GUTTMACHER INSTITUTE

Population Council

In Brief

2013 Series, No.4

Postabortion Care in Pakistan

The current law in Pakistan permits abortion only under narrow circumstances. As a result, women resort to clandestine and unsafe abortion procedures, which often lead to complications. This report summarizes findings from a study that examined the conditions under which women obtain abortion in Pakistan; the incidence, coverage and quality of facility-based postabortion care (PAC); and the extent to which recommended standards for PAC have been implemented in health facilities.

Key Points

- In 2012, 696,000 women in Pakistan presented at a health facility for treatment of complications of induced or spontaneous abortion.
- The annual abortion complication treatment rate was 15 per 1,000 women of reproductive age in 2012.
- The private sector plays a major role in the provision of postabortion care (PAC): In 2012, 62% of all PAC cases were treated by private-sector providers.
- Safe procedures for PAC—especially medication abortion—were more widely used in 2012 than in 2002; however, health facilities still rely on invasive procedures, such as dilatation and curettage (D&C).
- Many facilities do not have adequate equipment and supplies to provide WHO-recommended care for abortion complications.
- A high proportion of facilities are not able to provide around-the-clock services to manage severe abortion complication cases, because they lack trained and skilled staff.

In Pakistan, high levels of unmet need (25%) and low levels of contraceptive use (30%) put women at risk for unintended pregnancies.*[1] In 2006–2007, 24% of all births in Pakistan were unintended. Many women experiencing an unintended pregnancy resort to induced abortion: A nationwide study estimated that close to 900,000 unintended pregnancies were terminated by induced abortion in 2002.[2,3] This corresponds to 29 abortions per 1,000 women of reproductive age, which is close to the 2008 rate for the South-Central Asian subregion (26 per 1,000 women).[4]

The current law in Pakistan permits abortion to save the woman's life, as well as in early pregnancy, to provide "necessary treatment."[5] Given the narrow legal grounds for abortion and the lack of clarity in interpreting the law by both women and health care providers, women tend to resort to clandestine and unsafe abortion procedures. The resulting morbidity and mortality associated with unsafe abortion place a burden not only on women themselves, but also on their families and communities, as well as on the country's health system.

Indeed, according to the 2006–2007 Pakistan Demographic and Health Survey, the country's maternal mortality ratio was 276 per 100,000 live births, and 6% of maternal deaths resulted from complications of abortion.[1] This may be an underestimate, as the subregional average is 13%.[6]

In 2009, the Ministries of Health and Population Welfare of Pakistan pledged to institutionalize postabortion care (PAC) "in policies, guidelines, protocols and standards for health facilities at [the] national level."[7] This commitment is part of the Karachi Declaration, which aims to scale up best practices for maternal, newborn and child health, and family planning

*Preliminary results from the 2012–2013 Pakistan Demographic and Health Survey show that contraceptive prevalence has increased to 35%, a very slow rate of growth over the past six years (source: National Institute of Population Studies (NIPS) and MEASURE DHS, *Pakistan Demographic and Health Survey 2012–13: Preliminary Report,* Islamabad, Pakistan: NIPS and MEASURE DHS, 2013).

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to achieve the Millennium Development Goals. In 2010, PAC was included in the draft of the National Health and Population Policies.[8,9] But since the Ministry of Health and Population Welfare were abolished in 2011, each province is now expected to develop its own population and health policy. This process of decentralization has caused delays in the development and implementation of PAC policies at the provincial level.

This issue brief summarizes findings from a study that examined the conditions under which women obtain abortion in Pakistan, the coverage and quality of PAC, and the extent to which World Health Organization–recommended standards for PAC have been implemented.[10] Information on changes over the past decade is provided to allow for comparison of 2012 findings with those from a similar study conducted in 2002.

Methods

This report draws on several data sources. Data were collected through a study conducted by the Population Council in Pakistan and the Guttmacher Institute. The study gathered data through two quantitative surveys and various qualitative methods, described below.

- *Health Facility Survey*. We collected information on abortion and postabortion care through a nationally representative survey of 266 public and private facilities in four provinces of Pakistan, which assessed the incidence of abortion complications, as well as the availability and quality of postabortion care.
- *Health Professional Survey*. A purposive sample of 102 health professionals were surveyed in four provinces of Pakistan to obtain their opinions and perceptions regarding the conditions under which abortion is obtained, resulting health complications and postabortion care.
- *In-depth interviews*. Forty-four women who had had an induced abortion in the past six months were interviewed about their abortion experience and about the availability and quality of postabortion care. In addition, 19 in-depth interviews were conducted with service providers to gain insights and perspectives on abortion and postabortion care from providers working in the community.
- *Focus group discussions*. Ten focus groups were conducted among women with at least three children to obtain information on community norms regarding abortion and postabortion care. In addition, 10 informal group discussions were conducted with married men to get the male perspective on abortion and postabortion care.

Unless otherwise indicated, the information presented in this brief comes from a detailed report based on the study[10] or from unpublished analyses of study data. In addition, the 2002 data is based on findings from a similar study and draws from unpublished analyses of the 2002 data and from published reports on that study.

Conditions under which women obtain abortion

Provider type changed little, but methods changed substantially

According to health professionals, the types of providers from whom women in Pakistan obtain abortions changed little between 2002 and 2012: A slightly greater proportion of women in 2012 than in 2002 relied on physicians, while a slightly smaller proportion relied on midlevel providers, such as lady health visitors (LHV), nurses and midwives. Compared with nonpoor women in 2012, those who were poor were less likely to go to physicians (21% vs. 54% among urban women, and 13% vs. 32% among rural women) and more likely to go to untrained providers, such as traditional birth attendants (TBAs) or *dais* (30% vs. 11% among urban women, and 42% vs. 21% among rural women).

Although the types of providers changed little between 2002 and 2012, the use of safer methods—such as manual or electrical vacuum aspiration (MVA or EVA) and medication abortion—increased considerably over the period. Slightly more than one-third of respondents in 2012 said that the safe medication abortion drug misoprostol was one of the two methods most commonly used by women obtaining abortion in urban areas, and one-fifth reported its use by women in rural areas. In comparison, misoprostol was hardly mentioned by providers surveyed in 2002.

Complications from procedures by TBAs are common

Given the narrow legal grounds for which abortion is permitted, a large proportion of women—regardless of area of residence—experience complications associated with clandestine abortion, and the probability of doing so varies by type of provider. In 2012, the proportion of women expected to experience a complication from procedures performed by TBAs ranged from 55% among urban nonpoor women to 68% among rural poor women, which is even higher than the level expected from abortions attempted by women themselves (48–54%). Compared with nonpoor women, poor women were more likely to turn to TBAs for an induced abortion, which increases their risk of abortion-related complications. An estimated 41–49% of women who obtain an abortion from a midlevel provider such as a LHV, nurse or midwife are expected to experience complications, compared with only one-in-ten women who rely on a gynecologist.

Cost of abortion is high, particularly for the poor

As expected, health care professionals perceived the cost of an abortion in 2012 to be the highest when provided by a physician in a private hospital or clinic, and the lowest when obtained from a pharmacist or drug store. The estimated fee for a first trimester abortion performed by a physician in private practice ranged across population subgroups, from Rs.5,000 (US$50) for rural poor women to approximately Rs.11,500 (US$114) for urban nonpoor women. The range for a LHV, nurse or midwife was from approximately Rs.3,000 (US$30) to Rs.5,500 (US$55), and the range for a TBA was from about Rs.2,000 (US$20) to Rs.3,000 (US$30).

The absolute cost of an induced abortion appears to have nearly doubled in the past 10 years. When inflation is taken into account, however, the cost of obtaining an abortion changed little over the period.[11]

Postabortion complications

Facility-based treatment of complications has likely increased

In 2012, approximately 696,000 Pakistani women were treated in public- and private-sector facili-

ties for abortion complications,* which translates to a rate of 15 per 1,000 women of reproductive age. The rate of facility-based treatment of abortion complications was close to the national average in Punjab and Sindh provinces (16 per 1,000 women each), lowest in Khyber Pakhtunkhwa (9 per 1,000 women) and highest in Balochistan (20 per 1,000 women).

In 2002, 250,000 were treated in facilities for abortion complications; however, this figure only represents public-sector sites and private teaching hospitals. The rate of treatment in public-sector facilities for such complications in 2002 was 7 per 1,000 women. In comparison, the 2012 public-sector facility treatment rate was 6 per 1,000 women; the 2012 private sector rate was somewhat higher (9 per 1,000 women).

Much of the difference in the number of Pakistani women treated in health facilities for abortion complications in 2012 compared with 2002 can be attributed to the inclusion of private-sector data in 2012, whereas such data were not included in 2002. In addition, the increased number of Pakistani women hospitalized for abortion complications in 2012 is likely, in part, a result of population growth: The number of women of reproductive age increased by 37% between 2002 and 2012. Another factor contributing to an increase in the number of women treated for abortion complications is improved access to health facilities over the decade, in good part resulting from the growth of private sector provision of health care.[12] Finally, the incidence of abortion may have increased over the period, which also could have contributed to a rise in the number of women treated for complications.

Private sector is important for PAC provision

In 2012, 429,000 of all PAC cases in Pakistan were treated by private-sector facilities, and around 267,000 cases were treated by public-sector facilities (Figure 1). Overall, the private sector accounted for 62% of all PAC cases treated. Within the private sector, small facilities were largely responsible for PAC—accounting for 66% of patients treated; medium-sized facilities, large facilities and private teaching hospitals accounted for 17%, 13% and 4% of PAC cases treated by private-sector sites, respectively.† The public sector treated 38% of PAC cases overall. Rural health centers were the public-sector facility type that treated the most PAC patients (34%), followed by district headquarter hospitals (24%), public teaching hospitals (23%) and Tehsil headquarter hospitals (19%).

On average, each health facility treated 291 PAC patients in 2012. Overall, public-sector facilities treated an average of 289 cases per facility that year—fewer than in 2002 (317). Private-sector facilities treated an average of 292 cases in 2012. Public teaching hospitals was the facility type with the highest caseload in 2012 (an annual mean of 1,740 cases), followed by large private-sector facilities (917), public district headquarters hospitals (599) and private teaching hospitals (532).

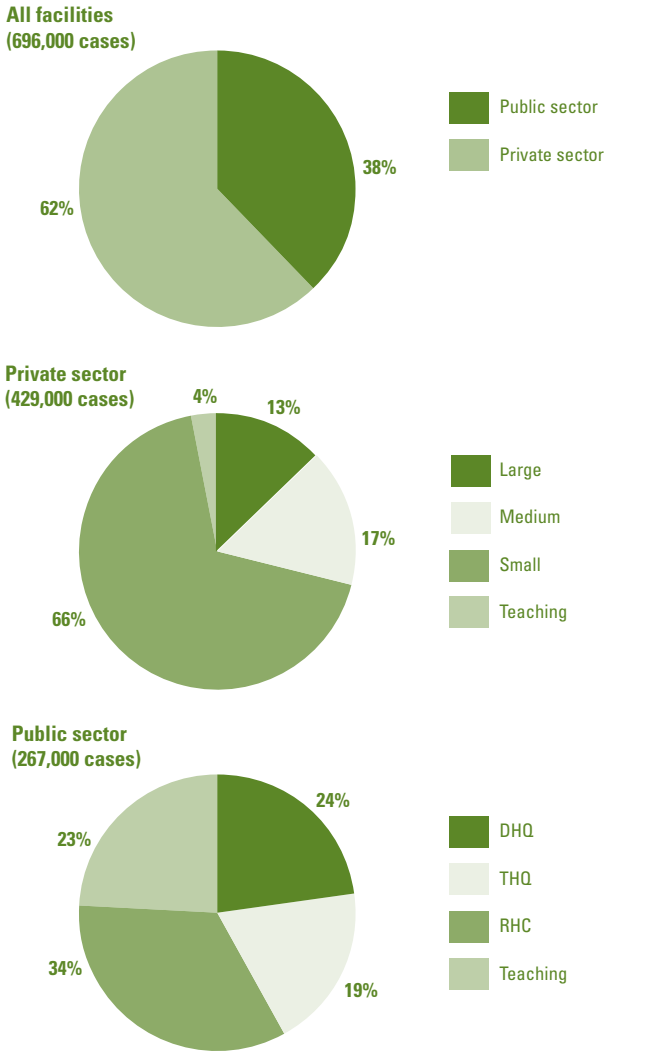
In in-depth interviews, service providers indicated that Pakistani women with abortion complications usually seek treatment in the private sector, and that mainly poor women go to government facilities. The reasons given for this pattern were that women fear being treated poorly by doctors and other staff, and that they expect public health facilities to lack proper equipment and needed medicines. Another reason cited was that private facilities are generally nearby, in the community, whereas government ones are often farther away.

An overwhelming majority of the Pakistani women interviewed who had experienced abortion complications confirmed the views expressed by service

Figure 1

PAC Cases Treated in Health Facilities

In 2012, the majority of PAC cases were treated in private facilities.



Notes: Private hospitals were categorized by bed size: small=5–19, medium=20–80 and large>80. DHQ=district headquarter hospitals. THQ=Tehsil headquarter hospitals. RHC=rural health center. *Source:* Reference 10.

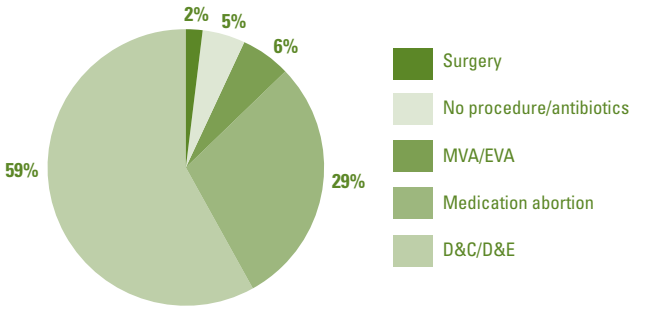
*Abortion complications include those resulting from both induced and spontaneous abortion. The 95% confidence interval around the total number of women treated for abortion complications in Pakistan in 2012 (695,861) ranges from 570,148 to 821,574.

†Private facilities were categorized by number of beds: small, 5–19; medium, 20–80; and large, ≥80.

Figure 2

Treatment for PAC Patients

In 2012, about three in 10 PAC patients in Pakistan were treated by medication abortion, and more than half by dilatation and curettage or dilatation and evacuation.



Notes: MVA/EVA=manual or electric vacuum aspiration. D&C/D&E=dilatation and curettage or dilatation and evacuation. Percentages do not add to 100 due to rounding. *Source:* Reference 10.

providers. Most said that they sought treatment in the private sector, preferring to return to the same service provider who initially induced their abortion. For example, one 36-year-old woman said *"I was feeling weak [after having an abortion], then I went to the same doctor (private) who provided me abortion services. You see, if I had gone to any other provider, I would need to tell them the whole situation again. It was convenient and preferable for me to go to the same doctor, where I did not need to restart anything."*

Quality of PAC and access to care

Safer procedures for PAC, but barriers remain

In 2012, the two most common procedures Pakistani health facilities used to treat abortion complications were dilatation and curettage (D&C) or dilatation and evacuation (D&E)* and medication abortion, which were used to treat 59% and 29% of all PAC cases that year, respectively (Figure 2). A greater proportion of women were treated by medication abortion at public facilities than at private facilities (39% vs. 23%). Despite its invasiveness and relatively high rate of complications, D&C or D&E was used to treat half of women in public facilities and close to two-thirds of women in private facilities. Very few women overall (6%) were treated by vacuum aspiration (MVA/EVA), which is one of the methods the World Health Organization recommends for the treatment of complications of first-trimester abortion.

The Health Facility Survey asked respondents about the procedures their facility may use for the treatment of abortion complications. The most dramatic change between 2002 and 2012 was in the proportion of facilities that reported using misoprostol for medication abortion, which rose dramatically from 2% to 90% (Figure 3). High proportions of facilities may have been using D&C or D&E to treat abortion complications (84% in 2002 and 89% in 2012), despite its invasiveness and relatively high level of medical risk. However, there was a decline between 2002 and 2012 in the use of surgery—from 66% to 40%—possibly because of a drop in the incidence of more severe complications (e.g., perforation of the uterus and gut). The proportion of facilities that may have been using MVA/EVA increased, from 25% in 2002 to 44% in 2012.

When asked to name the two most recommended procedures to treat complications of first-trimester abortion, a majority of providers (51%) mentioned Misoprostol as their first most

Figure 3

Procedures for Treatment of PAC Cases

The proportion of public facilities that may have used safer procedures for PAC increased between 2002 and 2012.

Notes: MVA/EVA=manual or electric vacuum aspiration. D&C/D&E=dilatation and curettage or dilatation and evacuation. Injectable (Syntocinon) was not mentioned in 2002. *Source:* Reference 10.

*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.

recommended treatment. D&C and D&E were mentioned first by 27% of providers. Half of respondents said that medication abortion was the second most recommended treatment. Few providers identified MVA or EVA as a first or second most recommended procedure (0–8%).

Many facilities are not adequately stocked

Equipment and supplies are basic requirements for the provision of PAC. Although PAC services were available in the majority of public health facilities surveyed, availability of the necessary equipment and supplies varied. In 2012, the vast majority of facilities reported having instruments for the provision of D&C (91%); however, only 25% had MVA kits and 24% had EVA kits. A greater proportion of private-sector facilities than of public-sector facilities reported having misoprostol available (89% vs. 54%; Figure 4).

Availability and training of staff is insufficient

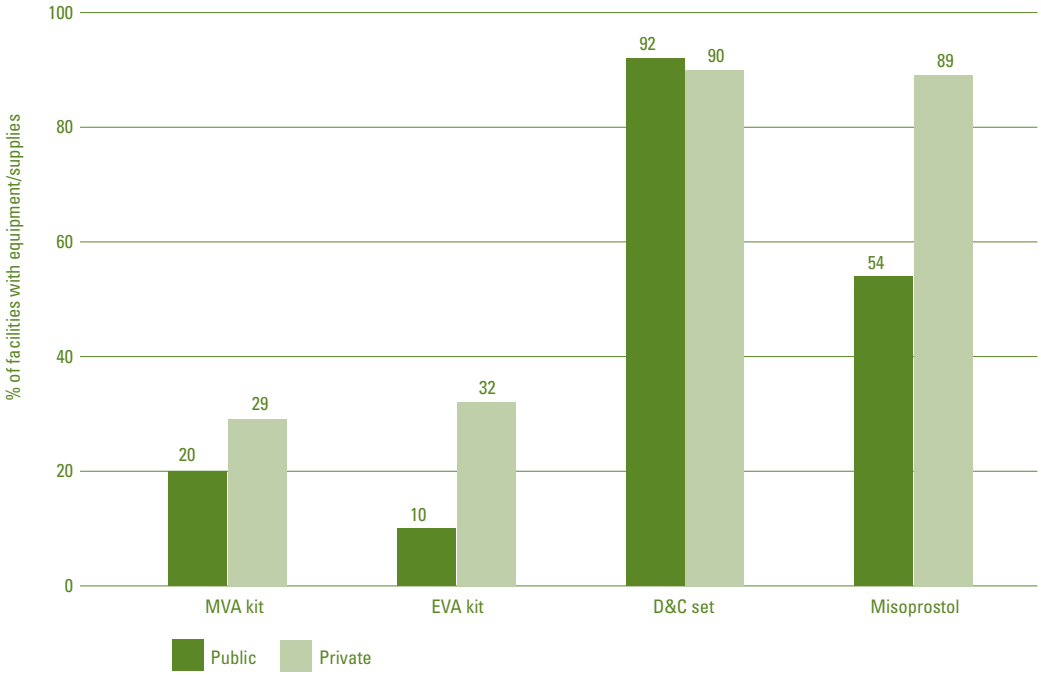
A high proportion of facilities in Pakistan lack 24-hour coverage by personnel essential for the treatment of more severe complications. Overall, 59% of facilities in 2012 lacked 24-hour coverage by a gynecologist, and 41% lacked such coverage by an anesthetist.

More doctors than nurses were trained in different components of PAC management (e.g., family planning, MVA, EVA, medication abortion). Training opportunities in different methods of PAC provision were mainly restricted to doctors at public teaching and DHQ hospitals in the provinces of Sindh and Punjab. Training was more likely to occur in public-sector and higher level facilities than in private-sector and lower level facilities.

Figure 4

Availability of PAC Equipment

In 2012, private-sector facilities were more likely than public-sector facilities to be equipped with functional PAC equipment and supplies.



Notes: MVA=manual vacuum aspiration. EVA=electric vacuum aspiration. D&C=dilatation and curettage. *Source:* Reference 10.

Large gaps remain in PAC provision

The provision of contraceptive counseling and services is one of the essential elements of PAC. A moderate proportion of Pakistani health facilities surveyed in 2012 reported providing counseling services (50% of private facilities and 61% of public facilities—Figure 5, page 6). The proportion of women leaving a facility with a contraceptive method following PAC treatment was somewhat greater in the public sector than in the private sector (54% vs. 46%); however, these proportions may in fact be even lower, because facilities may have inflated their responses to present their services in a more favorable light. According to the in-depth interviews and focus group discussions with women, very few providers give family planning counseling when treating abortion complications.

Providers' attitudes and service costs are barriers to PAC

Respondents from the Health Facilities Survey in 2012 almost universally agreed that PAC can save a woman's life and that it should be more widely available; however, 42% perceived providers as having negative attitudes toward PAC clients. Moreover, 35% believed that providers have reservations about treating PAC patients.

Focus group discussions with women and informal discussions with men revealed that the behavior of private providers was often better than that of public-sector providers. This is possibly related to the fact that private providers charge a fee for their services, as explained by one female focus group participant: *"Those who are paid, show good behavior. In a public hospital we do not pay, therefore they don't behave properly with us; they don't even examine us properly."*

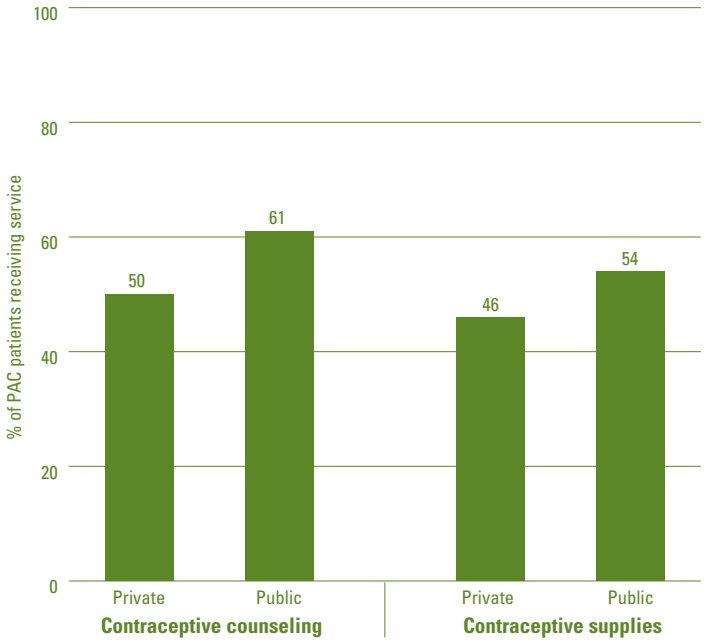
Although, as indicated above, health professionals agreed that PAC should be more widely available, the reality is that the cost of PAC services makes them difficult for women to access. Qualitative data indicates that among the barriers women experienced in accessing PAC services, financial constraints were the greatest and most common one cited by respondents of all categories and communities.

Money is required not only for treatment, but also for transportation to the health facility. If

Figure 5

Postabortion Contraceptive Counseling and Services

In 2012, public and private facilities reported that PAC patients were more likely to receive contraceptive counseling than an actual method.



Source: Reference 10.

the costs are too great, women will sometimes try to bear the complications instead of seeking necessary, possibly life-saving, treatment. In an in-depth interview, a 30-year-old woman with five children described her situation by saying *"I have no money. I am already worried about returning my loan* (she borrowed money for her abortion). *I have become weak because I don't get enough to eat. If I visit the doctor again, I will have to pay a fee for the consultation and then I won't be able to buy the medicines she prescribes. If I had money, I'd eat properly and maybe not require medicines. I am bearing pain and all problems due to shortage of money."*

In in-depth interviews, service providers pointed out that when women ignore or delay seeking treatment, the complications they are experiencing may be aggravated. In such cases, not only do the complications become more serious, but women end up spending more money on their treatment.

Women across all communities reported in interviews that the decision to seek PAC services is often not a woman's to make alone. In most cases, women in Pakistan have to consult their husband and seek his approval before going to a service provider. Some respondents reported that this depends to some extent on the personal financial situation: Women who do not need their husband to pay for the services can decide independently whether to seek PAC. Women in Pakistan, however, are generally economically dependent on their husband and, thus, cannot make such a decision independently.

Major recommendations

- There is a clear need for improving the quality of PAC and for scaling up the use of safer, World Health Organization–recommended methods for the treatment of PAC, such as MVA and medication abortion.

- Health facilities in both the public and private sectors need to be adequately equipped—especially with MVA/EVA kits—to enable them to provide the full range of PAC services.

- A national consensus needs to be built on providing training to midlevel providers by organizing national and provincial workshops and seminars. PAC should be part of preservice training for providers at all levels. In particular, providers require training in MVA techniques and the use of misoprostol, especially for those based in primary health care facilities. Misoprostol has been included in the Essential Medicines List (EML) in all provinces, which should ensure its availability in government health care facilities. Nevertheless, continued advocacy for its implementation is required.

- PAC protocols need to be developed to conform to the latest scientific advancements and to be disseminated widely along with service guidelines for PAC.

- Facilities providing PAC must have a full range of contraceptive services onsite or in their immediate vicinity and these services should be available 24 hours a day, seven days a week. At the moment, there is a very weak response to a large need, and an opportunity to provide quality counseling and family planning services to the very women who are most in need: women being treated for complications of abortion, almost all of whom have experienced an unwanted pregnancy. There are substantial gaps in availability of contraceptive commodities and in the provision of family planning counseling to PAC patients. Changes in this area would lower the incidence of unsafe abortion, by reducing unwanted pregnancies. These changes would also be particularly effective in reducing maternal morbidity and mortality in rural areas, where, compared with urban areas, PAC services are less accessible and women need to travel longer distances to access care.

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CREDITS

This *In Brief* was written by Zeba Sathar, Gul Rashida and Zakir Shah, all of the Population Council, Pakistan, and Susheela Singh and Vanessa Woog, both of the Guttmacher Institute. It was edited by Jared Rosenberg, Guttmacher Institute. The authors are grateful for comments provided by Dr. Sadiqua Jafarey from the National Committee for Maternal and Neonatal Health, and for contributions by the following Guttmacher colleagues: Isaac Maddow-Zimet, Gustavo Suarez and Michael Vlassoff.

The 2012 study on which many of the report's findings are based was supported by a grant from The Maternal and Newborn Health Programme Research and Advocacy Fund.

This document is an output from a project funded by the UK Department for International Development (DFID) and the Australian Agency for International Development (AusAID) for the benefit of developing countries. The views expressed and information contained in it are not necessarily those of or endorsed by DFID, AusAID or the Maternal and Newborn Health Programme Research and Advocacy Fund (RAF), which can accept no responsibility or liability for such views, for completeness or accuracy of the information, or for any reliance placed on them.

Population Council
House 7, Street 62, F-6/3,
Islamabad
051 8445566

Research & Advocacy Fund
(RAF)
House 9, St. 70, F-8/3
Islamabad
051-8317967-8 / 2852230

National Committee for Maternal and Neonatal Health (NCMNH)

36-C, Street 14 10038 USA
Off. Khayaban-e-Shamsheer
iPhase V, D.H.A.
Karachi-75500
Tel: 92-21-5341597-8
Fax: 92-21-5341505
ncmnh@cyber.net.pk

Advancing sexual and reproductive health worldwide through research, policy analysis and public education

125 Maiden Lane
New York, NY 10038 USA
Tel: 212.248.1111
info@guttmacher.org

www.guttmacher.org

August 2013