

## THE EXPERIENCES OF INDUCED ABORTION IN WOMEN

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### Abstract

This research aims to study women's encounters who undergo abortion in Pakistan. It investigates the challenges faced by women seeking induced abortion and the secrecy they attempt to keep with the imputation of triangulation of theories. A major Dramaturgical perspective by Erving Goffman (1959) was employed to elucidate the challenges women face. Under the Feminist perspective, Standpoint Theory by Dorothy Smith (1989) was used to explain how fewer reproductive choices of women lead to unintended pregnancies and abortion. The aim of the study is to incorporate the impact of negative attitudes towards abortion on women's choices of hazardous pregnancy termination procedures and their consequences on health of females. To conduct current research, a qualitative research methodology was employed under a social constructivist viewpoint with an interpretive epistemological approach employing in-depth interviews and further thematic analysis. The current research aims to study the issues faced by women undergoing induced abortion in Pakistan.

### INTRODUCTION

Induced abortion is any planned termination of pregnancy by means of “vacuum aspiration, dilation and evacuation (D&E)”, or abortion by medication (Ferguson, 2023). Studies have always indicated induced abortion is safe and effective provided it is done with proper medical care. But in some countries such as Pakistan where the reproductive choices are influenced by religious, legal and cultural factors, women have a big problem in accessing safe abortion services. Women who are pregnant with unintended or unplanned pregnancies are also choose to terminate pregnancy, and this is one of the trends witnessed in South Asia and the rest of the world (Sathar et al., 2014). According to Dastgiri et al. (2017), induced abortion is a serious health issue irrespective of its legality, and its safety relies on its availability and social acceptability. The Guttmacher Institute (2022) notes that abortion

is not easily available in a safe manner due to legal ambiguities, punitive legislation, misinformation, and high individual costs, such as travelling, childcare, and medical costs. Stigma is also another barrier to access since women tend to shun care so that they do not have to experience shame and stigma (Phelan et al., 2015; Knaak et al., 2015; Dell et al., 2021).

Regardless of these limitations, abortion is highly prevalent, and illegal abortion is much more widespread in the country where abortion is legally limiting (Sedgh et al., 2012). About 98 percent of the unsafe abortions practice is in low-income areas (Sedgh et al., 2007; WHO, 2011; Basinga et al., 2012). The consequences of pregnancy termination is very high in Pakistan because of legal limitations (Rahman et al., 1998), although the rate of abortion in the country is also very high, approximately 50 per 1,000

pregnancies (Joles, 2021). The literature indicates that the existence of legal restrictions fails to bring the number of abortions down but on the contrary, it makes them more unsafe (Bearak et al., 2020; WHO, 2012). According to the world health organization, health refers to the total physical, psychological, and social health rather than the lack of sickness. This definition lies at the basis of RCOG, which acknowledge abortion as a necessary medical care (Hewson, 2001; Royal College of Obstetricians and Gynaecologists, 2000).

Unsafe abortion is extremely dangerous physically as it can result in infection, hemorrhage, injury and even death (Hess, 2007; Ahman and Shah, 2004, 2007). A large number of women annually have unsafe abortions, and many of them have long-term implications (Sedgh et al., 2007; Kumar et al., 2009; Frederico, 2018). It is estimated that 3.8 million induced abortions were done in Pakistan in 2023, and this translates to 66 per 1,000 women aged 15-59 (Guttmacher Institute, 2025). Most of the 2.2 million unsafe forced pregnancy terminations conducted in Pakistan every year give rise to approximately 700,000 potentially fatal issues (Sathar et al., 2014; Mahipala et al., 2023). The major contributing factors are legal limitations, the fear of stigma (Cockrill et al., 2013; Kumar et al., 2009; Singh, 2006), and an unawareness of safe services (Alhassan et al., 2016).

The available literature includes various studies that discuss the prevalence of induced abortion, legal and religious limitations, medical complications of abortion, physical and psychological consequences of women seeking an abortion, and stigma of abortion in society. The role of stigmatization of abortion in making women hide their procedures and characterize them as miscarriages to escape the shame and embarrassment of the operation is also necessary to understand how women respond and how they cope in a male-dominated society. This qualitative study will greatly contribute to the existing understanding of abortion by providing a detailed discussion of reasons why women feel compelled to use unsafe and illegitimate means to end their pregnancy.

### Objective of the Study

Major objective of the research is to explore women's encounters of induced abortion in Pakistan.

### Literature Review

Abortion is very common around the world and in Pakistan but unsafe abortion practices jeopardize the health of women because of stigma and lack of reproductive autonomy. According to Niță and Goga (2020), cultural norms, moral issues, and legal regulations affect the choice of women. Low contraceptive use (24%), and high unmet needs (46) in Pakistan are the main reasons of unintended pregnancy (Fikree, 2002; Najmi, 1995; WHO, 1998; Rehan, 1998). According to the Guttmacher Institute, there are 3.8 million cases of unintended pregnancies per year, and many of the married women resort to abortion as a birth control method because of the low use of contraceptives (Joles, 2021). Hameed et al. (2014) observed that autonomy of women is not associated with contraceptive use unless their husbands are involved in decision-making, which evidences gendered control of fertility.

The rates of abortion differ among provinces: Khyber Pakhtunkhwa (37/1,000) and Balochistan (38/1,000) have the highest rates, which are compared to lower rates of contraceptive uptake (Sathar et al., 2007; Guttmacher Institute, 2022). According to Karachi studies, induced abortion rates in Karachi are very high compared to the national averages (Jamil & Fikree, 1998). Almost 88 percent of abortions are unintended pregnancies and contraceptive failure (Sathar et al., 2014; Gazdar et al., 2012). Socio-economic factors make many women choose abortion instead of contraception (Saleem & Fikree, 2001). Young women are more vulnerable because they do not have autonomy and have social restrictions and coercive pressures (Frederico et al., 2018). The medical risks are increased by delays in abortion because of absence of information, discriminatory providers, and legal barriers (Fay et al., 2022). Structural barriers within LMICs are restrictive laws, clinic information, high costs, Workforce shortage,

provider bias, and decision-making authority (Arroyave & Moreno, 2018).

In Pakistan, abortion has been legal since 1997, but only in cases of saving life or necessary treatment, although this term is vague (Patel, 2003; Zaidi et al., 2014). This ambiguity creates inconsistency in application, misinformation, and denial of reproductive rights of women (Jafri et al., 2012; Chahal and Mumtaz, 2017). The reform has to be aligned with the Islamic interpretations and cooperation between the legislators, religious scholars, and the judiciary (Pakeeza, 2016). A large number of abortions are done in a clandestine environment using uncertified practitioners (Rehan et al., 2001). Abortion is prohibited in most religions (Cherry, 2009; Pew Forum, 2013), which is one of the causes of covert and unsafe procedures (Frederico, 2018). Women hide abortions because of stigma (Cockrill et al., 2013; Kumar et al., 2009; Singh, 2006), lack of awareness about existing services (Alhassan et al., 2016), structural factors (Schuster, 2010), financial reasons, and pressure in the family (Hung, 2010).

In consideration of what the other scholars have done in this phenomenon, this qualitative research study explores the adverse impacts of abortion stigma on the well-being of Pakistani women aimed at filling a critical research gap in the local setting. The main aims are to examine how women encounter this stigma, the coping strategies they resort to in response to the related shame, anxiety, and embarrassment, and the factors that result in a hidden and possibly unsafe abortion procedures in order to preserve social and familial status. Finally, the research intends to deliver information that justifies safer, non-stigmatized access to abortion.

### Theoretical Framework

Abortion can be described as the ending of a pregnancy that is not yet capable to sustain the fetus out of the womb, usually prior to the first twenty weeks of gestation (Romania Academy, 1998; The Medical Dictionary Illustrated from A to Z, 2014). Although induced abortion is present in every community, the choice of women to abort is influenced by overlapping

healthcare, legal, moral, religious, and socio-cultural restrictions (Niță and Goga, 2020). To analyze the issues of women who have induced abortion in Pakistan, this paper relies on Standpoint Theory (Smith, 1989) and Dramaturgical Perspective of Goffman (1959), both of which anticipate the lived experience, power relations, and social interaction.

### Standpoint Theory

Standpoint Theory is a feminist theory which believes that knowledge is socially constructed and that the experiences of marginalized women expose power structures. Smith (1989) criticized mainstream objectivity of sociology that male relations of ruling (domination) systematically silence the voice of women. Feminist abortion literature has been preoccupied with legal rights without paying much attention to lived experiences of stigma, coercion, and lack of autonomy (Covan, 2020). Feminist theories consider reproductive regulation as a form of patriarchal authority (Ikemoto, 2018), and radical feminists associate limited choice with male hegemony (MacKinnon, 1987) and liberal feminists with abortion and contraception as the potential source of women agency and equality (Staggenborg, 1991).

The women in patriarchal family systems tend to have no control over reproduction and this leads to unplanned pregnancies and limited options. The husbands and family elders, especially mothers-in-law, often have a way to control others using moral, religious, or social persuasion and keeping the female voices down. Viewed through the lens of standpoint, it is not personal incompetence that leads to abortion-related distress, secrecy, and absence of support, but the result of gendered power relations. Layered on the basis of daily experiences of control and exclusion, women narratives reveal the reproduction of reproductive inequality by families and healthcare systems. Standpoint Theory therefore offers an analytical viewpoint on the concept of pregnancy termination as a gendered experience that is not entirely due to personal choice but opportunity to be marginalized by the systems.

### **Dramaturgical Perspective**

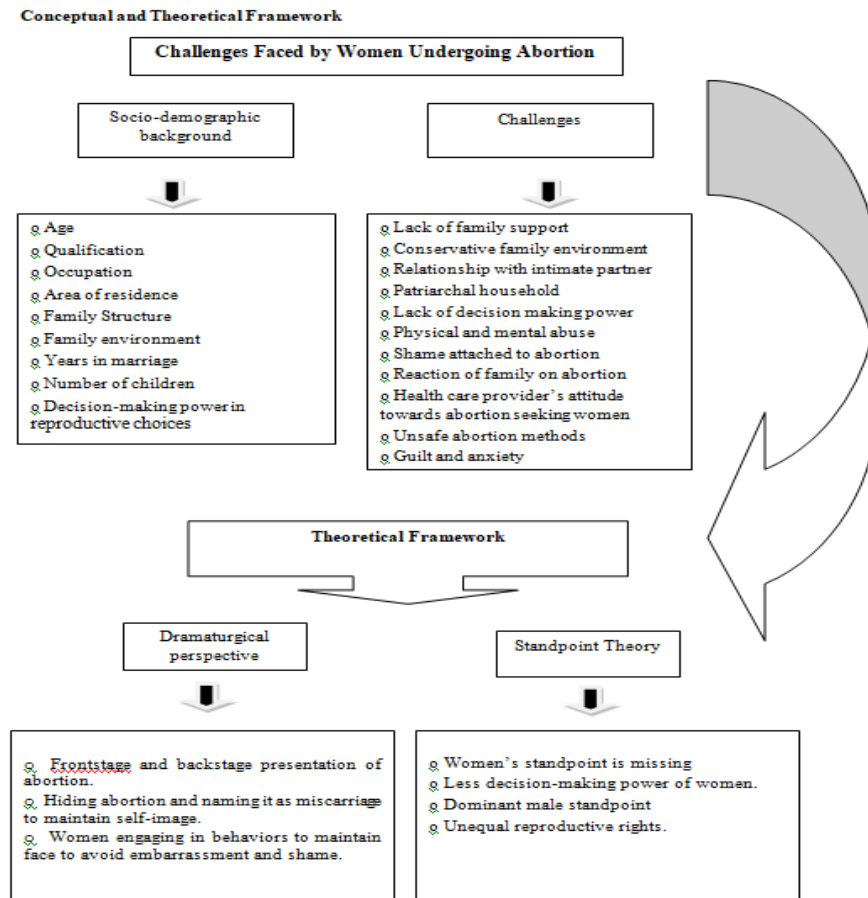
The concept of dramaturgical Perspective by Goffman views social life as a performance whereby people address impressions in order to uphold social acceptance (Goffman, 1959). The theory describes the process of people conforming their behavior to those of the society through the concepts of frontstage, backstage and face.

The frontstage is the behavior observed in public, and the backstage is the area where people can release their repressed feelings and truths. When applied to abortion, dramaturgy informs on the way women pursue conscious impression management to prevent stigma. Abortion is a subject that has been linked to sin, immorality, and social deviance in the morally conservative environment of Pakistan. Based on this, a great number of women are framing their abortions as miscarriages and acting on the frontstage to maintain honor, dignity, and family acceptance. This enables women to save face and not to be condemned but yet get social support. However, women at backstage suffer emotional distress, fear, isolation and health risks, without proper medical or psychological help.

The results of the study reveal that such concealment is often supported by family members, especially husbands and mothers-in-law, meaning that the frontstage performance is mutually supported. The framework of Goffman, therefore, unveils abortion as not only a medical occurrence but a socially controlled act with consistent emotional work and secrecy.

### **Integrating the Frameworks**

Combined, the Standpoint Theory and Dramaturgical Perspective visualize the abortion as a socially constructed event based on patriarchal power, stigmatization, and moral surveillance. Whereas Standpoint Theory focuses on the real lives of women in the context of structural inequality, dramaturgy describes how women have devised ways to survive in such circumstances. The tendency to refer to abortion as miscarriage is an indication of resistance and lack of autonomy, and it is the high time to change socially and institutionally to legitimize the experiences of women in their reproductive lives and to provide safe and stigma-free access to abortion care.



### Research Methodology

This qualitative research is a phenomenological study of how Pakistani women induce abortion based on the lived experiences of women who induce abortion. Though Standpoint Theory emphasizes the knowledge that women are situated in a patriarchal system, Phenomenology dwells on first-person narrative of women and encompasses the psychological, physical, and social nature of abortions. The Goffman's dramaturgical approach provides information on the interpretation of identity performance, stigma management, and concealment.

### Population and Sample size

The target population was married women, with at least a child living in Punjab or Islamabad. Purposive sampling method was employed to

recruit 15 respondents who experienced a medically or informally done abortion. This population was suitable because it is negotiating the moral, familial, and social pressures in a complex manner.

### Method for Data Collection

I gathered the data using face-to-face, in-depth, semi-structured interviews in order to achieve consistency and rapport. Interview guide assisted me to investigate decision-making, stigma, abortion methods, health effects, family impact, and coping mechanisms. Interview data was supplemented by observational notes.

### Data Analysis

Thematic analysis was performed according to the six steps of the Braun and Clarke (2006) model

familiarization, coding, theme development, review, refinement, and reporting. The analysis was inductive, that is, the themes were developed based on the narratives of the participants, but not imposed on them.

**Familiarization with the Data:** To be honest and participate in the narratives of the participants, I reread all transcripts and field notes over and over. At this stage, initial thoughts, emotions, and potential codes were noted on the margins.

**Creating Initial Codes:** The characteristics of relevant data were identified and assigned codes. Codes showed the common issues, phrases, experiences, and feelings that are connected to the key research questions, i.e., stigma, hiding, intimidation, autonomy, psychological distress, health consequences, and social blame.

**Themes Making:** Codes were then examined further with regard to deeper meaning trends. As with similar codes, they were arranged under potential themes. These initial themes represented important elements of the real experiences of the participants and the impact of the social, cultural, legal, emotional environment on them.

**Reviewing the themes:** Reviewing themes as compared to the real data assisted in ensuring that they accurately reflected the spirit and the substance of the narratives of the participants. Some of the themes were refined, merged or divided into sub-themes as was necessary.

**Defining and Naming Themes:** Once developed, every theme was precisely described and labelled to capture its main concept. Core conclusions of the research turned out to include themes like “Women’s Agency”, “Attitude Towards Abortion”, “Staging Abortion as Miscarriage”, “Damages on Mental Health of Women”, “Physical Damages”, and “Finding Unsafe ways of Abortion”.

**Writing the Report:** To create a persuasive and rich analysis in the discussion chapter, the last

stage was combining the thematic outcomes with participant statements, theoretical perspectives (Standpoint Theory and Goffman's Dramaturgical Perspective), and previously published literature.

The themes were constructed from the data itself instead of having to develop using previously present subjects. The feminist prism and interpretive framework helped to make sure that the structures of power, gender-specific experiences, and emotional labor presented in the participants' narratives receive adequate consideration. The interpretation additionally included the field observations' insights on physical expression, tone, apprehension and contextualized setting. The research conducted succeeded in trying to offer a comprehensive, sympathetic, and contextually grounded view of how women in Pakistan negotiate abortion among stigma, solitude, and institutional constraints by using thematic analysis in this systematic but adaptive manner.

#### **Positionality of the Researcher**

Being a young and unmarried woman studying abortion in Pakistan, where patriarchy, culture, and religion play a major role in society, my positionality, in its turn, had an irresistible impact on the research. My social location posed a challenge as well as an opportunity in a scenario where reproductive health is a sensitive issue, particularly among unmarried people. Although some of the participants were hesitant at the beginning because of the societal norms that unmarried women are not supposed to talk about abortion openly, my age and gender eventually built trust, which enabled a number of respondents to open up. I do not have the same reproductive experiences they do, but we all live within the same larger socio-cultural context, and, therefore, I was able to empathize with their silences, stigma, and constraints to make such decisions. This standpoint promoted reflexivity during the research, contributed to the development of my sympathetic yet objective attitude to interviewing, and enhanced my understanding of how brave the participants were to share their experiences

**Table 1. Participants' Socio-demographic Profile**

Sr. #	Age	Years in marriage	Number of children	Educational Background	Employment Status	Area of Residence
1	37 Years	20 Years	05	Matric	Unemployed	Rural
2	42 Years	26 Years	06	Primary	Unemployed	Rural
3	35 Years	15 Years	06	Intermediate	Home tutor	Urban
4	38 Years	15 Years	04	Graduation	School teacher	Urban
5	33 Years	11 Years	03	Masters	Employed	Urban
6	25 Years	2.5 Years (Divorced)	01	Intermediate	Unemployed	Rural
7	37 Years	14 Years	04	F.sc	Unemployed	Rural
8	40 Years	19 Years	04	Matric	Unemployed	Rural
9	34 Years	14 Years	02	Matric	Unemployed	Rural
10	32 Years	10 Years	02	Studying (BS)	Unemployed	Urban
11	35 Years	11 Years	03	B.A/ B.Ed	Unemployed	Urban
12	35 Years	14 Years	04	B.A	Beautician	Urban
13	24 Years	02 Years	01	B.sc	Unemployed	Urban
14	28 Years	07 Years	04	Primary	Unemployed	Rural
15	27 Years	04 Years	02	BS	Teacher	Urban

**Ethical Considerations**

Informed consent, voluntary participation, confidentiality, withdrawal rights, non-coercive language and emotional safety were considered ethical issues. The motive, potential harm, and gain of the study and pathways to refer to in case of distress were explained to the participants.

**Data Analysis**

This part includes a thematic analysis of personal narratives of 15 Pakistani women who had

induced abortions. It explores the sociopolitical, emotional, and structural factors that influence their experiences and how societal prejudice, reproductive autonomy, and institutional factors shape the decision to end pregnancy, as well as, post-abortion consequences. The analysis, inspired by Standpoint Theory (Smith, 1989) and Goffman's Dramaturgical Perspective (1959), discusses the influence of gendered power relations, social expectations, and stigma on women to address abortion-related limitations.

Though the wider MS study revealed a few themes, female agency, family influences, emotional effects, concealment, access to healthcare, and health hazards of unsafe procedures, the current article specifically examines two, which are the use of unsafe abortion techniques and its effects, and the performance of abortion as a miscarriage. The interpretation of these themes is done in conjunction with the available literature and understanding is gained on the common aspects as well as the situational realities of abortion in Pakistan.

**Staging Abortion as Miscarriage**

Results have shown that abortion is highly stigmatized so that most of the participants (10/15) used their abortion as a miscarriage to avoid stigmatizing questions and to protect their self-image. This concealment was very much influenced by fear of condemnation especially to

the close members of the family like the mothers-in-law. Some participants mentioned that they had initially told their immediate family members about their abortion but due to their negative reactions decided to tell other people that it was a miscarriage. Secrecy was also caused by anticipated stigma, which was informed by the negative experience of friends. Very few of the participants (4/15) had not covered their abortion. Nevertheless, the majority of them said they regretted it once they experienced social disapproval and negative attitude. One of the exceptions was where there was a medically necessary abortion and sharing the information did not lead to stigma. In general, the results indicate that both perceived and actual negative social responses make women conceal their abortions, which supports silence and stigma on the problem.

**Table 2.**

Attribute/Category	Description & Key Findings	Causes & Contributing Factors	Consequences & Outcomes
Participant Action: Choice of Method	The majority of participants (10/15) chose unsafe methods (e.g., midwife, taking pills from a pharmacy) to terminate pregnancy.	Lack of Safe Access: The core reason for this choice was the lack of availability of safe abortion methods.	Led to seeking help from non-professionals (midwives) or self-administering treatment (pills).
Motivation for Unsafe Choice	Participants actively avoided seeking professional help for safe abortion.	Fear of Stigma: Women chose covert unsafe methods (3 participants) or a local midwife (P8) to avoid the negative reaction and behavior they anticipated from healthcare providers.	This choice was based on friends' bad experiences and a desire to save themselves from negative social behavior.
Source of Pressure/Obstruction	Healthcare professionals (HCPs) and the institutional environment were major obstacles.	Professional Refusal: HCPs refused (6 participants) citing being "not allowed" by hospital authorities, or calling the act a "sin and crime" based on religious beliefs.	Forced many (3/6 who sought help) to face rejection and negative attitudes before finding a sympathetic doctor.

Health Consequences	The physical and mental risks resulting from the methods used.	Method Failure/Improper Use: Failure of unsafe abortion methods led to severe complications.	Physical/Mental Harm: Participants faced serious complications (3/15) or minor physical damage. P1 faced serious damage to her mental and physical health from failure.
System/Policy Need	The collective conclusion of all participants.	Widespread Lack of Acceptance: Lack of acceptance of abortion by both the general public and professional HCPs.	Recommendations: Participants emphasized the need for safe abortion methods provided with respect to reduce unsafe practices, and awareness of the dangers of unsafe methods.

**Table 3. Supporting evidence**

<p><b>Staging abortion as miscarriage</b></p> <p>“We decided to hide the abortion, and we told her that it was a miscarriage.” (participant 1)          “Whoever knew about my pregnancy, I told them that I had a miscarriage.” Participant 3)          “I did not share the news of my abortion with many people, which saved me from societal pressure and a negative attitude”. (participant 3)          “I decided that I will secretly find a gynecologist and will keep my abortion secret. My only intention by doing so was to maintain my self-image and to protect myself from the negative behavior of people”. (participant 5)          “After the negative reaction of my friends and family, I think I should have hidden it or should have said that it was a miscarriage”. (participant 7)          “I did not share the news of my abortion with anyone in my in-laws and others in my family. I told my mother-in-law after the abortion that I had a miscarriage”. (participant 10)          “When my partner got aware of my abortion, he said that my decision to hide the abortion was right, but I should have told him about it. He asked me to keep it secret and if anyone gets to know about it, tell them that it was a miscarriage”. (participant 13)</p>
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**Using Unsafe Abortion Methods and Their Consequences**

The results indicate that the unavailability of safe abortion services as well as their non-acceptability directly drives women into unsafe abortion habits. The majority of the respondents (10/15) had to use unsafe practices after professional care rejected them, and others simply did not want to enter healthcare providers because of the fear of being judged and negative attitudes. Even in those who eventually received professional help, there were numerous rejections, and the safer services were frequently obtained under the table

by personal contacts and on restrictive terms. The participants also reported severe physical and psychological effects of unsafe practices, including self-medication using abortion pills or help of untrained midwives. Each participant stressed that in Pakistan, abortion is generally not accepted by the society or the health providers and that refusal is justified by either institutional policies or the religious beliefs. They emphasized that the key to reducing unsafe abortion practices is respectful approach to safe abortion, and increased awareness of the dangers of harmful practices.

**Table 4.**

Category/Attribute	Prevalence (Participants)	Key Details & Causes	Consequences / Outcomes
Choice of Unsafe Methods	Majority (10/15)	Primary Reason: Lack of availability of safe abortion services.	Serious Complications: 3 participants faced serious complications due to failure. Minor Physical Damage: Others indicated minor physical damage.
Refusal by Healthcare Providers	6/15	Refused safe abortion by healthcare providers, leading them to choose unsafe ways.	P1: Visited many providers, all refused angrily. Led her to look for a midwife. Abortion failed, causing serious mental and physical damage.
Avoidance of Professional Help	3 participants	Did not seek professional medical help to avoid the negative reaction of healthcare providers and others.	P8: Decided to visit a local midwife based on friends' negative experiences. P12: Used abortion pills from a pharmacy without visiting a provider.
Finding a Professional Provider	6 participants	3 found a provider at first, and 3 faced rejection first, then found one.	Challenges: P9 faced harsh behavior. P5 and P6 faced multiple rejections before finding a willing provider. P14 found a doctor who carries out abortions secretly.
Reasons for Provider Refusal	All 15 participants reported lack of acceptance/refusal.	Providers refuse by citing: 1. Not allowed by hospital authorities. 2. Calling it a sin and crime (religious beliefs).	Forces women to choose covert, unsafe methods, increasing health risks.
Specific Unsafe Methods Mentioned	Multiple	Seeking a midwife (P1, P8), taking abortion pills from a pharmacy without assistance (P12).	Serious medical and physical complications (P12 required a gynecologist visit after complications).
Need for Change (Recommendations)	All 15 participants	Emphasized the need for: 1. Safe abortion methods provided with respect. 2. Awareness regarding the need for safe abortion and the dangers of unsafe methods.	Belief that safe services can help reduce unsafe abortion methods.

**Table 5. Supporting evidence**

**Using Unsafe Abortion Methods and Their Consequences**

“We visited some other healthcare providers, but they refused too. After some struggle, we found a lady who agreed to carry out the abortion, but she asked me to keep it secret and not to tell anybody”. (participant 1)

“My sister and I visited many gynecologists, but all of them strictly refused”. “My sister then suggested visiting a local midwife”. (participant 3)

“There is a lack of safe and affordable abortion services, which causes multiple problems for women, including physical and emotional damage. I faced serious health issues because I could not get a safe abortion from experienced gynecologists”. (participant 3)

“We visited 3-4 healthcare providers, but no one agreed.” “She refused and said that she can’t help in killing someone. On our way back, a lady came to us and said that she can help us abort the child, but said that we have to keep it secret”. (participant 4)

“There is a lack of safe abortion services. I also chose an unsafe method of abortion because there are no safe abortion methods available” (participant 13)

“Mostly professional healthcare providers working in reputed hospitals refuse to carry out abortion. After searching for a while, I got to know that it is nearly impossible for me to find a good healthcare provider” (participant 5)

“The behavior of healthcare providers after knowing that I want to abort the child was very rude. They strictly denied to help me and said that they are not allowed by the hospital administration to provide abortion service”. (participant 5)

“Yes, there is a lack of safe abortion services in our country; people who are providing abortion ask to keep the abortion secret”. (participant 14)

“Many women who are not provided abortion by a professional doctor seek unsafe ways of abortion, some try to abort by themselves and bear serious health issues. Women can be protected from so many problems if provided with safe abortion services”. (participant 6)

“Women like me, when they do not find a good healthcare provider and safe abortion service, they choose unsafe ways of abortion and face many complications as I did”. (participant 7)

“We then visited another healthcare provider, who said that come to my private clinic, I will provide you abortion there. She said that she was not allowed to provide an abortion by the authorities. It was not a government hospital, it was a private hospital, but the doctor had a separate setup of her own where she used to provide abortion secretly”. (participant 11)

**Key Findings**

**Stigma and Social Condemnation of Abortion**

The results show that abortion is a heavily seen as the socially inappropriate and morally wrong activity. Majority of the participants had or expected high levels of negative response on behalf of family members and the community at large. This stigma permeated most women to hide their abortions because revealing such acts was equated to blame, shame and loss of personal and family reputation. Mothers-in-law became a very powerful institution to enforce negative attitudes, and may pressurize or criticize the decisions of women to abort their pregnancies.

**Concealment of Abortion as a Coping Strategy**

Hiding was a prevailing technique that women adopted to handle the stigma and also to save their self-esteem. A significant percentage of participants said they had to pose their abortion as a miscarriage to avoid social stigma and family discord. Although women had reported their abortions to close relatives, negative responses often resulted in them taking a secretive approach later. The fear of social exclusion and the fear of being shamed by the people around, were crucial factors in influencing these practices of concealment.

### **Anticipated Stigma and Silence**

In addition to direct stigmatizing experiences, expected negative responses had a strong impact on behavior of women. Some of the participants did not reveal the abortion decisions due to the negative experience of their friends and acquaintances. This fear of judgment created silence and isolation that did not give women the opportunity to receive emotional support and professional healthcare advice in the process of abortion.

### **Limited Disclosure and Regret Among Women Who Spoke Openly**

Very few respondents did not conceal their abortion. Majority of these women said that they regretted after facing cruel responses by family members and others. This observation is yet another indication of social costs of being open about abortion. The only exception was observed in instances where abortion was done due to medically necessary reasons, where disclosure was received with less stigma.

### **Lack of Availability of harmless Abortion facility**

One of the important findings of this study is the inaccessibility and unacceptability of safe abortion services. Majority of the participants said they were refused abortion care by healthcare providers due to institutional, legal, or religious reasons. This absence of availability of services left women with very limited safe options, making them highly vulnerable.

### **Negative Attitudes of Healthcare Providers**

Healthcare environments were often characterized as stigmatizing environments where women could face judgment, rejection, and cruel treatment. A significant number of the participants stated that medical professionals positioned abortion as evil or a misdeed, which contributed to the fear and made them avoid professional assistance. Even in cases where abortions were later conducted, they were usually done in secrecy and under strict secrecy.

### **Resort to Unsafe Abortion Methods**

Because of constant rejection and fear of receiving bad treatment, most of the women had to use unsafe forms of abortion, such as self-medication and employing the services of untrained midwives. The main reason why these unsafe practices were selected was to avoid social exposure and moral criticism. Some of the participants had severe physical and psychological complications and others reported minor complications as consequence of hazardous abortion, which is a reminder of the endangerment of unsafe pregnancy termination.

### **Role of Social Networks in Accessing Abortion Services**

There were participants who could get comparatively safer abortion services, through personal networks, like friends or family members who had contacts with sympathetic healthcare professionals. Although the networks helped make access possible in some instances, they also highlighted the unequal and informal aspects of abortion care wherein access to safety is frequently based on individual privilege, as opposed to institutional support.

### **Need for Destigmatization and Safe Abortion Services**

On the whole, the results indicate that societal stigma, family pressure, and moralizing healthcare practices are all contributors, which lead women into secrecy and unsafe abortion procedures. Respondents were very vocal on the necessity to create awareness on safe abortion and the risk of unsafe procedures. Provision of safe abortion services which were respectful, non judgmental, and accessible was considered necessary to minimize unsafe abortions and protect the physical and psychological health of females in Pakistan.

### **Discussion**

This discussion interprets the study's two central themes, the staging of abortion as miscarriage and the use of unsafe abortion methods and their consequences, through the lens of Goffman's Dramaturgical Perspective (1959) and Smith's

Standpoint Theory (1989), and in relation to existing literature.

One of the main themes that come out as a result of the findings is an overwhelming social pressure that women face forcing them to hide their abortions most of the time by causing them to look like miscarriages. This was the strategy of most of the participants (10/15) so that the social judgment does not take place and dignity is maintained. Such behavior can be deemed as attributable to the concept proposed by Goffman (1959) of impression management, in which people manage the perception of others to a tactic to avoid stigma and prevent loss of face. The social cultural background of Pakistani society is characterized by patriarchy, moral conservativeness, and honor-related guidelines, which means that the identity of a woman who has miscarriage is not viewed as a problem under any circumstances, but abortion is severely criticized. As a result, women play a morally acceptable role on the frontstage as they suffer emotional, physical and ethical torture on the backstage.

Within the context of this performance in the public, women were reported to experience extreme psychological pain, fear of being discovered, and solitude. The backstage experiences were kept secret to safeguard the social status, which supports the idea of face-work, by Goffman. This tendency is consistent with Cockerill and Nack (2013), who acknowledge concealment as one of the major stigma-management mechanisms, and Purcell (2015), who defines silence as a coping mechanism to sociopolitical restraint. Equally, the study by Hanschmidt et al. (2016) and Sun et al. (2018) shows that abortion stigma within the traditional societies generates guilt, anxiety, and increased psychological load. Taken together, the above results indicate that the reproductive choices and self-representation of women are influenced by the prevailing principles of femininity, morality, and respectability.

In line with Gazdar et al. (2012) and Saleem and Fikree (2001), the study establishes that Pakistani women tend to bargain reproductive decisions in a clandestine manner because of family and

societal pressure, especially, honor. Imran et al. (2022) and Frederico et al. (2018) also add that open communication about abortion and reproductive health is limited by stigma and absence of autonomy, specifically in younger women. However, an original input of this research is an emphasis on active narrative construction, but not on silence. Women concealed abortions but also devised the strategy of re-interpreting them as miscarriages and showed agency in the face of constraint. This brings out a more active kind of resistance than what is generally recognized in the literature on stigma.

Although it provided temporary security, the hiding made emotional loneliness and suffering worse. Women who concealed abortion experienced the internalized guilt as compared to those who did not, like the Participant 7 and 14, who regretted disclosing their abortion because of social rejection. This contradiction between frontstage conformity and backstage suffering has been explained by Goffman as a cause of emotional fatigue. In this vein, Vlassoff et al. (2012) and Sathar et al. (2014) claim that secrecy and unsafe execution leads to worsened mental health, additionally, it causes impaired access to post-abortion care that aggravates trauma.

In the Standpoint Theory, the concealment strategies expressed by women can never be considered as a sign of vulnerability, but rather a logical reaction to the institutionalized oppression. The experiences they have show how stigmatization is internalized and reproduced via social expectations. According to Kumar et al. (2009), stereotypes attached to abortion is a three-fold phenomenon of silence, secrecy, and shame, which is highly evidenced in this study. Nevertheless, the current study is an expansion of the literature because it puts the strategic narrations of women especially the redefining abortion as a miscarriage into a perspective of survival and restricted agency in confining regimes.

According to Sathar et al. (2014) and Hussain (2013), the fear of judgment was one of the reasons why many women did not seek formal healthcare and used unsafe means. The stories of

the participants, especially the story of Participant 8, reveal how the negative experiences with the clinical can drive women to midwives, self-medication, or informal providers. This is accordant to the reports of Fay et al. (2022), Kumar et al. (2009), and Major et al. (2009), who associate stigma and concealment with late care and augmented physical and psychological danger.

In Standpoint Theory, the use of unsafe means by women is indicative of structural inability to appreciate the realities that they experience. The gap between the law and reality of access shows that there is institutional discrimination and ignorance of reproductive rights. Like Gazdar et al. (2012) and Imran et al. (2022), the paper points to the presence of profound distrust between women and healthcare systems. The influence of gender inequality, religious pressure, misinformation and lack of autonomy all determine reproductive decision-making. Policy reform and awareness, as postulated by Sathar and Casterline (1998) is needed to enhance the reproductive autonomy of women.

Significant structural barriers are also impacting. Battistelli et al. (2018) highlight the importance of systemic constraints in reproductive care and provider shortage, and Anderson et al. (2022) demonstrate that the insufficient knowledge of the providers about legal access points to treatment procrastinates treatment. These issues support the previous results of the Guttmacher Institute (2012) according to which legal uncertainty and a prevalent stigma are related to high rates of hazardous abortions in Pakistan. As is consistent with the literature by Sathar et al. (2014) and Hussain (2013), the participants reported not using formal care because of judgmental behaviour and fear of disclosure. Together, the literature highlights the importance of legal clarity, provider training and institutional accountability given that ethical gatekeeping still compels women to use unsafe alternatives. By anticipating the strategic agency of women in a patriarchal system, the paper adds to the current literature because it shows that silence, secrecy, and informal networks are not passively

determined, but are strategic choices in response to systemic exclusion.

On the whole, the results show that unsafe abortion practices in Pakistan are deeply embedded in patriarchal beliefs, control over the family, religious conservatism, and institutional stigmatization. Women hide abortions, make miscarriage stories, or undergo secret abortions in order not to be condemned by families, health care providers, and society. Although such measures provide some short-term safety, they intensify mental health problems and health risks. According to the idea of the relations of ruling, advanced by Smith (1989), women's reproductive life are still subject to control of the male power and the moral control, which leads to forced pregnancies, unsafe abortions, and permanent physical and psychological damage.

### Conclusion

This paper examined the ways in which Pakistani women maneuver abortion in a sociocultural domain characterized by stigma, lack of reproductive agency and institutional constraints. Two themes came out: the prevalence of unsafe abortion practices due to the absence of availability to safe abortion facility, and the tacticalization of abortion as a miscarriage to maintain its social acceptability. Applying the Dramaturgical Perspective by Goffman and the Standpoint Theory by Smith, the results reveal the way in which the reproductive decisions of women are influenced by moral judgment, religious interpretations, and structural obstacles to such decisions within healthcare institutions. As it was previously discussed (Joles, 2021; Imran et al., 2022; Gazdar et al., 2012), numerous participants experienced repeated refusal by medical providers and turned to unregulated or even dangerous options. Meanwhile, the deep-rooted stigma forced women to hide the abortions as miscarriages, the act of impression management that enabled women to maintain their social identity, but cope with emotional and physical implications in the privacy of their homes. Through the stories, it is clear that responses, silence, concealment, alternative telling and reliance of women on unsafe means is

not a failure but a logical approach in the confining social environments. These practices indicate the ways in which gendered power relations restrain reproductive choice, and how women are bargaining these restraints through resistance and self-defence. The research concludes by asserting that unsafe abortions and concealment of narratives are not personal failures of judgments but results of the inequities of the system, normative forces, and organizational oversights.

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