NARRATIVE REVIEW

Advancing reproductive rights in Pakistan: Recommendations for enhancing access to abortion and post-abortion care

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Abstract

The current narrative review was planned to develop evidence and rights-based recommendations for improving access, quality, and integration of safe abortion and post-abortion care services in Pakistan, guided by national evidence, global guidelines, and stakeholder consensus. A comprehensive literature review was conducted to assess trends, inequities, legal and religious frameworks, and health-system barriers related to abortion and post-abortion care in Pakistan. Draft recommendations were formulated based on findings from the 2023 Population Council-Guttmacher Institute national study and international evidence. These recommendations were reviewed and refined through consultations with experts from professional societies, civil society organisations, and health-system stakeholders. A hybrid consensus-building meeting and an online validation exercise were conducted to finalise the recommendations. Key gaps identified included restrictive legal interpretations of 'necessary treatment', provider biases, limited clinical autonomy, inadequate training, poor infrastructure, stigma and insufficient awareness of reproductive rights. Variations in practice further compromised quality of care. The validated recommendations focussed on strengthening legal and policy frameworks, improving awareness of reproductive rights, standardising clinical guidelines, promoting safe uterine evacuation methods, expanding telemedicine and self-care models, integrating post-abortion care and family planning, ensuring supply-chain readiness, and investing in comprehensive pre-service and in-service training.

Implementation of these recommendations grounded in human rights, clinical evidence and stakeholder consensus can strengthen quality, equity and continuity of reproductive health services.

Keywords: Post-abortion care, Reproductive rights, Policy recommendations, Uterine evacuation, Misoprostol, MVA, Telemedicine, Stigma, Health systems.

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Introduction

Pakistan, with a population of 241.5 million and an intercensal growth rate of 2.55%, is the fifth most populous country in the world.[1] Despite this large population, the contraceptive prevalence rate (CPR) has stagnated at 30-35% for over decades, with only 25% of couples using modern contraceptive methods.[2] The unmet need for family planning (FP) remains high at 17%, and the total fertility rate (TFR) stands at 3.6,[2] the highest in South Asia, contributing to significant reproductive health challenges.

The low use of contraception and the high unmet need are major contributors to unintended pregnancies, which often lead to unsafe abortions. Of the estimated 12.7 million pregnancies in 2023, nearly half were unintended. Alarmingly, 64% (3.8 million) of the six million unintended pregnancies ended in induced abortion, a marked increase from 54% in 2012, highlighting the growing reliance on abortion as a response to unintended pregnancies.[3]

According to the Pakistan Maternal Mortality Survey (2019),[4] spontaneous or induced abortion accounted for 10% of maternal deaths, making it the third leading cause of maternal mortality after obstetric haemorrhage and hypertensive disorders during pregnancy, childbirth and puerperium. The prevalence of induced abortion increased from 50 to 66 per 1,000 women of reproductive age between 2012 and 2023. These figures highlight the urgent need to strengthen reproductive health services, particularly FP, to prevent unintended pregnancies and mitigate the health risks associated with unsafe abortion.

Efforts to enhance post-abortion care (PAC) must be guided by a reproductive rights-based framework that ensures women's autonomy and informed choice. However, several barriers hinder the effective delivery of these services. Provider bias, infrastructural deficiencies, excessive workload and limited human resources often compromise privacy and quality of care. Additionally, many providers face restricted clinical autonomy, limiting their ability to offer individualised care. On the client side, low awareness

of reproductive rights continues to impede informed decision-making among women. Addressing these systemic gaps requires a multi-pronged approach.

In recognition of these challenges, the Population Council (PC), in collaboration with the Guttmacher Institute, conducted a national study in 2023[3] whose findings highlighted significant policy and programme-based gaps in PAC and FP. In response, the Association for Mothers and Newborns (AMAN) https://aman.org.pk/ was tasked to develop evidence-based policy recommendations aimed at improving access, quality and integration of safe abortion and post-abortion FP services across Pakistan. The current narrative review was planned to carry out the assigned task by developing evidence and rights-based recommendations guided by national evidence, global guidelines and stakeholder consensus.

Methods and Recommendations

The narrative review was conducted from January to May, 2025 at AMAN office, and comprised an extensive literature search which was conducted to support the formulation of policy recommendations. The draft recommendations were reviewed and endorsed by experts representing professional and civil society organisations, such as the Society of Obstetricians and Gynaecologists of Pakistan (SOGP), the Midwifery Association of Pakistan (MAP), the College of Physicians and Surgeons Pakistan (CPSP), the Pakistan Alliance for PAC (PAPAC), and various civil society organisations (CSOs) across Pakistan.

Key policy and programme areas were identified based on the literature review and situational analysis. A desk review was undertaken to examine existing legal frameworks and identify how the interpretation of 'necessary treatment' could be better aligned with clinical decision-making to ensure women's access to essential services. The review also explored religious perspectives on abortion and FP to inform the development of contextually appropriate recommendations.

A hybrid consensus-building meeting was convened, followed by an online validation process through a structured Google Poll circulated among the stakeholders. Consensus was achieved on all recommendations; two recommendations with initial reservations were resolved following further discussion during the validation exercise.

The following key recommendations along with implementation strategies were proposed to address the gaps and challenges identified:

A. Advocacy and Awareness Creation

1. Strong support should be ensured from the government, National Committee for Maternal and Neonatal Health (NCMNH), professional societies (SOGP, International Representative Committee of Pakistan for Royal College of Obstetricians and Gynaecologists, United Kingdom [IRCP-RCOG], Pakistan Medical Association [PMA], MAP, College of Family Physicians [CFP] etc.), CSOs (AMAN, PC, Ipas, Aahung, Pathfinder, Shirkat Gah etc.), and other stakeholders (PAPAC) for an integrated PAC service delivery model across both public and private health systems. This support should include the development of positive policies, an actionable implementation plan, and the enhancement of healthcare infrastructure, including dedicated spaces for care. There should be a sustained supply of essential equipment and supplies, along with the training of willing providers to offer woman-centred care and establish clear referral systems addressing the health system biases. Collaboration and leadership from professional associations can help motivate healthcare providers, fostering improved knowledge, commitment and coordination between public and private sector providers to ensure high-quality, accessible care.[3,5-8]

   As for implementation, task forces should be established along with champions comprising representatives from each stakeholder group to develop a shared vision for the integrated PAC model. Regular consultations, dialogues, meetings and workshops should maintain engagement, encourage feedback, and ensure the alignment of interests across sectors.

2. Barriers and stigma around abortion should be shattered by creating awareness about existing laws and organisational interventions to address stigmatising values and create positive workplaces.[9,10]

   In terms of implementation, stakeholders such as medical universities, educational institutions of pharmacy, CPSP, PMA, CFP and administrative bodies of health facilities should integrate Values Clarification for Action and Transformation (VCAT) workshops into undergraduate, pre-service, post-graduate and in-service training programmes.

3. Awareness must be raised among the stakeholders about legal ambiguities, such as the unclear definition of 'necessary treatment', and address religious misperceptions on the permissibility of abortions within 120 days of conception to promote informed decision-making and reduce stigma (Table). [3,11-15]

   Regarding implementation, professional bodies (SOGP, MAP, legal organisations) and CSOs (NCMNH, AMAN) should organise targetted awareness campaigns and

Table: Legal recommendations with evidence and the way forward.

No.	Evidence and studies	Recommendations	Advocacy Roadmap
1.	**Existing Legal Framework** Abortion is criminalised under Pakistan's Penal Code unless it is to save the life of the woman or provide "necessary treatment" to a woman before the organs of the foetus have been formed. (PPC Sec. 338). The term "necessary treatment" is not defined in Pakistan Penal Code and has not been clarified through judicial interpretation either. Once the organs have been formed, abortion is permitted only to save the life of the pregnant woman. (Pakistan Penal Code PPC Sec. 338 (B)). There is no federal legislation on abortion in Pakistan. The only provincial legislation on reproductive rights is the Sindh Reproductive Healthcare Rights Act 2019, which contains a reference to post-abortion services. The vague exception to criminalisation of abortion for "necessary treatment" before the organs of the foetus are formed is interpreted inconsistently by health-care providers. According to a 2023 fact-finding study titled "Unsafe and Unjust: The Legal and Social Barriers the Deny Women and Girls their right to safe abortion services in Sindh, Pakistan" conducted by the Center for Reproductive Rights (CRR) and Aahung, health-care providers have divergent understandings of the risks to a woman health that permit abortions. For example, one doctor interviewed during the fact-finding said that even if a pregnant woman is severely hypertensive and suffers from cardiac disease, she would not terminate the pregnancy. Most healthcare-providers stated that poor mental health of the pregnant woman is not a ground to terminate a pregnancy. (Unsafe and Unjust, Center for Reproductive Rights - CRR and Aahung p.17-18)[11] In its 2022 guidelines on abortion, the World Health Organisation (WHO) recommends the "full decriminalisation" of abortion. WHO further recommends that abortion be made available on the request of the woman, girl or other pregnant person. UN human rights mechanisms have called on Pakistan to reforms its legal framework on abortion. In its Concluding Observations to Pakistan in 2017, the Human Rights Committee observed that the "State party should review its legislation to ensure that legal restrictions do not prompt women to resort to unsafe abortions that may endanger their lives and health." The CEDAW Committee, in its Concluding Observations in 2020, recommended that Pakistan "review its abortion legislation with a view to legalising abortion in case of rape, incest, threats to the life or health of the pregnant woman or severe foetal impairment, and decriminalising it in all other cases, and, prepare guidelines to ensure women's and girl's access to safe post-abortion care . . ."	1. Establish an enabling legal framework for access to safe abortion services. a) Increase awareness among healthcare providers of existing legal framework on abortion, including the relevant provisions in the Pakistan Penal Code and where applicable, the Sindh Reproductive Healthcare Rights Act 2019. b) Abortion should be removed from the Pakistan Penal Code and no criminal penalties should be imposed on women seeking abortions and on HCPs who provide safe abortion services with the consent of women. So long as abortion remains criminalised, the threat of criminal sanction will have a chilling effect. It will also perpetuate the stigma against abortion and encourage biases of HCPs that cause them to deny safe abortion services. Law enforcement will also continue to harass women who have received or are suspected to have obtained abortion service. c) The current legal framework should be reformed to ensure that women and girls are able to obtain safe abortion as a right, without any requirement of third-party authorisation, in line with the 2022 WHO guidelines. Currently, the legal framework does not impose a clear legal obligation on HCPs to provide women and girls safe abortion services on request. In Sindh, the Sindh Reproductive Healthcare Rights Act 2019 should be amended to include the right of women to access safe abortion and post-abortion care and impose an obligation on healthcare providers to provide abortion services, including counselling, to women without discrimination consistent with 2022 WHO guidelines. Other provinces should enact legislation that sets forth obligations of HCPs to respect the rights of women in reproductive healthcare settings, including their right to access safe abortion services.	1. Civil Society Organizations (CSOs) should advocate for inclusion of the legal framework on abortion in the medical curriculum for all Health Care Providers (HCPs). 2. CSOs should hold regular trainings and consultations with HCPs to raise awareness about the law. 3. CSOs, through umbrella organisations such as the Pakistan Alliance on Post Abortion Care (PAPAC), should hold meetings and consultations with legislators to raise awareness about gaps in the current legal framework. They should identify key legislators who can introduce legislation or legal amendments that protect and promote the right of women to safe abortion services.
2.	Focus-group discussions with health-care providers show that healthcare practitioners' decision to provide abortion services is often influenced by factors beyond considerations of women's health and well-being. The Penal Code provision that permits abortion in certain circumstances is not a relevant in decision-making by health-care providers. Instead, their decision- making process is influenced by personal apprehensions about potential consequences, moral perspectives on abortion, and religious and cultural beliefs. For instance, doctors who perceive abortion to be morally wrong are more likely to refuse patients these services, regardless of legal provisions. Cultural perspectives on gender roles, family values, and the sanctity of life also shape a healthcare practitioner's understanding of when they may provide or deny abortions. (Unsafe and Unjust, CRR and Aahung, p. 15-16)[11] Health-care providers often discourage women from seeking an abortion at the very least, while in other instances pregnant women are insulted and verbally abused by doctors. In focus group	Educate and train HCPs to respect women and girls seeking abortion services and to provide quality abortion care, including adequate counselling. Judgmental and harsh attitudes of HCPs deter women from seeking safe abortion services from qualified professionals. The medical curriculum of doctors and other HCPs should clarify that the duty of care toward all patients includes provision of safe abortion services and proper counselling. Medical education should also emphasise that where HCPs have a conscientious objection to abortion, they must refer women to trained abortion service providers. Increase awareness among healthcare providers about the rights of all persons, including women, to bodily autonomy, privacy and informed consent with respect to any medical treatment. These rights emanate from fundamental rights guaranteed in Pakistan's Constitution as well as Pakistan's obligations under international human rights treaties. HCPs should be made aware of the right	CSOs should continue to hold trainings with HCPs on their duty of care towards women seeking abortion services. Provincial healthcare commissions should also be sensitised regarding HCPs' obligations towards women seeking abortion. These trainings should specifically cover fundamental rights guaranteed to all persons under Pakistan's Constitution.

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2.	Focus-group discussions with health-care providers show that healthcare practitioners' decision to provide abortion services is often influenced by factors beyond considerations of women's health and well-being. The Penal Code provision that permits abortion in certain circumstances is not a relevant in decision-making by health-care providers. Instead, their decision- making process is influenced by personal apprehensions about potential consequences, moral perspectives on abortion, and religious and cultural beliefs. For instance, doctors who perceive abortion to be morally wrong are more likely to refuse patients these services, regardless of legal provisions. Cultural perspectives on gender roles, family values, and the sanctity of life also shape a healthcare practitioner's understanding of when they may provide or deny abortions. (Unsafe and Unjust, CRR and Aahung, p. 15-16)[11] Health-care providers often discourage women from seeking an abortion at the very least, while in other instances pregnant women are insulted and verbally abused by doctors. In focus group discussions held with 30 women across Sindh, women reported instances of healthcare providers abusing women who sought abortions. Women also reported being told to wait for weeks before seeing the doctor again, at which point they are informed that it is too late to provide an abortion. The focus group discussions reveal that women are resorting to unsafe methods to avoid such interactions with skilled providers and in formal health facilities, because they are aware that they will likely be refused. Women also report receiving arbitrary information on abortion from their providers. (Unsafe and Unjust, CRR and Aahung, p. 25, 34.)[11] HCPs religious and cultural biases have also been extensively addressed through tools such as Value Clarification and Attitude Transformation (VCAT) training conducted by Non-Governmental Organizations (NGOs) and healthcare experts in Pakistan. Six of the total doctors interviewed for the CRR and Aahung fact-finding study on abortion in Sindh had undergone such training via NGOs, but only one doctor admitted that she provides induced abortion services for all unwanted pregnancies. (Unsafe and Unjust, CRR and Aahung, p. 35).[11] HCPs attitudes show that they are unaware of women's fundamental rights to dignity and autonomy. These rights are protected under Pakistan's Constitution and international human rights treaty obligations. These rights require that no medical treatment be provided to women in the absence of their informed consent. HCP's obligation to obtain informed consent of patients is also set forth in Pakistan Medical and Dental Council Code of Ethics. The fact that HCPs often preach their personal cultural and religious beliefs in the reproductive health setting and often fail to provide women proper guidance on medical options for abortion shows a lack of awareness and understanding of fundamental rights.	of all patients to informed consent as set forth in the Pakistan Medical and Dental Council Code of Ethics.	
3.	While the national and provincial guidelines recognise the right to safe abortion services, they are not enforced, and HCPs are not aware of them. Five doctors interviewed during the CRR and Aahung fact-finding study mentioned that they refer to WHO and International Federation of Gynecology and Obstetrics (FIGO) guidelines for management of abortion cases through misoprostol and MVA, but doctors were not aware about specific uterine evacuation guidelines provided by the federal or provincial government. (Unsafe and Unjust, CRR and Aahung, p. 33). [11] The HCPs continue to use dilation and curettage (D&C), and not all of them are aware that it is an unsafe method and that Manual	Implement guidelines for safe abortion services. All provincial health departments as well as the federal Ministry of National Health Services Regulation should update its guidelines on provision of safe abortion services and bring them in line with 2022 WHO guidelines. The guidelines should be disseminated among the healthcare community as well as the general public. Health departments should monitor the implementation of the guidelines, and ensure that HCPs discontinue use of outdated and dangerous methods of abortion, such as dilation and curettage. Particular emphasis should be placed on the quality of services provided in public health facilities, as women with limited means tend to approach these facilities for healthcare.	National and provincial guidelines should be disseminated widely in all public and private health facilities, and among healthcare commissions. The guidelines should be incorporated in medical curricula.

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3.	Vacuum Aspiration (MVA) is a better option. Some use both methods, while some others have shifted to MVA. HCPs say that since they are more experienced with D&C than with MVA, it is actually safer for the patient if they use this method. This reveals the continued lack of sufficient training on MVA, because HCPs point out that they end up practising the older method from their superiors during medical training. (Unsafe and Unjust, CRR and Aahung p. 33).[11]		
4.	The uptake in medical abortions using misoprostol has created room for self-care for abortion. As part of the self-care model, women are provided information on how to self-administer an abortion using misoprostol. WHO's guidelines on self-managed abortions state that they can be safely performed during the first trimester. Women assess their eligibility for a self-managed abortion, self-administer abortion medicine(s) without direct supervision from a provider, and self-assess the success of the abortion. Women, however, report that healthcare providers to not advise the about use of medication for abortion. Healthcare providers also report that pharmacists provide misoprostrol to women over the counter while misguiding them about proper use and dosage. (Unsafe and Unjust, CRR and Aahung p. 34).[11]	Enforce legal obligations on healthcare providers to provide proper guidance on how to administer medical abortions. HCPs should be required to provide clear and accurate guidance to women on how to administer medical abortions. All provinces should develop and enforce regulations that set forth obligations of HCPs to enable women to administer self-managed abortions consistent with 2022 WHO guidelines. Rules may be made under the Sindh Reproductive Healthcare Rights Act 2019 to obligate healthcare providers and healthcare facilities to provide prescriptions to misoprostol and proper guidance on how to administer the drug in accordance with 2022 WHO guidelines.	CSOs should work with provincial and federal health departments to develop clear policies on medical abortions in line with legal requirements. These policies should require HCPs to provide proper guidance to women on how to administer medical abortions in line with the latest WHO guidelines. Rules should be framed under the Sindh Reproductive Healthcare Rights Act 2019 to set forth clear obligations on HCPs to prescribe and provide guidance on medical abortions. Other provinces should also pass legislation that includes similar obligations on HCPs.

workshops for key stakeholders, such as healthcare providers (HCPs), focusing on clarifying legal ambiguities and addressing religious misconceptions about abortion. Accessible educational materials must be developed to highlight the legal framework around abortion and religious perspectives, while fostering open dialogue to reduce stigma and promote informed decision-making.

4. Reproductive rights-based services must be delivered by addressing barriers, such as provider bias, high workload, limited autonomy and lower awareness of reproductive rights among women and HCPs. This will ensure respectful, informed and equitable care.[7,16]

   The Pakistan Medical and Dental Council (PMDC), Pakistan Nursing Council (PNC), CPSP, SOGP, MAP etc. should integrate awareness of Pakistan's international human rights obligations, including Sexual and Reproductive Health Rights (SRHR), as ratified by the Human Rights Commission and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), into HCPs' training programmes at undergraduate, pre-service, post-graduate and in-service levels. Additionally, the Ministry of Women Development, national and provincial commissions on the status of women and community-based organisations (CBOs), such as Aurat Foundation, Shirkat Gah etc., should launch targetted awareness campaigns to educate women about their reproductive rights, ensuring both HCPs and the public are informed and empowered.

5. Any conscientious objection to treating a woman should be secondary to the primary duty of HCPs to treat, provide benefit, and prevent harm to patients. Essential services, including abortion care, must never be denied. A human rights framework should guide the balance between conscientious objection and the obligation to provide care, ensuring appropriate referrals are made in a timely manner. Conscientious objection must never be invoked in emergency situations. Health systems must strictly regulate conscientious objection and hold HCPs accountable for any misuse, ensuring that woman's rights to safe and timely care are upheld.[17,18]

   In this regard, information about the International Federation of Gynaecology and Obstetrics (FIGO) statement on conscientious objection should be widely disseminated in seminars, conferences, etc. to all HCPs through their professional networks.

6. Awareness among policy-makers, HCPs, distributors and users must be raised about the need to purchase Misoprostol only if packaged in double-aluminium blister packs to ensure drug potency and effectiveness. Proper storage is critical, and Misoprostol must be kept in a dry place at room temperature conditions (25°C and 60% humidity) to maintain its stability and therapeutic quality.[19-22]

The government and professional associations (SOGP, PMA and MAP) should issue communiqués to relevant stakeholders, including HCPs and administrators, regarding proper packaging and storage guidelines for Misoprostol.

7. The existing National Abortion Care Guidelines must be reviewed and disseminated to standardise practices and ensure the provision of safe, accessible and high-quality abortion services. These guidelines should be based on evidence-based practices, incorporating the recommendations of the World Health Organisation (WHO) and addressing the full spectrum of abortion care, from counselling to post-abortion support. The guidelines should also consider local legal, cultural and healthcare system contexts, ensuring that they are adaptable, widely applicable, and promote the protection of women's rights and health.[23,24]

   In terms of implementation, the NCMNH and AMAN, in collaboration with PAPAC and professional associations (SOGP, PMA and MAP) should lead the review and dissemination of the National Abortion Guidelines.

8. A data-driven approach for PAC was recommended to enhance service quality, accessibility and accountability. Standardised data collection, integration into digital health systems, and routine data reviews will enable evidence-based decision-making. Capacity-building in data use and leveraging insights for policy advocacy can improve client outcomes and reduce maternal morbidity.

   HCPs should start entering and analysing PAC indicators in the existing Health Management Information Systems (HMIS) and the District Health Information Systems (DHISs). Routine (monthly/ quarterly) data review meetings should be held at facility and district levels to analyse trends, identify service delivery gaps, and develop targetted action plans. Feedback loops should be formalised to ensure frontline HCPs receive performance insights and support. Data-driven evidence should inform policy dialogues and public health campaigns.

B. Re-design Service Delivery Models for Reproductive Health (RH)

9. Woman-centred care should be provided with a focus on ensuring privacy, reducing waiting times, and promoting quality communication between providers and women. Leveraging digital tools can significantly enhance the efficiency and delivery of reproductive health services, aligning with the principles of woman-centred care. [25,26]

   This recommendation can be implemented by enhancing existing service models at selected health facilities to establish a woman-centred care approach by incorporating a combination of in-person services, telemedicine and self-care options into routine practice. This model should be designed for scalability and replication across other facilities. This can be achieved by joint efforts of the government, management of health facilities (public and private) and provincial healthcare commissions.

10. Health services, including reproductive health, should be equitable and comprehensive, addressing the diverse needs of all communities, including disadvantaged and marginalised populations, regardless of age, socioeconomic status, race, ethnicity, gender, disabilities or geographical location. Well-trained HCPs who understand and respect cultural differences should be deployed at health facilities, offering services in multiple languages. Representation of diverse communities in healthcare staff must be ensured to further strengthen inclusivity and responsiveness to patients' needs. Expanding healthcare coverage (e.g., through universal health systems or insurance programmes) and removing financial barriers will improve equitable access to in-facility services. Leveraging telemedicine and digital health tools to reach remote or underserved populations results in significant cost savings. Finally, abortion laws must be supported by civil society and government leaders to ensure that associated policies are well-crafted and monitored to ensure successful implementation.[3,27-34]

    The government and CSOs should strengthen service coverage through universal health programmes and financial support mechanisms, like voucher schemes, to improve accessibility. Healthcare facilities must be expanded across rural areas and telemedicine and multilingual services must be integrated to ensure greater inclusivity.

11. Manual vacuum aspiration (MVA), Misoprostol and contraceptives, including emergency contraceptive pills, should be included in the federal and provincial Essential Equipment Lists (EELs) and Essential Medicine Lists (EMLs) to ensure their availability and accessibility. Additionally, efforts should be made to strengthen a sustainable, cost-effective supply chain for MVA equipment and medications. Online delivery of medications, particularly for remote areas, should be promoted by linking telemedicine systems with pharmacies.[3,23,35-39]

For this to happen, health facilities managements should educate HCPs on the significance of EEL and EML, ensuring department heads oversee procurement and availability. A cost-effective supply chain must be ensured and online medication delivery, especially in remote areas, must be facilitated by integrating telemedicine with pharmacy chains.

12. A self-care or home-based model for self-managed abortion must be introduced as an intervention to improve women's health, reducing reliance on unsafe procedures, preventing maternal mortality, staying within the legal boundaries while allowing women to manage the process at a time and place that suits them. Supportive health professionals and community workers can help bridge the gap with the medical system, while information, education and communication (IEC) materials, telemedicine, websites and other digital platforms can facilitate and support self-care. This approach increases accessibility, reduces costs, minimises pain and lowers the demand for specialised personnel or equipment, particularly for women in rural and underserved populations. Evidence shows that self-care models do not compromise safety, adherence or satisfaction.[3,22,31,40-43]

    User-friendly self-care models must be developed on platforms, like 'Bakhabar Noujawan' and social media outlets, linking them to telemedicine helplines. NCMNH and AMAN shall demonstrate these models for replication. Additionally, downloadable IEC materials, as currently being developed by PAPAC, shall be provided to community health workers, such as lady health workers (LHWs), 'Marvi/Noor' workers (HANDS Welfare Foundation - Former – Health And Nutrition Development Society) and Sitara bajis (Greenstar Social Marketing), to enhance community awareness.

13. Timely referrals for comprehensive abortion care must be strengthened through effective communication, digital tools and networking, thereby establishing a clear referral system across medical specialties and different levels of care. Access must be enhanced to supplies, particularly at lower-level facilities where most patients first seek care. The capacity of community health workers has to be built to create awareness about referral systems, including available digital tools, and thereby strengthen referral and follow-up activities.[3,32,44-47]

    To implement this recommendation, efficient referral pathways must be established and networking through local chapters of SOGP, MAP and other organisations, such as Greenstar Social Marketing, Rahnuma FPAP (Family Planning Association of Pakistan), Marie Stopes Society etc., must be strengthened by utilising digital platforms, like WhatsApp and helplines, for timely referrals.

C. Capacity Building Trainings, Pre-Service and In-Service

14. Reproductive rights-based FP and abortion services must be integrated into pre-service education curriculum for all cadres of HCPs. This should encompass comprehensive classroom teaching, practical training, and examinations to ensure that future HCPs are well-equipped to deliver these essential services effectively and with sensitivity.[16,18,48]

    For this to happen, PMDC and PNC must revise pre-service education curriculum for all HCP cadres, ensuring integration at both undergraduate and postgraduate levels.

15. Robust continuous professional development (CPD) programmes and supportive strategies should be established and evaluated by regulatory bodies for residency programmes and in-service education, with the goal of enhancing skills of HCPs to provide WHO-recommended PAC services.[37,49,50]

    As part of the implementation strategy, medical, nursing and midwifery institutions should provide HCPs with training on the National Service Delivery Standards and Guidelines for Safe Uterine Evacuation/PAC (2018) under the Ministry of National Health Services and the Post-Abortion Family Planning Policy (2020) by the Government of Sindh, integrating them into CPD programmes.

16. Capacity-building trainings for HCP must be used either in-person or through online digital platforms. These trainings should be complemented by continuous mentorship, handholding and supportive supervision, utilising digital tools, such as WhatsApp, to ensure sustained skill development and effective service delivery.[51,52]

    This should be done by integrating training into Costed Implementation Plans and conducting sessions either in person or through online learning management systems, facilitated by the Population Welfare Department (PWD), Health Department and other reputable organisations, such as NCMNH, AMAN, Greenstar Social Marketing, Ipas etc.

17. Trainings should focus on correct dosages, administration routes, potential side-effects, and self-assessment guidance for women. Additionally, it should

emphasise a woman-centred approach to care, comprehensive counselling, pain relief options, and VCAT. The providers should be well-versed in existing laws, their interpretation, such as 'abortion is legal but restrictive in Pakistan' and religious scholars' perspectives on the permissibility of abortion within 120 days of conception. Post-abortion family planning (PAFP), including emergency contraceptives, should also be integrated into care. Strengthening linkages between providers and distributors for the procurement of MVA, Misoprostol and FP commodities is critical. Effective networking and communication among stakeholders remain essential to achieving better outcomes and ensuring the provision of safe, accessible care.[3,35,53-55]

As part of the implementation strategy, organisations, such as NCMNH, AMAN, Ipas etc., should collaborate with professional bodies, like SOGP and MAP, to develop standardised training programmes for in-person trainings, and also host them on learning management systems. Moreover, linkages should be created among government, distributors and HCPs.

18. VCAT must be integrated into regular training programmes to address HCPs' biases and institutional barriers. VCAT encourages reflection on personal views, beliefs and values in relation to professional obligations, fostering attitude and behaviour change to ensure dignified, non-judgmental and respectful PAC. Additionally, mechanisms for screening and retraining HCPs with judgemental attitudes should be established to support the delivery of quality, stigma-free services.[15,16,48,56,59]

    For those to happen, VCAT must be integrated into medical university curricula through academic councils, leveraging the expertise of organisations, such as Ipas, AMAN, Aahung and Rahnuma FPAP etc.

19. Comprehensive, compassionate, non-judgemental and respectful counselling for individuals seeking abortion care must be enabled, ensuring they are informed about their choices regarding abortion methods and contraceptives in a safe and supportive environment. Community engagement initiatives, involving men, women and families, should be prioritised to address abortion stigma, improve perceptions of health facilities, and counter misinformation about the quality and cost of care.[3,57]

    For this, HCPs must be trained on standardised counselling protocols through in-person sessions or an online learning management system, facilitated by SOGP, MAP, PMA, NCMNH, or AMAN. Community awareness sessions must be conducted by LHWs and male mobilisers using culturally appropriate educational materials to promote informed choices and reduce stigma.

20. The use of WHO-recommended uterine evacuation technologies must be promoted, such as vacuum aspiration (VA) and medication regimens. MVA is a highly effective option for managing first-trimester pregnancy losses, offering advantages, such as minimal complications, reduced procedure time, lower blood-loss, and decreased pain. MVA can be performed in outpatient settings by a range of healthcare workers without the need for general anaesthesia, making it a cost-effective alternative to sharp curettage for both health systems and individuals. Additionally, the safety and tolerability of medical regimens for uterine evacuation are well-supported by evidence.[3,60-62]

    In this regard, the PMDC, PNC and CPSP must integrate information about WHO-recommended uterine evacuation technologies into pre-service and in-service training for all HCP cadres.

21. Dilation and Curettage (D&C) must be replaced with aspiration techniques or medication regimens for uterine evacuation. MVA and medication regimens significantly reduce the risk of complications, such as uterine perforation, bleeding, cervical injury, Asherman's syndrome (intrauterine adhesions), and procedural pain compared to D&C. In settings where uterine evacuation services are unavailable, the introduction of VA and medication regimens should be prioritised as safer and more effective alternatives.[3,22,63]

    The PMDC, PNC and CPSP should issue directives to eliminate the use of D&C by training HCPs on WHO-endorsed methods, including MVA and medications, through structured education programmes.

22. PAFP is a high-impact intervention and should be an integral component of PAC to prevent short inter-pregnancy intervals and unintended pregnancies. A comprehensive range of contraceptive methods, including long-acting reversible contraceptives (LARCs), should be offered to meet the diverse needs of women.[3,38]

    As part of the implementation strategy, academic institutions should develop a replicable model to educate and train medical, nursing, midwifery and pharmacy students, as well as all HCPs, on integrating PAFP into PAC.

23. Telemedicine models should be expanded to enhance access to high-quality, self-managed, person-centred abortion care, particularly in legally restrictive contexts. Telemedicine is a safe, effective and viable alternative for uterine evacuation, offering high satisfaction and good clinical outcomes similar to standard care in-clinic settings. This cost-saving intervention improves health, reduces abortion complications, and enhances the quality of life, especially for vulnerable groups, such as adolescents, undocumented immigrants, and those in remote areas. Telemedicine has proven to be effective during emergencies, like the coronavirus disease-2019 (COVID-19) pandemic, and should be scaled where feasible. Leveraging existing platforms, such as Meri Sehat, Ola Doc, Sehat Kahani and Bakhabar Noujawan, presents a valuable opportunity.[26,31,39,64-69]

    Professional associations (SOGP) and CSOs (NCMNH, AMAN) need to collaborate with existing telemedicine platforms and train their HCPs. This can later be expanded to other telemedicine networks.

24. Decentralisation of PAC services is needed. This can be done by expanding the pool of caregivers, including general physicians (men and women), pharmacists, complementary medicine professionals, lay community workers (including men), and dedicated FP counsellors at busy health facilities. This can be a feasible and effective strategy. Barriers such as personal, religious and political beliefs, lack of knowledge about available medicines and their proper dosage, and inadequate space and systems to support caregivers, should be proactively addressed. PAC services should be strengthened across all levels of the health system (public and private), with particular focus on lower-level facilities where most patients initially seek care. Integrating telemedicine services into primary care settings will improve patient access and autonomy, benefiting individuals of reproductive age.[3,47,50,70-75]

    This strategy can be implemented by strengthening PAC and PAFP training and services at the primary healthcare level across public and private sectors. Pharmacists and their networks must be engaged for relevant training and service delivery. Professional associations and CSOs should advocate with the government to create vacancies and hire FP counsellors in busy public-sector healthcare facilities.

25. Task-sharing by midwives, from pre-abortion counselling to PAC, is a feasible strategy that expands access to services and results in clinical outcomes comparable to those provided by physicians. To enable midwives to fulfil this critical role as primary caregivers, a supportive work environment and opportunities for CPD and resources are essential. Legal, political, organisational and financial barriers, as well as challenges related to material supply and human resources, must be addressed to empower midwives to deliver comprehensive care. Investing in the training and deployment of more midwives will not only strengthen healthcare systems, but also address abortion as a critical issue of social inequity, ensuring equitable access to safe and compassionate care for all.[3,76-78]

In terms of implementation strategy, midwives must be trained and empowered through advocacy efforts by professional organisations, such as SOGP and PMA, developmental partners, NCMNH, and supported by the government to make the doctors realise the importance of task-sharing.

Conclusion

Improving access to safe abortion and PAC in Pakistan requires integrated reforms addressing legal ambiguities, provider attitudes, service-delivery limitations, and data gaps. Implementation of these recommendations, grounded in human rights, clinical evidence and stakeholder consensus, can strengthen quality, equity and continuity of reproductive health services, and reduce preventable maternal morbidity and mortality.

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