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INDUCED ABORTIONS IN PAKISTAN: EXPOSITIONS, DESTINATIONS AND REPERCUSSIONS. A QUALITATIVE DESCRIPTIVE STUDY IN RAWALPINDI DISTRICT

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Summary. Over 2 million abortions occur annually in Pakistan, mostly in a clandestine and unsafe environment. This is an area of grave concern for the reproductive health of women. A dearth of credible data and incomplete information make the problem more difficult to address. This qualitative study was conducted in semi-urban settings in Pakistan to record perceptions and practices concerning care seeking, experiences and outcomes regarding induced abortions and post-abortion care services. Women who had had induced abortions and abortion service providers were interviewed. Unwanted pregnancies and poverty were found to be the main reasons for seeking an abortion. Moreover, the unwanted pregnancies occurred due to low use of contraceptives, mainly due to a fear or past experience of their side-effects, unfamiliarity with correct usage and perceived inefficacy of the methods, especially condoms. There is an obvious need for practical and innovative interventions to address unmet need for birth spacing through improved access to contraceptives. Contraceptive providers should be provided with up-to-date and detailed training in family planning counselling, and perhaps allowed unrestricted provision of contraceptives. As a long-term measure, improvement in access to education and formal schooling could increase young girls' and women's knowledge of the benefits of family planning and the risks of unsafe abortion practices. Males must be involved in all the initiatives so that both partners are in agreement on correct and consistent contraceptive use.

Introduction

The World Health Organization defines an unsafe abortion as 'a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards,

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or both' (WHO, 2012). The idea of an unsafe abortion, however, encompasses a wider range of characteristics. In many parts of the world, women may not seek medical care following an unsafe abortion even after the emergence of complications, owing to numerous legal, social and cultural factors, resulting in a substantial toll of maternal deaths. Lack of knowledge among women regarding the law on abortion is another major factor (Bose & Trent, 2006; Thapa *et al*., 2014). The 1994 International Conference on Population and Development in Cairo resonated its commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to unsafe abortion through expanded and improved family planning services (United Nations, 1994). Despite numerous interventions, little headway has been made in the reduction in maternal mortality due to unsafe abortion (WHO, 2011). In 2003, it was estimated that 42 million pregnancies worldwide had been terminated voluntarily, of which 20 million were terminated with unsafe methods (Sedgh *et al*., 2007). Mortality from unsafe abortion is fifty times greater than that following safe pregnancy termination (Sundstorm, 1993). Unsafe abortion, being one of the three major causes of maternal mortality (the other two being haemorrhage and sepsis following childbirth) make up half all of maternal deaths globally (WHO, 2008); and alone they account for about 13% of all maternal deaths (WHO, 2004).

The annual number of pregnancies in Pakistan is around six million, and 14% of these culminate in induced abortions. Of all unwanted pregnancies, which amount to 37%, a third are fated for an abortion, mainly because of poverty (Sathar *et al*., 2007). The figure for annual induced abortions in Pakistan rose from 890,000 (Casterline *et al*., 2004) to 2.25 million in 2012 (Population Council, 2014). In light of the high prevalence of induced abortions in Pakistan, and more importantly the alarming number taking place clandestinely with little or no regulation of medical practice, this has become an area of grave concern. Moreover, the socio-cultural factors related to access to health care, particularly for abortion-related services, are more dominant in such localities and communities, where there are no formally trained health providers. Women's empowerment for decision-making regarding their own health is also very limited or negligible (Shaikh *et al*., 2008). So women seeking abortion are more vulnerable, and the health system must be more responsive to the needs of those from disadvantaged communities. The problem remains relatively unexplored and, therefore, requires further investigation to bring the issue to the surface and help policymakers develop guidelines.

This study was conducted with the broad aim of contributing towards improving the reproductive health status of women of childbearing age in Pakistan by reducing mortality and morbidity related to unsafe abortions. The specific objectives of the study were to explore the reasons for abortions, to study the health-seeking patterns of women and to determine the perceived quality of care received by married women seeking abortions in a semi-urban setting in Pakistan.

Methods

Study setting

The study was conducted in Gujar Khan, the largest of seven sub-districts of metropolitan Rawalpindi in the Punjab Province of Pakistan, approximately 55 km

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south-east of the capital Islamabad. Gujar Khan is administratively subdivided into 30 Union Councils, both semi-urban and rural. It covers an area of 567 square miles and has a population of approximately 493,000. Gujar Khan has one secondary care hospital, three rural health centres, 27 basic health units and numerous small private clinics. Compared with urban centres, the semi-urban/rural areas of Gujar Khan have even poorer quality health facilities, and therefore women living in the district are at greater risk. Gujar Khan was selected as the study area because the issue of unsafe abortion has been little explored there, and because of the need to understand this particular context. Furthermore, the district has a diverse socioeconomic profile, ranging from indigent to semi-urban Union Councils. It was thus expected to have a range of income strata, hence reaching saturation of data, representing all sections of the population in the study area. The study period spread was over four months from April to July 2012. The researchers did not have any prior professional or personal connections in the study area.

Study design

This was a cross-sectional, qualitative study aimed at exploring and understanding the reasons behind induced abortion and the underlying circumstances; the health-seeking pattern of women, and the perceived quality of care they received. Qualitative research methodology explores issues holistically and reflects the diversity and variation of lived experiences, and thus the 'human' side of a matter (Erlingsson & Brysiewicz, 2013). It allows a rich understanding of the social context around an issue, and the exploration of otherwise intangible factors such as gender roles, the role of economics and social norms. In-depths interviews were conducted, each spanning a period of 1 to 1.5 hours. Due to the sensitive nature of the study, focus group discussions were not conducted, thus maintaining the highest level of participant confidentiality. Including men in the study, and inquiring about their perceptions, could have proven useful, but time limitation did not allow this. Due to time constraints, the study was conducted in one sub-district only; therefore, the information collected from this community may not necessarily be representative of the entire country, but only of similar settings.

Sampling

Purposive sampling was adopted to select clients and health care providers. Married women living in Gujar Khan, who had an induced abortion in the past six months, were identified as potential participants. Similarly, health care providers (both formal and informal) providing abortion-related services were identified. Given the real-world context in which most qualitative research is carried out, recognizing and negotiating access to research sites and subjects are critical parts of the process. Therefore Lady Health Workers (LHWs) were engaged in each area as our key informants to help identify participants, as well as to help develop a rapport with the women and providers. In order to engage LHWs, special written permission was obtained from the District Health Officer. The LHWs identified the participants (clients and providers) and visited them twice, once alone and once with the Principal Investigator (PI), before data collection to build a rapport and to explain the study objectives. A list of all those who

agreed to participate was finalized by the LHWs and the PI. An informed written consent was obtained from all those who agreed to participate in the study. The socio-demographic characteristics of the women respondents were as follows: age range 22–37 years; parity 0–7 children (median 3 children); 20% were illiterate, 50% had primary schooling only, 28% had done a 'matriculate' (or 'matric' for short; an exam taken at around the age of 16 at $9^{th}/10^{th}$ grade), and only 2% reported attending a higher secondary school; the majority (76%) were housewives, the rest working as maids, labourers or farm workers.

Field questionnaire

A field questionnaire comprising semi-structured, open-ended questions was used to conduct interviews with the clients and providers. For each question, 2–4 probes were developed with the help of a thorough literature review. Age, parity, occupation, husband's occupation, education and monthly income of the participating women were also recorded. The questionnaires were translated into Urdu, and pre-tested to check the sequencing of questions, identify redundant questions and to add some new ones. The questions included: What is an unwanted and untimely pregnancy? What do you know about abortion? What are different methods of inducing an abortion? When and from where did you seek advice for abortion? What does religion say about abortion? Which provider did you approach for abortion and why? How did you find the skills of the provider? Were there any complications after abortion? If chosen as a birth spacing method, would you again go for abortion or would you use contraceptives, and which ones?

Data collection and analysis

The interviews were audiotaped, and a note-taker took field notes. Data were collected until saturation was reached, i.e. no new information was being generated. A total of 25 clients (women who had an induced abortion within the past six months) and eight health care providers were interviewed, located in different parts of the study area. Data collected were transcribed in Urdu and then translated into English so as to get a descriptive record. The transcriptions were read, on a daily basis, several times by the PI and co-authors to gain an in-depth understanding of participants' life experiences and explanations of their reasons for choosing induced abortions, their health-seeking patterns for the same and the perceived quality of the care they received. This exercise helped in triangulating the information gained from the clients with that of the health care providers.

The analysis was done manually using the thematic content analysis method. Thematic analysis is a method for identifying, analysing and reporting patterns within data, which minimally organizes and describes data sets in rich detail, thus providing answers to the research question (Brauna & Clarke, 2006). Indexing was performed for the in-depth interview questions and the probes to develop codes. In order to improve the rigor of analysis, the coding schemes of different members of the research team were compared and rationalized where they disagreed. The finalized codes were grouped together into higher order sub-categories and then categories using the process of Inductive Category Development, where the data material is worked through and

categories are deduced in a step-wise fashion, directed from within the data set itself (Thomas, 2006). Related categories were aggregated as sub-themes and were later analysed to develop the thematic areas. Information gathered from the interviews was then triangulated among the respondents, i.e. clients and providers, and then with the literature to find similarities and differences on the issues surrounding abortion.

For the purpose of result writing, a descriptive model was used that applied a summary description followed by illustrative quotes from the data, i.e. verbatim from the respondents. The quotes that best described the categories were selected.

Ethical approval

Ethical approval for the study protocol was sought from the Institutional Review Board (IRB) of the Health Services Academy Islamabad. Respondents were given the right to informed verbal and written consent. Confidentiality of information and anonymity of respondents was ensured by keeping all the recordings and transcriptions in the locked custody of the Principal Investigator.

Results

The results are presented under seven main themes, followed by their sub-themes. In the quotations 'C' stands for client and 'HCP' stands for health care provider.

Reasons for unwanted pregnancies

When inquired about the reasons for unwanted pregnancies that were ultimately terminated as induced abortions, the respondents provided a rich set of information.

i) Non-use of contraceptives. The most common reason given was the non-use of contraceptives. When probed for a detailed account, a number of background factors emerged as being responsible for this non-use. Of these, the fear of side-effects of various contraceptive methods was the most commonly cited, and women were of the view that modern temporary contraceptives caused bleeding, infertility, obesity, cancer and even goiter:

> There are different perceptions among women regarding the family planning methods. They think that by using these tablets and injections, they will start menstruating heavily. This is the reason due to which I too didn't use anything. I have also heard that these cause menstrual irregularities and that women cannot become pregnant again for a long time or perhaps never.
>
> (C#2, age 23, primary education)

Among the other reasons mentioned by the respondents, the frequent ones were husband's disapproval of contraceptives, some serious side-effects leading to discontinuation of that particular method, general health issues, certain religious beliefs and fear of surgery (in the case of tubal ligation). About husband's disapproval, a woman shared:

> Many men do not use condoms because they don't enjoy having them on and are not satisfied.
>
> (C#14, age 26, higher secondary education)

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The experience of side-effects was mentioned by a woman:

> All these methods of family planning cause side-effects. When I was using tablets, they were giving me nausea. Before these tablets, I used injections but my menses stopped altogether, so I had to quit. Once I also had a tube inserted in the vagina, but it also caused bleeding.
>
> (C#18, age 30, no education)

Lastly, there were also respondents who perceived that they were naturally infertile for the period quoted:

> I got pregnant because I was not using any family planning methods. This was because I was breast-feeding my son, and the doctor had told me that I won't get pregnant while breast-feeding.
>
> (C#23, age 30, no education)

ii) Ignorance of contraceptive methods and their usage. Some of the respondents admitted that they did not know how to use contraceptives properly. One articulated:

> I was using pills but would skip doses, so got pregnant. I didn't have much knowledge that pills had to be taken daily and so regularly.
>
> (C#18, age 30, no education)

A more or less similar response was:

> I had heard about some pills and injections, but I never took an interest in them nor did I try to gain any knowledge about them.
>
> (C#1, age 27, matric education)

ii) Other reasons. God's will, non-availability of the product and refusal of the doctor to perform tubal ligation were quoted as other reasons for getting pregnant.

> That's all God's will. Even if we humans don't want it to happen, still it will happen if God wants it to.
>
> (C#19, age 25, primary education)

Another woman shared:

> At the time of my last delivery, I asked the doctors to do a permanent operation. They didn't agree and said you have only one daughter and a son. I told them that I have my ultrasound done, and this baby is also male and two sons and a daughter are enough for me. But they refused, and as a result I had another pregnancy because our condom ruptured.
>
> (C#8, age 28, primary education)

Virtually the same reasons were reported by the health care providers interviewed, and by and large the same frequency. Non-use of family planning was quoted as the most frequent reason, followed by carelessness and inefficacy of method use. Some statements are given below:

> I think it's merely carelessness. These family planning methods are available everywhere free of charge or at a minimal cost. But these women don't listen at all. There are

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> also misconceptions. When I tell them to use various methods, they start counting different side-effects. Many husbands don't allow their women to use these family planning methods. Especially regarding tubal ligation; they are very much against it. They consider it against Islam, and perhaps another reason is that they think that the female will lose her feminine nature and characters. They even threaten their wives with a second marriage, if they would opt for tubal ligation.
>
> (HCP#4)

> Condoms given by the national family planning programme are not reliable at all. I do private abortions, and many women who come to me are those who say that they were using those condoms.
>
> (HCP#6)

Factors leading to the decision to have an induced abortion

i) Economic constraints. Most women held poverty as being responsible for their decision to have an abortion, admitting that they could not afford to have any more children. The responses were more or less alike, such as:

> There are too many problems now, especially inflation. When I was last pregnant, I wanted very much to deliver but what can I do? I cannot even fulfil the needs of my present family. My husband is jobless, whereas I have to feed my children and educate them.
>
> (C#10, age 30, matric education)

The health providers were of an identical view and mentioned poverty as the main force compelling women to terminate their pregnancies:

> Most of the people here are very poor and they don't earn much. Poverty is one of the major reasons behind seeking abortions.
>
> (HCP#2)

ii) Unwanted and untimely pregnancy. The second most important factor that surfaced was an unwanted and mistimed pregnancy. According to the women, this was mostly due to a young child or children, complete families and husband's opposition to having another child:

> My son was very little when I had my daughter. I know that it causes great problem when you already have a small kid and you deliver another. My son got ill with diarrhoea. I could look after neither my children, nor the house.
>
> (C#1, age 27, matric education)

Unwanted pregnancy was the second most frequent factor behind an induced abortion, mentioned by the health care providers as well. In addition to the grounds mentioned by the women, the health care providers had more familiarity and so added some more factors which, in descending order, were: illegitimate babies, female fetus, fetal abnormality and pregnancies among commercial sex workers. This understanding of the health care providers was based on their own practical experience.

i) Potential care health providers. The most frequently consulted provider was a *dai* (traditional birth attendant). Others included doctors, nurses and Lady Health Visitors (LHVs: skilled nurses with a diploma working in the public sector):

> There can be different health providers you know. Doctors, nurses, LHVs and *dais* are some I have heard of. Regarding complications, they all are the same. A complication occurs due to God's will, may the provider be a doctor or a *dai*.
>
> (C#2, age 23, primary education)

ii) Reasons for provider preference. Most women declared that they went to a doctor for the induced abortion because they already knew the doctor, and because she/he was their family doctor:

> I went to a doctor because I always go to her, whenever I have some problem.
>
> (C#5, age 25, matric education)

The second-best choice of the women was a LHV, because of her being nearby and known to them. Husbands too preferred LHVs because they charge less than the doctor:

> There is an LHV in our area, and I went to her. For going to a doctor, you have to consider a lot of things and foremost is the money at hand.
>
> (C#4, age 37, matric education)

The few women who went to a *dai* did so because they could not afford a doctor. A few of them didn't even know who the abortion provider was. Some of the women played the part of provider themselves because either their husbands bought them some tablets, or because they had already heard of some tablet, so they took it:

> Husband bought some tablets; don't know from where and from whom.
>
> (C#20, age 30, no education)

When health providers were asked about women's preferred providers, contradictory opinions were picked up. The doctors asserted that most of women go to *dais* and consult them after a complication; whereas *dais* claimed that women go to doctors nowadays and come to them only when the doctor refuses to provide the service.

One doctor stated:

> They never prefer a doctor because of the financial issues. They go to *dais* and LHVs and come to us when they suffer some complication.
>
> (HCP#4)

And according to a *dai*:

> They usually go to the doctors nowadays, except those who don't know of any doctor assisting in abortion. The women who come to us have already visited a doctor, who has refused or is charging more.
>
> (HCP#1)

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iii) Issue of finding a service provider for abortion. The women highlighted the issue of finding an abortion provider. They said that doctors often do not agree to perform an abortion. Some health providers will do it, but only in secret so as to avoid getting a bad name, as abortion is not considered permissible in Pakistani society. The women said they had to ask many people before finding a provider who was ready to help:

> Yes, you do have to search for them and ask many people. It's quite difficult to find out who provides the service and who doesn't. They don't do it openly as they fear bringing a bad name to them.
>
> (C#18, age 30, no education)

The health providers thought otherwise. According to them, it is quite easy for women to find the health providers as every other provider is offering these services, and most of the health providers, such as LHVs, *dais* and midwives, can be found in the women's communities:

> I would say it's quite easy these days. The village women when they sit together always gossip about these things and come to know of the various health providers. Besides, we and various *dais* socially interact with the community here, and all women know us well.
>
> (HCP# 5)

Competence of abortion provider and adequacy of service

i) Experiences related to the procedure. The majority of women had their abortions done by tablets, injections and instruments used either alone or in combination. Some had also tried home remedies. The most popular method among the health care providers was dilatation and curettage, followed by tablets and injections. Some also reported using black glycerin, copper T and oxytocin drips. Very few used the manual vacuum aspiration.

ii) Disinfection and sterilization. Almost all the women admitted that the clinic and equipment were clean, except for one or two. However, they did not know whether the instruments were boiled/autoclaved or not:

> Yes the clinic was neat and instruments also seemed to be clean, though the health provider didn't boil them in front of me.
>
> (C#25, age 25, no education)

Health care providers, on the other hand, mentioned washing with soap, phenyl or Dettol to clean the place, while instruments were washed and then boiled in an ordinary pot. Very few had proper sterilizers, and only one had an autoclave.

iii) Health care providers' competence. All the women were satisfied with the doctor's treatment, yet they used this expression with reference to their age and experience, and not the actual qualification of the provider:

> I think she is quite old, and, therefore must be experienced too.
>
> (C#7, age 22, primary education)

Legal status of abortion: ignorance and fallacies

i) Knowledge of abortion law. Not a single woman knew the exact law in Pakistan pertaining to induced abortion. Some had heard of a law that defines abortion; however, the overall knowledge was not substantial at all:

> I don't know about any law nor do I care, because God is the one responsible for punishments and rewards; not the law.
>
> (C#2, age 23, primary education)

The health care providers too did not know any details of the law. Some had never even heard of it, and didn't care. Some had the perception that if the abortion is done with the husband's permission, then it is not punishable by law:

> I know that if the baby is aborted with husband's permission, then it's allowed in law.
>
> (HCP#1)

ii) Suggested amendments to law on abortion. Once the participants were informed by the researcher about the law on abortion, they were asked to opine on any amendments they would like to see in this. Many women suggested that the law must allow induced abortions in genuine circumstances. On further probing, nearly all respondents were of the view that, except for aborting a girl child, all are valid reasons for abortion:

> It should be allowed if inevitable. Those who abort without any genuine reason must be punished. Some people here are so poor that they cannot even buy medicine worth Rs10. If the family planning commodities had been charged, many people wouldn't be using them at all. I came to know recently that LHWs give these things free; otherwise the family planning centres give an injection worth Rs 50. Instead of spending Rs 50 there, why shouldn't I save some more money and buy flour?
>
> (C#21, age 22, primary education)

> Look, the baby I aborted was a legitimate child of my husband. If I abort a legitimate child and that too with my husband's permission, then it should be allowed.
>
> (C#22, age 32, primary education)

Among the health providers, a majority supported allowing abortion for all genuine reasons, especially for the sake of the health of the mother. When asked about who should decide what is or isn't a genuine reason, they had no explicit idea.

Costs of induced abortion

i) Health costs. The women were well aware of the various complications and problems that can ensue following an unsafe abortion. They mentioned bleeding, infection, trauma, infertility and even death. Although many were lucky enough not to suffer any of these themselves, there were others who had endured them; in particular bleeding, backache and abdominal pain.

The health providers also spelled out various complications following an unsafe abortion. A number admitted dealing with complications either during their own

procedures or when they attended patients treated by some other, unskilled provider. The most frequent complication cited by them was haemorrhage. A few also described dealing with a ruptured uterus and infection of patients who had been handled by a *dai*.

ii) Financial costs. As for the direct cost of the procedure, the women mentioned a wide range from Rs 500 to Rs 9000. They were of the view that doctors charge more than *dais* and midwives. On the other hand, the health care providers declared that the cost of a procedure is determined by the duration of the pregnancy, affordability for the patient and even the legal status of the conception:

> I am a *dai* and people give me very little money. If the person is affording, then I take Rs 4000 for a fetus of one month.
>
> (HCP#1)

The fee demanded could be quite high for women under severe obligation to abort:

> When women with illegitimate babies come to me, then I charge even more, as they have to get rid of it at any cost.
>
> (HCP#6)

Post-abortion pregnancy desire and contraception

i) Contraceptive information dissemination. A majority of the women admitted that they received the information about various contraceptive methods from their health providers at the time of an abortion, and they had also started using it. Moreover, all the health providers asserted that they disseminated information about contraception after providing women with an induced abortion. Nevertheless, they complained that even after the procedure, many women did not listen to their counselling with any interest:

> Yes, I have everything available and I do provide them with information. Some women do take more interest in gaining information once they are done with the procedure.
>
> (HCP#3)

ii) Contraceptive method being practised. The majority of the respondents mentioned using condoms post-abortion; very few were using injection or pills, and several were still relying on the withdrawal method. The health providers also confirmed that the most popular method used by women was the condom, followed by pills and then injections.

Suggestions to improve family planning services

Respondents were asked to make suggestions to improve the family planning services in their country, the absence or inadequacy of which leads to unwanted pregnancy, and ultimately induced abortions, mostly unsafe. The majority mentioned that it is of utmost important to overcome the misconceptions related to contraceptives, especially the rumours about side-effects:

> I think we should put emphasis on addressing the fears of side-effects among women, and also more emphasis should be put on dispelling the misconceptions that prevail regarding family planning methods.
>
> (C#6, age 25, primary education)

Women were of the view that men are usually the decision-makers in the family, and their word is considered as final; so they should be the ones telling their women about contraception and not vice versa:

> It all depends on men. They are the ones who have to understand the importance of birth spacing. They are the ones responsible for the health of their wives. They should be with their wives in every decision and allow them to use these methods. They need to be changed and be educated about this issue.
>
> (C#5, age 25, matric education)

Some even pointed out that the LHWs should be provided with the best and latest contraceptives, and that they always carry old products:

> Many new types of tablets are available, but LHWs are not providing these to us. If our family planning programme is based on LHWs, then they should be provided the best commodities.
>
> (C#7, age 22, primary education)

A small number suggested improving education as a whole to bring enlightenment and awareness among the masses on issues of reproductive health, including birth spacing and abortions.

> I think these issues will only be resolved with education and awareness. The government should focus on girls' education, and then they will start understanding what's good for them and what's not, and will opt for family planning more and more.
>
> (C#11, age 26, matric education)

The health care providers did not come up with any exceptionally different suggestion, except legalizing abortion for valid reasons to prevent maternal morbidity and mortality. A majority did not know what to say and regarded it as a hopeless effort and to let it be:

> A person coming for abortion is always extremely adamant, and if a doctor refuses her, she will still do it and go to an inexperienced *dai* for service. So I am of the view that if the doctors start giving abortions, in justified conditions, then perhaps complications can be prevented or reduced.
>
> (HCP#1)

> Regarding family planning practices and methods, I don't think things are going to change in the near future. We are not giving birth to human beings but numbers.
>
> (HCP#4)

Discussion

In Pakistan unwanted pregnancies remain a challenge, as one in three result in induced abortion, mostly unsafe, and the primary reason is low contraceptive use, indicating a high unmet need. One study in Pakistan found that 55 out of 72 terminated pregnancies occurred through lack of knowledge about contraceptives (Arif & Kamran, 2007). Lack of knowledge and awareness, coupled with a fear of the side-effects of hormonal contraceptives, have stopped many women using modern contraceptives. Moreover, husband's disapproval and deep-rooted beliefs also prevent women from using

preventive measures. Those who do use contraceptives often complain about their efficacy. Of course, the fact is that temporary contraceptive methods are far less effective than permanent ones (Gazdar *et al*., 2012). In the current study a few clients shunned all the arguments and just saw unwanted pregnancies as being God's will. These clients remain, by and large, the most stubborn ones. More or less, all these factors leading to unwanted pregnancies stem from a lack of education (Angeles *et al*., 2005; Bonnen *et al*., 2014; Dias *et al*., 2015).

While the factors resulting in unwanted pregnancies have been well established, the next problem is to determine the reasons why woman seek induced abortions. This study found financial constraints to be the foremost reason, a finding concurring with previous studies, one in Rawalpindi (Arif & Kamran, 2007) and another in Karachi (Saleem & Fikree, 2001). Health care service providers put forward a range of reasons: illegitimate conceptions, untimely pregnancy, economic reasons and pregnancies among commercial sex workers. A female fetus could be another reason to abort, but this was not alluded to very openly (Abrejo *et al*., 2009). Therefore, the social set-up, economic status, domestic issues and community norms are the primary antecedents of seeking abortions, and the literature supports these factors (Mumtaz & Salways, 2005; Erfani, 2011).

This study found the family doctor to be the first choice of abortion service provider, followed by an LHV and a *dai*. This is contrary to the findings of an earlier study in Pakistan (Population Council, 2004), where *dais* emerged as the top providers of abortions among the urban poor. The health care service providers in this study admitted to using boiling and simple antiseptics for sterilization. Very few had proper sterilizers, and almost none had an autoclave. Although women are aware of unsafe post-abortion complications, this does not stop them for consulting such health outlets. This is evident from the literature as well (Saleem & Fikree 2001). Little awareness of post-abortion check-ups was found, and this is in concordance with a previous study (Fikree *et al*., 2004).

The fees for the procedure in this study ranged from PkRs 500 to 9000, which is in concordance with a recent study in Pakistan (Naghma-e-Rehan, 2011). The legal status of the child, especially, is a significant determinant when it comes to the fee for a procedure, and it is widely established that all the providers exploit clients when the pregnancy is illegitimate. This has been reported in another study in Pakistan (Rashida *et al*., 2003). The most commonly used contraceptives in the study were condoms, followed by withdrawal, as was found by another study (Kamran *et al*., 2011). Vasectomy, despite being popular in the West, remains the least commonly used method (Soomro, 1994).

With regards to the law on abortion, neither the women nor the health providers in this study had the correct knowledge. Whereas, a study from Lahore showed that most health care providers were familiar with the law on abortion (Rehan, 2003). A study from India, however, has also shown extreme ignorance on the part of clients (Hirve, 2004). However, when the law was explained to the women, most of them became very vocal about amending it, stating that abortions should be permissible for genuine reasons. The Pakistan Penal Code largely shuns abortion and only allows it to save the life of the mother, or to provide her with necessary treatment (Azmat *et al*., 2012). On the religious grounds, the concept of 'ensoulment', as agreed upon by most Muslim scholars, has been decided as a cut-off point for abortion, and that abortion is a sin after

this has occurred. Specifically, ensoulment is believed by most Muslim scholars to occur 120 days after conception (Hessini, 2007).

In conclusion, since the primary factors underlying induced abortions in this context are unwanted pregnancies and poverty, this study provides clear information for practical and innovative interventions to address unmet need for contraceptives in rural communities in Pakistan. Overarching strategies to reduce prevailing poverty could make a small dent in the number of women resorting to unsafe abortions. More than 66% of Pakistan's population, mostly rural, are served by Lady Health Workers. With up-to-date, detailed training in family planning counselling and unrestricted provision of contraceptives, they could potentially deal with the issue very well. Many women still seek the services of informal health care providers, and women's access to safer, mainstream service providers needs to be improved. Improvement in access to formal education could play a significant role in informing young girls and women about family planning. Furthermore, the problem of unsafe abortions is likely to persist unless there is a strengthening of women's access to proper advice on contraception and post-abortion care, and increased women empowerment, especially in decision-making. The government of Pakistan and private and non-governmental organizations need to recognize unsafe induced abortion as a major public health issue.

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