Physical Anthropology 481 - 499

Knowledge and Practice of Menstrual Regulation

An Assessment among the Underprivileged People in Bangladesh

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Abstract: *Menstruation is seen as both a purifying and polluting event in many cultures, including Bangladesh. While seemingly contradictory, this way of thinking has actually two manifestations of the same concept. Menstruation is valued as a means of regularly flushing "bad blood" from a woman's body, cleaning the woman, and signifying that she is fertile. Once out of the body, however, menstrual fluids are believed to pollute anything they contract. To limit menstrual pollution, the general movements, religious and household activities of menstruating women have been severely restricted by social proscription[1]. The present study report is an attempt to assess the menstrual regulation (MR) services for marginalized and underprivileged people in Bogra and Rajshahi Districts in Bangladesh.*

Introduction

In Bangladesh, the law prohibits induced abortion except when a woman's life is endangered by her pregnancy. Village women, however, have long turned to traditional practitioners for abortion, even though the unhygienic methods used in these cases (often involving insertion of foreign bodies, such as roots, into the uterus[2]) may lead to life-threatening complications. Nearly half of admissions to gynaecology units of major hospitals in Bangladesh involve abortion-related complications[3], and community-based studies suggest that 7-16% of maternal deaths are associated with induced abortion[4].

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1 Walle, Etienne Van De and Elisha P. Renne, Regulating Menstruation: Beliefs, Practices and Interpretations, *Regulating Menstruation in Matlab, Bangladesh: Women's Practices and Perspectives,* accessed on 27 July 2009.

2 Islam S, Indigenous abortion practitioners in rural Bangladesh, in *Abortion Practitioners in Rural Bangladesh,* Dhaka, Bangladesh: Women for Women Publication, 1981; and Maloney C et al., *Beliefs and Fertility in Bangladesh,* Dhaka, Bangladesh: International Center for Diarrhoeal Disease Research, Bangladesh (ICDDR,B), 1981.

3 Measham AR et al., Complications from induced abortion in Bangladesh related to types of practitioners and methods, and impact on mortality, *Lancet*, 1981, I(8213):199—202.

4 Alauddin M, Maternal mortality in rural Bangladesh: the Tangail district, *Studies in Family Planning*, 1986, 17(1):13—21; Chen LC et al., Maternal mortality in rural Bangladesh, *Studies in Family Planning*, 1974, 5(11):334—341; Fauveau V and Blanchet T, Deaths from injuries and induced abortion among rural Bangladeshi women, *Social Science and Medicine*, 1989, 29(9):1121—1127; Khan AR et al., Induced abortion in a rural area of Bangladesh, *Studies in Family Planning*, 1986, 17(2):25—99; and Koenig MA et al., Maternal mortality in Matlab, Bangladesh: 1976—85, *Studies in Family Planning*, 1988, 19(2):69—80.

Since 1979, the practice of menstrual regulation has been permitted in Bangladesh. Menstrual regulation by vacuum aspiration may be performed until the 10th week following a missed menstrual period[5]—usually before the pregnancy is clinically confirmed.

Legalization of MR in 1979, the government of Bangladesh considers MR to be an "interim method of establishing non-pregnancy for a woman at risk of being pregnant whether or not she actually is pregnant". Because the majority do not use contraceptives to prevent unwanted pregnancy and adolescent lack an adequate understanding about the maturation process, fertile periods, and risks of unprotected sex. MR services have been widely available as part of the family planning programme through GO-NGOs and private participation and collaboration and as a result women's access to safe MR has been significantly increased.

Despite the widespread availability of legal and safe MR services, however, many young women resort to illegal and unsafe MR. Adolescents lack understanding about the risks and consequences of pregnancy termination, and many of them are unaware that MR services are available. But females' entitlement to take MR decision and to get safe MR services and socio-cultural barriers are being overlooked, which is taken into account while designing the intervention. These gaps and uneven quality of health care have been noted.

A large scale study[6] finds more than half (57%) of the unmarried adolescents and over 40% of the married adolescents have not heard of MR. Although family planning has been accepted by religious leaders and interpreters, still MR is debatable to many of the religious leaders. It should be noted that the Holy Quran is critical about MR ("Kill not your children for fear of want; it is we who provide sustenance for them as well as for you; for verily killing them is a great sin"[7]. Similarly Hindu perspectives about MR is a bad karma (action), (Vasu Murti and Mary Krane Derr), but liberal about MR. This confusion generates from their lack of knowledge about MR. Since Islam and Hinduism recognize birth control, so there is a space to work over there if religious leaders active participation would be ensured.

The most vulnerable groups in terms of sexual and reproductive health, stigma and marginality (both economy and social capital context) are selected for this research intervention. The target population are the female sex workers, female drug users, wives of male drug users, wives of male having sex with male (MSM), slum and lower middle class population including adolescent girls of Bogra and Rajshahi town and eight unions of Bogra Sadar thana. In total the target population will be around 82,093 at Bogra and 82,488 at Rajshahi as per project of Light House[8].

5 Dixon-Mueller R, Innovation in reproductive health care: menstrual regulation policies and progress in Bangladesh, *Studies in Family Planning*, 1988, 19(3): 129—140.

6 Barakat, Abul and *et al., "Human* and Economic Impact of Reproductive Health Supplies Shortages & Stocks-outs in Bangladesh" Human Development Research Center, FPAB, July 2009.

7 The Holy Quran, Chapter 17, Verse 31.

8 Light House is a well reputed non-profit voluntary development organization working for the development of rural and urban asset less poor, particularly the landless, homeless, distressed, school dropouts, child labour, marginalized and high risk population, and other disadvantaged adults and children in Bangladesh.It is a leading Non-Governmental Organization (NGO) in Bangladesh that was founded in 1988 following devastating and gigantic Flood. Feeling concern, a group of young and energetic men joined together to work for the flood victims. One of those founder members, Md Harun-or-Rashid is now the Executive Director of Light House. Gradually it becomes able to achieve people's trusteeship within the working areas keeping up better relationship with civil society, district and upazila level administration and local government. At present, Light House is working in 23 districts of 5 divisions of Bangladesh.

Objectives of the Study

To carry out a survey among selected target groups in each area determining living and social conditions, trend of contraceptive use, knowledge on access to MR, sexual and reproductive health and rights based issues.

To measure the accessibility to services of safe and unsafe MR of the targeted populations in their communities.

To identify the reasons/barriers for inaccessibility to safe MR and to compile a set of indicators for programmatic intervention for greater accessibility of the underserved populations.

Methodology of the Study

Research Approach. The study has conducted by applying both the qualitative and quantitative approach.

Source of Information. Both primary and secondary sources have been used for data collection. Primary sources are in-depth interview, focus group discussions and direct observation and secondary sources are books, research reports, website, statistical data etc.

Research Methods. The research has applied both the qualitative and quantitative tools and techniques to gather information .In order to conduct survey and focus group discussions, the following types of data collection tools were developed: structured questionnaire for survey and female respondent's guidelines for focus group discussions. The survey tools were designed with a view to obtaining information needed for achieving the study objectives. The tools were finalised through a process of holding meeting and soliciting comments of Light House staff members.

Area of Respondents. Respondents were selected from two districts namely, Rajshahi and Bogra.

Types of Respondents. There were four types of target populations, female sex workers, wives of MSM, wives of male drug users, slum and rural female Population including adolescent (15-49) outlined for the survey.

Number of Population of Targeted Groups:

Table 1: Population of targeted groups

Sl. No.	Target Groups	Number of Population		Total
		Bogra	Rajshahi	
1	Female Sex Workers	930	900	1,830
2	Wives of MSM	217	215	432
3	Female Drug Users	20	50	70
4	Wives of Male Drug Users	240	400	640
5	Slum Female Population (15-49)	21,750	34,800	56,550
6	Rural Female Population (15-49)	13,050		13,050
Grand total				72,572

* *(for Sl. no. 2 and 4) LH has access to 543 and 538 MSMs and 600 and 1000 Male Drug Users in Bogra and Rajshahi respectively under HIV/AIDS projects. It has empirical evidence based on practical experience during program implementation that almost 40% of the MSM and male drug users are married.*

** *(for Sl no 5 and 6) LH and KMSS have 50,000 and 80,000 slum population in Bogra and Rajshai respectively and LH has 30,000 Rural Population in Bogra as service recipients of other projects. On experiences, national male-female ration and deduction*

The researcher is very much grateful to the Light House authority as well as beneficiaries of the project for their entire support.

of child, slum female population and rural female population have been calculated.

Distribution of Sample

Table 2: Distribution of Sample in Surveyed Districts

Target Groups	Number of Population		Total
	Bogra	Rajshahi	
Female Sex Workers	30	30	60
Wives of MSM	15	15	30
Wives of Male Drug Users	15	15	30
Slum Female Population (15-49)	90	90	180
Grand Total			300

* *As the size of population of slum female and rural female is too high comparing to number of other target group members, distribution of respondents on proportion would not be proper. So it is decided to distribute respondents based on minimum number of response which is 30 for each target group. In this respect, the distribution of respondents is depended on size of targeted populations and research objective*

Selection of Sample. From total number of service recipients of especially HIV/AIDS project of the NGOs (LH and KMSS), the respondents were selected through listing technique for ensuring randomization of sample.

Selection Criteria of the Respondents. Age: will be specified only by the group of female- 15 to 49 years of age (no permission of the parents for the respondents will be necessary);

Sex. Only female will be interviewed.

Nature of Respondents: Mainly those women who have received or needed to MR services from anywhere, safe or unsafe. Besides those women who are vulnerable to MR.

Focus Group Discussion. It is assumed that focus group discussion (FGD) is very useful technique to get in-depth opinion in sensitive social issues. During one to one interview through structured close-ended questionnaire, the respondents' had limited scope to express her emotions, perception and practices in detail on the MR issues. But in the two FGDs, one in Rajshahi (15 participants) and another in Bogra (10 participants), 25 female sex workers discussed on few specific points very lively.

Knowledge and Practices on Contraception and MR

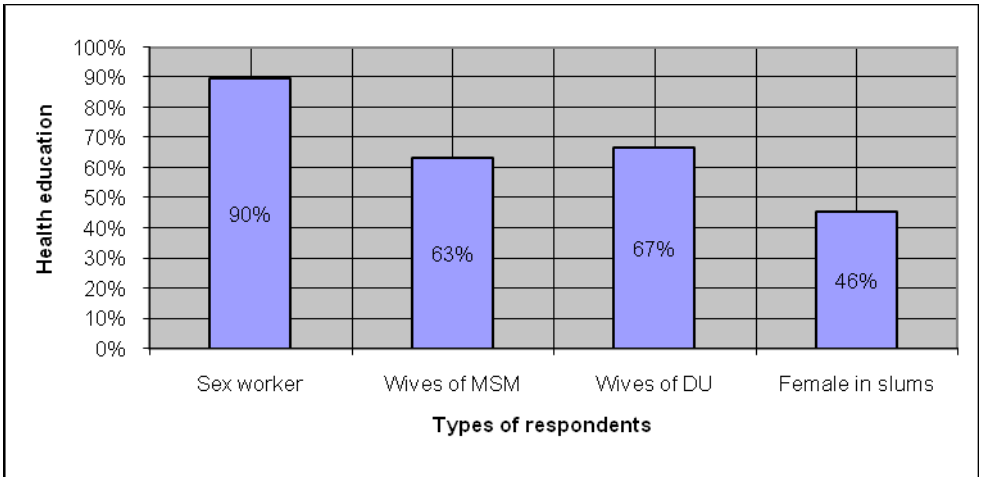
Before introducing any health intervention in the community, knowledge, and practices of them need to be assessed and identified. Proper knowledge and safe practices are the basic factors to achieve the project goals. In the project titled "Improving Access to Menstrual Regulation Services for Marginal and Under Served Populations in Bogra and Rajshahi", health care services for safe MR will be provided to the poor people. If MR services are provided in isolated manner, the respondents' may not take these services until they do not have proper knowledge. So, in this chapter Knowledge about and practices on health education, contraceptive methods, HIV/AIDS and MR issues have been highlighted.

Health Education

The respondents were asked whether they had received any health education on sexually transmitted diseases (STI), contraceptive methods, Human Immunodeficiency virus (HIV) and acquired immunodeficiency syndrome

(AIDS) or not. In response, above half of the respondents (59%) replied in the affirmative. Among them, most of the sex workers (90%) and above half of the wives of MSM and wives of DU have health education. But 46% of female including adolescent girls in slum have knowledge on STI, HIV/AIDS and MR. The study reveals that most of the respondents are service recipients of LH or KMSS. In addition, A few NGOs and government health centre are providing health facilities to these groups of marginalized women. From them they have got a little or wide knowledge on health. It is found that nearly about fifty percent have television as their recreational device. So they have also learnt about health issues from television.

Chart 1: Health education by types of respondents



When they were asked in the focus group discussion to mention the places from where they had received the health education, the majority mentioned NGO clinic, health worker, public health centre, relatives and other places. The other places included television, radio, clients, friends etc.

Knowledge about Birth Control Method

The respondents were also asked whether they have knowledge on birth control method/contraceptive method or not. In response, most of the respondents (93%) were affirmative. Because 94% respondents are married and they are the service recipients of NGO clinic or other health facilities. It is assumed that all married women should have knowledge on contraceptive method. But in the findings it is evident that one percent respondents were not aware about contraceptive method which was asked in the focus group discussion to find out the reason behind that. The respondents replied that some of them are newly married and some are infertile.

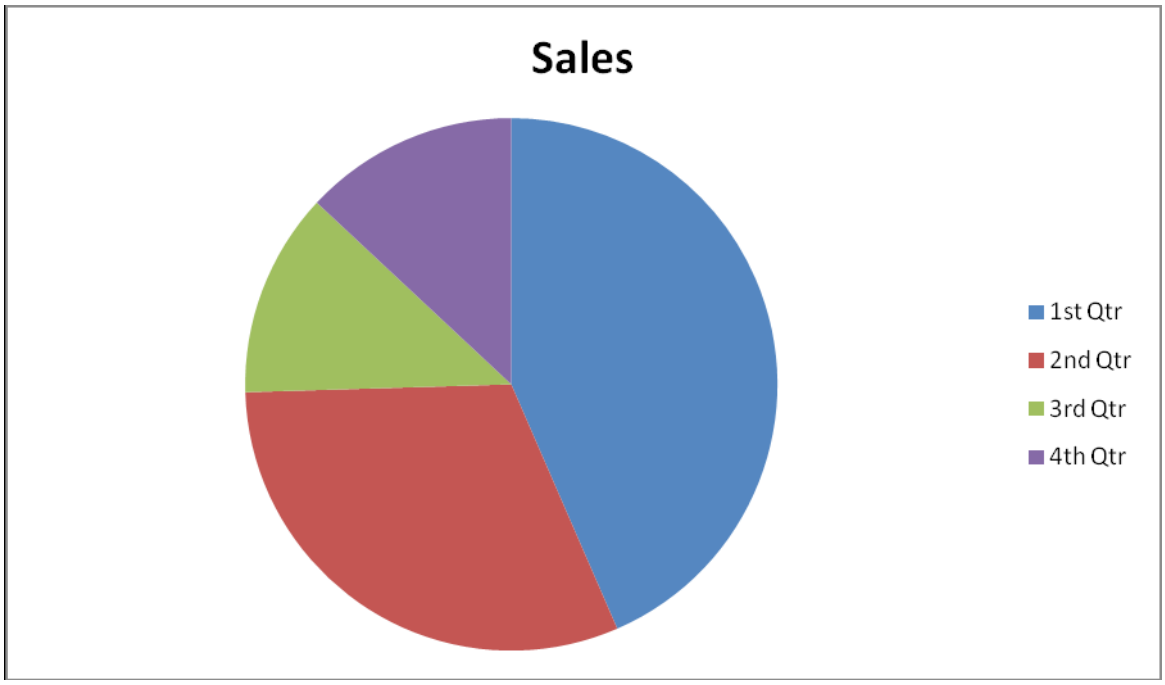
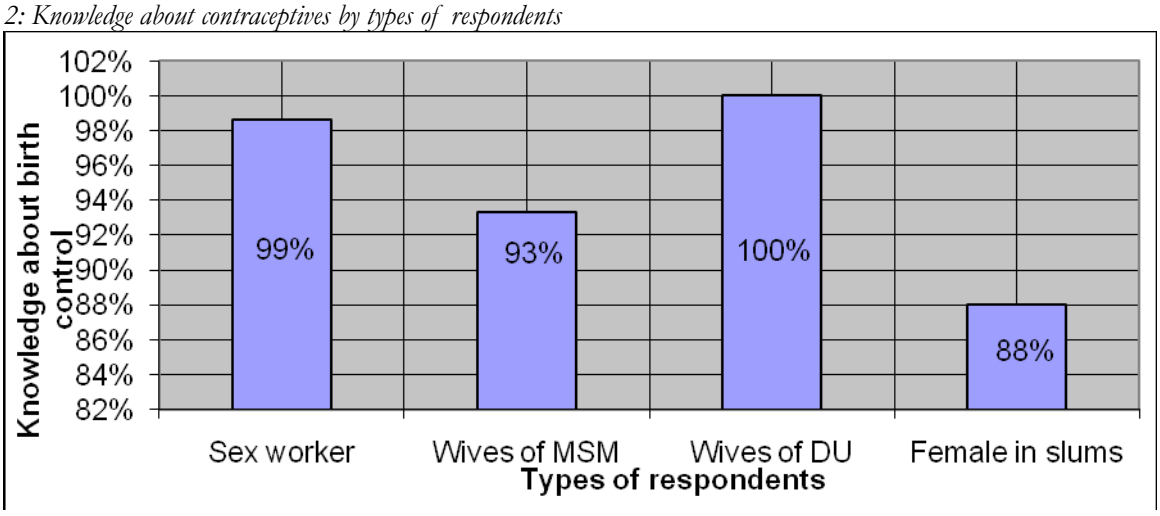


Chart 2: Knowledge about contraceptives by types of respondents



Among the respondents, all wives of drug users and the majority of sex workers (98.6%) and wives of MSM (93%) are aware about contraceptive methods. Beside these most vulnerable groups 88% of female including adolescent girls in slums are aware of. But those respondents who have knowledge about contraceptive methods, do not have knowledge about all methods of birth control. Some of them are acquainted with more than one method.

Table 3: Knowledge of contraceptive methods

Contraceptive methods	Responses*	Percentage
Natural	13	4.5
Pill	276	95.8
Condom	257	89.2
Injection	262	91.0
Calendar method	16	5.6
Withdrawal method	9	3.1
IUD	101	35.1
ECP	7	2.4
Tubectomy	169	58.7
Vasectomy	69	24.0
Norplant	154	53.5
Medical abortion	5	1.7

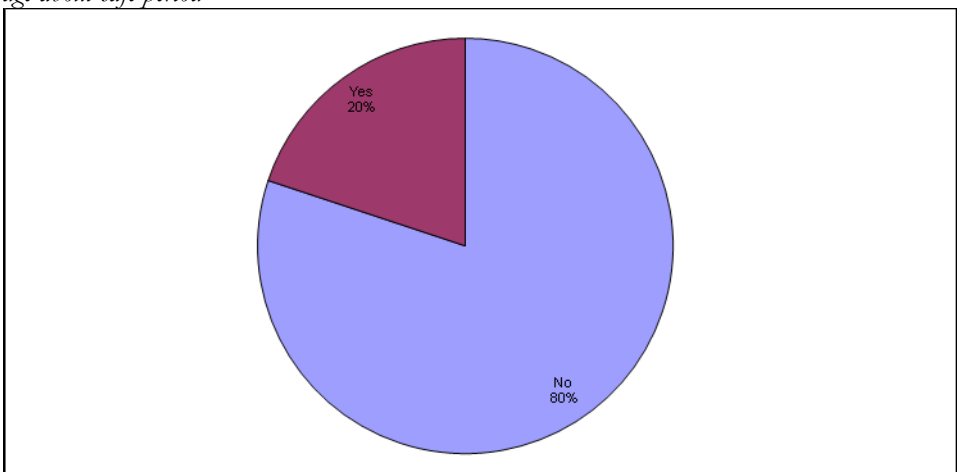
* *Multiple responses*

Around 89%, 84% and 83% of the respondents have knowledge about oral pills, condom and injections respectively as contraceptive methods. Government and non-government sector have been collaboratively implementing family planning activities to control population of our country. As part of it, they are giving pills, condom and injection free to the potential mothers. KMSS is also promoting different contraceptive methods under urban primary health care -2 project in their intervention areas where this survey is conducted. Besides 54%, 49.5%, one-third and one fourth of the respondents know about Tubectomy, Norplant, IUD and vasectomy respectively.

Knowledge about safe period

The respondents were asked whether they have knowledge about safe period which is related to pregnancy or not. Most of the responses were ignorant about the concept of safe period with pregnancy. In the focus group discussion the findings of the reasons are lack of adequate knowledge and health education about the safe period. As all the respondents are illiterate or less-literate, so they are not informed about safe period. Even those who know about it cannot calculate the actual timing of safe period.

Chart 3: Knowledge about safe period



Knowledge about menstrual regulation services

In order to ascertain the respondent's knowledge about menstrual regulation (MR), it is found that around 56% of them know about MR. Of them, 14% respondents do not know the timing of MR. The knowledge level in this issue is so high because of the intervention by the government and non-governmental organizations in the marginalized communities under HIV/AIDS and family planning activities. Some respondents have heard the term in the awareness programme but they do not have proper understanding. For this, some respondents did not know about the actual timing of taking service of MR, although they informed that they have knowledge about MR issues.

Places of getting information. When they were asked to mention the places from where they had been informed about MR, the majority mentioned health worker (49%), NGO clinic (45%), UHC/UHFWC (43%), relatives (40%) and other places (6%). The other places included clients, friends, training, television etc.

Service providers. The respondents who have knowledge about MR were asked about the MR service providers in their areas. In response, they mentioned the names of nurse (47%), health assistant (36%), doctors (28%), *dai*/TBA (26%) and relatives (20%). Although one-fourth of the respondents mentioned doctors as service providers, but sometimes they were confused to identify doctors. 26% respondents did not have information about the MR service providers.

Table 4: MR Service providers in the communities

Service Providers	Frequency	Percent
TBA	7	4.0
FWV	8	4.6
Health Assistant	62	35.9
Dai	38	22.0
Nurse	81	46.8
Relatives	35	20.2
Doctor	49	28.3
Others	24	13.9
Don't know	45	26.0

Places of MR. The health practitioners and professionals are providing services on MR from hospital, health complex, residence and NGO clinic. Most of the respondents mentioned the names of Places for MR as hospital (57%), NGO clinic (46%), TBA/FWV/HA/Dai/Relative's house (20%), health complex (17%). But out of 173 respondents, 22 did not know from where MR services are provided.

Table 5: Place of MR services provided

Place	Frequency	Percent
Hospital	99	57.2
Health complex	29	16.8
TBA/FWV/HA/Dai/Relative's house	35	20.2
NGO clinic	79	45.7
Other Place	8	4.6
Do not know	22	12.7

MR decision. Those respondents who are aware of MR have opinion or perception about the decision maker(s) of MR in our community. They perceived that still husband is the determining factor on making decision including MR. Around 51% respondents expressed in this way. The second highest percentage (43%) goes to the self-decision. In this respect, the participants of focus group discussion informed that some adolescent girls met unauthorized sex for money or love and being pregnant. Then they had no option except deciding MR on her own because she cannot share the conditions with anyone. Some married women also decided not to take any more children considering economic crisis and without taking consent from her husband and in-laws, they decided for MR on her own. A few respondents (5.2% and 5.8%) utteredthe names of health workers and relatives respectively.

"Taking MR-service is a sin."

"Killing a fetus is a sin. Allah, the almighty, never forgives her."
- a slum women, Rajshahi

Elements influenced to MR decision. Those respondents (173) who have knowledge about MR were asked which elements mostly influence to MR decision in our community. The majority (75%) responded that religion and related belief including prejudice are the very influencing factor to prevent MR decisions. Almost 62% of the respondents expressed money to determine MR decision. The third highest (60%) respondents opined about intervention of family members on MR decision because family bondage and extended family ties are still prevalent in our society. Besides around 8% respondents found accessibility and ignorance as influencing elements on MR decision. These responses are too small because the marginalized women in urban areas have also access to health services from NGO clinic and government service centres and they have become known to the necessity of MR services by the awareness programme of NGOs.

Table 6: Elements influenced to MR decision

Elements	Frequency	Percent
Religion and Belief	129	74.6
Family	104	60.1
Money	107	61.8
Accessibility	6	3.5
Ignorance	8	2.6
Others	9	5.2

In the concluding remarks, above half of the respondents of the survey have health education on HIV/AIDS, STI, safe period and MR and they are aware of contraceptive method as the outcome of the NGO activities and government family planning policy. But they cannot cope up with the learning of NGOs and government all the time for their lack of education and poor economic conditions. Although their level of awareness had been

increasing, but ignorance, prejudices and improper belief were also prevalent in their decision making. So many of them did not have sufficient information on health education, contraceptive methods, MR Service providers, places of MR etc.

Practices of contraceptives and MR

In the previous chapter knowledge of the community people on the contraceptive methods and MR have been illustrated. It is a partial view of the community regarding MR. To make it full practices of the peoples should be identified. So in this chapter practices of contraceptive methods, places to get contraception, frequencies of MR service recipients, places of services taken, quality of services etc. will be explored in detail.

Practices of contraceptives. The respondents were asked whether they used contraceptives in the last one year or not. In responses, 196 (68%) out of 288 respondents mentioned that they used regularly oral pills (30%), condom (16%) and injection (13%). Almost 7% respondents took vasectomy as permanent method of birth control. A few respondents used Norplant and IUD. Only three respondents followed calendar method and withdrawal method. Almost 10% of the respondents used contraceptives irregularly. That means they used more than one method in the last one year. Among them, around 7%, 6% and 7% used pill, condom and injection as contraceptives respectively. Around 22% of the respondents did not use any contraceptives, some of them are adolescents and some are infertile.

Table 7: Using contraceptive methods

Contraceptive methods	Regularly	Sometimes
Pill	86 (29.9)	19 (6.6)
Condom	47 (16.3)	18 (6.2)
Injection	36 (12.5)	19 (6.6)
Calendar method	2 (0.7)	2 (0.7)
Withdrawal method	1 (0.3)	1 (0.3)
IUD	2 (0.7)	-
Norplant	3 (1.0)	-
Vasectomy	19 (6.6)	-

** Multiple responses*

Contraceptives received from places. Those respondents (225) who used contraceptives in the last one year received contraceptives from different places such as hospital, government health care centre, NGO clinic, private clinic, pharmacy, vendors, relatives, clients and other places. In this regard, some of them received contraceptives more than one places. Above half of the respondents (56% and 52%) received contraceptives from NGO clinic and hospital respectively. Besides, nearly fifty percent of the respondents got contraceptives from government health centre and vendors/pharmacy. In some instances they got contraceptives from private clinic, clients and relatives. Almost 6% respondents did not specify the places from where she got contraceptives, as their husbands arranged the methods.

Table 8: Contraceptives received from places

Places	Frequency	Percent
Hospital	117	52.0
Govt. health centre	107	47.6
NGO clinic	125	55.6
Private Clinic	24	10.7
Pharmacy/Vendor	94	41.8
Relatives	6	1.9
Others	12	5.3
Do not know	13	5.8

** Multiple responses*

Practices of MR. The respondents were asked whether they received MR services in their life or not. In response, nearly 21% replied in the affirmative. Among them almost three-fourth of the respondents (71%) received MR services once and the rest 29% are more than one time.

"(*About an unmarried girl*) She had unauthorized sexual relations with her clients for money, so she had no other options except taking MR-service in clandestine."
- An experience of a woman, FGD, Rajshahi

"A boy induced a girl to get married later on and made an illicit sexual relationship. After few days he ran away while the girl was expecting. The girl was then an extremely awkward situation and frightened to disclose her pregnancy. Then she was compelled to abort her baby in secrecy by her neighbor (*a women having experience to practice MR in the slum*)."
- An experience of a sex worker, FGD, Bogra

Places and service providers of MR: The respondents received MR services mostly from Hospital (34%), Health Center (26%), Private Clinic- Doctor (19%) and NGO Clinic (17%). But one-fourth of the respondents received MR services from unsafe health practitioners i.e. Private Clinic- Non-Doctor and Dai. It is mentionable that some respondents received MR services from more than one places. The marginalized and poor women are extremely vulnerable to health risks in terms of unsafe MR. A number of private clinics are mushrooming in the urban areas including Bogra and Rajshai, although a little mechanism exists to ensure quality services in terms of doctors, diagnosis, medicines, cleanliness and environment. So the service recipients had got scope to get services of MR from non-doctors of these clinics. For which the marginalized and poor women are extremely

vulnerable to health risks in terms of unsafe MR.

Chart 4: Times of MR received

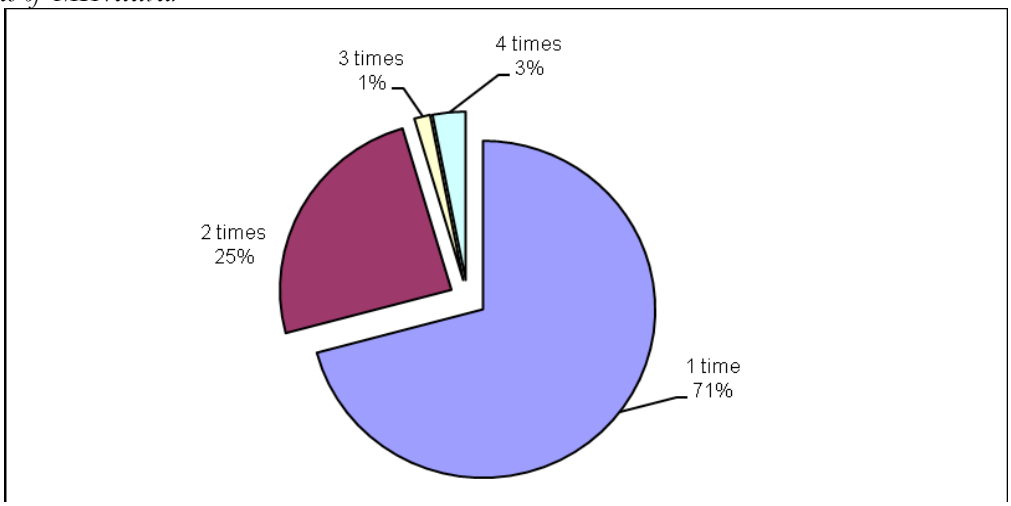


Table 9: Places and service providers of MR

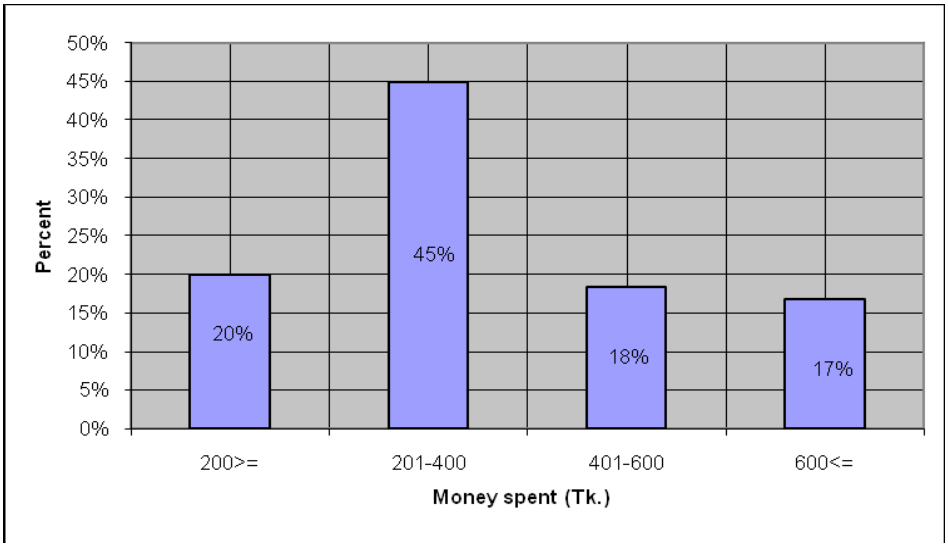
Place	Frequency*	Percent
Hospital	22	33.8
Health centre	17	26.2
Private clinic- doctor	12	18.5
Private clinic- non-doctor	9	13.8
NGO clinic	11	16.9
Dai	8	12.3

** Multiple response*

Time taken to reach MR place. Health facilities within limited distance are conducive to decrease health causalities and hazards. To know the places of health facilities, the respondents were asked how much time taken to reach the place. In response, 85% of the 65 respondents mentioned 30 minutes or less time taken to reach. This figure includes no time taken for services in own residence or adjacent relative's residence. But 15% respondents told that it took above 30 minutes to reach the place.

Money spent for MR. Among the service recipients of MR, most of the them (92%) spent money for receiving MR services. They spent ranging from Tk. 50 to Tk. 5000 and on an average Tk. 134. Most of the respondents (45%) spent amounting Tk. 401-600.

Chart 5 : Costs of MR services



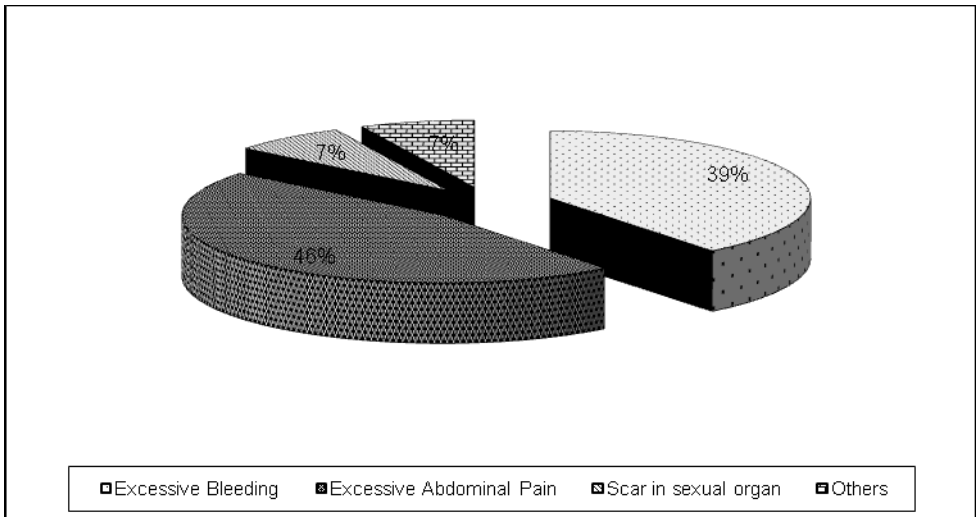
Quality of services. Three-quarters of the respondents were satisfied for the service quality. They declared that the services received were very good. Only 8% of them were not happy with the services.

Table 10: Quality of services

Quality	Frequency	Percent
Very good	5	7.7
Good	47	72.3
Moderate	8	12.3
Bad	3	4.6
Very bad	2	3.1
Total	65	100.0

Then almost 28% of the respondents faced problems after receiving MR services. Main problems were excessive abdominal pain (46%) and excessive bleeding (39%). Finally the respondents were asked who decided to receive MR. They majority replied that husband (48%) is the decision makers. The second highest responses (43%) came from own decision for MR. In six responses, parents and relatives helped to decide for taking MR services. As the respondents are aware of contraceptive methods and MR services in their areas for the service recipients of development organizations and government health facilities, most of them are using and maintaining properly. Then bad practices regarding unsafe MR are still prevalent in slum areas and the disadvantaged groups are deprived of their health rights. Because a substantial number of the respondents is taking unsafe and unauthorized MR services from dai (untrained birth attendant) or quack or unprofessional who may cause different health hazards such as bleeding, pains, fevers, damaging fertility permanently and even death threat.

Chart 6: Problems faced after receiving MR



We can know indepth infrmation about it from the below case studies.

Case study 1:
"Next door woman had regulated my menstruation. She took Tk. 100/200. But I got extremely pain, life almost left my body. I suffered for excessive bleeding, severe fever and abdominal pain for many days. My body became thin. Now I'm fine upon the blessings of Allah."

- a female in slums, in-depth interview, Bogra

Case study 2:
"I was pregnant within two months after getting married. But he flew away and left me alone. In these circumstances I had no alternative except regulating menstruation. There was a *dai* (untrained birth attendant) in our slum. She practices MR and abortion in her residence. While I met her, she agreed to regulate my menstruation for Tk. 200. She inserted a roots into my uterus. I suffered for excessive bleeding and abdominal pain. I took pain-killer medicines from pharmacy. But it couldn't reduce my pain. After five/six days I went to hospital. The doctor became irritated on me. He did not want to treat me primarily. Later on he prescribed with care. I became fine by one month and spent more than two thousand taka."

- a female in slums, in-dept interview, Rajshai

Case study 3:
"I do sex work for earning few more money for our household needs, but my husband is not informed about it. I always maintained extra caution during having sex with my clients. But I was feared on, once my menses was irregular in a month. I talked to my far-relative. She worked as a cleaner in a hospital. She informed me about a nurse who practiced MR secretly in her residence. I communicated with her and demanded two thousand taka for the service. I was compelled to take MR-service, but it was much more expensive for me."

- A sex worker, FGD, Rajshahi

Case study 4:

"I'm a sex worker. I don't usually agree to have sex with my clients without condoms. But a few clients don't want to have sex with condoms. I regretted some days to these clients. When I had very few clients who were willing to pay more for having sex without condoms I agreed. Besides few clients forcefully met without condoms when I was called in their residence. I became pregnant for four times for these reasons. Every time I visited to a woman at her house for regulating my menstruation. She knows better and takes fifty taka as charge. I didn't visit to hospital for avoiding lots of queries and formalities. In our experience, employees and doctors didn't pay attention properly to our health problems and considered as animal. They scolded in very nasty words every time. For this, I met with the *dai* (untrained birth attendant), although I suffered extremely for excessive bleeding and severe abdominal pain. I couldn't able to work for few days for sicknesses. But I regained every time."

- A sex worker, FGD, Bogra

Conclusion and recommendation

The study illustrates marginalized and underserved populations' knowledge on and attitude to the MR services and analyses the practices of birth control and MR. Based on the findings on socio-economic characteristics, it is concluded that the four categories of respondents such as sex workers, wives of MSM, wives of drug users and female in slums are extremely poor, having limited access to safe MR services in formal health facilities due to ignorance, unavailability of information, low income level, negative attitude and social stigma. As a few development organizations and public health departments have been working on sexual and reproductive health issues and delivering services to the marginalized groups under HIV/AIDS programmes, so their awareness level considering MR issues (57%) and birth control method (93%) has become higher.

Still, a lot of misconceptions on birth control methods, safe MR, legalization of MR, difference between MR and abortion, ethical and religious interpretation of MR etc. are dominant in their views. The majority of the respondents used pills (30%), condoms (16%) and injection (13%) as a single birth control method in a year. All methods are available in government health facilities, NGOs and pharmacies. In the patriarchal society of Bangladesh, male are dominant and decision makers in all matters even in the issues of sexual and reproductive health of women. So the findings show that 48% of MR-service recipients took decision on their husband's opinion. Here 43% of women decided to take MR on their own because they were separated, divorced, neglected or illicit relationship. Religion, belief and prejudice are widely considered as determining factors in our traditional customary societies without raising any questions. Sometimes religious scripts are misinterpreted by the religious leaders, arbitrators and anyone for their own interest.

In reality almost 75% of the respondents believed that religion and beliefs are influencing elements in taking MR decisions. In the surveyed two districts, Bogra and Rajshahi, almost 21% of the respondents received MR services for one time to four times from *dai* (30.8%), private clinic-non-doctor (24.6%), hospitals (15.4%), health centers (26.2%), private clinic-doctor (8%) and NGO clinic (16.9%). Better health facilities are available in the urban areas, though above fifty percent (55.4%) of the respondents received MR services from non-professionals. It causes health complications such as excessive bleeding, severe abdominal pain and scar in sexual organ.

Recommendations

Knowledge and awareness about prevention of unsafe MR must be increased engaging community mobilizers, trained dai, health professionals, religious leaders, teachers and so on through continuous efforts and engagements as knowledge gap on SRH and rights issues to overall population, across gender, class, status, and rural-urban continuum has already been recognized.

A set of communication materials with illustration in the forms of leaflets, brochures, festoons, banners, posters and electronic version of advocacy such as video footage, audio message must be produced and circulated and telecasted widely for right information on knowledge and practices of MR.

Specific health service providers (dai, quack, traditional healers) in the communities need to increase their knowledge as a part of capacity building so that they would be able to disseminate correct and right information to the MR clients.

Women must be aware of t their entitlements regarding sexual and reproductive health through knowledge dissemination and motivation. Without male's involvement in this matter it would not be possible to achieve the expected result.

Easy and smooth access to MR services must be ensured and enhanced by reducing socio-cultural and religious barriers engaging religious leaders, health professionals, trained birth attendants, community mobilizers and educated class of the societies.

High quality and free or minimum cost service delivery are primarily considered to prevent unsafe MR which is easily accessible and cheap.

Implementation plan and service delivery mechanism based on knowledge of MR and utilization in project areas must be flexible to accumulate new ideas, thoughts and socio-cultural barriers and the project should continue to function at these areas, otherwise the achievement may not be sustainable.

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