Women's Abortion Seeking Experience in Rural Chakwal, Pakistan

by

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Abstract

Background: In Pakistan, abortions occupy a highly contentious space. Legal and religious restrictions have created a substantial social stigma around this procedure. Irrespective of this restrictive environment however, women continue to pursue abortion services often turning to clandestine means in order to keep the procedure a secret. While this does allow women to maintain privacy, these unsafe services greatly elevate risks of maternal morbidity and mortality. Nonetheless, the topic of unsafe abortion and its impacts on maternal health remains understudied. To gain a better understanding of the abortion landscape in Pakistan, this study investigated women's abortion seeking behavior in the rural setting of Chakwal, Pakistan. Specifically, this study explored why demand for abortions has increased, and whether providers are willing to meet the increased demand.

Methods: A focused ethnography was conducted in Chakwal, Pakistan from September to December of 2013. Participants were recruited from the Rahnuma Family Planning Association of Pakistan, a non-governmental organization that provides family planning and reproductive health services, including abortions. Twenty three in-depth interviews were conducted with women seeking, or that had received an abortion and fourteen in-depth interviews were conducted with the facility's healthcare providers. One focus group discussion was conducted with providers.

Results: Findings revealed women had a strong desire to control fertility, but this need was not being met through contraceptives. Where confronted with an unplanned pregnancy women turned to abortions, specifically through the drug misoprostol to limit their fertility. The ease of this abortifacient's use not only enabled an increased reliance on abortion to terminate unplanned pregnancy but possibly as a preferred means of fertility regulation. Furthermore, safe abortion services were found to exist within a clinical setting. Two NGO's were providing safe, clinical abortion services through trained providers. But at the interface between patients and the health system, providers emerged as a key barrier in women's ability to access safe abortion services. Provider's negative views of the procedure and a system of patronage led to restrictive provision of this service.

Conclusions: To support women's access to safe abortions we recommend training mid-level providers to safely administer misoprostol within women's homes, as part of their existing home based care. Improving contraception uptake will also be important to prevent abortions in the first place. Furthermore, there is a need for greater attention to be given in hiring providers who are willing to conduct abortions, to improve providers counseling skills, and expand family planning services.

Preface

This thesis is an original work by Harneet Chahal. This research project, of which this thesis is a part of, received ethics approval from the University of Alberta Research Ethics Board, Project Name “Abortion seeking behavior among rural women in Chakwal, Pakistan” No. Pro00040576, 7/16/2013.

Dedication

To the women of Chakwal.

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List of Abbreviations

BZ	Behtar Zindagi
FP	Family Planning
D&C	Dilation & Curretage
ICPD	International Conference on Population Development
R-FPAP	Rahnuma Family Planning Association of Pakistan
MA	Medical Abortion
MDG	Millennium Development Goal
MS	Marie Stopes
MVA	Manual Vacuum Aspiration
NGO	Non-governmental Organization
PAC	Post Abortion Care
RH	Reproductive Health
TOP	Termination of Pregnancy
WHO	World Health Organization

Chapter 1: Introduction and Literature Review

INTRODUCTION

Reducing maternal mortality continues to be a pressing challenge for health systems around the world (Rai, Anand, Misra, Kant, & Upadhyay, 2012). For nearly three decades leading up to the year 2015, numerous attempts have been made to galvanize international commitments in reducing maternal morbidity and mortality. These include efforts initiated through the Millenium Development Goals (MDGs), the International Conference on Population and Development (ICPD), and the Safe Motherhood Conference all of which drew attention to the global impacts of maternal morbidity and mortality and the need to improve maternal health (WHO, 2005; Cook, 2006; Rehan, Inayatullah, & Chaudhary, 2001). But in the decades since these efforts were launched, while some countries have successfully improved maternal health outcomes (such as Bangladesh, Peru, Nepal, and Mexico) others have seen only marginal improvements (Shrivastava, Shrivastava & Ramasamy, 2013; Kmietowicz, 2012; Department of Health, n.d.).

One significant but commonly overlooked contributor to maternal mortality that continues to threaten the health of millions of women during their reproductive lives, is unsafe abortions (Warriner & Shah, 2006). As defined by the World Health Organization (WHO), unsafe abortions are the termination of an unintended pregnancy by individuals lacking the necessary skills or in an environment that does not conform to minimum medical standards, or both (WHO, 1992). Worldwide an estimated 22 million women undergo unsafe abortion every year, with 47,000 dying as a result of avoidable complications (WHO, 2012). Globally, this accounts for 13% of all pregnancy related deaths (WHO, 2011; Shaikh, 2010). An additional two to seven million women are estimated to suffer from an array of adverse health consequences resulting from unsafe abortions. Some of the most immediate include septicemia, hemorrhage, gas-gangrene, uterine perforation, genital tract injuries, bladder injury, gastrointestinal injuries, and acute renal failure. There is also a risk of many long-term disabilities such as chronic pelvic pain, pelvic inflammatory disease, secondary infertility, ectopic pregnancies, and chronic renal failure (Oye-Adeniran, Umoh, & Nnatu, 2002).

In addition to direct impacts on the mother's health and wellbeing, unsafe abortion also carries a number of indirect consequences (Grimes et al., 2006). This includes an emotional, social and financial burden on the woman and her family who must now cope with the consequences of an ill or deceased mother (Grimes et al., 2006). Unsafe abortions also acts as a drain on the health care system's limited resources as treating abortion complications requires a significant investment of health personnel, medications,

blood, supplies and overnight hospital stays (Grimes et al., 2006). These wide spanning consequences indicate that the cost of unsafe abortion are carried by society as a whole.

Although a global problem, the burden of unsafe abortion is not proportionately felt around the world. Most (98%) occur in developing or low-income countries, where abortions are often restricted by law and where health systems already struggle to meet peoples most basic health needs (Grimes et al., 2006; Baldwin, 2006).

Pakistan is among these developing countries that continues bear the burden of unsafe abortions. Two key forces that shape the accessibility of this procedure in Pakistan are law and religion. Legally, abortion is permitted on the condition that it is required to save the mother's life or to provide the mother with necessary treatment (Zaidi et al., 2014; Dalvie, Barua, Azmat, & Mustafa et al., n.d.). Similarly, the dominant religious view holds that abortions are permissible prior to 120 days of gestation only where a genetic condition has been identified (Jafri et al., 2012). While the conditions underlying these rules are poorly explained and several social, medical and psychological factors are left out dominant interpretations of the law and religion largely present abortions to be a highly restricted procedure (Azmat, Bilgrami, Shaikh, Mustafa, & Hameed, 2012a). This has created a substantial social stigma around abortions in which women who seek abortion services are often viewed as sexually promiscuous, unfaithful and are ultimately seen as violating gendered and cultural norms (Azmat, Shaikh, Mustafa, Hameed, & Bilgrami, 2012b; Kumar, Hessini, & Mitchell, 2009).

Irrespective of this restrictive environment however, unsafe abortions persist. Between 2002 and 2012, rates of induced abortion increased**,** from 890,000 to 2.25 million indicating an increasing demand for termination of pregnancy (Sathar, 2015). This means that out of estimated 4.2 million unintended pregnancies in Pakistan in 2012, over half (54%) were resolved through induced abortions (Vlassoff, Singh, Suarez, & Jafarey, 2009; Sathar, 2015). But in a setting that heavily restricts the procedure, this is concerning as women may be forced to subject themselves to unsafe and life threatening services. The negative consequences of this are reflected in the estimated 6-11% of maternal deaths that result from complications of unsafe abortion (Azmat et al., 2012b; Rukanuddin, Ali, & McManis, 2007). Furthermore, in 2012 alone an estimated 623,000 women sought post abortion care (PAC) as a result of complications of unsafe abortions (Sathar, Rashida, Shah, Singh, & Woog, 2013). This is likely an underestimation as there still may be more women who need but are unable to obtain any care.

Given the consequences of unsafe abortion, there is a need to understand why demand for induced abortions is growing and how Pakistan is positioned to respond to this. To explore these issues, a

literature review was conducted. Searches were done in the databases MEDLINE, Embase, Global Health, and PsycINFO. Sociology databases such as Sociologic Abstracts, Social Science Citation Index and SocINDEX were also searched given the experiential and behavioral focus of this research. This review was supplemented by searches in Google Scholar and Google. A combination of the terms "abort*", "termination of pregnancy", "access*", "provider*", "attitude*", "willing*" "perception*", "perspective*", "decision*", "prefer*", "Pakistan*"were used. Relevant papers were first selected based on their title, then narrowed down by reading through their abstract, followed by reading through the paper. Fourteen articles were found to be relevant to the topic of interest. Findings from this literature review have been presented below according to the most prevalent themes that emerged, namely: why demand for abortions may be growing, abortion methods, abortion services and provider attitudes.

LITERATURE REVIEW

Growing demand to limit fertility has translated to a growing demand for abortions

The literature suggests a growing desire to limit fertility paired with an unmet need for family planning through contraceptives may be driving the increased demand for induced abortions. Common reasons women reported for seeking an abortion included too many children, short birth spacing & contraceptive failure, with the common thread among these being a desire to limit or control fertility (Rehan et al., 2001). These reasons were given not only by women who had an abortion, but were also suggested by those who had not. In a study by Saleem & Fikree (2001) that investigated actual and perceived reasons for terminating an unplanned pregnancy, the most commonly reported reasons for termination of pregnancy among women *seeking* an abortion, was short birth spacing (45%) and too many children (15%) (ill health of the mother was cited by 13% of respondents) (Saleem & Fikree, 2001). Among women who had *never opted* for induced abortions, the perceived reasons were husband's unemployment (29.5%) and poverty (20.7%). Although the two sets of answers differed, the authors concluded that both groups described factors that directly influenced quality of life when the family size was large. Based on these findings it was inferred that limiting family size was the underlying rationale motivating the decision to terminate pregnancy (Saleem & Fikree, 2001). Drawing on data from the same study, Saleem & Fikree (2005) added that grand multi-gravidity (greater than five pregnancies) was also a strong predictor of induced abortions, once again indicating that pregnancies were terminated for purposes of birth spacing or limiting family size. More recent studies such as those by Rahim (2008), Shaikh (2010) and reviews by Khan AA (2013) and Khan (2013), indicate that these trends have remained consistent through time.

The predominance of contraceptive failure as a factor motivating pregnancy termination reflects that for some women a desire limit fertility does manifest in the use of contraceptives. For many women however, their efforts were not successful. Findings from Saleem & Fikree (2005) revealed that 40% of all abortion seeking patients in their study were using some form of family planning prior to conception. In fact, contraceptive use among abortion seekers grew from 40% to 50% in the post abortion period, demonstrating a persistent desire to limit fertility. It was also highlighted that women who had used contraceptives in the preceding pregnancy interval were twice as likely to resort to induced abortion as women who did not use contraceptives (Saleem & Fikree, 2001). Similar trends were highlighted in the review by Khan (2013) who went onto highlight that this trend indicated women were making the important decision to attempt to prevent pregnancy, but it did not work.

Despite prevention efforts by some women, recent contraceptive prevalence rates reported at 35% indicate that a significant proportion of women are still not using any family planning methods to prevent pregnancy (NIPS, 2013). Studies by Arif & Kamran (2007); Kamran, Arif & Vassos (2011); and Tsui et al. (2011), all found that even though couples did express a wish to limit fertility, no pre-planning prior to childbearing was done to meet these reproductive desires. Use of family planning remained low and inadequate by all standards and reproductive planning was largely non-existent (Kamran et al., 2011) (Tsui et al., 2011). It was not until several children were born, often in quick succession that family planning options were considered (Kamran et al., 2011). As Tsui et al. (2011) described, although couples did recognize that they had some influence on whether or not pregnancies occurred, and they had a high awareness of contraceptive methods (as well as a belief that they can be efficacious), conception was still commonly described as being beyond their control. It was viewed as a reflection of Gods will and was therefore something to be welcomed or at the least accepted dutifully (Tsui et al., 2011). Even if couples had reached their desired family size, not all were found to use contraceptives to limit further fertility (Tsui et al., 2011). This may be explained by a later finding highlighted by Tsui et al. (2011) that despite a preference for contraceptives, study respondents largely discussed them negatively, citing side effects, fear of infertility, weight gain, inconvenience (of condoms particularly), and high failure rates among their negative attributes. These findings indicate that despite a desire to limit or control fertility, there is a gap in women's actions to achieve those reproductive goals.

But regardless of whether women use or do not use contraceptives, the desire to limit fertility appears to be constant among abortion seekers. As Saleem & Fikree (2005) highlighted, irrespective of the patient's contraceptive use (using or not using), birth spacing and limiting family size were common reasons given for seeking an abortion. Similarly, Vlassoff (2009) highlighted that no evidence to date indicates

contraceptive use behavior influences whether or not women resort to induced abortion. In line with these findings, several studies have suggested that couples may be opting for opportunities other than modern methods of contraception to control their fertility, namely unsafe abortion (Saleem & Fikree, 2001; Saleem & Fikree, 2005; Vlassoff, 2009)**.** In line with this Rehan (2001) and Vlassoff (2009) highlighted women may be opting for abortion in place of contraceptives as a means to regulate fertility. This draws attention to a prevailing unmet need for family planning that is possibly being currently addressed by voluntary terminations.

Studies conducted by Arif & Kamran (2007), Kamran et al. (2011) and Tsui et al. (2011) however, all drawing from the same data, suggest a different picture. Working in the rural context of Tret Punjab, Pakistan, Arif & Kamran (2007) used qualitative methods to study how contraception and induced abortion are perceived, particularly as means to avoid unwanted births, and to understand ways of reproductive behavior decision making. This study revealed that men and women weighed the many health, and social consequences of contraceptives and abortions prior to their use (Arif & Kamran, 2007). In doing so, couples identified modern contraceptives as the preferred means of regulating fertility relative to abortions (Arif & Kamran, 2007). Couples described that abortions were only a back up to where contraceptives failed, not an alternative or replacement. Similarly Kamran et al. (2011) highlighted that despite low and inadequate use of contraceptives, and a fear of side effects or contraceptive failure, contraceptive use was still expressed as a more favorable fertility regulation option than induced abortions. Lack of contraceptive use however, led many couples faced with an unplanned pregnancy to consider induced abortion. Likewise Tsui et al. (2011) highlighted that virtually no mention was made of induced abortion as an alternative means of birth control or a disincentive to contraceptive use. When asked about the desirability of contraception versus induced abortion as means of birth control, contraception was consistently and overwhelmingly preferred (Tsui et al., 2011). The study however went on to explain that private choices to terminate pregnancy persist despite social sanctions against the procedure (Tsui et al., 2011). Many women were found to ignore the consequences of abortion stigma, especially if their economic or occupational circumstances were threatened by another pregnancy and if her husband was fully supportive and enabling of the decision. Given mixed findings however on the role abortions plays in allowing women to meet their fertility desires, additional research is needed on the issue.

Abortion method

The most common abortion method traditionally used by women in Pakistan was dilation and curettage (D&C) (Saleem & Fikree, 2001; Rahim & Ara, 2008; Rehan et al., 2001). D&Cs are procedures used for

termination of first trimester pregnancies in which a sharp curette is used to evacuate the uterus of its contents (Zaidi et al., 2014b). But in the time since these studies were conducted, newer abortion technologies such as such as manual or electrical vacuum aspiration (MVA or EVA) and medication abortion (MA) have become available. A study by Sathar (2013) specifically drew attention to the medical abortion inducing drug misoprostol. Misoprostol is a prostaglandin analogue drug that was initially developed for the use of gastric ulcers, but overtime has been used for gynecological purposes (such as induced abortion) due to its ability to induce uterine contractions (Cohen et al., 2005; Berer, 2005; WHO. 2012). In the study by Sathar (2013) it was reported that in 2012, slightly more than one-third of the study's healthcare provider respondents identified misoprostol as one of two methods women most commonly used to an abortion in urban areas; one-fifth of healthcare providers reported its use by women in rural areas. In comparison, misoprostol was hardly mentioned by providers surveyed in 2002. Given the controversy around abortions however, Khan AA (2013) expressed concern that the adoption of newer and safer procedures such as medical abortion through misoprostol has been delayed. No studies however have provided insight into this matter. Thus additional research is needed to better understand if and how the availability of new abortion technology, such as misoprostol, has affected women's abortion seeking behavior.

Abortion services

Pakistan's legal and religious stance on abortion suggests this service would be a rarity. But several studies show that women are obtaining abortions from not only traditional practitioners, but formally trained personnel such as doctors, nurses and Lady Health Visitors (LHVs), a cadre trained to provide midwifery services in rural areas (Vlassoff, 2009). In the study by Saleem & Fikree (2001), doctors and nurses were perceived to be, and were the most commonly sought providers among the study's respondents. Khan AA (2013), also highlighted that among the range of abortion providers are doctors and nurses. Shaikh (2010) revealed an equal number of doctors (36%) and LHVs (36%) were providing induced abortion services (20% of respondents went to a Dai and 8% went to a nurse). Rahim (2008) similarly found that 66% of their study participants had their abortion carried out by an LHV, and 10% by doctors. Between 2002 and 2012, a slight increase was recorded in the number of women who relied on physicians, while a slightly smaller proportion relied on midlevel providers, such as LHVs, nurses and other midwives (Sathar, 2013). In all of these studies however, it is not clear from where these trained providers were administering abortion services; whether it was from lone standing clandestine clinics or from within the health system. This is important to understand because even if it is a trained provider conducting the abortion, if the procedure is done in a clandestine setting where adequate tools are not available, or adequate information on how to conduct the procedure is not known, patients are at risk of

avoidable complications. In a study by Rehan (2001), that profiled 32 abortion clinics, 10 were found to be run by qualified female doctors, 13 by LHVs, 6 by nurses, and 3 by paramedics. But of these clinics, only 22% met WHO standards of medical care required to safely terminate pregnancy. Furthermore, there was again no explanation provided as to whether these clinics were a part of the formal existing health system or whether they were all lone-standing clandestine clinics. Thus there is a need to better understand from where these providers are operating.

Provider attitudes and willingness

A few studies also touched upon provider attitudes towards abortion. A limited but mixed picture was presented, with some studies indicating that providers had negative views of abortion, while others indicated that regardless of their views, providers *do* conduct abortions due to the demand.

A cross sectional opinion survey that assessed knowledge, attitudes and perceptions regarding induced abortion among medical and nonmedical students showed that while most medical students considered induced abortion to be a health issue, both student populations considered it to be an ethical issue (Kumar, 2002). The former reason was rooted in awareness that women die every year as a result of post abortion complications. The ethical side of this concern was explained by the finding that most students perceived induced abortions to be a result of extra and premarital affairs (67%) and rape (44%), a perception that associates induced abortions to illegitimacy and thus led to students perception that abortions were more an ethical than health issue.

In line with these negative views, a study by Rehan (2003) that investigated provider attitudes towards induced abortion and existing abortion laws revealed that 67.3% of providers had unfavorable attitudes towards induced abortions. All providers had an awareness of abortions laws and 37.5% felt the law should be changed, but most (80.9%) felt this change should make the law more strict. Based on these findings, Rehan (2003) conjectured that provider attitudes may be a major stumbling block to the development of better abortion services.

In contrast, Saleem & Fikree (2001) and Rahim (2008) suggest providers do conduct abortions irrespective of legal restrictions, due to the demand. In the study by Rahim (2008), 66% of the study respondents (women who self-identified undergoing an illicit induced abortion) said their abortion was carried out by LHVs, and 10% said they were carried out by doctors. This suggests, even if providers view the procedure negatively, there may be something motivating them to overcome this ambivalence, such that it does not translate into their practice. No studies to our knowledge however, have explored this possibility.

CONCLUSIONS

Overall, this literature review highlighted several important findings regarding abortions in Pakistan. The first was in regards to why demand for abortions is growing. Studies from this review showed that women do have a desire to limit fertility, but an unmet need for family planning through contraceptives may be motivating an increased reliance on abortions to regulate fertility (Rehan et al., 2001; Saleem & Fikree, 2001; Saleem & Fikree, 2005). In contrast, Arif & Kamran (2007), Kamran et al. (2011) and Tsui et al. (2011) all found no evidence of women using abortions as a replacement of contraceptives, rather they were a back up to where contraceptives failed. But care must be taken generalizing any one of these findings as some studies had very specific groups of participants while others explored topic matter of a different scope. Participants from the Rehan (2001) study were recruited from abortion clinics located in urban centers, where access to safe abortion services from trained providers may be greater and could therefore enable such a trend. With the Saleem & Fikree (2001) and Saleem & Fikree (2005) studies, participants were recruited from low-income squatter settlements in Karachi. These women were likely more marginalized than the general population and as such may have had poorer access to contraceptive services, leaving no choice but to rely on pregnancy termination as a means to control fertility. In regards to the studies by Arif & Kamran (2007), Kamran et al. (2011) and Tsui et al. (2011), while participants were drawn from rural Punjab Pakistan, it important to keep in mind that they explored women's *views* towards contraception and abortion as fertility regulation mechanisms. Views however are not necessarily indicative of actions, rather they may simply be an indication of broader social norms and expectations. Furthermore, these same studies showed that despite expressing a preference for contraceptives above abortion as a means to regulate fertility, women's use of contraceptives was low and most described contraceptive options negatively. As such it is possible that the actions of couples may not necessarily align with their stated preference for contraceptives as the primary means of regulating fertility. Nonetheless, given conflicting findings further research is required to understand if abortions have become a preferred form of fertility regulation.

In regards to abortion methods, the literature showed D&C to be the most common. Most of the studies indicating this however were older (preceding the year 2005). Since then, newer and safer abortion technologies have become available and as Sathar (2013) highlighted, are increasingly being used among women in both urban and rural centers. While Khan (2013) highlights that Pakistan's restrictive environment may have delayed the adoption of these newer methods (MVA, and misoprostol for medical abortions), none of the studies reviewed provided confirmation of this. As such research is needed to

investigate whether the introduction of abortion methods such as medical abortion through misoprostol has led to a change in women's abortion seeking behavior.

The literature also revealed that women often attempt seeking, or at least report seeking abortion services from safe, trained health care providers such as physicians, nurses and LHVs. But it remains unclear as to where these services are being administered from. Is there space within the formal health system or are these services being administered through clandestine means? More research is needed to better understand where these providers are operating from.

Furthermore, the literature also drew attention to provider attitudes as a factor that may influence women's access to abortion services. Limited but mixed findings were revealed in regards to this topic. Some studies showed providers had largely unfavorable attitudes towards unsafe abortions (Rehan, 2003) (Kumar 2002**)** while others suggested providers do conduct the procedure because of demand (Rahim & Ara, 2008; Saleem & Fikree, 2001). Decreasing fertility trends suggest demand for fertility regulation may only increase. Several limitations however must be kept in mind regarding these studies. Firstly both Rehan (2003) and Kumar (2002) focused on the views of providers rather than their actions. As mentioned earlier, care must be taken in evaluating views as they may be representative of social expectations more than personal thoughts. Furthermore, whether these views actually translate into actions, and if so to what degree also remains unclear. Kumar (2002) looked at medical students i.e. providers in training who were not yet practicing, and had not been in a situation where they were confronted with an abortion seeking patient. As such it is possible, their views may be subject to change once they are in the field and have had a first-hand opportunity to interact with abortion seeking patients. Lastly, in regards to Rahim (2008), Saleem & Fikree (2001) and Saleem & Fikree (2005), their studies were conducted in Peshawar and Karachi respectively, both urban centers in provinces other than Punjab. Overall, given the conflicting and limited information on provider's attitudes and actual willingness to conduct abortions, there is a need for additional studies to understand whether in light of a growing demand for abortions, providers are willing to meet this need.

Most of the studies presented in this literature review were descriptive and largely used quantitative data. To fully understand this growing demand for abortions, there is a need for more in-depth research that reveals the deeper intricacies of women's abortion experience. This can be accomplished through the use of qualitative research. Furthermore, most of the studies in this literature review were conducted in urban settings. There's a need for research to be conducted in rural settings as well where services are often more limited and are harder to access.

RESEARCH QUESTIONS

Based on the gaps identified within the literature, the specific research questions addressed in this study are:

- Why has the demand for abortions increased?
- Are providers willing to meet the increased demand?

Given a need for in-depth studies to understand the intricacies of women's abortion seeking experience, this study was conducted using a qualitative research approach.

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Chapter 2: Methods

METHODOLOGY

In order to understand why demand for abortions is growing and whether providers are willing to meet this demand, a holistic understanding of women's abortion experience needed to be gained. To accomplish this, I undertook a focused ethnography for this study using a feminist perspective to focus on the experiences, beliefs and needs of women. Ethnographies investigate a specific experience through immersion in the target community they seek to understand. Doing so not only reveals important contextual information that influences the phenomenon of interest, it also allows the experience to be understood through the eyes of those experiencing it (Mayan, 2009). As such, an ethnographic approach was well suited to exploring the research questions put forth in this study.

More specifically, a *focused* ethnography was conducted. This method reflects that attention was drawn to a particular target population, over a finite period of time, and was guided by a specific research question. This approach was well suited to my study given that over a limited time frame four months, I sought to understand women's abortion experience specifically from the perspective of those who were directly involved in the procedure i.e. patients and providers. Furthermore, specific research questions were developed to guide this investigation (Mayan, 2009). Given these conditions, a focused ethnography was best suited to this research.

STUDY SETTING

Data collection took place over four months between September and December 2013. During this time I worked within the province of Punjab Pakistan, in the town and district of Chakwal. This town was located in the northern part of the province. It has an approximate population of 104,365 people (much smaller than the population of a major city such as Islamabad, which has a population of 1.9 million) ("Chakwal", 2015). The nearest large urban centre was Rawalpindi, located an hour and half north of the town. This location was chosen due to my research supervisor's (and the University of Alberta's) experience working in this area. The dominant religion practiced in the region was Islam.

Geographically, the town of Chakwal was surrounded by densely clustered plots of farmland and villages. The primary crop grown was wheat, though numerous other crops such as vegetables, fruits, and peanuts were also common. Where farming was not the primary occupation, men worked within the town in labor jobs, or in town shops, restaurants or boutiques. Within Chakwal, it was also common for men to work abroad either in the army or in Dubai as a laborer.

In contrast to the men, it was uncommon for women to work outside of the home. This was due to Pakistan's highly patriarchal social-cultural context and clearly demarcated gender roles (Mumtaz et al., 2013; Qadir, Khan, Medhin, & Prince, 2011; Winkvist & Akhtar, 2000). Cultural practices such as purdah normalize women's seclusion within the home and limit women's mobility beyond the homes of extended family (*biradari* - defined as a group of households related by blood) (Khan, 1999; Mumtaz et al., 2013). Women's inability to travel alone and at will, has been identified as a key barrier in their ability to access health and other services (Durrant & Sathar, 2000). Nonetheless within this context it was frowned upon for women to work outside their home. Their primary responsibility was seen to be within the home, tending to household tasks such as cleaning, cooking and looking after their family. If women did work outside the home, it was typically due to dire financial conditions at home. Work taken up by women in such situations was usually as a maid, cleaner or dishwasher within the home of an upper class (*Chaudary)* family.

Furthermore within this patriarchal context, it is also uncommon for women to make fertility and reproductive decisions around issues such as seeking antenatal care, desired number of children, and whether or not to have an abortion, independently. Instead they must take input from their husband or mother-in-law, who's preferences often bear greater influence than the woman's in the final decision (Kadir, Fikree, Khan, & Sajan, 2003; Mumtaz & Salway, 2009).

Specifically within the town of Chakwal, I collected data in a clinic belonging to a nation-wide non-governmental organization called the Rahnuma Family Planning Association of Pakistan. This organization has a long history of providing reproductive health (RH) and family planning (FP) services in Pakistan. Rahnuma has played a major role in driving the agenda for rights and advocacy and in leveraging RH and FP onto the national stage and bringing together NGOs, government and donors on one platform (Khan AA et al., 2013). It was a pioneer of the family planning movement that began in Pakistan in the early 1950's (NIPS, 2013). Included in its umbrella role of providing RH and FP services, is the provision of abortion services and post abortion care. Given that this facility provides family planning and reproductive health services, and is also licensed to provide abortion services and post abortion care, choosing to work within this clinic made it easier to purposefully sample participants who had the shared experience of either undergoing or conducting an abortion.

This clinic was located in a central part of the town Chakwal, slightly removed (two minute drive) from the main market place where the majority of the town's shops, main bus station, and District Health

Center were located. The area around the clinic consisted mostly of closely aggregated homes, separated only by narrow walk ways winding through the residential communities.

PARTICIPANTS

Within the Rahnuma clinic, two groups of respondents were recruited using purposeful sampling: the first were patients who were seeking or previously had an abortion, and the second was providers in the Rahnuma clinic trained to conduct abortion procedures. These women were selected as they were best able to provide information on the topic of abortion (Mayan, 2009). Including both of these groups allowed us to gain a holistic understanding of women's abortion experience, as I could explore my research questions from both perspectives of the health system- through those who underwent the procedure and through those who administered it. Both groups of participants have been described in greater detail in the following sections.

Participants- Patients

A total of 23 patients were selected to take part in this study. These were women who either came to the clinic seeking an abortion, or were seeking other health services but identified having an abortion within 6 months of commencing our fieldwork, regardless of whether their abortion was obtained from this clinic or elsewhere. The time frame of six months was chosen to ensure women's memory of their abortion experience was fresh. The only exclusion criteria for patients in this study were women who came to the clinic seeking PAC as a result of a miscarriage as we were seeking perspectives of women who actively sought to induce an abortion.

Twenty-three women agreed to enroll in the study. Fifteen of the twenty-three respondents previously *had* an abortion within six months of initiating the study. They were equally split between those who had the abortion at the Rahnuma clinic and those who had gotten it elsewhere (most often through a Dai or self-induced). The remaining eight patients came to the clinic seeking abortion services.

Characteristics of the 23 patients have been outlined in table 1 below:

Table 1. Characteristics of patient participants.

CHARACTERISTIC	***NUMBER OF PATIENTS***				
DOMINANT RELIGION	**Islam**	**Other**			
	23	---			
MARITAL STATUS	**Married**	**Unmarried**			
	23	---			
FAMILY STRUCTURE	**Nuclear**	**Extended***	**Not Discussed**		
	7	*11*	*5*		
PATIENT'S AGE*	**20's**	**30's**	**40's**	**50+**	**Not discussed**
	10	*8*	*2*	*1*	*2*
NUMBER OF LIVING CHILDREN ***(AT TIME OF INTERVIEW)***	**One**	**Two**	**Three**	**Four**	**Five or more**
	*4***	*3*	*9*	*6*	*1*
NUMBER OF ABORTIONS ***(CURRENTLY SEEKING OR HAD AT TIME OF INTERVIEW)***	**1st**	**2nd**	**3rd**	**4th or more**	
	21	---	*1*	*1*	

* Note: Extended family refers to any additional family members beyond the immediate husband and children. This includes either mother's and father's in law, or brother's and sister's in law (and their family) or both.

** Note: Most women did not know their exact age, they simply provided a best estimate

*** Note: Interestingly all four women with one living child who sought an abortion, had a son. Furthermore, having one child is not typically preferred in Pakistani culture. Women who had one child were either older in age and had experienced difficulty getting pregnant earlier on in life (i.e. this was the only child she was able to have), or were still young and early in their marriage, meaning her previous child was her first and still required a lot or caretaking (namely breastfeeding).

Patient's in our study sample either lived in villages surrounding the town of Chakwal, or had a home within the town itself. Most of the women were of lower socio-economic status, reporting a monthly income of less than Rs.10,000 (which equates to less than $100 CAD). Only one woman had a husband running a 'successful' construction business (she did not provide an exact income amount but did describe that the income was enough to support her family, and her brother in law's family comfortably), and one happened to be the wife of a physician who was running his own clinic.

Participants- Providers

All 14 healthcare providers working within the Rahnuma clinic were also included in the study. These have been outlined in Table 2 below:

Table 2. Healthcare providers in the Rahnuma clinic in Chakwal.

POSITION	***NUMBER***
OBSTETRICIAN GYNECOLOGISTS	3
NURSE	1
LADY HEALTH VISITOR (LHV)*	7
MIDWIFE	3

**Note explaining LHVs*: The primary responsibilities of LHVs as described by the LHV Student's handbook created by the Population Council (n.d.), is to provide promotive, preventive, and curative care with a focus on Maternal and Child Health (MCH)/ Family Planning (FP), disease control, and to provide antenatal care. LHVs provide direct basic nursing care to patients as necessary, assist and conducts antenatal visits, conduct safe normal deliveries, and maintains the cleanliness of the clinic and its environment as part of their role.

All providers were female. The professional experience of each provider varied. One had only 9 months of experience, she began her post as an LHV immediately after finishing her matric and completing her LHV training course. The provider with the longest experience was also a LHV who had been working at the clinic for 16 years. Most of the physicians in the clinic would be posted at the facility for 2-3 years before moving elsewhere, typically a larger hospital.

The role of each provider varied according to their position: Physicians performed ultrasounds and counselled patients on health matters including both reproductive and general health issues. The nurse and more experienced LHVs counselled patients prior to seeing the doctor, and even prescribed medicines. Where necessary, LHV's were allowed to prescribe misoprostol for medical abortions. LHVs also assessed patient's contraceptive needs and either provided or prescribed patients the family planning method chosen. The less experienced LHVs were responsible for record keeping, registering patients and providing them with their prescribed medicines if available in the clinic. Midwives largely worked as provider's assistants, particularly physician and LHV assistants, doing menial tasks such as keeping patients orderly, serving tea, keeping equipment and materials stocked in provider rooms, and cleaning.

Despite these varying roles, all health care providers in the clinic were given holistic training on abortions. This included conferring providers with the medical skills needed to conduct abortion inducing procedures such as D&C, MVA and medical abortions, informing providers of complications associated

with each method, and how these issues can be resolved. Along with medical skills, providers were also given training on proper pre and post abortion counselling. It was emphasized that providers needed to be empathetic, respectful, non-judgmental and unbiased. This was essential to establish an open and welcoming stream of communication. It was stressed that counselling was not meant to be an interrogation, nor was it an opportunity for providers to convince patients of their views. Rather their priority was to help patients make an informed choice in selecting an appropriate abortion method (surgical or medical); inform patients of the outcomes to expect; and counsel patients on post-abortion contraception. Also included in this counselling training was preparation to help patients deal with any trauma, guilt or shame associated with pursing this procedure. This was in recognition of the fact that women may be seeking abortions as a result of a traumatic experience, such as rape or incest. Lastly, providers were also given background information on abortions to understand the why safe services are needed. This included informing providers on the rates of unsafe abortion in Pakistan; associated rates of morbidity and mortality; and common reasons abortions are sought. Interestingly, providers training manual also stated that despite the countries restrictive legal and religious stance on abortion, termination of pregnancy is occasionally permissible outside of these bounds. No explanation however, was provided to define what these exceptional situations are, leaving its interpretation open to providers.

METHODS

The primary method of data collection were semi-structured, in-depth interviews. Patients were only interviewed once, but because providers were regularly seen in the clinic and could be easily contacted we were able to conduct a few follow up interviews with providers to clarify ideas mentioned during previous interviews. This method and type of interview is well suited to eliciting comprehensive narratives and stories through direct and open verbal questions, during intimate encounters (Dicicco-Bloom & Crabtree, 2006). Our sample size of 23 patients and 14 providers was slightly higher than our initially projected sample size of 20 patients and 10 providers. This increase in sample size was necessary to reach data saturation (Mason, 2010). Furthermore, in regards to providers the decision to include all 14 was essential to ensure no one felt left out. Particularly given the different social standing of each of the provider positions (doctors vs nurses vs midwives), excluding a provider could have created animosity between myself, my research assistant and the facility staff, which could have potentially affected the data collection process. To ensure providers felt equally treated, all the clinic's 14 providers were included in the interviews.

In regards to patients, once a potential respondent was identified the providers invited the patients to participate in the study before seeing a provider for the care they were seeking. This was an important detail (particularly for patients who came to the clinic seeking an abortion) because we did not want the

power dynamics between providers and patients to influence patient responses. This approach helped ensure patient's responses were as authentic and honest as possible, and avoided patient's responses from being swayed in any way by providers (such as being cast over with more guilt, regret, or second guessing than they felt upon arriving at the clinic). Interviews were conducted with participants a private room within the Rahnuma clinic. This was done to ensure privacy since abortion is stigmatizing and women may have been seeking the service without their husband's or marital family's consent or knowledge.

Along with interviews, one focus group discussion (FGDs) was conducted with five health care providers; four LHVs (one older, three younger), and one midwife, selected primarily because of their availability and willingness to participate in the discussion. This focus group discussion was valuable in clarifying and supplementing ideas brought forth by patients and providers during their interviews. It also gave insight into social factors that shaped provider beliefs around abortions because when in a social setting, people's views may change according to those around them. Alternatively people may try to alter how they express or frame their views in an attempt to better align them with socio-cultural expectations. As such this FGD allowed us to compare provider's personal views of abortion and contrast them to the views expressed when the discussion was held in a group setting.

A semi-structured interview guide (for in-depth interviews and the focus group discussion) was used. The initial questions were broad and were aimed at making the patient to feel comfortable in the interview setting. Questions followed a funneling approach, progressing from socio-demographic characteristics (where they are from, how many children they have, age of the children and whether they go to school), then to the focus of the research study (questions regarding if the woman would like more children, what has brought her to the clinic today, what are her reasons for the procedure etc). Ultimately the interview guide was developed with the intent of being a starting point. Patient responses played a role in guiding the discussion as well, so long as the discussion remained within the scope of the study objectives, giving us the flexibility to explore topics of interest as they arose.

Initially the interview guide was created with the intention of exploring the role of gender and poverty in motivating women's decision to pursue an abortion. As data collection began however, the questions evoked a different set of answers than initially expected. Participant responses drew focus to a larger picture around the accessibility of abortions, growing demand for the procedure, how women navigate this within Pakistan's restrictive setting and what challenges women face in pursuit of this service. Given that an iterative, inductive analysis approach was used as data collection proceeded, the interview guide was modified slightly to understand not only what motivated women to obtain an abortion, but the overall

experience of seeking and accessing an abortion, including women's reasons for pursuing abortions, how they were accessing the procedure, and any barriers they faced in obtaining the procedure i.e. whether providers were willing to meet this demand. Our original interview guideline was already evoking participant answers in regards to these matters, so only a few modifications were required to further explore these topics.

Each interview and focus group discussion lasted between 10-20 minutes. Oral informed consent was obtained from all participants prior to the commencement of the interview or focus group discussion (more details are provided in the *Ethics* section). All interviews were digitally recorded after seeking permission.

Participant observation was the third data collection method used. We worked in the clinic for five days a week from 9:00 am to 2:00pm, its official operating hours. During this time we observed providers in their day to day tasks, engaging in informal interactions with them and thus garnering information about daily functioning in the clinic. Furthermore, by assisting with small tasks in the clinic such as helping providers to organize files, and participating in daily routines (bringing food to contribute to their break time snack) my research assistant and I were able to build rapport with clinic providers and establish a more comfortable and open environment. Overtime, rather than being foreign visitors at the clinic, they became more comfortable with our presence, creating a more open and relaxed environment for myself, the providers, and the study participants. We also observed patients and providers during their informal interactions and counselling. Doing so provided an understanding of the nature of patient- provider relations. Furthermore, patients were observed and informally conversed with while in the waiting room. This provided a deeper understanding of the patient's, their composure at the clinic and their overall experience seeking services from this facility.

Field notes and a reflexive journal were also used to clarify behavioral nuances from the interviews. Using daily field notes allowed me to verify and contextualize information gathered from other ethnographic methods and to modify interview guidelines where necessary. In addition, because transcription of the data did not begin until after data collection was complete, detailed field notes allowed me to stay aware of the information being collected through other methods.

RESEARCH ASSISTANT

Data was collected with the assistance of a young, female, research assistant (RA) named Zakia Rabani, who was fluent in the local language of Potohari and Urdu. While I was able to understand these

languages, my ability to speak them was not strong. As such it was important to have the help of someone who was fluently able to speak the language and could smoothly facilitate the interviews and focus group discussion. The decision to have a female RA was also intentional. Given the sensitive nature of the topic of abortions, as well as social considerations around the power dynamics between men and women in Pakistan, it was important to have a female RA to ensure the patients felt comfortable and were open in their interview responses. Zakia was from the neighboring district of Jhelum, from a small town. Her comfort level and familiarity with the rural environment we worked in made her a strength in our study. Though from a small town, she belonged to a relatively well-off, middle class family and had received a college education. This paired with her status as an unmarried woman meant she did not have pressing obligations to her family. As such she was able to fully commit her time to her duties as my research assistant; during our four months of data collection she lived with me in our field site home in Chakwal, returning home only on the weekends. Another major advantage of working with Zakia was that she had experience working as a research assistant on previous projects undertaken by my supervisor. She was therefore familiar with not only the data collection process, but the broader sensitivities of maternal health research and had a general familiarity of the scope and nature of the research being undertaken.

It is important to note however that even though my research assistant was the same gender and nationality as the participants, and that I myself was a South Asian Punjabi woman (and easily blended in with my RA and the broader social setting), the fact that we introduced ourselves as researchers likely created a power differential between us and the participants. This may have influenced the way participants responded to our questions. Specifically they may have felt pressured to provide more socially desirable responses or information, to provide a more 'correct' answer.

In preparation for data collection, I familiarized my RA with the study's background, objectives, and interview questions. I emphasized that the questions were meant to serve as outline but that it was important to allow patient responses to guide the discussion as well. I also emphasized the need to thoroughly probe patient's responses to understand the issues at a deeper level. At the end of each day of interviews, my research assistant and I debriefed to discuss interesting ideas or themes emerging in the data. We noted any important information that had been touched upon and planned how we would probe into unclear or interesting ideas in subsequent interviews. During the interviews, if any interesting topic arose that I felt needed to be explored further, I was familiar enough with the language to ask questions such as 'how so', or 'in what way' upon which my RA would know to further probe into the matter before moving on to the next question.

In addition to Zakia, I was also assisted by my supervisor Dr. Zubia Mumtaz and her Research Manager Afshan Bhatti. In regards to Afshan, although she was working on a different research project she remained with me in our field site home throughout the data collection process. Her extensive experience working with Dr. Mumtaz on various maternal health projects in Pakistan made her an extremely valuable mentor to have in the field site. She provided me with valuable tips on qualitative data collection and continually provided ways to continue improving my interview skills, such as how to pick up on subtle response or behavioral cues that required probing at a deeper level. I was also provided guidance by my supervisor Dr. Mumtaz. I regularly kept in contact with Dr. Mumtaz during my data collection via phone calls discussing the preliminary themes identified in the data. She provided critical insight into the information collected, suggested important points for me to think about as I moved forward in my data collection and helped focused my attention on novel themes emerging in the data. This was extremely important in achieving the high quality data collected. In the final month of data collection she also made a visit to the field site where she again provided valuable insight allowing me to critically understand the data, helping to direct me in my data collection, and to identify any gaps that remained to be explored.

ANALYSIS

All interviews and focus group discussion recordings were translated and transcribed into English by me. Data were analyzed through a content analysis approach. Specifically, a latent content analysis approach was employed, meaning data was analyzed whilst keeping the context of the data in mind (Mayan 2009). Descriptive codes were developed throughout the transcription process, then again by reading and re-reading transcripts once they were complete. Memo's were also kept to begin thinking about why 'something' was the way it is. Codes were then categorized to identify broader themes that captured commonalities and differences interwoven throughout the data. I then began theorizing to abstract deeper meaning and to build an explanation for the findings. Throughout this process, questions, insights and ideas were kept track of to aid interpretation of the data. Data from interviews, focus group discussions, and observation notes were merged to describe experiences and behaviors of patients and providers in the context of abortion access and provision. Furthermore, as mentioned previously, data analysis was conducted through an iterative and inductive process. I frequently listened to interviews during the data collection process to ensure unique or interesting leads were followed up on and to ensure the research questions were captured by the study findings.

RIGOR

A number of steps were taken to uphold rigour in this study. As described by Mayan (2009) rigour refers to "demonstrating how and why (through methodology) the findings of a particular inquiry are worth paying attention to". It was practiced through the criteria of '*trustworthiness'* developed by Lincoln and Guba (Mayan, 2009). This includes four main factors:

The first was *credibility*. This criterion sought to assess whether the findings were an accurate representation of the participants and the data (Mayan 2009). This was accomplished through the use of multiple data collection strategies (including interviews with patients and providers and a focus group discussion with providers), and a revision was made to the interview guide to ensure the phenomena of interest was being investigated. In addition, daily debriefings were held between myself and my research assistant after interviews to review interesting points brought up by participants as well as any tangents that needed to be further probed in future interviews. This allowed for negative cases to be explored. By working closely together and examining what went right and wrong in each interview as it happened, this allowed us to ensure we were answering the question at hand. During transcription, I also made sure to keep track of any words or phrases that I was unfamiliar with and clarified them with my supervisor who is fluent in the languages of Urdu and Potohari, to ensure accurate translation.

The second criterion was *transferability* which assessed the applicability of the findings to other settings (Mayan 2009). Transferability was achieved by providing an extensive and holistic description of the settings and participants through the use of field notes and a reflexive journal that documented both contextual details and self- perceptions that may have biased findings.

Thirdly, *dependability* refers to the process of reviewing how decisions were made throughout the research study (Mayan 2009). This was achieved through the use of an audit trail that documented how and why choices were made throughout the research study. An example of this includes identifying the emergence of unexpected themes around how women were accessing abortions, and the challenges they faced. In response to recognizing these interesting findings the decision was made to slightly modify the question guide. This decision was recorded as part of this audit trail. Also recorded as part of this audit trail was how my research assistant and I could better communicate during the interview. As described earlier, when I began questioning participants during the interview with questions such as 'how so' or 'in what way' my research assistant knew to probe into those topics further. This was a pre-planned step my research assistant and I came up with in response to initial interviews where my research assistant did not probe into points that could have been further investigated.

And lastly, *confirmability* was important to ensure study findings were logical, meaning to ensure the findings make sense (Mayan 2009). This was also ensured by an audit trail and by examining and interpreting the data throughout the data collection process. Confirmability was also ensured through reflexive journaling, which was done daily after interviews and was used as a reference to clarify any parts of the discussion or any observations that may have been unclear. Providing this clarification and reflecting on any potential personal biases ensured the data collected was logical.

ETHICS

Ethical clearance was obtained from the University of Alberta Research Ethics Board, as well as the National Bioethics Board, Pakistan.

In regards to participant consent, consent forms were read out to participants prior to initiating interviews and focus groups discussion. It was made clear that whether participants agreed to take part in the study or not, had no influence on the care or quality of care they would receive. Participants were also made aware of the purpose of the research, and were told if at any point they no longer wished to proceed in the interview, they could stop, again without any repercussions on their care. Consent was also asked to record the discussion. Once consent was given, myself and my research assistant (as the witness) signed the consent form. We would then started the recording and the discussion. Participants were not asked to sign or read the form in consideration of possible illiteracy among participants. This protocol was approved by the Human Research Ethics Board at the University of Alberta and the National Bioethics Board of Pakistan.

All of the data collected was stored in a password protected google docs database as well as on my password protect computer, only accessed by me. Furthermore, as per the protocol outlined for protecting the data, the data will be stored in a locked cabinet in my supervisor's office at the University of Alberta for five years following the completion of my research process.

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Chapter 3: Manuscript 1

Abortion services in Pakistan: a grey zone and compromises

Harneet Chahal and Zubia Mumtaz

Worldwide abortion occupies a highly contentious space. Even in countries where this procedure is legal, abortion often sparks a complex moral and ethical debate around a mother's autonomy over her reproductive choices, a fetus' right to life and challenges cultural norms around gender, motherhood, and female sexuality (Kumar, Hessini, & Mitchell, 2009; Norris et al., 2011). The resultant social stigma often pushes women to look for ways to conceal their pursuit of this procedure, even if it means compromising on its safety (Azmat SK, Bilgrami M, Shaikh BT, Mustafa G, & Hameed W, 2012).

In countries where abortions are illegal or heavily restricted these barriers are further exacerbated. Safe services are not likely to be offered through state mechanisms in the public sector and are therefore not widely available (Ganatra, 2006). They are also less likely to be performed in a regulated medical setting, by adequately trained providers (Warriner, 2006). Restrictions around abortion services however, do not deter women from seeking this procedure, instead they force women to seek services from clandestine sources where the procedure may be conducted by providers lacking adequate training, or in an environment that does not meet minimum medical standards (Ahman & Shah, 2011; Haddad & Nour, 2009; Shah & Ahman, 2010; Zaidi et al., 2014; WHO, 1992).

In Pakistan, abortions occupy an ambiguous legal and religious space. While at first glance, the law and religion appear to heavily restrict abortion procedures, in reality there is room to maneuver. According to Pakistani law, abortion is only permitted on the condition that it is required to save the mother's life or to provide the mother with necessary treatment (Zaidi et al., 2014; Dalvie, Barua, Azmat, Mustafa, n.d.). While initially this presents the picture of a highly restricted procedure, poor specifications defining these laws leaves them quite vague. It is not clarified whether the scope of 'saving the mother's life' refers purely to biomedical reasons or if it also encompasses the woman's mental and social wellbeing. For example young women pregnant before marriage may face the threat of punitive action from her father or brothers. Alternatively, she may face ostracism from her family and community even if the pregnancy was a result of rape. Furthermore, there is no explanation to resolve poor clarity around the term 'necessary treatment' leaving its meaning open to interpretation (Dalvie et al., n.d.).

Ambiguity around the permissibility of abortions also exists in the religious sphere. According to the dominant religious view in Pakistan, abortions are permissible prior to 120 days of gestation only where a genetic condition has been identified (Jafri et al., 2012). But the Quran itself does not explicitly address

Termination of Pregnancy (TOP) (Jafri et al., 2012). Rather, this view originates from interpretations of Quranic verses (Asman, 2004) addressing topics such as descriptions of the process of fertilization, fetal development and the point at which the soul is thought to enter the fetus (referred to as ensoulment) (Jafri et al., 2012). This once again leaves room for alternative interpretations.

As a result of this ambiguity in the legal and religious sphere, a grey zone exists where what constitutes permissible grounds for an abortion is debatable. This has created a space where safe abortion services can potentially be administered.

Officially, Pakistan does not condone the provision of abortions. Although the Punjab's maternal and reproductive health program (formally called the "Integrated Reproductive Maternal Newborn & Child Health & Nutrition program), emphasizes the need to improve women's reproductive health, abortion is only mentioned twice. Initially this gives the impression that abortions are a neglected component of the country's maternal health program. But important to note is the context in which abortion is mentioned. In both cases it was brought up in reference to improving Basic Emergency Obstetric and Newborn care (EmONC). This commitment was made as a means to address pressing obstetric issues such as postpartum hemorrhage, sepsis and complications of abortion- three elements that the document highlights to be responsible for close to 50% of maternal deaths. Thus even though abortion itself is only briefly mentioned, it is acknowledged as a factor that contributes to the persistence of maternal mortality in the region. The subtlety with which this is done provides a means to administer abortion services in Pakistan, while keeping within the larger social narrative which condemns the procedure. Adding support to this, is that Pakistan is signatory to a number of international agreements that have prioritized protecting women from unsafe abortions, as part of larger initiatives to provide comprehensive reproductive health care. These include commitments made at the International Conference for Population and Development, and CEDAW (The Convention on the Elimination of all forms of discrimination Against Women) (Dalvie et al., n.d.). So although abortion is not explicitly stated to be a priority, it does appear to be a strategically mentioned commitment.

The literature too, is silent about describing abortion services despite talking about the existence of abortions. As revealed by our literature review studies have repeatedly shown that women obtain abortions from not only from traditional practitioners, but from formally trained personnel such as doctors, nurses, and LHVs as well (Khan AA et al., 2013; Rahim & Ara, 2008; Saleem & Fikree, 2001; Sathar, Rashida, Shah, Singh, & Woog, 2013; Shaikh, Abbassi, Rizwan, & Abbasi, 2010; Vlassoff, Singh, Suarez & Jafarey, 2009). It is not clear however in these studies, from where trained providers were

administering abortion services; whether it was from lone standing clandestine clinics or from within the health system.

A scan of the social media and grey literature however provided insight into this gap, revealing that the private sector is actively engaged in the provision of abortion services. Whilst a large proportion of this is through clandestine providers, two large national level non-governmental organizations (NGOs) have taken advantage of the legal and religious loopholes and have created a space to provide institutionalized safe abortion services.

One of these NGOs is the Rahnuma Family Planning Association of Pakistan. This organization was a pioneer of the family planning movement that began in Pakistan in the early 1950's (NIPS, 2013) and has a long history of providing reproductive health (RH) and family planning (FP) services in Pakistan. It played a major role in driving the agenda for rights and advocacy and in leveraging RH and FP onto the national stage and bringing together NGOs, government and donors on one platform (Khan AA et al., 2013). Clearly stated on their website within its umbrella of RH and FP services are abortion services and post abortion care. Our observations within the Rahnuma clinic confirmed this and revealed that this organization has actually systematized the provision of this service by including formal abortion training for all providers hired to work at the clinic. A look at the providers training manual revealed that their training was multifaceted and holistic. It included conferring providers with the medical skills needed to conduct abortion inducing procedures such as D&C, MVA and medical abortions. It also included informing providers of complications associated with each method, and how these issues can be resolved.

Along with medical skills, the provider's training manual described how to properly conduct pre and post abortion counselling. It was emphasized that providers needed to be empathetic, respectful, non-judgmental and unbiased. This was essential to establishing an open and welcoming stream of communication. It was stressed that counselling was not meant to be an interrogation, nor was it an opportunity for providers to convince patients of their views. Rather their priority was to help patients make an informed choice in selecting an appropriate abortion method (surgical or medical); inform patients of the outcomes to expect; and counsel patients on post-abortion contraception. Also included in this counselling training was preparation to help patients deal with any trauma, guilt or shame associated with pursing this procedure. This was in recognition of the fact that women may be seeking abortions as a result of a traumatic experience, such as rape or incest. Lastly, providers were also given background information on abortions to understand the why safe services are needed. This included informing providers on the rates of unsafe abortion in Pakistan; associated rates of morbidity and mortality; and common reasons abortions are sought. Interestingly, providers training manual also stated that despite the

countries restrictive legal and religious stance on abortion, termination of pregnancy is occasionally permissible outside of these bounds. No explanation however, was provided to define what these exceptional situations are, leaving its interpretation open to providers.

In addition to the presence of trained staff, our observations showed the clinic itself was equipped with the tools needed to safely perform abortion procedures. This included the presence of a surgical ward, tools required to conduct surgical abortions, and the abortifacient drug misoprostol for medical abortions.

Last but not least, Rahnuma's website indicated that they also engage in abortion research. An example of this includes their 2008 study examining "Socio-cultural determinants and economic consequences of abortion in Pakistan" ("Some selected research assignments undertaken by R-FPAP," 2015)**.** This project aimed to create an enabling environment for improved service delivery and enhanced understanding of social and cultural factors that support women's right to access legal abortion services (*To see this and other studies undertaken by Rahnuma*: http://www.fpapak.org/about-us/research-and-studies.html , *the example referred to is Study 15*) ("Some selected research assignments undertaken by R-FPAP," 2015).

The second NGO observed to be providing clinical abortion services was the Marie Stopes (MS) society. Marie Stopes is an international NGO, and is an affiliate of Marie Stopes UK. This organization has a history of advocating for abortion care as women's rights in the UK. Unlike Rahnuma, MS's website only states that it providers post-abortion care. Our observations and informal interactions with providers revealed however, that MS (and their sister organization Behtar Zindagi (BZ)*) do provide safe abortion services in a clinical setting. In fact, the general perception held by both the patients and providers we spoke to was that MS and BZ provide abortions much more open and freely than Rahnuma. They were actually described as having a reputation in the community for providing abortion services. While at times this 'reputation' appeared to deter women from seeking services at this centre, out of a fear of false (or true) accusations of undergoing an abortion, (and deterred providers from seeking employment there, out of a fear of being labeled an abortion provider) this captures the more liberal approach MS had towards administering abortion services. This discrepancy between our observations and what was described on the MS website suggests abortion services may be offered but an effort is being made to conceal the provision of this service under the cover of PAC. As described earlier, abortions remain a highly controversial issue, with dominant religious and legal interpretations condemning the procedure. It thus makes sense that MS would attempt to conceal their provision of this service. Adding support to this argument, the MS website lists the organizations previous research projects- although these do not directly talk abortion, they do have a focus on family planning and empowering couples in making informed reproductive health choices i.e. they are again using vague language that could encompass abortions but allows them to avoid any explicit mention of the procedure.

Overall, these two NGOs, under the umbrella of Pakistan's international obligations to provide safe, reproductive health services, appear to rather bravely have begun providing both abortions and post abortion care as part of their routine clinical services. Given that these facilities are registered family planning clinics, they are providing these safe abortion services as part of the existing health system.

*(*Behtar Zindagi, meaning 'better life', is a reproductive health center operational under Marie Stopes, introduced in 2012*)

CONCLUSION

Overall, our observations reveal that despite dominant interpretations of law and religion that present abortions as a highly restricted procedure, safe abortion services are being offered within a clinical setting. Both the Rahnuma family planning Association of Pakistan and Marie Stopes Society, offer abortion and post abortion care as part of a broader set of reproductive health services. Doing this allows abortion services to be offered through the existing health infrastructure, in a setting that is well equipped, by trained staff, and in a medically safe environment.

The fact that Rahnuma openly states the availability of abortion services on their website, and that Marie Stopes is well known to provide these services within the community, suggests it is likely that higher level personnel within the government are also aware that this is happening. Yet these clinics continue to run and no known efforts have been made to punish these clinics or providers for conducting this procedure. This suggests there may be an informal recognition of the need for safe abortion services as an important reproductive health service, and as a means to improve maternal health. While social acceptance of liberalizing the law may still take time, it seems a compromise has been reached in making safe abortions services available through these family planning clinics that operate within the grey zone of abortion permissibility.

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Chapter 4: Manuscript 2

Misoprostol and Fertility Control

Harneet Chahal and Zubia Mumtaz

ABSTRACT

Background: Six decades of family planning programs in Pakistan have failed to significantly increase contraceptive uptake, which reached just 35% in 2012-13. Despite low contraceptive use rates, fertility has been declining. This may be due to increasing rates of induced abortions. Traditionally, religious and legal restrictions surrounding this procedure have forced women to resort to unsafe, clandestine services where the risk of maternal morbidity and mortality are magnified. But with the abortifacient misoprostol now available, women may have a safer and more practical abortion option. To explore this further, this study examined how the availability of misoprostol has impacted women's abortion seeking behavior.

Methodology: A focused ethnography was conducted in Chakwal, Pakistan from September to December of 2013. Participants were recruited from a non-governmental organization that provides family planning and reproductive health services, including abortions. Twenty three in-depth interviews were conducted with women seeking (inpatients) or that had received (outpatients) an abortion and fourteen with facility health service providers. One focus group discussion was conducted with healthcare providers.

Results: Our data revealed that contraceptives were not adequate in allowing women to meet their fertility needs. Consequently, women turned to abortions specifically through the abortifacient misoprostol to limit their fertility. The wide availability, low cost, safety and effectiveness of misoprostol meant it was not only became the preferred means of terminating pregnancy, but also the preferred form of family planning. Women reconciled this decision by avoiding discussion of the topic instead deflecting it as a mistake, miscarriage or menstrual cycle issue.

Conclusions: To support women's access to safe abortions we recommend training providers to safely administer misoprostol within women's homes. Contraception uptake will also be important to prevent abortions in the first place.

INTRODUCTION

Six decades of family planning programming in Pakistan have failed to significantly increase contraception uptake (Khan AA et al., 2013). Despite being one of the first to initiate family planning

programs in South Asia, increases in Pakistan's contraceptive prevalence rates have been marginal, rising from 5.5 % in 1968 to 12% in 1991, and to 35% in 2013 (Rukanuddin & Hardee-Cleaveland, 1992; Ghubaju & Durand-Moriki, 2003; NIPS, 2013; Sathar, 2009). This is a sharp contrast to other countries in the region such as Bangladesh where by the year 2011, contraceptive prevalence rates were reported to have reached 60% ("Contraceptive Prevalence", 2015). A number of reasons have been provided for this slow uptake of family planning, including but not limited to poor delivery of family planning services, resistance to use modern contraceptive, and a larger family size norm related to understanding the economic and sociocultural benefits of having a bigger family (Sathar, 2009; Avan & Akhund, 2006; Lolarga, 1983; Sarker, 1993; Sheykhi, 1995).

Recent evidence however, suggests family size preferences may be changing. This is reflected in Pakistan's decreasing fertility levels which have fallen from 6.2 children in 1990, to 4.5 in 1999, and further to 3.8 in 2012 (Sathar, 2009; Sathar, Singh, Rashida, Shah, & Niazi, 2014).

Clearly there is an incongruence between the shift towards smaller family size norms and the country's low contraceptive prevalence rate. But Sathar (2015) suggests induced abortions may help explain this gap. In the decade between 2002-12, the number of induced abortions increased from 890,000 to 2.25 million (Vlassoff, Singh, Suarez, & Jafarey, 2009). These numbers warrant concern as abortion is officially 'not-legal'. Provision of abortion services is not an element of reproductive health services that the state is mandated to provide. Coupled with religious restrictions and social stigma surrounding abortions, women have traditionally sought clandestine services (Sathar, 2007; Zaidi S et al., 2014a). While this allows women to ensure confidentiality and avoid punitive measures, these are typically administered by poorly trained providers lacking the appropriate equipment and medical training needed to safely perform the procedure (Ahman & Shah, 2011; Haddad & Nour, 2009; Sathar, Rashida, Shah, Singh, & Woog, 2013; Sathar, 2007; Shah & Weinberger, 2012; Zaidi et al., 2014a). Risks of acute and long term complications such as damage to reproductive organs and secondary infertility, are elevated in this setting (Berer, 2002). The impact of this can be seen in the 623,000 women that obtained post abortion care (PAC) for complications of unsafe abortion in 2012 (Sathar, 2015). Furthermore, between 6-11% of all Pakistan's maternal mortality is attributable abortion related complications (Azmat, Shaikh, Mustafa, Hameed, & Bilgrami, 2012; Rukanuddin, Ali, & McManis, 2007). Thus unsafe abortion has an impact not only women's health, but on the health care system as a whole (Warriner & Shah, 2006).

There is however potential for the abortion landscape to change now that the abortion inducing drug, misoprostol is available in Pakistan. This drug was originally developed in the mid-1980s for gastrointestinal purposes, specifically for the treatment of duodenal and gastric ulcers (Rowlands, 2012; "Misoprostol approved," 2015; Billings, 2004; Cohen et al., 2005; Sherris et al., 2005). But because it is a

prostaglandin E1 analogue, it also induces uterine contractions and cervical softening making it an effective agent in emptying the uterus of its contents (Billings, 2004; Sherris et al., 2005; WHO, 2012). In line with this, numerous studies have shown its efficacy in a range of obstetric gynecological indications including the prevention and treatment of post-partum hemorrhage, labor induction treatment of miscarriage and inducing abortions (Berer, 2005; Billings, 2004; Chong, Su, & Arulkumaran, 2004; Lokugamage, El Refaey, & Rodeck, 2003). The efficacy of misoprostol to act as an abortifacient has been well documented in the literature. Studies have increasingly shown that misoprostol has enabled many women to have safer abortions than otherwise would have been possible (Sherris et al., 2005). Berer et al. (2002) showed that in Brazil for example, women self-inducing abortions with misoprostol, reported fewer complications and shorter hospital stays. Evidence from clinical studies in low-resource settings such as in India, confirm that women can safely administer the misoprostol at home eliminating the need to travel to a clinic (Berer, 2005; Elul, 2011; Karki et al., 2009; Mundle, Elul, Anand, Kalyanwala, & Ughade, 2007).

In Pakistan, the use of misoprostol for uterine evacuation began in some hospitals approximately 15 years ago, when reports of its efficacy started appearing in the literature (Zaidi et al., 2014b). It was not however until 2012, after it was put on the WHO Essential Drug List, that misoprostol was accepted for reproductive health purposes in Pakistan' (Zaidi et al., 2014b). It is now included on the Essential Medicines List (EML) in all provinces in the country and medical abortion using misoprostol is included in the Pakistani midwifery curriculum (Sathar Z et al., 2013; Zaidi et al., 2014a). But given that misoprostol is a relatively new addition to Pakistan's health system, little is known of how women have responded to it. It is not well documented how misoprostol fits within this new context of a smaller preferred family size, low contraceptive prevalence rates, and increasing induced abortions. To address this gap in knowledge, this study sought to understand how the availability of misoprostol has impacted abortion seeking behavior of women in Pakistan.

METHODS

This paper draws on focused ethnographic work conducted in the town and district of Chakwal, Punjab Pakistan from September to December of 2013. The district of Chakwal is relatively well developed, with a primarily agriculture-based economy. It can be considered representative of conditions in Northern Punjab (Mumtaz, Levay, Bhatti, & Salway, 2013). This location was chosen due to the research team's (my supervisor and University of Alberta's) history of working in this area. Previously established

community networks allowed the primary investigator (PI) to quickly build rapport with the facility providers and patients, enabling the collection of high quality data.

Within the town of Chakwal, data was collected at the Rahnuma Family Planning Association of Pakistan clinic, a non-governmental organization that has been providing reproductive health (RH) and family planning (FP) services in Pakistan since 1953. Included among its service provision are abortions and post abortion care. Choosing to work within this facility enabled us to purposefully sample participants who had the shared experience of either undergoing or conducting an abortion.

In total 23 patients seeking abortion services (8/23) or that had previous had an abortion within six months of commencing the study (15/23) were enrolled in the study. Six months was chosen as the cut-off period as a means to ensure women's memory of their abortion experience was fresh enough to accurately recall. Patients seeking PAC as a result of a miscarriage were *not* included in the study sample. No other exclusion criteria was exercised. Patients identified to fall within our target profile were invited to participate in the study by the providers.

All 14 healthcare providers working within the Rahnuma clinic were also included in the study. These included 3 Obstetrician Gynecologists, 1 Nurse, 7 Lady Health Visitors (LHVs) and 3 Midwives. Given that the Rahnuma clinic provided services exclusively to women, all the providers were female. The professional experience of each provider varied from as little as 9 months to 16 years. All providers in the clinic had received training on the provision of abortions as an expected element of care they were to provide. The precise role each provider played however varied according to their position: Physicians performed ultrasounds and counselled patients on health matters including both reproductive and general health issues. The nurse and more experienced LHVs counselled patients prior to seeing the doctor, and even prescribed medicines. Where necessary, LHV's were allowed to prescribe misoprostol for medical abortions. LHVs also assessed patient's contraceptive needs and either provided or prescribed patients the family planning method chosen. The less experienced LHVs were responsible for record keeping, registering patients and providing them with their prescribed medicines if available in the clinic. Midwives largely worked as provider's assistants, particularly physician and LHV assistants, doing menial tasks such as keeping patients orderly, serving tea, keeping equipment and materials stocked in provider rooms, and cleaning. This paper focuses more heavily on the responses provided by patients.

Data collection was undertaken through semi-structured in-depth interviews, participant observation and a focus group discussion. All 23 patients and 14 providers were interviewed in-depth. This sample size was sufficient to reach data saturation (Mason, 2010). These interviews explored why women continue to seek

abortions, how, and the challenges they face within Pakistan's restrictive setting. Each interview was conducted within a private room in the Rahnuma clinic to ensure privacy and confidentiality. Oral consent was obtained from all participants prior to the commencement of the interview and discussions were digitally recorded.

One focus group discussion (FGDs) was conducted with five of the Rahnuma clinic's health care providers. This provided an opportunity to clarify and supplement ideas brought forth by patients and providers during their interviews. It also shed light on social factors shaping provider beliefs of abortions, as it created a point of comparison for provider's views of abortion when discussed individually versus in a group.

Participant observation was also a central data collection method. By observing providers in day to day tasks and engaging in informal interactions with patients in waiting rooms, data was collected regarding daily functioning in the clinic. Furthermore, observing patients and providers during counselling sessions provided an understanding of the nature of patient-provider interactions. Field notes and a reflexive journal were kept to record contextual information and to document participants behavioral nuances demonstrated during the interviews that were helpful in clarifying the data.

Data was collected with the assistance of a Research Assistant (RA) fluent in the local language of Potohari, Punjabi and Urdu, under the supervision of the primary investigator who was also able to understand these languages. All interviews and focus group discussion recordings were translated and transcribed into English by the primary investigator. Data were analyzed concurrent to and following data collection, through a latent content analysis approach. Descriptive codes were developed throughout the transcription process, then again by reading and re-reading transcripts once they were complete. These were then categorized to identify broader themes to abstract deeper meaning and to build an explanation for the findings. Data from interviews, focus group discussions, and observation notes were merged to describe the experience of patients and providers in accessing and providing abortion services, respectively.

Ethical clearance was obtained from the University of Alberta Research Ethics Board, and the National Bioethics Board, Pakistan.

RESULTS

The data identified two themes that could broadly be understood as first, women sought abortions to limit their fertility. Most felt their family size of 3-4 children was complete although some were satisfied after two. Their wish to limit their family size was embedded most often in financial constraints and the stress they experienced in response to another pregnancy was visible in their frantic and distraught behavior in the clinic. The subthemes within this included contraceptive failure, failure to use contraceptives because of side-effects, lack of permission from husband or neglect. The second major theme identified in the data was misoprostol enabled women to meet their fertility needs. Subthemes within this included misoprostol's many advantages in inducing abortion compared to traditional surgical methods, its emergence not only as the preferred abortion method but as the preferred fertility control mechanism, and how women reconcile their decision to use abortion in this manner.

WOMEN SEEKING ABORTIONS TO LIMIT THEIR FERTILITY

A key finding was that the majority of patients sought or had an abortion, did so to limit fertility. For just over half of our patient respondents (13/23), the desire to limit fertility did manifest in a pro-active effort to prevent pregnancy. These patients reported that they had at least tried some form of contraceptive prior to needing an abortion. But for most, their efforts were not successful.

Contraceptive Failure

The main reason given as to why contraceptives were inadequate in allowing women meet their fertility needs was contraceptive failure. Most of our respondents who reported using family planning prior to an unplanned pregnancy, described experiencing a failure in the method they were practicing. Among these respondents, condoms were the primary form of family planning being used although other methods such as birth control pills or an intra-uterine device (IUD) were also said to have failed. In a few cases this was a result of inappropriate use of the contraceptive method. Some reported they did not know that they needed to take their birth control pill daily while others struggled to remember. One woman took three birth control pills every three days in an attempt to manage nausea she was experiencing.

More commonly however women described that their contraceptive failed despite its proper and consistent use. This is possible given that there is a natural failure rate associated with all forms of contraception. A few cases may have been the result of provider's improper practice. One woman described that the birth control pills she was given were expired. Another described having a normal

experience with a previous IUD, but after getting it replaced suddenly experienced severe pain that resulted in the IUD being taken out.

> *I had gotten a copper T put in from here, I had kept it in for a long time. When my children were really young I had it put in. It was in for a long time… seven or eight years. Then I had a new one put in, but I had it taken out quickly, it caused so much pain in my waist* (Patient 30)

Experienced Side Effects

The second most commonly reported reason described as to why contraceptives were inadequate in meeting women's fertility needs, was the experience of side effects that led patients to discontinue their use; shortly after which they would become pregnant. The most common side effects women described, particularly in reference to injections, were heavy and persistent bleeding, disrupted or absent menses, pain and weakness.

> *I got an injection, the one that lasts three months, with that my periods stopped. For five months I did not get my period again!* (Patient 24)

> *After my daughter was born, I did not want another child to happen quickly so I got injections for six months. I got them from here. But, my body did not respond well. For six months I kept bleeding, I became weak, I mean very weak. Then we started using condoms* (Patient 25)

> *Sometimes I would get bleeding, for two months at a time… the third time I got scared, I thought this time I will not get the injection done* (Patient 34)

Some women described their discomfort more generally, saying just that "it didn't suit me". Women typically tolerated these side effects for several months before finally deciding they had enough and ceased its further use. For some women, this one negative experience was enough to prevent them from using another contraceptive method. But for most, while this experience did prevent women from re-trying that particular method, it did not deter them from trying alternatives. Most of the women who described experiencing side effects *had* tried multiple family planning methods, or had recently started another method following their abortion. But it was often in that short period of time between discontinuing one and looking for another that women became pregnant.

Thus for the majority of patients we interviewed contraceptives were not allowing them to regulate their fertility- they failed and were prone to eliciting side effects or discomfort, which ultimately led to discontinuation of the contraceptive method.

Restricted from using contraceptives

While most of our study respondents who wanted to limit their fertility did actively try to prevent pregnancy, some did not. One explanation respondents provided for this was that they were restricted from using contraceptives by their husbands. Reasons for this opposition included husbands concerns about the possible negative consequences contraceptives may have for their wife's health or physical beauty:

> "*he says with an injection my skin color may get wrecked, you can get spots on your face, my husband doesn't want these things*…" (Patient 13)

Alternatively some women said their husband claimed contraception was sinful. Although restrictions set on contraceptives use were frustrating for women who wished to limit the birth of more children, they had no choice but to abide by their husband's wishes given Pakistan's largely patriarchal society. Interesting to note however was once these women experienced an unwanted pregnancy and went through the experience of an abortion, all of them began using a contraceptive method, some with the consent of their husband, while others did so secretly without their husband's knowledge. This suggests the experience of an unwanted pregnancy and subsequent need for an abortion served as a wake-up call to couples that without active prevention of pregnancy, an unwanted child is possible.

Overlooked the need for preventive measures

A few of our respondents had simply overlooked the need to use a contraceptive despite wanting to prevent a pregnancy. These were typically older women who had already raised all of their children and mistakenly thought it was no longer possible for them to become pregnant.

This also included women who had minimal contact with their husband, either because he was abroad for work (in the army or working in Dubai as a laborer) or because they were no longer living together due to a tumultuous relationship. In these situations women were not practicing any form of continuous contraception, and happened to get pregnant during the one interaction they had with their husband.

There was, however, a small group of women who indicated that they had never used any form of contraception. One woman expressed no interest in trying any form of family planning, saying whether she got pregnant was "in the hands of God". The remaining were regretful about not using anything and expressed a wish to start a family planning method once they received an abortion.

MISOPROSTOL, ALLOWING WOMEN TO MEET THEIR FERTILITY NEEDS

Misoprostol made abortions more practical, accessible & easier

Our data suggest where women wanted to control fertility but were either unsuccessful in their family planning efforts (due to side effects or contraceptive failure) or had not pro-actively used any form of family planning, women turned to abortion as second point of fertility control. Specifically, it was the availability of the abortion inducing drug, misoprostol that made abortion a feasible option. Misoprostol has a number of advantages over traditional surgical methods which include:

Wide availability

Misoprostol is widely available in Pakistan. Providers in our study indicated that it was possible to obtain misoprostol over the counter (OTC) from a pharmacy or even through social networks (such as female relatives in their community). The wide availability of these orally ingested pills meant women could induce the abortion within their own homes. This eliminated the need travel to a clinic, a crucial variable in a context such as Pakistan where gendered norms limit women's mobility. Furthermore, our observations showed that this wide availability of misoprostol also conferred privacy, enabling the women to have an abortion at home without the involvement of a large number of people, an important factor given abortions are contested and stigmatized.

> *They eat the pills and that's it…. there is no need to come here to the clinic, nor is there any issue of getting home* (Provider Sh)

Lower cost

Another observed advantage of misoprostol was that it was cheaper than traditional surgical methods. Unlike D&C which could cost between Rs. 3500-4000, misoprostol could be attained for less than Rs. 100.

Safe

Abortion using misoprostol was also understood as a safe way to terminate a pregnancy. Women understood that abortions that required manual removal of the fetus was a dangerous procedure, especially when conducted by a *dai.* Misoprostol, as an oral pill obviated the need for such invasive procedures:

> *These Dai's, you never know what they can put inside you …* (Patient 25)

Effective

In addition to these advantages, misoprostol was comparable in effectiveness to traditional surgical methods. All of the women who had an abortion through misoprostol, reported it was successful within a week of its use.

> *They gave me some tablets. They said that you have to take these many and take them after four hours. Then it happened on its own… I took the tablets for around five days, after that bleeding started* (Patient 11)

Control

Misoprostol also gave women greater control in accessing an abortion by eliminating both their dependence on a provider and need to seek permission from their husband, and possibly their larger marital family. We observed that many women who came to the clinic seeking abortion services, were denied the procedure. Misoprostol on the other hand, could be accessed and used by women themselves.

Even where patients did seek the pill from a trained provider, misoprostol had the benefit of creating a separation between providers and the actual abortion procedure. With misoprostol, providers no longer needed to physically participate in the induction of the abortion. Instead their role was minimized to providing or prescribing the misoprostol pills, then leaving the patient to do the rest. This was a sharp contrast to traditional methods such as D&C or even modern methods such as MVA, which depend on the provider's active involvement in inducing the abortion.

Overall, by making abortions more accessible and practical, misoprostol allowed women to maintain control of their fertility, regardless of whether they had taken preventive measures to avoid a pregnancy.

Misoprostol, the preferred method for abortion & fertility control

Given the many advantages misoprostol conferred in accessing abortion, the majority of our respondents had used misoprostol to induce an abortion. Its use had surpassed the traditionally preferred method of D&C as well as other modern abortion methods such as MVA. Among the few women who had an abortion through other methods, most said they had either attempted to use misoprostol first or said they wished they had been given misoprostol instead; such as this woman who received a D&C but wished she had been given misoprostol pills:

> *…for the first time in my life I fainted. As I said, in giving birth to a child nothing happened to me. But at the time of getting an abortion that's when I lost consciousness … She did not give a*

medicine right, that's the problem. She used the tool, because of that I have had a lot of trouble. (Patient 25)

Similarly, most of the women who wanted an abortion came to the clinic specifically asking for this drug. For example one woman came to the clinic saying her husband had told her to get some pills to get rid of the pregnancy. At the very least, most patients showed an awareness of the drug.

The fact that women were well aware of misoprostol and that it was their primary choice for inducing abortions, suggests that the availability of misoprostol does factor into women's family planning and fertility control decisions. Most of the women who had or sought an abortion did so within days of realizing they were pregnant. But the fact that they came to the clinic specifically looking for misoprostol (so soon after this realization), suggests that they not only had knowledge of misoprostol as a back up to where contraceptives failed, but may in fact have pre-planned the use of misoprostol *in place of* family planning. While this option had not been practical when abortion required a minor surgery, the ease of abortions that misoprostol conferred has made this possible. Women could now take a more reactive approach to pregnancy, and get an abortion *when* and *if* the pregnancy happened, rather than having to put up with the side effects of a daily pill or another long term hormonal contraceptive (all while the possibility of contraceptive failure still existed). Contraceptive use remains mired in negative perceptions. This approach was also advantageous to women as it involved substantially less time, effort and persistence than using a contraceptive method.

The use of abortions as a family planning method was also echoed by providers. They expressed that although their clients wished to limit their family size or space pregnancies, proactive use of contraception was missing. Providers felt this was because women remained wary of continuous use of hormonally-based contraceptives and were concerned with possible side-effects. According to the providers, an abortion was viewed by their clients as an easier alternative to family planning, identifying misoprostol as the agent making this approach particularly feasible. Providers felt the easy availability of this drug relieved patients of the responsibility to prevent pregnancy. Instead, a simple orally ingested pill could now terminate an unwanted or unplanned pregnancy if and when it occurred.

"*Women have started preferring the option of aborting, they don't like using family planning methods…the reason is there are myths that if we get a copper-T put in, it will go up, it won't be able to come out. From that you can get cancer, this, that. They say all these things which in reality have no truth. Understand? The depo (depo-provera) will cause my periods to stop, or it will cause an excess amount of bleeding, so these types of things*" (Provider Sh).

"*For many abortion has become a trend*" (Provider S)

"if she gets an abortion once, then from now on she will not take any family planning, she will say I can just take the medicine and it will be aborted" (Provider F)

RECONCILING THE PURSUIT OF ABORTIONS

With women increasingly turning to abortions, not only to mitigate unplanned pregnancies, but potentially as the primary means of regulating fertility, this raises the question of how women were reconciling this decision? Abortions are restricted on both religious and legal grounds in Pakistan, which has resulted in the procedure being highly stigmatized. Our data suggests that in an attempt to reconcile the choice to undergo an abortion, most of our study's respondents avoided any discussion around the morality of their decision. Some indicated regret towards pursuing the procedure, stating they knew the procedure was seen as a sin, or simply that they had made a mistake.

*... we just made a mistake. After this I will get the treatment done… (*Patient 13)

For others a feeling of guilt (and experience of abortion stigma) was detected in the way they gradually transformed the recollection of their induced abortion into a spontaneous abortion. A lack of witnesses meant a subtle change in language was sufficient to change reality. Furthermore, the local term for the word abortion is 'zaya' which translates closest to 'waste'. The term is used for both induced and spontaneous abortions as there is no local word to differentiate the two. The fact that it was difficult to decide whether the waste was intentional or otherwise adds to the ambiguity of women's actions. Other women completely avoided the use of any term related to termination of pregnancy (intentional or spontaneous). Instead they framed the discussion around their menstrual cycle, saying that they had missed a period and that's when they knew they were in 'trouble', or that the provider gave them a medicine to help get their 'period started again'.

Irrespective of these subtle signs of possible guilt, most women had come to clinic with their mind made up. They knew they wanted to terminate their unplanned pregnancy and they came to the clinic with their reasons for wanting an abortion ready. Most emphasized it was their circumstances that left them with no choice but to limit their fertility. Ultimately this showed that women's decision to abort outweighed the morally contentious space abortion occupied. Instead their desire to limit their family size was so strong that it motivated them to overcome any reluctance they had in undergoing a 'sinful' abortion procedure.

DISCUSSION

The purpose of this study was to explore how the availability of misoprostol has impacted women's abortion seeking behavior. Our findings reveal that although most patients did try to prevent pregnancy through the use of family planning, failure or side effects leading to discontinued or irregular use meant contraceptives were inadequate in allowing women to meet their fertility needs. This paired with non-use of family planning (due to restriction set by husbands, overlooking their need or simply not using), meant women were at risk of having unplanned pregnancies. But with misoprostol now available, women had an easier means of exercising a second point of fertility control i.e. abortion. The wide availability, low cost, safety, effectiveness and the greater control this pill conferred to women, meant abortions were now more accessible and practical. In line with this, our findings showed that medical abortion through misoprostol had become the preferred means of terminating an unplanned pregnancy, surpassing traditionally used D&C or even more modern methods such as MVA. Women's growing awareness of this drug suggests it may factor into their fertility control decisions. By avoiding any discussion around the 'morality' of abortions and avoiding any acknowledgement of the procedure, women were able to reconcile their decision to have an abortion. Thus it appears women's decision to limit fertility is enough to outweigh any moral dilemma faced in regards to termination of pregnancy.

Once women made the decision to limit their fertility, there were two options available to achieve this (Berer, 2002). The first was to prevent pregnancy through the use of contraceptives. As previous studies in Pakistan have shown, our findings revealed most patients did at least try using some form of contraceptive before needing an abortion, (if not using one at the time of their unplanned pregnancy) (Sathar, 2007). But contraceptive failure was commonly cited. Although this was at times a result of improper use of the family planning method, more commonly it was due to the natural failure rate associated with all contraceptive methods, despite correct and consistent use (Berer, 2002; Bury, Bruch, Barbery, & Pimentel, 2012). This was likely exacerbated by the fact that most of the women who reported contraceptive failure were relying on low efficacy contraceptive methods, namely condoms. Similar findings were cited by Rehan, Inayatullah, & Chaudhary (2001) and Vlassoff (2009), who found women citing contraceptive failure as a reason for their abortion, commonly used methods such as condoms, withdrawal or the rhythm method.

Side effects were also common. Most women described experiencing some form of discomfort or side effect that eventually led to the discontinued use of that contraceptive method. This aligns with previous studies that have shown high discontinuation rates (37%) among those who have used any contraceptive, within one year of its use and the widening gap between ever-use and current use of contraception

(Sathar, 2010; Sathar, 2015). One reason Tsui et al. (2011) suggested for this is that women worry the hormonal effects of contraception may lead to an inability to have children in the future. Given a strong social taboo attached to infertility, women become reluctant to starting or continuing the use of contraceptives where they experienced any form discomfort (Arif et al., 2008). Thus for most patients contraceptives were not allowing women to maintain control of their fertility, more often than not for reasons out of their hands.

The remaining respondents were not using any form contraceptives. Some women were unable to use family planning due to restrictions set by their husbands who also worried that the use of hormonal contraceptives may have negative consequences on their wife's health or physical beauty. These are consistent with findings from previous studies that similarly showed opposition by husbands to be a common reason women report for not using contraceptives (Rehan et al., 2001; Vlassoff et al., 2009). Additional reasons for not using contraceptives included overlooking their need or simply never using any despite knowing of the availability of contraceptives and where to access them. Similar findings were highlighted by Arif & Kamran (2007); Kamran, Arif, & Vassos (2011) and Tsui et al. (2011), who revealed that despite a desire among couples to limit fertility, reproductive planning was largely non-existent. Even though couples expressed an awareness of contraceptive methods and acknowledged that contraceptives provided a means of controlling fertility, contraceptive uptake remained low and inadequate (Kamran et al., 2011). This suggests barriers to effective contraception go beyond a lack of awareness of modern methods, lack of access or poor delivery of contraceptive services (Bury et al., 2012; Sathar, 2009). Rather, it may rather reflect a reluctance among women to use contraceptives at all which as previously described, may be due to a fear of side effects, particularly those associated with hormonal contraceptives (Rahim & Ara, 2008; Rehan N et al., 2001; Vlassoff et al., 2009; Sathar, 2010).

Overall, these findings provide insight to Sathar (2015) finding that contraceptive use in Pakistan is at sub-optimal levels and is inadequate in meeting growing demand for fertility regulation. Method failure, discontinued use and not using any form of contraceptive were important factors behind the increasing number of unwanted pregnancies (Azmat et al., 2012). As stated by Puri (2012), as the need for fertility regulation grows, contraception may simply not be enough.

This brings us to the second fertility regulation option women had, abortion. Our findings revealed that regardless of whether women were actively trying to prevent pregnancy or not, the desire to limit fertility was common among all our study respondents. When confronted with an unplanned pregnancy, women turned to abortion to limit fertility. Specifically, women were turning to the abortion inducing drug misoprostol.

This drug offered a number of advantages to inducing abortion, relative to traditional surgical methods. The first was its wide availability. Our findings revealed women could now obtain this drug over the counter at a pharmacy, or through social networks such as female relatives in their community. This was advantageous given the traditional practice of *parda* which dictates the need for women to remain secluded within their home and sexually segregated (Khan, 1999). By eliminating the need to travel to a clinic misoprostol allowed women to access abortion services whilst bypassing mobility restrictions imposed upon them through parda (Acharya & Kalyanwala, 2012). In addition to accommodating socio-cultural norms, this wide availability and accessibility of misoprostol also captures the potential of this drug to expand access to safe abortions services. It offers an effective means of decentralizing abortion services within the constraints imposed by legal and socio-cultural requirements (Ganatra, 2006).

Increased privacy was another benefit conferred by misoprostol. Studies have shown in settings "where abortions are highly restricted or illegal, patients are heavily focused on keeping the procedure a secret, prioritizing the need for confidentiality above even medical safety (Shellenberg et al., 2011; Sjostrom, Essen, Syden, Gemzell-Danielsson, & Klingberg-Allvin, 2014). The same has been documented in Pakistan where women similarly turn to clandestine providers as a means to obtain abortions privately (Zaidi et al., 2014b). But because misoprostol was easy to access and could be used within the home, it allowed women to minimize the number of people that found out about the abortion. As described by Kumar, Hessini, & Mitchell (2009) "if an abortion is performed safely and early, there is no enduring stigma to indicate that a woman has had an abortion. The potential invisibility of many women who have safe abortions in relative privacy allows women to avoid self-identifying or adopting a tainted identity linked to the experience" (p.630).

Patients in our study also perceived medical abortions to be safer. Women understood that abortion procedures that required manual removal of the fetus were dangerous, especially if conducted by a *dai* or another untrained provider. This aligns with Cabezas (1998) study in Latin America which similarly noted that "in comparison to a surgical procedure, most women consider medical abortion to be 'non-invasive' and non-violent, as their bodies are not invaded by instruments and no surgical intervention is required. In line with this, medical abortions have been described in some studies as being more natural, as it simply requires the ingestions of pills and the remainder of the process more closely resembles a miscarriage than an induced abortion" (p. S145). Several studies have provided confirmation of this perceived safety. Studies in India and Latin America show misoprostol has allowed women to not only avoid the need to turn to risky or clandestine providers but also offers a safer means of self-inducing abortion compared to traditional attempts, which often involve the insertion of sticks, roots, or sharp instruments (Berer, 2002; Billings, 2004). Thus use of misoprostol has resulted in fewer complications

and shorter hospital stays (Berer, 2002). As documented in Latin America, a shift toward medical abortion is believed to have contributed to a marked decline in complications and mortality from unsafe abortion (Ahman & Shah, 2011; Billings, 2004; Bury et al., 2012; Costa & Vessey, 1993).

Misoprostol was also an effective means of inducing abortion. Women in our study who used misoprostol reported a successful abortion within a week of its use. This aligns with findings presented by Acharya & Kalyanwala (2012) which showed in India, that early pregnancy termination through medical abortion was a safe, non-invasive and effective alternative to surgical abortion. Several other studies such as those by Elul et al. (2001); Karki et al. (2009); and Ngoc et al., (2004) have similarly highlighted that women in low-resource settings can safely administer misoprostol at home with no statistically significant difference in efficacy from women who administered it in the clinic.

Our findings also showed misoprostol offered a more affordable abortion option relative to surgical alternatives. Compared to traditional D&Cs which could cost upwards of Rs.3500-4000, misoprostol could be obtained for Rs.100. This is advantageous for women from low income families who due to an inability to afford safe services, may have otherwise had no choice but to resort to clandestine providers. The low cost of misoprostol also made it comparable in affordability, to contraceptives. In the study by Arif & Kamran (2007), participants attributed their preference for contraceptives as a means of fertility regulation, partially to their lower cost relative to abortions. But with misoprostol now an option, the cost of abortions has been significantly reduced, meaning preferences around fertility regulation mechanisms, may be subject to change.

Last but not least, misoprostol also gave women greater control over their reproductive decisions. Because it could be obtained independently of a provider, misoprostol reduced women's dependence on the medical system, and provided them with greater autonomy over this important reproductive decision (Winikoff & Sheldon, 2012). As Puri et al. (2012) described of women in Nepal, misoprostol alleviated the concern of being denied abortion services or having to seek an abortion from clandestine and unsafe auxiliary health workers. Even where patients did seek the pill from a trained provider, misoprostol had the benefit of creating a separation between providers and the actual abortion procedure. It minimized provider's role to simply prescribing or providing the pill at most, rather than actively inducing the abortion, as was required of traditional methods such as D&C. This was beneficial to patients because where a provider may have been opposed to conducting an abortion, due to a moral opposition to the procedure, misoprostol offered a way to balance provider's beliefs, with patients health needs.

Ultimately, misoprostol has greatly increased the accessibility and practicality of abortions. This abortifacient is unique in that it provides a means of bridging the advantages women seek from

clandestine services (privacy and convenience) with the benefits of seeking facility based care from trained providers (greater safety and likelihood of a successful abortion). By drawing attention to the many advantages of misoprostol induced abortions, our data provides qualitative support and insight into why in the decade between 2001 and 2012/13, while the contraceptive prevalence rate increased by less than one percentage point per year, the abortion rate increased by 90 percent over the same decade (Sathar, 2015). They also provide insight into why, as Sathar et al. (2014) suggested, growing rates of abortion may be explained by wider access to improved abortion services, such as misoprostol.

In line with these numerous advantages, our data showed that misoprostol had become the preferred means of pregnancy termination. Those who had an abortion primarily did so through misoprostol, and those who wanted an abortion either sought misoprostol specifically or at least showed an awareness of it. This preference for medical abortion through misoprostol has been noted in many contexts. In a study tracking sales of misoprostol between 2002 and 2007, found substantial increases in a number of Asian countries, including India (646%), Bangladesh (128%) and Indonesia (118%), and regional increases of 86% in the Middle East-North Africa and 27% in Sub-Saharan Africa (Fernandez, Coeytaux, de Leon, & Harrison, 2009). These increases were also found to have occurred in Pakistan, where sales of misoprostol-NSAID drugs increased by 254% (Fernandez et al., 2009). Thus, in line with global trends our study demonstrates that medical abortions have similarly become well known and used in Chakwal.

Given that women were well aware of misoprostol and that it was the preferred means of inducing abortions where needed, this suggests that misoprostol does factor into women's family planning and fertility control decisions. Women may in fact have pre-planned the use of misoprostol *in place of* family planning. While this option had not been practical when abortion required a minor surgery, the ease of abortions that misoprostol conferred has made this possible. Women could now get an abortion *when* and *if* a pregnancy happened, rather than having to look for a suitable contraceptive method, and put up with the side effects of a daily pill or another long term hormonal contraceptive (all while the possibility of contraceptive failure still existed). This was advantageous to women as it involved substantially less time, effort and persistence than using a contraceptive method.

Together, growing awareness, ease and practicality of undergoing an abortion through misoprostol, paired with consistent satisfaction with the effectiveness of the drug, suggest demand may only increase. These findings support the possibility that misoprostol has enabled not only an increased reliance on induced abortion to avoid unwanted births but may also be transforming abortions into a preferred reproductive strategy (Sathar et al., 2013; Sathar et al., 2014). Our study also supports the conclusions drawn by Khan AA (2013), Rehan (2001), Saleem & Fikree (2001); and Saleem & Fikree (2005) who similarly described that women may be opting for abortions to attain their goals for a small family size *in place of* family

planning. Our study adds insight to these conclusions by revealing that misoprostol is the key element providing women with the means to do this.

Ultimately though, abortions remain a heavily stigmatized procedure in Pakistan. As revealed by our study, women appeared to reconcile their abortion decision in how they framed their actions. Most women avoided any discussion regarding the morality of the procedure. But where abortions were discussed, it was often recast as a spontaneous event, i.e. a spontaneous abortion or using the layman term, a miscarriage. Alternatively, some women spoke about their abortion in reference to their menstrual cycle, specifically in terms of the abrupt disappearance of their period and their attempts get it started again. This aligns with Kumar (2009) description of how "in many parts of the world, abortion is described by women and communities as a 'delayed' or 'missed' menstrual cycle, a 'dropped' or 'lost' pregnancy, or in terms that communicate the impermanence of pregnancy without assigning agency to anyone" (p. 631) (Renne, 1996; Schuster, 2005; Sobo, 1996; Whittaker, 2002). Irrespective of how women managed their guilt however, by the time they came to the clinic to get an abortion their mind was made up. They came to the clinic prepared with their reasons for wanting the procedure. Arif (2007) similarly found that the social costs of being stigmatized do not restrict women from induced abortion when they are determined. Our study indicates women's wish to limit fertility was so strong that it motivated them to overcome any moral dilemma faced in regards to termination of pregnancy (misoprostol was providing the means to do this).

Recommendations

The findings of this research have important implications for scaling up access to safe abortion services and to avert preventable maternal morbidity and mortality associated with unsafe abortion. One recommendation would be to reinforce training to mid-level providers, who have a presence in women's communities, to administer misoprostol within women's homes. Ensuring women have access to misoprostol would deter the need to resort to unsafe clandestine providers or to attempt self-induction of an abortion through unsafe means. This would include training local providers to inform women of the proper dosage, outcomes and warning signs of misoprostol so women who choose to self-administer the drug are able to do so safely and effectively. Supplementing this with the creation of low literate materials that describe the use of this drug (Bracken & Family Planning Association of India (FPAI)/Gynuity Health Projects Research Group for Simplifying Medical Abortion in India, 2010) would ensure even women obtain misoprostol OTC at a pharmacy or through unqualified means, know how to properly use the drug.

Lastly while it is important to expand access to safe abortions, it is also important that barriers to care such as low contraceptive uptake are also addressed. This requires not only promoting the use of contraceptives and improving access to contraceptive services, but providing women with information about family planning options, particularly on their side effects. Equipping women with information regarding normal, manageable side effects versus those that warrant concern would prevent the misinterpretation of outcomes and avoid quick discontinuation of contraceptives.

Limitations

There are several limitations to this study. The first relates to power dynamics that may have been in play between ourselves and the respondents and the potential social-desirability bias that may have resulted. Although we did not select for patients on the basis of socioeconomic status, most patient respondents were from rural families with strained financial conditions. We presented ourselves as we were, researchers but with knowledge of this women may have been more conscious of their responses. They may have under reported the number of abortions they had and may have attempted to better align their actions with social norms and expectations by inflating their recollection of contraceptive use (such as the number of contraceptive methods they tried to use). Nevertheless we did probe into patient responses to gain details about the types of contraceptives they used, and what led to either their discontinuation or failure. By probing into specifics we were better able to identify whether patients appeared authentic in their response or may have inflated their response at times.

Selection bias was also limitation of this study. Given the sensitive nature of abortions, sampling outside of a clinic or hospital setting is extremely difficult. Women who seek clandestine services, do so for a large part to keep the procedure a secret. As such, they are already less inclined to want others to find out about the abortion, meaning they are less likely to self-identify wanting or having had an abortion, after the fact. Women who came to the clinic were different in the sense that they actually came to the clinic for an abortion- there is another group of women who don't come to the clinic at all, but rather, likely rely on clandestine abortion providers.

Another issue related to the fact that this study was conducted in only the province of Punjab. Thus there are dangers in extrapolating and generalizing findings nationally. Rates of contraception uptake vary provincially and different social norms around cultural practices of *parda* may affect the feasibility of home based abortions, or the acceptability of abortions as a whole. Nevertheless, "it is likely that the broad conclusions presented below do have relevance elsewhere in Pakistan (beyond Chakwal), as well as in other settings where restrictions around abortion exist and misoprostol is available".

CONCLUSION

In conclusion, this research indicates that in a context where family planning programs have failed to increase uptake of contraceptives, and a wish to limit fertility remains, misoprostol has provided women with a more practical and accessible means to rely on a second point of fertility control, abortions. This abortifacient has become not only the preferred means of terminating pregnancy, but appears to have become a form of family planning in place of contraceptives. Given the numerous benefits of this drug, it is important to ensure that where a safe option exists, access to it is promoted.

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Chapter 5: Manuscript 3

Ideology trumps: health care providers a barrier to abortion services

Harneet Chahal and Zubia Mumtaz

ABSTRACT

Background: In Pakistan, abortions occupy a highly ambiguous space. Although at first glance the law and religion appear to denounce the procedure, in reality poor clarity around the conditions underlying these rules leaves providers with a negotiable space to administer abortions. The dominant social narrative however remains heavily opposed to the procedure. Thus even though some NGO's do provide safe abortion services, it is possible that healthcare providers may experience an ethical or moral dilemma in making decisions around termination of pregnancy. Some providers may interpret the rules in the interest of patients, while others may use these conditions to restrict services. Little is known however of provider views towards induced abortions in the Pakistani context. To explore this further this study examined provider views of induced abortion and how these views impact provider's provision of abortion services.

Methodology: A focused ethnography was conducted in Chakwal, Pakistan from September to December of 2013. Participants were recruited from a non-governmental organization that provides family planning and reproductive health services, including abortions. Twenty three in-depth interviews were conducted with women seeking (inpatients) or that had received (outpatients) an abortion and fourteen in-depth interviews were conducted with the facility's healthcare providers. One focus group discussion was conducted with providers.

Results: Provider beliefs emerged as a key barrier in patient's ability to access safe abortion services. Providers viewed abortions to be wrong, felt they facilitated a deviation from God's will and carried safety concerns for the mother's health. They also worried that abortions offered patients an 'easier' fertility regulation option and would consequently incite a deviation from women's gendered norms. The extent these negative views impacted provider's provision of abortions depended on whether a social relationship existed with the patient. Most patients however did not have any relation to providers and were consequently subjected to a value based assessment, aggressive counselling, and ultimately denied services.

Conclusions: To support women's access to safe abortions we recommend greater attention be given in hiring providers willing to conduct abortions, improve providers counseling skills, and expand family planning services.

INTRODUCTION

Worldwide, abortion occupies a highly contentious social and legal space. By its very nature, which involves a complex debate between a fetus's right to life and a mother's autonomy over her physical and reproductive health, abortion draws extreme reactions from people either in favor of, or against it. This polarity also exists at higher institutional levels. While countries such as Canada and Sweden are more liberal in their abortion laws others such as Pakistan, Uganda, and the Phillipines (among others), have placed greater restrictions on the accessibility of this procedure (Berer, 2002; Moore, Jagwe-Wadda, & Bankole, 2011; Rahman, Katzive, & Henshaw, 1998; Singh, Wulf, & Jones, 1997).

In Pakistan, abortions occupy an ambiguous legal and religious space. Although at first glance, the law and religion appear to denounce the procedure, in reality there is room to maneuver. According to Pakistani law, abortion is only permitted on the condition that it is required to save the mother's life or to provide the mother with necessary treatment (Zaidi et al., 2014; Dalvie, Barua, Azmat, & Mustafa, n.d.). While this initially presents the picture of a highly restricted procedure, the lack of specifications defining these laws makes them quite vague. It is not clarified whether the scope of 'saving the mother's life' refers purely to biomedical reasons or if it also encompasses the woman's mental and social wellbeing. For example young woman pregnant before marriage may face a threat of punitive action from her father or brothers. Alternatively she may face ostracism from her family and community even if the pregnancy was a result of rape. Furthermore, there is also no explanation resolving the poor clarity around the term necessary treatment (Dalvie et al., n.d.) leaving its meaning open to interpretation.

Ambiguity around the acceptability of abortions also exists in the religious sphere. According to the dominant religious view in Pakistan abortions are permissible prior to 120 days of gestation only where a genetic condition has been identified (Jafri et al., 2012). But the Quran itself does not explicitly address Termination of Pregnancy (TOP) (Jafri et al., 2012). Rather, this view originates from interpretations of Quranic verses addressing topics such as descriptions of the process of fertilization, fetal development and the point at which the soul is thought to enter the fetus (referred to as ensoulment) (Asman, 2004). This leaves room for alternative religious interpretations and there is general consensus among scholars that abortion is not entirely condemned in Islam (Jafri et al., 2012).

Room for alternative religious interpretations and unclear legal guidelines around the permissibility of abortions have created a grey space or loopholes used by non-governmental organizations to provide safe abortion services. Drawing upon Pakistan's international obligations and laws that promise to provide women 'reproductive health services', the Rahnuma Family Planning Association of Pakistan and Marie

Stopes Society (refer to chapter 1), are two such NGOs that have occupied this space to provide safe abortion services.

The dominant social narrative in Pakistan however, remains heavily opposed to abortion. Common in many parts of the world, abortions are a stigmatizing activity. According to Goffman (1963) (as cited in Norris et al., 2011, p.S49), stigma is "an attribute that is deeply discrediting. It reduces the possessor from a whole and usual person to a tainted, discounted one". There is also a relational nature to stigma, it not only affects the person undergoing the stigmatized action, but those who administer it as well. As described by Hughes (1956, 1958, 1971) (as cited in Harris, Debbink, Martin, & Hassinger, 2011, p. 1062), stigmatized work is "dirty work", and its practitioners are "dirty workers" as they perform socially necessary functions that are tainted by socially degrading, or morally dubious elements. Abortion is associated with three taints: physical (blood, fetal parts); social (contact with stigmatized patients); and moral (in this case violating the dominant legal and religious dictates) (Ashforth & Kreiner, 1999; Harris et al., 2011). While women who have the abortion are the most obviously stigmatized individual, abortion providers also risk adverse stigmatizing consequences, including status loss, discrimination, and disclosure difficulties (Healy, 1993; Major & O'Brien, 2005).

Within this nebulous legal, religious and social space the question then arises- how do providers, who are supposed to provide abortion care, operate? Recent studies show that between 2002 and 2012 in Pakistan rates of abortions have increased from 890,000 to 2.25 million (Sathar, 2015). But little is known of provider views towards induced abortions in the Pakistani context, particularly where reasons underlying the pursuit of this procedure extend beyond congenital abnormalities (Arif et al., 2008). The persistence of negative social views around abortion raises the concern that HCPs may experience a religious-legal/ ethical-moral dilemma in making decisions around TOP (Jafri et al., 2012). In the study by Davlie et al., (n.d.) it was argued that in such a context, some providers may interpret the rules in the interest of the woman, while others may use these conditions to limit services. This is dangerous because women denied care by qualified providers often turn to clandestine services, where risks of complications, and subsequent maternal morbidity and mortality are magnified (Warriner, 2006). Within this setting, understanding provider perspectives is important as it can offer information on how to improve access to, and support the availability of safe abortion services, a key step to reducing maternal morbidity and mortality in this region (Puri et al., 2012). To address this gap in knowledge, specifically in the context of Pakistan, this study sought to understand (1) provider views of induced abortions & (2) how these views shape provider's medical practice in respect to abortion provision.

METHODS

This paper draws on focused ethnographic work conducted in the town and district of Chakwal, Punjab Pakistan from September to December of 2013. The district of Chakwal is relatively well developed, with a primarily agriculture-based economy. It can be considered representative of conditions in Northern Punjab (Mumtaz, Levay, Bhatti, & Salway, 2013). This location was chosen due to the research team's (ZM and University of Alberta's) history of working in this area. Previously established community networks allowed the primary investigator (HC) to quickly build rapport with the facility providers and patients, enabling the collection of high quality data.

Within the town of Chakwal, data was collected at the Rahnuma Family Planning Association of Pakistan clinic, a non-governmental organization that has been providing reproductive health (RH) and family planning (FP) services in Pakistan since 1953. Included among its service provision are abortions and post abortion care. Choosing to work within this facility enabled us to purposefully sample participants who had the shared experience of either undergoing or conducting an abortion.

In total 23 patients seeking abortion services (8/23) or that had previous had an abortion within six months of commencing the study (15/23) were enrolled in the study. Six months was chosen as the cut-off period as a means to ensure women's memory of their abortion experience was fresh enough to accurately recall. Patients seeking PAC as a result of a miscarriage were *not* included in the study sample. No other exclusion criteria was exercised. Patients identified to fall within our target profile were invited to participate in the study by the providers.

All 14 healthcare providers working within the Rahnuma clinic were also included in the study. These included 3 Obstetrician Gynecologists, 1 Nurse, 7 Lady Health Visitors (LHVs) and 3 Midwives. Given that the Rahnuma clinic provided services exclusively to women, all the providers were female. The professional experience of each provider varied from as little as 9 months to 16 years. All providers in the clinic had received training on the provision of abortions as an expected element of care they were to provide. The precise role each provider played however varied according to their position: Physicians performed ultrasounds and counselled patients on health matters including both reproductive and general health issues. The nurse and more experienced LHVs counselled patients prior to seeing the doctor, and even prescribed medicines. Where necessary, LHV's were allowed to prescribe misoprostol for medical abortions. LHVs also assessed patient's contraceptive needs and either provided or prescribed patients the family planning method chosen. The less experienced LHVs were responsible for record keeping,

registering patients and providing them with their prescribed medicines if available in the clinic. Midwives largely worked as provider's assistants, particularly physician and LHV assistants, doing menial tasks such as keeping patients orderly, serving tea, keeping equipment and materials stocked in provider rooms, and cleaning. This paper focuses more heavily on the responses given by providers.

Data collection was undertaken through semi-structured in-depth interviews, participant observation and a focus group discussion. All 23 patients and 14 providers were interviewed in-depth. This sample size was sufficient to reach data saturation (Mason, 2010). These interviews explored why women continue to seek abortions, how, and the challenges they face within Pakistan's restrictive setting. Each interview was conducted within a private room in the Rahnuma clinic to ensure privacy and confidentiality. Oral consent was obtained from all participants prior to the commencement of the interview and discussions were digitally recorded.

One focus group discussion (FGDs) was conducted with five of the Rahnuma clinic's health care providers. This provided an opportunity to clarify and supplement ideas brought forth by patients and providers during their interviews. It also shed light on social factors shaping provider beliefs of abortions, as it created a point of comparison for provider's views of abortion when discussed individually versus in a group.

Participant observation was also a central data collection method. By observing providers in day to day tasks and engaging in informal interactions with patients in waiting rooms, data was collected regarding daily functioning in the clinic. Furthermore, observing patients and providers during counselling sessions provided an understanding of the nature of patient-provider interactions. Field notes and a reflexive journal were kept to record contextual information and to document participants behavioral nuances demonstrated during the interviews that were helpful in clarifying the data.

Data was collected with the assistance of a Research Assistant (RA) fluent in the local language of Potohari, Punjabi and Urdu, under the supervision of the primary investigator who was also able to understand these languages. All interviews and focus group discussion recordings were translated and transcribed into English by the primary investigator. Data were analyzed concurrent to and following data collection, through a latent content analysis approach. Descriptive codes were developed throughout the transcription process, then again by reading and re-reading transcripts once they were complete. These were then categorized to identify broader themes to abstract deeper meaning and to build an explanation for the findings. Data from interviews, focus group discussions, and observation notes were merged to

describe the experience of patients and providers in accessing and providing abortion services, respectively.

Ethical clearance was obtained from the University of Alberta Research Ethics Board, and the National Bioethics Board, Pakistan.

FINDINGS

PROVIDER VIEWS OF ABORTION

Abortions are wrong

Our data revealed that all 14 providers in the clinic, without exception, were opposed to the idea of an abortion. Only two begrudgingly performed the procedure. A third provider (a midwife) used to conduct abortions in her village based practice, but had ceased doing so two years ago. The remaining 11 providers, either denied the procedure or occasionally referred the patient to other clinics to get the abortion, such as the Marie Stopes clinic. Irrespective of their practice, all the providers interviewed in this study believed abortion was a sin and equated it to a crime as severe as murder:

> "*This is a crime, this is illegal and this is also forbidden by Allah. I try to make them understand, this is what God has said in the Quran, and all the risks… don't murder your children*" (Provider Ab)

Providers did appreciate the many circumstantially limiting factors that made raising another child difficult for some families. They acknowledged that poverty, a 'complete' family, an unmarried woman (called an illegal pregnancy), lack of support from family members (spouse or marital family), medical reasons, working mother, or being an older mother made having an unplanned child difficult. They were also aware of the risks women faced when denied services by a trained provider, as patients would be forced to seek clandestine services. One provider underscored this by citing that her own mother had died after an unsafe abortion. Despite this knowledge however, all our providers remained firm in their beliefs. This reflected the strength of abortion stigma in outweighing the power of knowledge and clinical experience toward the negative maternal health consequences of an unsafe abortion.

Fear of Divine Punishment

Our respondents viewed a child as a gift from God "*aulad rabb ki rehmat hoti hai" (- patient),* and a woman becoming pregnant as a reflection of Allah's will/ command (S, FGD, 02.10.2013). An abortion was interpreted as a direct violation of divine determination. So deeply embedded were these beliefs that

the providers worried they could be punished by 'Allah' if they performed an abortion. One provider shared her experience of her son falling severely ill, which she believed was in retribution for conducting abortions:

> *"No no Baji I used to conduct abortions but my youngest son fell ill, really ill! Meaning I thought that was the last hour he would be breathing. After that I promised Allah that from now on I would not conduct any more abortions… just 10 or 15 days prior to my son falling sick, I had done a D&C. My husband had told me making money doing such things was not a good idea. I always said people just say things. But after some time, I thought maybe that is why this has happened*." (Provider S)

Concerns regarding health and social consequences of abortion for women

Providers expressed concerns over the safety of abortions. They highlighted consequences such as infertility or obstetric complications as well as the implications these outcomes carried for the patient given gendered expectations of women in childbirth. Providers expressed that even where a patient may have her husband's support during the abortion, it was questionable whether he would support her if she became infertile:

> *Her husband may support her now when she wants the abortion, but if after that if she is not able to have any children, then…?* (Provider M)

Providers maintained that where families had not yet achieved their desired family size, ideal gender composition or had young children still at risk of dying, it was important that women retained their ability to have children. Otherwise she was at risk of being abandoned by her husband for a woman who *would* bear him offspring (particularly a boy).

Concerns of abortion becoming a form of family planning

Closely aligned with concerns over the safety of abortions, providers were concerned this procedure was being used as a form of family planning. They reported that although their clients wished to limit their family size or space pregnancies, proactive use of contraception was missing. They felt this was because women remained wary of continuous use of hormonally-based contraceptives and were concerned with possible side-effects. According to the providers, an abortion was viewed by their clients as an easier alternative to family planning. The availability of misoprostol made this approach particularly feasible. Commonly known by its trade name of Arthotec, the providers felt the easy availability of this drug relieved patients of the responsibility to prevent pregnancy. A simple orally ingested pill could now

terminate an unwanted or unplanned pregnancy if and when it occurred. Given this ease and convenience, providers worried it was becoming a trend.

> "*Women have started preferring the option of aborting, they don't like using family planning methods…the reason is there are myths that if we get a copper-T put in, it will go up, it won't be able to come out. From that you can get cancer, this, that. They say all these things which in reality have no truth. Understand? The depo (depo-provera) will cause my periods to stop, or it will cause an excess amount of bleeding, so these types of things*" (Provider Sh).

> "*For many abortion has become a trend*" (Provider S)

> *"if she gets an abortion once, then from now on she will not take any family planning, she will say I can just take the medicine and it will be aborted"* (Provider F)

Abortions enabling a deviation from gender norms

A further analysis of the data revealed that underlying all of the provider concerns listed above, was an apprehension that the availability of abortion services was facilitating women's deviation from gender and sexual norms. Providers feared that the demand for abortions and growing availability of such/ these services foreshadowed changes in norms around sexual relationships and expectations of marriage. In particular their identification of an emerging trend of women aborting a pregnancy shortly after marriage was considered a harbinger of such shifts. Traditionally gendered norms expect women to become pregnant and have a child soon after marriage (Mumtaz, 2002). This is viewed as proof of the woman's fertility and confirms her place within marriage. The fact that conception soon after marriage was becoming an impetus for abortion was an astonishing new trend for providers. In particular, young newly married women seeking an abortion because they were either not ready for 'motherhood', wanted to continue their studies or simply wanted to enjoy the first few years of marriage without child-rearing responsibilities disconcerted the providers. They did not want to be agents edging on the possibility of this worrisome trend.

> *"a patient had come, her mother in law and husband were both with her … it was their first child but they came in asking for abortion, saying we just got married, and we want to enjoy marriage without child-rearing right now. Look at that?!* " (Provider S)

They were also worried that the easy availability of abortions was allowing women to have sexual relationships outside of or prior to marriage because everyone*, married or unmarried* could have an abortion nowadays. Multiple abortions in particular were viewed as an indication of sexual promiscuity. This perspective was captured by one particular case, in which a patient with a record of six repeat

abortions was labelled as a prostitute by the clinic providers. Providers partly justified this view through recollections of seeing her wearing makeup while outside her home. Primarily though, providers reasoned that it was not logical for her to be aborting so many children if they truly were fathered by her husband. Her repeat abortions were not seen as proof of the patient's claims that she was abused and raped by her husband.

> *"If I am a house wife and the mother of [only] two children, then why would I think that I have to get an abortion done or that I want to get a BTL (bilateral tubal ligation) done… we have caught her twice on the streets, all dressed up with lipstick. The other thing is people in the mauhalla all know... her reputation is not good" (Provider F)*

> *"Obviously they were not his, that's why she got the abortion. If they were her husband's then one would be crazy to do this [ie abort six times]?" (Provider F)*

IMPACT OF PROVIDER VIEWS ON THEIR PROVISION OF ABORTION SERVICES

Our data showed that providers were unable to detach their personal views from their provision of abortion services. Providers saw themselves as reproductive health care providers. The fact that they had to conduct abortions within this role was a dissonance in their value system. Where patients came to the clinic seeking an abortion, providers grew frustrated as they were now forced into an uncomfortable position of having to act against their personal beliefs. Irrespective of this frustration, the extent to which provider's views impacted their provision of abortions was largely determined by whether there was any form of kinship connection between the patient and provider. In this section we discuss how their practice was shaped by kinship factors.

Patient Provider Connection Does NOT Exist

Value Based Assessment Criteria

Of the women who came to the clinic seeking an abortion, most lacked any connection to a provider. The majority of these abortion seeking patients were denied abortion services. The providers were hostile towards these patients that requested abortions. Particularly where they lacked a familial or *biradari* based connection to the patient, providers had no point of reference to gauge the depth of patients need and justification for seeking this service. Instead, to decide who 'deserved' the procedure, providers followed their own protocol to assess whether the woman 'deserved' an abortion, developing an unwritten value-based assessment criteria. They first checked if the woman had attempted to prevent the pregnancy, namely whether she was correctly using a contraceptive method. If there was any evidence of patients

mis-using or not using a contraceptive, or using abortion as a form of family planning, providers refused to conduct the procedure. These questions were not asked upfront, but assessed through inconsistencies in patients' recollection of their family planning efforts, whether there was a history of multiple abortions, and if the patient was indecisive in their initial selection of a contraceptive method prior to needing the abortion.

They were also not sympathetic to circumstantial factors such as poverty, or having too many children as the reason for seeking the abortion. Though they were aware that these were common reasons women sought abortion procedures, providers felt patients should have thought of these contextual matters BEFORE they became pregnant, and taken preventative steps in advance:

> *"I am not seeing any indications in you that, God forbid, you are as bad as the people on the street, those are not your conditions"* (Provider F)

> "*Yaar, she only has two children? Her husband is well, she came from home having had a good meal, from where would an abortion be justified*?" (Provider F)

Our data indicated providers were only sympathetic towards the need for an abortion where it was rooted in issues around the woman's age, marital status or health. Where the patient was a young (typically below the age of 16) unmarried girl, providers recognized the pregnancy was likely a result of sexual violence caused by a known or unknown man (rape or incest). For the sake of protecting this girl from facing social repercussions of pregnancy before marriage, such as being socially outcast or punished by her father/ (a male family figure- father or brother), and to ensure she had a future, providers conducted the abortion without opposition.

> "*Yesterday a little girl came… Baji told me she was unmarried, it was that type of problem… Now if she does not do this [abortion] then it will be a problem, her whole life will be ruined. It's a simple matter, she will get the medicine and her issue will be taken care of*" (Provider S).

Where the patient was an older married woman (typically in her late 40's or older), providers acknowledged the potential complications that could arise during pregnancy and childbirth that put the patient at risk. Similarly, where the mother had previously had one or more c-sections, providers understood the physical burden another pregnancy could cause. In these cases, providers agreed to conduct the abortion with greater ease and less hesitation.

An interesting observation was that abortion rooted in gender selection was a topic that conferred great discomfort and 'uproar' amongst the providers. All of the healthcare professionals in the Rahnuma clinic vehemently denied that such abortions were justifiable, labelling it as something backwards that happened

only among rural, uneducated people; not something that happens in the 'city' (their local township). Most providers denied even seeing such cases enter the clinic, let alone ever conducting one. While probing providers did often lead them to share stories of abortions being conducted on grounds of the sex of the fetus, they were careful to clarify that they themselves had never conducted such abortions.

> *"During my training there was a patient with six daughters who came once. She was in her seventh month of pregnancy and asked me to tell her the sex of the fetus. She had brought her entire family with her. Unfortunately the seventh time as well, it was a girl, but I did not tell her… From my end they did not get an answer. I had said no I can't differentiate it. But from my failure to give them an answer, they understood it was a girl*" (Provider Ab)

Aggressive Counseling

Given that most women were deemed not deserving of an abortion, they were aggressively counselled against it. Most providers did attempt to convince patients out of their decision to have an abortion, often reasoning with women and suggesting alternatives such as giving the child up for adoption. But where patients were set on obtaining the procedure, providers would begin belittling patient's reasons:

> "*And that is young? Look you have three children so far, and already you are fed up with them. The child is only a year and a half, in the time this next one comes it will be two and a half years old. Hmm*?" (Provider F)

Providers then progressed to blaming the mother for being in the situation she was in. Where the woman said her pregnancy was a result of a failure in her contraceptive method, providers held she was being dishonest and was attempting to conceal either an inappropriate or non-use of family planning.

Where the woman said she experienced negative consequences from using a contraceptive, providers questioned why the patient did not come back for a different method, or why did she not tell the providers what was wrong so it could be tried again.

> *"You should have come again, and gotten some medicine… If a problem came up with the injection, the Baji here who gives the injection tells all her clients that if any problem arises, then they should come back to the hospital…But you did not come back after you got the injection! Right?! So who's fault is this then?... It starts to suit you when the second or third injection is given, those hormones take time in settling down. All of this Baji must have told you when she gave you the injection. She doesn't just give the injection, she tells everything first. Understand."* (Provider F)

If patients indicated that their husbands had put restrictions on using contraceptives, then the providers reasoned it was the woman's responsibility to make her husband understand why family planning was needed and to abstain from sex if he did not comply.

Lastly, providers went into great detail about the underlying morality of the patient's decision. They reminded patients that the abortion was criminal and sinful. They also emphasized how unjust it was, that the unborn child was the one to 'suffer' for a mistake made by the parents:

> *"You should have thought with more sense to start with right. Why are you attempting this? This is your fault, why are you giving punishment to the one who is innocent*" (Provider Ab)

Providers followed these tactics even though they knew even if the patient was denied the abortion by a trained provider, her mind was made up and she would likely seek care through alternative clandestine means:

> "*Those who make up their mind, do it regardless*" (Provider M)

Patient- Provider Connection DOES Exist

Providers quickly shed these rules where they *did* have a social connection to the patient. With relatives and family friends providers were much more flexible and accepting of the need for an abortion. This was vested in the power that lies within kinship networks in Pakistani society. Where familial or biradari bonds exist, providers have a moral obligation to accede to patients request. The perceived immorality and criminality of abortions was no longer a pivotal element in the decision making process; as the needs of their relative now superseded such matters. A closer relationship to the patient also meant providers gave greater credence to the reasons patients cited for needing an abortion. This was because as a relative or family friend, providers could better envision and sympathize with the patients. Providers themselves may have witnessed the hardships the patient spoke of (they may have personally felt the financial pressures the patient was under or the burden of their numerous children). As a result, social reasons that would have otherwise been dismissed, were now tangible reasons underlying the need for an abortion. As an example this provider, made an exception to give an abortion when it was her sister who became pregnant and pleaded with her for help:

> *"Now it has been about two years, two years have passed since I have conducted an abortion. But Baji (my sister) was very forceful about it. I said I would not do a D&C, instead I told her to take the medicine first, and we would see from there. Thank God the pills did the job!"* (Provider S).

So overall, although providers negative views of abortion did deter provision of this service to most patients, it did not prevent providers from administering it to family members.

DISCUSSION

The objective of this study was to explore provider views of induced abortion and to examine how these views impacted provider's provision of this service. Findings from our study suggest providers are strongly opposed to abortions. Most felt that they were sinful, criminal, violated God's will and carried safety concerns for the mother's health. Furthermore, provider's worried the procedure offered patients an 'easier' fertility regulation option relative to contraceptives and had the potential to enable a deviation from accepted gendered and sexual norms. Overall, these negative views heavily deterred provider's willingness to conduct abortions. While providers did agree to conduct the procedure on the basis of a few life threatening social circumstances, most patients fell beyond this criteria of acceptability. As such, patients were commonly subjected to a value based assessment criteria to determine how 'deserving' they were of the abortion, and were aggressively counselled with the intent of changing the patients mind. Interestingly however, where providers did have a connection to the patient they were much more flexible in their provision of abortion services.

Providers in our study expressed predominantly negative views of abortion. They saw the procedure as being fundamentally wrong, categorizing it as sinful and criminal. This reflects at one level, that the providers are mindful of the legality of the procedure, and are fearful of potential legal repercussions. This aligns with previous literature from Pakistan that showed that 67% of health care providers are fearful of social and legal punishment if they conduct abortions (Dalvie et al., n.d.). This fear persists even though there is no record of a patient or provider being punished for receiving or administering an abortion (respectively) (Dalvie et al., n.d.). Our findings broaden this information, by revealing that provider fears of punishment also extend to religious grounds. Most respondents viewed pregnancy to be a reflection of God's will. As such providers worried that conducting abortions was a direct violation of divine determination, and left them vulnerable to some form of divine retribution. Similar findings were highlighted in a study by Tsui et al. (2011) who found that both male and female study respondents (selected from the general population of rural Tret, Punjab Pakistan) saw pregnancy as a reflection of God's will, and as something that should be welcomed, or at the very least dutifully accepted. These concerns of legal or religious punishment also reflect providers own experience of abortion stigma. Abortion stigma however, affects not only those who undergo the procedure but those who administer it as well (Harris, 2008). Providers are often referred to as 'abortionists' and 'murderers' (Mitchell et al., 2004; Kumar, Hessini, & Mitchell, 2009). As Kumar et al. (2009) describes "these are highly stigmatizing categories that contribute to the exclusion of pregnancy termination as a legitimate part of reproductive

healthcare, instead equating it to an abhorrent crime. This discursive frame seeks to create a schism between all health providers and those who provide this particular medical intervention" (p. 631). This stigma likely fuels these legal and religious fears. As such, providers want to avoid this label as well as any association to the procedure.

Another concern providers expressed towards abortions was in regards to its safety. Our findings showed providers commonly highlighted the immediate health risks (obstetric complications), secondary health risks (infertility), and potential downstream consequences (her husband subsequently remarrying) of abortions. Previous literature suggests however, there is little merit to these concerns. In regards to more immediate health concerns, it is important to highlight that when performed safely by trained providers in hygienic settings, abortions carry few health risks, and the likelihood of patients suffering complications are quite low (WHO, 2012). It is only when patients are forced to seek care through clandestine providers who lack adequate medical training or where the environment does not meet minimum medical standards, that risks of complications such as hemorrhage, infection, and uterine perforation are elevated (Grimes, 2006). Secondly, in regards to the more downstream consequences of infertility and divorce, Mumtaz, Shahid, & Levay (2013) highlighted that the endogamous nature of marriages in Pakistan and the need to prioritize *biradari* bonds, means the likelihood of a man re-marrying due to the woman's infertility, is uncommon. Given that most women sought abortions to limit their fertility, the issue of infertility was unimportant for them. Seeing as there was little merit to safety concerns, it is possible providers may have simply tried to use safety of the procedure, as a means to legitimize their refusal to conduct abortions. It allowed providers to re-frame their concerns around the patient, rather than around themselves and the punishment they feared they may subject to.

Providers also had concerns that abortions were becoming a form of family planning. Providers in our study reported that although patients expressed a desire to limit fertility, they were not always actively using contraceptives. Providers explained this was because patients were fearful of experiencing side effects of hormonal contraceptives and as a result, were increasingly relying on abortions, as an 'easier' fertility control mechanism. Our data and previous studies conducted in Pakistan suggest these concerns may in fact be valid. As highlighted by Sathar (2015), contraceptive use has not kept pace with the growing desire for smaller family size. Studies by Rahim & Ara (2008); Rehan, Inayatullah, & Chaudhary (2001); Vlassoff, Singh, Suarez, & Jafarey (2009) all revealed that fear of side effects heavily contributed to the reluctance in using contraceptive methods. Nonetheless, irrespective of the reason for poor contraceptive use, the literature and our data suggest that women may increasingly be relying on abortion to regulate fertility. This aligns with the point made by Sathar (2015) that between 2002 and 2012 as rates of unplanned pregnancy grew from 38% to 46%, rates of induced abortion also increased from 890,000 to

2.25 million. This suggests an increased reliance on induced abortion not only to manage unwanted pregnancies, but as a fertility control mechanism (Sathar, 2015). Studies such Khan AA et al. (2013), Saleem & Fikree (2001), and Saleem & Fikree (2005) and our own misoprostol paper (in Chapter 4 of this thesis) have also alluded to this trend, which has increasingly been made possible through the abortifacient misoprostol.

Last but not least, providers also worried that the growing availability and use of abortions would facilitate a deviation from gendered norms. This concern was partly rooted in provider's recognition of a new trend for patients to abort their first child. This was a departure from traditional norms and expectations of women in marriage. As Arif & Kamran (2007) and Bhandari, Hom, Sabina Rashid, & Theobald (2008) described of South Asian countries such as Pakistan, Bangladesh and Nepal, a key gendered expectation of women is to bear children soon after marriage (as well as to bear many children). Culturally, this is viewed to be important because it allows men to prove their masculinity and women to demonstrate their fertility (Bhandari et al., 2008). Seeking an abortion however, challenges this gendered role (Bhandari et al., 2008). Furthermore, abortions carry connotations of sexual relationships outside of marriage (Bhandari et al., 2008). Sex is viewed as an action reserved for the purpose of childbearing (particularly for women). Thus where a woman chooses to terminate her pregnancy, it is viewed as an indication of non-procreative and illicit sexual behavior (Kumar et al., 2009). As Harries, Stinson, & Orner (2009) described of the South African context, this view of promiscuity is especially true of women who have repeat abortions. These views reflect the violation of two fundamental ideals of womanhood: nurturing motherhood and sexual purity (Kumar et al., 2009). The desire to be a mother is central to embodying a good woman (Russo, 1979). Thus where a woman seeks to have an abortion, it is seen as counter to prevailing views of women as perpetual life givers and asserts women's moral autonomy in a way that can be deeply threatening (Kumar et al., 2009).

Overall, these negative views heavily deterred from providers willingness to openly conduct abortions. Although the providers in our study were working in a clinic mandated to provide abortions, and received training to administer this service, the fact that they had to conduct this procedure was a dissonance in their value system. While this largely culminated in provider's refusal to conduct abortions, our research revealed a nuance to this behavior that may relate specifically to the Pakistani context. According to our findings, the degree to which provider's negative views impacted their provision of abortion services was highly dependent on whether there was any social or familial connection to the patient.

Where there was no social connection to patients, providers were very selective in choosing who received an abortion. To determine who they felt was truly 'deserving' of the procedure providers exercised a value based assessment criteria. This was based on a combination of the woman's pregnancy prevention

efforts, social circumstances and the provider's personal perspective of what conditions justified an abortion. While providers did agree to conduct abortions where the woman was a victim of sexual violence (rape or incest) or where another pregnancy threatened her health, most other reasons were not seen to be justifiable, findings that parallel those of Harries et al. (2009) of the South African context. Patients who described being motivated by social factors such as poverty, too many children, contraceptive side effects or contraceptive failure, were viewed as a reflection of the patients own inadequate prevention efforts and were therefore determined to be undeserving of the procedure. These findings align with the study by Kumar et al. (2009) in India which found that when administering abortion services, providers differentiated between what they saw as "good abortions" vs "bad abortions" stemming from "good" and "bad" reasons for having them. Similarly Bhandari et al. (2008) similarly found in Bangladesh that provider's perceptions of client's marital, social and economic status shaped the quality of care patients received when seeking abortion services.

Nonetheless, our data showed that where patients were deemed to be undeserving of the abortion, providers aggressively counselled these patients with the intention of convincing them not to terminate their pregnancy. This included belittling patient's reasons for seeking an abortion, blaming them for the situation they were in, and reminding them of the morality of their actions. Most of these patients were denied services. Interesting to note however, is that studies conducted in developed countries show few women who seek an abortion actually need 'counselling' (Berer, 2002). Women who decide they want an abortion, usually have their minds made up and are not looking for 'counselling' to change their decision. Instead, what they are seeking is information on choice of abortion method, what happens during and after the procedure, possible complications, the need to seek help for these, what to do about resuming sex, and the offer of a contraceptive method (Berer, 2002). Providing this service may not only facilitate a more satisfactory clinical experience, but better meet women's health needs, and offers an opportunity to promote contraceptive uptake and prevent future abortions.

In contrast, where there was a social connection to the patient, our findings showed providers were much more accepting of patient's reasons for the abortion and were much more flexible in their provision of abortion services. As Yam, Dries-Daffner, & Garcia (2006) described of the Latin American context, providers had a tendency to exhibit greater willingness to assist close relatives seeking abortion than unknown patients in the same situation, suggesting the existence of a double standard. With regards to the Pakistani context, our findings suggest that providers are selectively administering abortion services, based on a system of patronage. This system is rooted in the ideologies set forth by the social structure of *biradari.* As Mumtaz (2002) describes, biradari refers to a social system based on institutionalized relationships of mutual dependency, with the central elements of membership being blood relationships,

affective ties, trust and reciprocity. In the absence of formal welfare institutions, the strong social ties conferred through biradari constitute the only form of social insurance (Mumtaz, 2002). But biradari-based networks do have their disadvantages. They can constrain opportunities to non-network members and can also place excessive demands on members (Mumtaz, 2002). In the case of abortions, these limitations are seen in the lower likelihood non biradari patients have in receiving safe abortion services within this clinical setting. For providers it meant that when a patient from within their biradari requested an abortion, they were obligated to conduct the procedure even if they were morally opposed to it. This means abortion, like most other resources or services in Pakistani society, are limited to a system of patronage and are therefore not accessible to everyone.

Overall**,** it has been documented that anticipation of abuse by medical personnel pose yet another barrier to women's pursuit of safe abortions (Moore et al., 2011). As highlighted by Casas (2009), while health care providers are entitled to their beliefs and to have those beliefs accommodated, it is neither viable nor ethically acceptable for conscientious objectors to exercise this right without regard for the right to health care of others, or for policy and services to be rendered ineffectual because of individual objectors. Healthcare professionals must remember that the care of their patients must be their first concern ("Patient care," 2008). Providers must balance the right to practice in accordance with their beliefs with patients' rights to receive timely medical care ("Patient care," 2008). At the heart of both these pieces of advice is a guiding principle that doctors everywhere should abide by: doctors must not allow their personal beliefs to compromise patient care ("Patient care," 2008).

Recommendations

The findings of this research have important implications on overcoming barriers women face in accessing safe abortion services. While denying abortions on the grounds of conscientious objection is an important of protecting the provider's rights as a health care provider, it becomes problematic and unjust when the majority of providers in an abortion providing clinic are denying care. As such, one recommendation would be to ensure that facilities mandated to provide abortion services, hire providers whose values align with job expectations. Provider must be willing to conduct abortions. At the least there needs to be provisions in place to ensure there is a balance of providers willing and unwilling to provide abortions. Where a provider objects to conducting abortions, they must have an awareness of staff on site or at another facility where the patient can be referred and receive the services they desire. Furthermore, even where providers may have a moral objection to the abortions, it is important that they still treat these patients with dignity and respect (Sjostrom, Essen, Syden, Gemzell-Danielsson, & Klingberg-Allvin, 2014). Counselling should be undertaken without making the patient feel bad, uncomfortable, or judged. Rather, patients should receive holistic information on selecting an appropriate

abortion method, post abortion care, and to select a contraceptive option following their abortion. Last but not least, it is also important that family planning services are improved and expanded so women and couples are better able to time and space their pregnancies and have the number of children they desire (Sathar, 2015).

Limitations

This study does have a few limitations. The first is the limited generalizability of the study to the whole country. Abortion rates and contraceptive use vary between provinces, as does the cultural acceptability of these practices. These factors may influence women's pursuit of abortion in the first place as well as how receptive providers are to conducting abortions. Nonetheless, it is likely these findings do carry some relevance within Pakistan and in other contexts where abortion is heavily stigmatized.

Second, it is also important to consider the possibility of social desirability bias. Providers may have attempted to align the way they described their views of abortion with social expectations. Abortions are heavily stigmatized, and as described earlier, this stigma is experienced not only by those who undergo the procedure, but those who conduct it as well. To avoid being labeled as an abortionist, providers may have expressed greater opposition to procedure than they actually felt or they may have claimed that they didn't perform the procedure when in reality they did. However over four months of participant observation, we were able to confirm that providers responses did align with their actions.

Another issue relates to the fact that the Rahnuma clinic seemed to occupy an interesting space. The providers did not openly accepted their abortion providing role. This may be differ in clinics where there is more acceptance of the need for abortions. Nevertheless, it is likely that the conclusions drawn below are representative of providers who confront some form of abortion stigma in their practice.

CONCLUSION

In conclusion, this research indicates providers are posing a barrier to women's access to safe abortion services. Their personal views and ideologies around termination of pregnancy are overriding their responsibility to prioritize the care and wellbeing of patients (regardless of the services they seek). By exercising greater care in the selection of providers and improving training around patient counselling, this will be helpful in addressing obstacles women face in accessing imperative maternal health services, and ultimately will help to reduce high rates of maternal mortality persistent in Pakistan.

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Chapter 6: General Discussion and Conclusion

DISCUSSION

The objectives of this study were to explore why demand for abortions has increased, and whether providers are willing to meet this increased demand. Overall, the data suggests women had a strong desire to control fertility, but this need was not being met through contraceptives either through the types of methods, quality of care, or inherent failure rates of the different methods. As a result, where confronted with an unplanned pregnancy women turned to abortions, specifically through the drug misoprostol, to limit their fertility. The wide availability and ease of misoprostol's use not only enabled an increased reliance on abortion to terminate unplanned pregnancy but possibly as a preferred means of fertility regulation. Our data also revealed that safe abortion services did exist within a clinical setting in Pakistan. Two NGO's were found to provide safe, clinical abortion services through trained providers. But at the interface between patients and the health system, providers emerged as a key barrier in women's ability to access safe abortion services. Provider's negative views of abortion and a system of patronage led to restrictive provision of this service.

Our findings indicate a growing demand for abortions is largely being driven by a desire to limit fertility, and an unmet need for family planning through contraceptives. Most patients reported that they had tried using some form of contraceptive method prior to their abortion, if not at the time of their unplanned pregnancy (Sathar, 2007). Despite these efforts however, contraceptive failure and side effects leading to discontinued use, were commonly cited as barriers to achieving fertility goals. Furthermore, still a large proportion of women in our study (just under half) were not using *any* family planning methods. This non-use of contraceptives was often a result of restrictions set by women's husband's, overlooking the need for family planning, never using any in the past, or a reluctance to start using them now (despite being aware of their availability and where to access them). In studies by Arif & Kamran (2007); Kamran, Arif, & Vassos (2011); and Tsui et al., (2011), it was similarly highlighted that despite a desire among couples to limit fertility and an awareness of contraceptive methods, reproductive planning was largely non-existent amongst Pakistani couples. This suggests barriers to effective contraceptive uptake go beyond a lack of awareness of modern methods, lack of access or poor delivery of contraceptive services (Bury, Aliaga Bruch, Machicao Barbery, & Garcia Pimentel, 2012; Sathar, 2009). Instead, it may reflect a reluctance among women to use contraceptives at all, which as previously described may be due to a fear of side effects (particularly those associated with hormonal contraceptives) (Sathar, 2010). These findings suggest that for most women, there is a gap between the desire to limit fertility and the actions or means needed to achieve these reproductive goals. This adds support to the point raised by Sathar (2015), that contraceptive use in Pakistan is at sub-optimal levels and is inadequate in meeting the growing demand

for fertility regulation (Sathar, 2015). Overall, these contraceptive use patterns align closely with those described in the literature review section.

Our data however expanded this literature by revealing that women may be filling this gap specifically through the use of misoprostol to induce abortions. Regardless of women's contraceptive use, the desire to limit fertility was common among all study respondents. Thus where confronted with an unplanned pregnancy, women turned to abortion to limit fertility. Specifically, women were turning to the abortion inducing drug misoprostol. This drug offered a number of advantages to inducing abortion relative to traditional surgical methods. Among these was its wide availability, privacy, safety, effectiveness, affordability and increased control it gave women over their reproductive decisions. These numerous advantages of misoprostol greatly increased the accessibility and practicality of abortions. Where confronted with an unplanned pregnancy, women now had an easier means of exercising this second point of fertility control. These findings help to shed light on the suggestion made by Sathar, Rashida, Shah, Singh, & Woog (2013) that growing rates of abortion "may partly be explained by wider access to improved abortion services, such as misoprostol". As Creanga, Roy, & Tsui (2008) highlighted, medical abortion through misoprostol offers great potential for improving access to abortion services.

In line with these numerous advantages, our data showed that misoprostol had not only become the preferred means of pregnancy termination, but may have factored into women's family planning and fertility control decisions. Given that women were well aware of misoprostol and that it was the primary choice for inducing abortions where needed, it is possible women may have pre-planned the use of misoprostol *in place of* family planning. While this option had not been practical when abortion required a minor surgery, the ease of abortions that misoprostol conferred has made this possible. Women could now get an abortion *when* and *if* a pregnancy happened, rather than putting up with the side effects of a daily pill or another long term hormonal contraceptive, all while the possibility of contraceptive failure, still existed. These findings adds support to the studies by Sathar et al. (2013) and Sathar, Singh, Rashida, Shah, & Niazi (2014) which similarly indicated that misoprostol has enabled not only an increased reliance on induced abortion to avoid unwanted births, but may also be transforming abortions into a preferred reproductive strategy. Our study also supports the conclusions drawn by Khan AA et al. (2013); Rehan, Inayatullah, & Chaudhary (2001); Saleem & Fikree (2001); and Saleem & Fikree (2005) who as described in our literature review, said women may be opting for abortions to attain their goals for a small family size *in place of* family planning. Our study adds insight to these conclusions by revealing that misoprostol is the key element providing women with the means to do this. Thus an increased reliance on abortion not only to terminate an unplanned pregnancy, but as a preferred means of fertility control, together may be driving the increased demand for abortions in Pakistan.

But while misoprostol has great potential to improve access to safe abortion services, an important caveat to keep in mind is that where the pill is obtained independent of a trained healthcare provider, women may not be given proper instructions on its use (Creanga et al., 2008). As described earlier, many study respondents described obtaining the drug over the counter from a pharmacy or through social networks. While this wide availability does help to facilitate increased access to abortion, it is concerning because these individuals likely have very little information about misoprostol's safe and effective use (Billings, 2004). Given that misoprostol is a very dose dependent drug, inadequate instructions on its use can lead to avoidable complications or ineffectiveness (Bury et al., 2012). Adding support to this concern, Sathar et al. (2013) showed that while rates of PAC have gone up, the severity of the cases has declined. This suggests women may be increasingly relying on safer abortion methods such as misoprostol, but because it is common to obtain the drug through means other than a provider, they are unaware of its proper use and are suffering avoidable (but less severe) complications.

Our findings show part of this concern has been addressed through the availability of safe, clinical abortion services. Despite legal and religious restrictions around abortions, our findings indicated that safe services were being offered through NGO-run family planning clinics in Pakistan. These included the Rahnuma Family Planning Association of Pakistan and the Marie Stopes Society. The Rahnuma facility was staffed with providers who received training on both the medical and counselling skills required to assist abortion seeking patients. This facility was also equipped with the tools needed to conduct both medical and surgical abortions. While the Rahnuma clinic openly stated their provision of abortions on their website, Marie Stopes used a more in-direct approach, stating they provide post-abortion care. Our observations and informal interactions with providers however, confirmed that Marie Stopes did indeed provide abortion services. They were, in fact, described by our study respondents as being more open to abortion seeking patients than the Rahnuma clinic. By providing abortions within a safe clinical setting and formalizing abortion training, these clinics have taken a brave step towards integrating safe abortions services into the existing health infrastructure.

Given that Rahnuma openly states the availability of abortion services on their website, and that Marie Stopes is well known to provide these services within the community, it is likely that higher level personnel within the government are also aware of these clinical abortion services. Despite legal and religious restrictions however, these clinics continue to run and no known efforts have been made to punish these clinics or providers for conducting this procedure. This suggests there may be an informal recognition of the need for safe abortion services as an important reproductive health service, and as a means to improve maternal health. Thus while social acceptance of liberalizing the law may still take

time, it seems a compromise has been reached in making safe abortions services available through family planning facilities that operate within the grey zone of abortion permissibility.

The availability of abortion services within the formal health system is a new finding for the Pakistani context. As highlighted in the literature review, several studies indicated women commonly seek abortion services from formally trained providers (such as doctors, nurses, and LHVs), but it had never been clarified from where these providers were administering abortion services, i.e. were they being offered through independently run clandestine clinics, or formally through the existing health system? A study by Dalvie, Barua, Azmat, & Mustafa, (n.d.) revealed that "a few NGOs had begun to offer treatment for post abortion complications". Among the clinics that pioneered these efforts were the Marie Stopes Society, and Rahnuma Family Planning Association of Pakistan. Our findings help to clarify this picture of abortion provision and demonstrate that along with post abortion care, safe abortion services are being administered through the existing health system.

At the interface between patients and the health system however, providers emerged as a key barrier in women's ability to access safe abortion services. Our findings revealed that providers had predominantly negative views of abortion. They described the procedure as being fundamentally wrong, sinful and compared it to a crime as severe as murder. They felt abortions facilitated a deviation from God's will and also carried safety concerns for the mother's health. Furthermore, provider's worried the procedure offered patients an 'easier' fertility regulation option relative to contraceptives and consequently had the potential to incite a deviation from accepted gendered and sexual norms.

These negative views heavily deterred from providers willingness to openly conduct abortions. Although the providers in our study were working in a clinic mandated to conduct abortions and received training to administer this service, the fact that they were expected to conduct this procedure was a dissonance in their value system. While this largely culminated in provider's refusal to conduct abortions, our research revealed a nuance to this behavior that may relate specifically to the Pakistani context. According to our findings, the degree to which provider's negative views impacted their provision of abortion services was highly dependent on whether there was any social or familial connection to the patient.

Where there was no social connection to patients, providers were very selective in choosing who received an abortion. To determine who they felt was truly 'deserving' of the procedure, providers exercised a value based assessment criteria. This was based on a combination of the woman's pregnancy prevention efforts, social circumstances and the provider's personal perspective of what conditions justified an abortion. While providers did agree to conduct abortions where the woman was a victim of sexual

violence (rape or incest) or where another pregnancy threatened her health, most other reasons were not seen to be justifiable. Patients who described being motivated by social factors such as poverty, too many children, contraceptive side effects or contraceptive failure, were viewed as a reflection of the patients own inadequate prevention efforts. These findings align with a study by Kumar, Hessini, & Mitchell (2009) conducted in India, which found that when administering abortion services providers differentiated between what they saw as "good abortions" vs "bad abortions" stemming from "good" and "bad" reasons for having them. Where patients were deemed to be undeserving of the abortion, providers aggressively counselled these patients with the intention of convincing them not to terminate their pregnancy. This included belittling patient's reasons for seeking an abortion, blaming them for the situation they were in, and reminding them of the morality of their actions. Most of these patients were denied services.

In contrast however, where there was a social connection to the patient, our findings showed providers were much more accepting of patient's reasons for the abortion and were much more flexible in their provision of this procedure. More specifically, providers were selectively administering abortions based on a system of patronage. This system is rooted in the ideologies set forth by the social structure of *biradari.* As Mumtaz (2002) describes, biradari refers to a social system based on institutionalized relationships of mutual dependency, with the central elements of membership being blood relationships, affective ties, trust and reciprocity. In the absence of formal welfare institutions, the strong social ties conferred through biradari constitute the only form of social insurance (Mumtaz, 2002). But biradari-based networks do have their disadvantages. They can constrain opportunities to non-network members and can also place excessive demands on members (Mumtaz, 2002). In regards to abortion, these limitations are seen in the lower likelihood non biradari patients have in receiving safe abortion services within this clinical setting. For providers it meant that when a patient from within their biradari requested an abortion, they were obligated to conduct the procedure even if they were morally opposed to it. This means abortion, like most other resources or services in Pakistani society, are limited to a system of patronage and are therefore not accessible to everyone.

Ultimately though it was unlikely for abortion seeking patients to have a biradari based connection to a health-care provider. As a result, a large majority of abortion seeking patients were denied care. While the health system had prepared itself to provide safe abortions (through availability of abortion providing clinics, proper equipment, trained providers, and the availability of the abortifacient misoprostol), providers own negative views of abortions created a barrier. Rather than prioritizing the health needs of patients, providers were prioritizing their own personal ideologies, and based their provision of this service on a system of patronage dictated by biradari bonds. Thus the actions of ground level providers had essentially nullified efforts made at higher institutional levels to expand access to safe abortion

services. These findings add support to the concern voiced by Rehan (2003) in our literature review that provider's negative attitudes towards abortion, may prove to be a major stumbling block to the development of improved abortion services. Unlike Rehan et al. (2001); Saleem & Fikree (2001); and Saleem & Fikree (2005), our findings revealed the growing demand for abortions was not enough to motivate providers in conducting this service, at least in safe institutional settings. Rather their provision of abortions was more heavily dictated by their own negative views of the procedure, and by social obligations dictated by the social structure of biradari. This ultimately created selective system of abortion provision in which biradari members were more likely to receive services, and non-members were more likely to be denied.

Misoprostol however may provide a means of reaching a middle grounds. As highlighted in Chapter 4 of this thesis, misoprostol had the benefit of creating a separation between providers and the actual abortion procedure. With this abortifacient, providers no longer needed to physically participate in the induction of the abortion. Instead their role was minimized to providing or prescribing the misoprostol pills, then leaving the patient to do the rest. This was beneficial because it offered a way to balance provider's beliefs, with patients health needs. By refocusing providers attention to this point, and reinforcing training on the negative health consequences women risk when denied care by a trained provider, this may help to reduce providers reluctance in conducting abortion procedures.

CONCLUSION

Overall, our study revealed that while women had a strong desire to control fertility, traditional family planning methods were not meeting this need. The availability of misoprostol however, provided women with an easier, more accessible and practical means of exercising a second point of fertility control i.e. abortions, often in place of contraceptives. Thus an increased reliance on misoprostol induced abortions as means to address unplanned pregnancy and regulate fertility, may be driving the increased demand for abortion. In line with this growing demand, our findings revealed that the health system has prepared itself, at least indirectly through the non-governmental sector, to provide safe abortion services. NGO run family planning clinics have begun providing safe abortions within a facility setting, by trained providers.

But at the interface between patients and the health system, providers have emerged as a key barrier. Provider's negative views of abortion, paired with a system of patronage led to limited provision of safe abortion services. Only women who had a biradari-based connection to a provider were likely to receive an abortion. This meant most abortion-seeking patients were ultimately at risk of being denied care. This type of service provision countered institutional efforts to expand access to safe abortion procedures. Once again women in need of this reproductive health service, were left at risk of seeking clandestine,

unsafe options. In order to capitalize on the space availability for safe abortion services, providers must be on board with these efforts.

This study addresses a number of gaps on the limited literature available on abortions in Pakistan. These include shedding a light on (1) how Pakistan is prepared to respond to abortion seeking patients, specifically what services are available to support safe abortions. (2) Secondly this study shed light on the practicality and ease of misoprostol use in the Pakistani context, as well as the importance of adequate information in ensuring its proper and safe use. (3) Last but not least, this study revealed a key barrier women face when accessing safe abortion services. Specifically this study drew attention to how provider's attitudes towards abortion can influence provider-client interaction and access to services (Ganatra, 2006).

Limitations

Selection Bias

Abortions are highly stigmatized procedures in Pakistan. Within such a context, it is difficult to capture abortion seeking patients outside of a clinic or hospital setting. This leads to a selection bias. Women who seek abortions from trained providers, within a clinical setting may prioritize safety more than privacy relative to women who seek services from unsafe clandestine settings. Alternatively, women who seek services from trained providers may do so because of better access to safe services. In both scenarios there are inherent social factors that differentiate these groups such as urban vs rural residence, education level, and socio-economic status. As a result women's reasons for seeking abortions may be different between these two groups. Furthermore, as our study indicated, most of the women who successfully obtained an abortion from the Rahnuma clinic, were those who had some form of social connection to providers. It is possible this system of patronage may be something women in the community are already aware of. Those who have a relationship to providers may be more likely to seek clinical abortion services, than women who don't. This suggests our study respondents may have had a greater advantage in seeking abortion services than women in the general population. As such it is important to recognize the possibility of selection bias.

Social Desirability Bias

Another important limitation to recognize was the possibility of social desirability bias. Given that all our respondents were informed that we were researchers, this may have created a power dynamic between ourselves and the respondents. As a result, both patients and providers may have become more conscious of their responses, and tried to align their answers more with social norms and expectations. Patients may

have under reported the number of abortions they had and inflated their recollection of contraceptive use. Similarly providers, to avoid being labeled as an abortionist, may have expressed greater opposition to abortions than they actually felt or may have claimed that they didn't conduct the procedure when in reality they did. To address these issues, we probed into respondent's answers to verify if their responses were true. With patients the details of their contraceptive use (asking what types of contraceptives they used, what specific side effects led to discontinuation, why their method failed, how did they use the method) and abortion history (how many children they had, if any passed away, if so how) were probed. By exploring these details in greater depth and assessing the consistency of patient's responses we were able to determine if they were being truthful. With providers a similar approach was taken. We probed into their views regarding abortions and their history of abortion provision to see if their responses were consistent. Furthermore, because we interacted with the providers on a daily basis over four months of our data collection, we were also able to confirm their responses through participant observation i.e. we were directly able to observe whether providers actions, aligned with what they stated (at least within the clinical setting).

Generalizability

Care must also be taken in generalizing these findings beyond the context of Chakwal, particularly beyond the province of Punjab. Rates of contraception uptake and abortion vary provincially as does the cultural acceptability of these practices. Different social norms around cultural practices such as *parda* could also affect the practicality of home based abortions via misoprostol, how receptive providers are to conducting abortions or public acceptance of family planning clinics that provide abortion services. Nonetheless, it is likely that the broad conclusions presented above do have relevance elsewhere in Pakistan (beyond Chakwal), or in other settings where abortions are similarly restricted.

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APPENDIX 1: Consent Form, Interview

Information and Informed Consent

University of Alberta

UNIVERSITY OF ALBERTA

Hello,

My name is Harneet Chahal and I am a graduate student with the School of Public Health at the University of Alberta. I am working in Chakwal, Pakistan over the next several months to learn more about family planning, maternal and reproductive health in Pakistan. I am not affiliated with the Rahnuma Family Planning Association of Pakistan in any way. Your participation in this study will have no impact on the care you will receive. By being involved in this project, you can share your experiences related to pregnancy and abortion and provide valuable information about barriers or difficulties you have faced.

1. Purpose of this research study

You are being asked to participate in a research study designed to investigate how reproductive and maternal health are influenced by economic and gender factors.

2. ***Data Collection Strategies***

You are being asked to participate in an interview. Each interview will last between 1-2 hours. If you agree to participate we will digitally record the interviews. No personal identifying information will be collected, and interviews will be conducted in a private location to ensure your identity is kept private and confidential.

3. Possible Risks or Discomfort

You will not experience any risks or discomforts during this study. We will simply be speaking to you through an interview setting. If at any point you no longer feel comfortable in the interview, you are free to withdraw from the study.

4. Possible Benefits

There are no direct benefits to you. However, information from this study will be shared with policy makers in Pakistan to develop new family planning programs that better meet family and maternal health needs.

5. Financial Considerations

To thank you for your participation, you will be provided with the small gift of a 1kg sac of lentils.

6. Confidentiality

Your identity in this study will be treated as confidential. No one from your family or community will know of your participation in this study, and no one will learn through the study that you were at the clinic. The results of the study, including laboratory or any other data, may be published for scientific purposes

but will not give your name or include any identifiable references to you. Interviews will be conducted in a private location, and the identities of the participants will be concealed and protected in every way possible. Names and any other personal identifying information will not be used. Participants will be assigned a code and only necessary information (age, gender) will be utilized in documents. Only the researcher will have access to participants' codes.

7. Termination of Research Study

If at any stage you feel uncomfortable, you are free to withdraw from the study without any repercussions. Furthermore, if at any point you wish to have your data withdrawn from this study, you would simply need to call Dr. Mumtaz's Research Project Manager in Pakistan, Afshan Bhatti at the following phone number: 03345133272. This request must be made within two weeks following the completion of your interview to ensure the research team can make necessary arrangements to respond to this data withdrawal.

8. Authorization

I have understood the consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws.

Witness Signature :_____
Date: _____

Investigator Signature: _____
Date: _____

APPENDIX 2: Consent Form, Focus Group Discussion

Information and Informed Consent

University of Alberta

UNIVERSITY OF ALBERTA

Hello,

My name is Harneet Chahal and I am a graduate student with the School of Public Health at the University of Alberta. I am working in Chakwal, Pakistan over the next several months to learn more about family planning, maternal and reproductive health in Pakistan. I am not affiliated with the Rahnuma Family Planning Association of Pakistan in any way. Your participation in this study will have no impact on the care you will receive. By being involved in this project, you can share your experiences related to pregnancy and abortion and provide valuable information about barriers or difficulties you have faced.

1. Purpose of this research study

You are being asked to participate in a research study designed to investigate how reproductive and maternal health are influenced by economic and gender factors.

2. ***Data Collection Strategies***

You are being asked to participate in a focus group discussion. Each discussion will last between 1-2 hours and will include a total of 4 participants. If you agree to participate we will digitally record the interviews. No personal identifying information will be collected, and focus group discussions will be conducted in a private location to ensure your identity is kept private and confidential.

3. Possible Risks or Discomfort

You will not experience any risks or discomforts during this study. We will simply be speaking to you through an interview setting. If at any point you no longer feel comfortable in the interview, you are free to withdraw from the study.

4. Possible Benefits

There are no direct benefits to you. However, information from this study will be shared with policy makers in Pakistan to develop new family planning programs that better meet family and maternal health needs.

5. Financial Considerations

To thank you for your participation, you will be provided with the small gift of a 1kg sac of lentils.

6. Confidentiality

Your identity in this study will be treated as confidential. No one from your family or community will know of your participation in this study, and no one will learn through the study that you were at the clinic. The

results of the study, may be published for scientific purposes but will not give your name or include any identifiable references to you. Focus group discussions will be conducted in a private location, and the identities of the participants will be concealed and protected in every way possible. Names and any other personal identifying information will not be used. Participants will be assigned a code and only necessary information (age, gender) will be utilized in documents. Only the researcher will have access to participants' codes.

7. Termination of Research Study

If at any stage you feel uncomfortable, you are free to withdraw from the study without any repercussions. Furthermore, if at any point you wish to have your data withdrawn from this study, you would simply need to call Dr. Mumtaz's Research Project Manager in Pakistan, Afshan Bhatti at the following phone number: 03345133272. This request must be made within two weeks following the completion of your focus group discussion to ensure the research team can make necessary arrangements to respond to this data withdrawal.

8. Authorization

I have understood the consent form, and I volunteer to participate in this research study. I understand that I will receive a copy of this form. I voluntarily choose to participate, but I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study. I further understand that nothing in this consent form is intended to replace any applicable Federal, state, or local laws.

Witness Signature :_____
Date: _____

Investigator Signature: _____
Date: _____

APPENDIX 3: Research Assistant Confidentiality Agreement

Confidentiality Agreement

University of Alberta

UNIVERSITY OF ALBERTA

Research Assistant, Translator & Transcriber Confidentiality Agreement

This study is being undertaken by Harneet Chahal through the School of Public Health, University of Alberta. The purpose of this project is to learn more about family planning, maternal and reproductive health in Chakwal, Pakistan. Data from this research may be used to create modifications and improvements to maternal health practices in Pakistan. The results may be written up for publication in academic journals, conference presentations and reports to organizations involved in maternal health projects in Pakistan.

Project title: Poverty and Gender Dimensions of Abortion Seeking Behavior in Chakwal, Pakistan

I, _____,the *Research Assistant/ Translator/ Transcriber*, agree to:

1. Keep all the research information shared with me during interviews and focus group discussions confidential by not discussing or sharing research information in any form or format (eg. Digital recordings, transcripts, etc.) with anyone other than the research team.

2. Keep all research information in any form or format (eg. Digital recordings, transcripts, etc) secure in my possession.

3. Return all research information in any form or format (eg. Digital recordings, transcripts, etc.) to the principal investigator when I have completed the research tasks.

4. After consulting with the researcher/research team, erase or destroy all research information in any form or format regarding this research project that is not returnable to the researcher/research team (eg. Information stored on a computer hard drive).

Research Assistant/ Translator/ Transcriber

_____	_____	_____
(Print name)	(Signature)	(Date/Time)

Principle Researcher/ Investigator

_____	_____	_____
(Print name)	(Signature)	(Date/Time)

If you have any questions or concerns about this study, please contact:

APPENDIX 4: Question Guideline

In-Depth Interview and Focus-Group Discussion guideline for Women and Health Service Providers at the Rahnuma Family Planning Clinic

Though this guide is geared primarily towards interviews, select questions will also be used to guide the focus group discussions. Participant(s) will be free to discuss whatever they want to and take the interview in the directions they deem important, within the framework of the research questions. This guide will be translated into Urdu, and piloted.

Question	Notes
Given that this is a very culturally sensitive and stigmatized topic, interviews shall start with grand tour questions. This will ensure that the main topic under investigation – abortion and poverty- are approached in indirect way *1. Understand Women's previous pregnancy experiences* Prompts i) Please tell me about yourself ii) Where are you from? iii) How long have you been married? iv) How many children do you have? v) How old are they? vi) Are they in school? vii) If any children are not in school, why not? viii) Could you please describe your pregnancies ? ix) Can you describe your first pregnancy? (let the woman get into the description of her pregnancies) *2. Understanding what has brought women to Rehnuma family planning clinic* Prompts i. Can you tell me about your pregnancy? ii. When did you find out you were pregnant? iii. When did you choose to have an abortion? iv. Why are you having an abortion? v. Why not carry through with the pregnancy? vi. If you were not looking to have an additional child, did you use contraceptives? vii. Does your husband know you received or are getting an abortion? viii. Has somebody come to the clinic with you?	* Start off by asking the women to narrate the details of pregnancy. What types of care did she seek, why? *Why they came to the facility, be sympathetic to her. *Get an idea of spacing

3. Understanding women's fertility desires and probing for information about financial limitations Prompts i. Would you like to have additional children? ii. If not, why? iii. Would your husband like more children? iv. Can you afford the cost of additional children? v. If not, what factors make it difficult to support additional children? vi. What does your husband do for a living? *4. To gain insight into what Health Service Providers witness with the women who come in pursuing abortion services* Prompts i. What are the reasons women pursue abortions? ii. Who are these women? iii. Do these women have permission from their husbands or from their direct family members? iv. Do women seem to have gender preferences that motivate their decision for an abortion? v. What do women say about not using contraceptives? vi. What is the most common abortion method women rely on? How do you feel about it? vii. Do women express concerns about finances?	