

SHORT REPORT

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Women's experiences with medication for menstrual regulation in Bangladesh

Heather M. Marlow^a, Kamal Biswas^b, Risa Griffin^a and Jamie Menzel^a

^aDepartment of Research and Evaluation, Ipas, Chapel Hill, NC, USA; ^bDepartment of Research and Evaluation, Ipas Bangladesh, Dhaka, Bangladesh

ABSTRACT

Menstrual regulation has been legal in Bangladesh since 1974, but the use of medication for menstrual regulation is new. In this study, we sought to understand women's experiences using medication for menstrual regulation in Bangladesh. We conducted 20 in-depth interviews with rural and urban women between December 2013 and February 2014. All interviews were audiotaped, transcribed, translated, computer recorded and coded for analysis. The majority of women in our study had had positive experiences with medication for menstrual regulation and successful outcomes, regardless of whether they obtained their medication from medicine sellers/pharmacies, doctors or clinics. Women were strongly influenced by health providers when deciding which method to use. There is a need to educate not only women of reproductive age, but also communities as a whole, about medication for menstrual regulation, with a particular emphasis on cost and branding the medication. Continued efforts to improve counselling by providers about the dose, medication and side-effects of medication for menstrual regulation, along with education of the community about medication as an option for menstrual regulation, will help to de-stigmatise the procedure and the women who seek it.

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Background

Abortion is not legal in Bangladesh except to save a woman's life. However, menstrual regulation is legal up to a maximum of 10 weeks after a woman's last menstrual period (Singh et al. 2012; Vlassoff et al. 2012). Menstrual regulation is the removal of the uterine lining using surgical methods or medication for women at risk of pregnancy, whether or not she is actually pregnant. It was first introduced in Bangladesh in 1974 and a national menstrual regulation programme was instituted in 1979 (Johnston et al. 2011; Vlassoff et al. 2012). Menstrual regulation is provided through government facilities in Bangladesh via trained providers, including doctors, family welfare visitors and paramedics (medical assistants and sub-assistant community medical officers) (Vlassoff et al. 2012). Paramedics and family welfare visitors are authorised to perform menstrual

CONTACT Heather M. Marlow  marlowh@ipas.org

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regulation up to 10 weeks after a woman's last menstrual period and doctors are permitted to perform menstrual regulation up to 12 weeks after last menstrual period (Vlassoff et al. 2012).

In 2010, an estimated 653,100 menstrual regulation procedures were conducted in Bangladesh or 18 menstrual regulation procedures per 1000 women of reproductive age (15–44 years old), of which 67% took place in government health facilities and the rest in non-governmental organisation or private facilities (Singh et al. 2012). There were 10,600 doctors and 7200 paramedics at government health facilities (from clinics to hospitals) in 2011 who were trained in menstrual regulation. However, the authors of recent studies warn that the number of menstrual regulation providers in these government facilities is insufficient, particularly in rural areas in Bangladesh, given the retirement of providers and current training levels for new providers (Hossain 2012; Johnston et al. 2011; Vlassoff et al. 2012).

Although menstrual regulation has been permitted in Bangladesh for over 30 years, there are still barriers to women's access to menstrual regulation services that lead women instead to unsafe abortion. Among women of reproductive age, approximately 30% are unaware of menstrual regulation, particularly in rural areas (NIPORT, Mitra-and-Associates, and ICF-Macro-International 2013). Even when women are aware of menstrual regulation, they may be too ashamed or embarrassed to access it or fear disapproval from family, religious leaders or community members (Bhuiya, Aziz, and Chowdhury 2001). Many Bangladeshi women require their husband's permission to leave the home and may not want to disclose their intent to access menstrual regulation (Gipson and Hindin 2008). The cost of travel and fees associated with menstrual regulation procedures, along with inequality in charging fees, creates a further barrier to menstrual regulation, particularly for poorer women (Johnston et al. 2011; Nashid and Olsson 2007). Menstrual regulation services are supposed to be provided free of charge at government facilities. However, providers at government facilities turn away approximately 26% of women seeking menstrual regulation stating reasons that are not government criteria for refusal, such as: the woman has not yet had a child, the woman is unmarried, she is too young or she does not have her husband's consent (Vlassoff et al. 2012). All of these barriers to women accessing menstrual regulation at government health facilities lead women to informal providers and the use of traditional methods, such as roots and homeopathic medicines, frequently resulting in unsafe abortion (Gipson and Hindin 2008). This is reflected in a high rate of treatment of complications from induced abortion – 6.5 women treated for abortion complications per 1000 women aged 15–44 (Singh et al. 2012). Poorer and less educated women are more likely to die from unsafe abortion compared to wealthier and more educated women (Chowdhury et al. 2007).

Misoprostol, a medication used for induced abortion, was not approved for menstrual regulation in Bangladesh until September 2014, but its use prior to that date has been documented. In a study of 43 women presenting at the Chakaria Upazilla Health Complex (a government facility) in Cox's Bazar who used misoprostol to induce an abortion, none experienced severe side-effects and all of them would use it again in the future and recommend it to others (Banu and Akhter 2010). Clients obtained misoprostol from pharmacists (37%), rural health service providers (medical assistants, family welfare assistants, nurses) (42%) and non-technical hospital staff (12%) and then took it on their own (Banu and Akhter 2010). In a study of mystery customer visits to 331 pharmacies in Dhaka and Gazipur, fewer than 50% of the pharmacists offered misoprostol or other medicines for menstrual regulation to customers, only 7% provided the correct regimen and 75% did not provide any

information about complications (Huda et al. 2014). Women taking misoprostol in other countries (primarily in Latin America) reported many advantages to using misoprostol for abortion, including flexible timing, increased privacy, it feeling less invasive and more 'natural', and it allowing them to experience the abortion at home with a partner, friend or family member (van Dijk et al. 2011; Lafaurie et al. 2005). In Bangladesh, Alam et al. (2013) found in their study that over 90% of 651 women taking medication for menstrual regulation were satisfied with the method.

In this study, we sought to understand women's experiences using medication for menstrual regulation in rural and urban Bangladesh. Specifically, we wanted to know how women received information about medication for menstrual regulation, what their experience in accessing medication for menstrual regulation was and what the medication for menstrual regulation experience for these women was like. Throughout this research, we document women's experiences with medication for menstrual regulation and make recommendations about the programmatic implementation of menstrual regulation with mifepristone and misoprostol combination medication. Misoprostol was approved for use in government facilities in September 2014, but was not widely available in the public sector at the time of the interviews.

Methods

We interviewed 10 women from rural communities and 10 women from urban communities between December 2013 and February 2014. Criteria for inclusion in in-depth interviews included being aged 18 years or older, having just used medication for menstrual regulation and the provision of written informed consent. Rural women were recruited through community workers affiliated to local community-based organisations. These workers were trained to refer women to menstrual regulation and were therefore able to identify women in need of services and approach them about the study. Urban women were recruited by staff at a non-governmental clinic where menstrual regulation services were provided. Women were asked if they were willing to participate in an interview at a later time. If they agreed, an interviewer contacted them about the interview. After providing consent, the interviews took place in Bangla at a private location of the woman's choosing, by a trained interviewer not affiliated with the facility where the woman received medication for menstrual regulation. Women were remunerated with 200 Taka (US\$2.50).

A semi-structured, in-depth interview guide was developed in English and translated into Bangla. The in-depth interview guide covered the following topics: how women learned about medication for menstrual regulation, how women decided to have medication for menstrual regulation, where women went to obtain medication for menstrual regulation, how much the medication cost, how women felt before and after medication for menstrual regulation, the overall medication for menstrual regulation experience and how the medication for menstrual regulation experience could have been improved. In order to ensure the privacy of the respondents, identifying demographic information (age, residence, etc.) was not collected. Pseudonyms are used in this paper to maintain confidentiality. Interviews lasted 1–2 hours and were tape recorded, transcribed and translated. The methods and procedures were approved by the Allendale Investigational Review Board, Allendale, USA, and by the Bangladesh Medical Research Council, Dhaka, Bangladesh. The four authors read all of the in-depth interview transcripts in English for

initial code identification. After reading the transcripts, a codebook was created with codes and their definitions. It included deductive codes from the in-depth interview guide as well as inductive codes emergent from the data. All in-depth interview transcripts were uploaded into Atlas.ti and coded using the codebook. Codes and themes were reviewed by the other authors after coding. Once all transcripts had been coded, the codes were grouped into themes. The unit of analysis was the individual.

Findings

Reasons women used medication for menstrual regulation

We asked women their reasons for taking medication for menstrual regulation and they cited a number of different reasons. Of the 20 women interviewed, 5 said that they used medication for menstrual regulation because they wanted to space their children or limit their family size. Two women explained:

My youngest baby is too young [and is still] breast feeding. My husband and I decided jointly. After making the decision we did menstrual regulation. (Ayesha, rural)

The size of my family is already large. If the baby came, [my family] would become bigger, wouldn't it? Our finances are little, we have no land. Having more children would be troublesome for us. (Ritu, rural)

Other reasons why women had medication for menstrual regulation included poverty, for health reasons of the mother, because the foetus had died, because the woman was too old to have another child and because it was not a good time for the couple to have a child.

Women's decision-making about taking medication for menstrual regulation

For most women ($n = 16$), the decision to have menstrual regulation was made with their husbands or immediate family members. One woman explained:

One of my cousin sisters who rented a house beside mine advised me [to use] medication for menstrual regulation. I asked her how [and whether I would experience] any problems. She told me no, there [should be] no problems. Then she bought the tablets for me. (Liya, rural)

Most of the women ($n = 11$) first learned about medication for menstrual regulation from doctors at the facilities they visited for menstrual regulation. In these cases, the doctors were highly influential in women's decisions to use medication for menstrual regulation:

I did not know that the MM kit [medication for menstrual regulation] was available here. At first, I wanted to have menstrual regulation. Then I was informed that [I could have menstrual regulation] with medicine. I discussed [medication for menstrual regulation] with my husband and decided to take the medicine. (Riya, urban)

The provider asked me, 'What is your decision? Are you going to keep it or have menstrual regulation?' I replied that I didn't want to keep the baby. The provider asked me, 'Would you like to take medicine or do you want to do menstrual regulation?' Then I asked the provider 'Would it be better to take the medicine? Would it work without any problems?' After all, I am a diabetic patient, I also have high blood pressure. I told her all these things and she assured me that there would be no problems if I took the medicine. (Amina, urban)

Even if women knew about medication for menstrual regulation prior to visiting the facility for menstrual regulation, doctors offered additional information about this method. Two women shared their experiences:

No, at first I did not have confidence in my sister's words [about medication for menstrual regulation], but when the doctor told me about this [medication for menstrual regulation] I was confident. (Tanisha, urban)

I saw people take medicine from the pharmacy or other places. There are some medicines that work very easily, but some expensive medicines do not work. Many people took the medicine, but it did not work, and they still had to do menstrual regulation.

Interviewer: So that is why you got the information about medication for menstrual regulation from the hospital?

Yes, I got the information from the hospital. I asked them if there was any medicine that would quickly bring back my menstruation. They told me that they had such a medicine, but that it is very expensive. (Rehana, urban)

One woman had previously used medication for menstrual regulation and, as a result, she made the decision to use medication for menstrual regulation again on her own. She explained:

I relied on the medicine because I had taken it twice before. I was confident.

(Dalia, rural)

The cost of medication for menstrual regulation

Some women obtained medication for menstrual regulation, known as the 'MM kit' comprised of misoprostol and mifepristone, at a non-governmental organisation clinic located in public facilities in urban areas. The MM kit cost 1800 Taka (US\$23). Drugs obtained from medicine sellers or pharmacy staff were likely to be black market drugs imported from India or Pakistan.

We asked women to recall the amount they paid for the medication they took for menstrual regulation. These amounts varied greatly, with one woman saying that she received the medication for free and five women reporting that they paid the highest amount reported, at approximately 1800 Taka (US\$23). The 18 women who recalled the cost paid for the medication reported an average cost of just over 800 Taka (US\$10). Some women told the interviewer that someone else, generally their husbands or another family member, had purchased the medication for them. Ten women in the study purchased their medication at a medical college or in a non-governmental organisation clinic, while five women reported that their medication was purchased from a medicine seller or pharmacy. The remaining women either had the medication purchased for them from an unknown source, or didn't report where their medication was purchased. Opinions on the cost of the medication were also diverse. One woman reported that:

The good side is its cost is very low, it is safe, and the period will return if you take it with some warm water. (Liya, rural)

Another woman, when asked if the cost was a lot for her, explained:

Yes, this was a load for me. My parents are poor. Since the expense is high, it was a problem ... I mean, it was sudden. My father built a new house at that time, so there was a crisis of money. If it had happened later, I would not have faced any problem. (Anika, rural)

Despite paying varied amounts and expressing assorted opinions about the cost of medication for menstrual regulation, most women reported that they were willing to pay a higher amount in order to purchase higher quality medicine. Though many women discussed concerns about the quality of the medication they purchased, only one woman in this study was sure that she knew the name of the medication she had purchased and taken. Three other women reported that they had used an MM kit, and one woman named a medication, but was unsure. Some women reported that the medicine seller or pharmacy staff person had kept the packaging for the medication, in order to avoid legal ramifications or community issues involved with selling medication for menstrual regulation drugs. Others explained their own reluctance to keep the packaging or labels for medication, due to fears that someone in their home or community might discover their medication for menstrual regulation. When asked if she knew the name of medication she had taken, one woman reported that:

I do not know the correct name of the medicine. It was given to me, so I took it. It might become public, it might lead to scandal, so I took one of them and used another one, and then left it ... I left the cover because there are children in my house. (Rehana, urban)

Because of this, many women had little to no opportunity to ascertain the quality of the medication they were taking.

Though many women expressed dissatisfaction with the cost of the medication, several women reported that they were willing to pay even a burdensome amount because the need to end their pregnancy was so great. One woman explained:

I would have had no other alternative, even if the price had been high. I was bound to buy it. (Rehana, urban)

Women's preferences for medication for menstrual regulation

Many women preferred medication for menstrual regulation over evacuation methods that were perceived to be more painful than medication for menstrual regulation. The women we interviewed considered medication for menstrual regulation to be a very simple, self-administered procedure since it only involves taking a few tablets. One woman commented:

If the tablet works, then why should I go for menstrual regulation? (Shirina, rural)

Seven women expressed a fear of other methods for menstrual regulation and this was a factor in their decision to use medication for menstrual regulation instead. These women feared that other methods would be painful ($n = 3$), complications would arise ($n = 1$) and that it wouldn't be successful ($n = 1$). Only one of these women had experienced menstrual regulation previously. The remainder were relying on information about menstrual regulation from external sources, such as friends. One woman mentioned that medication for menstrual regulation was less expensive, which added to her motivation to choose that method. Two women shared their experiences:

I was afraid that there might be problems [with menstrual regulation]. One woman told me that the effects of menstrual regulation are very serious – she showed us pictures. After seeing the pictures, I was frightened. The nurse told me about the medicine. I thought that the medicine might be better than menstrual regulation – it would have a good result. (Rimi, urban)

Two of my friends did menstrual regulation and told me that it was twice as painful as giving birth. (Priya, urban)

How the women felt before taking medication for menstrual regulation

Many women ($n = 9$) were not afraid to take the medication for menstrual regulation beforehand. Women were not afraid for different reasons, including having taken the medicine before, trusting her provider, believing that taking medicine is normal and feeling relief to know that she would no longer be pregnant. Several women described their feelings before taking the medication:

I often take different types of medicine. Why should I be afraid of this? Taking medicine is a normal phenomenon. (Ritu, rural)

No, I was not afraid. I took it before, so why should I be afraid? I knew it would bring positive results. (Dalia, rural)

I felt happy for the hope of getting rid of the pregnancy. (Liya, rural)

Seven women were afraid of taking the medicine but for most, fears were allayed by their provider beforehand or immediately after they took the medicine. Women were afraid of the side-effects of the medicine, including heavy bleeding, and several women were concerned about their future fertility. Three women described their fears before taking the medicine:

I was a bit afraid. I was worried that my health might become worse or I might suffer from heavy bleeding. (Anika, rural)

I was a little afraid because I was worried whether I would be able to be a mother again if I took the medicine for menstrual regulation. I was a little anxious about the medicine. (Priya, urban)

I was very afraid. I was scared of the side-effects. (Reshmi, urban)

Women's experiences taking medication for menstrual regulation

Of the 20 women interviewed, 16 reported having a positive experience with medication for menstrual regulation and had a successful outcome. These women had acquired the medication from a variety of sources, including medicine sellers/pharmacies, doctors and clinics. One woman described her experience:

After taking the medicine I felt something in my body, heaviness in my body. I thought there would be menstruation. Then at night, [my] menstruation came without any abdominal pain. It was written in the packet [that they gave me] there would be abdominal pain, vomiting and fever. But nothing occurred in my body. No pain, no fever, no vomiting. I menstruated at night, but it was not heavy. The bleeding stopped the next morning. (Tanisha, urban)

Nine of the women who had a successful outcome experienced normal side-effects from taking the medication. The most common side-effects experienced were abdominal pain ($n = 5$) and nausea ($n = 4$), followed by fever ($n = 2$), weakness ($n = 2$) and vomiting ($n = 1$). One woman described the side-effects:

I had abdominal pain. At first it was a little, then it was quite severe. Clotted blood came out then I understood that [it] was out. The doctor told me that when there was clotted blood you would [know that it had been successful]. (Bindu, rural)

Four of the women who took medication for menstrual regulation had negative experiences, the process failed and the women had to have a follow-up procedure. One woman purchased the medication from a pharmacy, one woman from another woman, one woman from a doctor and one woman received the medicine from a government health facility. For all of

the women, the medication for menstrual regulation was not successful. Women described their experiences thus.

After collecting the medicine from his shop and taking it, nothing happened. In fact [he] gave it for spoiling the foetus, not for [removal of the foetus]. He thought that I would take wash [have menstrual regulation]. But [the foetus had] died. I suffered from chronic pain. Later I told one of my sisters-in-law that I was bleeding profusely. Then I went to a health worker for a check-up. She told me there is still a clot of blood within your body, you must go through a wash [menstrual regulation] to clear the clot of blood. (Anika, rural)

I went to the toilet and saw the head of the baby. I pulled it then the baby came out. After the baby came out I washed my hands and legs, then lay down in bed. Then I found there was convulsion in my hands and legs and I felt weakness in my body. After that my husband went to the doctor and bought three saline from the doctor [from whom] he bought the medicine. The doctor came and gave me saline, after giving the saline he told my husband that I would be well. After the examination the doctor told me that the placenta was not expelled out. I had to go to the hospital for expelling out of the placenta by doing D&C. (Ayesha, rural)

Two of the women who had unsuccessful outcomes with medication for menstrual regulation later had a dilation and curettage (D&C), one woman had menstrual regulation but the method was not stated and another woman did not mention what her follow-up procedure was.

How women felt after taking medication for menstrual regulation

We asked women how they felt after they had taken the medication for menstrual regulation. Sixteen women expressed positive feelings. Several women ($n = 8$) said that they were happy after taking medication for menstrual regulation. One woman described her happiness:

[I was] happy because I did not have any problems, my menstruation was regulated, it was clear, and I did not have to go to any other place. For that I was happy. (Shirina, rural)

Other women who had positive emotions said that they felt relieved ($n = 2$), both happy and relieved ($n = 2$), or that they felt good about taking the medication ($n = 4$). One woman explained:

I felt relieved because I could not continue my pregnancy. I was afraid I might have a problem in the afterlife, but when I thought about my health, I felt relieved and good. It was good for my husband and for my health. (Mina, urban)

One woman said that she felt sad, one woman said that she felt badly. Both of these women, Anika and Ayesha, had failed menstrual regulation with medication. The women explain their feelings:

I was depressed that the foetus had been destroyed. All of my family members knew that I was pregnant, [now they will think badly of me]. I have to get divorced and my husband will marry [another woman]. For these reasons, I did not feel well. I was feeling bad. (Anika, rural)

I was sad.

Interviewer: Why were you sad?

I will never do this again [take medication for menstrual regulation].

May God never set me to do this [again]. (Ayesha, rural)

How the provision of medication for menstrual regulation could be improved

We asked women if anything could be done to improve their experience of medication for menstrual regulation provision. Several reported wanting more assurance of confidentiality and privacy regarding their medication for menstrual regulation experience. Other improvements mentioned were less pain during the medication for menstrual regulation, the medication for menstrual regulation taking only one day to complete, the medication for menstrual regulation requiring fewer pills, services being made available closer to the women's homes, more direction at the health facility about how to take medication for menstrual regulation, better treatment from doctors and clinic staff, and less stigma around the topic of medication for menstrual regulation and abortion so that they could seek support from their communities. Many women also felt that the option of medication for menstrual regulation wasn't emphasised enough. One woman reported that:

It would be good if they told other women not to do menstrual regulation, but to take the medicine [medication for menstrual regulation]. The women would agree to take the medicine rather than having menstrual regulation with a syringe. (Rimi, urban)

The most requested improvement was for information on medication for menstrual regulation to be more readily available in women's communities, and for health workers to visit women's homes with information. One woman explained that when she visited the clinic, she was too far along in her pregnancy to receive medication for menstrual regulation. She explained:

To get the proper information and to find a reliable medical centre, I had to waste a lot of time. (Sadia, urban)

Another woman said: If the doctor came to our community and visited us door-to-door, then we would benefit. We could avoid going to the market, which is troublesome. In that case, I would not have to tell my husband, I could do it myself. (Liya, rural)

Several women also mentioned that conveying information about medication for menstrual regulation via the television, radio and advertisements could help women to have better information about their options.

Discussion

Medical providers were influential in women's decisions to use medication for menstrual regulation instead of surgical menstrual regulation. Over half of the women learned about the option of medication for menstrual regulation from their provider at the facility, whereas they did not know of its existence prior to their visit. Even when women had some information about medication for menstrual regulation before coming to the facility, health providers were instrumental in making them feel more confident and comfortable with the method. In a study of Vietnamese women seeking abortion at public health facilities (Ngo et al. 2014), more women who had heard about medical abortion prior to their visit used it instead of manual vacuum aspiration compared to those who had not heard of medical abortion. Similar to those in our study, the Vietnamese women also reported that they received adequate counselling from their providers, which aided them in the decision to use medical abortion over manual vacuum aspiration (Ngo et al. 2014). In another study in Nepal, women seeking abortion who had prior knowledge of medical abortion were also more likely to choose it over manual vacuum aspiration and a majority of women, upon

receiving counselling about medical abortion and manual vacuum aspiration, chose medical abortion (Tamang et al. 2012). Therefore, providers' adequate levels of counselling about medication for menstrual regulation are clearly an important factor in influencing women to consider medication for their menstrual regulation and to boost their confidence to do so successfully.

Secrecy and stigma surrounding menstrual regulation leads to widely varying prices of medication and women's lack of knowledge about the name and quality of the medicine they are taking. The cost of the medication was affordable for some women, but not for others. Women in our study were not aware of a set cost for medication for menstrual regulation and therefore were unable to assess whether they were being charged a fair price. Even so, women in our study were willing to pay even higher amounts for medication for menstrual regulation because they were determined to end their pregnancies. Only one woman in our study knew the name of the medication she took for menstrual regulation. Some providers would not tell women the name nor give them the packaging. This, too, is problematic because women were unable to assess whether they were purchasing a product that is actually used for medication for menstrual regulation or something else. For several women, the medicine they purchased was ineffective and potentially dangerous. There is an urgent need to improve brand awareness of misoprostol and mifepristone as the drugs used for medication for menstrual regulation, as well as to educate women and community members about the cost of the drug.

To improve the medication for menstrual regulation experience, women suggested improvements in the clinical setting as well as in their community, and some of these suggestions address the issues we found in our study. Women wanted assurance of their confidentiality and privacy from the providers, which is an important piece of counselling about medication for menstrual regulation and which we found to be essential to women's positive experiences with medication for menstrual regulation. Counselling should also include information about side-effects and address any misconceptions about medication for menstrual regulation (e.g. it can affect a woman's fertility). Women in this study also thought that there could be even more in-depth counselling by providers about the option of medication for menstrual regulation instead of other methods and they wanted services available closer to their homes. Informants also emphasised the importance of reducing stigma in their communities so that they could seek support from within them for medication for menstrual regulation. Women suggested that medication for menstrual regulation be more widely advertised by television, radio and written advertisements so that they and their communities could be aware of the options for medication for menstrual regulation.

Conclusion

A majority of women in our study had positive experiences with medication for menstrual regulation and had successful outcomes, regardless of whether they obtained their medication from medicine sellers/pharmacies, doctors or clinics. Women were strongly influenced by their providers when deciding which method to use. There is a need to educate not only women of reproductive age, but also communities as a whole, about medication for menstrual regulation, with a particular emphasis on branding the medication and the cost. Continued efforts to improve counselling by providers about the dose, medication and side-effects of medication for menstrual regulation, along with education of the community

about medication as an option for menstrual regulation, will help to de-stigmatise the procedure and the women who seek it.

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