CENTER *for* REPRODUCTIVE RIGHTS

UNSAFE AND UNJUST:

THE LEGAL AND SOCIAL BARRIERS THAT DENY WOMEN AND GIRLS THEIR RIGHT TO SAFE ABORTION SERVICES IN SINDH, PAKISTAN

Established in 1995, **Aahung** is a non-profit organization based in Karachi which works to improve the sexual and reproductive health of men, women, and adolescents across Pakistan. The organization works on strengthening the capacity of service providers such as teachers, doctors, nurses, and community workers through enhancing their knowledge, skills, attitude, and comfort. Aahung develops relevant literature and resources in addition to carrying out research and advocacy in order to develop strategic linkages and networks with relevant experts and key actors in the field.

Aahung has been actively engaged in advocating for the right to safe abortion and is a member of the steering committee of the Pakistan Alliance for Post-Abortion Care (PAPAC), a national network coalition of over 40 local and international organizations.

The **Center for Reproductive Rights** is a global human rights organization of lawyers and advocates who ensure reproductive rights are protected in law as fundamental human rights for the dignity, equality, health, and well-being of every person. Since its founding in 1992, the Center's game-changing litigation, legal policy, and advocacy work—combined with unparalleled expertise in constitutional, international, and comparative human rights law—has transformed how reproductive rights are understood by courts, governments, and human rights bodies.

Working across the five continents, the Center is the world's only global legal advocacy organization dedicated to advancing women's reproductive rights as fundamental human rights. The Center is a driving force behind important advances in reproductive rights laws, policies, improving access to reproductive health care and advancing sexual and reproductive health and rights in Asia.

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1 Introduction

BACKGROUND

Abortion is criminalized under Pakistan's Penal Code unless it is to save the life of the woman or provide "necessary treatment" to a woman before the organs of the fetus have been formed.[1] The law is silent as to whether abortion on the grounds of pregnancy, incest or fetal impairment constitutes "necessary treatment." Once the organs have been formed, abortion is permitted only to save the life of the pregnant woman.[2] Aside from these two exceptions, abortion remains criminalized, and women undergoing abortions as well as service providers are liable to criminal penalties.[3]

Other than the Penal Code provisions pertaining to abortion, there is no law in Pakistan that regulates abortion services. The Sindh Reproductive Healthcare Rights Act was passed in the province of Sindh in 2019 and it sets forth a number of reproductive health guarantees including the requirement that WHO standards of "post abortion care" be followed in the province of Sindh. However, the law does not contain any specific provisions regarding abortion care.[4] Further, the Act does not specify any implementation mechanism or procedures.

Despite the narrow legal grounds for abortion, there were an estimated 2.2 million abortions in 2012, the last year for which figures are available, and the abortion rate was 50 abortions per 1000 women aged 15-29.[5] A majority of abortions in Pakistan are clandestine, which place the health and lives of women at risk.[6] In 2012, an estimated 623,000 women were treated for complications resulting from induced abortions, the vast majority of which were performed by unqualified providers or involved traditional methods.[7]

In April 2015, the Government of Punjab issued "Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-Abortion Care."[8] In March 2018, the Federal Government published guidelines similar to Punjab's policy.[9] In 2020, the Government of Sindh also adopted the guidelines, similar to those of the Federal Government. The guidelines provide the recommended methods for first trimester abortions based on the World Health Organization's guidelines of 2014,[10] the skills required of the healthcare provider, and healthcare provider obligations to women and girls. However, guidelines to service providers are not legally binding and do not contain provisions regarding monitoring and accountability. Although these guidelines have been shared with service providers, they have not been disseminated to the public at large, and therefore women remain unaware of the quality of abortion services they are entitled to under the guidelines.

Through a field-based study in the province of Sindh, this report aims to understand and document the impact of the restrictive legal framework on abortion on access to and availability of safe abortion services. The report documents the extent to which the criminal law deters women and girls from accessing abortion services and healthcare providers from providing these services. It also examines how healthcare providers and women and girls interpret the legal framework and the exceptions to criminalization in Pakistan's Penal Code.

In this chapter we will first discuss the normative framework for evaluating access to safe abortion services. We will then discuss the research method used for the report.

ABORTION IN INTERNATIONAL LAW

The right to abortion is an aspect of the right to life and liberty, the right to health, and non-discrimination protected under international human rights law. Over the years, UN Treaty Monitoring Bodies ("**UNTMBs**") and Special Procedure mandate-holders have established that criminalization of abortion and restrictive abortion laws violate human rights. The Programme of Action adopted at the 1994 International Conference on Population and Develop-

ment ("**ICPD**") also calls on states to uphold reproductive rights as human rights.[11]

The Committee on the Elimination of Discrimination against Women ("**CEDAW Committee**") has found criminalisation of abortion to be a violation of rights guaranteed under under the Convention on Elimination of All Forms of Discrimination Against Women ("**CEDAW**").[12] The CEDAW Committee has found that restrictions on abortion amount to gender-based discrimination and deny women the right to make informed decisions about their health.[13] It has also noted that "forced continuation of pregnancy and abuse and mistreatment of women and girls seeking sexual and reproductive health information goods and services are forms of gender-based violence that depending on the circumstances may amount to torture or cruel, inhuman or degrading treatment." The Committee on the Rights of the Child ("**CRC Committee**") has also called on State to provide adolescent girls access to safe abortion, and to ensure that girls are enabled to make pregnancy related decisions.[14]

In its 2019 General Comment No. 36, the Human Rights Committee ("HRC") recognized that criminal restrictions on abortion violate the right to life under the International Convention on Civil and Political Rights ("**ICCPR**").[15] The General Comment No. 36 calls on states to address criminal barriers to voluntary abortion and emphasizes that states may not regulate the voluntary termination of pregnancy if it violates a woman's right to life or other human rights.[16] The HRC has emphasized that states should remove existing barriers to access to safe abortion and should not create new ones. It has expressed concern that criminalization promotes unsafe abortions and puts lives of women and girls in danger.[17]

States have a positive obligation to ensure that quality abortion services are accessible and available to women without discrimination. Women and girls must also be free to make decisions about all aspects of their reproductive health without fear of criminal sanction. The UN Special Rapporteur on Health noted that "[c]riminal laws penalizing and restricting induced abortion are the paradigmatic examples of impermissible barriers to the realization of women's rights to health and must be eliminated."[18] He emphasized that criminal restrictions may impact the "dignity and autonomy" of women.[19]

UN human rights mechanisms have called on Pakistan to uphold its international obligations to respect, protect, and fulfill Sexual and Reproductive Health Rights ("**SRHR**"), including access to safe abortion. In its Concluding Observations to Pakistan in 2017, the HRC expressed concern that "abortion remains criminalized except to save the life of the woman or provide 'necessary treatment'; that the circumstances under which voluntary termination of pregnancy is allowed are not clearly defined or widely understood among medical professionals or the general public …".[20] The HRC further observed that the "State party should review its legislation to ensure that legal restrictions do not prompt women to resort to unsafe abortions that may endanger their lives and health."[21] The CEDAW Committee, in its Concluding Observations in 2020, recommended that Pakistan "review its abortion legislation with a view to legalising abortion in cases of rape, incest, threats to the life or health of the pregnant woman or severe foetal impairment, and decriminalizing it in all other cases, and prepare guidelines to ensure women's and girls' access to safe post-abortion care…"[22]

CONSTITUTIONAL SAFEGUARDS

Pakistan's Constitution guarantees the right to life, which has been interpreted by the Supreme Court of Pakistan to include all "amenities which a person living in a free country is entitled to enjoy."[23] Pakistan's Constitution also prohibits discrimination on the basis of sex.[24] In a series of orders passed in a constitutional petition filed on behalf of a woman who developed obstetric fistula that went untreated for several years, the Sindh High Court acknowledged the constitutional obligation of the Sindh government to provide affordable and quality reproductive health services to women and girls. Article 14 of the Constitution provides that the "dignity of man and, subject to law, the privacy of home, shall be inviolable. In addition

to fundamental rights, the Constitution sets forth "Principles of Policy", which includes "[f]ull participation of women in national life."[25]

WORLD HEALTH ORGANIZATION GUIDELINES

In its 2020 guidelines on abortion, the World Health Organisation (WHO) recommends the "full decriminalization" of abortion.[26] WHO further recommends that abortion be made available "on the request of the woman, girl or other pregnant person."[27] The guidelines also recommend against "laws and other regulations that prohibit abortion based on gestational limits."[28] WHO also recommends that abortion be available on the request of the woman, girl or pregnant person without the authorization of any other individual, body or person."[29]

METHODS

This study explores the role of the legal framework on abortion on availability of and access to safe abortion services in Sindh, Pakistan. The study also investigates whether the criminal law is being used by healthcare providers to deny abortion services, how the law is being used by law enforcement bodies, and how it is restricting women's access to safe abortion more broadly. The study also highlights socio-cultural barriers to abortion services, as well as determinants of women's access to high quality of care for safe abortion services.

The fact-finding adopted a qualitative approach, and data was collected primarily through in-depth, semi-structured interviews, and focus group discussions. Data was collected from five sets of stakeholders in three districts of Sindh: Khairpur, Hyderabad, and Karachi. Sindh is the second largest province in Pakistan by population.These locations were chosen to include participants from urban, peri-urban, and rural areas, with diverse socio-economic backgrounds, as well as accessibility of participants.

Table 1 shows key indicators in the province of Sindh, which reveal the current state of sexual and reproductive health in the province, where early marriage is still a common practice, and use of family planning methods is low. The literacy rate for women is also abysmal, and there is a large rural population which is still significantly underserved and has limited access to high quality SRH services.

<table>
<tr><td>Age at first marriage</td><td>Women: 20.0 years</td><td>Men: 26.2 years</td></tr>
<tr><td>Age at first sexual intercourse</td><td>Women: 20.4 years</td><td>Men: 26.7</td></tr>
<tr><td>Age at first birth</td><td colspan="2">Women: 23.0 years</td></tr>
<tr><td>Teenage childbearing</td><td>Women aged 15-19 who have had a live birth: 7.5%</td><td>Women aged 15-19 who have begun childbearing: 9.9%</td></tr>
<tr><td>Birth intervals</td><td colspan="2">Median number of months since preceding birth: 29.3 months</td></tr>
<tr><td rowspan="2">Contraceptive knowledge and use including married women using any contraception</td><td>Married women who have heard of any method: 97.3%</td><td>Married men who have heard of any method: 98.5%</td></tr>
<tr><td colspan="2">Married women using any contraception: 30.9%</td></tr>
<tr><td>Unmet need for family planning</td><td colspan="2">Married women: 17.7%</td></tr>
<tr><td>Maternal Mortality Ratio in Pakistan</td><td colspan="2">186</td></tr>
<tr><td>Maternal Mortality Ratio in Sindh</td><td colspan="2">224</td></tr>
<tr><td>Postpartum counseling</td><td colspan="2">Women: 20.9%</td></tr>
</table>

Percentage of rural population	48.11%
Pregnant girls aged 15-19	who are pregnant with first child: 2.4%
Literacy rate for women	43.5%

Table 1. Indicators for Sindh. Source: PDHS 2017-18,[30] Maternal Mortality Survey 2019,[31] Population Census 2017.[32]

Data was collected from the following stakeholders:

1. A total of 30 interviews were conducted with healthcare providers (HCPs), of which 15 were with gynecologists and obstetricians, and general physicians. The remaining 15 interviews were conducted with various community health workers, including community midwives and Lady Health Visitors,[33] Lady Health Workers, family planning workers affiliated with the Population Welfare Department, and traditional birth attendants (dais). The interviews explored HCPs knowledge and perceptions of the abortion law in the country, as well as their experiences with clients seeking abortions.

2. Five focus group discussions were conducted with women in specific local communities in all three districts, to understand their knowledge and interpretation of the law, as well as their experiences of accessing abortion services. Four of these FGDs were conducted with married women of different age groups, and one was with unmarried young women. The total number of women participants was 30. This set of stakeholders was limited to cisgender women, as the abortion law in Pakistan only refers to women seeking abortions.

3. Data was collected from a total of 10 lawyers, men and women, to assess their knowledge and understanding of the legal framework on abortion and how it impacts access to safe abortion services.

4. Data was also collected from 8 police officials in Karachi, including Additional Inspector Generals (AIGs), Senior Superintendents (SSPs), Deputy Superintendents (DSPs), Superintendents (SPs), and legal officers. These interviews were restricted to Karachi and Hyderabad, due to ease of access and approval from Sindh Police.

5. One senior program staff member was interviewed from four non-governmental organizations (NGOs) which provide safe abortion services and post-abortion care in Pakistan, including the province of Sindh.
Overall, a total of 52 interviews and five focus group discussions were conducted across the three research sites.

Data was collected after the study (along with all research tools and the informed consent form) received ethics approval from the National Bioethics Committee at the National Institutes of Health, under the Ministry of National Health Services, Regulation, and Coordination. A Pakistan-based law form, RIAA Barker Gillette also reviewed the informed consent forms on a pro bono basis. The approved form was used to obtain written informed consent from each study participant.

Due to the potential legal consequences of participants admitting to seeking or providing abortions, as well as the socio-cultural stigma around abortion, all participants were assured of complete anonymity, and none of their identifying information has been included in this report. Data privacy and confidentiality was maintained by restricting data access to the research team and storing it on password protected devices.

All interviews were conducted in Urdu, with some snippets in Sindhi language. All data was transcribed and translated into English primarily from Urdu. The process of analysis involved qualitative coding of the data using the Atlas.ti software. Moreover, an ongoing desk review was conducted to support analysis on legal barriers to abortion. The final report was written between June and September 2023.

Notes for Chapter 1

1. Pakistan Penal Code of 1860, s. 338.
2. Pakistan Penal Code of 1860, s . 338-B.
3. Pakistan Penal Code of 1860, s. 338-A, 338-B.
4. Sindh Reproductive Healthcare Rights Act 2019, s. 5(v)(b).
5. Sathar et. al. Induced Abortions and Unintended Pregnancies in Pakistan, Studies in Family Planning, 471-491, 471 (2014).
6. Guttmacher Institute, Factsheet: Unintended Pregnancy and Induced Abortion in Pakistan (2015) available at https://www.guttmacher.org/sites/default/files/factsheet/fb-pakistan.pdf
7. Sathar et. al. Induced Abortions and Unintended Pregnancies in Pakistan, Studies in Family Planning, 471-491, 481 (2014).
8. Government of Punjab, Service Delivery Standards and Guideline for High Quality Safe Uterine Evacuation and Post-Abortion Care (April 2015).
9. Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2018).
10. The guidelines are limited to standard of care for first trimester abortions as this appears to coincide with the definition of a legal abortion in Pakistan of up to 120 days of pregnancy to save the life of the woman or to provide "necessary treatment." The guidelines do not provide advice or insight with respect to application or interpretation of Pakistan's abortion laws.
11. Programme of Action, 1994 International Conference on Population and Development available at https://www.unfpa.org/sites/default/files/event-pdf/PoA_en.pdf
12. CEDAW Committee, General Recommendation No. 35 on Gender-based Violence Against Women Updating General Recommendation No. 19, U.N. Doc CEDAW/C/GC/35 (2017), para. 18.
13. Id.
14. Committee on the Rights of the Child, General Comment No. 20 on the implementation of the rights of the child during adolescence, para. 60, U.N. Doc. CRC/C/GC/20 (2016).
15. Human Rights Committee, General Comment No. 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life, para. 8, U.N. Doc. CCPR/C/GC/36 (2019).
16. Id.
17. Id.
18. United Nations General Assembly, Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, para 21, UN Doc A/66/254 (2011).
19. Id.
20. Human Rights Committee, Concluding Observations on Initial Report of Pakistan, CCPR/C/PAK/CO/1, 23 August 2017, para 15.
21. Human Rights Committee, Concluding Observations on Initial Report of Pakistan, CCPR/C/PAK/CO/1, 23 August 2017, para 16.
22. Committee on Elimination of Discrimination Against Women, Concluding Observations on Fifth Periodic Report of Pakistan, CEDAW/C/PAK/CO/5, March 2 2020, para 44.
23. Constitution of Islamic Republic of Pakistan 1973, Art. 9.
24. Constitution of Islamic Republic of Pakistan 1973, Art. 25.
25. Constitution of the Islamic Republic of Pakistan 1973, Article 34.
26. World Health Organisation, Abortion Care Guideline Executive Summary (2022),7, available at https://www.who.int/publications/i/item/9789240045163
27. World Health Organisation, Abortion Care Guideline Executive Summary (2022),7, available at https://www.who.int/publications/i/item/9789240045163

28. World Health Organisation, Abortion Care Guideline Executive Summary (2022),7, available at https://www.who.int/publications/i/item/9789240045163
29. World Health Organisation, Abortion Care Guideline Executive Summary (2022),8, available at https://www.who.int/publications/i/item/9789240045163
30. National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.
31. National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2020. Pakistan Maternal Mortality Survey 2019. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.
32. Government of Pakistan. 2017. Population Census 2017. Pakistan Bureau of Statistics.
33. Community midwives and Lady Health Visitors are trained and regulated by the Pakistan Nursing Council, which sets their curriculum and licenses practitioners (Pakistan Nursing Council 2023).

2

Impact of Legal Framework on Abortion Service Provision

This chapter explores the legal barriers women face when seeking abortion services. In interviews and focus group discussions, HCPs and women shared their understanding of the legal framework and factors that inform decision-making on whether to provide or obtain abortion services. The chapter also examines the causes behind HCPs' decision-making, and how that impacts women's access to services.

PROVISIONS IN THE PENAL CODE

The Pakistan Penal Code (Act XLV of 1860), Chapter XVI, Section 338(A)-(C) criminalizes abortion,[34] with the following provisions:

338. Isqat-i-Hamal. – Whoever, causes woman with child whose organs have not been formed, to miscarry, if such miscarriage is not caused in good faith for the purpose of saving the life of the woman, or providing necessary treatment to her, is said to cause isqat-i-haml.

Explanation.– A woman who causes herself to miscarry is within the meaning of this section.

338-A. Punishment for Isqat-i-haml.–, Whoever, cause isqat-i-haml shall be liable to punishment as ta'zir-

(a) with imprisonment of either description for a term which may extend to three years, if isqat-i-haml is caused with the consent of the woman, or

(b) with imprisonment of either description for a term which may extend to ten years, if isqat-i-haml is caused without the consent of the woman.–

Provided that, if as a result of isqat-i-haml, any hurt is caused to woman or she dies, the convict shall also be liable to the punishment provided for such hurt or death as the case may be.

338-B. Isqat-i-janin.– Whoever, causes a woman with child some of whose limbs or organs have been formed to miscarry, if such miscarriage is not caused in good faith for the purpose of saving the life of the woman, is said to cause Isqat-i-janin.

Explanation.– A woman who causes herself to miscarry is within the meaning of this section.

338-C. Punishment for Isqat-i-janin. – Whoever, causes isqat-e-janin shall be liable to,

(a) one-twentieth of the diyat if the child is born dead,

(b) full diyat if the child is born alive but dies as a result of any act of the offender, and

(c) imprisonment of either description for a term which may extend to seven years as ta'zir–

Provided that, if there are more than one child in the womb of the woman, the offender shall be liable to separate diyat or ta'zir, as the case may be for every such child.–

Provided further that if, as a result of isqat-i-janin, any hurt is caused to the woman or she dies, the offender shall also be liable to the punishment provided for such hurt or death, as the case may be.

The above provisions were introduced to the Pakistan Penal Code in 1997.[35] Prior to the 1997 amendments, voluntarily "causing miscarriage" was criminalized except when it was caused to save the woman's life. The 1997 amendments to the Pakistan Penal Code were enacted to bring it in line with "the Injunctions of Islam as laid down in the Holy Quran and Sunnah."[36] According to some scholars of Islamic jurisprudence, abortion is permitted before "organs have been formed" of the fetus in some circumstances.[37] Organs of a fetus are deemed to be formed after 120 days of pregnancy, according to some scholars.[38] During the first 120 days of pregnancy, abortion is permitted under certain conditions pertaining to the health of the woman and the fetus. This principle of Islamic jurisprudence is reflected in the 1997 amendments to the Pakistan Penal Code, which expanded the exceptions to the criminalisation of abortion. Abortion is now criminalized in Pakistan, except to save the life of the woman and for "necessary treatment" during the first 120 days of pregnancy and only to save the life of the mother after 120 days of pregnancy.

HCP DECISION-MAKING TO PROVIDE ABORTIONS

The provisions outlined above lack clarity, particularly regarding what would fall under "necessary treatment" that a healthcare provider could carry out in good faith. There is no guidance from superior courts in Pakistan on how this exception is to be interpreted and applied. This vagueness of the law creates room for interpretation by HCPs, which is often filtered through their own biases. The findings also show that awareness of the law among HCPs is very limited.

Awareness of the Law among HCPs

The testimonies of multiple doctors highlight a general lack of awareness among healthcare professionals regarding the legality of abortion. For instance, a government doctor from Karachi admitted,

"No, I don't know about the law. I have read about it in our medical books, but I have not read any law books, so I have no idea."[39]

Similarly, another government doctor from Karachi acknowledges,
"I don't have any awareness. I do think I should have, but I don't." When asked about the inclusion of abortion law in the MBBS curriculum, the doctor responds, "I have not read about it anywhere."[40]

While some HCPs claim that they are taught about the law during their medical education, others express a complete lack of knowledge in this area. A government doctor from Khairpur acknowledges the inclusion of legal knowledge in their postgraduate studies and exams. However, she argued that the knowledge gained during the early years of medical education may not be effectively retained or applied throughout their careers,

"We do study it in our first year of MBBS, in Forensic Medicine. You learn it in the first year. And, you wouldn't remember it after 20 years."[41]

Around 12 HCPs out of a total 30 HCPs believe that abortion is legal only in case of danger to the mother's health. All the other HCPs consider abortion legal in circumstances such as mother's health and fetal abnormality. Although they did not have awareness of the specific sections of the penal code or the particular provisions within it, they are aware that abortion is permitted to save a woman's life, but not of any other provisions, such as "necessary treatment". For instance, a private doctor from Karachi states,

> *"To my knowledge, there isn't any law regarding abortion at all. I think the law is against abortion due to our religion."*[42]

Similarly, another private doctor from Hyderabad argues,

> *"No, I don't think so. I don't have much knowledge about the law, and doctors do not generally possess such knowledge either. They work according to their own ways, brain, and thesis."*[43]

Furthermore, HCPs were not aware of the potential penalties associated with performing abortions.

Three doctors assigned as medico-legal officers in a government hospital displayed greater awareness of the Pakistan Penal Code (PPC) and its provisions. Conversely, Lady Health Workers (LHWs), Lady Health Visitors (LHVs), and Community Midwives displayed limited knowledge about the law in general. A LHW from Khairpur stated:

> *"The law allows for abortion in cases of abnormalities, or if the mother has a specific disease."* [44]

Meanwhile, a community health worker argued against aborting the baby regardless of any fetal abnormality:

> *"If the parents are financially and mentally strong, then they shouldn't go towards abortion whatever the case is."* [45]

Interpretations of the law are made arbitrarily. For example, while some practitioners adhere strictly to the exceptions outlined in the law, such as danger to the mother's health, others may extend it to include fetal abnormalities.

For instance, a government doctor from Khairpur noted:

> *"Until the 20-24th week of pregnancy a baby is considered not to be compatible with life as h/her organs are not developed. So if there is any abnormality then an abortion is recommended."* [46]

Meanwhile, another government doctor from Karachi noted:

> *"I think these handicapped kids are a test from God. Since God has given them to you, you should take care of it. I just personally think this is wrong because my heart doesn't agree to it."* [47]

This lack of uniformity in which circumstances abortions are allowed further exacerbates the challenges faced by patients seeking abortion services, leading to confusion and unequal access to care.

Use of Discretion in Interpretation of the Law

The vagueness of the terms in the Penal Code provisions means that healthcare providers use their discretion to interpret the legal prohibition and its exceptions. The implications of their interpretations can significantly impact the availability and accessibility of safe abortion services. The lack of definition of "necessary treatment" provides discretionary power to healthcare practitioners (HCPs) as technical experts, who decide which abortions are in good faith for "necessary treatment", or even to save a woman's life. The vagueness of the Penal Code provisions effectively lend discretionary power and authority to HCPs over women who wish to terminate their pregnancies. In our discussions with HCPs, we found that they have embraced this power and authority and consider themselves the technical, legal and especially moral authority in provider-client interactions, denying women services when they consider them unjustified as per their own interpretation of the law, religion, morality, and the circumstances of the abortion seeker.

Data collected from interviews with HCPs shows that the discretion exercised by healthcare

practitioners in interpreting necessary treatment is often influenced by factors beyond considerations of women's health, well-being, and adherence to legal provisions governing abortion. Instead, their decision-making process may be influenced by personal apprehensions about potential consequences, moral perspectives on abortion, and religious and cultural beliefs. For instance, doctors with particular religious values that perceive abortion as morally wrong are more likely to refuse patients these services, regardless of legal provisions.[48] Similarly, cultural perspectives on gender roles, family values, and the sanctity of life can shape a healthcare practitioner's understanding of which instances abortion should be provided in, leading to divergent practices and access disparities.[49]

CIRCUMSTANCES HCPs CONSIDER IN PROVIDING ABORTIONS

The exceptions in the PPC position the decision to terminate a pregnancy as a medical one, but they lack clarity. As a result, HCPs act on their own personal interpretations of the law and often deny women their reproductive rights, including the right to make decisions about their reproductive lives. Interviews with HCPs explored their understanding of the law and their views on different circumstances in which women may seek abortions, and whether or not they believe abortions should be provided in each of these instances.

Danger to Mother's Life and/or Health

All HCPs noted in interviews that if continuing a pregnancy poses a threat to a woman's life, they believe that abortions are medically recommended, legally permitted and morally justified. A government doctor from Khairpur supports a strict interpretation of the legality of abortion, specifically limited to cases with clear and compelling 'medical grounds'. These 'medical grounds' entail significant risks to the health and well-being of either the fetus or the mother. The primary justification for 'legal' abortions, according to this doctor, involves situations where continuing the pregnancy poses substantial risks to the mother's life or health, or if the fetus has severe abnormalities or impairments that would either limit the viability of the fetus, or its chances of survival after birth. To illustrate, she explains that in cases where a mother has a severe cardiac disease or pulmonary hypertension, rendering her incompatible with sustaining life, termination of pregnancy may be considered as a necessary measure to protect her health. She explains:

> *"Law divides it into Isteqat e Hamal and Isteqat e Janin. Law clearly states that a baby can only be aborted in case of a valid medical reason which threatens the baby or mother's life. You have to look at the baby and mother's safety first, only then you can go for termination of pregnancy. For example, if the mother has a severe cardiac disease or pulmonary hypertension then she is not compatible with life, and her physiology will be changed. Then what should be done? Doctors say that she should not conceive at all. This can present grounds for termination of pregnancy."*[50]

Supporting this viewpoint, a private doctor from Hyderabad provides an example of valvular heart disease where abortion is carried out to safeguard the mother's life.[51] However, there exists a general hesitance among doctors regarding the termination of pregnancies. Some doctors adopt a 'wait and see' approach, especially in cases where a patient has severe hypertension or cardiac disease. They believe termination is not the immediate treatment, as certain complications may naturally arise, which may require terminating the pregnancy for the mother's well-being.

A government doctor from Karachi states:

> *"If a patient is severely hypertensive or cardiac then we give them preference. But it doesn't mean we will terminate the pregnancy. Because termination is not the treatment of the problem. If a patient is severely cardiac then it happens automatically. After 23 or 24 weeks, the patient may suffer from pre-eclampsia, then termination is the treatment. We must*

terminate the pregnancy. Still, we admit the patient in the hospital, we monitor her. We try that the baby gets a little more mature."[52]

Hence, while HCPs say that safeguarding the life and health of the mother is their priority, the interpretation of what constitutes a significant enough risk to the woman's life varies across providers. For instance, severe heart disease may be considered justified grounds for an abortion, but many HCPs explained that hypertension and diabetes are not considered as justified health concerns for abortion, despite added risk from multiple past C-sections or other co-morbidities.

Mental Health

Interviews with HCPs and FGDs with women show that mental health is generally not considered a legitimate ground for abortion. HCPs did not include mental health within their understanding of what constitutes the health of the pregnant person. Even if a person is severely mentally ill and cannot care for their existing children, an HCP believes that abortion is not justified in such cases and should not be carried out.[53] A lawyer comments that if a doctor is willing then she is well within her right to interpret 'mental health' as a justified reason for abortion.[54] In addition to this, an NGO representative claimed to have included the importance of mental health in their VCAT's training syllabus for HCPs.[55] Only one government doctor from Khairpur spoke in favor of abortions due to poor mental health. She states:

"With mental health... the patient won't care for the child well; the diet and the health. A physician is involved in the physical health aspect. At any gestational age if it is harmful for mother health then we terminate it. If the physician or psychiatrist advises that this condition is dangerous for the mother then we don't proceed with the pregnancy."[56]

However, HCPs noted that those with severe cognitive or intellectual disabilities should be allowed abortions in case they do get pregnant. For instance, a government doctor states:

"Both are considered. Because a mental health patient won't care the child well; the diet and the health. A physician is involved in physical health aspect. At any gestational age if it is harmful for mother health then we terminate it. If the physician or psychiatrist advises that this condition is dangerous for the mother then we proceed with the pregnancy otherwise we don't."[57]

However, the examples provided by HCPs of such situations were all based on sexual assault of a disabled person who then became pregnant. They also approached this matter with a protectionist and ableist lens, generalizing that people with such disabilities have no ability to consent to sexual activity at all, and are necessarily victims in need of aid.

Abortion for Fetal Abnormalities

The data reveals that most HCPs agree that abortion is permitted in cases of fetal abnormalities, although many argue that it needs to be performed within a certain gestational period. While the law does not specify fetal abnormality as a circumstance in which abortion is permissible, HCPs use their discretionary power to label such abortions as legally and morally acceptable. However, some HCPs acknowledge the legal and moral permissibility of abortion for fetal abnormalities but personally struggle with the decision due to their religious values. A government doctor from Karachi explains:

"Yes, the Englishmen wrote our medical books, so we are doing it. Even in this I get hesitant. Recently, I am getting a patient who is pregnant with a baby who has polycystic kidneys and both the husband and wife are literate. And they want to keep the baby to term even though the wife already has had 3 to 4 C-sections. I think these handicapped kids are a test from God. Since God has given them to you, you should take care of it. I just personally think this is wrong [abortion in case of fetal abnormality] because my heart doesn't agree to it. So I follow my heart."[58]

Some HCPs hold religious beliefs that consider all forms of abortion as morally objectionable, including cases involving fetal abnormalities. Their religious convictions create a conflict between what they consider their professional obligations and their personal moral compass. The existence of this conflict highlights the complex ethical terrain HCPs navigate when encountering cases of fetal abnormalities. It should be emphasized that most HCPs derive their ethical perspectives primarily from personal religious values, often prioritizing them over legal mandates and professional duties. Interviews show that there is consensus among the HCPs that fetal abnormalities like anencephaly require termination of pregnancy, however, not all of them are willing to conduct abortions themselves, so they provide appropriate referrals in such cases, because they believe that abortion for this reason is acceptable.

It is important to note that many HCPs believe that their professional obligations include enforcing their notions of religion and morality on their patients, whom they view from a protectionist lens - as those can be protected from committing sin. In denying women abortions in different circumstances, HCPs believe they are refusing to enable people in committing a sinful act.

> *"Yes, I feel like I am committing a sin. If I am not doing it myself, then my referral also means I am complicit."*[59]

Abortion in Rape Cases

There was considerable uncertainty regarding whether the law permits abortion in cases of rape. However, 17 HCPs expressed the view that if the pregnancy resulted from a rape case, abortion should be allowed, as the victim should not be held responsible. A government doctor from Karachi argues:

> *"I think we should help the woman in this because if someone is forcing a woman to bring a child in this world, and she doesn't want to, then she should be helped. If it was in my power, then I would definitely help."*[60]

Additionally, another government doctor from Hyderabad believes in case of rape the abortion can be induced until there is a fetal heartbeat.[61] In addition to this majority of LHWs, LHVs and community midwives also agreed that rape induced pregnancies could be aborted. These views reflect general empathy among the HCPs for the victims of rape; however, the HCPs relied on moral rather than legal grounds.

Another government doctor from Khairpur acknowledged the ethical necessity of providing abortions for rape victims.[62] However, due to her personal values, she does not perform abortions herself. Instead, she refers these cases to another healthcare provider. The doctor explained that ideally, they should perform the abortion since rape victims are already enduring an immense crisis and carrying the pregnancy can add to their trauma. Nevertheless, she personally does not perform abortions and believes that referring them to another provider is the appropriate course of action. She also gave an example of a woman who was being raped by her father-in-law while her husband was frequently away from the city, and got pregnant as a result of the rape. The doctor empathized with her plight, recognizing that she may have lacked awareness of her rights and felt powerless to speak out. Moreover, she acknowledged the difficult choices she faced, as speaking up may have resulted in her husband abandoning her, leaving her and her children in a vulnerable situation. In light of these complexities, the respondent advocated for provisions in the law to address such cases, acknowledging the unique circumstances faced by victims of rape.

In contrast, three HCPs recommended that rape victims marry their rapists instead of opting for abortion. They justified these opinions based on their religious values, which strictly prohibit the "murder" of a baby through induced abortion. A government doctor in Karachi stated that they do not handle rape cases and, when discussing a rape victim considering

abortion, emphasized that as a Muslim, she should give birth to the child, suggesting adoption as an alternative. Similarly, a private doctor from Hyderabad argued against abortion in pregnancies resulting from rape and proposed that the rape victim marry her rapist to provide legal protection for the baby.[63] Another government doctor from Khairpur believed that the law permits abortion in rape cases but refrains from performing abortions in such situations due to her personal religious views.[64]

Abortion in Cases of Unwanted Pregnancies

Unwanted pregnancies due to multiple children, family planning failures, or socioeconomic reasons are generally not considered justifiable reasons for inducing abortions by doctors. Healthcare providers (HCPs) often cite the illegality of such abortions according to the law and also express ethical and moral concerns based on their religious values. Additionally, HCPs fear that allowing abortions in these cases could lead to a moral crisis as it may result in an increased demand for abortion services. Women in FGDs mentioned they knew of people who had sought abortions for these reasons. While married women with children empathized with those seeking abortions for unwanted pregnancies, they were skeptical of whether or not such abortions are permitted in Islam and are morally justified. [65] [66]

A private doctor from Hyderabad emphasizes that, in their understanding, abortions are only lawful and acceptable in situations involving medical emergencies, threats to the woman's life, or fetal abnormalities. The doctor suggested that she knew of fellow professionals who prescribe medical abortions in such situations up to the 5th or 6th week of gestation, but not beyond. However, another private doctor from Hyderabad firmly refuses to even engage with patients seeking abortions for unwanted pregnancies, expressing a strong stance against it.

How are Doctors Treating Abortion-Seekers? Examining "Positive Counseling"

During interviews, some HCPs revealed that they conduct 'positive counseling' of clients who approach them for abortion. When clients explain that a pregnancy is unwanted, this type of counseling is used to intimidate and dissuade people from having an abortion. They are not only refused by the HCP they approach but are also discouraged from approaching anyone else, because HCPs intimidate them by providing them with misinformation and telling them that seeking an abortion is wrong. Among HCPs, some doctors said that they use whatever argument they can think of to scare women. They cite religion most often, to say that it is a sin to have an abortion and that Islam does not permit abortions. They also make moral arguments, stating that abortion is equivalent to murdering a child, and sometimes mention that abortion is unlawful. Finally, they also provide misinformation, telling clients that an abortion could negatively impact their health.

One doctor from Karachi, practicing at a government facility noted that she provides "positive counseling" to women because once conception has occurred, the child belongs to the couple and abortion is not allowed.[49] The doctor expressed concerns about allowing termination in such cases, suggesting that it may lead to a normalization of abortion as patients would choose abortion as a solution rather than adopting family planning methods. Other doctors also referred to "positive counseling", during which they refuse abortions and then pressure patients to continue with their pregnancies.

Government Doctor – Karachi
"We counsel the woman. She has conceived, even if it is unwanted. It has happened now. The child is theirs; they knew it beforehand. Abortion is not allowed. If we allow termination in this case, then people become habitual. They don't get tubal ligation done and continue with the practice of termination."[67]

Government Doctor – Karachi
"Yes, in that case also we counsel them to continue with pregnancy. Since the patient is fine, and the baby is also okay. We want them to welcome the baby and carry on...We will never terminate a pregnancy that has no issues."[68]

Government Doctor – Hyderabad
"First, we do counseling for them to keep the baby, then we tell them that we'd do their tubal ligation after this baby. I will do this..."[69]

Government Doctor 2 – Khairpur
"Failure of family planning methods does not happen in 100% cases. Even if they fail you do not terminate the baby. If you do end up having a baby, then we counsel the patients to have regular checkups to ensure a healthy and safe baby."[70]

A private doctor from Hyderabad pointed out that induced abortions in unwanted pregnancies are common, often performed by unskilled providers, or self-induced by pregnant women.[71] Consequently, patients then seek medical assistance, and may come to doctors with missed abortions, infections, and other complications. On the other hand, a government doctor from Khairpur argues that socio-economic reasons are indeed valid, especially considering the current economic situation.[72] They emphasize the importance of providing assistance in such cases. These contrasting views reflect the divergence within the medical community regarding the acceptable grounds for inducing abortions. While one doctor asserts the limitations of socio-economic factors as valid reasons, another emphasizes the significance of addressing these concerns in today's economic climate.

Abortion for Unmarried Women

Most of the interviewed HCPs perceive induced abortion when women are unmarried as entirely illegal. There are strong moral judgments held by these HCPs towards unmarried women who engage in consensual sexual activities. It is worth noting that while most HCPs acknowledge the limited reporting of unmarried abortion cases and the tendency of unmarried women seeking abortions to turn to informal facilities and unskilled providers, they nevertheless uphold their stance on the illegality and moral implications of induced abortion in unmarried situations.

While the majority of HCPs adhere to this stance, there are a few exceptions. For instance, a government doctor from Khairpur acknowledges conducting an abortion for an unmarried girl in her private clinic.[73] She emphasizes that these women fear their identities being disclosed and prefer seeking care in settings where there are fewer people due to social stigma. On the other hand, another government doctor from Khairpur said that she would prefer referring unmarried girls to NGO facilities for induced abortions, as performing induced abortions in government hospitals for unmarried girls is illegal according to her.[74]

Some HCPs say that by granting these requests, it may encourage a habit of seeking abortions and perpetuate immoral sexual practices among unmarried girls. A private doctor from Khairpur[75] exemplifies this viewpoint, stating that while she can empathize with women in such circumstances, she denies abortions to discourage what she considers immoral behavior. She believes that withholding cooperation will ultimately lead to a realization that such practices -sexual activity outside or marriage - are wrong. This notion is further reinforced by a government doctor from Khairpur, who emphasizes the need to discourage unmarried women seeking abortions and provide services only when a patient is already suffering from post-abortion complications or has a missed or incomplete miscarriage.

These conflicting opinions among HCPs shed light on the limited power that women have to exercise bodily autonomy. The scrutiny of their bodies by law and moral judgments becomes

evident in this discourse. The example of the government doctor conducting a private abortion suggests that fear of social repercussions and the understanding of the provisions in the law play significant roles in shaping the HCPs' decisions. It becomes apparent that women face challenges in navigating their reproductive choices and accessing safe healthcare services due to the prevailing social and legal norms surrounding unmarried pregnancies.
A private doctor from Hyderabad states:

> *"In illegal abortions, the doctors have to face legal charges. Unmarried cases are all illegal."*[76]

This interpretation is likely influenced by the vagueness of the legal framework, and by prevalent social and cultural norms, which place a high value on marriage and view premarital sexual activity as morally unacceptable. It is also important to mention that a number of doctors, LHVs and community midwives expressed fear that any further relaxation in abortion law would encourage people to indulge in sexual activity outside the bounds of marriage despite the fact that a very few unmarried women cases are reported to them. One LHV from Hyderabad commented:

> *"I think even if we are giving safe abortions, then there should not be repeated cases of abortion. Women should hesitate and worry a little before doing such a thing."*[77]

People who consider abortion as a sin anticipate a moral crisis in case of legalizing abortions. A government doctor noted:

> *"The law makes sense. Law's restriction is important to monitor and regulate. In some conditions it can be changed to make it better."*[78]

In a specific case highlighted during the interviews, an HCP advised unmarried girls seeking abortion to repent for their "sins" and marry the same partner.[79] Unmarried women facing unplanned pregnancies often avoid approaching HCPs due to fear, shame, or anticipation of judgment. Instead, they seek abortion services through informal centers, which operate outside the purview of legal regulations and medical standards.[80]

Abortion for Underage Girls

In the context of access to abortion for underage girls, a lawyer from Karachi highlights the challenges involved in handling cases for underage girls seeking induced abortion. The lawyer explains that the difficulty arises from the issue of consent, as minors are unable to provide consent for the surgical procedure. In such cases, parental consent is typically required. However, the lawyer points out that the situation becomes complex in the context of underage girls due to the existence of child marriage, child rape, and consensual sexual relationships. The legal system presents a situation of legal dilemma for married minors, wherein they are treated as adults by medical professionals and law enforcement agencies. However, the requirement of parental or spousal consent complicates their ability to make independent medical decisions. This creates a contradictory situation where married minors are treated as adults in some respects but are restricted when it comes to accessing abortion services. A lawyer points out the legal complication surrounding abortion for underage unmarried girls,

> *"It is statutory rape, and it is also fornication - having sexual relations before age, and outside of marriage." Prevailing social norms make marriage a prerequisite for accessing reproductive healthcare."*[81]

REASONS FOR RESTRICTED ABORTION ACCESS

Religious and Cultural Biases

The influence of religious and cultural biases plays a significant role in healthcare practi-

tioners' (HCPs) decisions regarding induced abortions. Our data reveals that a majority of these HCPs prioritize their religious values over provisions in the law, leading to the refusal of induced abortion services. A government doctor from Khairpur[82] acknowledges the permissibility of terminating pregnancies within 12 weeks in some circumstances according to the law but cites religious restrictions as the primary reason for refusing abortion services. She emphasizes that therapeutic termination is performed in compliance with the law; however, she believes that aborting pregnancies in cases of fetal deformities, even when legally allowed, is prohibited in Islam. According to her religious perspective, if a fetus with abnormalities has cardiac activity, the pregnancy cannot be terminated. Additionally, she cited religious beliefs as the reason for refusing abortion in case of family planning failure.

On the other hand, a private doctor from Hyderabad presents a different religious interpretation. Referring to a verse in the Quran, the doctor believes that until four months of gestation, the baby is considered a clot of blood, allowing for abortion during this period.[83] However, based on medical teachings indicating cardiac activity after seven weeks, the doctor questions the four-month theory and concludes that if there is cardiac flicker,[84] it signifies a live pregnancy. According to the religious understanding, doctors explain that cardiac flicker signifies the entering of the soul into a baby's body after which abortion is not allowed.

A government doctor in Karachi explained that while patients may request prescription pills for abortion or inquire about alternative methods, she refrains from providing such services.[85] Instead, the doctor offers folic acid supplements and urges patients to continue the pregnancy. The doctor's decision aligns with their Islamic viewpoint, which opposes any involvement in procedures that terminate pregnancies. It is evident that religious interpretations significantly impact HCPs' decisions regarding induced abortions. The varying interpretations and practices among HCPs highlight the complexities arising from the intersection of religious beliefs, medical knowledge, and legal frameworks. Such religious biases may hinder access to safe and legal abortion services, particularly for women with unwanted pregnancies.

Religious and cultural biases are also a significant factor in making women hesitant to seek abortion services from hospitals, clinics, and skilled providers. This is because religious and cultural ideas around abortion lead to intense social stigma. This is reinforced by the attitudes of providers when women go to them seeking an abortion. A married woman participant explained her case:

> *"My 9-year-old child - we did not want him to be born. So, we went to the doctor to tell her that I wanted an injection so I could get my periods, but she scolded me for it. She said now that you are pregnant, have the child - we are not sitting here to abort your children. So, we thought about it, and then decided to keep the child."*[86]

Women are discouraged from seeking an abortion at the very least, while in other instances they are insulted and verbally abused by doctors, and even misled by doctors providing vitamins/supplements instead of misoprostol prescriptions, and being told to go home and wait for weeks before seeing the doctor again, at which point they are informed that it is too late to provide an abortion.[87] [88] Interviews show that government hospitals in particular adhere to a more conservative approach, as they provide abortion services to married women only, particularly in cases of fetal abnormalities or when there is a significant risk to the mother's life in continuing the pregnancy.[89] Our findings indicate that government doctors have the most restrictive interpretation of the law, and coupled with their religious and cultural biases, they refuse to provide induced abortions.
One government doctor from Khairpur underscored this policy, stating,

> *"If it's illegal I won't do it...Because I am scared that if Allah gets mad...there are complications during the procedure."*[90]

The fear of social stigma is an important factor which leads to HCPS refusing abortion ser-

vices. It is due to the fear of being labeled as "abortion providers" by their communities and peers. A government doctor from Karachi highlights that she hesitates in doing legal abortion also because of religious obligation:

> *"Yes, I feel like I am committing a sin. If I am not doing it myself, then my referral also means I am complicit."*[91]

The following comment from a LHV further helps us to establish the point that social stigma plays a major role in HCP's decision making:

> *"I can't say as everyone has their own perception. But, I think if the law legalizes abortion, then it would just increase behayai [immorality]. ....Or, else people think that this center is open for everything. I live in this community, and people pass remarks. It affects my reputation. This reduces the respect. I don't do it for money, I do it to help the patients such a woman who has been raped."*[92]

These comments show that this HCP is concerned about her social standing if she provides abortion services. Due to this, women seeking abortion continue to seek support from informal means as evident from the experience of a woman participant of a FGD:

> *"Yes. Once there was a midwife. And then she gave me this tea, and then I got my period. So, she told me that I was about to have a child, but that it was not going to be formed properly. So, she gave it to me."*[93]

The negative societal attitude towards both those seeking abortions and those providing the service subjects them to social stigma, exacerbating the challenges surrounding abortion provision.

Fear of the Law

HCPs have a vague understanding that the law criminalizes abortion, although they are unaware of what instances it criminalizes and even the punishment laid out in the penal code. A government doctor from Karachi in response to a question about punishment in law said:

> *"No, I don't know about the law. I have read about it in our medical books, but I have not read any law books so I have no idea."*[94]

In addition to this a NGO representative explains the complex situation a HCP faces even in cases of 'legal' abortion:

> *"I think they both are the challenge because people don't know the law, people are not aware of the law. And they are scared to be labeled as abortionists. You know, a lot of clinics are scared that if I do the services, I'll be labeled as abortionists. And they can be attacked at the clinics. They are scared of that. Then when you talk about the law, we say that you're not doing anything illegal. We have got a restricted law. We don't say it's illegal in Pakistan. But it is restricted in Pakistan. So these clarifications are not there with the provider."*[95]

HCPs acknowledge that implementation of the law in Pakistan is generally limited, and that it is unlikely that anyone would actually be incriminated for seeking or providing an abortion. They do not seem to be afraid of any criminal penalty, but rather being involved in any tedious legal process in case clients themselves or their families take any action against them. Our data confirms that no doctor knew about any particular convictions of their fellow HCPs under the abortion law. A private doctor notes,

> *"Most of these cases never come up officially. Cases are made for sure. However, I can't recall any specific case at the moment."*[96]

One lawyer from Hyderabad was aware of a case in which an HCP was booked under abortion law. However, according to the lawyer this case ended up in a compromise.[76] This lack of awareness and understanding of the Penal Code provisions is identified as a hindrance by a

NGO representative, who emphasizes the importance of educating people about their rights and the abortion law of to facilitate abortions according to law,

> *"...But the hindrance is that a lot of people don't know the law, for them this is not a right thing to do, they think they cannot kill life, even if it matters putting the mother's life in danger or the fetus. We work on a lot of value clarification and transformation; we tell them this is very much in line with the law to do an abortion within 120 days, or in the first trimester..."*[97]

Aside from HCPs themselves, a lawyer from Karachi[98] holds the opinion that doctors are not necessarily afraid of the law due to the general lack of accountability and lawlessness in the country. The lawyer points out that there is little to no consequence for medical negligence, whether related to abortion or not, which may impact doctors' perceptions of the law and its implementation.

ATTITUDES OF HCPs TOWARDS WOMEN

While providers have some fear of becoming embroiled in any legal matters, focus group discussions with women revealed that they are not afraid of the law, as they do not know that any law regarding abortion exists. Hence, fear of the law does not seem to contribute to their decision to seek abortions or whom to seek it from. However, they hesitate to seek services from government hospitals, formal private facilities, and skilled providers, because of the attitudes they face from providers. They are discouraged, intimidated, and even insulted and abused by doctors. Our focus group discussions reveal that women are resorting to unsafe methods to avoid such interactions with skilled providers and in formal health facilities, because they are aware that they will likely be refused. Women reported receiving arbitrary information on abortion from their providers. One woman from Khairpur shared her experience with a doctor when she was seeking an abortion,

> *"When I asked the doctor, before 8 weeks or 40 days, before there is a heartbeat, is it allowed. The doctor said that before 40 days it's allowed."*[99]

Their hesitation in seeking abortions also stems from their own religious and cultural beliefs, because while they are unaware of the law, they do seem to be aware that abortion is not allowed in Islam, and is still a sinful act.[100] Women in FGDs who admitted to having had abortions expressed that while they had done so due to valid reasons, it was still wrong to have an abortion.

ABORTION USED AS FAMILY PLANNING

HCPs refusing abortion services insist that those seeking abortions should have used family planning services to prevent pregnancies.[101] Women also note that they are repeatedly told by HCPs, especially doctors, to use family planning services.[102] Those who have sought abortions confirm that they are told by doctors that they should have used family planning methods, and that now that a pregnancy has occurred, it should be carried to term, after which contraceptives can be utilized to avoid another pregnancy. However, interviews and FGDs show that women do not have access to adequate family planning counseling, and this is corroborated by HCPs themselves, who blame high patient load for this inadequacy. Myths and misconceptions around family planning continue to prevail among communities. For example, focus group discussions showed that women have misconceptions regarding various forms of hormonal birth control and tubal ligation, and do not know how to correctly use emergency contraceptive pills.

A woman in Karachi expressed her reluctance to use family planning methods due to apprehensions about their side effects, such as getting sick from injections or inserting an IUCD.[103] This lack of accurate information and fear of potential discomfort discourages women from

considering family planning options. Inadequate availability and affordability of contraceptives, coupled with the prevailing misconceptions, lack of adequate counseling, and arbitrary consent requirements (such as husband's consent for prescribing oral contraceptives, placing IUCDs or conducting a tubal ligation), contribute to a low uptake of family planning methods. Moreover, while HCPs acknowledge that family planning failure does occur, they still blame clients for unwanted pregnancies.

According to our data around 5 HCPs interviewed believe that the failure of contraception is often regarded as an 'excuse' employed by married women seeking abortions, who were not actually using contraceptives at all or as prescribed.[104] [105] HCPs exhibit unprofessional behavior, as revealed by a private doctor from Karachi who admitted to 'scolding' women seeking induced abortions for multiple pregnancies due to their perceived failure in effectively adopting family planning methods. Another government doctor from Khairpur further exemplifies the dismissive attitude prevalent among some HCPs in such cases, saying that she refuses abortions and questioning why women with multiple pregnancies do not utilize contraceptives when they are aware of the potential consequences. HCPs are concerned that abortion itself is being used as a family planning method. This is corroborated by other small-scale studies, such as one in Punjab in which HCPs reported that they believe younger married couples are not using family planning and are instead relying on abortion to delay their first child.[106]

CONCLUSION

Findings show that HCPs interpret the criminal law on abortion based on their own ethical, religious or cultural views on the permissibility of abortion. Consequently, there is wide divergence among HCPs working in Sindh on views regarding the legitimate grounds for providing abortion services. HCPs and women do not report a strong fear of prosecution or conviction under the criminal law; however, the vagueness of the exceptions to criminalisation of abortion encourages the arbitrary denial of abortion services.

Notes for Chapter 2

34. Criminal Law (Amendment Act) 1997.
35. Criminal Law (Amendment Act) 1997.
36. A. Alamri, Islam and Abortion, Journal of Islamic Medical Association of North America, Vol. 43, 2011.
37. A. Alamri, Islam and Abortion, Journal of Islamic Medical Association of North America, Vol. 43, 2011.
38. Pakistan Penal Code of 1860, s. 338
39. Interview with government doctor, gynecologist at a tertiary care hospital, in Karachi (March 22, 2023) (on file with author)
40. Interview with government doctor, at a tertiary care hospital, in Karachi (March 24, 2023) (on file with author)
41. Interview with a government doctor, gynecologist at a tertiary care hospital, in Khairpur (March 1, 2023) (on file with author)
42. Interview with a private doctor, 10 years of experience running private clinic, in Karachi (March 14, 2023) (on file with author)
43. Interview with a private doctor in Hyderabad (March 15, 2023) (on file with author)
44. Interview with a LHW, experience of over 20 years working with the community, in Khairpur (March 2, 2023) (on file with author)
45. Interview with a CHW in Karachi (March 22, 2023) (on file with author)
46. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
47. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
48. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
49. Interview with a government doctor in Hyderabad (March 16, 2023) (on file with author)
50. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
51. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
52. Interview with a government doctor, MCPS training from Karachi's Civil Hospital and also an ultrasound instructor, in Karachi (March 24, 2023) (on file with author)
53. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
54. Interview with a lawyer, experienced lawyer and a teacher at a renowned higher education institute, in Karachi (March 15, 2023) (on file with author)
55. Interview with a NGO representative, an international NGO working on SRHR, in Karachi (March 21, 2023) (on file with author)
56. Interview with a government doctor, a total of 10 years of experience, in Khairpur (March 1, 2023) (on file with author)
57. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
58. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
59. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
60. Interview with a government doctor, gynecologist with almost 20 years of experience, in Karachi (March 22, 2023) (on file with author)
61. Interview with a government doctor, gynecologist with almost 20 years of experience, in Karachi (March 22, 2023) (on file with author)
62. Interview with a government doctor in Hyderabad (March 16, 2023) (on file with author)
63. Interview with a government doctor, a total of 10 years of experience, in Khairpur (March 1, 2023) (on file with author)
64. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
65. Interview with a married woman, participant of FGD, in Khairpur (March 3, 2023) (on file with author)
66. Interview with a married woman, participant of FGD, in Karachi (Feb 16, 2023) (on file with author)

67. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
68. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
69. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
70. Interview with a government doctor, MCPS training from Karachi's Civil Hospital and also an ultrasound instructor, in Karachi (March 24, 2023) (on file with author)
71. Interview with a government doctor in Hyderabad (March 16, 2023) (on file with author)
72. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
73. Interview with a government doctor, MCPS training from Karachi's Civil Hospital and also an ultrasound instructor, in Karachi (March 24, 2023) (on file with author)
74. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
75. Interview with a government doctor, a medical legal officer, in Khairpur (March 2, 2023) (on file with author)
76. Interview with a government doctor, a total of 10 years of experience, in Khairpur (March 1, 2023) (on file with author)
77. Interview with a private doctor, a medical legal officer, in Khairpur (March 2, 2023) (on file with author)
78. Interview with a private doctor in Khairpur (March 1, 2023) (on file with author)
79. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
80. Interview with a LHV, working in the field since 2010, in Hyderabad (March 16, 2023) (on file with author)
81. Interview with a government doctor, MCPS and additionally trained in ultrasound, in Karachi (on file with author)
82. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
83. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
84. Interview with a lawyer, experienced in domestic violence cases and family law, in Karachi (on file with author)
85. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
86. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
87. Prior to the point where the heart chambers have formed and are observable through ultrasound, which typically occurs around the 17–20-week mark of gestation, it would be imprecise to label the progress of the embryo's or fetus's heart as a "heartbeat." Instead, the terms "embryonic cardiac activity" are appropriate before the eighth week of gestation, while "fetal cardiac activity" should be used after the eighth week of gestation (ACOG Guide to Language and Abortion). The American College of Obstetricians and Gynecologist (ACOG), ACOG Guide to Language and Abortion (Last Accessed on Aug 28, 2023). Available at: https://www.acog.org/contact/media-center/abortion-language-guide
88. Interview with a government doctor, diploma in OB-GYN, in Karachi (March 24, 2023) (on file with author)
89. Interview with a married woman, participant of FGD, in Karachi (Feb 16, 2023) (on file with author)
90. Interview with a government in Karachi (March 24, 2023) (on file with author)
91. Interview with a LHV, trained in public health with experience of around 20-25 years, in Karachi (March 10, 2023) (on file with author)
92. Interview with a married woman, participant of married women FGD, in Hyderabad (Feb 16, 2023) (on file with author)
93. Interview with a government doctor, experienced gynecologist with 20+ years of experience, in Karachi (March 22, 2023) (on file with author)
94. Interview with a NGO Representative, working in Sindh on family planning and post abortion, in Karachi (March 20, 2023) (on file with author)
95. Interview with a private doctor in Hyderabad (on file with author)

96. Interview with a lawyer, experienced in criminal, civil and constitutional, in Hyderabad (March 16, 2023) (on file with author)
97. Interview with a NGO Representative, a leading NGO working in the field of Family Planning, in Karachi (March 7, 2023) (on file with author)
98. Interview with a lawyer, teaching law in a leading higher education institute and also does private practice, in Karachi (March 15, 2023) (on file with author)
99. Interview with a married woman, participant of FGD, in Khairpur (March 3, 2023) (on file with author)
100. Interview with a private doctor in Hyderabad (Feb 15, 2023) (on file with author)
101. Interview with a government doctor, experienced gynecologist with 20+ years of experience, in Karachi (March 22, 2023) (on file with author)
102. Interview with a married woman, participant of FGD, in Karachi (Feb 16, 2023) (on file with author)
103. Interview with a young married woman, participant of FGD, in Karachi (Feb 27, 2023) (on file with author)
104. Interview with a private doctor in Hyderabad (on file with author)
105. Interview with a government doctor in Karachi (March 24, 2023) (on file with author)
106. Chahal, HK. Women's Abortion Seeking Experience in Rural Chakwal, Pakistan, Department of Public Health Sciences University of Alberta (2015). Available at: https://era.library.ualberta.ca/items/e379be3c-e9d8-4dd6-a520-e308239657a6/view/e4d5b63f-b2a2-4463-a716-8cadc7639002/Chahal_Harneet_Kaur_201507_MSc.pdf

3 Impact of Legal Framework on Quality of Service Provision

This chapter explores the impact of the legal framework on the quality of abortion service provision, exploring the experiences of women seeking abortion and barriers in the way of quality service provision.

SERVICE PROVISION ACROSS FACILITIES

The provision of abortion services in Sindh, Pakistan, stretches across various sectors, including government facilities, private hospitals and clinics, informal healthcare providers, as well as NGO service centers and providers trained and supported by NGOs. However, the quality of care provided is inconsistent across all of them. The lack of awareness and understanding of the legal framework, among healthcare providers operating in government facilities as well as the discretion they exercise in providing services leads to a gap in service provision for induced abortion within government clinics and hospitals. Therefore, small private clinics, informal and unskilled providers, as well as NGOs address this gap by providing services to women seeking abortion care.[107]

Tertiary government hospitals, which are large facilities linked to medical colleges, largely only provide post-abortion care, either in case of a missed miscarriage, or an incomplete miscarriage.[108] While in some instances these are naturally occurring miscarriages, interviews with HCPs reveal that women arrive in such states, or with severe complications such as heavy bleeding, after having induced abortion either at home with various herbal remedies, or through unskilled providers. In such cases, it is observed that most women turn to unskilled providers after being denied care by trained medical practitioners.[109]

Larger private hospitals, for their part, mimic the approach of government institutions. Unless the mother's life is in danger or the fetus has significant abnormalities, they do not offer induced abortion services. This stringent policy leaves a significant portion of women without access to safe abortion procedures, leading them to informal providers or smaller private clinics.[110] One of our respondents, a government doctor in Khairpur, explained that when women are refused abortion services, they often turn to clinics run by community health workers. These informal centers, often run by unskilled providers, deliver substandard abortion services. Some doctors have raised concerns about this issue, with a government doctor from Karachi stating,

> *"Patients who have gotten their abortion properly usually don't have complications. However, women who get their abortion done from informal places then there are complications. If you go in interior Sindh villages then you will observe that patients come to us after trying out 3 to 4 such unrecognized 'doctors'/dais. Patients get septic sometimes and even expire."*[111]

Despite their concerns about unsafe abortions, and their own experiences of managing severe complications resulting from unsafe methods, 5 government doctors we interviewed said that they are unwilling to provide services themselves or offer adequate referrals to patients, citing the law, religion and culture, and blaming women and married couples for not using family planning.

Due to a lack of accessibility of safe abortion services and the lack of awareness of appropriate qualifications, 30 women who participated in focus group discussions who have had abortions or know someone who has had an abortion, do not seem to have much knowledge regarding who is adequately trained to provide abortion services. During fieldwork, the research team observed that in some areas of Hyderabad, community health workers who are not trained in abortion care are providing this service, using unsafe methods and in inadequately equipped facilities. These workers were advertising themselves as doctors on signboards of small clinics, and through informal conversations with locals, the team learned that these individuals were providing services that they were not qualified to perform. The team was unable to

corroborate this from these health workers themselves, as they were hesitant in participating in the study or providing any information.

NATIONAL AND PROVINCIAL GUIDELINES ON ABORTION

The Ministry of National Health Services, Regulations, and Coordination collaboratively developed and approved the "National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Postabortion Care" in March 2018.[112] The purpose of the document is to provide a comprehensive standard of care and provide guidelines to HCPs on abortion and post-abortion care. In 2020, the Sindh Department of Health developed and approved its own guidelines, the same as the federal ones, titled "Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Postabortion Care."[113] The following are some of the key standards outlined in the federal and Sindh documents. These guidelines provide essential insights into recommended standards of abortion care, encompassing not just clinical considerations such as methods and infection prevention, but also client-centered care, informed consent, and referral systems.

- The very first standard states that the best uterine evacuation method should be determined by taking into account women's personal preferences, clinical condition, gestational age, and the availability of equipment, supplies, and staff. Vacuum aspiration (electric/manual) or medical methods (mifepristone followed by misoprostol, or misoprostol alone if mifepristone isn't accessible) are recommended for first trimester uterine evacuation care. Sharp curettage/dilation and curettage is not recommended because it is less safe than other methods.

- All trained healthcare staff (doctors, non-physician and mid-level providers) can provide uterine evacuation care. The staff should be trained in basic clinical procedures:

    - related to reproductive health - including bimanual pelvic examination to determine the age of pregnancy and positioning of the uterus, uterine sounding and other transcervical procedures

    - The trainings should aim to address healthcare provider's attitudes and beliefs about sexual and reproductive health, abortion, safeguarding privacy and non-discrimination in different type of cases (rape survivors and etc.).

- The Sindh guidelines state that HCPs should discuss the potential advantages and disadvantages of each uterine evacuation method with the patient and obtain their informed consent. There is no other consent requirement mentioned in the guidelines, except from the abortion-seeker herself. Consent for minors is addressed in Standard 22, which states: "Healthcare workers must support minors to identify what is in their best interest, including consulting parents or other trusted adults about their pregnancy, without bias, discrimination or coercion."

- Standard 26 of the Sindh guidelines addresses HCP refusal to provide abortions, stating that HCPs can conscientiously refuse abortions, but must provide referrals for safe abortion.

- Standard 25 addresses the specific needs of rape survivors: "Women and girls who are pregnant as a result of rape are in need of particularly sensitive treatment, and all levels of the health system should be able to offer appropriate care and support without requiring involvement of administrative or judicial procedures."

Overall, the guidelines reinforce that safe abortion is a right of all women and girls. Standard 19 of the guidelines states:

"All women and girls have the right to high-quality, safe, comprehensive uterine evacuation care. Healthcare providers must provide high-quality care while protecting the human rights of their clients, including clients' rights to privacy and confidentiality, information, dignity and autonomy. High quality woman/girl-friendly care must be provided without discrimination, with special attention to equal treatment for marginalized groups such as young girls, poor women, and women with disabilities. Healthcare providers must be prepared to offer effective and compassionate interaction, communication, emotional support and, if desired, counseling that focuses on the women and girls' needs."[114]

COMPLIANCE WITH NATIONAL AND PROVINCIAL GUIDELINES ON ABORTION

While the national and provincial guidelines note abortion as a right, they do not supersede the law. Moreover, the guidelines are not enforced, and the HCPs we interviewed were not aware of them. In response to a question about awareness of any standard guideline, a government doctor from Khairpur commented: "I think there should be a protocol which states which kind of patients should the government institutes entertain or not entertain. If there is a protocol, then the doctors will follow it."[115] Despite federal and provincial guidelines, the doctor is still in search of a standard protocol. Another government doctor comments on the inquiry of being provided with government guidelines:

"Not yet. When I was doing FCPS, Dr X gave a workshop on misoprostol updates and promoted MVA. He came on behalf of WHO."[116]

Five doctors mentioned that they refer to WHO and FIGO guidelines for management of abortion cases though misoprostol and MVA in interviews, but according to our data, doctors were not aware about specific uterine evacuation guidelines provided by the federal or provincial government.

Abortion Methods

In Pakistan, three primary methods are commonly employed for abortion: medical abortion, manual vacuum aspiration (MVA), and dilation and curettage (D&C). [117] [118] Typically, medical abortion includes a combination of drugs, such as mifepristone and misoprostol. While mifepristone is taken orally to block progesterone, a hormone critical in maintaining pregnancy, misoprostol is administered afterwards, orally or vaginally. Misoprostol, once absorbed, induces uterine contractions and labor, leading to expulsion of the pregnancy. Medical abortion is considered as a safe and effective method during the early stages of a pregnancy as it is non-invasive.[119] However, it requires access to the appropriate medication and proper medical guidance about the dosage. Manual vacuum aspiration (MVA) is a less invasive surgical method for abortion. It involves the use of a handheld manual vacuum aspirator to gently suction out the contents of the uterus. MVA is considered safer and more cost-effective than D&C, especially for early-stage pregnancies. It can be performed in outpatient settings and does not require general anesthesia. Dilation and curettage (D&C) is a surgical procedure used to remove the contents of the uterus. It involves dilating the cervix and scraping the uterine lining with a curette. There is a higher risk of complications in performing D&C as compared to other methods, such as the risk of infection, excessive bleeding, or perforation of the uterus. [120] [121]

The HCPs we interviewed continue to use D&C, and not all of them are aware that it is an unsafe method and that MVA is a better option. Some use both methods, while some others have shifted to MVA. HCPs say that since they are more experienced with D&C than with MVA, it is actually safer for the patient if they use this method.[122] This reveals the continued lack of sufficient training on MVA, because HCPs point out that they end up practicing the older method from their superiors during medical training. NGOs also provide technical

training to providers, particularly the use of misoprostol and MVA. However, despite D&C/D&E being cited as an unsafe method in national and international guidelines, it is still being used. NGO representatives themselves noted that despite an uptake in MVA, D&C is not being phased out. However, NGO training has proved effective in increasing MVA use among doctors, and LHVs and midwives.[123]

Use of Misoprostol

Despite the pervasiveness of unsafe surgical methods, the uptake of medical abortion by misoprostol has increased over the years.[124] While HCPs report using the medicine, its efficacy, and its health and monetary benefit to patients who can avoid surgical intervention, our interviews reveal that there is misuse of the drug, with women self-administering it at home after someone, usually their husbands, purchase it from pharmacies.[125] Despite misoprostol being a prescription medication, respondents (HCPs, NGO representatives, and women) shared that there is little regulation on its distribution in pharmacies and that it can easily be purchased over the counter. Alongside its easy availability in pharmacies, respondents also noted that untrained pharmacists also misguide buyers on the dosage of the medication, which needs to be prescribed by trained healthcare providers depending on a patient's individual profile.

HCPs report receiving complications, generally with heavy bleeding, after women self-administer the dose and take several times the required dose to induce abortion.[126] [127] [128] One step taken by an NGO to counter this has been to train pharmacists on correct dosages,[129] so they can provide the necessary information to those purchasing the medicine. Moreover, respondents also raised concerns about the quality and effectiveness of medications such as misoprostol, due to different brands being available in the market. According to a senior program staff member at an NGO, storage conditions can impact the effectiveness of misoprostol, such as temperature conditions, pointing to the need for further education and regulation.[130]

Client-centered Care

While the guidelines call for client-centered care, FGDs with women and interviews with HCPs show that they are not being practiced. Women in our FGDs reported that they were refused and/or mistreated by HCPs when seeking abortions.

What do Abortion Seekers Experience? One Woman's Story

"I talked to a few doctors and told them I don't want this baby, then they said how far along are you? I said 10-15 days. They told me to come back after two weeks…So, I waited and then went back, then they said now the baby's heart is formed and you can hear the heartbeat, so we can't do an abortion."[122]

The case of a Khairpur woman highlights the challenges and barriers faced by women seeking access to abortion services. She shared her story during a focus group discussion, recounting her desperate attempts to terminate a pregnancy when she already had three children and felt her family was complete. The quote above describes her experience of seeking an abortion after her fourth pregnancy. She was unable to find a provider who would agree to it, and then decided to continue the pregnancy as she felt it was wrong to terminate it after the first few weeks had already passed.

She went on to explain that she only intended to have two children, but that she had not had adequate family planning counseling, and hormonal contraceptives were causing her side-effects so she stopped using them. Meanwhile, her husband refused to opt for barrier methods such as condoms. She tried to convince her doctor for a tubal ligation after her second, third, and fourth child, all born via Cesarean sections. After her fourth pregnancy, her doctor agreed to a tubal ligation, however, her husband refused to provide consent for it, without which doctors were unwilling to do the procedure.

After yet another unwanted pregnancy (which occurred six months before the focus group discussion), she did not wish for a fifth child. This time, she decided that she would not approach any HCPs at all, for fear that they would mislead her or verbally abuse her. To try and terminate the pregnancy at home, she took estrogen pills used to treat amenorrhea. However, they did not induce abortion. She then spoke to a friend who told her to buy misoprostol from a pharmacy. Her husband, now willing to have her terminate the pregnancy, bought her the medication.

"There were 10 tablets and after every hour I had to take 2 tablets. It was something called miso. I took them and then I was making food, and my friend had told me this procedure would be painful, and it was really painful and a lot of bleeding. I started having diarrhea, and it was so painful. After 5 hours, I could not even move… I just had to stay in the bathroom. After the 10th tablet, my bleeding started, but there was so much flow… I can't tell you. In that one week I could not look after the children or myself. I was just in the washroom and sitting in one place. I could not even move because when I was moving there was much more flow. Then after one week, there was a gap, so I thought it was getting better, but then again that whole process started again, and I was in that condition, bleeding, for 40 days. I got dark circles and was so weak, but I could not go to a doctor. At that time my husband was getting food from the hotel and looking after the children. He understood I was in pain and was doing the best he could, but I could not go to the doctor. Because I was afraid of what the doctor would say and did not think it would be helpful... Most of the doctors have such a bad tone, they say, why did you do it?"[131]

This woman's story captures not only the obstacles women face in seeking abortions, but the fear they have of healthcare providers, who mistreat them for seeking abortions, so much so that even when she was bleeding severely and needed medical attention, she chose to risk her health and her life, rather than go to an HCP and admit to them that she had induced an abortion.

Other women also provided examples of being verbally abused and mistreated by doctors. One woman in Hyderabad recounted that when she asked her doctor for an abortion, a doctor threw her patient file in her face and yelled at her to leave her clinic, telling her that she does not do "this kind of work".[132] HCPs fail to provide accurate information about the options available to women who approach them with unwanted pregnancies. Instead they display judgemental and attitudes and express disapproval of abortion, perpetuating stigma and creating fear and hesitation in women regarding seeking abortion.

Our interviews with personnel working in NGOs revealed that training programs, workshops, and sensitization campaigns for healthcare providers are being conducted to increase awareness around the importance of providing patient-centered care. Furthermore, they are also generating more awareness about the abortion law and its specific provisions so that healthcare providers understand it better instead of citing it as a reason to deny abortion services across the board. Our conversations with NGO representatives show that HCPs religious and cultural biases have also been extensively addressed through tools such as Value Clarification and Attitude Transformation (VCAT) training. In our interviews with HCPs, we found that 6 of the total doctors had undergone such training via NGOs, but only 1 out of 15 doctors conceded that she provides induced abortion services for all unwanted pregnancies, without being restricted to reasons such as fetal abnormality or mothers' health. This particular provider worked at a government facility in Khairpur, and had undergone training through one of the NGOs included in this study. Her colleagues at the same facility who had also undergone training continued to refuse abortion services and displayed highly conservative attitudes. The effectiveness of training providers is limited by the law itself, which criminalizes abortion rather than setting forth any positive obligation on HCPs.

NGOs rely on religion rather than law to sensitize providers and alter their attitudes on abortion, both because the law criminalizes, and because HCPs are far more concerned about Islamic provisions for abortion rather than legal ones.[133] This is because healthcare providers, and other stakeholders including law enforcement, believe that Islamic law - and their interpretations of it - stand above the Penal Code and any other law in the country. This was clearly stated by respondents from all stakeholder groups, who noted that despite what the law

of a country says, Muslims ought to follow Islamic jurisprudence.[134] One HCP noted that she had attended an NGO VCAT training, but disagreed with the information provided regarding the provisions for abortion Islam that was shared during training.[135] Similarly, at least 6 doctors shared their experiences of VCAT and other sensitization trainings, but said that they disagreed with the content shared in them and it had not altered their opinion on the matter, even when the trainings cited established Islamic scholars.

Women in FGDs expressed that NGO facilities which provide abortion services are much needed, because they provide safe abortions to those who are refused by skilled government and private practitioners. Women shared that they were afraid to approach doctors in hospitals, for fear that they would not only be refused an abortion, but would also be judged, insulted, and verbally abused.

Arbitrary Third-Party Consent Requirements

The national and provincial guidelines on abortion only specify informed consent from the person seeking an abortion herself, and the law on abortion only mentions consent of the woman seeking an abortion. However, despite the law and the guidelines, interviews and FGDs show that there are arbitrary consent requirements imposed on abortion seekers. Typically, the husband's consent is sought for an abortion procedure, and in his absence, another family member's consent is obtained. In one of our interviews a government doctor mentioned:

> *"Husband and if not husband, then mother-in-law or blood relative."*[136]

A woman in Hyderabad expressed that the hospital staff always prioritizes husband's consent:

> *"First of all, they asked where the child of the father is and to get his permission first."*[137]

In addition to this, two government doctors also emphasized on the importance of taking consent from the husband. A government doctor claims that husband's consent is a legal requirement.[138]

This leads to women becoming sidelined in the decision-making process as their consent is not considered sufficient to conduct the abortion.

A nurse from Karachi reiterated how common the practice of obtaining husband's consent is, with the example of induced abortion in case of fetal abnormality.

> *"...the first priority is the husband's consent."*[139]

Even a lawyer amongst our respondents believed that a husband's consent is required for abortions,

> *"The doctor should ask for written permission from the husband."*[140]

However, the same lawyer agrees that there is no mention in the law about husband's consent. Our data shows that in total 4 police officers claimed that husband's consent is necessary. They argued that it is not because of the law but due to cultural and religious values. In total 5 other HCPs (including LHVs and community midwives) argued that husband's consent is important.

Conscientious Refusals and Referrals

The national and Sindh guidelines address conscientious objection by HCPs in Standard 26, which states that while providers can conscientiously refuse an abortion, they have to ensure that the patient receives timely and quality care by referring her to another trained provider or a health facility where she can receive abortion services. If a referral is not possible, then HCPs must provide safe abortion to save the person's life, or to prevent serious harm to her

health.

"Healthcare providers have a right to conscientious refusal to provide abortion, but that right does not entitle them to impede or deny access to lawful abortion services because it delays care for women and girls, putting their health and life at risk. Where a healthcare provider refuses to provide uterine evacuation, they must refer the woman/girl to a willing and trained provider in their facility, or another easily accessible healthcare facility. Where referral is not possible, the healthcare provider who objects must provide safe abortion to save the woman/girl's life and to prevent serious injury to her health." [141]

However, interviews with HCPs and FGDs with women show that this standard is not being practiced.[140] This is in part because HCPs are conscientiously refusing to even provide referrals, arguing that doing so would make them complicit in a sinful and immoral action. A government doctor from Karachi said:

"Yes, I feel like I am committing a sin. If I am not doing it myself, then my referral also means I am complicit."[142]

Our FGDs with women reveal that this attitude amongst providers serves to intimidate abortion-seekers, and makes them more hesitant to approach skilled providers and safe facilities because they feel they will likely be refused. It also adds to the stigma they experience as abortion seekers, because HCPs shame and judge them for seeking this service. Lack of adequate referrals leads people to unskilled providers who perform unsafe abortions - this is corroborated by women in FGDs, who revealed that they (or someone they know) had sought abortions from unsafe facilities and unskilled providers because they were refused by doctors and did not know any trained professional they could go to. In one of the instances a woman commented on her own experience of having an abortion,

"I had it done through a nurse, and it was okay. It was for two months, and I had it done through a tube. I had it done because my husband also wanted me to get an abortion. It was a nurse I knew, and it was in a house. It was clean."[143]

Due to a lack of referrals from skilled HCPs, women develop their own informal referral system for the (usually unskilled) providers in their communities who are willing to perform abortions at an affordable cost. For instance, in an FGD with married women in Karachi, all the respondents named a particular woman in their community who is known to perform abortions - she is unskilled and operates out of a small clinic. The women reported that this woman had even had legal cases against her for malpractice in different cases, not just abortions. However, she had managed to avoid prosecution each time, temporarily shutting down her clinic while the case was settled, and then reopening it. The respondents knew women in their family and the community who had gone to this unskilled provider for abortions. Women reported that they share this information with each other and refer those seeking abortions to this provider. They do so despite knowing that she is unskilled, because they feel they have no other option.

SELF-CARE APPROACH TO BYPASS OBSTACLES

Despite the standards and guidelines on abortion by the federal and provincial government, women continue to face barriers to safe abortion, including refusals, poor quality of care, and arbitrary third-party consent requirements. The uptake in medical abortions using misoprostol has created room for self-care for abortion, which is one way in which NGOs are helping women bypass the myriad obstacles they face in accessing abortions. As part of the self-care model, women are provided information on how to self-administer an abortion using misoprostol. WHO's guidelines on self-managed abortions state that they can be safely performed during the first trimester.[144] Women assess their eligibility for a self-managed abortion, self-administer abortion medicine(s) without direct supervision from a provider, and self-assess the success of the abortion.

One NGO representative explained that they conduct community outreach programs, through which they guide women on self-care, connect them with medical professionals if needed, and provide post-abortion family planning counseling. Furthermore, they also strive to reframe the conversation around abortion, shifting the focus from a polarizing debate over the right to abortion to a more nuanced understanding of self-care and preventative health measures. While NGO representatives noted that this approach could yield positive results, women's perspectives on it are yet to be explored, as the women in FGDs did not have any experiences of receiving self-care guidance from NGOs.

CONCLUSION

Women continue to receive poor quality abortion services, in spite of national and provincial guidelines developed by government Health Departments. Biases of HCPs influence the nature of counseling provided to women seeking abortion services. Women are also not provided proper guidance on how to administer medical abortion, exposing them to the risk of avoidable complications.

Notes for Chapter 3

107. Interview with a NGO Representative, a leading NGO working in the field of Family Planning, in Karachi (March 29, 2023) (on file with author)
108. Interview with a Government Doctor, MCPS trained doctor & trained in ultrasound, in Karachi (March 7, 2023) (on file with author)
109. Interview with a government doctor, a medical legal officer, in Khairpur (March 2, 2023) (on file with author)
110. A missed miscarriage is one in which the fetus has died but not been naturally evacuated from the uterus, while an incomplete miscarriage is one in which the fetal and pregnancy tissue have not naturally been completely evacuated, and the remaining matter requires expulsion (Hang-lin Wu and others). Wu, Hl., Marwah, S., Wang, P. et al. Misoprostol for medical treatment of missed abortion: a systematic review and network meta-analysis, Sci Rep 7, 1664 (2017). Available at: https://doi.org/10.1038/s41598-017-01892-0
111. Interview with a Government Doctor in Khairpur (March 1, 2023) (on file with author)
112. Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2018). https://pakistan.ipas.org/wp-content/uploads/2021/06/Pakistan-National-SGs_Final-copy-March-30-2018.pdf
113. Government of Sindh, Provincial Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2020).
114. Interview with a Private Doctor in Hyderabad (Feb 15, 2023) (on file with author)
115. Interview with a government doctor, MCPS and additionally trained in ultrasound, in Karachi (on file with author)
116. Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2018). https://pakistan.ipas.org/wp-content/uploads/2021/06/Pakistan-National-SGs_Final-copy-March-30-2018.pdf
117. Interview with a Private Doctor in Hyderabd (Feb 15, 2023) (on file with author)
118. Sathar et al. Post-abortion care in Pakistan: A national study, Islamabad: Population Council (2013). Available at: https://knowledgecommons.popcouncil.org/cgi/viewcontent.cgi?article=1154&context=departments_sbsr-rh
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120. Interview with a Government Doctor, 15 years of experience, in Hyderabad (March 16, 2023) (on file with author)
121. Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2018). https://pakistan.ipas.org/wp-content/uploads/2021/06/Pakistan-National-SGs_Final-copy-March-30-2018.pdf
122. Interview with a Private Doctor in Hyderabad (Feb 15, 2023) (on file with author)
123. Interview with a NGO, National NGO working on training service providers & other SRHR services, in Karachi (March 20, 2023) (on file with author)
124. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
125. Interview with a government doctor in Khairpur (March 1, 2023) (on file with author)
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130. Interview with a married woman, participant of FGD, in Khairpur (March 3, 2023) (on file with author)

131. Interview with a married woman, participant of married women FGD, in Hyderabad (Feb 16, 2023) (on file with author)
132. Interview with a government doctor, 10 years of experience, in Khairpur (March 1, 2023) (on file with author)
133. Interview with a NGO representative in Karachi (March 21, 2023) (on file with author)
134. Interview with a private doctor in Hyderabad (March 15, 2023) (on file with author)
135. Interview with a government doctor, a fresh medical graduate, in Karachi (March 24, 2023) (on file with author)
136. Interview with a married woman, participant of FGD of older married women, in Hyderabad (Feb 27, 2023) (on file with author)
137. Interview with a government doctor, experience of working in both private and government hospital, in Hyderabad (March 16, 2023) (on file with author)
138. Interview with a Nurse, experienced nurse and an instructor, in Karachi (March 24, 2023) (on file with author)
139. Interview with a lawyer, experiences in family, civil and criminal law, in Hyderabad (Feb 15, 2023) (on file with author)
140. Government of Pakistan, National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Post-abortion Care (March 2018). https://pakistan.ipas.org/wp-content/uploads/2021/06/Pakistan-National-SGs_Final-copy-March-30-2018.pdf
141. Interview with a Government Doctor, MCPS and 13+ years of experience, in Karachi (March 24, 2023) (on file with author)
142. Interview with a government in Karachi (March 24, 2023) (on file with author)
143. Interview with a married woman, she was part of our married women FDG, in Khairpur (March 3, 2023) (on file with author)
144. World Health Organisation (WHO), Recommendations on Self-Care Interventions Self-management of Medical Abortion (2022). Available at: https://apps.who.int/iris/bitstream/handle/10665/332334/WHO-SRH-20.11-eng.pdf

4 Enforcement of the Abortion Law

This chapter examines the role of law enforcement in relation to abortion access, exploring if and how the abortion law is being enforced. The chapter also examines the role of law enforcement in situations involving minors, unmarried women, and survivors of rape. Desk research revealed that there are no known convictions under the Penal Code provision. This was corroborated by police officials and lawyers who participated in the study. However, we found that criminal complaints are lodged under the Penal Code provision on abortion, generally by family members accusing each other of unlawful abortions. The complaints seem to arise from personal conflicts and feuds, and are used to either harass and intimidate women, or are lodged by women who have suffered abuse from family members that caused miscarriages.

LAWYERS' UNDERSTANDING OF THE LAW

Lawyers present different interpretations of "necessary treatment" within the Penal Code on abortion. A lawyer from Karachi who has been active in advocacy efforts on abortion noted that there is room for a broad interpretation of "necessary treatment" in the law. She explained that HCPs play a significant role in women's access to abortion. The lawyer states,

> *"But still, I would say that the law itself is giving you space to have the right to abortion - whatever reason stated, like saving a woman's life or if the pregnancy is less than 4 months old. These are conditions, yes, but if a woman does get an abortion, what will you do? Will you arrest the doctor? He will say he did it in good faith. He has his defense ready."*[145]

This perspective of the lawyer was that an HCP can interpret "necessary treatment" in "good faith" based on medical considerations. This lawyer suggests that the vagueness in the law means that HCPs are not likely to face penalties, because they are exercising their discretionary power.

However, other lawyers who are not sensitized on abortion held different opinions. A lawyer states that a broader interpretation of 'good faith' would go against Islam:

> *"The biggest problem here is the Islamically point of view. Islamic scholars would be very against this. Meaning of one verse in the Quran, which explains how saving one person saves entire humanity and killing one person kills humanity. So, from this point of view, as Pakistan is a Muslim country, we cannot make a law that is against Islam."*[146]

POLICE OFFICERS' UNDERSTANDING OF THE LAW

Police officers' interpretations of "necessary treatment" and "good faith" vary as well. A police officer from Karachi commented on the need to expand the definition of "necessary treatment" to include various considerations by medical practitioners. They suggest that if the definition of "necessary treatment" and "good faith" can be expanded and clarified, it can accommodate more scenarios where abortion is deemed necessary for the mother's health, and allow for a broader set of acceptable circumstances for abortion.[147] However, another police officer from Karachi believed that abortion is only allowed when the mother's life is in significant danger, and any other abortion would be considered criminal, because it would not be considered part of "necessary treatment".[148]Another police officer claims that the Penal Code sections would apply to any woman who has an induced abortion for any non-medical reason (limited to her physical health).[149] This is supported by another police officer who adheres to a strict definition of "necessary treatment" in "good faith", "Abortion is not allowed in any circumstance. However, you can see there is a 'good faith' word used. Good faith can be applied when a mother's health is in danger. Only then abortion is allowed, and that is not punishable. But other than that, it is called criminal abortion. So both the doctor and woman will be charged."[150]

Police officials, similar to HCPs and other stakeholders, also believed that Islamic jurisprudence is more important than a country's law. One officer said,

> *"See, abortion is not permitted in any situation because the baby that is about to be born also has fundamental rights. According to the Quran, saving one person's life is equivalent to saving the entire humanity. This is clear."*[151]

CASE EXPERIENCE OF LAWYERS AND POLICE OFFICERS

Lawyer's and police officials spoke about abortion in rape cases, because these involve a criminal act aside from abortion that gets reported to law enforcement. Termination of other types of pregnancies is less likely to be reported, because those instances do not necessarily involve another crime which needs to be reported. Lawyers noted that in case of pregnancies resulting from rape, it is challenging for women to seek an abortion. A lawyer from Hyderabad highlights the obstacles faced by rape victims, stating,

> *"Rape happened three or five months ago, and pregnancy is established. Then the baby is given to someone else or thrown away. If the family gets to know about the pregnancy after rape in the early stages, then they don't inform the police or court. They directly go to the doctor and get the baby aborted. If the girl reports, her pregnancy to the police after rape then the police can character shame her and accuse her of getting pregnant with someone else's baby. This prolongs the case to 50 years. People will not marry that girl if her character is subjected to such scrutiny by the police."*[152]

The lawyer noted that people choose not to report their pregnancy to the police, even if they do report the rape. This is because they wish to avoid further social stigma, and because they may wish to avoid any restrictions they may face in seeking an abortion once a pregnancy is officially reported. By subjecting rape survivors to such treatment, law enforcement makes it more challenging for survivors to access essential healthcare services such as abortion.

Lawyers and police officials also noted that pregnancies from rape may not be terminated because once the child is born, paternity tests are used as evidence against the perpetrator. One police officer from Karachi stated,

> *"Baby is also an evidence in case of rape. We don't suggest for abortion in this. There have been 2 cases in our police station and in another area in Karachi, this year, where the baby was born after rape."*[153]

While other respondents shared this opinion, they were not able to provide any documentation regarding cases where pregnancy from rape counted as evidence against a rapist. Moreover, a couple of police officials in an interview argued that abortion is still a criminal offense, even if the pregnancy is the result of another crime such as rape.[154]

While women who are seeking abortions are facing challenges, one lawyer also described a situation in which a woman was pressured to have an abortion against her wishes,

> *"I told you that there is a case I am dealing with in which the lady police took the rape victim, and the abortion was done. She was in the first or second month of her pregnancy. The girl was forced to get this done because she didn't want it [the abortion]. The police informed me that the family wants this to happen."*[155]

Police officials and lawyers did not have any specific case experience regarding minors seeking abortions outside of rape cases, but they believed that the abortion law would apply to both minors and adults. These two sets of respondents were also unclear on how abortion law would apply if abortion-seekers were unmarried, although one police official believed that if such an abortion were reported to the police by anyone involved, an unmarried abortion-seeker would also be incriminated for fornication under a separate provision of the Penal

Code.[156] Another police officer from Hyderabad acknowledges the lack of clarity in the law regarding unwanted pregnancies of married women.[157] Another police officer from Hyderabad mentioned the implications of fornication charges for unmarried women seeking abortions.[158] However, they noted that physical cases of unmarried women accessing abortions are not reported.

As noted above, lawyers did not share much experience regarding abortion cases, because complaints filed under the abortion law do not tend to move beyond First Information Reports (FIRs) lodged with the police. All lawyers and police officials we interviewed said they had never heard of a conviction, whether of women or healthcare providers (HCPs), under the abortion law. Interviews with these respondents reveal that complaints registered under the abortion law often revolve around family disputes, where spouses and family members involve each other in court proceedings due to personal conflicts.[159]

Complaints Under the Abortion Law: Examining First Information Reports (FIRs)

One police official in Karachi provided the research team with copies of three FIRs registered at his police station, which had complaints under the abortion law.

Complaint 1, citing Section 338C and 338C. The complainant is a woman who alleged that she was physically abused by her husband throughout their marriage, including when she was seven months pregnant. After she filed for divorce from him, he came to her parents' house where she was then staying, and kicked and punched her in the stomach, causing her to have a miscarriage. She gave birth to a stillborn daughter when she was taken to the hospital. The FIR cites both 338A and 338C, which refer to isqat-e-hamal and isqat-janin, even though the latter would be applicable since the organs of the fetus were formed when her husband caused her to miscarry with his beating.

Complaint 2, citing section 338B, along with 380 (which addresses theft in a dwelling/ house) and 109 (which refers to abetting a crime). The complainant is a man who claimed that his daughter-in-law, SS, created a difficult living environment for his family after marriage. Then, when she got pregnant, she had a written agreement with her husband and in-laws that while she is separating from her husband, she would give birth to their child, the husband would pay her alimony, and then she would hand over the child to him after some months. The complainant also alleged that SS colluded with his other son's wife to steal all the jewelry she was given when she married and took it with her when she separated from her husband. He claims that when he and his son went to her house to make the first alimony payment, they found out that she had had an abortion, while she was still married to the complainant's son. In the FIR, he also alleged that after the abortion, the woman filed for divorce, without informing the court of her abortion. Along with theft of the jewelry, the complainant is accusing her of aborting the child without her husband's consent, which seems to be the main allegation rather than the abortion itself.

Complaint 3, citing Section 338B and 34 (which relates to an act committed with the help of others). The complainant is a woman, who alleges that her first husband of 13 years with whom she had two sons, divorced her. Her father then forcefully married her to another man, while she was still five months pregnant from her first husband. She alleges that her new in-laws abused her, and that her brother-in-law and his wife forcefully took her to a clinic, where the brother-in-law posed as her husband and forced her to have an abortion. She alleges that the abuse continued after that, and she was tortured by being locked in a room without food or water. Her second husband then divorced her and kicked her out of the house. She then went back to her father's house, and her former husband filed a complaint against her for adultery in another police station. The main allegation is against her second former husband and his family of forcing her to have an abortion.

REPORTING MALPRACTICE

Lack of convictions for abortions that may be considered unlawful helps avoid further restrictions on access to abortions, as providers and women are not afraid of the law, because they know that they will not face any serious legal action. However, because abortion is still criminalized, it means that there is no room for women to report unsafe abortions. Respondents from all groups of stakeholders (police, lawyers, HCPs, women, and even NGOs), noted that there is little to no accountability for providers, especially unskilled, who are performing unsafe abortions.

Police interviews show that if women were to make allegations against a skilled or unskilled provider for an unsafe procedure which caused them harm, they would incriminate themselves under the abortion law. A Karachi police official notes,

> *"Since these things are happening with the person's consent, so whoever quack is involved, or medical person, so to keep them confidential and to keep the family confidential, even if anything that happens to the mother, they don't openly disclose it."*[160]

This statement points to the culture of silence on abortion, which results from abortion being practiced underground, largely due to the social stigma surrounding it (as people are not afraid of the law but of social censure), but ultimately also because of the law which criminalizes it.

Instead of calling for decriminalizing abortion and working to destigmatize it, police officials, (and respondents from other stakeholder groups as well) believe that unsafe abortions will be reduced if action is taken against quacks. They fail to understand that it is the culture of silence, the stigma, and the climate of fear around abortion (particularly of facing refusals and abuse from qualified HCPs) which is leading people to unskilled providers in the first place.[161]

Notes for Chapter 4

145. Interview with a lawyer, 5 years of experience in family and criminal law, in Karachi (on file with author)
146. Interview with a lawyer, experience in constitutional law, in Khairpur (March 2, 2023) (on file with author)
147. Interview with an inspector ranked police officer in Karachi (April 19, 2023) (on file with author)
148. Interview with a senior police officer in Karachi (March 30, 2023) (on file with author)
149. Interview with a inspector police, working as a law officer, in Karachi (April 4, 2023) (on file with author)
150. Interview with a senior police in Karachi (March 29, 2023) (on file with author)
151. Interview with a senior police officer in Karachi (March 30, 2023) (on file with author)
152. Interview with a lawyer, experienced in criminal and family law, in Hyderabad (Feb 15, 2023) (on file with author)
153. Interview with a lawyer - expert of family and civil law - in Hyderabad (Feb 15, 2023) (on file with author)
154. Interview with police officers -SSP investigation & legal officer- in Karachi (March 29, 2023) (on file with author)
155. Interview with police officers -SSP investigation & legal officer- in Karachi (March 29, 2023) (on file with author)
156. Interview with lawyer -experienced in criminal, civil and family law- in Hyderabad (Feb 15, 2023) (on file with author)
157. Interview with a senior police officer, AIG Establishment in service since 2013, in Hyderabad (April 15, 2023) (on file with author)
158. Interview with a police officer, sub divisional officer, in Hyderabad (April 10, 2023) (on file with author)
159. Interview with a police officer, sub divisional officer, in Hyderabad (April 15, 2023) (on file with author)
160. Interview with a police officer in Karachi (March 29, 2023) (on file with author)
161. Interview with a police officer in Karachi (March 29, 2023) (on file with author)

5 Conclusion

Findings from this study demonstrate that there are various legal and social barriers to abortion. Most significantly, the Pakistan Penal Code criminalizes abortion except in case of danger to a woman's life, or for "necessary treatment" during the first few weeks of pregnancy. This curtails individuals' reproductive rights and autonomy. The following discussion notes key findings from the study, and provides recommendations to expand access to abortion.

KEY FINDINGS

1. The vagueness in the Pakistan Penal Code provisions on abortion, through terms such as "necessary treatment" gives discretionary power to healthcare providers, who often choose to deny women essential abortion services primarily due to their religious and cultural beliefs on abortion and on arbitrary interpretations of the law.

2. HCPs, like other stakeholders who participated in this study, have little knowledge of provisions in the law. HCPs also displayed little understanding of the application of constitutional rights and international human rights. They choose to provide or deny abortions based on a moral assessment of circumstances such as danger to a woman's life or health, fetal abnormalities, or marital status. HCPs dissuade and intimidate abortion-seekers as they see fit, with some providers labeling this "positive counseling."

3. Women report negative experiences with HCPs when seeking abortions, which not only discourage them from visiting that same provider again, but also from approaching other skilled providers. Women report that HCPs do not provide client-centered care, displaying judgemental attitudes at the very least, and even verbally abusing abortion-seekers. Women did not display awareness of the criminal law, hence, it is not a fear of the law which drives them towards unsafe abortions. Rather, it is the attitudes and behaviors they encounter in skilled HCPs which leads them to informal facilities and unskilled providers.

4. Since providers at government and formal private facilities are reluctant to provide abortions, women report that they seek abortions from informal facilities and unskilled providers. Women who have had abortions or know someone who has had an abortion, do not seem to have much knowledge regarding which providers are adequately trained to provide abortion services.

5. HCPs are not aware of nor compliant with the federal standards and guidelines on abortion services, titled "National Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Postabortion Care." They are also unaware of the provincial standards and guidelines (which are the same as the federal ones) titled, "Service Delivery Standards and Guidelines for High Quality Safe Uterine Evacuation and Postabortion Care." Sharp curettage is still being used, despite the guidelines noting that it is not recommended as it is less safe than other methods.

6. HCPs impose arbitrary third-party consent requirements on women. They demand written consent by the husband of the abortion-seeker, and if the husband is not available, then the consent of an accompanying family member is obtained. This severely curtails access to safe abortion services.

7. HCPs often opt for conscientious refusals, for which there is provision in the federal and provincial standards and guidelines. The standards note that the right to conscientiousness refusal does not mean that HCPs can deny women their right to safe abortion, and so they must provide referrals to other safe facilities or providers. If such a referral is not possible, then they need to provide the service themselves to avoid endangering the health or life of the abortion-seeker. However, there is little compliance with this standard, and HCPs refuse to provide referrals at their whim, referring to their own reli-

gious and cultural beliefs on abortion.

8. Respondents noted that misoprostol is being purchased over the counter, with misinformation being provided to women regarding dosage by untrained pharmacists and by word of mouth, leading to misuse of the drug that could endanger the health and lives of women. NGOs report that the self-care model is a way to bypass obstacles abortion-seekers face.

9. Lawyers and police officers also lack a clear understanding of the law, and express conservative views regarding abortion. Similar to other stakeholders, they are more concerned with Islamic jurisprudence on abortion rather than the law.

10. The study found that there are no known convictions under the Penal Code provision, and this was corroborated by police officials and lawyers who participated in the research.

While there are no convictions, criminal complaints in the form of First Information Reports (FIRs) are lodged under the Penal Code provision on abortion. Police officers report that these complaints tend to be initiated by family members engaged in personal conflicts and feuds, who are accusing each other of having or causing unlawful abortions.

11. There is little to no accountability for those providing unsafe abortion services, and police officers believe that if women try to lodge a criminal complaint regarding such malpractice, they could incriminate themselves by admitting to an unlawful abortion.

RECOMMENDATIONS

1. **Decriminalize abortion and establish an enabling legal framework for access to safe abortion services.** Abortion should be removed from the Pakistan Penal Code and no criminal penalties should be imposed on women seeking abortions and on HCPs who provide safe abortion services with the consent of women. So long as abortion remains criminalized, the threat of criminal sanction will have a chilling effect. It will also perpetuate the stigma against abortion and encourage biases of HCPs that cause them to deny safe abortion services. Law enforcement will also continue to harass women who have received or are suspected to have obtained abortion service.

The current legal framework should be reformed to ensure that women and girls are able to obtain safe abortion as a right, without any requirement of third party authorization, in line with the 2022 WHO guidelines. Currently, the legal framework does not impose a clear legal obligation on HCPs to provide women and girls safe abortion services on request. In the absence of such a framework, HCPs will continue to deny women and girls abortion services based on their arbitrary biases.

2. **Educate and train HCPs to respect women and girls seeking abortion services and to provide quality abortion care, including adequate counseling.** Judgmental and harsh attitudes of HCPs deter women from seeking safe abortion services from qualified professionals. The medical curriculum of doctors and other HCPs should clarify that the duty of care towards all patients includes provision of safe abortion services and proper counseling. Medical education should also emphasize that where HCPs have a conscientious objection to abortion, they must refer women to trained abortion service providers. The rights of women and girls under the Constitution as well as international human rights treaties must be conveyed to HCPs during their education and training.

3. **Implement guidelines for safe abortion services.** The Sindh Health Department

should update its guidelines on provision of safe abortion services and bring them in line with 2022 WHO guidelines. The guidelines should be disseminated among the healthcare community as well as the general public. The Health Department should monitor the implementation of the guidelines, and ensure that HCPs discontinue use of outdated and dangerous methods of abortion, such as dilation and curettage. Particular emphasis should be placed on the quality of services provided in public health facilities, as women with limited means tend to approach these facilities for healthcare.

4. **Ensure that women are provided proper guidance on how to administer medical abortions.** Medical abortion is safe and cost-effective, and the findings show that women opt for this method. Proper guidance on how to administer medical abortion, however, is not widely available. As a result, women experience avoidable complications. Medical abortion should be made available in pharmacies and healthcare facilities, especially public health facilities. HCPs and pharmacists must be trained on the proper use and dosage of medical abortion.

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