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Menstrual regulation outside health facilities in Bangladesh:
a qualitative study

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Funded by Marie Stopes International
Statement of own work

I, Elisabeth Eckersberger, confirm the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed:

Date: 7 September 2019
Abstract

Abortions are restricted in Bangladesh, and menstrual regulation (MR) exists as an approved alternative. MR is available from health facilities, yet more than twice as many procedures were performed outside health facilities in 2014, often performed under unsafe conditions and little is known about the reasons women seek informal providers.

I conducted 43 interviews with women who had undergone MR outside health facilities to understand the lived experiences of women. I also conducted observations services, and had conversations about MR provision and services with community members, pharmacists, health staff, and official MR providers to contextualize women’s experiences. I used frameworks on trajectories to seeking abortion-related care and ecological models to examine women’s experiences.

Participants spoke about restrictions of movement, how relationships with families, communities, and informal providers could facilitate or hinder seeking services, and how they themselves defined their pregnancies and MR procedures. Their experiences varied and they sought MR from informal providers for a multitude of interrelated reasons. Women did not attempt to seek MR at approved facilities before seeking informal providers, citing structural barriers such as finding clinicians at health facilities difficult to access. While more than two thirds of women sought follow up care, only 9 women ultimately sought follow up care at formal health facilities, and described additional difficulties accessing this care. A subset of women who used methods that can be safe, such as allopathic medication from pharmacies, had negative experiences and judged their procedures not to have been effective.

Women spoke about significant barriers to seeking MR in health facilities, and in many cases struggle with essentially all aspects of care seeking. Experiences with formal providers led women to not consider these as options, and they found female information providers easiest to access. For MR to be more accessible at the community level, the wider cultural context of women’s domestic and social lives needs to be taken into account.

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of writing up, when I know I sometimes showed up at the office on Monday morning bleary eyed and tired from weekend PhD work.

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# Table of contents

**STATEMENT OF OWN WORK** .................................................................................................................. 2

**ABSTRACT** ............................................................................................................................................. 3

**ACKNOWLEDGEMENTS** .......................................................................................................................... 4

**LIST OF TABLES** .................................................................................................................................... 8

**CHAPTER 1. INTRODUCTION** .................................................................................................................. 9

1.1 STATEMENT OF THE PROBLEM ........................................................................................... 9

1.2 RESEARCH AIMS AND QUESTION ...................................................................................... 9

1.3 ORGANIZATION OF THE THESIS ......................................................................................... 10

**CHAPTER 2. BACKGROUND** ................................................................................................................. 12

2.1 GLOBAL LANDSCAPE OF ABORTIONS AND ABORTIONS OUTSIDE HEALTH FACILITIES ................. 12

2.2 ABORTION AND MENSTRUAL REGULATION IN BANGLADESH .............................................. 17

2.3 CONTRIBUTIONS TO THE FIELD .......................................................................................... 27

2.4 CONCLUSION ........................................................................................................................... 30

**CHAPTER 3. THEORETICAL APPROACH** ............................................................................................. 31

3.1 THEORETICAL APPROACH TO ABORTION AND CARE-SEEKING ............................................. 31

3.2 PRIOR KNOWLEDGE OF THE TOPIC OF ABORTIONS ...................................................................... 34

3.3 THEORETICAL FRAMEWORKS USED IN THIS THEORY ................................................................... 35

3.4 REFLECTING ON WOMEN’S INTERVIEWS .............................................................................. 44

3.5 LANGUAGE AND DEFINITIONS USED .................................................................................... 45

**CHAPTER 4. METHODS** ........................................................................................................................ 47

4.1 STUDY DESIGN AND METHODOLOGY ................................................................................ 47

4.2 SAMPLING AND DATA COLLECTION METHODS ...................................................................... 52

4.3 RESEARCH TEAM ..................................................................................................................... 56

4.4 DATA COLLECTION ..................................................................................................................... 58

4.5 PARTICIPANT CHARACTERISTICS .......................................................................................... 66

4.6 DATA ANALYSIS ....................................................................................................................... 72

4.7 ETHICAL CONSIDERATIONS ................................................................................................... 75

4.8 REFLECTIONS ON MY POSITION AS RESEARCHER ..................................................................... 81

4.9 CONDUCTING FIELDWORK ..................................................................................................... 84

**CHAPTER 5. RESULTS OVERVIEW** ....................................................................................................... 88

5.1 THESIS STRUCTURE .................................................................................................................... 88

5.2 INDIVIDUAL AIDS OF THESIS PAPERS ............................................................................... 88

**CHAPTER 6. CONCEPTUALIZING THE RELATIONSHIP BETWEEN MENSTRUAL REGULATION AND ABORTION IN BANGLADESH** ................................................................................. 90

6.1 INTRODUCTION .......................................................................................................................... 90

6.2 ABSTRACT ................................................................................................................................... 93

6.3 PAPER 1 ......................................................................................................................................... 94

**CHAPTER 7. BARRIERS TO SEEKING MENSTRUAL REGULATION IN BANGLADESH** ..................... 108

7.1 INTRODUCTION .......................................................................................................................... 108

7.2 ABSTRACT ................................................................................................................................... 111

7.3 PAPER 2 ......................................................................................................................................... 112

**CHAPTER 8. INTERACTIONS WITH PROVIDERS OF INFORMAL MENSTRUAL REGULATION IN BANGLADESH** ................................................................................................................................. 127

8.1 INTRODUCTION .......................................................................................................................... 127
List of tables

Table 1: Description of study locations ...........................................................................52
Table 2: Participant characteristics ...................................................................................66
Chapter 1. Introduction

1.1 Statement of the problem

In this thesis I explore the context of menstrual regulation (MR), a legal alternative to abortions, outside health facilities in Bangladesh. I explore why women sought informal providers and methods instead of seeking care at health facilities, and what their experiences with those providers and methods were.

I led on all aspects of research design and planning, data collection, analysis, and write-up. The first year of this study was spent developing the project and study tools, receiving ethical approval, and presenting it for upgrading from MPhil to PhD at LSHTM. I then spent 18 months in Dhaka, Bangladesh for data collection, translation, and analysis. Another 18 months of further analysis, writing up results, and thesis composition followed.

I was invited to present preliminary findings on women who used medication for MR at the IUSSP conference on medical abortion in 2016, an opportunity that led to the development of the paper presented in Chapter 11. I also presented two posters based on results in Chapters 10 and 11 at FIAPAC, in 2018.

The study was developed in collaboration with and funded by Marie Stopes International and Marie Stopes Bangladesh, who were interested in the findings to inform local service delivery.

1.2 Research Aims and Question

Main research question
Why are women in Bangladesh seeking menstrual regulation procedures outside health facilities, and what are their experiences in doing so?

Research Aims
This thesis has the following aims: 1) to investigate women’s experiences of menstrual regulation (MR) procedures outside health facilities in Bangladesh, 2) to understand why women turn to informal providers for possibly unsafe procedures instead of going to health facilities for MR, and 3) to explore how women view the nature of their MR procedure, and how context, perceptions, and community affect their care-seeking.
In order to explore these aims, I recruited and conducted interviews with women who had undergone MR outside health facilities.

1.3 Organization of the thesis
This thesis is arranged as a paper-style publication, with separate papers in Chapters 5–8. Chapter 1 includes the background of the thesis. Chapter 2 outlines and discusses my theoretical approach, and in Chapter 3, I describe my methods in more detail than is included in the individual results papers. Chapter 4 presents an overview of my results, and Chapters 5–8 present the findings of my study in four separate papers. In Chapter 9, I conclude with a summary and discussion of the study and all paper findings, and their implications for further research.

In the findings of the thesis (the four individual research papers), I explored aspects of the care-seeking process, which I identified during data collection and analysis. The organization and focus of the papers result from a combination of a priori aims and foci I identified from the data during analysis. Examining women’s experiences, for example, was an aim of the thesis, and the data showed that key parts of their experiences served as barriers in accessing services, and in their interactions with formal and informal providers. Similarly, while women’s being turned away from clinics has been described elsewhere in the literature as an experience central to seeking MR (Hossain et al. 2017), I did not identify this from this set of interviews, so it is not a primary focus of the results. Letting the data lead, I identified four foci from the data, and also answered the research question as to women’s pathways and experiences. Although I wrote the individual papers as stand-alone articles for publication, I present them in their entirety in this thesis in an order that builds on each other to explore different aspects of the care-seeking process.

Individual aims of the papers in this thesis are as follows:

1. Chapter 5, Paper 1. The aim of the first paper was to gain insight into the conceptualization of MR by women who have MR procedures themselves. I examined how women defined the procedures they had, and how they related, both in theory and in practice, to menstruation and pregnancy.

2. Chapter 6, Paper 2. The aim of the second paper was to explore the social context of women who sought MR outside health facilities, and how this choice affected their
treatment-seeking and decision-making. Understanding women’s stories and pathways from a holistic standpoint allowed me to investigate what interventions may be possible, especially for those women unreachable through individually-focused healthcare delivery strategies.

3. Chapter 7, Paper 3. The aim of the third paper was to better understand women's interactions with informal providers of MR. I explored where, and to which provider, women went for MR, whether they knew these were informal providers, and their experiences using these providers. I examined why women sought such providers, and identified whether there were common characteristics of the providers or specific elements of the interactions that made these particular providers easier to access than formal providers at approved health facilities.

4. Chapter 8, Paper 4. In this study, I investigated women's experiences of using medication for MR outside approved health facilities in Bangladesh, with the aim of understanding why they used unapproved sources, and their experiences of using these medications.
Chapter 2. Background

Menstrual regulation (MR) is a procedure performed in Bangladesh as a legal alternative to abortions. While MR procedures outside health facilities are common, much remains unknown about women's pathways to seeking them outside clinics and facilities. In this chapter I will place MR in the global context of abortions and highlight gaps in current knowledge, which I sought to address in the study. I will also examine both historical and current contexts of menstrual regulation in Bangladesh through an examination of previous research on the subject. The background will further explore reasons why women seek care outside health facilities and identify where further research on the topic is needed.

2.1 Global landscape of abortions and abortions outside health facilities

Global abortion incidence

Abortions are common procedures, and an estimated 55.7 million are performed globally each year. Abortions can be safely provided by physicians and mid-level providers, such as midwives, nurses, and other non-physician providers (Barnard et al. 2015). Evidence that women can safely induce their own abortions with medication is mounting (Giri et al. 2015). Complications from abortion, when provided by trained healthcare providers, or with the use of effective medications, are low (Sherris et al. 2005; Hyman et al. 2013; Tamang et al. 2017).

Recent approaches to global estimate of unsafe abortions using a Bayesian hierarchical model took into account all available empirical data from 182 countries on abortion methods, providers, and setting, as well as factors affecting safety; these studies arrived at more accurate estimations of safe, less safe, and least safe abortions occurring worldwide, yet acknowledge that their findings are limited by the dearth of empirical data (Ganatra et al. 2017). Data revealed that an estimated 25.1 million of the 55.7 million abortions that occurred each year between 2010 and 2014 were deemed unsafe (Ganatra et al. 2017). The burden of unsafe abortion is disproportionately shared, with 97% of unsafe abortions occurring in developing countries (Ganatra et al. 2017). Fewer than one in two abortions in south-central Asia were classified as safe (Ganatra et al. 2017). Globally, unsafe abortion is one of the leading causes of maternal mortality (Say et al. 2014), and the World Health Organization reports that deaths from abortions are more common in countries with more restrictive abortion laws (WHO 2007).
**Abortions outside health facilities**

Studies investigating women’s pathways and care-seeking outside health facilities have found a number of reasons why women sought care there and have stated the necessary to consider the various intersecting components that lead to actual service utilization on the ground (Payne et al. 2013).

The overview presented below is based in large part on an literature review currently in progress by the author (EE) investigating what women had reported when asked why they had sought care outside health facilities (Eckersberger, Footman, et al. 2019). This review found that a common reason why women sought care outside health facilities was that legal restrictions limited access to legal abortions in formal facilities. Laws surrounding abortion vary widely and fall along a continuum, but abortion provision is safest where it has long been legal (Singh et al. 2018). Six percent of women of reproductive age live in locations where abortion is prohibited without exception, 25% live where abortion is only legal to save a woman’s life, 11% where abortion is permitted only to save physical health, 4% to protect mental health, and 21% on socioeconomic grounds. Thirty percent of reproductive-aged women live somewhere abortion is available without restrictions as to reason, but almost all have gestational limits (Rahman, Katzive and Henshaw 1998; CRR 2018). Women may also find that access is unequal between different regions of the same country, such as in India, where abortion is more commonly provided in urban areas making them less accessible to the larger rural population (Singh et al. 2018); studies in Latin America, for example, found that indigenous women have below average access to reproductive care as this is not available in the communities in which they live (Wurtz 2012).

Studies in a number of countries also found that women reported restrictions on abortions as the main reason for seeking informal care, such as in Sri Lanka (Arambepola and Rajapaksa 2014), Pakistan (Azmat et al. 2012; Naveed, Shaikh and Nawaz 2016), Myanmar (Belton and Whittaker 2007; Arnott et al. 2017), Bolivia (Bury et al. 2012), Uruguay (Fioł et al. 2012), Philippines (Gipson, Hirz and Avila 2011), Gabon (Hess 2007), Burkina Faso (Ouedraogo and Sundby 2014), and Argentina (Ramos, Romero and Aizenberg 2014).

Even when abortion is legal, it may not be fully accessible practice (Singh et al. 2018). For example, Women reported seeking informal providers because they were denied care at facilities supposed to provide abortions (Hossain et al. 2016; Arnott et al. 2017) and in Ghana women reported seeking informal providers because they had been mistreated by nurses on a previous visit to a formal facility (Schwandt et al. 2013). Small-scale studies in Nepal, South
Africa, and Tunisia found that women were denied care even when they legally qualified for an abortion (Gerdts et al. 2015). Even when women were able to access legal abortion services they reported barriers that made this more difficult (Becker et al. 2011). In Nepal, Hong Kong (Hung 2010), Nigeria (Koster 2010), and Zambia (Coast and Murray 2016), where abortions are legal, women sought informal providers due to cost, both direct and indirect costs such as time needed to seek approval from multiple physicians for formal services. A study from South Africa found that women who sought care in the informal sector, many of them sex workers, felt that this offered them more privacy, and feared mistreatment at public sector facilities (Gerdts et al. 2017). In Nepal women sought informal providers after, for example, formal providers found their reasons for abortions insufficiently persuasive and refused to provide abortion services to them (Puri et al. 2018). In India, women sought informal providers after experiencing procedural delays when attempting to seek formal providers at healthcare facilities (Bhattacharya, Bashar and Singh 2017). Other global studies reported that women found informal providers more confidential and private (Warriner and Shah 2006), friendlier (Ganatra and Visaria 2004), more relatable, and women were referred to them by family members or friends who had used the service (Ankomah et al. 1997).

Women may also experience stigma when seeking their MR procedures. Goffman's definition of “stigma” refers to an “attribute that is deeply discrediting,” (Goffman 1963; Kumar, Hessini and Mitchell 2009; Norris et al. 2011) and Kumar et al. define abortion stigma as “a negative attribute ascribed to women who seek to terminate a pregnancy that marks them [...] as inferior to ideals of womanhood” (Kumar et al. 2009, p.628). Stigma is culturally constructed and reproduced locally (Kumar et al. 2009) and, as with the legal availability of abortion, removing barriers and restrictions to abortion does not automatically eliminate stigma women feel and perceive (Singh et al. 2009; Ganatra et al. 2017; Bearak et al. 2018). Studies in the US found that two thirds of women felt the need to keep their abortion a secret, although the authors did not report women's reasons in more detail (Shellenberg and Tsui 2012). Stigma can lead women to seek information about abortion only from trusted friends and relatives, regardless of their knowledge levels, and countries with high incidence of unsafe abortion reported higher levels of women being stigmatized when seeking abortions (Yegon et al. 2016). Stigma around abortions also contributes to the global underreporting of both formal and informal abortions, as women underreport procedures due to fear of being shamed or judged (Singh et al. 2009; Ganatra et al. 2014).

Social elements also may force women to seek care wherever they believe they are able to, such as women in Zambia (Coast and Murray 2016) or Ghana (Rominski, Lori and Morhe 2017), who
reported believing that the risk of continuing with the pregnancy was lower than the risk of seeking abortions with less safe methods. In India, lack of social support and stigma led women to avoid formal facilities (Banerjee and Andersen 2012). Women also reported they were better able to keep their procedures secret with informal providers in Bangladesh (Gipson and Hindin 2008), Zambia (Dahlbäck et al. 2007), and Kenya (Izugbara, Egesa and Okelo 2015).

Studies in Zambia (Dahlbäck et al. 2010) and India (Banerjee and Andersen 2012) have also reported a lack of knowledge of the legality of abortions, and in Bangladesh (Gipson and Hindin 2008) women said informal providers were more available to them in their communities. Reasons noted as “other’s involvement” in women’s abortions have also been reported for seeking care outside health facilities, such as advice from others in Zambia (Dahlbäck et al. 2007) and Kenya (Izugbara, Egesa and Okelo 2015) and unknown medication provided or procedures arranged by others in Pakistan (Naveed, Shaikh and Nawaz 2016), Bangladesh (Gipson and Hindin 2008), and Zambia (Dahlbäck et al. 2010).

Studies commonly focus on women who seek postabortion care in formal facilities, after suffering complications from unsafe procedures (Payne et al. 2013), to enquire about their previous abortion attempts. Even where abortion is restricted postabortion care is commonly accepted and provided (Sedgh et al. 2016). However, not all women who need postabortion care after suffering complications from unsafe abortions receive care: an estimated 40% of women who need postabortion care do not receive it (Singh, Darroch, et al. 2017). The costs of postabortion care are often carried by health systems and an estimated US $232 million are spent each year on postabortion care (Singh, Darroch, et al. 2017), a figure that rises to US $562 million if one were to include the 40% who needed postabortion care but did not seek or receive it because of the costs of complications that resulted from the lack of care. Additional costs associated with needing postabortion care after an unsafe abortion include as loss of productivity, negative consequences for children, and overall deterioration of economic circumstances (Sundaram et al. 2013).

Education and sociodemographic status also affect women's care-seeking. In Nepal, women in the age group 25–34 years (OR 0.43; 95% CI 0.19, 0.97) and those who were in the richest wealth quintile (OR 0.10; 95% CI 0.04, 0.25), were less likely to undergo an unsafe abortion. Educated women of 25–34 years, reporting “health risk” as the reason for abortion, had less than a 10.0% chance of going through the unsafe abortion than others (Yogi, Prakash and Neupane 2018).
Presence of a facility may ultimately also not suffice to ensure women are able to access the services (Donabedian 1972). The definition of access by the UN Committee on Economic, Social and Cultural Rights encompasses four domains: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility (UN Committee on Economic, Social and Cultural Rights (CESCR) 2000). This definition of access includes concepts such as freedom of movement, ability to pay for services, or ability to access correct information, all mentioned as reasons women do not seek services in facilities.

Women may turn to providers outside facilities if turned away from facilities where they should, in theory, have been able to seek legal care. In Nepal, women reported being turned away by providers because the provider believed the reasons for the abortions insufficient (Puri et al. 2018), or due to lack of availability of medications for abortions (Gerdts et al. 2015). In South Africa women report being turned away for logistical reasons, such as no staff available at the facility to perform abortions that day, or their own inability to pay for the procedures (Gerdts et al. 2015; Harries et al. 2015). In India, women report being turned away due to procedural delays (Bhattacharya et al. 2017).

Studies have also found that women themselves may have different concepts of safety and risk, which occupy multiple domains, and decisions may not be based on safely considerations alone, but may also include the risk a woman faces when she continues her pregnancy (Izugbara et al. 2015; Coast and Murray 2016). The same can be said for quality of care, which women may define differently in different circumstances and according to the services they are able to access. A study in the United States found that privacy and freedom from judgment when seeking abortion care was mentioned as a crucial component of quality of care in the US when women were asked what they would be looking for in a “good quality” abortion (Altshuler et al. 2017). Similar issues have been found in other types of services predominantly accessed by women. Literature from Africa and Asia, not focused on abortion or MR, but on other healthcare commonly sought by women alone (such as maternal care), found that the perceived and measured quality of care, and likelihood of dissatisfaction, depended on shorter wait times and overcrowding (Anand and Sinha 2010a; Hutchinson, Do and Agha 2011; Do et al. 2017; Mehata et al. 2017). Studies looking at antenatal care in Kenya and Namibia, for example, found a disconnect between patients’ perceptions and clinical quality of services (Diamond-Smith, Sudhinaraset and Montagu 2016). Other elements found for healthcare utilization in India were doctor availability, waiting time, cleanliness, privacy, and affordability. These elements made it more likely that a woman would use the facility for any reproductive purpose, rather than any element related to clinical quality of reproductive services provided (Anand and Sinha 2010b).
2.2 Abortion and menstrual regulation in Bangladesh

Bangladesh context

I conducted this study in several locations in urban and rural areas of Dhaka Division, Bangladesh. Average household income in Bangladesh is low, and social inequalities persist. The gross national income (GNI) per capita was US$1,314 in FY 2014–2015 (Bangladesh Bureau of Statistics (BBS) 2015) but a steep urban-rural divide exists; half of the urban population (49%) is in the highest wealth quintile, compared with only 9% of rural residents (National Institute of Population Research (NIPORT) and Training Mitra and Associates and ICF International 2016).

Improvements to women’s equality have been made in many areas in Bangladesh, despite a remaining gender inequality. In 2014, 64.7% of men reported working, formally and informally, at the time of the survey, whereas only 24%–33% of women reported the same (demographic survey numbers are inconsistent in the figures they report) (NIPORT et al. 2016). Only 34.7% of women who reported working were employed by non-family members (NIPORT et al. 2016). Women live isolated lives, and 47% have no regular exposure to radio, television, or a newspaper (NIPORT et al. 2016).

Despite poverty and inequality, Bangladesh “presents a puzzling paradox of substantial mortality reductions alongside uneven health burdens, due to the mixed effects of direct health actions and many social determinants of health” (Chowdhury et al. 2013, p.1734). Fertility rates in Bangladesh are low: the total fertility rate per woman was 2.3 births in 2014, and 54% currently married women of reproductive age report using modern contraceptive methods (NIPORT et al. 2016). Women in Bangladesh most commonly use short-term contraceptive methods, and of those using any method 27% used the hormonal birth control pill, 12.4% injectable contraceptives, 6.4% condoms, 4.6% female sterilization, 1.2% male sterilization, 0.6% copper inter-uterine devices, and 1.7% implants (NIPORT et al. 2016).

Maternal mortality in Bangladesh decreased from 574 deaths per 100,000 livebirths, in 1991, to 194 deaths per 100,000 livebirths in 2010 (NIPORT 2012). Unmet need for family planning among currently married women, aged 15–49, in Bangladesh declined from 22% in 1994 to 12% in 2014 (NIPORT et al. 1994, 2016); community level variables, such as exposure to family planning, ideal number of children, and education, were significantly associated with the level of unmet need (Pradhan, Dwivedi and Dwivedi 2015).
Menstrual regulation and abortion

Menstrual regulation (MR) is not commonly defined as abortion, but as "any procedure which disrupts the intrauterine environment so that embryonic implantation either cannot occur or cannot be maintained" (Brenner and Edelman, 1977, p.179). In Bangladesh MR is defined as "the procedure of regulating the menstrual cycle when menstruation is absent for a short duration" (Akhter 2001; Bangladesh Directorate General of Family Planning 2014; Hossain et al. 2017). While under Bangladeshi law menstrual regulations are not considered abortions, when methods commonly used for MR, such as manual vacuum aspiration (MVA), are performed by informal, possibly untrained, providers and in possibly unsafe conditions, they are commonly classified as "clandestine abortions" (Singh, Hossain, et al. 2017).

The most widely used definition of an unsafe abortion is "a procedure for terminating an unintended pregnancy that is carried out either by persons lacking the necessary skills or an environment that does not conform to minimal medical standards, or both" (WHO, 1992, p.1). As such, menstrual regulation procedures performed by untrained personnel outside health facilities and legal guidelines fall within the definition of unsafe abortions. Historically, it has been difficult to measure the extent of unsafe induced abortions, and the morbidity and mortality associated with them.

Papers about MR in Bangladesh commonly do not state how they define MR and abortion. Akhter, for example, recruited women who had had "induced abortions," but then referenced whether women knew anyone who did "indigenous MR" in looking at facts associated with seeking MR outside facilities (Akhter et al. 1998). Other papers make even fewer distinctions; for example, they equate "induced abortion" in Bangladesh with "unsafe abortions" (Bhuiya, Aziz and Chowdhury 2001).

Safe and unsafe terminations of pregnancy

While the term "unsafe abortion" is commonly used in the literature, it is more accurate to refer to a "spectrum of risk" between two extremes (Ganatra et al. 2014). It has been argued that a wider definition is needed that includes both the current standards of medical care as well as complications resulting from unsafe procedures (Adler et al. 2012). The Bayesian model study cited above conceptualized abortion as falling into three categories: safe, less safe, and least safe (Ganatra et al. 2017). By this categorization, "safe" methods are those performed by a trained provider with a method recommended by WHO (medical abortion, vacuum aspiration, or dilatation and evacuation), and appropriate to the pregnancy duration. "Less safe" characterizes those in which only one of the two criteria were met—i.e., either the abortion was done by a
trained provider but with an outdated method (e.g., sharp curettage), or a safe method of abortion (e.g., misoprostol) was used but without adequate information or support from a trained individual. "Least safe," then, classifies abortion procedures provided by untrained individuals using dangerous methods, such as ingestion of caustic substances or insertion of foreign bodies (Ganatra et al. 2017).

In Bangladesh, the spectrum of risk is wide. It is estimated that approximately 15% of MR procedures outside health facilities can be defined as "safe illegal MR," performed illegally or outside health facilities, but safely by trained doctors, paramedics or family welfare visitors (Singh et al. 2012). On the other end of the spectrum, a study in a rural area of Bangladesh found that 45% of women terminating a pregnancy went through the process without any assistance from a trained healthcare provider or medical doctor (Bhuiya et al. 2001).

_Menstrual regulation today_

Abortions are restricted in Bangladesh today, except to save the life of the woman, but menstrual regulation (MR) exists as an alternative regulated by the government (Justice Ministry of Law and Parliamentary Affairs 1977; Akhter 2001; Bangladesh Directorate General of Family Planning 2014; Hossain et al. 2017). Family welfare visitors (FWVs) are women with 10 years of basic education who receive 18 months of reproductive health training, and who mostly perform home visits in rural areas and provide maternal-child health, emergency care, and referral services (Saindon and Koblinsky 1984). FMVs are licensed to perform MR after receiving an additional three months training in uterine evacuation (Ross 2002; Johnston et al. 2011).

MR is legally provided by doctors, family welfare visitors, and paramedics in formal health facilities (Akhter 2001; Bangladesh Directorate General of Family Planning 2014; Hossain et al. 2017). MR, a common procedure, was performed at a rate of six per 1,000 women aged 15-49, in 2014 (Hossain et al. 2017). MR is most commonly carried out using manual vacuum aspiration (MVA), within eight weeks of their last menstrual period (LMP), by a paramedic (or trained FMV), or within ten weeks from the first day of the LMP by a trained medical doctor (NIPORT et al. 2016). In 2013 the Directorate of Family Planning approved a combination-pack of mifepristone plus misoprostol (CombiPack) for MR up to nine weeks after their LMP, which can be prescribed by trained, clinic-based personnel (Bangladeshi Directorate General of Family Planning 2014). Menstrual regulations are most commonly performed by MVA, which, at the program’s inception, involved using a simple syringe with a plunger. MVA does not require
anesthetics, an operating theatre, or electricity, yet is safe and effective (Hemlin and Möller 2001; Tasnim et al. 2011; WHO 2012).

In Bangladesh, the number of MR procedures (either by MVA or medication) provided in formal settings declined from approximately 40% from 653,000 procedures, in 2010, to 430,000 in 2014 (Hossain et al. 2017). Despite the availability of MR, a study using the Abortion Incidence Complications Methodology (AICM) (Singh et al. 2010) estimated additional 1.19 million procedures were performed outside health facilities or by unapproved providers (Singh, Hossain, et al. 2017), an increase from the estimated 647,000 procedures performed in 2010 (Singh et al. 2012). The number of women treated for complications from MR outside health facilities was 257,000 in 2014 (Singh, Hossain, et al. 2017), an increase from the 231,000 procedures in 2010 (Singh et al. 2012). The AICM methodology has been adapted for use in various settings (Singh, Prada and Kestler 2006; Sathar et al. 2014; Mohamed et al. 2015; Sedgh et al. 2015), and the authors of the Bangladeshi adaptation note that in the Bangladesh setting their estimates may be too conservative or overestimated if based on different assumptions, such as the number of women seeking facility-based care for birth, or estimates of clandestine misoprostol use (Singh, Hossain, et al. 2017). The estimates are, however, the most accurate and up-to-date figures available, and are used with the above caveats throughout this thesis.

When performed by informal and possibly untrained providers, informal MR procedures are associated with higher mortality than formal, approved MR (Rahman, DaVanzo and Razzaque 2014). Between 8% (Say et al. 2014) and 15% (Kassebaum et al. 2014) of maternal deaths are associated with informal MR provided by informal providers. While mortality from MR is equivalent to that of live births, mortality from MR outside health facilities is estimated to be 4.9 times higher (Rahman, DaVanzo and Razzaque 2014). Complications and mortality are especially high for poorer women; women from the poorest-asset quintile are twice as likely to die from abortion-related complications than those in the wealthiest-asset quintile (Briozzo et al. 2006; Chowdhury et al. 2007).

When performed by trained staff in hygienic conditions, MR is a safe procedure with low rates of complications (2.2 per 1000), which can safely be performed by mid-level providers as well as doctors (Warriner et al. 2011). However, informal healthcare providers vastly outnumber professionals (95% to 5%) (Ahmed et al. 2011; Khan et al. 2015). due to a severe shortage of licensed health care professionals in Bangladesh, which includes both general healthcare providers as well as those providing MR.
The history of menstrual regulation

MR in Bangladesh cannot be understood—as concept, idea, or legal tool—outside a context of specific historical events and the establishment of the procedure. Any discussion about women's “rights” to abortion “tends to obscure the way in which historical and social relations are built into the very fabric of technologies” (Wajcman, 1994, p.161). MR in Bangladesh is no exception. The strict abortion laws in Bangladesh were first eased following the war of independence with Pakistan. Rape was used as a weapon of war, and in 1972 abortion restrictions were waived for the “heroines of war” (Johnston et al. 2011, p.12). Bangladeshi doctors received training on performing safe abortions from international organizations, who in addition to their technical training were introduced to the idea of abortion as a woman's right and a part of reproductive health (Akhter et al. 1998; Johnston et al. 2011). The war and post-war years brought fears of a Malthusian crisis; the cyclone of 1970, war of 1972, and famine of 1974 saw a situation where the Bangladeshi population exceeded food supply and Bangladesh was nearly fully reliant on donor support. As a result of these fears the government of Bangladesh implemented a rigorous family planning program, and MR was conceived as a form of “birth control,” and in cases of contraceptive failure (Piet-Pelon and Rob 1999). It was first offered only in a selected number of urban clinics, but by 1979 the government had included MR in the national family planning program. The then so-called non-profit organization (NGO) The Pathfinder Fund – today known as Pathfinder International – had begun a training program in medical hospitals and government district hospitals. As part of this program American medical consultants came to train paramedics and doctors, and doctors were sent to Singapore for training (Piet-Pelon 1998; Ross 2002). MR was therefore not introduced to address issues such as women's rights, or bodily autonomy, or control over their own lives; it was introduced as a method of population control, with the idea of lifting those with too many children out of poverty, and a remedy to war crimes committed by Pakistani soldiers.

Having trained medical staff and established safety standards, the Bangladeshi government had established a population of medical staff prepared to defend a woman’s right to abortions (Potts and Diggory 1977; Amin 1996; Piet-Pelon 1998; Khan 2000; Johnston et al. 2011), and, due to broad support for MR among this staff, was unable return to restricting women's access to MR (Lee et al. 1995). MR program was finally fully introduced in 1979, and doctors and paramedics were instructed to provide MR in all government hospitals, and health and family planning complexes (Chowdhury et al. 2004).

The MR program in Bangladesh has since suffered from various funding shortages. Until 1983, USAID financially supported the MR program through The Pathfinder Fund, but, after the
imposition of the Mexico City Policy of 1984, barred all support of abortion services (Blane and Friendman 1990; Crane and Dusenberry 2004). The Pathfinder Fund halted all MR activities and, by 1998, the Swedish International Development Cooperation Agency (SIDA) was the only organization supporting MR activities (Johnston et al. 2011). This funding shortage resulted in fewer trained doctors, paramedics, and family welfare visitors, and also led to continuing shortages (Johnston et al. 2011). Estimates suggest that up to one third of facilities that could provide MR have insufficient trained personnel or equipment to do so (Hossain et al. 2012).

**Menstrual regulation outside health facilities**

Reasons for seeking MR outside health facilities vary and authors of studies state they have been unable to clearly identify why women seek out MR procedures from informal providers outside health facilities (Bhuiya, Aziz and Chowdhury 2001). Reasons may include costs (Akhter et al. 1998; Chowdhury et al. 2004; Oliveras et al. 2008), restriction of movement (NIPORT et al. 2016), lack of knowledge (DaVanzo and Rahman 2014; NIPORT et al. 2016), or a desire for secrecy (Bhuiya, Aziz and Chowdhury 2001; Kamran, Arif and Vassos 2011; Singh et al. 2012; Yasmin et al. 2015). Previous studies in Bangladesh have examined decisions between methods in clinics, or the pathways that lead women to seek medical care in clinics after previous pregnancy termination attempts have failed (Khan et al. 1984; Akhter et al. 1998; Singh 2006; ICDDR,B 2011; Nanda and Mishra 2011; Alam et al. 2013). Less is known about the pathways and processes utilized by women before they arrive in clinics with complications.

Despite women commonly buying medication from pharmacies without prescriptions or involvement of a health professional, studies examining experiences with medication for MR most commonly recruit women from facilities and have found that that medication for MR is acceptable and satisfactory for women (Alam et al. 2014; Yasmin et al. 2015), Alam et al. investigated women’s satisfaction and experiences when offered the choice of MVA or medication for MR in health facilities, and found that the majority of women had successful uterine evacuations without surgical intervention, and were satisfied with the pills for their MR (2013). Recruiting women from hospitals after they had sought care for informal procedures, and disclosed they had undergone an MR to hospital staff, Akhter et al., found that low knowledge of the health system, and whether the woman knew someone who performed informal procedures in her community, were factors that made women more likely to seek informal procedures (1998). Formal providers are also known to levy unnecessary requirements, such as requiring the signature of the woman’s husband (Piet-Pelon and Rob 1999; Ganatra et al. 2004; Vlassoff et al. 2012; Huda et al. 2013).
Studies examining where women went when they sought MR outside facilities, or why they went there, commonly recruited participants from health facilities after treatment for complications from these procedures (Akhter et al. 1998). Studies often do not outline how they asked questions, when participants were asked why they had MR procedures outside facilities before coming in for postabortion care. One study, for example, recruited women from health facilities after they were treated for complications after procedures, only including women who disclosed they had had "induced abortions"; this study noted that those with no knowledge of MR were 1.6 times as likely to have informal MR procedures than women who knew about MR (Akhter et al. 1998). Still, it remains unclear from the publication how the women were asked about their terminations, or how they defined them if not as "MR."

In studies where women were recruited from hospitals or clinics, they reported that knowing and trusting someone in the community who performed abortion, and low general knowledge, was associated with women seeking care outside facilities (Akhter et al. 1998). Women also reported paying informal providers lower fees than they would have to pay to formal providers, but the study did not specify whether this was a reason for not seeking care in facilities (Akhter et al. 1998).

Other studies reported on purported reasons for why women sought care outside health facilities after being recruited from facilities, but failed to state whether the women themselves reported these reasons or if they were hypothesized by the authors. Chowdhury et al. (2004), for example, suggests that women may seek informal MR providers due to government hospitals not being women-friendly (little privacy, lack of confidentiality, lack of cleanliness), because provider attitudes vary and some may be judgmental or impose spousal or parental consent, and because hospitals may levy unofficial payments (Chowdhury et al. 2004). These findings meant that women did not know how much they would have to pay, or that going to distant government facilities would incur transportation costs. It is not stated in the publication, however, if women themselves reported these as reasons they sought informal or private providers.

The Bangladeshi Demographic and Health Survey (DHS) reports on officially provided MR, but does not inquire about informal or self-induced procedures. The DHS showed that, in 2014, only 45% of ever-married women and 46% of currently married women knew of MR (NIPORT et al. 2015).
Other studies using DHS data have found that the likelihood of pregnancy terminations are positively associated with education, and the more education a woman has the likelier she is to have a pregnancy termination by safer methods. Why this is, however, the authors state remains unclear (DaVanzo and Rahman 2014). Similar studies have found that risk factors for seeking care with informal providers include being an adolescent (Kapil Ahmed, van Ginneken and Razzaque 2005; Khan, Kabir and Mori 2006; Gipson and Hindin 2008).

Studies examining where women went for MR outside health facilities have found that, when sampled from the DHS as having had an “induced abortion,” women reported that they went to traditional providers and village doctors (Caldwell et al. 1999; Bhuiya, Aziz and Chowdhury 2001), allopaths (the authors of the research papers do not further define this term, likely pharmacists providing allopathic medication) (Bhuiya, Aziz and Chowdhury 2001; Gipson and Hindin 2008), homeopaths (Caldwell et al. 1999; Bhuiya, Aziz and Chowdhury 2001; Gipson and Hindin 2008), family members, or self-induced (Bhuiya, Aziz and Chowdhury 2001; Gipson and Hindin 2008). The authors of the paper do not describe if women directly reported this, but state that lack of support by husbands or families, especially for younger women, may be related to seeking MR from informal providers (Bhuiya, Aziz and Chowdhury 2001). In one such study, the main reason women gave for seeking informal providers was confidentiality, with cost and proximity mentioned less frequently (Caldwell et al. 1999). Women from these samples reported little concern about risks of untrained providers, although those who had sought formal services from government providers reported using these because they perceived their services to be safer (Caldwell et al. 1999). Women may also use “readily available” inexpensive methods before seeking methods they perceived as more effective but expensive (Gipson and Hindin 2008).

Other studies did not ask women who sought MR directly, but interviewed health professionals associated with MR, such as researchers, OBGYN and nonspecialist physicians, program managers, administrative health officials, and other professionals as to why women may seek MR outside health facilities (Vlassoff et al. 2012). These agents estimated that rural women were less likely to seek safe providers than urban women, especially poor rural women, and that cost and income disparities might be at root of this; formal rural providers were found to charge 500–1100 Taka and urban providers 800–2100 Taka, while informal providers only charged 300–400 Taka, meaningful differences when considering the disparity in income levels, with averages wages being 2000 Taka in rural, and 3700 Taka in urban areas (Vlassoff et al. 2012).
Studies also report on women being turned away from health facilities when seeking MR for reasons such as not having consent from their husbands or being unmarried (Vlassoff et al. 2012). Women who sought MR outside health facilities recruited through clinics reported using a variety of providers, including pharmacy workers (Alam et al. 2013; Reiss, Keenan, Dijkerman, Choudhury, et al. 2015), traditional providers, untrained village doctors, and homeopathic practitioners (Kapil Ahmed, van Ginneken and Razzaque 2005). Some studies hypothesize that women may not be aware that they did not seek care from approved providers; traditional village doctors may have practices nearly indistinguishable from those of licensed allopathic physicians (Hamid Salim et al. 2006).

Care-seeking behaviors are, moreover, highly context-specific and context varies between communities and environments. As Petchesky has argued, the social and individual/bodily aspects of pregnancy and abortion cannot be separated (1990). Women in Bangladesh inhabit a specific space governed by a patriarchal system that traditionally secludes women from the outside world and from men (NIPORT et al. 2016). We cannot act outside the specific community and social system we inhabit (Ortner 2006) and patient choices, including women who seek MR, are influenced by (infra)structural aspects, process, and outcomes (Victoor, Delnoij, et al. 2012; Victoor, Friele, et al. 2012). Reasons to seek out informal MR providers may therefore be based on trust and long-standing relationships (Mahmud et al. 2015), convenience, affordability, and social and cultural reasons (Hamid Salim et al. 2006), not simply a choice between formal and informal providers and locations. Reputation, familiarity, and ability to pay on credit or in kind may also play roles in healthcare provider selection (Rashid, Akram and Standing 2011). Women may also seek different providers for different types of illness or diseases (Groenewoud et al. 2015) and seeking MR may be different from seeking healthcare for other ailments or diseases. This more general care-seeking could also be different from how they approach, or seek reproductive care or contraception.

Women may also seek informal providers after being turned away from healthcare facilities. A study reported that in 2014, 27% of women seeking MR were turned away from facilities for reasons such as having exceeded the legal time limit for MR, being childless, being too young, unmarried, lacking consent from the husband, or other unspecified medical reasons – yet fewer than half of these women ultimately obtained MR procedures (Hossain et al. 2017). Singh et al. suggest that those women who are turned away from healthcare facilities may seek what they call “safe illegal abortions,” performed by trained providers outside of hours, or in homes, because these women are at least aware that MR exists and are knowledgeable about clinics and trained providers (2012).
The role of mifepristone and misoprostol

Self-use of medical abortion pills purchased from pharmacies, whether combined mifepristone and misoprostol or misoprostol alone, can be safe and effective if pharmacists know what the correct medications and regimens are, and are able to provide correct information, including what to do if a woman experiences complications (Sneeringer et al. 2012). When women have sufficient information on drug and dosage, pharmacists can provide medical abortion as well as effectively assess outcomes and need for possible follow up care (Sherris et al. 2005; Hyman et al. 2013; Tamang et al. 2017). Until recently, MR was only legally available as a surgical procedure, but, in 2013, the Directorate of Family Planning approved the CombiPack consisting of mifepristone and misoprostol for medical MR, which can be prescribed by clinic-based personnel who have received training for MR with medication (MRM) (Bangladeshi Directorate General of Family Planning 2014). A prescription is needed for the medication, which is currently unavailable through government facilities (Government of the People’s Republic of Bangladesh 2015). Misoprostol is more readily available and cheaper than mifepristone (Costa and Vessey 1993) and is commonly used alone in lower- and middle-income countries where access to safe and legal services is restricted (Sherris et al. 2005). In Bangladesh, misoprostol alone is likely the most frequently used drug (Alam et al. 2013; Reiss, Keenan, Dijkerman, Choudhury, et al. 2015). While the CombiPack is now legal in Bangladesh, it remains unavailable through either the government system or public sector facilities (Huda et al. 2017) limiting women’s access.

Pharmacy workers in Bangladesh often lack formal training and their shops are unregulated (Ahmed and Hossain 2007), which may lead to incorrect or insufficient advice (Huda et al. 2014). Studies have shown that information provided by pharmacy workers is inadequate. For example, 80.5% of the mifepristone and misoprostol combination pack users were sold the correct regimen versus nine out of 20 misoprostol users (Footman et al. 2017). Since pharmacy workers may also lack information on gestational age limit for MR, the recommended dosage of mifepristone and misoprostol was only recommended to half of all mystery clients (Huda et al. 2017), still higher than 7% found in a 2014 study (Huda et al. 2014).

Menstrual regulation, menstruation, and abortion in Bangladesh

There is a gap in the literature on how Bangladeshi women themselves define their procedures – whether they see a difference between MR and abortion, or whether MR is simply a euphemism for abortion. One study noted time and duration of pregnancy as factors, stating that women believe if they “wash our uterus when we are one or two months pregnant, it is not a sin” (Gipson and Hindin, 2008, p.1831). Even this, however, acknowledges the existence of a
pregnancy and the possibility of "sin" rather than delayed menstruation. The only other reference in the literature states that the perception of MR depends on the perceptions regarding the causes of a delayed period (Dixon-Mueller 1988), but does not give further insight for how these perceptions are constructed.

Both MR and the use of medical abortion call into focus the understanding and "construction" of menstruation as a concept. Historically, menstruation has been viewed as both positive and negative in a woman's life. Menstruation was considered part of a "healthy woman" and could be stopped by various illnesses and ailments. In mid-nineteenth-century England, it was believed that any exertion, mental or physical, could be fatal if it stopped the menstrual flow (Shuttleworth 1990). Today, women in various cultures believe menstruation rids the body of "bad blood" and "poisonous wastes" (Dixon-Mueller 1988), and that stopping it could be hazardous to health. A cross-cultural study on menstruation conducted by the World Health Organization (WHO), found that women saw menstruation as "a natural, vital, physiological occurrence indicative of good general health," and would be hesitant to use birth control that would stop it (WHO Task Force, 1981, p.13).

In Bangladesh, menstruation is generally understood as something shameful and embarrassing, best kept out of public discourse. Menstruation inhabits two separate philosophical spaces. On the one hand, as part of MR, it is deemed as natural and “a healthy demand from a healthy lady” (quote from Senior ministry of health official Dixon-Mueller, 1988); simultaneously it is used to seclude women from society (Johnston et al. 2011). Women in Bangladesh are often placed in purdah and sequestered when they are menstruating. This contrasts the "natural and healthy" perceptions of menstruation with community perceptions of women as "unclean" during menstruation (Maloney 1981). The traditional and religious concept of menstruation as taboo, combined with purdah, could also partly explain why women aim for secrecy and seclusion during MR procedures and abortions.

2.3 Contributions to the field
Studies commonly give no reasons why women make the decisions they do regarding their abortions. Drawing from global literature and local publications in Bangladesh, we found that most research to date, on women who had attempted or sought MR outside health facilities, had recruited women only from facilities where they sought postabortion care, or through population-based household surveys. A systematic review currently in progress (search updated in 2018) (Eckersberger, Footman, et al. 2019) found that, of 65 papers giving locations
where women sought abortions outside health facilities in lower- and middle-income countries, 23 addressed why women sought abortions where they did. This means that, in many cases, no answer is reported as to why women did not seek facility-based care, or why they sought care with informal providers.

Regularly updated comprehensive data exists on provision and access to MR in Bangladesh, estimated by both international non-profit organization (Singh et al. 2012; Hossain et al. 2017; Singh, Hossain, et al. 2017) and the Bangladeshi DHS (NIPORT 2012; NIPORT et al. 2016) including data on reasons why women aged 15–49 are turned away from health facilities (Hossain et al. 2017). The DHS (NIPORT et al. 2016) reports on MR provided officially but does not inquire about informal or self-induced procedures, and we therefore know little about women’s experience outside formal facilities (Hossain et al. 2016, 2017). This is especially true of personal, cultural, and community barriers, or those related to relationships with either formal or informal providers. Exploring a phenomenon in a specific context is important, and “the demonstration of geographical variation adds yet another element to the range of arguments that these things are in fact socially constructed” (Massey, 1994, p.178). Few studies have investigated how women in Bangladesh experience their lives, their healthcare decisions, and MR procedures in a specific way that also contextualizes their surroundings and beliefs.

I sought to investigate this specific gap in the literature, focusing on women’s experiences who had abortions, or menstrual regulations, outside health facilities. This current study specifically sought to investigate women’s experiences in Bangladesh, asking them about their lives and obtaining the stories of women who in other research may have been “effectively silenced” (Reid, 1993, p.143). This current research differs from much of the existing literature in that, in my interviews, I did not include questions about motivations for seeking MR, or investigate reasons why women noted as to why they were choosing to terminate their pregnancies. I focused instead on women’s pathways after they had already decided to seek an MR, investigating aspects of the decision-making process that women underwent when seeking care.

This study is the first to focus on the experiences of women in Bangladesh who had had MRs outside health facilities. Other studies have found considerable variation in patterns of behavior between participants recruited through facilities and those not in contact with those same institutions (Zinberg 1984; Watters 1988); it was important to focus on the latter population, who are missing from clinic-based studies.
Reasons for seeking MR outside health facilities are varied and interrelated, and we have yet to identify who is most at risk and how their social context and community may influence the decision to seek informal care (Huda et al. 2013). Despite the importance of this at-risk population, little research has been conducted on it, leading to knowledge gaps about the situations of women most likely in need of better care.

Hospitals and healthcare clinics form only one part of the spectrum of health care (Edmeades, Lee-Rife and Malhotra 2010), and looking at health facilities misses an important population of women who seek MR elsewhere (Kapil Ahmed, van Ginneken and Razzaque 2005). Studies focused on women seeking postabortion care in clinics miss both women who used unsafe methods effectively for complete terminations, and those who sought follow-up care outside the formal healthcare system. Both types of studies, those recruiting from clinics and those from the community, may ultimately miss women who were unsuccessful in their attempts to seek MR and carried to term, either because the method they sought or were given was ineffective, or because they were unable to seek care altogether. Women may also return to informal providers for follow-up treatment.

I also identified gaps in how women make the decision to have MR, or abortions overall, in the global literature. In the extant literature very few researchers investigated women's pathways to seeking care or decision-making processes in more detail, and many papers tend to fall back onto reasons such as a lack of knowledge (DaVanzo and Rahman 2014; NIPORT et al. 2016), not defining however, what exactly they lack knowledge about. In such cases this lack might concern the abortion or MR process, the legality of the procedure, where to seek safe procedures, or overall lack of knowledge about healthcare. I also sought to investigate a gap in the knowledge about women who have abortions outside formal health facilities in an environment where an alternative place is, at least legally, available. To develop effective interactions and to support women in seeking safe services we must know more about how they make their decisions, and how they end up choosing the pathways and methods they do.

Finally, I was unable to draw firm conclusions on how Bangladeshi women themselves define their procedures – whether they see a difference between MR and abortion, or whether MR is simply a euphemism for abortion. Answers to this question may link women's experiences in Bangladesh with those of women in other countries, or, additionally, allow us to investigate their experiences more closely based on alternative definitions of their procedures.
2.4 Conclusion

MR in Bangladesh is simultaneously not defined as abortion by the Bangladeshi government yet linked to the global burden of unsafe abortions by public health researchers. Despite MR being a common procedure in clinics and provided by informal providers outside health facilities, little is known about women who seek MR outside health facilities. Where researchers asked women about previous procedures, they commonly recruited them from clinics and health facilities and will have missed women who never sought formal care.
Chapter 3. Theoretical Approach

3.1 Theoretical approach to abortion and care-seeking

I viewed my data on MR through a constructivist lens to diagnosis, treatment, and practice, following Berger and Luckmann, who argued that “society exists as both objective and subjective reality” (1966, p.149). This formulation is not to reject the material world’s existence but instead to argue that our realities within it are socially constructed.

Constructivists claim that a material, biological base exists, which is then shaped and molded—as are our actions, reactions, and opinions—by society and the cultural context in which it exists (Connell 1987; Shilling 2003). Searle (1995) draws lines between what he calls “brute” and “institutional facts.” Brute facts, such as rocks, grass, or sunshine, require no human institutions for their existence. Money, by contrast, is an institutional fact—money exists and is real in our everyday lives—yet it only exists within the context of society, and requires comprehension and acceptance of social institutions for its existence and power.

Pregnancy, abortion, and MR are biological processes. Yet these processes are imbued with layers of opinion, beliefs, and values, that then shape biological certainties into institutional facts with additional meanings. For example, when women in Bangladesh have MR procedures, they undergo a medical procedure that in their environments is viewed differently from other medical procedures: it is subject to community and religious meanings and perceptions. Our views, actions, and reactions only make sense in the cultural context within which they occur. In the words of Turner the body is both “concurrently socially contracted and organically founded” (1992, p.17). Whatever the epistemological stance and the validity of knowledge, single or constructed view of medicine, it is undeniable that society’s reaction to the physical body impacts upon the lived body (Nettleton 2006).

Conceputalizing abortion as part of reproductive rights

Abortions are a “coupling of science and morality” (Pollard and Hyatt 1999). How they are treated and approached in many societies exemplifies how a safe and common medical procedure can be turned into something that contributes to deaths and disabilities.

Many terms used today, by both opponents and supporters of abortion, are structured around beliefs that cloud the issues at hand; “for decades, imprecise, misleading and obsolete abortion terminology has hindered, not helped, the ongoing debate about abortion” (Grimes and Stuart
On a social level, abortion challenges long-held ideas about women's societal roles (as mothers and nurturing caregivers), their place in the family, perceived physical weakness, and ability to make the best choices for themselves and their bodies (Greenwood and King 1981). Women are simultaneously blamed for having many children and judged for attempts to control fertility. This returns to the idea of women as nurturing mothers instead of sexual beings.

Abortion transgresses norms about who should be having sex where (Kumar, Hessini and Mitchell 2009). Abortion stigma is common, and pregnancy terminations remain censured and taboo in popular culture (Grimes et al. 2006). The concept of abortion furthers the extent to which women can be valued for roles other than wife and mother (Greenwood and King 1981) while unsettling men's roles as decision-makers, on both accounts promoting gender equity by allowing women to take control of their own lives. To quote the reproductive rights activist Merle Hoffman: "That's the most difficult thing for people to accept—that the woman is the ultimate arbiter. Not the state. Not a judge. Not a group of 'ethicists.' Not some men in black robes. But this individual woman." (2012, p.76) The very fact that abortions occur despite restrictions shows that they are a "contested space where agency and resistance are dynamic" (Kumar, Hessini and Mitchell 2009, p.628).

Conceptualizing menstrual regulation
MR in the Bangladeshi context is an especially interesting case, as a legal and conceptual distinction is made between abortion and menstrual regulation. Biologically, both are terminations of pregnancies. MR is not the neutral product of technical imperatives as medical processes or devices (Wajcman 1994), and must be examined in not only its reality, “but also with the processes by which any body of ‘knowledge’ comes to be a socially established reality” (Berger and Luckmann 1966, p.15). MR cannot exist without the institutional facts that surround it: beliefs about abortion and coinciding laws, beliefs about menstruation, and beliefs about what it means to be a healthy woman.

Conceptualizing MR as a medical treatment shows how framing and language can affect how treatment is viewed and administered. A menstrual period is missed and the woman's body is, via MVA – a technique and technology seen by all, including foreign donors, as an abortion – returned to its previous, non-pregnant state. MR can also be viewed as a way of terminating a pregnancy without assigning agency or blame (Kumar, Hessini and Mitchell 2009).
Conceptualizing abortion and menstrual regulation with medication

Medication for MR, as method and a technology, provides a relatively recent addition to the discussion around abortion and menstruation. When women have described medical abortion, they have described the process of heavy bleeding without insertion or surgery as more natural and less invasive (Clark, Ellertson and Winikoff 2000; Lafaurie et al. 2005). This description once again conjures images of menstruation being natural and healthy.

As a technology, MR is convenient; medication for MR can be purchased by anyone from several places and can be taken in secret. This gives women an opportunity to subvert convention and take their health into their own hands—reclaiming control over their bodies from the male-dominated medical profession and its sanctioned methods. Second-wave feminism was concerned with the medicalization and technological intervention taking power over women’s bodies (Nettleton 2006). Medication for medical abortion, however, purchased from pharmacies and used off-label, is an example of “women’s capacity to subvert the intended purposes of technology and turn it to their collective advantage” (Wajcman 1994, p.58).

This postmodernist view of misoprostol and its power points to a breakdown in the hierarchies of knowledge (Nettleton 2006), where women know and decide what is best for their own bodies. Women construct their own knowledge of what they know to be right. They leave behind the government’s or a doctor’s “superior” knowledge, relying on their own opinions instead.

The act of purchasing medication for abortion, especially in the “safe illegal” way it is purchased from pharmacies and other informal drug sellers, highlights that “medical technology is imbued with, and cannot stand outside, social relations” (Arnold and Faulkner 1985, p.32). Pharmacists and drug sellers can provide familiarity, trust, secrecy, local availability, and the option for a family member to purchase the drug on behalf of the woman. These are all aspects of clandestine medical abortion and cannot be separated from technology as it exists today. In this case, the provider is inseparable from the drug and its use.

Conceptualizing interactions between providers and women seeking abortions

Interactions with providers, both formal and informal, are an important aspect of care-seeking. Different models of patient-provider relationships and treatment styles affect treatment seeking and the care patients receive. Treatment may differ from person to person. Women in Bangladesh may have very specific experiences related to their place in the culture and society, as well as the specific treatment sought. Who they seek, the care they receive, and the overall
experience they have when seeking MR outside facilities may therefore be different not only from care received in formal health facilities, but also different from care for any other illnesses and ailments. One researchers explicitly stated that that they were unable to identify what they called “a systematic pattern” to treatment-seeking behaviors (Rashid, Akram and Standing, 2011, p.28).

3.2 Prior knowledge of the topic of abortions

Classic grounded theory maintains that “learning not to know is crucial to maintaining sensitivity to data” (Glaser 1978, p.127) that theory is directly generated from the data, and that “preconceived ideas to prove or disprove” exist (Mills et al. 2006, p.2-3). While I did not attempt to do this research “blind,” but rather approached all aspects of data collection and analysis with a preconceived focus on understanding women's experiences of specific issues, I was aware this ran the risk of “forcing,” or “looking for data rather than at it” (Robrecht 1995, p.145). There is no easy answer to this, with Charmaz (2006) calling the issue “unresolved.” I have endeavored to let the data lead as much as possible.

Constructivism “disavow[s] the idea that researchers can or will begin their studies without prior knowledge and theories about their topics” (Charmaz 2008, p.402). Bryant concludes that how researchers “manage this feat of cognitive evasion is not clear” (2003, para. 9). For this study the best approach was to maintain awareness of this issue in the research, and to point out the contradiction between prior knowledge and the data when possible. There is a “difference between an open mind and an empty head” (Dey 1999, p.251). I remained aware of how prior knowledge shaped my approach to the data, and I attempted to add new knowledge to the process where possible and appropriate.

Although I had been engaged with reproductive health topics and feminism before beginning this work, my involvement with these topics had been less academic, and more informal. Not until I began preparing for this study did I delve more deeply into the topic of abortion and reproductive rights. In some cases, it was hard to discern whether prior knowledge (Glaser 1978) would not have benefitted me, and would have allowed me to ask questions I may have missed. I cannot know what topics I missed or data I did not see. With diligence and open-mindedness, however, I was able to learn about and develop concepts as the study progressed.
3.3 Theoretical frameworks used in this theory

A theoretical framework, in Miles and Huberman’s words, can show "the main things to be studied – the key factors, concepts, or variables – and the presumed relationships among them." (1994, p.18) In order to select a framework or theoretical approach for this study, I explored different directions and points of view that might help ground my work more fully in existing thought.

To ground my work in the broader theoretical thinking, I used Uri Bronfenbrenner’s 1979 socioecological model to guide my thinking, and as a tool to consider a wide range of elements that may influence a woman's actions and experiences (Bronfenbrenner 1979; Bronfenbrenner and Crouter 1983). Using this socioecological model (Bronfenbrenner 1979) during data analysis was also useful to guide the analysis, and to focus on certain pieces that began to stand out as important, specific, and common experiences in women's stories. In addition to the socioecological model, I used Coast et al.'s (2018) conceptual framework on seeking abortion-related care to frame my analysis (Coast et al. 2018).

As the research progressed, data analysis continued, and I identified themes about women and their lives from the data, I explored additional areas of theory and emerging literature to understand women’s lives. These frameworks provided insight in addition to the primary frameworks used in this thesis, and were used to explore and illustrate elements of the data, rather than fully framing my results.

Because I was trying to understand and situate women's experiences in both their individual contexts and the wider literature, I found additional concepts useful in understanding women's experiences: decision-making theories and theories around social relationships, and how these theories shape care and care-seeking. When conducting the analysis on data from interactions with providers, for example, I had thought that a decision-making framework could work for analyzing how women chose a provider and the method they wanted. Yet ultimately, the data showed that, in making these decisions, women were more concerned with relationships with community members and providers, and where they felt comfortable going (see Chapter 7, Paper 3). Below I explore the different frameworks and theories that guided my analysis.
3.3.1 Primary frameworks

Bronfenbrenner’s socioecological model

Using Bronfenbrenner’s 1979 socioecological model to guide my research initially, I referenced and built on the concept on interconnectedness (Bronfenbrenner 1979). In particular, I viewed abortions, pregnancies and MR as inseparable from the environment in which they occur. As Crouch stated: “. . . in order to fully understand that reality, we need to take into account its social context” (2006, p.485). Neither can abortions, pregnancies, or MR procedures be seen separately from the local framework in which they occur: women’s decisions do not occur in isolation.

During data collection and initial analysis Bronfenbrenner's socioecological model aided me in considering the elements that may influence a woman’s actions and experiences (Bronfenbrenner 1979; Bronfenbrenner and Crouter 1983). In his original 1979 model Bronfenbrenner identified four environmental systems that influence the individual: the micro-, meso-, exo-, and macrosystems (Bronfenbrenner 1979). The microsystem, focuses on the individual’s immediate surroundings, including partners, family, neighborhood groups, or friends. The mesosystem describes the environment beyond this immediate circle, and includes others with whom the individual has personal contact, such as work, school, religious, or community institutions. The exosystem outlines the next sphere of influence, which does not personally or directly come into contact with the individual, but nevertheless influences their lives; this includes media, social services, or government policies. The macrosystem describes the culture within which the individual lives more broadly and includes attitudes and ideologies of the culture within which they live, including historical content.

While Bronfenbrenner originally used the socioecological model to understand human development, this framework also gave me the opportunity to examine what works for whom in what specific circumstance (Pawson and Tilley 1997), “offering a theoretical framework for understanding the dynamic interplay among persons, groups, and sociophysical milieus” (Stokols, 1996, p.285) and highlighting the synergy between individuals and their social environment (Bronfenbrenner 1979). This framework is also built on reciprocal determinism (Golden and Earp 2012), which moves beyond the idea of individual change and focuses on the wider environment within which the individual is situated, using a “whole-system” approach to health (Moore, de Silva-Sanigorski and Moore 2013). For this current study this type of approach implies that the only way to understand women’s decisions around where they seek MR is by looking at all aspects of their lives.
Over the past decades Bronfenbrenner’s socioecological model has been adapted to provide guidelines for health promotion (Stokols 1996) to provide specific intervention strategies at each level of influence (McLeroy et al. 1988). Adaptations of the model have been used successfully across various healthcare settings and topics, such as HIV (Gombachika et al. 2012), suicide (Cramer and Kapusta 2017), health literacy (McCormack et al. 2017), vaccine uptake (Kumar et al. 2012), adolescent sexual health in the United States (Salazar et al. 2010), and reproductive care seeking in refugee and migrant settings (Mengesha et al. 2017).

During the development of this research project, I referred to Bronfenbrenner’s original model to understand the context of women’s lives. In early versions of the model Bronfenbrenner suggested that “...within any culture or subculture, settings of a given kind – such as homes, streets, or offices – tend to be very much alike, whereas between cultures they are distinctly different.” (1979, p.4) He later included biological and genetic factors as he feared the person at the center of the model was being lost (Bronfenbrenner 2005). Criticism of his model includes possibly highly interrelated factors, which other studies have found could be located under or between different levels (Gombachika et al. 2012). However, I found that biological and genetic factors were unlikely to add valuable dimensions to the care-seeking process in the case of women seeking MR, and also found that Bronfenbrenner’s original model was best suited for examining these women’s lives. I found it important to investigate the different factors that could be influencing women’s decisions and to develop an evidence base before attempting to find solutions. The model also gave me the opportunity to examine and attempt to understand processes at multiple levels, and their interactions with each other (Moore, de Silva-Sanigorski and Moore 2013). While the model cannot fully explain relationships and how different socioeconomic environments affect the various spheres, it demonstrates that we cannot easily act outside the specific community and social system we inhabit (Ortner 2006).

Coast et al.’s framework on trajectories to obtaining abortion-related care
During the course of this study Coast et al. published a conceptual framework on abortion-related care trajectories, including all to-date known factors and how they influence women’s trajectories to seeking abortion-related care (Coast et al. 2018). This framework ultimately proved very useful in placing my analysis within the broader literature and evidence on how women seek abortions, and the elements of the trajectory that may be important to capture. Coast et al.’s framework has similar characteristics to a socioecological model, but also includes time-dependent processes specific to abortion.
The Coast et al. (2018) conceptual framework groups influences shaping trajectories into three categories:

1. **Abortion-specific experiences**
   Abortion-specific experiences, beginning with pregnancy awareness and ending with abortion-related care, also include abortion attempts and (perceived) outcomes from these. While time-oriented, the elements of this domain are not linear and may change along the trajectory; for example, a woman’s emotions about the pregnancy before and after an attempted abortion, or the need to disclose to additional or different people after abortion attempts.

2. **Individual context**
   This domain focuses on the characteristics of the individual seeking the abortion, including her interpersonal networks. This domain includes the specific context at the time of the abortion, which may vary due to marital status or already-born, living children, or knowledge about abortion. Socio-economic characteristics and community context are also captured here, as are women’s relationships.

3. **(Inter)national and sub-national context**
   The wider context and macro-level environments are captured in this domain, including legal context and government policy or enforcement. This also includes civil society actors and influences, including faith-based institutions and health systems influences, both including formal and informal care providers.

Coast et al.’s framework on abortion care-seeking trajectories provides more details applied to abortion, which broadly map onto elements of the socioecological framework, i.e. the individual (such as socioeconomic or demographic characteristics, or individual awareness of the pregnancy), the microsystem (such as partner or family), the mesosystem (such as faith-based institutions, community context, or knowledge environment), and the exosystem (government influence, anti/pro-natalist and associated politics).

In using this framework on abortion care-seeking trajectories I was able to examine women’s experiences more closely and situate their experiences among those of other women seeking abortion-related care, thus providing a more grounded approach for the analysis of the study.
3.3.2 Additional approaches informing this thesis

Using a constructivist grounded theory approach

Phenomenology, a philosophical approach based largely on the work and ideas of Edmund Husserl (1931) is, at its core, the study of a lived experience of a phenomenon (Creswell 1998). Some authors have gone so far to pronounce all studies phenomenology (Natanson 1973), as they focus on a specific phenomenon, topic, or object. For this study, the phenomenon was one all participants shared: having had an MR outside a health facility. Phenomenology is a particular theoretic approach (Crotty 1998), so combined it with a grounded theory approach to data analysis to examine the data collected about this phenomenon, allowing me to move beyond description (Creswell 1998) of the phenomenon to generate broader theories from the data.

Glaser and Strauss, in their original 1967 book of classic grounded theory, suggest that authors adapt the grounded theory approach with their own ideas: the “principal aim is to stimulate other theorists to codify and publish their own methods for generating theory” (italics in original) (Glaser and Strauss 1967, p.8). Because I would interpret all data collected and make all decisions about analysis and presentation, it was important to explicitly acknowledge my own ideas and how they could affect all elements of the research.

In using a constructivist grounded theory perspective, I particularly referenced the work of Kathy Charmaz. Constructivist grounded theory rethinks the traditional grounded theory methodology, where the researcher develops what Charmaz called “constructivist grounded theory” strategies as “just that—strategies for creating and interrogating our data, not routes to knowing an objective external reality” (Charmaz 2008, p. 401). She argues these strategies are “unabashedly interpretive” (Charmaz 2006, p. 128). In this approach, then, theories do not emerge on their own; they are actively constructed through the researcher’s interactions with the data and the participant’s responses. They are “a construction – or reconstruction – of reality” (Charmaz 2006, p.27), rather than an objective reality that can be validated and verified. These ideas informed how I designed the study and collected data, as well as how I conducted the data analysis. Charmaz’ approach theorizes that reality is constructed by individuals as they assign meaning to the world around them (Appleton and King 2002).

Constructivist grounded theory is especially applicable in cases such as this study—where women participants, in interviews, reconstructed their past experiences, perceptions, and feelings about their MR procedures. I, the researcher, am present in this project as an active participant as designer, witness, and reconstructor of their experiences. Women told me things
that were meaningful to them, and then, from a constructivist perspective, I created meaning as I interacted with and interpreted their stories (Crotty 1998). In looking for specific details, I had a purpose that affected data analysis. But I also let the data speak, and found information (for example, on how closely informal MR and pharmacies are related) that I had not expected.

Barney Glaser has been critical of Charmaz’s approach, stating it was a way to “avoid the work of confronting researcher bias” (Glaser 2002, para. 11), which he felt would be revealed during the constant comparative process. He asserted that by taking great pains not to intrude their own views in the data, researchers could minimize human biasing, and that by using constructionism Charmaz neglected the “carefulness of the grounded theory method which makes the generated theory as objective as humanly possible” (Formatting Citation).

As Charmaz notes, the researcher plays a large role in the construction of the research process. There are several areas where I, as researcher, am especially present in this project. As the Principal Investigator (PI), I was solely responsible for many elements of the study and analysis, and insert myself into every element of the process. While I did have a research team, both locally in Bangladesh and in the UK, I was ultimately responsible for completing all elements of this study. And after spending 18 months in Bangladesh during data collection, I was convinced there would be little chance of leaving myself entirely out of the process, from research design to data collection, analysis, and theory generation. Readers may not share my interpretation but, by describing my methods and presenting evidence, they may follow how I came to my conclusions (Koch 2006).

Constructivists argue that realities, as we perceive them, are social constructions created in our minds (Lincoln and Guba 2000). As such, it was important, in using the socioecological model and framework on trajectories to seeking care, to look at women's lives and their care-seeking behaviors as a whole, but also to explore how they experienced the world around them. The problem of access, for example, involves much more than the physical presence of a service, and encompasses different elements for different people, such as whether one is able to afford the service, or is free to travel there. Furthermore, barriers women speak of may not be physical but cultural. Limited mobility, for example, could be due to physical barriers, such as cost or lack of transportation, but also cultural barriers, such as women not commonly being seen in public spaces, and thus being seen outdoors could lead to stigma and judgment from other community members.
Classic grounded theory is firmly grounded in positivist thought, and the notion that, ultimately, the research can produce a correct answer from the analysis. It became known as the most realist and positivist of qualitative methods (Van Maanen 1988) and stated that “truth emerges from data representativeness of a 'real' reality” (Glaser 1978). Husserl claimed, like Glaser and Strauss of their approach, that phenomenology is “genuine positivism” (Husserl [1931] Sinha, 1963, p.562) Struggles remain between positivism and constructivism, and a post-modern critique has called ethnographic and constructivist methods a crisis of legitimacy, where ultimately everything is subjective and up for interpretation, and nothing is “true” (Brewer 2000).

In this research I held the position that, while I may not know what is “true,” it is apparent that there is an issue that needs to be addressed: women are not seeking safe or effective MR services. We should therefore not overlook the opportunity to tell their stories or possibly develop solutions simply because it may be “too hard.” Every woman’s story lives in her own subjective reality; as Douglas (1976) said: “all worldly truth rests ultimately on the direct individual experience” (Douglas, 1976, p.6). I, however, ultimately rejected the notion that this means we cannot carefully and consciously draw general themes and discuss possible conclusions from this current research’s data set as a whole. Everyone experiences the world in their own ways, and no two experiences are alike, but, broadly, as part of the human experience we share commonalities.

I, as the researcher, had to make decisions in my process: who to interview or observe, for example, or which data to record and how, and how to report my findings (Goodwin et al. 2003). My study relies on a certain positivist position, in that I wanted to ask a clear question, and regardless of what the answer was or ended up being, I was looking for an answer. This stance assumes that I was asking particular questions, looking for particular information, and that my question had an answer. There was an “impulse behind” (Stenhouse 1975) my research question and preparatory work, in that I did not approach my work objectively (Jones 2001). I recognized that women’s narratives reflected their perceived experiences, or how they wanted me to think they perceived them. My work is an account of the "betweenness" (England, 1994, p.251) of the women’s worlds and mine. At times their narratives did not align with more commonly accepted narratives, such as when women described "Doctors" differently from my notion of what a doctor is. Alternatively, if we had similar notions of “doctor” (i.e., a trained medical professional), they may have believed that the persons they called "doctor," in fact, had
these qualifications, when they actually did not. The final results are thus “co-constructed” (Mills et al. 2006) both by myself and by the participants.

Constructivism also brings together the idea that while knowing is an experience that is had by someone (Hufford 1995), the “someone” in question is both the participant and the researcher, and that these are not necessarily exactly the same, as they will both “construct” themselves on their own. Ultimately, neither positivists or naturalists can assume that a “body of data [is] uncontaminated by the researcher” (Hammersley and Atkinson, 1983, p.14). I took a “learning” rather than testing approach (Agar 1998), which should not preclude me from drawing conclusions; however, such conclusions have the caveat that I was aware of “constructing” them. As Crouch argues, in identifying themes we assume, at least implicitly, a common social world exists (Crouch and McKenzie 2006) in which women conduct their lives. Ultimately, this study falls between Positivism and Naturalism (Hammersley and Atkinson 1983), attempting to understand a phenomenon rather than conducting an experiment.

Finally, Bourke has noted that research, especially qualitative research, continues as we reflect on our process, and “on the development of an idea; on data collection; on findings, and; on implications” (1990, p.1). It was important to make sure I was constructing my reports in ways that resembled what women were telling me because I was attempting to portray their experiences as accurately and closely tied to their telling of their stories as possible. In terms of this study, the data collection was ongoing, and local women were involved in the research process, thus steered my research through explanations and recommendations (Ong 1995; Ashkenazi and Markovitz 1999). I was less successful at including women once I turned to analysis and write-up. The final text of this thesis stands as the “final construct and responsibility” (England 1994, p.250) of myself as the researcher.

**Decision-making in the context of abortion provision**

The focus of this research was on the context and experiences of MR, and examining how decisions are made between different methods and providers forms an element of this. Bronfenbrenner’s model (Bronfenbrenner 1979) centers around the individual’s environment, and I found it valuable to examine how women made decisions within their own environments or situations.

Research on how women decide between different methods has mostly focused on how women manage pregnancies and decide for or against the option of abortion, or between surgical and medical methods of abortion in health facilities.
Research from Bangladesh has examined women's decision-making for methods in clinics, and found that most women learned of medical methods from health providers, and that, once offered information about these, chose medication over surgical methods (Marlow et al. 2016). Similar studies in other locations also looked at choices between methods in clinic settings. For example, in Latin America, women chose medical abortion to avoid surgical procedures (Lafaurie et al. 2005), or reported adequate preparation and comfort managing their medical abortion at home after receiving care at clinics (Mitchell et al. 2010). Conversely, a study in Vietnam found that when women were given a choice between the two, uptake of medical abortion was lower than MVA (Ngo et al. 2014). An operations research study found that medical abortion could be successfully introduced as a choice in South Africa (Blanchard et al. 2015). Similar studies have been conducted in developed countries such as the Netherlands, where a study found that medical abortion satisfaction was lower than that for surgical options, but most women would nevertheless choose medical abortion again (Loeber 2010), or in New Zealand, one which found that both medical abortion and MVA from health facilities was safe and effective (Goodyear-Smith and Knowles 2009).

Moreover, not much is known about how decisions are made between seeking care at health facilities versus from informal providers, about how methods are chosen outside clinic settings or about decision-making in restricted settings, where economic, socioeconomic and logistic reasons may be as influential as personal choice when seeking abortion care. A study in Ghana, examining the relationship between motivation for seeking a pregnancy termination and method safety, focused only on methods available through health facilities and coded them as "safe," whereas all methods outside health facilities and from informal providers were coded as "unsafe" (Biney and Atiglo 2017). The Ghanaian study also found that women were most likely to use unsafe methods if they were terminating the pregnancies for financial reasons; however, the researchers failed to ask women directly why they had chosen to seek care outside health facilities, or to distinguish between different informal providers and the methods they possibly used or were offered.

In light of a lack of information on this topic, I examined decision-making theories and literature from other contexts to inform my analysis. Examining women making decisions in the specific context in Bangladesh (Khan et al. 2016), I first looked at Bettman et al.'s work on emotional tradeoffs (Bettman, Luce and Payne 1998). I had originally sought Bettman et al.'s framework because they discussed difficult choices, and included such factors as completeness and format.
of information, comparing choices, time pressure, and need to justify the choice to others after it had been made.

Bettman et al. hypothesized that, for decisions with negative emotions, the consumer’s goal will be to minimize these negative emotions (Bettman, Luce and Payne 1998). Minimizing these negative emotions can either be done by problem-focused coping (extensively processing information) or emotion-focused coping (avoiding aspects of the decision-making that carry negative emotions). Other research has found that regret could have been experienced before the decision was made and the consequences actually experienced (Zeelenberg, Inman and Pieters 2001), and that the fear women may have of being discovered may also have colored their decision-making.

I returned to other decision-making literature on “goals-based choice” (Carlson et al. 2008), as women spoke about being focused on having the MR largely to the exclusion of other options or considerations, and went where they could get the procedure done. Other research around difficult decision-making has found that once a difficult decision has been made – in this case the decision to have an MR – the decision-maker may resist seeking or introducing additional new information in an effort to avoid additional stress (Janis and Mann 1977). As all women included in the study ultimately had one goal (obtaining a successful MR), I further examined the literature around goals-based choice, largely built around the concept that a goal, or “a desired direction or state that guides behavior” (Carlson et al., 2008, p.4) guides our behavior. The concept has been used primarily in consumer decision-making and states that a choice “depends critically on the goals of the decision-maker” (Bettman, Luce and Payne, 1998, p.188).

3.4 Reflecting on women’s interviews

As researcher, I co-constructed results and theories, with the women who told the stories they wanted me to hear. The concepts of abortion, pregnancy, and menstrual regulation are social constructs, as well as biological realities, similar to women’s recollections of their experiences with menstrual regulation. To insist on a positivist “truth,” therefore, did not make sense in this context. The data could not speak for itself without being shaped by the participants and myself.

I cannot know with certainty if what I was told by anyone (key informants, community members, colleagues, friends, or acquaintances) corresponded to actual circumstances or events. I only refer to their narratives, and compare and cross-reference them with information gathered from other sources. As I drew conclusions, I recognized that these conclusions were
my own. While acknowledging that stories and data are constructed, I agree with Gergen that constructionism is not ontologically mute; “It does not deny, nor affirm, that there ‘is a world out there’” (Gergen, 1997, p.170). The theories of Berger and Luckman (1966) show this occurrence as illustrating that while the material world is not necessarily constructed, the way we shape our realities within this world is. My participants and I both inhabit and experience a world informed by our understandings and prior experience, thus construct different realities and worlds based on our individual lives.

3.5 Language and definitions used

In placing my work in the larger field of reproductive health and abortion care-seeking, at times discrepancies in language existed between the use of “menstrual regulation” (or MR in Bangladesh) and “abortion” in the wider literature. Similarly, discrepancies abound between the phrases "MR outside health facilities" and “unsafe abortion.”

I ultimately decided to use the terminology the participant women used when reporting their experiences, but after finding that they viewed their MR procedures as terminations of pregnancies (as outlined in Chapter 5, Paper 1), I was confident in linking the results of my work (i.e., MR) to the wider literature on abortion, acknowledging that all describe the same or a closely overlapping phenomenon or experience. As outlined in the Coast et al.'s framework on abortion care-seeking trajectories, women have a wide range of experience when seeking abortion care and the language and definition used by both women and policymakers comprises another element of their experiences; MR and abortion are not wholly separate entities.

Therefore, in accordance with terminology used in conversations, both with funders and local staff, during the development of the study, I call all menstrual regulations “MR,” unless they were specifically defined as abortions or other procedures by the women themselves. In this thesis I distinguish between MR procedures performed legally, in clinics and health facilities by healthcare workers or trained Family Welfare Visitors, and those performed outside health facilities. The exception to this, specifically requested by research team members from Marie Stopes Bangladesh, were MR procedures performed in health facilities, but outside the legal terms. These so-called “non-regulation menstrual regulations” can include MR procedures performed after the 10-week time limit, by trained practitioners working in clinics, or those performed after hours for a larger fee.
In all areas of reproductive health, researchers are now, more than ever, recognizing the need for gender inclusive language (Zimman 2017), although others have pushed back stating that using words such as “person” or “individual” in many ways erases (cis)women’s fight to be recognized as autonomous beings (Open Letter to MANA 2015). In this thesis I acknowledge that the use of “woman” and “women” refers ultimately to all persons able to get pregnant and seek terminations for those pregnancies. This includes transsexual men, intersexed, or gender-nonconforming individuals. The individuals who participated in my study exclusively identified themselves as women in their narratives, and I have kept the language they used throughout.
Chapter 4. Methods

In this chapter I present an overview of the methods for this thesis; this includes the study design, data collection, and analysis methods, and how they relate to the aims of the overall thesis. I explore my approaches for this particular subject matter and sample population, describe how I set this approach into practice during data collection, and outline my data analysis approach and execution: how data was collected and analyzed for meaningful results. I additionally reflect on my role in the research, and any effect I may have had on the study.

4.1 Study design and methodology

Having identified the experiences of women who have had MR outside health facilities as a gap in the literature, my methodology focused not on capturing incidence or frequency, not the “how many,” but rather the “what” (Walker, 1985, p. 3) of this phenomenon. I took a qualitative phenomenological approach for this study. As it was important to capture women’s experiences from their points of view and in their own words, the methodology or “broad theoretical and philosophical framework” (Brewer, 2000, p. 2) of my methods and procedures was largely interpretive.

I focused on individual interviews with women themselves. I avoided relying on information given to me by healthcare workers, community members, or people otherwise involved in the topic. The women’s lived experiences were necessary to capture in my phenomenological approach the study (Husserl 1931; Mapp 2008), even as reproductive health, including abortion, is shaped by social relations and institutions (Price and Hawkins 2007), and must be examined as such. Letting women recommend future participants and explain situations in their own words increased the probability that the research might be transformed by the women themselves (England 1994).

The qualitative phenomenological study was the most appropriate method to investigate women’s experiences. I chose the women to participate in the study because of this one phenomenon, one “object” of human experience (Van Manen, 1990, p. 163) they had in common: the MR outside a health facility. Because women who have this experience are best placed to tell us about their experiences, the nature of this phenomenon then dictated both my further methodology (using constructivist grounded theory approach) and methods (in-depth interviews).
Moreover, the methodology included my understanding that the world is constructed and can be understood through social actors who engage in activities that make meaning. The nature of my subject therefore dictated the methodology; I wanted to understand women’s experiences and the contexts within which they had their experiences. I used in-depth interviews to uncover experiences and the social conditions surrounding women’s experiences (Crouch and McKenzie 2006).

Leaning on ethnographic methods, I set out to understand the phenomenon women experience: going outside formal providers to access MR. I could not study this phenomenon without some method (Hammersley and Atkinson 1983), and while it would not have been possible to do a formal ethnography (including methods such as observation of practices and interactions) of this topic, reviewing and incorporating ethnographic concepts into my thinking provided a useful guide for an approach that attempted to understand the cultural landscape in which the women lived from their point of view (Teherani et al. 2015). A qualitative approach explores issues holistically and gives space for the lived experiences; the “human” side of a matter (Erlingsson and Brysiewicz 2013). Qualitative researchers attempt to study things in their natural settings, and “attempt to make sense of phenomena in terms of the meanings people bring to them” (Denzin and Lincoln 2005, p.37). Interviews give an authentic insight into people’s experiences (Silverman 2013). I recognize that “authenticity” in this case was a co-construction of knowledge: the data from the women’s recounting of their experiences in interviews and my interpretation of these, limited by what women told me and how I interpreted their words.

Understanding the sociocultural dimensions was particularly important in this case of women seeking MR, where so little research has been conducted. In the case of women seeking MR outside facilities, as Hammersley notes, not only may we “not know why people are doing what they do, we often do not even know what they are doing” (emphasis in original)(Hammersley and Atkinson, 1983, p.7). Ethnography also “describes and measures” (Brewer 2000), but does so using “data” from “natural language” rather than from numbers and figures, relying on long quotations, field notes, and personal documents and observations (Brewer 2000).

Bronfenbrenner’s socioecological model (Bronfenbrenner 1979) and Coast et al.’s (2018)’s framework on abortion-seeking trajectories (Coast et al. 2018) related closely to my methodological approach. It is virtually impossible to hold our knowledge and awareness of
social structures separate from our own beliefs (England 1994); therefore I sought to investigate the entire context within which the participants lived and make decisions.

Collaboration with Marie Stopes International and Marie Stopes Bangladesh

This research was funded by Marie Stopes International (MSI) and conducted in collaboration with Marie Stopes Bangladesh (MSB). Costs covered included all research expenses and a consultancy salary for the author.

To intervene effectively and provide safe services, MSB programs on the ground need insights into the pathways women take to obtain MR services outside health facilities. How women seeking MR obtain information, who they consult and trust to provide this information, how they access services and key touch points, and any other variables influencing their choice of provider and method form vital information for Marie Stopes Bangladesh to provide services effectively. If programs to assist women overcoming barriers to obtaining MR, they must identify and understand such barriers and what kinds of support are needed at each stage of the MR process, including postabortion care. This information will help MSB understand where and how to further engage with women at their preferred contact points and methods.

In a recently published article, Storeng and Palmer (2019) reported on their experiences of conducting an evaluation of a program funded by the UK’s Department for International Development (DFID), in which they reported feeling censored by MSI and another non-profit organization, Ipas. In this section I comment on my own experience, based only on my study, funded and conducted in collaboration with MSI and MSB.

I was hired as a consultant by MSI in the UK by the then-Director of Research, with whom I had discussed wanting to complete a PhD, and looking for an appropriate project and funding. I developed and designed the research in close collaboration with MSI and MSB research and programmatic staff, but ultimately led all aspects of the research. Staffing changes at MSI during the study period meant I was overseen by three different supervisors in two years, who provided varying viewpoints and were supportive of, but not overly involved in, a project they had largely inherited.

While my research team and I had a desk at the local office of MSB, and I regularly discussed findings with staff there, I was not involved either in the service delivery or program side of their work, nor did this influence my study. I had initial conversations with MSB clinic staff, but did not work directly with them or their community health workers in recruiting women. My
study was not an evaluation of their projects or programs, and as such was treated separately from these. While studies collaborating with non-profit organizations on other topics, such as one on microfinance programs (Siwale 2015) where the researcher had to contend with gatekeepers and questions about the intentions behind her research, I was unconnected to anything related to service delivery. Usually MSB conducts exit surveys and collects programmatic data at their facilities, and while women who seek care there could have resulted in frustrations of being “over-researched” (Clark 2008), the population of women I sought was (as far as I was aware) not part of any other regular or related research studies.

Some women we interviewed were aware of us working with MSB, and some knew of MSB while others did not. There are other clinics and government hospitals providing MR in Bangladesh, and we were clear in the interviews that we were asking about “health facilities” overall, and not specifically Marie Stopes facilities. We never had detailed conversations with women about services provided there, although two women did speak of having gone the MSB clinics in the past for contraception.

I had always planned – as was open about this in my conversations with MSI and MSB – to develop this research a thesis, and all involved were aware that this would include more in-depth theoretical pieces in the development and write-up. MSI is currently in the process of publishing a two-page factsheet about the study, which is being written by a consultant hired by MSI. Results and conclusions in this thesis are mine, with no gatekeeping or direction by either MSI or MSB. The current research portfolio manager read the papers included in this thesis before I submitted the thesis, and there are no findings that I have been asked to omit or change.

There were also ways in which this research was influenced by outside forces, such as the legal landscape and local government (Doiron and Asselin 2015) and, in my case, possibly also my funder, MSI. The Bangladeshi government affected my research mainly in its laws: by making MR available yet restricting legal abortions, this government created a grey area of meaning and understanding, in which the terms “MR” and “abortion” are used without taking into account how women themselves define their procedures and experiences. (I further investigate this definition in Chapter 5, Paper 1.)

I felt no particular influence either of other non-profit organizations or by my funder (MSI) in conducting the study. This was largely because, by investigating women’s experiences outside health facilities or formal healthcare providers supported by MSB, I was not directly involved
with their work. I felt no pressure to provide certain results or answers, and, to date, have only ever received positive feedback about my work from both MSI and MSB.

Study setting
I conducted the study in Dhaka Division, which includes the capital city, Dhaka, Bangladesh. On the advice of MSB staff we had initially planned to include additional areas in urban and rural areas of Chittagong, but due to political violence during the first months of the study travel to these areas was unsafe.

The MSB program and clinical staff instead identified two districts, Mirpur and Kaliganj, where anecdotal evidence suggested that many MR procedures were being conducted outside approved health facilities, and that higher than average numbers of women sought care in MSB facilities after attempting MR outside facilities. We first began recruitment in these districts, both accessible as a day trip from Dhaka. Mirpur is an urban district in north-east Dhaka, densely populated with many garment factories that employ female workers; Kaliganj is a predominantly rural area about two hours’ drive north of Dhaka with a largely agricultural population. Due to the intense political violence and frequent strikes in early 2015, we were unable to conduct interviews in more rural areas at the start of the study, or to travel far outside of Dhaka division throughout the study period.

As the study progressed and sampling strategies adapted to include as wide a range of stories as possible, we interviewed women in other areas of Dhaka and the surrounding areas: in Motijeel, a historic urban center in Dhaka, and on Dhaka university campuses, as well as more rural areas in the Narsingdi district further north-west of the city. Data collection in Narsingdi and Kaliganj occurred in small villages within the districts. (See Table 1 for overview and description of the study setting.)
Table 1. Description of study locations

<table>
<thead>
<tr>
<th>Upazila/Thana</th>
<th>Urban/rural</th>
<th>Population</th>
<th>Literacy %</th>
<th>Main source of income</th>
<th>Second source of income</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urban</td>
<td>Rural</td>
<td>Urban</td>
<td>Rural</td>
<td></td>
</tr>
<tr>
<td>Kaliganj</td>
<td>Rural</td>
<td>36,733</td>
<td>215,710</td>
<td>62.0</td>
<td>43.4</td>
</tr>
<tr>
<td>Narsingdi</td>
<td>Rural</td>
<td>17,432</td>
<td>404,243</td>
<td>59.0</td>
<td>36.0</td>
</tr>
<tr>
<td>Mirpur</td>
<td>Urban</td>
<td>27,453</td>
<td>73.73</td>
<td>Service</td>
<td></td>
</tr>
<tr>
<td>Motijeel</td>
<td>Urban</td>
<td>225,999</td>
<td>76.22</td>
<td>Service</td>
<td></td>
</tr>
</tbody>
</table>

Source: (Bangladesh Bureau of Statistics 2007)
(Note: More recent comprehensive data not available)

4.2 Sampling and data collection methods

Sampling strategy

Women who have abortions, or MR procedures, outside health facilities comprise a hidden population who may not disclose their experiences to others (Singh et al. 2010) due to stigma, a negative attribute ascribed to women who seek abortions (Kumar, Hessini and Mitchell 2009). This population often only becomes visible when they enter institutional settings (Watters and Biernacki 1989), in this case for complications after unsafe abortion or for postabortion care.

I used a multi-modal sampling frame, relying on the constant comparative method and theoretical sampling, deciding “what data will be gathered next and where to find them on a basis of provisional theoretical ideas” (Boeije 2002).

The constant comparative method (Glaser and Strauss 1967) served as a theoretical guide to sampling, in which data collection and initial analysis occur simultaneously. Practical steps were taken as the data was collected, and included the following:

1. Comparisons between individual interviews
2. Comparisons between individual interviews and literature/data collected by others
3. Comparisons between participant interviews, key informant and local expert conversations, and observations
4. Comparisons between similar prior interviews and new individual interviews
With this comparative method I attempted to capture different views and stories. I chose the sample to maximize diversity. Women who had MR procedures outside health facilities were difficult to recruit, or even to locate, because of the stigma attached to these procedures. (Singh et al. 2010) As a marginalized group, they were difficult to sample in a systematic way (Faugier and Sargeant 1997), and I used various methods, including personal contacts or contacts with local community members. As Watters and Biernacki stated:

Rigid adherence to conventional procedures simply cannot serve researchers engaged in the study of such populations. However, through an interactive process of adjusting research targets, recruitment methods, and research questions and instruments, inquiry can be focused on the most appropriate subjects for study (1989, p.427).

We aimed to interview women of different ages and from different socioeconomic groups to include as wide as possible a range of experiences. In practice, recruitment was challenging. We attempted (by explaining our needs to key contacts and asking them to help) to find women where there were “gaps” in the demographic spread, such as recruiting women with college degrees, or those who had had prior contact to reproductive health facilities but did not go there to seek MR.

In the field I used progressive focusing, a process by which the qualitative analyst interacts with the data and gradually refines the focus (Parlett and Hamilton 1976). This process suggested that “if early questions are not working, if new issues become apparent, the design is changed” (Stake, 1995, p.22). This ensured flexibility and the possibility of “shifting focus” and “honing in” on the topics at hand, while still having a pre-developed data collection and analysis plan. This also meant adding new questions to the interview guide used and changing, or discarding, those questions that yielded no answers or were poorly received by the participants.

Sample sizes
Determining sample size in qualitative research studies is notoriously difficult; the answer to how to determine the size is most commonly given as “it depends” (Baker and Edwards 2012). Qualitative researchers do not have quantitative researchers’ means of calculating margins of error and confidence intervals, and must rely on subjective evaluations that the information obtained builds a convincing analytical narrative (Bonde 2013). Researchers commonly refer to the concept of saturation as the gold standard of data collection (Guest, Bunce and Johnson 2006); the point at which further data collected reveals no additional insights (Glaser and Strauss 1967), and recent research has focused on different approaches to saturation,
concluding that, as noted above, saturation depends on the research question, theoretical position, and analytic framework adopted (Saunders et al. 2018).

Researchers’ estimates of how many samples are needed to reach saturation – however defined in that particularly setting and study – vary widely. A review of 15 authors’ recommended sample sizes revealed recommendations anywhere from one to 260 interviews as ideal in achieving data saturation (Baker and Edwards 2012). One research team found that after 12 interviews they had created 92% of the total number of codes developed (Guest, Bunce and Johnson 2006). Other researchers state numbers without giving evidence for their estimates, such as 36 for “most ethnographic studies” (Bernard 2013), or 15 for “smaller sample sizes” (Bertaux 1991), or six (Morse 1994) to five to 25 (Creswell 1998) for phenomenological studies, 25 (Creswell 1998) to 35 (Morse 1994) for grounded theory studies, or 100–200 “units of the item studied” in qualitative ethnography (Morse 1994). Yet other researchers state the interview number needed depends on the degree of competence for the inquiry in question (Romney, Weller and Batchelder 1986) or that different numbers are needed for different study goals and with respect to theoretical grounds of the study for which the research strategy is chosen (Crouch and McKenzie 2006) – such as authors who state that 6–12 interviews are needed for homogeneity or 12–20 when looking for disconfirming evidence or maximum variation (Kuzel 1992).

Theoretical variation aside, waiting to reach saturation in the field is often not an option due to financial and time constraints; researchers must generally indicate an estimate of number of interviews or focus groups to budget and plan for before they start data collection (Guest, Bunce and Johnson 2006).

My views remain somewhat unresolved regarding saturation, but balanced with realism: balancing knowledge that data collection must stop at some point with the knowledge that it is impossible to know whether true saturation has been reached. I remain unconvinced of the concept of “saturation” as this assumes a level of finiteness in relation to an experience or topic studied – that there comes a point where no new data could exist, and “all” data has been collected.

As I set out to discover the “‘what’ rather than the ‘how many’” (Walker, 1985, p.3) I explored women’s experiences, not testing a hypothesis or providing a theory. During my extended stay in Bangladesh I came to realize that some topics – such as the extent to which women were limited in their ability to move freely in public – were “rarely more than hinted at in the
respondents’ accounts” (Crouch and McKenzie 2006, p.490) and I was only able to fully explore and understand further through conversations with others outside the formal interviews conducted.

Hence, I based my sample size on a number of elements, including theoretical and practical considerations. After reviewing suggestions from the literature, I had initially planned to do 20–25 interviews for both a rural and urban area – up to 50 interviews in total. This number seemed ambitious but achievable, and I hypothesized it would yield sufficient data points to allow exploration of the subject. This falls squarely within what phenomenological researcher Polkinghorne recommends: to interview two – twenty-five individuals with the same experience (1989). Based on prior studies, my assumption here was that – for this particular phenomenon – the experiences between rural and urban women could differ significantly (NIPORT et al. 2016).

While I developed theories from the data collected, because I do not speak Bengali and the delays that occurred during translation, I was not able to fully review all collected data before conducting the next interview. I was therefore unable to know in real time when no, or few, new concepts were being discovered (Glaser and Strauss 1967). The final sample does, however, have what Becker calls “enough interviews to say what you think is true and not to say things you don’t have that number for” (Becker, in Baker and Edwards, 2012, p.15).

**Sampling procedures**

I used a qualitative study design, conducting in-depth interviews with Bangladeshi women who had had MR procedures outside health facilities. This data was supplemented by conversations with key informants, stakeholders, and community members, and by my observations of formal and informal facilities.

Once the research team was assembled, we began by conducting formative interviews with local experts, including MSB headquarters and clinic staff, local reproductive health experts, and community members who had worked or were working with women in the community. Sometimes key informants in the community became “quasi-research assistants.” They helped us to understand the situation on the ground while directing us toward women and experiences they believed we should be capturing.

We accessed some women via more traditional snowball sampling, where women already participating in the study recommended peers or acquaintances. Snowball sampling, however,
is a strategy that relies on, and assumes, links between initial subjects and other members of the population (Berg 1988; Atkinson and Flint 2001), and excludes those people or participants to whom no link exists in an already known population (Browne 2005). In many cases of women seeking MR outside approved health facilities this sampling method proved unsuitable: women do not comprise a collective, do not openly share experiences with each other, and cannot easily recommend other women who have had the same experience.

Community health workers, who themselves provide no MR services, were invaluable in the data collection process; we worked closely with one health worker in the peri-urban area. We discovered she had not obtained her knowledge of women’s MR outside health facilities due to women seeking specific MR-related advice from her, but rather, women shared these experiences with her when they became pregnant or gave birth and sought her care, at that point sharing their MR experiences. She had also been a member of the community for decades and appeared to be especially well-liked and trusted by women in the community.

Informal conversations with community members, friends, and acquaintances were crucial throughout the data collection process. In a handful of cases, research assistants interviewed people they knew in their personal lives, who, after learning what the research assistant was working on, revealed that they themselves had received MRs outside health facilities. In one instance, an acquaintance told her husband about our project one evening, and he suggested she talk to a friend of his: a well-off university student who had received an MR outside an approved health facility. We would have never been able to speak to her were it not for his vouching for us. Using such connections, we were also able to sample women with very different stories (such as middle-class university students), which added new insights and nuances to our data. After numerous prior conversations, it took around three months of developing trust and contacts before the first formal interview was conducted.

Women were reimbursed 200Tk ($2.50) as a compensation for wage loss, an amount advised by staff at MSB to be approximately equal to 1.5 hours of minimum wages for garment workers at the time of the study. Participants were additionally also offered tea and snacks wherever possible.

4.3 Research team
I recruited research assistants with the support of Marie Stopes Bangladesh staff, who advertised the positions and recommended women they had worked with in the past. I hired
three research assistants throughout the project period; two at the start and one later, to replace one who left to return to her home village. All three research assistants were young women who had recently completed, or were just completing, social science university degrees, and who had at least some experience in conducting qualitative research.

Of the research assistants I worked most closely with Arunima Islam, who had extensive experience conducting qualitative, community-based research, and led much of the recruitment and data collection. She proved to be invaluable to the study, particularly in her skill talking to community members and providing contextual information throughout the study. She had completed both an undergraduate and graduate degree in Anthropology and spoke English fluently. I learned during our initial interview and later through our many informal conversations that she came from a liberal and progressive family, and she had a keen interest in feminism and women’s roles in Bangladesh. Arunima was interested in the topic and research and, as such, was an ideal ally and partner to work on with this study. From the outset of the study she offered critique and appraisals not only the process, but also giving input into the procedures and ethical aspects of the project. She knew, for example, that conservative women, who infrequently left their homes, would prefer gifts of fruits or vegetables over the 200 Taka compensation we gave others, and arranged to bring them when she conducted the interview.

I realized that the educated research assistants I hired, who spoke English, would be seen as “other” (to the study’s participants) in many ways through class privilege (Lal 1996). By hiring anthropology students interested in these topics, I wanted to avert some of the issues arising from their bias and that of the participants.

While, ideally, my local team allowed me to bridge some of the cultural gap, by hiring educated, English-speaking women differences nevertheless existed between the cultures, not only “between the west and non-West, but within these geographies and temporalities as well” (emphasis in original) (Parashar 2016, p.371). Arunima, who helped to coordinate much of the research, was from an upper-middle-class family and a long line of editors, teachers and philosophers, making her upbringing and situation markedly different from many of the women we interviewed.

**Research assistant training**

I conducted five days of training with the research assistants. In addition to covering the topics of the study, we addressed skills such as rapport-building, conducting interviews with empathy and non-judgment, adapting to different personalities and emotional states where necessary to
prepare for different participants, asking open-ended questions, and using non-leading probe questions to broaden the discussion. We also included exercises from the Values Clarification and Attitude Transformation Toolkit (VCAT), designed to let participants explore their own views of abortions and how this could affect their actions.

As part of my training, I included exercises from values clarification workshop materials developed by Ipas in 2008 (Turner and Chapman Page 2008). Values clarification is a concept whereby participants are given the opportunity to examine their moral reasoning and values (Rokeach 1973). Turner and Page's VCAT (2008) and other evidence suggests that using this toolkit results in improved knowledge, attitudes, and behavioral intentions related to abortion care (Eckersberger, Fetters and Powell 2017; Turner et al. 2018). I conducted selected VCAT exercises during my training sessions, which led to longer discussions about stigma in Bangladesh, and how attitudes and stigma during the study could harm women and affect the study. As in the studies cited above, these exercises were designed to give the research assistants the opportunity to examine and evaluate their own feelings towards the topic of abortions, and MR.

Additionally, I checked in with the research assistants daily during the data collection process to address any issues that arose as we reviewed data. During these conversations we covered not only the interviews they had conducted, but also noted whether there had been any issues with the logistics of data collection, or if any part of the data collection activities was proving challenging.

4.4 Data Collection
The research team conducted interviews between May and September 2015. All interviews were conducted in person by the research assistants. One participant was interviewed both formally and informally (in a later conversation), and all other participants were interviewed only once. Throughout the process we remained aware that interviewers should use in-depth interviewing to explore, not to interrogate (Charmaz 1991).

All but one interview was conducted in Bengali by a research assistant. This allowed conversation to flow without interruption, even though it also meant the data review could only be done after the interview's completion. Our experience during data collection proved our assumptions about non-Bengali interruptions or interjections was correct, as there were a handful of interviews where I interrupted in English with either logistic questions or
clarifications, and nearly all of the interruptions significantly affected the conversation taking place and interrupted the flow of the topic discussed.

Most interviews took place in women’s homes, or in the home of the woman who had recommended her. In the rural area, the remaining interviews took place in the small back room of a local community clinic, which provided reproductive health services but not MR. For Bangladeshi women, many of whom do not go outside in public often or freely, this location turned out to be a safe space they could go without attracting unwanted attention, as they had visited it before for their children’s and their own healthcare. They sometimes brought their children to these interviews, too. The community health worker in charge of the clinic was interested in and supportive of our work, and was happy to provide us the use of a room in the clinic.

I was present for the interviews unless asked specifically by the research assistants not to attend and was ultimately present for 27 of the 43 interviews included in this study. This participation allowed me not only to take notes about the setting and where possible the tone of the interview, but also to attend to other logistical details such as carrying tea, buying snacks, or entertaining the participant’s small children if they had come along to the interview.

4.4.1 Inclusion and exclusion criteria

Inclusion criteria

Any woman who had had an MR procedure outside a health facility and wanted to talk to us about her experience was included in the study. Reasons for the procedure were not part of the inclusion criteria.

The following inclusion criteria were applied:

- Women aged 16–49 years
- Had had an MR procedure outside an approved health facility
- Willing to talk about their experiences, and choice of methods and provider

We had initially planned to give preference to women who had sought the procedure in the five years prior to the study (2009–2014), to capture the current picture most clearly and include recent developments such as the provision of misoprostol or the misoprostol and mifepristone combination. During data collection, however, this plan proved unrealistic as women only spoke
about their procedures during the interview, not during recruitment and we discarded this
criterion.

Non-participation/Exclusion criteria
No women were excluded from the data collection procedures during the sampling and
recruitment. In accordance with our sampling strategies we instead monitored content and
themes throughout the study and adapted our recruitment strategy to include as much diversity
in our sample population as possible.

We excluded two fully conducted interviews after the fact as these women had been referred to
the study in error; they had had their MR in a formal health facility.

4.4.2 Data collection methods

Interview process
Interview location, duration, and who was to present during the interview were agreed upon
with the participants. We did not encounter any conflict between the women's individual wishes
and what the research team could accomplish, and we were able to accommodate participants’
needs.

Women were generally interviewed alone. In some cases, however, they were joined by the
person who had recommended them to the study, their children, and in one case, a husband for
the final 15 minutes of the interview.

Interviews
The interviews gave women the opportunity to discuss their lives and choices without
prescribed boundaries or set questions, and allowed for their tangents and explanations. They
also gave me the opportunity to include not only topics the literature suggested, but stories the
women told about their lives and the things that mattered to them, which gave us a more
nuanced understanding of the issues (Creswell 1998). A qualitative approach allowed us to try
and understand women in their worlds, “attempting to make sense of, or interpret, phenomena
in terms of the meanings people bring to them” (Denzin and Lincoln 2005, p.2). Individual in-
depth interviews in a place of their choosing also provided as safe a space as possible, due to the
sensitive nature of the inquiry and my desire to hear individual stories that the tellers might
have difficult feelings in recounting. We found that women were, without exception, always
interested in us and our subject matter across socioeconomic status, geographic location, and
where we (or I) met them. Sometimes, per Bernard, all it took was to get people on to a topic of
We had loose guidelines for these interviews. At first more structured, the conversations loosened as they progressed, depending on the person currently speaking and including topics related to their life, work, community, but also anything else the women wanted to speak about in relation to their MRs.

**Interview guide**
The interviews the team conducted with participants investigated how perceptions of MR, community views, and relationships affected their choice of methods and providers, and what barriers women faced to accessing legal, safe procedures.

I developed the interview questions from the literature, with input from experienced researchers at the London School of Hygiene & Tropical Medicine (LSHTM) including my supervisor, Cicely Marston, and researchers from Marie Stopes: Kate Reiss, Sadid Nuremowla, and Pronab Chowdhury. Once I arrived in Bangladesh, I received extensive feedback from local staff, both researchers and clinical professionals, as well as from the research assistants during training. I incorporated the local knowledge and views they provided into the final interview guide which was around broad topics to allow flexibility and to “create a balance between asking significant questions and forcing responses” (Charmaz 2006, p.32). We peer-tested the guide as extensively as possible, including role-playing within the team, and asking MSB staff outside the study team to review final versions.

I developed the interview guide in English; then a member of the research team at MSB (Dr Pronab Chowdhury, Monitoring and Evaluation Specialist) unrelated to my study translated it to Bengali, and my research assistant subsequently back-translated the final draft to check for validity. In line with our sampling and data collection and analysis plan. We also adapted the interview guide as the study progressed to conform to our sampling, data collection, and analysis plan. In practice, this meant addressing topics identified throughout data collection, such as how women themselves defined their MR procedures, or (attempting to delve deeper into how knowledge is acquired) why the beginnings of marriages are particularly difficult for women in Bangladesh.

**Conversations and observation**
I supplemented the data from interviews with conversations and observations in Bangladesh. We conducted informal interviews, sometimes in English and sometimes in Bengali,
with 24 key stakeholders, informants, and community members. This included, but was not limited to, MSB research and clinical staff, nurses, doctors, paramedics and administrators at clinics, community health workers in urban and rural communities, pharmacists in urban and rural areas, and community members in all communities in which we conducted interviews. We would start by interviewing one person, then ask them at the end of the interview if they knew of anyone else we should talk to, or who might be willing to talk to us. This process simultaneously set key informants up as gatekeepers and connectors, and granted us access to women we may not have spoken to otherwise. These turned out not to be formal key informant interviews and were therefore not included in the data analysis itself, but used to ensure that the meanings I drew were a "valid understanding of the sociocultural contexts, processes, and meaning systems that are of significance to the study population" (Whitehead, 2005, p.5).

I spent 18 months living full-time in Bangladesh while conducting this study and working as a consultant. I was able to observe life in Bangladesh and to some extent become accustomed to local life, make local friends, and get to know local communities. I remained an outsider within the communities where I conducted interviews, but through this extended stay I was better able to understand the context of the data gathered. I visited and used government institutions, waited in lines for hours to receive services, was condescended to by men, and navigated bureaucracy in the ways women described during their interviews. It became clear as the interviews progressed that many of the barriers women faced were sociocultural and structural; this insight caused me to reconsider what I was seeing and the interactions I had in day-to-day life. Such quotidian observations then gave me the opportunity to discover Bangladesh, unobtrusively and in my own time. These interactions also allowed me to identify causality in a different way by understanding "how things work" first-hand in Bangladeshi society (Dey 2007).

**Field notes**

I kept a journal throughout this time, noting processes of interactions and my reactions, thereby increasing self-awareness of events and interactions (Koch 2006). I made extensive notes and wrote about my general life and experiences, and my observations of Dhaka. Memoing outside the formal study gave me space to incorporate daily life into the study, and use my personal observations in the research. For example, when going to the market left me exhausted and frustrated at having attracted so much attention, I explored my own feelings of being a woman in Dhaka’s public space. While this remains a particular experience of a Caucasian European woman in Dhaka, writing about experiences like that in the moment, when my emotions were most vivid, enabled me to connect with participants stories of being unable to move unwatched.
in their own communities, as women reported in the interviews.

Once I returned to the United States I discovered an additional source of rich data; emails I had sent home to friends and family. These primarily contained anecdotes expressed either humorously or with frustration, both of a different substance than the notes in my journal notes of Bangladesh. These emails also later served as vivid reminders of my feelings, moods, and attitudes towards what I was experiencing.

Memoing

In addition to the field notes I took throughout the interview process, I conducted formal memoing. I composed memos as soon as possible after the interviews. Memoing allowed me to capture any contextual cues I may otherwise have forgotten, as well as review what had been discussed. These further captured any tacit knowledge: “the largely unarticulated, contextual understanding that is often manifested in nods, silences, humor, and naughty nuances” (Altheide and Johnson 1994, p.492-93). Dhaka’s notorious traffic was an unexpected boon in this regard, because the hours long commutes and drives gave me a chance to discuss the preceding interview in detail with a research assistant immediately after its conclusion. If I was not personally present at the interview, we discussed this as soon as possible, generally within 24 hours. The research assistants went over any notes they had taken during the interview, and informed me about the interview: the general story, what MR methods the women had used, what the environment and tone of the interview had been like, whether someone else had been there. These reviews included personal notes as well.

Notes taken during the interview also allowed me to consider the location, context, who was attended, and anything noteworthy that might happen during the interviews (for example, interruptions). The research assistant was then free to focus on the interview participant and on spoken words, only very occasionally taking notes herself, or turning to me if something noteworthy happened that she thought I should know in that moment. This latter occurred very rarely.

4.4.3 Data collection recording

All but two interviews were recorded. In both cases of unrecorded interviews, women consented to be included in the study and to participate in the interviews, but wanted not to be audio-recorded. In these cases, extensive field notes were taken by the research assistant in situ, typed up within 24 hours of the interview, and discussed with me at length (after I read the field
notes) to ask about anything of interest.

If present, I took notes to capture the context and tone of the interview. I took photographs of the surroundings when appropriate (never of participants). When I was not present, I gave the research assistants a camera to capture the context and surroundings for me.

4.4.4 Data management
All participants were assigned numbers through which they were identified. Physical copies of consent forms were stored in locked files at my desk at the MSB offices, and digital copies of interview transcripts remain in password protected computer files.

I used nVivo and the note taking program Evernote extensively throughout the study to capture and organize data. Notes related directly to data were made in nVivo during the coding and analysis of the data.

4.4.5 Translation of interviews
Translating the interviews turned out to be a surprisingly difficult undertaking; even in hindsight I cannot fully explain some of the difficulties we encountered. My background was beneficial throughout this process. I am Austrian and grew up speaking English and German, later Spanish. While I have worked predominantly in English speaking environments, German remains my mother-tongue. As a result from the outset of the study, I easily distinguished between differences in words, contexts, and connotations as I translated between three languages. This experience lent an inherent awareness of the difficulty in translating concepts and ideas between cultures and languages, which could only strengthen the research. It also made me aware of my dependence on the research team for content of the interviews.

At the start of the study, I hired an experienced translation company recommended by MSB. Early interviews were translated as soon as possible after the interviews, but in reviewing these with the research team, we found numerous errors, including entire passages untranslated. After several reviews and equally incorrect additions, we decided to find new translators. On the recommendation of an anthropologist, I hired three university students who were fluent in English. They provided far superior translations, yet in reviewing the completed translations we discovered that they had missed words and sentences as well, and one had, again, left out large portions of recorded material. With Arunima’s help, I reviewed nearly all of the translations,
word for word and sentence by sentence, until we were satisfied the captured data was accurate as possible.

Achieving “conceptual equivalence”—the idea that both original language and culture, and translation have the same content and technical meaning (Flaherty et al. 1988; Wang, Lee and Fetzer 2006; Lee et al. 2009) — proved challenging. We discovered that different concepts were used and defined differently by different populations. While the Bangladeshi government defines MR legally as a procedure within specific parameters and as being separate from abortion, the women we interviewed saw it as analogous to termination of pregnancy, i.e. an abortion. Women also used the abbreviation "MR" to describe a particular method with which the pregnancy is terminated: manual vacuum aspiration (MVA).

Translators frequently erred in translating both words and contexts, substituting the correct English word for the content instead of using the direct translation. For example, they might substitute the English word "abortion" for when participants were using the phonetic English letters 'M' and 'R' (ɛm ær'). As a result, we found that when translators conflated the literal meaning with how the word relates conceptually in the context (Gee 2012), the result was poor and incorrect translations.

Verbatim translation was therefore necessary in the first round. The best example of verbatim translation appeared with the concepts of abortion and MR. Participants used the word “noshto” (Bengali: “to spoil”) to describe their pregnancy, which was translated to its conceptual meaning; “abortion”. In their translations "noshto hoise" became "I aborted it," when women were literally saying "I spoiled it," using the same word they would use for spoiled meat or rotten vegetables.

Nevertheless, the data we collected was stronger for these struggles, however time-consuming and frustrating they were at the time. Through the translation process, I learned exactly how women individually described their experiences and discussed their MR procedures. I also appreciated the opportunity to talk through every translation in depth with a native speaker familiar with the project. By the conclusion, I had grown intimately familiar with nearly every word of every interview we conducted.
4.5 Participant characteristics

I included 43 formal participant interviews in the analysis, and innumerable informal conversations and observations. Table 2 presents the participant pseudonym (i.e., numbers) and their characteristics and demographic information. The team and I attempted to sample for diversity, including women from different areas and socioeconomic backgrounds, as well as married and unmarried women. We also included more women from rural than urban areas, in keeping with the hypothesis that rural women are more likely to attempt informal MR (NIPORT et al. 2016).
<table>
<thead>
<tr>
<th>No.</th>
<th>Location</th>
<th>Marital status</th>
<th>Age</th>
<th>Living children</th>
<th>Occupation</th>
<th>Education</th>
<th>Method (primary)</th>
<th>Method (additional)</th>
</tr>
</thead>
<tbody>
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<td>1</td>
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<td>33</td>
<td>3</td>
<td>Housewife, previously in garments</td>
<td>Primary</td>
<td>Medication from pharmacy</td>
<td>Additional medication from pharmacy</td>
</tr>
<tr>
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<td>25</td>
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<td>Medication from pharmacy</td>
<td>Informal MVA</td>
</tr>
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<td>45</td>
<td>3</td>
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<td>Government hospital, method unclear</td>
</tr>
<tr>
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</tr>
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<td>Primary</td>
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</tr>
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<td>Religious</td>
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<td>Medication from informal provider</td>
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<td>Age</td>
<td>Parity</td>
<td>Occupation</td>
<td>Education</td>
<td>Medication From</td>
<td>Method</td>
</tr>
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<td>DNC in government hospital</td>
</tr>
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<td>Informal provider &quot;washed uterus&quot;</td>
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68
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<td></td>
<td>(never worked)</td>
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<td></td>
<td></td>
<td>(garden, animals)</td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(never worked)</td>
<td></td>
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</tr>
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<td>Medication from clinic</td>
</tr>
<tr>
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</tr>
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<td>29</td>
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<td>--</td>
<td>Informal MVA</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
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<td>33</td>
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</tr>
<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>23</td>
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<td>Occupation</td>
<td>Education</td>
<td>Provider of Medication</td>
<td>Provider of Treatment</td>
</tr>
<tr>
<td>-----</td>
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<td>4</td>
<td>Housewife and domestic animals, previously in a factory</td>
<td>--</td>
<td>Informal MVA</td>
<td>Medication from informal provider</td>
</tr>
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</tr>
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<td>2</td>
<td>Factory</td>
<td>--</td>
<td>Root inserted into uterus</td>
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<td>Rural</td>
<td>Married</td>
<td>35</td>
<td>3</td>
<td>Housewife</td>
<td>--</td>
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<td></td>
</tr>
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<td>MVA from informal provider</td>
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<td>Education</td>
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<td>Method of pregnancy control</td>
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<td>Tertiary (at time of study)</td>
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<td></td>
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<tr>
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<td>41</td>
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<tr>
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<td>5</td>
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<td>Primary (incomplete)</td>
<td>Homeopathic medicine</td>
<td>Root inserted into uterus</td>
</tr>
</tbody>
</table>

*: missing data
4.6 Data Analysis

4.6.1 Theoretical framework for data analysis

I took a constructivist grounded theory approach to analysis (Charmaz 2006) and used iterative thematic coding (Hammersley and Atkinson 1983) to identify themes and categories, and constructed themes and results from the data. Grounded theory approaches involved letting a positivist "truth" arise from the data (Glaser 1978), yet I was fully involved in the generation of the results presented here, based on what women told us about their worlds. The data analysis, like the data collection, was colored by my 18 months in Bangladesh, which led to richer data, and a deeper understanding of the concepts and themes developed through the formal analysis process. Throughout, I remained aware I was actively naming data (Charmaz 2006) and remained a part of the process as researcher.

I particularly appreciated Miller and Crabtree's thoughts on positioning the researcher within the reading of texts and analyses (1999). They suggest considering how the researcher is positioned within the analysis as a three-step approach:

1. Literally
   - Letting the text lead. The literal context and form of the text. In my case this meant following what women were telling me: where did they go, who did they trust, how were they describing their feelings about their decisions and experiences?

2. Reflexively
   - The researcher leads and considers her own orientation. This meant considering whether I was being empathetic or judgmental, or whether I could understand their decisions, or identify with their choices in any way.

3. Interpretively
   - An interpretation of text in its context, both literally and regarding the researcher. This meant constructing an interpretation of the text while recognizing my role in constructing it.

Using this active separation allowed me to consider how much of the final analysis could be affected by my own thoughts layered atop the actual text and how that colored my interpretation. As data analysis was conducted iteratively the selection of data for results and organization of data was not fully decided a priori. Letting the data lead, I identified four foci from the data, which also answered our research question as to women's pathways and experiences. These four foci are presented in this thesis as papers in Chapters 5-8.
4.6.2 Coding

Coding in grounded theory practice, both the classic and the constructionist approaches, is a continuous multi-layered and multi-step process. "Coding is analysis" (Miles and Huberman, 1994, p.56) Coding takes apart the different segments of data, gives them names in concise terms, and analytically develops abstract ideas for interpreting each segment of data (Charmaz 2006). This process was not linear; it involved contextualizing my thoughts and findings, and circling back to previous ideas and the data. As an iterative process the coding meant, for example, that I took questions and comments from my supervisor back to the data, then back to the research assistants and translators to make sure I was interpreting it correctly in the local context, before discussing it again with my supervisor. It was again important to know that I, as researcher, was at the center of the data analysis and the one determining and naming the codes. I identified concepts and theories from the data, and actively named the codes (Charmaz 2006).

I used the following definitions and steps for the coding process:

1. Initial coding
   a. Initial coding stuck close to the data. How many or how few codes are given depends on the data, pre-determining word-by-word or line-by-line coding can lead to a micro-approach Glaser called “over-conceptualization,”(1992) losing concept in the minutiae of data (Allan 2003).
   b. This step included:
      i. A priori codes
         • Codes developed prior to data collection and established in the interview guide.
      ii. Emergent codes
         • Codes based on ideas and themes identified in the data as we collected it. These ideas we may not have thought of before and not directly included in our interview guide.
   c. Initial codes were sometimes clearer and sometimes simply inklings—things noted and referred to that piqued my own, or the research team’s interest, without rhyme, reason, or hierarchy.

2. Focused coding
   a. The next step was focused coding, where initial codes are sorted, synthesized, integrated, and organized into more conceptual categories (Charmaz 2006).
Glaser notes that compared to the initial coding, this stage of the analysis is more directed, selective, and conceptual (Glaser, 1978). In this step, especially, the researcher moves to actively "acting upon the data rather than passively read them" (Charmaz 2006, p.59). This gives the researcher the opportunity to take the text and initial codes, and reassemble them in new ways for their data (Creswell 1998).

b. During this time there were many conversations with my research assistants and local Bangladeshi colleagues and friends. This ensured my interpretations made sense in the local context, and I, as a foreigner, was not interpreting things in a way that was inaccurate or made no sense to them.

3. Axial coding
   a. Axial coding was an important third stage to both further define categories, their properties, and dimensions (Charmaz 2006), as well as developing relationships between various codes and themes.
   b. At this point the organization of the data into chapters was loosely formed, where it became clearer which concepts and themes were related, and formed an interesting and conceptually clear narrative.

Throughout the process, I frequently checked in with those involved in the study such as my research team, other MSB staff, MSI and LSHTM researchers, and my co-investigators. They were able to help me refine codes and ensure validity not only locally, but also across wider concepts important to reproductive health.

4.6.3 Theory generation

I followed Strauss and Corbin's definition of theories: "a set of well-developed concepts related through statements of relationship, which together constitute an integrated framework that can be used to explain or predict phenomena" (1998, p.22). Charmaz favors what she calls an "alternative definition" of theory, "emphasizing understanding rather than explanation" (italics original) (2006, p.132). In this study I was not only intended to develop academic theories, but also to firmly ground the research in narratives about real-life experiences and possible real-world solutions that could be turned into practice. Because it needed to be placed in the larger context of reproductive and sexual health service provision, the study required a broader explanation of women's situations and actions, well beyond a simple understanding of what was
occurring in time and space. I was aware of this as a balancing act, for which clear guidelines were not readily available.

Theorizing for this study occurred at individual, community, and societal levels, considering the “why,” not simply the “what and how” (Gubrium and Holstein 1997). Something is legal or illegal, because of, or regardless of, how it is viewed in one way or another by the community. Further, the individual must navigate and negotiate community and societal spheres as well as her own. It was important to consider here how stigma, local notions, and the larger society “exchanged” ideas back and forth and influenced each other (e.g., women have secret abortions because they are aware that their society judges abortions harshly). The concept of menstrual regulation was particularly interesting to theorize because little had been done on this subject. I was able to use the data gathered to refine my understanding and investigate meaning (Schutt 2002).

4.6.4 Using frameworks in data analysis

While I did not use Coast et al.’s (2018) framework for studying trajectories to obtaining abortion-related care to conduct my analysis, relying instead on the grounded theory approach described above, I did use it to organize the writing after identifying initial themes.

Linking my results to Coast et al.’s (2018) framework domains allowed me to contextualize the data in terms of existing literature, and helped me to understand my findings in the larger context of abortion care-seeking. In this way I was able to line up my data with themes identified in previous studies and, where there might be differences, point to elements demonstrating the experiences of women in my study as different from those in other areas and studies. I could also identify elements I missed during my data collection and analysis this way.

4.7 Ethical considerations

The study received ethical approval from the London School of Hygiene & Tropical Medicine ethics committee, the Marie Stopes International Ethical Review Committee, and the Bangladeshi Medical Review Committee (BMRC). (Ethical approvals are attached in Appendix F.) The following concepts were considered throughout data collection and analysis.
Consent

Consent was obtained at multiple stages throughout sampling, recruiting, and data collection. Throughout the recruitment process, consent was passed down through the chain of people who recommended women to participate. The research team never directly contacted women themselves, instead asked the person who recommended the woman to either arrange a time and place convenient for her, or passed along a research assistant’s phone number for her to call to arrange a meeting.

At the time of the interview, we gave women information and consent forms, either letting them read the forms and ask questions, or in case they were illiterate reading the forms to them (See Appendix B-E). In discussion with the local research team and MSB staff, it was initially decided to either let women sign the consent form, or give verbal consent, with a witness rather than asking for thumb prints, as these are used for government business and affairs and we feared this would make women hesitant to agree to participate. We found, however, that all women were comfortable signing the consent form, even those who did not want to have the interview recorded. Participants knew that the research assistants and principal investigator (EE) worked for Marie Stopes, and that we were conducting these interviews to improve services for the women. They were therefore fully aware of the study goals.

Confidentiality

We stressed confidentiality throughout every part of the contact with community members, key informants, and women interviewed. Training given to research assistants, and each person involved in any part of the study and recruitment, included information on confidentiality and the necessity to preserve it at all stages.

At the start of every interview we asked women if they knew why they were meeting with us, to ensure they had been given the correct information by the contact who had recommended them, and to clarify that they had agreed to speak about menstrual regulation. All women in the study were able to answer this correctly, and none who met with us were unaware.

The study team took care to ensure that women’s privacy was respected. In most cases the location of the interview ensured sufficient privacy, although in one case an interview was temporarily halted because the woman thought she recognized someone walking by outside the open window and did not want to be overheard.
Safe consent form and information sheet

Because the study concerned a very sensitive topic, which could result in the participant being stigmatized if her participation was discovered, it was important for the research team to ensure that their participation was kept confidential and could not be accidentally discovered by members of her community. Women were informed of all aspects of the study, and were given to read, or had read to them, the full information and consent forms. However, they were given a “safe” version of the two forms to take away with them if they chose. This “safe” version only referred to “women’s health” rather than “menstrual regulation,” so that no one could connect the woman to the study or procedure. This design did not affect the information provided to the woman herself, only the written materials she took away with her.

Documentation

Subjects were referred to through their assigned numbers only, and any document that could lead back to a woman’s identity (consent form or audio recording) was kept in a secure, locked cabinet accessible only to myself as lead researcher of the study, and to be destroyed once the study was completed.

Any other potentially identifying information was removed before publication of any quotations from the interviews, and the recordings and transcripts will be kept in secure, password-protected files. They will be archived only for the length of time necessary to ensure any queries about the work can be answered (usually a maximum of seven years after publication). The files will be archived on a secure server at the London School of Hygiene & Tropical Medicine.

Research team safety

I was given security training by Marie Stopes International, and included aspects of this in the training sessions with the research assistants. During the time of the study, there was an increase in political violence in Bangladesh and strikes just preceded and carried over into the first months of data collection. This made movement in public difficult. During those days, no interviews were conducted. The research team stayed in our homes, as did the remaining population of Dhaka.

Members of the study team always travelled in pairs. They were given credit for their mobile phones, emergency cash to carry, and instructed to call either me or the MSB security contact if they ever felt unsafe in any data collection situation. Fortunately, this did not occur. I also travelled with another member of staff, not alone.
**Physical risks**

There were no physical risks for participants directly as a result of participating in this study. There was, however, the risk of being discovered by someone (a husband, family or community member) and facing retribution if that person disagreed with their participation.

There was a risk of emotional upset because of the topic, and we provided referrals to local services and our own contact details in the event participants wanted to discuss any issues further after the interview.

We provided two referrals for women to local Marie Stopes services in the urban area around Gazipur, one for a woman who spoke about continuing pains after her informal MR, and another who wanted more information about contraceptive methods.

**Sensitivity of subject matter**

Research assistants were trained in sensitive interviewing techniques and to ensure participant well being at all times. As noted above, we did a number of VCAT exercises (Turner and Chapman Page 2008) during the training to talk in more depth about the interviewer's own attitudes and beliefs about MR. The research assistants were supportive of the issue and in favor of improving women's access to health care and their lives generally.

Interviewing women on abortions and MR involves asking them about sensitive and potentially upsetting topics. What constitutes a “sensitive” topic depends on both context and cultural norms and values (McCosker, Barnard and Gerber 2001); commonly, however, it contains concepts related to private, stressful, sacred topics, such as sexuality or death, issues that may cause stigmatization or fear, or those related to potential political threats or social conflict (Lee 1993). MR and abortion are both related to sexuality and are often stigmatized (Kumar, Hessini and Mitchell 2009); as such they can be considered sensitive subjects. Subjects may be sensitive for either or both participants or researchers, and have the potential to cause physical, emotional, or psychological distress (Cowles 1988; Sieber and Stanley 1988; Elmir et al. 2011).

To assure that women were interviewed respectfully and sensitively, we discussed the topic of sensitive researching at length and reviewed possible ways this process could be made easier for them, such as assuring them of confidentiality where necessary, acknowledging (not dismissing) emotions they might experience during the interviews, or speak about having had experienced. We spoke about building rapport, and discussed topics that women might be more comfortable speaking about in the Bangladeshi context, such as their children or home villages.
Duty of care

Participants were given the contact information for local Marie Stopes Bangladesh or government clinics if they had any medical questions or concerns relating to the subject matter.

I was aware that some aspects discussed in the interviews (such as sexual or domestic violence) might be difficult for the research assistants to discuss. The team prepared accordingly by discussing possible issues and reactions in advance. The research assistants were also given the opportunity to discuss and digest these issues afterwards during formal memoing sessions with me. There was one instance in which one of the research assistants was troubled by details a participant revealed in an interview. Afterward, she and I spoke at length. She cleared her thoughts, and we spoke about how we were doing this work in hopes of improving the lives of women. I gave her the option of taking the following day off on paid leave, which she declined. I also discussed any personal issues arising from the research or any logistic aspects with my supervisor, who once referred me to another researcher when I was upset by an issue she did not feel she could adequately address. My colleague Kate Reiss had previously conducted several studies in Bangladesh and was a great resource on topics that I identified throughout the study.

Interviewing friends and colleagues

As part the snowballing sampling used to recruit participants, the team interviewed a small number of friends, either mine or those of the research assistants, including one I interviewed in English.

Interviewing people can be ethically difficult, especially when discussing a topic as sensitive as abortion and MR. In all but one case (where a research assistant's husband recommended someone who might be interested and that person turned out to be a mutual friend of the couple) all known interviewees came forward on their own accord after hearing a member of the team talking about the work informally (not for recruitment purposes but in conversation). This means we would not have known about their experiences, the status quo would have been maintained if they had not volunteered the information, and it was unlikely they felt any kind of pressure to participate. As we were not working with a formal program and were ourselves unaligned with health professionals, we could avoid participant’s expectations to address any problems or solve issues, as other clinical researchers have found (McConnell-Henry et al. 2010) and there were no “two hats” for us to exchange. We did not set out to interview friends or acquaintances, we did not sample amongst our friendship groups, and only included these if they approached the study team themselves.
In one case a young research assistant had an experience with someone she knew, who had approached her after learning about the project. In the event, the research assistant interviewed this person for the study. This interview was not particularly noteworthy, or distinguished from other interviews the research assistant had conducted, until later when she reacted with shock and consternation as a result of the interviewee’s responses. The research assistant called me to debrief, distressed, saying she had had no idea what her acquaintance (who had had complications) had gone through, and how she had suffered, furthermore how in everyday life and interactions she had thought the participant such a positive person and would never have otherwise known she had experienced something so difficult. As such, the friendship brought the issue of informal MR home, so to speak, and made it more real. The research assistant said she had more respect and admiration for her friend now, knowing what she had been through while still maintaining a positive attitude.

I certainly felt different about the one person where I was able to conduct the interview in English, but due more to a deepening of the relationship and better appreciation of her person and her life, than because I was uncomfortable adopting the role of keeper of secrets (McConnell-Henry et al. 2010). I also found that our friendship added a unique dimension to the research (Harris 2002), where we were able to speak at more length and depth about her experiences, actions, and relationships. As McRobbie (1982) suggests, as part of her stance on feminist researching, I acknowledged my own biography and spoke about my experiences too, sharing experiences of pregnancy scares and everyday fears as we spoke about her MR (McRobbie 1982). As such, there was an element of “reciprocal disclosure” (McConnell-Henry et al., 2010, p.46).

Ethical consideration conclusion
Data analysis for this study was firmly grounded in constructivist approaches (Charmaz 2006), using iterative methods to identify themes that were then later organized along the framework by Coast et al. (2018) This combination of approaches assisted me in conducting both an analysis that remained true to letting the data and women’s experiences speak for themselves, and without losing the place of my research in the larger environment of research and abortion care-seeking behavior.
4.8 Reflections on my position as researcher

Positionality

Researching abortion, especially something as difficult or complex as unsafe abortions, “is not an innocent or distant academic exercise but an activity that has something at stake and that occurs in a set of political and social conditions” (Smith, 2012, p.3). As such, it was important to ensure my constant awareness and consistent examination of my position in relation to the context within which the research occurred – the social and political context, the community, organization, and participant groups encountered (Coghlan and Brydon-Miller 2014) affected by, or included in this work. I am a white, western, very privileged woman, investigating a subject I would almost certainly never be confronted with myself; my position brought with it questions about power and culture, and representation. I was aware throughout the entire research time in Bangladesh that I was “other”; this position permeated everything. I was aware in this particular situation, living in Bangladesh, doing research, as part of the expat community and moving among Bangladeshis as a white person, “[r]acialization is part of the normal, and normalized landscape” (Kobayashi and Peake, 2000, p.392). Recognizing and paying attention to these facts may have also given context to my findings, as developed from the data I collected.

My position as a researcher was influenced by the choice to use modified constructed grounded theory methodology and positioning that addressed the research issue at hand; for example, by the way I sought to do this research: to find out what women were doing and why and in what context. My beliefs, political stance, and cultural background were important variables affecting the research process (Bourke 1990). In taking a constructivist approach, I was involved in all steps of the process as researcher. I was passionate about this subject, and, as Bryant wrote in response to Glaser there could be no guarantee of neutrality (Bryant 2003). On a human level, it was impossible for me to remain unaffected by the subject and participants. My positions on feminism, reproductive rights, and abortion were also critical in both selecting the research question and conducting the study. For example, my study, unlike other studies, did not focus on why women had abortions, or how they made the decision to terminate the pregnancy, although these questions factored if the women themselves brought them up as related to the methods chosen or paths taken.

I instead investigated what women were doing, why, and in what context they sought abortions and MR. I initially entered this field and research topic with few ideological stances. I had been raised and later surrounded by almost exclusively liberal feminist friends and acquaintances, and entered the topic with what, later I accounted for as a metaphorical shrug of the shoulders: Of course everyone should have access to abortions, why would that not be the case? In
hindsight this prejudging feels naive, but may also have led me to take the approach that focused beyond the "why" of women having abortions.

I sought to represent women and their stories by relying on their stories and the data, and to stay "out of the way" as much as possible. There is no doubt, however, that this research was done "under Western Eyes" (Mohanty, 1988, p.61). I represented not only a colonial past, but a neocolonial present (Vanner 2015). In these particular circumstances I was not alone in my data collection, and certainly could not have conducted this research without my local research team. I could never be sure how the women felt about me – a white woman – interested in interviewing them, seemingly outside a general curiosity. I remain unaware if they ever thought I was incapable of understanding their plight, or could not represent them accurately; as, due to the language barrier my contact with them was always mediated by my research assistants.

**Reflexivity**

Reflexivity is the process of turning the researcher lens back onto oneself (Berger 2015). It also involves investigating and taking responsibility for one's own personal place in the research, and questioning how one's position has affected the research, including how data was collected, analyzed, and interpreted. If I were a different person, the study would also be different, with different results. Being reflexive can make us more "aware of the asymmetrical or exploitative relationships, but it cannot remove them" (England, 1994, p.81); it also includes a process of self-scrutiny and an awareness of the relationship between the researcher and the participant (Chisleri-Strater 1996; Pillow 2003). It is the process by which "humans study humans" (Hufford, 1995, p.57). Reflexivity is an active process that you need to "do," rather than a state of "being" (Dowling 2006).

How did I affect the research process? I sought to ensure that I would be conscious of my empathic nature in a way that could minimize its effects on the interviewee. However, my position as a white foreigner was certainly in some ways detrimental to the actual data collection, and overall research process.

Working with a local community health worker had its benefits: it gave us an "easy in" to the community, but could also have left women feeling coerced, or as if they had no other option but to participate. As far as I could sense this was not the case. I was likely perceived as a "dominant figure" in the collection of data (Vanner 2015) especially among this vulnerable population. Power imbalances can be a problem in "north-south" partnerships (Walsh, Brugha and Byrne 2016). I attempted to minimize the way power imbalances could affect both those women I was
working with as well as my study, by working with this community health worker who was neither directly involved, nor dependent on my research (she received a stipend for her assistance with the data collection, but her practice remained her primary source of income).

I suspect the study could have been better conducted by a local researcher, or if I had spoken Bengali, and been more aware of cultural processes from the beginning. I also would have understood intricacies of the Bangladeshi culture. I sought to circumvent these shortcomings by talking about everything with my local research assistants and colleagues.

Overall, two primary factors could have been detrimental to the research: (1) the power differentials between myself, Arunima, and the participants, and (2) my understanding and position as an outsider: there was likely information women did not want to tell us as “others” from outside, and we may also have misunderstood what they were saying. I tried my best to interact with women as equals. I introduced myself and the research, alternatively tried to avoid getting in the way of interviews, being helpful where I could, playing with children, fetching tea or biscuits, and so forth.

The research I conducted presented a problem or problems, and my desire to solve things, to fix problems, could have had unwanted or unknown effects. I have difficulty, as Hufford writes, “learn[ing] to tolerate uncertainty and ambiguity, while holding the reducing of uncertainty and ability (…) as primary goals” (1995, p. 60) without ever achieving them. I can be very practical, and ran the risk of being too quick to define a problem I was encountering, so I could go about attempting to devise or define a solution for it. Often, however, I also felt hopeless in the face of women’s stories and experiences – even as I was likely not able to even imagine or fully grasp the ramifications of what they were telling me. I was certainly able to understand and grasp what they were describing, but was then unsatisfied with my ability to devise a solution, or to find a way that my research could directly contribute to their lives in a positive way. This meant that I had to tolerate more ambiguity than usual, and to set aside my need to prescribe a concrete solution or fix things.

Throughout this study I was a complete observer (Junker 1960). I was neither part of the community or of the action of seeking, nor did I need MR. Throughout my fieldwork I developed into what Schatzman and Strauss call a "methodological pragmatist" – using a system of strategies and operations to get certain answers of events of interest to me (1973). I asked my research assistants, my friends, and colleagues questions. I told them of de-identified data (data with all identifying information removed) I was collecting, and listened to their thoughts and
opinions, allowing all different types of data to be included in the analysis. We therefore began our initial data collection in two areas but ultimately collected data in more places when interesting data became available.

4.9 Conducting fieldwork

Postmodern approaches emphasize the necessity of understanding the researcher's context as part of the interpretation (Angrosino 2005). As Sultana notes, "fieldwork is always contextual, relational, embodied, and political (2007, p.374). In this section I present my experiences conducting fieldwork and research on the ground in Bangladesh, and how my presence as a foreigner and outsider may have affected the research.

Feminist researching

The author bell hooks defines feminism as "the struggle to end sexist oppression" (hooks, 2000, p.240). My work, holds to this definition of feminism, in that my position argues women should have the right to control their own bodies and lives, including when and how to have abortions. My research specifically focused on asking the women themselves about their experiences, rather than asking health providers or community members to speak for them. Unsafe abortions also disproportionally affect poor and marginalized women (Ganatra et al. 2017), who have been "shut out and also shut up" (Reid 1993, Title) and I made a concerted effort for them to be central to focus of the research. Hence, my research was inherently about class and poverty.

Feminist theory also explicitly examines the relationship between the researcher and the researched, and openly acknowledges the reliance of the researcher on the participants to gain insight into their lives (England 1994), which I address by being reflexive in my constructed grounded theory approach.

Feminist intercultural research has placed emphasis on building connections with women in other cultures, yet remaining conscious of their own power and positionality; such researchers have brought up the question whether "we have a right to talk about people from 'other worlds"' (Staeheli and Nagar, 2002, p.167), and how to make visible and depict "Third World" women (Radcliffe 1994). Can I do this research with these women "without colonizing them in a manner that reinforces patterns of domination"(England 1994). I can never know and understand what it is like to be a Bangladeshi woman and will never face any of the situations the women in my study face; but currently nobody else is telling their stories. While I maintain that somebody telling their stories is ultimately better than nobody doing so, but nevertheless, I
had no particular “right” to their stories, therefore can only report what they freely told me; otherwise, in the current climate, these stories would remain untold.

Other researchers writing about their experiences in Asia have noted the experience of attracting public attention unsettling (Gaetano 2016), but, as this was not a new experience for me, I was unsurprised by the attention. I had spent years in Latin America and other Asian countries before conducting research in Bangladesh, and, due to my very fair complexion and light brown hair, and much taller stature than most people around me, had stood out and attracted attention everywhere. Being foreign (in this case white) came with such circumstances in Bangladesh, a lot of staring and attention, but also immediate and unjust experiences of privilege (especially as a foreign woman) such as being moved to the front of the line at banks.

As a white woman in Bangladesh, I was immediately visible and attracted enormous amounts of curiosity and attention wherever I went. I was paid extraordinarily well by local standards, and researched situations and issues I am unlikely to experience personally. Power differentials are almost certainly part of the women’s experiences, regardless of whether they appear explicitly in the data (Clarke 2005). I attempted to remain aware of this and reflexive throughout the process, as I took into account how my status and position might affect my work and my data collection and analysis.

There were both advantages and disadvantages to my outsider status. A lack of lived experience and intimate knowledge of the culture and community gave me the opportunity to notice things that may not have seemed interesting or odd to others. I spent many hours in deep Dhaka traffic conversing with my research assistants before and after interviews, asking them to explain occurrences and concepts to me in a way they likely never would with someone more familiar with the local culture. Foreigners are rare in many parts of Bangladesh, which (with no lack of humor) my research assistants used to their advantage. Community members, especially other women, were always curious and keen to come say hello and ask questions, which my team thought not only amusing but useful as an immediate entry point for further conversation. The research assistants were equally curious at times. The conversations we had about our respective marriages and families led us to a familiarity that allowed for deeper conversations about the data.

At other times this status was a disadvantage. There were certain interviews, for example, I was asked not to attend. In these cases, the research assistants thought that either it would not be
safe for a foreigner in a particular neighborhood, or that my presence there as a foreigner could breach the confidentiality of the woman by attracting too much attention.

What was new to me, however, was acting in an environment as strictly patriarchal as Bangladesh. And while the meaning of "woman" in Bangladesh is certainly not uniform (Crenshaw 1986) across local and white women, I nonetheless experienced sexism, although this was tempered by distance because of my whiteness. It felt like I was foreign first, and a woman second, but unwanted sexual attention was nevertheless constant, more commonly experienced from "friends" rather than colleagues or strangers.

Throughout my stay in Dhaka, I experienced Bangladeshi culture from the perspective of both an outsider and a woman. I regularly found myself not taken seriously, talked over, or spoken of and about as if I were not there. In some ways, these experiences brought me closer to other women in Bangladesh, and let me experience their worlds in small ways. In one instance, a male staff member treated me very rudely—refusing to answer my questions or to translate, snatching papers from my hands, and generally being disrespectful. This made working with him difficult and at times distressing. When I spoke to a male Bangladeshi supervisor about this, he did not feel that action could be taken as he felt none of the incidents were specific enough to warrant action or a response from him. It was only after my frustrating experience that other women started talking to me about him, sharing their own stories, telling me not to worry, that it was nothing personal, and that he, in their words, "misbehaved with all the ladies" but as he worked in HR, no one dared speak up. Experiences like this led me to see, and better discuss, my research in a different light and gain valuable insight into the lives of Bangladeshi women. This attitude led me to assume less bias and more trust (Hesse-Biber 2014), and perhaps become a more effective researcher.

Spending a significant amount of time in Bangladesh allowed me to see different sides and elements of Bangladesh, and possibly look beyond the "developed-developing" world dichotomy, distinguishing where I am from and where I work (Austria, the UK, and US), from where I conducted my research (Bangladesh). This prolonged stay also allowed me to understand things differently over time, and looking back on early interactions with women—both throughout the study as well as personally—I was able to see how my thinking evolved, reading nuances and understanding concepts better than I had when I first arrived. For example, over time I came to understand the multiple ways in which purdah affected women’s lives much. In my first weeks in Bangladesh, for example, I went on a tour of the Sundarbans, a large mangrove forest in the Bay of Bengal. I met a woman there with her husband and young
son. She wore a Niqab in public and offhandedly mentioned that she had not been outside in years. At the time, I was unaware that this was a common practice and interpreted her "outside" as a western woman with freedom of movement would, an odd phrasing, and thought she meant "outside" as out in the countryside, or outside the city itself. Only later, when I learned more about the culture, did I understand that she was likely speaking literally and that she may not have left her house, or family compound, in many years. Had I had more knowledge of this practice, I may have been able to ask more questions about women's communities and their contact with the public sphere, how they accessed goods and services and with whose, if anyone's, help.

I agree with Fay, who states that "knowing an experience requires more than simply having it; knowing implies being able to identify, describe, and explain." (1996, p.396) While I cannot claim to know, physically or through personal experience, what women's lived experiences were like, I have strived to place their stories within the global conversation about abortions (and MR), and through this hope to contribute a context and a richness that having the experience alone might not possess. As researchers, perhaps, we can only ever occupy the space between (Dwyer and Buckle 2009): we investigate experiences others have, attempting to capture their stories as accurately as possible, but ultimately never knowing if the results of our analysis accurately reflect experiences had by the participants of our study.

However much women took part in my research voluntarily, I remained aware that I – and my research study – was an intrusion in a society and system or relationships (Stacey 1988), that I remained apart from these and would possibly never understand. There is an inherent difference in researching an issue and living it and retelling it, and I remain uncertain what retelling or rethinking the stories may have done in these women's lives. Ultimately, my justification for intruding on their lives, and using their experiences as data, is that I could find no other way to tell their stories, and might possibly use the results from the study and intrusion to assist other women in the same situation.

I also ultimately could not know how the participants in the study truly felt about me, what their opinions and thoughts of a white foreigner and her local colleagues asking questions about likely difficult experiences in their lives. They could have found me strange or questioned my capacity to understand their experiences (Dwyer and Buckle 2009). Some women, especially those who during the interviews told me they did not leave their houses frequently, may also not have had regular contact with any outsiders, foreign or Bangladeshi.
Chapter 5. Results overview

5.1 Thesis structure

This thesis is arranged by publication, with separate papers presenting the results of the study in Chapters 5–8. Chapters 2 and 4 described additional background and methods not included in the individual papers that follow.

I present the results of the thesis as four individual research papers, each exploring an aspect of the abortion care-seeking process, and identified during data collection and analysis. The organization and focus of the papers result from a combination of a priori aims and foci identified from the data during analysis. Examining women's experiences, for example, was an aim of the thesis: the data showed key parts of their experiences as barriers faced in accessing services, as well as illustrated the interactions they had with formal and informal providers.

Similarly, while the phenomenon of women being turned away from clinics has been described elsewhere in the literature as an experience central to seeking MR (Hossain et al. 2017), this was not identified from the data during analysis and was not a focus of the results.

5.2 Individual aims of thesis papers

Chapter 5 (Paper 1): "Conceptualizing the Relationship Between Menstrual Regulation and Abortion in Bangladesh." The aim of the first paper was to gain insight into the conceptualization of MR by women who have MR procedures themselves. I examined how women defined the procedures they had, and how these descriptions related both in theory and in practice to menstruation and pregnancy.

Chapter 6 (Paper 2): "Barriers to Seeking Menstrual Regulation in Bangladesh." The aim of the second paper was to explore the social context of women who sought MR outside health facilities, and how this choice affected their treatment-seeking and decision-making.

Chapter 7 (Paper 3): "Interactions with Providers of Informal Menstrual Regulation in Bangladesh." The aim of the third paper was to better understand women's interactions with informal providers of MR. I explored where and to which provider women went for
MR, whether they knew these were informal providers, and their experiences using such providers. I also examined why women sought these providers, and identified whether there were common characteristics of the providers or specific interactions that made these easier to access than providers at approved health facilities.

Chapter 8 (Paper 4): "Using Allopathic Medication for Menstrual Regulation Outside Health Facilities in Bangladesh." In this paper, I investigated women’s experiences of attempting to use allopathic medication using medication for MR outside approved health facilities in Bangladesh, with the aim of understanding why they used unapproved sources, and their experiences of using these medications.

Letting the data lead, I identified four foci from the data to answer my research question as to women’s pathways and experiences. The order in which I present the papers reflects the order in which reading them conveys the fullest pictures of women’s experiences, beginning with how women themselves conceptualized their menstruation and menstrual regulation procedures and how these perceptions affected their care-seeking (Chapter 5, Paper 1), how women’s sociocultural environment affected seeking care (Chapter 6, Paper 2), identifying their interactions with providers (Chapter 7, Paper 3), and, finally, how women who could have used effective medication from pharmacies sought care, and what their experiences were (Chapter 8, Paper 4).

In Chapter 9, I consolidate the results discussion, including overarching conclusions from the four papers presented, a discussion of limitations of the wider study, and suggestions for possible future research. References for all chapters are presented in a consolidated reference section at the end of the thesis.
Chapter 6. Conceptualizing the Relationship Between Menstrual Regulation and Abortion in Bangladesh

6.1 Introduction
Chapter 5 (Paper 1) describes how women themselves conceptualized their menstrual regulations (MR) procedures. In developing my thesis, I found little research had been conducted and little had been written about how women thought of their own MR procedures in Bangladesh. Previous studies did not state, or investigate, how women perceived these procedures, the legal differentiation of MR and abortion, or what might influence their own definition of MR. It was equally not reported how their perception of MR may have affected how they sought care. This study investigated whether women thought of MR as related to contraception and family planning, as something healthy to regulate their menstrual cycles, or if they perceived their procedures to be abortions.

In researching MR and abortion, how women experienced MR procedures, and how this experience may differ from the policy definition of MR, I found, as expected, that these covered many of the elements in the first “abortion-specific” section of Coast et al.’s framework on trajectories to seeking abortion related care (2018), including the influence of structural and institutional environments through the legality of MR and language used in Bangladeshi health policy.

In this paper I present the research on women’s own beliefs about their MR and pregnancies, which maps closely to the first element of the framework: “abortion-specific experience.” I identify the awareness of their pregnancies and discuss how this is different from the Bangladeshi policy definition, and how MR is viewed as negatively as abortion is in other contexts. While the Coast et al.’s (2018) framework separates “emotions about pregnancy/abortion” and individual characteristics, including socioeconomic characteristics, as separate, I found that the women spoke about them as closely linked; the reasons they gave for seeking MR were most closely tied to the reality of raising another child in already resource-constrained environments.
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SECTION A – Student Details

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| Thesis Title        | Menstrual regulation outside health facilities in Bangladesh: a qualitative study |

| Primary Supervisor  | Prof Cicely Marston |

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

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SECTION C – Prepared for publication, but not yet published

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SECTION D – Multi-authored work
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I am the first author on this paper. I was responsible for all aspects of study design, data collection, data analysis, and writing. Cicely Marston assisted in the conception and protocol development, analysis and critical revision.

SECTION E

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6.2 Abstract

Introduction

In Bangladesh, menstrual regulation (MR) is not legally defined as abortion, but as an approved alternative to regulate women’s menstrual cycles. The Bangladeshi government defines MR as a backup family planning method rather than a termination of a pregnancy, and providers in healthcare facilities commonly perform the procedure without a prior pregnancy test. MR outside health facilities is, however, commonly linked to the global burden of unsafe abortions in the literature. We do not know how women in Bangladesh define their MR procedures, and how this relates to their conceptualizations of menstruation, pregnancies, and abortions.

Methodology

We conducted qualitative interviews with 43 women in urban and rural Dhaka division of Bangladesh. All participants had undergone self-defined MR procedures outside health facilities. We asked women about the methods they had used for the MR and why, and how they thought about their MR procedures in relation to abortion.

Results

Women had perceived themselves as being pregnant before they sought menstrual regulation procedures. They said they had taken pregnancy tests before seeking providers and methods for menstrual regulation. Women spoke about having conceived a child and considered possible future children, and discussed their pregnancies in terms of gestational ages, sometimes seeking specific methods according to how far they thought their pregnancies had progressed.

Discussion

Women in this study defined MR in their own terms, and in ways that fall outside the Bangladeshi legal definition. Pregnancy tests being widely available may have changed the environment within which MR is sought today compared to when it was first introduced. We cannot conclude with certainty whether women benefit from different definitions or the term “MR,” or whether by using these definitions they are prevented from seeking the best possible care.
6.3 Paper 1

Introduction

How medical procedures are defined affects both how they are offered and sought, and whether the care and treatment received is appropriate and effective. One such procedure, menstrual regulation (MR), is an approved alternative to abortion in Bangladesh. MR is defined, not as a termination of a pregnancy or abortion, but as “the procedure of regulating the menstrual cycle when menstruation is absent for a short duration.” (Government of the People’s Republic of Bangladesh Directorate General of Family Planning MCH Services Unit, 2013, p.5). In this definition absent menstruation is not directly linked to pregnancy. Moreover, as pregnancies are “not clinically diagnosed prior to the procedure, MR is considered a backup family planning method rather than an abortifacient” (Hossain et al., 2016, p.2) by Bangladeshi policymakers.

Little is known about how women themselves experience and conceptualize their pregnancies, and even less about how this relates to abortion and menstrual regulation.

In this paper we examined the conceptualization of MR among women who have sought MR outside health facilities. Furthermore, we sought to understand how women who undergo the procedures themselves define MR, how this definition affects how they perceive their bodies and lives, and how they conceptualize a missed menstrual period and actions they might take as a response.

Bangladesh is unique in terms of how menstrual regulation and abortion are conceptualized. Officially defined abortions, restricted except to save a woman’s life (Bangladesh Government of the People’s Republic of 1973), are so rare as to generally not be included in the Bangladeshi Demographic Health Survey (NIPORT et al. 2016). MR however is common; an estimated 1.62 million MR procedures were performed in 2014 by formal and informal providers combined (Singh, Hossain, et al. 2017). Government guidelines define types of formal MR provider, facilities where MR can be performed, and duration after last menstrual period (LMP) (Akhter 2001; Bangladesh Directorate General of Family Planning 2014; Hossain et al. 2017). The Bangladeshi government mandates that MR be provided at no cost from health facilities nationwide, and carried out using either manual vacuum aspiration (MVA) – within 12 weeks of the first day of the LMP (Government of the People’s Republic of Bangladesh Directorate General of Family Planning 2014) – or with mifepristone and misoprostol (prescribed by trained, clinic-based personnel) within 9 weeks from LMP (Bangladeshi Directorate General of Family Planning 2014).
Coast et al. recently published a conceptual framework on abortion-related care trajectories, including all identified factors to date, and how they influence women’s trajectories in seeking abortion-related care (2018). This framework groups influences shaping women’s trajectories into three categories: (1) abortion-specific experiences, (2) individual context, and (3) (inter)national and sub-national context, and asserts that women’s “trajectory begins with becoming aware of a pregnancy” (Coast et al., 2018, p.202). In this paper we explore the nature of women’s awareness of their pregnancies in Bangladesh and how this might affect care-seeking and their abortion-seeking trajectories.

**Abortion-specific experiences**

In Bangladesh MR is intended to be performed without confirming any pregnancy, and is commonly performed on women who have not taken a pregnancy test (Chowdhury et al. 2004; Ganatra and Visaria 2004; Singh et al. 2012). This practice places MR outside what other authors have called the pregnant/not-pregnant binary (Gerber 2002) and may or may not be terminating a pregnancy. In contrast, women in the United States, for example, appear at times to be placed in what is described as “preconception care” (Waggoner, 2013, p.345), where women are treated as if they could be pregnant at all times, viewing women’s behavior, social roles, and medical treatments through the lens of prenatal care and possible present or future pregnancies (Hubbard 1994; Waggoner 2013). Public policy and law in Bangladesh however treat women’s missing menstrual cycles as a topic apart from possible pregnancies. This stance may cause women to undergo unnecessary procedures, as other studies have found. One research paper, for example, describes the case of a woman who had not taken a pregnancy test before seeking an informal MR. Her informal procedure resulted in complications that could have been avoided had she been aware that the injectable contraceptives she was using could cause amenorrhea, and taken a pregnancy test before seeking the procedure (Ahmed et al. 1999). Pregnancy tests may not be readily available or may be unaffordable for women (Stanback et al. 2013), but there is currently no data on the extent women in Bangladesh have access to pregnancy tests, or if this access has changed over time.

Women worldwide closely link their menstrual cycles, and lack thereof, with pregnancies. A study in India found that a missing period, termed *din chadna*, “period overdue”, signifies that pregnancy has occurred (Garg, Sharma and Sahay, 2001, p.19). In Greece the word “menarche” was associated with becoming a woman, and the potential to become a mother, but also with “when I am unwell”(Christoforou, 2018, p.51). A study among Somali and Afghani Muslim migrants similarly found that, among these populations, first periods signified that women were able to become pregnant and become mothers (Hawkey et al. 2017). The concept of “bringing
down” the period is common around the world (Castaneda, Garcia and Langer 1996; Renne 1996; Sobo 1996; Cosminski 2001; Hammer 2001). In Mexico women describe abortion as both “bringing down the period” as well as "throwing away the child" (Castaneda, Garcia and Langer 1996). Negative perceptions of menstruation are common (Johnston-Robledo and Chrisler 2013; Chrisler et al. 2015; Hawkey et al. 2017) and menstruating women can face restrictions while menstruating (Caplan 1989; Garg, Sharma and Sahay 2001; Adinma and Adinma 2008; Garg and Anand 2015; Sommer et al. 2015). Conversely, a cross-cultural study on menstruation, conducted by the World Health Organization of 14 cultural groups in 10 countries, found that women commonly saw menstruation as a natural, vital occurrence indicative of good general health and would be hesitant to use birth control that would stop it (WHO Task Force 1981).

In the literature, MR is defined differently by different researchers and institutions. Some authors writing about MR in Bangladesh have linked their definition of informal MR to the global burden of unsafe abortions (Singh, Hossain, et al. 2017), while others have either counted all terminations (MR and MR outside health facilities) as abortions (Alam et al. 2013) or distinguished between approved and illegal procedures, defining all termination of pregnancy procedures outside approved MR facilities “illegal abortions” (Warriner et al. 2006; Gipson and Hindin 2008). Another recent study, examining women's experiences after being denied MR termed all procedures outside approved MR guidelines, regardless of method or provider, “unsafe abortions”(Hossain et al. 2016), and yet another defines MR as per current legal status, but in the same paper the authors go on to discuss pregnancies and fetuses, which are not part of the current concept of MR (Nashid and Olsson 2007). Other researchers have built the ambiguous definition into their work but do not resolve it, writing that menstrual therapies need not be abortions, but fail to elaborate what would delineate MR from abortion (Bandewar 1998). In these instances MR could be perceived as a way of terminating a possible pregnancy without assigning agency or blame to either the provider or the client (Kumar, Hessini and Mitchell 2009). Even so, we note throughout our study that however researchers define, or do not define MR, they seem not to ask how women define it, or base their categorizations and definitions on how the women thought of their own procedures.

**Individual context**

We found only two studies that mentioned that women may have their own definitions of MR but neither gave further insight into these definitions. Gipson and Hindin observed that time and duration of pregnancy are factors in women's decision to have an MR, quoting one woman who remarked that if “we wash our uterus when we are one or two months pregnant it is not a sin” (2008, p.1831). Moreover, Dixon-Mueller argues that the definition of MR depends on
perceptions regarding the causes of a delayed period, but does not elaborate on what these perceptions are (1988). The author’s recent study focused on post-MR contraception, and found that when women experienced irregular menstruation their fear focuses on unwanted pregnancy, rather than worry about their health or menstrual cycles – at least in terms of their being necessary for good health (Eckersberger et al. 2017).

**Inter)national and sub-national context**

Religions worldwide commonly take particular stances on abortion (Tomkins et al. 2015). The Bangladeshi population most commonly belong to the Hanafi school of Islam, which stipulates that a fetus is not a person until the fourth month of pregnancy and terminations are technically permitted, in a religious sense, until that point of gestation (Amin 1996). Muslim communities in other South-east Asian countries hold similar views. According to women’s beliefs in Indonesia, “ensoulment” of the fetus takes place at 120 days of pregnancy (Bennett 2001), and women in Myanmar report that fetuses only become “human-like” in the third or fourth month (Belton and Whittaker 2007). Sociocultural beliefs in Bangladesh, however, are based on a mixture of religion and local traditions, in which pregnancy terminations are forbidden and stigmatizing (Maloney 1981).

In Bangladesh, menstruation appears to inhabit two separate philosophical spaces. As part of MR, it is deemed natural and “a healthy demand from a healthy lady” (according to a senior official of the Ministry of Health in Dixon-Mueller 1988), while simultaneously being used to exclude women from public society (Maloney 1981; Johnston et al. 2011). Schoolgirls are often absent from school and excluded from activities while menstruating (Alam et al. 2017), and menstruation is viewed as “dirty” (Ahmed and Yesmin 2007). Women may be hesitant to involve men in the management of their menstrual hygiene, as men often believe that menstruating women are polluted and bring bad luck (Blanchet 1984).

**Methods**

Between June and October 2015, we conducted in-depth interviews with 43 women in urban and rural Dhaka Division. Women aged 16–49 years who had used any method of MR outside an approved facility were eligible for inclusion in the study. In addition, we conducted observations of approved and informal locations where MR was performed, and community health clinics where MR was not offered as a service. We conducted informal conversations about MR provision and services with community members, pharmacists, health staff, and official MR providers. We used this data to contextualize the women’s experiences.
We used a multi-pronged referral system to identify possible participants, starting with personal contacts among clinicians, healthcare workers, pharmacists, and community members’ recommendations of women who might want to take part in the study. We also asked the women we interviewed to refer us to other women who were eligible for the study. Sampling women who have accessed MR outside health facilities was challenging because of the often-hidden nature of this practice and the lack of centers to sample from. For this study, individuals providing referrals arranged a meeting or phone call between any potential participant and a member of the research team. We monitored the sample to ensure that we interviewed women of different ages and from different socioeconomic backgrounds to include as wide a range of experiences as possible.

**Interviews and interview guide**

We developed an interview guide that was translated into Bengali and back-translated to English by independent translators to check that meaning was maintained. The interview guide included questions on the context of the woman’s MR, the type of medication and provider, her experiences during the process, whether she had a complete MR, how relationships and community affected her decisions, and perceived barriers to seeking care in clinics. We asked women how they defined the procedures they had, whether they had taken pregnancy tests, and how their definition related to concepts of pregnancy and the termination of their pregnancies.

Participants chose the interview locations, usually the woman’s home, the home of a friend or acquaintance, or a local community clinic. We gave women 200 Taka (US$2.50) to compensate them for costs associated with their participation.

Interviews were conducted in Bengali by bilingual Bengali-English research assistants after five days of training which included overviews of concepts of MR and abortion, qualitative interviewing methodology and techniques, and recruitment and consent procedures. Interviewing women on menstruation and abortion can be a sensitive subject (McCosker, Barnard and Gerber 2001) and our interviews could possibly have caused physical, emotional, or psychological distress (Cowles 1988; Sieber and Stanley 1988; Elmir et al. 2011). To counter these possibilities, we placed particular focus during the training on interviewing respectfully and sensitively.

EE discussed each interview with the interviewer immediately afterwards and made extensive notes and formal memos, recording main content, contextual details about interview location,
interviewee mood, tone, and body language, and anything else noteworthy. Interviews were conducted, recorded, and transcribed in Bengali then translated into English. EE worked closely with bilingual translators and interviewers to ensure the narratives were rendered in English as clearly as possible and to gain crucial contextual information for the analysis.

**Data Analysis**

We used a constructivist approach to analyze the data, explicitly acknowledging that theories are a construction-reconstruction of reality (Charmaz 2006) and women’s experiences occur within socially constructed situations and social structures (Charmaz 2008). As an outsider taking the lead in the research, EE repeatedly checked in with co-authors, local partners, fieldworkers and community members to ensure that the identified themes were as meaningful as possible within the context. We used iterative thematic coding of the interview transcripts to identify themes and categories from the data.

We present our findings organized according to the domains of the framework on women’s trajectories to obtaining care developed by Coast et al. (2018) to place our work within the larger theoretical work on abortion care. Having developed cross-cutting themes around women’s experiences and perceptions of the procedures they underwent, we investigated how these themes related to the definition of MR, and whether or not women’s perceptions affected the care they sought.

In this paper, we use the terminology local to Bangladesh and the term MR as the default for procedures women attempted to restore their menstrual cycles. In cases where women use specific language different from MR to refer to terminations of pregnancies, we use their words and definitions. We also distinguish between formal MR performed in approved clinics and healthcare facilities by healthcare workers or trained Family Welfare Visitors, and informal MR performed by providers outside of those guidelines.

The study was approved by the London School of Hygiene & Tropical Medicine Ethics Committee, the Marie Stopes International Ethics Committee, and the Bangladesh Medical Research Council.

**Participant characteristics**

We conducted 43 interviews with women who had obtained MR procedures outside approved healthcare centers. Their ages ranged from 19 to 45. Most women had completed at least elementary school, five had no formal education and were illiterate, and two were university
students. All but three were married at the time of the MR. The participants’ occupations were varied, including housewife, construction day laborer, fashion model, and nurse at a non-profit health facility. All women were ultimately successful in terminating their pregnancies. Nine of the 43 women interviewed ultimately ended up seeking care at a facility for postabortion care.

Results
We found that, in contrast to the official definition of menstrual regulation, which refers to the absence or irregularity of women’s menstrual cycles, the participant women spoke of MR explicitly in terms of terminating pregnancies.

Abortion-specific experiences
Awareness of pregnancy
Women in the study spoke about their circumstances in a way that suggested they had perceived themselves as pregnant and sought to terminate this pregnancy. Women in our study spoke about menstrual regulation as a method to terminate pregnancies. They used different terminology and euphemisms for different methods of MR, but were never ambiguous in their narratives that they believed they had been pregnant. When giving reasons for seeking MR, they spoke of child rearing costs and efforts and noted their family’s economic situation. They also spoke about experiencing symptoms of pregnancy such as morning sickness. Women also noted that they were not alone in this perception of themselves as pregnant and spoke about their families having the same thoughts about their situation before they sought MR:

Then my mother in law and everyone in the family said that you cannot handle two babies at the same time. Your health will break down, and you and your only other child will become weak... and then they told me to do MR. But my husband said no, we will not do this. Allah gave this to us. It could be dead or alive... whatever happens, but we will not spoil another child. (Participant 5)

As did Participant 5, other women in the study commonly referred to their MR procedures with the Bengali word “noshto” (literally: to spoil), saying they spoiled “it” or “the baby.” They used the same terminology in speaking of seeking treatment, rather than specifically referring to MR, abortion, or menstruation: “Then I asked [the informal provider] – is it possible to spoil the baby?” (Participant 35). Participants linked their procedures to concepts of spontaneous and inducted terminations of pregnancies, describing these in different ways:
common ordinary people in the villages […] they understand that the baby got spoiled. A baby got spoiled [meaning miscarriage/spontaneous abortion] and a baby that was spoiled [meaning induced abortion]. They are two different things. (Participant 12)

*Awareness of pregnancy and ability to access resources for abortion*

The majority of women we interviewed had taken pregnancy tests to confirm their pregnancies before seeking MR. Their narratives also suggest that pregnancy tests are relatively widely available, including to women with limited resources. Women spoke of pregnancy tests as commonplace, and none appeared surprised to have been asked to take one by an informal MR provider, nor said that they had difficulty procuring a test. Pregnancy tests are affordable and commonly available in Bangladesh; a community health worker told us she charged 30 taka (US$0.35) for tests at her clinic (where she did not perform MR), but that if purchased from the pharmacy or market the cost was around 20 Taka ($0.20). Women reported that they procured pregnancy tests in a variety of ways: (1) from pharmacists, (2) alone or before purchasing medication for MR from the pharmacies, or (3) from the informal providers they sought. One woman took the pregnancy test twice, as she was sure she was pregnant: “Then I got the test done, I did the urine test. It [the pregnancy] got detected then. The first time it wasn’t detected, I did it again for a second time, then it got detected.” (Participant 15)

Some pharmacists and informal providers required that women take pregnancy tests before receiving any medication or administering other treatment from the provider. In some cases, husbands procured the pregnancy tests and in one case the husband took his wife’s urine to the market to get tested there. Other women went to clinics to confirm their pregnancies when they had suspicions (Participant 25).

*Abortion attempt(s)*

Women spoke of being aware of their menstrual cycles and of watching whether they correlated with the moon cycle, and using this method to tell whether their menstrual cycle was delayed. Women spoke about their pregnancies in terms of gestational age, speaking about elapsed time and the growth of the fetus. Most commonly the participants noted that their last menstruation had been between 1.5 and 3 months prior to seeking the MR. Participants who sought MR distinguished between pregnancies of different gestational ages and perceived the procedures they underwent differently. One woman said that having the MR early in her pregnancy was less sinful, and others observed that different informal providers performed MR up to different gestational ages.
Since it had only been two months I got it [the MR] done. I wouldn’t have done it if it had been longer, that killing a baby is more sinful. (Participant 7)

Perceived/experienced outcomes from (attempted) abortions
Women almost exclusively spoke about menstruating and menstruation as linked to pregnancies indicating that for them, menstruation is closely linked the ability to become pregnant, or to the possibility of being pregnant. Only one woman, who spoke about her menstruation without directly referencing a pregnancy, said that she simply took medicine to “make my period regular” (Participant 1). However, she also spoke about having taking a test before she took the medication, and reported that the test showed “two marks” (Participant 1), the two marks indicating a positive pregnancy test.

MR methods were sometimes sought when menstruation stopped, but the women referenced pregnancy tests, pregnancies, and children when describing their actions:

One son and one daughter is enough. We are living with a lot of difficulty. […] My period stopped again. Two years after I had my daughter. [My husband} went and brought tablets from some doctor, then after taking them I had my period again. […] I did the urine test. I gave my urine; her father took it in a jar to the marketplace [to do the test]. Then I took tablets. (Participant 10)

I spoiled it [the pregnancy]. I already had two children and I had to work for a living; who will feed another one? (Participant 32)

The women described returning menstrual cycles only as a sign that the MR had been successful and the pregnancy terminated, and not as linked to their overall health. The women used their returning menstrual cycles to gauge whether their procedures had been successful, and worried that they were still pregnant when their menstrual cycles had not returned two months after having taken the medication. They also linked their menstruation to different forms of birth control, and were aware that it could be irregular with some forms of birth control: “Menstruation doesn’t happen while on injections” (Participant 26).
**Individual context**

*Knowledge and beliefs about abortion*

Closely related to the women’s awareness of pregnancy described above, their knowledge about pregnancies and abortions affected how they sought care. While most women spoke about being able to recognize their pregnancies as such, some described this process as more complex and were not always able to do so easily. Some participants spoke about initially not having recognized earlier pregnancies due to irregular menstrual cycles, or beliefs that they were taking sufficient precautions to avoid getting pregnant, and that they sometimes took more than one pregnancy test to confirm the pregnancies. Other women had been told by others that they were pregnant; in one case the woman had pregnancy-related symptoms she had mistaken for an illness and an informal provider she sought told her she was pregnant. Another unmarried woman was told she was pregnant by her mother, who recognized the symptoms.

**(Inter)national and sub-national context**

*Structural and institutional environment*

Contrary to the Bangladeshi legal definition of MR as a process, the participant women frequently spoke of MR as a specific medical procedure, which they distinguished from the reproductive health concept definition of terminating pregnancies. They commonly spoke of MR as synonymous with manual vacuum aspiration (MVA). The women pronounced “MR” phonetically as the English letters (‘ɛm ɑr’), not using the term “menstrual regulation” or substituting Bengali words, but also using the non-technical term *noshto* as described above. Women distinguished between what they understood to be MR, i.e. MVA, and other methods they used to terminate their pregnancies: "But I asked for the medicine and didn’t want to go through the trouble of MR." (Participant 37) One woman spoke about having believed that at the time of her MR she was “[…] only going to have my menstrual cycle activated” (Participant 36), but stated she only held this belief when she was younger, and that she now understood this was a pregnancy termination. Women’s narratives were also sometimes complicated – even after taking a pregnancy test, which was positive and taking medication, Participant 1 said she “did not have MR,” but only took the medications to make her period regular.

*Socio-cultural context*

Women spoke about how MR is perceived negatively in their communities, and none of the women spoke about MR being something “healthy” or a common treatment. Some spoke of being embarrassed of wanting or needing to seek MR, that their husbands considered it a sin, that the wider community disapproved, and that they wanted to keep their MR a secret. As one
woman said, “I didn't tell anyone because of embarrassment. They will say that I have spoiled a baby, and if I am with child, I should have it” (Participant 10).

Emotions about pregnancy/childbearing/abortion
The topic of why women seek MR was not central to this study, but when women spoke about their decision-making processes for how they decided to seek MR, they made no indication of being conflicted about choosing MR or ending their pregnancies. In describing the circumstances and contexts of their MR, women spoke confidently about feeling they were making the best decisions for themselves, their lives and their families, even in the face of negative community views. One woman showed indifference about the community views.

Most think of it [MR] as a bad thing. I know of my own circumstances, I knew it would be good for me if I did it. I have little money, unable to lead a livelihood properly, how shall I live? I don’t care about the bad things of the people, will the people feed me? (Participant 21)

Discussion
We found that women saw their MR procedures as terminations of pregnancies, i.e., induced abortions. We acknowledge that using Coast et al.’s framework at times meant using different vocabulary to describe the same procedure and concept, and that where women in Bangladesh say MR or menstrual regulation, the same concept to us meant “abortion,” as is described by the word in the wider literature. This analysis frames further analysis and places the findings more firmly among concepts of care-seeking for abortions.

The findings from this study aligned closely with many elements of the “abortion-specific” domain in Coast et al.'s framework to seeking abortion-related care (2018), such as the awareness of the pregnancy and pregnancy testing, abortion attempts, and perceived outcomes from the attempted pregnancy terminations. The findings also show how women are influenced by structural and institutional environments through the legality of MR and language used in policy. Our results illustrate the relationship between women's abortion-specific experiences and the (inter)national and sub-national context, and “[e]ach step is embedded in contexts both micro (individual) and macro” (Coast et al., 2018, p.202).

The women in our study defined MR in their own ways, all of them different from the Bangladeshi policy definition. The definition of MR in Bangladesh is narrow, and closely linked
to the structural and institutional environment in Bangladesh. The ambiguity of the official definition of MR allows for multiple interpretations of the meaning of a missed menstrual period (Sobo 1996). The women in our study defined MR in their own ways, indicating that terminology and language make possible the disclosure of the human world (Schwandt 2000) and reveal how these women thought of their bodies and health.

While the results of this study show the inter-connectedness of the different domains of Coast et al.’s framework, they also highlight that the domains are at times separate and do not ultimately influence each other. In this study women defined their procedures as abortions despite the government and policy’s definitions, showing a discrepancy between policy and reality on the ground. The women and the public policy in Bangladesh therefore have different interpretations this biological phenomenon (Connell 1987; Shilling 2003) and the way the female body is socially constructed (Turner 1992). Despite the ways law and public policy define situations or procedures, the women in this study remained, at least in this instance, arbiters of their lives and bodies (Hoffman 2012).

Women in our study used pregnancy tests as a cheap and fast way to ascertain whether additional, costlier MR treatment were needed. To our participants a positive pregnancy test, not a missing menstrual cycle, indicated the need for further treatment. Pregnancy tests can also be purchased from facilities or locations not associated with MR or reproductive health, such as pharmacies or neighborhood clinics, where women could conceivably seek other care and could be easier for women to access. There is therefore no reason for women not to confirm their pregnancies before undergoing further treatment or seeking terminations. Women suspected they were pregnant and then moved to confirm or refute that belief, indicating a distinction between the two sides of the pregnant/not-pregnant binary (Gerber 2002).

Women distinguished between terminations of pregnancies at different gestational ages. A study of early terminations in France found similar results—that women reported “something qualitatively different about interrupting a pregnancy depending on where it occurs in this continuum”(Gerber, 2002, p.96). It is possible that women’s perceptions of MR as being legally available until eight weeks (or two months) after LMP is affected by incomplete or hearsay knowledge of the MR program itself. Until recent changes allowing MR to be performed up to 12 weeks after LMP, for example, the MR was only performed up to eight weeks after LMP.

While Coast et al.’s framework separates “emotions about pregnancy/abortion” and “individual characteristics,” including socioeconomic characteristics as separate, the women in this study
spoke about them as closely linked (2018). The reasons the women gave for seeking MR were most closely tied to the reality of raising another child in already resource constrained environments. MR is both biology and culture, and as stated by Lock “there is of course a biological reality, but the moment that efforts are made to explain, order and manipulate that reality [...] the dynamic relationship of biology with cultural values and the social order has to be considered” (Lock, 1988, p.7).

Examining how Bangladeshi women themselves perceive their procedures also shows how they perceive the world around them, how these perceptions can affect how, where, why, and from whom they seek care (Berger and Luckmann 1966). Our interviews were post hoc and we could not know for certain whether women were pregnant when they sought MR, outside of what they told us. Without knowing how women themselves perceive their circumstances the public, medical and research communities, cannot understand their worlds in the same way. There may be discrepancies between the emic perspective (insider) and etic diagnoses (outsider) with respect to women’s gynecological problems (Ross et al. 1998). A recent study in India showed that the medical community perceived women's health issues differently from women themselves, and when women reported health problems and symptoms, medical personnel commonly regarded these as “non-problems.”

This study will have missed women unable to overcome barriers and unable to obtain the MR they wanted, or those who never revealed their MR to anyone. Similarly, we will have missed women who believed they were going to an approved health facility and instead had gone to an informal provider, or those unsuccessful in terminating their pregnancies and carried them to term. Another limitation of our study became apparent during sampling: our eligibility requirements sought women who had not gone to facilities and we therefore do not know how women who did go to health facilities for MR define their procedures. Those women may believe they were, in fact, only “regulating their menstruations” rather than terminating pregnancies.

**Conclusion**

The results from our study indicate that how women approach seeking MR, and their subsequent experiences are shaped by their own perceptions of health and menstruation, such as taking pregnancy tests or seeking specific methods according to their perceived gestational ages. The current definition of MR may have both benefits and disadvantages for women in Bangladesh. On one hand, the government definition could give women the opportunity to terminate their self-determined pregnancies without facing legal repercussions; on the other
hand, the disparity of definitions for MR may inhibit a frank and honest conversation on women’s health, including their pregnancies and reproductive rights.
Chapter 7. Barriers to Seeking Menstrual Regulation in Bangladesh

7.1 Introduction

Chapter 5 (Paper 1) described how the study's participants thought of their own pregnancies and MR procedures. In Chapter 6 (Paper 2), I examine how they described and situated their MR procedures in the context of their lives and explore the barriers they faced in seeking care.

In this paper I investigated the broader aspects of abortion care-seeking using Bronfenbrenner's ecological systems theory and socioecological model (1979) to guide the analysis and frame results. With Coast et al.'s (2018) framework this paper's analysis and results largely fall in the "Socio-cultural context" within the "(inter)national and sub-national context" domain, and I found that using the Bronfenbrenner's model allowed me to examine elements of women's sociocultural lives in more detail.
RESEARCH PAPER COVER SHEET

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SECTION A – Student Details

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SECTION B – Paper already published

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SECTION D – Multi-authored work

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For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

I am the first author on this paper. I was responsible for all aspects of study design, data collection, data analysis, and writing. Cicely Marston assisted in the conception and protocol development, analysis and critical revision.

SECTION E

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7.2 Abstract

Introduction
Seeking menstrual regulation (MR) outside health facilities is common in Bangladesh. Because we know little about women who seek informal services and informal MR can be unsafe or ineffective, we investigated how social contexts influences women's decision to use these informal services. We used an ecological model to examine the social context of women's care-seeking, and how such contextual factors affect treatment-seeking and decision-making.

Methods
We conducted qualitative interviews with 43 women who had MR outside health facilities to understand the lived experiences of our participants. We also conducted informal interviews with stakeholders involved in reproductive health in Bangladesh, as well as observations of formal and informal healthcare facilities.

Results
The participants experienced numerous barriers to care. When seeking care, women spoke about receiving support from other women in their communities, and from their parents and other members of their natal families. They spoke of cultural practices restricting their movements, making it difficult for them to go to health facilities to access care, especially if they were seeking care without their family's financial or logistical support. Some participants told us they did not know where to go to access formal services for MR. Women spoke about difficulties in acquiring information, that they had received no sexuality education as part of their schooling, and that when they were married nobody spoke to them about reproductive health.

Conclusion
The women in this study struggled with virtually all aspects of seeking care. For MR to be more accessible at the community level, the wider cultural context of women's domestic and social lives needs to be taken into account.
7.3 Paper 2

Introduction

Women in Bangladesh live in a specific "local-cultural space/place" (Massey, 1994, p.178), which defines their lives and community in oftentimes narrow and restrictive ways. In this study, we explored how these restrictions affect their access to healthcare, specifically their access to menstrual regulation (MR), which is subject to legal restrictions but available from formal healthcare facilities. MR is defined in Bangladesh as "the procedure of regulating the menstrual cycle when menstruation is absent for a short duration" (Government of the People’s Republic of Bangladesh Directorate General of Family Planning MCH Services Unit, 2013, p.5). Despite the availability of formal services women commonly use informal providers to access MR, approved MR procedures are outnumbered by those provided informally; in 2014 only 430,000 approved procedures were performed in health facilities in 2014, i.e., government hospitals, primary care facilities, non-governmental organization (NGO) clinics, and private clinics, while 1.9 million were performed outside healthcare facilities (Singh, Hossain, et al. 2017).

In this study we used Bronfenbrenner’s socioecological model to context of their lives to investigate reason why women use informal providers, and what barriers they face in obtaining MR safely and effectively. Understanding the circumstances in which women seek informal rather than formal services is a crucial first step to improving access to MR in the Bangladeshi setting. In our theoretical approach we considered different spheres that can influence women to discern with more certainty what barriers they faced, from whom and how, why they make the choices they do, and how to best support strategies to seek safer care. The socioecological model accounts for and conceptualizes different spheres of influence within the participants’ lives, distinguishing how people can be affected by personal choices, family, community, religion, and the wider cultural environment in their care seeking behaviors (Bronfenbrenner 1979).

Bronfenbrenner developed his original model of the socioecological model in 1979 identifying four environmental systems that influence the individual (Bronfenbrenner 1979). The socioecological model gave us “a theoretical framework for understanding the dynamic interplay among persons, groups, and the sociophysical milieus” (Stokols, 1996, p.285). It highlights the synergy between individuals and their social environment (Bronfenbrenner 1979) and focuses on the wider environment within which the individual is situated, using a “whole-system” approach to health (Moore, de Silva-Sanigorski and Moore 2013).
The microsystem describes the person's immediate surroundings, such as family members and their relationships and interactions with them. Women's husbands, for example, may have complete control over household income; in 2014 only 32% of currently married women reported that they themselves decide how their own income was spent, and 13% reported having no say at all in how their own earnings were spent (NIPORT et al. 2016). Families may also be reluctant to spend money on women's healthcare (Schuler, Bates and Islam 2002). In contrast, informal providers may take payment in kind (Mahmud et al. 2015), possibly making them easier to access for women with no access to hard currency. While MR is intended that MR is to be provided free of cost at government facilities, unauthorized fees are common (Vlassoff et al. 2012), and non-governmental or private facilities may use sliding scales, but commonly charge upwards of 800 Taka (US $10) for initial MR treatments (provider, personal communication, March 2015).

The mesosystem describes the space between the person's individual space and their environments, and other individuals directly in contact with them. Bangladesh is a patrilocal society, where women move in to live with their husbands' families after marriage. A move away from their natal home separates them from familiar social networks and structures of everyday life (Schuler and Rottach 2010), and while women commonly retain at least some connection to their matrilineal families after marriage (Perry 2017), without family or social networks they may be unable to ask others for advice and support when seeking MR. Making decisions in isolation limits the possibilities of what women may consider as options (McIntyre, Anderson and McDonald 2001), which may ultimately not include formal MR services.

In Bangladesh, limits can include women’s ability to access the space around them as well. Women can only seek MR in places they can access and with the means available to them to travel and consult a provider. The high numbers of MR procedures sought outside health facilities indicates that in Bangladesh the legal availability of MR has not ensured that women can access these services. The definition of access must therefore be expanded beyond physical presence of facilities and legally available services. A broader definition of access is provided by the UN Committee on Economic, Social and Cultural Rights, and encompasses four domains: non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility (UN Committee on Economic, Social and Cultural Rights (CESCR) 2000). Results from studies on empowerment in and healthcare seeking in Bangladesh suggest that women may be restricted in their access in one or more of these domains (Deb, Kabir and Kawsar 2011; Nahar et al. 2014).
The exosystem includes elements that influence a person's life, such as social services or government policies. This can include the educational system, and a lack of knowledge about sexual and reproductive health may also mean that women remain unaware of where to seek safe care. Fewer than half of ever married women in Bangladesh had ever heard of formal and legally available MR in 2014 (NIPORT et al. 2016), and lack of knowledge is particularly pronounced at the beginning of women's marriages (Khan, Townsend and D Costa 2002).

The macrosystem includes all of the elements from within the culture in which the person lives. In Bangladesh, one of the most powerful elements that governs women's lives is purdah, the traditional gender separation and seclusion of women from the public sphere, under which women are expected to remain in their homes or family compounds, leaving only when accompanied by a male relative (Nahar et al. 2014). While some studies have suggested that the restrictions of purdah are relaxing in Bangladesh (Schuler, Bates and Islam 2002), a recent analysis found that women in Bangladesh remain restricted on all three aspects of multidimensional empowerment: economic decision-making, household decision-making power, and freedom of movement (Deb, Kabir and Kawsar 2011). Married adolescents are the least empowered people in the Bangladeshi social structure and were most restricted in terms of all aspects of empowerment (Deb, Kabir and Kawsar 2011). Women in Bangladesh commonly marry young – the average age of marriage is only 16.5 years (NIPORT et al. 2016) – and most first pregnancies occur between 15 and 19 years of age (Sayem and Nury 2011) these adolescents may face additional restrictions and barriers to seeking care.

Under the gender segregation of purdah, women may also be reluctant to go places where they might encounter men without the accompaniment of a male relative (Islam 1989; Paolisso and Leslie 1995). Speaking to men unrelated to them can be seen as disobedience to their husbands (Naved et al. 2017), and the possibility of speaking to a male being necessary could inhibit care-seeking at both health facilities where male practitioners provide care, or other locations such as pharmacies, which in Bangladesh are exclusively staffed by men (Reiss, Keenan, Dijkerman, Mitu, Nuremowla and Thoai D. Ngo 2015). Purdah is also likely to affect other areas of women's lives, such as that a recent analysis found that in Bangladesh purdah has a statistically significant and negative effect on women's participation in paid work (Asadullah and Wahhaj 2017).

Empowerment may not occur simultaneously across dimensions, and social norms related to gender can affect care-seeking and the way we understand events around us (Connell 2002). Women in Bangladesh reported feeling least empowered and most significantly restricted in
terms of freedom of mobility (Mahmud, Shah and Becker 2012). The Bangladeshi DHS reported that, in 2014, 30% of women across Bangladesh were unable to go to a health center or hospital alone or alone with their children (NIPORT et al. 2016), and a study in 2015, in a rural area found that only 12% of women felt empowered to make their own decisions about seeking healthcare (Mainuddin et al. 2015). Ability to move freely also changes with age; the proportion of women who report being unable to go to hospitals and health centers alone ranges from 25% of women aged 45–49, to 57% for those 15–19 years old (NIPORT et al. 2016). Researchers have hypothesized that, especially in rural areas, women may also be unable to travel long distances to facilities (Singh et al. 2012; Huda et al. 2013; Alam et al. 2016).

In this study, we examined the social context of women who sought MR outside health facilities. We focused on women’s lives in their communities, and how these affect, or were perceived by women to affect, seeking MR. We investigated women’s healthcare decision-making from an ecological standpoint that views behavior as affected by and affecting the social environment (McLeroy et al. 1988). This includes how the women’s cultural context affects care-seeking rather than focusing solely on individual choice and preference. Understanding women’s stories and pathways from their own viewpoints may give us insights into possible strategies and interventions to make seeking MR in health facilities easier for women.

**Methods**

We describe methods in more depth elsewhere (Eckersberger, Marston, et al. 2019b). We used a qualitative design to conduct in-depth interviews between May and September 2015 with 43 women who had had MR procedures outside formal health facilities. We monitored the sample to attempt to interview women of different ages and from different socioeconomic backgrounds to include a wide range of experiences. We used a multi-pronged referral system and also included observation of formal and informal health facilities, and informal conversations with stakeholders and community members. We gave women 200 Taka (US$2.50) to compensate them for costs associated with their participation. Interviews were conducted, recorded, and transcribed in Bengali, then translated into English.

We examined the inter-connected and inter-twined factors that affect women’s care-seeking using Bronfenbrenner’s socioecological model (1979). We initially coded using a grounded theory approach, where data leads to developing themes (Charmaz 2006). We reviewed the themes and coded them according to the domains of the socioecological model for further analysis. This process and mode of analysis allowed us to continue using a data-driven iterative
approach, while also drawing on the structure and theoretical elements of the socioecological model to situate our findings in existing theory. We took a social constructivist approach to analysis, explicitly acknowledging that theories are “a construction-reconstruction of reality” (Charmaz 2006) and that women’s experiences occur within “socially constructed situations and social structures” (Charmaz 2008).

The study was approved by the London School of Hygiene & Tropical Medicine Ethics Committee, Marie Stopes International Ethics Committee, and Bangladesh Medical Research Council.

Results

The participants we interviewed were women aged 19 to 45. Most women had completed at least elementary school and all but three were married at the time of their MRs. Only nine women ultimately sought postabortion care at locations we could confidently identify as formal facilities by name or location, such as particular non-profit facilities or government hospitals.

The women in our study appeared to interact with and be influenced by two spheres of Bronfenbrenner’s socioecological model in particular: the microsystem – their families – and the macrosystem – the attitudes and ideologies that constitute the wider culture they live in. (Bronfenbrenner 1979) Their families and the cultural ideology of their communities regulated where they live, how they navigated space, and how they accessed care. None of the participants testimony demonstrated health systems, media, or industry, for example, as influencing their decision-making or care seeking behaviors.

Microsystem

Barriers to care in the microsystem

Most women described receiving little support from their husbands or in-laws when they wanted an MR procedure, and in some cases faced open hostility to accessing care. Some who observed purdah said their husbands were their only source for goods and services from public spaces, including healthcare. This meant that if they did not want to disclose their MR to their husbands, they were unable to seek formal care or access health facilities. Women reported not wanting to disclose or ask for their husband’s support of their MR because the husband had been unsupportive in other areas, such as refusing to use condoms before to prevent the
pregnancy. In some cases, these women reported having MR procedures without disclosing this to their husbands.

Accessing care – whether formal or informal – was difficult for women without their husbands’ support. For example, when asked how she had made the decision not to continue with the pregnancy and seek an MR, one participant responded:

Participant: Yes, he made the decision, otherwise would I have been able to bring it [the medication] and have it [the MR]? Oh God! (laughs)

Interviewer: Why? You couldn’t do it with only your decision?

Participant: No, impossible! (Participant 10)

Women who had accessed informal MR told us they could have sought formal clinics if they had received support from their husbands and families. In this particular case, the woman did not want to even disclose the MR to her husband for fear of his disapproval:

If […] my husband was good, then I would have had him take me to the hospital, but my husband is not good; he would have shouted at me […], so I didn’t go. (Participant 32)

In one case a woman’s husband actively prevented her from accessing a health facility: "We didn’t go to the doctor at first because it was embarrassing and all that […] and he was embarrassed about it and thought other people would know." (Participant 24) Other interviewees reported that their husbands simply stayed uninvolved and left the decision to them. One woman, for example, told us her husband did nothing to stop her from seeking MR, but also made it clear that he wanted nothing to do with the MR: "He just said the liability is yours, I won’t participate in this sin" (Participant 4).

In some cases, however, interviewees reported their husbands were helpful and offered support: they were involved in procuring medication or information or went to consult with the pharmacist after the woman developed complications from the informal procedure.

Strategies to overcome barriers to care in the microsystem

Women reported that, when they needed MR, the most supportive and trusted people in their lives were their parents or female community members. Despite living with their husbands and
in-laws, women were sent to, or went back to, their parents to have the MR or when they needed further care. This was for conveniences, so that the woman’s family could care for her if she needed assistance, or sometimes so the husband’s family would learn nothing by accident in their own community. Only women of higher socioeconomic status, either university students or those working outside their homes in professional roles, reported asking friends or peers for advice and assistance.

Mesosystem

Barriers to care in the mesosystem

Even where husbands and partners tried to be helpful and offer support however, women reported finding it difficult to engage with them, preferring to confide in female friends. Female support, in particular, was felt as an important facilitator to being able to access health facilities:

The main reason is that there wasn’t anyone to be at my side, a companion, like my mother or sister, or if my sister-in-law had been living close by at the time [...] if there had been someone like that then perhaps I would have gone to a clinic. (Participant 7)

Strategies to overcome barriers to care in the microsystem

In light of these restrictions, women reported finding ways to seek MR that circumvented the barriers they encountered. In cases where women reported being unable to navigate the public sphere themselves, they told us their mothers, aunts, mothers- and sisters-in-laws, sometimes husbands, or even employers and informal providers brought medication and other informal methods such as sticks and homeopathic medicines to their homes. A common strategy was to enlist the help of other, mostly older, women who – with increased age – could navigate the public sphere in ways the women themselves could not. The participants described these female neighbors and community members as family, using the Bangladeshi “vavi” (literally: sister-in-law, used to describe close female relations) and “apa” (literally: sister, used to address women with respect and affection). One participant who did not want to disclose her MR to her husband described her process:

If I want to go anywhere I have to get his permission. Or I have to go there with him. And I didn’t want him to know about this matter [the MR]. That is why I consulted with my mother and had it [the medication] brought from the pharmacy. (Participant 15)
Another participant, a university student, who moved freely in the public sphere, spoke extensively about her friend’s support in the process, both in helping her seek the MR but also in understanding how her life would be impacted if others were to learn she had had the procedure. This friend was a medical student who took her first to a maternity clinic for an ultrasound and then to a paramedic’s house to have an MR clandestinely.

Participant: She just shouted at me again and again.

Interviewer: [...] was she nice?

Participant: (laughing) No! She just shouted at me! [...] 

Interviewer: Really?

Participant: Because she loves me a lot and she said “How could do this? Why weren’t you more careful?” And I just said I didn’t think about it... I didn’t think about it, I don’t think it [the pregnancy] could happen. She said, “Why didn’t you think?!” At that time, she asked me questions, but if I tried to give any kind of explanation, she just shouted at me (laughing). [...] 

Interviewer: Was she shouting like she was nice, like (exasperated voice) “You shouldn’t have done this!” or was she very angry?

Participant: She is nice, and she was very thoughtful, I think... she’s ... she was very thoughtful about the solution. She is trying to rescue me [...] During this time [the MR] I felt very bad, because when the doctor did the ultrasonography he told me that “we found the baby’s heartbeat” and for this reason I felt very bad with it, and S [her friend] told me not to feel bad; “after some time you’ll become pregnant again, you’ll get it, there will be another baby, there will be another baby coming to your womb. don’t feel bad about it.” She said lots of things, “We’re doing this for a better future...” [...] [After the procedure] I had the ultrasound report in my bag and when we started our journey to my house, from the clinic, from the paramedic’s house, S [her friend] took all the papers and just [makes ripping gesture].

Interviewer: Ripped them?
Participant: Hmm (affirmative). Just threw them in the dustbin (laughing) and make little, little, little piece of the paper (laughing) and throw it in the dustbin. And I said, “Why did you do this?” because, and she said “We did lot of things for our parents, for the society and if you took this and if anyone see this, notices it, then what would you say. No need to take this. Just throw it away.” (Participant 40)

The details of Participant 40’s account highlight the complexities and life effects women must consider when making their decisions. Even with freedom of movement, physical access to facilities and accurate information, this participant felt she could not seek care at a formal health facility.

Women also described going to informal providers after previous experiences had shown that they would were unable to access formal health facilities for MR. One woman spoke about making a clandestine trip to a health facility, her husband following her there and bringing her back home before she could seek MR. When she then wanted another MR she went to an informal provider to avoid detection.

**Exosystem**

*Barriers to care in the exosystem*

Women noted a lack of knowledge of reproductive health and where and how to seek services, often specifically at the time of their own MR, which prevented them from seeking formal care, which points to an unmet need for education. Women spoke about learning more about reproductive health over time, specifically noting that they knew more now, at the time of the interview, than when they were younger and newlywed. They reported learning nothing about MR and that no comprehensive sexuality education was available to them when growing up. One woman described how, at the time of the MR, she “had only just got married, and I was a student before that. Talking about such matters while being a student was out of the question” (Participant 12).

Some women had their husbands support and assistance, but even with this were not able to access formal care. Participants told us their husbands knew nothing about MR and were unable to help them, or directed them to ask others for advice, and generally believed it easier for the women themselves to acquire further information. Participants commonly told us their spouses instructed them to talk to their own friends or referred them back to their mothers for further advice, even when the husband had friends who had studied medicine.
Seeking information about MR was particularly difficult for participants who did not want to disclose the MR to their immediate families. These women recalled they had little involvement in general healthcare decisions in their household, one saying that “my mother in law, she gives me advice on how to treat the children, what to do... [...] she directs us to go to the doctor” (Participant 9). When she then wanted an MR and did not want to disclose this to family members, she did not know where to go herself, and had nobody to turn to for advice.

**Strategies to overcoming barriers in the exosystem**

When women turned to those around them, the information received was in some cases helpful, in others women received incorrect information about safe and effective methods and providers. None of the women reported questioning the advice they received; in most cases they reported going along with the suggested method or informal provider and did not speak of having questioned this method or having sought another option or opinion. Women were sometimes aware that the person they asked for advice was not particularly knowledgeable and unlikely to provide accurate information, but reported they had nobody else to ask:

I did not have a grandmother in my family, I didn’t have an aunt. Where would I get to know about MR [such as] which method involves less risk, which method is safer for me? Then I did not understand any of it, I was young, and I was embarrassed. I told my mother, who was also an old-fashioned person, she said she had a sister-in-law who used to carry out kobiraji [traditional medicine] treatment. (Participant 12)

**Macrosystem**

**Barriers to care in the macrosystem**

Women reported that purdah confined them to their homes and prevented them from seeking formal services. Particularly when first married, women faced severe restrictions of movement: “At that time I was a newlywed wife, it was prohibited of me to go outside” (Participant 19). They spoke directly of the link between this lack of mobility and being able to seek care at health facilities: “At the time I was newly married, I couldn't come to this place” (Participant 35). The possibility of men being involved in providing the procedure was particularly problematic, and women reported feeling unable to speak to male pharmacists, because they never had contact with men outside their families: “I didn't go to any male person before, for seeking anything” (Participant 25). This unfamiliar encounter made the woman shy in front of the male pharmacist, and reluctant to ask for more information on the medication he gave her.
Women related nothing about restrictions of movement specific to cost or distance of the formal service, but repeatedly told us that simply *going outside* was difficult. Participant 36, interviewed at her home in a rural area, reported:

> I am a very secluded person. I have three children, but I don’t even go to any neighbor’s house. [...] My mother in law is young. So, she also has the habit of talking about my whereabouts. (Participant 36)

We encountered this narrative at various points throughout the study, from women in different areas and from diverse socioeconomic groups. We were told, for example, by a well-known local artist (who spoke English well and interacted regularly with both Bangladeshi and foreign visitors in her home and studio), that all her landscape paintings were from photographs because she could not go outside the family compound. Community members and research assistants confirmed the ubiquity of this confinement, saying it could last anywhere from six months to five years after women were first married. Women who shared the office with one of the researchers (EE) during this study described similar versions of this restriction; they had studied, had had some freedom of movement, now worked as doctors and bankers, but outside of traveling to and from their workplaces they rarely went anywhere without their husbands.

Not all participants faced the same restrictions. Some women from higher socioeconomic statuses reported regularly going outside unaccompanied especially if university students, and some women reported going to healthcare facilities by themselves for other ailments, or procuring pills from pharmacies for their MR.

*Strategies to overcome barriers to care in the macrosystem*

Women reported that people in their communities could impede or facilitate their access to formal MR. Some women worried that going to health facilities would expose their visit to people who knew them. One woman, with both the means and contacts to seek official MR from a formal health facility maintained she was unable to access any of these places because people there knew her and her family; she was afraid of anyone finding out about her visit. Others noted the opposite as true, and they could only go places where they knew someone and sought informal care from women they already knew in their communities.

Conversations with community members revealed that in smaller communities everyone knew other community members’ whereabouts, and that, in particular, men watched women in their
daily lives. Public spaces in Bangladesh are overwhelmingly male-dominated; an informal count by the research team found between 20–25 men to every woman in the street at any given time. Women in the study noted being watched and observed, and Participant 3’s husband, who met her at the end of the interview, told the study team about watching women in the neighborhood in which they lived, and knowing their whereabouts. He stated with certainty that he knew which women were buying what at the pharmacy he frequented. One participant in the rural community mentioned that she sometimes traveled to neighboring towns to shop or run errands, as men in her own village congregated in the market and streets and would watch her movements in public. She said their behavior resulted in gossip and comments on her whereabouts and actions from other community members, which she found uncomfortable and annoying.

Discussion
Women spoke about a range of barriers to seeking formal MR in health facilities, and our findings show that the MR procedure, as it currently available, is not enough to ensure access for women. The interrelated difficulties women faced comprised both structural and cultural barriers; in some ways women struggled with virtually all aspects of seeking care. When they wanted MR women found themselves in difficult positions; they knew they had insufficient information on where to seek formal care, little if any support from their families to do so, and could not move freely outside their homes to access health facilities.

Bronfenbrenner’s socioecological model was particularly useful in highlighting influences in women’s lives, as well as those areas that were absent from women’s narratives (1979). The model describes a number of factors that could influence women’s ability to seek care and make decisions, but in the end, in Bangladesh, only a small number of factors such as family support and cultural restrictions, were mentioned.

Purdah – mainly located in the macrosystem – particularly affected women’s ability to seek safe and effective care. In contrast to other studies, which found that cultural and social restrictions on women were relaxing (Schuler, Bates and Islam 2002), we found that mobility and movement were, among our population, still severely restricted. A women’s place – and space – is still the home; these women could not easily navigate public spaces, which remain the spaces of men. In these women’s accounts men were viewed as the proverbial flaneurs (as described by Wolff): urban explorers and strollers, free to observe and judge those around them (1985). For some women, familiarity with community members appeared to complicate care-seeking.
Health facility visibility may then present a dilemma for these women: while it makes sense for clinics to be visible to assist access the women in our study viewed this visibility as a detriment.

Women spoke of being alone when they sought MR, elements of which stretched from the micro- to the mesosystems; their homes and their communities. Moving into their husband’s homes upon marriage significantly affected women’s decision-making power and ability to seek information. Living in an unfamiliar new community, women may believe their husbands do not support them, but are constrained by custom and cannot leave their homes to make acquaintances. In just the testimony of the women in this study, we found a cause and effect: if they had a support system and others to help them, they could have made better decisions. Their assumption may ultimately be accurate; research has shown that couples who agreed on decisions were better able to meet their contraceptive needs (Uddin, Pulok and Sabah 2016), and the same may be true for MR and abortions. The small circles these women moved in lacked those most willing to help, or were seen as most responsible for helping them: primarily their parents and natal families.

While barriers cut across several domains, strategies to overcoming the barriers lay firmly within the microsystem as the restrictive environment affected how much women could move, learn, and access services. Even where barriers to seeking care could be found outside of women’s immediate microsystem – such as a lack of comprehensive sexuality education in their schooling – women turned to – mostly female – family members or close acquaintances for support. This finding lies in contrast to a study in Malawi that similarly used a socioecological approach to analysis, but found that the factors influencing how women sought sexual and reproductive care were highly interrelated and could be located under different spheres (Gombachika et al. 2012).

Despite restrictions and barriers the women in our study found ways to retain control over their lives, even if they themselves knew their approach was imperfect. They found ways to navigate their environment and use the tools and options available to them, although in this study they were used imperfectly as women remained unable to access health facilities. In some ways the option to seek government-approved MR seemed like an illusion of choice (Harcourt 1996), and the women’s narratives reflected them going to the only provider, or using only the method, they believed was available to them. This point, however, also illustrated that not all women faced the same barriers, and that some overcame their particular barriers easier than others, especially those of higher socioeconomic status or those with more education.
Not all participants described the same barriers, however, and women’s experiences varied. In the face of restrictions women developed agency of their own (Schütte 2014) and sought MR to the best of their knowledge and abilities. Women who had more positive experiences were generally more educated and less restricted under purdah; they were also in positions where they could ask someone with medical knowledge for more information, be it a physician friend or pharmacist. For some women there would likely also have been an element of luck that determined their more positive experiences; the neighbor or family member they sought had accurate information and was willing to assist them; or the informal provider they sought decided they would help them instead of turning them away for reasons of their own. The fact that over one million women sought MR despite facing restrictions and barriers indicates that the space in which they can and cannot seek care is a contested space where agency and resistance are dynamic (Kumar, Hessini and Mitchell 2009).

The women in our study mentioned not being able to access various elements outlined in the UN Committee on Economic, Social and Cultural Rights definition of this term (UN Committee on Economic, Social and Cultural Rights (CESCR) 2000), such as freedom of movement, ability to pay for services, or accessing correct information, which were mentioned in the interviews as reasons women could not access services in facilities. The attitudes and ideologies that accompany purdah show the importance of considering women's environment as a variable when investigating their decisions and behaviors.

In examining the data from a socioecological perspective, we found we could not fully capture how women’s lives – in particular restrictions of movement – changed significantly over time. Women appeared to live freer lives as small children in elementary school, then lived under most restricted conditions when they first married, and finally less restricted conditions again later in their lives, as their status in their families and communities changed. These women must therefore redraw their freedom of movement at different life stages, and they showed keen awareness of other women in their lives doing the same.

This study will have missed women unable to overcome barriers to obtain the MR they wanted, or those who never revealed their MR to anyone. Similarly, we will have missed women who believed they were going to an approved health facility and instead had gone to an informal provider, or those unsuccessful in terminating their pregnancies and carried them to term.
Conclusion
Bronfenbrenner’s model highlights the various elements that affect the individual and the world constructed around her. Wold asserts that “. . . [t]he world is full of examples of people with good personal functioning who feel nevertheless unfulfilled because their social environment is not supportive” (Wold and Mittelmark 2018), which bore out for the women in my study: individual change was difficult because their environment was unsupportive. Therefore, we must first focus on the conditions and environments in which women live, not on policies and organizations that attempt to produce individual change, as many public health interventions have done (Golden and Earp 2012).

This failure to produce change can be especially true when women cannot influence or overcome the barriers they face, i.e., those socially constructed, as in this study, such as restrictions of movement or lack of education, and which men inhabiting the same society do not face. The model also highlighted areas that appear not to play a part in women’s lives at all. This does not make the model less useful, but highlights what possible interventions could focus on, and where they might not be particularly effective. Any attempts at making MR more accessible to women at the community level must include a consideration of the restrictive social environment they live in, and women’s perceived lack of options and knowledge, especially when first married.
Chapter 8. Interactions with Providers of Informal Menstrual Regulation in Bangladesh

8.1 Introduction
This chapter includes Paper 3, on the individual interactions and relationships women had with informal MR providers and the experiences of seeking the MR procedures outside formal health facilities. Interview questions concerned healthcare seeking for other health issues because we had hypothesized that seeking care for MR procedures may follow similar or related patterns especially considering cultural barriers Bangladeshi women face in all aspects of their lives. We ultimately found that participants sought providers specifically for MR, and that reasons for this choice related to both the specific service sought, their relationships with the providers, and the larger structural environment of formal healthcare provision in Bangladesh.

In examining women’s interactions and relationships with MR providers, I found elements of all three domains described in Coast et al.’s framework on trajectories to seeking abortion related care (2018). Women described abortion-specific elements such as not wanting to disclose seeking this particular procedures, individual elements such as believing the informal provider treated them better due to their own circumstances, and structural elements such as previous experiences with the formal healthcare system acting as deterrents to attempting to seek care there again.
RESEARCH PAPER COVER SHEET

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<td>Primary Supervisor</td>
<td>Prof Cicely Marston</td>
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For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)

| I am the first author on this paper. I was responsible for all aspects of study design, data collection, data analysis, and writing. Cicely Marston assisted in the conception and protocol development, analysis and critical revision. |

SECTION E

| Student Signature | [ ] |
| Date | 24 August 2019 |

| Supervisor Signature | [ ] |
| Date | 05 Sept 2019 |
8.2 Abstract

Introduction

Women in Bangladesh commonly seek menstrual regulation (MR), “a government approved procedure of regulating the menstrual cycle when menstruation is absent for a short duration” outside health facilities. They seek informal providers, some who conduct MR with possibly unsafe methods. Reasons for this are not entirely clear; in this paper we investigate women’s interactions with informal providers of MR, exploring why they chose these and their experiences with them.

Methodology

We conducted 43 interviews with women who had had menstrual regulation procedures outside health facilities, and also conversations with key stakeholders, such as community health workers or local reproductive health experts, as well as observations of formal and informal health facilities.

Results

The participating women's stories demonstrate that most found formal providers difficult to access. Most women sought care for complications, and described further difficulties in seeking care at formal health facilities. The informal providers participants sought were almost exclusively female, and women noted that these providers occupied safe spaces more accessible to providing clandestine care. In nearly all cases women were aware that they were seeking informal providers, not qualified professionals and formal healthcare facilities. Participants also described structural barriers to seeking formal care, such as needing their husbands’ signatures to seek formal providers.

Discussion

Women spoke of different care profiles between formal and informal providers, and purposefully sought out informal providers, who were better able to meet their needs. Informal providers occupy a space that is more easily accessible to women without having to disclose their MR procedures.
8.3 Paper 3

Introduction

When women in Bangladesh seek menstrual regulation (MR), they are influenced by both (infra)structural aspects such as being able to access transport or ability to pay (Victoor, Delnoij, et al. 2012; Victoor, Friele, et al. 2012), as well as beliefs they hold in respect to the causes of the disease, proper forms of communication with providers and community members, and perceptions of therapeutic outcomes (Ross et al. 1998). MR is an approved alternative to abortion and available from government facilities (Bangladesh Directorate General of Family Planning MCH Services Unit 2013; Singh, Hossain, et al. 2017), yet in 2014 1.19 million procedures were performed outside health facilities or by unapproved providers in addition to the 430,000 performed by approved providers in health facilities (Singh, Hossain, et al. 2017). MR outside health facilities is associated with higher mortality than official, approved MR (Rahman, DaVanzo and Razzaque 2014) and in 2014, 275,000 women undergoing such procedures from informal and possibly untrained providers were treated for complications (Singh, Hossain, et al. 2017).

The aim of this study was to better understand women’s interactions with informal providers of MR. We explored where and to which provider women went for MR, whether they knew these were informal providers, and their experiences in using these providers. We also investigated why women sought a particular informal provider.

Coast et al. recently published a conceptual framework on abortion-related care trajectories, including all known factors of such trajectories and how they influence women in seeking abortion-related care (2018). Their framework groups influences shaping women’s trajectories into three categories: abortion-specific experiences, individual context, and (inter)national and sub-national context. In this paper we use this framework to investigate the relationship between women seeking MR and the informal providers they seek.

Abortion-specific experiences

Women seek a variety of informal providers for MR; pharmacy workers (men selling medicines with no formal medical training), traditional healthcare providers, untrained village doctors, and homeopathic practitioners (Kapil Ahmed, van Ginneken and Razzaque 2005; Iqbal, Hanifi and Wahed 2009; Alam et al. 2013; Reiss, Keenan, Dijkerman, Choudhury, et al. 2015; Reiss, Keenan, Dijkerman, Mitu, Nuremowla and Thoai D. Ngo 2015). Studies looking at overall healthcare have found that up to 80% of Bangladeshis use or prefer traditional healers and medicine over modern methods (Harun-Or-Rashid et al. 2011; Karmakar et al. 2012). Seeking
care for MR may follow this general pattern and seeking informal providers for MR may simply follow where women seek other healthcare they require. Providers may also vary by type of illness or disease (Groenewoud et al. 2015), and care-seeking for MR may look different than for other health issues; being a likely infrequent issue in a sensitive situation may mean women cannot build relationships and acquire knowledge the same way they can for care-seeking for reoccurring chronic conditions, for example (Culwell and Hurlwitz 2013). Reputation, cultural familiarity, and ability to pay on credit or in kind may also play roles in healthcare provider selection (Rashid, Akram and Standing 2011) and yet others hypothesized that fear of community disapproval, stigma and shame may be reasons women avoid seeking MR at health facilities (Bhuiya, Aziz and Chowdhury 2001; Kumar, Hessini and Mitchell 2009; Kamran, Arif and Vassos 2011; Singh et al. 2012; Yasmin et al. 2015).

Social norms related to gender play a major role in women’s lives in Bangladesh, and seeking MR – seen as “women’s business” (Bhandari et al. 2008) – is likely to be governed by specific social and gender norms which may determine what is socially acceptable to discuss with a healthcare provider (Kaba and Sooriakumaran 2007). Research focused reproductive issues – but did not specifically include MR – showed that all traditional informal providers women sought for reproductive care were female (Ross et al. 1998), and that for “menstrual irregularities” less than 10% of Bangladeshi women went to formal medical doctors, 27% to village doctors and pharmacists, 13% to homeopathes, and 10.9% to family planning workers (Rashid, Akram and Standing 2011). Seeking contraceptives appears to follow a different pattern: 50% of women using modern contraceptives currently get their supplies from the public sector, 38% from pharmacies and the remainder from private hospitals, non-governmental organizations, and other private sources (NIPORT et al. 2016).

**Individual context**

Availability of MR at health facilities is uneven (Hossain et al. 2017) and while the procedure is intended to be furnished free of cost, providers frequently levy unofficial fees (Chowdhury et al. 2004; Vlassoff et al. 2012). MR providers have also been found to require signatures from husbands of women seeking MR, despite no legal requirement for women older than 18 years to obtain them (Piet-Pelon and Rob 1999; Ganatra and Visaria 2004; Vlassoff et al. 2012; Huda et al. 2013). Additionally, in 2014, 27% of women seeking MR were turned away at the facilities that provide MR for reasons such as exceeding the gestational limit for MR, not currently having children, being too young, being unmarried, having no consent from the husband, or other unspecified medical reasons (Hossain et al. 2017). In one study, Mahmud et al. conclude that women chose informal providers on trust and long-standing relationships (2015); in another,
Hamid Salim et al. note that convenience, affordability, and social and cultural reasons play a role (2006), while further studies have concluded that they could not discern reasons for women seeking informal providers (Bhuiya, Aziz and Chowdhury 2001; Rashid, Akram and Standing 2011).

**Inter)national and sub-national context**

Study authors have hypothesized that providers’ legitimacy may be difficult to discern for some women; traditional village doctors may have practices that to some are indistinguishable from those of licensed physicians (Hamid Salim et al. 2006), and women may not be able to discern whether the facilities they go to are authorized to perform MR (Hossain et al. 2016; NIPORT et al. 2016). Healthcare providers themselves occupy specific positions in the community, and have reputations as specific persons providing care within a particular context and possibly a particular disease (Kaba and Sooriakumaran 2007). Healthcare clients use information differently when faced with different diseases and severities of their disease; they also have individual choice profiles they use to make healthcare decisions, such as beliefs about morality or socioeconomic or individual health characteristics (Groenewoud et al. 2015; Coast et al. 2018). Legal and informally enforced structural barriers may also affect women’s access. A severe shortage of licensed healthcare professionals in Bangladesh means that informal providers vastly outnumber professionals (95% to 5%) (Ahmed et al. 2011; Khan et al. 2015).

Bangladeshi women seek both formal and informal providers within a system of established power dynamics. Patient-provider relationships take on predominantly paternalistic (Szasz and Hollender 1956) forms, which may be exacerbated by strong patron-client relationships in Bangladesh, which result in poor people – and particularly women, who in Bangladesh suffer from an unequal power dynamic and lack of agency and decision-making (Shahabuddin et al. 2017) – having difficulty seeking appropriate care without a more powerful and influential patron to support them (Schuler, Bates and Islam 2002).

**Decision-making**

Literature on decision-making for abortions commonly focuses on reasons why women have abortions and not, ultimately, on how they chose the methods or providers once deciding to terminate their pregnancy. Considering the possibly stigmatizing nature of MR in Bangladesh (Norris et al. 2011; Eckersberger, Marston, et al. 2019b), we referenced frameworks on decisions with emotional tradeoffs (Bettman, Luce and Payne 1998), and how emotions before and after decisions can affect how these were made (Luce, Payne and Bettman 2001).
**Methods**

The full methods for the study are described in more depth elsewhere (Eckersberger, Marston, et al. 2019b). We conducted in-depth interviews with 43 women who had received MR procedures outside formal health facilities. We monitored the sample to ensure that we interviewed women of different ages and from different socioeconomic backgrounds to include as wide a range of experiences as possible. We used a multi-pronged referral system and included observation of formal and informal health facilities, and informal conversations with stakeholders and community members.

The interview guide included questions on the context of the woman's MR, the type of medication and provider, her experiences during the process, whether or not she thought she had a complete MR, how relationships and community affected her decisions, and barriers to seeking care in clinics. We gave women 200 Taka (US $2.50) to compensate them for costs associated with their participation in the study. We conducted and recorded interviews, transcribed them in Bengali, and then translated them into English. The PI (EE) worked closely with translators and interviewers to ensure the narratives were rendered in English as clearly as possible, and to gain crucial contextual information for the analysis.

We took a social constructivist theoretical approach to analysis, meaning we explicitly acknowledge that theories are a construction-reconstruction of reality (Charmaz 2006), and that women’s experiences occur within socially constructed situations and social structures (Charmaz 2008). Interviews were initially coded using a grounded theory approach (Glaser and Strauss 1967), and the developed themes were then reviewed and coded along Coast et al.’s framework categories, with which we highlighted the main themes we identified from the interviews (2018). This process and mode of analysis allowed us to continue using a data-driven iterative approach while also drawing on the structure and theoretical elements of Coast et al.’s established framework.

The study was approved by the London School of Hygiene & Tropical Medicine Ethics Committee, Marie Stopes International Ethics Committee, and Bangladesh Medical Research Council.

**Results**

We interviewed 43 Bangladesh women, ages 19 to 45, most women having at least elementary school education, and all but three married at the time of the MR. Only nine women ultimately
sought postabortion care at locations the study team could confidently identify as formal facilities by name or location, such as a particular non-profit facility or government hospital. Women reported seeking a variety of informal providers for MR, and described diverse interactions with both formal and informal healthcare providers.

We identified the following themes from the interviews: (1) Women seek different MR methods from a variety of informal providers; (2) Difficulty of seeking postabortion care at health facilities; (3) Women criticized for their choice of provider; (4) Seeking informal providers to conceal the MR; (5) Informal providers safe spaces for some women, unsafe for others; (6) Women turned away by informal providers; (7) Difficulty accessing formal providers; (8) Gender as an important part of seeking MR with informal providers; and (9) Women's awareness of their not seeking care at formal health facilities.

We divided the themes by the subcategories of Coast et al.'s framework on abortion care-seeking trajectories (2018): (1) Abortion-specific experiences; (2) Individual Context; and (3) (Inter)national and sub-national context. Below we outline each theme and give results taken from participant interviews for each.

**Abortion-specific experiences**

*Women used different MR methods from a variety of informal providers*

The participants reported seeking and using a variety of providers, such as former paramedics and midwives, pharmacists and untrained former hospital staff, homeopathic and local medicine providers, as well as relatives or community members. Women told us they had manual vacuum aspiration (MVA) in homes, rooms adjoining pharmacies or in informal clinics, and took different medications from various sources: homeopathic or traditional medicine, or pills of unknown medications from pharmacies. Women also reported multiple methods from the same provider; women reported receiving MVA and medication from the same informal provider, or reported having gone to a pharmacy for medication only to be directed to informal providers conducting MVA adjoining the shop. Participant 5 described how two "old women" working alongside a male pharmacist provided MVA in the pharmacy building: “They keep it [the MVA] hidden. Yeah, they have a flat on the first floor [of the pharmacy] and they do it there.”

Women knew to ask for allopathic medication (i.e., they asked for specific medication from a pharmacy as opposed to seeking homeopathy or traditional remedies) and never mentioned seeking out any other methods by name. None of the women discussed asking for a specific
medication by name, ultimately taking whatever pills they were given either by the pharmacist, or family member or acquaintance procuring them. We asked the women what medication(s) they had taken, but only one was able to tell us the brand name and dosage (Participant 12).

Most women we interviewed did not describe asking for a specific method for MR; rather, they described a process focused on the outcome; a successful MR, or termination of their pregnancy. Whether they could, in fact, obtain an MR seemed to be more important to them than how it was performed, and women reported letting the provider choose the method.

Women were criticized for their choice of provider
Women reported being criticized and scolded for their actions by both formal and informal providers. Formal providers admonished women, but nearly all this criticism concerned the perceived safety of the initial methods and informal providers women had chosen, not the MR itself. By women’s accounts, the criticisms centered around the danger they had put themselves in by seeking MR outside approved centers. For example, one woman described the doctor’s response in a clinic where she had sought care for complications: “Then he said it [the MR] wasn’t done the right way. Said it wasn’t right to get that work done by such women [the informal providers].” (Participant 14)

Seeking informal providers to conceal their MR
Women maintained they could use informal providers more easily without anyone in the community finding out. As Participant 22 put it, “one way or another” people would know if she went to a formal clinic. Women appreciated that the homes or pharmacies where informal providers worked were not immediately associated with MR or even health services; for example, about the informal provider who performed her MR, Participant 5 noted: “the place doesn’t look like a place where they do MR.” Formal community health centers and reproductive health clinics commonly have clearly visible signs identifying them as such, and our conversations with community members revealed that such facilities were well known by people in the area. Women reported that some of the informal methods – medication, both allopathic and homeopathic/traditional, and other traditional methods, such as sticks inserted into the vagina or uterus – had the added benefit in that someone else could bring them to the woman’s home without her having to go anywhere outside her home. Women also trusted the informal providers to keep their confidence, and one woman emphatically stated: “She didn’t tell anyone, and she won’t either!” (Participant 22)
Participants reported that to their knowledge informal providers made no official or paper record or appointments or treatment, leaving no evidence of the MR having taken place. This was alternatively viewed as a positive and negative practice, in addition to secrecy women were aware that it also meant a lack of accountability. Participant 8, who had severe complications after the treatment by the informal provider, told us that "even if I died that day, there was no way to catch them. There was no proof of what they did."

The stigmatizing nature of MR meant that women felt the providers would themselves be negatively affected their providing MR became public, and they were invested in keeping their service provision secret. As one woman told us: "Will they not ask her [the provider] 'Why are you doing this?' If my children, husband, father in law, and mother in law find out what I have done, won't something happen to her?" (Participant 35)

**Individual context**

*Informal providers created safe spaces for some women, unsafe for others*

Women drew direct comparisons between how their perceptions of and experiences with formal providers led them to seek MR with informal providers. Women reported being afraid, linking that fear to a sense of being powerless over what – possibly more invasive – procedures would be performed. As one woman told us: "I got scared that they would use the syringe to pull it out." (Participant 17) and another spoke of not feeling comfortable asking the pharmacist she sought for additional information about the medication he gave her. In contrast, women felt comfortable openly discussing treatment options and disagreeing with informal providers. One woman reported the informal provider had suggested she undergo an MVA because the woman was too far along in her pregnancy for medication. The woman instead wanted to try medication first, which the provider gave her, but ultimately she returned to the same provider later for an informal MVA when she deemed the medication not to have terminated the pregnancy.

Informal providers were sometimes community members known to the participants, such as relatives or local women, which was important if women lived in their husband’s village and knew few people, or if they did not want to ask someone else and have to reveal the MR. Sometimes the informal providers were relatives: "I told my mother [...] she said she had a sister-in-law who carries out kobiraj [traditional medicine] treatments” (Participant 12). Another woman referred to the informal provider as akin to family: "[...] she’s like my sister” (Participant 22).
Which providers women were comfortable consulting varied, and being familiar with a formal provider could make seeking care or asking for advice more difficult. Participant 24 reported that she and her husband had spoken about consulting a – as far as the study team could tell, respected and well liked – community health worker when seeking MR, but ultimately her husband was too embarrassed to speak to the healthcare worker about MR and they therefore did not seek her advice.

Women considered informal providers convenient and supportive of them and their lives. They reported the informal provider considering their relationships or ability to pay and charging them less: “She does take money from others, but she didn’t take any from me. She knows me.” (Participant 29). Others told us that informal providers are more flexible and made life easier for them, by doing things like delivering the medicine for MR directly to their homes.

*(Inter)national and sub-national context*

*Women were turned away by informal providers*

For the women in our study being turned away by informal providers was a more common experience than from formal facilities. Only one woman (Participant 43) attempted to seek MR in a formal health facility first; she went to a government-run public facility (“government clinic”) and reported being denied service because the paramedic she spoke to had said that “this might be the child that would take of her when she was old,” and refused to perform the MR. The traditional belief that the children take care of the parents when they get older is common in Bangladesh, although in this case the participant already had five living children, male and female. She found an informal provider instead and had a successful MR.

The experience of being turned away by informal providers was common. One woman was turned away by an informal provider for reasons unknown to her, despite this provider commonly providing MR to other women in the community, including, coincidentally, the woman above who had been turned away from the government clinic. Another sought MR from an informal provider fearing that this fifth pregnancy she was carrying would be another girl, and she already had four daughters. She was turned away by the informal provider, who said she (the informal provider) would take care of the child if it was another girl. Both women ultimately sought a different informal provider for MR.

*Formal providers were disrespectful and presented additional barriers*

Women who had sought treatment from the formal healthcare sector for other types of care described these experiences as another deterrent to seeking MR there. They said they felt the
formal providers disregarded their time and efforts and treated them poorly. They recounted long wait times, complicated ticket systems, and uncertainty about whether they would even be seen. Participant 35 spoke with frustration of trying to see a doctor at S, a government hospital:

When I first went to S, I didn't get to see the doctor, and I went there again the next day. The next day the doctor said: “[...] I don’t have time, I’m leaving.” So, I left. Two days have now been lost. [...] Sometimes it takes one day—it takes the whole day at the doctor’s! (Participant 35)

Women described barriers to seeking formal care they had not found with informal providers. One of the reasons for not accessing formal providers, women explained, was formal providers requiring their husband’s signature and approval. Women who wanted the MR without their husbands knowing, or had husbands unsupportive of their choice, therefore felt they could not go to a health facility. In contrast, none of the women in our study reported being concerned about or ultimately being asked to provide their husband’s consent by the informal providers they sought. Participant 27, for example, told us her relationship with her husband was not trusting enough to confide in him about wanting to have an MR; so, when asked why she didn’t seek care at a clinic, her main reason was the need to get an MR without her husband’s consent and signature (in this case from R, a government hospital):

It wouldn't happen without his signature; the husband's signature is needed everywhere. [...] R requires the husband’s signature. [...] It wasn’t needed with that woman [the informal provider she sought]. (Participant 27)

Women drew direct comparisons between formal and informal providers. A woman who had multiple MR procedures with both formal and informal providers, noted the difference between care she had received and what she paid at the two locations. She felt she received more cost-effective treatment from the informal provider:

I went to N [informal provider, a former paramedic], I paid 1000 taka (US$12) and she also gave me medicine. When I did it at T [Nonprofit clinic], they didn’t give me any medicine and I still paid 1000 taka. N gave me pain killers, vitamin tablets and saline. T gave me nothing; I just wasted my money there. (Participant 4)

In comparison, Participant 28 reported that the formal provider had been kinder to her than the informal provider, and that the doctors “behaved well” while the local healer “was a bit rude.”
In some cases women also were correct in the belief that the informal providers would offer services formal providers would not. One woman reported having gone to a clinic where she was told that at four months gestation, there was nothing they could do. She instead sought care with an informal provider where she believed – and was ultimately correct – that she would receive the service there.

**Difficulty of seeking postabortion care at health facilities**

Of the 43 women we interviewed, 34 considered their initial MR either unsuccessful or needing further treatment; yet, ultimately only nine participants sought care at formal healthcare facilities. Most women initially went back to the same informal provider they had sought for MR, not going to formal facilities until they believed they were very unwell, describing symptoms such as fainting, prolonged bleeding, and months-long pain. Women described the same barriers to seeking postabortion care as for initial treatments and saw these as a last resort for care, when most or all other options had been exhausted.

Additionally, one woman reported that when she did seek postabortion care at a formal facility, the provider initially refused to even examine her because she had not had the initial MR procured at that clinic. The formal provider told her what she had done was illegal, and if they treated her now they would be implicated in this illegal activity. She described her self and her husband pleading with them, until the formal provider eventually conducted an ultrasound and prescribed medication that appeared to have resolved her remaining pain.

In some cases, needing and seeking follow-up care put women in exactly the position they had sought to avoid by seeking MR outside health facilities. Participant 31 described a difficult relationship with her husband after disagreements over birth control and his refusal to use condoms, and she knew he was unsupportive of MR. She had therefore sought a local healer, where she could go to alone when she needed an MR, and who gave her roots to insert into her uterus. She later, however, had severe complications and had had to tell her husband of her attempt to procure an MR because she needed his help to access the formal facility for postabortion care.

**Gender as an important part of seeking MR with informal providers**

Gender appeared to compound uneven power dynamics and paternalistic aspects of participant seeking care with formal providers. In addition to obviously gendered requirements such as needing the husband’s approval, women also talked about previous interactions with formal
providers where they believed they were not taken seriously because of their gender. One woman reported earlier experiences at government facilities, saying she no longer went to seek care there due to these experiences.

I don’t go because if I go and say something, they don’t give it much value or importance, there at S. [Government Hospital]. If I go and tell them that I had a ligation [Note: this could be a tubal ligation] and ask them for medicine, they say that they don’t know. They don’t want to give it to me. (Participant 34)

Women also reported gender norms affecting where they could seek care and avoiding spaces where they would encounter men. One woman stated that she believed that being treated by a female provider was easier for her:

I discussed it with two doctors, one of them said to do it in a clinic, and as a woman I got embarrassed and all [laughs]. So, did it with a woman. He said that a woman would do it for me, a man wouldn’t do it, even then I had a fear and panic about what would happen. Then after discussing it with this woman I […] did it with her. (Participant 7)

Women reported sometimes receiving medication from men in pharmacies and one participant described a male provider conducting an ultrasound, but all other providers discussed in their narratives were female. All physical procedures reported by participants were performed exclusively by female informal providers. In pharmacies, a collaboration between male and female informal practitioners occurred, and women reported that "[...] the doctor [pharmacist] is male and the procedure is done by a woman" (Participant 35); participants sometimes called the female collaborator a “Lady Doctor.” In two cases, it was the pharmacy worker’s wife who provided MR in a room adjoining the pharmacy. While many women expressed concern about interacting with male providers, this was not universal. One woman, for example, told us explicitly that she had not avoided the clinic because doctors there might be men but that they had gone to a pharmacy because her husband was too embarrassed to seek formal care.

Women’s awareness of their not seeking care at formal health facilities
Women’s narratives suggest that they distinguished between formal and informal providers within the Bangladesh health system, and in most cases knew which was which. They described their usual healthcare providers, which they sought for other services including contraception, by specific formal names referring to family planning clinics and government hospitals. In
contrast, they referred to the informal providers by first name, or simply as pharmacists or pharmacy workers, clearly thinking of these as different from formal health facilities.

Women used the word English word “doctor” to describe nearly all healthcare workers they encountered, including, in some cases, pharmacy workers. Despite this usage, their narratives demonstrated they understood these persons were not medical doctors with degrees in medicine, commonly referred to “MBBS Doctors” (Bachelor of Medicine, Bachelor of Surgery) or “pash kore doctor” (literally: Exam-passed doctor). Sometimes they used similar descriptors for informal providers, using phrases like “Doctors manush” (literally: doctor person) or “Grameer doctor” (literally: village doctor), or “khokon doctor” (literally: lady doctor).

Women also distinguish the places where they had their MR from the official health facilities they visited for other healthcare. Participant 8 distinguished the informal provider as: not “like the diagnosis centers that are in Mirpur, it’s not like them,” and Participant 2 distinguished between informal and formal physical attributes in describing where she went, “there is a machine there, but it doesn’t have facilities like other clinics.”

Informal providers appeared to gain their reputation of competence by association; their being peripherally related to health facilities appeared to make the women in our study assume that they had medical expertise. One informal provider was a retired midwife from a government hospital, another had been a cleaner at a clinic. In several instances, the informal providers were trained paramedics, either working from home, because their clients wanted to avoid being seen going to the clinic, or – as we were told by local community health workers – because they had lost their positions as paramedics by providing MR in a facility that did not support it.

In another case, Participant 27, was convinced that the facility she had gone to was a formal health clinic, as it was near a large government hospital (T) and staffed by someone who had formally held a position there. Although the participant insisted that the provider was a nurse, according to other parts of her narrative this provider had been employed as a cleaner, not in any medical capacity at the hospital.

Interviewer: Inside? The doctor at T saw you?

Participant: No, the women got rid of it. [...] she took me to a clinic behind T.
Interviewer: What clinic is that? [...] Where you went behind T afterwards, is that an actual clinic?

Participant: Yes, she is a woman from T, she is retired, so she opened a clinic at her house.

Interviewer: She used to work at T?

Participant: Yes.

Interviewer: Do you know what she used to work there as?

Participant: She was a maid [...] 

Interviewer: And does she only do MR or other things?

Participant: No, she only does MR, she also prescribes medicine for those who have big problems, like I saw that one girl went, the unmarried girl suffered a lot, she kept the girl at her house for 2 days and did it on that girl. [...] 

Interviewer: And how did you find out about that? [...] 

Participant: Yes. The maids at T, they ask you what do you want to do, you want to do an MR? So, if you tell them you want to do an MR they ask you to come with them, it is difficult at the T so come, let me take you there. [...] There are the women there who sweep and stuff, they take you to that clinic. (Participant 27)

The participant’s description of this particular information provider indicates that she believed the provider she visited was qualified after having worked at the government clinic, even if in a non-medical capacity, and that the former cleaner provided compassionate care for girls, such as unmarried girls and those who are suffering, where others did not.

Discussion
Participants in our study knowingly went to informal providers and made no mention of worrying about the safety or quality of services, which may be different from those done by
formal providers. We found a number of areas where participant interactions with abortion providers influenced their decision-making, care-seeking, and experiences with MR. When women spoke about their experiences, they spoke of elements within and across the different domains Coast et al.’s framework of seeking abortion-related care (2018).

**Abortion-specific experiences**

Women’s choice of provider was influenced by their not wanting to disclose seeking the initial MR, but many ultimately found themselves having to reveal the MR once they faced complications from an informal procedure. This is an addition to how “disclosure” is described in Coast et al.’s framework, which describes the disclosure of the initial pregnancy to others (2018). Women in our study described what can in some ways be seen as a “forced disclosure,” where they either believed they had no choice but to disclose the procedure in order to seek the postabortion care at formal facilities they felt they needed or had complications they were unable to hide from those around them.

The informal providers women described seeking occupied a specific place in their communities, and women did not seek them for other services. This points to MR being different from other healthcare and may mean participants are particularly constrained: they seek a voluntary, stigmatizing, and time-sensitive treatment within an environment where they have insufficient knowledge to seek safe care and are restricted in their movements. Participant assumptions that informal MR providers would want to keep their provision hidden additionally illustrate how abortion stigma is also extended to those who provide abortions (Mitchell et al. 2005).

**Individual context**

Participants described informal providers being cognizant of their individual’s specific circumstances – their gender, their ability to pay, their gestational age, who would take them seriously – they felt the informal provider provided a safer space within which they would receive treatment. This belief may either stem from the worry that providers would be men and, by patriarchal rules, make decisions for women out of hand, or that providers, regardless of gender, would not take the women's concerns seriously.

In examining how women chose from provider and treatment options, we found that decision-making was largely outcome-oriented, and women went sought the provider where they felt confident about receiving the MR they wanted. For them, choice among options depended critically on their goals (Bettman, Luce and Payne 1998). Multiple-goal attainment and changing
preferences with contextual factors (Fishbach and Dhar 2008) may also explain why women felt comfortable going to formal health facilities for other health issues, but went to informal providers for MR. Women also describe situations where they face violence or humiliation if they disclose their thoughts about seeking MR, in which case “a tradeoff is not just a tradeoff” (Luce, Payne and Bettman 2001) when multiple goals with different emotional values and goals underlie their decision-making (Fishbach and Dhar 2008). Their goals were more closely aligned with Bettman's hypothesized “minimizing negative emotions” and “getting it done” rather than seeking best possible medical expertise and quality of care (Bettman, Luce and Payne 1998). Considering the barriers women faced in seeking care (Eckersberger, Marston, et al. 2019a), they may also not have believed they even had choices, and simply took the option at hand.

**((I)n)national and sub-national context**

Women in our study knew they were seeking informal providers and had no trouble distinguishing between the two, unlike hypothesis in previous studies from Bangladesh where authors suggested women may be unable to discern informal from formal providers (Hamid Salim et al. 2006; Hossain et al. 2016; NIPORT et al. 2016). Women did however ascribed a level of expertise to informal providers, distinguishing them from those with medical degrees, but using words such as “Lady Doctor”, suggesting that despite being aware these were not formal medical doctors, participants believed such providers were part of the spectrum of where to seek healthcare. Large government hospitals and non-profit clinics known by name could be perceived as synonymous with the highest level of care or most officially provided care, and providers associated with lower levels of healthcare provision – such as pharmacies – as not as official, but still part of the healthcare provision spectrum. Informal providers who provided only MR, such as informal providers who perform MR in their homes, are ultimately viewed as a particular type of provider for a particular illness – in this case, MR.

Only one woman in our study attempted to seek care at a formal facility before turning to informal providers, unlike other studies that found women are routinely turned away from formal providers where MR is legally available (Vlassoff et al. 2012; Hossain et al. 2017). Rather, we found that women were commonly turned away from informal providers. This points to a larger societal perception of MR and associated stigma (Kumar, Hessini and Mitchell 2009), as reasons informal providers gave mirrored those of formal providers who turned women away (Hossain et al. 2017).
Other authors have suggested that those women who are turned away from healthcare facilities may seek what they call "safe illegal abortions," performed by trained providers outside office hours or in homes, because such women were at least aware that MR exists and knowledgeable about clinics and trained providers (Singh et al. 2012). We found this not to be the case for participants in my study; the barriers to seeking care with formal providers were such that visiting the clinic location after hours, or traveling to a home far from their own, were not more viable or easy options than seeking care with formal providers in the first place for the MR. The only two participants who described this type of care-seeking – i.e., with formal providers outside of formal clinic hours or locations – were university students who had the means and knowledge to seek formal care, but chose not to because they wanted to keep the procedure secret, and were able to make the provisions to see formal providers secretly.

Previous experiences and interactions appeared to act as strong deterrents for women in considering formal providers, describing formal providers' rude or condescending behavior. Women, already negatively affected by power structures, were particularly affected by this unequal power dynamic. This may also be why women did not seek care with the well-liked, but formal, community health worker – they might have associated her with the "formal" health system and avoided approaching her for something they considered stigmatizing and for which they might face judgment. A study examining maternity care similarly found that longer wait times and overcrowding increased the likelihood of dissatisfaction with care (Mehata et al. 2017). Studies in India have found that doctor availability and shorter wait times, among other factors, enhance the probability that women will use a particular facility for reproductive health purposes (Anand and Sinha 2010b).

When examining Coast et al.’s “health systems” component, we found examples of concepts related to the “individual” domain; however, not for the women themselves, but for the individual informal abortion providers and the role they played in women's care-seeking (Coast, 2018). Providers reacted in very empathetic ways, but also inserted their own belief systems into the care provided. Scolding women for using unsafe methods, or denying certain women abortions while providing them for others influenced women's trajectories in nuanced ways that go beyond the informal/formal provider binary. This study shows how the influential individual personal characteristics of abortion providers can be in the care-seeking process, beyond whether or not the provider will provide the service.

Women’s narratives suggest an overall perception that poor people are treated poorly by the system, and that especially poor women therefore seek a specific type of “lady doctor,” who will
treat them appropriately and with respect. While documenting practices of mistreatment at health facilities overall has improved, less research has addressed structural gender equalities, and women – especially those who defy traditional stereotypes of chastity – remain disproportionately disadvantaged in seeking care (Betron et al. 2018). This could mean that because Bangladesh’s healthcare system is paternalistic, and those in lower economical spheres have trouble accessing care, such women seeking a stigmatized procedures may face even more difficulties.

**Decision-making**

We found that women’s decisions were more complicated than merely minimizing negative emotion and maximizing the ease of justification of their decision (Bettman, Luce and Payne 1998). In some cases, decisions for providers and methods were made primarily because women did not want to disclose their MR. In others, however, they spoke of a more outcome- and knowledge-based approach to their decisions; they wanted an MR and went to the person or place they knew could assist them with this. Women noted they could make their decisions in that moment, under those particular circumstances. They talked about knowledge limiting their options. At times it appeared that the existence of other providers, including formal health facilities, was an “illusion of choice,” (Harcourt 1996) rather than a real possibility when combined with money, knowledge, access, and the social and cultural aspects present in everyday life of the woman.

Recruiting women using community-based methods was a difficult process, and we will have missed women who never revealed their experiences to anyone. Our recruitment methods will also have missed women unaware that their provider was not a formal MR provider, those unsuccessful in terminating their pregnancies, and women who decided to carry to term. We also supplemented data gained from interviews through extensive fieldwork during the PI’s (EE) 18 months in the field. While in many cases this means that the data collected was more nuanced, it could have biased the data. For example, we believed the community health worker was well liked and respected – the team spent long stretches of time with her, valued her insights, and observed how she interacted with the study team and patients alike; but our high opinion of her could also have led us to overvalue her compassion, which she may not have shown to all patients alike.
Conclusion
We identified informal MR providers as providing a specific service for women, inhabiting a space easily accessible for women; they were local, female, and able to provide MR in confidence, often in a hidden, environment. Women's choice of informal providers and their interactions with them remind us that human behavior is shaped by the structure of the task environment and the abilities of the actor (Simon and Alexander 1977; Turpin and Marais 2004). Women could have had little choice in where they went for healthcare and seeking MR in particular – gendered and stigmatized in its nature – which compounds the barriers these women face. Cultural barriers that prevented participants from moving freely limited the providers they could access; finally, their choice was about access: finding someone who performs the MR and will also not turn them away.

This current study is, to our knowledge, the only one that has attempted to recruit women exclusively through community-based methods and not through health facilities. While most women (34 of 43); sought further care after their initial MR attempts, only nine of these ultimately sought care from formal providers at health facilities. That women described difficulties and negative attitudes from others in their seeking post-MR or postabortion care is particularly worrying and could indicate that many with complications from unsafe, informal MR never received appropriate care. Researchers who recruit women at facilities where they are seeking care for complications after MR are likely to work with providers who readily accept and treat postabortion care patients, and will miss reports of providers turning away women seeking postabortion care.

Future interventions in these women's lives and health, especially in seeking MR, must continue to incorporate gendered economic power structures, and relationships women have inside their communities and with providers, and how all these affect care-seeking behavior. Even before structural changes can be brought about, or MR made more widely available, first steps are to insure that all women can access high quality post-MR care. This step includes being able to seek both without risking familiar or community incrimination, fear of condescension or being turned away. Another future strategy includes formal care facilities working with informal providers, as research has shown that abortions can, for example, be safely provided by pharmacists and under “self-use” guidelines by women themselves.
Chapter 9. Using Allopathic Medication for Menstrual Regulation
Outside Health Facilities in Bangladesh

9.1 Introduction
Chapter 7 (Paper 3) described the various providers women sought, and women's interactions and experiences with them. One method women described using was allopathic medication procured from a variety of informal providers. In Chapter 8 (Paper 4), we analyzed a sub-sample of the women interviewed, all of whom had used allopathic medication, procured without a prescription to attempt their menstrual regulation. These women used a method that has been termed "less-safe" rather than "least safe" or "unsafe" (Ganatra et al. 2017), in comparison to many other methods the participants described using. Of all providers and methods women sought in our study, allopathic medication from pharmacies holds the greatest potential for women to use safely and effectively outside health facilities and we focused on their experiences in more detail.

While abortion with medication is becoming increasingly common, women's preferences and experience with self-use of medication for abortion has been identified as an important research gap (Kapp et al. 2018). This paper is organized differently from the other chapters; instead of focusing on a specific aspect of women's experiences, I here focus on the overall experiences and stories of women using allopathic medication, spanning their perceptions to outcomes of a single method. In light of the possibilities of allopathic medication for self-use, it was important to investigate all aspects of women's care-seeking pathways and experiences.

In examining women's experiences with allopathic medication, I found elements of all three domains described in Coast et al.’s framework on trajectories to seeking abortion related care (2018). Participants described abortion-specific experiences such as seeking the medication as a first attempt at MR and, then, perceiving it to have failed, their individual context dominated how much they knew about this particular method they had chosen, and described their perceptions of the national context, wherein they told us they had not sought medication from formal healthcare providers.

I wished to explore the case of women who used medication for MR, because self-use of medication for abortion is becoming more common globally (Gomperts et al. 2008; Sneeringer et al. 2012; Footman et al. 2017). What we found, however, was a slightly off-kilter set of circumstances; we were unable to confirm what medication women had taken and could only
provide a situation analysis of women using unknown allopathic medication for MR rather than what might be compared to more formal or better known: MRM (menstrual regulation with medication), or medical abortion in other settings. Regardless, this analysis describes what occurs in settings where women have some knowledge and some access to medication. However, situations like this – where women know medication for MR exists, but then take unknown medicines to treat their unwanted pregnancy – show us important problems that may occur in other settings too.
RESEARCH PAPER COVER SHEET

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I am the first author on this paper. I was responsible for all aspects of study design, data collection, data analysis, and writing. Cicely Marston assisted in the conception and protocol development, analysis and critical revision.

SECTION E

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9.2 Abstract

Introduction

Abortion is restricted in Bangladesh, and menstrual regulation (MR) exists as an alternative, for which an increasing number of women use allopathic medication from pharmacies without prescriptions. Not much is known about these women, and in this paper we explored their objectives and experiences in seeking and using allopathic medication for MR from informal providers.

Methods

We conducted a multi-method qualitative study in urban and peri-urban Dhaka including 43 interviews with women who had undergone MR outside health facilities, and observation of official and unofficial facilities for MR, as well as informal interviews with key stakeholders. Fifteen of our interviewees had used medication for MR, most commonly obtained indirectly (via a third party) from pharmacies or informal providers of manual vacuum aspiration.

Results

We found that women's family members made decisions about using medication for MR, rather than the women themselves. Only one woman knew what medication she had used. Many women deemed their procedure unsuccessful, suggesting they may have used ineffective medications or incorrect doses or not known how to recognize a successful MR. After the medication failure, women returned to the same informal providers for further unregulated, more invasive, services. They only sought services from official sources after exhausting other options.

Discussion

Women obtain medication for MR from informal providers via go-betweens (e.g., family members). Our participants experienced unsuccessful procedures and sometimes painful and distressing physical symptoms. Our findings suggest that a comprehensive intervention is needed in Bangladesh to improve knowledge and use of medications for MR not only among pharmacists and drug sellers, but also for the health and well-being of MR clients and their family members.
9.3 Paper 4

Background

Using medication for abortion from pharmacies can be a safe and effective alternative to surgical methods in health facilities (Giri et al. 2015), and pharmacists can be instrumental in expanding women’s access to abortions (Sneeringer et al. 2012), especially where abortion laws are restrictive (Jelinska and Yanow 2018). For this, pharmacists and pharmacy workers must know the correct medications and regimen, and provide correct information, including instructions and procedures for cases where a woman experiences complications (Sneeringer et al. 2012). Access to safe and effective abortions remains unequal even within the same legal environment; a study across 10 legally restrictive countries found that poor and rural women were more likely to self-induce abortions (Singh et al. 2018). Recent studies show that when women have sufficient information on drug, dosage, and mode of use, pharmacists can provide medical abortion, assess outcomes and need of possible follow up care effectively (Sherris et al. 2005; Hyman et al. 2013; Tamang et al. 2017). Misoprostol is more readily available and cheaper than mifepristone (Costa and Vessey 1993) and is commonly used over-the-counter without a prescription in lower and middle income countries such as Bangladesh, where access to safe and legal services is restricted (Sherris et al. 2005).

In Bangladesh, where abortion is restricted, MR is an approved alternative and defined as “the procedure of regulating the menstrual cycle when menstruation is absent for a short duration” (Government of the People’s Republic of Bangladesh Directorate General of Family Planning MCH Services Unit, 2013, p.5). Until recently, MR was legally available only as a surgical procedure using manual vacuum aspiration (MVA), but in 2013 the Directorate of Family Planning approved a combination regimen of mifepristone and misoprostol for medical MR (mifepristone and misoprostol), which can be prescribed by clinic-based personnel who have received training for MR with medication (MRM) (Bangladeshi Directorate General of Family Planning 2014). A prescription is needed for the medication, and is not currently available through government facilities (Government of the People’s Republic of Bangladesh 2015). In 2014, approximately 1.19 million MR procedures occurred outside approved healthcare facilities (Singh, Hossain, et al. 2017), and women in Bangladesh reported accessing MR outside approved health facilities from traditional providers, untrained village doctors, and homeopathic practitioners (Kapil Ahmed, van Ginneken and Razzaque 2005).

Purchasing abortifacient medications from informal providers is increasingly common globally (WHO 1994; Gomperts et al. 2008; Wilson, Garcia and Lara 2010; Dzuba, Winikoff and Peña 2013; Footman et al. 2017), and off-label use of misoprostol without prescriptions is common in
Bangladesh (Alam et al. 2013; Reiss, Keenan, Dijkerman, Choudhury, et al. 2015). When women purchase abortifacient medications – or what they believe or are told are abortifacient medication – from informal sources they may not be receiving the correct medication at correct dosages. Moreover, little is known as to whether they are receiving sufficient information on how to use the medication and identify successful outcomes or when to seek follow-up care for complications.

While MR is not officially called abortion per Bangladeshi law (Akhter 2001; Bangladesh Directorate General of Family Planning 2014; Hossain et al. 2017), previous research suggests that women view the procedure – whether performed surgically with MVA, with allopathic medication or other traditional methods – as a termination of pregnancy (Eckersberger, Marston, et al. 2019b). This links MR procedures to the global agenda on the self-use of abortifacient medication or medical abortion, which has also identified women’s preferences and experience with self-use of medication for abortion an important research gap (Kapp et al. 2018).

Pharmacy workers in Bangladesh commonly sell misoprostol without physician’s prescriptions (Alam et al. 2013; Reiss, Keenan, Dijkerman, Choudhury, et al. 2015), but lack formal training; their shops are unregulated (Ahmed and Hossain 2007) and they may provide incorrect or insufficient advice (Huda et al. 2014) on dosage and use. A mystery client survey in 2011 found only 7% of pharmacists offered an effective regimen of misoprostol (either alone or with another medication (Huda et al. 2014), while in 2015, 54% of pharmacists were able to provide the recommended dosage of the mifepristone and misoprostol combination (Huda et al. 2017). Rates for counseling on side effects and complications remain low, and the mystery client survey found that only 11% of pharmacists counseled clients on possible complications (Huda et al. 2017). Another survey found that 80.5% of mifepristone and misoprostol users were sold the correct regimen, versus only nine out of 20 misoprostol-only users (Footman et al. 2017). The same study found, however, that nearly one in five women who reported purchasing the pre-packaged combination pack containing mifepristone and misoprostol failed to receive the correct dosage of medication, and only 69% of those who received the full pack with the correct dosage took the correct regimen (200 mcg mifepristone followed by 800 mcg misoprostol after a 24-hour interval (WHO 2012; Footman et al. 2017). This means that even where medication is available and pre-packaged in correct doses, women may not always purchase, receive, or use it correctly.
Studies have investigated women’s choices between different MR methods in clinics (ICDDR B 2011; Nanda and Mishra 2011; Alam et al. 2013), and their experiences of using medication for MR in clinical settings (Marlow et al. 2016). A lack of research remains about women using medication for MR outside these settings in Bangladesh. Authors have noted that reasons for women seeking MR outside approved health facilities remain unclear (Bhuiya, Aziz and Chowdhury 2001), although lack of knowledge (Bates et al. 2003), desire for privacy (Bhuiya, Aziz and Chowdhury 2001; Kamran, Arif and Vassos 2011), uneven service provision (Hossain et al. 2012), and cost (Akhter et al. 1998) have been posed as possible factors. Studies have recruited women seeking care for complications at health facilities after taking medication from MR from pharmacies (Giri et al. 2015; K and Shanthini 2015), but these could not capture the experiences of women who had successful MR procedures with the medication, or who sought care for complications from informal providers instead of going to formal facilities, a common practice in Bangladesh (Eckersberger, Marston, et al. 2019c).

In this study, we investigated women’s experiences of using non-prescription allopathic medication for MR outside approved health facilities in Bangladesh with the aim of understanding why they used unapproved sources, and their experiences using these medications. In this paper, we use the term “allopathic medication for MR” to describe the method women used, as it represents the most accurate description of women’s experiences in the current legal setting. Previous studies have used terms such as “menstrual regulation with medication” (Hossain et al. 2017) or “medical MR” (Hena et al. 2013), both abbreviated as “MRM.” Women in our study reported using both allopathic and homeopathic medication from a variety of providers, but this study only focused on those who reported using – what we perceived with reasonable certainty to be – allopathic medication. We therefore used a phenomenological approach to investigate a particular shared lived experience (Husserl 1931).

We undertook this study before the mifepristone-plus-misoprostol treatment was approved, and provide insight into the conditions into which it is now being introduced. The study may provide further insights into how women can best be supported in safe and effective use of the combined mifepristone-misoprostol pack, or the continued use of misoprostol alone. We distinguished between medically trained pharmacists and men (women do not usually work in this capacity (Reiss, Keenan, Dijkerman, Mitu, Nuremowla and Thoai D Ngo 2015)) working in pharmacies as “pharmacy workers,” with limited training and knowledge of medications and pharmacology (Sneeringer et al. 2012; Alam et al. 2014). “Pharmacies,” in Bangladesh, constitute any location where allopathic medications are sold, regardless whether staff are trained, or the facilities are registered as such.
In this study we describe the elements of women’s experiences across the domains of Coast et al.’s framework on abortion-related care trajectories, which includes all known factors of such trajectories and how they influence women in seeking abortion-related care (2018). This framework groups influences shaping women’s trajectories into three categories: abortion-specific experiences, individual context, and (inter)national and sub-national context.

Methods
Full methods are described in more depth elsewhere (Eckersberger, Marston, et al. 2019b). We conducted in-depth interviews with 43 women who had undergone MR procedures outside formal health facilities. Women aged 16 to 49 years who had used any method of MR outside approved health facilities were eligible to participate in the study, whether they had chosen to use medication or not. Of the 43 women interviewed, 15 reported having taken allopathic medication for MR, which they had either obtained themselves or which someone else brought to them from a pharmacy or other non-approved health facility. This study focused on the experiences of this sub-sample of 15 women. We used a multi-pronged referral system, and included observation of formal and informal health facilities and informal conversations with stakeholders and community members.

We devised an interview guide that included questions on the context of each woman’s MR, the type of medication and provider, her experiences during the process, whether she had a complete MR, how relationships and community affected her decisions, and barriers to seeking care in clinics. We gave women 200 Taka (US$2.50) to compensate them for costs associated with their participation. Interviews were conducted, recorded and transcribed in Bengali, then translated into English. The principal investigator (EE) worked closely with translators and interviewers to ensure the narratives were rendered in English as clearly as possible and to gain crucial contextual information for the analysis.

We took a social constructivist approach to analysis and explicitly acknowledge that theories are a “construction-reconstruction” of our reality (Charmaz 2006). In this study, women’s experiences occur within socially constructed situations and structures (Charmaz 2008). Results are presented along the main themes as we identified them from the from the interviews, and how they relate to the study objective of investigating women’s experiences with medication for MR. In this paper we identified the following themes from the interviews: (1) Women sometimes chose medication as first step in seeking MR; (2) Most women deemed
the medication not to have worked; (3) Women knew to ask for medication for MR, but could not give further details; (4) Women’s overall awareness of medication for abortion was low; (5) Seeking correct information possibly related to support network; (6) Women had not considered going to formal providers for medication; and (7) Women sought medication from many sources.

We sorted the themes into the three domains of Coast et al.’s framework on abortion care-seeking trajectories (2018): (1) Abortion-specific experiences; (2) Individual context; and (3) (Inter)national and sub-national context. Below we outline each theme and give results taken from participant interviews for each.

The study was approved by the London School of Hygiene & Tropical Medicine Ethics Committee, Marie Stopes International Ethics Committee, and Bangladesh Medical Research Council.

**Results**

Of the 43 women we interviewed, 15 spoke about using allopathic medication procured by themselves, or an acquaintance, from pharmacies. Fourteen of the 15 women were married; one was separated. Five said they had never worked a paid job, and six others described themselves as housewives and had previously held work, such as in the garment industry or making and altering garments at home, or as a domestic worker, landlady, or day laborer. Two participants were tutors and one worked in fashion design. The participants were aged 20 to 39 years. All but one had children; 11 had two or three children, two had one child, and one had four. All but two women had some education. Four had left school without completing primary level, one had left without completing middle school, and five had left before completing secondary level. Two had completed secondary level and one attended a religious school. Most had left school when they got married. Thirteen of the 15 women had used medication for MR between six months and four years before the interview, one had done so six years previously, and two within the previous 10 years.

**Abortion-specific experiences**

*Women sometimes chose medication as a first step in seeking MR*

In the trajectory of attempting to seek abortion care, women described using medication from informal sources as a first step to end pregnancies, sometimes specifically to avoid possible treatment at a formal clinic. They said they knew that taking the medication might not be
sufficient to end their pregnancies, and noted the possibility of follow-up treatment. In some cases the person providing the medication to participants instructed them that if it did not work they would need to return for further procedures. One woman, for example, described her initial discussion with her informal provider:

I said that I will try it at home [with medication]. If it doesn’t happen then I will go [have the MVA]. Then I contacted her when I planned to go [have the MVA]. (Participant 35)

Many women knew about the concept of MR from general talk with neighbors, relatives, and friends; their knowledge about MR and such was gained from their social circle. A typical scenario, given in the interview with Participant 35, covered what she had heard about ending her pregnancy by getting MR from an informal provider:

Participant: I heard from someone and someone else, I heard that something like this can be done. [...] 

Interviewer: [...] at that time did you know that it was called MR?

Participant: No.

Interviewer: then what did you ask for at that place?

Participant: Back then I said – ‘is it possible to get rid of [noshto, literally: spoil] the baby? Can anything be done?’ That’s all I said. Then they said ‘Yes, yes, can be done’.

Interviewer: Did you do it that day?

Participant: No, two or three days later.

Interviewer: How much did it cost?

Participant: It cost... not too much. Because it’s a village. If we went to a large hospital it would cost a lot. As we live in the same village and she is somehow related to us [...] 

Interviewer: How much money did you pay?
Participant: [...] Around 300 [taka]. [...] she gave me medicine to take.

In this case the information that the information provider would charge less is correct; an MR – whether MVA or medication for MR – costs upwards of 800 Taka (US$10) in formal health facilities.

**Most women self-diagnosed medication failure**

Women’s lack of knowledge about medications for MR included not knowing what to expect physically with symptoms and aftermath, which affected their experience of the procedure overall. Women reported having only a vague idea of what would happen once they took the medication, such as that there would be bleeding or that the process would take 24 hours. Most said they had no idea at all what to expect. Women reported being scared before taking the medication and during the experience of its effects. Seven, or just under half, reported experiencing distressingly heavy bleeding and severe pain lasting up to 10 days after they took the medication. In two cases, these symptoms were accompanied by loss of consciousness. Three women reported having felt unwell for two to three months after using the medication.

 [...] my body was so weak, and I was so out of it that I really couldn't tell. From the morning I was unconscious [...] There was just pain. Like the pain you have after delivering a child, even more painful. I mean that much pain. (Participant 9)

All the women who tried to use medication for MR were ultimately successful in terminating their pregnancies. Over two-thirds of women (11) underwent additional procedures after they had taken medication. Three of these 11 described taking a second round of medication and two of these went on to have a surgical procedure. The remaining women either went from what they considered “unsuccessful” MR with medication to undergoing MVA procedures from informal providers, or went to female informal providers to obtain manual “clearing” of their uteruses with gloves or hands. MVA providers often operated from a room upstairs or adjoining a pharmacy, suggesting they were worked in tandem with the pharmacy worker. In some cases, women said the informal providers supplied allopathic medication for MR, and subsequently also conducted the informal MVA procedures.

After using the medication, women told us they themselves assessed whether the MR had been successful. Some women reported that “nothing happened” after they had used the medication; they judged their MR to have been unsuccessful and sought further treatment. Others, who experienced bleeding and pain judged the MR to have been unsuccessful, and said they believed
they needed additional treatment. This second group of women gave few specific details about how they had self-diagnosed the medication’s failure. For instance, they noted that the amount of bleeding they experienced was important in determining the MRs success, but provided no details on how they assessed or what amount they considered to indicate MR success or failure. When we asked for more information, these participants simply reiterated that they “knew” the medication had not worked. Most of the women said they waited overnight to see whether the MR had been successful (in their view) before seeking additional care. Only one woman mentioned waiting two days.

When asked, our interviewees told us they had not considered going to clinics for follow-up care, although one woman reported worrying she would be refused treatment in a clinic because she had not gone there for the initial MR. Despite sometimes describing frightening experiences, such as excessive bleeding and becoming severely ill, few women reported having sought follow up care in official facilities, only doing so when the situation was very bad. Participant 24, for example, stated:

I hadn’t stopped bleeding after seven or eight days. I went to the [formal] doctor as I became very ill.

Allopathic medication from pharmacies was not chosen for any one specific reason
In the context of Bangladesh, pharmacies were not described as easier or more difficult to access than other providers or treatment options, and women did not discuss this having influenced their choice of method. Where women used medication brought to them by others, the decision to disclose the desire to terminate their pregnancies was generally expressed before the choice to use medication was made. In these cases, participants accepted the method they were given, whether medication or other methods.

**Individual context**

*Overall awareness of methods for MR, including medication, is low*
Women’s interviews demonstrated an overall lack of awareness of medication and other methods for MR. Only the 15 women who had used medications spoke about medication for MR at all during the interviews. This lack of familiarity with the specifics of MR methods available in Bangladesh was typical across participants in the study, regardless of what methods they ultimately used. Women who had used methods other than medications for their MR were generally unable to explain in more detail what their method had entailed. For example, those
using traditional medicines could not name the roots or tree medicine they used; most who
described a surgical procedure knew neither the name of that procedure or what it entailed.

Women used a variety of ways to describe the MR when they arranged the procedure. Women
commonly distinguished between “medicine” and “MR” to end pregnancies. One woman told us
of how she knew of MR and medication: "[...] my mother got to know it [MR] from others,
everyone knows it really from one another. That it [bleeding] comes if you take medicine or do
an MR” (Participant 5). In one case, a participant told us she was unaware the medication was
meant for an abortion, saying she had been ignorant, believing it just worked to "restore her
menses”, stating she knew now she had in fact been pregnant.

Women asked for general abortifacient medication for MR instead of brands or specific drugs
Women knew to ask specifically for allopathic medicine for MR, but seemed not to know what
medication they had used. They were clear that such medication differed from traditional
remedies which came from old women or traditional healers, such as bonati (tree medicine), or
homeopathic medicines; they referred to allopathic medication as bori (tablets) or oshod
(medicine) and commonly referenced pharmacies. Women also commonly distinguished
between different types of medication when speaking of both medication they used for MR and
medication they used for other ailments. For example, Participant 30 distinguished clearly
between remedies she used for other ailments: "[...] sometimes I also took homeopathy along
with allopathy.” Women spoke about the differences in effectiveness of various types of
medication; for instance, that homeopathic drugs worked slower than allopathic medication.

Even with detailed questioning only one woman knew the exact medication she took
("Isovent©”; misoprostol). Most participants reported taking two tablets, although others
reported being given one, three, or five tablets, and took them by a variety of methods: orally
(with or without warm water), under the tongue, vaginally, or a mixture of oral and vaginal
routes. Women clearly demonstrated the understanding that specific allopathic medication for
MR existed, and none reported using or requesting other types of medication, such as
contraceptive pills or painkillers. Similar to their reports on the medication itself, women did
not question the dosage or route of administration they were given. They did not speak about
the costs of medication, or that costs factored into the dosage; neither did they report being
unable to afford additional pills or higher doses of medication, being previously aware of a
specific dosage they believed they should take but could not afford.
As a result of being focused only on the outcome of terminating their pregnancies, women reported not taking time to seek further information about the medication, as a result of being focused only on the outcome of terminating their pregnancies. Participant 1 both laughed and admonished herself for having been to the non-profit family planning clinic only a few days before and having completely forgotten about the possibility of using the clinic at the crucial moment when she needed MR. She brought this omission up several times over the course of the interview and talked about the stress of the situation she had been in. She explained how she had obtained medication from the pharmacy, taking one medication that did not work, and returned for “the expensive one”:

I don’t know myself. Later I had a good laugh about it, I had gone there and made a card [for family planning services] as well. [...] I didn’t even check whether it was expired or not, the expiry date and stuff which is there, I didn’t look at those, it was given to me and I just took it and used it. [...] I should have seen it first whether it still wasn’t expired yet, or which company, at the time I didn’t have any interest. But normally I do see whether it is expired or which company it is from, I see all that, but then I had all that stress about when I’d have my period, if taking the medicine would make it happen. Things like that. (Participant 1)

(International and sub-national context

Women had not considered going to formal providers for medication

None of the women in our study had considered using clinics or health facilities to seek medication for their MR. None referenced being aware that medication was available at some facilities, and reported having little understanding of where to go, or simply believed clinics or health facilities were too expensive to consider as options.

It didn’t occur to me at all to go to T [non-profit family planning clinic]. [...] I had forgotten, I had forgotten about T, that I could have gone there, and all the methods that they have there. (Participant 1)

Sometimes the women’s past experiences of approved clinics put them off. One woman previously had an MR procedure at a clinic; it had been painful, so she feared going there again. Initially she preferred the local healer, but she reported that, in the end, the local healer had been rude and the MR dangerous. Another woman reported being fearful of going to the clinic because she had had a Caesarean section there, and did not wish to endure any similar
experience. Her husband obtained medication for her from a pharmacy worker nearby and her MR was successful.

When seeking medication for MR, women perceived pharmacy workers as equivalent to formal providers. Participant 11’s narrative demonstrates this idea of equivalence between the clinic and the informal MR medication providers. She described how she went to a clinic for a pregnancy test (which came out positive), yet the following day rather than seeking MR at the clinic, her husband secured medication for MR from a pharmacy worker he knew. She also emphasized the qualifications of the pharmacy worker:

He is very good. He had a job at P. Hospital [a large government hospital] for a long time. Now he has opened a pharmacy. A doctor even comes there. [Note: community members told us that this pharmacy worker was not a trained medical doctor]. (Participant 11)

She reported that afterwards she got sick and bled excessively and went to a formal clinic. Participant 25 was also clearly aware of the clinics, and used them, but reported that she and her husband were "embarrassed" to go to the doctor for MR.

Overall, the interviews strongly suggested that participants perceived the local pharmacy as less troublesome than going to the clinic. Participant 37’s testimony appears to distinguish between medicine and MR, and by MR she likely means MR MVA; “I asked for the medicine [from the pharmacy] and didn’t want to go through the trouble of MR.” The women sometimes already knew the informal provider or pharmacy worker; or their family members knew either the person at the location where they sought the medication or knew the person they recommended to provide medication.

**Women sought medication from many sources**

Women described asking someone for advice, and then following that advice without describing further processes of thought or discussion with them. Women received suggestions and advice from female family members (mothers, mothers- and sisters-in-law, aunts), their husbands, pharmacy workers, or female informal providers of MR or MVA. For example, Participant 36 reported: “I went [to the pharmacy] and told them to fix this for me. They did whatever they felt right.”

Women received the medication for MR itself from a number of sources; to mothers, mothers- and sisters-in-law, aunts, pharmacy workers, and a range of informal female providers. Women
also received dosage information from these sources. When women themselves sought the medication, they relied either on a pharmacy worker, an informal provider, or a family member or friend. These persons, in turn, obtained medication for the women from the pharmacy and gave them dose and regimen information.

Many women told us they hid the MR from certain family members, usually husbands or in-laws although a few spoke about seeking MR completely alone.

I talked to my oldest sister-in-law, [...] Her response was ‘don’t worry about it, I’ll bring you medicine.’ And then she brought me two tablets. (Participant 8)

Some women reported their husbands were involved in seeking and procuring medication for MR. One woman reported talking about MR with her husband and that they had decided to seek advice from a “doctor,” but ultimately went to consult an untrained pharmacy worker. Other women however, felt endangered and hid the MR from their husbands.

It would be a problem if he got to know about it, he would scold and beat me. He does not like all that. Even now he does not know it. [...] Just my mother, sister in law, and sister know. (Participant 15)

Discussion
This study provides insight into women’s experiences of accessing informally and using allopathic medication for MR. The study is the first we know of to examine the perspective of women recruited in the community, as opposed to those recruited in previous studies, which identified eligible participants through pharmacies known to stock correct medication (Footman et al. 2018). When examining women’s stories about their experiences with allopathic medication for MR, we found that most of their discussion fell within Coast et al.’s framework on trajectories of abortion-related care (2018).

We refer to allopathic medication used for MR here rather than “medical abortion” or “MRM”, because, save for one case, women were not aware of the drug or brand names of the pill(s) they took for MR. We were aware that we had no level of certainty which medications in what doses women ultimately were given and took, thus use only terms the women used in their responses in the interview. We could not ascertain whether any of the pills or medications the women
described were recommended by the pharmacist or ultimately taken correctly in accurate doses.

Abortion specific
We did not find a particular pattern of disclosure, or how it related to the use of allopathic medication. It is possible that disclosure is a more important element in environment where the use of traditional methods and medicines is not as common and allopathic medication from pharmacies form part of a more defined binary of clinics vs. pharmacies.

Our study participants overwhelmingly described having had negative experiences after taking medication for MR outside health facilities. None of the women in our study reported being counseled on side effects, therefore were unlikely to know what to expect after taking the medication. This lack of information may therefore have caused some of the negative feelings associated with the procedure. It is possible that some women questioned the efficacy of the medication from the start, and interpreted their experiences with a skeptical or pessimistic outlook. Among participants who reported their medication for MR had not worked, some may have experienced the expected effects of MR medication, but simply failed to recognize them as such.

Individual context
Women seemed to make the initial decision of who to ask for advice, but then accepted their recommendations without question. Women described a variant on surrogate decision making, which is most commonly described for inpatient mental health facility or intensive care patients (DeMartino et al. 2017) but in this case may relate more to gender structures in Bangladesh, which tend to dictate women's subservience, thus they may lack empowerment (Mahmud, Shah and Becker 2012; Mainuddin et al. 2015; Eckersberger, Marston, et al. 2019a). Letting others make decisions may therefore not be strange or unusual for these women.

Women in our study were able to access medication for MR with relative ease, but this did not translate to access to effective or safe methods. Most participants seemed to have been aware prior to using it, that MR with allopathic medication was possible, but not always clear on what using the medication would involve. Whether or not the women's proxies were given correct information at the point of sale – and past studies suggest that informal pharmacy sellers may not have correct information themselves – adds to the possibility of errors especially because the proxy must transfer the information to the end user.
All but two of the 15 women had used medication for MR before the mifepristone and misoprostol combination pack was approved in Bangladesh. This implies that, at best, they took misoprostol without mifepristone. It is also possible that they were given other medications, possibly ineffective or causing side effects and complications (Sneeringer et al. 2012). The World Health Organization recommended dosage for using misoprostol alone in the first trimester is 800 micrograms followed by up to three repeat doses of 800 microgram if needed (WHO 2012). In Bangladesh, misoprostol alone is usually sold in packages of individual 100 or 200 microgram tablets, meaning that if women in our study—as reported—only took between two and five pills in total, even if they took misoprostol, the dose would have been too low to be effective.

The single participant who reported taking misoprostol at the correct dosage described visiting the pharmacy with her husband after they decided together to obtain more information. Socially, in Bangladesh it could be easier for women to ask questions of a male pharmacist with her husband present. A study on contraception in Bangladesh found that couples who engage in concordant decision-making are better able to meet their contraceptive needs (Uddin, Pulok and Sabah 2016). In most cases in the current study, we remained uncertain what medication women took (as they themselves did not know).

(International and sub-national context

The women in our study, however, appeared not to have considered going to health facilities and thus could not have accessed the medication legally. Previous studies in Bangladesh on medication used for MR have examined cases of women seeking it from clinic settings or pharmacies monitored and known to stock the correct medication in correct doses. The findings of such studies showed that women had far more positive outcomes than the women in our study (Alam et al. 2013; Marlow et al. 2016; Footman et al. 2017). The key differences may well be linked to the lack of correct medication and information on how to use it, or assess its effects.

Far better information is needed at the community level about what kind of medication should be used for MR, the dose and regimen needed for a safe, complete abortion, and the reasons that women should seek MR services from approved providers, regardless of the apparent qualifications of their local pharmacy worker. For informal providers, equipping women with correct drugs and better information is a crucial first step to improving the situation. Community-based solutions may be more useful: several studies have found that training and call-centers in health facilities may improve pharmacy provision of medication for MR (Fetters et al. 2014; Tamang et al. 2014; Reiss, Keenan, Dijkerman, Mitu, Nuremowla and Thoai D Ngo.
2015). This current study helps to illuminate why the rate of complications from unsafe abortion in Bangladesh remains as high as it is.

Access at the community level remains difficult and we remain unsure if the combination pack in its current form can reach women at the community level, or provide them with correct medications and correct doses. In another study, one in five women received an incorrect dose from pharmacies approved to carry the correctly packaged and labeled combined mifepristone-misoprostol pack (Footman et al. 2017), but the study’s authors did not report or speculate on why this might be. It may point to pharmacists selling individual pills, or giving incorrect advice on dosage, or women might not be able to access effective doses and medications under these circumstances. This study however did not note what was recommended to women – whether they received the correct medication and dosage, or if the correct recommendation included telling the woman to seek a provider at a health facility as the government guidelines suggest.

This study’s limitations include that, as a qualitative study, we cannot know the extent to which the proportions we reported are generalizable. However, large numbers of women in Bangladesh are treated for complications after attempting to access MR outside approved health facilities; our study indicates practices and problems likely to apply more widely. Using a constructivist grounded theory approach (Charmaz 2006; Mills et al. 2006) means that we, the researchers, constructed the themes presented here and we thus acknowledge the possibility of having misinterpreted, or misrepresented women’s lives. Women have reported using a variety of methods for MR from different informal providers (Eckersberger, Marston, et al. 2019c, 2019b), as well as procured allopathic medication from numerous sources, so ultimately cannot know whether they perceived this to be a method apart from other methods, in the way we presented it in this paper.

**Conclusion**

If women have information on how to access the correct medication at correct doses, they might circumvent legal restrictions to obtain effective medications and information on how to use them. Our study, however, shows that this hypothesized path to greater women’s autonomy over their bodies, even if possible in theory, remains a long way off in practice. Participant narratives suggest that social factors limiting women’s autonomy in general restrict women’s lives in several subtle ways, and they must rely on others to obtain medication for MR. Our study shows that tackling community norms that restrict women more generally would likely reduce risky, unsafe recourse to unknown medications for MR.
This study also demonstrated women's views of access as including the various elements the concept of access encompasses. Evidence of the presence of services or even women's physical access (Donabedian 1972), whether a facility or, in this case, pharmacies, did not mean that women could access comprehensive abortion care. They were able to access medication for abortion in some form – whether in seeking it from pharmacies themselves or by proxy – but seemed not to access information for correct names of medications, information on dosage and mode of use, how to manage side effects, or to recognize complications.
Chapter 10. Discussion

This study aimed to investigate women’s experiences with menstrual regulation outside health facilities in Bangladesh, specifically addressing (1) why women turned to informal providers instead of seeking care at approved health facilities, (2) what their barriers to seeking care were, (3) from whom and with what methods they sought care, and (4) what their experiences were, and how they themselves conceptualized their procedures.

10.1 Principal findings

Despite the availability of menstrual regulation from approved centers, findings from this study suggest that availability alone may not be enough to make MR accessible to women. I investigated the definition of abortion and menstruation in Paper 1 (Chapter 5), and the definition and conceptualization of MR. Different definitions existed in the literature, but not studies investigated or reported how women themselves thought of their procedures, and whether their understanding affected how they sought, or were able to seek, care. I found that virtually all women thought of their MRs as terminations of pregnancies: abortions. They took pregnancy tests and talked about the possibility of a child should the pregnancy continue, and spoke of their families and communities as having the same perceptions. This idea of MR as termination of pregnancy differs from the Bangladeshi official definition of approved MR, as a backup family planning method. I cannot conclude with certainty whether women benefit from their definition or if it hinders seeking safe and effective care.

I also examined sociocultural barriers women face in accessing MR in health facilities in Paper 2 (Chapter 6). I found that they faced significant, interrelated barriers to seeking MR. Women spoke about not having sufficient knowledge to seek safe MR care, and noted the cultural environment in which they live that restricts their movements in the public sphere, including accessing care at health facilities. Women struggled with most aspects of seeking care in health facilities, and most commonly received support from other women in the community, and from their maternal families.

In Paper 3 (Chapter 7), I examined women’s relationships with MR providers, and how these affected their care-seeking. I found that women found formal MR providers and approved health facilities difficult to access, due to both structural issues (such as requiring their husbands’ signatures and cost) and previous negative experiences with formal health providers. In
contrast, they described informal providers as easier to approach and as inhabiting safe spaces, accounting for this because informal providers tended to be female community members.

Finally, in Paper 4 (Chapter 8) I examined a subset of women who had used allopathic medication from pharmacies for MR. We found that only one woman could tell us what medication she had taken, and in what dosage, and that most women had negative experiences after taking the medication. Most had judged their MR procedures to have been unsuccessful, and had sought additional treatments.

### 10.2 Organization of papers and themes

The order in which the results and papers are presented follows how I conceptualized women's experiences: Paper 1 informs how I framed the issues in the other chapters; women thought of their MR procedures as terminations of pregnancies/abortions; Paper 2 outlines the barriers women face when seeking care for the MR; and Paper 3 describes their interactions with providers they were able to seek despite these barriers. Paper 4 then singles out a specific, informal method my participants could have used safely to procure the desired MR/abortion under the above circumstances.

While these were the most significant and interesting results to arise from the data, I will have missed other aspects of women's experiences with informal MR. Due to my research interests I focused more heavily on tangible barriers and relationships and delved less deeply into women's emotions about their MRs, their reasons for seeking the procedures, or practical elements that may have influenced women in their care-seeking. Ultimately, I presented the most important and clearest themes I identified from the data, judging that the interviews contained insufficient information to argue other themes.

### 10.3 Discussion of themes identified in the thesis

*Seeking MR and health care overall was difficult for women*

Many of the women interviewed struggled with virtually all aspects of care-seeking. When seeking reproductive health care, their situations were influenced and determined by a combination of their own needs, medical and market demands, and social and cultural contexts (Harcourt 1996). Women spoke of MR and non-MR specific reasons for seeking care outside health facilities. Barriers women faced in their community were interrelated and associated with each other. Examining women who purchased medication from pharmacies, and where
they could theoretically have received safe, effective care, revealed that, even in these cases, women mostly had negative experiences.

*Women found ways to regain control over their lives and care they wanted*

Despite the barriers women described, they found ways to retain control of their lives. They used the tools available to them and adapted their behaviors according to barriers they faced, such as a woman seeking care with an informal provider when she had previously been prevented by her husband from seeking an MR from a formal provider.

Women spoke of structural issues throughout the process of seeking care. They were aware of providers possibly requiring their husband’s signatures and noted previous experiences with healthcare providers who were difficult to access. Self-use of medication for abortions can provide a safe and effective alternative to clinic based surgical abortion (Giri et al. 2015), but women are currently unable to legally seek the Combipack of mifepristone and misoprostol without seeking a formal provider first.

Other studies have examined women’s experiences after being turned away from health facilities (Hossain et al. 2016), or have reported that access to MR can be difficult due to a decline in facilities that offered MR services (Hossain et al. 2017). We found that, in virtually all cases, women did not attempt to seek care at health facilities and turned directly to informal providers. Women seeking post-MR care at health facilities after informal MR appeared equally rare and difficult.

The participants in this study spoke about significant restrictions of movement, lack of knowledge, and feeling isolated in their decision-making and actions, but did not speak directly about having experienced any reduction in restrictions in the way studies report other women have (Schuler, Bates and Islam 2002). When women say they cannot travel far, this is due less to financial issues or other obligations, but to cultural restrictions, as is their preference for female providers. When women report providers being difficult to access, this belief is based on previous experiences within a patriarchal power structure (Eckersberger, Marston, et al. 2019a).

Gender and the subsequent cultural restrictions and expectations appear to play the largest roles in how women are able to access care, whereas education, class, and place of residence played roles in women’s ability to access care. As Whitehead stated; “Gender, then, like race, is never absent” (1979, p.11). This is true in terms of cultural restrictions on women as well as in
terms of the gender of the providers they felt comfortable seeking. Women hesitated to access care at health facilities where they might encounter men. Informal providers of MR are overwhelmingly female, and in cases where women simply took medication and received no physical treatment they often obtained the medication from other women rather than directly from pharmacies staffed by men. Seeking care in the informal sector meant women could control whom they interacted with.

Many of the married women in our study reported that their husbands were unsupportive; they either wanted not to tell them or received no assistance from their husbands, and ultimately found themselves in similar situations as unmarried women or those with a partner. Another study in Mexico found that marital status can affect the obstacles women face, and that single and separated (or divorced) women faced the highest risk of experiencing obstacles to seeking abortion care (Becker et al. 2011). This may be similar for women in Bangladesh too. Women reported that having their husband’s support would have made seeking safer care easier, but that some women’s husbands had either incorrect information or told women to seek help from female friends and family members indicates this may not ultimately be as useful in seeking safe services as women thought, and women themselves are more comfortable talking to female friends and relatives.

Information on reproductive health and care-seeking is difficult for many women to obtain. This begins with a lack of comprehensive sexuality education before they are married, and where to go once they find themselves needing an MR; but also any information about the methods used, including allopathic medication from pharmacies, and whether to use their own judgment when deciding to seek care for complications. In the case of allopathic medication for MR, from the way women described the number of pills taken, they appeared to take insufficient doses even if they took misoprostol. While pharmacist knowledge appears to be improving (Huda et al. 2014, 2017; Footman et al. 2017), women in our study seemed not to have access to correct information on medication and doses and did not report or know how the dose was determined and by whom, or how much information the provider or participant had had.

Women seek MR in a changing environment

Women today seek MR in an environment that may be markedly different from when the procedure was conceived in 1979, at which time pregnancy tests were not as widely available as they are today. In our studies, women described cheaply and easily accessing pregnancy tests and being aware that medication for MR existed, even if not knowing accurate details about the procedure or the medication. While other research has suggested that the restrictions of
may have relaxed (Schuler, Bates and Islam 2002), we found that the women in our study were restricted in terms of freedom of movement. Progress and empowerment may not occur equally across populations, and our sample may have – through specifically looking at women who avoided formal health facilities – included those among the least empowered.

Stories of accessing MR outside health facilities illustrate how women operate within a system where they believed services in health facilities remain outside of their reach. The history of MR in Bangladesh has been argued as developing at least as much for population control (Wajcman 1994) and the good of the state (Harcourt 1996) as for women themselves. It seems not to have prioritized women's lives and environments in the least. Women's struggles to access MR in health facilities appeared firmly embedded in the wider culture. This suggests that our research approach using constructivist grounded theory was appropriate, as women did not face “hard” restrictions, such as being turned away or not having money for transportation, but when they reported they “could not go outside” this was a circumstance not stemming from an actual, physical obstacle, but from a cultural barrier women in this study perceived as equally insurmountable.

Women’s definition of MR at odds with the Bangladeshi policy decision
While MR is legally defined as being different from abortion in Bangladesh, I found that most women did not make or perceive a conceptual difference between the two; both were terminations of pregnancies. This finding supports my decision to adopt a constructivist approach, which emphasizes “eliciting the participant’s definitions of terms, situations, and events” (Charmaz 2006), in this case elucidating and investigating their own definition of the term “MR.” Also, in this case, the woman’s definition of MR as a termination of pregnancy is more closely related to Searle’s “brute” facts (1995), which need not necessarily require human institutions for their existence and definition, and more closely related to a material, biological base than being tied to society and the cultural context in which it exists (Connell 1987; Shilling 2003).

My findings are ultimately inconclusive on whether women benefit from this discordance in definitions, or whether such definitions could hinder them from seeking care. In a way, calling the procedure “menstrual regulation” as opposed to “abortion” gives women in Bangladesh the opportunity to seek care they may otherwise be unable to access; but it is also clear that MR is a euphemism for abortion for women seeking the procedure, and ultimately stigmatized and hard to access. Additionally, this dichotomy ignores women’s lived realities in which they seek care, and could make advocacy for additional activism for stigma reduction more difficult, as MR is
not legally recognized as something difficult to access or part of the global landscape of abortion care-seeking. Women reported barriers seeking MR, not described as facing when seeking other medical care and remain hesitant to seek MR care from those they would ordinarily turn to. In terms of academic research and advocacy, this definition that separates MR from abortion may also exclude women in Bangladesh from the larger conversation about abortion rights globally. Women telling us they sought contraception from formal clinics they were able to identify by name also indicates they are not equating MR with family planning methods; thus efforts to increase access to and family planning methods are likely inadequate to increase access to MR.

Women’s understanding of their world, language, and identification of health and illness
While women were clearly able to identify formal clinics and especially larger government hospitals, they also used the word “doctor” for informal providers who, as far as we were able to discern, had no formal training. When told, for example, by participants that a “Lady Doctor” worked upstairs in a pharmacy, my knowledge of the community, the health system in Bangladesh, and the shortage of health professionals led me to conclude that this was unlikely to be a formal medical doctor. I cross-checked this assumption with community members and community health workers in the area, who confirmed my theory. Participants calling such women Lady Doctors reveals how their own realities within this world are constructed (Berger and Luckmann 1966), although I might point out that the meaning of “doctor” as someone who has studied medicine is also socially constructed. In light of the theories of Berger and Luckman, the occurrence of “Lady Doctor” shows that, while the material world is not necessarily constructed (i.e., in fact women upstairs in that pharmacy did provide services), our realities within this world are (in this case that the women providing services were called doctors and seen as part of healthcare system) (Berger and Luckmann 1966).

Women’s common use of the English word “doctor” suggests it is likely that their definitions and perceptions of medical professionals may be more inclusive than simply the formally trained healthcare providers. One hypothesis – illustrated by the participant’s story (see Chapter 7, Paper 3) noting the provider working near a government hospital as providing effective and appropriate care – is that associated between trained professionals and the environment within which those professionals operate. It was difficult to ascertain whether women believed these persons had formal medical training, or whether they simply saw them as along the continuum of the healthcare system they accessed for healthcare. They accessed formal facilities for other illnesses, which led me to the hypothesis that MR itself – stigmatized and rare in their lives – may have broadened their view of where care could and needed to be sought.
10.4 Returning to theoretical approaches

Coast et al.'s framework on trajectories to obtaining abortion-related care

Once I had completed the analysis of the interviews and developed a focus for Paper 1 (results showed that women saw their MR as terminations of pregnancies and abortions), it became important to embed the research more firmly in the global literature on unsafe abortions, including Coast et al.'s framework on trajectories of women's abortion-related care (2018). Since women thought of MR as abortions, we examined MR within the global context of abortion stigma. Regardless of whether they considered it a family planning method or a termination of a pregnancy, women felt unsupported by their families and feared judgment from their communities, leading them to carry out MR in secret.

I found Coast et al.'s framework on women's trajectories to obtaining abortion-related care valuable to guiding my work (2018). I used a grounded theory approach to analysis, developing themes from the data (Glaser and Strauss 1967), then used Coast et al.'s trajectory domains, situating my findings in up-to-date scientific evidence and theory. Reviewing and re-analyzing my results in light of Coast et al.'s global framework allowed me develop links to other work on abortion care-seeking, as well as to discover where my results could further knowledge (2018). Using this framework provided an overview of all factors that could, technically, have influenced the study’s participants. I found elements were related and women's barriers to seeking care, for example cut across on all domains. We also found that, when they specifically wanted abortion care, their MR or abortion-specific experiences were closely liked to certain providers in certain parts of the health system. National policies, on the other hand, had little to no effect on culture and realities on the ground; i.e., thus, MR being legal and available not translate into ready access for all the women who sought it.

Coast et al.'s framework also aided our closer examination of where women's experiences were abortion-specific, or more broadly related to their lives overall. In some areas, such as women reporting they could seek other healthcare at formal facilities, using an abortion-specific framework highlighted the need to examine abortion-specific care-seeking differently. Other areas, such as when women reported being unable to leave their homes or unable to seek any kind of care, were not as directly related to specific care they sought in abortions.

Bronfenbrenner's socioecological model

Bronfenbrenner's socioecological model (1979) highlights the ways in which women's lives could be affected by their environment and surroundings. My research showed that the socioecological model was useful in considering different elements that could possibly have
affected women's care-seeking, and in examining why some elements remained more present and prevalent than others. The surprising feature of the socioecological model was, ultimately, its accentuating the ways in which women's actions or decisions were influenced by only a small number of factors. The model highlighted a number of different environmental factors that could influence women, but, again, in Bangladesh only a few factors can come into play. These "gaps" were ultimately useful to my analysis, and led me use the full original model rather than adapt it as others have done, ie Golden and Earp (2012). The socioecological model was also useful in highlighting factors that possible interventions could focus on, and those in which interventions might not be particularly effective.

As most women did not attempt to seek care at formal healthcare facilities before turning to informal providers, we heard few stories of their being turned away, or of conscientious objection by providers playing a significant role in women's experiences. The political or provider context in my study also appeared not to play a significant role in participant care-seeking. This point demonstrates women as not only experiencing the world differently from each other, but also as likely experiencing it differently from the men in their communities.

I found two particular limitations of using Bronfenbrenner's socioecological model: (1) the model does not easily allow for detecting changes over time, and (2) does not easily allow examinations of accounts of different experiences within the same environment. Women in my study spoke clearly of time passing and the developments in their lives across time affecting their lives. The barriers they faced, for example, changed over time and, with this, how restricted they were in their movements. In developing the socioecological model, Bronfenbrenner's hypothesis was that "...within any given culture or subculture, settings of a given kind – such as homes, streets, or offices – tend to be very much alike, whereas between cultures they are distinctly different." (Bronfenbrenner, 1979, p.4) I found this not to be true in my participants' lives, and women described different experiences within the same communities. Women in my study spoke of situations that varied widely across their experiences, and the model failed to capture the dynamics of women's lives and their environments, as within even the same community women experienced events and interactions differently.

The analysis of the socioecological model is important to consider when developing possible interventions for the issues we found in this study, as it focuses on the conditions and environments in which polices and programs are formed and implemented (Golden and Earp 2012). Using the model helped highlight, for instance, how much the environment influences
women’s agency. Any approach must emphasize a holistic, women-centered model that considers “the intersection of power relations through which women’s reproductive actions in the world are delimited” (Macleod, Beynon-Jones and Toerien 2017). Moreover, strategies to improve quality of care or availability of MR at health facilities must also include factors outside the health system to ensure in particular that women can access facilities in the first place. One option is increasing social support for women through a community or local peer network, especially for newlywed women recently moved into an unfamiliar community. In the long term, expanding women’s roles in society through employment, for example, can also improve their agency and their standing within the family. Ideally to one where their economical productivity takes priority over their reproductive role (Rashid 2006), and to greater freedom of movement or greater power of decision-making over their own incomes.

**Decision-making frameworks**

I later returned to the decision-making literature focusing on research and theories on “goal-based choice” (Carlson et al. 2008) to examine additional elements of women’s narratives that focused on the outcome of “having the MR,” or terminating their pregnancy, rather than how they decided whether to have the MR overall. Any choices women made depended on their goals (Bettman, Luce and Payne 1998) rather than particular elements of the procedure, and they made the decisions within the environments they were able to navigate despite the barriers they faced seeking care.

### 10.5 Strengths and Limitations

**10.5.1 Methods**

**Methodology**

I used a qualitative phenomenological approach to examine women’s experience with MR outside health facilities (Walker 1985). Another option for approach and analysis could have been to examine life histories, i.e., how women spoke about their experiences, and how they described their levels of knowledge and freedom of movement changing, from their teenage years and marriage to when both they and other women in their communities became older (Hagemaster 1992). Ultimately, as a phenomenological study focusing on one aspect of women’s lives, my approach to data collection which allowed women to speak about pieces of their past they believed had influenced the phenomenon I was exploring – the informal MR – gave me the opportunity to include those elements from women’s pasts that were relevant to the MR.
Using a phenomenological approach limited me to only included women who saw themselves as having had this experience (the MR outside health facilities), and therefore will have missed women who define their own experience differently, or if the person recruiting them didn’t understand or explained the phenomenon I was studying poorly. This was likely the case for the two interviews we ultimately ended up excluding because women had had formal MR in facilities; either they or someone who had told them about the story would likely have missed an element of our phenomenon, that the MR was outside health facilities, and not that we were just studying the experience of anyone who had had MR anywhere.

**Data collection methods**

As a qualitative study conducted by a foreign PI, our study had both strengths and limitations. A qualitative approach is necessarily dependent on the skill of the researcher, but also the only way to answer the research questions in ways that fully investigated complex practices and social processes. I relied not only on in-depth interviews with women who had MR procedures outside health facilities, but also on observation, key informant interviews, and conversations with local women. By contrast, having ascertained that women’s reasons for seeking MR outside health facilities were not fully known (Rashid, Akram and Standing 2011), the qualitative approach allowed us to understand anything enigmatic or confusing (Eisner 1998).

By conducting interviews with women in places of their choosing I empowered them in ways they may not have experienced with other approaches: with the power to tell their own stories, the stories they wanted me to hear and the experiences they wanted to share, which I took at face value. This ultimately meant that themes presented here are firmly rooted in the "betweenness" (England, 1994, p.251): between the women’s worlds and mine, and ultimately co-constructed with me, the researcher.

Practically, as a foreign researcher in a country where I could not speak the language, I will have missed information (data) in interviews. For example, in some cases I was not able to ask additional questions in the interviews due to misunderstanding or not fully comprehending what was being discussed, and in others the lag time between interviews and correct translations being completed was too long.

Limitations of the qualitative approach included that we were unable to determine how representative our sample ultimately was. Another limitation pertained to the methods, which, ultimately, were not as participatory as I would have liked. Ideally, I would have developed a methodology that sought to work in collaboration with participants in the community, which
could enhance opportunities for participants and other stakeholders (Vanner 2015). There were limits, however; especially because the research involved clandestine and possibly stigmatizing behavior, and where participants likely could not disclose their participation to the community about the nature of the inquiry without endangering – or feeling like they would endanger – themselves.

**Recruitment and sampling**

Several strengths appeared in this study, to my knowledge the first to have investigated experiences of women who had undergone MR outside health facilities. My recruitment strategy meant I included women who had never had contact with the formal health system, and were purposefully not descending, but ascending (van Meter 1990), allowing women's testimonies and data already collected to lead the analysis. I exercised as much control over the sample as needed to reflect what I knew of the particular population's general characteristics (Biernacki and Waldorf 1981), but could not ensure completely that this was representative of the population. However, as my results showed that women mostly had contact with other women when they sought MR, I am confident that this was the most appropriate recruitment strategy.

My analysis demonstrated that women often revealed their stories about MR to healthcare workers during prenatal care and childbirth. As participants were recruited through contacts in the community, we could have passed over women reticent to speak of their experiences to others; we could also have missed “isolates,” those not connected closely to anyone in our network (van Meter 1990). While I cannot know what was left out, my conversations with community members, local health providers, and reproductive health experts informed me with some confidence that no significant themes were neglected. With the exception of the MSB staff, conversations with reproductive health experts clustered toward the beginning of the study, and conversations with community members and local health providers in the communities continued throughout data collection and into analysis. This meant that I was able to circle around to local women community health workers with some of the (de-identified and redacted) results, and could ask them questions about information that struck me as interesting, or that I did not fully understand. In hindsight, it could have been useful to loop back around to reproductive health experts at local organizations and universities, to have similar discussions as data collection and analysis continued, but this, unfortunately, was not possible given time restraints once the study was underway.

I attempted to sample for diversity by monitoring recruitment throughout the process. I made every attempt to supplement the data with key informant interviews, and informal
conversations with healthcare workers and community members. Nevertheless, we will have missed some perspectives, but have no reason to believe that missed perspectives would substantially change the findings, although some could have filled in gaps. In particular, we were unable to gain access to conversations with informal providers without compromising the confidentiality of the women we interviewed.

I was able to interview only a small number of unmarried women in my sample, one of whom ultimately married the man who had been her boyfriend at the time of the MR. The unmarried participants were almost exclusively recruited through close friends acquainted with the study, most commonly through peers who knew me or about the study but not participants themselves. The unmarried women were most commonly university students – or in the process of taking entry exams for university – and from more educated or economically prosperous families; their status at the time of the MR may in part explain why they had not yet married at age 18, despite it being common for women to marry before that age in Bangladesh (NIPORT et al. 2016).

Despite attempts to sample for diversity, there were aspects of the sampling we could not control, which may have affected the participants ultimately included in the study. We began recruitment by specifically attempting to speak to women who had had menstrual regulation outside facilities. We could not ensure, however, what kind of wording women in the community used when recruiting other women, and we may have missed women who spoke about their procedures in ways other than indicating they were conducted outside facilities. We might have captured these women if the women who recommended them thought of the procedures as MR, even as a prospective participant herself did not, but there was no way to confirm this.

Data collection

One of the benefits of face-to-face interviews is to mind social cues and occupy the same time and place (Opdenakker 2006), which can add very richly to the data. I lost some of this benefit in the necessity of interviews being conducted by a research assistant on my behalf. Reviewing the translated transcripts and having conducted interviews myself for other studies – and for one participant with whom the interview was conducted in English – I would likely have been able to add depth and nuance to some parts of the interview and gained additional insight into some areas of the study. In some ways this meant that I may not have been able to provide an "authentic insight into people’s experiences" (Silverman 2013), or at least meant it may have been possible for someone other than me to investigate the research questions in greater depth.
The delay I faced in receiving accurate translations of the interviews also caused me to miss opportunities to add additional questions as early as I would have liked. For example, I could have further explored participant perceptions of informal providers of MR in villages, or discovered how widespread the knowledge of these informal providers was within the communities where they practiced; I could also have explored participants’ feelings around knowing they had insufficient information to make informed decisions, or how their decision-making process might be affected by such feelings.

Had I been able to ask more questions about it in the moment, another area that I had thought would be interesting was women’s decision-making. I cannot help but wish that I would have been able to ask more questions about this in the moment. How did women they feel about possibly not being fully involved in the decisions they, or others were making? This was a topic that was not fully formed when my research assistants were conducting the interviews and, while I spoke to my team about my ideas, they ultimately were not included as questions in the remaining interviews conducted in Bengali.

**Saturation**

Saturation is defined in a number of ways (Saunders et al. 2018), but most commonly viewed as an endpoint of data collection: when data collected yields no new information or becomes redundant (Given 2008). Our final sample balanced the costs of conducting further interviews with the benefits of additional information participants provided. At this stage, key themes were starting to repeat in the interviews, which led us to believe our analysis would likely be meaningful. Conversations with community members throughout the study were also helpful in judging saturation, and I remain confident that we have included the most important stories collected on the ground. Ultimately, it would be impossible to say with certainty whether we missed important themes.

**Interviews**

Our semi-structured interviews with women allowed them to tell their stories in the environments comfortable for them. We attempted to give them opportunities to speak openly about their lives and to tell their stories with no specific order or focus, hoping in this way to elicit rich data. While I had conducted extensive training with the research assistants on sensitive interviewing techniques, the participant women may nevertheless have felt uncomfortable sharing certain details. We gave participants plenty of time and space to discuss the issues in their own ways. By focusing directly on these women’s own experiences rather
than on general views, we were able to illuminate how participants “do things,” rather than how they “see things” (Silverman 2000).

While our experiences could be skewed to the bias of women having volunteered to speak to our team (those uncomfortable speaking about their abortions would not have volunteered), a number of women reported having not yet spoken to anyone except the person who had referred them to us about their experiences, and noted they had been pleased to share their stories.

While we had noted the possibility of this occurring, there were no instances of women becoming visibly upset or tearful. Some were angry, particularly with their husbands or in-laws, as they recounted stories, but none showed remorse or suffering, although we cannot know how they felt subsequent to the interview.

We conducted no follow-up interviews with women, something that, in hindsight, I realized could have been useful. I had not realized that some topics mentioned during the interviews, such as questions around autonomy in relation to care-seeking, or women’s experiences after taking MR medication, would subsequently trigger a number of unanswered questions; there were also topics I would like to have asked more about. The gaps in the knowledge in this thesis also resulted from the overall methods of conducting this work in a language I did not understand, which created a significant lag time between when the interview was conducted and when I was able to read the interview transcripts in English.

Due to the nature of the recruitment process, and sensitivity of contacting and meeting with participants, we were unable to do follow-up interviews, which would have been valuable concerning themes that we identified during data analysis. I supplemented this data where possible with observations and conversations, discussing findings with my research assistants and de-identified findings and ideas with local friends and community members.

10.5.2 Analysis

Using a grounded theory approach

Grounded theory has its strengths and limitations. In this study, the strength of grounded data was that I relied on women’s stories and words as much as possible. I ensured that I developed themes were grounded in the data, and included many participant quotes around the themes to “see what the researcher is talking about” (Murphy et al., 1998, p.173). Working closely with the
data while constructing the results and conclusions allowed me to ensure providing a much better picture of women's experiences than I could have conjured without it (Bogdan and Biklen 2007).

Yet one of the limitations of grounded theory analysis is its reliance on data, and that some information lies outside the data. In order to see as full a picture of Bangladeshi women's lives as possible, it was necessary to take into account their lives as a whole, their surroundings and social context (Crouch and McKenzie 2006). I tried to counter this limitation by including observations and discussing my data and themes I was developing with local researchers, but as a foreign, Caucasian researcher, ipso facto I will have missed some data. Ultimately this adapted approach improved the results from the study.

**Using a constructivist approach**

Constructivist grounded theory also has strengths and limitations. We chose a constructivist approach to data collection and analysis, in recognition that I would be co-constructing all aspects of the research (Charmaz 2014). As a foreign researcher, however, I may have introduced bias into the process of gathering results and reaching conclusions.

I used a constructivist approach to both the thesis' methodology and analysis, the characteristics of which can be seen simultaneously as a strength and a potential liability. This approach acknowledges that the researcher is part of everything and additional thought must be given to how they influence the work. The approach potentially skirts "reality" or decries everything as constructed (Schwandt 2000); without a discoverable truth, or answering the open question of whether anything discussed and discovered has a basis outside of the researcher's interpretation.

A frequent criticism of the social construction approach lies in "its very incapacity to take a position" (Gergen, 1997, p.93). At times I struggled with simultaneously wanting to retain the thick description that comes with interpretivist work, yet wanting to draw some conclusions based on my work, and to find strategic patterns or themes that held across women's experiences (Lin 1998). In the end my approach most closely resembles the "post-positivist" approach: the research explored a new topic and field in a way that could lead to more quantitative, positivist work, as others have suggested (Wildemuth 1993).

In response to his criticism I adopted what Longino called "contextual empiricism" (1993). I left open the question of whether there was a "real" existence outside of human experience (Lincoln
and Guba, 2000, p.2005) and focused on the reality women described and that which was borne out in the data, particularly how I, the researcher, would interpret it. It was important to tell women’s stories and to convey the realities in which they lived, and how they chose to convey those to me. Through reflexivity and close examination of my own positions, I portrayed their lives as well as I could. For example, when participants told me they could not leave their homes, I recognized this as their reality and, together with other interviews, could recognize such realities as built against a backdrop of shared understandings, practices, and language (Schwandt 2000).

The opposite may however also be true; that I saw something as a reality that the participants in my study did not. For example, Paper 4 (Chapter 8), in which I focus on women who used allopathic medication without prescriptions for their MR, I never knew whether women themselves saw this method in any other way different from other methods they used, particularly other pills or medications taken orally. In this study in particular, I could know how the different elements were “co-constructed” (Mills et al. 2006) by the researchers and the participants and a construction-reconstruction of a reality (Charmaz 2006); in distinguishing the experiences of women using medication as separate from other methods I may make too stark a case here.

Using a constructivist grounded theory approach – which relies heavily on both the data and the researcher to draw conclusions – can limit the generalizability of the results. While acknowledging myself so clearly in the research process was the correct approach, and ultimately corresponds to the research and analysis process, it also meant I must acknowledge that another researcher, with the same data, could have drawn different inferences, or come to other conclusions.

**Authenticity**

Authenticity is often difficult to ascertain in qualitative research. Because this study’s research findings could at some stage be used to inform service delivery, it was especially important to ask: were our findings “sufficiently authentic (isomorphic to some reality, trustworthy, related to the way others construct their social worlds) that I may trust myself in acting on their implications?” (Lincoln and Guba, 2000, p.178).

An objective of this thesis was to “generate data which give an authentic insight into people’s experiences” (Silverman, 1993, p.91). Authenticity is a wholly constructivist term (Shannon and Hambacher 2014), which attempts to fairly represent the participant’s stories as they choose to
tell them. I ultimately decided to view the respondent’s story – as told to me – as a "culturally honoured status of 'reality'" (Miller and Glassner, 1997, p.99).

I used several techniques to ensure authenticity of the study’s data, most importantly in discussing the results and conclusions with research staff, local experts, and study co-authors to confirm that these were based on the contributions of a range of people, and not individual viewpoints (Shenton 2004). I also discussed de-identified data with community health workers and, where no possibility of a breach of confidentiality existed, with community members. I also compared the interview data against all other data collected in formal and informal ways. It was important, for example, that in 18 months I never saw a female pharmacist in any pharmacy I visited, which supports findings of other studies and matches what participant women reported. As others have hypothesized, by using triangulation I was able to offset and overcome the weaknesses of each approach (Green and Thorogood 2004; Neuman and Robson 2009).

Studying behavior in the past can subject data to biases, but this also meant that the research team could not influence decisions women were taking. I made sure to include and consider deviant cases in our analysis, such as those that contradicted the evidence we were otherwise finding (Anderson 2010) and gave me the opportunity to consider possibly alternative explanations during the analysis and add nuance to the themes I was developing. Examples included women who spoke about regularly navigating the public sphere alone, or those who did not consider their MR procedures to be terminations of pregnancies.

I attempted to ground my research firmly in the local population by including my research assistants constantly in the development process and by having multiple conversations with local community members. I was aware these methods of grounding the data are not the same as truly participatory research, but they allowed me to include local community ideas and thoughts nonetheless.

The additional actions I took (for example, talking to people, going over my work with other locals) were not to verify the accuracy of information or data – there was no way to verify the accuracy of anything because women’s experiences were subjective – but to ensure that my interpretations reflected the experiences of the women most accurately.

Fay asked: “Do you have to be one to know one?” (1996) In my role in this study, ultimately the answer was “yes,” but nevertheless I bring a measure of life and authenticity to women’s stories as they were told to me.
Theoretical sensitivity
I was aware throughout that the final product would be “directly dependent upon the quality of the research workers understanding of the phenomena under observation” (Turner 1983). This meant developing my own theoretical sensitivity, keeping in mind that learning to recognize which data would be important in developing my results, conclusions, and theories. This extended to my research assistants and translators, as “extensions” of myself. While I agree that, in theory, Glaser and Holton are correct in stating that the “first step in gaining theoretical sensitivity is to enter the research setting with as few predetermined ideas as possible,” (2004, p.11) in reality this is impossible. Instead, then, I attempted to maintain an open mind in data collection and analysis, letting the data speak for itself as much as possible, and to remind myself to work out ideas from the data during the research.

10.6 Contributions to research
Unsafe abortion is a fully preventable pandemic (Grimes et al. 2006), yet 25 million unsafe abortions occurred in 2014 alone (Ganatra et al. 2017). While Bangladesh has made legal policy to use MR as an option for adoption, 1.19 million MR procedures were nevertheless conducted in 2014 outside health facilities (Singh, Hossain, et al. 2017).

As this is the first study that exclusively recruited women who had had MR procedures outside health facilities, the study complements the detailed information available both on access and provision in clinics (Hossain et al. 2017; Singh, Hossain, et al. 2017), in particular, on what happens to women when they are turned away from clinics (Hossain et al. 2016), and how women access the informal sector for other healthcare issues (Rashid, Akram and Standing 2011).

That only one woman in this study attempted to seek care at a formal health facility before turning to informal providers, and only nine women sought post-MR care at health facilities, suggests our study population is likely to be different from that recruited through facilities. Examining women’s experiences through health facilities alone is likely to underestimate several factors, such as the obstacles women encounter accessing post-MR care at all, and will not capture some of the structural barriers these women face. Community barriers highlighted here may be particularly important, as these will necessarily not be reflected by women who are able to attend a clinic.
Primary contributions of study to abortion-care access research is its demonstration of how access was more important to participants than legality or availability of healthcare facilities, and how legal availability only partly determines how and where women can access abortion care (Berer 2013).

Women spoke about needing to keep their MR secret, but they generally seemed more concerned with the end results of obtaining the MR than their concern for secrecy, recognizing that they would be stigmatized in their communities (Kumar et al. 2009). They did not commonly speak about internal stigma or guilt; rather they believed they were doing what needed to be done in the context of their lives. This illustrates not only that stigma is pervasive even when government policy supports something (like MR), in efforts not to stigmatize women who seek it, but that women differentiate between their own and other's opinions of the MR. Rehnström Loi et al. found that in cases where women felt the need to keep the abortion secret from their husbands, they worried less about being stigmatized, or judged or tainted, by their communities overall, than about their husbands either disagreeing with them on the abortion or believing they were morally culpable for doing so (2018).

Women were also much more constricted by their surroundings than worried about secrecy, i.e., the reality of being unable to access outside overall than going outside specifically for the MR. Women did not seem to seek informal MR due to fear of stigma in going to health facilities, but rather were led by who they asked for advice, and where they knew they could get a successful MR.

While women appeared most concerned with the practicalities of obtaining an MR, stigma can be particularly devastating to women in Bangladesh. It is most commonly played out in the context of social relationships and cultural constructs (Yang et al. 2007), which, judging by Bronfenbrenner's socioecological model view of how women's lives are organized, could affect the entirety of their lives. In other words, the socioecological model showed women's lives as completely formed of “close” social constructs in the model's microsystem; if they lost face in any area they were susceptible to lose face in all aspects of their lives.

This research also carries implications for studying hard-to-reach populations. Lessons learned from the recruitment of women into this study might provide useful insights for future studies conducting community-based research on hidden populations. Methodologically, this thesis contributes to the evidence base for accessing hard-to-reach populations, especially those not commonly interacting with each other or that have shared experiences as part of their group.
This makes abortion seekers significantly different from other hidden or isolated populations, such as drug users (Watters and Biernacki 1989; Griffiths et al. 1993), who interact with each other more frequently than women who have abortions do. I found that multiple methods are necessary to access the widest possibly variety of experiences.

Despite initially using snowball sampling, and women recommending other women, to recruit women, we found that personal connections were invaluable in getting women to speak to us, either through someone in the community in which we were attempting to conduct interviews, or through the research assistants’ personal connections.

We found that the supportive community insider, who is linked to the population but not associated with the sensitive behavior, was best for accessing participants. In our case this was a community health worker who had lived in the community long enough to know most of the women, had been in contact with them through pregnancies, deliveries, and involved in their children’s health, but did not herself provide MR. This meant that she was not associated with any of the stigma attached to MR, and was someone whom women could easily speak and meet without arousing suspicion. The added benefit of this healthcare worker was that she was happy to rent us a small room at the back of her clinic to conduct our interviews. Women who participated therefore had a relatively safe place to come speak to us – somewhere they might have come anyway with their children or families, and which attracted no undue attention – and without anyone coming to their homes.

Another unexpectedly successful recruitment method was simply speaking to friends and acquaintances about the study. Nearly every study team member had an experience in which someone approached them privately after learning about the study and asked to be included in the study. This included couples, female friends, or sometimes more distant acquaintances, as in one case of the cleaner of a dorm where one of the research assistants lived. The one unifying aspect of all these encounters was a trusted personal connection involved, whether through a person in the community who the participants both trusted enough to tell them of the MR in the first place, who was then able to contact them again, or someone who felt comfortable approaching the study team members to tell their own story. In hindsight it seems unsurprising that snowball, or chain-link sampling would have provided the best recruitment methods and results. Women generally did not speak to other women who had had MRs when needed; rather, they turned to older female figures or family members in the communities, not including information in their narratives whether these women had had MR procedures themselves. Or they directly approached informal providers they knew in the community, or pharmacists.
This idea of access can also be an important element in future studies’ methodologies: although women were unable to seek MR services in formal facilities, they were in many cases equally restricted in seeking postabortion care there, too. When future studies recruit women from health facilities where they sought postabortion care, these may yet again be a different population. These might be either women who have chosen not to seek the initial MR at a formal facility, but had the means or ability to seek postabortion care there, or women – like many of the women in this study who ultimately sought care at formal facilities – who had more severe complications after their informal procedures and were seeking formal care as a last, often desperate, resort. These profiles are potentially different care-seeking modes altogether.

Previous studies in Bangladesh have concluded that women were not able to tell whether the facility they sought was indeed a formal healthcare facility (Hamid Salim et al. 2006). Results from my study show that this result may ultimately be more complicated than previously assumed. Women can clearly tell the difference between the government hospitals and the informal providers where they sought abortion care, but then they also call everyone “doctor.” This discrepancy could indicate that their spectrum of care-seeking is different: that in their minds there are more formal doctors and facilities where one seeks care, and know that it is difficult to come by and expensive, but the best care, and, then, other people who are also part of the healthcare spectrum and provide healthcare, but simply do it differently.

10.7 Reflections on the research experience

Other authors have written about unexpected factors encountered during their fieldwork (Siwale 2015) and this project is no different; I found gaps between textbooks or ideal situations and the reality in the field. In reflecting on my work, I would have done a number of things differently, both from a theoretical position and in some practical considerations.

Whereas previous work in both Latin America had prepared me for some common pitfalls of north-south research, I believe I gave enough thought to some of the more practical aspects of not speaking the language, for example. I had previously worked closely with translators in Mexico, but I underestimated the extent to which even my basic Spanish was instrumental in being able to follow interviews, at least broadly, and in prompts for follow-up questions. For this current study however, I was unable to follow anything that was said in the interviews without the help of an interpreter or translator.
Conducting research in an environment where qualitative research was not commonly conducted meant that research assistants had not developed skills in conducting in-depth interviews or iteratively adding questions to questionnaires or related techniques. In hindsight I would have worked more closely with research assistants and possibly conducted longer refresher trainings along the way, or reviewed and rehearsed prompts or follow-up questions more often as the study progressed. There were some elements, like the translations, that I simply did not anticipate or prepare for, and which ultimately delayed or affected data collection.

After having completed my interviews and grappling with the fact that I simply did not know what medication women had taken, I learned of methods that other researchers were employing that would have been useful in this instance – pictures of the medications, for example, or including more descriptive questions about sizes and colors.

I would ultimately also conduct more formal key-informant interviews, especially toward the end of the study. I did fewer of these because, in particular, the formal ones provided little to significantly contribute to the data. I had a handful of conversations with senior health system staff and researchers, who spoke about topics that imparted little else than tropes: women were “ignorant” and lived in “backwards” rural communities, for example. This experience was also reinforced as I presented findings from another project (unrelated to this research) I consulted on while in Dhaka, where an attendant ministry of health official and a senior research at a local organization repeatedly probed my findings and questioned whether women were, in fact, able to use voice messaging technology they confidently used in the project I consulted on. I came away from this presentation feeling annoyed and defensive of the women included in both studies, and it certainly affected my enthusiasm – and likely actions – around interviewing additional stakeholders. In hindsight I would likely have benefitted from making a greater effort to seek out more diverse voices, as well as additional conversations and further probing after I had collected and analyzed the data, which due to logistics, this was ultimately not possible.

10.8 Remaining gaps in women’s experiences

There were elements of women’s experiences that my study did not focus or report on, and gaps remain. One such gap concerned quality of care, both perceived and real. Only one woman spoke about directly comparing experiences with formal and informal providers and, due to the nature of this study and that I was not able to observe informal procedures or interview informal
providers, I could not ascertain what these procedures entailed and to what extent they may have been conducted safely.

I was also unable to investigate concepts of safety and risk more closely, as women perceived them. Women spoke mostly about outcomes and noted that going somewhere they could procure MR was the most important element of their choices, but I could not ascertain how this related to their perception of safety and risk: Was the risk of continuing the pregnancy higher for them? And was seeking the type of care they did their preferred option, or was this something that factored little or not at all in their thinking?

Focusing our analysis in part on women who used medication for their MR, we attempted to add to the research here, which in many ways “has not kept abreast of women's self-use of medical abortion” (Kapp et al. 2018, p.184). I am aware that the results from my study are limited because we remained unaware of what women had taken; nevertheless, these results add an important element to the picture of medical abortion self-use. They show how women use, or attempt to use, medical for MR or abortion where information is lacking, and what their experiences were in this environment. The women's responses in our study demonstrated a situation where some knowledge of medication for abortions/MR exists, and the results show that this environment and lack of information is not enough for women to have safe and effective procedures.

Finally, I did not ask women why they had abortions, as this was ultimately not the focus of my research, but this could ultimately have led me to miss some nuances of the women's stories. Other research from Bangladesh has examined how reasons for wanting to terminate the pregnancy affect the ultimate decision of whether or not to seek an MR/abortion (Gipson and Hindin 2008), but do not report on whether the reason women chose to seek an MR affected the methods they chose. None of the women in my study sought MR because of medical reasons, such as fetal abnormalities or the pregnancy endangering the woman's health. It may be that in such cases women felt more empowered to seek formal care, or their families supported the decision to an extent that they facilitated the women's seeking care at healthcare facilities.

10.9 Implications for future research

This study highlighted a need for a holistic approach to care-seeking. Identifying future entry points to improve access could include supporting comprehensive sexuality education in
schools and/or focusing on community knowledge and the ways can be transmitted to women who may not be able to seek care outside their limited community.

An examination of the different experiences of women from the same community who sought care in clinics may also provide valuable insights into how these women were able to overcome barriers. The current data adds to other research on stigmatizing behaviors, suggesting experiences outside health facilities are different (Zinberg 1984; Watters 1988), but more updated, localized research on MR and sexual and reproductive health are needed. Investigating the women who were able to access health facilities may highlight not only barriers they, or all women face, but possible facilitators or interventions need to assist those women currently not seeking care there.

Further research is also needed on women using allopathic medication from pharmacies. In my study I did not know what medications women are taking, but the results showed that they are likely either taking ineffective drugs or doses or have insufficient knowledge to recognize or manage side effects or complication safely.

Further information is needed, both from health facilities and individual communities, on how post-MR care happens. It is necessary to establish how many women in the population attempt to access health facilities for care for complications after informal MR but are unable to access it. This research is necessarily community-based and must include a wide range of providers, as conducting research primarily in health facilities known to accept patients for post-MR care is unlikely to give a full picture.

10.10 Implications for practice

Results from this thesis could be used to inform practice and service delivery. Many barriers women face derive from outside program delivery and encompass all areas of their lives, such as the inability to move freely within their communities or being cut off from all support systems when they get married.

From a programmatic standpoint, a striking finding was women's difficulty seeking post-MR care. Considering the sheer volume of women who undergo MR outside health facilities, it is necessary to ensure that they can seek care for any complications with ease. Some of this care could be provided in facilities that do not provide MR, and would be more accessible for women fearing community stigma.
Informal provision could be improved by providing better information about and access to correct medication for menstrual regulation. Increasing access and provision of medication for MR is likely to increase with the more widespread availability of the Combi-pack. While not foolproof, and research shows that many women purchasing the Combi-pack still received incorrect information and doses (Footman et al. 2018), its packaging with instructions increases the likelihood that women would receive a correct dose.

Recommendations to improve access or knowledge in the short term could include increased home visits by family welfare visitors or community health workers. These, however, seem problematic as long as they remain within an inherently restricting system where women cannot leave their houses. On the other hand, it would seem that every opportunity, however imperfect, of increasing women's contact with the outside world, and increasing their knowledge, may ultimately be positive and could lead to other changes later on.

Thus, a combination of meeting women where they are and improving their overall empowerment and independence is needed. Producing a Combi-pack with correct instructions, and making it more readily available, for example, would help women who are unable to go to facilities; however, bringing the medication to them in their homes, for example, operates within the restricted environment within which women live, and fails to address the overall lack of empowerment in their lives. They should get effective and safe care without having to resort to an untrained "lady doctor." Furthermore, even if they must send an unknowledgeable person to the pharmacy, that person might still return with effective medication, if the full package and correct dosage is obtained.

Supporting women seeking care at approved health facilities requires consideration of their whole lives—their choices and actions, as well as the sociocultural environment within which they live. Individual approaches are likely to miss factors that affect care-seeking and barriers women face in the community, so approaches to improving care may not necessarily be reduced to the realm of menstrual regulation or abortion care. These would also include structural improvements such as easier access to healthcare for other ailments, or reducing restrictions women face in all aspects of their lives. Future interventions and approaches must include support for overall health systems including government facilities, community-based approaches, and new technological approaches, such as medical MR.
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224


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## Appendices

### Appendix A – Interview guide

<table>
<thead>
<tr>
<th>Interview Guide - Part 1</th>
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<tbody>
<tr>
<td><strong>Follow chronologically</strong></td>
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<tr>
<td><strong>Background</strong></td>
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</table>
I/EE will then look at all the information collected and analyze it; looking for patterns, similarities and differences in the experiences by the women. I/EE will write a report on what we found, and will present this to MSB and her university in London.

I have an information sheet about the study and a consent form for you to sign. (Read both)

Are you happy for us to talk now or would you like to take away the sheets and think about it, or is there a better time/place for us to meet?

Make sure consent form is signed before moving to any other questions.

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Demographics. Setting scene, establishing context. Network and community.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it ok if I ask some questions about you and your life?</td>
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<tr>
<td>There are no right or wrong answers, this is really just to find out more about you and hear more about your experiences. Again, please let me know if you have any questions at any time. I would also like to reiterate that you do not have to answer any questions you do not want to or talk about topics you don’t want to.</td>
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<tr>
<td>Are you currently married? How long have you been married? How old were you when you were married?</td>
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<tr>
<td>Where do you live?</td>
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<tr>
<td>Are you originally from here (where she lives now)? (If not, where from? How long have you lived here?)</td>
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<tr>
<td>Does your husband work? What does he do?</td>
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<tr>
<td>What about you, do you work? (Depending on answer - Did you work in the past?)</td>
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<tr>
<td>How long did you go to school? (*is there a better way to ask this?)</td>
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<tr>
<td>Who lives in your house with you?</td>
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<tr>
<td>Own Procedure</td>
<td>Establishing frame of reference. Context for procedure.</td>
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<td>----------------------------------------------------------</td>
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### Interview Guide - Part 2

**Follow chronologically, exceptions below.**

*If she volunteers information about a section out of order, this can be skipped to.*

*If she covers any topics when talking about her own procedure or in related sections, these can be skipped in below.*

### Context

Establishing context of pregnancy, contraceptive use, role of MR in family planning

<table>
<thead>
<tr>
<th>Do you have any children? How many? Boys or girls? How old are they?</th>
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<tbody>
<tr>
<td>Were you pregnant at any other times?</td>
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<tr>
<td>What happened with these pregnancies?</td>
</tr>
<tr>
<td>Do you use any form of contraception to prevent pregnancies? If yes, which?</td>
</tr>
<tr>
<td>Are you currently using it?</td>
</tr>
<tr>
<td>Were you using it at the time of your procedure?</td>
</tr>
</tbody>
</table>

### Methods


<table>
<thead>
<tr>
<th>I’d like to talk a little more about the method you used for your MR.</th>
<th>*Go with the term she uses. If in doubt, use MR.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Which method did you use?</td>
<td>Possible overlap with information, relationships, provider.</td>
</tr>
<tr>
<td>Why did you choose this method?</td>
<td>Prompts: access, ease of use, cost, safety, time, efficacy, secrecy, pain, tradition, natural vs unnatural.</td>
</tr>
<tr>
<td>How did you find out about X (this method)?</td>
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<tr>
<td>Did you like X (this method)? Why yes/why no?</td>
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<tr>
<td>What was the most important aspect of the method you used?</td>
<td>Prompts as above.</td>
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<tr>
<td>Was it how you had imagined? If no, how was it different?</td>
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<tr>
<td>Would you use it again?</td>
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<td>Would you recommend it to others?</td>
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<tr>
<td>Was X (this method) the only thing you used? Did you try anything else before? How come you chose this particular order of methods?</td>
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<tr>
<td>Did you have any prior experience with X (this method)? If yes, can you tell me a little more about it?</td>
<td></td>
</tr>
<tr>
<td>Are there any other methods you know about?</td>
<td></td>
</tr>
<tr>
<td>Where there any other methods you considered but did not use? If yes, why not?</td>
<td>Prompts as above.</td>
</tr>
<tr>
<td>Do you have any experiences with other methods? If yes, what were they?</td>
<td></td>
</tr>
<tr>
<td>What would your preferred method have been, if it had not been for X? Why?</td>
<td></td>
</tr>
<tr>
<td>Is there anything you can think of that we could provide that could have helped you access Y (preferred method)?</td>
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</tr>
</tbody>
</table>

**Questions about specific methods:**

**Miso**
- How did you know how much to take, and in what dosage?

**Drugs from pharmacy (non-miso)**
- do you know what they were, and in what dosage?

---

<table>
<thead>
<tr>
<th>Post abortion family planning</th>
<th>Comprehensiveness of services outside of clinics, inclusion of PAFP. Knowledge and awareness of PAFP.</th>
<th>Did the provider talk to you about other family planning and maternal health services?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Did he/she mention anything about family planning? If yes, what?</td>
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<tr>
<td></td>
<td></td>
<td>If yes, did you take them up on the offer? Why/why not?</td>
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<td>If no, would you have been interested? If yes, in what? If no, why not?</td>
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<tr>
<td>Providers</td>
<td>Is there somewhere else you usually go for family planning services?</td>
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<tr>
<td>Reasons for choice of provider.</td>
<td>Can you tell me a little more about where you purchased X/went for Y procedure? Possible overlap between questions below and other sections.</td>
<td></td>
</tr>
<tr>
<td>Experiences with provider.</td>
<td>Can you tell me a little bit more about X (the provider)? Why did you whose X (the provider)? Prompts: Cost, relationship, access, previous experiences.</td>
<td></td>
</tr>
<tr>
<td>Perceived/felt difference between providers, previous experience with provider. Services provided by different providers.</td>
<td>What were some of the good things about this provider? Were there any bad things?</td>
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<tr>
<td></td>
<td>Was this provider like you had imagined? Why/why not?</td>
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<td></td>
<td>Were there any other providers that you considered going to? If yes, what were they? Prompts, as above and: alone or joint decision? Easy or difficult decision?</td>
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<tr>
<td></td>
<td>What made you chose X in the end?</td>
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<tr>
<td></td>
<td>Was this your first choice of provider? If not, what would your first choice have been? How come you did not go there? Prompts: preventive care, illnesses, family planning, reproductive health.</td>
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<tr>
<td></td>
<td>Who do you usually go to to get treatment for other health issues? If this is different, why?</td>
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</tr>
<tr>
<td>Abortion and MR</td>
<td>You have referred to your procedure as X (abortion or MR), why is that? Prompts: time, development of fetus, confirmation of pregnancy, religious and personal views, legality, natural vs unnatural process, methods.</td>
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<tr>
<td></td>
<td>Do you feel there is a difference between the two? If yes, what is it? If no, why not?</td>
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<td></td>
<td>What makes it an abortion vs a menstrual regulation?</td>
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<td></td>
<td>Do different methods make it an abortion vs MR?</td>
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<tr>
<td></td>
<td>Do you think the difference between MR and abortion is important?</td>
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<tr>
<td>Question</td>
<td>Answer</td>
<td>Prompts</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Was this difference important to you, and your process and decisions?</td>
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<tr>
<td>Do you think people treat the situation differently if they think it’s going to be an abortion vs and MR procedure?</td>
<td></td>
<td>Possible different methods, providers, sharing information.</td>
</tr>
<tr>
<td>Key sources of information.</td>
<td>You told me you had used X method, how did you know to use X?</td>
<td>Possible overlap with relationship domain.</td>
</tr>
<tr>
<td>Information about legality and safety. Preferred source of information</td>
<td></td>
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</tr>
<tr>
<td>You told me you had used X method, how did you know to use X?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How did you find out about X? Did you go somewhere for more information?</td>
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</tr>
<tr>
<td>Is there a source you would consider most knowledgeable and trustworthy about MR? Did you go talk to them? Why/why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there someone you would not trust at all? Why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it difficult to find someone who you think is knowledgeable to talk to about MR?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What kind of information did you find out before using X (method)? Was there anything you wanted to know that you could not find out?</td>
<td>Prompts: safety, efficacy, legality.</td>
<td></td>
</tr>
<tr>
<td>Is there something you know today that you wish you had known before the procedure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any advice you would give others about where to go to find out about MR/X method?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What would be the easiest way for you to receive information? Is there a source that would work best for you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ever go to clinics/Doctors/health centers to find out information about MR? Why/why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where do you usually go to find out information about other health problems? If different, why?</td>
<td>Prompts: preventive care, illnesses, family planning, reproductive health.</td>
<td></td>
</tr>
<tr>
<td>Medical Abortion</td>
<td>Knowledge of MA, perception of MA, why/why not chosen.</td>
<td>Have you heard of medical abortion, misoprostol, or the miso-mifepristone combination?</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If yes, what are some of the things you know about it?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where or from whom did you find out about miso?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is it something you considered using? Why, why not?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(If she didn't use miso but knows about it) How come you did not chose miso for your MR?</td>
</tr>
<tr>
<td>Concerns</td>
<td>Concerns at different stages, changing concerns.</td>
<td>Were there things you were worried about before the procedure?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompts: safety, efficacy, fertility, side effects, cost, pain.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Was there someone you talked to about these concerns?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Were your concerns realized during the procedure?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you have any concerns now, after the procedure?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is there a way your concerns could have been alleviated?</td>
</tr>
<tr>
<td>Relationships</td>
<td>Role of friends and family in choices made, trust, hierarchy of trust, husband's role. Disclosure vs support seeking.</td>
<td>Did you talk to someone about the method and provider before using it going to see them?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prompts: Husband, mother, mother in law, sisters, aunts, friends.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did you just tell them, or did you discuss the methods together?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did they help you make the decision to choose this method and provider?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did they give you advice, or tell you what they thought you should do?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In the end, did you do what they said, or was it more a joint decision?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did you receive any advice against the method/provider you chose?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Did you tell anyone after the procedure was completed? How did they react?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Are family planning decisions generally made in the same way? Is there anyone else you discuss these with?</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Are there community views on different methods and providers?</td>
<td>Are there methods/providers that are seen as more traditional, and some as more modern?</td>
</tr>
<tr>
<td></td>
<td>What is the most common way to seek MR in the community?</td>
<td>Do you agree with them/disagree?</td>
</tr>
<tr>
<td></td>
<td>Did your community affect the method/provider you chose? In what ways?</td>
<td>Did you/did you not do what is usually done in the community for MR? Why/why not?</td>
</tr>
<tr>
<td></td>
<td>Were you afraid of anyone finding out?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do you think your decisions (provider, method) were affected by how the community feels about perceives it?</td>
<td>Possibly: need for secrecy, shame, understanding?</td>
</tr>
<tr>
<td></td>
<td>Has there been a situation where the community has found out? What happened?</td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td>Lessons learnt, change of circumstances. Future use.</td>
<td>Did everything with the procedure go as planned?</td>
</tr>
<tr>
<td></td>
<td>Did it differ from your expectations? If yes, what were some of the differences?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is there anything you would do differently if you had to do it again?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are there any recommendations you would give other women?</td>
<td></td>
</tr>
<tr>
<td>Barriers</td>
<td>Main barriers to safe services, why wasn’t the clinic chosen? Past</td>
<td>Did you consider going to a clinic, or health center?</td>
</tr>
<tr>
<td></td>
<td>How come you did not go there? Prompts: Access, cost, knowledge, past experiences.</td>
<td></td>
</tr>
<tr>
<td>Experiences with clinics.</td>
<td>Is there anything we/MSI could have done to help?</td>
<td>Are there other illnesses for which you have gone to clinics?</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Is there somewhere else where services could be offered that would be easier for you? Prompts: pharmacy, mobile clinic, teleservice.</td>
<td></td>
</tr>
</tbody>
</table>

**Interview Guide - Part 3**

**Follow chronologically**

<table>
<thead>
<tr>
<th>Conclusions: Concluding questions, rounding out interview.</th>
<th>Those were all the questions I had, was anything else you think I should know? Is there anything else you'd like to tell me that I haven't asked, or a topic that we didn't cover?</th>
<th>Do you have any other questions for me? Is there anything else you would like to know?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referrals: Continue sampling, initiate new referral process.</strong></td>
<td>Like X suggested you, we would also like to ask you if you know anyone else who you think we should talk to, who might like to tell her story.</td>
<td>Prompts: MR outside of centers, inclusion and exclusion criteria.</td>
</tr>
<tr>
<td></td>
<td>If you do, please don't tell us now but check with her first if it's ok that we know about her or contact her.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you can't think of anyone, that's totally fine! You can also always contact us later on if you do think of someone.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you're not comfortable recommending anyone, or don't want anyone to know that you've talked to us, that's completely fine too. There is absolutely no obligation to do so.</td>
<td></td>
</tr>
</tbody>
</table>

**Contact information:**

<table>
<thead>
<tr>
<th>Availability for future questions and concerns, feedback.</th>
<th>My, and Dr Rasul's, contact information are on the sheet, please feel free to contact us at any point if you have any further questions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>There are also addresses of clinics we recommend in your area on the information sheet.</td>
</tr>
</tbody>
</table>

240
If you had any issue with us, or the interview today, you can also contact the Bangladeshi Medical Review Council (BMRC). Their contact information is also on the sheet.

<table>
<thead>
<tr>
<th>Thank you</th>
<th>Valued time and expertise Use of study. Reaffirm confidentiality.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thank you so much for the time. It was really great to meet you and I'm very glad I got the chance to hear more about your story. Thanks for sharing your experience, it was really important to us and to the project.</td>
</tr>
<tr>
<td></td>
<td>Also, please do get in touch if you think of someone else!</td>
</tr>
</tbody>
</table>
Appendix B – Information sheet for participants (explicit)

Pathways to menstrual regulation outside of centers

Principal Investigator: Elisabeth Eckersberger, LSHTM
Local Partner: Dr Sadid Nuremowla, Marie Stopes Bangladesh

Introduction
Good morning/afternoon. I am _______, and I am working with Marie Stopes Bangladesh and the London School of Hygiene & Tropical Medicine. I would like to explain a little more about the study, is that ok? Please ask me if there is anything that is unclear, or anything that you would like more information on.

Please note that everything is voluntary, if any of these questions or information make you uncomfortable at any time you are free to leave at any stage and terminate the interview. Once I have explained everything you will be asked if you wish to take part in the study.

You will be given a copy of this information sheet and the Informed Consent form.

What is the study?
The purpose of this study is to find out more about women’s experience with menstrual regulation outside of centers, to help improve services for them in the future. Menstrual regulation is the establishing of non-pregnancy up to 10 weeks after a missed period. We would like to understand which methods are chosen for menstrual regulation, and why these methods were chosen. This study will take place in Mirpur.

Why have I been invited to take part?
You have been invited to take part in this study because _______ (chain link referee) recommended you as a valuable contact, who is knowledgeable about the topic.

What will happen if I take part?
If you agree to take part, we will talk more about MR outside of centers, either here or at a place and time of your choosing.

What are the risks and benefits of the study?
There are no direct benefits or risks to you for participating in this study. Some questions may
be embarrassing for you, and you do not have to answer any questions you do not want to.

Overall, the information you provide will be used by our health program to provide safer and better services for women in Bangladesh.

What if I have questions regarding medical or counseling services about the topics we are discussing?
If you have any questions regarding MR procedures, I can give you information about a nearby Marie Stopes Bangladesh clinic or government facility that will be able to advise and assist you.

Will my participation in the study be kept confidential?
Yes, everything you tell me as part of this, and any other interviews and conversations, will be kept private and confidential. Nobody will be told you participated in the study. Your name will only be recorded on the consent sheet. The consent sheet and recording of the interview will be kept in a secure location to which only the study team has access. A pseudonym (a made up name to hide your real name) will be used anywhere else anything you have said will be written down. Any names you mention will not be recorded and like for you, pseudonyms will be used. At a certain time after completion of the study, all records will be destroyed.

Nothing you tell us will be shared with or reported to anyone, or any action taken. This includes unauthorized or illegal activities; they will remain confidential within the team.

You will be asked if there is anyone else who you think would like to take part, or would be fitting for this study, but it is absolutely up to you to let them you know you have taken part. You are free to refer them without letting them know you have taken part in the study.

You are equally completely free not to refer anyone, this will not affect your participation or interview. You can also always change your mind if you feel like you may want to recommend someone now, but do not want to later on.

Do I have to take part?
No, not at all. You participation in this interview and all other conversations is completely voluntary. If you don’t want to answer any of the questions, you do not have to respond. You can decline to participate or are free to stop the interview at any time without any reason or consequences for you.
How long will the study last?
We interview will take approximately 1-2 hours, but we do not have to do it in one piece and can meet in a number of shorter sessions if you would prefer. There will be no follow up visits or interviews after the completion of the interview.

What will I receive for participating?
Your experience and options are very important to us. You will receive 200 Taka for any wage loss during the time spent participating in this study.

Who has reviewed this study for ethical issues?
This study has been reviewed by the Bangladeshi Medical Research Council, the Marie Stopes International Ethics Review Committee, and the London School of Hygiene & Tropical Medicine Ethics Committee. These groups have checked all study questions and materials and have made sure participants in this study are treated well.

What if I would like more information?
Please ask our study team any questions you may have, or if you have questions or concerns at any other time please contact the principal investigator:

- Elisabeth Eckersberger
  - (Local phone number)
  - Elisabeth.eckersberger@gmail.com

- Dr Sadid Nuremowla
  - (Local phone number)
  - sadid.nuremowla@mariestopesbd.org

What if I have a problem with you or with any of the questions?
In case you feel unfairly treated or have any other complaint about the study or the way you were treated, please contact the Bangladesh Medical Council at:

- BMRC (Local phone number)
Appendix C – Information sheet for participants (safe)
Study on women’s health in Bangladesh

Principal Investigator: Elisabeth Eckersberger, LSHTM
Local Partner: Dr Sadid Nuremowla, Marie Stopes Bangladesh

Introduction
Good morning/afternoon. I am _____, and I am working with Marie Stopes Bangladesh and the London School of Hygiene & Tropical Medicine. I would like to explain a little more about the study, is that ok? Please ask me if there is anything that is unclear, or anything that you would like more information on.

Please note that everything is voluntary, if any of these questions or information make you uncomfortable at any time you are free to leave at any stage and terminate the interview. Once I have explained everything you will be asked if you wish to take part in the study.

You will be given a copy of this information sheet and the Informed Consent form.

What is the study?
The purpose of this study is to find out more about women’s health in Bangladesh. This study will take place in Mirpur.

Why have I been invited to take part?
You have been invited to take part in this study because ______ (chain link referee) recommended you as a valuable contact, who is knowledgeable about the topic.

What will happen if I take part?
If you agree to take part, we will talk to you more about the topic of children and women's health, either here or at a place and time of your choosing.

What are the risk and benefits of the study?
There are no direct benefits or risks to you for participating in this study. Some questions may be embarrassing for you, and you do not have to answer any questions you do not want to.

Overall, the information you provide will be used by our health program to provide safer and
better services for women in Bangladesh.

What if I have questions regarding medical or counseling services about the topics we are discussing?
If you have any questions regarding any of the topics, I can give you information about a nearby Marie Stopes Bangladesh clinic or government facility that will be able to advise and assist you.

Will my participation in the study be kept confidential?
Yes, everything you tell me as part of this, and any other interviews and conversations, will be kept private and confidential. Nobody will be told you participated in the study. Your name will only be recorded on the consent sheet. The consent sheet and recording of the interview will be kept in a secure location to which only the study team has access. A pseudonym (a made up name to hide your real name) will be used anywhere else anything you have said will be written down. Any names you mention will not be recorded and like for you, pseudonyms will be used. At a certain time after completion of the study, all records will be destroyed.

Nothing you tell us will be shared with or reported to anyone, or any action taken. This includes unauthorized or illegal activities; they will remain confidential within the team.

You will be asked if there is anyone else who you think would like to take part, or would be fitting for this study, but it is absolutely up to you to let them you know you have taken part. You are free to refer them without letting them know you have taken part in the study.

You are equally completely free not to refer anyone, this will not affect your participation or interview. You can also always change your mind if you feel like you may want to recommend someone now, but do not want to later on.

Do I have to take part?
No, not at all. You participation in this interview and all other conversations is completely voluntary. If you don’t want to answer any of the questions, you do not have to respond. You can decline to participate or are free to stop the interview at any time without any reason or consequences for you.

How long will the study last?
We interview will take approximately 1-2 hours, but we do not have to do it in one piece and
can meet in a number of shorter sessions if you would prefer. There will be no follow up visits or interviews after the completion of the interview.

What will I receive for participating?
Your experience and options are very important to us. You will receive 200 Taka for any wage loss during the time spent participating in this study.

Who has reviewed this study for ethical issues?
This study has been reviewed by the Bangladeshi Medical Research Council, the Marie Stopes International Ethics Review Committee, and the London School of Hygiene & Tropical Medicine Ethics Committee. These groups have checked all study questions and materials and have made sure participants in this study are treated well.

What if I would like more information?
Please ask our study team any questions you may have, or if you have questions or concerns at any other time please contact the principal investigator:

- Elisabeth Eckersberger
  - (Local phone number)
  - Elisabeth.eckersberger@gmail.com
- Dr Sadid Nuremowla
  - (Local phone number)
  - sadid.nuremowla@mariestopesbd.org

What if I have a problem with you or with any of the questions?
In case you feel unfairly treated or have any other complaint about the study or the way you were treated, please contact the Bangladesh Medical Council at:

- BMRC (Local phone number)
Appendix D – Participant consent form (explicit)

<table>
<thead>
<tr>
<th>Consent Form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Study Title:</strong> Pathways to menstrual regulation outside of centers</td>
</tr>
<tr>
<td><strong>Principal Investigator:</strong> Elisabeth Eckersberger (<a href="mailto:Elisabeth.eckersberger@lshtm.ac.uk">Elisabeth.eckersberger@lshtm.ac.uk</a>) (local phone number)</td>
</tr>
<tr>
<td><strong>Local principal investigator:</strong> Dr Sadid Nuremowla <a href="mailto:sadid.nuremowla@mariestopesbd.org">sadid.nuremowla@mariestopesbd.org</a> (local phone number)</td>
</tr>
</tbody>
</table>

**Participant**

- I have understood the information I read, or was read to me about the study.
- I have received an explanation of the study and why I have been asked to take part, and what my part will be.
- I understand that everything discussed here is confidential, and my name or any identifying information will not be shared.
- I understand that I do not have to answer any questions or discuss topics I do not want to, without giving a reason.
- I understand that participation in this study is completely voluntary, and I can terminate the interview and withdraw from the study any time I would like, without having to give a reason.
- I agree that information I give here may be used in reports and publications, but my name will never be used.
- I have been given the opportunity to ask questions about the study and anything that is unclear to me.
- I have been given a copy of the information leaflet and this consent form.

<table>
<thead>
<tr>
<th>Participants name (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant signature or thumb print</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

**Investigator or research assistant**

I confirm that I have explained and discussed the nature of the study, study procedures, potential risks and benefits, confidentiality of personal information, as well as voluntariness of participating in the study. To the best of my abilities, I believe the participant has understood the study and is taking part in good faith.
<table>
<thead>
<tr>
<th>Researcher name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
# Appendix E – Participant consent form (safe)

<table>
<thead>
<tr>
<th>Consent Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study Title: Pathways to menstrual regulation outside of centers</td>
</tr>
<tr>
<td>Principal Investigator: Elisabeth Eckersberger (<a href="mailto:Elisabeth.eckersberger@lshtm.ac.uk">Elisabeth.eckersberger@lshtm.ac.uk</a>)</td>
</tr>
<tr>
<td><em>(local phone number)</em></td>
</tr>
<tr>
<td>Local principal investigator: Dr Sadid Nuremowla <a href="mailto:sadid.nuremowla@mariestopesbd.org">sadid.nuremowla@mariestopesbd.org</a></td>
</tr>
<tr>
<td><em>(local phone number)</em></td>
</tr>
</tbody>
</table>

## Participant

- I have understood the information I read, or was read to me about the study.
- I have received an explanation of the study and why I have been asked to take part, and what my part will be.
- I understand that everything discussed here is confidential, and my name or any identifying information will not be shared.
- I understand that I do not have to answer any questions or discuss topics I do not want to, without giving a reason.
- I understand that participation in this study is completely voluntary, and I can terminate the interview and withdraw from the study any time I would like, without having to give a reason.
- I agree that information I give here may be used in reports and publications, but my name will never be used.
- I have been given the opportunity to ask questions about the study and anything that is unclear to me.
- I have been given a copy of the information leaflet and this consent form.

<table>
<thead>
<tr>
<th>Participants name (optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant signature or thumb print</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

## Investigator or research assistant

I confirm that I have explained and discussed the nature of the study, study procedures, potential risks and benefits, confidentiality of personal information, as well as voluntariness of participating in the study. To the best of my abilities, I believe the participant has understood the study and is taking part in good faith.
<table>
<thead>
<tr>
<th>Researcher name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher signature</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F – Ethical approvals

National Research Ethics Committee

Elisabeth Eckersberger
PhD Candidate &
Independent Consultant at Marie Stopes International
London School of Hygiene & Tropical Medicine
15-17 Tavistock Place, London, WC1H, 9SH.

Subject: Ethical Clearance

With reference to your application on the above subject, this is to inform you that your Proposal entitled “Pathways to Menstrual Regulation Outside of Centers” has been reviewed and approved by the National Research Ethics Committee (NREC).

You are requested to please note the following ethical guidelines as mentioned at page 2 (overleaf) of this memo-

(Dr. Mahmood-uz-jahan)
Director

252
MSI Ethics Review Committee approval for application number [019-14-E]

**Project Title:** Pathways to menstrual regulation outside of centers - Bangladesh

**Submitting Officer:** Kate Reiss, Research Analyst, Marie Stopes International

**Approval Date:** 20 January 2015

Dear Kate Reiss,

I am pleased to notify you that the above-titled protocol has been reviewed and approved by the independent Ethics Review Committee (ERC) of MSI. This approval is conditional upon approval by an ethics committee in the host country. The ERC's approval is valid for 12 months after the approval date.

Please submit the following to the ERC, as and when appropriate:

- Proof of approval by a local ethics committee (if not already provided)
- Final scientific report, or published paper
- Incident form (if applicable)
- An Amendment Form in the event of any modifications to the protocol reviewed by the ERC, before any such changes are implemented.
- A Continuing Review Application if the study continues beyond 12 months after the approval date.

We wish you the best of luck with your study.

Sincerely,

Signed: [Signature]

Date: 20 January 2015

Marika McAdam
Co-Chair, MSI ERC
Ms. Elisabeth Eckerberger  
Research Degree Student  
PHP  
LSHTM  
3 November 2014

Dear Ms. Eckerberger,

Study Title: Pathways to menstrual regulation outside of centers in Bangladesh  

LSHTM Ethics Ref: 8653

Thank you for your letter of 22 October 2014, responding to the Observational Committee’s request for further information on your research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows -

<table>
<thead>
<tr>
<th>Document Type</th>
<th>File Name</th>
<th>Date</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Sheet</td>
<td>Pathways E.Eckerberger Consent Form Explicit.docx</td>
<td>17/09/2014</td>
<td>1</td>
</tr>
<tr>
<td>Information Sheet</td>
<td>Pathways E.Eckerberger Consent Form Solicitous.docx</td>
<td>17/09/2014</td>
<td>1</td>
</tr>
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</tr>
</tbody>
</table>

After ethical review

Any subsequent changes to the application must be submitted to the Committee via an Amendment form on the ethics online applications website. The Principal Investigator is reminded that all studies are also required to notify the ethics committee of any serious adverse events which occur during the project via an Adverse Event form on the ethics online applications website. At the end of the study, please notify the committee via an End of Study form on the ethics online applications website. Ethics online applications website link: http://dev.lshtm.ac.uk

Yours sincerely,

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Chair

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254