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# Safeguarding women's health: Trends, inequities, and opportunities in Pakistan's abortion and post-abortion care services

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## Trends, Inequities, and Opportunities in Pakistan's Abortion and Post-Abortion Care Services


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# Abbreviations

| | |
|---|---|
| AICM | Abortion Incidence and Complications Method |
| AJK | Azad Jammu & Kashmir |
| BHU | Basic Health Unit |
| CPR | Contraceptive Prevalence Rate |
| D&C | Dilatation and Curettage |
| D&E | Dilatation and Evacuation |
| DHQ | District Headquarters Hospital |
| DHS | Demographic and Health Survey |
| EVA | Electric Vacuum Aspiration |
| FHT | Female Health Technician |
| FP | Family Planning |
| GB | Gilgit-Baltistan |
| HFS | Health Facilities Survey |
| HMIS | Health Management Information System |
| HPS | Health Professionals Survey |
| ICT | Islamabad Capital Territory |
| IRB | Institutional Review Board |
| IUCD | Intrauterine Contraceptive Device |
| KP | Khyber Pakhtunkhwa |
| LHV | Lady Health Visitor |
| MCH | Maternal and Child Health Center |
| MNCH | Maternal, Newborn, and Child Health |
| MoNHSR&C | Ministry of National Health Services, Regulations and Coordination |
| MVA | Manual Vacuum Aspiration |
| NCMNH | National Committee for Maternal and Neonatal Health |
| NIPS | National Institute of Population Studies |
| NPFP & PHC | National Program for Family Planning and Primary Health Care |
| PMDC | Pakistan Medical and Dental Council |
| RHC | Rural Health Center |
| TBA | Traditional Birth Attendant |
| TFR | Total Fertility Rate |
| THQ | Tehsil Headquarters Hospital |
| WHO | World Health Organization |
| WMO | Woman Medical Officer |

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# Executive Summary

This report presents the findings of a comprehensive study on abortion and post-abortion care in Pakistan, conducted in 2023 by the Population Council in partnership with the Guttmacher Institute. The study addresses a critical need for updated information on women's reproductive health in Pakistan, a country facing significant challenges including a high population growth rate (2.55% per annum), low contraceptive use (34% for any method, 23.4% for modern methods), and a high unmet need for family planning (17.3%).

The study is the third of its kind since 2002, building on previous research conducted in 2002 and 2012. It comes at a crucial time when Pakistan faces economic challenges that may impact access to healthcare services. The 2023 study design offers several strengths:

- Nationally representative coverage, including all provinces and regions (Gilgit-Baltistan, Azad Jammu and Kashmir, and Islamabad)
- Inclusion of smaller public sector facilities not covered in the 2012 study
- A more comprehensive sampling frame, especially for private sector facilities
- Analysis of changes in abortion care over time, including methods, provider training, and facility readiness

## Key Findings

- Women are seeking abortions at a younger age compared to 11 years ago, with increased autonomy in decision-making.
- Misoprostol is widely available and used for induced abortions and treating post-abortion complications.
- Abortion costs have risen significantly, with doctors being the most expensive providers. Poor women, especially in rural areas, often resort to cheaper but potentially riskier options.
- Despite increased use of medication abortion, 20-26% of women who had an abortion were likely to experience complications, indicating that abortion care remains generally unsafe.
- An estimated 870,185 post-abortion complication cases received treatment within the formal health system in 2023, with the majority presenting as outpatients.
- The rate of abortion complications has declined from 15.9 per 1,000 women aged 15–49 in 2012 to 12.9 per 1,000 in 2023.
- Quality of care remains a concern, with one in five primary and referral-level public facilities not providing mandated post-abortion care.
- Post-abortion family planning services are less available compared to post-partum family planning, with gaps in counseling and contraceptive method availability.

## Recommendations

- Establish a supportive policy framework to enhance access to safe abortion services.
- Reduce the financial burden on the public health system by promoting effective contraception and enhancing family planning services.
- Expand training and improve guidance for medication abortion to ensure safer usage.
- Minimize the use of outdated abortion methods in favor of safer, WHO-recommended techniques.
- Address gaps in post-abortion care by ensuring facilities meet comprehensive care standards.
- Reduce inequities in health services across regions, residential areas, and income groups.
- Increase the availability of vacuum aspiration in primary-level facilities.
- Improve referral systems and emergency response capabilities.
- Promote safety in abortion care and family planning to reduce unintended pregnancies and complications.

This study provides critical, timely evidence to inform policies and programs aimed at improving contraceptive and abortion services in public and private health facilities across Pakistan. Its comprehensive approach and expanded scope offer valuable insights into the evolving landscape of reproductive health care in the country. Implementing these recommendations can significantly enhance women's reproductive health outcomes and reduce the burden on the healthcare system, particularly in the context of current economic challenges.

CHAPTER 1

# Introduction

## 1.1 | The Context

With a staggering population growth rate of 2.55% per annum,[1] low contraceptive use (34% for any method and 23.4% of modern methods), and a high unmet need for family planning (17.3%),[2] women in Pakistan face numerous reproductive health problems, including abortion and post-abortion complications.[3] Spontaneous or induced abortions accounted for 10% of maternal deaths in 2019.[4]

Abortion is criminalized under Pakistan's Penal Code unless it is performed to save a woman's life or to provide necessary treatment before the organs of the fetus have been fully formed.[5] However, the phrase "necessary treatment" is not clearly defined. Similarly, there is ambiguity regarding the permissibility of abortion in Islam, compromising the availability of safe and legal abortion care. [6] While legal barriers and religious norms seldom deter families from procuring abortion, they do contribute to unsafe abortions as health clinics are not able to offer abortion services openly. Consequently, many women approach unskilled health providers or self-induce abortion using risky methods, predisposing them to adverse health outcomes both in terms of mortality and morbidity. According to the 2019 Pakistan Maternal Mortality Survey (PMMS 2019), spontaneous or induced abortion complications were the third major cause of maternal mortality in Pakistan after obstetric hemorrhage and hypertensive disorders in pregnancy, childbirth, and puerperium.[7]

The abortion landscape in Pakistan is now changing with the widespread availability of misoprostol.[8] Misoprostol is being used and is available throughout much of the country, routinely used in tertiary care facilities for first and second-trimester abortions in cases where the continuation of pregnancy is dangerous to the life of the mother.

Abortion services are more readily available from private facilities as opposed to public health facilities which poses an economic challenge for many, especially for the urban poor and those living in rural areas and remote districts who can ill-afford the cost of private healthcare.

In response to the need emphasized by service providers for updated guidelines on post-abortion care, the Department of Health of Punjab in 2015 drafted the "Service Delivery Standards and Guidelines" for post-abortion care.[9] These guidelines align with the World Health Organization's (WHO) 2012 policy and technical guidance on safe abortion/post-abortion care.[10] They were formulated to guide health workers in service delivery—improving the quality of service and enabling health administrators to assess quality of care against a given standard and provide checklists for monitoring and supervision.[11]

The Sindh Reproductive Healthcare Rights Act was passed in the province of Sindh in 2019.[12] It sets forth several reproductive health guarantees including the requirement that WHO standards of "post-abortion care" be followed in the province. However, this law does not contain any specific provisions regarding abortion.[13]

In 2020, the Ministry of National Health Services, Regulations and Coordination (MoNHSR&C) published the Essential Package of Health Services (EPHS) at the Community and Primary

Healthcare Centre (PHC) Level.[14] As part of the package, the Ministry recommended the provision of services at primary care facilities and first-level hospitals covering: management of miscarriage or incomplete abortion and post-abortion care (PHC level), pharmacological therapeutic abortion using mifepristone and misoprostol or misoprostol alone (PHC level), and abortion by vacuum aspiration and dilatation and curettage (D&C) (first-level hospitals).[15]

## 1.2 | Unintended Pregnancies, Abortion, and Post-abortion Care

With low contraceptive prevalence in Pakistan and the frequent use of ineffective traditional methods or inconsistent use of condoms or oral contraceptives, it is no surprise that many women experience unintended pregnancies.[16] Out of the 9 million pregnancies that took place in 2012 in Pakistan, nearly 4 million were unintended and among these, 2.2 were aborted.[17] According to the PDHS 2017–18 the high level of unmet need for family planning that continues to prevail also accounts for unintended pregnancies.[18]

The Population Council, Pakistan, in partnership with the Guttmacher Institute, conducted two earlier national abortion incidence studies, most recently in 2012 and an earlier one in 2002. Both studies were widely disseminated and paved the way for many partners to extend family planning and post-abortion care and medical abortion training to make abortions safer for women in Pakistan.

Comprehensive post-abortion care is an essential component of sexual and reproductive health. This study addresses the issue of the provision of comprehensive quality care in Pakistan, which varies across provinces, public and private sectors, and by type of facility. By comparing data gathered from preceding studies, we can assess if post-abortion care has changed over time towards more reliance on misoprostol to treat incomplete abortion instead of surgical methods, as recommended by WHO and government guidelines. Additionally, we examine whether greater reliance on misoprostol has strengthened the capacity of smaller facilities to offer post-abortion care, especially those located in rural areas. The study also looks at aspects of quality of care, such as the adequacy of training, the ability of smaller facilities to efficiently refer patients who need care to higher-level facilities, and the adequate availability of supplies and equipment.

## 1.3 | The Study

While laws relating to abortion are vaguely worded, there is broad recognition in Pakistan, including within government circles, that abortion is a common recourse for millions of Pakistani women facing unintended pregnancies. One of the key pieces of evidence used to advocate for the expansion of family planning services to the Council of Common Interests (CCI)—a coordination body headed by the Prime Minister with representation of the chief ministers of the federating units of the country—was the Population Council's study on unintended pregnancies and induced abortions. This led to the landmark decisions taken by the CCI in 2018.[19] A task force was set up on the orders of the Chief Justice of Pakistan in 2018 to develop a procedure to cope with the accelerating population growth.[20] The team came up with a set of recommendations to help increase the country's contraceptive prevalence rate (CPR) and lower the total fertility rate (TFR).[21] These recommendations were reviewed and endorsed by the CCI, the inter-provincial highest-level decision-making body, in November 2018. Subsequently, they became legally binding, making them a part of the country's roadmap for enhancing family planning through the collective efforts of concerned stakeholders, especially public sector bodies.[22]

There has been a significant demand for the study to examine the current situation regarding incidence of abortion, abortion complications, and the quality of post-abortion care. The deteriorating social and economic situation of families, coupled with emerging constraints on improving the health system, heighten the importance of generating evidence to inform policies and programs.

In response to this demand for information on women's health, especially regarding life-saving post-abortion care, the Guttmacher Institute and the Population Council collaborated on a study in 2023 to generate timely policy-relevant evidence. This evidence will be used to advocate for increased access to safe abortion services, high-quality comprehensive post-abortion care, and family planning. The study is the third of its kind since 2002, with a 10-year gap between each iteration.

The 2023 study obtains the views and experiences of healthcare providers from different levels of facilities on abortion-related healthcare. It was conducted from January to May 2023 and covered 596 health facilities spread across all provinces and regions of the country. Comparisons have also been made with the studies undertaken in 2002 and 2012 that used the same methodology.

## Objectives of the 2023 study

- **Measure the incidence of post-abortion complications** in public and private health facilities and among provinces across Pakistan and for urban and rural areas
- **Estimate the incidence of induced abortions and unintended pregnancies** nationally and by province
- **Assess the quality of post-abortion care** provided in public and private health facilities
- **Evaluate the readiness of health facilities** to offer abortion and post-abortion care services by level of facility in public and private sectors
- **Analyze the patterns of utilization** of abortion-related care by province and income group
- **Provide evidence** for national and provincial policies and programs to improve contraceptive and abortion services in public and private health facilities

## 1.4 | Organization of the Report

To address these objectives and to cover in-depth the critical strands of abortion and post-abortion care, this report is organized into distinct, yet interrelated, chapters.

**Chapter 2:** We first describe the design and methodology.

**Chapter 3:** Recognizing the importance of understanding the background characteristics of women seeking abortion, this chapter profiles women seeking induced abortion and their care-seeking behavior. It also provides information on methods and providers used by women in urban and rural areas, as well as by women from poor and non-poor backgrounds. Since the cost of abortion procedure and provider significantly impact women's choice and potential consequences, this chapter also explores these factors. Finally, the chapter concludes with estimates of the likelihood of experiencing complications by type of method and provider used, disaggregated by urban/rural and poor/non-poor women.

**Chapter 4:** Building on the information presented in Chapter 3 and incorporating additional data, this chapter provides estimated national and provincial incidence rates of treatment for post-abortion complications, along with treatment rates across public and private sectors, and by facility level. Comparisons are also made with the 2012 study to assess changes in complication rates.

**Chapter 5:** Recognizing the critical role of quality post-abortion care in treating complications, this chapter first examines the typical profile of women seeking post-abortion care. It then discusses procedures and providers for treating abortion-related complications, including perceived safety by type of method. The chapter explores the extent to which the increased use of medical procedures contributes to safer post-abortion care. Additionally, it assesses the critical elements of quality care, including availability of staff and equipment, access to transportation, and the capacity and training of healthcare providers to address post-abortion complications.

**Chapter 6:** Given the importance of family planning in preventing unintended pregnancies and repeat abortions, this chapter examines the readiness of health facilities, categorized by public and private sectors, to provide timely post-partum and post-abortion family planning counseling, methods, and/or referrals.

**Chapter 7:** The final chapter brings everything together, highlighting conclusions and policy recommendations emerging from the study. These recommendations aim to better address women's needs for preventing unintended pregnancies and for accessing abortion and post-abortion care.

CHAPTER 2

# Study Design and Methodology

To measure the incidence of abortion and post-abortion complications, we used the Abortion Incidence and Complications Method (AICM), which was applied previously in the 2002 and 2012 studies in Pakistan and in several other countries. AICM requires nationally representative surveys of (1) health facilities and (2) health professionals. The overall design of the 2023 study was based on AICM, a widely used indirect estimation technique employed in countries across the world. Developed by the Guttmacher Institute, this methodology estimates the number of women with post-abortion complications treated in health facilities to construct an estimate of the number and rates of induced abortions.[23] The two surveys required for the application of AICM are described below.

## 2.1 | Health Facilities Survey

A Health Facilities Survey (HFS) was used to collect critical information from healthcare institutions, encompassing teaching hospitals, District Headquarter Hospitals (DHQs), Tehsil Headquarter Hospitals (THQs), Rural Health Centers (RHCs), Basic Health Units (BHUs/BHU+) and Maternal and Child Health (MCH) centers in the public sector. Additionally, similar-sized health facilities in the private sector were included in the study. Public and private hospitals recognized by the Pakistan Medical and Dental Council (PMDC)/PHC that provide gynecology/obstetric services were included for sampling.

Utilizing a structured digital questionnaire, data collection involved interviews with healthcare providers working in gynecology or obstetrics departments within each facility. The primary objective of this investigation was to evaluate the capacity of these healthcare institutions to deliver high-quality post-abortion care services. The survey collected information related to service availability, staffing, medical procedures, and equipment. Furthermore, the study aimed to determine the number of women undergoing treatment for abortion-related complications.

### 2.1.1 | Sample Design for Health Facilities Survey

For sampling health facilities, a two-stage stratified probability-based design was employed. Research subjects (facilities) were stratified by sector (public/private) and facility level to ensure a sample that encompasses the full spectrum of service facilities in Pakistan. Further, we ensured wide geographic coverage within the sample, accounting for potential variations in access to post-abortion care across different regions. To achieve this, we considered all administrative divisions and selected two districts through random sampling. Each province was treated as an independent stratum to get a provincially representative sample of public and private health facilities.

The stratified sampling was done through disproportionate sample allocation across different strata using an allocation scheme to accommodate the representation of all administrative areas and provinces. This sample design resulted in statistically enough numbers from public and private health facilities categorized according to provinces and areas. The sample frame comprised public

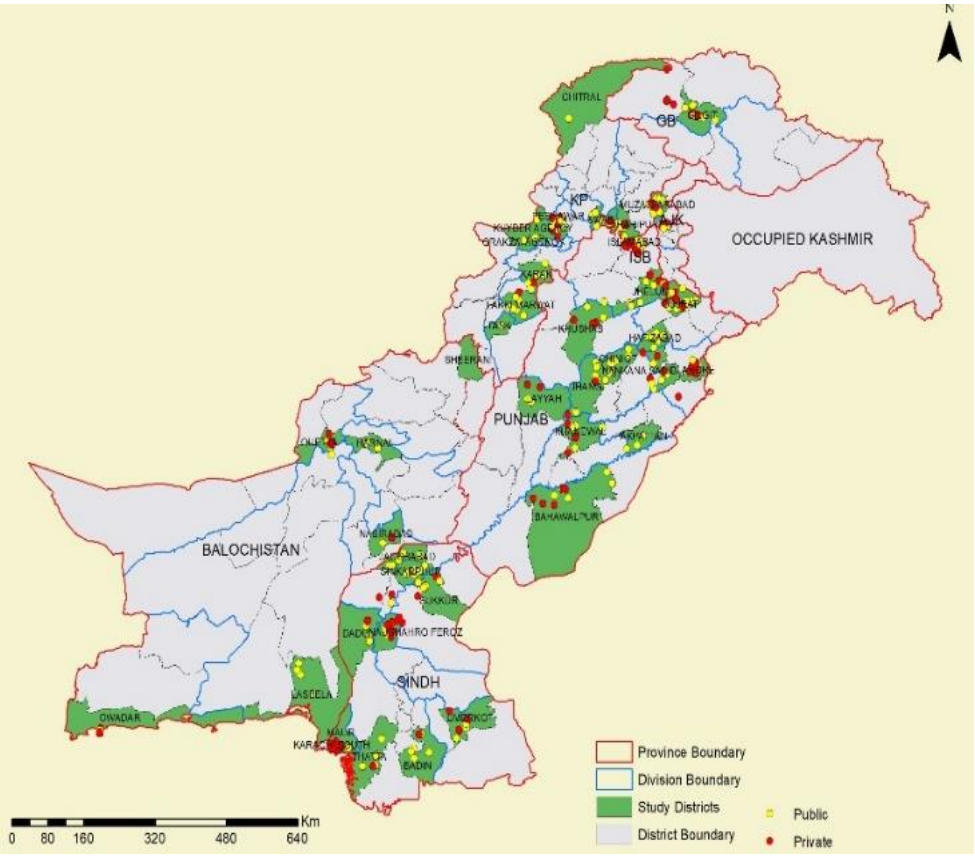
and private health facilities located in all provinces and administrative areas, yielding both nationally and provisionally representative samples.

### 2.1.2 | Sampling Approach

A representative sample was achieved by selecting at least one district from each administrative division of the country. Pakistan comprises 30 divisions across four provinces, including Islamabad Capital Territory (ICT), Gilgit-Baltistan (GB), and Azad Jammu and Kashmir (AJK) regions as separate divisions, thereby encompassing a total of 33 divisions in the population frame. Each division comprises of 3–4 districts.

Thirty-seven districts were shortlisted from across Pakistan, spanning Punjab, Sindh, Balochistan, and Khyber Pakhtunkhwa (KP), along with ICT, GB, and AJK. The selection process prioritized provincial and regional representation, resulting in a sample of 12 districts from Punjab, 10 from Sindh, 9 from KP, 6 from Balochistan, and one each from GB and AJK. Additionally, Islamabad was treated as a distinct entity in the sampling process. Figure 2.1 shows the geographical distribution of study districts and facilities sampled across Pakistan.

**Figure 2.1 | Geographical distribution of 2023 study districts and facilities**




#### Stage 1: Selecting districts for the Study Sample

The sample was drawn using a probability-based, two-stage, stratified sampling design. During the first stage, Pakistan was divided into 33 administrative divisions. Our sampling strategy involved a randomized selection process through which we picked one district from each of the divisions listed in Table 2.1. This approach aimed to ensure a broad and representative coverage of the country.

**Table 2.1 | Number of districts selected in each division and their population in the 2017 census**

| Province/region | Division | District (randomly selected) | Population in 2017 Census |
|---|---|---|---|
| Punjab (12 districts) | Bahawalpur | Bahawalpur | 3,669,176 |
| | D.G. Khan | Layyah | 1,823,995 |
| | Faisalabad | Chiniot | 1,368,659 |
| | | Jhang | 2,742,633 |
| | Gujranwala | Gujrat | 2,756,289 |
| | | Hafizabad | 1,156,954 |
| | Lahore | Lahore | 11,119,985 |
| | | Nankana sahib | 1,354,986 |
| | Multan | Khanewal | 2,920,233 |
| | Rawalpindi | Jhelum | 1,222,403 |
| | Sahiwal | Pakpattan | 1,824,228 |
| | Sargodha | Khushab | 1,280,372 |
| Sindh (10 districts) | Hyderabad | Badin | 1,804,958 |
| | | Dadu | 1,550,390 |
| | | Thatta | 982,138 |
| | Karachi | Malir | 1,924,346 |
| | | Karachi south | 1,769,230 |
| | Larkana | Jacobabad | 1,007,009 |
| | | Shikarpur | 1,233,760 |
| | Mirpur Khas | Umer kot | 1,073,469 |
| | Sukkur | Sukkur | 1,488,372 |
| | Shaheed Benazir Abad | Naushahro Feroze | 1,612,047 |
| KP (9 districts) | Bannu | Lakki Marwat | 875,744 |
| | Dera Ismail khan | Tank | 390,626 |
| | Hazara | Haripur | 1,001,515 |
| | Kohat | Karak | 705,362 |
| | | Orakzai | 254,303 |
| | Malakand | Chitral | 447,625 |
| | Mardan | Swabi | 1,625,477 |
| | Peshawar | Peshawar | 4,267,198 |
| | | Khyber | 984,246 |
| Balochistan (6 districts) | Kalat | Lasbela | 576,271 |
| | Mekran | Gwadar | 262,253 |
| | Nasirabad | Nasirabad | 487,847 |
| | Quetta | Quetta | 2,269,473 |
| | Sibi | Harnai | 97,052 |
| | Zhob | Sherani | 152,952 |
| Regions | | | |
| Islamabad (1 district) | Islamabad | | 2,003,368 |
| Azad Jamu Kashmir (1 district) | Muzaffarabad | | 650,330 |
| Gilgit-Baltistan (1 district) | Gilgit | | 330,000 |

## Stage 2: Sampling of health facilities

In the second stage, a list of public and private health facilities was obtained through different sources and compiled into a database. For the public sector, different provincial health departments were contacted. The process of obtaining a private sector list was challenging and entailed cumbersome research. Compiling an accurate and comprehensive list of private sector facilities required significant efforts on different fronts.

Firstly, we utilized the lists of those facilities that were registered with the Provincial Healthcare Commissions to start assembling the universe of private facilities. Since the list was based only on those facilities that self-registered, it was considered incomplete. We complemented it with a list of facilities served by pharmaceutical representatives who regularly scout the landscape of potential outlets. Lastly, we sent out interviewers to verify and add to the lists by visiting districts. While our list may still lack full coverage of all private facilities, we are confident that most of the facilities have been captured in the sampling frame used to draw the private sector facilities.

The selection of health facilities in both the public and private sectors was carried out through systematic sampling with a random start. This sample design does not possess inherent self-weighting characteristics. Consequently, sampling weights have been computed for all sample areas within each province or stratum. These weights play a crucial role in generating accurate estimates of survey variables.

We found that of the sampled facilities, seven facilities in the public sector and another seven in private sector had been closed, damaged, or were inoperative. Therefore, these facilities were replaced with facilities of a similar level, randomly selecting them from the original sampling list.

Tables 2.2 to 2.5 provide information on the selection of public and private facilities by province/region and level of facilities.

**Table 2.2 | Number of public health facilities in sample districts by geographic domain and percentage of universe**

| | | Pakistan | Punjab | Sindh | KP | Balochistan | AJK | Gilgit Baltistan | Islamabad |
|---|---|---|---|---|---|---|---|---|---|
| Teaching hospital | | | | | | | | | |
| U | (n) | 63 | 26 | 12 | 13 | 5 | 5 | 0 | 2 |
| S | (n) | 27 | 12 | 1 | 7 | 4 | 1 | 0 | 2 |
| S/U | (%) | 43 | 46 | 8 | 54 | 80 | 20 | 0 | 100 |
| DHQ | | | | | | | | | |
| U | (n) | 126 | 31 | 19 | 30 | 27 | 9 | 7 | 3 |
| S | (n) | 37 | 10 | 8 | 9 | 4 | 1 | 2 | 3 |
| S/U | (%) | 29 | 32 | 42 | 30 | 15 | 11 | 29 | 100 |
| THQ | | | | | | | | | |
| U | (n) | 251 | 130 | 60 | 36 | 4 | 16 | 5 | 0 |
| S | (n) | 83 | 47 | 17 | 15 | 0 | 1 | 3 | 0 |
| S/U | (%) | 33 | 36 | 28 | 42 | 0 | 6 | 60 | 0 |
| RHC | | | | | | | | | |
| U | (n) | 788 | 327 | 134 | 176 | 94 | 48 | 6 | 3 |
| S | (n) | 231 | 87 | 59 | 53 | 19 | 7 | 3 | 3 |
| S/U | (%) | 29 | 27 | 44 | 30 | 20 | 15 | 50 | 100 |
| BHU+ | | | | | | | | | |
| U | (n) | 1,750 | 1,342 | 369 | 0 | 39 | 0 | 0 | 0 |
| S | (n) | 487 | 360 | 115 | 0 | 12 | 0 | 0 | 0 |
| S/U | (%) | 28 | 27 | 31 | 0 | 31 | 0 | 0 | 0 |
| BHU | | | | | | | | | |
| U | (n) | 3,465 | 1,160 | 523 | 848 | 643 | 255 | 21 | 15 |
| S | (n) | 881 | 279 | 152 | 240 | 130 | 62 | 3 | 15 |
| S/U | (%) | 25 | 24 | 29 | 28 | 20 | 24 | 14 | 100 |
| MCH center | | | | | | | | | |
| U | (n) | 755 | 260 | 69 | 57 | 83 | 226 | 58 | 2 |
| S | (n) | 233 | 110 | 30 | 18 | 24 | 39 | 10 | 2 |
| S/U | (%) | 31 | 42 | 43 | 32 | 29 | 17 | 17 | 100 |
| Total | | | | | | | | | |
| U | (n) | 7,198 | 3,276 | 1,186 | 1,160 | 895 | 559 | 97 | 25 |
| S | (n) | 1,979 | 905 | 382 | 342 | 193 | 111 | 21 | 25 |
| S/U | (%) | 27 | 28 | 32 | 29 | 22 | 20 | 22 | 100 |

Sources: ICT; DHO Islamabad, Punjab; Primary & Secondary Health Department, Sindh; DHIS 2020, KP; DG Health and DHIS 2020, Balochistan; DG Health and DG Office Quetta, AJK; MNCH Program and Gilgit Baltistan; Health Department.
U = Universe; S = Sample.

## Table 2.3 | Number of private health facilities in sample districts by geographic domain and percentage of universe

| Domain | | | Pakistan | Punjab | Sindh | KP | Balochistan | AJK | Gilgit Baltistan | Islamabad (ICT) |
|---|---|---|---|---|---|---|---|---|---|---|
| **Tertiary level** | | | | | | | | | | |
| | U | (n) | 75 | 26 | 20 | 21 | 0 | 2 | 0 | 6 |
| | S | (n) | 54 | 19 | 15 | 12 | 0 | 2 | 0 | 6 |
| | S/U | (%) | 72 | 73 | 75 | 57 | 0 | 100 | 0 | 100 |
| **Secondary level** | | | | | | | | | | |
| | U | (n) | 629 | 245 | 315 | 6 | 24 | 2 | 9 | 28 |
| | S | (n) | 405 | 226 | 115 | 1 | 24 | 2 | 9 | 28 |
| | S/U | (%) | 64 | 92 | 37 | 17 | 100 | 100 | 100 | 100 |
| **Primary level** | | | | | | | | | | |
| | U | (n) | 5,053 | 4,039 | 724 | 202 | 20 | 14 | 16 | 38 |
| | S | (n) | 1,741 | 1,320 | 286 | 53 | 14 | 14 | 16 | 38 |
| | S/U | (%) | 34 | 33 | 40 | 26 | 70 | 100 | 100 | 100 |
| **Total** | | | | | | | | | | |
| | U | (n) | 5,757 | 4,310 | 1,059 | 229 | 44 | 18 | 25 | 72 |
| | S | (n) | 2,200 | 1,565 | 416 | 66 | 38 | 18 | 25 | 72 |
| | S/U | (%) | 38 | 36 | 39 | 29 | 86 | 100 | 100 | 100 |

Sources: ICT; Healthcare Commission Islamabad, Punjab; Urban Unit and IPAS, Sindh; Healthcare Commission Sindh, Balochistan; DG Office Quetta and DHO of all Districts, AJK; DHO Muzaffarabad, Kohli, Jhelum, Vally and Mirpur and Gilgit Baltistan; DG Office and PWD GB.

Tertiary level = Teaching Hospitals (Pvt.)
Secondary level = 20–80 bed ~ THQ +81/ more bed ~ DHQ
Primary level = 5–19 bed ~ RHC + 1-4 bed ~ BHU
U = Universe; S = Sample.

## Table 2.4 | Number of sampled public facilities by geographic domain and level of facility and percentage of full universe

| | Teaching hospital | | DHQ | | THQ | | RHC | | BHU+ | | BHU | | MCH center | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % | n | % | n | % | n | % | n | % |
| **Pakistan** | **12** | **19** | **25** | **20** | **22** | **9** | **57** | **7** | **63** | **4** | **70** | **2** | **41** | **5** | **290** | **4** |
| Punjab | 5 | 19 | 8 | 26 | 8 | 6 | 18 | 6 | 35 | 3 | 10 | 1 | 15 | 6 | 99 | 3 |
| Sindh | 1 | 8 | 6 | 32 | 7 | 12 | 10 | 7 | 18 | 5 | 8 | 2 | 5 | 7 | 55 | 5 |
| KP | 2 | 15 | 5 | 17 | 3 | 8 | 12 | 7 | 0 | 0 | 25 | 3 | 4 | 7 | 51 | 4 |
| Balochistan | 2 | 40 | 3 | 11 | 0 | 0 | 7 | 7 | 10 | 26 | 7 | 1 | 5 | 6 | 34 | 4 |
| AJK | 1 | 20 | 1 | 11 | 1 | 6 | 4 | 8 | 0 | 0 | 7 | 3 | 7 | 3 | 21 | 4 |
| Gilgit Baltistan | 0 | 0 | 1 | 14 | 3 | 60 | 3 | 50 | 0 | 0 | 3 | 14 | 4 | 7 | 14 | 14 |
| Islamabad (ICT) | 1 | 50 | 1 | 33 | 0 | 0 | 3 | 100 | 0 | 0 | 10 | 67 | 1 | 50 | 16 | 64 |

Source: The Health Management Information System (HMIS) covers the provincial health departments of Pakistan in 2022.

**Table 2.5 | Number of sampled private facilities by geographic domain and level of facility and percentage of universe**

| | Tertiary level | | Secondary level | | Primary level | | Total | |
|---|---|---|---|---|---|---|---|---|
| | n | % | n | % | n | % | n | % |
| **Pakistan** | **13** | **17** | **68** | **11** | **219** | **4** | **300** | **5** |
| Punjab | 3 | 12 | 22 | 9 | 109 | 3 | 134 | 3 |
| Sindh | 3 | 15 | 22 | 7 | 46 | 6 | 71 | 7 |
| KP | 3 | 14 | 0 | 0 | 21 | 10 | 24 | 10 |
| Balochistan | 0 | 0 | 8 | 33 | 9 | 45 | 17 | 39 |
| AJK | 2 | 100 | 2 | 100 | 9 | 64 | 13 | 72 |
| Gilgit Baltistan | 0 | 0 | 6 | 67 | 10 | 63 | 16 | 64 |
| Islamabad (ICT) | 2 | 33 | 8 | 29 | 15 | 39 | 25 | 35 |

Tertiary level = Teaching Hospitals (Pvt.)
Secondary level = 20–80 bed ~ THQ +81/ more bed ~ DHQ
Primary level = 5–19 bed ~ RHC + 1-4 bed ~ BHU

## 2.2 | Health Professionals Survey

The Health Professionals Survey (HPS) involved interviewing a diverse group of healthcare professionals, comprising gynecologists, female doctors, lady health visitors (LHVs), nurses/midwives, health managers, as well as researchers and policymakers with knowledge and expertise related to abortion and post-abortion care. The HPS was designed to capture the perspectives of these health professionals on induced abortion and post-abortion complications. It sought to gather their insights independently of their specific affiliations with facilities or organizations, aiming for a comprehensive understanding of their views and experiences in the broader context of abortion-related healthcare. The facility sample frame provided the basis for the HPS. The targeted sample size of 162 professionals representing a diverse range of professions was divided into five categories: general physicians/ WMO (category I), obstetricians / gynecologists (category II), mid-level providers such as, nurses, midwives and LHVs (category III), non-medical professionals including policymakers and policy advisors (category IV), and, lastly, health sector journalists, media, and researchers (category V). These categories of professionals were interviewed in all regions as illustrated in Table 2.6.

**Table 2.6 | Number and category of interviewed health professionals by province**

| | General physician/WMO n | Obstetrician/ Gynecologist n | Nurse/Midwife/ LHV n | Policy maker/ policy advisor n | Journalist /media Researcher n | Total n |
|---|---|---|---|---|---|---|
| **Punjab** | **12** | **7** | **7** | **6** | **2** | **34** |
| KP | 8 | 7 | 4 | 2 | 0 | 21 |
| Sindh | 7 | 8 | 6 | 5 | 1 | 27 |
| Balochistan | 5 | 3 | 7 | 1 | 0 | 16 |
| Islamabad (ICT) | 4 | 5 | 6 | 13 | 6 | 34 |
| GB | 5 | 3 | 6 | 0 | 0 | 14 |
| AJK | 3 | 6 | 7 | 0 | 0 | 16 |

Source: HPS 2023.

The HPS questionnaire was revised to align with the HPS previously fielded in Zimbabwe and included additional topics. Broadly, the domains of the HPS questionnaire were:

1. Identification
2. Module i: Basic information
3. Module ii: Service provision
4. Module iii: Abortion complications
5. Module iv: Opinions and attitudes of service providers
6. Module v: General

## 2.3 | Computation of Weights for Public and Private Sectors

As the objective of this study was to provide a comprehensive overview of post-abortion care on a national scale, it was crucial to establish weights. This was to enable the conversion of sample findings into national estimates of abortion-related complications. This process was implemented during the 2023 HFS.

The District Health Management Information System (HMIS) records the details of public sector facilities, including their numbers and bed capacity. We computed weights (w) for each type of facility—consisting of those that had the capacity to provide basic care and others that provided comprehensive care, among others.

The computation was based on the average size of beds of health facilities within each geographical zone: Punjab, Sindh, Balochistan, KP, AJK, GB, and ICT. Weights were derived by dividing the total bed count for each facility type (for instance, primary-level, mid-level and higher-level) in a province by the total universe of beds in that province. Ultimately, the weights obtained through the estimation of bed-size were utilized to present nationwide public sector data. Table 2.7 provides details of the weights used by facility level, sector, and province/region.

**Table 2.7 | Final weights proposed based on sampled facilities and corresponding numbers in the public and private universe of health facilities by level, province, and region**

| | | Final Weights | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Level of facility | Punjab | Sindh | KP | Balochistan | AJK | GB | ICT |
| **Public** | | | | | | | | |
| | Higher facility | na | 1.00 | na | na | na | na | na |
| | Teaching hospital | 5.20 | 5.00 | 5.50 | 2.00 | 2.00 | 0.00 | 2.00 |
| | DHQ | 3.00 | 2.13 | 6.40 | 9.00 | 9.00 | 7.00 | 0.00 |
| | THQ | 15.13 | 8.57 | 12.00 | 0.00 | 16.00 | 3.33 | 0.00 |
| | RHC | 18.17 | 13.40 | 9.42 | 15.70 | 12.00 | 0.00 | 1.00 |
| | BHU+ | 53.23 | 37.20 | 0.00 | 37.90 | 0.00 | 0.00 | 0.00 |
| | BHU | 53.23 | 37.20 | 33.92 | 37.90 | 36.43 | 5.25 | 1.67 |
| | MCH center | 17.33 | 11.50 | 14.25 | 13.83 | 32.28 | 9.67 | 2.00 |
| **Private** | | | | | | | | |
| | Tertiary level | 5.33 | 5.67 | 3.33 | 0.00 | 1.00 | 0.00 | 1.50 |
| | Secondary level | 11.14 | 16.58 | 3.00 | 3.43 | 1.00 | 2.25 | 2.00 |
| | Primary level | 36.7 | 7.54 | 9.05 | 2.22 | 1.71 | 3.17 | 4.22 |

**Source:** HFS 2023. na = not applicable.

Importantly, the 2023 study is considered more representative of the health system and reflects the growth of facilities between 2012 and 2023. The addition of public sector primary health care facilities has also enhanced the representativeness of the sample of facilities.

Table 2.8 shows a considerable increase in the number of facilities that are part of the public sector health system, rising from 922 to 7,105. This increase is mainly due to the addition of BHUs, BHU+, and MCH centers, which make up a significant number of facilities in the public health system. Even without these entities, the universe represented in the 2023 study is 1,134 facilities, representing a 22% increase since 2012.

The private sector universe has also increased between 2012 and 2023. The overall number of private facilities has increased more than threefold from 1,472 to 5,312. The major increase is in primary level facilities in the private sector, rising from 1,077 to 4,630 in 11 years.

## Table 2.8 | Weighted and unweighted numbers of public and private facilities by level and province/regions

| | Pakistan | | | | Punjab | | | | Sindh | | | | KP | | | | Balochistan | | | | AJK | | GB | | Islamabad | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2012 | | 2023 | | 2012 | | 2023 | | 2012 | | 2023 | | 2012 | | 2023 | | 2012 | | 2023 | | 2023 | | 2023 | | 2023 | |
| | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW | W | UW |
| **Public** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Higher facility | na | na | 1 | 1 | Na | na | 0 | 0 | na | na | 1 | 1 | na | na | 0 | 0 | na | na | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Teaching | 35 | 33 | 55 | 13 | 19 | 17 | 26 | 5 | 9 | 9 | 10 | 2 | 6 | 5 | 11 | 2 | 2 | 2 | 4 | 2 | 2 | 1 | 0 | 0 | 2 | 1 |
| DHQ | 107 | 24 | 116 | 26 | 33 | 10 | 24 | 8 | 12 | 8 | 17 | 8 | 24 | 3 | 32 | 5 | 38 | 3 | 27 | 3 | 9 | 1 | 7 | 1 | 0 | 0 |
| THQ | 155 | 44 | 243 | 22 | 72 | 20 | 121 | 8 | 43 | 15 | 60 | 7 | 30 | 6 | 36 | 3 | 9 | 3 | 0 | 0 | 16 | 1 | 10 | 3 | 0 | 0 |
| RHC | 625 | 63 | 719 | 53 | 322 | 30 | 327 | 18 | 141 | 17 | 134 | 10 | 92 | 9 | 113 | 12 | 69 | 7 | 94 | 6 | 48 | 4 | 0 | 0 | 3 | 3 |
| **Total** | **922** | **164** | **1134** | **115** | **446** | **77** | **498** | **39** | **205** | **49** | **221** | **27** | **153** | **23** | **192** | **22** | **118** | **15** | **125** | **11** | **75** | **7** | **17** | **4** | **5** | **4** |
| BHU | na | na | 3134 | 91 | Na | na | 905 | 17 | na | na | 484 | 13 | na | na | 848 | 25 | na | na | 606 | 16 | 255 | 7 | 21 | 4 | 15 | 9 |
| BHU+ | na | na | 2082 | 43 | Na | na | 1597 | 30 | na | na | 409 | 11 | na | na | 0 | 0 | na | na | 76 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| MCH | na | na | 755 | 45 | Na | na | 260 | 15 | na | na | 69 | 6 | na | na | 57 | 4 | na | na | 83 | 6 | 226 | 7 | 58 | 6 | 2 | 1 |
| **Total** | **0** | **0** | **5971** | **179** | **0** | **0** | **2762** | **62** | **0** | **0** | **962** | **30** | **0** | **0** | **905** | **29** | **0** | **0** | **765** | **24** | **481** | **14** | **79** | **10** | **17** | **10** |
| **Public overall** | **922** | **164** | **7105** | **294** | **446** | **77** | **3260** | **101** | **205** | **49** | **1183** | **57** | **153** | **23** | **1097** | **51** | **118** | **15** | **890** | **35** | **556** | **21** | **96** | **14** | **22** | **14** |
| **Private** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tertiary level | 32 | 21 | 51 | 15 | 11 | 7 | 16 | 3 | 15 | 10 | 17 | 3 | 7 | 4 | 10 | 3 | 0 | 0 | 0 | 0 | 2 | 2 | 0 | 0 | 6 | 4 |
| Secondary level | 362 | 16 | 631 | 72 | 307 | 9 | 245 | 22 | 50 | 5 | 315 | 19 | 4 | 1 | 6 | 2 | 1 | 1 | 24 | 7 | 4 | 4 | 9 | 4 | 28 | 14 |
| Primary level | 1077 | 65 | 4630 | 214 | 606 | 40 | 3964 | 108 | 273 | 15 | 362 | 48 | 76 | 5 | 199 | 22 | 121 | 5 | 18 | 8 | 12 | 7 | 38 | 12 | 38 | 9 |
| **Private overall** | **1472** | **102** | **5312** | **301** | **924** | **56** | **4225** | **133** | **338** | **30** | **694** | **70** | **87** | **10** | **215** | **27** | **122** | **6** | **42** | **15** | **18** | **13** | **47** | **16** | **72** | **27** |
| Public | 922 | 164 | 7105 | 294 | 446 | 77 | 3260 | 101 | 205 | 49 | 1183 | 57 | 153 | 23 | 1097 | 51 | 118 | 15 | 890 | 35 | 556 | 21 | 96 | 14 | 22 | 14 |
| Private | 1472 | 102 | 5312 | 301 | 924 | 56 | 4225 | 133 | 338 | 30 | 694 | 70 | 87 | 10 | 215 | 27 | 122 | 6 | 42 | 15 | 18 | 13 | 47 | 16 | 72 | 27 |
| **Overall** | **2394** | **266** | **12418** | **595** | **1370** | **133** | **7485** | **234** | **544** | **79** | **1877** | **127** | **240** | **33** | **1312** | **78** | **240** | **21** | **932** | **50** | **574** | **34** | **143** | **30** | **94** | **41** |

Source: HFS 2012, 2023. W = Weighted; UW = Unweighted. na = not applicable.

## 2.4 | Technical Advisory Group (TAG)

In the preparatory phase, we established a Technical Advisory Group (TAG) comprising prominent reproductive health specialists in Pakistan (see Annex 2). This group provided technical guidance related to research, particularly on study tools. Additionally, TAG gave feedback during different phases of the study's implementation and contributed to the formulation of recommendations. We held three TAG meetings during the study.

The first TAG meeting was held on September 14, 2022, as a preliminary consultation before finalizing the study. TAG members received a briefing on the study design, scope, domain, duration, sampling strategy, and data collection tools. Based on their feedback, we included additional districts to increase the geographical spread of the study and make the sample more nationally representative. We also updated the data collection tools based on TAG recommendations.

The second meeting occurred on November 4, 2022. TAG members were briefed on the study's progress, especially approvals from local and international Institutional Review Boards (IRBs) and preparations for data collection.

In the third meeting occurred on July 23,2024, we shared the initial findings of the study and sought feedback from TAG members for dissemination of the findings and for further analysis.

## 2.5 | Ethical Considerations

The IRBs of both the Population Council and Guttmacher Institute granted ethical permission for the study on May 23, 2022, before the start of fieldwork. On September 13, 2022, the Health Services Academy (HSA) approved the study and granted further permission in accordance with national ethical protocol (see Annex 1). Prior to the start of the training, the National Institute of Population Studies (NIPS) also received district and provincial administrative approvals to start field work.

Before starting interview, the interviewers briefed respondents about the purpose of the study and their right to decline or stop the interview. They also explained the procedures that would be used to ensure privacy and confidentiality. Only those who provided their informed consent to participate in the study were interviewed.

## 2.6 | Training of Field Staff


The responsibility of hiring staff to conduct fieldwork was outsourced to the National Institute of Population Studies (NIPS). Candidates were shortlisted after being interviewed both telephonically and in-person by the Population Council's study management team and NIPS.

Most interviewers were medical doctors, who were better suited to the survey content since the survey questions required an understanding of medical terms. Doctors were found to comprehend the purpose of the survey and to be more comfortable asking technical questions.

Training was conducted by staff of the Population Council and included pre-testing over two days. It covered interviewing techniques, the design and content of the questionnaires, and building the capacity of trainees to ask questions through mock interviews.

In Islamabad, the training was held in the NIPS office and included teams from Punjab, Balochistan, GB, AJK, and KP. The training for the team in Sindh took place in Karachi. Data collection began immediately after interviewer training.

## 2.7 | Data Collection

To ensure speed and efficiency in concurrent data collection, teams were split into seven groups: two from Punjab, three from Sindh, two from KP, one from Balochistan, one from GB, and one from AJK.

The mobile application "Do Forms" was used for collecting data and monitoring the day-to-day progress of fieldwork.

Due to the severely cold temperatures in Balochistan, GB, and AJK in January–February 2022, districts in GB had to be substituted when interviewers were unable to reach their destinations due to bad weather. This resulted in a temporary halt to the fieldwork in some cases. Only in one district in GB did we exhaust the sample of facilities and decided to take on some additional equivalent facilities from the adjacent district.

## 2.8 | Data Management and Analysis

Tablet computers were used to collect, compile, process, and archive data efficiently. Instant feedback was provided to the teams in the event of any data discrepancies. After the data were cleaned, the datasets underwent rigorous scrutiny to identify and rectify any inconsistencies.

An extensive process of data cleaning was employed for both HFS and HPS. This involved checking for inconsistencies or anomalies to ensure quality and reliability. Furthermore, a significant number of health professionals and respondents from health facilities were re-contacted telephonically to reconfirm the accuracy and reliability of portions of the collected data.

Data analysis was carried out using SPSS version 25. The original data were re-coded to present it in a tabular form. The reported results included means, proportions, descriptive statistics, percentage distributions, two and three-way cross-tabulations of variables of interest, and an aggregate count of events such as abortions and complications related to abortions.

## 2.9 | Study Strengths

The study employs an internationally recognized methodology for estimating abortions and abortion complications that has evolved over two decades and has been utilized in several countries globally. The core of the questionnaire remains similar, and the study has been conducted in Pakistan by the Population Council in 2002, 2012, and now in 2023. The staff of Population Council and Guttmacher Institute who worked on the study have participated in several studies, possessing the capability to adapt this methodology in Pakistan.

The survey's geographic scope was expanded at the suggestion of the Technical Advisory Group to include two new regions, GB, and AJK, as well as ICT as a separate stratum, unlike last time when it was included in Punjab. Consequently, the 2023 study is more representative of the nation than the previous two rounds.

We also expanded the programmatic scope of the study in two ways: by including lower-level facilities such as BHUs, BHU+, and MCH centers in the public sector, and by obtaining a more representative sample of the private sector. This is because of deliberate efforts through the Essential Service Package, the move towards universal primary health care coverage, the National Health Support Program, and other initiatives to improve the quality of primary health care to include basic reproductive health services.[24] Additionally, there is definitive evidence of the expanding private sector catering to deliveries and other reproductive health services. However, most of this expansion is undocumented, and a significant part of the study in its initial phases was devoted to obtaining a much more accurate reflection of the universe of private sector reproductive health facilities.

## 2.10 | Study Limitations

The study sampling was based on the best available sampling universe of facilities in both public and private sectors. While such a universe is available for public sector health facilities, we updated information, especially for smaller facilities such as BHUs and MCH centers, telephonically.

A comprehensive list of all private sector facilities does not exist. Compiling the private sector master list took several months and involved multiple channels of information. We constructed a listing of different levels of private health facilities using data from healthcare commissions, pharmaceutical listings, and an array of other sources, including our own outreach in each of the sampled districts.

While every effort was made to sample carefully within available resources to obtain enough numbers of facilities across geographic domains and facility levels, the sample sizes of lower-level facilities like BHUs in the public sector and smaller facilities in the private sector posed a challenge. Since the mean number of post-abortion care cases in these facilities are relatively small, the weights for these facilities are quite high, leading to some degree of uncertainty regarding the total numbers of cases estimated for these facilities.

The teams tried to conduct interviews in all selected facilities but encountered challenges in the field due to refusals, and weather-related delays and difficulties. A total of 610 interviews were successfully conducted, constituting 90.8% of the 672 planned interviews. Refusals were encountered in 23 cases, making up 3.4% of the total interviews. Additionally, 39 interviews were replaced due to refusals or other reasons, accounting for 5.8% of the total interviews.

While every effort was made to closely monitor data quality, some interviews had to be repeated after quality checks. The study did not interview women directly due to the sensitivity of the topic and to preserve their privacy and confidentiality. Therefore, information about the profile of women seeking abortion and post-abortion care was indirectly obtained from health professionals and based on their perception and experiences.

CHAPTER 3

# Profile and Care Sought by Women Seeking induced Abortion

- Women typically seeking abortions in 2023 were reported to be young (under 35 years old) and with four or fewer children.
- Women seeking abortions are more likely to be poor and from rural areas compared to those who are non-poor and from urban areas.
- Non-poor women are most likely to consult doctors for abortion care.
- Poor women are more likely to seek care from midwives, nurses, or traditional providers (dais). A substantial proportion (37%) also chose to self-induce abortions.
- Women seeking abortion care from doctors are likely to report using surgical procedures: dilatation and curettage (D&C), electric vacuum aspiration (EVA), manual vacuum aspiration (MVA), along with misoprostol.
- Paramedics are most likely to provide D&E and D&C, followed by misoprostol.
- Traditional providers (dais) primarily provide misoprostol for most abortion cases
- The highest percentage of misoprostol use was reported among urban poor women, while surgical methods are most commonly used by the urban non-poor women.

Induced abortion in Pakistan is legally permitted to provide "necessary treatment" under specific conditions to save a woman's life. The law allows abortions based on the recommendation of health providers assessing dangers to women's lives, offering restricted but available options. Due to some flexibility in the interpretation of the law, many providers in private practice do offer safe abortion services. The public health system, on the other hand, is mandated to provide post-abortion care as part of reproductive health services. Although the provision of legally permissible abortion is part of the services they ought to provide, in practice few, if any, public sector facilities provide abortion care.

This chapter describes the socio-economic and demographic profile of women who seek induced abortion as reported by health professionals interviewed in the Health Professionals Survey (HPS). The characteristics of women seeking abortion are compared with earlier rounds of similar surveys carried out in 2002 and 2012 using the same methodology. We have estimated the range of costs associated with abortions corresponding to different types of service providers.* Furthermore, data from the 2023 HPS have been used to analyze the patterns of abortion-related care of four groups of

*Providers range from doctors, paramedics, pharmacists, traditional providers (dais) (anyone without formal training) to women who self-managed their abortion.

women categorized as poor and non-poor,† and further sub-categorized as rural and urban. We can identify the types of providers and the methods used for abortions across these groups. The abortion methods used range from surgical procedures to medication abortion, and other methods. Lastly, the chapter includes the views of the HPS respondents on the likelihood of women experiencing complications based on the type of service provider and type of method used.

## 3.1 | Profile of Women Who Seek Induced Abortions

Table 3.1 presents data based on information obtained in the HPS, where respondents (health professionals) were asked about their perception of the demographic characteristics of women who typically seek induced abortions in Pakistan. These characteristics include age, marital status, education, number of children, residence, economic status, and whether they are likely to be accompanied by someone and by whom.

**Table 3.1 | Reported background characteristics of women who most commonly seek abortions**

| Characteristics | 2012 (%) | 2023 (%) |
|---|---|---|
| Age group | | |
| 15–19 | 5 | — |
| 20–24 | 9 | 13 |
| 25–29 | 23 | 30 |
| 30–34 | 38 | 30 |
| 35–39 | 21 | 23 |
| 40 or more | 5 | 5 |
| Number of living children | | |
| None | 8 | 1 |
| 1 to 2 | 4 | 12 |
| 3 to 4 | 23 | 43 |
| 5 or more | 65 | 44 |
| Usually accompanied by women seeking abortion | | |
| Alone | 10 | 18 |
| Husband | 31 | 44 |
| Mother-in-law | 26 | 43 |
| Sister | 16 | 43 |
| Relatives | 54 | 54 |
| Friends | 30 | 22 |
| Mother | 7 | 7 |
| Others | 3 | 9 |
| Number of respondents | (102) | (162) |

Source: HPS 2012, 2023.

In 2023, the typical women who sought abortions were most likely to be married (94%) (data not shown) and belonged equally to the age groups of 25–29 (30%) and 30–34 (30%). In 2012, a greater proportion of women (65%) were reported to be of high parity, with five or more children, compared to 44% in 2023. In 2023, women were more likely to be accompanied by their husbands (44%) compared to 31% in 2012, indicating an increase in the level of support and involvement of husbands in abortion care over the years.

## 3.2 | Methods of Abortion Used by Women Seeking Abortions

The HPS included questions to health professionals about the range of methods currently being used in Pakistan for induced abortions. Figures 3.1 presents the proportion of respondents who indicated

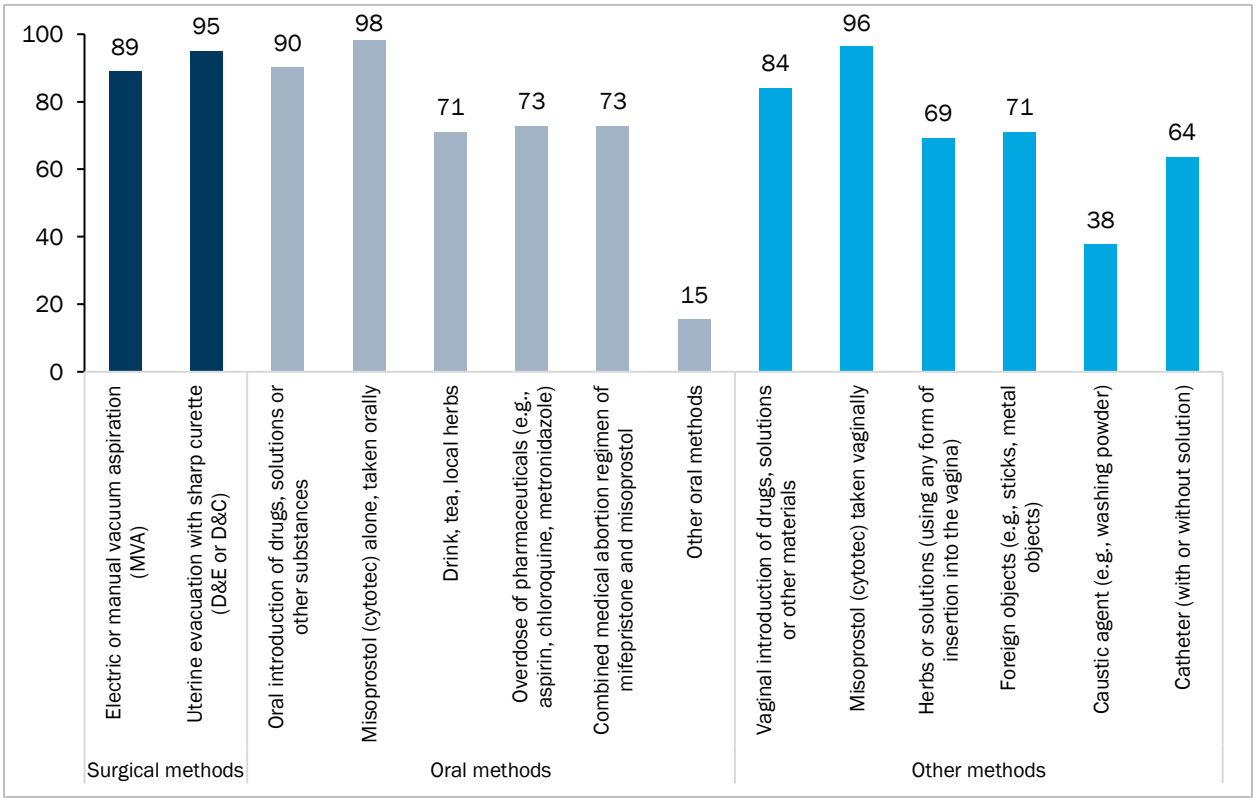
† "Poor" = women with monthly household income of less than 25,000 PKR.

a particular method in their responses. A majority reported using MVA (89%), D&E or D&C (95%), and above all, misoprostol (98%) as being used for induced abortions.

Additionally, a very high proportion of respondents also reported the administration of drugs, solutions, or substances other than misoprostol orally to induce abortion (90%). Other oral methods such as tea and herbs (71%) and an overdose of pharmaceuticals (73%) was less frequently reported.

In the case of methods other than oral and surgical, almost all respondents reported the use of Cytotec, a medication containing misoprostol, vaginally (96%) followed by the vaginal introduction of other drugs, solutions, or materials, reportedly used to induce abortion by 84% of respondents (Figure 3.1). It was surprising to find that some other methods such as herbs or solutions (69%), foreign objects (e.g., sticks, metal objects) (71%), caustic agents such as washing powder (38%), and catheter (64%) were still reported as being used for abortions.

**Figure 3.1 | Percentage of health professionals reporting the likelihood of use of a range of methods for induced abortion**




Source: HPS 2023. Multiple responses permitted.

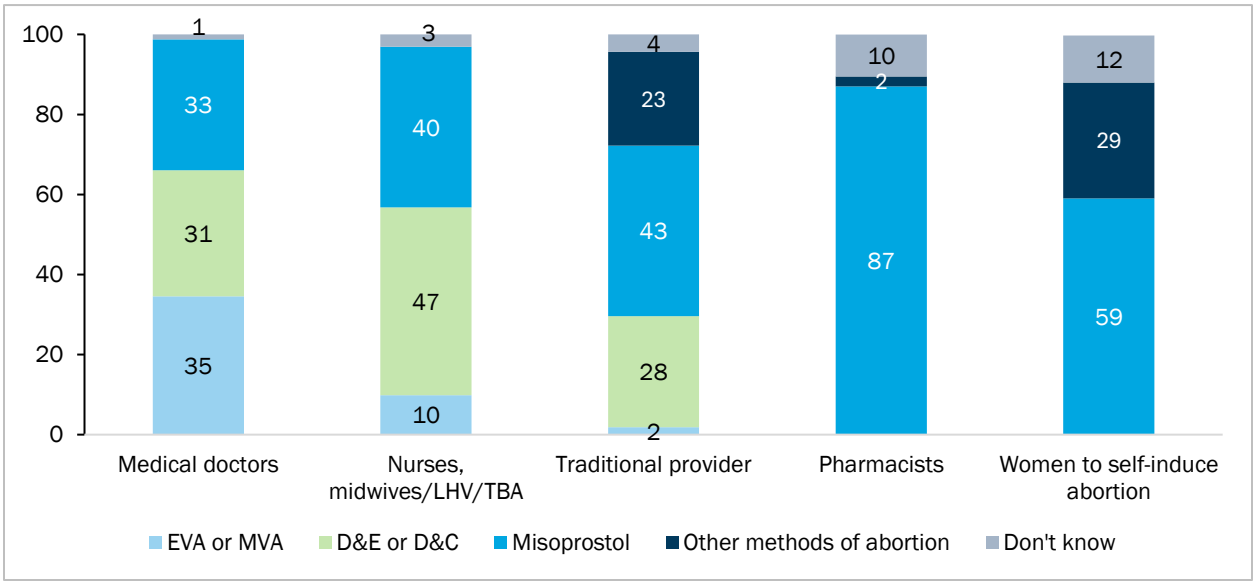
Results reveal that doctors were almost equally likely to use two surgical procedures (D&C and electric or manual vacuum aspiration) and medication abortion (misoprostol) for inducing abortion (Figure 3.2).

HPS respondents perceive nurses/midwives/LHV/TBA or other trained providers to most frequently provide abortion using D&E and D&C to terminate pregnancies, using the method in 47% of the cases. Misoprostol is given in 40% of the cases which is an encouraging finding and implies the possibility of engaging with these mid-level practitioners to use the drug more often for induced

abortion in a safer manner. A very small proportion of this category of service providers use EVA or MVA, implying they are either reluctant or not trained to provide this procedure.

Traditional providers (dais) reportedly provide misoprostol in 43% of abortion cases. They are less likely to provide surgical procedures, probably owing to a capacity deficit, though D&E and D&C are again second in their range of methods for terminating pregnancies (47%). Almost all pharmacists, when consulted, offer misoprostol as the most common method for induced abortion. Women who self-induce are likely to use misoprostol in most cases (59%), while the remaining one-third use other unspecified methods (29%).

**Figure 3.2 | Percentage distribution of the method commonly utilized for induced abortions by type of provider**




Source: HPS 2023.

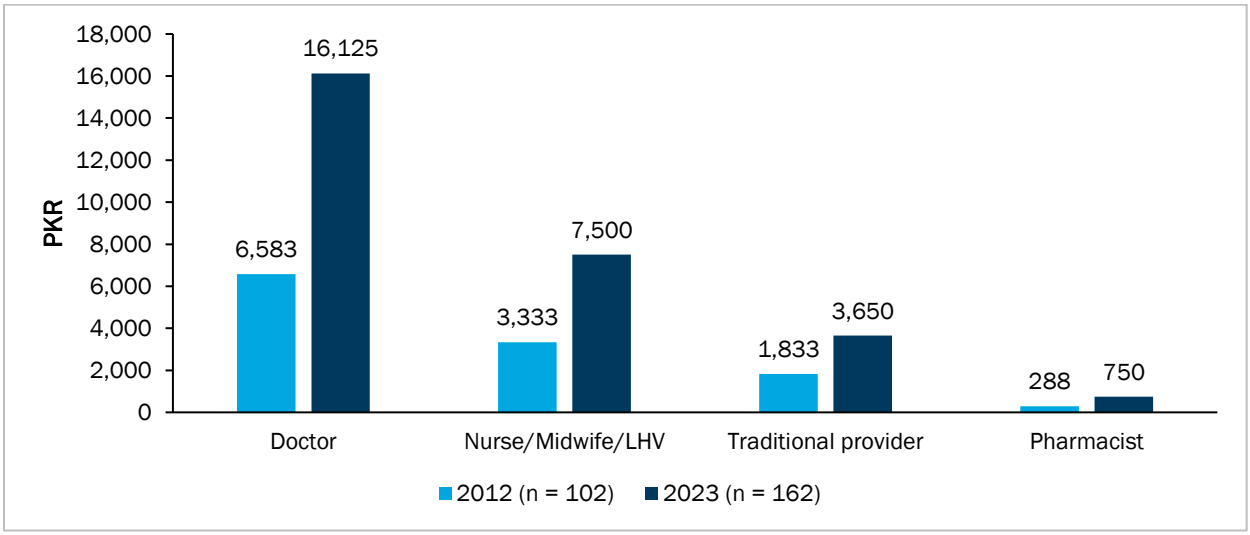
## 3.3 | Costs of Abortion

The cost of induced abortion stands out as a major challenge for many women seeking to terminate an unwanted pregnancy and may limit their choice of providers. Figure 3.3 gives a breakdown of the range of costs by level and type of service provider. Respondents provided minimum and maximum amounts, from which we computed the median cost of abortion.

As expected, doctors charge the highest fee for performing induced abortion, with a median figure of Rs 16,000 and a range varying from Rs 250 to Rs. 260,000. Nurses/midwives, on the other hand, charges range from Rs 750 to Rs 52,500, with a median value of Rs. 7,500 in 2023. The median cost of abortion performed by traditional providers is Rs. 3,650. The least expensive option for obtaining an abortion is through pharmacists who recommend medication abortion using a pill such as misoprostol, with a median cost of Rs 750.

Comparable data were not available for 2012 when respondents were asked to estimate costs rather than provide a range. it was observed that the mean cost for each type of provider in 2012 was lower than the mean cost computed at the lower end of the range in 2023. The upper end of the range was reported to be much higher in 2023. There is a definite increase in costs, though perhaps not as dramatic as expected given inflation over the last 10 years.

**Figure 3.3 | Median cost of abortion (in rupees) by type of provider**



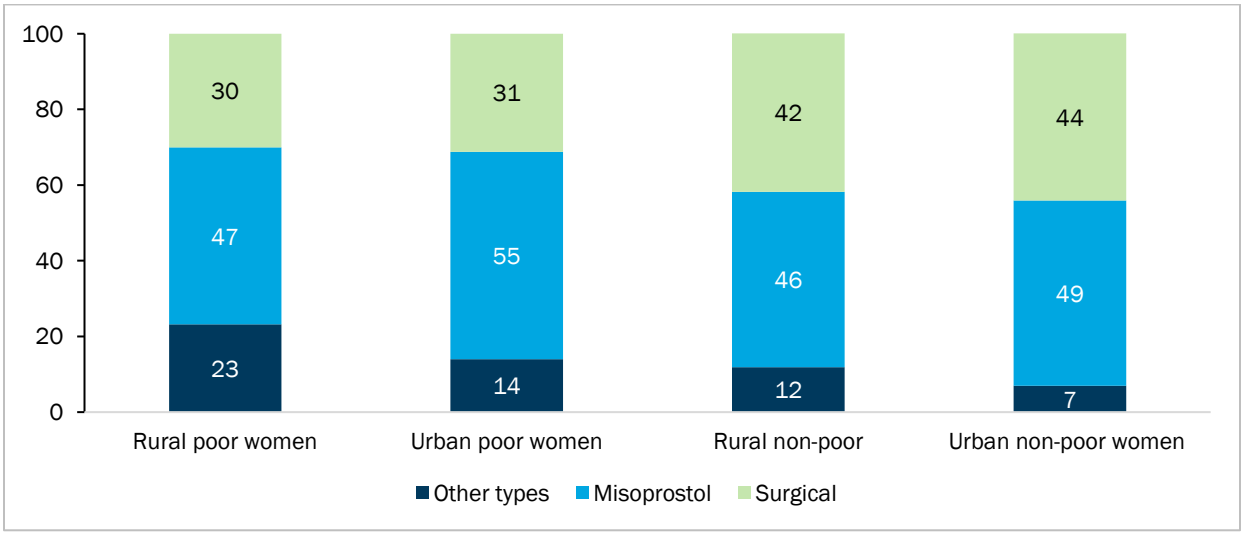

Source: HPS 2012, 2023.

## 3.4 | Choice of Abortion Methods and Providers

Earlier, we examined health professionals' perceptions regarding the service providers likely to be chosen by poor and non-poor women. We now delve further into HPS respondents' estimates of the distribution of poor and non-poor women in urban and rural areas according to the abortion methods they use (Figure 3.4). Responses are expected to reflect the information, availability, and affordability of the three major types of methods for the four diverse subgroups of women.

The most striking finding is the high level of misoprostol use by all four subgroups, regardless of income and residence—reflecting its pervasive availability and utilization across Pakistan. The next most used are surgical methods, which are higher among non-poor women (42–44%) compared to poor women (31–30%). This is balanced by higher reliance on "Other" methods among poor women (7–12%) compared to nonpoor women (14–23%).

**Figure 3.4 | Percentage distribution of methods used for induced abortions among rural and urban women by socioeconomic status**




Source: HPS 2023.

Table 3.2 provides integrated information on the choice of method and provider by women of different economic standings from urban and rural areas.

When responses about the choice of provider and type of method used for an abortion are combined, it presents interesting differences by economic and residential grouping.

The most common method used by urban poor women who had an abortion was misoprostol obtained from a nurse/midwife/LHV/TBA or other trained providers (18.2%) followed by doctors (15.5%). Among urban non-poor women, a large proportion also obtained, misoprostol from doctors (23.1%), though a significant percentage underwent a surgical abortion performed by a doctor (27.1%).

Economic power appears to be a stronger determinant of provider choice than residence. Rural poor women, like urban poor women, utilize nurses/midwives/LHVs/TBAs or other trained providers and obtain medication or surgical abortions from this group of providers (14.6% and 17.8% respectively). Rural non-poor women, also like urban non-poor counterparts, are most likely to obtain abortion services from doctors for both surgical methods and misoprostol (20.6% and 18.3% respectively).

**Table 3.2 | Percentage distribution of women by combination of method of abortion used and provider type, by socio-economic and residence subgroups**

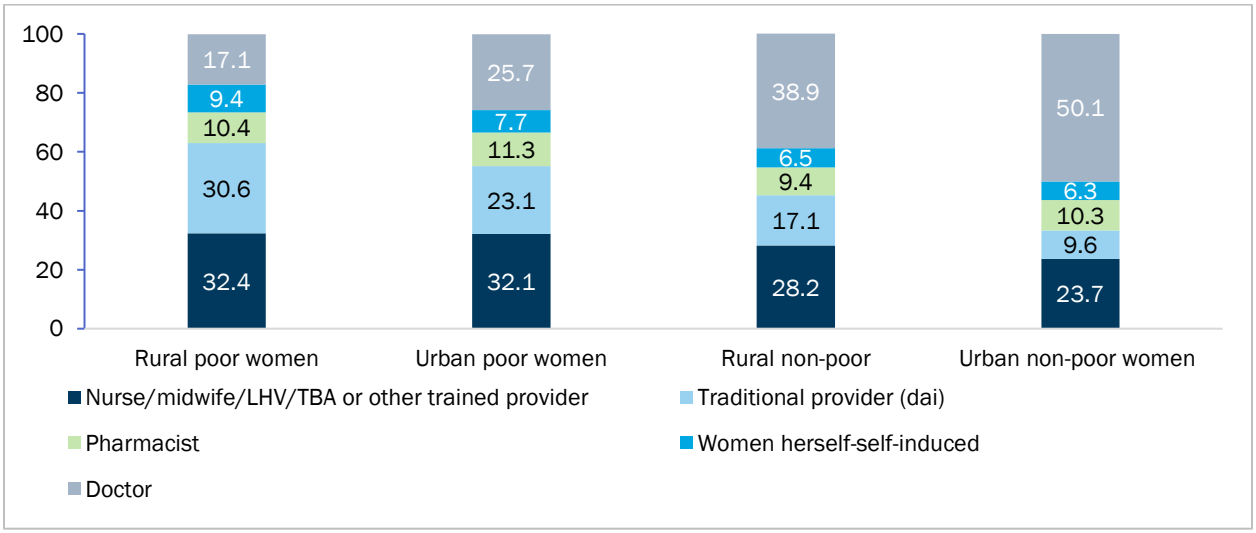
| | Method of abortion | | | |
|---|---|---|---|---|
| Type of abortion provider | Surgical | Misoprostol | Other types | Total |
| **Rural poor women** | | | | |
| Doctor | 7.1 | 10.1 | na | 17.1 |
| Nurse/midwife/LHV/TBA or other trained provider | 14.6 | 17.8 | na | 32.4 |
| Traditional provider (dai) | 8.3 | 9.4 | 12.9 | 30.6 |
| Pharmacist | na | 5.6 | 4.8 | 10.4 |
| Women herself-self-induced | na | 4.0 | 5.4 | 9.4 |
| **Distribution of all women** | **30.0** | **46.8** | **23.2** | **100.0** |
| **Urban poor women** | | | | |
| Doctor | 10.2 | 15.5 | na | 25.7 |
| Nurse/midwife/LHV/TBA or other trained provider | 13.9 | 18.2 | na | 32.1 |
| Traditional provider (dai) | 7.1 | 8.8 | 7.3 | 23.1 |
| Pharmacist | na | 8.0 | 3.3 | 11.3 |
| Women herself-self-induced | na | 4.3 | 3.4 | 7.7 |
| **Distribution of all women** | **31.2** | **54.8** | **14.0** | **100.0** |
| **Rural non-poor** | | | | |
| Doctor | 20.6 | 18.3 | na | 38.9 |
| Nurse/midwife/LHV/TBA or other trained provider | 15.1 | 13.1 | na | 28.2 |
| Traditional provider (dai) | 6.2 | 5.6 | 5.3 | 17.1 |
| Pharmacist | na | 5.9 | 3.5 | 9.4 |
| Women herself-self-induced | na | 3.4 | 3.1 | 6.5 |
| **Distribution of all women** | **41.9** | **46.3** | **11.9** | **100.0** |
| **Urban non-poor women** | | | | |
| Doctor | 27.1 | 23.1 | na | 50.1 |
| Nurse/midwife/LHV/TBA or other trained provider | 13.2 | 10.5 | na | 23.7 |
| Traditional provider (dai) | 3.9 | 3.3 | 2.4 | 9.6 |
| Pharmacist | na | 7.8 | 2.5 | 10.3 |
| Women herself-self-induced | na | 4.2 | 2.1 | 6.3 |
| **Distribution of all women** | **44.2** | **48.9** | **7.0** | **100.0** |

Source: HPS 2023. na = not applicable.

Figure 3.5 illustrates that poor women are more likely to seek abortion services from nurses, midwives, LHVs, or traditional providers (those without formal medical training) compared to non-poor women. Notably, 9.4% of rural poor women attempt to self-induce abortion, while this figure is lower at 6.3% among urban non-poor women. In contrast, non-poor urban women are significantly more likely (50.1%) to consult a doctor, compared to just 17.1% of rural poor women. This clearly suggests that economic status plays a crucial role in determining the choice of abortion provider.

Across both urban and rural areas, fewer poor and non-poor women visit pharmacists for abortion services, indicating that pharmacists are generally not perceived as a primary resource for such care across socioeconomic groups. Additionally, on a positive note fewer women, regardless of urban or rural residence or economic status, are opting for self-induced abortions. This trend points to a shift towards safer, potentially more formal healthcare options for abortion services.

**Figure 3.5 | Type of provider commonly consulted for an induced abortion by socio economic status and residence of women**




Source: HPS 2023.

## 3.5 | Post-Abortion Complications by Abortion Method and Provider

The percentage of women experiencing abortion complications varies based on method used and type of provider. Generally, a higher proportion of women undergoing surgical abortion experience abortion complications compared to those using medication abortion even when the same type of provider is considered. This pattern holds across all four socio-economic and residence groups (Table 3.3). For example, surgical abortion performed by a nurse, midwife, or LHV is likely to result in abortion complications for 40.7% of rural-poor women, 33.8% of urban-poor women, 35.6% of rural non-poor women, and 24.8% of urban non-poor women. By comparison, the proportion having complications from misoprostol abortions obtained from the same type of provider is lower, ranging between 19% to 29% across the four subgroups. Across the four population groups, between 20% to 27% are likely to experience abortion complications if medication abortion is obtained from a traditional provider or self-induced by women complication levels comparable to those from medication abortions provided by nurse/midwife/LHV.

**Table 3.3 | Percentage of women likely to experience abortion complications, by abortion method, provider type, and socioeconomic subgroup**

| | % likely to experiencing abortion complications | | |
|---|---|---|---|
| | Surgical | Misoprostol | Other types |
| **Rural poor women** | | | |
| Doctor | 19.1 | 15.3 | na |
| Nurse/midwife/LHV/TBA or other trained provider | 40.7 | 29.0 | na |
| Traditional provider (dai) | 50.9 | 28.9 | 31.5 |
| Pharmacist | na | 20.7 | 19.2 |
| Women herself-self-induced | na | 26.9 | 28.5 |
| **Urban-poor women** | | | |
| Doctor | 17.2 | 15.3 | na |
| Nurse/midwife/LHV/TBA or other trained provider | 33.8 | 25.3 | na |
| Traditional provider (dai) | 42.3 | 27.6 | 29.4 |
| Pharmacist | na | 19.9 | 16.8 |
| Women herself-self-induced | na | 24.8 | 25.3 |
| **Rural non-poor** | | | |
| Doctor | 19.1 | 17.3 | na |
| Nurse/midwife/LHV/TBA or other trained provider | 35.6 | 21.5 | na |
| Traditional provider (dai) | 44.5 | 20.9 | 22.6 |
| Pharmacist | na | 19.8 | 17.9 |
| Women herself-self-induced | na | 24.0 | 22.0 |
| **Urban non-poor women** | | | |
| Doctor | 20.9 | 19.5 | na |
| Nurse/midwife/LHV/TBA or other trained provider | 24.8 | 19.0 | na |
| Traditional provider (dai) | 31.0 | 18.2 | 20.5 |
| Pharmacist | na | 19.8 | 15.9 |
| Women herself-self-induced | na | 22.1 | 20.8 |

## 3.6 | Summary

The 2023 HPS findings demonstrate significant changes since 2012.

The profile of women seeking abortions has shifted, with younger women now more likely to seek abortions in 2023 to manage their reproductive decisions. They are doing so more independently or in consultation with husbands.

The second finding is the widespread use of misoprostol, which has become the most widely used method for an abortion. The method is provided by various types of providers and in both urban and rural settings, presenting an equalizing influence due to its widespread availability and lower cost. Surgical methods, which were earlier considered safer and a better choice, are still available.

Thirdly, the choice of provider and method of abortion are linked to economic status: non-poor women in both rural and urban areas mostly opt for a doctor for their abortion procedure, while poor women choose mid-level trained providers and traditional untrained providers.

An important finding is that over 20% of both poor and non-poor and women in urban and rural areas are likely to experience post abortion complications. Rural-poor women are most likely to experience post-abortion complications, but other groups are also susceptible. Even relatively safer methods like misoprostol and surgical procedures are associated with risks of complications. This reflects the need for improving the quality of information and services provided by doctors and paramedics, who are top of the range in terms of costs but probably not meeting uniformly high standards of care. This finding is corroborated in the next chapter, where we present the numbers of post-abortion complication cases.

CHAPTER 4

# Incidence of Treatment for Post-Abortion Complications

- In 2023, an estimated 870,185 women across Pakistan's four provinces, as well as AJK, GB and Islamabad, were treated for complications from induced and spontaneous abortion in public and private facilities.
- The national rate for any abortion complication was estimated at 15 per 1000 women of reproductive age. Remote regions such as Balochistan, AJK and GB had higher complication rates than the national level.
- The public sector treats most post-abortion complications (62%), with the remaining 38% treated in the private sector.
- Within the public sector, BHU and BHU+ facilities handle the highest proportion of post-abortion care cases (23.1%), followed by teaching hospitals (16.6%).
- In the private sector, the smallest facilities handle the greatest burden of post-abortion care, managing 27% of all post-abortion cases in Pakistan.
- Limiting data to the same regions and facility levels in 2012 and 2023, we estimate a 31% decline in the post-abortion complication rate, from 15.1 per 1,000 women in 2012 to 10.4 per 1,000 women in 2023.
- The annual post-abortion care caseload for public teaching hospitals has increased between 2012 and 2023. However, the caseload has decreased for all other types of public sector facilities (DHQs, THQs, and RHCs) and private sector facilities included in both 2012 and 2023.

## 4.1 | Post-Abortion Care: Variation by Province, Sector, and Facility

This chapter presents results on the incidence of women undergoing treatment for post-abortion complications as reported in the 2023 Health Facilities survey (HFS). The 2023 study surveyed a nationally representative sample of facilities from the public and private sector. In case of the public sector, the 2023 HFS was more comprehensive than the 2012 survey and included lower-level facilities (BHUs, BHU+ facilities open 24/7, and MCH clinics). The 2023 HFS also had wider geographic coverage than the 2012 study, including the regions of AJK and GB.

Sampled facilities included teaching hospitals, DHQs, THQs, RHCs, BHUs, BHU+, MCH centers, and their equivalents in the private sector. The facilities were weighted to reflect the universe of each type of facility across Pakistan, totaling 12,417 health facilities.

Respondents from a sample of 595 facilities were asked to provide an estimate of the number of cases of post-abortion complications treated in each health facility in an average month, as well as the number treated in the past month. These two time periods were used to obtain a more accurate estimate: respondents may overestimate the number for the average month, and the past month may not be representative of the typical caseload. We used the mean of these two estimates as our best estimate of the caseload for a facility. Data were obtained for two types of patients (in-patients and out-patients) for the average month and the past month, and these were summed to provide the total caseload for a facility.

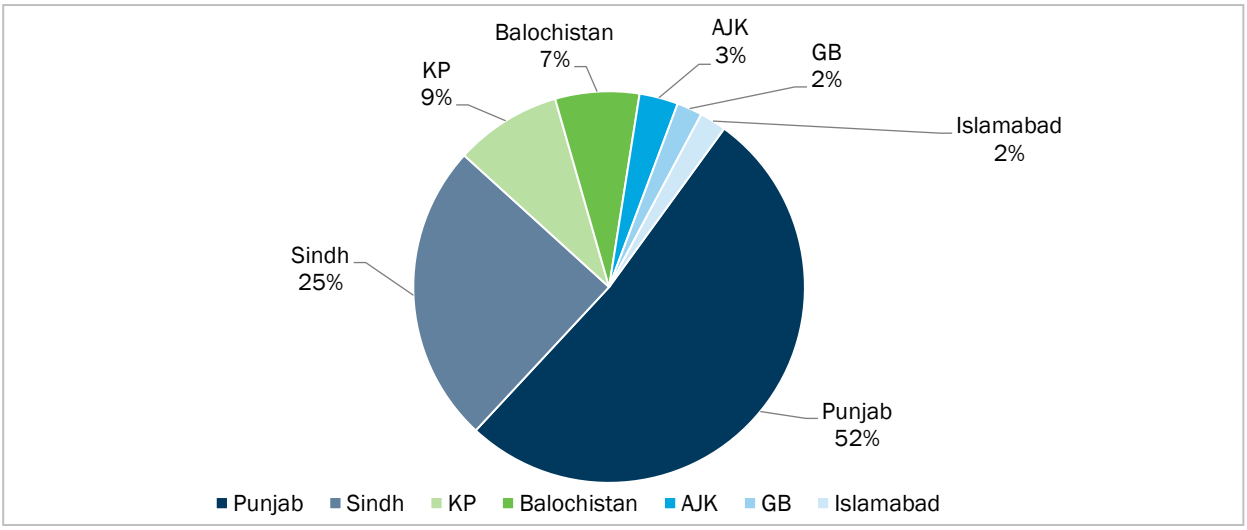
**Table 4.1 | Numbers of post-abortion patients treated annually as out-patients by province and regions**

| | Out- and In-patient | | Out-patient | | In-patient | | Unweighted |
|---|---|---|---|---|---|---|---|
| | Sum | % | Sum | % | Sum | % | N |
| **Pakistan** | **870,185** | | **604,119** | | **266,066** | | **595** |
| Punjab | 451,820 | 54 | 328,626 | 52 | 123,194 | 46 | 234 |
| Sindh | 215,940 | 21 | 125,848 | 25 | 90,092 | 34 | 128 |
| Khyber Pakhtunkhwa | 76,706 | 9 | 53,940 | 9 | 22,766 | 9 | 78 |
| Balochistan | 60,419 | 8 | 49,690 | 7 | 10,729 | 4 | 50 |
| Azad Jammu & Kashmir | 27,876 | 4 | 23,374 | 3 | 4,502 | 2 | 34 |
| Gilgit Baltistan | 18,283 | 2 | 11,310 | 2 | 6,974 | 3 | 30 |
| Islamabad | 19,140 | 2 | 11,331 | 2 | 7,809 | 3 | 41 |

Source: Weighted results, HFS 2023.

Figure 4.1 provides a detailed breakdown of out-patient and in-patient healthcare utilization for post-abortion care across different regions of Pakistan. Nationally, 870,185 women were treated for post-abortion complications in 2023. Punjab has the highest percentage of post-abortion cases, accounting for 52%, followed by Sindh with 25%. KP recorded over 9% while Balochistan and AJK show lower but still noteworthy levels of 7% and 3% post-abortion care visits, respectively. Gilgit Baltistan and Islamabad report relatively lower levels of post-abortion care visits, around 2% each. Despite the lower absolute numbers, data from smaller regions reflect a significant demand for post-abortion care services and the likelihood of abortions occurring across all parts of Pakistan.

**Figure 4.1 | Percentage of post-abortion care patients treated annually as out- and in-patients by province and regions**




Source: Weighted results, HFS 2023.

When post-abortion care patients are classified by which type of public facility, they presented their complications, one in four is treated in teaching hospitals with 63% of them admitted as in-patients (Table 4.2). In contrast, 71% of all postabortion care patients in the private sector (or 235,001) are treated at primary level facilities and 77% were treated as out-patients. The caseload of BHU, BHU+ and MCH combined is about half of all post-abortion care patients in the public sector, but most of them are treated as out-patients. Therefore, lower-level facilities in both public and private sectors, end up treating the largest numbers of post-abortion care but mainly as outdoor patients while more complicated cases are being treated as in patients at the teaching or tertiary facilities.

**Table 4.2 | Number of post-abortion care patients treated annually as out- and in-patients by level of facility**

| | | Out- and In-patient | Out-patient | In-patient | Number of facilities |
|---|---|---|---|---|---|
| | | Sum | Sum | Sum | Unweighted |
| Public | Higher facility | 11,100 | 5,400 | 5,700 | 1 |
| | Teaching | 133,689 | 48,822 | 84,868 | 13 |
| | DHQ | 48,910 | 32,063 | 16,848 | 26 |
| | THQ | 34,582 | 22,697 | 11,885 | 22 |
| | RHC | 61,920 | 38,661 | 23,259 | 53 |
| | BHU | 123,169 | 103,087 | 20,083 | 91 |
| | BHU+ | 77,689 | 72,490 | 5,198 | 43 |
| | MCH | 48,123 | 36,456 | 11,667 | 45 |
| | **Overall** | **539,182** | **359,676** | **179,508** | **294** |
| Private equivalent | Tertiary level | 10,465 | 5,163 | 5,302 | 15 |
| | Secondary level | 85,537 | 58,848 | 26,689 | 72 |
| | Primary level | 235,001 | 180,433 | 54,567 | 214 |
| | **Overall** | **331,002** | **244,445** | **86,558** | **301** |

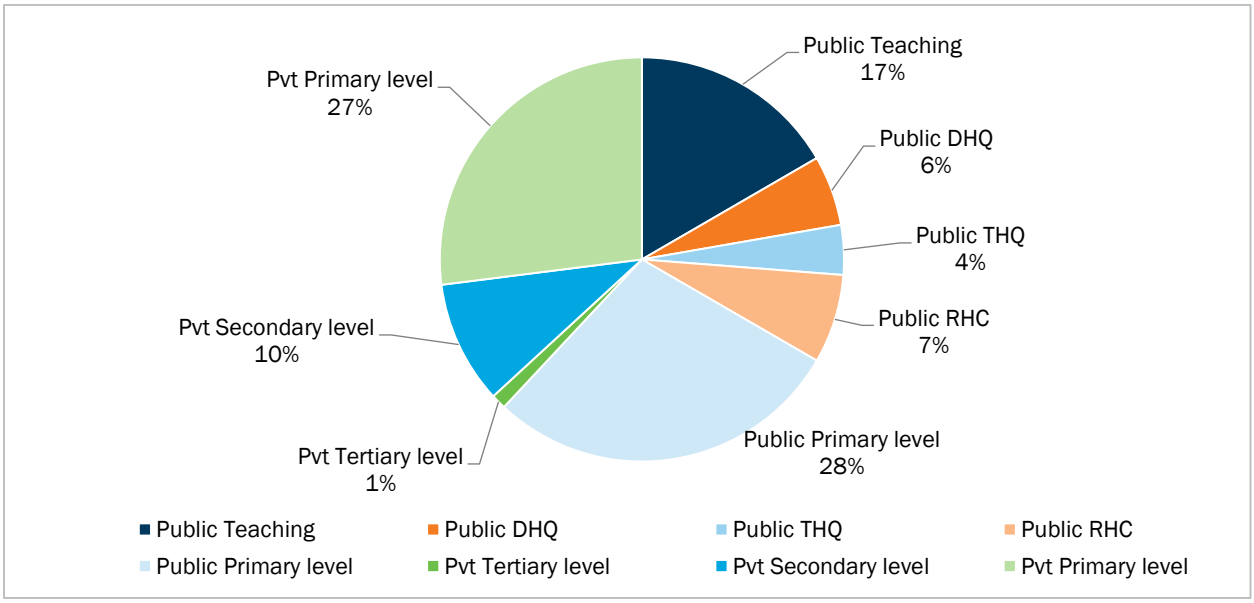
Source: HFS 2023.

In both public and private primary level facilities, which include BHUs, BHUs+, and MCH centers in the public sector, 28% are served in public facilities and 27% in private facilities (Figure 4.2). In an earlier chapter, we found that the private sector deals with most of induced abortions. However, it is the public sector that provides the greater part of post-abortion care. Primary facilities in the private sector that provide post-abortion care to a relatively large number of women do so mainly in the form of out-patient care.

It is important to note that the provision of post-abortion care is part of the essential services packages and is mandatory at public facilities. Generally, public health services are much more affordable, and therefore many women rely on public facilities for post-abortion care. Nonetheless, smaller private sector facilities still have an important role in the provision of post-abortion care, probably because of their geographical proximity and lower costs.

Overall, these findings highlight the substantial burden on public healthcare facilities, particularly at higher and primary levels, indicating the critical role they play in delivering post-abortion healthcare services to women across the country.

**Figure 4.2 | Percentage of post-abortion care patients treated annually as out- and in-patients by level of facility**




Source: Unweighted results, HFS 2023.

Table 4.3 presents a comparison between 2012 and 2023 of the geographical spread of post-abortion care cases. Out of the total 604,521 visits reported, 60% were treated in Punjab and Islamabad in both 2012 and 2023. In 2012, Sindh accounted for 25% of all patients; by 2023, the proportion of Sindh visits had risen to 27%. By 2023, KP accounted for 9% of all visits, up from 8% in 2012. Balochistan accounted for 7% of all patients in 2012; by 2023, that percentage had dropped to 4%.

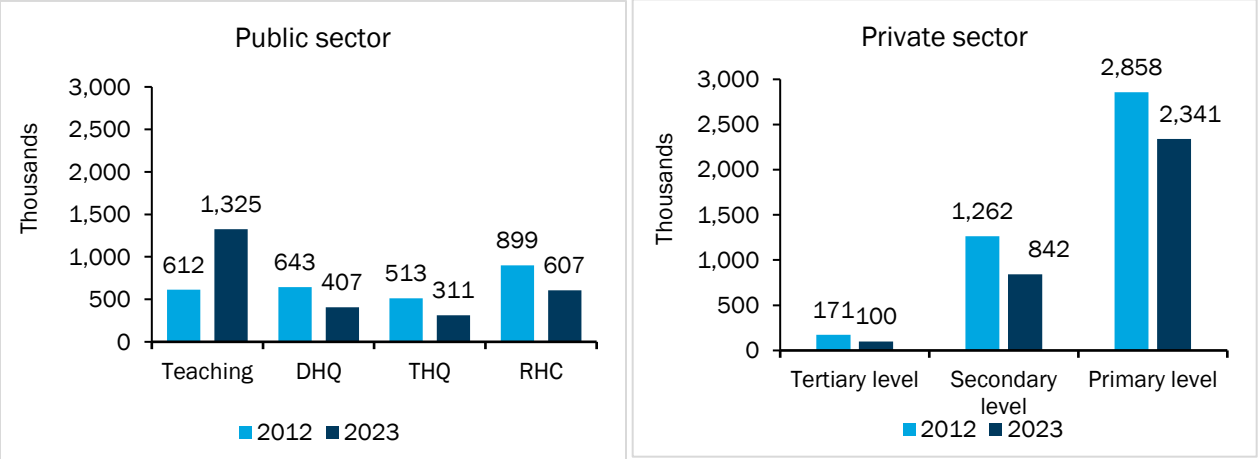
**Table 4.3 | Annual numbers of post-abortion care patients treated as out- and in-patients by province and regions**

| | Out- and In-patients | | | | Out-patients | | | | In-patients | | | | UW | UW |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2012 | | 2023 | | 2012 | | 2023 | | 2012 | | 2023 | | 2012 | 2023 |
| | % | n | % | n | % | n | % | n | % | n | % | n | n | n |
| **Pakistan** | **100** | **695,861** | **100** | **604,521** | **100** | **456,973** | **100** | **380,623** | **100** | **238,889** | **100** | **223,898** | **266** | **376** |
| Punjab & Islamabad | 60 | 416,433 | 60 | 360,617 | 62 | 284,441 | 64 | 245,005 | 55 | 131,993 | 52 | 115,612 | 133 | 203 |
| Sindh | 25 | 174,908 | 27 | 162,089 | 26 | 117,729 | 22 | 85,402 | 24 | 57,180 | 34 | 76,687 | 79 | 98 |
| KP | 8 | 57,159 | 9 | 55,922 | 4 | 18,369 | 9 | 33,839 | 16 | 38,790 | 10 | 22,082 | 33 | 49 |
| Balochistan | 7 | 47,361 | 4 | 25,893 | 8 | 36,434 | 4 | 16,377 | 5 | 10,926 | 4 | 9,516 | 21 | 26 |

Source: HFS 2023. UW = unweighted.

Figure 4.3 presents data comparing the number of women treated by health sector and type of facility in 2012 and 2023. There are notable differences across categories of facilities: while the case load of teaching hospitals has increased more than two-fold in terms of their annual post-abortion care in the 11-year period, DHQs, THQs, and RHCs have experienced a marked reduction in the numbers of cases between 2012 and 2023. For RHCs, the percentage decline is over 32.4%. A similar decline is seen in the number of clients in the private sector at secondary , tertiary and primary levels.

**Figure 4.3 | Number of post-abortion care patients treated annually in public and private sector facilities by facility level**



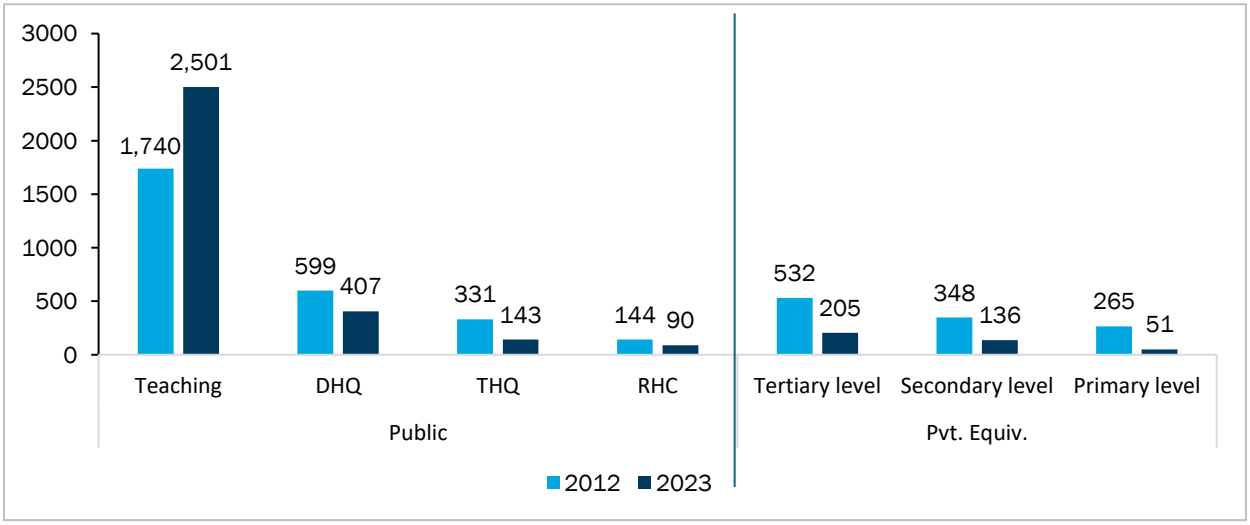

Source: Weighted results, HFS 2012, 2023. AJK and GB excluded; BHU, BHU+, and MCH excluded in 2023.

The annual number of post-abortion care cases per facility is derived from the average monthly/yearly caseload and the numbers of facilities represented in each stratum. The number of facilities has increased as shown in Table 2.8. Here we examine the data on the average number of cases per healthcare facility recorded annually across both public and private sectors for 2012 and 2023.

The caseload at public teaching hospitals has increased significantly, from 1,740 in 2012 to 2,501 in 2023 (Figure 4.4). This trend highlights the increasing need for specialist treatment as well as the growing function of teaching facilities in managing complicated medical situations.

There is a consistent decline in the annual cases in DHQ facilities, going from 599 in 2012 to 407 in 2023. A reduction in cases was also observed at THQs and RHC facilities, suggesting once again that post-abortion care is mainly directed to larger facilities in the public sector. A similar caseload decline is observed across all levels of facilities in the private sector, again confirming that the private sector's share in providing post-abortion care is shrinking over time.

**Figure 4. 4 | Mean number of post-abortion care patients treated as out- or in-patients by sector and facility level**




Source: Weighted results, HFS 2012, 2023. AJK and GB excluded; BHU,BHU+, and MCH center excluded in 2023.

## 4.2 | Post-Abortion Complication Rates in 2012 and 2023 by Province

Perhaps the most definitive measure of change in complications due to abortion is through a standardized rate per 1,000 women aged 15-49, which accounts for the change in the population size of women.

Table 4.4 presents the number and rate of women treated for any post-abortion complications (induced or spontaneous abortion) per 1,000 women aged between 15 and 49. The national rate of treatment for any abortion complication in 2023 is 15 per 1000 women. The lowest treatment rate is in KP at 8.1. Islamabad has double the national complication rates, followed by AJK with 23.9. GB has a complication rate of 39.5, which is more than twice the national complication rate.

An important factor to bear in mind is that if a city (such as Islamabad) is treating patients from outside its boundaries, those cases are included in that city's rate, inflating its rate and lowering the rate in the areas the patients come from. The other, perhaps more crucial, factor is that rates of treatment reflect both the relative safety of abortion (the number needing treatment in each given area) and accessibility (the proportion of those who need care who are able to obtain treatment).

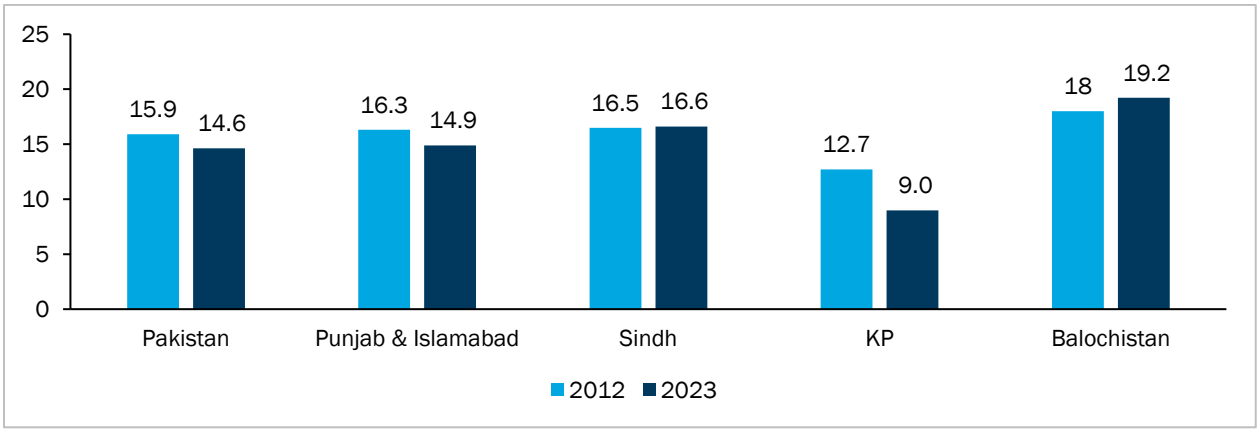
We compared the number and rate of treatment for any abortion complications in 2012 and 2023, excluding areas and types of facilities that were included in 2023 but not in 2012. The results show that the total number of women treated for abortion complications has declined from 695,861 in 2012 to 604,521 in 2023, a decline of 11.8%. When population growth is considered, we see that the decline in the rate of treatment for complications was much larger, at 31%. A province-wise comparison shows that the rate of complications decreased in all provinces over the same period with a dramatic decline in the rate in Balochistan from 20.3 to 8.4 (Figure 4.5). It is possible that the latter decline is overestimated, given the shift in treatment resulting from the use of misoprostol for treating post-abortion complications. Smaller primary-level facilities (BHU, BHU+, MCH) in the public sector now account for a very large share of post-abortion care treatment in Baluchistan (and other very rural areas of Pakistan). These facilities were not included in the 2012 survey because, for the most part, they were not equipped to provide post-abortion care at that time.

**Table 4.4 | Number of patients treated for post-abortion complications (induced or spontaneous abortion) and the treatment rate per 1,000 women aged 15–49 by province and region**

| | Number of women age 15-49 | No of women with complications (HFS Data) 2023 | Rate of complications per 1000 women |
|---|---|---|---|
| **Pakistan** | **57,878,117** | **870,185** | **15.0** |
| **Province** | | | |
| Punjab | 31,609,413 | 451,820 | 14.3 |
| Sindh | 13,088,008 | 215,940 | 16.5 |
| KP | 9,481,058 | 76,706 | 8.1 |
| Balochistan | 3,099,273 | 60,419 | 19.5 |
| **Region** | | | |
| ICT | 600,364 | 19,140 | 31.9 |
| AJK | 1,167,902 | 27,876 | 23.9 |
| GB | 463,288 | 18,283 | 39.5 |

Source: HFS 2023. ICT=Islamabad Capital Territory; GB=Gilgit Baltistan; AJK=Azad Jammu and Kashmir.

**Figure 4.5 | Comparison of post-abortion complications (induced or spontaneous abortion) treatment rate per 1,000 women aged 15–49 by province**




Source: HFS 2012, 2023. For purposes of comparability, the additional regions (AJK and GB) are excluded from 2023 data presented in this figure.

## 4.3 | Summary

An estimated 870,185 women were treated in 2 023 for post-abortion complications (resulting from induced or spontaneous abortion) across all provinces and regions of Pakistan. This heavy caseload is a daunting challenge for the health system.

While the motivation for abortion is to end an unwanted or mistimed pregnancy—a difficult and costly decision for most women and couples—the complications that follow come with their own set of challenges, including possible health-related consequences and financial costs. The paradox of the public health system is that, while it does not offer legal and safe abortion services, it provides almost two-thirds of medical treatment for post-abortion complications across the country.

Teaching hospitals manage a larger proportion of post-abortion care cases than other categories of facilities, though primary healthcare facilities in the public sector also cater to many such cases. Meanwhile, DHQs and THQs do not handle as many cases. Within the private sector, primary-level facilities manage most cases, primarily providing post-abortion care to outpatients.

A comparison of 2012 and 2023 data shows a decline in the number of cases over this period. Additionally, the mean annual number of post-abortion care cases treated at each type of facility has also declined between 2012 and 2023, except for teaching hospitals, where the average caseload has increased drastically.

When population growth is considered, results show that the rate of treatment for abortion complications per 1,000 women has decreased by 31%—from 15.1 to 10.4 per 1,000 women over the period 2012 to 2023. Importantly, when we include additional regions (such as AJK and GB) and primary healthcare facilities, the overall national complication rate for Pakistan in 2023 is estimated at 15 per 1,000 (almost the same as the rate in 2012). This is largely due to the high caseload of post-abortion complications in these regions and the added caseload of primary health facilities in the public sector. As mentioned, this rate for 2023 may be somewhat overestimated because of the likelihood that an unknown proportion of cases reported by primary-level public sector facilities were in fact referred to higher-level facilities, where they would also be counted.

CHAPTER 5

# Service Provision, Facility Capacity, and Attitudes Regarding Post-Abortion Care and Abortion

- Most health professionals believe post-abortion care falls within the public sector's responsibility and should be readily accessible.
- A significant majority (80%) of surveyed healthcare providers consider medication abortion as the safest method for treating first-trimester post-abortion cases.
- Women seeking post-abortion care most commonly fall between the ages of 30–35, are more likely to be educated, and have three or fewer children.
- A matter of concern is that facilities often struggle with delays in transferring patients due to communication issues or lack of functional ambulances. These delays can postpone critical treatment and potentially endanger patients' lives.

Provision of quality post-abortion care is important given the continuing large number of women who experience post-abortion complications in both rural and urban areas across all provinces and regions. Access to high-quality, comprehensive post-abortion care is critical to protect women's reproductive health and rights. Comprehensive post-abortion care requires health facilities with skilled medical staff and a range of methods.

In this chapter, we explore the characteristics of women seeking post-abortion care and assess the quality of care that is being provided across levels and types of facilities. The analysis of the quality of post-abortion care is drawn mainly from the survey of Health Facilities Survey (HFS) and partially from the Health Providers Survey (HPS). We especially focus on the availability of services that conform to the requirements of the National Service Delivery Standards and Guidelines for High Quality Safe Uterine, Evacuation/Post-abortion Care developed by the Government of Pakistan, and the extent of training and knowledge of medical professionals regarding post-abortion care. Additionally, we include a comparison of services provided at both public and private sector facilities.

## 5.1 | Profile of Women Seeking Post-Abortion Care

In the HFS of 2002, 2012, and 2023, health professionals were asked to describe the characteristics commonly associated with women attending health facilities for the treatment of post-abortion complications (Table 5.1). Among women seeking post-abortion care, the highest percentage was estimated to be in the age group 30–34 years in 2023 (36%), compared to 39% in 2012. The average age of women receiving treatment in 2023 is younger than in 2012. A larger proportion of younger women were seeking post-abortion care in 2023 than in previous decades.

**Table 5.1 | Background characteristics of women most likely to attend health facilities for treatment of post-abortion complications**

| | | 2012 (%) | 2023 (%) |
|---|---|---|---|
| **Age group** | | | |
| | Younger than 19 | 3 | 3 |
| | 19–24 | 12 | 11 |
| | 25–29 | 28 | 29 |
| | 30–34 | 39 | 36 |
| | 35–39 | 14 | 19 |
| | 40 or older | 4 | 2 |
| **Number of living children** | | | |
| | None | 9 | 1 |
| | 1 to 2 | 2 | 11 |
| | 3 to 4 | 30 | 53 |
| | 5 or more | 59 | 34 |
| | Don't know | — | 1 |
| **Economic status** | | | |
| | Poor | 83 | 69 |
| | Non-poor | 17 | 24 |
| | Don't know | — | 6 |
| **Usually accompanying woman seeking abortion** | | | |
| | Alone | — | 5 |
| | Husband | 33 | 55 |
| | Mother | — | 5 |
| | Mother-in-law | 32 | 64 |
| | Sister | 16 | 44 |
| | Relatives | 57 | 57 |
| | Friends | 15 | 4 |
| | Others | 20 | - |
| **No. of facilities** | | **102** | **596** |

Source: Weighted results, HFS 2023.

Most HFS respondents believed that the largest proportion of women who would go to a health facility for an abortion-related complication would be married. More educated women with middle or higher education were most likely to seek treatment from a health facility for post-abortion care in 2023, whereas most women who had post-abortion care in 2012 were generally believed to be uneducated (data not shown).

In 2012, most women going to a health facility for post-abortion care were expected to have over four children. This perception changed for 2023, and the highest percentage of respondents were now believed to have lower parities: four or fewer children (65%). The comparable figure in 2012 was 41%.

Most HFS respondents in both 2012 and 2023 believed that most women (83% and 69%, respectively) who would end up in a health facility for post-abortion care would be poor. Poor women usually cannot afford quality healthcare and therefore resort to undergoing a low-cost abortion procedure, which is likely to subject them to the risk of complications.

Most respondents in 2023 suggested that women attending health facilities for post-abortion care would be accompanied by their mother-in-law (64%), which doubled from 32% in 2012. In 2012, the highest percentage (57%) was of relatives accompanying the woman.

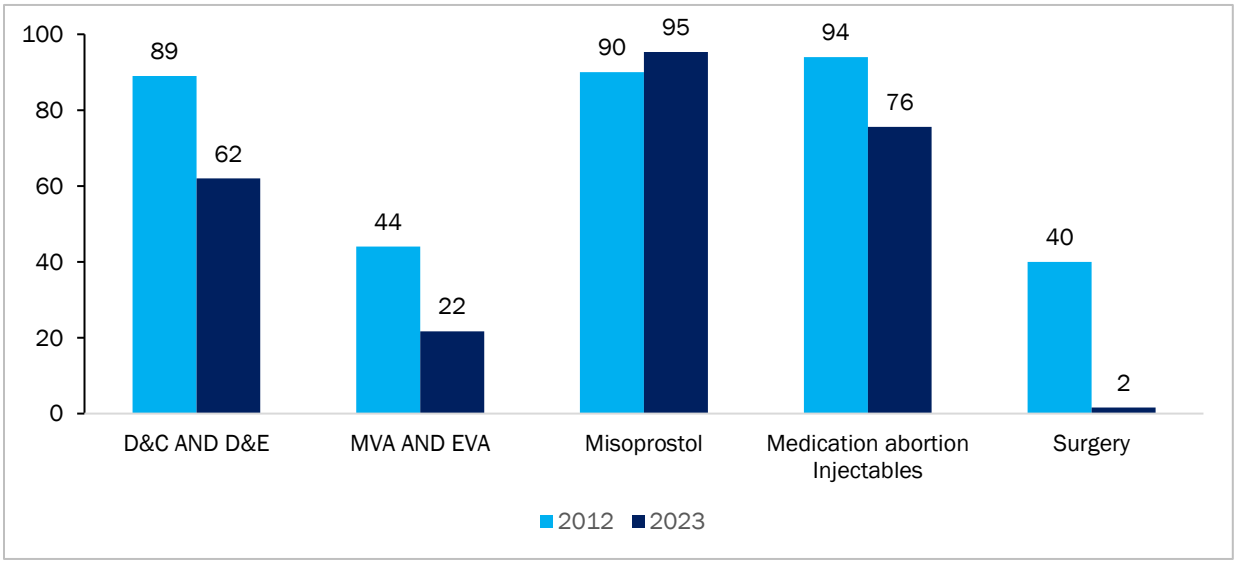
## 5.2 | Treatment of Abortion-Related Complications: Procedures and Providers

The most significant change in methods used for treating post-abortion complications has been the increased use of misoprostol. The reliance on this technique surged from nearly negligible usage in 2002 to 90% in the 2012 survey and to 95% in 2023 (Figure 5.1).

A high proportion of respondents (89%) from public health facilities had reported the use of D&C and D&E to treat post-abortion complications in 2012. In 2023 we see a dip in the use of D&C and D&E. The WHO discourages use of D&C as it is an invasive procedure with a higher level of risk.

We also see a reduction in the use of surgery to treat abortion-related complications. This could possibly be due to a drop in the incidence of more severe complications (such as perforation of the uterus and gut). There was a drop in the use of MVA/EVA, from 44% in 2012 to 22% in 2023. Almost all health facilities in both studies reported the use of antibiotics to treat post-abortion complications.

**Figure 5.1 | Percentage of respondents at public health facilities reporting various procedures for treating post-abortion complications**




Source: Weighted results, HFS 2023. Only those providing post-abortion care are included; n = 497.

*Dilatation and curettage (D&C) is a surgical procedure in which the cervix is dilated and part of the lining of the uterus or contents of the uterus is removed by scrapping. Dilatation and evacuation (D&E) is a surgical procedure in which the cervix is dilated, and the contents of the uterus are evacuated. D&E is normally used in second-trimester abortion. Some providers use the terms D&C and D&E interchangeably, and therefore we combine these two methods when discussing results. Manual vacuum aspiration (MVA) uses a syringe attached to a tube for evacuating the uterus while electronic vacuum aspiration (EVA) uses a pump attached to a thin tube for uterine evaluation.

## 5.3 | Use of Medical Procedures for Treating Post-Abortion Care Patients: Changes from 2012 to 2023

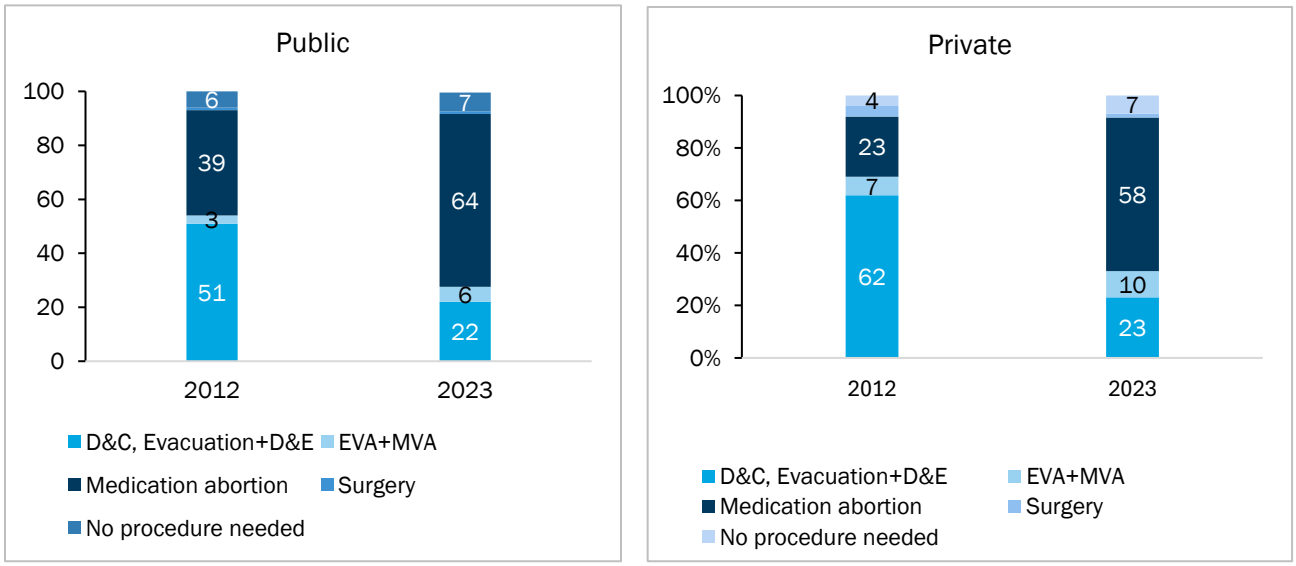
Figure 5.2 compares the distribution of post-abortion care patients according to the procedures used to treat their complications in public and private sector facilities. We see a marked shift in the pattern of medical procedures used, with lower proportions being treated by D&C and D&E in

2023 compared to 2012 (22% and 51% respectively for public facilities; and 23% and 62% respectively for private facilities).

On the other hand, the proportion of patients treated by medication abortion (misoprostol) rose from 39% in 2012 to 64% in 2023 in public facilities and from 23% in 2012 to 58% in 2023 in private facilities. Complications associated with uterine surgery have decreased to negligible levels in both public and private sector facilities over the same period. In 2023, most post-abortion care patients were treated by medication abortion (misoprostol for the most part) in both the public and private sectors (64% and 58% respectively).

We also find that the use of EVA and MVA to treat complications was slightly higher in private sector facilities (10%) compared to public facilities (6%). Use of D&C and D&E to treat complications was about the same in both sectors.

**Figure 5.2 | Percentage distribution of women treated for post-abortion care by type of procedure**




**Source:** HFS 2012, 2023. Weighted results.

### 5.3.1 | Perceived Safety of Abortion by Type of Method

Table 5.2 reflects the opinions of respondents from public and private facilities regarding the methods they considered the *safest* and the *least safe* for treating first-trimester post-abortion patients. Overall, 80% (78% in public and 82% in private sector) of respondents referred to medication abortion as the safest way to treat a first-trimester case. Misoprostol administered in injectable form was considered a safe method for post-abortion care treatment. MVA was reported as the second safest method. This perception aligns with the international medical recommendations referred to earlier in the report.

**Table 5.2 | Percentage of respondents who report that each procedure is very safe or very unsafe for treating an uncomplicated first-trimester post-abortion case by type of method and sector**

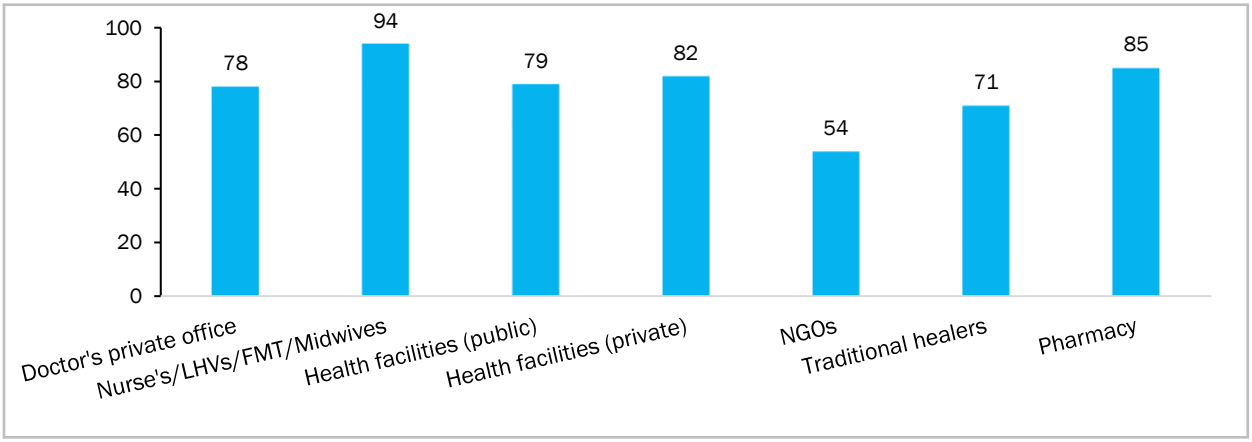
| | Public | Private equivalent | Total |
|---|---|---|---|
| **Very Safe** | | | |
| Dilatation and Curettage | 13 | 5 | 9 |
| Dilatation and Evacuation | 4 | 3 | 3 |
| MVA | 40 | 30 | 36 |
| EVA | 10 | 14 | 12 |
| Medication abortion oral/vaginal | 78 | 82 | 80 |
| Medication abortion injectables | 40 | 50 | 44 |
| **Very unsafe** | | | |
| Dilatation and Curettage | 40 | 29 | 35 |
| Dilatation and Evacuation | 37 | 23 | 31 |
| MVA | 22 | 22 | 22 |
| EVA | 30 | 38 | 33 |
| Medication abortion oral/vaginal | 6 | 5 | 5 |
| Medication abortion injectables | 17 | 21 | 18 |
| **Unweighted number** | **102** | **107** | **209** |

**Source:** Weighted results, HFS 2023. On a scale of 1 to 5; 1= very unsafe and 5= very safe.

### 5.3.2 | Access to Misoprostol: Some Highlights

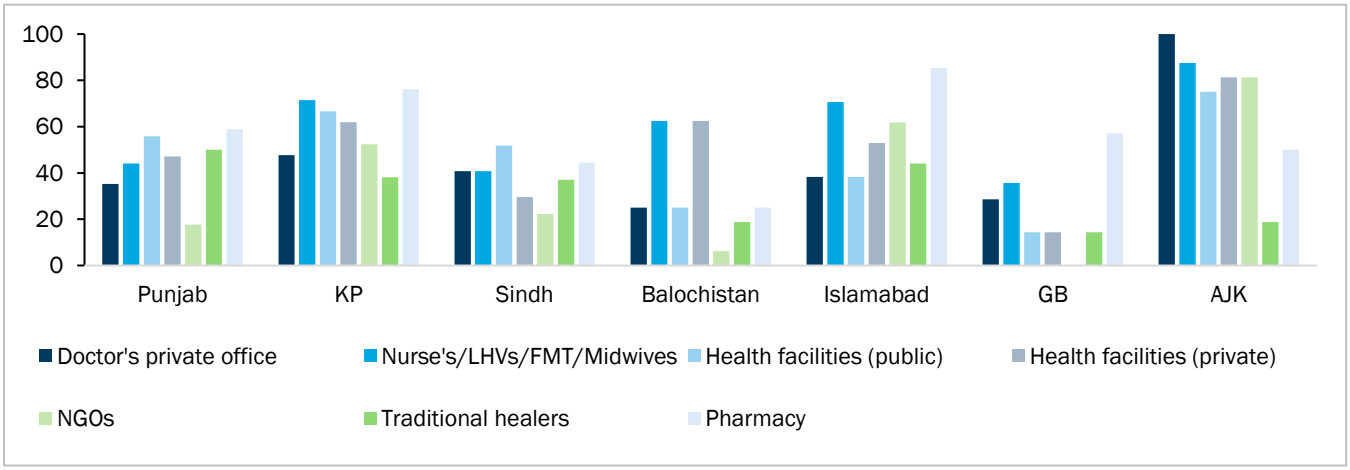
- Misoprostol is the most available method in different parts of the country.
- 94% of women seeking misoprostol access it from nurses/LHVs/FMT/midwives, followed by pharmacies (85%) Figure 5.3.
- Most women from the Balochistan, AJK, and GB regions access misoprostol from a doctor's private clinic (Figure 5.4).
- Private health facilities are common service providers for misoprostol in KP, supplying misoprostol to 62% of women seeking abortion, while 76% obtain it from a pharmacy.
- In Sindh, women who use misoprostol are least likely to get the medication from private health facilities; only 30% of women in the province get it from these facilities.
- Many women who get misoprostol from traditional service providers are from Punjab and Islamabad, with a minority based in Balochistan, AJK, and GB.

**Figure 5.3 | Percentage of women accessing misoprostol from major places and service providers to induce an abortion**




Source: HPS 2023.

**Figure 5.4 | Percentage of women accessing misoprostol from major places and service providers to induce an abortion by province and region**



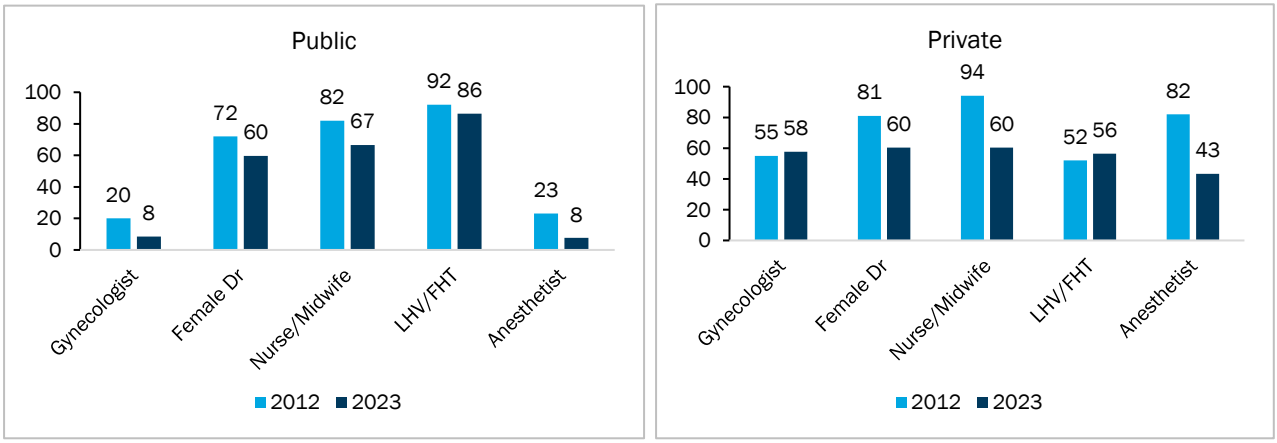

Source: HPS 2023.

## 5.4 | Provision of Post-Abortion Care

### 5.4.1 | Availability of Staff and Equipment

As seen in Figure 5.5, the 24-hour availability of different cadres of staff at both public and private sector facilities has decreased between 2012 and 2023. A substantial decrease was noted in the 24-hour availability of nurse midwives in private sector facilities, dropping from 94% in 2012 to 60% in 2023. There is very slight increase in the availability of gynecologists and LHVs/FHTs in private facilities.

**Figure 5.5 | Percentage of facilities that have 24-hour coverage of staff by type of staff, facility, and public/private sectors**




Source: Weighted results, HFS survey 2012, 2023.

A prerequisite of the national guidelines is the availability of post-abortion care at primary and referral level facilities across Pakistan. According to these guidelines, all PHC facilities in the public and private sectors should have 24-hour staff availability, trained staff, antibiotics, and uterotonics. All referral facilities should have these plus four family planning methods, sterilization procedures, a functional operation theatre with a blood bank, and an anesthetist.

Table 5.3 shows that four-fifths of all facilities offer the full management of post-abortion complications. A higher proportion of these facilities are in urban areas, particularly among referral facilities compared to primary facilities. Notably, private sector primary and referral facilities tend to offer a slightly higher proportion of services compared to their public sector counterparts.

Approximately three-fourths of all facilities provide medication abortion services, with higher availability in urban areas (four-fifths) compared to rural areas (three-fourths). Private sector primary and referral facilities show higher rates of offering these services compared to public sector facilities. Specifically, nearly four-fifths of both private sector PHC and referral facilities offer medication abortion services, while in the public sector, three-fourths of PHC facilities provide these services.

Despite the potential benefits of MVA, only a quarter of all facilities, inclusive of both public and private sectors, offer this procedure, which can be administered by a range of providers. MVA is offered equally by public and private sector referral facilities and more so by private PHC facilities. Surprisingly, nearly half of all facilities continue to offer D&C services, which pose greater risks post-procedure. The limited availability of MVA services may stem from inadequate staff training in this procedure.

Here we present the results stratifying the provision of post-abortion care services as per the requirements outlined in the National Post-Abortion Care Guidelines.

**Table 5.3 | Percentage of health facilities providing types of post-abortion care by locality, sector, and level of facility**

| | | | % Public | | % Private | | |
|---|---|---|---|---|---|---|---|
| | Urban | Rural | Primary | Referral | Primary | Referral | All facilities |
| **Facility type*** | | | | | | | |
| Facilities that treat post-abortion complications | 83 | 77 | 78 | 86 | 80 | 94 | 80 |
| Facilities that provide delivery services but not post-abortion care | 11 | 18 | 17 | 9 | 14 | 4 | 15 |
| **Methods offered for post-abortion care** | | | | | | | |
| Medication abortion (misoprostol) | 82 | 73 | 74 | 84 | 80 | 85 | 77 |
| Vacuum aspiration (manual and/or electric) | 29 | 20 | 15 | 45 | 32 | 44 | 24 |
| Dilatation and curettage | 54 | 46 | 44 | 73 | 52 | 75 | 50 |
| Dilatation and evacuation | 39 | 30 | 27 | 66 | 35 | 71 | 34 |
| **Contraceptive services** | | | | | | | |
| Provision of counseling | 82 | 77 | 78 | 85 | 78 | 92 | 79 |
| Referrals for contraceptive methods | 49 | 55 | 54 | 31 | 52 | 47 | 52 |
| Provision of four or more reversible, modern contraceptive methods** | 50 | 51 | 53 | 69 | 44 | 62 | 51 |
| **Number of facilities** | **310** | **286** | **232** | **63** | **216** | **85** | **596** |

Source: HFS 2023.

*Not shown: 5% of all interviewed facilities that do not offer post-abortion care or delivery services and one facility with missing information on delivery services.

**Condom, pill, injection, implant, IUCD, emergency contraception.

Number of facilities are unweighted totals; percentage of facilities are weighted estimates.

### 5.4.2 | Round-the-Clock Provision of Services by Urban/Rural Area

Generally, referral facilities exhibit better 24-hour coverage, with 82 percent reporting service availability around the clock. However, a breakdown of service provision by provider type reveals significant disparities in 24-hour coverage across urban and rural settings (Table 5.4).

Notably, within both sectors, urban areas tend to have higher female staff availability on a 24-hour basis, except for LHVs in the private sector. Critical deficiencies in 24-hour coverage were observed in the public sector, particularly in the availability of anesthetists and gynecologists in rural areas. Similarly, in the private sector, a notable shortfall was observed in the availability of gynecologists, with a significant difference between urban-rural private sector (63% vs 38%). Overall, 24-hour coverage of gynecologists is higher in private urban and rural facilities than in public urban and rural facilities. Female doctors, on the other hand, are more available in public facilities than in private facilities-both in urban and rural areas.

**Table 5.4 | Percentage distribution of facilities that have 24-hour coverage of staff by type of staff and sector**

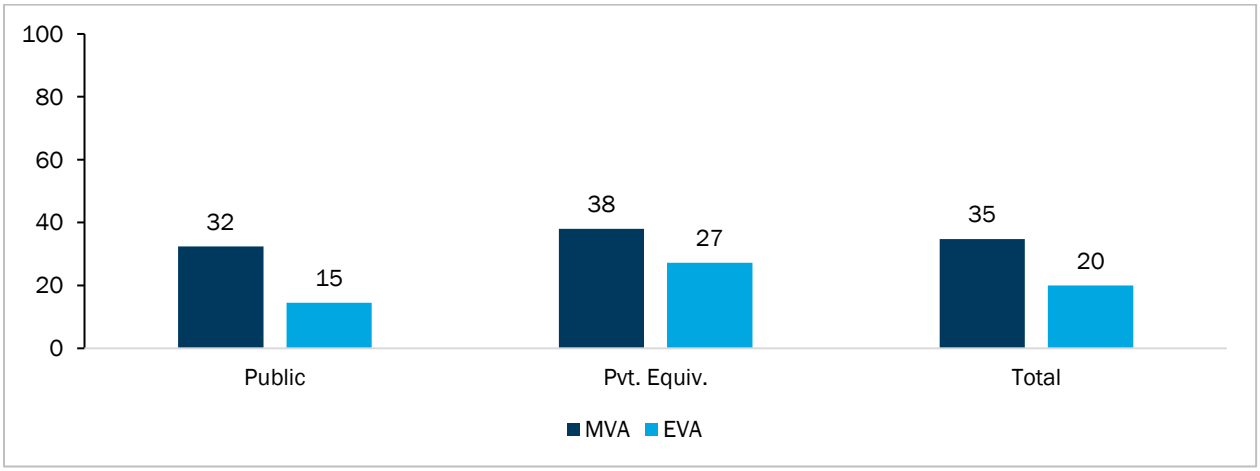
| | Public | | Private equivalent | |
|---|---|---|---|---|
| | Urban | Rural | Urban | Rural |
| Gynecologist | 17 | 7 | 63 | 38 |
| Female Doctor | 71 | 57 | 63 | 50 |
| Nurse/Midwife | 74 | 65 | 64 | 42 |
| LHV/FHT | 97 | 84 | 55 | 63 |
| Anesthetist | 21 | 5 | 44 | 37 |
| Laboratory Technician | 57 | 46 | 62 | 48 |
| **Total** | **57** | **46** | **63** | **48** |
| **Unweighted** | **84** | **210** | **226** | **76** |

Source: Weighted results, HFS 2023.

## 5.5 | Training of Health Care Providers

Figure 5.6 shows that a higher proportion of health facility respondents received training in MVA (35%) compared to EVA (20%). The percentage of professionals who received training in MVA was slightly higher in private health facilities (38%) than in public health facilities (32%). Similarly, the percentage of health professionals trained in EVA was greater in private health sector facilities (27%) than in public sector facilities (15%).

**Figure 5.6 | Percentage of providers who are reported to have received training in EVA and MVA for abortion care by private and public sector**




Source: Weighted results, HFS 2023.

### 5.5.1 | Capacity to Provide Post-Abortion Care

Looking at the capacity to provide post-abortion care, we find that referral and RHC facilities in both the public and private sectors are now generally well-equipped with essential supplies such as antibiotics, uterotonics, infection prevention measures, and sterilization equipment like autoclaves and chlorine disinfectants (data not shown).

Table 5.5 indicates that the availability of MVA kits has increased over the years, with 91% of teaching hospitals in the public sector and 90% in the private sector reporting availability of these kits. However, MVA sets were available in only half of the PHC facilities in public and private sectors. On the other hand, the comparatively unsafe D&C equipment, which has been in use for a long time, was universally available in both public and private sector facilities in urban and rural areas.

**Table 5.5 | Percentage of facilities with post-abortion care equipment by type of facility**

| | Public facilities | | | | | | | | Private facilities | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Teaching | | DHQ | | THQ | | RHC | | Tertiary level | | Secondary level | | Primary level | |
| | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 |
| MVA set | 54 | 91 | 18 | 61 | 17 | 58 | 19 | 41 | 42 | 90 | 29 | 59 | 28 | 51 |
| EVA set | 70 | 74 | 25 | 42 | 15 | 43 | 3 | 8 | 68 | 41 | 21 | 35 | 35 | 30 |
| D&C set | 100 | 100 | 97 | 100 | 88 | 92 | 91 | 94 | 100 | 97 | 83 | 94 | 92 | 76 |

**Source:** Weighted results, HFS 2023.

Another finding was that blood transfusion facilities were available in only 35% of THQ hospitals in the public sector and 49% in equivalent private sector facilities (Table 5.6). PHC facilities are not mandated to have blood transfusion services, hence their lower reported numbers.

Functional ambulances were available in all tertiary care facilities in the public sector. However, only half of the public sector RHCs and BHU+ centers had functional ambulances, while one-fifth of the MCH centers were linked to ambulance services. In the private sector, only 12% of PHC facilities and 60% of secondary health facilities had links to functional ambulances. Overall, public sector facilities had better ambulance coverage than private facilities.

Table 5.6 | Percentage of health facilities equipped with standard post-abortion care supplies by type of facility

| Equipment and supplies | Public | | | | | | | | | | | Private | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Teaching | | DHQ | | THQ | | RHC | | BHU | BHU+ | MCH | Tertiary level | | Secondary level | | Primary level | | Total | |
| | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2023 | 2023 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 | 2012 | 2023 |
| Sterilizer/Boiler | 97 | 100 | 88 | 84 | 78 | 92 | 72 | 87 | 77 | 96 | 82 | 95 | 100 | 100 | 95 | 94 | 94 | 88 | 88 |
| Autoclave | 100 | 91 | 100 | 84 | 63 | 73 | 58 | 71 | 58 | 91 | 43 | 95 | 100 | 94 | 96 | 91 | 74 | 82 | 72 |
| Bleach/Chlorine solution | 85 | 100 | 99 | 96 | 69 | 80 | 46 | 93 | 79 | 97 | 75 | 91 | 98 | 100 | 95 | 94 | 93 | 81 | 89 |
| Broad spectrum antibiotics | 100 | 91 | 100 | 93 | 92 | 95 | 91 | 90 | 90 | 100 | 85 | 95 | 87 | 100 | 86 | 98 | 81 | 96 | 88 |
| Analgesics | 100 | 100 | 79 | 96 | 81 | 84 | 90 | 74 | 83 | 89 | 72 | 95 | 87 | 100 | 80 | 97 | 75 | 94 | 80 |
| Misoprostol | 91 | 70 | 60 | 93 | 60 | 83 | 50 | 72 | 75 | 87 | 58 | 95 | 93 | 90 | 72 | 89 | 73 | 76 | 75 |
| Uterotonic drugs | 100 | 100 | 99 | 90 | 72 | 85 | 77 | 83 | 76 | 79 | 58 | 95 | 82 | 100 | 73 | 85 | 58 | 85 | 69 |
| Plasma expanders | 100 | 100 | 100 | 100 | 61 | 100 | 51 | 94 | 91 | 92 | 71 | 95 | 100 | 94 | 81 | 89 | 79 | 79 | 86 |
| Blood transfusion | 100 | 100 | 100 | 84 | 65 | 62 | 32 | 22 | 9 | 6 | 14 | 95 | 95 | 97 | 92 | 78 | 41 | 70 | 28 |
| Ambulance | 100 | 100 | 99 | 87 | 96 | 69 | 85 | 47 | 21 | 49 | 25 | 95 | 97 | 25 | 56 | 21 | 12 | 49 | 29 |
| **Overall n** | **33** | **14** | **24** | **26** | **44** | **22** | **63** | **52** | **91** | **43** | **44** | **21** | **15** | **16** | **71** | **65** | **216** | **266** | **594** |

Source: Unweighted results, HFS 2012, 2023.

Since post-abortion care is mandated in all public facilities, services should be available in facilities offering other reproductive care, especially as part of, or an extension of, maternal health services. Table 5.7 presents the distribution of facilities that offer the full range of maternal health services in the private and public sectors. Most teaching hospitals, DHQs, and THQs in the public sector, as well as tertiary and secondary-level facilities in the private sector offer a full range of maternal health services. THQs and secondary facilities are slightly lacking in post-natal hemorrhage care. In general, primary level facilities in the private sector are roughly equivalent to lower-level facilities in the public sector except for BHU+ which provide a broader range of services.

**Table 5.7 | Percentage distribution of health facilities that offer maternal health services by type of service and sector**

| Services | Public facilities | | | | | | | Private facilities | | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Teaching | DHQ | THQ | RHC | BHU | BHU+ | MCH | Tertiary level | Secondary level | Primary level | |
| Antenatal care | 100 | 98 | 100 | 100 | 100 | 100 | 100 | 100 | 97 | 100 | 100 |
| Delivery services | 100 | 100 | 95 | 93 | 78 | 97 | 79 | 98 | 100 | 76 | 83 |
| Postnatal care | 100 | 100 | 100 | 100 | 96 | 97 | 91 | 98 | 100 | 98 | 98 |
| Postnatal hemorrhage | 100 | 100 | 85 | 83 | 66 | 63 | 70 | 95 | 94 | 72 | 71 |
| **Unweighted number** | **14** | **26** | **21** | **53** | **85** | **43** | **44** | **15** | **70** | **211** | **582** |

Source: Weighted results, HFS 2023.

### 5.5.2 | Factors Influencing the Choice of Post-Abortion Care Facility and Provider

According to documented information, the quality of post-abortion care offered in public facilities is generally equivalent to that offered in private facilities, with a few exceptions.

Most men and women in Pakistan prefer to use private facilities for most aspects of healthcare.[25] We asked respondents the reasons why clients make this choice. In most cases, the staff at private health facilities are considered more polite, even though the required medicines are available in public facilities and the providers working there are equally competent. Furthermore, public sector services are less costly. Overall responses indicate that people are generally drawn to the attitude of staff at private facilities, the greater confidentiality and privacy they offer, the shorter waiting times, and the perceived better quality of care.

**Table 5.8 | Percentage distribution of reasons for choosing public or private sector facility among women who undergo abortion or for treatment of post-abortion complications by type of reason**

| | Public preferred | Private preferred |
|---|---|---|
| Staff is polite/ cooperative | 6 | 46 |
| Provider is competent | 30 | 31 |
| Female staff available | 51 | 34 |
| Medicines available | 52 | 24 |
| Better quality of medicines | 17 | 39 |
| Give proper time/attention | 13 | 61 |
| Timing of the facility suits clients | 22 | 27 |
| Free-of-cost services/charge less | 89 | 8 |
| Nearby location | 53 | 21 |
| Confidentiality is ensured | 0 | 52 |
| Treat with respect | 1 | 42 |
| No waiting times | 2 | 30 |
| Privacy is ensured | 1 | 45 |
| Informed choice respect | 0 | 6 |
| Ambulance available | 30 | 3 |
| **Unweighted number** | **83** | **71** |

Source: HPS 2023. Multiple responses permitted.

### 5.5.3 | Perspectives of Healthcare Providers on Post-Abortion Care, Family Planning, and Induced Abortion

Table 5.9 provides insights into the perspectives of different service providers on the provision of post-abortion care, as examined in the 2023 HPS. The service providers were divided into three categories: 1) General physician/WMO/obstetrician/gynecologist; 2) Nurse/midwife/LHV; 3) Program manager/health administrator/journalist/media researcher.

Survey results indicated that most service providers endorsed the following statements:

- It is the responsibility of the public sector to provide post-abortion care.
- Post-abortion care should be available and accessible.
- Adequate post-abortion care saves women's lives.

When the survey results for each category of service providers were disaggregated, it was revealed that many general physicians/WMOs/obstetricians/gynecologists supported the aforementioned statements. However, there were differences for other statements. Compared to physicians (98%) and nurse/midwife/LHV (88%), a lower percentage of program managers/health administrator/journalist/media researchers (78%) stated that post-abortion care is the responsibility of the public sector. Furthermore, health professionals were divided about the adequacy of training provided to service providers to offer post-abortion care services, with many feeling they were not adequately trained. A substantial proportion also reported that these providers had a negative attitude towards post-abortion care cases; doctors doubted the capability of paramedics. Non-medical respondents were even more negative in their assessment.

**Table 5.9 | Percentage of respondents who agree with statements regarding post-abortion care by category of service provider**

| Post-abortion care | General Physician/ WMO/Obstetrician/ Gynecologist | Nurse/ Midwife/ LHV | Program Manager/Health Administrator/Journalist/ Media Researcher |
|---|---|---|---|
| It is the responsibility of the public sector | 98 | 88 | 78 |
| Post-abortion care should be available and accessible | 99 | 98 | 100 |
| Adequate post-abortion care saves women's lives | 98 | 98 | 97 |
| Providers are not trained to treat post-abortion care patients | 48 | 47 | 64 |
| Doctors do not consider paramedics competent to provide post-abortion care services | 46 | 40 | 64 |
| Providers have a negative attitude towards post-abortion care patients | 48 | 37 | 64 |
| **Total** | **83** | **43** | **36** |

Source: HPS 2023.

The 2023 HPS also sought to assess the attitude of service providers towards family planning by asking HPS respondents to select statements from a given list. There was convergence in the responses.

Table 5.10 shows that most service providers across all categories approved of all the statements given in the table. The highest percentage (98% overall) supported the following statements:

- Family planning/birth spacing services should be more widely available.
- Correct and consistent use of family planning methods can prevent pregnancy and, therefore, induced abortions.

100% of program managers/health administrators/journalists/media researchers agreed with these statements and also:

- Women should use contraception to prevent unwanted pregnancies.

Nurses/midwives/LHVs, at 88%, agreed with the statements:

- A woman has the right to decide whether or not she wants to have a child, when to have and how many to have.
- Women should use contraception to prevent unwanted pregnancies.

This represents the smallest percentage of service providers who supported these statements.

**Table 5.10 | Percentage distribution of respondents by opinions regarding contraception/family planning and category of service provider**

| Attitude towards contraception | General physician/ WMO/Obstetrician/ Gynecologist | Nurse/ Midwife/ LHV | Program manager/Health administrator Journalist/ Media researcher | Overall |
|---|---|---|---|---|
| Family planning/birth spacing services should be more widely available | 98 | 98 | 100 | 98 |
| A woman has the right to decide whether or not she wants to have a child, when to have and how many to have | 94 | 88 | 97 | 93 |
| Women should use contraception to prevent unwanted pregnancies | 96 | 88 | 100 | 95 |
| Correct and consistent use of family planning methods can prevent pregnancy and, therefore, induced abortions | 99 | 95 | 100 | 98 |
| **Unweighted number** | **83** | **43** | **36** | **162** |

Source: HPS 2023.

The 2023 HPS assessed service providers' attitudes towards induced abortions by scoring their agreement with value statements listed in Table 5.11.

Most respondents (99% overall) agreed with the statement, "Abortion is acceptable to protect a woman's life." Comparing the data by service provider, 100% of program managers/health administrators/journalists/media, 98% of nurses/midwives/LHVs, and 99% of general physicians/WMO/obstetricians/gynecologists concurred.

The lowest level of agreement across all categories (80%) was on whether "Abortion is acceptable for a woman who has been raped."

**Table 5.11 | Percentage distribution of opinions regarding abortion by category of service provider**

| Attitude towards abortion | General physician/ WMO/ Obstetrician/Gynecologist | Nurse/ Midwife/ LHV | Program manager/ Health administrator/ Journalist/Media Researcher | Overall |
|---|---|---|---|---|
| Abortion is allowed under certain circumstances | 99 | 91 | 97 | 96 |
| Abortion is acceptable when fetus is abnormal | 95 | 98 | 97 | 96 |
| Abortion is acceptable to protect a woman's life | 99 | 98 | 100 | 99 |
| Abortion is acceptable for a woman who has been raped | 75 | 88 | 81 | 80 |
| **Unweighted number** | **83** | **43** | **36** | **162** |

Source: HPS 2023.

## 5.6 | Summary

While all public and private sector facilities are designated to offer post-abortion care, as per government guidelines, currently about 20% are not offering this service. Furthermore, even among the facilities that offer post-abortion care, not all have the full capacity to provide comprehensive care. In other words, critical post-abortion care services may be inaccessible to many women depending on where they live and how much they can afford.

Generally, higher-level facilities are better equipped. The quality of care varies widely depending on the facility level, with only 11% providing comprehensive services round-the-clock. Urban facilities generally outperform rural ones, which raises equity concerns.

Referral-level facilities, especially in the public sector, are more likely to have adequate equipment for post-abortion care. The relatively safer MVA method needs to be more readily available at PHC facilities, along with training for staff in its use.

National guidelines on post-abortion care should be implemented at primary, secondary, and tertiary care facilities to ensure comprehensive care. A major priority should be making the referral system from PHCs to higher-level facilities operational by providing functional ambulances at PHC facilities.

A notable finding is that while misoprostol is increasingly used as a method of abortion, the probability of complications remains substantial, likely due to incorrect usage and inadequate counseling from abortion providers.

Another finding is that, although declining, outdated methods like D&C persist despite WHO recommendations against them. Many facilities lack the ability to provide the relatively safer vacuum aspiration procedure mainly due to a shortage of trained staff.

CHAPTER 6

# Provision of Pregnancy-Related Services with a Focus on Contraceptive Care: Post-Abortion and Post-Partum

- Most public and private facilities offer a wide range of women's health services.
- Almost all facilities offer antenatal and post-natal services, and about 80% offer delivery care.
- Around 80% of facilities provide post-abortion care, and 70% offer post-partum hemorrhage care.
- Family planning services are reportedly offered at 94% of public health facilities and 83% of private health facilities.
- Post-abortion family planning services are offered in 94% of public health facilities, but the provision varies by facility level, with about 50% of smaller facilities referring women to higher-level facilities for post-abortion family planning.
- Provision of post-partum counseling was similar in public and private facilities—95% and 94%, respectively. However, provision of contraceptives for post-partum care was available in 90% of public health facilities and 75% of private facilities.
- Provision of post-partum counseling and contraceptives for post-partum family planning is widespread with some noteworthy differences: nearly all public facilities in Balochistan, Azad Jammu and Kashmir, and Punjab provide post-partum counseling compared to 77% in Islamabad.

Women's reproductive health needs are varied and, therefore, it is important to assess the extent to which these are addressed by health facilities. Respondents of the Health Facilities Survey (HFS) provided information about the services they offer. In addition, the HFS included questions on the provision of post-abortion and post-partum family planning services, which are critical to preventing unintended pregnancies and associated health risks, thereby reducing the need for other reproductive health services. This chapter first provides information on the availability of various reproductive health services, followed by details on the provision of post-abortion and post-partum family planning services. We examine the availability of these services by public and private sectors, level of facility, and region.

## 6.1 | Women's Health Service Provision by Level of Facility and Region

Overall, 98% and 96% of all health facilities provide antenatal and post-natal care, respectively (Table 6.1). Over 90% of facilities at all levels and in both public and private sectors provide antenatal and post-natal care, except for MCH centers, which still have a figure of 90% for postnatal care. Delivery services are also widely available—over 90% at different facility levels, except in primary-level facilities of the private sector. Overall, delivery services are offered by 94% of public health facilities and 78% of private facilities.

There is a considerable variation in provision of post-abortion care across different levels of facilities in both the public and private sectors. Almost 100% of higher-level facilities, such as teaching hospitals and DHQs, provide post-abortion care, but this drops to below 80% in smaller facilities. Overall, post-abortion care is offered in 82% of private facilities and 79% of public facilities.

Post-natal hemorrhage treatment is the least available service and surprisingly lower in public facilities, especially in BHUs and BHU+. Family planning counseling and contraceptives are offered by over 90% of public and private sector facilities.

**Table 6.1 | Percentage of facilities providing women's health services by type of service, public/private sector, and level of facility**

| | Antenatal care | Providing delivery services | Postnatal care | Postnatal hemorrhage | Providing post-abortion care | Family planning Services* | Overall number |
|---|---|---|---|---|---|---|---|
| **Public** | | | | | | | |
| Teaching | 100 | 100 | 100 | 100 | 100 | 100 | 14 |
| DHQ | 98 | 100 | 100 | 100 | 100 | 100 | 26 |
| THQ | 95 | 95 | 95 | 80 | 76 | 92 | 22 |
| RHC | 100 | 94 | 100 | 83 | 83 | 94 | 53 |
| BHU | 97 | 90 | 93 | 63 | 79 | 92 | 91 |
| BHU+ | 100 | 100 | 97 | 63 | 76 | 98 | 43 |
| MCH | 99 | 91 | 90 | 70 | 77 | 92 | 45 |
| **Private Equiv.** | | | | | | | |
| Tertiary level | 100 | 98 | 98 | 95 | 98 | 91 | 15 |
| Secondary level | 94 | 96 | 96 | 91 | 92 | 78 | 72 |
| Primary level | 98 | 75 | 96 | 71 | 81 | 84 | 215 |
| **Public** | 98 | 94 | 95 | 67 | 79 | 94 | 294 |
| **Private Equiv.** | 97 | 78 | 96 | 73 | 82 | 84 | 302 |
| **Total** | **98** | **87** | **96** | **70** | **80** | **90** | **596** |

Source: Weighted results, HFS 2023. *Facilities providing contraceptives.

When we examine the same services across provinces and regions, the level of provision shows a different picture (Table 6.2). Regional and provincial differences are most pronounced, with all public health facilities in Punjab, Sindh, Balochistan, and AJK providing antenatal care compared to 90% in KP and GB, and the least, 77%, in public facilities of Islamabad. However, 100% of private health facilities provided antenatal care in KP, AJK, and Gilgit Baltistan while over 94% of private facilities offered this service in the remaining provinces/regions.

Provision of delivery services varied between public and private facilities and across regions, with the widest margin in Islamabad, where 53% of public facilities compared to 94% of private facilities reported providing delivery service. Notable differences were also found between public and private facilities providing delivery services in Punjab (97% vs. 73%) and Balochistan (80% vs. 95%).

Post-natal care was provided in almost all public and private facilities, except in public facilities in KP (79%) and Islamabad (77%). Compared to other women's health services, post-natal hemorrhage care was the least provided, especially in public facilities in Punjab (68%), KP (44%), Balochistan (42%), and Islamabad (38%). The level of provision in private facilities was broadly similar to public facilities in the same province/region.

Provision of post-abortion care ranged from 70% of public facilities in Islamabad to 98% of public facilities in Balochistan. While all private facilities in Balochistan and Islamabad provided post-abortion care, only 60% of private facilities did so in Gilgit Baltistan. Family planning counseling and provision of contraceptive services were generally widely available with minor differences across provinces/regions and public/private facilities.

**Table 6.2 | Percentage of public and private health facilities providing specific pregnancy-related services by province and regions**

| | Punjab | | Sindh | | Khyber Pakhtunkhwa | | Balochistan | | Azad Jammu & Kashmir | | Gilgit Baltistan | | Islamabad | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Public | Pvt. Equiv. | Public | Pvt. Equiv. | Public | Pvt. Equiv. | Public | Pvt. Equiv. | Public | Pvt. Equiv. | Public | Pvt. Equiv. | Public | Pvt. Equiv. |
| Antenatal care | 100 | 98 | 100 | 95 | 90 | 100 | 100 | 95 | 100 | 100 | 90 | 100 | 77 | 94 |
| Providing delivery services | 97 | 73 | 95 | 99 | 93 | 100 | 80 | 95 | 100 | 94 | 100 | 100 | 53 | 94 |
| Postnatal care | 98 | 96 | 100 | 98 | 79 | 100 | 100 | 100 | 94 | 94 | 84 | 100 | 77 | 94 |
| Postnatal hemorrhage | 68 | 71 | 93 | 92 | 44 | 45 | 42 | 95 | 94 | 94 | 90 | 95 | 38 | 86 |
| Providing post-abortion care | 76 | 80 | 88 | 91 | 64 | 92 | 98 | 100 | 71 | 66 | 79 | 60 | 70 | 100 |
| Family planning services* | 97 | 85 | 95 | 75 | 80 | 86 | 95 | 100 | 100 | 94 | 90 | 100 | 92 | 86 |
| **N** | **101** | **133** | **58** | **70** | **51** | **27** | **35** | **16** | **21** | **13** | **14** | **16** | **14** | **27** |

Source: Weighted results, HFS 2023. *Facilities providing contraceptives.

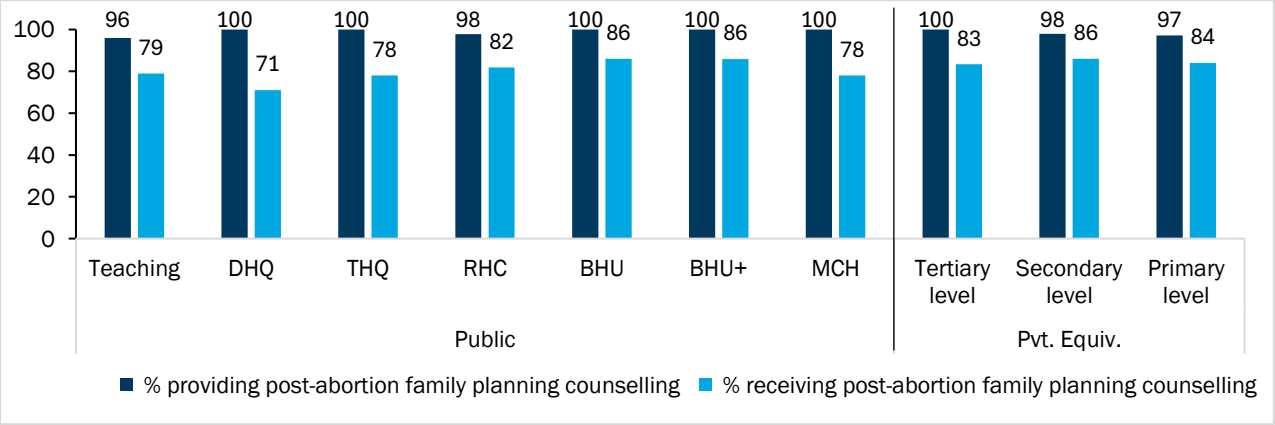
## 6.2 | Post-Abortion Family Planning Counseling and Services by Sector

Post-abortion family planning counseling is effective in curtailing unplanned pregnancies and, therefore, reducing the likelihood of abortions or unwanted births.[26] This is an essential element in reproductive health services as it lowers the chances of women undergoing unsafe abortion procedures, especially in a country such as Pakistan where there are legal hurdles to accessing safe abortion care.

We assess the extent to which health facilities and providers offer post-abortion and post-partum family planning, including the type of contraceptive methods discussed during counseling. Additionally, we examine the type of contraceptives offered by health facilities, along with the referral of patients for family planning counseling and methods.

Post-abortion counseling on one or more topics is universally provided across all levels of public and private facilities (Figure 6.1). Within public health facilities, however, the highest proportion of women offered counseling on post-abortion family planning was in the smaller BHUs and BHU+, with a somewhat lower proportion offering the same in larger teaching hospitals, THQ, and DHQs. A considerable attrition was observed in the level of post-abortion counseling as figures dropped to 80% or lower. A higher number of smaller private health facilities offer post-abortion family planning counseling. This supports the perception that with a higher caseload, staff in larger health facilities and teaching hospitals are pressed for time and, therefore, unable to devote sufficient attention to post-abortion family planning counseling.

**Figure 6.1 | Percentage of public and private health facilities providing general post-abortion counseling and percentage of women who received post-abortion family planning counseling by sector and level of facility**

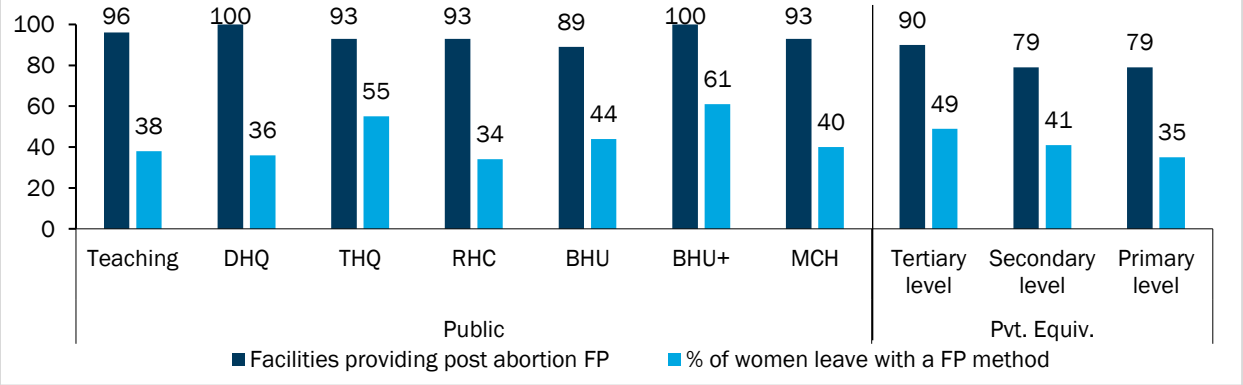



Source: HFS 2023. n = 497.

The greatest attrition is seen in the low proportion of women who leave post-abortion care services with a contraceptive method. Less than 50% of women visiting public or private facilities for post-abortion care leave with a contraceptive method (Figure 6.2). The reasons for this could be because not all women want to use contraception; it must be the woman's decision and preference. Other reasons could include insufficient and low-quality counseling, as well as a lack of availability of methods in the facility. The availability of contraceptive methods is essential for women to leave with a method of their choice. A higher percentage of women receiving post-abortion care in public facilities (48%) leave with a method compared to those in private health facilities (36%). (Data not shown)

There were important differences across varying categories of public health facilities. The highest percentage of women leaving with a contraceptive method were those treated at BHU+ facilities. The proportion of women leaving larger public teaching hospitals and DHQs with contraceptive methods was barely half the comparable proportion among BHU+ clients. This may be partly because they are less likely to receive family planning counseling as shown in Figure 6.1.

**Figure 6.2 | Percentage of public and private health facilities providing post-abortion family planning services and percentage of post-abortion care clients who leave with a family planning method by sector and level of facility**




Source: HFS 2023. n = 497.

The proportion of facilities with contraceptive methods available on-site was much lower than those offering counseling, as shown earlier in Table 6.1. Public sector facilities were more likely to have contraceptive methods available compared to private facilities (Table 6.3). Oral pills, injectables, and intrauterine contraceptive devices (IUCDs) were the three most commonly available methods in both public and private health facilities. Emergency contraception (EC) pills were in about a third of the facilities. Implants, despite their market shortage, were available in 25% of facilities. Tubal ligation was primarily offered in teaching hospitals, DHQs, THQs, and higher-level private facilities.

**Table 6.3 | Percentage of facilities providing contraception to post-abortion family planning clients by type of method, sector, and level of facility**

| Sector | Facility level | Method availability at facility | | | | | | | | UWN |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Condom | Oral Pills | Injectables | EC pills | IUCD | Implant | Tubal ligation | Vasectomy | |
| **Public** | Teaching | 68 | 87 | 74 | 52 | 96 | 65 | 52 | 20 | 14 |
| | DHQ | 57 | 94 | 89 | 54 | 98 | 53 | 28 | 0 | 26 |
| | THQ | 64 | 93 | 89 | 64 | 79 | 66 | 28 | 23 | 17 |
| | RHC | 68 | 90 | 80 | 26 | 78 | 19 | 2 | 0 | 45 |
| | BHU | 67 | 81 | 78 | 27 | 66 | 26 | 2 | 0 | 68 |
| | BHU+ | 89 | 100 | 97 | 32 | 91 | 34 | 5 | 2 | 33 |
| | MCH | 58 | 79 | 82 | 19 | 76 | 18 | 0 | 0 | 36 |
| **Pvt Equiv.** | Tertiary level | 19 | 90 | 77 | 41 | 90 | 28 | 52 | 6 | 14 |
| | Secondary level | 47 | 79 | 72 | 43 | 78 | 48 | 41 | 7 | 68 |
| | Primary level | 39 | 76 | 73 | 40 | 70 | 15 | 7 | 0 | 176 |
| **Public** | | 72 | 88 | 84 | 30 | 77 | 29 | 4 | 2 | 239 |
| **Pvt Equiv.** | | 40 | 77 | 73 | 40 | 72 | 20 | 12 | 1 | 258 |
| **Total** | | **58** | **83** | **79** | **34** | **75** | **25** | **8** | **1** | **497** |

Source: Weighted results, HFS 2023.

Table 6.4 shows the percentage of public or private health facilities providing referrals for family planning to post-abortion care patients. Overall, a similar percentage of all public and private facilities (53% and 52%, respectively) provide referrals for family planning. BHUs have the highest level of referrals for post-abortion family planning (60%) and most of the cases are referred to DHQ facilities (46%), followed by teaching hospitals (36%). In the private sector, primary level facilities refer post-abortion patients mostly to teaching hospitals (50%) or to DHQ facilities (47%). Importantly, fewer patients are referred to private facilities for post-abortion family planning.

### Table 6.4 | Percentage of public and private health facilities providing referrals for post-abortion family planning by level of facility

| | Type of facilities referring | | Types of facilities where the referrals were made* | | | | | | | | | | Overall n |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Public | | | | | | Private | | | | |
| | % of facilities referring | Overall n UWN | Teaching Hospital | DHQ | THQ | RHC | BHU | MCH Centers | Tertiary level | Private Hospital | Private Clinics | Pharmacy | UWN |
| **Public** | | | | | | | | | | | | | |
| Teaching | 0 | 14 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| DHQ | 35 | 26 | 27 | 0 | 0 | 0 | 0 | 0 | 0 | 22 | 0 | 0 | 8 |
| THQ | 32 | 22 | 58 | 57 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| RHC | 50 | 53 | 28 | 58 | 24 | 0 | 0 | 1 | 0 | 11 | 3 | 0 | 28 |
| BHU | 60 | 91 | 36 | 46 | 23 | 14 | .1 | 2 | 5 | 10 | 4 | 0 | 52 |
| BHU+ | 46 | 43 | 15 | 66 | 34 | 6 | 0 | 0 | 0 | 8 | 0 | 0 | 19 |
| MCH | 56 | 45 | 62 | 28 | 8 | 0 | 0 | 0 | 0 | 6 | 0 | 0 | 25 |
| **Pvt. Equiv.** | | | | | | | | | | | | | |
| Tertiary level | 36 | 15 | 92 | 8 | 0 | 8 | 0 | 8 | 0 | 0 | 0 | 0 | 6 |
| Secondary level | 47 | 72 | 39 | 41 | 29 | 0 | 0 | 15 | 0 | 12 | 0 | 0 | 29 |
| Primary level | 53 | 215 | 50 | 47 | 8 | 4 | 1 | 4 | 1 | 2 | 2 | .4 | 107 |
| Public | 53 | 294 | 33 | 50 | 24 | 8 | .0 | 1 | 3 | 9 | 2 | 0 | 139 |
| Pvt. Equiv. | 52 | 302 | 49 | 46 | 10 | 4 | 1 | 5 | 1 | 3 | 1 | .3 | 142 |
| **Total** | **52** | **596** | **40** | **48** | **18** | **7** | **.3** | **3** | **2** | **6** | **2** | **.1** | **281** |

Source: Weighted results, HFS 2023. Multiple responses allowed.

## 6.3 | Post-Partum Family Planning Counseling and Contraceptive Services by Public/Private Sector

Post-partum family planning (PPFP) is a widely recognized high-impact best practice. It increases family planning uptake by encouraging the use of family planning methods within the first 12 months of childbirth to prevent unintended pregnancy and poorly spaced birth. In the case of immediate PPFP, contraception is used within the first 48 hours after childbirth. Post-partum counseling for family planning aims at spacing births by at least two years to preserve the mother's health, reducing the possibility of maternal and child mortality, and allowing the family to have a better quality of life. It can also help limit family size for those who want no more children.

Over 90% of facilities in both the public and private sectors provide information and counseling on post-partum family planning (Table 6.5). This highlights a significant potential for increased PPFP uptake in Pakistan. The provision of information and counseling on post-partum family planning was similar across sectors: 95% in public and 94% in private facilities.

A large percentage of public and private healthcare facilities provided four contraceptive methods (58% to 62%)—IUCDs, condoms, oral pills, and injectables—as the most widely available contraceptive methods for post-partum women. Tubal litigation was the least offered method, provided by only 4% of all health facilities. However, while 90% of public and 75% of private facilities provide contraceptive methods on-site, important PPFP-recommended methods such as implants, and EC pills were hardly available (13% and 25% respectively).

**Table 6.5 | Percentage of public and private health facilities providing post-partum family planning counseling and percentage of available contraceptive methods by sector and level of facility**

| | Counseling on PPFP Available* | PPFP service provision available* | Methods available for PPFP | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Condom | Oral Pills | Injectables | EC pills | IUCD | Implant | Tubal ligation | Vasectomy | |
| | % | % | % | % | % | % | % | % | % | % | UWN |
| **Public** | | | | | | | | | | | |
| Teaching | 100 | 91 | 53 | 66 | 52 | 30 | 91 | 41 | 37 | 2 | 14 |
| DHQ | 100 | 100 | 63 | 76 | 79 | 35 | 86 | 31 | 16 | 0 | 26 |
| THQ | 92 | 87 | 56 | 67 | 75 | 31 | 65 | 31 | 10 | 6 | 22 |
| RHC | 97 | 90 | 54 | 69 | 67 | 22 | 63 | 7 | 0 | 0 | 53 |
| BHU | 93 | 84 | 60 | 64 | 60 | 20 | 53 | 18 | 1 | 0 | 91 |
| BHU+ | 98 | 98 | 77 | 63 | 73 | 20 | 77 | 16 | 2 | 0 | 43 |
| MCH | 96 | 89 | 63 | 61 | 69 | 10 | 68 | 6 | 0 | 0 | 45 |
| **Private** | | | | | | | | | | | |
| Tertiary level | 100 | 87 | 23 | 64 | 74 | 27 | 87 | 16 | 30 | 6 | 15 |
| Secondary level | 92 | 75 | 52 | 69 | 62 | 48 | 70 | 45 | 35 | 2 | 72 |
| Primary level | 94 | 76 | 49 | 56 | 57 | 29 | 59 | 4 | 2 | 0 | 215 |
| Public | 95 | 90 | 65 | 64 | 66 | 20 | 64 | 16 | 2 | 0 | 294 |
| Private | 94 | 76 | 49 | 58 | 58 | 31 | 60 | 9 | 6 | 0 | 302 |
| **Total** | **95** | **83** | **58** | **61** | **62** | **25** | **62** | **13** | **4** | **0.2** | **596** |

Source: Weighted results, HFS 2023.

Provincial and regional variations in the provision of counseling and contraceptives for post-partum family planning are noteworthy. While 99%–100% of public facilities in Balochistan, AJK, and Punjab provide post-partum counseling, 86% in KP, and 77% in Islamabad provide this service (Table 6.6). All private facilities in Balochistan and Gilgit Baltistan provided post-partum family planning counseling, compared to 89% in Sindh and 91% in Islamabad.

The provision of contraceptives for post-partum family planning was most common (over 90%) in public facilities in Punjab, Sindh, Balochistan, AJK, and Islamabad, while it is lowest in KP (60%). All private facilities in Balochistan provide contraceptives for post-partum family planning compared to 55% of private facilities in AJK. Over 70% of private facilities reported providing contraceptives for post-partum family planning in other provinces and regions.

**Table 6.6 | Percentage of public and private health facilities providing post-partum family planning counseling and contraception by province and region**

| | | Counseling Post-partum | Providing contraceptives to PPFP | |
|---|---|---|---|---|
| | | % | % | Unweighted N |
| **Public** | Punjab | 99 | 97 | 101 |
| | Sindh | 89 | 95 | 58 |
| | Khyber Pakhtunkhwa | 86 | 60 | 51 |
| | Balochistan | 100 | 92 | 35 |
| | Azad Jammu & Kashmir | 100 | 91 | 21 |
| | Gilgit Baltistan | 90 | 80 | 14 |
| | Islamabad | 77 | 92 | 14 |
| **Private Equiv.** | Punjab | 95 | 75 | 133 |
| | Sindh | 89 | 75 | 70 |
| | Khyber Pakhtunkhwa | 92 | 77 | 27 |
| | Balochistan | 100 | 100 | 16 |
| | Azad Jammu & Kashmir | 94 | 55 | 13 |
| | Gilgit Baltistan | 100 | 80 | 16 |
| | Islamabad | 91 | 83 | 27 |
| Public | | 95 | 90 | 294 |
| Private | | 94 | 76 | 302 |
| **Total** | | **95** | **84** | **596** |

Source: Weighted results, HFS 2023.

## 6.4 | Summary

Provision of reproductive health services varied by type of service, region, level of facility, and sector.

Treatment for post-natal hemorrhage was the least provided service, while antenatal, post-natal, and family planning services were the most widely provided.

Family planning is critical in avoiding health risks associated with an unintended pregnancy. It can therefore reduce the need for other reproductive health services such as for antenatal care, delivery care, post-natal care, post-natal hemorrhage treatment, abortion, and post-abortion care. Post-partum amenorrhea serves as a temporary contraceptive method soon after childbirth. Therefore, post-partum women should be counseled about family planning after delivery during post-nata care visits.

Although post-partum family planning counseling may be quite widely offered, HFS data show that fewer health facilities, both public and private, provide post-abortion contraceptive services. This suggests that the need for family planning among post-abortion care clients is less well addressed compared to post-partum women.

These differences aside, improving the provision of quality family planning services to women receiving both post-partum and post-abortion care is crucial in Pakistan. This can help prevent repeat abortions, poorly spaced high-risk births, and empower women and couples to achieve their family size.

CHAPTER 7

# Conclusions and Recommendations

This report presents the most recent information about abortion services—the methods and providers that women use, the probability of women experiencing post-abortion complications, and the number of women treated in public and private health facilities for such complications across all provinces and regions of Pakistan. It also explores the readiness of health systems to respond to the need for an essential reproductive health service affecting millions of women across the country.

The 2023 study design and sample selection are nationally representative, covering all provinces and the regions of Gilgit-Baltistan, Azad Jammu and Kashmir, and Islamabad Capital Territory. It includes smaller public sector facilities that were not part of the earlier 2012 study. Moreover, the current listings of health facilities are more comprehensive than those used in the earlier study, resulting in a more complete sampling frame, especially for private sector facilities. Additional questions regarding women's health services have also been added in this round.

Utilizing an approach developed by the Guttmacher Institute for estimating post-abortion complications, the 2012 study provided a timely marker for a key component of reproductive care in Pakistan. The 2023 study goes beyond this, analyzing changes in abortion care ranging from the choice of abortion methods and the training of providers to the readiness of facilities to provide abortion care at levels prescribed by the Government of Pakistan and international standards.[27]

## 7.1 | Key Findings

**The first finding of the study is that the average age of women seeking abortions in Pakistan is estimated to be lower than it was eleven years ago.** Based on knowledgeable key informants' perceptions, women are more likely to make decisions related to abortion independently or after discussing with their husbands. Induced abortions are being used by women earlier in their childbearing years to make key reproductive choices about the timing and numbers of children.

**The second important finding is the widespread use of misoprostol as a method to induce abortion and treat post-abortion complications.** Almost half or more of women in both rural and urban areas use misoprostol for an induced abortion. Almost all key informants mentioned misoprostol as a currently provided method. While surgical abortions are still a dominant option provided by doctors and paramedics, they are mainly availed by non-poor women in urban and rural areas. On the other hand, poor women, especially in rural areas, tend to go to pharmacists to procure medication for self-inducing abortions or consult traditional providers.

**The third finding is that the costs of abortion have risen dramatically across different categories of providers.** While misoprostol itself is inexpensive, the provider a woman chooses largely determines the overall cost of an abortion. Doctors are the most expensive, followed by nurses and LHVs. Traditional providers present the cheapest option. Due to cost, surgical procedures are more common among non-poor women. The poorest women may have little or no access to these choices, as abortions are offered by private sector providers and not as part of the public health system. Among poor women, especially in rural areas, a notable proportion seek care from traditional

providers or attempt self-induced abortion likely due to financial constraints, according to health professionals.

**The fourth finding concerns the safety of abortion care.** We estimated safety based on the combination of method used and the type of provider administering the method, or whether the abortion was self-induced. Overall, 20%–30% of women who had abortion regardless of method were reported to face complications. This indicates that abortion care is generally unsafe in the country, despite the increased use of medication abortion, a method which is considered low risk when used appropriately.

While the reported complications are highest among poor-rural women (29.7%), they were reported to be quite high for non-poor rural (23.7%), and urban poor women (25.1%). Meanwhile, the proportion reported as experiencing complications is lowest for urban non-poor women (21.0%).

Poor women who used misoprostol were reported to have the highest level of complications. Surprisingly, complication risks were considerable when abortions were administered by doctors and paramedics.

**The fifth finding is that there are an estimated 870,185 post-abortion complication cases—including induced and spontaneous abortion complications—receiving treatment nationwide within the formal health system in 2023.** This does not include those who go to traditional providers or self-treat complications. The majority present as out-patients (604,199) and a little less than half that number (266,066) present as in-patients. The largest number of complications are reported for Punjab (451,820), followed by Sindh (215,940), and the rest are spread over KP (76,706), Balochistan (60,419), AJK (27,876), GB (18,283), and Islamabad (19,140).

Public teaching facilities see the most post-abortion cases, followed by BHUs with a substantial number (123,169). While private primary facilities also tend to have a high number (235,001), the majority are out-patients. Overall, the higher volume and wider availability of public facilities contribute to the larger total. The public sector is clearly the preferred option for post-abortion care, particularly because care is subsidized and less expensive.

Limiting data to the same regions and levels of facilities in both the 2012 and 2023 studies, we find the total number of post-abortion cases to have declined in Pakistan and in facilities in both the public and private sectors, except in public teaching hospitals. It is quite possible that more serious complications, especially those requiring in-patient care, are being seen more frequently by large teaching hospitals, where the number of cases have increased more than threefold from 23,973 to 84,118.

In terms of the distribution of post-abortion cases between public and private sector facilities, the numbers have remained stable in the public sector at 265,044 but declined (by almost 100,000 cases in the private sector) to 328,376. The data suggest that, while the private sector is wholly providing abortions, the load of post-abortion cases falls squarely on the public sector, posing a significant drain on limited, subsidized resources. Notably, the highest level of teaching hospitals and tertiary facilities in the public sector are seeing an average of 2,431 women for post-abortion care annually.

**The sixth finding is on the rate of abortion complications (induced and spontaneous combined) per 1,000 women and its comparisons over time.** This analysis considers the increased number of women of reproductive age and the increase in the number of births between 2012 and 2023. It provides a direct comparison of the rate of abortion complications nationwide and by province and

region. When considering the number of complications estimated for Pakistan, including all its provinces and regions and the expanded numbers of facilities, we find that the rate of all abortion complications has declined from 15.9 per 1,000 women aged 15–49 in 2012 to 12.9 per 1,000 in 2023 (a 19% decline). However, if we exclude the number of complications occurring in the expanded part of the study coverage and restrict it to comparable regions and levels of facilities in the 2012 study, we find a much larger decline (about 35%) in the complication rate, to 10.4 per 1,000 women in 2023.

**The seventh finding relates to the quality of care. While all primary- and referral-level facilities in the public sector, especially those providing maternal health care in Pakistan, are mandated to provide post-abortion care,[8] we found that one in five of these facilities do not provide this service, potentially leaving post-abortion care out of reach for many women.** Most of these facilities report that they provide delivery services, which indicates that they should also be able to offer basic care for abortion-related complications.[12] Notably, a larger proportion of referral facilities, more so in the public than the private sector, report having adequate post-abortion care equipment and supplies.

**The eighth finding is that while post-partum family planning (PPFP) is taking root and counseling is mentioned by most facilities, the same facilities report much lower levels of post-abortion family planning services.** Only 79% of teaching facilities in the public sector and even lower proportions of DHQs (71%) and THQs (78%) report availability of post-abortion family planning counseling. The availability of contraceptive methods by facility type follows a similar pattern to the one reported for PPFP, except availability levels are even lower. Only 57% of public and 33% of private facilities report the availability of condoms, which should be a widely available method, for post-abortion family planning.

In 2023, post-partum and post-abortion family planning counseling was reportedly provided by 94% and 86% of all public and private facilities, respectively. However, designated counselors are rarely available (9%) in both sectors, and doctors and nurses are not as likely to provide counseling as LHVs (95%) in the public sector. The availability of contraceptive services on-site, even in public sector facilities, is patchy: condoms, pills, injectables, and IUCDs are available in only 58%–62% of facilities. Implants and tubal ligation are available in less than 15% of public facilities. In the private sector, the availability of contraceptives is even lower.

## 7.2 | Policy and Program Recommendations

Significant progress has been made in the provision of abortion and post-abortion care. Yet, many gaps in service provision and quality of care continue to exist. Findings of the 2023 study have gained heightened significance due to prevailing high inflation, making access to private providers—the main service provider for safe abortion—less affordable. The current financial situation has also constrained much-needed investment in the health system by the federal and provincial governments. Thus, evidence-informed high-priority recommendations are critically needed at this juncture.

The findings of this study highlight critical areas for policy and programmatic interventions to improve abortion and post-abortion care services in Pakistan. Below are key recommendations aimed at addressing the gaps and challenges identified.

## Establish a Supportive Policy Framework

To enhance women's access to safe abortion services, it is essential to address legal ambiguities and religious misperceptions. A clear policy framework is needed to provide clarity and support for necessary medical treatments.

- Develop policies that support women's access to safe abortion services by clarifying legal ambiguities and addressing religious misperceptions.
- Initiate dialogue among medical experts, legal professionals, and religious scholars to enhance understanding of “necessary treatment” for preserving health, including physical, mental, and social well-being.
- Incorporate religious scholars' perspectives on the permissibility of abortions within 120 days of conception to inform the interpretation of existing laws.

## Reduce Financial Burden on the Public Health System

Pakistan’s already fragile health system bears a significant financial burden by subsidizing services for post-abortion complications. Effective contraception and enhanced family planning services are critical to reducing the number of unintended pregnancies and abortions.

- Promote effective contraception to prevent unintended or mistimed pregnancies and increase modern contraceptive prevalence.
- Enhance access to quality family planning services in both public and private sectors, with a strong emphasis on post-partum and post-abortion family planning.
- Place designated family planning counselors in all facilities and ensure greater availability of contraceptive services and methods, especially in facilities where deliveries occur.
- Make emergency contraceptive pills readily available, especially through community-based health systems, to address situations where couples are not using modern family planning methods consistently due to limited access or irregular sexual activity.
- Expand counseling at the household level by lady health visitors and community midwives to address rural–urban inequities in access to family planning information and services.

## Expand Training and Improve Guidance for Medication Abortion

The use of medication abortion, a safer and more accessible option for self-managed abortion and treatment of post-abortion complications, has grown over time. However, this increase is accompanied by a rise in associated complications, particularly in public facilities. This suggests potential problems with incorrect use due to inadequate guidance or counseling. The complication rate for medication abortion administered by trained providers (including nurses, midwives, LHVs, TBAs, and others) remains unacceptably high, with one in five women experiencing complications. Proper training and information dissemination are crucial.

- Increase the training of providers and pharmacists on the quality provision of medication abortion.
- Provide accurate information on correct usage, potential side effects, and self-assessment guidance for women purchasing medication abortion to ensure timely care in case of complications.
- Implement task sharing between community and facility-based providers to offer support for women using medication abortion.

### Minimize Use of Outdated Abortion Methods

The continued use of outdated methods such as dilatation and curettage (D&C) poses significant risks. Safer, WHO-recommended methods should be prioritized.

- Reduce the use of D&C in favor of safer methods, as recommended by WHO.
- Ensure that surgical abortion methods are only provided by trained doctors, particularly for poor women, to reduce the risk of complications.

### Address Gaps in Post-Abortion Care

Significant gaps exist in providing the essential elements of post-abortion care outlined in the MoNHSRC's 2018 service delivery guidelines.[9] These gaps are present in both public and private sectors, as well as at all facility levels. Notably, one in four referral or higher-level facilities lack essential components needed to treat severe post-abortion complications. Comprehensive care standards must be met.

- Ensure all referral and higher-level facilities meet the MoNHSRC 2018 service delivery guidelines for treating severe post-abortion complications.
- Train staff, equip facilities, and ensure the availability of key staff such as gynecologists and anesthetists 24/7.
- Enhance the quality of care in all facilities to provide comprehensive post-abortion care services, including round-the-clock trained staff, surgical cover, and specialist coverage.

### Reduce Inequities in Health Services

Inequities in abortion and post-abortion care services exist across different regions, residential areas, and income groups. Targeted efforts are needed to address these disparities.

- Implement targeted investments and efforts by federal and provincial governments to address regional, residential, and income group disparities in abortion and post-abortion care services.

### Increase Availability of Vacuum Aspiration

Vacuum aspiration, a safer method recommended by WHO, is underutilized. Three-quarters (76%) of primary-level facilities do not provide vacuum aspiration. Increasing its availability and provider training can improve abortion safety.

- Expand the availability of vacuum aspiration in primary-level facilities, as recommended by WHO.
- Increase training for providers in vacuum aspiration procedures to ensure wider use of this safer method.

### Improve Referral Systems and Emergency Response

Timely referral and emergency response are crucial for minimizing complications from abortion. Effective communication and transportation systems are needed.

- Enhance communication capabilities between primary-level and referral facilities to ensure timely patient transfers.

- Ensure the availability of functional ambulances to facilitate the prompt treatment of patients with severe complications.

### Promote Safety in Abortion Care and Family Planning

Ensuring safe abortion care and promoting family planning are essential to reducing unintended pregnancies and abortion complications.

- Ensure greater safety in abortion care through enhanced training and guidelines for providers.
- Steadfastly promote post-abortion, post-partum, and general family planning use to reduce unintended pregnancies, abortion complications, and enhance overall health benefits.

# Annexes

## Annex 1 | Approval of Protocols

POPULATION COUNCIL
Ideas. Evidence. Impact.

*Institutional Review Board*
*Population Council*
*1230 York Avenue*
*New York, NY 10065*

**APPROVAL OF PROTOCOL**

DATE: May 23, 2022

TO: Z. Sathar, Principal Investigator

FROM: Nick Gontarz, IRB Administrator, on behalf of John Townsend, Chairman Institutional Review Board (IRB)

DS NG May-23-2022

RE: *Approval of Protocol 999* – Unwanted Pregnancies and Post-Abortion Complications In Pakistan

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The Institutional Review Board (IRB) on human research of the Population Council has approved the above request to involve humans as research subjects.

DATE OF IRB APPROVAL: MAY 23, 2022

ADVERSE REACTIONS/COMPLICATIONS/UNANTICIPATED PROBLEMS: All serious and/or unexpected side effects and unanticipated problems must be reported immediately by email to the Population Council's SAE Desk (Safety@popcouncil.org) which will notify the IRB of the Population Council.

MODIFICATIONS: All Protocol changes involving subjects must have prior IRB approval. If this project is to continue, it must be renewed as specified by the IRB. THE EXPIRATION DATE FOR THIS PROJECT IS MAY 23, 2023. This renewal application consists of a brief status report summarizing the results obtained during the past period and a short statement of the research plan for the coming year.

If you have any questions, please contact Nick Gontarz at telephone number [917] 685 -7660, email ngontarz@popcouncil.org.

cc: IRB Records and Reports File for Protocol 999

HEALTH SERVICES ACADEMY
Degree Awarding Institute under HSA (Restructuring) Act, 2018
Government of Pakistan

No. 7-82/IERC-HSA/2022-29 13th Sept, 2022

# ETHICAL CLEARANCE

This is to certify that the Institutional Ethical Review Committee (IERC) of the Health Services Academy Islamabad has reviewed the research protocol along with tools of **" Unwanted Pregnancies and Post-Abortion Complications In Pakistan"** submitted by Dr. Zeba A. Sathar**, Population Center, Pakistan**.

2. The study has been assigned protocol **No.7-82/IERC-HSA/2022-29**. The IERC has granted ethical clearance for conducting this study in Punjab, Sindh, Khyber Pakhtunkhwa, Balochistan and Islamabad. The validity of this approval will be till the completion of this project.

3. While the study is in progress, please inform us of any adverse events or new, relevant information about risks associated with the research. In case changes have to be made to the study procedure, the informed consent form and or informed consent process, the IERC (HSA) must review and approve any of these changes prior to implementation.

**(Muhammad Adnan Khan)**
Secretary IRB Committee

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## Annex 2 | Members of the Technical Advisory Group and Study team

| Name | Designation |
|---|---|
| **Professor Dr. Farrukh Zaman** | Senior Gynecologist |
| **Dr. Rubina Sohail** | Gynecologist/Member SOGP |
| **Dr. Azra Ahsan** | Technical Consultant NCMNH/Gynecologist; Member SOGP-Karachi |
| **Dr. Saima Zubair** | Information Secretary and Chapter Coordinator SOGP Rawalpindi/Islamabad |
| **Dr. Shabnam Gul** | Director Licensing, Healthcare Commission, Khyber Pakhtunkhwa |
| **Dr. Seyda Batool** | Former Head of Department MCH center PIMS |
| **Dr. Najma Ghaffar** | Gynecologist, Bolan Medical College Quetta |
| **Dr. Mariam Ahsan** | Program Manager (PCP) |

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