planning occurs as per need and all elements are included in the Annual Operational Plan and Budget of the government.
4. Pilot training of drug sellers on MRM in selected areas of Barishal with the help of civil society partners with whom Naripokkho has a long standing relationship. Thereafter monitor those pharmacies along with civil society partners.
5. Monitor MRM services from government facilities in selected areas of Barishal through civil society partners with whom Naripokkho has a long standing relationship.
6. Coordinate with the networks of sex workers and NGOs working with them to ensure that they are aware of MRM, have full information and can reach out in case of complications to appropriate centres when needed.
7. Liaise with regional partners working on abortion and rights of women in order to share experiences and learn from others experiences as well as remain updated on any new developments.
8. Work with other relevant groups such as human rights groups, women's groups and civil society partners to together pressurise policy makers and service providers to ensure that women's reproductive and sexual health needs and rights are not compromised especially when and if new regulations are formulated.
9. Ensure communication and referrals between different service points for sexual and reproductive health such as One Stop Crisis Centre.

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8 ANNEXES

ANNEXE 1 : Checklist for field staff to determine quality of services by directly observing at facilities and pharmacies

A. Facility Data

Facility Preparedness

1. Does the facility have separate counseling, screening and examination rooms to ensure privacy?
2. Does the facility have a comfortable waiting space for the clients?
3. Are clean toilets available for use by clients?
4. Is there running water?
5. Is the electric supply adequate with back up?
6. Note number of providers in the facility who provide SRH services
7. Note number of providers who provide MRM services.
8. Is the National Guideline on MRM available at the facility?
9. Are there appropriate BCC material for MRM, displayed on the wall?
10. Check if there is adequate available stock of related drugs (at least three months stock to be considered adequate)

MRM Statistics

1. Is there a separate register maintained for MRM clients?
2. Note number of clients who received MRM service in the last 12 months.
3. Note age range of clients.
4. Note number of post MRM complications treated during the last 12 months.
5. Note number of major types of post MRM complications recorded as per gravity of the problem.
6. Note number of clients who adopted any FP method post MRM
7. Check if there was any need for referral service for post MRM complication and types of complications referred.

B. Pharmacy Data

Drug Sellers Behaviour

1. Check whether correct doses of mifepristone-misoprostolare sold
2. Check if adequate information about the use and effectiveness is provided
3. Check whether possible complications of MRM are explained
4. Check whether any follow up visit is recommended
5. Check whether any post-MR contraception is offered

ANNEXE 2 : In-depth interview guideline (with service providers)

This in-depth interview guideline is for service providers at different facilities to assess quality of services. Prior to starting the interview written informed consent has to be taken using the consent form and the following information completed.

Name of the Facility: _____

Location of the Facility: _____

Position of the Interviewee: _____

Interviewer's name: _____

Signature of interviewer: _____

Date of Interview: _____ (dd/mm/yyyy)

Starting time of interview:

Ending time of Interview:

The interview will cover the following five sections with further details under each section. All questions are guides and not restricted to only these points. Please expand for better understanding.

1. Safe and confidential environment:

i) In your opinion, does the clinic have adequate infrastructure – adequate and appropriate space, availability of storage space for client records, medicines, etc.

ii) What are the opening times of the clinic?

iii) What is the geographical area that the clinic covers? Do they receive clients who live far away? How accessible is the clinic for clients in terms of location and availability of transport?

iv) Is the clinic located in an area that is safe for women to travel to? Do the providers feel safe and are not threatened?

v) Is the room where MRM is provided private? Does the room allow for maintaining clients' privacy during consultation and examination? Expand

vi) Can confidentiality be maintained? How are records maintained? Is confidentiality of records ensured?

2. Comprehensive and integrated services

i) Is there availability of other related services that women may need or provision of referrals if required?

ii) Is complete history taking carried out? Obstetrical, gynaecological, surgical, medical (allergies, etc)

iii) Is complete examination conducted? - external genitalia, speculum examination, bimanual examination.

iv) Is full information provided to clients to enable her to make an informed decision? e.g. information on MRM such as dosage, possible side effects, how to recognise potential complications, and how and where to seek help if required.Does she receive help in making a final decision?

v) Who conducts counselling? If it is not you, you does this and where is it done? Does counselling ensure communication in a simple and understandable language? Is there a two-way communication – is the client able to talk freely and ask questions and clarify issues?

vi) Is emotional support provided?

3. Post MRM Service and contraception

i) Is the client given full information on discharge? e.g. when she can resume her normal activities, avoiding sexual intercourse for 2 weeks, information on bleeding following MRM.

ii) Does the provider review the risk of the client becoming pregnant again? And what advise does the provider give to the client such as provide contraceptive information and offer contraceptives most suitable for her.

iii) Are other medications offered such as iron, folic acid, pain medication, etc.

iv) Is the client advised to return for follow up? If yes, when? Do moct clients return for follow up?

v) Is the client informed about signs indicating complications for which the client should seek care?

vi) What are the most common complications seen here? How are they managed? Are referrals available if required?

4. Skilled and respectful personnel

i) How many staff at this facility provide MRM services? Who are they (positions)? Are there adequate number of skilled personnel available at the clinic? If not, why not?

ii) Have all personnel received adequate training? Describe. If not, why not?

iii) Are the personnel non–judgemental and supportive? Check if they have refused MRM to women based on personal views and beliefs.

iv) Have female sex workers ever availed these services from this clinic? If yes, were there any issues regarding this? – expand. If not, do you feel that there is discrimination against them? Expand.

v) Do you take consent from women seeking MRM? If yes, why and how? Do women access MRM services from your clinic on their own or do they need to be accompanied by a guardian?

5. Logistics

i) Is the supply chain of MRM medications maintained? i.e. adequate supply, properly stored (away from light, in a cool place), expiry date taken into account, etc.

ii) Is the register of women seeking MRM maintained separately and kept in a safe and confidential environment? Check how this is done.

Finally, do you have any recommendations for improvement?

ANNEXE 3 : Questionnairefor Service providers of MRM

Interview code No.:

Type of service providing institution: (give a √ mark)

1. MCWC ☐ 2. UHC ☐ 3. UH&FWC ☐ 4. NGO clinic ☐

Nameofservice providing institution:.....

Name of district: .....

Name of Upazila/City Corporation: .....

Name of Union/Ward: .....

Date of Interview: .....

Interviewer's name: .....

Interview starting time:----------(HH:MM) (24HR)

Interview ending time:---------- (HH:MM) (24HR)

Has the interview been completed? Yes/No

If no, why (only one answer allowed): .....

Checked by the supervisor: Signature - - - - - - - - - - - - - - - - - - Date: ---------- (DD/MM/YYYY)

Section 1. Safe and confidential environment

No.	Questions and filters	Coding categories	Skip to	Var. name
101	Do you think the facility is designed to meet the requirements of women seeking MRM services?	Yes ..... 1 No ..... 2 If no, why not? 99		V101
102	Are the opening times convenient to clients?	Yes ..... 1 No 2		V102
103	Is the general maintenance of the facility satisfactory?	Satisfactory ..... 1 So so ..... 2 Not satisfactory ..... 3 No response ..... 98 Explain if not satisfactory		V103
104	Is the facility accessible by public transport?	Yes ..... 1 No 2		V104
105	Is it cheap to reach the facility by public transport?	Yes ..... 1 No 2		V105
106	Is the located in an area safe for women to travel to on their own?	Yes ..... 1 No 2		V106
107	Is security of clients and staff ensured?	Yes ..... 1 No 2		V107
108	Is entry into consultation rooms restricted during client interviews and physical examinations?	Yes ..... 1 No 2		V108
109	Is client's audio and visual privacy ensured?	Yes ..... 1 No 2		V109
110	Do you maintain client records?	Yes ..... 1 No 2		V110
111	If yes, how are client records maintained?	Paper copies ..... 1 Computer ..... 2 Online web based ..... 3 Other(specify) 96		V111
112	Are client files/records kept confidential?	Yes ..... 1 No ..... 2 If yes, how? ..... If no, why not?		V112

Section 2. Comprehensive integrated services

No.	Questions and filters	Coding categories	Skip to	Var. name
201	Who are the staff that deliver MRM services at this facility?	Doctor ..... 1 Nurse ..... 2 FWV ..... 3 Counselor ..... 4 Other (specify) ..... 5 (multiple response possible)	 208	V201
202	Do you follow the national MRM guideline?	Yes ..... 1 No ..... 2 If not, why?		V202
203	Is the national guideline on MRM available to all staff at this facility?	Yes ..... 1 No 2		V203
204	What medications do you dispense here for MRM?	Mifepristone ..... 1 Misoprostol ..... 2 Both 3		V204
205	Is complete history taking carried out priori to dispensing medicines?	Yes ..... 1 No ..... 2 If not, why?	301	V205
206	Is physical examination conducted for reproductive health?	Yes ..... 1 No 2		V206
207	If physical examination is carried out, which type of examination?	External genitalia ..... 1 Speculum examination ..... 2 Bimanual examination ..... 3 Others (specify) ..... 96 (Multiple response possible)		V207
208	If physical examination is not carried out, why is this not done?	Facilities not amenable to conduct exams ..... 1 No time ..... 2 Too many clients ..... 3 Other (specify) ..... 96 (Multiple response possible)		V208
209	Is there a counselor available at this facility who counsels MRM clients?	Yes ..... 1 No 2		V209
210	If not, who provides counseling?	Doctor ..... 1 Nurse ..... 2 FWV ..... 3 Other (specify)..... 96 (Multiple response possible)		V210
211	Are appropriate counseling tools used during session (model, charts)?	Yes ..... 1 No 2		V211
212	Is full information provided to clients to enable her to make an informed decision?	Yes ..... 1 No ..... 2 If not, why?		V212

213	What information is provided?	Choice of medication ..... 1 Dosage ..... 2 Possible side effects ..... 3 Possible complications ..... 4 How to recognise potential complication ..... 5 How and where to seek help if required ..... 6 Other (specify) ..... 96 (Multiple response possible)		V213
214	Do you answer questions and/or concerns raised by the client?	Yes ..... 1 No 2		V214
215	Does the client receive emotional support?	Yes ..... 1 No ..... 2 No response 98		V215
216	Are other related services that women may need available at this facility?	Yes ..... 1 No ..... 2 If yes, specify the service		V216
217	Do you have provision for referrals if required?	Yes ..... 1 No 2		V217
218	Do you think your referral system particularly in cases of emergency is adequate?	Yes ..... 1 No ..... 2 If not, why?		V218
219	If client is being referred, what are the usual reasons for the referral	Describe.....		V219
220	Do you have a list of referral facilities with whom you have an understanding with?	Yes ..... 1 No 2		V220
221	Explain the referral process	.....		V221
222	Do you keep records of clients being referred or requiring follow-up?	Yes ..... 1 No 2		V222

Section 3. Post MRM Service and Contraception

No.	Questions and filters	Coding categories	Skip to	Var. name
301	Is the client given full information on discharge?	Yes ..... 1 No 2	303	V301
302	If yes, what information is provided?	When she can resume her normal activities ..... 1 How long sexual intercourse should be avoided ..... 2 Information on possible bleeding ..... 3 Information regarding other complications ..... 4 Others (specify) ..... 96 (Multiple responses possible)	306	V302
303	Is the risk of the client becoming pregnant again reviewed?	Yes ..... 1 No 2		V303
304	Is advice given to avoid pregnancy in the future?	Yes ..... 1 No 2		V304
305	If yes, specify	Information on contraceptive options ..... 1 Offering suitable contraceptives ..... 2 Other(specify) ..... 96 (Multiple responses possible)		V305
306	Are other medications offered such as iron, folic acid, pain medication, etc.	Yes ..... 1 No 2		V306
307	Is the client advised to return for follow up?	Yes ..... 1 No 2		V307
308	Is the client informed about signs indicating complications for which the client should seek care?	If yes, when? (in weeks) ..... Yes ..... 1 No 2		V308
309	What do you usually do when a client returns with complications?	(Describe)		V309

Section 4. Highly skilled and respectful personnel

No.	Questions and filters	Coding categories	Skip to	Var. name
401	Is the facility fully staffed as needed?	Yes ..... 1 No 2		V401
402	Have you received training on providing MRM?	Yes ..... 1 No 2	404	V402
403	If yes, when was training last conducted?	..... (Days if within 1 month, otherwise in months)		V403
404	Do you think the training was adequate?	Yes ..... 1 No 2	406	V404
405	If you think training was not adequate, how can it be improved?	Describe		V405
406	Have all relevant staff at this facility been trained on providing MRM?	Yes ..... 1 No ..... 2 If not, why?		V406
407	Do refresher training programstake place?	Yes ..... 1 No..... 2		V407
408	Do you listen patiently to client's needs and concerns, and answer questions?	Yes ..... 1 No 2		V408
409	Do you use language the client understands?	Yes ..... 1 No 2		V409
410	Do you describe services available according to client's needs?	Yes ..... 1 No 2		V410
411	Have you ever refused clients MRM services?	Yes ..... 1 No 2	413	V411
412	If yes, why?	Personal beliefs ..... 1 Religious beliefs ..... 2 Too late for MRM ..... 3 Other contraindications (specify) ... 96 ..... (Multiple responses possible)		V412
413	Do you take consent from women seeking MRM?	Yes ..... 1 No 2	415	V413
414	Do women access MRM services from your clinic on their own or do they need to be accompanied by a guardian?	Own ..... 1 Accompanied by a guardian 2		V414

415	If consent is taken, how is this taken?	Written ..... 1 Oral 2	417	V415
416	If written consent is taken, is there a specific form for this?	Yes ..... 1 No 2		V416
417	Do women accessing MRM services from your facility need to be accompanied by a guardian?	Yes ..... 1 No ..... 2 If yes, why?		V417
418	Have you ever had female sex workers accessing MRM services from this facility?	Yes ..... 1 No ..... 2 Don't know ..... 97 No response 98		V418
419	Do you feel that they are treated similar to all other women who come to this facility?	Yes ..... 1 No ..... 2 Don't know ..... 97 No response 98		V419

Section 5. Logistics

No.	Questions and filters	Coding categories	Skip to	Var. name
501	Is the supply chain and storage of MRM medications maintained?	Adequate supply ..... 1 Properly stored (away from light, in a cool place) ..... 2 Expiry date taken into account ..... 3 Other (specify) ..... 96 (multiple response possible)		V501
502	Is the register of women seeking MRM maintained separately?	Yes ..... 1 No 2		V502
503	Is the register of women seeking MRM kept in a safe and confidential environment?	Yes ..... 1 No 2		V503

ANNEXE 4 : FGD guideline for drug sellers to determine quality of services

This FGD guideline is for drug sellers of pharmacies to assess quality of services. Prior to starting the interview verbal consent has to be taken from the group as a whole.

I have come to you from Naripokkho and, BAPSA. My name is _____. I know that you have been providing MRM services from your pharmacies. We are conducting a study to better understand how MRM services are provided from different facilities and what the different aspects of the services provided include in order to ascertain whether women are receiving services properly. It is important to understand this as it will ensure quality services and further increase the demand so that unwanted pregnancies which often lead to termination can be avoided. It is known that many women face obstacles in accessing MRM services and when they do access available services they may face other barriers that could result in complications. Understanding all issues is crucial in ensuring availability of quality services that will benefit both the providers and the women who need the services.

As you are currently providing MRM services to women and you have the experience of delivering these services within the existing conditions of your pharmacies, we would like to hear from you regarding your experience in providing MRM and the issues, if any, that you may face that could hamper delivering quality services.

Your identities will remain strictly confidential and your names will not be recorded anywhere. I would like to tape this discussion to ensure accuracy of my records but if you do not want me to do this, I will not tape. If you agree to participate in this discussion, I will proceed.

Location of the FGD: _____

FGD Group: _____

Number of people in the FGD: _____

Position of FGD members: _____

Interviewer's name: _____

Signature of interviewer: _____

Date of FGD: _____ (dd/mm/yyyy)

Starting time of FGD: _____

Ending time of FGD: _____

The FGD will cover the following five sections. Each section has topics presented as questions, that need to be covered and expanded upon. All questions are guides and not restricted to only these points. Please expand and add for better understanding.

1. Accessible, safe and confidential environment:

What are the opening times of the pharmacy? Can women come at all hours? When do they usually come?

Do you know where most of your clients come from? Do you have clients who live far away? How accessible is the pharmacy for clients in terms of location and availability of transport?

Where does consultation take place with women who seek MRM? Is there a separate room for this? Is their enough space in the pharmacy to ensure privacy of the clients? Can confidentiality be maintained?

Do you maintain client records? If yes, how is confidentiality of records ensured?

2. Skilled and respectful personnel

Who dispenses the medications? Can anyone dispense?

Is there a doctor available? If yes, at what times? What happens when the doctor is not there?

Is counselling provided? Who does this? What are the basic elements that are provided during counselling?

Are you aware of the national guidelines on MRM? Do you have a copy in the pharmacy?

Have all personnel received adequate training on MRM in the pharmacy? If yes, describe. If not, why not?

Are the personnel non–judgemental and supportive? Check if they have refused MRM to women based on personal views and beliefs.

Do you take consent from women seeking MRM? If yes, why and how?

Do women access MRM services from your clinic on their own or do they need to be accompanied by a guardian?

3. Comprehensive and integrated services

Is complete history taking carried out? Is physical examination conducted? If not, how do you judge whether a client does or does not have contraindications to MRM? And if yes, where is that carried out? Is the doctor's room adequately furnished for a proper physical exam?

Is full information provided to clients to enable her to make an informed decision? e.g. information on MRM such as dosage, possible side effects, how to recognise potential complications, and how and where to seek help if required,

Does she receive help in making a final decision?

Is there scope for referrals if you suspect that a client needs more medical support? If yes, where do you usually send your clients? If not, what do you do?

4. Post MRM Service and contraception

Is the client given full information? e.g. when she can resume her normal activities, avoiding sexual intercourse for 2 weeks, information on bleeding following MRM.

Do you review the risk of the client becoming pregnant again? And what advise do you give to the client such as provide contraceptive information and offer contraceptives most suitable for her.

Are other medications suggested such as iron, folic acid, pain medication, etc.?

Is the client advised to return for follow up? If yes, when?

Is the client informed about signs indicating complications for which the client should seek care?

5. Logistics

Is the supply chain of MRM medications maintained? i.e. adequate supply, properly stored (away from light, in a cool place), expiry date taken into account, etc.

Is a register of women seeking MRM maintained? If yes, is this kept separately and in a safe and confidential environment?

Finally, do you have any recommendations for improvement?

ANNEXE 5 : FGD guideline for women of reproductive age

This FGD guideline is to understand the knowledge and experiences of women of reproductive age who are potential clients or are have used MRM. Prior to starting the interview verbal consent has to be taken from the group as a whole.

I have come to you from Naripokkho and BAPSA. My name is _____. We are conducting a study to better understand how MRM services are provided from different facilities to you; whether you are aware of these services and whether you have easy access to those services. If you have received MRM, we want to understand what information and services you have received, from where and whether you are happy with those services. We also want to understand if you have received MRM, whether you experienced difficulties such as complications and how those were managed. It is important to understand all this as it will ensure that better services are provided in future that meet your needs.

We would therefore like to hear from you regarding your knowledge and experience in receiving MRM services and services for complications, if any, and barriers to access that you may have faced. Your identities will remain strictly confidential and your names will not be recorded anywhere.

I would like to tape this discussion to ensure accuracy of my records but if you do not want me to do this, I will not tape. If you agree to participate in this discussion, I will proceed.

Location of the FGD: _____

FGD Group: _____

Number of people in the FGD: _____

Position of FGD members: _____

Interviewer's name: _____

Signature of interviewer: _____

Date of FGD: _____ (dd/mm/yyyy)

Starting time of FGD: _____

Ending time of FGD: _____

The FGD will cover the following five sections. Each section has topics presented as questions, that need to be covered and expanded upon. All questions are guides and not restricted to only these points. Please expand and add for better understanding.

1. Awareness and information about MRM

Have you heard about MRM? If yes, what have you heard? Where did you get this information?

Can you tell me what information you have about MRM and where you received this information? (this question is looking for more detail regarding WRA knowledge no MRM)

How many of you have used MRM? For those who have not, would you use MRM and under what circumstances? If you needed MRM and have not used it, why not?

Is this something that you would keep secret from different members of your family? If yes, who would you confide in and talk to? Do you think there will be anyone in your immediate circle of family or friends who you can trust to discuss with and who can help and support you to decide on taking such services?

Who would you go with to access MRM services? Why would you go with the person that you mention?

Will you need permission from someone to access MRM?

2. Accessible, safe and confidential environment

Do you know where these medicines/services are available?

In your opinion, is that a suitable location for dispensation of MRM? Is it far away? Is it a safe journey to undertake? is it expensive to travel to?

What times are the facilities open?

Do you think the facility is a good one? Does it have enough space? Do you feel that your privacy can be ensured there?

If you accessed MRM services, did you have a private consultation with no one else listening in? did you feel comfortable in that environment? Did you feel your confidentiality was maintained?

Did you have to sign any consent form?

Did you have to be accompanied by a guardian? If yes, who was your guardian?

3. Skilled and respectful personnel

When you went for services, who provided those services – (e.g. doctor, Drug seller, Counsellor, Nurse)?

Did they ask you about your problems before they gave you medicine? If yes, what did they ask you.

Do you feel that they helped you in making a final decision by explaining MRM to you in detail?

Did you feel the staff were good and they treated you well? Did you feel that they were supportive? Did you feel they treated you with respect? Check to see whether WRA felt service providers were rude and judgemental.

Was anyone of you and or anyone you know refused MRM? If yes, do you know why? Do you know which facility refused treatment?

Did you feel ashamed and that you could not speak frankly and openly? If not, why? If yes, expand.

4. Comprehensive and integrated services

Did they talk to you and tell you about how to take the medicine, in what dose, for how long?

Did they check your body before giving the medicines? If yes, can you explain what they checked?

Did they tell you if there will be any side effects and complications, how to recognise potential complications? If yes, did they explain what to do and where to go if complications arose?

Did they tell you about whether and when you should return? If yes, when? Did you go back as advised?

5. Post MRM Service and contraception

Were you told when you can resume your normal activities, how long to avoid sexual intercourse, information on bleeding following MRM.

Did you receive advise about contraception in the future and were you offered suitable contraceptives? If yes, expand.

Did you receive other medications such as iron, folic acid, pain medication, etc.?

If you had complications, what were they? What did you do for those complications? Where did you go for treatment? Were your problems treated adequately?

Finally, would you like to add anything that you feel we need to know?

ANNEXE 6 : FGD guideline for women who undertook MRM and experienced complications

This FGD guideline is to explore the experiences of women who undertook MRM and experienced complications. Prior to starting the interview verbal consent has to be taken from the group as a whole.

I have come to you from Naripokkho and BAPSA. My name is _____. We are aware that you have suffered complications following receiving MRM services. We are conducting a study to better understand how MRM services are provided from different facilities to you, whether you were given enough information and how your complications were managed. It is important to understand all this as it will help ensure better services are provided in future that meet your needs. We would therefore like to hear from you regarding your knowledge and experience in receiving MRM services and services for complications, barriers to access that you may have faced.

Your identities will remain strictly confidential and your names will not be recorded anywhere. I would like to tape this discussion to ensure accuracy of my records but if you do not want me to do this, I will not tape. If you agree to participate in this discussion, I will proceed.

Location of the FGD: _____

FGD Group: _____

Number of people in the FGD: _____

Position of FGD members: _____

Interviewer's name: _____

Signature of interviewer: _____

Date of FGD: _____ (dd/mm/yyyy)

Starting time of FGD: _____

Ending time of FGD: _____

The FGD will cover the following four sections. Each section has topics presented as questions, that need to be covered and expanded upon. All questions are guides and not restricted to only these points. Please expand and add for better understanding.

1. Accessible, safe and confidential environment:

Where did you receive your MRM services? What sort of a facility was it (pharmacy, GoB, NGO, private)?

In your opinion, was the facility a suitable location for dispensation of MRM? Was it far away? Was it a safe journey to undertake? Was it expensive to travel to?

Do you think the facility was a good one? Did it have enough space? Did you feel your privacy was ensured there?

When you accessed MRM services, did you have a private consultation with no one else listening in? did you feel comfortable in that environment? Did you feel your confidentiality was maintained?

Did you have to sign any consent form?

Were you accompanied by a guardian? If yes, who was your guardian?

2. Skilled and respectful personnel for MRM services

When you went for MRM services, who provided those services – (e.g. doctor, Drug seller, Counsellor, Nurse)?

Did they ask you about your problems before they gave you medicine? If yes, what did they ask you.

Did you feel the staff were good and they treated you well? Did you feel that they were supportive? Did you feel they treated you with respect? Check to see whether WRA felt service providers were rude and judgemental.

Did you feel ashamed and that you could not speak frankly and openly? If not, why? If yes, expand.

Did they talk to you and tell you about how to take the medicine, in what dose, for how long?

Did they check your body before giving the medicines? If yes, can you explain what they checked?

Did they tell you about whether and when you should return? If yes, when? Did you go back as advised?

3. Post MRM Service and contraception

Were you told when you can resume your normal activities, how long to avoid sexual intercourse, information on bleeding following MRM.

Did you receive advise about contraception in the future and were you offered suitable contraceptives? If yes, expand.

Did you receive other medications such as iron, folic acid, pain medication, etc.?

Did they tell you if there will be any side effects and complications, how to recognise potential complications? If yes, did they explain what to do and where to go if complications arose?

4. Comprehensive PAC services

What complications did you experience? Were you aware that such complications could occur? Did they inform you about it when you received MRM?

What did you do for those complications? Explain in detail – who did you consult first? What did you do next? Where did you first seek treatment? Did you need to go to different facilities before you finally got the right treatment? Where did you finally get treatment?

Were your problems treated adequately? If not, explain.

Was the treatment free of cost? If not, how much did you need to spend?

At the PAC facility, did they treat you with respect and dignity? Were your concerns addressed?

Do you still have problems? If yes, describe.

Finally, would you like to add anything that you feel we need to know?

ANNEXE 7 : FGD guideline for sex workers

This FGD guideline can be used for female sex workers to determine knowledge, access and quality of MRM services. Prior to starting the interview verbal consent has to be taken from the group as a whole.

This FGD guideline is to understand the knowledge and experiences of women of reproductive age at the Union level who are potential clients or are have used MRM. Prior to starting the interview verbal consent has to be taken from the group as a whole.

I have come to you from Naripokkho and BAPSA. My name is _____. We are conducting a study to better understand how MRM services are provided from different facilities to you; whether you are aware of these services and whether you have easy access to those services. If you have received MRM, we want to understand what information and services you have received, from where and whether you are happy with those services. We also want to understand if you have received MRM, whether you experienced difficulties such as complications and how those were managed. In addition, we want to understand that whether, you as a group, face any prejudices and hindrances in receiving services. It is important to understand all this as it will ensure that better services are provided in future that meet your needs. We would therefore like to hear from you regarding your knowledge and experience in receiving MRM services and services for complications, if any, and barriers to access that you may have faced.

Your identities will remain strictly confidential and your names will not be recorded anywhere. I would like to tape this discussion to ensure accuracy of my records but if you do not want me to do this, I will not tape. If you agree to participate in this discussion, I will proceed.

Location of the FGD: _____

FGD Group: _____

Interviewer's name: _____

Signature of interviewer: _____

Date of FGD: _____ (dd/mm/yyyy)

The FGD will cover the following five sections. Each section has topics presented as questions, that need to be covered and expanded upon. All questions are guides and not restricted to only these points. Please expand and add for better understanding.

1. Awareness and information about MRM

Have you heard about MRM? If yes, what have you heard? Where did you get this information?

Can you tell me what information you have about MRM and where you received this information? (this question is looking for more detail regarding WRA knowledge no MRM)

How many of you have used MRM? For those who have not, would you use MRM and under what circumstances? If you needed MRM and have not used it, why not?

Do you feel you need to be accompanied by someone when you go for MRM? If yes, why? Who would you go with to access MRM services? Why would you go with the person that you mention?

2. Accessible, safe and confidential environment:

Do you know where these medicines/services are available?

In your opinion, is that a suitable location for dispensation of MRM? Is it far away? Is it a safe journey to undertake? is it expensive to travel to?

What times are the facilities open?

Do you think the facility is a good one? Does it have enough space? Do you feel that your privacy can be ensured there?

If you accessed MRM services, did you have a private consultation with no one else listening in? did you feel comfortable in that environment? Did you feel your confidentiality was maintained?

Did you have to sign any consent form?

Did you have to be accompanied by a guardian? If yes, who was your guardian?

3. Skilled and respectful personnel

When you went for services, did you reveal you are a sex worker? Did you think it was relevant to reveal that? Were you asked about your profession? Did you hide your profession? If yes, why? Expand.

Did you feel the staff were good and they treated you well? Did you feel that they were supportive? Did you feel they treated you with respect? Check to see whether sex workers felt service providers were rude and judgemental.

When you went for services, who provided those services – (e.g. doctor, Drug seller, Counsellor, Nurse)?

Did they ask you about your problems before they gave you medicine? If yes, what did they ask you.

Do you feel that they helped you in making a final decision by explaining MRM to you in detail?

Was anyone of you and or anyone you know refused MRM? If yes, do you know why? Do you know which facility refused treatment?

Did you feel ashamed and that you could not speak frankly and openly? If not, why? If yes, expand.

4. Comprehensive and integrated services

Did they talk to you and tell you about how to take the medicine, in what dose, for how long?

Did they check your body before giving the medicines? If yes, can you explain what they checked?

Did they tell you if there will be any side effects and complications, how to recognise potential complications? If yes, did they explain what to do and where to go if complications arose?

Did they tell you about whether and when you should return? If yes, when? Did you go back as advised?

5. Post MRM Service and contraception

Were you told when you can resume your normal activities, how long to avoid sexual intercourse, information on bleeding following MRM.

Did you receive advise about contraception in the future and were you offered suitable contraceptives? If yes, expand.

Did you receive other medications such as iron, folic acid, pain medication, etc.?

If you had complications, what were they? What did you do for those complications? Where did you go for treatment? Were your problems treated adequately?

Finally, would you like to add anything that you feel we need to know?

(Footnotes)

[1] Conduct D&C, a brief surgical procedure of removing uterus lining and/or contents; since it clear all the remaining products of conception local people call it washing the uterus/pregnancy.

About Naripokkho

Naripokkho is a membership-based, women's activist organisation working for the advancement of women's rights and entitlements and building resistance against violence, discrimination and injustice. Since its founding in 1983, Naripokkho has met every Tuesday to discuss problems, issues and strategies related to these concerns. These discussions form the basis for Naripokkho's programmes and activities, which include campaigns, cultural events, training, research, lobbying and advocacy, and the maintenance of a regular participatory discussion forum. Occasionally this leads to a specific project, which is carried out with grant funding. However, most of Naripokkho's activities are voluntary and financed through resources contributed by the membership.

Naripokkho's work is focused on the following five inter-related thematic areas:

- Equality and the Political Empowerment of Women
- Violence Against Women (VAW) and Women's Human Rights
- Women's Health and Reproductive Rights
- Communal Harmony
- Women's Economic Rights

Naripokkho has extensive experience in developing sustainable networks and alliances as well as in conducting research, workshops, seminars, training and national level conferences.

Naripokkho's campaigns, projects and advocacy interventions are conducted by members with the support of full-time staff. Naripokkho has through the collective knowledge and experience of its membership and the engagement of individual members in various movement-based and advocacy roles, achieved a strong reputation of expertise in gender and rights issues.

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About ARROW

ARROW is a regional and non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Since it was established in 1993, it has been working to advance women's health, affirmative sexuality and rights, and to empower women through information and knowledge, evidence generation, advocacy, capacity building, partnership building and organisational development.

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