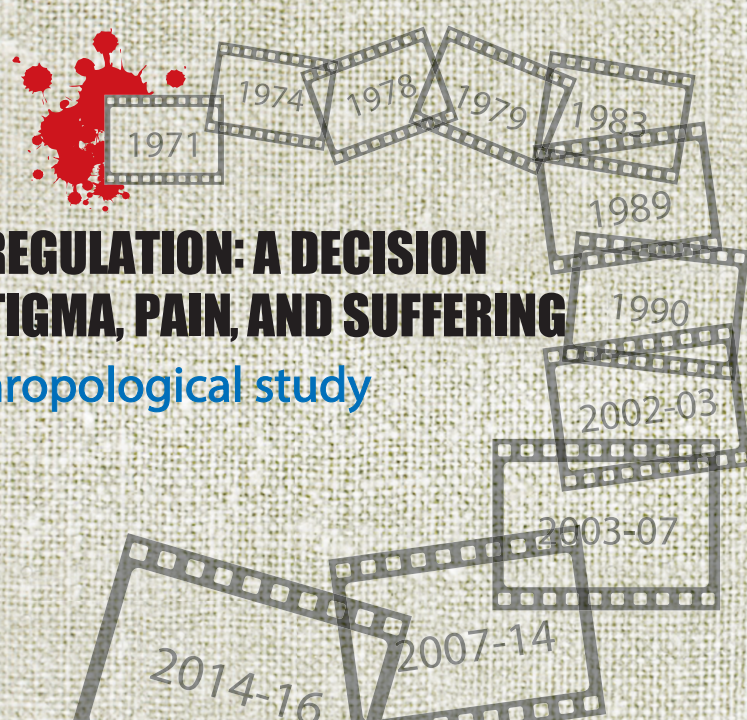


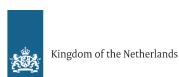


MENSTRUAL REGULATION: A DECISION TAINTED WITH STIGMA, PAIN, AND SUFFERING

An anthropological study



Rasheda Khan
Afroza Khanom, Marzia Sultana, Rashida Akter, Sayeda Bilkis
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Cover Design: It illustrates the bloody beginning of the nation as well as the menstrual regulation movement in Bangladesh and provides an illustrative flow of events since then up to the present day.

Mr. Zuber Mahbub Tusher from Asiatic Talking Point conceptualized the design in consultation with the investigators.

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Acronyms:

BDT	Bangladesh taka
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DH	District Hospital
FGD	Focus Group Discussion
FWA	Family Welfare Assistant
FWC	Family Welfare Centre
FWV	Family Welfare Visitor
GoB	Government of Bangladesh
HW	Health Worker
IDI	In-depth Interview
LAM	Lactational amenorrhea
LMAF	Local Medical Assistant & Family Planning
MCWC	Maternal and Child Welfare Centre
MCH	Medical College Hospital
MR	Menstrual Regulation
NGO	Non Governmental Organization
RMP	Rural Medical Practitioner
SACMO	Sub-assistant Community Medical Officer
THC	Thana Health Complex
UHC	Upazila Health Complex
VD	Village Doctor

Executive Summary

Introduction

Around 47,000 deaths occur worldwide due to unsafe abortions while 97% of these deaths occur in developing countries. In Bangladesh, approximately 33% of all births are unplanned. 45% of all the unplanned pregnancies end in menstrual regulation procedures and back-alley abortions. It is estimated that 26% of all clients presenting themselves at the menstrual regulation (MR) clinics are refused services for various reasons, consequently pushing these women to resort to illegal and unsafe back-alley clinics.

Little or no work has been done to understand the perceived notions of stigma/shame and conservatism, although these and possibly a plethora of other reasons deter women from availing the services from safe sources and in a timely manner. The need to understand the barriers deterring women from exercising their rights, in this case their reproductive rights, is crucial.

Objectives

The broader objective of the study was to describe the sociocultural aspects and women's perceptions on MR and related services that affect utilization of the services in Bangladesh. To understand these objectives, the study explored

1. Attitude, perception, and acceptability of communities, including women of reproductive age, in urban and rural settings, with regard to MR and MR related services
2. Socio-cultural aspects and perceived and/or actual barriers in availing MR services and reasons for delay in seeking care
3. Women's expectations in terms of access and quality of care and services
4. Providers' perspectives on access and quality of care and services related to MR

Methodology

The study design was entirely qualitative, with standard qualitative tools being used to gather information on our research interest. The study was carried out from March 2009 to September 2011 in four districts of Bangladesh: Dhaka, Bandarban, Sylhet, and Shatkhira. The research was designed with the consideration of capturing widest variations as the guiding principle. These variations were captured in terms of geographic locations (coastal areas and hilly parts), socioeconomic status (religious backgrounds and slum dwelling) and areas with existing MR programmes.

Several methods were applied with purposive sampling of different types of informants. In-depth open-ended interviews were carried out with women having MR experiences (n=27) and rejections for MR services (n=25) to capture beliefs and practices surrounding MR, decision-making process at the household level, care-seeking pattern, and barriers to care seeking. To understand the context from a broader perspective, one or two family/community member/s of primary informants (n=38) were interviewed as well. To understand the community perceptions, 24 (6 in each site) focus group discussions (FGDs) were carried out with elderly females (n=4), males (n=4), young females (n=8), and young males (n=8). Twenty-nine interviews were carried out with different formal and informal healthcare providers that included FWVs, paramedics of different facilities, MBBS doctors, homeopathic doctors, religious healers/*kobiraj*, TBAs, village doctors, ayah of various facilities (literally ayahs are nurses' assistant), pharmacists, *boiddos*, and *ojha*. Sixteen key informant interviews (with 4 from each site) were also conducted. Many informal discussions (~80) were carried out with women with or without experiences of MR and healthcare providers.

We followed a phenomenological approach in terms of analyzing the data, which is reflected in the story-telling format of the report that should help the reader recreate the phenomenon of our research interest-menstrual regulation-from the point of view of the women who experienced it or wanted to receive services but were rejected.

Results

1. Socioeconomic status and demographics of informants

Women's age-range was 21-40 years in three areas while the age-range was a bit smaller for the woman in Kamalapur/Dhaka, which was 14-30 years. Interestingly, husbands' age-range varied in all these four areas, with the lowest in Dhaka (19-35 years) and the highest in Sylhet (30-70 years).

In general, 23 women did not have any formal education, 14 had 1st to 5th grade, nine had 6th to 10th grade, and five had 10+ grade of education. However, the highest level of educational qualifications among the women was noticed in Bandarban and the lowest level in Sylhet. On the other hand, 14 husbands did not have any formal education and the highest level of education among men was in Shatkhira, with the lowest in Sylhet.

In terms of income-generating activities, wide variations in terms of occupation were noticed among the women in Dhaka, Bandarban and Shatkhira, which included different formal jobs such as teaching and working for NGOs. A lot of women in Bandarban were also involved in *jhum* cultivation. Women in Sylhet were involved in primarily helping husbands in their work. On the other hand, husbands' occupational involvement shows that most of the husbands were involved in day-labor in three other sites while men in Bandarban were mostly involved in *jhum* cultivation.

The range of age at marriage was 13-25 years. Most of the women were married during the time of interview; only one was divorced and one was separated. The household composition data showed that most women lived in nuclear family settings, with the highest number in Dhaka. The number of children in the household was more in Sylhet and Bandarban.

2. Perception and knowledge of MR (including reasons for doing MR)

In-depth interviews and group discussions suggested that people considered MR as sin equal to killing a life as proscribed by religion. People view it as intervening in God's work. This is why people in Sylhet and Shatkhira buried their aborted fetuses. However, somewhat contradictorily, the same people believe that life come into a fetus only after the third or the fourth month. Therefore, it is okay to get rid of the fetus before that. Despite these beliefs, the feeling of having to have committed a sinful act persists.

Despite believing that MR is sinful, women still choose the procedure for reasons, such as poverty, too many children, being too old to carry another child, etc. Women also talked about marital violence as one of the reasons why they did not want any more children. Some women in Shatkhira mentioned hampering their normal work as a reason too.

Regardless of the practical considerations, the society at large is not permissive of the procedure. People often directly relates it to being *bad* and having extra or non-marital relationships. Consequently, the process of having an MR become more and more clandestine. In Bandarban, our experience suggested a different picture. Although people are not permissive of MR for younger couples, they are not that critical and/or judgmental of children born out of wedlock.

Irrespective of all study sites, it was found that people do not know the differences between "MR" and "abortion." They used terms such as "*bachha felano*," "*bachha noshto kora*," "*wash kora*," "*bachha porishkar kora*," "*pet phalano*," "*noshto kora*," "*ashehkheanchoh*," etc., all of which implied "getting rid of the baby". Interestingly, none of our informants knew about the exact legal timing for the procedure.

3. Unplanned pregnancies (FP history; decision-making)

The most-used family planning method in all of the sites, as in the case of the country in general, was the contraceptive pill. Condoms and natural methods were spoken of, but were not popular, irrespective of the sites. In recent times, use of biomedical methods, again pills, is increasing. Long-term methods, such as injection, IUD and sterilization were extremely low. In addition, we observed a tradition of non-use of FP methods among the newly-married couple.

As expected, women bore the primary responsibility of family planning, and, as a consequence, faced a lot of physical and technical problems in continuing FP methods. Side-effects (as reported by the women), compounded with social problems such as lack of correct information on FP methods, husband's and other family members' passive roles, often resulted in irregular use and consequent pregnancies.

4. Care-seeking

The exploration in four different sites in Bangladesh led investigators to discover that an unplanned pregnancy was a clandestine affair. If a pregnancy was to be ended, it was not to be known outside the immediate circle of confidants since the social stigma attached to ending a pregnancy or going for an MR was ubiquitous in the society. The desire to keep it a secret often led women to try home remedies or visit

informal places and service providers, since the risk of being exposed at the formal places was perceived as greater.

5. Costs for MR

Cost is one of the most important factors in terms of decision-making to avail MR services. Generally speaking, the work has been done among the poorer households, where earning for livelihood is a challenge on its own. Non-cooperative husbands, critical communities, and failing health system made the situation worse. In such cases, women ended up selling their meager assets to get an MR, despite the economic hardship. In Sylhet, people also talked about micro-credit loans for this purpose. However, if women had supportive husbands and congenial communities, it became easier to handle the situation since they could pull their resources together and act accordingly.

The Government of Bangladesh provides MR services free of charge but, practically, the out-of-pocket expenses that were incurred for services became an important issue. More often than not, women presented themselves beyond the legal limit for MR, for which they were charged higher prices. In addition to the issue of cost, a lot of women avoided these services since they feared being exposed as this health facilities were often situated in public places. Other formal places were also avoided for similar reasons. Consequently, they ended up with informal service providers, where complications often resulted in greater expenses.

Among the indigenous communities, seeking care from a government facility or any other formal facility was very costly since they had to travel long distances to get to the place. Even if they managed to get the service itself at a cheaper price, the wages lost, cost of food and accommodation for the time spent away from home, etc. added up and became a huge burden. Again, this drove women to *kobiraj/boiddos* and/or TBAs, which was often risky.

6. Barriers and delays

Women were often late in resorting to care outside of home for MR. Primary reasons for this delay included: not knowing if and when one got pregnant, decision making regarding whether or not to terminate pregnancies due to social stigma and religious restriction, not knowing where to go for MR, delay in figuring out how much it is going to cost, and then managing that fund. Negligence of service providers in giving the right information on MR and related services and incorrect report of pregnancy also added to the delays. Distance, especially in the hill district of Bandarban, was a major problem for the purpose of getting to a safe place for MR. Non-functioning health facilities that were close by made the situation even worse. The 'hush-hush' culture and religious injunctions surrounding MR were great barriers to getting proper and timely MR care. Women found themselves conflicted within their basic notion of MR being bad and MR being a necessity at the same time. Cost incurred in the process of availing MR services was also mentioned repeatedly. In most cases, poor households could not manage the cost and ended up with suffering in more than one way (i.e. financial disaster, ill-health, and too many children to take care of).

7. Health system

It can generally be said that women were quite unaware of the available services in the community. It was only when one needed the services she made an attempt to find out. This is why the presence of community volunteers acting as the bridge between the women and the health system. Judging from this fact, it can safely be said that the atmosphere of keeping MR a matter not to be discussed contributed heavily to this lack of knowledge.

In Dhaka, there were several sources for MR. There are registered places like NGO clinics and GoB facilities, and there are unregistered individuals providing MR services in their shanties and rented homes. Often these unregistered places were in fact formal providers in a GoB or NGO facility providing services beyond the ambit of legal jurisdictions. One interesting point to note here is that no traditional providers were found who would provide herbal medications and procedures. Being in the capital city with the availability of several biomedical sources might have had a lot to do with this. People in Dhaka suggested that the government increase the services in order to control the population growth.

In Sylhet and Shatkira, formal MR services are available only in GoB facilities and a few NGO facilities. Other than these institutions, the informal providers dominated the scene, which includes TBAs, herbalists, homeopaths, and village doctors. Among the village doctors, misoprostol seemed to be one of the most common drugs for the purpose.

Though the governmental system was pretty much the same in Bandarban, people do not know about the availability of MR services there and ended up travelling to district town for the services. Other primary and secondary facilities provides the services but not as regularly, which also contributes in making the travel necessary. Presence of a lot of *boiddos* or traditional healers and TBAs with self-proclaimed knowledge of getting rid of a pregnancy may be the reason behind this situation. Generally speaking, pre and post MR counseling was not observed as a standard practice.

Invariably, all of our informants mentioned being tested for pregnancy. It did not matter if they actually availed the services or not, or if they were formal or informal providers.

Discussion/Conclusion

1. Attitude/perception/acceptance regarding MR and related services

People in the community believed that MR is a sin. However, women still avail the services despite that fact due to pragmatic reasons. They did an internal analysis and then judged whether it was better to end the pregnancy or not.

Society puts stigma on women who carry out MR, which is why women were extremely secretive about the matter. Often this clandestine behavioral pattern pushed women toward informal providers, whom they trusted and feared less about being exposed.

2. Barriers and delays to avail MR services

- a. Delay in identifying pregnancy:* Women in Bangladesh do not always know that they are pregnant. If and when they suspect, they go to an informal service provider to check if they are pregnant. Often these reports are negative and incorrect. These result in delays that put women beyond the legal limit of having an MR done at a registered facility.
- b. Delays in decision making whether or not to do the MR:* MR is considered sin in general in the context of Bangladesh. Women and couples, once they identified the pregnancies, took time considering whether or not to terminate pregnancies due to social stigma and religious restriction. This also put women to delay in seeking care right away.
- c. Delay in identifying a suitable place for MR:* Women do not know where to go for MR services and have to depend on others. Facilities do not make it easy for women to find out what is available and what is not. This was specifically the case with MR services. Finding a person with experience or the knowledge takes time and, even then, it is often not the right person that they find. Again, this results in critical delays.
- d. Delay in managing the cost:* The cost for an MR procedure at a government facility is minimal. However, when various delays put the women beyond the legal limit, the cost for the procedure goes up. Quite easily, the prices go well beyond what a poor woman can afford. Therefore, women have to find alternative means to manage that cost, which, in turn, takes time.

3. Access to and quality of care

- a. Availability of services:* Although MR services are available in many government facilities, community members do not know about it. This makes their access to the required services very limited. The cultural atmosphere that does not condone such an act contributes further in making the access more difficult. Considering the cultural aspects, NGOs do not advertise their services aggressively either.
- b. Costs:* By the time women can know about their pregnancy status, they are often over the legal limit of MR, for which they are often rejected services at the registered places. The same service providers offer to provide the services beyond the legal ambit but with higher costs.
- c. Pregnancy test:* Invariably, for all women who present themselves at a facility, be it a government, NGO, or an informal one, pregnancy tests are done right away. No MR is done without knowing the pregnancy status of a woman.
- d. General quality of care:* Generally speaking, quality of services at a registered facility is perceived to be higher but is also more expensive. Therefore, people often avoid these services and resort to informal care. In the informal sector, there is no control in terms of quality.

1. Introduction

True estimate of global burden due to unsafe abortion is hard to measure. Based on global maternal mortality data, WHO estimates it to be 13% of all maternal mortality or 47,000 maternal deaths (WHO, 2010). Unfortunately, 97% of these deaths occur in the developing countries (WHO, 2004). In Bangladesh, approximately 33% of all births are unplanned (Oliveras, 2007). 45% of all the unplanned pregnancies end in menstrual regulation procedures and back-alley abortions (Singh, Hossain, Kamal, & Perez, 1997). Depending on which study findings one would rely on, 5-19.2% of overall maternal mortality in Bangladesh is due to these unsafe abortion practices (NIPORT, 2003; Dieltiens, 2004; Chowdhury, Botlero, Koblinsky, Saha, Dieltiens, & Ronsmans, 2007). The most recent BMMS 2010 shows much lower estimates, but there remain a substantial proportion of unidentified maternal deaths, where deaths due to MR/abortion may lie (NIPORT, 2010). In absolute terms, around 647,000 induced abortions were performed in Bangladesh, while 231,400 of that were treated for complications. Incidentally, a much larger number in fact did not get treated at the facilities for complications, which were around 341,000 women (Singh, Hossain, Maddow-Zimet, Bhuiyan, Vlassoff, & Hussain, 2012; Hossain, Maddow-Zimet, Singh, & Remez, 2012). On top of this, around 653,000 menstrual regulation procedures were performed at various facilities, with one in every 10 of those reporting complications (Singh et. al., 2012). It is estimated that 26% of all clients presenting themselves at the MR clinics are refused services for various reasons, consequently pushing these women to resort to illegal and unsafe back-alley abortion clinics (Singh et. al., 2012).

The Menstruation Regulation Programme of Bangladesh has gained enormous success with their existing resources (as the number of abortion has increased, deaths due to unsafe abortion has decreased and the fact that a significant decline in the fertility growth has been noticed) (Oliveras, 2007; Hossain et. al., 2012). However, it has now come into the present shape (vacuum aspiration for uterine evacuation at the primary care level since 1979) facing different challenges over the time both from domestic and international levels which are based on religious and political ground for which the programme could not achieve its goal of making MR services safe, accessible, and available to all those who needed it. For instances, while a policy environment was created to legalize abortion during the year 1977 as part of reducing unintended pregnancies associated with maternal mortalities and morbidities, the then political party put a bar on it explaining that an explicit legalization might arouse religious opposition (Ross, 2002). It was not until the year 1979, when the MR programme was adopted in the national Family Planning programme, though MR was mentioned less frequently and less explicitly in policy documents. The programme faced a more severe problem when, during 1984, the Mexico City Policy put a bar on financing and giving technical support to organizations that provided any support to abortion related activities, including MR (Johnstone, Schurmann, Oliveras, & Akhter, 2011).

Fairly well developed literature exists on understanding the non-use of family planning services. Casterline and colleagues showed that women's reproductive preferences, husband's fertility preferences, and perceived detrimental side-effects of contraceptive methods are the primary determinants of contraceptive use (or non-use). This study conducted in the Philippines also stated the preference-behavior gap or the unmet need is not an artifact of survey measurement (Casterline, 1997). Charles Westoff developed the standard formulation of unmet need. In this formulation the unmet need group includes all sexually active and fecund women who are not using any method of contraception and who either do not want to have any more children or want to postpone their next birth for at least two years (Westoff, 1994). Interestingly, this formulation does not include unmarried but sexually active women, who naturally have a much higher need. This is a serious limitation (Ropey, 1996). Using the standard definition, women with unmet need in Bangladesh are estimated to be around 4.4 million.

Trying to understand the reasons behind the non-use of family planning or behind this unmet need is a formidable task in and of itself. Demographic Health Surveys do provide a basis, but they typically investigate the principal reasons as mentioned above (Westoff, 1994; Ainsworth, 1985; Hollerbach & Nortman, 1984). Problem with these "principal" reasons is that they fail to capture the context of women in which they make their choices (Mahmud, Chowdhury, Siddiqi, Theobald, Ormel, Biswas, Jahangir, Sarker, & Rashid, 2015).

Often the reasons cited are not complete (Westoff, 1994), or that there are more than just those reasons (Curtis & Westoff, 1996; Barrios et al. et. al. 1997; Bongaarts & Bruce, 1995; Mahmud et. al., 2015) or that

the importance of a reason not disclosed is more than the one mentioned (Casterline, 1997; Nag, 1984). This prompted more small-scale in-depth explorations of the subject matter revealing attitudes, interests, and values of women (Westoff, 1995; Mahmud et. al., 2015). The discipline of public health is now finding immense use of these research findings that add “color and depth” to numbers obtained from large-scale surveys (Rimon, Blake, & Odallo, 1994).

In-depth qualitative explorations have provided several insights into the context and meaning of the reasons behind unmet need or non-use of family planning methods that are problematic to discern through survey methods. For instance, an in-depth study conducted in Philippines revealed that women with unmet need believe that the risks of using contraception methods are greater than pregnancy. Their own fear coupled with their husbands’ fear explained their unmet need – something that was not possible to explore through the surveys (Piotrow, Kincaid, Rimon II, & Rinehard, 1996). Similarly in Nepal, another qualitative study showed that many women with unmet need did not use contraception since they “perceived” the quality of treatment to be low. They also mentioned their fear of side-effects, but this fear was more due to the costs that would incur due to their sickness (Casterline, 1997).

Methodologies that have been applied are based on the methodologies developed in understanding the non-use of family planning services as mentioned above. Studies are taking cues from the reviews of several DHS reports on one hand and qualitative studies conducted on the other. We strongly feel about the first recommendation made in the Population Reports Series published by Johns Hopkins School of Public Health, Population Information Programme, September 1996, where it categorically mentioned utilizing qualitative research methods along with surveys in understanding reasons behind unmet need (Ropey, 1996).

More specifically, little is known about community perceptions and attitudes toward the issue of MR and social stigma attached to availing the services and discussing it with others (Bhandari, Hom, Rashid, & Theobald, 2008). It is important to understand the context of this stigma and how this may deter women from availing services on time. Due to patriarchal norms mixed with the prevailing religio-political atmosphere, women’s mobility is restricted here and issues related to sexuality and reproductions are stigmatized (Stash, 2000; Bhandari et. al., 2008). Even within these cultural barriers, a large number of MR and abortion take place with untrained providers, which only shows that there is great demand for the services (Nashid & Olsson, 2007). Seeking MR services with untrained providers are the results of unawareness of gestational period (a major reason for refusal at the MR clinics), unavailability of the services, stigma, perceived negative social attitudes and perceived religious notions out of which a huge number of women suffer from unsafe procedures (Dieltiens, 2004; Chowdhury et. al., 2007). The country profile published from the World Health Organization provides detailed information regarding these unsafe procedures, including its extent, reasons, and consequently the context in which a woman’s decision is exercised (Khan, 2002; Bhandari et. al., 2008; Nashid & Olsson, 2007).

In terms of fertility transition, in all societies where women on average have the number of children they want, this is achieved through a combination of contraceptions and abortion (WHO, 2003; Van Der Tak, 1974; Kulczycki, 1999; David, 1999), although not every woman resorts to the use of abortion. Information obtained across 170 countries indicates that no country has reached replacement level fertility without widespread access to safe abortion for poor women as well as the rich (Potts, Diggory, & Peel, 1997). In fact, if all unwanted births could be avoided, TFR (total fertility rate) would fall from 3.3 to replacement level of 2.2 in Bangladesh (Campbell, Prata, & Potts, 2008). DHS data from Bangladesh shows a fall in total fertility rates (TFR) without a significant rise in contraceptive use or any major changes in the age of marriage (NIPORT, 2015). It is plausible that there has been a significant rise in abortions, though the most recent Bangladesh Maternal Mortality Survey reports to the contrary (NIPORT, 2012).

National and international data suggests that city dwellers and educated people have positive attitudes towards MR and abortion. Bangladesh is an agrarian society and most of the population is still uneducated. Little is known about rural uneducated people’s attitude towards MR, though 70%-90% of the MR and abortion takes place amongst them and remains unreported (NIPORT, 2009).

Existing data suggest that there has been very little policy dialogue and/or debate regarding MR and abortions, which could have had huge impact in designing relevant policies. These works revealed two significant reasons behind scant policy dialogue: 1) there is unwillingness to discuss reproductive matters in public (stigma/shame) and giving women reproductive freedom is thought to promote

promiscuity, and 2) perceived conservatism. However, little or no work has been done to understand these perceived notions of stigma/shame and conservatism, though these and possibly a plethora of other reasons deter women from availing the services from safe sources and in a timely manner. The need to understand the barriers deterring women from exercising their rights, in this case their reproductive rights, is crucial.

The study will have important impact at various levels. Studies focusing on socio-cultural attitudes toward MR are few and far between. Therefore this study will be a reference point for public health researchers, policy makers and programme implementers who are working in this field. In addition, despite the obvious social welfare and demographic significance of unmet need for family planning, very little is known about its context (Dixon-Mueller & Germain, 1992; Chowdhury and Moni, 2004; Bulatao, 1997). Therefore, data on barriers related to availing MR services from facilities will inform programme implementers and policy makers to design their programmes and policies to accommodate measures to overcome these barriers. As Campbell and colleagues suggest, "...the reduced barriers theory means that the final stage of the fertility transition does not require an abridgement of rights. Instead, it requires that women be free to have control over their childbearing, enabling them to have access to their preferred method of fertility regulation... It sets a research agenda to quantify [and identify] the many and various existing barriers to access to voluntary fertility regulation" (Campbell et al., 2008). Moreover, conservatism was and is being cited as a barrier for raising policy dialogue on this issue. The significant outcome of the study is that it will provide us with the information whether the fear of conservatism is true for our country or not. If it is true, then we would like to see to what extent it is so, and if not then we expect that to have a huge impact in terms of designing MR and abortion related policies.

The study design is entirely qualitative. Therefore, this study does not provide a statistically representative catalogue of people's perceptions and views on MR and abortion. Instead, it provides in-depth information about people's feelings, motivations and sentiments with regard to MR and MR services. It provides cultural context within which issues of MR revolve. Instead of proving or disproving a certain hypothesis, it generated hypotheses that can be tested further through epidemiologic studies.

Taking clues from the scanty researches that have been conducted on people's views with regard to MR, it is understood that the topic itself can prove to be controversial and/or uncomfortable for a number of group members we will be working with. Discussing sexuality and reproductive health matters is tantamount to being a taboo in this region of the world. Though we did not experience any kind of social backlash in response to this research effort, extreme caution was taken at all times nonetheless. The section on methods describes the activities in further details and the caution taken with adequate attention to the sensitivity attached to the subject in order to ensure confidentiality.

Field-based data collection followed the formal literature review. In this phase, we elicited the responses primarily from the members of the community and secondarily from other stakeholders. Details regarding the sites are provided in the methodology section below.

There is an obvious limitation of the study. Due to its qualitative design, the findings from this study are not statistically representative of the nation. This means that further research on this issue will have to be done in order to establish statistical representation, if needed.

2. Aims and objectives

The overall objective of the study was to describe the socio-cultural aspects and women's perception on MR and MR services that effect utilization of the services in Bangladesh.

The specific objectives of the study were to:

- a. Explore attitude, perception, and acceptability of communities, including women of reproductive age, in urban and rural settings surrounding MR and MR related services
- b. Identify socio-cultural aspects and perceived and/or actual barriers in availing MR services and reasons for delays in seeking care
- c. Explore community/women's expectations in terms of access and quality of care and services
- d. Explore providers' perspectives on access and quality of care and services with regard to MR

3. Methodology

In order to address the objectives as stated above, a phenomenological research design was opted for the study. The units of analysis were several women, men, and healthcare providers who have lived experiences relating to menstrual regulation (MR), which is the phenomenon of the research interest in the context of various Bangladeshi societies. The attempt was to “grasp the very nature of the thing” (vanManen, 1990). Following the footsteps of philosophers, such as Edmund Husserl (1859-1938), Martin Heidegger (1889-1976), Jean Paul Sartre (1905-80), and Maurice Merleau-Ponty (1908-61), the study employed phenomenology in order to understand various dimensions of MR as it relates to women who have either experienced it or have tried to avail the services, different sides of care provisions related to it and thereby contextualize the entire process.

As the study approached the matter, this is important to pay attention to the following philosophical assumptions (adapted from Stewart & Mickunas, 1990):

- ***Basic philosophy used in the approach:*** Philosophy is a search for wisdom. However, with the rise of science and its influence on all aspects of knowledge, it somewhat became a handmaiden of science. Empirical means thus became the only legitimate way to gain knowledge. However, “lived-experiences” are where meanings are born and if one is to meaningfully intervene to improve lives, one must understand those meanings, and empirical science can only provide limited information in that regard.
- ***Suspending judgments:*** The approach is to make an explicit attempt in suspending judgments and thereby approach the matter without presuppositions. The study sought to gain an understanding from the point of view of the people in the community and this (if any) is the presupposition. Neither the researchers separated themselves from the data completely, nor it is deemed possible. However, an explicit attempt was made to prioritize the *emic* or the “lived-experiences” over the *etic* (outsiders’ point of view).
- ***Reality:*** People work under the assumption that reality, including its ethical and moral dimensions, is inextricably attached to the experience of it. In other words, abstract notions of what is real and what is moral played a lesser role in people’s understanding than what people experience to be real and moral.

There are two phenomenological approaches practiced among the qualitative researchers: hermeneutic and transcendental phenomenology. The study followed the former, which was based on textual interpretation of experiences as gathered from people who have lived the phenomenon, which, in this case is MR.

3.1. Site selection and entering into the communities

The proposed research was conducted with the consideration of capturing the widest variations as the guiding principle. The study has considered capturing variations in terms of geographic locations, socio-economic status (including religious backgrounds and slum dwelling) and ethnic variations while selecting the sites. A secondary consideration was to conduct the study in some sites where existing MR programmes are available. The study has included four sites in order to accommodate variations across the country. The star signs in the map show the geographical locations of study areas around the country.

Figure 1: Bangladesh map showing study sites



3.1.1. Kamalapur, Dhaka: Slum dwellers

Kamalapur is at the heart of the capital city Dhaka. It is densely populated by slum dwellers of lower economic people who come and stay here from all different parts of Bangladesh. Incorporating this group gave an unique opportunity to gather information regarding the perceptions and attitudes of participants towards MR in an urban slum and information on access, utilization and barriers to utilization of MR services by the lower income group of urban Dhaka.

The total population of Kamalapur is approximately 3,744,100 as reported in the demographic surveillance report published from icddr,b. It has a total of 87,000 households, with around 75,693 women of reproductive age and 86,374 men of reproductive age. The total number of abortions, as reported, is 4,737.

Kamalapur slums were an established icddr,b surveillance area and the study used this network to enter into the site. Before commencing the fieldwork, investigators met with the head of surveillance system in icddr,b and with the focal person who was in-charge of Kamalapur site. This group helped to provide data needed for basic demographic information, different maps to visualize the study area and ways to get around the slum. These connections also helped the researchers to get introduced into the community.

3.1.2. Kanaighat and Zakiganj, Sylhet: Perceived conservative population

Popular parlance suggests that most of the inhabitants of Sylhet region are motivated through religious injunctions. Sheer number of religious schools in this region seems to suggest a similar picture. However, truth of the matter is a matter of contention. Rationale behind including this site was to yield important findings related to perceived conservatism of people, their perceptions and attitudes related to MR and MR services and assess to what degree religious injunctions are a factor, if at all, in terms of utilization of MR services.

Kanaighat and Zakiganj sub-districts in Sylhet are considered to be relatively more conservative sub-districts in Sylhet. The total population of Zakiganj and Kanaighat were approximately 174,038 and 178,654 respectively. Among these people in Zakiganj and Kanaighat, 50.55% and 50.49% are males while 49.45% and 49.51% are females respectively. Religious demography suggests that in Zakiganj and Kanaighat, 86.48% and 95% are Muslims, 13.74% and 0.2% are Hindus while the rest are Buddhists, Christians and others respectively. There are lots of religious institutions in these two sub-districts compared to that of regular secular schooling system. This speaks for the religious conservatism as is supposed of this area of the country.

Zakiganj and Kanaighat has been the field sites for famous neonatal health intervention research project PROJAHNMO of icddr,b. The study took the support of this study and it's CHWs and their knowledge of the community to get the researchers introduced into the community. A meeting was organized with these CHWs where researchers gathered relevant information regarding the communities they work in (i.e. basic demographic information and ways to get around the site). These CHWs also helped to collect maps with detailed information on health facilities which helped to visualize the study site. The connections helped in a great deal in terms of getting introduced into the community.

3.1.3. Shyamnagar, Shatkhira: Coastal people

This is a coastal region in the Southwest corner of Bangladesh where family planning and other women's health services are very rare (personal communication: Shushilon). Being situated right next to the Sundarbans, a mangrove forest area, this provides a geographic variation to the study site selection. This is also a site where Shushilon, a national NGO has been working with the people and implementing MR related programmes. There are many not-so-easily accessible areas in Bangladesh where health services are poor in general. It is believed that the information from this area will help to understand the needs of the geographically marginalized population and where maternal health programmes were few.

The total population of Shyamnagar, Shatkhira is approximately 265,004 (source: Banglapedia). Among them, 50.46% is male while 49.54% is female. Religious demography suggested that 74 % are Muslims,

25% are Hindus while the rest are Buddhists, Christians and others. Literacy rates are 38% for the males and 17% for the females.

Shushilon has been working in this area since 1991 and along with MR activities, Shushilon also has been working in the areas of socio-economic development of the under privileged poor, education, health and nutrition, human rights and good governance and sustainable environmental resources management. Shyamnagar has 12 unions and in each union, Shushilon had one UHE (Union Health Educator). These UHEs were the main entry point for this research which was arranged by the Project Manager of Shushilon who helped to get introduced into the community and to gather relevant information regarding the communities they work in (i.e. basic demographic information and ways to get around the site). This office also provided different maps which helped to visualize the study site.

3.1.4. Thanchi, Bandarban Hill District: Indigenous population

Bandarban is situated in the hillier southwestern region of Bangladesh. The total population of Bandarban district is 292,900 along with similar male-female ratio to that of the rest of the country. There are 12 indigenous populations (i.e. Marma, Murong, Tripura, Bawm, Mro, Tanchangya, Chakma, Chak, Khyang, Khumi, Lushei, and Pankho) as well as Bangalees¹ who inhabit this place. The primary reason behind choosing this site has been dictated by the presence of indigenous people in the region and the difficult geographical terrain where these people live. The research wanted to see how these unique features make the experiences related to MR and MR services different from the rest of the country.

The study selected Thanchi upazila of Bandarban, farther into the district, closer to the Myanmar border. In terms of population, this sub-district stands in direct contrast with the rest of the country – only 16,104 people live here with only 4,321 households very sparsely dispersed around the hilltops organized as *paras* (a collection of houses on raised platforms). Thanchi has predominantly a Buddhist population (43%) with only around 22% Christians, 8% Muslims, 2% Hindus and 22% others who practice animistic religious traditions. Most of the indigenous population in this region belongs to one of the seven groups i.e. Marma, Murong, Khumi, Tripura, Bawm, Chakma and Khyang.

Unlike ShatkHIRa, Sylhet or Dhaka, the study team went into Bandarban district without having made a formal connection with an existing NGO or GoB programme working in the area of maternal and/or child health. Though the research team was able to get in touch with programmes concentrating on regions in and around Bandarban Sadar², similar programmes were literally absent in the remote site of Thanchi sub-district.

The researchers contacted a guide who provides support to tourists. Interestingly, this guide turned out to be a Govt. Family Planning Assistant and his job responsibilities had already sensitized him regarding the sensitivity of the topic, which made the entrance into the community smoother than it could have been. However, even though the communication with the guide was smooth, and the study team was able to communicate out their needs to him efficiently, that was only half of the job. Getting into the community, building rapport, overcoming the language barrier etc. were still important aspects of the grand challenges that still had to be answered. There were days when some of the team members had to stay overnight at a *para* amongst the indigenous people. In some cases, the places where the informants were located were so far away from Thanchi sadar that researchers had to travel by boat for several hours, find a suitable place to live and then interview the prospective informants. This enriched the ethnographic data as a whole and not diminished it, though it felt physically taxing, time-consuming and often frustrating.

3.2. Duration of the study

The study was carried out from May 2010 to October 2011, where a whole year was spent to carry out field works and data collections. The remaining six months were spent in recruiting and training the field researchers at the initial stage and analyzing data and writing the report at the end of the project.

¹ The term Bangalee means people those who speak Bangla language, as opposed to the indigenous population who have their own language.

² Sadar implies the main district or sub-district town

3.3. Research methods and sample size

3.3.1. Theoretical approach

There are no known guidelines to determine non-probabilistic sample -sizes (Guest, Bunce, & Johnson, 2006). Point of saturation or point of redundancy has been and still is the “intellectual guiding principle” in terms of deciding how many interviews to conduct for a qualitative study with the purposive sampling as its basis. As mentioned, it is only an intellectual guiding principle with little or no on-the-ground guide to sample size estimation that will be required to reach this saturation (Guest et al., 2006).

Probabilistic sampling is straightforward and can be calculated with statistical power and confidence intervals. However, non-probabilistic sampling required in the case of purposive sampling (sampling based on predetermined criteria relevant to research objectives) cannot rely on such procedures (Guest *et al.* 2006). As stated above, most of the non-probabilistic sampling relies on intellectual saturation point. Theoretical saturation occurs when all of the main variations in the phenomenon have been identified and incorporated into the emerging theory. In this approach, the researcher deliberately searches for extreme variations of each concept in the theory to exhaustion. However, this saturation point is quite vaguely defined and serves mostly an intellectual purpose. This does not serve the purpose of preparing a research proposal where one needs to mention upfront the number of interviews to be conducted, time required data collection, and most importantly, funds needed to complete the task. In search for an evidence-based source to indicate the estimated sample-size for this study, it was considered “How many interviews are enough? An experiment with data saturation and variability” where explicit recommendations were made on data saturation, which was based on codes being developed. It stated that elements for meta-themes are present within first six interviews, but first twelve often reaches saturation (Guest et. al., 2006). Meaning, most of the codes are developed within the first 6 interviews and hardly any new codes are generated after the twelfth. For our purposes, we decided to conduct 8-12 in-depth interviews at each site to capture most of the variations within each site, while the criteria for site selection (as mentioned above) provided us with the variation on a national level.

3.3.2. Methods, sample size and sampling procedures

The study is entirely qualitative. Accordingly, the methods used for the study are qualitative as well. The following table (Table1) shows the research methods applied in the field and proposed and actual sample size. Initially, the study proposed to employ the first three methods and planned sample size shown in the table. However, over the time, the study has incorporated a number of approaches or methods (Key informant interviews and Informal Discussion) and the sample size has changed based on the circumstances and context associated with the issue (MR).

Table 1: Methods with numbers of planned and achieved interviews

Methods	Types of Informants	Proposed Sample size	Actual Sample size
Focus Group Discussions	Married women	12 (3 per site x 4)	12
	Married men	12 (3 per site x 4)	12
	Senior women	4 (1 per site x 4)	4
	Senior men	4 (1 per site x 4)	4
In-depth interviews	Women with MR	24 (6 per site x 4)	27
	Women without MR	24 (6 per site x 4)	25
	Family members of women with MR	24 (6 per site x 4)	21
	Family members of women without MR	24 (6 per site x 4)	17
Semi-structured interviews	Providers (formal and informal)	16 (4 per site x 4)	39
Key informant interviews	MR volunteer and community leaders	N/A	16
Informal discussions	Health care providers	N/A	23
	Women with MR	N/A	29
	Women without MR	N/A	26

3.3.2.1. FGDs: women and men of reproductive age and senior women and men

FGDs were designed to conduct during the very initial stage in each field. Along with others, one of the main objectives of conducting the FGDs initially was to identify the informants for in-depth interviews (women with or without MR and health care providers/services). However, this did not transpire as planned and therefore, the study needed to change its strategy in later fields. In the later fields, the FGDs were carried out at the very end of the data collection period.

Participants of the FGDs of women and men of reproductive age were purposefully selected from the community and they were married (with or without the experience of MR). Participants of the FGDs of senior women and men were ever-married people.

Women from different homesteads of a community were invited for an open discussion on family planning and contraceptives failure. Only those women were asked to participate who showed pro-active interests to be involved in the discussion. For the interviews with men, a bazaar or market places, where men gather around tea-stalls and sometimes, a paddy field where men were working, were selected. It was often hard to find men to have a discussion since they were mostly busy during the daytime and were unwilling to talk later in the evening. However, covering the geographical area of the sites with dispersed variety was maintained.

Older and younger people were not included in the same group as elders, mother/aunt/mother-in-law or father/uncle/father-in-law may make the young people silence in expressing their opinions. Each FGD took around 2 to 2 ½ hours of informants' time and each FGD included 8-10 participants.

3.3.2.2. In-depth interviews: women (with or without MR) and their family members

As mentioned earlier, the experience in Dhaka field in terms of identifying the informants through FGDs for in-depth interviews did not work out. Participants of the FGDs simply did not get back to the researchers to share their personal experiences. This somewhat influenced to modify the strategy of identifying the informants. Researchers carried out *transact walk* for days: in Dhaka site after completing the FGDs and in other three sites, it started at the beginning of entering into the study sites. These transact walk specifically started to focus on identifying women through informal discussions who were pregnant (i.e. could be that their pregnancy was not desired), women who had children less than 36 months of age (i.e. their child might have been due to an unplanned pregnancy) along with women who sought MR services beyond the legal limit. *Snow Balling Technique* was also applied during the transact walk to identify study participants. This modified strategy helped to address the study objectives in a more comprehensive way, i.e. by incorporating a huge number of informal discussions and by identifying Key informants for the study. This also helped to arrange the participants for FGDs in other three fields besides Dhaka where FGDs has been conducted at the very beginning of data collection period.

Once a number of women were identified through transact walk and snow balling technique, a sub-set of women were purposively selected from this group for in-depth interviews. Purposive sampling was applied only with stated opinion of experiencing an unwanted pregnancy in the last one year. Half of the informants were selected having experiences with MR and half having an experience of wanting to have MR but was unable to avail the services for whatever reason.

Interviews with these women took a broad approach in the beginning which reflected on women's lives in general and reproductive health in specific. This provided the context necessary to understand the experiences they have been through before getting into the details of MR and related experiences.

Each individual in-depth unstructured interview took around 2 to 2½ hours. In several occasions, researchers had to return to the informants twice or thrice in order to complete the interviews upon obtaining the informants' consent further.

Upon completion of the interviews with these women, one or two family/community member/s were selected who were involved with the entire process of seeking care for her MR. Incorporating these person/s in the study was important to understand women's support mechanism, which in turn, provided clues to understand the possible barriers women faced in taking such decision. Women were asked if the

person/s she mentioned was involved with her experience, could be interviewed or not. In many cases, it was the husbands. In some cases it was a community member who was instrumental in the decision-making process. Only upon obtaining consent from the women, the researchers proceeded to interview their family/community members.

3.3.2.3. Semi-structured interviews with health care providers

Among the care providers interviewed, there were both formal and informal practitioners representing just about all types of healthcare practices. For instance, interviews were carried out with Family Welfare Visitors (FWVs), paramedics, MBBS doctors, homeopathic practitioners, traditional birth attendants, village doctors/drug-sellers/pharmacists³, traditional healers (including herbalists, *boiddos*⁴, and *ojhas*⁵) and ayahs (Nurses' assistant) at the facilities. Initially, the idea was to interview only the most popular care providers in the community. However, this could not be followed strictly given the humongous types of providers involved in MR services. A detailed description of the health care providers is provided in Table 5 (page: 33).

Formal and informal sector MR services providers were interviewed for their perceptions related to clients' satisfaction and/or dissatisfaction over MR services and their perceptions on MR and MR services. Informants were identified through two sets of group discussions (women and men of reproductive age and senior women and men), through the in-depth individual interviews, through transact walk and through snow balling. All the formal and informal care providers that were elicited through all these techniques were listed down and a sub-set was sampled from the list based on context and association. A number of informal discussions were also carried out with several formal and informal providers as found in the community during different occasions. The health care providers' interviews were conducted at the end of the data collection in each site.

3.3.2.4. In-depth interviews: Key Informants

Several (16) in-depth interviews were conducted with persons who often served as the bridge between MR service providers and the women/couple. In many cases, these people were not the care providers but had extensive knowledge about the services available in and around the communities. These people were considered as key-informants since they provided important insights regarding available MR services and the overall scenario surrounding MR in the community.

3.3.2.5. Informal discussion: women and health care providers

Facing the challenges of field-reality when entering into the field, researchers, through *transact walk* ended up meeting and talking to several individuals about their experiences and with probable knowledge in the field of MR. This transact walk was also important to know a community and to build rapport within a site especially when a sensitive issue like MR was explored. Substantial conversations took place with the people identified through transact walk since they had important and relevant information to divulge that were directly or indirectly related to research objectives. These short but substantial conversations were considered as "informal discussions" which was also helpful for identifying the prospective informants for IDIs and FGDs.

³In the context of rural Bangladesh, a village doctor, a pharmacist, and a drug seller all refer to the same category of healthcare provider. Basically, it is a person who sells medicine from a drugstore. This person is often referred to as the pharmacist or simply a doctor in the rural context. Along with selling medicines based on a given prescription, this person and other like him, often prescribe medicines (and sell them).

⁴*Boiddo*, is a local term denoting an herbalist. They are the local healthcare providers who often prescribe medicinal plants and pastes made out of those plants and their roots for various purposes.

⁵*Ojha*, is a local term denoting a spiritual healer, who relies heavily on spiritual incantation and other related practises. A synonymous English term would be exorcist.

3.3.3. Challenges in the field

a) Perceived “conservatism” and patriarchal environment: While conservatism was and could be a problem in any part of the country, Sylhet was specifically perceived as such. Presence of a huge number of religious institutions and women’s absence in public places indicate that this perception could very well be real in practical terms. This context made the researchers extra-careful in terms of talking to people about menstrual regulation, which was nevertheless a sensitive topic, regardless of all the sites. For instance, though Thanchi, Bandarban was felt more liberal in terms of many traditionally sensitive topics and issues; MR was still a topic that was not discussed as any other topic would be. The topic, thus, had its own barriers, just like the rest of the study sites we sampled.

Due to such heightened sensitivity, researchers figured the best thing to do was to piggy-back on existing programmes/research projects to get into the community. This was why the study communicated with a local NGO in each site who were working in the area of neonatal and maternal healthcare research. The community health workers of these local NGOs and the relevant important personal of the organizations also warned the study team to not being too open about the topic of research since that might trigger unwanted attention and turmoil the data collection. This further fueled carefulness for the researchers.

During the interviews with any type of informants, a high level of cautiousness was maintained. Researchers did not dare to dive into the research topic right away, rather, used family planning and related topics as a gateway to inch the way to the area and only then were able to probe into the area of research interest.

The all-women team of researchers also faced added hurdles in order to make their objectives clear to men. It was very difficult to talk to them about marriage, family planning, and MR. The general ambiance also made the researchers fearful in terms of moving around after dark. Finding and conducting interviews (IDIs and FGDs) with men also became difficult in that environment. Often the husband was the most crucial person for an informant women and it was not possible to conduct a few of these interviews since the primary informants (women) told not to discuss things with them fearing a backlash (which was a reality given their situation).

In Dhaka slums, researchers also faced eyeballing of men and their curiosity often made it difficult to move around. Though the environment was not conservative as it was in Sylhet, it was nonetheless restricting since men did not hesitate to stop and ask unnecessary questions just to harass. It was a delicate balance that the researchers had to maintain since they knew they would not be able to conduct their interviews if they did not behave cordially with them.

b) Snow balling often did not work: Snow balling, our preferred method of informant identification did not work in some fields. In Sylhet, the stories of MR of each of the informants were well hidden and rarely people outside of the immediate family got to know about it unlike Dhaka. Often husbands were the only person knew about this issue and this remained with them. In a culture that was overwhelmingly male-dominated, it was difficult to get to the informants crossing all the hurdles.

c) Voice recording was a problem: Initial experience suggests that whenever voice recorder was brought out, health care providers became self-aware and started sharing only that information that they deemed less risky. Besides, there were health workers who did not allow to record their interviews. Considering all these, voice recording of the interviews of care providers was avoided in instances. Instead, researchers went back to the classical anthropological method of taking copious notes during the interview, incorporating relevant thoughts immediately after the interview and producing full-transcription on a priority basis.

d) Language barrier: Talking to *Sylheties* (inhabitants of Sylhet) was a trouble since their language is substantially different from Bangla and posed a formidable barrier in the beginning, but researchers could overcome this in time. Language was also a biggest problem in Thanchi, Bandarban. Hardly anyone in the community knew Bangla to a level that would enable them to provide an intense interview and therefore local interpreters were hired. However, researchers couldn’t always have the confidence in them that they were relaying all the information exactly as they were receiving them.

e) Availability of the informants: Reaching the informants both for FGDs and in-depth interviews were a huge challenge. Thanchi in particular is a completely hilly region. People live up in the hilltops and the

only way to reach there was walking miles after miles and/or a boat sometimes during the rainy season. For anthropologists born and raised in plain land Bangladesh, this posed a huge problem though with their undaunted spirits, they were able to overcome the hurdle. Both men and women in Thanchi are agricultural labourers who were mostly out during the daytime. Quite religiously, men and women woke up early in the morning and left for the hills only known to them. They often stayed in the hills for days. For those who returned daily (when the hills were not too far), it was already dusk and pretty late for the researchers to be there for the interview. Sometimes, the only option left for them at that points was to stay overnight in those *paras*.

3.4. Ethical consideration

Written consent was not considered since providing written consent can quite easily intimidates rural women/men. Usually, written consent implies something very serious for which one has to write off their rights or something similar. For instance, signing a consent form for a medical procedure, i.e. an operation. Therefore, in cases where there was no or very little risk involved, asking for a written consent only increase the complexity and raise the level of sensitivity for no apparent reason. The level of sensitivity for this study was high since talking about MR is often assumed to be private and secret. Furthermore, if the non-literate population were to be taken into consideration, getting a written consent would have rendered itself meaningless. On the other hand, asking for a thumbprint for something that they couldn't even read themselves would have been even more out of place. Judging the points above and considering the level of risks to the study subjects, it was only prudent not to ask for written consent for this study. Therefore, verbal informed consent was obtained as appropriate for each of the methods described from all individuals participating in the study. After the informants were identified as eligible, researchers read out the appropriate consent form, ensuring that the informant understood what was being said.

High level of confidentiality was ensured in terms of interviewing the *back-ally* and/or informal care providers. Through the informed consent, they were informed about the research topic in great detail and were ensured that their practices would not be hampered for taking part in this research.

Since the topic was sensitive, it was expected that several women (and men) and providers would decline to have their interviews tape-recorded anyways. Therefore, interviews were tape recorded only if a woman (and men) consented. When tape recording was not allowed, researchers took copious notes and prepared transcripts of interviews with field notes added on to those notes as soon as possible so that minimal amount of data was lost.

All interviews were conducted in Bangla, with a bit of difference in Thanchi, Bandarban, where researchers had to take the assistance of interpreter-translators. A two-day training was carried out with the interpreter to explain the objective of the study and their role and expectation from them.

In all cases, participants themselves suggested and provided the space in the most appropriate place for a discussion to take place.

Identity of all study participants remained confidential. Records were used by researchers only in connection with carrying out their obligations relating to the research and every effort was made to keep the records confidential. Data were analyzed using informant's identification numbers only.

3.5. Data analysis

The study adapted the analytical process described by Moustakas to analyze qualitative data (Moustakas, 1994). The report hopes to provide and/or recreate the experiences of women experiencing MR and MR related services in Bangladesh through the analysis in order to get to the essence of the phenomenon (Polkinghorne, 1989).

The next step with the transcript prepared from the recorded and hand written interviews and notes from the field, was to search for significant statements or smallest meaningful units, which is called codes. Each of the researchers went through an interview and identified as many codes as they could find. This resulted in the draft codebook, which was developed in consultation among the investigators and

researchers as the coded interview was reviewed. For the sake of consistency, a reliability assessment was made and a consensus reached (please refer to the section on reliability assessment). Atlas.ti, software to organize textual data, was used to code the data, which included all the in-depth interviews, focus group discussions, field-notes, and informal conversations.

Once all the interviews were coded, researchers looked for clusters of meaning or a group of codes that could be placed under a theme and/or concepts. These clusters of meaning or themes have basically recreated the description of experiences that were analytically organized into the section on findings below. The section on discussion is basically a composite description of all these findings from the textual data, which hopefully expresses the underlying structure or the common experience.

3.5.1. Reliability and Validity

Reliability and validity in terms of qualitative research basically means how consistent (reliable) and meaningful (valid) the research results are (Sykes, 1990). In other words, reliability refers to the degree to which the findings are not a result of some accidental factors of the study and validity refers to the degree of how correctly the findings have been interpreted (Kirk & Miller, 1986). For the purposes of this study, the investigators conducted a semi-formal reliability assessment and have taken in a methodological consideration in order to address validity which is triangulation.

a) Reliability:

There are several ways to address reliability in a qualitative research, i.e. inter-coder or synchronic, intra-coder or diachronic, stability or quixotic, and internal consistency (Goodwin & Goodwin, 1984; Kirk & Miller, 1986). However, this research only addresses inter-coder or synchronic reliability.

Simply put, inter-coder or synchronic reliability refers to the amount of agreement between independent coders of the data. In case of this research, these independent coders were the researchers themselves. As it should be obvious, the agreement was measured during the analysis phase when the researchers coded the same interview independently.

In terms of points and areas of agreement, the researchers and investigators looked at the codes and the textual segment to be put under the codes. After adjusting for obvious misconceptions regarding a number of codes developed, the inter-coder reliability stood at 68%. This, the investigators believe was more than what could be expected given the nature of the inquiry, which is non-positivistic (Lincoln & Guba, 1985).

In terms of calculating the degree of agreement, investigators could have considered employing Cohen's Kappa (Cohen, 1960) but since distribution of coded data were not known *a priori*, investigators, instead, considered the total number of codes and segments of texts that were put under those codes and simply matched to see if the researchers produced a similar pattern of result. Based on these, a debriefing session was conducted with the researchers to establish a common understanding regarding all codes.

It is important to mention here that in a non-positivistic research paradigm, the researchers are considered to be a tool and the data that is generated to be something that is a resultant of communication between the researcher and the informant. Here, the researcher is not independent in any way. This aspect of qualitative research produces data that are heavily dependent on the interactions that take place in the field and are often unique in their own right.

b) Validity:

There are several ways to address the aspect of validity in qualitative research. For the purposes of this research, it wanted to ensure validity via a methodological mix. By methodological mix this study meant to employ more than one method to investigate the same concern, which is MR in this case. The study used in-depth interviews, conducted focus group discussions, key-informant interviews, and informal discussions where investigators wanted to address not exactly the same, but similar aspects of MR and MR services in Bangladesh. This method is known as "triangulation" in qualitative research.

All of the findings, generated off of the codes are a comparative understanding gained from all the different methods mentioned above. The study report the ones that have been confirmed from at least two different methods used.

4. Findings

Findings are presented below based on the themes that were generated out of the analytical process. In terms of presenting them, a strict and uniform structure is not followed rather, described each section as it fit in terms of laying out the story of MR and MR services in the communities as women have experienced them. Therefore, in some case, the reader will notice that the findings are divided into field sites and then in some other cases, they are written as a whole.

4.1. The social and economic reality

4.1.1. Socio-economic context of informants

The table below (Table 2) provides a glimpse of the socio-economic background of our informants in order to contextualize the findings. As of the table, on an average, women were younger in Dhaka than in other sites. Women's age range also indicates a similar pattern (i.e. 21 to 40 years in all three sites, while 14-30 in Kamalapur). Interestingly, husbands' age -range varied in all four areas, with the lowest in Dhaka (19-35 years) and highest in Sylhet (30-70 years).

Most of the women within the sample did not have any formal education (24 out of 52). Some of the informants had primary level schooling, though most of them cannot be considered literate since they even forgot to sign their own names. Only a few (5 out of 52) had schooling beyond high school, which seem to represent outliers given the general context. Husbands of these informants show a similar pattern of education where 20 out of 52 had no formal schooling.

In terms of income generating activities, women in Bandarban were found to be involved the most. Most of the women there (6 out of 13) were actively involved in *jhum*⁶ cultivation, while the rest were involved with other income generating activities along with Jhum cultivation. Data indicates that some women in Dhaka were involved in irregular informal professions, i.e. being a helper in a hotel or similar activities. In Shatkhirra, the devastating cyclones have had a marked impact on every aspect of people's lives. Though the cultural norms might have dictated that women stay at home and be the home-makers, the situation there at that time demanded that they get involved in some kind of economic activities, be it shrimp cultivation or be it helpers of the road construction workers as a day wagger. In Sylhet, most of the women were housewives during the time of data collection.

On the other hand, as one would expect, all of the husband's were involved in some kind of income generating activities, except one who at that time was unemployed. Men's occupation also indicates a national pattern, where in all three of the non-Dhaka field sites, men were involved in mostly farming. However, a lot of the men in Shatkhirra were trying to do small businesses or working as day laborers, since regular farming has been severely disrupted due to cyclones. In Dhaka, which is out and out an urban site, men were found to be mostly drivers of various types of vehicles.

The range of age at marriage was 13-25 years for women. The household composition data shows that most women lived in nuclear family settings, with the highest number in Dhaka. This is clearly indicative of changing family structure of Bangladesh, where people are increasingly becoming nuclearized.

Number of pregnancies and living children among the informants' families also indicate a familiar picture - highest in Sylhet and pretty similar for the rest of the three sites. It could be assumed that low contraceptive prevalence and high neonatal mortality in the Sylhet region accounts for this disparity.

⁶*Jhum* is the local term for slash and burn technique of agriculture. This is the major life-sustaining activity of the peoples in the hilly region of Bangladesh.

Table 2: Socio-economic variables of the informants*

Sites Variable	Dhaka (12)	Sylhet (12)	Shatkhira (15)	Bandarban (13)	Combined (52)
Woman's age (mean)	24	30	32	29	29
Woman's Education (in years)					
Average schooling	3	4	4	3	3 (average)
No formal education	6	2	8	8	24 (total person)
1-5	4	8	1	1	14 (total person)
6-10	2	2	4	1	9 (total person)
10+	-	-	2	3	5 (total person)
Woman's occupation					
House wife	9	9	5	1	24 (total person)
School teacher	-	-	2	-	2 (total person)
Jhum cultivation	-	-	-	6	6 (total person)
Shopkeeper	-	1	-	1	2 (total person)
Pig raising	-	-	-	1	1 (total person)
NGO worker	-	-	-	1	1 (total person)
Health worker	-	-	-	2	2 (total person)
Business	-	-	-	1	1 (total person)
Land Owner	-	2	-	-	2 (total person)
Day labourer	3	-	8	-	11 (total person)
Marital status					
Married	12	11	14	13	50 (total person)
Divorcee	-	1	1	-	2 (total person)
Duration of marriage (in years)	9	14	17	9	13 (average)
No. of pregnancy (mean)	3	6	5	4	4 (average)
No. of living children (mean)	2	4	3	2	3 (average)
Husband's age (mean)	32	41	38	32	36 (average)
Husband's education					
Average schooling	3	4	5	7	5 (average)
No formal education	5	4	6	5	20 (total person)
1-5	2	5	3	-	10 (total person)
6-10	4	3	3	6	16 (total person)
10+	1	-	3	2	6 (total person)
Husband's occupation					
Day-laborer	1	4	6	2	13 (total person)
Cleaner	1	-	-	-	1 (total person)
Service holder	-	-	1	3	4 (total person)
Driver	5	3	1	-	9 (total person)
Farmer	-	2	-	7	9 (total person)
Small business	1	1	6	-	8 (total person)
Unemployed	-	-	1	-	1 (total person)
Working abroad	-	1	-	-	1 (total person)
Van-puller	3	1	-	-	4 (total person)
Mechanic	1	-	-	-	1 (total person)
Local chairman	-	-	-	1	1 (total person)
Family type					
Extended	1	2	6	4	13 (total person)
Nuclear	11	10	9	9	39 (total person)
Religion					
Islam	11	11	15	-	37 (total person)
Buddhist	-	-	-	12	12 (total person)
Christianity	-	-	-	1	1 (total person)
Hinduism	1	1	-	-	2 (total person)

* Both MR success and MR failure cases of each field were analyzed together

* Divorced cases' husbands' information was incorporated in the table with whom the pregnancy took place

4.1.2. Women's role and position in the society

a) Kamalapur, Dhaka

Congested living, densely populated with people coming from all parts of country, narrow and dirty alleyways and poverty characterizes Kamalapur slum area. It is an older slum that began with the government providing space for Class IV-level employees of the city corporation. Since then, the area has expanded with population increasing at a far greater pace.

Unlike any other place in the country, men and women can be seen here to be openly interacting with each other without any restrictions. The environment seemed permissive of women being out of their homes. However, this should not be readily taken to be a '*women-friendly*' atmosphere either. In fact, it is riskier for women in the slum than any other non-slum places in the city.

Both men and women of Kamalapur slum area are involved in just about all kinds of economic activities as one can imagine. Many of them are legal but there are many that are not only illegal but also risky, i.e. selling drugs, appearing as false witness in the court and so on.

As far as women are concerned, many are involved in the garments industry, a booming business in Bangladesh. However, neither everyone is employed by this sector nor are they encouraged. As one woman, echoing many others, said, (pointing to her mother in law and husband) that they did not allow her to work in the garments. Consequently, women find themselves working as the helpers of male day-labourers (*jogali*), field workers of various cooperatives, water suppliers for hotels, roadside vegetable sellers, illicit drug -sellers and so on.

Women appear to be very concerned about making a living, since hardly anyone of their husbands supports them regularly. As a result, they have to fend for themselves. Lot of the women commented negatively about their pregnancies in this regard, which were often unplanned/unwanted, since it was hard to find a job or continue with the current one in that situation. With dependents in the family, this situation puts them in downward economic spiral. One woman commented,

"It was not right that I became pregnant now. It will hinder me from earning...."

MR, in a situation like this, becomes a natural choice for many women. Interestingly, many men asks women to have MR or abort the foetus stating that woman needs to take care of herself first and then think about having babies. However, many women feels that men say this so that they do not have to take on the responsibility or worse yet, so that they do not feel tied to one woman. A woman said:

"Do not listen to what he says. He is saying this so that he does not have to feed you and your baby. If you listen to what he says, then you will have to forget about him altogether."

However, the reality is, having children do not guarantee that the husband would stick around and become responsible. Multiple marriages and extra-marital relations are extremely common in the slum; consequently, women find themselves trying to provide for her family all by herself. This is also a major reason for MRs in the community and women decide on their own to go through it. Often those decisions to have MR are taken either independently or only in consultation with the natal family members. Since the burden of reproductive health lies squarely on the women, men are not too concerned about it either.

Family planning methods are available through health workers and health centres but often the regularity in which methods need to be adopted is absent due to uncooperative husbands. The predominant feature in this regard is, '*those things are woman's responsibility, she needs to take care of that.*' as one husband mentioned. By shoving the responsibility on her shoulder, husbands also rationalize that the cost incurred for the methods is also something that a woman should manage and/or bear.

Normal social fabric and norms seem to have taken on a very different meaning in the slum area. Incidents of women being abandoned are common but on the other hand, women also remarry as they

find it very difficult to raise children without the support of men. Women talk about sexual desire openly. One woman said,

"Her husband pulls a rickshaw... she is not worried about what he does otherwise... whether he sleeps here and there or not. She is satisfied as long as he gives his penis."

b) Kanaighat and Zakiganj, Sylhet

Compared to Kamalapur, Kanaighat and Zakiganj seem to belong to a completely different universe altogether. First of all, it is a rural site, but cultural ambiance is very different even when compared to other rural sites. Secondly, it is extremely patriarchal and women can hardly be seen out on the roads or in public places. If women go outside, they veil themselves thoroughly or at least have an umbrella to hide their faces from other men on the streets.

The patriarchal situation can be noticed in terms of women's decision making capacity (or lack of it that is) about her own health and/or reproductive matters: how many and when women would bear children is a matter that the men will decide, not her. There is no consultation over it either. A man said,

"Good cows bear many calves, just like good women bear many children."

Domestic violence seems like a common phenomenon in the area. Many of our informants mentioned that they are afraid to talk to anyone outside of their family without explicit permission of their husbands. They are even afraid to talk to the researchers for the interviews. A man confirmed this fear when he said,

"If a woman errs, then it is okay to beat her."

Due to the fearful atmosphere and severe lack of autonomy of women, decisions and activities related to reproductive health and concern becomes a secret issue for the women in this area. Women's clandestine behavior related to care seeking for MR suggests and reconfirms this general ambiance of the area. To further attest this, a man said,

"Women often do illegal things that a man usually does not. However, when a woman is involved in an extramarital affair and has sex, she runs the risk of becoming pregnant. That is why she needs to have recourse to various methods, which men do not."

Researchers found that several women in the field were extremely interested to talk to them about their reproductive history, their health concerns and such the fact that they usually do not have anyone to talk to about these things.

In terms of income generating activities, it does not seem women being a part of that in any mentionable scale. Men and women's spheres are quite demarcated in this area, where men are the proverbial bread earners while women are homemakers.

c) Shyamnagar, Shatkhira

Shyamnagar presents yet another dimension in our selection of field sites for the study. A few years ago, this area has been devastated by two cyclones - SIDR and AILA. These cyclones have left the place barren. People lost their land, their homes, their gardens and their family members. Destitution is striking and there is very little to fall back on. Most of the people are then involved in shrimp cultivation, which in fact is depleting the soil further and raising the salinity of the land, which has already been adversely affected through the cyclones.

Women here in Shyamnagar, unlike Sylhet, are visible everywhere. The cultural ambiance permits both men and women to talk to each other, mingle, and so on without restrictions even if they are unknown. Like any other rural sites in Bangladesh, most of the women are primarily housewives here but they have to come out of their houses and be involved in income generating activities since the general economic condition is extremely poor. Now women can be seen in the marketplaces, on the streets and in the public transports. There are some national NGOs working in this area and they have had employed many women as their field workers. Women are also found to run shops and work in the fisheries, including shrimp

cultivation along with other men. In terms of attire, they do not veil themselves, nor do they feel shy while talking to unknown men from outside of their houses. Women are also seen riding bikes. In fact, female NGO workers working in this area, always use bikes for their work.

Working outside of home has given a distinct voice to the women of this area – at least that is the case with some women. One informant said,

"I work. I earn. I go to the market. I do everything. He does not. I support my family of four..."

Another woman said,

"All of this work... this big house that you see, was reconstructed with my money. I did not take a single taka from my husband. It was all mine."

One needs to travel over to sub-district centre in order to seek care from formal sectors since care is not regularly available at the union level. This makes the care seeking difficult for many when it is needed. This is part of the reason why there are many informal providers in the area. However, some of the NGOs working in the area have been very vigilant about these informal care providers especially providers of unskilled MR services, as they try to address maternal mortality and morbidity due to unsafe abortions.

Women seem more aware of their condition than their education allows them to be. They think of planning their families but fail to do so under the pressure of the cultural norms of complying with their husband's demand. One woman commented.

"It does not mean anything if I keep on taking children. This only means that I only sleep with my husband and get pregnant and then let them be on the streets...I have four kids but two would have been better. Then I would have been able to get both of them educated properly. But I had to take three children because of severe pressure from others and then another one... What would I do now?"

d) Thanchi, Bandarban

The hilly district of Bandarban and its sub-district Thanchi provide a completely different picture from the rest of the sites in just about all aspects. Geographically, it is hilly and culturally it is indigenous: language, customs, religion, food, and attire – everything stands in direct contrast to the rest of the sites as well as the entire country.

Women are as visible as the men are in this community. Women toil alongside the men – in the fields, in the households and in the market places. As mentioned earlier, Bandarban and Thanchi in particular, is a completely hilly region. People live up in the hilltops and the only mode of transportation is one's own two feet or if one is lucky, a boat. It is not all uncommon to see women climbing up and down the hills with heavy loads on their shoulders.

Needless to mention here that all of the *pahari* people (people living in the hilly region) are extremely hardworking. In fact, they do not have an option – otherwise, they simply will not survive. Women are heavily involved in *jhum* cultivation as much as their male counterparts are, if not more. It is also found a couple of female informants working as NGO extension workers along with their regular fieldwork. Some also mentioned that they raise pigs as a profession too. In addition, a couple of informants also mentioned that they own a shop at local markets.

Modern education is yet to be strongly established in these communities. Only a few studied up to Higher Secondary Levels and that is the highest education. Most of others do not have any more knowledge than to simply sign their own names, if that even. What stands true for the rest of the country, that it is hard to find women without any education at all, it does not stand true for this region. By and large, most of the people are still beyond the reach of modern education, and whoever gets a little of it, they migrate to plain land in order to make a living. This leaves the community without a person who can read and write and communicate with others who are educated.

Most of the families in Thanchi are nuclear. It seems that the extended family structure is on its way out, like it is in the rest of the country. However, these households are part of a *para*⁷ or a collection of households situated on hilltops or on the slopes of hills, operates almost like communes. Here the young of the community are taken care of by the old of the community while the rest go for *jhum* cultivation.

Communities in Thanchi are very interesting in that they are openly not too welcoming of the idea of MR, but if and when one go through it, they do not judge the matter too negatively either. The society is permissive, open and welcoming in just about all affairs.

4.2. Availability of family planning services

a) Kamalapur, Dhaka

In Kamalapur, Dhaka, a huge number of non-Govt. organizations along with a number of medicine shops and private clinics are available that provide the FP services in the community. A national NGO is working here in collaboration with the government to ensure a better FP services in the community. In terms of coverage and availability of services here, this site found to be the most organized. The surveillance of newly married couples and dissemination of information on FP are simply incomparable to that of other sites. One man during an FGD confirmed this assumption, saying,

"Health care providers are always here... they always keep track of the newly-wed couples and constantly counsel them on FP methods..."

Several men talked about using condom at some point in their lives, but they also admitted discontinuing it since they thought it was in fact, "ineffective." According to them, condoms often leak or break, rendering it useless. Men also talked about other temporary and permanent methods. On the other hand, women mentioned about health workers who informs them about FP methods and their availability. They also talked about emergency pills and that they are quite available in the area. According to them, it costs around 60 BDT and that one has to take it for three consecutive days. Community volunteers or health workers also confirmed the availability of such pills and said that they have been trained on this via various organizations.

Even though the methods are available, women still lack the knowledge of proper usage of FP methods. One of our key informants confirmed this lack of awareness and talked about a woman who forgot to take pills and started to take injections. According to her, this woman later suffered from severe bleeding for several days and later had to have a DNC as she was pregnant. Women and men in the FGDs also talked about problems related to continuing pills as one woman mentioned,

"We are illiterate, we do not know how to take the pill properly. Therefore, we fell in laughter whenever they say in the uthan boithok [courtyard session] to continue the pills. Our husbands do not live with us (work outside), then why would we take the pills (everyday)?"

Though community members mentioned about availability of different FP methods, service providers showed dissatisfactions related to uncertainty of logistic supplies. A service provider from the NGO working in this area said,

"... dipo (injection) is not available with us all the time. Many patients come for ligation and we have to refer them to either our head office or to a GoB facility. In the past, providers from Mohammadpur Fertility Services and Training Centre used to come here and organize campaigns on sterilization and we used to collaborate with them. Now that it has stopped, we cannot do all these here and as a result, we have to refuse many clients who come for services."

Another NGO manager said,

"We have trained to insert Norplant, IUD and so on. However, we do not have supply according to the demand and as a result; we have to refuse the patients when they come for those services... People will come to a facility if the services are available..."

⁷*Para*, as explained above, is a collection of households, often situated on hilltops or on the slopes of hills, and is usually home to people belonging to one ethnic identity. Often, most or all of the people living in a *para* are related to each other in one or more familial ways.

2) Kanaighat and Zakiganj, Sylhet

In Kanaighat and Zakiganj area of Sylhet, a number of health facilities are available who provide family planning services that include both GoB (THC and UHC) and non-GoB organizations. In this particular area, there are CHWs who provides pills, injections and condoms at doorsteps of newly married couples. Besides the doorstep services, there are static and satellite clinics providing similar services. In terms of long-term methods, they are only available at the sub-district or district level facilities and these are only available on certain pre-fixed dates. Lower level facilities inform women about the dates so that they can go there if they are interested. Health workers also talked about providing emergency contraception to mothers as one health worker said,

"I provide easy pills to women who forget to take pills for three consecutive days; one tablets need to be taken within 72 hours of intercourse, the second pill needs to be taken 12 hours after the first one. A woman will not get pregnant if she completes the course properly. I also suggest them to take this pill if the condom breaks/leaks or a woman forgets to take injection on time."

An NGO working in these areas maintains a list of people whom they provide pills and condoms regularly at home. One of the key informants, who happened to be a GoB provider at the community level, talked about a few reputable pharmacies in the bazaar that sell pills and injections. As part of their routine counseling, they advise woman to go there when other sources are not available but she also warns them not to go there all the time since they do not check women's health condition for a particular method.

One of our key informants talked about the burden of continuing pills and that it becomes extremely cumbersome for many women. To take pill every night, according to her, is a major problem, especially when women do not have their husbands around all of the time. Not too many women keep on taking the pills through out the month anticipating their husband's return. The reason is women do not find it logical. Side effects of these pills, i.e. constant dizziness and spotting are other major reasons for not choosing pill.

Pill distributed through GoB channels are perceived to have more side effects than the ones available in the market with a higher price. This consequently becomes another reason for discontinuation. Service providers talk about having different kinds of pills available with them so that they could provide women option which they cannot at this point due to logistics shortage.

c) Shyamnagar, Shatkhira

In Shyamnagar, Shatkhira, people usually collect short-term methods from THC and often a health care provider come at the door step to provide pills and injections. Besides these, there are many private clinics and pharmacies in the local market where the methods especially pills and injections, are available. Availability of FP services in this coastal area is very encouraging. Besides the bio-medical methods, homeopathic medicines are also available to contain family size.

As in the case of other sites, women do not prefer to have pills from the governmental sources since they perceive them causing more side effects. This is why some of the health workers carry more than one kind of pills so that women could have a choice (which she sell to them). Women often switch from one brand of pills from the other to deal with side effects. In an FGD, one man stated,

"My wife faces problems if she takes government pill. She bought Femicon from pharmacy and it suits her well."

Informants said that condom as a method of FP is not that common among men. This is why the healthcare providers do not carry them all the time. Condoms are usually used only as a stopgap measure. One man said,

"Only two percent of the men use condom when necessary. When a wife faces side affects causing by pill or injection or CT or implant, only then men use it to save her from suffering."

Compared to other fields, the discussion related to Copper-T, implant and sterilization is more evident though the prevalence of these methods is not understood. Interviews from the formal health care providers reveal that they carry out campaigns to increase the usage of sterilization or long-term methods, indicating there is not much usage of it in the area. One woman from an FGD said,

“They always talk about cutting your belly so that you do not conceive anymore. They tell us that we will not have to pay anything for it rather they will give us money if we adopt those methods. We say anything... We feel our children are still very young... what if they die suddenly? What if we cannot do hard work after that?”

Counseling on other methods such as condom and injection also take place in these campaigns. However, people in these areas feel that more awareness raising campaigns on the usages of FP methods are needed as one man stated,

“We are illiterate people and unaware of many things. There is nobody here who can make us understand about the importance and proper usages of it. There is nobody here who can really have a discussion with us and provide us information and services according to our choice and need...”

Women often face problems in continuing it properly because of the socio-economic condition of the area. Often the husbands visit their wives after a long gap and they do not want to use condom. Therefore, women use pill only during the time when the husband is around. Such practice of pill is ineffective, however, women perceive that there is no point of continuing the pill for a long time assuming a sudden visits of their husbands.

d) Thanchi, Bandarban

In Thanchi, Bandarban, there are four unions and every union includes a large number of *adivasi*⁸ or indigenous communities. Information from various sources reveals that government health workers are deployed in those areas, but their number is not enough to cover the need for FP services in that region. One of the key informants who happen to be a mid-level FP official in Thanchi said that the government is not doing anything about it despite knowing the fact. He stated that Govt. and its health system is not considering the remoteness of the region seriously and hence no intervention are being initiated. However, the person also talked about various NGOs working in close collaboration with the government who are trying to address the problem recently.

Settlements in Bandarban are few and far between. They are usually on hilltops, away from union or sub-district centers. Often the union level facilities do not have providers or they do not have enough supply of required methods, or both. On top of that, when men and women leave their settlements (*para*) for *jhum* cultivation, then they are really out of the reach of any kind of health services. Several women talked about not having pills during those days.

Generally speaking, women in Bandarban have a high rate of unmet need in terms of FP services. Government health workers usually get their supplies particularly pills, injections and condoms once a month from Thanchi THC and supply methods to eligible couples either from their home or through house-to-house visits in their vicinity. Satellite clinics, if and when these happen and EPI centers also distribute FP methods. However, neither the supply nor the surveillance is up to the level required. In case of the long-term methods, i.e. sterilization, Copper-T and implant, these health care providers either take the clients to Bandarban DH or refer them there. People in the community know that a woman would get a sari and 1,000 BDT if she adopted a permanent method. However, women are less interested in taking these methods and prefer pills and injections more. Especially pill is particularly preferred since the side effects due to injections are considered more severe than that of the pills.

When the CHWs run out the monthly supplies of short term FP methods before the stipulated time, she then refers women to the pharmacies where different types of pills are available. However, these pharmacies are only available at bigger markets like that of Thanchi itself.

Though pills are available free of cost at the governmental facilities, many couple resort to pharmacies and buy pills of their choice. Just like in other sites, pills distributed through the governmental channels are not trusted and are correlated with side effects, unlike the pills of their choices available in the market. It is having that option that makes the difference.

⁸Literally *adivasi* means “the original inhabitants.” In the UN documents, this has been treated as synonymous to “indigenous” population.

4.3. Couples' experiences with family planning method usages

Family planning history, irrespective of all fields, shows that most women as well as men did not know much about the usages of FP services and methods until the time of their marriage. It was often their friends or other family members who first initiated the discussion regarding FP method around the time of their wedding and often these people did not know much about the proper usages of it. Though family planning workers make an attempt to go door to door, their coverage is not quite adequate and many newly married couples are not reached on time. One woman said,

"I was not that experienced. He was not either. He did not use anything and I also did not take any suggestions from anybody. Consequently, I got pregnant for the second time."

All except four cases used family planning methods at different stages of their lives, however, not all the women or couples started taking the FP method just after the marriage. It was often after the first or second birth/pregnancy. This practice is often derived from the fact that it is only natural to have children just after the marriage as one woman said,

"Do you have anything if you do not have children? No... People marry to have children."

In Bandarban, the reasons for taking the child immediately after the marriage is derived more from an economical point of view, where a child is thought of as an added labour for the work needed to be done in the field. One woman said,

"I took baby immediately after marriage so that s/he can help us in the field soon... in our community, parents consider having children to reduce their hardship/workload as fast as possible."

Interestingly, counter examples are also found. Many husbands as well as their wives said that taking children immediately after the marriage is shameful. They thought it is also an expression of uncontrolled or illegal sexual activities. One woman commented,

"People may say that the pregnancy might be from an illegal relationship before the marriage if I get pregnant just after marriage."

However, even if it was perceived to be shameful to become pregnant right after marriage, this does not mean that couples would start adopting FP methods right away. There are erroneous beliefs that still persist in the communities regarding FP methods and that it is practically harmful for the body that might prevent women from becoming pregnant in the future. Therefore, it is expected to take a method after taking one or two children. A woman exclaimed,

"If you take pills just after marriage, you will develop fat in the canal of the uterus. If you have fat growing there, you may never become pregnant."

Interestingly, most of the women in our study did not show a serious concern relating to contraception. Experientially they figured that even if women do not use any FP method, they do not always get pregnant right after marriage or right after a delivery. A lot of times, they had noticed that women do not get pregnant even if they are not using any methods for an extended period of time. These anecdotal experiences informed them that it is not all that important to systematically use an FP method. When coupled with perceived and/or real sides' effects, i.e. constant dizziness, lack of breast-milk of a nursing mother, enthusiasm regarding FP methods fades further away. One woman said,

"My breast-milk used to dry up when I was taking pill...Therefore, I stopped taking them..."

Data also show that women always took on the burden of family planning – this stands true in all four of our sites. Pills were the most common of all methods, with injection next to pills. Some women in Bandarban were found to be using IUDs and also some herbal methods. Usually, pills were provided to women through governmental channels, but women also procured from NGOs and pharmacies. Along with the regular pills, Emergency pills were also being used in Sylhet and Shatkhira.

The study also explored the practice of using pills in all sites and has been able to dig out enormous body of information on it. FGDs and in-depth interviews revealed that taking pill everyday was a very cumbersome task for women and they often forgot to take it regularly. Many of them, having a migrant husband, said that they only used pill when the husband was around. One woman said,

"I take pill whenever he comes home and he comes twice a week or sometimes, once a month or so..."

Interestingly, women said that they do see a point of taking pill for the entire month when the husband is even intermittently around, however, they find it very difficult to continue it for the entire month. Over time, some women seemed to have switched to emergency pills instead but they did not remember to administer that on time even. A woman in Shatkhira said,

"I did not understand this so well... he came during the night and I thought that I will take the pill (emergency pill) in the morning. But I forgot to do that and got pregnant..."

Another woman said,

"Pill (the one she was using) was not available at that time. I was not sure what to do... He (husband) suggested that I buy that pill (emergency pill) and take it in the morning...However, I forgot all about it in the morning..."

Not just pills, women also talked about injections and that they did not remember the dates for the next cycle. They also complained about its effectiveness – that they became pregnant despite the fact that they took the injections on time. There is a widespread belief among women that this is due to administering expired injections. Some also mentioned that injection is not a user friendly method like pill which can be stopped anytime if one develops any side-effects while one has to simply bear with the side effects of injection in anytime of the cycle. One woman said,

"Pill can be stopped any time, but not injection which is for three months..."

Perceived and experienced side effects associated with different types of methods were a huge concern in the lives of the women. Women seemed to consider government pills to have more side effects and therefore most women used pills from the market where they had more options. However, this is not to say that those pills do not have any side effects. Side effects for pills, irrespective of all field sites, included headache, dizziness, high blood pressure and weight gain. With regard to injections, heavy bleeding, irregular bleeding and spotting were mentioned. One woman said,

"I took pills for some days... there were only two pills left... However, I could not take it any longer. I had severe weakness. I could not get out of bed in the morning and go to the office... I felt weak and dizzy all day long. So I gave up..."

Another woman said,

"I used to be slim and beautiful. Now I have become fat because of the pill."

Another woman who used to use injections said,

"People say it will harm your body if you use a method for a long time. You will develop burning sensation in the legs and hands and acidity if you use injections for too long."

Several husbands of our informants noticed such problems and restricted their wives from using injectable and pill as one such husband said,

"She has been using injection for a long time. But, she was getting thin day by day. Noticing this, I told her to stop taking it."

For all these above mentioned technical difficulties and side effects, women switch from one method to another or one type of pills to another all through their reproductive cycle and while doing this, they often become pregnant which is not planned or desired. One woman said,

"I took injection and I had heavy bleeding. Then I started pill and continued that for one year. I have been continuing it regularly, but I am not sure how I got pregnant... I wonder how I got pregnant..."

Data show that often there is a huge gap when women stop taking the method and switch to another method or another brand of pill. Women do not see the importance of adhering to the rules too strictly and therefore get pregnant which is unintended.

Many husbands were aware of the side effects, but still did not take any initiatives to address that. It was found that just a couple of husbands decided to adopt the natural/traditional method (withdrawal or safe period) in response to their wives' side effects. Unfortunately, they faced unwanted pregnancies often in the course of adopting those methods. Condom usage was extremely rare across all sites and in Bandarban, there were no husbands who ever used condom in their lives. Husbands who used condom often used it temporarily when their wives complained about severe side effects related to pills or injections. The study explored the inhibition towards the usage of condom and found the principal reasons are its ineffectiveness and lack of sexual pleasure. Many said that it often broke inside and women got pregnant anyways. A husband said,

"My trust in condom has been ruined. Both of my children were born while I was using condoms."

Another husband said,

"I tried that once or twice to test it how it feels. I did not like it. She did not like it either. It does not give pleasure to any of us. It gives a great sense of pleasure when you have skin-to-skin contact. With condom, you do it with a screen, which does not give you pleasure."

For reasons mentioned above, men were not found to be active users of condoms, though some wives have tried many different ways to convince them (i.e. asking others to convince them or trying to convince by themselves). One woman, who was not using anything due to side effects, said,

"I told him that my sister warned me not to take children immediately and therefore, we should use something and that he should use something such as condom. However, he did not listen to me."

Interestingly, men in Sylhet were more cooperative than any other places as we found more condom users there. However, they were also not too regular about it. Only one woman was able to convince her husband to use it regularly.

Husbands were not only passive in using methods, but several of them even restricted their wives to use the FP methods. As one woman said,

"Whenever it was time for my injection, he restricted me saying - what was the point anyways and why did I have to take it?"

Another woman said, she had to stop taking pills since her husband restricted her. She said,

"I have to obey him. I have to stop taking pill if he restricts me. What if he leaves me and remarries? That is why I stopped taking the pill."

There was only one woman with a permanent method (i.e. tubal ligation) in the study sample. Both men and women had several misconceptions regarding this method. All the informants knew about it, but they never considered taking it since they believed that it had severe health consequences. Some also believe that it is sinful too. As one man said,

"I heard that there are serious health problems related to this. Again, what if I want a child in the future!"

Another man said,

"I thought about it, but I also heard that it is a great sin. Our religious leaders say that too. According to them, a man will not have a janaza (i.e. funeral prayer) if he does/agrees to it."

Quite surprisingly, a woman in Bandarban said,

"I know about the process (i.e. tubal ligation)...I want to do that too. If I do that once, I will never get pregnant and then I will be able to work like men... Men never get pregnant!"

Women, as mentioned so far, found to be fighting with many barriers. However, still end up with unwanted pregnancies at various stages of their reproductive life. Women, even with Copper-T and ligations, reported becoming pregnant (i.e. in Bandarban and Shatkhira).

4.4. Missed menstruation, unwanted pregnancy and initial responses

As suggested in the earlier section, prevalence of method failure across the study sites was high and in many times, this resulted into missed menstruation. In this section, it will be explored how they perceived the missed menstruation and what their initial response was towards these pregnancies.

Irrespective of all sites, it was found that many women did not recognize their pregnancies until two to four months of their last menstruation. Many of them simply did not connect discontinuation of menstruation with pregnancy and thought it would automatically be regulated as they have experienced it before. There is a widespread belief that woman may not menstruate for different reasons which did not necessarily mean that they are pregnant. One woman in Dhaka said,

"I thought menstruation would start in the next month since apas (community health workers) often said that women do not menstruate if they do not have blood or if they are mal-nourished. I took the red pills to regulate the menstruation but it still did not happen..."

A health worker, who was interviewed as an accompanying person, talked about women's perception on irregular menstruation and said,

"She did not take it seriously like the previous MRs. She thought since her husband is not around all the time and only comes once in a while, there was no reason for her to get pregnant. She thought her menstruation had stopped for other reasons... When I asked her how long has it been stopped, she could not say..."

Several informants got pregnant during their LAM (lactational amenorrhea) period, who could not say how and when they got pregnant. One woman said,

"I cannot say when I got pregnant. I did not have my menstruation for a year... how will I know when I got pregnant?"

As data suggest, women in all sites tried different things at home to regulate their menstruation. For instances, women irrespective of all sites took a bunch of red FP pills⁹ with hot water, women in Bandarban took a number of herbal treatments and women in Shatkhira used homeopathic medicines to regulate menstruation. In various FGDs in Bandarban, men and women said that they know a number of medicinal treatments that are used to regulate menstruation. Interestingly, when they adopted all these home remedies, they did not have aborting the foetus in mind.

Once these home remedies did not work, women became concerned about their missed menstruation. Data suggest that during this stage one of their first responses was to test for pregnancy with a strip done at home. Village doctors and community health workers also identified their pregnancies through pregnancy strips or through a manual abdominal test to confirm their pregnancies. In Shatkhira, one homeopathy doctor to whom one of the informants went during her fourth month of missed menstruation, denied to provide treatment for regulating the menstruation suggesting that he does not want to be blamed for killing a human being since he understood that she was already carrying.

On the other hand, it was also found that often women were somewhat fatalistic in their approach and did not even bother to do any tests since they understood that its been a long time they missed their menstruation which might be nothing but pregnancy. The first pregnancy test of these cases occurred at the facilities if and when they sought care for MR. At the facility level, the tests usually included urine tests but some also reported abdominal and per vaginal physical examinations. Needless to mention here that in all facilities, be it formal or informal, pregnancy tests were done and pregnancy status was established before conducting MR.

However, the above does not describe the entire situation. Some woman did connect their irregular menstruation with pregnancy immediately, particularly in Dhaka. Accordingly, they immediately proceeded to take actions to terminate the pregnancies and avoided the delays in seeking care. Table 7 (page: 36) shows that women carried out MRs or attempted to carry out MRs often at a very late stage of pregnancy and it is presumed that not connecting missed menstruation immediately with pregnancy resulted in the first stage of delays in care seeking.

⁹ Iron pills contained within the strips of birth control pills

4.5. Perceptions and attitudes towards pregnancy termination

Pregnancy termination in general is a matter of shame from different religious and social perspectives in all societies. Most people believe that pregnancy termination is not an issue to be talked about in public spheres. Though people try to keep it secret, it does not remain secret all the time. Data from Dhaka suggests that everybody knew everybody's MR histories and when situations arose, they used it to degrade others in public. Living in close proximity and in a densely populated area might have a lot to do with this where nothing really is personal and everyone is almost always on a defense against the other.

MR volunteers are the primary source for seeking care in Bandarban, Shatkhira and Dhaka sites. People often knew other's MR histories from these volunteers; however, unlike Dhaka, these histories are not used to demean women in Shatkhira and Bandarban. Rather, in Shatkhira, other women who wanted MR consider them as a source of information and in Bandarban, demeaning others or talking about one's stories in public is completely absent there. MR is viewed as a misdeed in Bandarban too, however, when one does it, people try to see it as one's personal matter. A very different scenario was found in Sylhet, where husbands were the primary persons involved in the process. This was due to the idea of not involving other people in the matter and keeping it as hidden as possible. One husband in Sylhet said that he did not want anybody to know about the MR and that was why he collected the medicines needed for it so that his wife would take that at home. When his wife started to bleed severely after taking that traditional methods and people showed concern, they tried to say people that the miscarriage took place due to taking medicines for other health reasons which they did not know and identify.

The study tried to explore why MRs is such a sensitive issue in these communities. Findings suggest that irrespective of all the study sites, people hardly made a distinction between "MR" and "abortion". The terms used for the process are "*bachcha felano*," "*bachcha noshto kora*," "*wash kora*," "*bachcha porishkar kora*," "*pet phalano*," "*noshto kora*," "*mashik niyomito kora*," "*ash kheanchoh*," etc. All of these expressions basically mean "getting rid of the baby," "clean up the abdomen," or "regulate periods". Often they use these expressions interchangeably to either refer to menstrual regulation or to termination of pregnancy.

Data from in-depth interviews and FGDs suggest that people consider MR as sin, equal to killing a life as proscribed by religion. People view it as intervening in God's work. One woman in Dhaka, who failed to have an MR, said,

"Am I not doing a sin by terminating a pregnancy? Am I not to be blamed for a great sin? Is it good to kill a child? Many women cannot have children while we are killing a human being by strangling its throat."

One woman in Bandarban said,

"Older women say that terminating a pregnancy is a sin. Life may not be there until the third month but there will be life in the body one day. That is why it is like killing a life which is a sin."

One woman from Shatkhira, said,

"The quran and hadith say that it is a dire sin to kill a jaan/life. And if you die while doing an MR, you will not even get a place in the grave. Terminating a pregnancy is a great sin. Is not that a crime?"

People in Sylhet and Shatkhira practice proper funeral rites for their aborted fetuses and perform "*janaja*" (funeral prayer) before burying it. The perception is that, if religious rituals were not performed properly, the foetus would become an evil spirit and harm people. One husband from Sylhet said,

"It is like a clot of blood during the 3rd month...but according to Quran, it develops different parts of the body, like legs, hands, eyes within ten days after 3rd month and by 6th month, it takes the shape of a human being."

There is this widespread belief that Allah would punish people during the dooms day who carries out MRs. Not only that, they believe that people will also suffer in this world as the foetus would curse them which one earned for terminating that pregnancy. One woman in Sylhet said,

"Many Muslim women, who have MRs keep of fearing thinking that she earned a curse for doing this..."

Another woman in Dhaka said,

"Terminating a child is not good. I have done a sin. Allah gave me the child and I terminated it. I have done a great sin by doing this. I did not insert the child into my abdomen. We had sex and the life came... I should not have done this."

One woman who wanted to have an MR but failed, said,

"If I did the MR, I will have to pray to Allah to forgive me, but Allah still may not forgive me. However, even though I thought I would do it. And lastly I could not do it. Now, I think that I did not commit a sin. Though I am suffering with too many kids, but still I am not a sinner to Allah. If I were to do the MR, I would have been considered a bad person to both Allah and people."

Echoing the same perception, one MR case in Shatkhira said,

"I prayed to Allah to forgive me for doing the MR. I promised Him that I will not do this again in my life."

Another woman who did an MR said that she felt guilty for doing this, as she said,

"Should not I feel guilty? I killed a life!"

Often post-MR morbidities are related to the perceptions that imply them that it is a sinful act. For instance, women those who had bleeding following a partial and/or incomplete MR were asked to see religious healers in the community and to repent for their sins – only then, it is believed that their illness would be cured. People also believe that if god wanted a soul to come into this world, nothing could stop that. One woman who failed to have an MR in Sylhet said,

"I could not terminate this pregnancy. Everything depends on His (God's) will. Nobody can kill anybody if He (Allah) does not want it."

A senior woman from an FGD said,

"Human being cannot create a human being if Allah does not want it. Not even a single leaf can move without a signal from Allah. Those who terminated pregnancies will go to hell!"

Therefore, whenever such sinful deed is done by anybody, people consider that person/couple bad. Such social stigma led them to do MRs secretly which were often with informal providers as one woman from Sylhet said,

"I did not let anybody know about this. They will consider me as a bad woman. They will point fingers at us for aborting the foetus. They will say that we are sinners, they will rebuke us and say bad things about us."

One husband in Sylhet said,

"Society does not take it lightly. It never accepts pregnancy termination. It does not even permit family planning either."

The society at large is not permissive of the procedure across the sites. People often directly relate it to being "bad" and having extra or non-marital relationships. Consequently, the process of having an MR becomes more and more clandestine.

However, somewhat contradictorily, the same people believe that life comes into a foetus only after the 3rd or the 4th month. Therefore, it is okay to terminate the foetus before that. Despite the wide spread belief of sin, many informants, both from in-depth interviews and FGDs, said that people do MRs when they face unavoidable situations, such as poverty and having too many children or other practical situations of life. One woman from Sylhet said,

"Getting rid of a baby is equal to murdering a human being. Allah has given you the baby, why do you need to do this? Our religion does not [condone] this. Even then people abort their child because of their hopeless situation; they already have too many children and they will not be able to raise them properly. Under such situation, what do you do if you got pregnant suddenly?"

One woman from Dhaka said,

"Yes, it is a sin, but will this sin feed me and my child if I took another child?"

Another woman from Bandarban said,

"Older women say that it is a sin to kill a life, but they do not know how hard it is to raise a child these days."

Another woman from Dhaka, who after failing to do the MR, said,

"It is better to have an empty herd than having bad cows. There is no point of taking children if you cannot raise them properly."

Another woman from Bandarban said,

"What can you do if society tells bad things to you? You have to take it, right?"

Many people said that there is no necessity to abort a foetus especially when there are so many FP methods available. Women are considered idiot for such stupid action when they know the community perceptions and attitudes towards it. Therefore, it is suggested that in order to face the trauma of the society, women should be a bit careful in controlling their pregnancies. One woman from Dhaka, who failed to do an MR, said,

"There is no point in blaming the society. I did a bad thing and I knew people consider it negatively. I would not have gotten pregnant if I were careful... society would not have anything to say either..."

Data from Shatkhirra and Dhaka suggests that not only from the society and family, women often were restricted by health providers for doing MR as one woman from Shatkhirra said,

"They do not kill child. They have ethics and they do not want to do a such sinful act. Nobody wants to kill a child, not even a doctor (who does abortion)."

In Bandarban, social pressure for doing such act is not as hard as that of other three sites while MR is still considered sinful from a religious point of view. "Vantey" or their religious leaders, restricts them from such activities. One woman from an FGD said,

"You never know what that child could turn into...s/he might be a vantey, a doctor, a lawyer, and you have no right to restrict her/him from coming into this world and have others be benefited by her/him."

The religious sensitivity around pregnancy termination might be as dire as that of other three fields, but it still do not affect the social life of the couple/woman. The religious restriction towards

MR is so strong in Bandarban that they even can be permissive towards children beyond wedlock. Such cases were found in many communities there though the process of such acceptance is not always easy. The process they follow to accept a child beyond wedlock is described as a case here which depicts perception related to the aspect of pregnancy, marriage and MR in Bandarban.

Besides all these perceptions, women also view MR harmful for their health, indicating the side effects and deaths due to this they have seen in their community. One woman from Shatkhirra, who did an MR, said that she decided to do that despite knowing the risks involved in the procedure,

"They cut the blood vessel. They cut the blood vessel of the child as well. Sometimes, bleeding does not stop and the woman dies."

Case study 1: On pregnancy, marriage, and MR

When a woman is identified with pre-marital pregnancy, the village leaders first try to identify the biological father of the child and try to arrange the marriage with the guy. The next step for the couple is to contribute a big pig for the community. This pig is then slaughtered and the couple is asked to mark on every house of the community with the blood of that slaughtered pig and acclaim that they have committed a sin by bringing a child in this world out of wedlock. When they do this, the entire community follows them around and makes them feel ashamed as they hurl abusive words at them. After this, they are given into marriage. The meat of the pig is cooked for the community while the heart of the pig is given to the headman as a sign of respect. In case the concerned girl or boy denies accepting the marriage, then there are rules for that as well. For instance, if any of them denies marrying the other person, then her or his family will have to bear the cost of the ritual surrounding the pig. The girl will live a normal life with her kid after that and both the boy and the girl will be permitted to get married whoever they want to in the future. Nobody in the community will blame the child as illegal and grows up as other child in the community.

4.6. Key decision makers and reasons behind termination of pregnancy

Once pregnancy was identified, the next step for the family's/couple's was to make the decision surrounding the pregnancy – whether to continue it or not. Since the study purposefully sampled those women who had MRs or wanted to have MRs, the result of this decision making in these cases was in favor of terminating the pregnancies. Therefore, this section will only talk about who and how these decisions were made.

Table 3 shows that it was mostly the couples across the field sites who took the decision and data suggest that these couples discussed the matter between themselves and decided together to terminate the pregnancy considering various aspects of their socio-economic situations. However, in several cases, it was just the women deciding to terminate their pregnancies and data suggests that they had strong stand regarding the termination of the pregnancy and later they convinced their husband to agree to their decisions and in most of the cases, women were able to convince their husbands (all but one case in Bandarban).

Table 3: Primary decision makers for pregnancy termination

Sites	Decision-maker	Woman	Couple	Husband/ In-laws	Natal family
Dhaka (n=12)		6	3	2	1
Sylhet (n=12)		1	11	0	0
Shatkhira (n=15)		4	9	2	0
Bandarban (n=13)		2	11	0	0
Total (n=52)		13	34	4	1

In cases where the women were not a major player in decision making, it was mostly their husbands, mother-in-laws, other members in the in-laws' family or the natal family that played the crucial role. In these cases, the decision was somewhat imposed on her and they were powerless to stand against it. One woman in the data set even received a divorce letter for not terminating the pregnancy according to her husband's and mother-in-law's decision.

Regardless of who took the decision of terminating the pregnancy, it is just evident that that all these 52 informants/families/couples took such decision ignoring different social and religious boundaries mentioned in the previous sections. Data suggest that around a quarter of the informants had multiple MRs (i.e. 2-3 times) and a majority of them suggested that they wanted to terminate more than one of their pregnancies but could not do so for various reasons as described above. While all of them conceived all these religious and social ideas and beliefs, they decided to do this for practical reasons. Reasons that found to be the most cited for their decisions to terminate the pregnancy or attempting to terminate the pregnancies included already having too many children, poverty, birth-spacing (previous child/children were still too young), becoming pregnant in later stages of one's reproductive life which is shameful, having a child at that time would be a problem for woman's job, did not want to take any more children, women's health problems which would not allow her to carry more children and preferences for alternative sex of the child.

The most common reason found in all fields was poor economic condition of the family, where another child was viewed to be increasing the burden on it further. Many women mentioned about their irregular and poor earnings for which they were already facing problems in bearing the cost of livelihood. One woman who had MR in Dhaka said,

"There is nothing to give a second thought. I have to raise other two children. My economic condition is not well. I may be in a better position after a couple of years and I can then think of taking another child. I am not infertile. I can be pregnant again."

One woman, who failed to do the MR and who was a temporary house made in Dhaka, said,

"I decided to do the MR thinking that this would be good for me. I will be able to work. I already have three children. I cannot feed them and manage cloths or education cost for them. How would I bear the cost of another child?"

Economic consideration was often a result of joint husband wife discussion, as one husband in Sylhet, whose wife had an MR, said,

"When she informed me about her pregnancy, I did not let others know about it but we decided together that we will terminating the pregnancy. My shop (grocery) was too small then and the income was too little. On the other hand, I also thought that she is very weak, and she will not be able to perform household chores if she went through it again. Considering all these, we decided to do this ..."

In Shatkhira, which is a very poor area, many women talked about their economic condition as being the reason. One woman who had MR said,

"The other 2 children are very young. I do not have the ability to send them to school...How would I manage all these things for another child? People will also say bad things about me if I cannot raise them properly."

Having too many children and consequently the burden of it on the family was also mentioned in Bandarban, as one woman who did MR, said,

"It is hard to raise children with such economic constraints..."

One woman in Sylhet said,

"I did MR because I thought that I would be in great trouble. It does not make any sense if I brought the child in this world but could not raise it properly. People would say bad things about me however, they will also see that I do not have the capacity to raise another child."

Some women did not want to have an MR, however they still had to since their in-laws or husbands wanted them to. Interestingly even with these husbands and their families, the main concern was household economy. One woman in Dhaka confirmed this as she was talking about how her husband made her do it,

"I was very angry. I told him how he could do that being a religious person! I told him that he would be punished for it! Then he told me that we already have 2 sons and there is no need to take another one!"

Another similar case was observed in Sylhet, where the woman was against terminating the pregnancy while her husband thought differently. She complained,

"...a human being's fate for food and other things has been ordained by Allah 40 days before its birth. Allah will take care of it. Killing a human being for this reason is not ideal. Isn't that a great sin?"

Several women in the study sample suggest that having older children was also a reason not to have any more children. As one woman exclaimed,

"My sons are already grown up. Would not they say that our mother is going to give birth again! Don't you feel uncomfortable thinking that? Isn't that shameful?"

Another woman with MR in Shatkhira said,

"It is time to get my daughter married off... What would people say if they know that I am going to have another child when I am supposed to become a mother-in-law?"

One woman who failed to do MR in Dhaka said,

"...I know that it is a shame...however, don't you have to do it if you need to? There is no meaning of taking children one after another. You need to feed them properly and raise them properly. There is no meaning of taking the child and just letting them wander around here and there. Having raised the child does not mean anything for the parents."

Confirming the same connotations, a woman from Shatkhira, who failed to do the MR and is now regretting for not being able to do it, said,

"For me, it was better to die. I have 5 kids now. I cannot feed them. I cannot educate them. How should I feel as a mother? Isn't it better to die?"

Several women talked about their jobs as being the reason why they did not want a child and therefore, opted for MR. One woman in Shatkhirra said,

"There is no one to earn in the family. I earn and I take care of the family. If I got pregnant now, I will be pregnant for ten months and then I have to give extensive care to the newborn after the delivery. Would I be able to work then...Who is going to take care of my family during that period?"

While explaining the problem of work, one woman who had MR in Bandarban said,

"We live in very remote high-altitude areas. We have to go up and down for various reasons, such as jhum cultivation, fetching water and so on. It becomes very hard to do all these when you are pregnant."

Women's health condition was also mentioned in two fields. In Bandarban, a woman wanted to have MR, which the husband denied, but he consented when he noticed his wife was getting sick.

Birth spacing and not wanting to any child was also found in some field sites, as one husband from Bandarban, whose wife failed to have MR, said,

"My other child was too little. I thought how she would take care of two little babies. One may die while taking care of the other... For this reason, we both decided to abort the pregnancy."

In different field sites, other reasons were mentioned for terminating the pregnancy. For instance, two cases in Bandarban and Shatkhirra wanted to wait until they figured out the sex of the child. In Bandarban, it is said that if the head of the child appeared on the left side of abdomen, then it would be a boy. One couple, from this physical sign, understood that it was a boy which they did not want. So, they went for termination of that pregnancy without even doing an ultrasound. Conversely, in Shatkhirra, a couple wanted a boy and wanted to have an MR thinking that it was a girl. They did an ultrasound before terminating the pregnancy and figured out that it was a boy and so they decided against termination.

Case study 2: Pro-life and pro-choice

This woman did not realize that she was pregnant till the end of the third month. It was, in fact, her in-laws who suspected when they saw her throwing up. Her in-laws, along with her husband, asked her to terminate the pregnancy, but she did not want to since it was her first pregnancy. Her husband threatened her that he would commit suicide if she did not comply with his wishes. She wanted to convince him explaining the religious restrictions; however, her husband still did not budge from his position. During the next two months her husband and her mother-in-law took her to various places – from herbalists to formal care providers. Somehow she was able to signal the care providers about her wishes. They even took her to an informal care provider, in whose hands a couple of women had lost their lives. She was scared and urged to her mother-in-law to not make her to go through this procedure. But they did not listen. Luckily, she was able to convince this informal care provider not to terminate the pregnancy as well. Having no other options left to them, they sent her back to her natal home and threatened to divorce her if she would not comply with their wishes. At this point, she was very scared and went back to her in-law's house. They took her to a clinic this time and convinced the care provider there to terminate the pregnancy. They said that they would make her to terminate the pregnancy in any case and the care provider thought she had no other option because; the woman might face riskier situations otherwise. So, the abortion took place. The woman said, ***"I thought I should abort it since he does not want it at all. I thought I would get pregnant again if he is around. But I cried and cried and tears flowed like river. I was so very sad. But he did not care about my emotions at all."*** When she came back home, her husband started having anal intercourse with her. This came as a shock to her. Physically and mentally, it hurt her like anything. She said, ***"He used to say, 'you would get pregnant if I do it through that area (vagina), but you won't get pregnant if I do it in this way'...it was very painful, my body used to burn... I used to sweat a lot and it felt like my hair was on fire."*** Many months passed by and the woman was not getting pregnant, though she wanted to. Her natal family spent a lot on her treatment since the doctors said she had developed some sort of problem in the birth canal. It was a huge burden for them since they were not well-off in any sense of the term. However, she finally got pregnant and was determined to keep the child this time. Her husband was still unwilling and wanted her to abort once again. This time she did not listen to him and kept her baby. Seeing this, her husband and her mother-in-law sent her back to her parent's place and sent her a divorce letter after some time. Her parents were thinking about filing a case against her in-laws, but she was holding them back from it. She was still hoping to return to her husband's family one day. She was worried about her daughter's future and did not want to be known as a divorcee. She said that it was becoming very hard for her to live with her parent's house day by day. She said, ***"My parents do not tell me anything. They are fine with me. It's the other people who say bad things about me. I don't know how much longer I will be able to take it. It does not look good for a girl to stay with her parents after marriage... It is too much of a shame for me to receive a divorce letter... Now, I just think that woman has only one thing to do. She should complete their education, earn, and be independent. I only have one wish in my life. I would like to raise my daughter with that view."***

There were some cases where pregnancy was not meant to be terminated during the initial stage, but, due to some social reasons, woman wanted to terminate the pregnancy at around 7th month of her gestational age. In another case, the woman did not want to terminate the pregnancy but her mother made her to do it since her husband was a drug addict and did not have any income. In another case, the woman said that she never wanted to terminate the pregnancy and it was her husband and in-law's family members who forcefully made her to do that. The following is the case history of this woman.

4.7. Care seeking for MR

Care seeking of the informants for MR was very complex, which confirms the findings of other studies with regard to any reproductive and maternal morbidity. A plethora of services and care providers are found in the exploration of care seeking of women for the care of MR.

Table 4 shows the number of care seeking with all different kinds of care providers, stages of care seeking and at what stages MR was done or failed ('failed' means MR was sought but was not obtained for whatever reason). As Table 4 shows, some women/families/couples went up to the 9th stage (column 16 and 17) in order to get MR services. Data suggested that around 61% of all care seeking was from non-formal sectors of the health system available to women/couples. The non-formal sector in the analysis includes pharmacists, paramedics, homeopaths, herbalists, TBAs, other informal care providers and home remedies. Out of this non-formal care seeking, around 44% was with pharmacists and other informal providers while 24% was with the traditional providers. Please note that the purple colour-coded columns are for MR volunteers and CHWs who were not MR care providers but were sources of information for women seeking MR care. They were included in table 4 and in the diagrams (below) to indicate stages of care seeking but they were not included as MR care providers *per se* in the calculations above.

Table 4: Care seeking of informants (MR success and MR failure cases)

Providers Care seeking stages	Home remedy	TBA	Herbalist/ Religious Healer	Homeopathy	Pharmacy	Informal (Other)	MR Volunteers	Field Workers	Paramedic	FWC	THC	Private clinic	NGO clinic	District Hospital	MCWC	MR success cases	MR failure cases
1 st	7	1	1	4	10	1	2	6	3	4	6	2	3	-	2	3	4
2 nd	5	1	1	3	12	1	2	1	4	3	3	1	7	1	-	5	5
3 rd	2	-	1	2	8	3	1	1	4	2	5	-	5	-	-	6	4
4 th	1	3	3	3	5	1	2	-	2	-	1	1	4	-	-	4	5
5 th	-	-	2	-	3	-	-	-	3	-	2	1	4	-	1	6	1
6 th	-	-	1	-	2	-	-	-	1	-	2	1	2	-	-	1	3
7 th	1	-	-	-	1	-	-	-	1	-	-	2	-	-	-	-	2
8 th	-	-	-	-	1	-	-	-	-	-	-	2	-	-	-	2	-
9 th	-	-	-	-	-	-	-	-	-	-	-	1	-	-	-	-	1
Total	16	5	9	12	42	6	7	8	18	9	19	11	25	1	3	27	25

Diagrams 1 and 2 below (one for the women who got their MRs done and other one for women who wanted but were unable to get MR services) show the stages of care seeking for each informant with different health care providers. These diagrams illustrate the varied and complicated nature of care seeking of women who sought MR services in all of the four study sites. In general, it can be said that women tried their level best once they decided to do the MRs. Consequently, these two diagrams show that those who did not get the services, had more care seeking episodes then women who were able to, since they kept on trying till they exhausted all the possibilities open to them. Data show (as the diagrams on care seeking also suggest) exactly the same - care seeking episodes for women who were able to have MR was 3.6 while it was 4.8 for women who wanted but could not get the MR done. These is not a quantitative study, but with average number of care seeking episodes, this attempt was made only to illustrate the levels of care seeking stages women went through in order to get the desired services.

Diagram 1: *Care seeking of women who had MR*

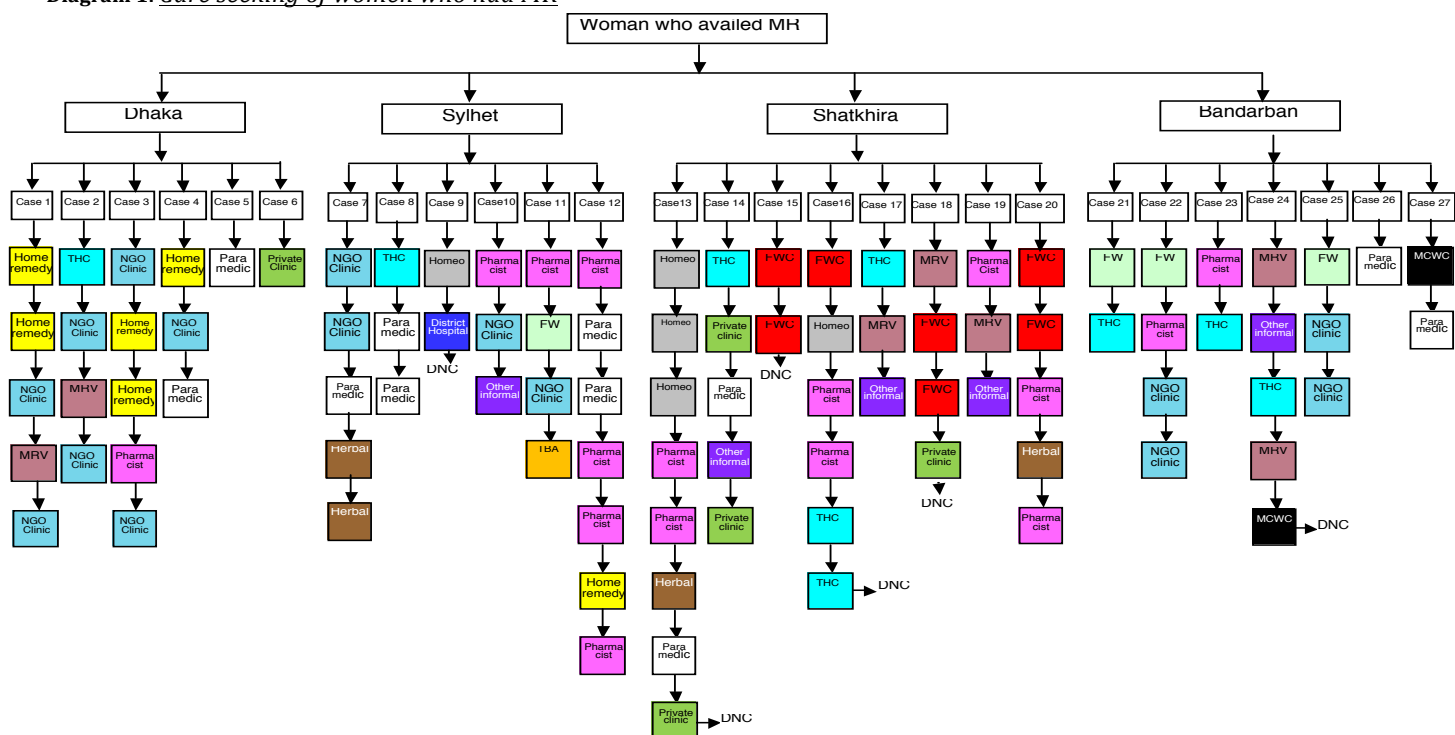
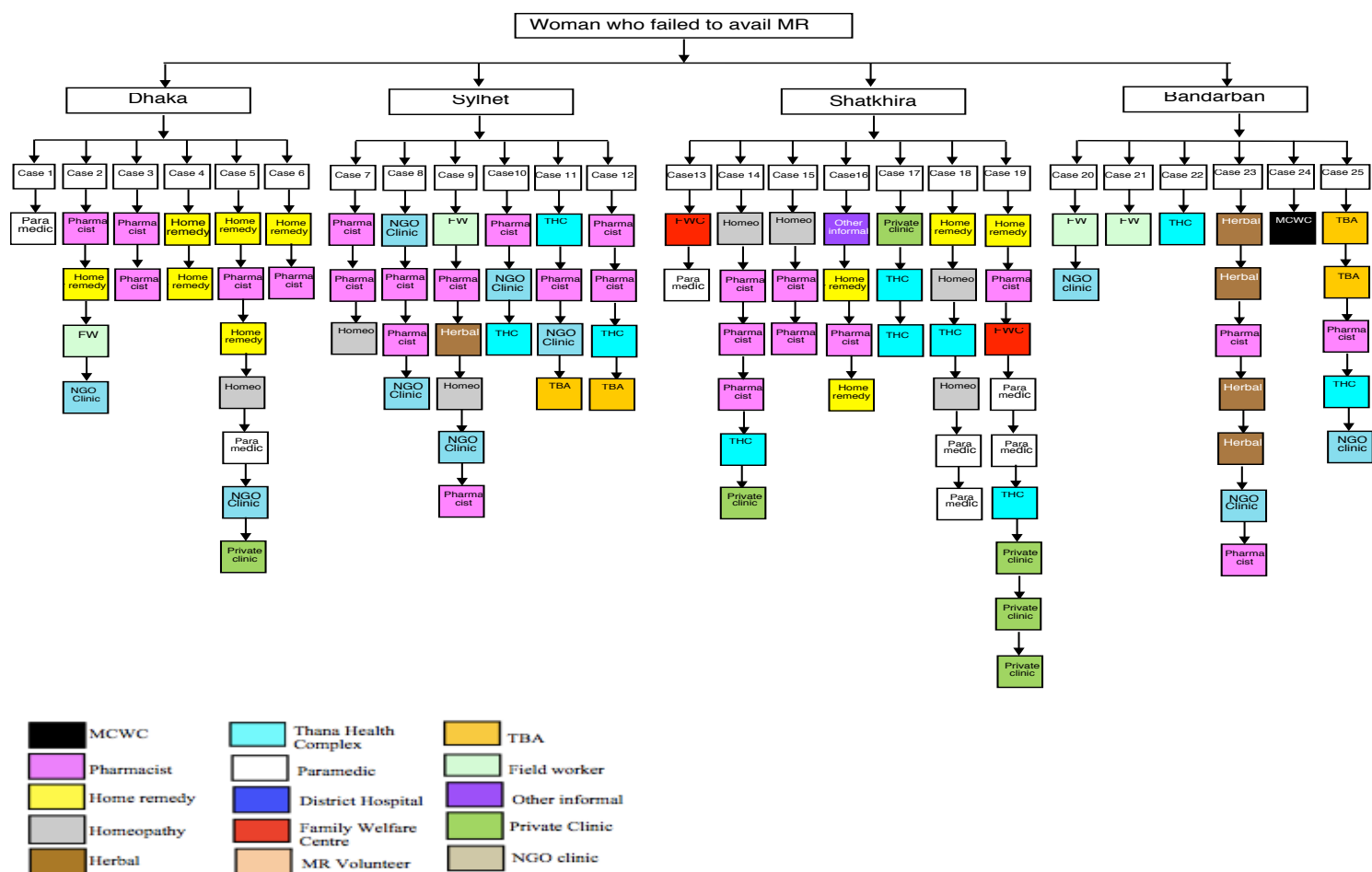


Diagram 2: *Care seeking of women who sought but failed to avail MR*



For the sake of clear description of the scenario, a detailed description of the providers/facilities, their services and availability is provided in the table below (Table 5). Please refer to Table 5 when the context of a certain provider/facility is discussed order to clarify what exactly it meant across the sites.

Table 5: Type of care providers/facilities and their availability

No.	Facility/Providers	Explanation of services	Where available
1.	Home remedy	Green papaya and pineapple, tamarind, red FP pills with hot water, only hot water, heavy household chores, wandering around in the places where <i>evil spirit</i> would abort the foetus	All sites
2.	TBA	Herbal roots that is inserted in the vagina and abort foetus within 48 hours	Sylhet, Shatkhira, Bandarban
3.	Pharmacist, village doctor, medicine shopkeeper, Drug vendor	Usually provides 4 to 6 tablets (Misoprostols, Gynocomicide) and suggest to put two into the vagina and another 2 for oral feeding. Often if the first dose does not work, another circle is suggested. Some pharmacists also carry out MRs with medical instruments	All sites
4.	Kobiraj/Ojha/Herbalist	Different types of herbal pastes to feed and insert medicinal roots/leaves in the vagina	Sylhet, Shatkhira, Bandarban
5.	Homeopathy	Provide watery medicines and sugar pills for MR	Sylhet, Shatkhira
6.	MR volunteers	Women who provide information on sources of MR services, accompany them to different formal and informal MR service providers and often bargain cost for them with provider. Usually do not have official affiliation with any organizations	Dhaka, Shatkhira, Bandarban
7.	Field Worker	FWAs and NGO community based workers. During their routine household visits, they do pregnancy tests, provide information, accompany women to different formal and informal MR service providers and bargain on costs for them with the providers and often prescribe red pills to regulate menstruation. Affiliated with either Govt. or NGO activities	Dhaka, Shatkhira, Bandarban
8.	Other informal provider	Ayahs (support staff of facility) and FWAs who conduct MR with bio-medical procedures as well as with toots or leaves of medicinal plants at their house	All sites
9.	Paramedic	FWV, NGO paramedics and nurses providing MR services at home when they are still in their service/job	All sites
10.	FWC	MR is done in official settings by trained providers	Sylhet, Shatkhira, Bandarban
11.	THC	MR is done in official settings by trained providers	All sites
12.	Private clinic	MR is done in private official settings by trained providers	Dhaka, Sylhet, Shatkhira
13.	NGO clinic	MR is done in official settings by trained providers	Dhaka, Sylhet, Shatkhira
14.	District hospital	MR is done in official settings by trained providers; people also go there for DNC	Sylhet, Bandarban
15.	MCWC	MR is done in official settings in by trained providers; people also go there for DNC	Bandarban

a) Home Remedy

Diagrams 1 and 2 and Table 5 show that several women started with home remedy (please see Table 5 for the lists of home remedies used). Often woman used a bunch of red FP pills to terminate their pregnancies without even consulting anybody due to the widespread belief that red pills can regulate menstruation. It is important to mention here that red FP pills were also used once the pregnancy was confirmed and in such cases, the usages of red FP pills was meant to be terminating a pregnancy and not just regulating menstruation. Usually this method was adopted right after women figured out that their menstruation was stopped however, data suggest its use in later stages too.

b) TBAs and herbalists

Table 4 shows that a substantial proportion of care seeking took place with traditional providers, which include TBAs, religious healers/herbalists and homeopathic doctors. It also suggests that traditional care providers are more common in Shatkhira, Sylhet and Bandarban. Generally speaking, traditional care providers prescribe medicinal roots to be inserted into the vagina and advise various types of pastes or juices to be ingested orally. The study also revealed that a few traditional care providers also give blessed water for the same purpose. In one of the cases, an herbalist prescribed misoprostol along with medicinal paste for quick and better results. These healers often come over to the informants' home or in many cases; husbands of the women fetched the medicines from the healers. In either case, secrecy is maintained. Usually, TBAs or herbalists tell women that they would be able to do the MR in 24-48 hours

with severe bleeding. However, they suggest no further treatment for severe bleeding. Often informants faced profuse bleeding with severe lower abdominal pain which continued for a long time. Findings from different sources suggest that in all these three field sites, these traditional care providers are very common and people know about their existence. People also know that they could abort up to 7th months of gestational age. One FGD from Sylhet with the older males aged around 45-65 years suggest that there is a male herbalist in the community who wanders around in the community and carry out MRs at client's home during the night so that other people do not get to know about his client's secrets.

Interviews in Bandarban revealed something of interest for the research. Data suggest a very little care seeking with the traditional providers there. However, FGDs and informal conversations revealed huge prevalence of such providers in that area. It might be possible that researchers were not able to explore this very closely due to the language barrier. Case 23 of Diagram 2 shows a number of stages of care seeking with such providers and data suggests that both sets of women (with MR and failure cases), after recognizing pregnancy, did not go to formal providers immediately. It took them one to two month/s before they actually sought care with an NGO clinic or THC. It might be assumed that during this interim period, a number of informal providers were taken into consideration. It was also found that many of these women's pregnancy tests were done by local TBAs. However, they said that they did not try to terminate pregnancy with them.

c) Homeopathy

Homeopathy doctors are among the other such traditional care providers who are prevalent in all three field sites and not in Bandarban. Homeopathic doctors particularly provide watery medicines and tablets that most of the time do not successfully complete the process of MR. However, the study informants reported severe side effect due to these processes. Case 9 from Sylhet (Diagram 1) had to go for a DNC after having homeopathic treatment for MR at around 3.5 months of gestational age.

d) Retired Ayahs/FWAs (Nurses'/FWV's assistants)

In the categorization of the providers, informal care providers also included retired *ayahs* (nursing assistants) and/or retired FWAs. These providers provided MR services in all three sites besides Dhaka. Basically, these care providers do not have any formal training on MR procedures. What they learned was through observation and assisting FWVs as they performed MRs. Based on this experiential knowledge, they started their own practice in their homes. The researchers were often very perplexed to identify their designation and skills from women's interviews since there are a lot of FWAs doing similar practices at their homes in Shatkhira. Using different sources of data helped understand their designation and role. These care providers often carry out MRs even up to 6th months of gestational age. Among cases 10, 17 and 19 (Diagram 1), one carried out her MR during 4th months and two during 5th months of gestational age with such providers.

e) Pharmacists

The highest number of care seeking episodes took place with the pharmacists. This confirms to the general pattern of care seeking for any illness across Bangladesh. This stands true for both – women those who had MR or women who wanted MR but could not do it. It should also be noted here that the trend of going to these pharmacists is relatively higher in Sylhet and Shatkhira. The pharmacists often provided care (misoprostol or so on) during the fourth or fifth months of gestational age and data suggest that they often advised women to put two tablets into vagina and two to be administered orally. Pharmacist also informed these women that they would have their MRs within 24 hours of adopting the medicines along with bleeding. Often this did not work and women on their own, administered a similar dosage following the first one. The alarming side of this practice is that, close to one-third of women consulting the pharmacists experienced side effects.

f) MR volunteers

The diagrams show that women often sought care with Field Workers and MR volunteers. Strictly speaking, they are not MR care providers, but they are the sources of information for the women. The activities of both of these care providers are more or less same as mentioned in Table 5. MR volunteers in Shatkhira and Dhaka often have an unofficial affiliation with formal and informal care providers and they get 'percentages' of charges from providers for bringing in MR clients. On the other hand, though field workers in Dhaka were only providing information, they played a great role in Bandarban context. Along with providing information, in most of the cases, they were the one who accompanied women/couples to

health facilities to do MRs and often this required spending two to three days with them since the facilities were far from their homes. However, they usually do not receive any money either from the care providers or from the clients for this support. They do this on a completely humanitarian ground. Clients simply bear the cost of food and transportation when FWs accompanied them.

g) Paramedics/Nurses/FWVs

Table 6 shows that paramedics conducted MRs for 6 women out of 27 cases, which is more than any other care providers in the sample. As mentioned in Table 5, paramedics, nurses, and FWVs are skilled providers who are affiliated with different formal institutions: both Govt. and NGOs. These providers often provide MR services at private settings (i.e. their homes and or medicine shops – particularly in Shatkhira). These care providers receive MR clients either through MR volunteers or field workers and carry out MRs up to the 5th months of gestational age at high price. Table 6 shows that several women sought care from THC and FWCs (6 of 27). Interestingly, in many cases, these paramedics did not even need to use their houses for private practice; they, with higher prices, carried out MRs of women way above the legal limit of gestational age (even beyond 4 months), using the MR facilities of THCs and FWCs they worked in. Paramedics of NGO clinics particularly have had their private practice in their homes and data reveal that many of their clients were the refused cases from the NGO clinics they worked in.

h) NGO Clinics

Data suggest (see the Diagrams) that there are no NGOs providing MR care in collaboration with the government in Shatkhira, while in all the other three sites, there are big national NGOs working in close collaboration with the government institutions. Consequently, there are more care seeking episodes from the NGO facilities in Dhaka, Sylhet, and Bandarban (5 out of 27 cases carried out MRs in NGO facilities: Table 6). Despite having MR services available in the three sites, care seeking from these NGO facilities is relatively lower than expected. This might not be entirely true in Dhaka but this was definitely the case in Sylhet. According to the informants, the price asked at the NGO facilities in Sylhet is much higher than what the people could afford. Interestingly, seeking care from the government facilities, such as THCs and FWCs, is higher in Shatkhira than any other field sites since there is no such NGO activity.

In Dhaka, Sylhet, and Bandarban, women often sought care with some NGO clinics where MR services were in fact not available but only pregnancy tests and ANC or PNC care were offered. While such NGOs in Dhaka and Bandarban refer women to appropriate MR facilities, care providers in Sylhet offer to have the MRs done privately.

The NGO clinic in Bandarban is situated in the compound of MCWC, which is often a matter of three to five days expedition, costing a huge amount of money for food and accommodation. Diagram 1 and 2 show that a number of cases went to the NGO clinic overcoming all these barriers, though there is a THC nearby where the paramedic/FWV carries out MR even beyond the legal period. However, this paramedic carries out MRs only when she sits in the THC, which is often once a month. This complicates the matter for a lot of women and seeing no other options, they travelled over to the district town instead.

Diagram 1 shows that six women went for DNC as their MRs were not completed and this was found across the sites where women sought care from different health care providers and had incomplete MR. It is evident that the majority of DNC cases resulted from having their MRs done in government facilities.

For easy reference and understanding, this table (Table 6) provides a list of all the care providers who carried out MRs of the study participants found in four study sites.

Table 6: List of providers with whom MR was carried out by the informants

Sites Providers	Dhaka (N=6)	Sylhet (N=6)	Shatkhira (N=8)	Bandarban (N=7)	Total (n=27)
NGO Clinic	3	-	-	2	5
THC	-	-	1	3	4
FWC	-	-	2	-	2
Paramedic	2	1	1	2	6
Pharmacist	-	1	1	-	2
Private clinic	1	-	1	-	2
TBAs	-	1	-	-	1
Other informal	-	1	2	-	3
Herbalist	-	1	-	-	1
Homeopathic	-	1	-	-	1

4.8. Legal period of MR and gestational age when MR was sought

Table 7 shows that most of the MR, irrespective of all fields, took place beyond the legally stipulated two-month limit. Histories of MR cases suggest that MRs were done in more early gestational period in Dhaka than other three sites where it went up to as late as 7 months of gestational age.

Table 7 also shows that woman who wanted to do MR but failed, tried to do it as late as the 7th months of pregnancy. On an average, gestational ages of these women in Dhaka, Sylhet, Shatkhira, and Bandarban were 3.6, 4.7, 5.5, and 3.8 months respectively. Women those who wanted to terminate their pregnancies during the 7th months of pregnancy (Dhaka and Shatkhira) were atypical cases in the sample. One of them wanted to terminate because her husband forced her to do that by giving her divorce threat and the other woman's husband wanted to wait until the 7th month of the pregnancy to know the sex of the child and then went for termination.

Table 7: Gestational age when MR was done or sought

Status Field sites	Months MR done by cases	Months until MR tried by cases
Dhaka	*N=6 (ave. 2.9) 2 months: 1 Case 3.5 months: 2 Cases 4 months: 3 Cases	*N=6 (ave. 3.6) 1.5 months: 1 Case 3 months: 3 Cases 4 months: 1 Case 7 months: 1 Case
Sylhet	*N=6 (ave. 3.6) 3 months: 3 Cases 5 months: 2 Cases 6 months: 1 Case	*N=6 (ave. 4.7) 3 months: 1 Case 5 months: 5 Case
Shatkhira	*N=8 (ave. 4.2) 1 month: 1 Case 4 months: 3 Cases 4.5 months: 1 Case 5 months: 2 Case 6 months: 1 Case	*N=7 (ave. 5.5) 4 months: 1 Case 5 months: 2 Cases 5.4 months: 1 Case 6 months: 2 Cases 7 months: 1 Case
Bandarban	*N=7 (ave. 3.5) 2 months: 1 Case 3 months: 3 Cases 4 months: 1 Case 4.5 months: 1 Case 5 months: 1 Case	*N=6 (ave. 3.8) 3 months: 2 Case 3.5 months: 1 Case 4 months: 1 Case 4.5 months: 1 Case 5 months: 1 Case

Most women in Dhaka, Sylhet and Bandarban and some women in Shatkhira, regardless of MR success and MR failure cases, did not know about legal period when MR should be done. One woman from Sylhet says that there is no such propaganda from the Govt. as she said,

"The Govt. has provided the 'Maya bori' (birth control pill) to control the pregnancy. Now, if you want to take a child, you do not take the bori and if you do not want to take a child, you take the bori. The Govt. has told to take two children. Govt. does not tell you to terminate the pregnancy."

Some women said that it could be between 2 to 3 months and some said that it could be until 3 to 4 months as they saw providers doing it during this time. Women said that they never heard about or read about anything regarding this legal period of when and when not MR should be done. Some women said that they heard from some providers that it should be done between 2 to 3 months, however, when the same providers carry out the MR even during the 7th month of pregnancy, then they consider that there is no legal period for doing the MR. One women from Dhaka in this respect said,

"I did not do it (MR) not because it was beyond the legal period. I never heard about any legal period of doing the MR. Those with whom we do the MR, say that it should be done between 1.5 to 2 months."

Another woman form Shatkhira said,

"Only those, who conduct the MR for us, would be able to say about this (the legal period)."

Another woman from Shatkhira said,

"I do not know about the legal timing. The doctor say that it should be done before 2 months, however, they do it beyond 2 months."

However, women in general, as described in previous sections, perceive that pregnancy termination should be done up to 2 to 3 months since feotous develops different parts of the body and that it gets life in it after that period. Women said that the feotous is like a 'clot of blood' before two to three months and therefore it is safe for the mother as well as from religious point of view to do the MR during that time.

Surprisingly, at least half of women in Shatkhirā knew the legal period of doing the MR and they said that it should be between 6-10 weeks of gestational period. Interestingly, most of these women were MR failure cases who sought care for MR at the very late stage. These women informed that they knew this from Shushilon (the NGO working in this area on MR) and some women said that they received a book from this NGO where this legal period of doing the MR is written down. One woman even knew that MR could not be done before one month since the blood (the product) is not mature enough to come through the process as she said,

"Blood forms in clot (embryo) when it is 80 days of age and it could be done only when the blood clots."

One woman from this region said,

"I do not know about govt. But I know from Shushilon that MR should be done between 6-10 weeks."

4.9. Reasons for rejection

4.9.1. MR success cases

Seven of 27 women who availed MR were rejected from formal health care facilities for over gestational period. Among these seven cases, one was from Dhaka (case 4, Diagram 1) and two were from Sylhet (case 8 and case 10, Diagram 1) with the 3rd, 5th and 6th months of pregnancy. Case 4 and case 10 were rejected from an NGO clinic and case 8 was rejected from THC. After rejection, case 10 did MR with an informal care provider while case 4 and case 8 were offered services by the same paramedic who conducted the MR at home.

Among the remaining four of seven cases, one was from Bandarban (case 27, Diagram 1) who went to MCWC where she was not directly rejected but the paramedic wanted 6,000 BDT to terminate the pregnancy at the 4th months of gestational age. The couple returned there after one month and by the time, it was the 5th months of her pregnancy. They managed to do the MR with 2,000 BDT with another paramedic whom they met in the same hospital compound. The remaining three cases were from Shatkhirā (case 14, case 17 and case 20), who were rejected from either THC or FWC at their gestational age of 4th, 5th and 6th months respectively. Interestingly, all three were later offered MR with high prices, which they could not avail and ended up doing MR with informal providers and pharmacists. Case 20 was not only rejected for over age of the foetus but for having two previous MR histories, which the care provider knew and counseled her not to do it for the third time since she may face severe side effects.

4.9.2. MR failure cases

Twelve of 25 cases, those who failed to do MRs were rejected for over gestational age from the formal health care providers/facilities. Among these 12 cases, one was from Dhaka (case 2 of Diagram 2) and one case was from Sylhet (case 10 of Diagram 2) and they had 4th and 5th months of gestational age respectively. Both cases were rejected from the Go- NGO clinics. In case of the first woman in Dhaka, care provider was so reluctant to have her MR at this gestational age that they lied to her and said that the pregnancy was already terminated since she had already tried various medicines at home and from pharmacists. To confirm this, she did an ultrasound and figured that they were lying. By that time, however, she decided to keep the baby and stopped looking for any further care. The NGO care provider referred the second case, which was from Sylhet, to Sylhet Medical College Hospital. They went to nearby THC from where she was rejected once again for the same reason. At this point, they gave up seeking any further treatment and kept continued the pregnancy.

Among the remaining 10 of 12 cases, four were from Shatkhirā and six were from Bandarban. The gestational ages of the Shatkhirā cases (case 13, case 14, case 17, and case 19 of Diagram 2) were 4th, 5th, 6th and 7th months. The first case (case 13 of Diagram 2) was offered the services privately with 200 BDT for each gestational month. She did not have the money while she needed 800 BDT. She went back home and by the time, she managed the money, it was already the 6th months of her pregnancy. She went to the paramedic's house, where she was counseled against it. At this point, she gave up the idea of having MR and continued her pregnancy. Case 14 of Diagram 2 went to several places and had severe side effects before she was actually rejected from the THC. They tried again during the 5th month when they were

rejected again from a private clinic and finally, the couple decided to keep the child. Case 17 identified pregnancy at around 5.5 months and was rejected from different formal facilities. Lastly, case 19 of Diagram 2 was a special case, who did not want to abort the child and her husband wanted to do it until at the 7th months of pregnancy when the ultrasound results showed that it would be baby boy.

Among the six MR failure cases in Bandarban, in one case (case 21 of Diagram 2) a Field Worker told the woman that she would be rejected for her gestational age, so, she did not try any further. Two of the cases (case 22 and case 25 of Diagram 2) were rejected at the THC as they were both beyond the 4th months of gestational age. One of them (case 22) gave up seeking for further care since her husband was not agreeing to do MR and another case further went to another NGO clinic which did not provide such services and upon their counseling, she gave up seeking further care. Two more cases (case 20 and case 23 of Diagram 2) were rejected at the NGO clinic at the district town for the gestational age. One (case 20 of Diagram 2) of these two cases was in very remote area during *Jhum* cultivation and she was at her 5th months of pregnancy when she sought MR there and the other one (case 23 of Diagram 2), after trying various methods for terminating pregnancy, went to an NGO clinic and got rejected there for the same reason. Case 24 was a very different case that went to MCWC for ligation and figured out that she was pregnant for three months after going through the procedure (Ligation). She wanted to terminate that pregnancy, but the care providers wanted a huge amount of money that she could not afford.

4.10. Physical consequences

Both sets of women, MR success and failure cases, faced a plethora of side effects after doing MR or taking medications for MR. Table 8 below shows that women who could avail MR, developed more side effects than cases who failed to get MR. Data suggests that women suffered from more than one syndromes at a time as a consequence of having or trying to have MRs.

Table 8: Side effects due to MR (MR success and failure cases)

Side-effects	Field sites				Total	No. of women who failed MR				Total
	Dhaka	Sylhet	Shatkthira	Bandarban		Dhaka	Sylhet	Shatkthira	Bandarban	
Bleeding for 1 week	1	-	-	-	1	-	-	-	-	0
Bleeding for 2 weeks	-	3	1	-	4	-	-	-	-	0
Bleeding for 3 weeks	2	1	3	2	8	-	1	2	-	3
Bleeding for 1 month	-	1	1	-	2	-	-	-	-	0
Bleeding for 3 months	-	-	-	-	0	-	1	-	-	1
Unconscious with heavy bleeding	-	2	-	1	3	-	-	-	-	0
Convulsion for a few days	-	-	1	-	1	-	-	1	-	1
Lower abdominal pain	2	2	3	-	7	1	-	2	-	3
Weakness	-	1	1	-	2	-	1	2	-	3
Dizziness	-	1	-	1	2	-	-	1	-	1
Lost appetite	-	-	1	1	2	-	-	1	-	1
Prolonged body-ache/ burning sensation	-	-	2	1	3	-	-	-	-	0
Vomiting during bleeding	1	-	1	-	2	-	-	-	-	0
Fever	-	-	1	-	1	-	-	1	-	1
Pain/burning sensation in the vagina	1	-	1	-	2	-	-	-	-	0
Infertility	-	-	2	-	2	-	-	-	-	0
Injury in the uterus	-	-	1	-	1	-	-	-	-	0
Sever pain during sex/Dyspareunia	-	-	1	-	1	-	-	-	-	0
Infection/sore in the vagina	-	-	1	-	1	-	-	-	-	0
White discharge	-	-	1	-	1	-	-	-	-	0
Headache	-	-	1	-	1	-	-	-	-	0
Heavy feeling in lower abdomen	1	-	-	-	1	-	-	-	-	0
Pain in anus	1	-	-	-	1	-	-	-	-	0
Weight lose	1	-	-	-	1	-	-	-	-	0
Swollen abdomen for a long time	-	-	1	-	1	-	-	-	-	0
Edema	-	-	-	-	0	-	1	-	-	1
Uterine prolapsed	-	-	-	-	0	-	1	-	-	1

4.10.1. MR success cases

Our data suggest that 21 out of the 27 women who availed MR developed side effects after the procedures and 15 of them had bleeding between 1 to 4 week/s (see Table 8) with severe abdominal pain following the procedure. The severity of bleeding was huge during the initial stage while for some cases, it remained constant for days. Case 12 and case 27 in Diagram 1 became unconscious several times during the first three/four days with severe bleeding and abdominal pain while case 18 in Diagram 1 had recurrent convulsions immediately after the procedure. One informant from Dhaka said,

"Usually, my menstruation stays for five days. However, this time it was for 20 days. I was very scared and informed my mother-in-law about my condition. She was very concerned too. She took me to the clinic and got me medicines..."

Besides bleeding, all these informants suffered from various other side effects as mentioned in Table 8 and some of these side effects lasted for a very long time. Case 15 in Diagram 1 had been suffering for the last five years after getting MR done at an FWC. The following case (Case study 3) depicts her condition.

Data suggest that only 6 of 21 informants, who had side effects, had their MRs done from non-formal (specially unskilled and traditional) care providers. The remaining 15 cases sought care from either an NGO clinic or a government facility or a private clinic or an unauthorized but skilled paramedic. The following case (Case study 4) depicts a scenario of side effect management and care seeking.

Case study 4: Managing costs for treating side effect

This woman carried out three 3 MRs in her life and the last one was during 5th months of gestation. Once she identified the pregnancy, FWC provider gave her some tablets which made her suffer with severe lower abdominal pain the next 3 days. A homeopathy doctor was consulted for the pain and it did not work. Later the couple sought care with a pharmacist who gave her two tablets to be taken and another two to be inserted into the vagina. She used the tablets accordingly and started bleeding during the night, and she bled for the entire night and the following day. The pharmacist was called next day, which provided her some medicines which lessened her bleeding and pain a bit. However, she was having severe side effects during the next one month: weakness and severe pain in the vagina with bad odor, which affected her HH chores and her work as a school teacher. She was confused if the pregnancy was terminated. She went to the nearby THC and had a pregnancy test done which showed a positive sign. The FWV there examined her, heard her experiences with the pharmacists and said that her child was dead inside the abdomen and she needed a DNC, but before that she needed her vaginal infection cured. She was given high antibiotics for 7 days and then she had the DNC. She said that she had pain even after the DNC and she had to take high antibiotics for a long time. She said, ***"I was having severe pain (in the vagina). I could not walk or stand properly. She gave me high antibiotics. Each antibiotic costs 17 taka and I have to take three of them each day. Still then I was having severe pain. I used to work slowly and go to school in slow pace. After taking those medicines for one and a half months, I got cured."***

Case study 3: Infertility, violence, and side effects

She got pregnant during her LAM period and had an MR at FWC during 1st month of gestation. She developed bleeding and spotting after the MR and it continued for next 1.5 months. She used to have pain with heavy bleeding during intercourse and consequently affecting her marital life, HH chores and social life. She later had a DNC. Her bleeding stopped after the DNC however; she still used to have pain during intercourse. Over time, her physical difficulties increased. It's been five years and since last year, she became bed-ridden for having severe pain, infection in the vagina and severe itching and severe weakness. Her pain during intercourse was, sometimes, so severe that she cried loudly. Both natal and in-law's house families were very poor and they tried to manage treatment for her which was often not adequate for a complete diagnosis. Her natal families often managed money for her treatment to save her marriage. In-law and husband never spent any money on her. She said, ***"Now a day, the pain is even severe. It feels like my lower abdomen is going to burst when I have sex with. I cannot walk and do chores during the next 5-6 days after having intercourse. My husband does not care about my condition...he made me sleep whenever he wants. My mother and father-in-law know this. They bring me pain killers after the intercourse. I feel less pain if I stay without sex."*** She was taken here and there and nothing cured her suffering. Recently, in-laws families took her to a doctor with the money taken from her poor natal family once again. Doctor informed that she developed an inverted fallopian during when she did the MR 5 years back and developed severe ulcer over there. He suggested 6 months' medicines and a surgery of the uterus if the medicine does not work. She had been using FP pills on and off and doctors suggested her to drop the method, which might automatically reverse the condition of the fallopian tube. She had been trying to get pregnant since last five years but failed. She dropped using methods but, could not continue the prescribed medicines due to financial instability. Her husband started maintaining an extra marital relationship recently and she said, ***"If women deny sex, men become desperate. Men will go to other women in a condition. Since I have pain during sex, I reject him. He became so bad tempered since then. I cannot make him happy. So, he is maintaining relation with other women."*** Husband recently threatened her that he would get married again. People talked about her MR and she felt very uncomfortable about this. Her in-law's family was annoyed about her physical complexes too. She said, ***"My mother-in-law says that other women abort more than 2-3 pregnancies, and they don't feel problems. I just aborted one and I am having so many physical problems."*** Natal family wanted her to get pregnant again and this was an add on mental pressure on her since her treatment (surgery) would make her infertile which finally would ensure his husband's marriage. She said, ***"Doctor advised for intercourse (which was very painful) and said that I can be pregnant only if God wants."***

4.10.2. MR failure cases

Among the MR failure cases, side effects were more prevalent in Sylhet and Shatkira than other two field sites as Table 8 suggest and a huge number of women took different types of herbal and biomedical medicines from pharmacists in all four sites.

Data suggest that 9 of 25 women who failed to avail MR services suffered from different types of side effects. Four out of these nine cases had bleeding. Case 11, case 14 and case 15 of Diagram 2 had bleeding for around three weeks while case 8 (Diagram 2) had bleeding for 3 months. On the other hand, case 15 had convulsions with high fever after attempting MR and the pharmacy provider kept on providing her medication one after another but it did not help. Bleeding was severe during the initial stage as these women mentioned. All these four cases that had bleeding, took misoprostol from pharmacists along with other treatments such as medicinal roots from the TBA and homeopathic medicines for the procedures. Case 11 had bleeding with uterine prolapse after inserting the medicinal plant while other three had bleeding after using the medicines from pharmacists. Women with bleeding suffered from other side effects as well during the same time.

Several women who failed to have MR and developed side effects for the procedures they adopted to terminate the pregnancy, remained untreated due to economic constraints.

4.11. Post MR counseling

Table 6 shows that 19 out of 27 MR cases were carried out with biomedical care providers (authorized or unauthorized but skilled) and 8 cases carried out MRs with traditional and unskilled care providers. With all of these informants, the nature of post MR counseling and its compliances was explored. Findings suggest providers, irrespective of types, asked their clients for follow-up visits or call them if any complications arose. However, most women did not go for a follow-up visit. When asked about follow-up visits, a woman who developed bleeding after the procedure, said,

“Why would I call her? Do I need to call her for this? She was supposed to give the treatment to terminate pregnancy and she did her job. Why do I call her for this problem?”

When the MR was carried out with bio-medical formal healthcare providers, there was a tendency to return to those providers when there were side effects. However, in some places and with some informants, distance was a huge factor. This was an obstacle for them to return to the same care providers for post MR follow-up visits. In such cases, they consulted near-by health care providers.

Besides asking women to return for follow-up visits during immediate post-MR period, data suggests that informants hardly received any post-MR counseling in any field sites, except in Dhaka slum. Most women carried out MRs with an NGO clinic in Dhaka and health care providers counseled them on restricting heavy chores and intercourse for 15 to 30 days. They also provided painkillers along with antibiotics. NGO services were available in other areas too, but women did not find such extensive level of counseling anywhere else.

Table 6 suggests several women carried out MRs in the government facilities, however, post-MR counseling at those government facilities were all but absent. Some women talked about receiving some medicines, but not much in the way of counseling. Only one woman from Shatkira talked about counseling from a government facility. She said,

“Yes, they discussed with me that I should not have sex for 15 days...they also told me not to carry big water pot and heavy things for one month. I told them that I will tell my husband to not to come to home for one month and I will manage a woman to do heavy things for me.”

One informant in Bandarban, regarding post-MR counseling, said,

“No, they did not give me any suggestions. They did not provide me any medicines either. They did not inform me how I should take care of myself at home afterwards.”

Unfortunately, there were no comprehensive suggestions on adopting family planning methods after MR either – not even in the NGO clinics in Dhaka. Data suggest that only three women who said they were

asked to adopt FP methods but even then, they did not receive any definitive suggestions. A number of methods were suggested however, feasibility and the convenience of using the methods for a particular client was not usually discussed. One woman from Shatkhira said,

“They told me that I could take injections. They also told me that I could use pills too or take capsules (implant). They told me about following the natural method as well...”

4.12. Cost for MR and economic consequences

Managing the cost for MR was one of the main barriers for women/families/couples. Table 9 shows not only MR cases, but women who failed to do MRs also spent a lot of money for the services they wanted. The table also shows a wide-ranging difference between fields in terms of expenditures. For instance, while the cost was 3,000-6000 BDT for the entire process including food, accommodation and transportation in Bandarban, it was between 100-1500 BDT for most of the informants in other three sites. Data suggest the lowest cost in Shatkhira and the highest in Bandarban for MR services. Costing for MRs was very different in every field and therefore, each field’s result was described separately.

Table 9: Cost spent by women/families on MR care seeking

Sites Cost (BDT)	Women who availed MR (n=27)				Women who failed to avail MR (n=25)*			
	Dhaka (6)	Sylhet (6)	Shatkhira (8)	Bandarban (7)	Dhaka (4 of 6)	Sylhet (6 of 6)	Shatkhira (5 of 7)	Bandarban (2 of 6)
100-500	2	2	1	-	3	2	3	-
600-1000	1	-	1	-	1	1	-	-
1100-1500	2	-	2	2	-	-	-	-
1600-2000	1	-	2	-	-	-	1	-
2100-2500	-	-	-	-	-	2	-	-
2600-3000	-	-	-	-	-	-	-	1
3100-3500	-	2	-	1	-	-	-	-
3600-4000	-	-	1	-	-	-	-	-
4100-4500	-	-	-	-	-	-	-	-
4600-5000	-	-	-	2	-	1	1	1
5100-5500	-	-	-	-	-	-	-	-
5600-6000	-	1	1	-	-	-	-	-
6100+	-	1	-	2	-	-	-	-

* Of the 25 MR failure cases, 17 had to spend even if they failed to do MR

4.12.1. Kamalapur, Dhaka

Managing the cost for MR was very hard for women in Dhaka for both MR success and failure cases. Many women took loan or loan with interests for doing the MR and side effect management. Many women still could not repay the loan that they took from others for having the MR or pay the installment that they owe to the clinic where MR was done. One woman said,

“He (husband) said he will not give me any money and therefore, I will not be able to do it (MR). However, I thought I would beg for the money to abort... that is more important for the survival of my present one.”

Another woman said that she had to take a loan of taka 1,000 BDT of which 600 BDT was for MR and 400 to buy medicines for side effects. Some woman sold their gold ornaments, wedding sari and their daughter’s silver anklet to manage the money for MR and side effect management. These women were very upset thinking about their precious assets.

4.12.1.1. MR success cases

In Dhaka, costs for MR varied among different NGOs. As Table 9 shows, two cases spent around 500 BDT; one spent around 1,000 BDT and the other three cases spent between 1,000 BDT - 2,000 BDT.

Data suggest that two cases (case 1 and case 2 of Diagram 1) did MR in a local NGO clinic during their 3rd months of gestational age. These women went there with MR volunteers who took them to that particular clinic. Case 3 of Diagram 1 said that before going to the clinic (government collaborative NGO), another volunteer offered her to do MR for 5,000 BDT for her third month’s pregnancy. She refused and contacted her neighboring MR volunteer who took her to a clinic that wanted 900 BDT where she could manage it

for 600 BDT after bargaining with them. The volunteer also bargained and arranged a payment plan with the care provider, which the client paid in installments. This woman said,

"You can bargain with them and whatever they will get from me, they will give her (MR volunteer) some portion of it."

Case 4, case 5, and case 6 of Diagram 1 carried out MR either with private clinic or with a paramedic. Case 4 was rejected by an NGO clinic but took the woman to her house and did MR there. Case 6 said that she knew she would have a cheaper rate for MR if she went to the NGO clinic, but she decided to go to a distant place instead in order to keep it secret from the people of her vicinity. When asked about the charges in that clinic and what type of clinic it was, the woman said,

"They say they are government facility. If so, then why would they take money? They charged 200 taka for each month of pregnancy. If you are 1 month pregnant, they will take 200 taka, if you are two months' pregnant, they will take 400..."

She further mentioned that there were options for various types of procedures.

"They take more money if they do it by making you senseless... procedures for which they take 3,000 taka. For the poor, they charge 300/400 or 500 taka. Those who cannot take pain, carry out MR with high prices."

4.12.1.2. MR failure cases

Among the MR failure cases in Dhaka, three cases spent around 500 BDT and this money was particularly for buying medicines from the pharmacist and other service providers and for transportation.

An NGO clinic rejected a case (case 2 of Diagram 2) since she was on her 4th months of pregnancy. She was then asked to go to Dhaka Medical College Hospital, but she decided not to go there since it would cost her even more than what her husband could afford at that time. No one else agreed to perform the procedure either. She said,

"I wanted to go to Dhaka medical Medical Collage where I could get free treatment. But apa (MR volunteer) said I would need transport cost in addition to the cost for medicines which might cost me 1,000 taka. Hearing all these, he (husband) told me to stop this...He did not have a job at that time...."

Another woman (case 3), who wanted to abort her child at the 7th months of pregnancy, agreed to provide 3,700 BDT to a pharmacist who demanded 8,000 BDT based on her gestational age as the process would require a surgery which she denied. She said,

"To my understanding, my pregnancy was not going to be washed since it (the foetus) was already too big. I thought he would do a surgery and, therefore, he wanted such a big amount."

4.12.2. Kanaighat and Zakiganj, Sylhet

Managing the money for all the cases for doing the MR was a huge burden in Sylhet and many informants in the MR failure group could not avail it due to economic constraint. Many cases' side effects remained untreated because of the same reason. Most of the families had to borrow money from others to initiate the care outside home. One informant's husband said,

"You have to do whatever is required. Like I had to take a loan and still have 10-12 thousand taka to pay back..."

4.12.2.1. MR success cases

In Sylhet, the actual cost for MR was very low (~ BDT 300 to 500 BDT) for two cases which was done with traditional care providers and pharmacists (refer to Table 9). However, the remaining four cases ended up spending around 3,000 BDT to 6,000+ BDT and data suggested that this amount included expenditure for side effect management.

Data suggest that two cases (case 7 and case 12, Diagram 1), on their 3rd and 5th months of pregnancy, refused to do MR from the paramedics of the NGO clinic when it demanded 2,000 BDT. Both women ended up having MR with unskilled care providers (one with herbalist and one with a pharmacist) and

developed wide range of side effects. These women carried out the MRs with only 300 to 400 BDT but they remained untreated for their side effects since they did not have the money for the treatment.

Diagram 1 suggests that case 8 did her MR with a paramedic once she was refused from the THC and it was at her the 6th months of gestational age. She did MR with a very high price, which was 3,000 BDT. This woman managed this money by selling her nose pin. She had severe side effects, for which she had to spend another 4,000 BDT eventually.

Three remaining cases (case 9, case 10 and case 11) carried out their MRs with unskilled and traditional care providers. All these three cases were at their three to 5th months of gestational age and developed side effects, one requiring DNC and spent around 3,000 to 6,000 BDT for its management.

4.12.2.2. MR failure cases

Among the MR failure cases in Sylhet, three women spent 100-1,000 BDT who sought care with different traditional and unskilled providers. The remaining three cases (case 8, case 9, and case 11 Diagram 2) spent somewhere between 2,000 - 5,000 BDT which included cost for side effect management as well. All except one case (case 7) among the MR failure cases in Sylhet, either went to an NGO clinic or THC or both as Diagram 2 suggests. Unfortunately, all of them were asked to pay a huge amount of money at those facilities (~ 2,000 to 3,000 BDT) five of whom went there at their 5th months of gestational age. All five of them refused to take services from there and as Diagram 2 shows, some stopped seeking further treatment (case 8 and case 10). One informant, who was asked to pay 3,000 BDT by an NGO provider, said,

"They heard that I have taken many medicines and therefore they wanted 3,000 taka. He (husband) got scared as he had only 500 taka. They denied taking even a single taka less. Then he told me to keep the child."

Another woman who was rejected from a Govt. facility, said,

"They wanted 3,000 taka. We were starving during that time ...how would we manage 3,000 taka to terminate it? We requested them to reduce a bit, but they did not..."

4.12.3. Shyamnagar, Shatkhira

In Shatkhira, costs for MRs varied a great deal since women went to different care providers. As of Diagram 1 and Diagram 2 suggest, a number of women sought care with pharmacists and data suggest that these pharmacists provided them misoprostol at 90 to 120 BDT for 4-6 tablets while sometimes they prescribed them double dosages that increased the cost two folds. One case (case 20, Diagram 1) spent 800 taka with the pharmacist who provided her misoprostol on several occasions.

In this site also, managing money for MR was very hard for women and their families. Many families took loans, which they could not repay even after two years. Many informants said that they were trying to do extra work to repay their loans. One woman said that they had to sell their crops for two years to repay the loan that had huge interests on it. The husband said,

"What can I do about the cost? Initially, I gave 90 taka to buy the medicines. Then I managed more money (took a loan) for the termination. Before even repaying those loans, we had to spend a huge amount of money for her treatment. She needed to give saline and injections as she did not have any blood in her body (after doing the MR). I took loan once again. There is not much to do in this area since it has been severely affected by the cyclones.... I did not have money when she needed it. It took more than one week to manage that money which delayed the process...."

4.12.3.1. MR success cases

Diagram 1 show that 3 cases (case 15, case 16, and case 18) did their MRs in at FWCs and THC. One case (case 15) did MR at FWC with a very minimum amount of money, however, she had to go through a DNC and ended up with severe side effect and has been suffering for the last five years. This woman now even does not know how much was spent so far. Case 16 and case 18 spent around 1,000-2,000 BDT in governmental facilities at their 4th and 4.5th months of gestational age along with one spending around 2,000 BDT in a private clinic for DNC.

Diagram 1 shows that two women from Shatkhira (case 17 and case 19) carried out MR with informal providers and both spent around 1,100 BDT for the procedures whose gestational age were 4th and 5th months. Case 17 was asked to pay 2,000 BDT at the THC, which she denied. She said,

"She (the care provider) said, I will need 2,000 taka for MR. I returned home since I did not have the money. She said, I was already on my 4th months, and that it would require that much..."

On her way home, this woman was taken to an informal care provider's place where she could manage to do the MR with a lesser amount. The informal care provider put a medicinal plant which made her bleed severely for a long time. She sought treatment for it and had to go through a lot of hardship as a result.

Case 13 and case 14 spent 2,000 BDT who sought care from a paramedic or a private clinic at the gestational age of 4th and 5th months respectively. One spent another 4,000 BDT for DNC. Diagram 1 shows that both cases went to different providers before they actually did it and the cost excluded all those expenses.

4.12.3.2. MR failure cases

Table 9 shows that five cases had to spend money, despite the fact that they did not even get their MRs done. Two cases (case 13 and case 17) did not have to spend anything since they were rejected due to their 6th and 5.5th months of pregnancy. They did not seek any further care either.

Three cases (case 15, case 16, and case 18 of Diagram 2) spent between 100 to 500 BDT. Two of them (case 15 and case 16) spent on misoprostol and one (case 18) went to THC but returned since the care provider demanded 1,000 BDT from her.

Two cases (case 14 and case 19) spent around 2,000 and 5,000 BDT. Case 14 spent a little amount of money to buy medications from pharmacist but spent 5,000 BDT while she had to be admitted at the hospital for side effect management. The other woman went to various places till the 7th months of her pregnancy and ended up spending a lot for ultrasound and other things.

4.12.4. Thanchi, Bandarban

4.12.4.1. MR success cases

Bandarban is a hilly terrain and the health facilities were far away from many of the settlements. Though THC was close for a lot of people, they did not know about the cost there. Besides, the care provider only sites there once a month at that facility. Informants (case 21, case 23, and case 24, Diagram 1) who did MRs with her in THC said that they gave 1,500 BDT (gestational age: 2-4 months) for doing the MRs with her. None of them knew if the cost went up with gestational age, as it did in other field sites.

Data suggest that care providers did MRs within the health complex. One of these three cases (case 24, Diagram 1) had to go through DNC at MCWC for which she spent another 5,000 BDT (approx.) for treatment and transport. It should also be noted that all of these informants had to bargain to fix the price.

Among the remaining four cases, one (case 22 of Diagram 1) did MR in an NGO clinic that collaborates with the government institution when she was at her 3rd months of pregnancy. She only had to pay for food and accommodation, but not for the procedure itself since she was within the 3rd months. Two cases (case 25 and case 26, Diagram 1) spent around 5,000 BDT which included the cost for MR, travelling, food and accommodation. Doing MR in the District town means that a family needs to make travel plans for several days for almost the entire family including food and accommodation for all. These families said that they lost valuable cultivation time in the process. One husband said,

"I could not do it (cultivate land). But what is the point of saying that. You have to do whatever you have to do."

The last case spent at around 6,500 BDT and this informant had to go to District town twice, which made the cost huge. During the first time, the care provider at the government facility asked for 6,000 BDT (she was on her 4th months of pregnancy then). They came back as they did not have that money. They took another month to save money and could manage only 1,000 BDT and carried out the MR with a paramedic whom they met at the corridor of the hospital. This paramedic also wanted 2,000 BDT and it

was during the 5th months of pregnancy. The woman said that her husband had to sell a pig and borrow money from a couple of different sources to arrange the money.

4.12.4.2. MR failure cases

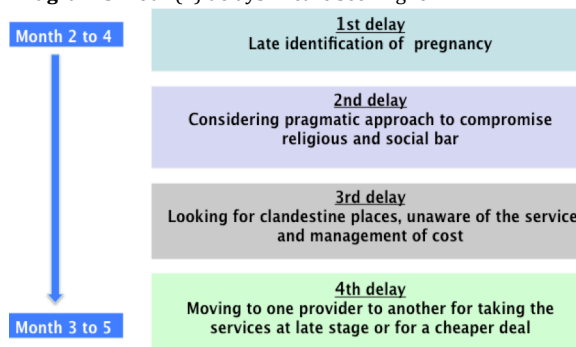
Table 9 shows that two (case 20 and case 23, Diagram 2) of the six MR failure cases in Bandarban had to spend 3000-5000 BDT even without getting MR and these cost were spent mostly for transportation. One case (case 23) spent a lot of time trying different care providers nearby and ended up spending quite a bit.

Four of the six MR failure cases did not spend any money since care was not sought. One of these four (case 21) said that she knew she could have done the MRs for free in the NGO clinic in the district town, however, she would need 3,000 BDT to travel including food and accommodation for her and the accompanied persons. This amount was beyond her capacity to manage. In addition, she learnt that she might be rejected since she had a late gestational pregnancy. Two cases did not have to spend money even for travelling since they went up to THC.

4.13. Reasons behind delays in care seeking

From the discussions above, it shows that careseeking has been delayed for various reasons and at various stages. Table 7 shows that women did MRs or sought MRs during a very late gestational period. Data suggest that women faced a lot of barriers in terms of care seeking for MR services. Identifying the pregnancy at a later stage remained one of the barriers behind late care seeking. Besides these, moving from one provider to another delayed the process of care seeking as well. Decision making process around MRs within the family considering the social stigma and religious barriers and trying to do it at home with pharmacists or other informal and traditional providers or at a distant facility so that no one would know about the incident, also played a great role in delaying the process, though this resulted into having serious health hazards for women. Managing the cost was one of the main barriers, which delayed the process irrespective of sites and with just about all the cases. The Diagram 3 above shows how the delays took place for most of the women though there were many women whose delay was more than what this Diagram shows.

Diagram 3: Four (4) delays in care seeking for MR



As Table 6 suggests, most women had their MRs done with skilled providers (19 of 27), but these skilled persons were not always the authorized providers since they not only carried out MRs beyond the legal gestational period but also did it at their residences in an unhygienic condition. Fear of medical procedures also delayed proper care seeking and prompted women to seek care with informal providers.

Reasons behind delays in care seeking for MR after such late-term of gestational period included couples' striving for finding the right kind of care when they spent most of their precious time. A frustrated woman in Dhaka exclaimed,

"I went to 14 hospitals and took 20-25 types of medicines for this incidence (MR)."

One woman from Bandarban said,

"I took the decision during the 3rd month to abort the child. During the 4th month, I went to Bandarban and talked to them and they asked for a huge amount of money. Then I came back thinking that how would I manage such a big amount of money. Then I thought how I would rear all these kids in such economic hardship. I went there the next month. So, you can see that I spent months just thinking about these things!"

Delays in care seeking also took place for various other reasons, such as, preferences for child with specific sex, though in very few cases.

4.14. Perceptions surrounding MR as a family planning method

In Dhaka field site, there is often a debate in various different circles as to whether MR is treated as a birth control or a family planning method. Data suggest that women, who went through the process, do not think it as an FP method. According to them, it is something that is done in order to address a concern in a given situation. It is a way out of an unplanned pregnancy. However, some providers seem to think that women do perceive it as an FP method. They said that women would like to avoid the hassle of taking pills every day, avoid having post-injection spotting, etc. and that is why they go for MR.

Given the nature of MR practices, it seems people in Sylhet and Shatkira field sites use MR as an alternative family planning method. Repeated MRs in one's life, reluctance to adopt more permanent methods of FP, etc. also indicates that MR is taken as part of Family Planning Programme. This is further confirmed by the notion when they mentioned about misoprostol, as a kind of a pill that regulates the menstruation. However, people do make a distinction between taking pills and having a procedure like MR: FP methods stops women from becoming pregnant, while the MR is a response to unwanted pregnancy. Similar perceptions were revealed from the Bandarban field site as well. One woman said,

"It is better to take pills than to murder a child."

However, providers in these two fields do not seemed to be too keen on the difference between MR and FP, if there was any. One herbalist provider from Shatkira, said,

"MR is a family planning method because the herbal medicine that I provide takes only 25-30 minutes for termination, it reduces the responsibility of having the medicines every day. For this reason, women would like to take this medicine. It is a quick relief or remedy from an unplanned pregnancy."

4.15. Health system surrounding MRs

The following table shows the MR service providers in different sites interviewed in this research. As the table shows, the list included different care providers ranging from traditional to biomedical and skilled to unskilled categories, who are involved in providing MR services in the communities.

Table 10: List of health care providers interviewed

Provider	Sites	Dhaka	Sylhet	Shatkira	Bandarban	Total
Formal providers						
Residential surgeon (MCH)		-	1	-	-	1
Register, Gynecology Department, (MCH)		-	1	-	-	1
NGO clinic manager/Centre manager (GO-NGO)		-	2	-	-	2
MR counselor (Govt. collaborative NGO)		1	-	-	-	1
Medical officer (Govt. collaborative NGO)		-	-	-	1	1
Senior Staff Nurse (THC)		-	1	-	-	1
FWV (FWC)		-	1	1	-	2
FWV (THC)		-	-	1	1	2
FWV (MCWC)		-	-	-	1	1
GO-NGO paramedic		1	1	-	-	2
Other NGO paramedic		2	-	-	-	2
Paramedic (Private clinic)		-	-	1	1	2
SACMO (THC)		-	1	-	-	1
Informal providers						
Retired ayah		1	1	1	-	3
NGO's CHW		-	1	-	-	1
Pharmacist		2	8	7	4	21
Other informal		-	-	1	-	1
Traditional providers						
TBAs		-	2	1	6	9
Herbalists/Kobiraj/Ojha		-	-	4	1	5
Homeopathy		-	-	3	-	3
Total		7	20	20	15	62

4.15.1. Formal providers

A number of skilled care providers were interviewed in all fields ranging from clinic managers to different paramedics and other higher officials involved with MR services.

Providers of different NGOs and public facilities clearly define the differences between MR and abortion while describing the time period of MR done in the facilities. Many said that they do not do the MR beyond two months as it would be an abortion. One FWV said,

"We do not do MR beyond two months, it will be then abortion. When the embryo is formed, it does not come with the MR procedures. The embryo then needs to be taken out with abortion."

Similarly one paramedic, denying doing MR beyond two months, said,

"There will be huge bleeding if we do it beyond two months. Then the women need to do DNC and need blood transfusion. We work in the village level. We do not do this. There will be a severe chaos..."

On the other hand, many health providers acknowledged terminating pregnancy even beyond two months and they explained that they had to do this for various reasons. One such FWV said,

"When we do the PV (per vaginal test), we can understand the gestational age of the pregnancy and often we find 6 weeks, 8 weeks or 10 weeks and we arrange the process accordingly as the process is different for different gestational ages. Officially, we are not supposed to do beyond six weeks; however, we do it upto 10 weeks...we do not find patients within six weeks. They try this and that when the pregnancy is identified and by the time they come to us, it is already 10 weeks..."

Similarly, an NGO paramedic said,

"We can terminate pregnancy at three months. But we are not supposed to do beyond two months. Sometimes, we register the patients showing less gestational month and women come to us when they fell into danger. How do we reject them? At best, she will be bleeding a little bit, what else is going to happen to her if she does it in later gestational age...therefore, to save them, we often terminate pregnancy at late months."

Providers in Bandarban said that they receive more clients from poor socio-economic background. Women with more children and couple wanting gap in between childbirths come for MR. The care providers of this region said that "adivasi" women come to them since pregnancy hamper their "Jhum cultivation" which needs them to travel to a distant place with their husbands. On the other hand, health care providers in Sylhet said that they receives a number of women with illegal pregnancies in this religious conservative areas, which often seems very unusual to them as one field worker said,

"There is a proverb in the village...the head is covered while the ass is nude...there are a lot of religious persons here in this area. However, there are a lot of MR cases here as well..."

Another care provider, echoing the same concern, said,

"The rate of MR is very high in Sylhet. I know this from my experiences of working in other areas. Here most of the husbands stay abroad and the brother in-law, the father in-law, and others get the chance to have illegal relationship with the woman. I found mother and daughter was sleeping with the same person. I found father in-law having relationship with the daughter in-law. All these people come to us with illegal pregnancies."

The care providers in Shatkhira and Dhaka also mentioned illegal relationships,

"Sometimes, widows come...there is a college here and a lot of unmarried women come from there too...we have to perform this MRs to save them from society. They also provide a high price for doing this..."

A high official from Sylhet said that they are not supposed to do MR beyond 10 weeks of gestational age. However, they had to carry out MRs to save women from different situations; they receive a huge number of such patients due to high rate of very abnormal cases of illegal relationships. The informant in this respect described two cases to understand the intensity of this situation.

This high-level officials said that they encounters a lot of such cases and considering the social stigma and pressure, they often do MR beyond the legal timing to save women, which they often do not record in the

hospital record register book. Often these cases, the health care provider mentioned, directly go to other informal places risking their health and life. He said,

"Most of the illegal cases go to the private clinic. They also go to the providers who do it at home secretly since it remains secret. ...There cannot be any record if they do it there. The hospital keeps all the records, which is a problem. There are also many brokers waiting outside our facility who tract these patients and take them to these informal and unlicensed providers...."

Case study 5: Clandestine MR – I

A mother-in-law came to the facility with her widowed daughter-in-law who was pregnant for 3 or 3.5 months. Watching the gestational age, health care providers rejected the case saying that they do not do MR for such a late month. The mother-in-law then fell into hauling and described that her widowed daughter-in-law has been pregnant by her husband (the widow's father in-law) and they needed to do MR in any situation to save the life of the daughter-in-law as well as the social pressure on the family. They asked to show them other facilities where they could avail the services since they would have to do it anyway. Watching the condition, the health care providers did the MR.

Almost all the Govt. and NGO high level personnel said that, on an average, they receives 10 to 20 patients per month while they think that the need for MR is even more. A high official from Bandarban said that they receive a number of patients with abortion-related complications and they know that different paramedics as well as traditional care providers perform these MRs. There is this widespread belief among the formal care providers that many paramedics and FWVs, who carry out MR in their houses or other places, use unclean instruments, which results into severe complications over the time.

According to them, seeking care with pharmacists or other traditional or informal care providers often create huge physical consequence on women. Additionally, they mentioned that often the MR is not complete with them and ultimately, women at the end, has to seek care with formal providers. One such high level official said,

"They take a number of medicines from pharmacists. There is no problem if MRs took place with these methods. However, they come to us when the product does not come out entirely and the thing gets decomposed there. When they come with such condition, it becomes hard for us to identify the gestational age... it's like the broken yolk then..."

Care providers from all sites complains about pharmacists' providing different medicines to women which they thinks are causing a number of health problems as another high level physician said,

"Pharmacists provide a lot of medicines to women for MR. Later, these women face a lot of problems and then these pharmacists tell them that they are facing these problems as the menstruation has been regulated and now they need to deal with these problems. Then they give them a huge amount of medicines further. This is how their business runs. They, in- fact, try to do the MR in this way which does not complete the MR rather, cause various problems."

Case study 6: Clandestine MR – II

A mother came to the facility with her unmarried 16 years old daughter to terminate the pregnancy which was around 3-3.5 months. Once the providers rejected for late gestational age, the mother desperately requested them to save them explaining that the daughter went to visit her sister in law few months back where she was raped by her sister's husband. The teenage girl did not share this with anybody out of shame and fear, however, when she got pregnant, her sister, whose husband raped her, understood the condition and send her to natal house without taking any actions. Now that the mother took her to the health facility to abort the child since it would create a huge affect on them. On the one hand the girl is unmarried and on the other hand, the fact that they are from a different religion background (Hindu) where marital arrangement within same caste is a huge issue. Considering all these things, the health care providers in the facility did the MR.

Along with pharmacists, skilled providers also mentioned about other informal and traditional care providers' activities that cause a lot of problem. One informant said,

"...first they (patients) do not want to tell us anything what they did to terminate the pregnancy and we find plant root into the vagina inserted up to this level (showing a four-inch length) when we do the tests."

An NGO clinic provider in Dhaka mentioned about an informal provider who has long reputation in the community and women usually visit her before coming to NGO clinic.

Care providers at all facilities said that they face a lot of barriers carrying out their activities. One of the main barriers is to reach the clients and to motivate them to get skilled services and this is largely due to negative perception towards pregnancy termination. One care provider from an NGO clinic, offering MR service provision, said,

"There is a huge need of the service, but we do not get many patients. We have not been able to motivate them yet. They do not want to continue pregnancy, but they do not come to us in time since they are scared of doing MR as MR is considered a sin from the religious point of view. So, they do not want others to know about it and want to do it secretly."

Informants of all field sites said that due to such social pressure, women, a lot of time, first go to unskilled providers which results into many unsafe clandestine MR. One informant, while describing this, said,

"Often we find many clandestine clients. Many come to us secretly. Many first buy medicines from pharmacy and then come to us after having severe side effects. When they come to us they said about using medicines from the pharmacists which caused them such problems..."

Providers of different Govt. and NGO clinics said that location of MR facilities often work as a huge barrier for women/couples who want to do MRs secretly. One NGO provider from Sylhet said,

"Everybody knows that we provide MR services here. Whenever a woman comes, everybody thinks that she came here for MR. Nobody thinks that she could go there for other health needs. Therefore, their situation does not remain secret and as a result, many women do not want to come here."

Care providers in Bandarban Sadar said that they receive a huge number of patients during the 'bazaar¹⁰-days' when women come to sell their products in Sadar/District town and these are the days when women sought MR as this saves a lot of money for them (for commute back and forth transportation and for food and accommodation when they travel from a long distance)

Another provider of an NGO clinic in Sylhet said that running the NGO with MR services is very hard for them in this religiously conservative area. She said,

"Suppose a woman comes here for MR. She comes here secretly, however, she suddenly meets other people from her community. Then the question arises why she is here? The FWC is in a secluded place and, therefore, women go there. Ours is in the market place and, therefore, women do not want to come here since they have the fear of meeting known people here and, therefore, we do not find a lot of MR clients here..."

Providers from different Govt. and NGO clinics raised the issue of cost that deter women from skilled care and drive them to seek care with informal providers first, which is cheaper. Often women come to them before knowing the cost and then refuse to take the service when they figure out the high price of it because of the fact that they just cannot afford the price.

Besides all these above mentioned problems in terms of providing MR services to community women, skilled providers from different facilities said that they also face internal organizational problems in serving the women for MR. Many providers informed about unavailability logistics and supplies, unavailability of post MR medicines and lack of privacy in the facility. For instance, one FWV said,

"The room is very old. The furniture is also very poor and old. The MR table is very old too. We do not have enough supplies as well. An MR patient needs to take rest at least for half an hour. Many bleeds after MR. Many have lower abdominal pain. But we have to take the patients out from the room immediately after MR since the bed can be broken any time..."

The study also explored providers' perceptions regarding pregnancy termination and data suggested that most of the care providers conserve the same belief similar to the belief of the community. They also consider MR as sin and equal to killing a life. One such provider from Bandarban said,

"...however you want to call it, is it not killing a human being? We call it MR. We call it regulating the menstruation. However, are we not in-fact aborting a human being? Is not it a sin then?"

Often many of them justifies this for the sake of their jobs, as one of them said,

"Whatever I do, I do for my job. Personally, I do not like this job. It is like killing a life."

Another provider from another field said,

¹⁰ Bazar literally means a market and "bazar-days" refer to a specific day of the week when a lot of people bring in their products to sell at a specified place.

"Often I think that I am doing a sinful deed. I feel scared of it thinking this. Then I think about my profession. I say to myself that I am a doctor and therefore, I will have to do it. Other providers are doing it too. On the other hand, women are coming to seek help from me in dire situation. How can I refuse them thinking about my sin?"

Many care providers said that, although they do not face any barriers from the society or community regarding their jobs, their family members often restricts them and advise them to leave the job. However, there are also opposite views as well who think that terminating a foetus within a particular time is alright, as one health care provider said,

"I do not feel guilty if I do it within one and a half months or two months. Even it is not a sin if you do it during the third months...until that period, the life does not come. The heartbeats come after three months and it will be a sin if you do it beyond third months."

4.15.2. Informal providers

a) Ayahs/retired health assistant

Three care providers who are retired *ayahs/assistants* in the sample do not have any formal training and they provide MR services in an unlicensed setting in their houses. All of them learnt the process of doing MR while they were working as supporting staff in different government, non-government facilities and private clinics. These support staff eventually started their own practice as MR providers. One of these providers, who used to be an assistant (*ayah*) to a non-government MR clinic, said that she even used to carry out MRs in that clinic for cases who sought MR care after the legal period. She mentioned that she used to do that with the permission of a higher-level care provider of that facility as she said,

"The elder apa (sister), the head of MR apa used to tell me to do the MRs of the women at late gestational age. I used to use the office room. Based on the gestational age, I used to charge them and I used to pay half of money to apa....that was the deal in exchange of letting me use the office room. I did all these things for saving the women. When women with illegal pregnancy came to us, we used to charge more from them like 2,000 taka..."

This *ayah* said that she lost her job from that clinic since there was complaint against her from the community when a woman developed severe bleeding after doing MR with her. Later this provider bought MR instrument and started her own business at her home. She was encouraged to do this since she figured out that other assistants like her were doing the same thing at their home setting. This informal provider said that she not only use the medical instrument for doing the MR but also use a plant. This plant, she claimed, she found through dreams to be used for MR. She said that her method is found to be very effective for which she has earned a good reputation in her community and around. She described the process in the following way,

"I work with instruments and root. With the instruments, I first hit the place to bleed and then I insert that thing (the medicinal root). Then I tell them to wait for 24 hours (for having the menstruation)."

This provider said that a paramedic of the local NGO clinic refers most of the women to her and she receives a lot of women with over gestational age of pregnancy and with illegal pregnancy. She confidently said that women doing MR with her hardly face any side effects - sometimes, they develop fever but most of the time they remain alright, though she fears that a woman would become susceptible to cancer if MR was carried out in this way for more than twice. Like her, another such informal provider, while talking about her good reputation in the community, said that many women, both from poor and middle socio-economic backgrounds, come to her for MR services. She added that though there are many Govt. and non-Govt. facilities around the area, they come to her since the service is cheaper. Women also prefers her since their MR incidents remain secret which is not possible in a facility located in a public place as she said,

"They come to me when this is a case of extra marital or pre-marital relationship's pregnancy. They come to me to keep their incident secret, to keep their prestige."

Retired *ayah* who uses both instruments and medicinal plants together said that she does MR even up to six months while other two retired *ayahs/assistants* said that they do the MRs up to three months of gestational age. However, information revealed from the women through in-depth interviews, who

sought care from them, informs that these two informal care providers carry out MR in very late gestational ages.

The second set of informal provider of the sample is a NGO community health worker who learnt the process while serving in a private clinic as a support staff for MR. This provider said that she has not been providing any care since one year (at the time of the study) because a case has been filed against her. A woman died who carried out MR with this provider and the family members filed this case. Though this health worker said that she carries out MR between 1-2 months of gestational age; however, findings from in-depth interviews suggest otherwise which is further confirmed by the case filed against her. She has been fighting against the case and wants to start her business again. She recently took a formal training on MR. The Governing body of that area still does not want to give her the permission due to her previous reputation and the fact that she carries out MR in a very unhygienic atmosphere.

b) Pharmacists

As Table 10 shows, a number of pharmacists were interviewed in all the field sites. Data from this set of interviews suggest that they receive patients at around one to 5th months of gestational age. A pharmacist from Sylhet said that sometimes, women with the 7th months of pregnancy also come to them to collect medicines for terminating pregnancy. Pharmacists in Sylhet said that they receive patients from both middle and poor socioeconomic class while it is mostly the poor people in the other three field sites.

It was mostly women who come to the pharmacists for such care in Dhaka and Shatkhirra but in Sylhet, it was mainly men/husbands seeking care from pharmacists for their wives. On the other hand, pharmacists of Bandarban said that both men and women come to them for such services. Pharmacists from Sylhet and Bandarban said that they receive a number of women with illegal pregnancies while pharmacists in Dhaka mentioned about sex workers. Different scenarios were found in different fields sites in terms of the practices of the pharmacists.

Pharmacists of Dhaka field site said that they usually ask women to confirm the pregnancy with the pregnancy stick. Once the pregnancy is confirmed and it is identified at the 1st or 2nd months of gestational age, they provide “*gynococide*”. They usually have a deal with the nearby NGO or private clinics where they refer patients when the gestational age is more than three months and they get some commission for referring such women there. One pharmacist from Dhaka said that he knows a clinic that carries out MR even during the 8th months of pregnancy.

Data also suggest that these pharmacists often charge a high cost for the tablets when they figure out that the pregnancy is from an illegal relationship. One pharmacist said that he usually does not want to give medicines for termination of a foetus which is beyond three months considering the physical consequences of the woman. However, he needs to do that sometimes to save the mother from a social chaos for an illegal pregnancy. He mentioned that such cases give him the opportunity to earn more since these types of woman do not want to go to public facilities.

In Sylhet, all pharmacists denied selling of “*Gynococide*” except one who also said that he used to sell it in the past. All of them denied selling anything to woman or husbands/men that terminates the pregnancy though they know that there were lots of such medicines that are used for this purpose. They also heard other pharmacists selling these medicines however, researchers never could identify one such pharmacist in their search. Pharmacists said that they usually refer such woman or men for their wives to NGO clinics or to TBAs who they know carries out such procedures with herbs and medicinal plants.

In Shatkhirra, some pharmacists mentioned about “*Gynococide*” and confirmed that they provides this to women when they come for pregnancy termination while some denied selling such medicines. Those who acknowledged about selling this said that they send women to clinics or hospitals when the process does not complete the termination with their medicines. One pharmacist from this site gave descriptive information about the medicines provided for terminating the pregnancy. He said,

“A syrup named ‘Sehalazin’ is used for menstruation regulation. This medicine works if the pregnancy is within 1 to 2 month/s. There are other medicines like ‘Esoben’ which is from India and another named ‘EP-4’ and then there is misoprostol.”

He said that these medicines are used in different dosages if the first dosage does not work and all these are available in his shop. He also takes women to a clinic if these medicines do not work and he gets 300-400 BDT from that clinic for each client.

Findings from Bandarban are complex. Pharmacists here said that they usually counsel women to keep the child when they come for medicines to be used to terminate pregnancy. When the women are not convinced, then they send them to THC or District Hospital. Pharmacists mentioned that they do not want to take the risk of these women who may develop infection or bleeding as one pharmacist said,

"...sometimes taking gynococide and some other same group of tablets cause heavy bleeding. The success rate is one or two in 100 cases. However, even though they (women) want to use this..."

They also said that they usually give such tablets when the pregnancy is not confirmed in the pregnancy tests and if they understood that the menstruation is stopped for various other reasons. Many pharmacists know that these medicines work until 3rd months of gestational age and even though they said they avoid using this. One pharmacist said that he once stored the medicines at her shop understanding the need and demand for it as he said,

"They sometimes ask for a way to get rid of their unplanned pregnancy. Gynocide is the most common tablets they want. I brought the tablet for my shop after learning the name of the medicine from a woman. I did not even know the name of that tablet before but they knew about it and asked to keep it in the shop..."

Two pharmacists from the study sample carry out MR with medical instruments and findings from in-depth interviews suggest that there are many such pharmacists in all field sites. One pharmacist learnt the method from another provider in his village who is an LMAF (licensed medical assistant for family planning). The pharmacist said that the LMAF took the training on MR and started his business in the village. The pharmacist said,

"He told me that the training went on for 15 days in the class room and 6 months in the field...they showed them the procedure in the class room once with a very tiny hair clip. They said that MR is like pinching a balloon with such a clip. There is a curtain within which the blood clot is developed and if we pinch that curtain, the blood will come out and the MR will be done. They could train them with the main instrument, but they trained with a hair clip...just to show how easy the process is..."

Pharmacists in all field sites think that terminating pregnancy is equal to killing a human being, which they do not want to do willingly; however, since there is a demand for it and since it brings money to them easily, they took it as their profession. One pharmacist from Shatkhira said,

"Doing MR is equal to killing a life, you will go to hell if you do it. This is a sin from religious point of view and for this reason, people want to do such thing hiding from others. People do not do a sinful deed by letting others know. Will you say good thing about me for my sinful deed? For this reason, most of the people do it secretly."

Not all pharmacists think the same way (of killing a life), as one pharmacist from Sylhet said,

"It should not be called abortion if it is done after three months. It should be called MR then and doing MR within this period is legal from our religious point of view. The reason is, life does not come before 120 days and you should not call it a 'jaan' (life) before life comes to it."

Besides the perceptions surrounding MR as sin, many pharmacists raised the issue of side effects and implications on women's health, which often demotivates them from doing the MRs as one pharmacist, who provided MR services, said,

"I would like to quit from the profession. I feel bad doing this. Women suffer a lot for doing MR. Many women become infertile if they do it twice. There is a lifelong impact on a woman. Society is also going to be immoral too. Illegal relationship will increase among people if MR became that accessible. This is not good..."

Side effect is a major concern to many pharmacists for which many pharmacists do not want to do this, as one pharmacist said,

"There is life risk if a woman does MR beyond fifth month of pregnancy. There will be huge bleeding if a woman carries out MR during this stage. MR is very sensitive in many other ways. A woman may become infertile if MR is done at such a late stage."

c) Other informal providers

The study also sampled a person in Shatkhirra who was once an herbalist carrying out MR with herbal medicines which he learnt from his mother. Later on, when he realized that women develop a lot of side effects for doing MRs with herbal things, he gave up doing the MR in this way and took a training on bio-medical instrument. He took this training from another person in his village who has been doing the MR with the instrument and this person did not have any formal training on MR. This person said,

"Sometimes the herbal medicine works and sometimes it does not. Besides, women face huge bleeding with that process. Then I went to a doctor in my village and learnt from him how to do MR with instrument. He showed me some instrument and showed me how to do this with those instruments. Then I went to Khulna and bought those instruments..."

This person said that since then, he terminates pregnancies even after 6th months of gestational period.

4.15.3. Traditional providers

1) TBAs

TBAs are generally involved in deliveries, however, almost all of them in our study were involved in regulating menstruation.

All the TBAs in Thanchi, Bandarban, said that they know about traditional medicines for menstrual regulation and interestingly they define it as "*menstrual regulation*" and not as "*termination of pregnancy*". The theoretical and political definitions of MR may be found in Bandarban as they said that they regulate the menstruation even before identifying the pregnancy. TBAs are the primary sources of information in this area with whom women first consult for any reproductive health matters, who are available all the time and have longer reputation and familiarity in the community. Therefore, when menstruation stops, they are the ones women consult with. Unlike Bandarban, TBAs are not as such primary care providers in Sylhet and Shatkhirra for women who seek care with them for other health matters, rather a lot of women go to them to terminate pregnancies.

Findings suggest two types of medicinal plants usages for terminating pregnancy or regulating menstruation: one is making paste of a kind of a root along with a kind of a leaf and feed women to regulate pregnancy and the other one is inserting medicinal plant's root or vines into the vagina of the women. The first one is mostly found in Bandarban while the second one is found in Bandarban and Sylhet. Findings suggest, in Bandarban, medicinal liquid or paste are used to regulate pregnancy during the first two months and when the pregnancy is around 4 months or beyond, the second method is used. One TBA in Bandarban said,

"For regulating menstruation, I made the paste of the root and feed this to women... for terminating pregnancy; I put a root in the mouth of the vagina. The tip of the root needs to be prepared like a brush. You need to take the root after two hours. If you see blood on the tip, then you will understand that the pregnancy will be terminated soon. If there is no blood, then you need to understand that the root has not been placed accurately. Then you need to place it again properly."

Similarly, a TBA from Sylhet described the medicinal plant, which she put into the vagina,

"The name of the plant is 'Lutki'. This is like a straight vine plant. There is no leaf, no flower, and no fruits as well in that vine plant. It does not grow on any trees. It just grows on the ground straightly...."

While describing the process of it, she said,

"(I) put it there (in the vagina). Once you put it there, everything is finished...you have to put it there for three and half days....at least one and a half fingers of length should be inserted into the vagina and a similar size of the root should be out of the vagina. After three days, it will come out...during these three days, she will do her normal movement..."

Researchers requested the TBAs to show them the medicinal plant, however only one (in Sylhet) showed the plant, which she grows in the backyard of her house and nobody knows about it. One TBA from Bandarban said that she collects the medicinal plant from a very difficult place inside the hill and nobody knows about the plant, which she found through a dream at the age of twelve. She said that she never

keeps the medicinal plant at home and usually collects it whenever one wants the service. One TBA from Bandarban said,

"This is, in fact, a root of a tree. You will find it in deep forest and it is often very hard to find this tree. Still I have to collect it since women need it to terminate pregnancy..."

In Bandarban, TBAs said that whenever they terminate pregnancy or regulate menstruation, they feed another medicinal juice or paste to women so that women do not develop huge bleeding. Some TBAs said that often they do not find the second medicine, which is also a rare plant and in such case, they usually deny performing the MR due to fear of women's suffering. One TBA said that a mother in another community died due to hemorrhage after regulating menstruation and the TBA who did it, did not have the medicines for stopping the bleeding. She said,

"If the bleeding is severe, the paste of another medicinal plants needs to be fed to the woman with cold water."

On the other hand, one TBA in Sylhet said that she uses a kind of tablet for accelerating the process of pregnancy termination. She collects this tablet from the border area of India and Bangladesh which she also provides to different pharmacies in the Bazaar as well. She said,

"The tablets need to be fed orally and the plant vine needs to be inserted through the vagina...only plant root does not work alone all the time. The foetus also needs to come down, and then the root will work. Otherwise, the child will not die..."

TBAs in all field sites receive clients with pregnancy up to 6 months. Data suggest that TBAs in Bandarban usually try to convince women for not terminating the pregnancy at such a late stage fearing the health hazards and later consequences or refer them to Bandarban. One TBA from Bandarban said,

"Women come to regulate their menstruation when it is stopped for 1 or 2 month/s, however, often women come to terminate pregnancy at around 6th or 7th months of pregnancy. I do it until the 4th months and not beyond that since it is risky for the women. There can be huge bleeding if you do it at that stage of pregnancy."

On the other hand, TBAs in Shatkira and Sylhet do not care about this and try to terminate pregnancy at any stage. One TBA from Sylhet said,

"What should I do? They come and start crying holding my legs. I feel bad and helpless. Many women are so poor that they do not have the ability to pay. In those cases, I have to do MR without any charges."

TBAs in all field sites are not too positive about pregnancy termination considering the religious conjunctions. One TBA from Bandarban said,

"It is not good to terminate pregnancy. I do not want to prescribe anything when they come at around three months. I am afraid of doing this. The child might be a religious leader or a wise person. Religiously, it is a sin to terminate the pregnancy. Whenever anybody comes to me at that late age (of the foetus), I tell them I will only do that if they take the burden of such activity."

Echoing the same feeling, one TBA in Sylhet said,

"It is true that its like a blood clot in the womb. But this does not mean that it's not a human being. Its like murdering"

TBAs in Bandarban and Sylhet said that they often receive women with illegal pregnancy. TBAs in Bandarban said that even if it was illegal, they usually encourage women to keep the pregnancy while in Sylhet, TBAs have to perform MR to save the women from different social chaos.

2) Kobiraj/Ojha

These kind of providers use different kinds of medicinal plants and things to abort foetus like the TBAs, however, the main differences between these providers and TBAs is - TBAs are involved with deliveries, along with pregnancy termination while these people provides medicines for other health complications, along with menstruation regulation. Interestingly, such providers always say that they give medicines for menstruation regulation and not for pregnancy termination while TBAs directly talk about pregnancy termination.

The Ojha in Bandarban said that he gives medicines for regulating menstruation up to four months and he never provides medicines for terminating the pregnancy. It remains unclear how he understands if the menstruation is stopped due to other reasons and not for pregnancy.

Regarding the process of medicines for MR, he said it is a big, rare medicinal plant's root found in the deep forest and the root that extended to the east from the main root needs to be collected. There is also a measurement of how much of the roots needed to be taken. He said that a kind of paste is made from this root rubbing it on the stone with water and fed to women until she gets her menstruation with huge bleeding. The herbalists said that though he knows that the paste is to regulate menstruation, it could be used to terminate pregnancy even up to 7 or 8 months as he said,

"This medicine need to be given for 5 to 6 days when the pregnancy is 7 or 8 months; you need to take it for only once for a missed menstruation for 2 months."

This herbalist said that there is a huge demand of the medicines from him and from his father as well, from whom he inherited the lessons. However, he fears to give medicine for terminating the pregnancy since he is afraid of excessive bleeding of women. He fears he may not be able to stop it all the time, though he said whenever he gives medicines for menstruation regulation, he provides another medicine for controlling excessive bleeding. Personally, he does not want to do it which he considers equal to killing a human being as he said,

"Life comes to the foetus during the 5th or 6th months. It is like a human being then and it seems like killing a human being..."

Herbalists in Shatkhirā named three types of small plants' root called 'Shonai', 'Joarmoni lota', and 'Shisha khondo'¹¹. All these three types of plants' roots are used for terminating pregnancies as they mentioned. Either one of these plants' root is inserted into the vagina of a woman which is long as six inches (from the tip of the thumbs to the tip of the pinky). The other side of the root is tied with a thin rope to be tied with the waist so that the root does not go inside or fell down. The root is to be inserted with oil for easy insertion and in 24 hours, the women will start bleeding and the root will be coming out automatically. This root is used to terminate pregnancy up to three months and the herbalists said that it would be risky for a woman if it was used for a pregnancy which is beyond three months of gestational age as he said,

"It is not easy to terminate a four month pregnancy and often such medicines will not work for a pregnancy which is 4th months of gestational age..."

One herbalist said that there are a number of biomedical care providers in Shatkhirā who do not have the training on doing this however, they learnt the procedure while they were working in different hospitals. He added that most women needing the care, go to them since the bio-medical procedure takes less time, (an hour or so) while their process takes at least 24 hours. On the other hand, a woman cannot do any chores during the time while the root is inserted in her vagina until the bleeding starts. For all these reasons, people, now a day, go to bio-medical providers more than to the herbalists. Besides, medicinal plants are not available anymore after the big cyclones in Shatkhirā and hence their practice is not as common as before.

Another traditional healer in Shatkhirā who used a different type of medicine for terminating pregnancy said that he makes a type of pill mixed with tiger pines, a tree called 'shimul' and 'Bajbiruni'¹². The medicine is fed to women every 15 minutes and for some women, it works immediately after the first pill while it could take several dosages for others. He added that, later these women develop severe pain and the pregnancy gets terminated within 35 minutes. He knows that terminating a pregnancy is equal to killing a life and people say bad things about him for his job but he does not mind doing this as he said,

"Religion says to save life. I may be killing a life, but I am also saving some women and families"

¹¹These are medicinal plants of which we were unable to get the English terms.

¹²These are local medicinal plants of which we were unable to get English terms.

3) Homeopaths

Homeopathic doctors are mainly found in Shatkhira. These homeopathy doctors said that they provide medicines for only two months of gestational age since the medicines they use do not work beyond this period. One homeopathic doctor said,

"We provide a medicine named 'Pulsetela'¹³ to women for taken orally whose menstruation is stopped for 1.5 or 2 months. If this does not work, then the dosages need to be increased. However, this is the main medicine to be used to menstrual regulation. There is another medicine named 'Gosepin'¹⁴ to be used for this as well..."

Like the other providers, homeopathy doctors feel bad to terminate pregnancy and consider it equal to killing a life. They think that within two months, it can be terminated since it is a blood clot until that period and that it is believed that no life is still there. However, after this period, life comes to the foetus and it is equal to murder. For this reason, many couples want to do it secretly. One of the homeopathy doctors said,

"I feel very bad to kill a life. Usually, I abort foetus of 1/2 months. I do not feel bad doing this... it is like a blood clot during that time. However, the foetus grows its body parts during the 5th or 6th months. To abort a foetus during that time is like killing a life..."

Homeopathy doctors said that it is more harmful for women's health if the foetus is aborted during that time. However, they often faced a problem in identifying the gestational age. Often they feel that the pregnancy strip does not give the right information, and often women cannot appropriately informed about their missed menstruation for which the homeopathy doctors often face problems in regulating menstruation properly.

¹³This is a local medicinal plant for which we were unable to get the English term.

¹⁴This is a local medicinal plant for which we were unable to get the English term.

5. Discussion and conclusion

5.1. On Family Planning

Historically, family planning has been a “woman’s domain” and unfortunately, it still remains so (Schuler, Hashemi, Cullum, & Hassan, 1997; Carr, Gates, Mitchell, & Shah, 2012). Despite it being a “woman’s domain,” a woman faces numerous barriers in availing the services ranging from lack of knowledge with regard to proper usage to restrictions on mobility. This and several other local and regional studies attest to this aspect (Keya, Rob, Rahman, & Bajracharya, 2014; Lama & Krishna, 2014; Davanzo & Rahman, 2014; Vlassoff et. al., 2012).

Though our study design was not suitable to pick up the exact rates, but we believe the rate of unwanted pregnancies as reported in the interviews suggest that the rate of unmet need of FP is still quite high. Study findings indicate, lack of knowledge with regard to particular methods, their perceived effectiveness, and consequent sexual behavior being the primary reason behind it. BDHS 2014 reports that the overall unmet need of FP is around 12 percent, but these rates are mightier in certain divisions, i.e. in Chittagong and Sylhet it is more than 17% (NIPORT, 2015). Though Bangladesh has been lauded as one of the success stories in family planning, there still are pockets where contraceptive prevalence rate (CPR) is much lower than the national rates. BDHS also indicates a similar pattern (NIPORT, 2015). We believe this points toward a differential programming mode in order to achieve the goals of MGD and otherwise.

Awareness raising campaigns will gain little if not supplanted with non-health interventions like initiatives to increase the level of female education (Vlassoff et. al., 2012; Davanzo & Rahman, 2014). Empowerment of women should also be a major factor to consider in terms of programming. Often women are involved in major income-generating activities but their involvement is not even considered in the same way as it would be the case with men (Schuler et. al., 1997; Upadhyay, Gipson, Withers, Lewis, Ciaraldi, Fraser, Huchko, & Prata, 2014). Still in many pockets of the country, women’s mobility is restricted and it directly affects the care seeking patterns and delays in the process. These findings correlate with global experiences from the developing world (Upadhyay et. al., 2014).

Patriarchal atmosphere has made women dependent on men about most aspects of life, including her health concerns (Schuler et. al., 1997; Upadhyay et. al., 2014). Several women talked about their contraception choices being dictated by their husbands. The atmosphere, somewhat contradictorily, made family planning exclusively a woman’s domain, which was pronounced in men unwilling to use condoms. Any health intervention working toward reaching women should, we believe, also reach men and have them on board as well (Upadhyay et. al., 2014).

Unpopularity of condoms should be addressed in a greater degree, though there has been a slow but gradual rise (NIPORT, 2015). It creates both gendered bias against women and health risk for women (Huda, Chowdhuri, Robertson, Islam, Sarker, Azmi, & Reichenbach, 2013; Blanc, 2001). Being innovative and taking lessons where successful interventions have taken place with regard to having men as actively involved in FP as women will have to be adopted and implemented (MacDonald, Jones, Thomas, & Thu, 2013). The entire culture surrounding FP and its usage will have to be duly addressed. Though our study was not designed to pick up demographic changes in the country, but it is most likely that the pattern, especially the structure of families, is moving from extended to the nuclear types is taking place (Hayes & Jones, 2015). In this regard, importance of involving men/ husbands into the programme gains further thrust.

FP education is a must to have an informed population. Where there is thrust to have children as soon as possible after marriage, the importance of this education is all the more pertinent. Positive deviance and counter examples can be employed in innovative techniques to educate community couples (Hayes & Jones, 2015; Upadhyay et. al., 2014). Studies to particularly focus on what kinds of beliefs people harbor with regard to FP methods will have to be carried out in order to effectively address them with valid information. Simply disregarding the culture will only backfire (Upadhyay et. al., 2014).

It is not that women do not want to adopt FP methods or are against it. It often is impractical for them, as study findings suggest. Often, women’s voices ring with a fatalistic note – that this is what it is like to be a

woman. With education and awareness, this needs to be dispelled. Cultural proscription often is the most dominant indicator of one's FP usage. When we get deep enough into a woman's mind, we see more woman would like to control their lives and thereby plan their families accordingly (Creel, Sass, & Yinger, 2002; Schuler & Hossain, 1998).

Having available and accessible options in choosing the right type of FP method is a right that every woman should have. They should not be pushed to accept only what is available and which is perceived as "ineffective" or "bad for health" (Rahman, Rahman, Ali, Naznin, & Aztar, 1999; Creel et. al., 2002; Schuler & Hossain, 1998; Hardee, Harris, Rodriguez, Kumar, Bakamijian, Newman, & Brown, 2014).

The hilly Thanchi suffers from ill-functioning health system and lack of modern education. Because of education, the area and its people are falling behind from the mainstream. Literally and figuratively, they are on the periphery. We believe differential planning is required, with the prioritization of education and making the health system more responsive (Rahman, Keilman, McPake, & Normand, 2012; Huda et. al., 2013; Islam & Biswas, 2015).

Emergency pills are becoming increasingly popular, but the information on it is not widely disseminated, though it is available in the market place. The government of Bangladesh needs to establish the advantage and disadvantage of this pill and duly inform the people. Often it was felt that it has become another "oxytocin" like miracle drug that solves the problem. However, just like oxytocin, its usage needs to be addressed so that it is not abused and that it does not harm a woman. Disseminating of the right kind of knowledge and information on FP methods and services must reach all women, especially the young adults and the newly married couples. For this there should be active pregnancy surveillance and follow up (Dawson, Tran, Westly, Mangiaterra, & Festin, 2014).

Most of the informants talked about the problems related to pills. Then they also talked why injections are a problem as well. In this situation, options will have to be ensured, and above all – all the couples must be counseled properly so that they are able to take an informed decision.

Increasingly, pharmacies and allopathic village doctors are becoming more and more accessible to the people in the community. In a situation where often the products available at the governmental facilities are not trusted, the use and also the abuse of village doctors and/or pharmacists become more important. In this context, these drug sellers/village doctors can be brought into the ambit of an intervention, so that a basic counseling package is provided to the FP clients. Judging from their popularity and the poor economic condition of our people, we could think of subsidizing FP services at the private drug stores where the methods are available. Proper information on all aspects of an FP method must be known to people to take informed decisions. Concerns and worries about a particular method must be answered. Counseling as such seems to be missing from the programme, where women are left to decide on their own or simply reply on others for it (Huda et. al., 2013; Huda, Ngo, Ahmed, Alam, & Reichenbach, 2014).

While the need for awareness raising campaigns is a foregone conclusion, supply will have to be ensured along with raising awareness, and thereby raising its demand.

The issue of human resource needs to be addressed as soon as possible. We believe, differential programming is necessary to address this problem, since the needs of Bandarban Hilly areas is in no way comparable to that of the plain land. There are other pockets of hard to reach areas as well, which deserve such differential planning (Rahman et. al., 2012; Huda et. al., 2013; Islam & Biswas 2015).

5.2. On Menstrual Regulation: sin and pragmatism

Expressions to mean MR and/or abortion are straightforward. People refer to the exact activity without evading what is actually being done. However, this is only when they are talking about it. Otherwise, they simply avoid the matter altogether and make no mention of it. For a lot of women, aborting and regulating one's menstruation is not synonymous. Irregular menstruation is a common event and so is trying to regulate it. From this point of view, the programme on MR or Menstrual Regulation does resonate with the cultural understanding of it.

It should be stated that pregnancy tests before MR is an established practiced across sites. Though this goes against the legal statue, this is what the process is like.

MR is a clandestine affair. In addition, Sylhet is known to be a conservative area. Here people go to lengths in order to hide their MRs. Consequently, care seeking for MR and related side-effects become harder to access. This raises the need for awareness raising campaigns (Stash, 2000; Bhandari et. al., 2008).

There seems to be no doubt in people's mind that performing an MR is a sin and that it is almost synonymous to killing a baby. However, despite these feelings, people go through the process of terminating a pregnancy, but the knowledge of society's perception and view on MR and/or aborting a fetus, makes women become even more secretive (Huda et. al., 2013). No one wants to be rebuked and looked down upon.

Moral pangs are almost more corrosive than the social rebuke. One can hide from the society but how will one hide from oneself. May be this is why we see contradictory beliefs being prevalent in the same social settings where MR is considered a grave sin. Often people justify their acts by beliefs such as life begins around the 3rd or the 4th months of pregnancy, not before that. Interestingly, not many studies have focused on this particular aspect of women's experiences.

Practical life situations are the greatest motivators of wanting to have an MR and/or abortions (i.e. terminating a pregnancy). Poverty, inability to provide for the children who are already being raised without much care, and children been led astray due to lack of guidance often prompt women to decide against a certain pregnancy.

Social admonition goes both ways – they say bad things even if one terminates a pregnancy, and then they also say bad things if one cannot raise her children properly. Therefore, it is with the couple who will have to decide how they want to proceed. Women do not blame the society for being critical of women who have MRs. They are in fact more critical about themselves. In fact, they share in the views of the society at large. They accept the fact that they have done something wrong, but they believe they have chosen the lesser evil. The perceived risk of having an MR is high. Even the providers are not too willing to conduct the procedures. However, the need supersedes the perceived risks. Programmes should take a close look at these needs (Bates, Maselko, & Schuler, 2007).

Reasons cited by the families and women indicate that women would like to have control over their lives. This goes contrary to the fatalism that is often referred to in the literature that people in Bangladesh has left everything up to Allah and that they have nothing to say in that regard. Instead we found, they would like to be able to plan their families and provide for the children properly. It also indicates the general poor economic situation of the people in the sites we worked in.

Though pragmatism was not pronounced in all of the women's interviews, but that is the spirit of all behind taking the decision to terminate a pregnancy or to have an MR. May be it is time for us to start thinking differently of Bangladeshi women, since they do not always think about making homes. Some of the informants opted for MR because they wanted to continue their jobs. The world is increasingly a problematic place to survive only on one person's income. Here – both the husband and the wife needs to work (Upadhyay et. al., 2104). The social reality is slowly but surely changing the stereotypes.

Exploring violence surrounding decision-making with regard to MR was not an explicit objective of this study, but it came out as a natural part of it. This study points toward further studies that can be conducted only to explore this aspect. It is not only social violence that should be considered, but the procedural violence involved in MR care provision should also be a focus (Pallitto & O'Campo, 2005).

Options – that is what the policy environment should offer women. It is not about making MR easily accessible. It is about making choices available to women so that they can take informed decisions.

Analysis of the data suggests women go to lengths in order to obtain the MR care they seek and need. As it should be evident, this is a result of a combination of reasons that include not knowing where to go, wanting to keep the matter hidden, being late in seeking care, etc.

5.3. On barriers and delays

Cardinal reasons for delay in care seeking are: 1. Identifying pregnancy, 2. Decision-making at home, 3. Pluralistic care seeking, and 4. Managing the cost. This corroborates with the other study findings in the

country, though findings exposed a four-layer model than the established three-layer model (Thaddeus & Maine, 1994; Bhuiya, Aziz, & Chowdhury, 2001).

Often women do not readily link their missed menstruation with them being pregnant. As reported, a lot of women do not experience regular menstruation in their reproductive life as it is. Therefore, when they miss a period, they immediately do not think of it being anything else other than a simple missed period, which will soon return. Once this goes into the second or third month, then they start to consider other options and seek to confirm if they are pregnant. This results considerable delays.

Then the second delay occurs while women and their families try to decide what to do with the pregnancy. Decision-making regarding pregnancy termination is a matter of family politics and often women are powerless in the process. However, the trend seems to be leaning toward women and their independent decision-making can be observed despite the patriarchal structure of our society. The fact that these decisions and their executions are often clandestine, that also has a lot to do in this situation (Upadhyay et. al., 2014).

The third delay occurs during an expressed pluralistic pattern of care seeking. Care seeking patterns of women seeking MR are wide-ranging and complicated to say the least. From home remedies to specialized care – women seek care from all levels, though not always from the right place at the right time (Huda et. al., 2013; Huda et. al., 2014). Not knowing where to go and wanting to keep care seeking regarding MR a secret, women often begin at home and then explore informal providers. When they fail there or start to have side effects due to procedures at these places, they move toward formal facilities. This is why women have multiple stages of care seeking, which still does not result in success in obtaining desired services.

The fourth, and may be the most important delay, occurs as the poor families attempt to manage the cost involved in going through the process. This, once again, becomes another reason to seek care from back alley providers, which eventually burdens them with side-effects.

5.4. On accessing MR care

5.4.1. Clandestine affair

As mentioned above, MR is a clandestine affair for women in rural as well as urban Bangladesh. Social rebukes, personal moral stances, and the impression that “bad” women do MRs, all push women to ensure the secrecy of the process. This motivation often pushed women to seek care from lesser-known and non-formal facilities.

5.4.2. Availability of services

Results suggested that the more inaccessible the formal healthcare were, the greater the presence of traditional and non-formal healthcare provisions became. This is the reason why there are more traditional and informal care providers in Shatkhira, Sylhet, and Bandarban. In contrast, there were hardly any non-formal services in Kamalapur, where a prominent presence of both NGO and Governmental services were available. Our health system, *vis a vis*, the policy environment, should consider this aspect of accessibility and what happens when it is less accessible while planning a programme (Islam & Biswas, 2015).

Availability of GoB staff is often a concern, which makes the services unavailable or available intermittently. Programmes need to be able to ensure staff's availability in order to ensure proper and timely services.

5.4.3. Costs

Calculating the costs for MR is difficult since it differs from one context to the other. However, it is prudent to suggest that often costs for MRs, especially when conducted beyond the legal gestational age, is a burden on the poor women seeking it. Depending on the pluralistic care seeking patterns of women, this cost goes up phenomenally. When additional costs for managing the side-effects are considered, then it literally goes beyond what the poor families can afford. Selling the last piece of gold jewelry, the wedding sari, a pig, or asking for a loan is commonplace in managing the costs related to MRs and related morbidities.

5.4.4. Pregnancy test

As mentioned above, pregnancy test is a standard pre MR procedure in all facilities that provide MR. Based on the results; clients are either accepted or rejected for the service. Rejections have always been due to gestational age, but often women who seek MR care are somewhat adamant and would like to have MR despite the difficulties involved. Being rejected, in many cases, only delayed the process further and made the situation for the women even riskier. We believe, proper counseling and dissemination of correct information will help women to decide what they want to do and feel at one with the decisions they make (Chowdhury & Moni, 2004).

5.4.5. Quality of services

MR provision and providers associated with it is so varied and complicated that it is hard to categorize them neatly. Paramedics (i.e. nurses and FWVs) are formal providers since they are affiliated with formal institutions, but they often work informally – either at their residences or in their work places. This often obliterates the formal and non-formal distinctions. Programmes should also pay attention to this aspect, since this can and will have implications in terms of quality control.

Quality of procedures needs to be ensured – especially at the governmental facilities. Just about all the MR cases had mild to severe side effects. For some it lasted for years. This is a serious concern. Given the fact that MR is being promoted as a safe procedure, this situation stands as a stark contrast to that claim. MR programme needs to be able to address this.

The rate of side effects reported from informants seeking care from skilled providers is alarming. In our study sample, it is substantially more than side effects reported from informants who sought care from unskilled and traditional providers (Hossain et. al., 2012). This is not to suggest that informal and traditional places are safer, but this raises concerns with regard to the quality of services provided at more formal places where skilled providers are available. The policy environment should address the quality of concern with due importance to save women from morbidities that are entirely preventable (Mridha, Koblinsky, Moran, Ashraf, Campbell, & Anwar, 2012).

Basically post-MR counseling is absent in just about all of the facilities where MR is available – be it governmental or NGO. Only in a few NGO facilities in Dhaka women talked about getting some advices that can be considered as counseling, but that is all. Counseling on FP methods after MR was also absent. Some women were advised to adopt an FP method, but they were not provided guidance so that they can take an informed decision. We believe, post-MR counseling needs to be a necessary part of the MR package, since MR itself is not desired and with this counseling a lot of MR and termination of the foetus can be avoided (Vlassoff et. al., 2012).

With unskilled providers, there was hardly any post-MR counseling. Though they ask women to return to them if they face problems, women often choose not to return. Tendency to return for post-MR complications to the same providers was higher with the formal healthcare providers, but it was limited to only those facilities or providers who were close by. Besides, it was only when they had problems they returned, otherwise no one thought about seeking the provider.

Moderate or lenient MR regulations might be good for people in a conservative environment where abortion is illegal and only MR is legal, but this opens up the avenue for haphazard manipulations of it, where MR starts to become available everywhere. At the end of the day, it can become a boomerang for women's health and empowerment (Mridha et. al., 2012).

5.5. On providers and health system

This study did not have a representative sampling. Therefore, it is not designed to provide exact rates and proportions. However, it can still serve the purposes of illustrating patterns. In this case, it is safe to say that most of the care seeking with regard to MR is sought outside of the formal fold of the health system. Moreover, a substantial proportion of care seeking is with the pharmacists or village doctors. In terms of MR, traditional providers also occupy a major chunk (Huda et. al., 2013).

5.5.1. Traditional providers

With regard to traditional providers and their practices, we would like to make the point that traditional care is not necessarily bad. However, since it is unregulated, safety of women availing these services remains beyond the reach of the health system. Also, some of the practices observed within some of the communities appeared to be extremely risky and the health system should be aware of them.

From a practical/pragmatic point of view, use of traditional providers ensures secrecy and the local explanatory model would suggest a synergy between the explanatory models of the providers and users, making the practice more acceptable (Kleinman, 1988). We do not outright condone or condemn these practices. Instead, we would like to study these aspects of local models further in order to establish the beneficial and detrimental aspects of these practices.

5.5.2. Village doctors and pharmacists

Village doctors are neighbors, and relatives of the people in the community. They are easily accessible, one can bargain with them, and in many cases, confide in them. Therefore, it is not a surprise that they would most likely be the first line of care provider. From selling pregnancy tests to various abortifacients – they sell it all. However, reported usage patterns of their prescribed medicines, rate of side-effects, and consequent management of related illnesses are a matter of concern. Programmes seeking to take medical abortion to scale must take this into consideration (Huda et. al., 2014).

5.5.3. MR volunteers

In the absence of active awareness raising and information disseminating activities from GoB, HWs and MR Volunteers have become a good source of information and support for women seeking MR care, but they are often ill informed and often motivated by economics of the process than a concern for women's health care needs. Policies should either make use of such volunteers by properly informing them about the processes and services available or deregulate them through substituting them with paid staff doing similar things.

Presence of MR volunteers in most of the sites (save Sylhet, where there are NGO staff filling in the information gap somewhat) is an interesting phenomenon. Often these volunteers work in the interest of the women seeking MR care, but they also serve the interest of the MR providers. Since they are not a regulated body, there is no way to ensure that they have the correct information.

Shatkira and Dhaka had MR volunteers. Not in Sylhet. In Bandarban – there are no such volunteers like in Dhaka where they would take in money, but they help in negotiating the price and related aspects. These are NGO workers voluntarily helping women in the communities.

5.5.4. Formal and informal health system

Generally speaking, Kamalapur had more services available to women and families with regard to MR than any other sites. Consequently, the numbers of unskilled and traditional providers were the least there. In comparison, Shatkira and Sylhet had higher numbers of unskilled and traditional providers. However, in all the sites, there is a marked presence of NGO activities, who provide MR services as well as work toward raising awareness. Compared to other sites (except for Dhaka), GoB activities are greater in Shatkira. People avail their services as well. Health system in Sylhet is not functioning well either.

Judging from the presence of various healthcare provision in all different sites, it seems the better a health system performs, the lesser the activities of unskilled and traditional providers will be. This, however, does not tell the whole story in Bandarban, where the health system is not optimally functioning and still care seeking with the traditional providers is not pronounced (Mridha et. al., 2012). We have posited our assumptions for this scene, which calls for further research on the matter (i.e. might be that it was not able to probe far enough into the matter and that the language barrier ultimately barred researchers from getting to the truth of the matter). It seems, for researches such as this one, it is of paramount importance that inclusion of researchers with extensive knowledge of the local languages is considered. Otherwise, nuances of various important aspects can and will remain unexplored (Vlassoff et. al., 2012).

Another point to note with regard to MR services was the provision of care through the facility-based providers in an informal basis. Often women, who were rejected or denied services for their gestational age being over the legal limit, were offered “informal” private services at a higher price. Quality, infection control, etc. were a major concern in this regard.

There was a lack of awareness raising activities from the government side, and that is why a lot of women do not even know what services are available at various governmental facilities.

While sticking to their official language, formal healthcare providers talked about when and how they perform MR but as we got deeper into their experiences with the procedure and the community reality, they disclosed the real situation. They freely admitted to the fact that they provided services to women well beyond the legal limit of MR. Providers divulged a lot of information – some interesting and some downright harrowing. This information painted a picture that showed how they are pushed to take certain decisions against their professional rules and how they have to bend and break them.

Social reality is often stranger than fiction. Stigma, conservative environment, and events of highly objectionable sexual relations often co-exist and often seem to be the reason for each other’s existence. This also makes MR a necessity. It seems important to create a space for further studies into this. This is especially the case where violence within families exists and are silenced in the name of social repercussions (Vlassoff et. al., 2012; Mridha et. al., 2012; Huda et. al., 2013).

5.5.5. Treating side effects

Treating MR and abortion related complications are a common practice for the formal providers. This indicates how rampant the process is in the communities and that unregulated practice of it might be doing a lot more harm to women than we would like to think. Complaints against village doctors and pharmacists raged high amongst the formal providers. According to them, most of the complications occur due to them. However, the reality may not be as simple when the social context of women is taken into consideration. Social reality then needs to be understood in conjunction with unavailability of quality care, rising costs, and the like.

6. Recommendations

a) Responsive health system and awareness raising campaigns: FP services need to be more responsive to the needs, and the needs are primarily related to knowing the proper usage of various methods. Men will have to be a part of the programme since their involvement makes a practical difference in more than one domain. Differential programming should be introduced since needs are different in different regions. Investment should also be made in non-health interventions, i.e. female education, income generation. Programmes that pay attention to people's belief regarding various FP methods will have to be implemented.

Having accessible options and the knowledge to choose from it wisely is a must. Along with this, availability of services will have to be ensured. Emergency pills are becoming very popular. Its proper use and safety needs to be ensured. Side effects of various FP methods, especially the pills and the injection, needs to be addressed since a lot of women become irregular users due specifically to these side effects. Village doctors need to be trained to counsel women on FP methods since they are the first line of health care providers.

b) Investing in creating a women-friendly environment and revisiting the legal status of MR: MR, as it appears to us, is a professed need of the women and their families. They have a pragmatic view of life and they negotiate with the available options. Judging from this context, it is important that policy makers try to ensure women's safety. They should also invest in creating a better atmosphere for the care seekers so that they are not pushed toward unsafe places. In addition, services need to be made safe and hygienic and their availability needs to be ensured. We believe it is time to revisit the legal aspect of MR in Bangladesh. Rejection at the formal facilities is pushing women to illegal establishments, with increasing risks of morbidity.

A few interesting points to be noted here are: women's perception of when they should, if they do, avail MR agrees to the legal gestational limit, which is "before there is life." This roughly translates into two months of gestation for women. However, often the willingness of healthcare providers to offer MR services beyond the legal limit contributes in confusing women about the actual legal limit. It needs to be stressed here that, apart from Shatkira, where an NGO has been extensively working on providing family planning and MR services, none of the informants in any of the other sites could provide a clue about the legal limit.

Availability and presence of informal and traditional practices concerning MR is a direct result of unavailability of safe and legal MR services. Therefore, safe and legal services will have to be ensured before cracking down on illegal establishments, otherwise we will be pushing women into further danger.

c) Pre and post MR counseling: Pre and post MR counseling will have to be ensured. Counseling should begin at the time when women seek care the first time. This will help her with her options, decision-making, and will reduce the time spend in pluralistic care seeking. Needless to mention, this will also substantially reduce the cost.

d) Differential programming: It is recommended that there be differential programming in order to ensure availability of services at all levels in different regions of the country. Quality of care needs to be regulated, along with ensuring that formal providers are not involved in unsafe practices only to make some money.

e) Re-evaluating the role of village doctors: Village doctors will have to be taken seriously with regard to the provision of care for MR. They are unquestionably the first line of care providers. They will have to be educated and skilled, if they are to provide care for it. They need to have a proper place for it that provides confidentiality and comfort to the care seekers. Currently, this is not being regulated at all.

f) Investing in creating skilled providers: Training of the providers is necessary and should be given to all who are eligible on a standardized manner. However, we need to keep in mind that training implies authorization. For instance, infection prevention must be major part of this training, so that it is not performed anywhere and everywhere like it is now. The policy environment should be able to standardize the care provision and ensure that it does not become something like the RMP or LMAF certification, which provided a blanket certification to all village doctors to practice medical treatment.

7. References

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